DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

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ELECTRONIC HEALTH RECORDS (EHR) DEMONSTRATION

Demonstration Summary

GOAL

The goal of this demonstration is to foster the implementation and adoption of EHRs and health information technology (HIT) more broadly as effective vehicles not only to improve the quality of care provided, but also to transform the way medicine is practiced and delivered. Adoption of HIT has the potential to provide significant savings to the Medicare program and improve the quality of care rendered to Medicare beneficiaries. This demonstration is designed to leverage the combined forces of private and public payers to drive physician practices to widespread adoption and use of EHRs.

DEMONSTRATION SITES

The demonstration will be implemented in 12 locations in two separate phases, one year apart.

Phase I

1. Louisiana
2. Maryland and the District of Columbia
3. Pennsylvania – 11 counties in the Pittsburgh area
4. South Dakota (and some border counties in Iowa, Minnesota, and North Dakota)

Phase II

5. Alabama
6. Delaware
7. Florida - 6 counties in the Jacksonville area
8. Georgia
9. Maine
10. Oklahoma
11. Wisconsin (selected counties)
12. Virginia

Selection of sites was based on a competitive process to identify “community partners” to assist CMS with education, outreach activities, and recruitment of physician practices. Community partners will also collaborate with CMS on an ongoing basis in an effort to assist us in achieving our goal of leveraging the combined forces of private and public payers to drive physician practices to widespread adoption and use of EHRs. A complete list of community partners for each site is provided in Attachment 1.

DEMONSTRATION DESIGN

The EHR demonstration is a pay for performance demonstration with two separate but inter-dependent incentive payments: one for the adoption and use of an electronic health record and one for the reporting (after year 2) or performance (after each of years 3 through 5) on 26 clinical quality measures related to the care of diabetes mellitus (DM), congestive heart failure (CHF), coronary artery disease (CAD) and preventive care services.

This is not a grant program and there is no up-front payment for the purchase or implementation of an electronic health records system.

The demonstration expands upon the foundation created by the Medicare Care Management Performance (MCMP) Demonstration which began in July 2007 with almost 700 primary care practices in Arkansas, California, Massachusetts and Utah. However, there are some significant differences between the two demonstrations. First, the EHR Demonstration will be implemented in two phases, each of which will last five years. Practices participating in the EHR Demonstration will also be required to annually complete an Office Systems Survey (OSS) to measure the use of an electronic health record (EHR). In addition, the EHR Demonstration involves a randomized control design in which half of the eligible practices that apply will be assigned to a demonstration treatment group and will be eligible to earn incentive payments and half will be assigned to a control group that will not be eligible to receive demonstration incentives.

While practices are not required to have implemented an EHR in order to apply to participate in the EHR Demonstration, they should intend to do so within the first two years of the demonstration. Most significant, in the EHR demonstration, by the end of the second year, all participating physician practices will be required to have implemented and be using a Certification Commission for Healthcare Information Technology (CCHIT)-certified EHR to perform certain minimum core functions that can positively impact patient care processes. These include documentation of patient visits, the recording of orders and results for laboratory and other diagnostic tests, and the recording of prescriptions. Practices that do not meet this requirement will be dropped from the demonstration and will not be eligible to receive any incentive payments.

CMS will recruit approximately 200 eligible practices in each location to participate in the demonstration. Eligible practices will be randomly assigned to either a “treatment” or “control” group. Practices that are assigned to the “treatment” group will be eligible to receive financial incentives for participating in the demonstration and meeting all other demonstration requirements. Practices that are assigned to the “control” group will not be eligible to receive financial incentives but they also will not have to meet any of the other demonstration requirements such as implementation of a CCHIT-certified EHR by the second year, the annual OSS, or reporting of clinical quality measures. Practices assigned to the control group

will be asked to complete the OSS at the end of the second and fifth years of the demonstration and they will receive compensation for their time to complete the survey.

PRACTICE ELIGIBILITY

This demonstration is intended for small to medium sized primary care practices. Small to medium-sized is defined as 20 or fewer physicians. In addition, this may include advanced-practice nurses and/or physician assistants who bill Medicare independently for services. For purposes of determining whether a practice meets the "up to 20" limit, all providers, regardless of specialty are counted. However, only primary care providers may actually participate in the demonstration. Although it is desirable for all of the primary care providers in a practice to participate in the demonstration, this is not a requirement. Primary care providers that are part of a multi-specialty group may participate as a practice even if the specialists are not eligible to be included in the practice for demonstration purposes. Similarly, a group of primary care providers may participate as a practice even if one or more of their primary care colleagues in the practice are not interested in participating. If we receive more applications in an area than we can accommodate, preference will be given to the smallest practices and those that are in the early stages of adopting EHRs.

Primary care includes general practice, family practice, internal medicine and geriatrics. In addition, medical sub-specialists (e.g. cardiologists, endocrinologists, etc.) whose practice is predominantly primary care *may* be eligible participate. However, the latter should be aware that if they are selected to participate, they will be expected to submit the same clinical quality measures on DM, CHF, CAD and preventive care services for all of their assigned patients as will all other primary care providers participating in the demonstration.

CMS recognizes that practices may define themselves in a variety of ways and in different ways for different purposes. For the purposes of applying to the demonstration, a practice may be a single location or include multiple locations, particularly if the providers work at several sites. For the demonstration, a practice is usually a single, independent organization that provides services to patients. In general this would be at a single location, but not necessarily so. A practice may be comprised of several physicians that each bill under their own Tax Identification Number (TIN) but share space, nursing support, etc. Or, a practice may be a part of a larger organization that bills under one Tax ID number for multiple smaller practices. Although a practice is generally a single site, this is not necessarily so if the physicians work at multiple sites and patients may see the same doctor at different sites depending, for example, on the day of week. The key in defining a practice is that CMS must be able to uniquely "assign"[1] patients to a single practice and group of providers and that services billed

[1] CMS has created a "beneficiary assignment" algorithm that, based on historic claims data during any given reporting period, assigns a patient to the practice where s/he received the most primary care visits. This is a retrospective process and does not, in any way, affect where a beneficiary may receive care in the future. The

by those providers can be uniquely and accurately assigned to the practice. Therefore, as part of the demonstration application, we require that the practice be able to uniquely define the providers participating in the practice by TIN, individual Medicare Provider Identification Number (PIN), and individual National Provider Identifier (NPI).

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). Beneficiaries enrolled in hospice care are also not counted. CMS will use claims data to determine where beneficiaries received the plurality of their primary care services and assign them to that practice.

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

- Practices may or may not have an electronic health record (EHR) in order to apply to participate in the demonstration. However, if the practice has not yet implemented an EHR, it should be committed to doing so within the next two years. Practices that are selected to participate in the demonstration and have not implemented a Certification Commission for Healthcare Information Technology (CCHIT)-certified EHR by the end of the second year or are not using it for the specified core functionalities will be terminated from the demonstration and will not be eligible to receive any incentive payments.

PAYMENT METHODOLOGY SUMMARY

Practices participating in the EHR demonstration will be eligible for two separate financial incentives. The first is an incentive based on their use of a CCHIT-certified EHR. The second is an incentive for reporting clinical quality measures and, in years three through five, meeting performance standards for treating patients with DM, CHF, and CAD. 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. Attachment 2 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).

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assignment process is used to determine the number of Medicare beneficiaries seen by a practice and which patients are eligible for reporting on the clinical measures, and, therefore, impacts payment.

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 providers or practices will be made public.

The potential payment for both of these incentives is a "per beneficiary" amount and determined, in part, by the number of beneficiaries for which the practice provides the plurality of primary care visits. In the section below, the rules for determining which practice a beneficiary is assigned to are described.

BENEFICIARY ASSIGNMENT

Payment under this demonstration is determined, in part, by the number of beneficiaries for whom the practice is the main provider of primary care services. In addition, practices are only expected to report the clinical quality measures on patients for whom they have seen for primary care and for whom it can reasonably be expected that they would be responsible for providing certain services or coordinating with other specialists to make sure that such services are received.

CMS has developed a "beneficiary assignment algorithm" that assigns patients to practices for each reporting period based on where the patient received the greatest number of primary care visits, as reflected on Medicare claims data for that period. This is a retrospective process and does not at all influence or determine where a patient may receive care in the future. Throughout the demonstration, beneficiaries covered under the traditional Medicare fee-for-service program remain free to see any provider they choose. A beneficiary assigned one year to one practice may, in fact, be assigned to another practice in the following year if s/he moves or sees another provider for more primary care services for whatever reason. However, for purposes of the demonstration, a beneficiary can only be assigned to one practice for any given demonstration year.

The process of assigning beneficiaries to practices[2] starts with examining all Medicare claims data for the reporting period. Only claims for primary care services by providers with a primary care related specialty are considered. Beneficiaries are assigned to the practice that provided the greatest number of such services during the reporting period. Then, based on the diagnosis data on all claims (not just primary care claims), beneficiaries are further categorized as to whether they have DM, CHF, CAD, or one of a range of other chronic conditions that would make them eligible under the demonstration for reporting on the group of preventive care measures. A beneficiary may be assigned to none, one, or more than one of these "condition" categories based on whether s/he has any claims with the relevant

[2] Beneficiaries are assigned at the practice level and not to individual providers unless the practice is comprised of a solo practitioner. The reason for this is to aggregate those visits to the primary care provider with those to partners in the practice that may cover for him in his/her absence.

diagnoses. For example, a beneficiary with CHF and DM will be assigned to the DM category, the CHF category, and the "chronic condition" category for reporting the preventive care measures.

The number of beneficiaries assigned to each category will determine the potential payment for each practice, as described in the "Payment Model" section below. In addition, it is from these groups of assigned patients by category, that patients will be selected for reporting the clinical quality measures. The specification for each clinical quality measure may, in addition, have its own requirements (e.g. age or gender; prior hospitalization; diagnostic test, etc.) that determine which beneficiary is ultimately eligible for reporting any given measure.

Accurate coding of diagnoses and submission of the provider identification numbers (e.g. PIN, TIN, and NPI) on both the demonstration application form and claims are, therefore, critical because of the impact of the beneficiary assignment process on reporting and payment.

PAYMENT MODEL

Within the two broad categories of incentives (EHR-related and clinical quality related), there are three types of financial incentives:

1. An annual incentive payment for performance on the Office Systems Survey; and

2. A payment after the second year of the demonstration for reporting the clinical quality measures; and

3. A payment after each of the third through fifth years of the demonstration for performance on the clinical quality measures.

To assist in reporting the clinical quality measures, CMS will provide as much information as possible to practices including identification of which patients are eligible for each measure and relevant data from Medicare claims. This should limit the amount of medical record abstraction that is required. CMS will also provide an electronic reporting tool called the Performance Assessment Tool ("PAT") to be used for reporting. Practices may export some or all of the data needed for reporting from their electronic health record system into this tool, thereby further limiting the amount of manual work that might be needed for reporting. There is no fee for using this tool or submitting the data.

Annual Incentive for Performance on the Office Systems Survey

At the end of each year of the demonstration, practices will be asked to complete an Office Systems Survey.[3] The survey will include questions about the EHR system used by the practice and how it is being used to manage patient care. In order to receive any credit under this incentive, practices will have to have implemented and be using a CCHIT-certified EHR and be using it for minimum core functionalities including recording of patient visit notes, recording of diagnostic test orders and results, and recording of prescriptions. Payment will be tied to both the score on the survey and the number of beneficiaries with a chronic condition that are assigned to the practice. Practices will receive up to $45 per beneficiary under this incentive.

For example, a practice with two physicians that has 200 beneficiaries with chronic conditions assigned to it that scores 100% on the survey could earn $9000 (200 x $45 x 100%) under this incentive. If the same practice scored only 60% on the survey, the payment would be $5400 (200 x $45 x 60%). All demonstration practices will be required to complete the survey each year and the amount of money earned is tied to the score on the survey that year. A practice that scores 60% in year one will, hopefully, improve its score and earn greater financial incentives in subsequent years by using its EHR for more advanced functionalities. In total, practices will be eligible to earn up to $5000 per physician (up to $25,000 per practice) per year under this incentive. Practices should note that, regardless of score on the OSS, starting in the second year of the demonstration, payment of this incentive is contingent upon reporting the clinical quality measures and, in years three through five, achieving minimum performance standards on them. To the extent that measures are not fully reported or minimum scores are not achieved for any given category, the payment on the OSS will be reduced. (See Table I, as discussed in greater detail below).

Year 2 Incentive Payment for Reporting Clinical Quality Measures

After the end of the second year, the demonstration will include a "pay for reporting" incentive to provide baseline information on the clinical quality measures and to help physicians and their staff become familiar with the quality measurement data collection process. For Year 2, practices will be paid $20 per beneficiary with a chronic condition[4] for reporting the clinical quality measures. The total amount available to practices for this incentive is $3,000 per physician (up to $15,000 per practice) based on the number of

[3] Practices assigned to the control group will be asked to complete the OSS only after the second and fifth years of the demonstration. They will be paid for their time to complete the survey, but will not be eligible for the incentive payments.

[4] 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.

beneficiaries assigned to the practice. For this baseline data collection only, payment will not be contingent upon a practice's scores (performance) on the quality measures.

EXAMPLE #1:

In the example below *(Table 1*), the sample practice has a single physician with the indicated number of beneficiaries assigned in each category. Because the practice did not report on some of the clinical quality measures, it does not receive the full reporting incentive payment for that category and the payment for the OSS score is also reduced proportional to the number of measures reported (3 measures out of 26, or 11.5%). In addition, the clinical reporting payment is also reduced because the initial calculated amount is above the cap for a solo practitioner. In total, this provider would earn $6204.82 for the year. Although the scores on the clinical quality measures are calculated for the practice, they are for information only and are not used in the incentive payment calculation in the second year.

TABLE 1: EXAMPLE OF INCENTIVE PAYMENT CALCULATION

Years 2 (Pay for Reporting)

	CLINICAL QUALITY INCENTIVE PAYMENT				EHR BASED INCENTIVE
Practice Size = 1 Physician	**DM**	**CHF**	**CAD**	**Preventive Care Services**	**Office Systems Survey**
# Medicare patients assigned to the practice with relevant diagnoses	50	36	25	100	100
Payment Per Patient for Performance	$20	$20	$20	$20	$45
# Quality Measures in Category	8	7	6	5	26
Maximum Possible Points	40	35	30	25	
Points earned	38	25	8	8	
Composite Quality Score	95%	71%	27%	32%	80%
	score calculated but not used for reporting				*(score on OSS)*
Measures Reported	8	7	6	2	
% Clinical Reporting Incentive Earned	100% reported on all measures	100% reported on all measures	100% reported on all measures	40% did not report on three of five measures	80%
	50 x $20 x 100%	36 x $20 x 100%	25 x $20 x 100%	100 x $20 x 40%	100 x $45 x 80%

Sub Total Payment	$ 1,000.00	$ 720.00	$ 500.00	$ 800.00	$ 3,600.00
Total Payment for Clinical Performance *	$ 3,020.00				
Clinical Payment Due After Maximum Cap Applied				$ 3,000.00	
Reduction in OSS Incentive Due to Failure to Report All Measures in a Category				11.5%	$ (415.38)
Total Payment for OSS Use					$3184.62
Total Payment For Year	$				$6204.62

** Note: Maximum clinical reporting payment for year 2 is $3,000 per physician, up to $15,000 per practice per year. Maximum OSS incentive is $5,000 per physician up to $25,000 per practice per year.*

Year 3-5 Incentive Payment Based for Performance on Clinical Quality Measures

Starting at the end of the third year and for the remainder 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 each demonstration year. This is the key payment incentive under the demonstration, as reflected in the greater payment amounts potentially available to participating treatment practices. Data will be collected starting approximately four or five months after the end of each demonstration year, allowing sufficient lag time so that claims data are complete. CMS will compare each practice's score on each of the relevant clinical measures to an established threshold[5]. Practices will be able to earn up to 5 points for each measure, depending upon their individual score. Within each category (DM, CAD, CHF 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 $45 per beneficiary[6] for each patient with each of the specific disease categories and $25 per beneficiary for each 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[7] will not be eligible to earn any incentives for that category. Between these two end points, the payment level earned will be prorated.

[5] 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. Lower scores will receive reduced point scores.

[6] The targeted conditions are diabetes, congestive heart failure, and coronary artery disease. The preventive care measures apply to beneficiaries with a range of chronic conditions, as noted above.

[7] For the third year of the demonstration, practices must achieve a composite score of at least 30% in order to earn any incentive payment for the category. During the fourth and fifth years of the demonstration, the minimum required percentage of points to earn any payment will be raised to 40% and 50%, respectively.

EXAMPLE #2:

In the example below *(Table 2*), the sample practice has a single physician with the indicated number of beneficiaries assigned in each category. Assume that the data is for year 3, the first year in which performance scores on the quality measures determines the incentive payment. Because the practice did not achieve a minimum score of 30% (*See footnote 6*.) on the Coronary Artery Disease (CAD) measures, it earns no clinical incentive payment for that category and is penalized in the calculation of the OSS related incentive proportional to the number of measures in that category (6 out of 26 or 23%). However, because the practice scored over 90% on the diabetes measures, it earns 100% of the potential incentive in that category. In total, this provider would earn $8304.95 for the 3rd year.

TABLE 2: EXAMPLE OF INCENTIVE PAYMENT CALCULATION

Years 3-5 (Pay for Performance)

	CLINICAL QUALITY INCENTIVE PAYMENT				EHR BASED INCENTIVE
Practice Size = 1 Physician	**DM**	**CHF**	**CAD**	**Preventive Care Services**	**Office Systems Survey**
# Medicare patients assigned to the practice with relevant diagnoses	50	36	25	100	100
Payment Per Patient for Performance	$45	$45	$45	$25	$45
# Quality Measures in Category	8	7	6	5	26
Maximum Possible Points	40	35	30	25	
Points earned	38	25	8	18	
Composite Quality Score	95%	71%	27%	72%	80%
Measures Reported	8	7	6	5	*(score on OSS)*
% Clinical Performance Incentive Earned	100% (over 90th percentile)	79% (prorated)	0% (below min. 30th percentile)	80% (prorated)	80%
	50 x $45 x 100%	36 x $45 x 79%	25 x $45 x 0%	100 x $25 x 80%	100 x $45 x 80%
Sub Total Payment	$ 2,250.00	$ 1,285.71	$ -	$ 2,000.00	$ 3,600.00
Total Payment for Clinical Performance *	$ 5,535.71				
Clinical Payment Due After Maximum Cap Applied	$ 5,535.71				
Reduction in OSS Incentive Due to Below Minimum Quality Score			23%		$ (830.77)
Total Payment for OSS Use					$ 2,769.23
Total Payment For Year	$ 8,304.95				

** Note: Maximum clinical performance incentive for years 3-5 $10,000 per physician per year up to $50,000 per practice per year. Maximum OSS incentive is $5,000 per physician up to $25,000 per practice per year.*

PAYMENT SUMMARY

Table 3, below, summarizes the total potential payment per year for each of the incentives available under this demonstration.

TABLE 3: PAYMENT SUMMARY BY YEAR AND CATEGORY					
	EHR Adoption (Office Systems Survey)	**Reporting Clinical Quality Measures**	**Clinical Quality Measure Performance**	**Maximum $ / provider / Year**	**Maximum $ / Practice/ Year**
Year 1	$5,000	n/a	n/a	$5,000	$ 25,000
Year 2	$5,000	$3,000	n/a	$8,000	$ 40,000
Year 3	$5,000	n/a	$10,000	$15,000	$ 75,000
Year 4	$5,000	n/a	$10,000	$15,000	$ 75,000
Year 5	$5,000	n/a	$10,000	$15,000	$ 75,000
			Total Potential Payment	$58,000	$290,000

Practices should keep in mind that due to the retrospective nature of the reporting process, there will be a lag between the end of the demonstration year and when reporting and payment occur. In particular, with the reporting of clinical quality measures, CMS must wait at least 3 months to insure that all of the necessary claims data for the reporting period is complete. It then takes approximately 8 weeks for CMS and its contractors to analyze and prepare the data and put it in a format that practices can use to report the data. This includes running the beneficiary assignment algorithm, determining which beneficiaries in each practice are eligible for each measure, "pre-populating" the Performance Assessment Tool (PAT) for each practice, and distributing the reporting databases to each participating treatment practice. Practices are then given approximately 8 weeks to complete the tool and submit the measures. Once the data is submitted, it is then analyzed for completeness and obvious reporting errors before practice-specific summary reports are distributed and payments issued. In addition, a small sample of practices may be selected for audit. In total, practices can expect a delay of approximately 9 months after the reporting period before payments are issued. All payments will be issued electronically.

DEMONSTRATION EVALUATION

CMS will be conducting an independent evaluation to determine the impact of financial incentives on the rate of adoption of EHRs and their impact on quality and costs for the Medicare program. Mathematica Policy Research has been awarded the contract to conduct this evaluation which will include analyses of the quality measures and OSS data, Medicare

claims, beneficiary and provider surveys, and site visits. Practices participating in the demonstration will be expected to cooperate with the evaluation if they are asked to be part of a survey or interview. Every effort will be made to work with practices and minimize any possible disruption. All data collected will be kept confidential and no data at the individual beneficiary, provider, or practice level will be made public.

TIME LINE

CMS will be recruiting physicians in Phase I sites to participate in this demonstration in the late summer and fall of 2008. All applications will be due by November 26, 2008. Once all applications have been received, they will be reviewed for eligibility and then randomly assigned to the treatment or control group. Practices will be notified of their selection and assignment to either the treatment or control groups by the end of March, 2009. Practices that are assigned to the demonstration treatment group will be invited to an all-day informational "kick off" meeting in their state in May 2009.

Below are some key dates and general time frames to keep in mind for the first few years of the demonstration for ***Phase 1*** sites.

Fall 2008

- Practices submit completed applications to participate in demonstration. Applications should be submitted no later than November 26, 2008 to receive full consideration.

November 2008 – March 2009

- CMS reviews all applications for eligibility and randomly assigns those eligible to the treatment or control group.

- Late March – CMS notifies practices of their assignment to the treatment or control group.

May 2009

- Demonstration "kick-off" meetings in each location (dates and locations to be announced) for practices in the demonstration treatment group.

June 1, 2009

- First operational year of the demonstration starts.

Late Spring / Summer 2010

- Practices complete and submit the Office Systems Survey (OSS).

Fall 2010

- CMS calculates and sends to practices the initial incentive for performance on the OSS.

Late Spring / Summer 2011

- Practices complete and submit a second Office Systems Survey (OSS).

Fall 2011

- Practices complete and submit clinical quality measures for the second demonstration year.

Winter / Spring 2012

- CMS calculates and sends to practices Year 2 "pay for reporting" and OSS incentives.

FOR MORE INFORMATION

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

http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1204776

Practices can sign up for email alerts to receive automatic notification whenever new information is added to the demonstration.

If you have additional questions, you may also email the CMS Demonstration Project Officer at: EHR_Demo@cms.hhs.gov *(note: There is an underscore between 'EHR' and 'Demo' in the email address.)*

Community Partners for the Electronic Health Records Demonstration Project *(rev 7/7/08)*

1	Louisiana	Statewide	Louisiana Health Care Quality Forum
1	Maryland & Washington, DC	Statewide; district-wide	MedChi & Maryland Health Care Commission
1	Pennsylvania – Pittsburgh area	Allegheny, Armstrong, Beaver, Butler, Fayette, Greene, Indiana, Lawrence, Somerset, Washington & Westmoreland Counties	Pittsburgh Regional Health Initiative
1	South Dakota – and selected counties in bordering states	**South Dakota**- Statewide **Minnesota**- Big Stone, Clay Cottonwood, Jackson, Lincoln, Lyon, Murray, Nobles, Pipestone, Redwood, Rock, and Yellow Medicine counties **Iowa**- Buena Vista, Clay, Dickinson, Emmet, Lyon, O'Brien, Osceola and Sioux counties **North Dakota**- Dickey county	South Dakota Dept. of Health / SD E-Health Collaborative
2	Alabama	Statewide	Alabama Medicaid Agency
2	Delaware	Statewide	Delaware Health Information Network
2	Florida – Jacksonville area	Baker, Clay, Duval, Nassau, Putnam and St. Johns counties	Duval County Health Dept.
2	Georgia	Statewide	Georgia Dept. of Community Health
2	Maine	Statewide	Maine Chartered Value Exchange Alliance
2	Oklahoma	Statewide	Oklahoma State Dept. of Health
2	Virginia	Statewide	MedVirginia, LLC
2	Wisconsin – selected counties	Statewide EXCLUDING Ashland, Barron, Chippewa, Clark, Eau Claire, Lincoln, Marathon, Oneida, Portage, Price, Rusk, Sawyer, Shawano, Taylor, Vilas, Washburn and Wood counties	Wisconsin Medical Society

CLINICAL QUALITY MEASURES IN THE EHR 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

DM-1	*HbA1c Management – The percentage of diabetic patients with one or more A1c tests*
DM-2	*HbA1c Control - The percentage of diabetic patients with a most recent A1c level >9.0% (poor control)*
DM-3	*Blood Pressure Management - The percentage of diabetic patients with a most recent BP < 140/90 mmHg*
DM-4	*Lipid Measurement – The percentage of diabetic patients with at least on low-density lipoprotein (LDL) cholesterol test*
DM-5	*LDL Cholesterol Level - The percentage of diabetic patients with a most recent LDL cholesterol <130 mg/dl*
DM-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)*
DM-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).*
DM-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

HF-1.	*Left Ventricular Function Assessment- The percentage of CHF patients who have quantitative or qualitative results of LVF assessment recorded.*
HF-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.*
HF-3.	*Weight measurement – The percentage of CHF patients with weight measurement recorded.*

HF-5.	*1. 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*
HF-6.	*Beta-Blocker Therapy – The percentage of CHF patients who also have LVSD who were prescribed beta-blocker therapy.*
HF-7	*ACE Inhibitor Therapy - The percentage of CHF patients who also have LVSD who were prescribed ACE inhibitor therapy.*
HF-8	*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

CAD-1	*Antiplatelet Therapy – The percentage of CAD patients who were prescribed antiplatelet therapy.*
CAD-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).*
CAD-3	*Beta-Blocker Therapy – The percentage of CAD patients with prior MI who were prescribed beta-blocker therapy.*
CAD-5	*Lipid Profile – The percentage of CAD patients receiving at least one lipid profile during the reporting year.*
CAD-6	*LDL Cholesterol Level- The percentage of CAD patients with most recent LDL cholesterol <130 mg/dl.*
CAD-7	*ACE Inhibitor Therapy - The percentage of CAD patients who also have diabetes and/or LVSD who were prescribed ACE inhibitor therapy.*

Preventive Care

PC -1.	*Blood Pressure Screening – The percentage of patients' visits with blood pressure measurement recorded.*
PC -5	*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.*

PC -6.	*Colorectal Cancer Screening- The percentage of beneficiaries 50 years or older who were screened for colorectal cancer during the one year measurement period.*
PC-7	*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.*
PC-8	*Pneumonia Vaccination – The percentage of patients with a chronic condition 65 years or older who ever received a pneumococcal vaccination.*