Medicare Care Management Performance Demonstration

Kick-off Meeting
Spring 2007

Physician Office
Pay for Performance

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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2. Introductions of CMS team including all contractors	CMS
3. Detailed overview of demonstration design	CMS
4. Clinical quality measures a. Beneficiary assignment (ARC) b. Review quality measure categories and definitions c. Options for data collection & reporting i. Medicare claims data ii. Manual medical records abstraction iii. Electronic medical records reporting d. Audit process e. Training plans & schedule	Actuarial Research Corporation (ARC) & RTI International (RTI) & Iowa Foundation for Medical Care (IFMC)
5. Overview of evaluation design	Mathematica Policy Research (MPR)
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Medicare Care Management Performance Demonstration
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May 17, 2007
10:00 a.m. to 3:30 p.m.
(Hilton Salt Lake City Center)

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2. Introductions of CMS team including all contractors	CMS
3. Detailed overview of demonstration design	CMS
4. Clinical quality measures a. Beneficiary assignment (ARC) b. Review quality measure categories and definitions c. Options for data collection & reporting i. Medicare claims data ii. Manual medical records abstraction iii. Electronic medical records reporting d. Audit process e. Training plans & schedule	Actuarial Research Corporation (ARC) & RTI International (RTI) & Iowa Foundation for Medical Care (IFMC)
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Medicare Care Management Performance Demonstration
California (Los Angeles) Kick-off Meeting
May 22, 2007
10:00 a.m. to 3:30 p.m.
(Four Points Sheraton – Los Angeles International Airport)

Event	Speaker(s)
1. Keynote & welcome	Centers for Medicare and Medicaid Services (CMS)
2. Introductions of CMS team including all contractors	CMS
3. Detailed overview of demonstration design	CMS
4. Clinical quality measures a. Beneficiary assignment (ARC) b. Review quality measure categories and definitions c. Options for data collection & reporting i. Medicare claims data ii. Manual medical records abstraction iii. Electronic medical records reporting d. Audit process e. Training plans & schedule	Actuarial Research Corporation (ARC) & RTI International (RTI) & Iowa Foundation for Medical Care (IFMC)
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Medicare Care Management Performance Demonstration
California (San Francisco) Kick-off Meeting
May 24, 2007
10:00 a.m. to 3:30 p.m.
(Marines' Memorial Club and Hotel)

Event	Speaker(s)
1. Keynote & welcome	Centers for Medicare and Medicaid Services (CMS)
2. Introductions of CMS team including all contractors	CMS
3. Detailed overview of demonstration design	CMS
4. Clinical quality measures a. Beneficiary assignment (ARC) b. Review quality measure categories and definitions c. Options for data collection & reporting i. Medicare claims data ii. Manual medical records abstraction iii. Electronic medical records reporting d. Audit process e. Training plans & schedule	Actuarial Research Corporation (ARC) & RTI International (RTI) & Iowa Foundation for Medical Care (IFMC)
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Medicare Care Management Performance Demonstration
Arkansas Kick-off Meeting
June 7, 2007
2:00 p.m. to 7:30 p.m.
(Hilton Little Rock Metro Center)

Event	Speaker(s)
1. Keynote & welcome	Centers for Medicare and Medicaid Services (CMS)
2. Introductions of CMS team including all contractors	CMS
3. Detailed overview of demonstration design	CMS
4. Clinical quality measures a. Beneficiary assignment (ARC) b. Review quality measure categories and definitions c. Options for data collection & reporting i. Medicare claims data ii. Manual medical records abstraction iii. Electronic medical records reporting d. Audit process e. Training plans & schedule	Actuarial Research Corporation (ARC) & RTI International (RTI) & Iowa Foundation for Medical Care (IFMC)
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MEDICARE CARE MANAGEMENT PERFORMANCE DEMONSTRATION

Section 649 of the Medicare Prescription Drug, Improvement, And Modernization Act of 2003 (MMA)

Demonstration Summary

GOAL

The goal of this demonstration is to establish a 3-year pay-for-performance pilot 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 beneficiaries. Doctors who meet or exceed performance standards established by CMS in clinical quality performance will receive an incentive payment for managing the care of eligible Medicare beneficiaries. Practices that are able to report this data to CMS electronically will be eligible for an additional incentive.

DEMONSTRATION SITES

The demonstration will be implemented in Arkansas, California, Massachusetts and Utah in conjunction with the Doctor's Office Quality Information Technology (DOQ-IT) Project in those states. Participation is voluntary, but in order to participate in the demonstration, practices must be enrolled in the DOQ-IT program. The Quality Improvement Organizations (QIOs) will provide technical assistance to practices enrolled in the DOQ-IT program that are also enrolled in the demonstration.

In addition to the above, practices must also meet the following requirements in order to participate in the demonstration:

- The practice must be the main provider of primary care to at least 50 Medicare beneficiaries with Medicare Part A and B coverage under the traditional Medicare fee-for-service program (i.e. not enrolled in a Medicare Advantage or other Medicare health plan). CMS will use claims data to determine how many patients receive the predominance of their primary care services from a practice.

- Only those physicians providing primary care will be included in the demonstration. Practices with specialists that are not eligible may still participate as a practice if they meet other requirements. Nurse practitioners and physicians assistants who provide primary care services are not eligible for payment under the demonstration, but if they bill Medicare independently, their claims may be included in determining which practices provide the predominance of primary care for a beneficiary.

- Physicians must practice in a solo or small to medium-sized physician group practice, which is defined as up to ten physicians. Although this is not an absolute cut-off, CMS reserves the right to limit the number of practices participating, and preference will be given to smaller practices.

- The practice must bill for Medicare services through a Medicare carrier (not a fiscal intermediary) using a HCFA 1500 form or electronic equivalent.

CLINICAL QUALITY PERFORMANCE MEASURES

Practices participating in the MCMP demonstration will be financially rewarded for reporting quality measures and meeting clinical quality performance standards for treating patients with diabetes, congestive heart failure, and coronary artery disease. In addition, they will be measured on how well they provide preventive services (immunizations, blood pressure screening and cancer screening) to high risk chronically ill Medicare beneficiaries. Table 1 provides a list of the 26 measures to be used. Most of these measures will be familiar to physicians as they have been used by health plans and other organizations for several years. The majority of these measures are endorsed by the Ambulatory Quality Alliance (AQA) and/or the National Quality Forum (NQF).

Practices will be asked to submit data annually on their patients on each of these measures.

- The demonstration will begin with a 'pay-for-reporting' component. Practices will be required to submit the quality measurement data for 2006 to establish a demonstration baseline.[1] Payment will not be contingent upon actual scores on the measures, but on the number of beneficiaries for whom they report information.

- Subsequently, following each of the three demonstration years, practices will receive an incentive payment that is tied to the scores achieved on the quality measures. Data collection for each of the demonstration years will begin approximately 3-4 months after the end of the demonstration year (June 30th), allowing sufficient lag time for the vast majority of claims for that demonstration year to have been processed. Practices that are not initially able to submit data on all of the measures can still participate in the demonstration, but will not be eligible for the full incentive payment.

- CMS will calculate all of the measures that can be calculated using claims based data, but some measures will require data from a patient's medical record.

CMS will provide as much information as possible to practices, including identification of which patients are eligible for each measure based on Medicare claims data, to limit the amount of medical record abstraction that is required. CMS will also provide an electronic reporting tool to facilitate this process. There is no fee for using this tool or submitting the data.

[1] New practices that were not operational in 2006, and therefore are not able to report baseline data, will not be required to do so but will also not be eligible to receive the initial incentive payment.

Those practices that have a CCHIT[2]-certified electronic medical record system and are able to abstract and submit the data electronically will be eligible for an additional incentive over and above the amount earned based on their actual performance on the clinical quality measures.

Details regarding the data submission and validation process will be provided to participating practices at a demonstration "kick-off" meeting to be held next spring in each of the demonstration states. Training and technical assistance will be available from both the QIOs and CMS's contractors during the course of the demonstration.

All of the data submitted by any of the practices as part of this demonstration will be kept strictly confidential. No personally identifiable data on any beneficiaries or details regarding the performance of individual practices will be made public.

PAYMENT MODEL

Payment under the demonstration consists of 3 components:

1. An initial payment for reporting baseline clinical quality measures;

2. An annual payment for performance based on a practice's score on the clinical measures; and

3. An additional annual bonus payment if some or all of the measures are reported electronically from a CCHIT-certified electronic health record system.

Initial Payment for Reporting Clinical Quality Measures

In the first year, the demonstration will include a "pay for reporting" incentive to provide baseline information on the clinical quality measures and to help physicians become familiar with the quality measurement data collection process. Practices will be eligible to earn up to $1000 per physician (up to $5000 per practice) based on the number of beneficiaries for whom quality measure data is reported. For this baseline data collection only, payment will not be contingent upon a practice's scores on the quality measures. In addition, while the measures may be submitted electronically, for this initial incentive, there is no bonus for electronic submission of the data. The quality measures for which data will be reported are listed in Table 1. It is projected that this data will be submitted early in the first demonstration year (data collection during the summer 2007 for calendar year 2006) so that payments can be made within the first six months of the demonstration.

Annual Incentive Payment Based on Performance on Clinical Quality Measures

[2] CCHIT (Certification Commission for Healthcare Information Technology) is the recognized certification authority for electronic health records and their networks, and is an independent, voluntary, private sector initiative.

Subsequently, on an annual basis for each of the three years of the demonstration, practices will be eligible to earn an incentive payment of up to $10,000 per physician per year (up to $50,000 per practice per year) based on the practice's scores on the clinical quality measures during the demonstration year. Data will be collected approximately four months after the end of each demonstration year[3], allowing sufficient lag time so that claims data is complete. CMS will compare each practice's score on each of the relevant clinical measures to an established threshold[4]. Practices will be able to earn up to 5 points for each measure, depending upon their individual score. Within each category (diabetes, coronary artery disease, congestive heart failure and preventive services), the scores on all of the measures will be added up to calculate a composite score representing the percentage of total possible points earned. Based on this composite percentage, practices will be able to earn up to $70 for each patient with each of the specific disease categories and $25 per patient with any chronic disease for scores on the preventive measures. Practices that score 90% or more of the potential points in a category will be eligible for the full per beneficiary payment in that category. Practices that score less than 30% of the available points in a category[5] will not be eligible to earn any incentives for that category. Between these two end points, the payment level earned will be prorated.

Annual Bonus Payment for Submitting Clinical Quality Measure Data Electronically

Those practices with a CCHIT-certified electronic health record system that are able to abstract and submit the data to CMS electronically will be eligible to increase the 'pay for performance' payment by up to 25%, or $2,500 per physician (up to $12,500 per practice) per year[6]. The amount of this additional payment will be prorated based on the number of measures that are submitted electronically. For example, practices that are able to submit half of the measures electronically from a CCHIT-certified electronic health record and submit the other half of the measures manually through the abstraction tool will be eligible for 50% of the additional bonus or 12.5% (50% x 25%).

Example of Incentive Calculation for a Sample Practice

CMS will use Medicare claims data to assign patients to practices based on which practice provided the greatest number of primary care visits to the patient during the reporting year. In the chart below, the sample practice provided primary care services to 75 Medicare beneficiaries with one of a range of specified chronic conditions. Of these 75, 25 had diabetes (DM), 15 had

[3] The demonstration year will run July 1 – June 30. After allowing three months for claims to be processed, and some time for CMS and its contractors to aggregate and prepare the data, practices can expect to be collecting the data in the fall following the end of each year. For example, data for the first demonstration year, July 1, 2007- June 30, 2008, will be collected in the mid-late fall of 2008.

[4] In the first year, practices that meet the top quartile of the most current Medicare HEDIS performance data will score full points for the measure. Where HEDIS standards are not available for a measure, a 75 percent compliance rate will be used as the threshold for full points.

[5] During the second and third years of the demonstration, the minimum required percentage of points to earn any payment will be raised to 40% and 50%, respectively.

[6] Practices that have an electronic medical record system which is not CCHIT certified may still submit the data electronically if they are able to do so, but they will not be eligible for the additional bonus payment. In addition, the bonus for electronic submission will not be applied to the initial incentive payment for submission of the baseline data.

congestive heart failure (CHF), and 15 had CAD.[7] A patient with multiple chronic conditions is counted in each applicable category.

Our sample practice achieved a composite score of 95% on the diabetes measures- above the 90% level and, therefore, high enough to earn 100% of the incentive payment for this category. The composite scores on the CHF and Preventive care measures are 71% and 72%, respectively. For CAD, it scored only 27%, which is below the minimum level to earn any incentive payment for that category at all. The composite scores are then prorated to determine the percent of the incentive payment earned.

The chart below shows how the payment is calculated. The number of eligible patients in each category is multiplied by the full per beneficiary payment rate and then by the prorated composite quality score percentage in that category.

Practices will be eligible to receive up to $10,000 per physician (up to $50,000 per practice) for each year of the demonstration for meeting the clinical performance standards.

If this practice had a CCHIT-certified electronic medical record system and submitted the data to CMS electronically, it would be eligible for a 25% bonus, over and above what it has earned based on scores on the clinical quality measures. The total payment for the year would then be:

$4083.70 x 1.25 = $5,104.63

If the practice had submitted only some of the measures electronically, the additional bonus payment for the year would be reduced proportionately.

Total Payment

Adding all of the incentives together, **over the course of the three-year demonstration, physicians will be able to earn up to $38,500 (up to $192,500 per practice**) for reporting the baseline data, meeting the quality standards, and being able to submit the data electronically.

The determination of the payment amount in each year of the demonstration will be independent of every other year. Payments will be calculated retrospectively based on claims data submitted during the demonstration year as well as the clinical data from the medical record that is submitted by the practice.

[7] Patients with a claim during the reporting year with any of the following diagnoses will be counted in the "any chronic disease" category: congestive heart failure, coronary artery disease, stroke, atrial fibrillation, atherosclerosis, diabetes, Alzheimer's disease and/or senile dementia, depression, kidney disease, COPD , emphysema, asthma, rheumatoid arthritis, osteoporosis, and cancer. This count of patients with a chronic disease will be used to calculate payment of the clinical incentive on the preventive services measures. Patients counted for the specific disease measures (diabetes, coronary artery disease, congestive heart failure) will be a subset of this group.

SAMPLE PRACTICE

	DM	CHF	CAD	PC
# Medicare Patients	25	15	15	75
Payment Per Patient	$70	$70	$70	$25
# Quality Measures in Category	8	7	6	5
Maximum Possible Points	40	35	30	25
Points earned	38	25	8	18
Composite Quality Score	95 %	71 %	27 %	72 %
% Incentive Earned	100 % (over 90th percentile)	79.4 % (prorated)	0 % (below minimum 30th percentile)	80 % (prorated)
Total Payment	$70 x 100 % X 25 = $1750	$70 x 79.4 % X 15 = $833.70	$ 0	$25 x 80 % X 75 = $1500
Total Payment for Clinical Performance	$1750.00 + $833.70 + $1500.00 = **$4083.70**			
Bonus for electronic reporting of all measures from a CCHIT-Certified EHR	$4083.70 x 25% = **$1020.93**			
Total Payment	**$4083.70 + 1020.93= $5,104.63**			

TIME LINE

CMS will be recruiting physicians to participate in this demonstration through the QIOs during the winter of 2007. The first operational year of the demonstration will begin on July 1, 2007. All practices that sign up to participate in the demonstration will be invited to an informational "kick off" meeting in their state in the late spring of 2007.

Below are some time frames to keep in mind for the first 18 months of the demonstration.

Winter / Early Spring 2007

- Physicians and practices participating in DOQ-IT program submit completed applications to participate in demonstration. Applications should be submitted no later than April 15, 2007 to receive full consideration.
- CMS notifies practices of selection to participate in demonstration.

Late spring 2007

- Demonstration "kick-off" meetings in each state (dates and locations to be announced).
- Practices register for QNET exchange so that clinical measures data may be transmitted securely.

Summer 2007

- Clinical performance measures data collected for the baseline year (2006).

Late Fall 2007

- CMS calculates and sends to practices initial incentive for reporting baseline data.

Fall 2008

- Clinical performance measures data collected for the first demonstration year (July 2007- June 2008)

Winter 2008/2009

- CMS calculates and sends to practices incentive payment for performance on clinical measures during first demonstration year..

FOR MORE INFORMATION

For more information about the demonstration, please check the demonstration web site:

http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=3&sortOrder=ascending&itemID=CMS057286

Physician practices should also contact their local Quality Improvement Organization for more information about DOQ-IT or the demonstration.

If you have additional questions, you may also email the CMS Demonstration Project Officer at: mcmpdemo@cms.hhs.gov .

Table 1: Clinical Quality Measures in the MCMP Demonstration

Diabetes	**Heart Failure**	**Coronary Artery Disease**	**Preventive Care** ***(measured on population with specified chronic diseases)***
DM-1 HbA1c Management	HF-1 Left Ventricular Function Assessment	CAD-1 Antiplatelet Therapy	PC-1Blood Pressure Measurement
DM-2 HbA1c Control	HF-2 Left Ventricular Ejection Fraction Testing	CAD-2 Drug Therapy for Lowering LDL Cholesterol	PC-5 Breast Cancer Screening
DM-3 Blood Pressure Management	HF-3 Weight Measurement	CAD-3 Beta Blocker Therapy – Prior MI	PC-6 Colorectal Cancer Screening
DM-4 Lipid Measurement	HF-5 Patient Education	CAD-5 Lipid Profile	PC-7 Influenza Vaccination
DM-5 LDL Cholesterol Level	HF-6 Beta Blocker Therapy	CAD-6 LDL Cholesterol Level	PC-8 Pneumonia Vaccination
DM-6 Urine Protein Testing	HF-7 ACE Inhibitor/ARB Therapy	CAD-7 ACE Inhibitor/ARB Therapy	
DM-7 Eye Exam	HF-8 Warfarin Therapy for Patients with AF		
DM-8 Foot Exam			

Diabetes Mellitus

1. HbA1c Management: Testing (DM-1): The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had Hemoglobin A1c (HBA1c) testing

2. HbA1c Management: Poor Control (DM-2): The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had HbA1c in poor control (>9.0%)

3. Blood Pressure Management (DM-3): The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had a BP <140/80 mmHg

4. Lipid Management Testing: (DM-4): The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had LDL-C screening performed

5. Lipid Management: Control < 100mg/dl (DM-5): The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had LDL-C testing <100 mg/dL

6. Urine Protein Screening (DM-6): The percentage of patients 18-75 year of age with diabetes (type 1 or type 2) who had medical attention for nephropathy

7. Eye Examination (DM-7): The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had an eye exam (retinal) performed

8. Foot Examination (DM-8): The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had a foot exam (visual inspection, sensory exam with monofilament, and pulse exam)

Heart Failure

1. LVF Assessment (HF-1): Percentage of patients with quantitative or qualitative results for LVF assessment

2. Left Ventricular Function (LVF) Testing (HF-2): Percentage of patients with LVF testing during the current year for patients hospitalized with a principle diagnosis of HF during the current year

3. Weight Measurement (HF-3): Percentage of HF patient visits with weight measurement recorded

5. Patient Education (HF-5): Percentage of patients who were provided with patient education on disease management and health behavior changes during one or more visit(s)

6. Beta-Blocker Therapy (HF-6): Percentage of patients who were prescribed beta-blocker therapy

7. ACE Inhibitor/ARB Therapy (HF-7): Percentage of patients who were prescribed ACE inhibitor or ARB therapy

8. Warfarin Therapy for Patients with Atrial Fibrillation (HF-8): Percentage of patients with paroxysmal or chronic atrial fibrillation who were prescribed warfarin therapy

Coronary Artery Disease

1. Antiplatelet Therapy (CAD-1): Percentage of patients who were prescribed antiplatelet therapy

2. Drug Therapy for Lowering LDL Cholesterol (CAD-2): Percentage of patients who were prescribed a lipid-lowering therapy (based on current ACC/AHA guidelines)

3. Beta-Blocker Therapy - Prior Myocardial Infarction (MI) (CAD-3): Percentage of patients with prior MI at anytime who were prescribed beta-blocker therapy

5. Lipid Profile (CAD-5): Percentage of patients who received at least one lipid profile (or ALL components tests)

6. LDL Cholesterol Level (CAD-6): Percentage of patients with most recent LDL cholesterol <100 mg/dL

7. ACE Inhibitor or ARB Therapy (CAD-7): Percentage of patients who also have diabetes and/or LVSD who were prescribed ACE inhibitor or ARB therapy

Preventive Care

1. Blood Pressure Measurement (PC-1): Percentage of patient visits with blood pressure (BP) measurement recorded

5. Breast Cancer Screening (PC-5): The percentage of women 40-69 years of age who had a mammogram to screen for breast cancer

6. Colorectal Cancer Screening (PC-6): Percentage of patients screened for colorectal cancer during the one-year measurement period

7. Influenza Immunization (PC-7): Percentage of patients who received an influenza immunization during the one-year measurement period

8. Pneumonia Vaccination (PC-8): The percentage of patients 65 years or older who ever received a pneumococcal vaccination

PRACTICE NAME: _____ PRACTICE #: _____

Demonstration Agreement

Preamble

The goal of this demonstration is to promote the adoption and use of health information technology in small to medium sized physician offices in order to improve the quality of patient care for chronically ill Medicare beneficiaries. Doctors who report clinical quality measures and meet or exceed performance standards established by the Centers for Medicare & Medicaid Services will receive financial rewards for managing the care of eligible Medicare beneficiaries.

This demonstration is mandated under Section 649 of the Medicare and Medicaid Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). It is being conducted in coordination with the Doctor's Office Quality Information Technology (DOQ-IT) project in Arkansas, California, Massachusetts and Utah. DOQ-IT is a national initiative run by the Quality Improvement Organizations under a contract with CMS as permitted by the QIO statute in Part B of Title XI of the Social Security Act (the Act), and the QIO regulations in 42 CFR Parts 476 and 480. The DOQ-IT project promotes the adoption of Electronic Health Records (EHRs) and Information Technology (IT) in small- to medium-sized physician offices. The program aims to help physicians increase access to patient information, decision support, and reference data, as well as to improve patient-clinician communications.

1. Participation in this three year demonstration is contingent upon participation in the Doctors Office Quality – Information Technology (DOQ-IT) project sponsored by the Quality Improvement Organization (QIO) in each state. The participating demonstration physician practice ("practice") agrees to continue to participate in the DOQ-IT project and comply with all DOQ-IT requirements during the three year course of this demonstration.

2. This is a voluntary three year demonstration. However, it is expected that practices will commit to participating for the full duration of the demonstration. Any practice that terminates its participation in the demonstration before the end of the three years will not be eligible to receive any incentive payments for any year during which they do not fully participate or for which they do not comply with all of the demonstration requirements. Any practice that intends to terminate its participation in the demonstration shall provide at least 30 days advance, written notice to the Center for Medicare & Medicaid Services

3. The practice agrees to provide CMS and/or its contractors tax identification numbers, national provider identification numbers, Medicare provider identification numbers and other information as needed to link beneficiaries and claims data to the appropriate physician/provider and practice in order to implement this demonstration. The practice agrees

to notify CMS in writing within 30 days of any changes to these numbers and/or the organizational structure and physicians/providers (e.g. the addition or termination of physicians to the practice; changes in the types of care and/or specialties of physicians in the practice, etc.) that it represents that may impact CMS's ability to pull claims for purposes of assigning beneficiaries and determining performance payments under the demonstration. Failure to provide this information in a timely manner could affect payment.

4. The practice agrees that all claims to Medicare will be submitted electronically and that the claim will include complete and accurate information (individual National Provider Identifier (NPI) and/or Medicare Provider Identifying Number (PIN), as required) identifying the physician providing each service on the claim as well as the location where the services were rendered. In addition to meeting all requirements for Medicare claims submission, accurate use of provider identifying information is critical to assigning beneficiaries to the appropriate provider. Failure to provide this information in a timely manner could affect payment.

5. The practice agrees to submit clinical performance data to CMS and/or its contractors during the course of the demonstration in accordance with the procedures established for the demonstration. The practice agrees to cooperate with any audit of submitted data that may be required by CMS and/or contractors.

6. The practice agrees to complete and submit all surveys and/or other assessments of office based practices or information systems capabilities to the QIO as required under the DOQ-IT program and/or the demonstration.

7. The practice acknowledges that the determination of the payment methodology for this demonstration is solely the responsibility of CMS. Decisions regarding payment levels and methodology made by CMS are final. A description of the payment methodology is incorporated in the Demonstration Summary provided in Attachment A to this agreement.

8. All demonstration incentive payments will be processed electronically. The practice agrees to provide on a timely basis to CMS and/or its contractors the information necessary for processing incentive payments under this demonstration. This includes the attached form (CMS Form #588). This form must be completed and submitted to CMS before any payments can be processed. Failure to complete and submit this information on a timely basis could result in a significant delay in receiving payments.

9. The practice agrees to notify beneficiaries, through signage, notices and/or other mechanisms agreeable to the CMS project officer, of the practice's participation in the demonstration. Notices must describe the goals and objectives of the demonstration, and the use of financial incentives to improve quality under the demonstration.

10. The practice shall maintain the confidentiality of all project-related information that identifies individual beneficiaries. The practice agrees to comply with the HIPAA Privacy Rule and other HIPAA Provisions.

11. The practice agrees to cooperate with the independent evaluation contractor and implementation contractors selected by CMS. This may include participating in surveys and/or site visits as requested by the evaluation contractor.

12. The practice and its participating practitioners agree to allow the QIO to share with CMS and/or its contractors any data that the QIO would be authorized to share under the QIO confidentiality regulations at 42 CRF Part 480 or as otherwise authorized under its contract for work performed specifically for the demonstration. CMS' contractors can include those assisting in the implementation or evaluation of the DOQ-IT program and/or the MCMP demonstration project.

13. All of the data collected by CMS during the course of this demonstration shall be confidential and will be used solely for the purpose of implementing or evaluating the demonstration. No individually identifiable (either by beneficiary or physician/practice) data shall be made public. Any data about the demonstration that is made public shall be anonymous or at the aggregate level and will not include any individually identifiable data.

14. The practice acknowledges that the Medicare fee-for-service information, including Provider Identifying Numbers (PINs), National Provider Identifiers (NPIs), diagnosis codes, procedure codes, and other data relevant for claims payment and assessing performance submitted to CMS, directly affects the assignment of beneficiaries to physicians/practices and determination of performance on certain clinical measures. The practice attests, based on its best knowledge, information, and belief that such information submitted to CMS or its contractors will be complete, accurate, timely and truthful. Misrepresentations about the information may result in termination from the demonstration and nullify performance payments under the demonstration.

15. CMS may suspend or terminate from the demonstration any practice at any time before the planned expiration date of the demonstration, should it determine that the practice has materially failed to comply with the terms of the demonstration. CMS will promptly notify the practice in writing of the determination and the reasons for the suspension or termination, together with the effective date. All decisions by CMS are final and may not be appealed.

16. During the demonstration, CMS will monitor expenditures for claims and incentive payments against projections to insure that the demonstration, as a whole, will be budget neutral. CMS reserves the right to adjust future incentive payment levels, as it determines necessary, to insure budget neutrality.

17. CMS reserves the right to terminate the demonstration in whole, or in part, at any time prior to the three year duration requirement in section 649(a)(3) of the MMA if doing so later becomes permissible under that or another statutory authority if it determines that continuing the project is no longer in the public interest. CMS will promptly notify the practice in writing of the determination and the reasons for such termination, together with the effective date.

18. The practice shall assume responsibility for the accuracy and completeness of all data submitted as part of this demonstration. This includes, but is not limited to, data related to the clinical office systems survey, data used to support calculation of performance measures, and any information provided to CMS and/or its contractors. The practice attests, based on its best knowledge, information, and belief that such data is complete, accurate, timely and truthful. Misrepresentations about such information may nullify performance payments under the demonstration.

PRACTICE NAME: _____ PRACTICE #: _____

Affirmation and Agreement:

I hereby affirm that I am authorized to sign this agreement and that my signature binds the Practice

_____ _____

MCMP Practice Representative Date

_____ _____

Physicians covered by this Practice:

Physician Name	Medicare Provider Identifying Number (PIN)	National Provider Identifier (NPI)

Add additional lines as necessary to include all physicians in the practice

ATTACHMENT A

MEDICARE CARE MANAGEMENT PERFORMANCE DEMONSTRATION

Section 649 of the Medicare Prescription Drug, Improvement, And Modernization Act of 2003 (MMA)

Demonstration Summary

GOAL

The goal of this demonstration is to establish a 3-year pay-for-performance pilot 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 beneficiaries. Doctors who meet or exceed performance standards established by CMS in clinical quality performance will receive an incentive payment for managing the care of eligible Medicare beneficiaries. Practices that are able to report this data to CMS electronically will be eligible for an additional incentive.

DEMONSTRATION SITES

The demonstration will be implemented in Arkansas, California, Massachusetts and Utah in conjunction with the Doctor's Office Quality Information Technology (DOQ-IT) Project in those states. Participation is voluntary, but in order to participate in the demonstration, practices must be enrolled in the DOQ-IT program. The Quality Improvement Organizations (QIOs) will provide technical assistance to practices enrolled in the DOQ-IT program that are also enrolled in the demonstration.

In addition to the above, practices must also meet the following requirements in order to participate in the demonstration:

- The practice must be the main provider of primary care to at least 50 Medicare beneficiaries with Medicare Part A and B coverage under the traditional Medicare fee-for-service program (i.e. not enrolled in a Medicare Advantage or other Medicare health plan). CMS will use claims data to determine how many patients receive the predominance of their primary care services from a practice.

- Only those physicians providing primary care will be included in the demonstration. Practices with specialists that are not eligible may still participate as a practice if they meet other requirements. Nurse practitioners and physicians assistants who provide primary care services are not eligible for payment under the demonstration, but if they bill Medicare independently, their claims may be included in determining which practices provide the predominance of primary care for a beneficiary.

- Physicians must practice in a solo or small to medium-sized physician group practice, which is defined as up to ten physicians. Although this is not an absolute cut-off, CMS

reserves the right to limit the number of practices participating, and preference will be given to smaller practices.

- The practice must bill for Medicare services through a Medicare carrier (not a fiscal intermediary) using a HCFA 1500 form or electronic equivalent.

CLINICAL QUALITY PERFORMANCE MEASURES

Practices participating in the MCMP demonstration will be financially rewarded for reporting quality measures and meeting clinical quality performance standards for treating patients with diabetes, congestive heart failure, and coronary artery disease. In addition, they will be measured on how well they provide preventive services (immunizations, blood pressure screening and cancer screening) to high risk chronically ill Medicare beneficiaries. Table 1 provides a list of the 26 measures to be used. Most of these measures will be familiar to physicians as they have been used by health plans and other organizations for several years. The majority of these measures are endorsed by the Ambulatory Quality Alliance (AQA) and/or the National Quality Forum (NQF).

Practices will be asked to submit data annually on their patients on each of these measures.

- The demonstration will begin with a 'pay-for-reporting' component. Practices will be required to submit the quality measurement data for 2006 to establish a demonstration baseline.[1] Payment will not be contingent upon actual scores on the measures, but on the number of beneficiaries for whom they report information.

- Subsequently, following each of the three demonstration years, practices will receive an incentive payment that is tied to the scores achieved on the quality measures. Data collection for each of the demonstration years will begin approximately 3-4 months after the end of the demonstration year (June 30th), allowing sufficient lag time for the vast majority of claims for that demonstration year to have been processed. Practices that are not initially able to submit data on all of the measures can still participate in the demonstration, but will not be eligible for the full incentive payment.

- CMS will calculate all of the measures that can be calculated using claims based data, but some measures will require data from a patient's medical record.

CMS will provide as much information as possible to practices, including identification of which patients are eligible for each measure based on Medicare claims data, to limit the amount of medical record abstraction that is required. CMS will also provide an electronic reporting tool to facilitate this process. There is no fee for using this tool or submitting the data.

[1] New practices that were not operational in 2006, and therefore are not able to report baseline data, will not be required to do so but will also not be eligible to receive the initial incentive payment.

Those practices that have a CCHIT[2]-certified electronic medical record system and are able to abstract and submit the data electronically will be eligible for an additional incentive over and above the amount earned based on their actual performance on the clinical quality measures.

Details regarding the data submission and validation process will be provided to participating practices at a demonstration "kick-off" meeting to be held next spring in each of the demonstration states. Training and technical assistance will be available from both the QIOs and CMS's contractors during the course of the demonstration.

All of the data submitted by any of the practices as part of this demonstration will be kept strictly confidential. No personally identifiable data on any beneficiaries or details regarding the performance of individual practices will be made public.

PAYMENT MODEL

Payment under the demonstration consists of 3 components:

1. An initial payment for reporting baseline clinical quality measures;

2. An annual payment for performance based on a practice's score on the clinical measures; and

3. An additional annual bonus payment if some or all of the measures are reported electronically from a CCHIT-certified electronic health record system.

Initial Payment for Reporting Clinical Quality Measures

In the first year, the demonstration will include a "pay for reporting" incentive to provide baseline information on the clinical quality measures and to help physicians become familiar with the quality measurement data collection process. Practices will be eligible to earn up to $1000 per physician (up to $5000 per practice) based on the number of beneficiaries for whom quality measure data is reported. For this baseline data collection only, payment will not be contingent upon a practice's scores on the quality measures. In addition, while the measures may be submitted electronically, for this initial incentive, there is no bonus for electronic submission of the data. The quality measures for which data will be reported are listed in Table 1. It is projected that this data will be submitted early in the first demonstration year (data collection

[2] CCHIT (Certification Commission for Healthcare Information Technology) is the recognized certification authority for electronic health records and their networks, and is an independent, voluntary, private sector initiative.

during the summer 2007 for calendar year 2006) so that payments can be made within the first six months of the demonstration.

Annual Incentive Payment Based on Performance on Clinical Quality Measures
Subsequently, on an annual basis for each of the three years of the demonstration, practices will be eligible to earn an incentive payment of up to $10,000 per physician per year (up to $50,000 per practice per year) based on the practice's scores on the clinical quality measures during the demonstration year. Data will be collected approximately four months after the end of each demonstration year[3], allowing sufficient lag time so that claims data is complete. CMS will compare each practice's score on each of the relevant clinical measures to an established threshold[4]. Practices will be able to earn up to 5 points for each measure, depending upon their individual score. Within each category (diabetes, coronary artery disease, congestive heart failure and preventive services), the scores on all of the measures will be added up to calculate a composite score representing the percentage of total possible points earned. Based on this composite percentage, practices will be able to earn up to $70 for each patient with each of the specific disease categories and $25 per patient with any chronic disease for scores on the preventive measures. Practices that score 90% or more of the potential points in a category will be eligible for the full per beneficiary payment in that category. Practices that score less than 30% of the available points in a category[5] will not be eligible to earn any incentives for that category. Between these two end points, the payment level earned will be prorated.

Annual Bonus Payment for Submitting Clinical Quality Measure Data Electronically
Those practices with a CCHIT-certified electronic health record system that are able to abstract and submit the data to CMS electronically will be eligible to increase the 'pay for performance' payment by up to 25%, or $2,500 per physician (up to $12,500 per practice) per year[6]. The amount of this additional payment will be prorated based on the number of measures that are submitted electronically. For example, practices that are able to submit half of the measures electronically from a CCHIT-certified electronic health record and submit the other half of the measures manually through the abstraction tool will be eligible for 50% of the additional bonus or 12.5% (50% x 25%).

Example of Incentive Calculation for a Sample Practice

[3] The demonstration year will run July 1 – June 30. After allowing three months for claims to be processed, and some time for CMS and its contractors to aggregate and prepare the data, practices can expect to be collecting the data in the fall following the end of each year. For example, data for the first demonstration year, July 1, 2007- June 30, 2008, will be collected in the mid-late fall of 2008.
[4] In the first year, practices that meet the top quartile of the most current Medicare HEDIS performance data will score full points for the measure. Where HEDIS standards are not available for a measure, a 75 percent compliance rate will be used as the threshold for full points.
[5] During the second and third years of the demonstration, the minimum required percentage of points to earn any payment will be raised to 40% and 50%, respectively.
[6] Practices that have an electronic medical record system which is not CCHIT certified may still submit the data electronically if they are able to do so, but they will not be eligible for the additional bonus payment. In addition, the bonus for electronic submission will not be applied to the initial incentive payment for submission of the baseline data.

CMS will use Medicare claims data to assign patients to practices based on which practice provided the greatest number of primary care visits to the patient during the reporting year. In the chart below, the sample practice provided primary care services to 75 Medicare beneficiaries with one of a range of specified chronic conditions. Of these 75, 25 had diabetes (DM), 15 had congestive heart failure (CHF), and 15 had CAD.[7] A patient with multiple chronic conditions is counted in each applicable category.

Our sample practice achieved a composite score of 95% on the diabetes measures- above the 90% level and, therefore, high enough to earn 100% of the incentive payment for this category. The composite scores on the CHF and Preventive care measures are 71% and 72%, respectively. For CAD, it scored only 27%, which is below the minimum level to earn any incentive payment for that category at all. The composite scores are then prorated to determine the percent of the incentive payment earned.

The chart below shows how the payment is calculated. The number of eligible patients in each category is multiplied by the full per beneficiary payment rate and then by the prorated composite quality score percentage in that category.

Practices will be eligible to receive up to $10,000 per physician (up to $50,000 per practice) for each year of the demonstration for meeting the clinical performance standards.

If this practice had a CCHIT-certified electronic medical record system and submitted the data to CMS electronically, it would be eligible for a 25% bonus, over and above what it has earned based on scores on the clinical quality measures. The total payment for the year would then be:

$4083.70 x 1.25 = $5,104.63

If the practice had submitted only some of the measures electronically, the additional bonus payment for the year would be reduced proportionately.

Total Payment

Adding all of the incentives together, **over the course of the three-year demonstration, physicians will be able to earn up to $38,500 (up to $192,500 per practice**) for reporting the baseline data, meeting the quality standards, and being able to submit the data electronically.

[7] Patients with a claim during the reporting year with any of the following diagnoses will be counted in the "any chronic disease" category: congestive heart failure, coronary artery disease, stroke, atrial fibrillation, atherosclerosis, diabetes, Alzheimer's disease and/or senile dementia, depression, kidney disease, COPD , emphysema, asthma, rheumatoid arthritis, osteoporosis, and cancer. This count of patients with a chronic disease will be used to calculate payment of the clinical incentive on the preventive services measures. Patients counted for the specific disease measures (diabetes, coronary artery disease, congestive heart failure) will be a subset of this group.

The determination of the payment amount in each year of the demonstration will be independent of every other year. Payments will be calculated retrospectively based on claims data submitted during the demonstration year as well as the clinical data from the medical record that is submitted by the practice.

SAMPLE PRACTICE

	DM	**CHF**	**CAD**	**PC**
# Medicare Patients	25	15	15	75
Payment Per Patient	$70	$70	$70	$25
# Quality Measures in Category	8	7	6	5
Maximum Possible Points	40	35	30	25
Points earned	38	25	8	18
Composite Quality Score	95 %	71 %	27 %	72 %
% Incentive Earned	100 % (over 90th percentile)	79.4 % (prorated)	0 % (below minimum 30th percentile)	80 % (prorated)
Total Payment	$70 x 100 % X 25 = $1750	$70 x 79.4 % X 15 = $833.70	$ 0	$25 x 80 % X 75 = $1500
Total Payment for Clinical Performance	$1750.00 + $833.70 + $1500.00 = **$4083.70**			
Bonus for electronic reporting of all measures from a CCHIT-Certified EHR	$4083.70 x 25% = **$1020.93**			
Total Payment	**$4083.70 + 1020.93= $5,104.63**			

TIME LINE

CMS will be recruiting physicians to participate in this demonstration through the QIOs during the winter of 2007. The first operational year of the demonstration will begin on July 1, 2007. All practices that sign up to participate in the demonstration will be invited to an informational "kick off" meeting in their state in the late spring of 2007.

Below are some time frames to keep in mind for the first 18 months of the demonstration.

Winter / Early Spring 2007

- Physicians and practices participating in DOQ-IT program submit completed applications to participate in demonstration. Applications should be submitted no later than April 15, 2007 to receive full consideration.
- CMS notifies practices of selection to participate in demonstration.

Late spring 2007

- Demonstration "kick-off" meetings in each state (dates and locations to be announced).
- Practices register for QNET exchange so that clinical measures data may be transmitted securely.

Summer 2007

- Clinical performance measures data collected for the baseline year (2006).

Winter 2007 / 2008

- CMS calculates and sends to practices initial incentive for reporting baseline data.

Fall 2008

- Clinical performance measures data collected for the first demonstration year (July 2007- June 2008)

Winter 2008/2009

- CMS calculates and sends to practices incentive payment for performance on clinical measures during first demonstration year..

FOR MORE INFORMATION

For more information about the demonstration, please check the demonstration web site:

http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=3&sortOrder=ascending&itemID=CMS057286

Physician practices should also contact their local Quality Improvement Organization for more information about DOQ-IT or the demonstration.

If you have additional questions, you may also email the CMS Demonstration Project Officer at: mcmpdemo@cms.hhs.gov .

Table 1: Clinical Quality Measures in the MCMP Demonstration[8]

Diabetes	**Heart Failure**	**Coronary Artery Disease**	**Preventive Care** ***(measured on population with specified chronic diseases)***
DM-1 HbA1c Management	HF-1 Left Ventricular Function Assessment	CAD-1 Antiplatelet Therapy	PC-1Blood Pressure Measurement
DM-2 HbA1c Control	HF-2 Left Ventricular Ejection Fraction Testing	CAD-2 Drug Therapy for Lowering LDL Cholesterol	PC-5 Breast Cancer Screening
DM-3 Blood Pressure Management	HF-3 Weight Measurement	CAD-3 Beta Blocker Therapy – Prior MI	PC-6 Colorectal Cancer Screening
DM-4 Lipid Measurement	HF-5 Patient Education	CAD-5 Lipid Profile	PC-7 Influenza Vaccination
DM-5 LDL Cholesterol Level	HF-6 Beta Blocker Therapy	CAD-6 LDL Cholesterol Level	PC-8 Pneumonia Vaccination
DM-6 Urine Protein Testing	HF-7 ACE Inhibitor/ARB Therapy	CAD-7 ACE Inhibitor/ARB Therapy	
DM-7 Eye Exam	HF-8 Warfarin Therapy for Patients with AF		
DM-8 Foot Exam			

[8] Revised 01/08/07. Measure specifications are subject to change and may be updated during the course of the demonstration.

Diabetes Mellitus

1. *HbA1c Management: Testing (DM-1): The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had Hemoglobin A1c (HBA1c) testing*

2. *HbA1c Management: Poor Control (DM-2): The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had HbA1c in poor control (>9.0%)*

3. *Blood Pressure Management (DM-3): The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had a BP < 140/80 mmHg*

4. *Lipid Management Testing: (DM-4): The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had LDL-C screening performed*

5. *Lipid Management: Control < 100mg/dl (DM-5): The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had LDL-C testing l <100 mg/dl*

6. *Urine Protein Screening (DM-6): The percentage of patients 18-75 year of age with diabetes (type 1 or type 2) who had medical attention for nephropathy*

7. *Eye Examination (DM-7): The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had an eye exam (retinal) performed*

8. *Foot Examination (DM-8): The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had a foot exam (visual inspection, sensory exam with monofilament, and pulse exam)*

Congestive Heart Failure

1. *LVF Assessment (HF-1): Percentage of patients with quantitative or qualitative results for LVF assessment*

2. *Left Ventricular Function (LVF) Testing (HF-2): Percentage of patients with LVF testing during the current year for patients hospitalized with a principle diagnosis of HF during the current year*

3. *Weight Measurement (HF-3): Percentage of HF patient visits with weight measurement recorded*

5. *Patient Education (HF-5): Percentage of patients who were provided with patient education on disease management and health behavior changes during one or more visit(s)*

6. *Beta-Blocker Therapy (HF-6): Percentage of patients who were prescribed beta-blocker therapy*

7. *ACE Inhibitor/ARB Therapy (HF-7): Percentage of patients who were prescribed ACE inhibitor or ARB therapy*

8. *Warfarin Therapy for Patients with Atrial Fibrillation (HF-8): Percentage of patients with paroxysmal or chronic atrial fibrillation who were prescribed warfarin therapy*

Coronary Artery Disease

1. *Antiplatelet Therapy (CAD-1): Percentage of patients who were prescribed antiplatelet therapy*

2. *Drug Therapy for Lowering LDL Cholesterol (CAD-2): Percentage of patients who were prescribed a lipid-lowering therapy (based on current ACC/AHA guidelines)*

3. *Beta-Blocker Therapy - Prior Myocardial Infarction (MI) (CAD-3): Percentage of patients with prior MI at anytime who were prescribed beta-blocker therap.*

5. *Lipid Profile (CAD-5): Percentage of patients who received at least one lipid profile (or ALL components tests)*

6. *LDL Cholesterol Level (CAD-6): Percentage of patients with most recent LDL cholesterol <100 mg/dl*

7. *ACE Inhibitor or ARB Therapy (CAD-7): Percentage of patients who also have diabetes and/or LVSD who were prescribed ACE inhibitor or ARB therapy*

Preventive Care

1. *Blood Pressure Measurement (PC-1): Percentage of patient visits with blood pressure (BP) measurement recorded*

5. *Breast Cancer Screening (PC-5): The percentage of women 40-69 years of age who had a mammogram to screen for breast cancer*

6. *Colorectal Cancer Screening (PC-6): Percentage of patients screened for colorectal cancer during the one-year measurement period*

7. *Influenza Immunization (PC-7): Percentage of patients who received an influenza immunization during the one-year measurement period*

8. *Pneumonia Vaccination (PC-8): The percentage of patients ≥65 years and older who ever received a pneumococcal vaccination*

Form Approved
OMB No. 0938-0626

AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER (EFT)

Reason for Submission: ❑ New EFT Authorization
❑ Revision to Current Authorization *(i.e. account or bank changes)*
❑ EFT Termination Request

Chain Home Office: ❑ Check here if EFT payment is being made to the Home Office of Chain Organization
(Attach letter Authorizing EFT payment to Chain Home Office)

Physician/Provider/Supplier Information

Physician's Name _____

Provider/Supplier Legal Business Name _____

_____

Chain Organization Name _____

Home Office Legal Business Name *(if different from Chain Organization Name)* _____

_____

Tax ID Number: *(Designate SSN* ❑ *or EIN* ❑*)* ___ ___ ___ ___ ___ ___ ___ ___ ___

Doing Business As Name _____

Medicare Identification Number (*OSCAR, UPIN, or NSC only)* _____

Depository Information (Financial Institution)

Depository Name _____

Account Holder's Name _____

Street Address _____

City _____ State _____ Zip Code _____

Depository Telephone Number _____

Depository Contact Person _____

Depository Routing Transit Number *(nine digit)* ___ ___ ___ ___ ___ ___ ___ ___ ___

Depositor Account Number _____

Type of Account *(check one)* ❑ Checking Account ❑ Savings Account

Please include a voided check, preprinted deposit slip, or confirmation of account information on bank letterhead with this agreement for verification of your account number.

Authorization

I hereby authorize the Medicare contractor, _____, hereinafter called the COMPANY, to initiate credit entries, and in accordance with 31 CFR part 210.6(f) initiate adjustments for any credit entries made in error to the account indicated above. I hereby authorize the financial institution/bank named above, hereinafter called the DEPOSITORY, to credit and/or debit the same to such account.

If payment is being made to an account controlled by a Chain Home Office, the Provider of Services hereby acknowledges that payment to the Chain Office under these circumstances is still considered payment to the Provider, and the Provider authorizes the forwarding of Medicare payments to the Chain Home Office.

If the account is drawn in the Physician's or Individual Practitioner's Name, or the Legal Business Name of the Provider/Supplier, the said Physician/Provider/Supplier certifies that he/she has sole control of the account referenced above, and certifies that all arrangements between the DEPOSITORY and the said Physician/Provider/Supplier are in accordance with all applicable Medicare regulations and instructions.

This authorization agreement is effective as of the signature date below and is to remain in full force and effect until the COMPANY has received written notification from me of its termination in such time and such manner as to afford the COMPANY and the DEPOSITORY a reasonable opportunity to act on it. The COMPANY will continue to send the direct deposit to the DEPOSITORY indicated above until notified by me that I wish to change the DEPOSITORY receiving the direct deposit. If my DEPOSITORY information changes, I agree to submit to the COMPANY an updated EFT Authorization Agreement.

Signature Line

Authorized/Delegated Official Name *(Print)* _____

Authorized/Delegated Official Title _____

Authorized/Delegated Official Signature_____Date_____

PRIVACY ACT ADVISORY STATEMENT

Sections 1842, 1862(b) and 1874 of title XVIII of the Social Security Act authorize the collection of this information. The purpose of collecting this information is to authorize electronic funds transfers.

The information collected will be entered into system No. 09-70-0501, titled "Carrier Medicare Claims Records," and No. 09-70-0503, titled "Intermediary Medicare Claims Records" published in the Federal Register Privacy Act Issuances, 1991 Comp. Vol. 1, pages 419 and 424, or as updated and republished. Disclosures of information from this system can be found in this notice.

Furnishing information is voluntary, but without it we will not be able to process your electronic funds transfer.

You should be aware that P.L. 100-503, the Computer Matching and Privacy Protection Act of 1988, permits the government, under certain circumstances, to verify the information you provide by way of computer matches.

Instructions for Completing the Authorization Agreement for EFT

The following instructions will guide you through the EFT Authorization process. If you are submitting multiple requests, a separate Authorization Agreement must be completed for each provider identification number (OSCAR, UPIN, or NSC). All EFT requests are subject to a 15-day pre-certification period in which all accounts are verified by the qualifying financial institution before any Medicare direct deposits are made. In the meantime, all payments will be mailed via hard copy checks directly to the "Pay To" address that the Medicare contractor currently has on file. Please contact the Provider Enrollment Unit to verify the "Pay To" address. This agreement must be completely filled out. Omission of any information will delay the processing of your request. If you have any questions, please contact your Medicare contractor. For a list of contractors see www.cms.hhs.gov/providers/enrollment/contacts/.

Please indicate your reason for completing this form: New EFT authorization; Change to your account information; or Termination of your EFT authorization.

If you are authorizing EFT payments to the Home Office of a Chain Organization of which you are a member, you must attach a letter authorizing the contractor to make payment due the provider of service to the account maintained by the Home Office of the Chain Organization. The letter must be signed by an authorized official of the provider of service and an authorized official of the chain home office.

Enter the Name of the Physician or Individual Practitioner, or the Legal Business Name of the Provider/Supplier as reported to the Internal Revenue Service (IRS). The account to which EFT payments are made must exclusively bear the Name of the Physician or Individual Practitioner, or the Legal Business Name of the person or entity enrolled with Medicare.

For EFT payments to the Home Office of a Chain Organization, the depository account must be established in the legal business name of the Home Office, and must match the Home Office name provided above on this form, as well as the Home Office name provided in the appropriate sections of the relevant Form CMS-855 (Provider/Supplier Enrollment Application).

Enter your Tax Identification Number as reported to the IRS. If the business is a corporation, provide the Federal Employer Identification Number (EIN), otherwise provide your SSN.

Enter your Medicare Identification Number. If you are a Part A Provider, or certified Supplier this will be your 6-digit OSCAR number. If you are enrolled as an individual practitioner or a group practice this will be the 6-position alphanumeric UPIN. If you are enrolled as a supplier of durable medical equipment, this will be the 10-digit National Supplier Clearinghouse number.

Enter your depository name (this is the name of the bank or qualifying financial institution that will receive the funds), address, name of a contact person, and contact person's telephone number.

Enter your electronic Routing Transit Number, Account Number, and the type of account in which deposits will be made (Checking or Saving). Attach a voided check, preprinted deposit slip, or confirmation of account information on bank letterhead for verification of your account number. The documentation on bank letterhead should confirm the name on the account, electronic routing transit number, account number and type, and the bank officer's name and signature.

If you do not submit this information, your EFT Authorization Agreement will be returned without further processing.

Read the Authorization carefully. By your signature on this form you are certifying:

1. That the account is drawn in the Name of the Physician or Individual Practitioner, or the Legal Business Name of the Provider/Supplier;
2. The Physician/Provider/Supplier has sole control of the account to which EFT deposits are made in accordance with all applicable Medicare regulations and instructions;
3. That all arrangements between the depository and the said Physician/Provider/Supplier are in accordance with all applicable Medicare regulations and instructions;
4. The effective date of the EFT authorization; and
5. That you will notify the Medicare contractor regarding any changes in the account in sufficient time to allow the contractor and the depository to act on the changes.

The EFT authorization form must be signed and dated by the same Authorized Representative or a Delegated Official named on Form CMS-855 which the Medicare contractor has on file.

Mail this form with the original signature (no Fax signatures can be accepted) to the Medicare Contractor that services your geographical area. For a listing of contractors, see www.cms.hhs.gov/providers/enrollment/contacts/.

Medicare Care Management Performance Demonstration

Demonstration Kick Off Meeting

Jody Blatt
Medicare Demonstrations Program Group
Centers for Medicare & Medicaid Services

Demonstration 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

Demonstration Design Overview

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

Practice Eligibility

- 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
  - Assignment at the practice level (vs. individual physician)
- Algorithm uses retrospective (reporting period) Medicare claims data
  - Office/nursing home/home based E&M services
  - Only claims from primary care providers and some medical specialties included
- Beneficiaries assignment not 'fixed'
  - Assignment can vary each year based on where patient received most care during reporting period.

Beneficiary Assignment

Remember:

- **Correct assignment of beneficiary and demo payment is dependent upon correct use of PIN, TIN & NPI.**
  - **PINs on claims must be specific to location of service**
  - **NPI – use group or individual as appropriate to billing**
  - **TIN on carrier/MAC provider file must be accurate**
  - **If TIN has changed, YOU MUST NOTIFY carrier/MAC officially– not just submit correct TIN on claim**

Beneficiary Eligibility

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

* 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

Incentive Payments

Three components:

1. One-time, Initial "Pay for Reporting" of baseline data
   - Payment not contingent upon performance scores
2. Annual "Pay for Performance"
   - Payment for achieving quality benchmarks during demonstration year
3. 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

Diabetes	**CHF**	**CAD**	**Preventive Care (measured on population with specified chronic diseases)**
DM-1 HbA1c Management	HF-1 Left Ventricular Function Assessment	CAD-1 Antiplatelet Therapy	PC-1 Blood Pressure Measurement
DM-2 HbA1c Control	HF-2 Left Ventricular Ejection Fraction Testing	CAD-2 Drug Therapy for Lowering LDL Cholesterol	PC-5 Breast Cancer Screening
DM-3 Blood Pressure Management	HF-3 Weight Measurement	CAD-3 Beta Blocker Therapy – Prior MI	PC-6 Colorectal Cancer Screening
DM-4 Lipid Measurement	HF-5 Patient Education	CAD-5 Lipid Profile	PC-7 Influenza Vaccination
DM-5 LDL Cholesterol Level	HF-6 Beta Blocker Therapy	CAD-6 LDL Cholesterol Level	PC-8 Pneumonia Vaccination
DM-6 Urine Protein Testing	HF-7 Ace Inhibitor /ARB Therapy	CAD-7 Ace Inhibitor / ARB Therapy	
DM-7 Eye Exam	HF-8 Warfarin Therapy for Patients with AF		
DM-8 Foot Exam			

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

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: late summer/fall '07

Annual Incentive: Pay for Performance (P4P)

- Performance on clinical measures determines payment
- Eligible for electronic reporting bonus
- Key issues
  - Scoring
  - Rewarding Improvement vs. Absolute scores
- Three annual performance years
  - July – June

Pay for Performance (P4P): Clinical Performance Incentive

- Maximum payment <u>each year</u> 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 electronically 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
- Detailed specifications for measures and reporting presented at public meeting in March & on web site

Summary: Total Potential Payments

1. Initial "Pay for Reporting" Incentive:
   - Up to $1,000/physician; $5,000/practice
2. Annual "Pay for Performance" Incentive:
   - Up to $10,000/physician; $50,000/practice per year
3. 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

Time Frame

- May / June 2007
  - Kick off meetings in demonstration states
  - Follow up conference calls for additional Q & A
- July 1, 2007
  - Demonstration begins
  - Beneficiary Notification
- July – Sept. 2007
  - Data collection for baseline reporting year (2006)
  - QIOs provide T & A to practices / serve as primary contact point
- Winter 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

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

Questions

Post Kick off meeting Q& A Calls:

- Tuesday June 5th - 2:30 - 4 pm Eastern time
- Thursday June 14th – 12:30 – 2 pm Eastern time

DIAL-IN NUMBERS: 888-791-1856
PASSCODE: MCMP DEMO

Questions

CONTACT:

Jody.Blatt@cms.hhs.gov

Medicare Demonstrations Program Group
Office of Research, Development & Information
Centers for Medicare & Medicaid Services
(410) 786-6921

Demonstration website:

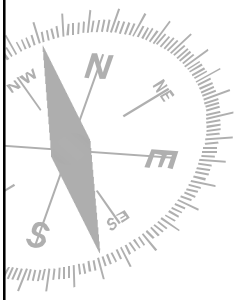
http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/:

- click on "Medicare Demonstrations" in left side block
- Search on "Care Management Performance"

email: mcmpdemo@cms.hhs.gov

Beneficiary Assignment for the Medicare Care Management Performance Demonstration

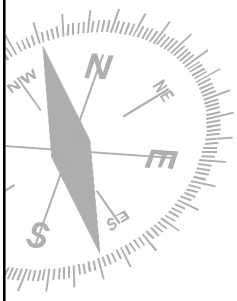
Kickoff Meeting



John Wilkin and Kerry Moroz
Actuarial Research Corporation
(ARC)

Types of Beneficiary Assignment

I. Assignment to practices
II. Assignment to chronic condition categories



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I. Practice Assignment

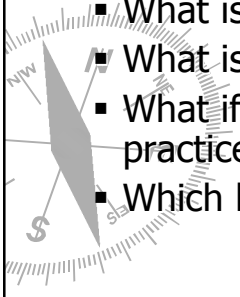
- A physician practice participating in the demonstration should be the principle primary care provider for assigned eligible Medicare beneficiaries

- How are beneficiaries "assigned" to a practice?

3

I. Practice Assignment

- Medicare beneficiaries are assigned to the practice with the greatest number of primary care visits
  - What is the data source?
  - What is a practice?
  - What is a primary care visit?
  - What if there is a tie among two or more practices?
  - Which beneficiaries are eligible?



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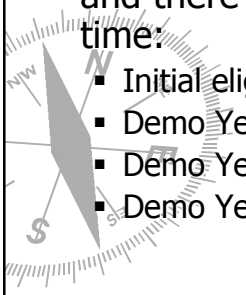
I. Practice Assignment

What is the data source?

- ARC will use Medicare physician claims data for the applicable demonstration years
- Beneficiary assignment will take place four times, and there may be different assignments each time:
  - Initial eligibility: January 2006 – December 2006
  - Demo Year 1: July 2007 – June 2008
  - Demo Year 2: July 2008 – June 2009
  - Demo Year 3: July 2009 – June 2010



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I. Practice Assignment

What is a practice?

- A practice is a group of tax ID numbers (TINs) and individual Medicare Provider ID Numbers (PINs)
- These are the identifiers which are found on every physician claim, and also which were collected on the demonstration applications

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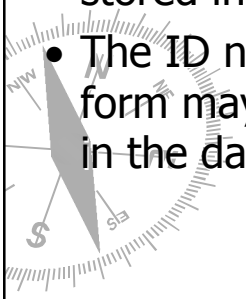
I. Practice Assignment

What is a practice?

- It is imperative that the TINs and PINs we are provided by the practice match what is stored in CMS's data systems
- The ID numbers submitted on your claim form may not be the same numbers stored in the data



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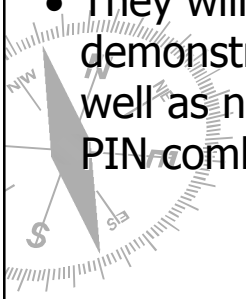
I. Practice Assignment

What is a practice?

- Demonstration practices have been defined by their application submission
- They will be compared to all other demonstration applications in their state, as well as non-demonstration individual TIN + PIN combinations in the claims data



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I. Practice Assignment

- Example Practices

TIN	PIN	Physician Name	MCMP Practice ID
Group 1			
000111222	A123456	John Wilkin	MARC01
000111222	H006452	Kerry Moroz	MARC01
000111222	W740919	Erika Yoshino	MARC01
Group 2			
999851677	WIN123	Michael Sandler	MARC02
123456789	ARF99884	Laurie Pekala	MARC02
Group 3			
410740919	001001003	Gordon Trapnell	MARC03

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I. Practice Assignment

What is a primary care visit?

- A visit to a physician, nurse practitioner, or physician's assistant having an eligible specialty
  - General Practice, Internal Medicine, Preventive Medicine, Family Practice, Geriatric Medicine, Cardiology, Gastroenterology, Osteopathic Medicine, Medical Oncology, Pulmonary Disease, Allergy/Immunology, Rheumatology, Hematology
- A visit with a qualifying Evaluation & Management (E&M) code
  - Includes visits to home or nursing home

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I. Practice Assignment

<u>What is a primary care visit?</u>

- Visits not meeting these criteria will be dropped from the beneficiary assignment process to ensure that we are assigning beneficiaries to their actual primary care physicians

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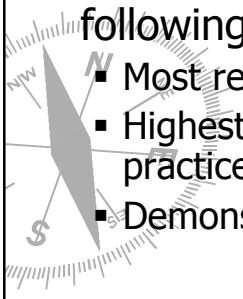
I. Practice Assignment

<u>What if there is a tie among two more practices?</u>

- If a beneficiary has had the same number of visits to more than one practice, the following tie-breakers are applied:
  - Most recent visit
  - Highest total MCR allowed charges for the practice for that patient
  - Demonstration site vs. non-demonstration site



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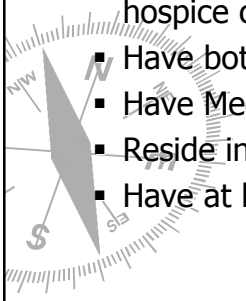
I. Practice Assignment

<u>Which beneficiaries are eligible?</u>

- To be eligible for assignment (and thus, for payment) a beneficiary must:
  - Be fee-for-service (FFS) (i.e., not in a MA plan or hospice care)
  - Have both Part A and Part B
  - Have Medicare as the primary insurer
  - Reside in the demonstration state
  - Have at least one of specified chronic conditions



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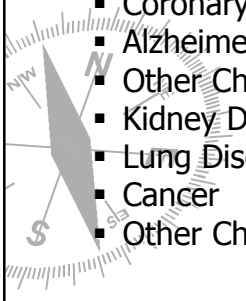
II. Chronic Condition Assignment

- Specified chronic condition categories for beneficiary eligibility (based on ICD9-CM diagnostic codes):
  - Diabetes Mellitus
  - Congestive Heart Failure
  - Coronary Artery Disease
  - Alzheimer's and Mental Health
  - Other Chronic Cardiac or Circulatory Disease
  - Kidney Disease
  - Lung Disease
  - Cancer
  - Other Chronic Diseases (Osteoporosis, Arthritis)



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II. Chronic Condition Assignment

- Chronic condition assignment is based on physician and hospital claims data for one year[1]:
  - Beneficiaries must have at least one inpatient claim (or ER visit for diabetes) for one of the specified diagnostic codes

    OR
  - Two outpatient claims on different dates having specified diagnostic codes for the same condition
- This population forms the basis for performance payments on preventive measures

1. For Diabetes assignment two years of data are used.

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II. Chronic Condition Assignment

- Demonstration target conditions are a subset of the specified chronic conditions
  - Congestive Heart Failure (CHF)
  - Coronary Artery Disease (CAD)
  - Diabetes Mellitus (DM)
  - Overlap: beneficiaries may be in more than one target category

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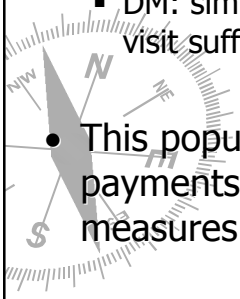
II. Chronic Condition Assignment

- Target condition assignment based on:
  - CHF: CHF diagnosis on 1+ inpatient hospital claim OR 2+ outpatient claims on different dates
  - CAD: same as CHF, but for CAD diagnosis codes
  - DM: similar, but 2-yr measurement period, and one ER visit sufficient to qualify
- This population forms the basis for performance payments on disease-specific clinical quality measures



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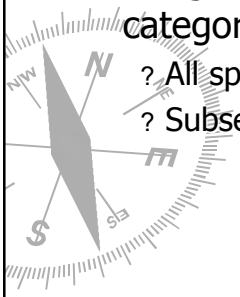
Beneficiary Assignment Summary

- Claims experience used to:
  - Assign beneficiaries to practices providing majority of primary care
  - Assign beneficiaries to chronic condition categories
    - All specified chronic conditions
    - Subset target conditions: CHF, CAD, DM



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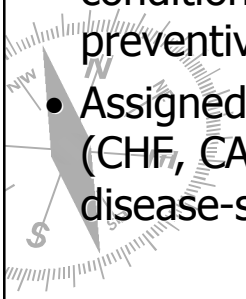
Beneficiary Assignment Summary

- Practices receive performance payments for treatment of assigned beneficiaries
- Assigned beneficiaries with general chronic conditions form basis for payments on preventive clinical quality measures.
- Assigned beneficiaries with target conditions (CHF, CAD, DM) form basis for payments on disease-specific clinical quality measures.



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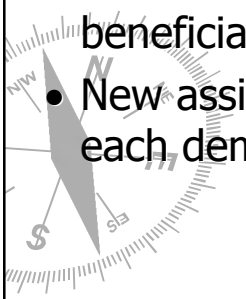
Beneficiary Assignment Summary

- First beneficiary assignment already completed and used to determine whether each practice was the primary care provider for at least 50 eligible Medicare beneficiaries.
- New assignments will be made at the end of each demonstration year.



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MCMP Quality Measures Summary Table

Clinical Module	Measure Number	Measure	Measure Description	Measure Owner	Claims-Based?
Diabetes Mellitus	DM-1	HbA1c Management: Testing	The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had Hemoglobin A1c (HbA1c) testing	NCQA	YES
	DM-2	HbA1c Management: Poor Control	The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had HbA1c in poor control (>9.0%)	NCQA	NO
	DM-3	Blood Pressure Management	The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had a blood pressure <140/80 mmHg	NCQA	NO
	DM-4	Lipid Management: Testing	The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had LDL-C screening performed	NCQA	YES
	DM-5	Lipid Management: Control (<100 mg/dL)	The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had LDL-C testing <100 mg/dL	NCQA	NO
	DM-6	Urine Protein Testing	The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had medical attention for nephropathy	NCQA	YES
	DM-7	Eye Examination	The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had an eye exam (retinal) performed	NCQA	YES
	DM-8	Foot Examination	The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had a foot exam (visual inspection, sensory exam with monofilament, or pulse exam)	NCQA	NO
Heart Failure	HF-1	Left Ventricular Function (LVF) Assessment	Percentage of patients with quantitative or qualitative results for LVF assessment	AMA	NO
	HF-2	LVF Testing	Percentage of patients with LVF testing during the current year for patients hospitalized with a principal diagnosis of HF during the measurement period	CMS	YES
	HF-3	Weight Measurement	Percentage of patient visits with weight measurement recorded	AMA	NO
	HF-5	Patient Education	Percentage of patients who were provided with patient education on disease management and health behavior changes during one or more visit(s)	AMA	NO
	HF-6	Beta-Blocker Therapy	Percentage of patients who were prescribed beta-blocker therapy	AMA	NO
	HF-7	ACE Inhibitor/ARB Therapy	Percentage of patients who were prescribed ACE Inhibitor or ARB therapy	AMA	NO

MCMP Quality Measures Summary Table

Clinical Module	Measure Number	Measure	Measure Description	Measure Owner	Claims-Based?
	HF-8	Warfarin Therapy for Patients with Atrial Fibrillation	Percentage of patients with paroxysmal or chronic atrial fibrillation who were prescribed warfarin therapy	AMA	NO
Coronary Artery Disease	CAD-1	Antiplatelet Therapy	Percentage of patients with CAD who were prescribed antiplatelet therapy	AMA	NO
	CAD-2	Drug Therapy for Lowering LDL Cholesterol	Percentage of patients who were prescribed a lipid-lowering therapy (based on ACC/AHA guidelines)	AMA	NO
	CAD-3	Beta-Blocker Therapy-Prior Myocardial Infarction (MI)	Percentage of patients with prior MI at any time who were prescribed beta-blocker therapy	AMA	NO
	CAD-5	Lipid Profile	Percentage of patients who received at least one lipid profile (or ALL component tests)	AMA	YES
	CAD-6	LDL Cholesterol Level	Percentage of patients with most recent LDL cholesterol <100mg/dl	CMS	NO
	CAD 7	ACE Inhibitor or ARB Therapy	Percentage of CAD patients who also have diabetes and/or LVSD who were prescribed ACE Inhibitor or ARB therapy	AMA	NO
Preventive Care	PC-1	Blood Pressure Management	Percentage of patient visits with blood pressure (BP) measurement recorded	AMA	NO
	PC-5	Breast Cancer Screening	Percentage of women 40-69 years of age who had a mammogram to screen for breast cancer	NCQA	YES
	PC-6	Colorectal Cancer Screening	Percentage of patients screened for colorectal cancer during the one-year measurement period	AMA	NO
	PC-7	Influenza Vaccination	Percentage of patients who received an influenza vaccination during the one-year measurement period	AMA	NO
	PC-8	Pneumonia Vaccination	The percentage of patients 65 years or older who ever received a pneumococcal vaccination	NCQA	NO

Medicare Care Management Performance (MCMP) Demonstration

Kick-Off Meetings

May – June, 2007

Michael Trisolini, PhD, MBA
Musetta Leung, PhD
RTI International

RTI INTERNATIONAL

Presentation Outline

4. Clinical Data Measures
   b. Review of measure categories and definitions
   c. Options for reporting
      i. Claims data

Handout: Listing of MCMP quality measures

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b. Review of measure categories and definitions

MCMP Quality Measures

- 26 quality measures total
- Based on Doctors Office Quality (DOQ) project
- Updated to 2007 by measure owners (AMA, NCQA, CMS)

MCMP Condition Modules

	Measures
■ Coronary Artery Disease (CAD)	6
■ Diabetes Mellitus (DM)	8
■ Heart Failure (HF)	7
■ Preventive Care (PC)	5

Total	26

Measure Owners

- AMA -- CAD (except CAD-6)
  -- HF (except HF-2)
  -- PC-1, PC-6, PC-7
- NCQA -- DM
  -- PC-5, PC-8
- CMS -- HF-2, CAD-6
- Maintain and update the quality measures to preserve consistency and check evidence base

Denominator Exclusions

- Medical reasons
- Patient reasons
- System reasons
- Clinical data
- Age, gender
- Applied for selected quality measures, based on measure owners' guidelines

Measure Specifications

- Detailed specifications provided in the MCMP Quality Measurement Specifications Report
- Specifications define both denominators and numerators in detail for each measure
- Measures may be updated during MCMP demonstration based on changes made by measure owners
- Summary descriptions of the 26 MCMP quality measures on the following slides

CAD Quality Measures

CAD-1: Percentage of patients with CAD who were prescribed antiplatelet therapy

CAD-2: Percentage of patients with CAD who were prescribed a lipid-lowering therapy

CAD-3: Percentage of patients with CAD, who also had a prior MI at any time, who were prescribed beta-blocker therapy

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CAD Quality Measures (cont.)

CAD-5: Percentage of patients with CAD who received at least one lipid profile

CAD-6: Percentage of patients with CAD with most recent LDL cholesterol < 100 mg/dL

CAD-7: Percentage of patients with CAD, who also have diabetes and/or LVSD, who were prescribed ACE inhibitor or ARB therapy

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DM Quality Measures

DM-1: Percentage of patients with diabetes who had Hemoglobin A1c (HbA1c) testing

DM-2: Percentage of patients with diabetes who had HbA1c in poor control (> 9.0%)

DM-3: Percentage of patients with diabetes with most recent blood pressure < 140/80 mmHg

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DM Quality Measures (cont.)

DM-4: Percentage of patients with diabetes who had LDL-C screening performed

DM-5: Percentage of patients with diabetes who had LDC-C testing < 100 mg/dL

DM-6: Percentage of patients with diabetes who had medical attention for nephropathy

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DM Quality Measures (cont.)

DM-7: Percentage of patients with diabetes who had a retinal eye exam performed

DM-8: Percentage of patients with diabetes who had a foot exam

HF Quality Measures

HF-1: Percentage of patients with HF with quantitative or qualitative results for LVF assessment recorded

HF-2: Percentage of patients with HF with LVF testing during the current year for patients hospitalized with a principal diagnosis of HF

HF-3: Percentage of patient visits with weight measurement recorded for patients with HF

HF Quality Measures (cont.)

HF-5: Percentage of patients with HF who were provided with patient education on disease management and health behavior changes during one or more visits

HF-6: Percentage of patients with HF who were prescribed beta-blocker therapy

HF-7: Percentage of patients with HF who were prescribed ACE inhibitor or ARB therapy

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HF Quality Measures (cont.)

HF-8: Percentage of patients with HF with paroxysmal or chronic atrial fibrillation who were prescribed warfarin therapy

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PC Quality Measures

PC-1: Percentage of patients visits with blood pressure measurement recorded for patients with chronic conditions

PC-5: Percentage of women 40-69 years of age with chronic conditions who had a mammogram to screen for breast cancer

PC-3: Percentage of patients with chronic conditions screened for colorectal cancer

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PC Quality Measures (cont.)

PC-7: Percentage of patients with chronic conditions who received an influenza immunization

PC-8: Percentage of patients with chronic conditions who ever received a pneumococcal vaccination

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c. Options for reporting
i. Claims data

Data collection options for MCMP quality measures

- Medicare claims data
- Manual medical record abstraction
- Electronic health record reporting

Claims-based quality measures

- Seven MCMP quality measures can have data collected from either claims or medical records
  - DM-1, DM-4, DM-6, DM-7
  - HF-2
  - CAD-5
  - PC-5
- The other 19 MCMP quality measures require medical records data, either manual or electronic

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Hybrid data collection option

- The 7 claims-based MCMP measures can have data collected from both claims and medical records
- Claims data are pre-populated into the MCMP medical records abstraction tool
- Either claims or medical records data count for numerator “hits” to boost measured performance

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Pre-populated claims data

- Numerator hits for the 7 claims-based quality measures
- Dates of lab tests where values needed from charts, whether provided inside practice
- Available claims data for chart-based measures (e.g., immunizations) to reduce practice workloads
- Physicians treating patients according to claims data

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Pre-populated patients in MCMP chart abstraction tool

- Patients assigned for chart abstraction for each practice identified by claims data
- Up to 327 patients randomly selected for each of the 4 condition modules (218 required plus 50% oversampling)
- If less than 327 eligible patients per module, then all patients pre-populated

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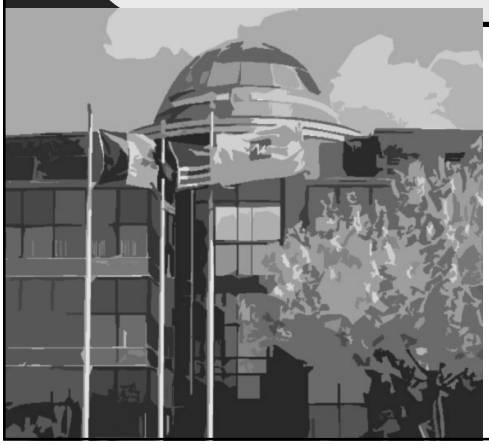
Medicare Care Management Performance (MCMP) Demonstration Kick-Off Meetings



Sherry Grund
Special Projects Director
Francis Landiza
Senior Programmer Analyst
Mary Schrader
Special Projects Coordinator

IOWA FOUNDATION FOR MEDICAL CARE

Topics

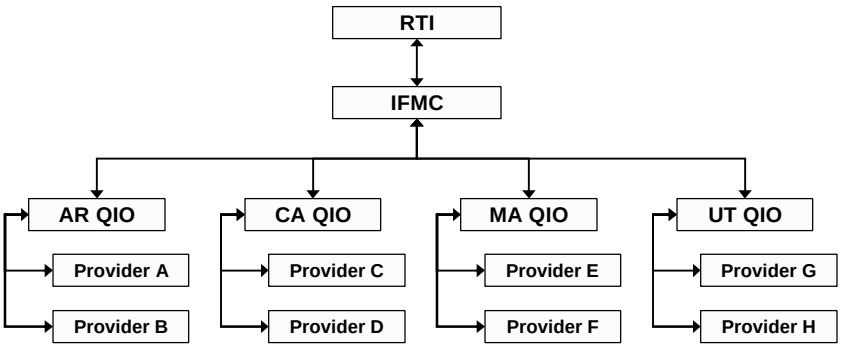
- Data Distribution and Collection
- MCMP-PAT features
- Manual Abstraction
- Import Utility
- Audit Process
- Training Plans & Schedule
- Technical Assistance

Purpose of Today's MCMP-PAT Discussion

- Only an overview
- Detailed discussion during training sessions

3

Data Distribution & Collection



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MCMP-PAT Features

- Organization
  - Groups measures by topic
  - Displays related elements in hierarchical structure
  - Allows navigation by mouse or keyboard
- Validation
  - Checks for invalid values and dates
  - Checks for completeness and inconsistencies
- Reports
  - Creates patient summary
  - Counts totals of completed records, incomplete records, etc.
  - Contains claims-based measure information

5

MCMP-PAT Features

- Backup & Recovery
  - Makes backup copy of database
  - Creates usable database from backup file
- Security
  - Authenticates each user
  - Requires a unique key for each provider
- Flexibility
  - Allows abstraction of all or some measures
  - Allows individual user preferences
  - Allows administrators to configure the settings of all users

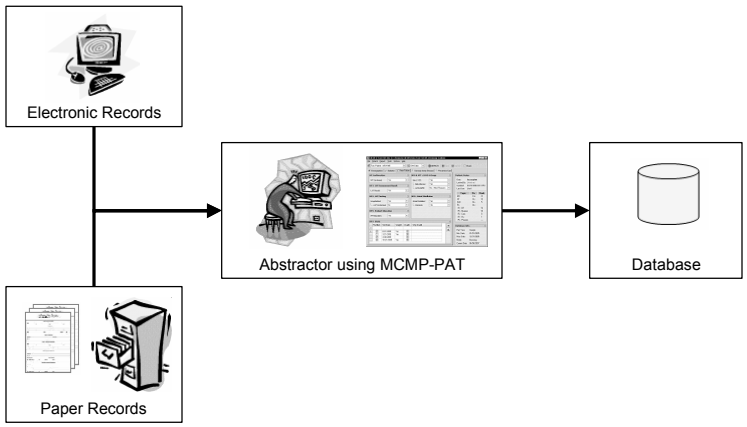
6

MCMP-PAT Features

- Data Transfer
  - Export
    - Exports lists of patients, visits, clinics and providers
  - Import
    - Imports data from file created by an EHR system
- Audit Trail
  - Logs modifications to records
  - Logs other actions
- Automatic Update
- User's Guide
- Context-sensitive Help

7

Manual Abstraction Process



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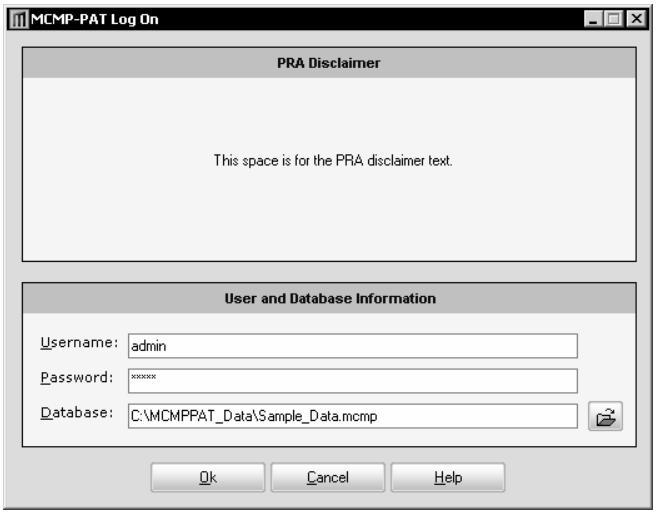
Log On Screen



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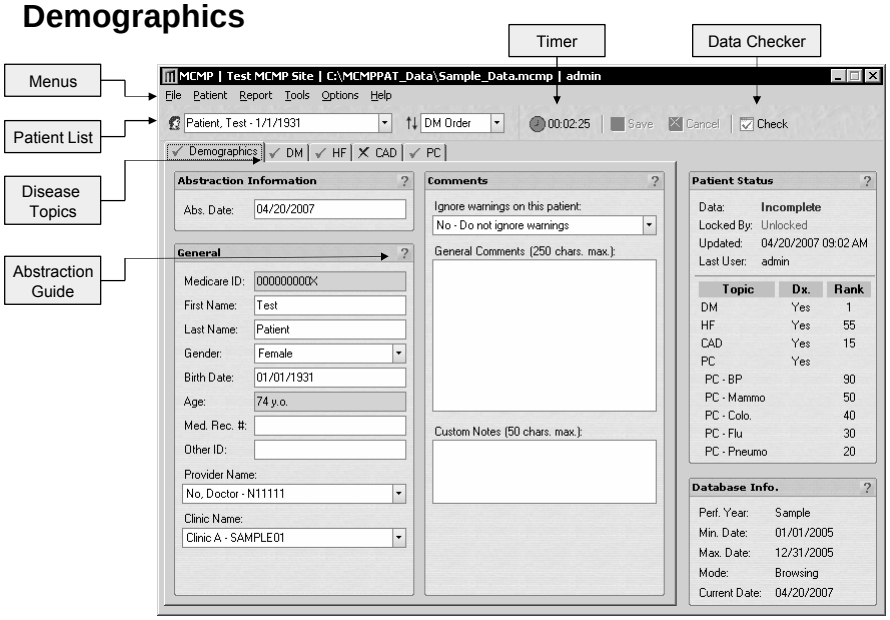
Demographics



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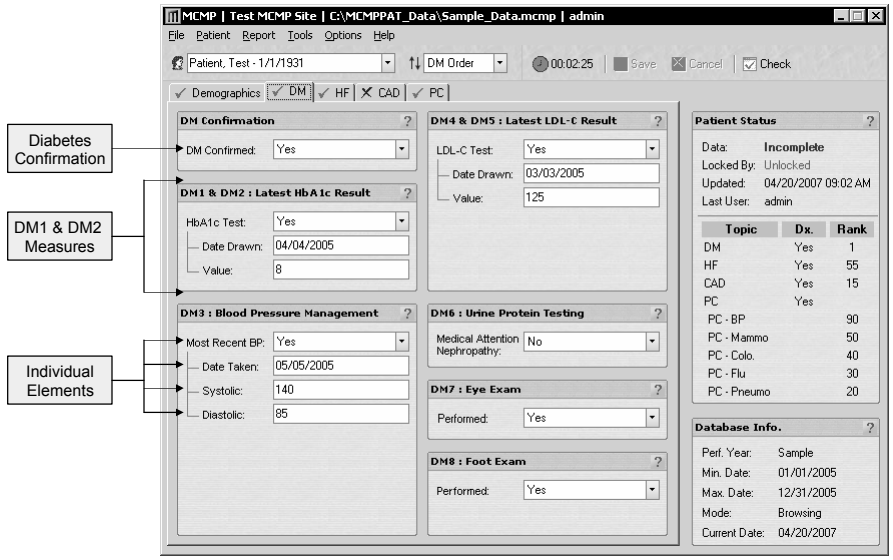
Diabetes Mellitus Topic



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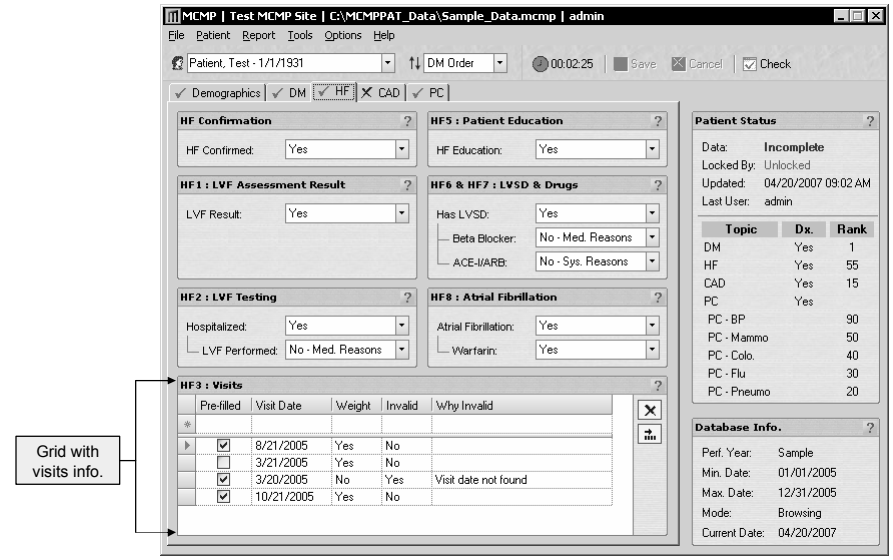
Heart Failure Topic



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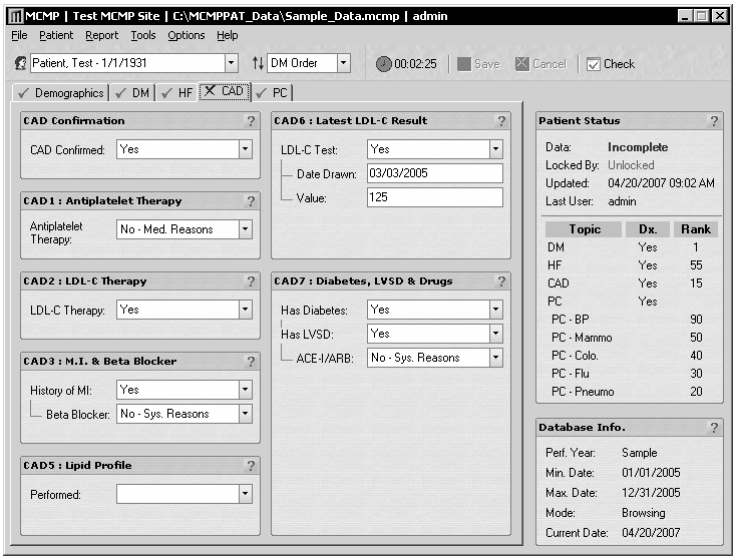
Coronary Artery Disease Topic



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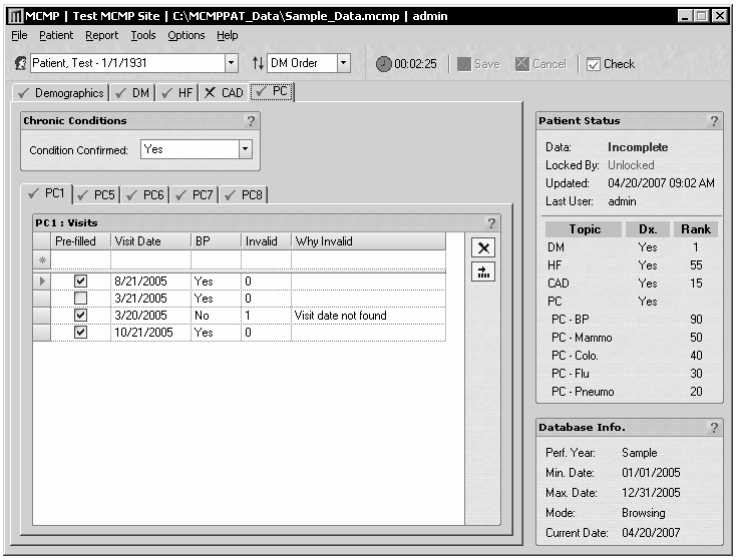
Preventive Care Topic – PC1



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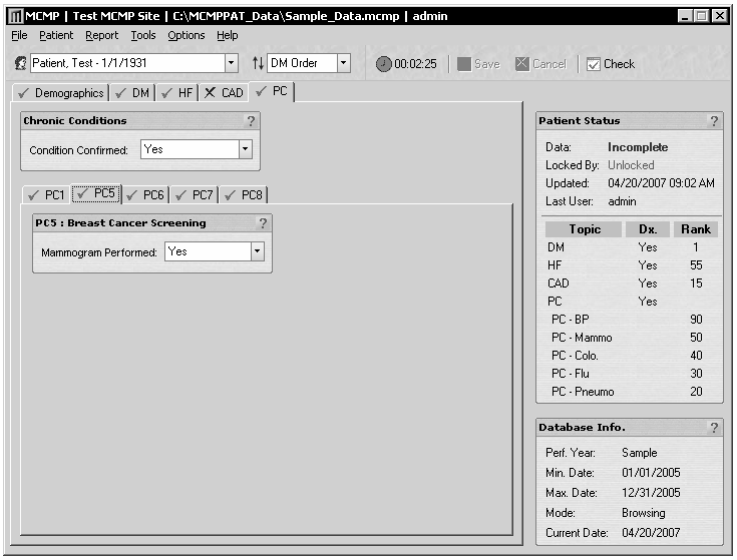
Preventive Care Topic – PC5



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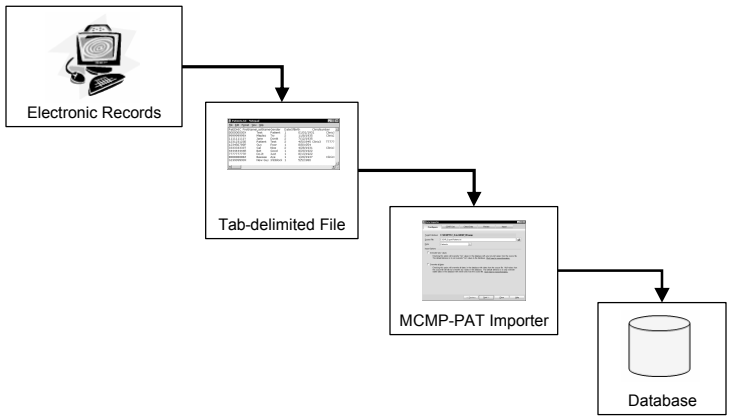
Import Process



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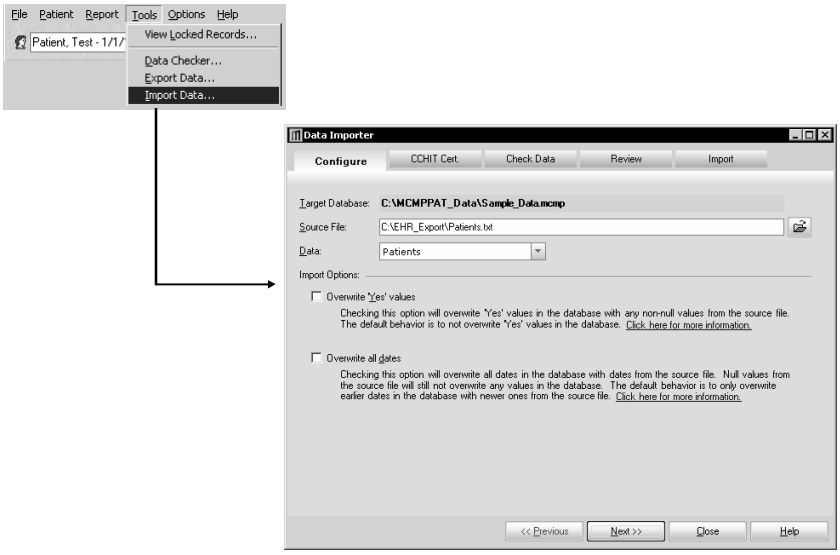
Import Utility



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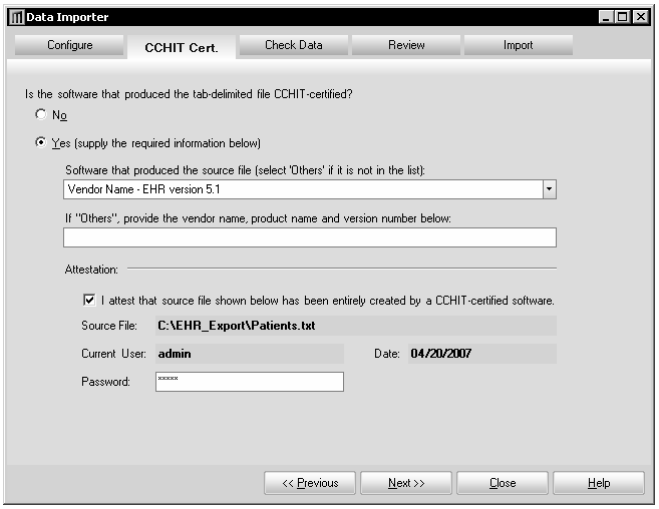
CCHIT Certification



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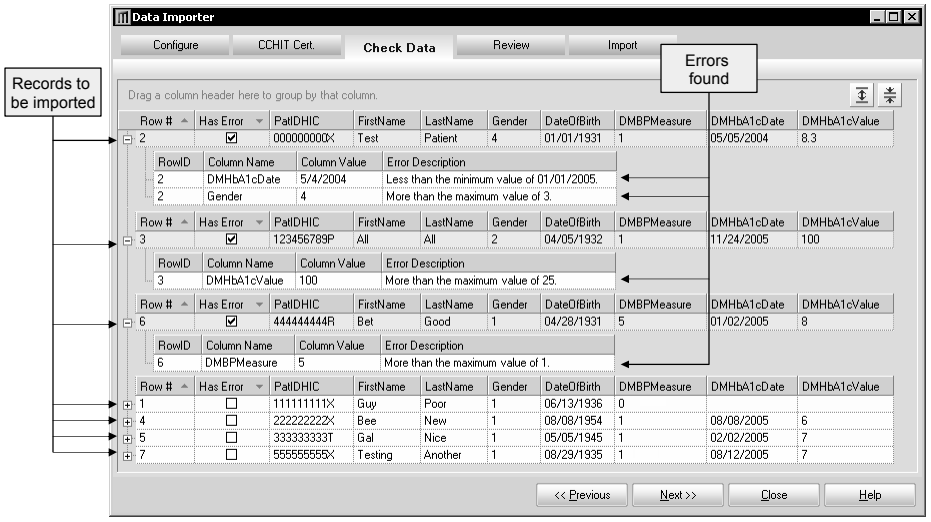
Data Validation



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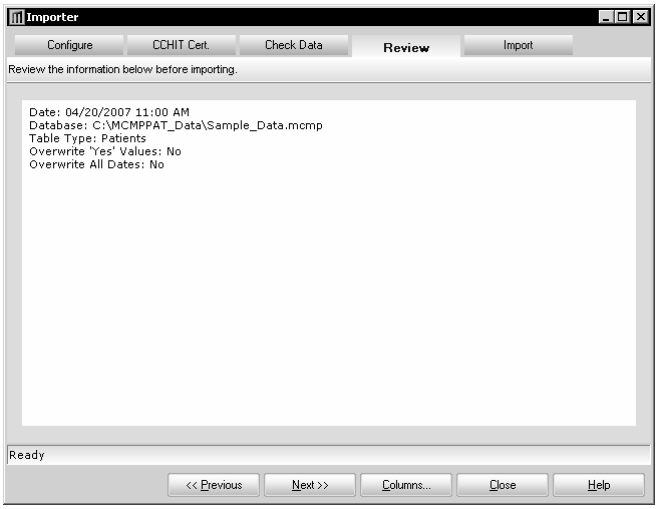
Import Review



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Methods of Data Abstraction

- Manual abstraction
- Data import
- Combination of both methods

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Overview of MCMP-PAT

- Questions?

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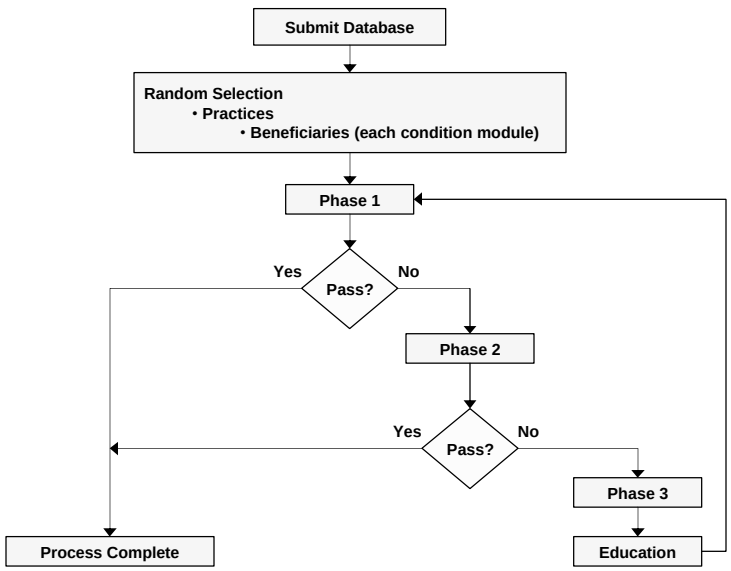
Audit Process

- Results confidential
- Examines the following questions:
  - Was record appropriately included in numerator?
  - Was record appropriately excluded from denominator?

23

Audit Process



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Phase 1

- 8 of the 30 sampled records audited
- If no mismatches, audit process complete
- Phases 2 & 3 not conducted
- Written results provided

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Phase 2

- If ≥ 1 mismatch in first 8 records
  - Remaining 22 records audited
  - Agreement rates for 30 records calculated
  - If ≥ 90% agreement rate, audit process complete
  - Phase 3 not conducted
  - Written results provided

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Phase 3

- If < 90% agreement rate
  - Education provided
  - New random sample of 30 beneficiaries identified
  - Phase 1 repeated

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Audit Documentation

- Audit list posted to QNet Exchange
- Documentation supporting numerator inclusions and denominator exclusions required

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Audit Process

- Questions?

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Training Plans & Schedule

- Via WebEx - Recorded to access as needed
- July 13, 17, and 20
  - 11:30 a.m. – 4:30 p.m. Eastern
  - 10:30 a.m. – 3:30 p.m. Central
  - 9:30 a.m. – 2:30 p.m. Mountain
  - 8:30 a.m. – 1:30 p.m. Pacific
- Sign up at https://ifmcevents.webex.com
  MCMP-PAT Training

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Detailed Training Includes

- Processes for completing manual & electronic collection & submission of measure data
- Data collection efficiencies
- Opportunity for MCMP practices to ask additional questions regarding the measures & their calculations
- Method for obtaining technical assistance

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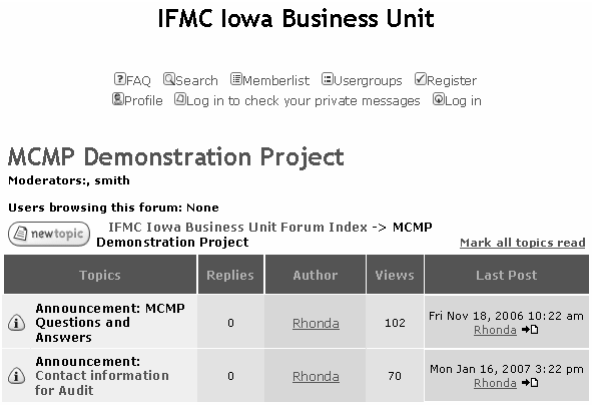
Method for Technical Assistance: Bulletin Board



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Ongoing Technical Assistance

Contact your QIO for assistance with:

- Installation & use of the MCMP-PAT
- Measure specifications
- Use of QNet Exchange for transmitting data to the QIO

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Training Plans & Schedule

- Questions?

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EVALUATION OF THE MEDICARE CARE MANAGEMENT PERFORMANCE DEMONSTRATION

Lorenzo Moreno
Stacy Dale
Leslie Foster

MATHEMATICA
Policy Research, Inc.

Virginia Commonwealth University

Plan for Today

- **Research Questions**
- **Evaluation Design**
- **Data Sources**
- **Evaluation Reports**

Research Questions

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Evaluation Components

- Impact Analysis
- Implementation Analysis
- Synthesis

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Impact Analysis

- What is the incremental effect of financial incentives to demonstration practices on:
  - Quality of care, Medicare costs, use of services, and adoption and use of HIT (primary outcomes)
  - Access to care and continuity of care, satisfaction with care, and physician satisfaction (secondary outcomes)?

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Expected Demonstration Effects

- Organizational changes (HIT use, quality and safety, care management)
- Quality changes for target conditions and overall
- Service use
- Medicare costs
- Beneficiary and physician satisfaction

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Implementation Analysis

- What are the dynamics of practice response to the incentives?
- What factors impeded or facilitated each practice's efforts?
- How has the practice adapted its patient flows as HIT is implemented?

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Synthesis Analysis

- Which practice characteristics are associated with improved outcomes?
- Did practice performance change or improve over time?
- How is use of HIT associated with key outcomes?

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Confidentiality

- All data will be aggregated at state level for analysis
- None of the practices, physicians, or beneficiaries will be identified or identifiable in the reports

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Evaluation Design

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Comparison-Group Design

- Alternative to randomization of practices
- Preferred design: practices already in DOQ-IT in non-demonstration states:
  - Reflects actual operation of a P4P program
  - Answers research questions
  - Minimizes demands on comparison practices

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Design Implementation

- Identify comparison states
- Obtain baseline practice characteristics
- Select comparison practices that:
  - Participate in DOQ-IT
  - Match demonstration practices on a number of criteria (size, experience with HIT)

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Data Sources

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Overview

Data	Source
Beneficiary Survey	MPR
Physician Survey	MPR
Medicare Claims Data	ARC
Clinical Measures	RTI
Scores and Payment Levels	ARC
Office Systems Survey	Maine Health Information Center
Site Visits and Telephone Interviews	MPR

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Beneficiary Survey

- 4,800 completed interviews (600 demonstration and 600 comparison in each state)
- Mail with telephone followup (15 minutes)
- 19 months after demonstration start (January 2009)
- Key topics: Access to care, adherence to self-care management, continuity of care, awareness of the demonstration (or DOQ-IT), satisfaction with care

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Physician Survey

- 1,600 completed interviews (200 demonstration and 200 comparison in each state)
- Mail with telephone followup (10 minutes)
- 25 months after demonstration start (July 2009)
- Key topics: Barriers to transforming clinical encounters, barriers to adoption of EHRs, experience with P4R and P4P, satisfaction with (1) EHRs, (2) quality of care delivered, and (3) incentives

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Medicare Claims Data

- Linked beneficiaries to physician practices (ARC)
- Both demonstration and comparison groups
- Baseline Period: CY 2006
- Demonstration Period: July 2007 – June 2010

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Clinical Measures for the Evaluation

Chronic Condition	Medical Records Only	Medicare Claims	Beneficiary Survey	Available for Comparison Practices
CAD	5	1	0	1
CHF	5	1	1	2
Diabetes	4	4	1	5
Other Eligible	0	4	1	5
Sum	14	10	3	13 (26)

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Medicare Expenditures

Component	Demonstration Practices	Comparison Practices
Total		
Part A		
Part B		
Part D (if available)		
Average Incentive Payment per Practice		n.a.
Average Medicare Savings per Practice		

n.a. = not applicable

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Office Systems Survey

- Both demonstration and comparison practices in 2007 and 2010
- Focus on:
  - Practice characteristics (size, location)
  - Use of HIT to improve quality

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Site Visits and Telephone Interviews

- 8 demonstration practices and 2 comparison practices per site in Spring 2008 and Fall 2010
- Focus will include:
  - Practices' implementation and operational experiences in the demonstration
  - Implementation and use of HIT

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Evaluation Reports

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Reports to CMS

- Implementation Report
- Cost Neutrality Monitoring Report
- Interim Synthesis Reports
- Site Visits Report
- Final Synthesis

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Report to Congress

- Due 12 months after the end of the demonstration
- Concise report for an audience of high-level policymakers and decision makers

MATHEMATICA Policy Research, Inc.

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MEDICARE CARE MANAGEMENT PERFORMANCE (MCMP) DEMONSTRATION EVALUATION SUMMARY

As part of the mandate for designing and operating the MCMP Demonstration, Congress also required an independent evaluation of this demonstration. Centers for Medicare & Medicaid Services (CMS), with funding from the Agency for Healthcare Research and Quality (AHRQ), has contracted with Mathematica Policy Research, Inc. (MPR) to conduct this evaluation.

Goal of the Evaluation. The main goal of the evaluation is to provide CMS with valid estimates of the incremental effect, or *impact*, of providing performance-based financial incentives on the quality of care, use of Medicare-covered services, implementation and use of health information technology (HIT), and Medicare costs of the chronically ill, fee-for-service Medicare beneficiaries served by the demonstration practices. To provide this information, the evaluation must generate rigorous quantitative estimates of the intervention's impacts. In addition, the evaluation will examine the dynamics of practice response to the incentives and supports provided by the demonstration.

Evaluation Components. The evaluation will include an impact analysis, implementation analysis, and synthesis analysis. We provide an overview of each analysis below and summarize the primary research questions, data sources, and planned analysis methods in Table 1.

TABLE 1

RESEARCH QUESTIONS, DATA SOURCES, AND ANALYSIS METHODS FOR THE MCMP EVALUATION, BY ANALYTIC COMPONENT

Research Question	Data Source	Analysis Method
Impact Analysis		
What were the demonstration's effects on:		
Quality of care	Medicare claims data and Beneficiary Survey	Regression-adjusted comparison of demonstration and comparison-group means
Medicare service use and costs	Medicare claims data	
Implementation and use of HIT	Physician Survey and Office Systems Survey	
Continuity of care and care coordination	Medicare claims data, Beneficiary Survey, and Physician Survey	
Patient and physician satisfaction	Beneficiary Survey and Physician Survey	

TABLE 1 *(continued)*

Research Question	Data Source	Analysis Method
Implementation Analysis		
What types of practices participated?	Office Systems Survey, practice-level scores, and financial payment data for demonstration practices	Comparison of characteristics of practices submitting data to those enrolled but not submitting data
What changes have practices made in terms of HIT use in response to the demonstration?	Office Systems Survey	Comparison of the HIT use of demonstration practices over the demonstration period
What were physicians' views of the demonstration and how their practice responded to it?	Site visit data and telephone discussions with successful and unsuccessful practices (or practices that withdrew)	Qualitative analysis
Synthesis Analysis		
For which types of practices were the incentives most effective?	Financial payment data, Medicare claims data, Office Systems Survey, Beneficiary Survey	Comparison of mean characteristics of successful and unsuccessful practices; regression analysis of the relationship between practice characteristics and outcomes
How did clinical outcomes vary with the incentives?	Financial payment data, Medicare claims data, Office Systems Survey	Regression analysis of the relationship between clinical outcomes and incentive payments in previous year
How did quality of care, Medicare costs, and the financial incentives vary with HIT use?	Financial payment data, Medicare claims data, Office Systems Survey	Regression analysis of the relationship between Medicare costs and HIT use; regression analysis of the relationship between HIT use and incentive payments in previous year

The impact analysis will compare regression-adjusted outcome measures for the treatment and comparison groups in order to test the hypotheses that the financial incentives (1) improve quality of care, (2) lower Medicare costs, (3) promote the implementation and use of HIT, (4) improve continuity of care and care coordination, and (5) improve patient and physician satisfaction. The quality-of-care analysis will assess the care delivery process and the clinical outcomes of Medicare beneficiaries. The analysis of HIT use will assess whether practices adopted or increased their HIT use in various office procedures. The continuity-of-care analysis will assess whether the adoption of P4P reduces care fragmentation. The cost analysis will include impacts on costs to the Medicare program and Medicare service use. In the satisfaction analysis, both patient and physician satisfaction will be covered. Subgroup analyses will test whether the intervention is more effective for certain types of beneficiaries and practices than for others. Outcome measures will be drawn from Medicare claims data, the Beneficiary Survey, and the Physician Survey.

The implementation analysis will use qualitative analysis and descriptive statistics to study the planned interventions as envisioned by a representative set of practices, practices' actual experience with the adoption and use of performance measurement technology (for example, electronic health records [EHRs] or disease registries) and disease management services, and the factors that helped or hindered the practices' efforts. The detailed description of the practices' plans will cover the background information on the range of HIT used before the demonstration, the groups targeted to receive the services, and how the practices implemented the intervention (that is, the specific changes made to improve patient adherence, refine care processes, lessen fragmentation of care, or avoid adverse drug interactions). Finally, this analysis will compare

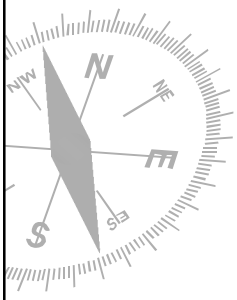
the types of practices that participated in the demonstration (that is, those that submitted data), to those that enrolled, but did not participate. Data sources will include site visits, telephone interviews with practices, financial payment data, practice-level scores, and the Office Systems Survey.

Finally, the synthesis will combine the practice-specific analyses, using impact estimates and implementation analysis findings, to draw inferences about the types of practices that appear to be most successful, and for which groups. It will use regression analyses to investigate (1) the relationship between clinical outcomes and the previous year's incentives, (2) Medicare costs and HIT use, and (3) HIT use and the previous year's incentives. It will also examine the generalizability and scalability of the demonstration. As required by CMS, the synthesis will be the basis for the report to Congress, and it will be included in the final evaluation report.

Challenges for the Evaluation. Several technical challenges must be overcome to achieve the evaluation's objectives. The main challenges are to (1) obtain valid, comparable estimates of impacts for each state; (2) measure some qualitative outcomes; (3) link specific changes in HIT use to specific improvements; and (4) assess the scalability and generalizability of the demonstration.

Reporting of Demonstration Findings. The demonstration evaluation will produce several reports, including an implementation report, a report on site visits, and a cost neutrality monitoring report, as well as interim and final reports that synthesize findings across states and analytic components. The interim reports will be adapted to develop a report to Congress.

Payment Determination for the Medicare Care Management Performance Demonstration



Kickoff Meeting

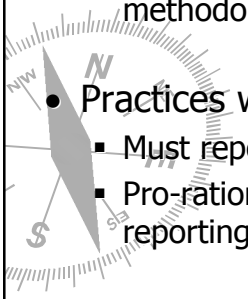
John Wilkin and Kerry Moroz
Actuarial Research Corporation
(ARC)

Payment Methodology

- Each practice is eligible to receive three payments:
  I. A one-time initial payment for reporting
  II. Annual payment for performance (PFP)
  III. Annual electronic reporting incentive

I. Initial Payment
General Concepts

- "Pay for Reporting" clinical measures for eligible beneficiaries during base year (2006)
  - This is an opportunity for practices to become familiar with reporting tools, data collection, and scoring methodology in a risk-free environment
- Practices will be paid for all assigned beneficiaries
  - Must report on all eligible for reporting in each category
  - Pro-ration if practice does not report on all eligible for reporting



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I. Initial Payment
Payment Amounts and Maximums

- Practices will be paid $20 for each beneficiary assigned
- Maximum payment of $1000/physician; $5000/practice
- No bonus for electronic submission
- Submissions will be made around late summer of 2007

4

I. Initial Payment
Example Initial Payment

	Diabetes	CHF	CAD	Preventive Care
Number of Medicare Patients	30	10	20	150
Patients Reported On	25	10	20	125
Payment per Patient	$20	$20	$20	$20
Total Payment for each condition[1]	$600	$200	$400	$3,000
Total Payment for practice	**$4,200**			
If practice has 1 physician, payment = $1,000				
If practice has 4 physicians, payment = $4,000				
If practice has 5+ physicians, payment = $4,200				

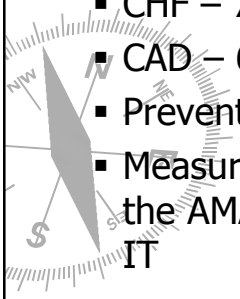
1. Assumes the practice has reported on all eligible in each category.

I. Initial Payment
Constraints

- Beneficiaries are only eligible for initial payment if they have been systematically assigned to the practice and are eligible with one of the pre-specified chronic conditions
- Practices which were assigned no beneficiaries in the baseline period will receive no initial payment
  - This includes new practices

II. Annual Payment For Performance
General Concepts

- Payment based on performance score in 26 clinical areas:
  - Diabetes – 8
  - CHF – 7
  - CAD – 6
  - Prevention – 5
  - Measure specifications are defined by NCQA and the AMA, and are similar to those used in DOQ-IT



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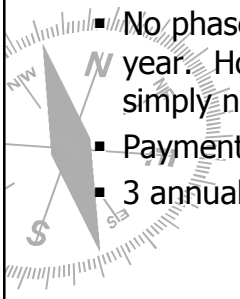
II. Annual Payment For Performance
General Concepts

- Converting performance scores to dollars
  - Incremental (not all or nothing)
  - Full payment for good (but not perfect) performance
  - Low minimum requirement
  - No phase-in, all measures are implemented in the first year. However, there is no penalty for not reporting, simply no payment.
  - Payment based on score, not on improvement
  - 3 annual periods July through June (ending in 2008-10)



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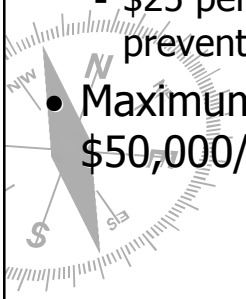
II. Annual Payment For Performance
Maximum Amounts

- Maximum payment per beneficiary =
  - $70 per beneficiary with one of the targeted conditions (CHF, CAD, Diabetes)
  - $25 per beneficiary with chronic condition for preventive measures
- Maximum payment = $10,000/physician; $50,000/practice



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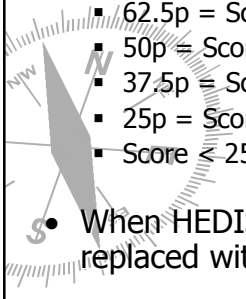
II. Annual Payment For Performance
Determining Points

- 0-5 points given for each of the 26 measures
- Points are based on Medicare HEDIS results for the 2006 reporting year (when available)
  - Score = HEDIS 75th percentile (75p) = 5 points
  - 62.5p = Score < 75p = 4 points
  - 50p = Score < 62.5p = 3 points
  - 37.5p = Score < 50p = 2 points
  - 25p = Score < 37.5p = 1 point
  - Score < 25p = 0 points
- When HEDIS results are not available, percentiles will be replaced with percent of beneficiaries meeting measure



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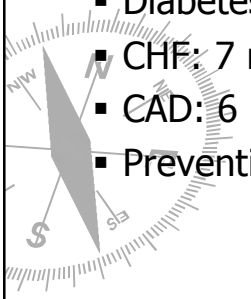
II. Annual Payment For Performance
Determining Points

- The maximum number of points for each condition is 5 times the number of measures for that condition
  - Diabetes: 8 measures * 5 = 40 points
  - CHF: 7 measures * 5 = 35 points
  - CAD: 6 measures * 5 = 30 points
  - Preventive services: 5 measures * 5 = 25 points



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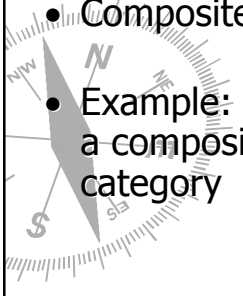
II. Annual Payment For Performance
Points -> Composite Score

- The points will be used to calculate a composite score for each payment category
- Performance points will be summed for each condition
- Composite Score = $\frac{\text{Total Points Earned}}{\text{Maximum Points}}$
- Example: 30 Diabetes points earned translates to a composite score of 75% for the Diabetes category



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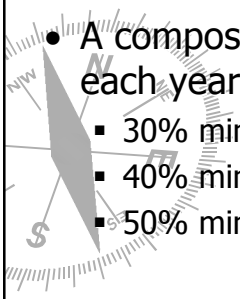
II. Annual Payment For Performance
Composite Score -> Dollars

- The composite score will be used to calculate the dollar amount paid per beneficiary
- A composite score of 90% or higher will earn the maximum per beneficiary payment
- A composite score lower than the minimum for each year will earn no payment
  - 30% minimum in year 1
  - 40% minimum in year 2
  - 50% minimum in year 3



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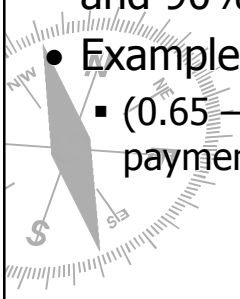
II. Annual Payment For Performance
Composite Score -> Dollars

- The per beneficiary payment will be interpolated over the range 0% – 90% for composite scores between the minimum and 90%
- Example: Composite score of 65%
  - (0.65 – 0) / (0.9 – 0) = 72% of beneficiary payment earned



14

II. Annual Payment For Performance
Total Payment Calculation

- Total payment for a condition = (amount per beneficiary for that condition) * (the number of beneficiaries with that condition)
- Total payment for all four conditions = sum of the total payments calculated for each condition
- Each beneficiary may have more than one condition, so that up to four separate payments could be made for any beneficiary

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II. Annual Payment For Performance
Example Payment Calculation

	Diabetes	CHF	CAD	Preventive Care
Number of Medicare Patients	**30**	**10**	**20**	**150**
Maximum PMT Per Beneficiary	$70	$70	$70	$25
Payment Earned by Performance				
Maximum Possible Points	40	35	30	25
Points Earned	38	25	8	18
Composite Score	95%	71.43%	26.7%	72.0%
Percentage of Payment Earned	100%	79.37%	0.0%	80.0%
Payment Amount Earned Per Beneficiary	**$70**	**$55.56**	**$0.00**	**$20.00**
TOTAL PAYMENT	**$2,100**	**$555.60**	**$0.00**	**$3,000.00**
TOTAL PAYMENT FOR PRACTICE*	$5,655.60			

*Assumes no measures were reported electronically and that all patients were reported on. Subject to maximum payment limits.

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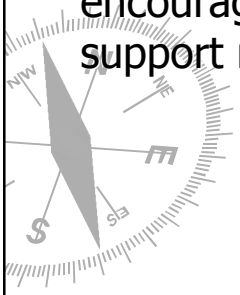
III. Payment for Electronic Reporting
General Concepts

- This bonus payment is for measures that are reported from a CCHIT certified EHR
- CMS has provided vendors specifications to encourage development of functionality to support reporting



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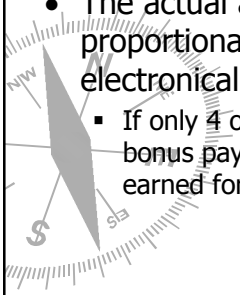
III. Payment for Electronic Reporting
Payment Amounts and Maximums

- Bonus equals a maximum of 25% of earned annual performance payment
  - If no performance payment is earned, then no incentive payment can be earned for reporting electronically
- The actual amount of the bonus payment will be proportional to the number of measures submitted electronically for each condition
  - If only 4 of the 8 diabetes measures are reported electronically, the bonus payment would be (25%)*(4/8) = 12.5% of the payment earned for diabetes



18

III. Payment for Electronic Reporting Example

	Diabetes	CHF	CAD	Preventive Care
Number of Medicare Patients	**30**	**10**	**20**	**150**
Maximum PMT Per Beneficiary	$70	$70	$70	$25
Payment Earned by Performance				
Payment Amount Earned Per Beneficiary	**$70**	**$55.56**	**$0.00**	**$20.00**
TOTAL PAYMENT EARNED	**$2,100**	**$555.60**	**$0.00**	**$3,000.00**
Bonus Payment Calcualtion				
Measures Reported Electronically	4 / 8	7 / 7	4 / 6	0 / 5
Maximum Bonus Percentage	25%	25%	25%	25%
Pro-rated Bonus Percentage	12.5%	25%	16.7%	0%
Bonus Payment	$262.50	$138.90	$0.00	$0.00
TOTAL PAYMENT	**$2,362.50**	**$694.50**	**$0.00**	**$3,000.00**
TOTAL PAYMENT FOR PRACTICE	$6,057.00 (subject to maximum pmt. limits)			

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Payment Calculation Summary

Performance score for each measure

↓

Points for each measure

↓

Composite score for each payment category

↓

Per beneficiary payment ($$$)

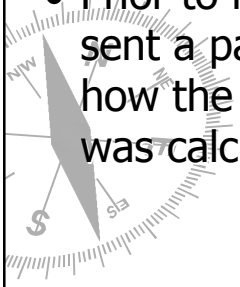
↓

Total Payment Earned
(before bonus)

20

Payment Processing

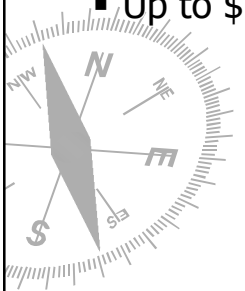
- The payment information for your practice will be sent to a contractor, who will then transfer the necessary funds
- Prior to receiving the payment, you will be sent a payment summary report showing how the payment amount for your practice was calculated



21

Summary

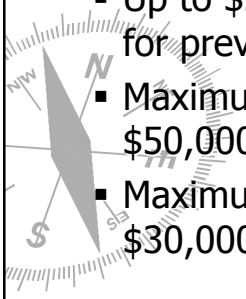
- Initial "Pay for Reporting" Payment
  - Risk-free introduction to reporting system
  - $20 per eligible beneficiary reported on
  - Up to $1,000/physician; $5,000/practice



22

Summary

- Annual "Pay for Performance" Payment
  - Up to $70 per beneficiary with targeted conditions
  - Up to $25 per beneficiary with chronic condition for preventive measures
  - Maximum yearly payment = $10,000/physician; $50,000/practice
  - Maximum total demonstration payment = $30,000/physician; $150,000/practice



23

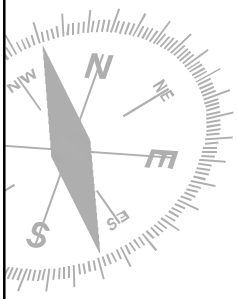
Summary

- Annual Bonus for Electronic Reporting
  - Up to 25% of "pay for performance" payment
  - Up to $2,500/physician; $12,500/practice per year
  - Up to $7,500/physician; $37,500/practice over 3 year demonstration

24

Summary

- Potential payment over 3 year demonstration
  - $38,500/physician; $192,500/practice



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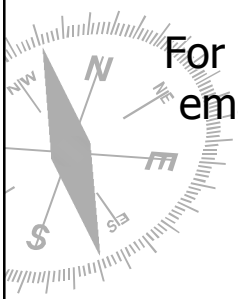
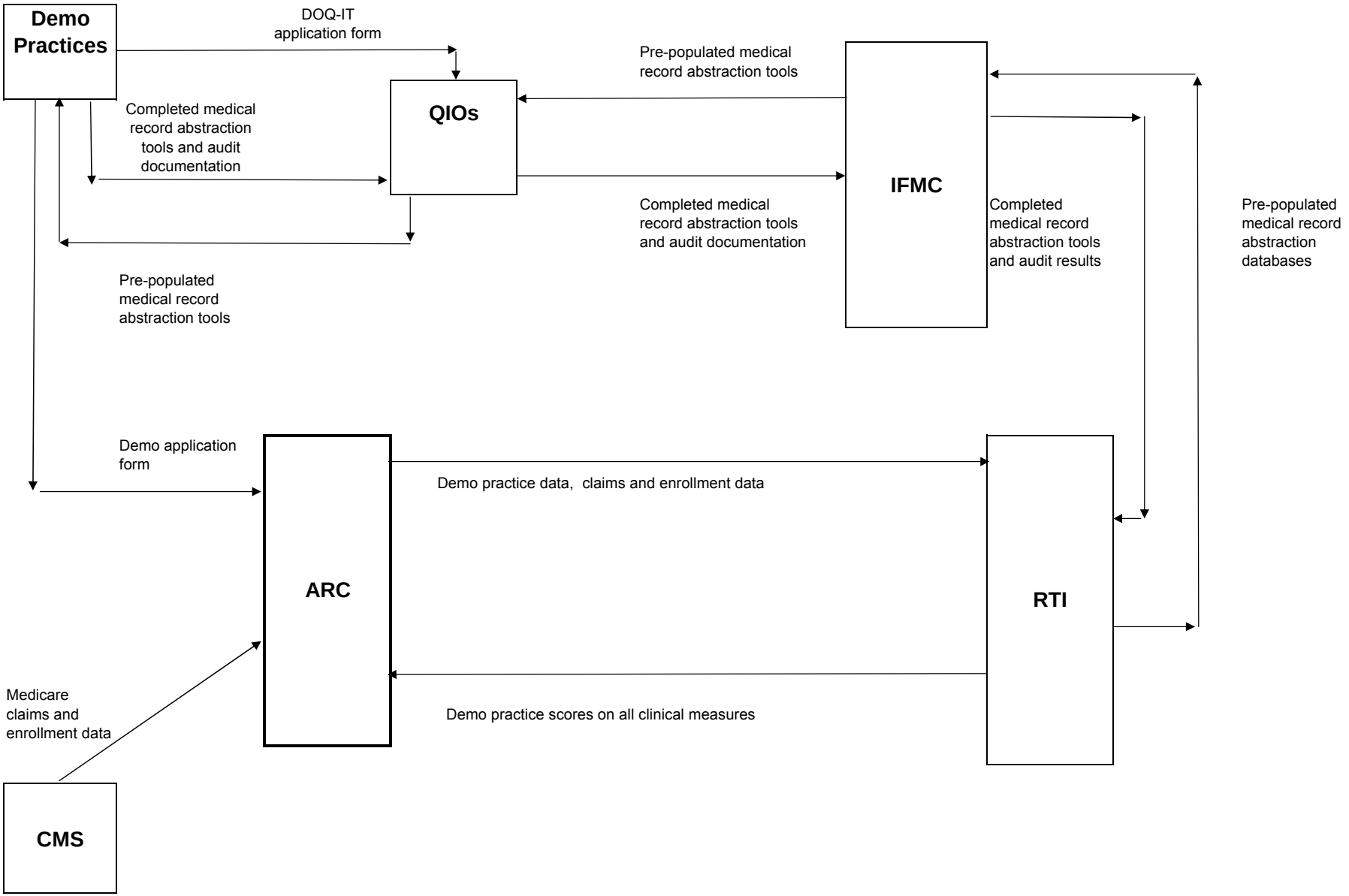
The End

For questions on payment, please email MCMPdemo@cms.hhs.gov



MCMP Demonstration Summary Data Collection Flow Chart



Medicare Care Management Performance (MCMP) Demonstration

Kick-Off Meetings

May – June 2007

Michael Trisolini, PhD, MBA
Musetta Leung, PhD
RTI International

Presentation Outline

7. Review of data collection and payment processes flow charts & timelines

Handout: Flow chart of data collection processes

Organizations involved in MCMP data collection processes

- Physician practices
- QIOs
- CMS
- ARC
- RTI
- IFMC
- MPR

Data Collection Roles: Physician Practices

- Complete the computerized medical record abstraction tool once per year
- Hard copy medical record documentation provided if sampled for audit

Data Collection Roles: QIOs

- Transmit medical record abstraction tools to physician practices in their state
- Provide technical assistance and training to physician practices to support medical records data collection
- Check completed medical record abstraction tools submitted by each physician practice, resolve problems as needed, and transmit completed tools to IFMC

RTI INTERNATIONAL

Data Collection Roles: CMS

- Provide Medicare claims and enrollment data to ARC
- Overall supervision of data collection
- Review and approve annual results

RTI INTERNATIONAL

Data Collection Roles: ARC

- Conduct annual beneficiary assignment process for each physician group
- Provide Medicare claims and enrollment data to RTI and MPR
- Calculate annual performance payments for each physician practice

RTI INTERNATIONAL

Data Collection Roles: RTI

- Calculate performance results for claims-based quality measures
- Pre-populate sampled patients and claims data into the medical record abstraction tools for each physician practice
- Calculate quality measure performance results for each physician practice from completed abstraction tools
- Provide technical assistance to QIOs

RTI INTERNATIONAL

Data Collection Roles: IFMC

- Programming for MCMP-PAT medical record abstraction tool
- Liaison with measure owners, prepare measure specifications, and update as needed
- Preparing MCMP-PAT abstraction tools for distribution to physician practices
- Data checking and cleaning for completed abstraction tools
- Technical assistance to QIOs

RTI INTERNATIONAL

Data Collection Roles: MPR

- Analysis of quality measure performance results for non-demonstration comparison group physician practices
- Evaluation of demonstration effects

RTI INTERNATIONAL

Data Collection Timeline

1) Medicare claims data sent from CMS to ARC
   – 3.5 months after end of performance period

2) Assigned beneficiaries calculated by ARC, claims data sent from ARC to RTI
   – 4.5 months after end of performance period

3) Claims-based quality measures calculated by RTI, pre-populated abstraction tools sent from RTI to IFMC
   – 6 months after end of performance period

RTI INTERNATIONAL

Data Collection Timeline (cont.)

4) IFMC completes and checks abstraction tools, IFMC transmits tools to QIOs, QIOs transmit tools to physician practices
   – 6.5 months after end of performance period

5) Physician practices transmit completed tools to QIOs
   – 8.5 months after end of performance period

6) QIOs and IFMC check completed abstraction tools, resolve problems as needed, IFMC transmits completed tools to RTI
   – 9.5 months after end of performance period

RTI INTERNATIONAL

Data Collection Timeline (cont.)

7) RTI calculates results for chart-based measures, RTI finalizes results for claims-based measures with hybrid data collection, RTI transmits results to ARC
   – 10.5 months after end of performance period

8) ARC calculates performance payments owed to non-audited physician practices based on quality measure results
   – 11.5 months after end of performance period

9) IFMC and RTI conduct audit on a sample of practices, ARC calculates payments owed to audited practices after results finalized
   – 13.5 months after end of performance period

RTI INTERNATIONAL

Medicare Care Management Performance (MCMP) Demonstration Project Kickoff Meeting

Donna H. Curran
Project Leader
Masspro

May 15, 2007

MASSPRO *Making an Impact.*

Introductions

- Donna Curran – Project Leader
- Susan Ordway – Senior Director of HIT Services
- Joseph Holtschlag – DOQ-IT Manager
- Theresa Marino – Healthcare Information Systems Advisor
- Patricia Manning – Healthcare Information Systems Advisor
- Anne O'Donnell – Physician Practice Advisor
- Denise Scott – Physician Practice Advisor
- Ellen Burneika – Physician Practice Advisor
- Joanna Wissler – Physician Practice Advisor
- Julie Borden – Physician Practice Advisor
- Don D'Amore – Business Analyst
- Cheryl Gilbert – Administrative Assistant

MASSPRO *Making an Impact.*

About Masspro

- Massachusetts Quality Improvement Organization (QIO) since 1985.
- Headquartered in Waltham with over 120 employees.
- An independent, nonprofit, healthcare consulting organization dedicated to improving the quality, safety, and integrity of healthcare.
- The only organization in Massachusetts working across the full continuim of providers, including hospitals, physician offices, nursing homes and home health organizations.
- Contracts with federal, state, local governments, and other organizations.

Doctor's Office Quality-Information Technology

- There are currently 318 practices enrolled in DOQ-IT, a CMS funded program that assists small to medium sized practices with EHR adoption and use.
- Practices enrolled in DOQ-IT receive assistance in:
  - Readiness assessment and strategic preparation for EHR implementation
  - EHR Vendor selection and contracting
  - Process re-engineering for improved operational and clinical effectiveness.
  - Paper to paperless transition planning
  - Using EHR to enhance care management

MCMP Assistance

Masspro Physician Practice Advisor assist with:

- **Completion of all necessary forms**
  - **Application-enrollment,**
  - **QNet registrations**
  - **Surveys**
- **Technical assistance as practices begin data abstraction**
- **Assistance to help practices achieve the highest possible payment levels**

Timeline

- **May**
  - **QualityNet (QNet) Exchange Registration**
- **June**
  - **Practice Preparation**
  - **Practice Training on the Performance Assessment Tool (PAT)**
- **July/August**
  - **PAT made available to practices**
  - **Practice data collection and baseline reporting**
  - **Complete Office Systems Survey**
- **September/October**
  - **The Centers for Medicare & Medicaid Services (CMS) will calculate incentive for reporting baseline data**

QualityNET 101

➢ **QualityNet (QNet) Exchange Registration**

- **Secure Internet site where all data will be exchanged between the practice, Masspro and CMS.**
- **All accepted practices must be registered by early July.**
- **If you do not register for QNet, you will not get paid!**

QNET Registration Form

QualityNet Exchange Security Administrator Registration Form

*NOTE: All fields marked with an asterisk are required and must be completed to obtain approval.

Access Request

*Request Date: | *First Name: | Middle Initial: | *Last Name:

*Business E-Mail Address:

*Job Title:

*Business Name:

*Specify Setting: (Check only one) ☐ QIO ☐ Hospital ☐ Physician Office ☐ Nursing Home ☐ State Agency ☐ CMS ☐ Home Health Agency ☐ ESRD Network ☐ ESRD Facility ☐ Health Care System ☐ Other (Specify):
☐ Vendor: Hospital-HDC ☐ Vendor: Hospital-HCAHPS ☐ Vendor: Physician Office ☐ Vendor: Nursing Home-NHIFT ☐ Vendor: Premier

Medicare Provider Number: (If applicable): | Vendor ID Number: (If applicable):

*Business Address: Street | City | State | ZIP

*Work Phone: ( ) | Extension: | Fax: ( )

*Security Question (answer only one): City of birth ______ Pet's name ______ Mother's maiden name ______

Signatures Required

*Applicant: | *Date:

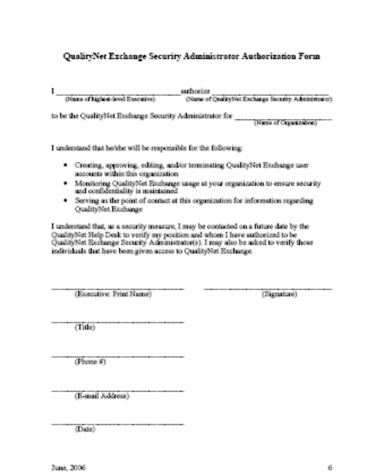
*As The Assigned Notary Public I have used the following ID as verification
☐Driver's License ☐Passport ☐Other: ______

*Notarized Date: ______ Notary Expiration Date: ______

*Notary Public (seal or stamp):

*Notary Signature: ______

June, 2006 5



QualityNet Exchange Security Administrator Authorization Form

I ______ (Name of highest-level Executive) authorize ______ (Name of QualityNet Exchange Security Administrator)

to be the QualityNet Exchange Security Administrator for ______ (Name of Organization)

I understand that he/she will be responsible for the following:

- Creating, approving, editing, and/or terminating QualityNet Exchange user accounts within this organization
- Monitoring QualityNet Exchange usage at your organization to ensure security and confidentiality is maintained
- Serving as the point of contact at this organization for information regarding QualityNet Exchange

I understand that, as a security measure, I may be contacted on a future date by the QualityNet Help Desk to verify my position and whom I have authorized to be QualityNet Exchange Security Administrator(s). I may also be asked to verify those individuals that have been given access to QualityNet Exchange.

______ (Executive: Print Name) ______ (Signature)

______ (Title)

______ (Phone #)

______ (E-mail Address)

______ (Date)

June, 2006 6

QNET Registration Process

- Complete and notarize the form.
- Recommended that each practice designate two representatives to create accounts.
- Fax to Masspro when complete.

Attn: Cheryl Gilbert
MCMP Special Study
Fax: 781-419-2508

Great Opportunity for Massachusetts

- Bring money into Massachusetts practices.
- Lead the nation in EHR adoption.
- Provide the foundation for enhanced quality of care.

Contact Information

Donna Curran
Massachusetts MCMP Project Lead
Phone: (781) 419-2881
E-mail: dcurran@maqio.sdps.org

Cheryl Gilbert
Massachusetts MCMP Project Coordinator
Phone: (781) 419-2895
E-mail: cgilbert@maqio.sdps.org

Medicare Care Management Performance Demonstration

Utah Kick-off Meeting

Sharon Donnelly

May 17, 2007

HealthInsight

- Quality Improvement Organization (QIO) for Utah and Nevada
- Contracted by CMS to provide technical assistance to healthcare providers in:
  - Hospitals
  - Nursing homes
  - Home health agencies
  - Outpatient clinics
- Objective: improve care for all patients

Clinic Liaisons - Facilitator

Anna Baker
Anne Smith
David Cook
Gary Berg
Linda Johnson
Sharon Donnelly

Keith Parker
Southern Utah
Therese Bjorge
Administrative Assistant
Kim Bateman
John Nelson
Medical Directors

Doctor's Office Quality – Information Technology (DOQ-IT)

- Assist adult primary care providers in Utah and Nevada to adopt and more effectively use electronic health records (EHR) to improve patient care
- 150 practices in Utah
- DOQ-IT participation required for MCMP
- Clinic involvement in DOQ-IT varies by need and stage of EHR use

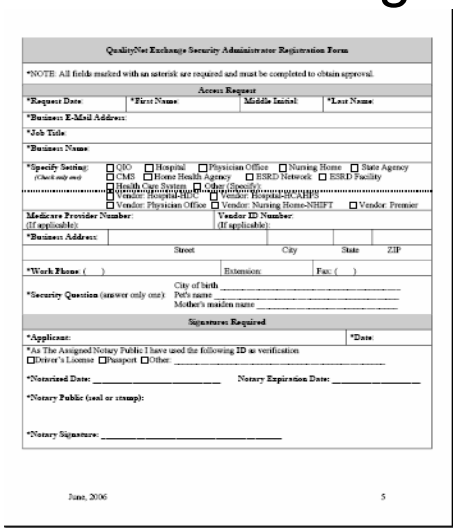
Roadmap To EHR Adoption

- Assessment - ready for EHR?
- Planning - goals
- Selection - objectivity
- Implementation - vendor driven
- Evaluation - use, HIT, data
- Improvement - patient centered

MCMP Assistance

- QIO point person for each clinic
- Assist with all those forms:
  - application, enrollment, QNet Exchange, surveys
- Additional onsite training available as you begin data abstraction
- Help you to achieve highest possible payment levels

QNet Registration Form



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*Business E-Mail Address:

*Job Title:

*Business Name:

*Specify Setting: (Check only one) ☐ QIO ☐ Hospital ☐ Physician Office ☐ Nursing Home ☐ State Agency ☐ CMS ☐ Home Health Agency ☐ ESRD Network ☐ ESRD Facility ☐ Health Care System ☐ Other (Specify) ☐ Vendor: Hospital-IMPAC ☐ Vendor: Hospital-HCAHPS ☐ Vendor: Physician Office ☐ Vendor: Nursing Home-NHHFT ☐ Vendor: Premier

Medicare Provider Number: (If applicable) | Vendor ID Number: (If applicable)

*Business Address: Street | City | State | ZIP

*Work Phone: ( ) | Extension: | Fax: ( )

*Security Question (answer only one): City of birth _____ Pet's name _____ Mother's maiden name _____

Signature Required

*Applicant: | *Date:

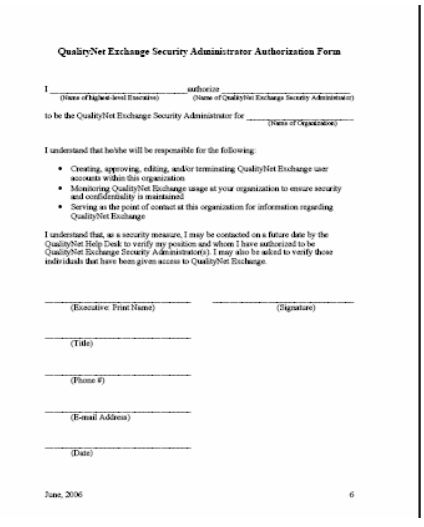
*As The Assigned Notary Public I have used the following ID as verification: ☐Driver's License ☐Passport ☐Other: _____

*Notarized Date: _____ Notary Expiration Date: _____

*Notary Public (seal or stamp):

*Notary Signature: _____

June, 2006 5



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- Monitoring QualityNet Exchange usage at your organization to ensure security and confidentiality is maintained
- Serving as the point of contact at this organization for information regarding QualityNet Exchange

I understand that, as a security measure, I may be contacted on a future date by the QualityNet Help Desk to verify my position and whom I have authorized to be QualityNet Exchange Security Administrator(s). I may also be asked to verify those individuals that have been given access to QualityNet Exchange.

_____ _____
(Executive: Print Name) (Signature)

_____
(Title)

_____
(Phone #)

_____
(E-mail Address)

_____
(Date)

June, 2006 6

Highest Payment, Lowest Cost

1. Targeted health care services provided
   - Diabetes
   - Heart Failure
   - Coronary Artery Disease
   - Prevention
2. Documented in a way that is easy to find

1. Highest Quality of Care

- Check sheets to remind (paper charts)
- Template adaptation and/or registry features to prompt (EHRs)
- Workflow analysis
  - Role redesign
  - Provider agreement on care processes
- Plan and execute changes to improve care
  - Ongoing improvement
  - 2006 data will be a source of baseline information

2. Documentation (to ease abstraction)

- Flow or check sheets
- Templates and registries
- Workflow analysis
  - scanning and manual processes
- Plan and execute improvement changes
- 2006 data abstraction will be a learning experience

Great Opportunity for Utah

- Bring more money into Utah clinics
- Get ahead of the game on evidence of providing highest quality of care
- Lead the nation in EHR adoption
- Hope to lead in quality of care

Thanks For Joining Us!

Sharon Donnelly, MS
Healthcare Redesign/HIT Lead
sdonnelly@healthinsight.org
801.892.0155 – office
801.892.6668 – direct
801.560.9001 – cell

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801-892-6652

Lumetra
Brighter insights. Better healthcare.

Medicare Care Management Performance (MCMP) Demonstration Project Kickoff Meeting

Peter Boumenot
Healthcare IT Consultant
Lumetra

May 2007

About Lumetra

- California Quality Improvement Organization (QIO) since 1984.
- Headquartered in San Francisco with more than 160 employees.
- An independent, nonprofit, healthcare consulting organization dedicated to improving the quality, safety, and integrity of healthcare.
- Contracts with federal, state, local governments, and other organizations.

Introductions

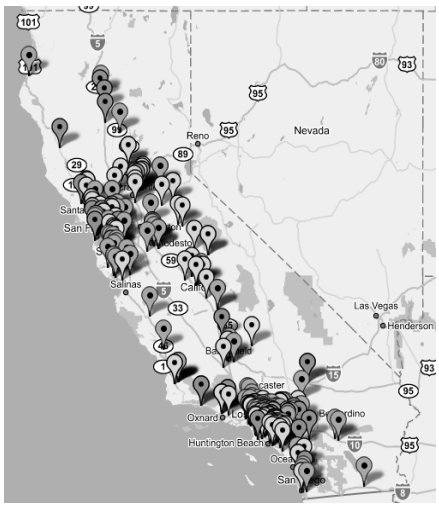
- Dr. Joseph Scherger – Medical Director, Informatics
- Ida Ahmadpour – Senior Manager
- Peter Boumenot – Healthcare IT Consultant
- Jennifer Clarke – Healthcare IT Consultant
- Eric Korsgaard – Healthcare IT Consultant
- Cathy Coleman – Healthcare Consultant
- Evelyn Rupp – Healthcare Consultant
- Gordon Wright – Project Coordinator

Lumetra

3

Where Is DOQ-IT Now?

- California
  - → 265 Total Practices
  - → 133 Selection
  - → 36 Implementation
  - → 96 Optimization
- Consultative Model
  - →Site Visits
  - →Workflow Assessments



Lumetra

4

Lumetra's Role in MCMP

- Serve as initial point of contact for all project-related activities.
- Facilitate the data abstraction process for participating physicians.
- Facilitate data exchange transfer for all participating physicians.

Lumetra

5

Timeline

- **May**
  - QualityNet (QNet) Exchange Registration
- **June**
  - Practice Preparation
  - Practice Training on the Performance Assessment Tool (PAT)
- **July - September**
  - PAT made available to practices
  - Practice data collection and baseline reporting
  - Complete Office Systems Survey.
- **Fall 2007/Winter 2008**
  - The Centers for Medicare & Medicaid Services (CMS) will calculate and send to practices initial incentive for reporting baseline data.

Lumetra

6

QualityNet 101

- QualityNet (QNet) Exchange Registration
  - Secure Internet site where all data will be exchanged between the practice, Lumetra, and CMS.
  - All accepted practices must be registered by early July.
  - If you do not register for QNet, you will not get paid!

Lumetra

7

QNet Registration Process

- Recommended that each practice designate one representative.
- Multi-site groups will require one registrant.
- Each registrant will receive a unique username and password to use for submission of data reports.
- Notarize the registration form and mail original to Lumetra when complete.

Attn: Gordon Wright
MCMP Special Study
Lumetra
One Sansome St.
San Francisco, CA 94104

Lumetra

8

Contact Information

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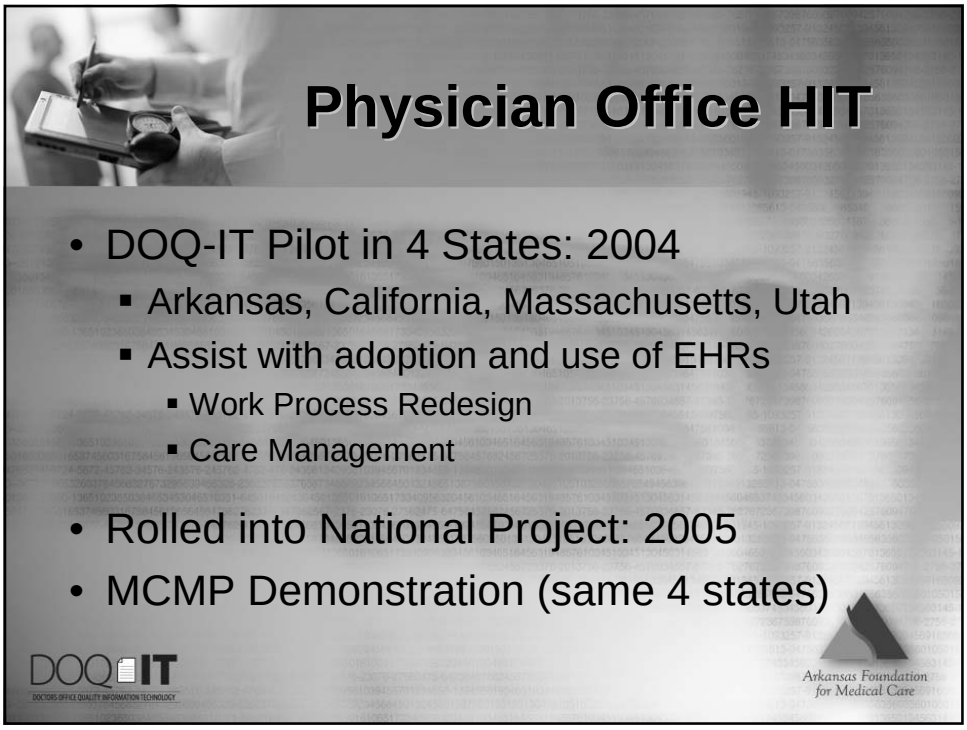
Lumetra

This material was prepared by Lumetra, the Medicare Quality Improvement Organization for California, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Contract number HHSM-500-200-CA02 8S0W-CA-1D1-07-39


Medicare Care Management Performance (MCMP) Demonstration
We're Here to Help…
DOQ-IT
DOCTORS OFFICE QUALITY-INFORMATION TECHNOLOGY
Arkansas Foundation for Medical Care


About AFMC
• Our Mission: To promote excellence in healthcare through evaluation and education.
• Quality Improvement Organization for Arkansas
• Quality Program assists with:
– Development & Implementation of Quality Initiatives
– Health Information Technology
– Professional & Consumer education
DOQ-IT
DOCTORS OFFICE QUALITY-INFORMATION TECHNOLOGY
Arkansas Foundation for Medical Care


Physician Office Team
Nancy Archer AVP, Quality
Julie Kettlewell Team Leader
Kimberly Hayman Academic Detailer
Rhelinda McFadden Academic Detailer
Jo Nycum Academic Detailer
Rebel Ward-McKnight HIT Specialist
Sarah Neumeier Project Coordinator
DOQ-IT
DOCTORS OFFICE QUALITY-INFORMATION TECHNOLOGY
Arkansas Foundation for Medical Care


Physician Office HIT
• DOQ-IT Pilot in 4 States: 2004
▪ Arkansas, California, Massachusetts, Utah
▪ Assist with adoption and use of EHRs
▪ Work Process Redesign
▪ Care Management
• Rolled into National Project: 2005
• MCMP Demonstration (same 4 states)
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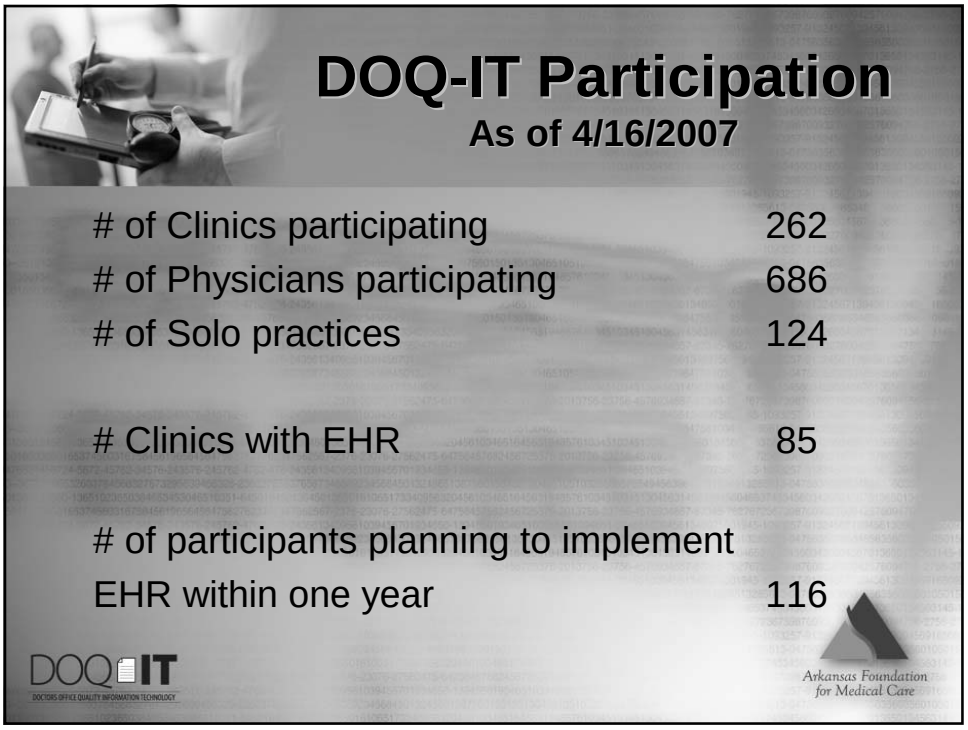
DOQ-IT/MCMP Roadmap
Recruit Enroll
Assess Onsite/Everything/Team
PLAN Goals/Redesign/Improve
Select Software & Hardware
Implement Clinic support
Evaluate Goals met/Data capture
Improve Care management
DOQ IT
DOCTORS OFFICE QUALITY INFORMATION TECHNOLOGY
Arkansas Foundation for Medical Care


DOQ-IT Participation
As of 4/16/2007
# of Clinics participating 262
# of Physicians participating 686
# of Solo practices 124
Clinics with EHR 85
of participants planning to implement EHR within one year 116
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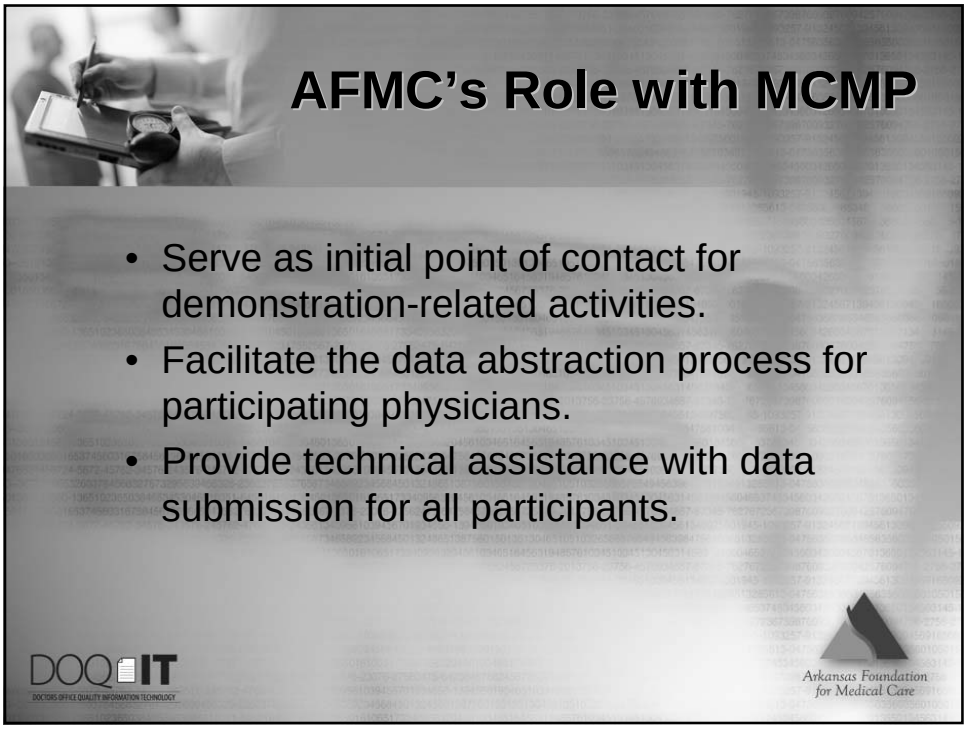
DOCTORS OFFICE QUALITY INFORMATION TECHNOLOGY
Arkansas Foundation for Medical Care


AFMC's Role with MCMP
• Serve as initial point of contact for demonstration-related activities.
• Facilitate the data abstraction process for participating physicians.
• Provide technical assistance with data submission for all participants.
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Timeline
• This Month
– Follow-up Q & A calls for practices
– Designate Office MCMP Coordinator
• Summer
– Data Abstraction Training for ALL practices
– Practice data collection and baseline reporting
– Complete Office Systems Survey
• Fall/Winter
– CMS will process initial practice reported baseline data.
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QualityNet Exchange
www.QualityNet.org
– Secure Internet portal where data exchange will occur
– All accepted practices must be registered by early July
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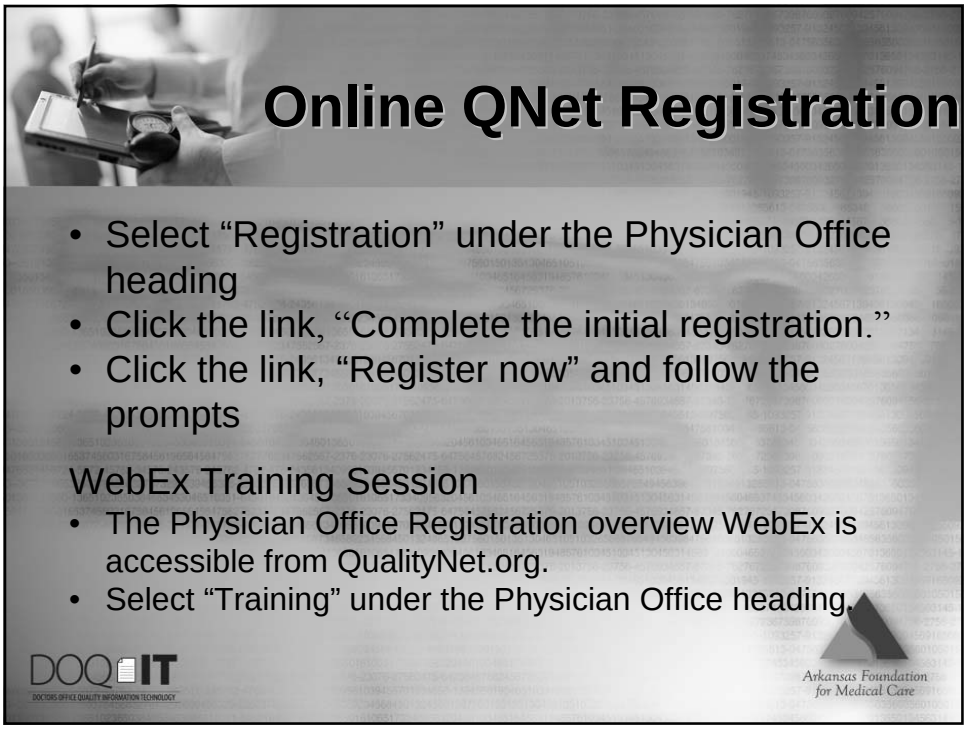
Online QNet Registration
• Select “Registration” under the Physician Office heading
• Click the link, “Complete the initial registration.”
• Click the link, “Register now” and follow the prompts
WebEx Training Session
• The Physician Office Registration overview WebEx is accessible from QualityNet.org.
• Select “Training” under the Physician Office heading.
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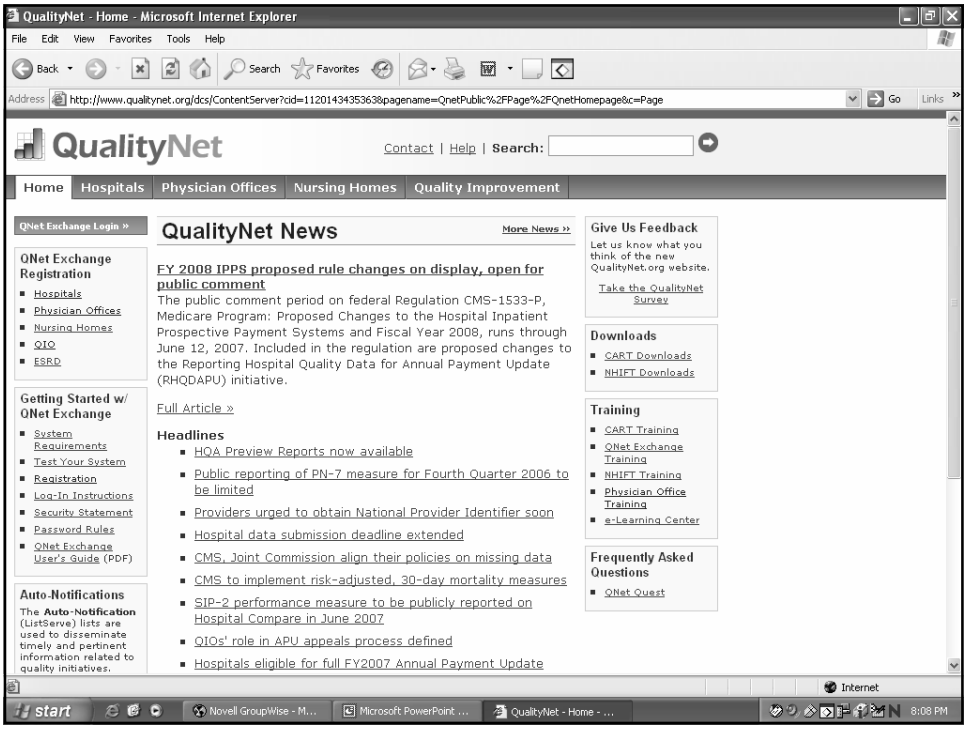
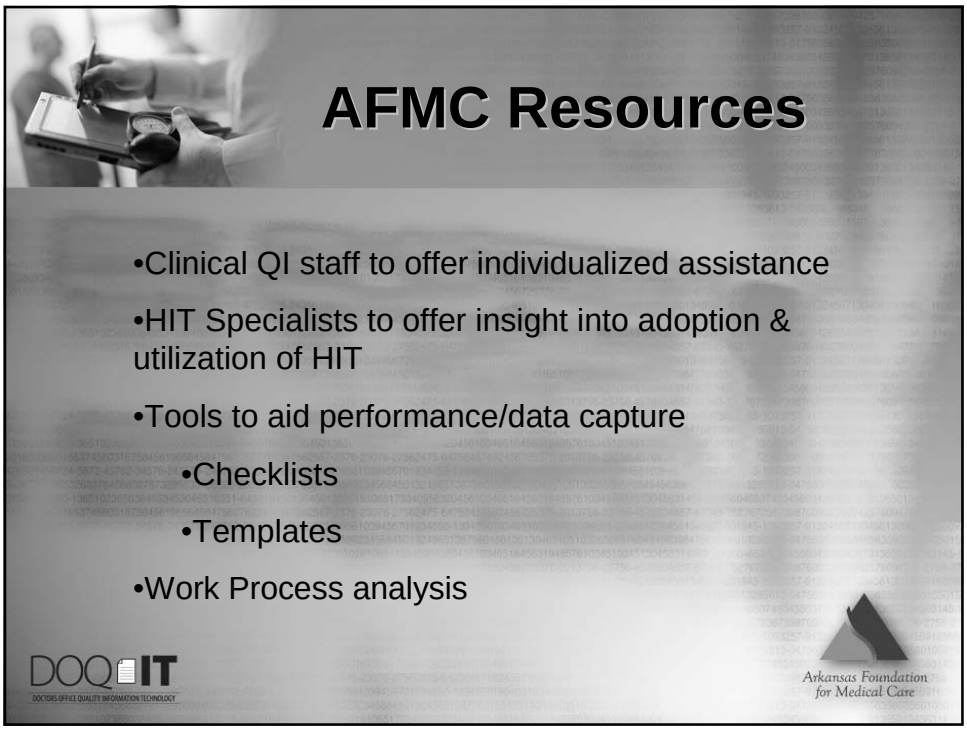
Arkansas Foundation for Medical Care


QualityNet - Home - Microsoft Internet Explorer
File Edit View Favorites Tools Help
Back Search Favorites
Address http://www.qualitynet.org/dcs/ContentServer?cid=1120143435363&pagename=QnetPublic%2FPage%2FQnetHomepage&c=Page
Go Links
QualityNet
Contact | Help | Search:
Home Hospitals Physician Offices Nursing Homes Quality Improvement
QNet Exchange Login »
QNet Exchange Registration
Hospitals
Physician Offices
Nursing Homes
QIO
ESRD
Getting Started w/ QNet Exchange
System Requirements
Test Your System
Registration
Log-In Instructions
Security Statement
Password Rules
QNet Exchange User's Guide (PDF)
Auto-Notifications
The Auto-Notification (ListServe) lists are used to disseminate timely and pertinent information related to quality initiatives.
QualityNet News
More News »
FY 2008 IPPS proposed rule changes on display, open for public comment
The public comment period on federal Regulation CMS-1533-P, Medicare Program: Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008, runs through June 12, 2007. Included in the regulation are proposed changes to the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) initiative.
Full Article »
Headlines
HQA Preview Reports now available
Public reporting of PN-7 measure for Fourth Quarter 2006 to be limited
Providers urged to obtain National Provider Identifier soon
Hospital data submission deadline extended
CMS, Joint Commission align their policies on missing data
CMS to implement risk-adjusted, 30-day mortality measures
SIP-2 performance measure to be publicly reported on Hospital Compare in June 2007
QIOs' role in APU appeals process defined
Hospitals eligible for full FY2007 Annual Payment Update
Give Us Feedback
Let us know what you think of the new QualityNet.org website.
Take the QualityNet Survey
Downloads
CART Downloads
NHIFT Downloads
Training
CART Training
QNet Exchange Training
NHIFT Training
Physician Office Training
e-Learning Center
Frequently Asked Questions
QNet Quest
Internet
start
Novell GroupWise - M...
Microsoft PowerPoint ...
QualityNet - Home - ...
8:08 PM


AFMC Resources
•Clinical QI staff to offer individualized assistance
•HIT Specialists to offer insight into adoption & utilization of HIT
•Tools to aid performance/data capture
•Checklists
•Templates
•Work Process analysis
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DOCTORS OFFICE QUALITY INFORMATION TECHNOLOGY
Arkansas Foundation for Medical Care


Arkansas MCMP Team
physicianoffice@afmc.org
1-877-375-5700
DOQ IT
DOCTORS OFFICE QUALITY INFORMATION TECHNOLOGY
Arkansas Foundation
for Medical Care

SDPS MEMORANDUM

MEMO NBR: 06-518-PO

DATE: December 22, 2006

SUBJECT: Physician Office QNet Exchange Registration Process

TO: SDPS PO Point of Contact, QIOSA Point of Contact

FROM: SDPS Team, Kathy Barberio

Physician Office QNet Exchange Registration (online)
This memo is released to provide helpful hints for QIOs assisting physician practices with the online QNet Exchange registration process available on QualityNet.org. The online process includes strict validation rules to ensure registrant information is accurate and secure. A registration checklist is attached that displays the type of information needed to complete the registration process. In situations where a physician office is unable to complete the online registration, additional information may be required as described below.

Information entered during the online process is validated against the Program Resource System (PRS) and Part B Medicare Claims data. In order for the practice to successfully complete the registration, data in PRS must match the information the practice enters during the online registration process. The QIO should verify the registrant's Tax ID in PRS is the same Tax ID the registrant uses to submit Part B claims to CMS.

For group registrants, the next step of validation matches the following two fields seen on PRS on the Physician Group Maintenance screen:

- Tax ID
- Provider Number (Medicare Billing Number)

For individual registrants, the next step of validation matches the following two fields seen on PRS on the Physician Maintenance List screen:

- TIN
- Medicare Billing Number (located on the Physician Contact, Address, and Telephone Maintenance screen)

The Provider Number/Medicare Billing Number in PRS must be the same number the practice has used to submit Part B Claims to CMS. The Provider Number/Medicare Billing Number is located in field 33 and the Tax ID/TIN is located in field 25 on the 1500 Claim Form (attached).

Please notify your internal point of contact if you have any questions. He or she may contact the QualityNet Help Desk if additional information and/or assistance are needed.

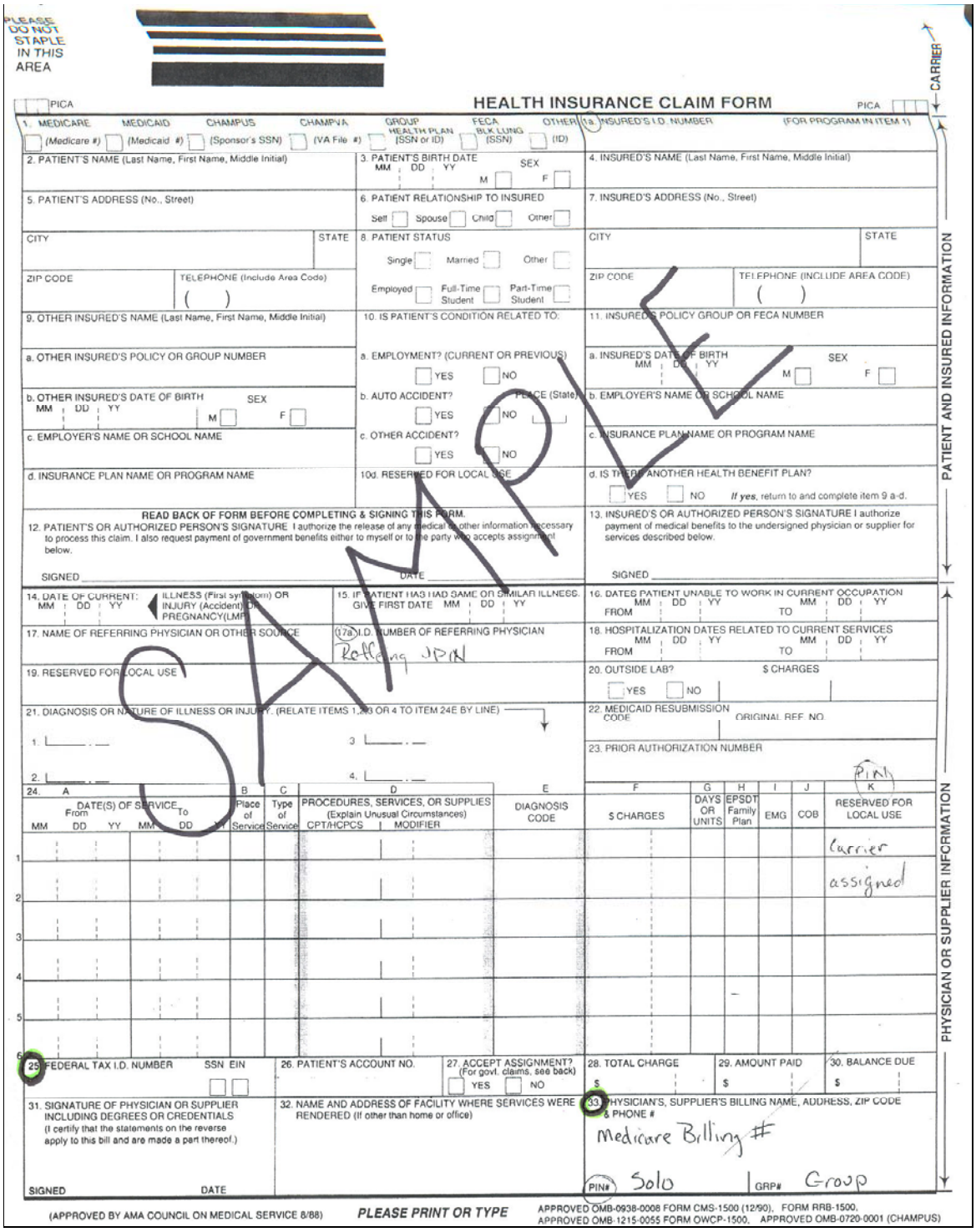
Physician Office Registration Checklist

What do I need in order to complete the registration process?

☑	Information Needed	Description
	Primary Practice Information	ZIP Code (for the physical location of your practice) Group UPIN Business Address City State Main Phone Number
	Individual Physician UPIN (for a solo practitioner)	The Individual Physician UPIN is a 6 digit number that uniquely identifies either an individual physician within a group, or a solo physician practicing on his/her own and not within a group practice setting. The physician UPIN is assigned by the physician registry.
	Tax ID	The Tax Identification (ID) Number is a 9 digit number used by the practice to submit claims to CMS. The Medicare Billing Number associated with this Tax ID in the Program Resource System (PRS) maintained by the QIOs must be the Medicare Billing Number the practice submits Part B claims to CMS.
	National Provider Identification (NPI) Number	The National Provider Identification (NPI) number is a unique national identifier number assigned to each and every provider of Medicare health care services – individuals, organizations and groups.
	QualityNet Exchange Security Administrator Information *(The QualityNet Exchange Security Administrator serves as the point of contact at your organization for information regarding QualityNet Exchange)*	First Name Last Name E-mail Address Title/Designation Work Phone Number **Note:** It is highly recommended that each practice designate two people as QualityNet Exchange Security Administrators for the organization; one acting as the primary QualityNet Exchange Security Administrator and the other as a secondary administrator. Both the primary and secondary administrators can be registered via the registration process. Information for both administrators is necessary.
	Approving Officer Information *(Your Approving Officer is the highest-level executive at your location.)*	First Name Last Name Work Phone Number Title/Designation Signature
	Access to a Notary Public	The completed QualityNet Exchange Security Administrator Registration Form must be signed by the applicant in the presence of a Notary Public. The Notary's signature and seal/stamp are required on the form. **Note:** Most banks and libraries have a Notary available. While not required in some states, a Notary seal/stamp **is required** on the QualityNet Exchange registration form for approval.
	Adobe® Acrobat® Reader™ software	Adobe Acrobat Reader (latest version) is needed to view and print your QualityNet Exchange Registration forms. Adobe Acrobat Reader is available for download, at no cost, from the Adobe website, http://www.adobe.com.

Mail original, signed and notarized registration forms to the QualityNet Help Desk:
The QualityNet Help Desk
6000 Westown Parkway
West Des Moines, IA 50266

** For additional assistance with practice/physician identifying information, please contact your QIO.



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN Rolling JPIN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ___ 3. ___

2. ___ 4. ___

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PIN

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										Carrier
2										assigned
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Medicare Billing #

PIN# Solo GRP# Group

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0008 FORM CMS-1500 (12/90). FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500. APPROVED OMB-0720-0001 (CHAMPUS)

QualityNet Exchange SECURITY ADMINISTRATOR Registration Forms and Instructions

Completion of the QualityNet Exchange Security Administrator Registration Form and QualityNet Exchange Security Administrator Authorization Form, in this packet, are required to request access to the secure QualityNet website as the QualityNet Exchange Security Administrator for your organization.

Please refrain from making any changes or modifications to these forms, as this can delay the registration process. If you feel you have a business need to modify the registration forms, please contact the QualityNet Help Desk.

As a QualityNet Exchange Security Administrator, your responsibilities will include:

- Creating, approving, editing, and/or terminating QualityNet Exchange user accounts within your organization
- Monitoring QualityNet Exchange usage at your organization to ensure security and confidentiality is maintained
- Serving as a point of contact at your organization for information regarding QualityNet Exchange

It is highly recommended that each organization designate **two** people as **QualityNet Exchange Security Administrators** -- one to serve as the primary security administrator and the other, to act as a backup security administrator.

The following information is specific to QIOs:

- **Single State QIOs**: Two QualityNet Exchange Security Administrators, a primary and a backup may be authorized.
- **Multi-state QIOs**: Multi-state QIOs have a top-level group along with sub-groups for each of the individual states. If a QIOSA is assigned to the top-level group, that individual then has the ability to manage users at any of the sub-groups and is counted as one of the two allowed QIOSAs for each of the state sub-groups.

To initiate the registration process, please complete the following steps:

1. **Print** your information **legibly** and **completely** in each of the applicable fields on the **QualityNet Exchange Security Administrator Registration Form**.

2. **Sign** and **date** the **QualityNet Exchange Security Administrator Form** in the presence of a Notary Public, obtaining the Notary's stamp and seal on the form. Even though not all states require the stamp or seal of the notary, it is required by QualityNet Exchange.

3. Have the highest-level **executive** at your location **complete** and **sign** the **QualityNet Exchange Security Administrator Authorization Form.**

4. Based on your organization affiliation, refer to the table below for mailing instructions of the original, completed **QualityNet Exchange Security Administrator Registration Form** and the **QualityNet Exchange Security Administrator Authorization Form.** Photocopies or faxes of the forms will not be accepted. Keep a copy of all forms at your office.

   Forms mailed to the wrong location will delay the registration process. If you have questions about the mailing address, please contact the QualityNet Help Desk for correct information *prior* to mailing.

Organization Type	Mail Original Forms to:
• ESRD Facility, Network	ESRD Network ESRD Network Directory available at http://www.esrdnetworks.org/.
• Hospital* *Registering for a single hospital	Quality Improvement Organization QIO Directory available at www.medqic.org under QIO Listings
• Health Care System* *Report-only access for multiple hospital representation	QualityNet Help Desk 6000 Westown Parkway, Suite 350E West Des Moines, IA 50266
• Vendor	QualityNet Help Desk 6000 Westown Parkway, Suite 350E West Des Moines, IA 50266
• All Others	Quality Improvement Organization QIO Directory available at www.medqic.org under QIO Listings

5. A **QualityNet Exchange Security Registration Forms Checklist** has been included in this packet for your convenience. Please use the checklist to verify that you have completed all the necessary steps of registration prior to mailing the completed forms.

6. Your QualityNet Exchange Security Administrator will enter your registration information online in the secured area of QualityNet. They will then mail the original, completed forms to the QualityNet Help Desk, keeping a copy at their office.

7. The QualityNet Help Desk will process your registration forms. When processing is completed, they will notify you by e-mail that the **registration** process is

complete and that the secure area of **QualityNet** is now **accessible to you**. The e-mail you receive will contain your Log-In ID. If your QualityNet Exchange Security Administrator has not notified you of your password, click on the Forgot Your Password? link on the Log-In screen of the QualityNet Exchange website at https://qnetexchange.org/qnet/userLogon.do and enter the requested information. A temporary password will be e-mailed to you.

8. All QualityNet Exchange users need to run the **Test Your System** feature to test the compatibility of their computer with the QualityNet Exchange site to insure that they have the required Java Runtime Environment and associated policy files to utilize the system. Follow instructions found on the Getting Started/w QNet Exchange/Test Your System section of the QualityNet website at http://www.qualitynet.org/.

9. If you have any questions regarding this process, contact the QualityNet Help Desk at (866) 288-8912 or by e-mail at Qnetsupport@ifmc.sdps.org.

QualityNet Exchange Security Administrator Registration Form Field Descriptions

Access Request	
Request Date	**REQUIRED**. The date the **QualityNet Exchange Security Administrator Registration Form** is completed.
First Name	**REQUIRED.** The first name of the person for which the QualityNet Exchange access request is requested. *This person will now be referred to as the user.*
Middle Initial	The first initial of the middle name of the user.
Last Name	**REQUIRED.** The last name of the user.
Business E-mail Address	**REQUIRED.** The user's e-mail address at his/her organization.
Job Title	**REQUIRED.** The job title of the user.
Business Name	**REQUIRED.** The name of the organization where the user will access QualityNet Exchange. If applying to be a QualityNet Exchange Security Administrator for a Health Care System (HCS), enter the name of the HCS.
Setting	**REQUIRED.** The type of organization for which you are applying to be the QualityNet Exchange Security Administrator.

Medicare Provider Number (If applicable)	The Medicare provider number of the organization.
Vendor ID Number (If applicable)	The Vendor ID number assigned by IFMC. Contact the QualityNet Help Desk if you need assistance with identifying this number.
Business Address	**REQUIRED.** The address of the organization.
Work Phone Number	**REQUIRED.** The work telephone number of the user.
Extension Number (If applicable)	The work telephone extension number of the user.
Fax Number	The fax number of the organization.
Security Question/Answer	**REQUIRED.** A Security Question that is easily answered by the user but that would be difficult for others to answer. Security Question choices: City of birth, Pet's name, or Mother's maiden name. Enter the correct answer next to the selected Security Question. This question is used for security and password validation purposes.

Signatures Required	
Applicant	**REQUIRED.** The signature of the user. The user must sign in the presence of a Notary.
Date	**REQUIRED.** The date the **QualityNet Exchange Security Administrator Registration Form** is signed by the user.
ID Verified by Notary	**REQUIRED.** The type of identification the Notary used to verify the identity of the applicant. If “Other” is selected, please specify.
Notarized Date	**REQUIRED.** The date the Notary Public signs the form.
Notary Expiration Date	The commission expiration date of the notary.
Notary Public (seal or stamp)	**REQUIRED.** The notary seal or stamp for the Notary Public who notarizes the form. This requirement applies for all registration requests, including those from states where the Notary is not required to use a stamp or seal.
Notary Signature	**REQUIRED.** The signature of the Notary Public who notarizes the form.

QualityNet Exchange Security Administrator Registration Form			
*****NOTE: All fields marked with an asterisk are required and must be completed to obtain approval.			
Access Request			
***Request Date**:	***First Name**:	**Middle Initial**:	***Last Name**:
***Business E-Mail Address**:			
***Job Title**:			
***Business Name**:			
Specify Setting**: ***(Check only one)	☐ QIO ☐ Hospital ☐ Physician Office ☐ Nursing Home ☐ State Agency ☐ CMS ☐ Home Health Agency ☐ ESRD Network ☐ ESRD Facility ☐ Health Care System ☐ Other (Specify):		
	☐ Vendor: Hospital-HDC ☐ Vendor: Hospital-HCAHPS ☐ Vendor: Physician Office ☐ Vendor: Nursing Home-NHIFT ☐ Vendor: Premier		
Medicare Provider Number: (If applicable):		**Vendor ID Number**: (If applicable):	
***Business Address**:	Street	City	State ZIP
***Work Phone**: ( )	Extension:	Fax: ( )	
***Security Question** (answer only one):	City of birth _____ Pet's name _____ Mother's maiden name _____		
Signatures Required			
***Applicant:**		***Date**:	
*As The Assigned Notary Public I have used the following **ID** as verification ☐Driver's License ☐Passport ☐Other: _____ ***Notarized Date: _____** **Notary Expiration Date: _____** ***Notary Public (seal or stamp):** ***Notary Signature: _____**			

QualityNet Exchange Security Administrator Authorization Form

I _____authorize _____
(Name of highest-level Executive) (Name of QualityNet Exchange Security Administrator)

to be the QualityNet Exchange Security Administrator for _____
(Name of Organization)

I understand that he/she will be responsible for the following:

- Creating, approving, editing, and/or terminating QualityNet Exchange user accounts within this organization
- Monitoring QualityNet Exchange usage at your organization to ensure security and confidentiality is maintained
- Serving as the point of contact at this organization for information regarding QualityNet Exchange

I understand that, as a security measure, I may be contacted on a future date by the QualityNet Help Desk to verify my position and whom I have authorized to be QualityNet Exchange Security Administrator(s). I may also be asked to verify those individuals that have been given access to QualityNet Exchange.

_____ _____
(Executive: Print Name) (Signature)

_____
(Title)

_____
(Phone #)

_____
(E-mail Address)

_____
(Date)

June, 2006

QualityNet Exchange Security Registration Forms Checklist

Please validate the following have been completed to avoid delays in processing your registration:

☐ All required fields have been completed on the QualityNet Exchange Security Administrator Registration Form.

☐ You have signed and dated the QualityNet Exchange Security Administrator Registration Form before a Notary Public.

☐ The Notary has fully completed the notary section, including both the notary signature and seal.

☐ The highest-level executive at your organization has completed the QualityNet Exchange Security Administrator Authorization Form.

☐ Verify that you have obtained the correct address for mailing your completed forms. (See the table on page 2 for mailing instructions.) Photocopies or faxes of the completed forms will not be accepted.

Please contact the QualityNet Help Desk if you have any questions or concerns at 866-288-8912 or e-mail at qnetsupport@ifmc.sdps.org.

June, 2006

BENEFICIARY NOTIFICATION SAMPLE LANGUAGE

As required in the terms and conditions, physician practices must notify beneficiaries of their participation in the demonstration. The key points to be conveyed to beneficiaries in your communication material is information about the demonstration's incentive arrangement, sharing of medical information in a confidential manner, and goals and objectives of the demonstration (i.e. coordinating and improving care, no change in beneficiary's existing benefits and freedom of choice, plus referencing any additional services are at no cost to the beneficiary). However, any communication materials may not imply that your participation in the demonstration reflects a competitive selection, special certification or other status from CMS.

Attached is sample language developed by CMS working with our beneficiary communications staff that may be used in your communication materials. The sample language may be used as is or can be modified to be incorporated into your communication materials. However, if you do modify this language, please submit it to Jody Blatt, the CMS project officer, at:

Jody.Blatt@cms.hhs.gov
or
CMS
Mail Stop C4-17-27
7500 Security Blvd.
Baltimore MD 21244.

In addition, our beneficiary communications staff is available to provide feedback on your materials. If you would like to get their comments on your materials, please forward a draft to the CMS project officer.

(XYZ Physician Group) is taking part in a study that rewards doctors for giving high quality health care. The study is being conducted by the Centers for Medicare & Medicaid Services, the federal agency that runs the Medicare program. Your doctor will work with you and other doctors and nurses to coordinate and improve the care you receive. You will continue to get your regular Medicare-covered services, and you can still see your current doctor and any other doctor you choose. During the study, Medicare may need to share your personal medical information with your doctor. This will allow your doctor to make sure that you are getting quality health care and that you are getting the services you need. By law, Medicare is required to protect the privacy of your personal medical information. Your personal medical information is important so Medicare takes every step to make sure your information is kept private. If you need more information about this study, please ask your doctor.

MEDICARE CARE MANAGEMENT PERFORMANCE DEMONSTRATION

Contact List

Centers for Medicare and Medicaid Services		
Jody Blatt	(410) 786-6921	Jody.Blatt@cms.hhs.gov
Lisa Waters	(410) 786-6615	Lisa.Waters@cms.hhs.gov
Lorraine Johnson	(410) 786-9457	Lorraine.Johnson@cms.hhs.gov
Quality Improvement Organizations (QIOs):		
Masspro (MA):		
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HealthInsight (UT):		
Sharon Donnelly	(801) 892-6668	sdonnelly@healthinsight.org
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Lumetra (CA):		
Peter Boumenot	(415) 677-2072	pboumenot@caqio.sdps.org
Gordon Wright	(415) 677-2071	gwright@caqio.sdps.org
Arkansas Foundation for Medical Care (AR):		
Arkansas MCMP Team	(877) 375-5700	physicianoffice@afmc.org
Actuarial Research Corporation (ARC):		
John Wilkin	(410) 740-9194, x14	jwilkin@aresearch.com
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RTI International:		
Michael Trisolini	(781) 434-1752	mtrisolini@rti.org
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Iowa Foundation for Medical Care (IFMC):		
Sherry Grund	(515) 223-2112	sgrund@ifmc.org
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Mathematica Policy Research (MPR):		
Lorenzo Moreno	(609) 936-2766	LMoreno@mathematica-mpr.com
Stacy Dale	(610) 395-7752	SDale@mathematica-mpr.com
Leslie Foster	(609) 936-3265	LFoster@mathematica-mpr.com

Questions?

Here is your opportunity to get them answered.

Q&A 1st call
Most convenient for Mountain & Pacific time zones

CALL DATE: June 05, 2007 (Tuesday)
CALL TIME: 02:30 PM EDT, 1:30 CDT, 12:30 MDT, 11:30 PDT

Q&A 2nd Call
Most convenient for Central and Eastern time zones

June 5th didn't work for you? Here is an alternate date and time.

CALL DATE: June, 14, 2007 (Thursday)
CALL TIME: 12:30 PM EDT, 11:30 CDT, 10:30 MDT, 9:30 PDT

****DIAL-IN NUMBERS: 888-791-1856****
****PASSCODE: MCMP Demo****
Call duration will be 1 hr 30 min.
Led by: Ms. Jody Blatt

SAVE THE DATE

MCMP—PAT Training

via the Internet and Telephone (i.e., Webex)

(Medicare Care Management Performance=MCMP Performance Assessment Tool= PAT)

Only one training session needed

- July 13th: 11:30 a.m. to 4:30 p.m., Eastern
- July 17th: 11:30 a.m. to 4:30 p.m., Eastern
- July 20th: 11:30 a.m. to 4:30 p.m., Eastern

Who should attend this training?

- Whoever will be collecting or overseeing the medical record data collection process.
- Equipment needed: Computer with High Speed Internet access and a telephone line.

How do I register for the training?

- Sign up at https://ifmcevents.webex.com
- Event Name: MCMP-PAT Training
- Click on Enroll button to the right of event title
- Enter the required information & then you will receive an e-mail with instructions for joining the meeting

What do I do on the day of the training?

- Connect your computer to the webex training website, following the instructions that will be provided to you via e-mail after you have registered successfully.
- Call this number: 888-677-8795, and when prompted, provide the following information:

  Leader: Ms. Jody Blatt Passcode: MCMP Demo

Attention

Volunteer Beta Testers Needed

For MCMP-PAT

(Medicare Care Management Performance=MCMP — Performance Assessment Tool= PAT)

Testers will have these advantages:

- **Opportunity to use the tool before the final release — more experience**
- **Have your questions and concerns addressed early in the process**
- **Have the option to use your "real" patient information — no need to re-enter during the final implementation**
- **Have an opportunity to help shape the final version of the tool**

As testers, we want your feedback on:

- ***Problems encountered during installation and abstraction***
- ***List of features needing improvement & ones that are most useful***
- ***Overall experience in using the abstraction tool***

Interested?
Please contact:
Rhonda Esdohr
resdohr@ifmc.org
(515) 440-8223

Glossary of Acronyms

AHRQ	Agency for Healthcare Research and Quality
AMA	American Medical Association
ARC	Actuarial Research Corporation
CCHIT	Certification Commission for Healthcare Information Technology
CMS	Centers for Medicare and Medicaid Services
DOQ	Doctors Office Quality
DOQ-IT	Doctors Office Quality Information Technology
E&M	Evaluation and Management
EHR	Electronic Health Record
FFS	Fee-for-Service
HEDIS	Health Plan Employer Data and Information Set
HIT	Health Information Technology
IFMC	Iowa Foundation for Medical Care
MA	Medicare Advantage
MAC	Medicare Administrative Contractor
MCR	Medicare
MCMP	Medicare Care Management Performance
MCMP-PAT	Medicare Care Management Performance – Performance Assessment Tool
MMA	Medicare Modernization Act
MPR	Mathematica Policy Research
NCQA	National Commission for Quality Assurance
NPI	National Provider Identifier
NQF	National Quality Forum
OMB	Office of Management and Budget
P4P/PFP	Pay for Performance
P4R	Pay for Reporting
PIN	Provider Identification Number
QIO	Quality Improvement Organization (MA=Masspro; UT=HealthInsight; CA=Lumetra; AR=Arkansas Foundation for Medical Care)
QNET	QualityNet
RTI	Research Triangle Institute
T&A	Training and Assistance
TIN	Tax Identification Number

FRIENDLY REMINDERS

After you leave this meeting, please make sure your practice completes all of the following:

- ÿ Return the signed MCMP Demonstration agreement
- ÿ Return the Electronic Funds Transfer form
- ÿ Sign up for Q-Net Exchange
- ÿ Participate in a Q & A telephone session June 5th or June 14th if you have questions
- ÿ Sign up for one of the Web-Ex training sessions on the use of the clinical data collection tool (MCMP-Performance Assessment Tool, or MCMP-PAT)
- ÿ Attend the Web-Ex training session