

MEDICARE CARE MANAGEMENT PERFORMANCE DEMONSTRATION APPLICATION TO PARTICIPATE

The goal of the Medicare Care Management Performance demonstration, mandated in section 649 of the Medicare Prescription Drug Modernization Act, is to establish a 3-year pay-for-performance demonstration project with small and medium sized physician practices to promote the adoption and use of health information technology to improve the quality of patient care for chronically ill Medicare patients. Doctors who meet or exceed performance standards established by CMS patient outcomes will receive incentive payments for managing the care of eligible Medicare beneficiaries. Physician practices enrolled in DOQ-IT in Arkansas, California, Massachusetts and Utah are eligible to enroll.

Each practice applying to participate must have a “lead physician or designated staff” authorized to speak for the group and provide requested information. All physicians who are members of the practice and who wish to participate in the demonstration must sign the enclosed data sharing consent form agreeing to share data submitted to the QIO or CMS with CMS and /or its contractors assisting in the implementation or evaluation of the demonstration

Those who wish to participate should fill out this form completely. Completing this form does not guarantee participation in the demonstration pilot. CMS reserves the right to limit the number of practices that may participate. Operation of this pilot is contingent upon approval by the Office of Management and Budget.

Physician Office Information

For QIO use only
DOQ-IT Practice

Name of Practice _____

1. How many physicians are part of this practice? _____
Of these how many primarily provide primary care (*general practice, family practice, gerontology, internal medicine*)? _____

2. Briefly describe your practice in terms of how it is organized, locations, services offered, affiliation with larger networks etc. _____

3. Address of primary practice location

Street Address			Office Number
City	State	Zip	Country

4. List all other locations that are part of this practice and participating in the demonstration

Location #2 Name of Practice at this location	Office Number
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Street Address			
City	State	Zip	Country

Location #3 Name of Practice at this location	Office Number
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Street Address			Office Number
City	State	Zip	Country

Check here if additional locations. Attach information on additional pages

5. Lead Physician/ Authorized Contact Person

Name of Lead Physician/ Authorized Contact Person

Street Mailing Address *(if different from primary practice location)*

City	State	Zip	Country
Telephone	E-mail		

6. Administrative Contact

Administrative Contact *(if different than Lead Physician)*

Street Mailing Address *(if different from primary practice location)*

City	State	Zip	Country
Telephone	E-mail		

7. Estimated number of Medicare Fee For Service patients that rely on your practice for primary source of care _____

8. Of these Medicare patients approximately how many have the following conditions

Coronary Artery Disease	Congestive Heart Failure	Diabetes Mellitus
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9. Tax ID number

Tax ID number this practice uses to bill Medicare

10. All incentive payments associated with the demonstration will be made to the entity represented by the above Tax ID number unless otherwise specified below.

Name of alternative business entity to which payments should be made

Street Mailing Address <i>(if different from primary practice location)</i>			Tax Identification Number
City	State	Zip	Country

CONSENT TO SHARE DATA

As an applicant to the Medicare Care Management Performance Demonstration project I agree to comply with the requirements of this demonstration including sharing all data submitted to the Quality Improvement Organization or CMS with CMS and/or its contractors assisting in the implementation or evaluation of the demonstration.

This consent is subject to any restrictions imposed by any applicable law if gathered or viewed by a QIO operating under its contract with CMS under Part B of the title XI of the Social Security Act, CMS, or the contractor engaged by CMS under §649(d) of the MMA to perform administrative tasks for the demonstration project as described in that provision.

Provider Name *(print)*

Provider Signature

Medicare Provider Identification Number	Date
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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number for this information collection is 0938-0965. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.
