Medicare Care Management Performance Demonstration

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Medicare Modernization Act:
SEC. 649. Medicare Care Management Performance Demonstration (MCMP)

…The Secretary shall establish a pay-for-performance demonstration program with physicians to meet the needs of eligible beneficiaries through the adoption and use of health information technology and evidence-based outcomes measures…

GOALS:

- Improve quality and coordination of care for chronically ill Medicare FFS beneficiaries
- Promote adoption and use of information technology by small-medium sized physician practices

Overview

- Practice Eligibility
- Beneficiary Assignment
- Clinical Quality Measures
- Payment
    - Pay for Reporting
    - Pay for Performance
    - Incentive for Electronic Reporting
- Independent Evaluation
- Timeline

Practice Eligibility

- 4 demonstration states
  - Arkansas, California, Massachusetts & Utah
- Participation in DOQ-IT program
- Small – Medium sized practices
  - <= 10 physicians (approx.)
- Focus on physicians providing primary care and/or care to patients with targeted conditions
- Minimum number of assigned FFS Medicare beneficiaries = 50

Beneficiary Assignment

- Beneficiary assigned to practice with greatest # primary care visits
- Algorithm uses retrospective (reporting period) Medicare claims data
- Beneficiaries assigned at the practice level (vs. individual physician)
- Beneficiaries assignment not ‘fixed’
  - Assignment can vary each year based on where patient received most care during reporting period.

Beneficiary Eligibility

- Beneficiary must have had traditional Medicare Fee for Service coverage (A & B) for >= 6 months in the reporting year
  - Beneficiaries do NOT need to enroll
  - Beneficiaries remain free to see any Medicare provider
- Medicare must be primary insurer
- Not in hospice

Beneficiary Eligibility

- All assigned beneficiaries categorized based on diagnoses on claims:
  - Misc. chronic conditions*
  - Specific Chronic Condition
    - CHF
    - CAD
    - Diabetes

* *Includes CHF, CAD, Other chronic cardiac or circulatory diseases, Diabetes, Alzheimer's and other mental health conditions, Kidney Disease, COPD and other chronic lung diseases, Cancer, Osteoporosis, and Arthritis*

Beneficiary Eligibility

- Categories not mutually exclusive.
  - Beneficiaries counted in each category for which they are eligible.

- Assignment process re-determined for each reporting year
  - Assignment in each year independent of previous/ future years

Incentive Payment

Three components:

- One-time, Initial "Pay for Reporting" of baseline data
  - Payment not contingent upon performance scores

- Annual “Pay for Performance”
  - Payment for achieving quality benchmarks during demonstration year

- Annual EHR / Electronic Reporting Incentive
  - Bonus for reporting quality measures electronically from a CCHIT certified EHR

Clinical Quality Measures

- 26 measures
  - Diabetes – 8 measures
  - Congestive Heart Failure – 7 measures
  - Coronary Artery Disease – 6 measures
  - Preventive Services – 5 measures

- Goal- Consistency of measure specifications with NQF, DOQ-IT and other Medicare quality measures

Clinical Quality Measures
Clinical Quality Data Collection

- Claims based measures will be automatically calculated.
  - Practices will have ability to supplement with information from chart (e.g. ‘denominator’ exclusions)

- Chart based measures may be reported manually from paper chart or electronically from EHR
  - CMS will identify eligible patients
  - Practices may exclude patients for medical or other applicable reasons
  - Practices to submit data on all eligible patients unless number is large enough for valid sampling

Clinical Quality Data Collection

- CMS to provide electronic reporting tool
  - Tool “pre-populated” with demographic and/or clinical information from claims on beneficiaries eligible for measure.

- CMS contractor will identify patients to report on.
  - Must be “assigned” to practice
  - Meet diagnostic/demographic specifications
  - 100% eligible patient reporting (in most cases)
  - For larger practices and/or measures affecting larger #s of patients, random sampling will be used
  - CMS contractor will identify sample for practices

- QIOs available for technical assistance to practices

Initial Incentive:
Pay for Reporting (P4R)

- Payment contingent upon reporting clinical measures for eligible beneficiaries during baseline year (2006)
  - Opportunity for practices to use reporting tools / learn data collection & scoring methodology in risk free setting (scores will not affect initial incentive payment.)

- Per beneficiary per condition payment
  - Up to $1000/physician; $5000/practice
    - Measures may be submitted electronically but initial incentive (P4R) not eligible for 25% electronic reporting bonus
    - Data submission time frame: Aug-Sept ’07

Annual Incentive:
Pay for Performance (P4P)

- Performance on clinical measures determines payment
- Bonus for electronic reporting
- Three annual performance years
  - July – June

Pay for Performance (P4P): Scoring

- 0-5 points given for performance on each measure depending upon score
- Points within each category (DM, CHF, CAD, PC) summed
- Composite % calculated based on total possible points in each category
- Separate payment for each category (DM, CHF, CAD, PS) based on number of beneficiaries with condition or, for preventive care, any chronic condition

Pay for Performance (P4P): Clinical Performance Incentive

- Maximum payment *each year* for clinical performance incentive (3 year demonstration)
    - Up to $10,000 per physician / year
    - Up to $50,000 per practice / year

Incentive for Electronic Reporting

- Demonstration goal to encourage implementation and adoption of HIT.
- Measures must be reported from a CCHIT certified EHR
  - Up to 25% bonus over clinical performance incentive (% determined by # measures reported electronically)
  - No bonus if clinical measure scores too low
- Baseline data may be submitted electronically but not eligible for additional bonus
- Specifications public to encourage vendors to enhance EHR functionality to support reporting

Summary:
Total Potential Payments

- Initial “Pay for Reporting” Incentive:
  - Up to $1,000/physician; $5,000/practice

- Annual “Pay for Performance” Incentive:
  - Up to $10,000/physician; $50,000/practice *per year*

- Annual Bonus for Electronic Reporting:
  - Up to 25% of clinical “pay for performance” payment tied to # measures reported electronically
  - Up to $2,500 per physician; $12,500/practice *per year*

Maximum potential payment over 3 years:
$38,500 per physician; $192,500/practice

Evaluation

- Report to Congress due 12 months after demonstration
- CMS & AHRQ jointly funded contract with Mathematica Policy Research, Inc. (MPR)
- Evaluation design:
  - Non randomized, matched comparison group
  - DOQ-IT practices in non demonstration states
  - Use of Medicare claims data, patient & physician surveys, DOQ-IT office systems survey

Time Frame

- Late 2006 / Jan. 2007
  - Applications mailed to DOQ-IT practices

- April 15, 2007
  - Last date to submit applications

  APPLICATIONS SHOULD BE SUBMITTED EARLY TO GET FULL CONSIDERATION

- May / June 2007
  - Kick off meetings in demonstration states
  - Follow up conference calls for additional Q & A

Time Frame

- July 1, 2007
  - Demonstration begins
- July – Sept. 2007
  - Data collection for baseline reporting year (2006)
  - QIOs provide T & A to practices / serve as primary contact point
- Winter 2007/2008
  - Payment for baseline reporting to practices

Time Frame

- Three year demonstration period
  - Year 1: July 2007 – June 2008
  - Year 2: July 2008 – June 2009
  - Year 3: July 2009 – June 2010

- Clinical Data Collection
  - Year 1: Fall 2008 /Winter 2009
  - Year 2: Fall 2009 /Winter 2010
  - Year 1: Fall 2010 /Winter 2011

Questions

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Demonstration website:
http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?filterType=dual,%20keyword&filterValue=performance&filterByDID=0&sortByDID=3&sortOrder=descending&itemID=CMS1198950&intNumPerPage=10

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