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

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[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.

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[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 – The percentage of diabetic patients with one or more A1c tests*

2. *HbA1c Control - The percentage of diabetic patients with a most recent A1c level >9.0% (poor control)*

3. *Blood Pressure Management - The percentage of diabetic patients with a most recent BP < 140/90 mmHg*

4. *Lipid Measurement – The percentage of diabetic patients with at least on low-density lipoprotein (LDL) cholesterol test*

5. *LDL Cholesterol Level - The percentage of diabetic patients with a most recent LDL cholesterol <130 mg/dl*

6. *Urine Protein Testing - The percentage of diabetic patients with at least one test for microalbumin during the measurement year; or who had evidence of medical attention for existing nephropathy (diagnosis of nephropathy or documentation of microalbuminuria or albuminuria)*

7. *Eye exam - The percentage of diabetic patients who received a dilated eye exam or evaluation of retinal photographs by an optometrist or ophthalmologist during the measurement year, or during the prior year (this measure is adapted for claims data measurement).*

8. *Foot exam - The percentage of diabetic patients receiving at least one complete foot exam (visual inspection, sensory exam with monofilament, and pulse exam).*

Congestive Heart Failure

1. *Left Ventricular Function Assessment- The percentage of CHF patients who have quantitative or qualitative results of LVF assessment recorded.*

2. *Left Ventricular Ejection Fraction Testing - The percentage of CHF patients hospitalized with a principle diagnosis of heart failure during the current year who had left ventricular ejection fraction testing during the current year.*

3. *Weight measurement – The percentage of CHF patients with weight measurement recorded.*

4. *Patient Education- The percentage of CHF patients who were provided with patient education on disease management and health behavior changes during one or more visit(s) within a six month period.*

5. *Beta-Blocker Therapy – The percentage of CHF patients who also have LVSD who were prescribed beta-blocker therapy.*

6. *ACE Inhibitor Therapy - The percentage of CHF patients who also have LVSD who were prescribed ACE inhibitor therapy.*

7. *Warfarin Therapy for Patients with Atrial Fibrillation – The percentage of CHF patients who also have paroxysmal or chronic atrial fibrillation who were prescribed warfarin therapy.*

Coronary Artery Disease

1. *Antiplatelet Therapy – The percentage of CAD patients who were prescribed antiplatelet therapy.*

2. *Drug Therapy for Lowering LDL Cholesterol - The percentage of CAD patients who were prescribed a lipid-lowering therapy (based on current ATP III guidelines).*

3. *Beta-Blocker Therapy – The percentage of CAD patients with prior MI who were prescribed beta-blocker therapy.*

4. *Lipid Profile – The percentage of CAD patients receiving at least one lipid profile during the reporting year.*

5. *LDL Cholesterol Level- The percentage of CAD patients with most recent LDL cholesterol <130 mg/dl.*

6. *ACE Inhibitor Therapy - The percentage of CAD patients who also have diabetes and/or LVSD who were prescribed ACE inhibitor therapy.*

Preventive Care

1. *Blood Pressure Screening – The percentage of patients' visits with blood pressure measurement recorded.*

2. *Breast Cancer Screening – The percentage of female beneficiaries aged 50-69 years who had a mammogram during the measurement year or the year prior to the measurement year.*

3. *Colorectal Cancer Screening- The percentage of beneficiaries 50 years or older who were screened for colorectal cancer during the one year measurement period.*

4. *Influenza Vaccination – The percentage of patients with a chronic condition 50 years or older who received an influenza vaccination from September through February of the year prior to the measurement year.*

5. *Pneumonia Vaccination – The percentage of patients with a chronic condition 65 years or older who ever received a pneumococcal vaccination.*