

# **Independence at Home (IAH)**

## **Frequently Asked Questions for Applicants**

**December 2011**

### **Background and Eligibility Information**

**A.1. What is the purpose of the IAH Demonstration?**

The IAH Demonstration will test a payment incentive and service delivery model that uses primary care teams led by a physicians or nurse practitioners to deliver timely, in-home primary care to Medicare beneficiaries with multiple chronic illnesses and functional impairments. These beneficiaries experience multiple hospital admissions, emergency department (ED) visits, and large amounts of care that are costly for the Medicare program. The Demonstration will assess the effects of timely, in-home primary care on health care costs, quality of care, and rates of preventable hospitalizations, hospital readmissions, and ED visits.

**A.2. How long will the IAH Demonstration run? When is the start date?**

The publication of the Demonstration is Wednesday, December 21, 2011. The official start date will depend upon the submission of applicable beneficiaries by the practice and its selected option, i.e. sole entity, consortium, or national pool. Section 3024 of the Affordable Care Act mandates a demonstration period of not more than 3 years.

**A.3. Is the implementation date of the Demonstration a specific date, or will a “rolling” start be allowed?**

All practices entering the Demonstration as individual practices or in the national pool begin at the same time (deemed initial start date). All practices participating as a consortium will start 90 days after the initial start date, unless an individual consortium is prepared to begin on the initial start date. However, participating practices may continue to add patients over the course of the Demonstration until the 10,000 maximum total applicable beneficiary threshold is reached.

**A.4. Why would a practice want to participate in the IAH Demonstration?**

This is an opportunity for practices to test whether in-home primary care can reduce hospitalizations, hospital readmissions, emergency department visits, and costs while increasing the quality of care. If a practice achieves cost savings in comparison to target expenditures, CMS will provide incentive payments to those practices that also meet the quality standards for the Demonstration.

**A.5. How does a beneficiary benefit from practices participating in this Demonstration?**

Home-based primary care allows beneficiaries to receive primary care at home, rather than in an office or facility, thereby increasing access to care. An important goal of at-home care is to improve patient satisfaction by reducing hospitalizations and emergency department visits and promoting care consistent with beneficiary preferences.

**A.6. Are all practices eligible?**

Practices must meet the following requirements in order to be eligible for the Demonstration.

The practice must be a legal entity comprised of physicians or nurse practitioners, or a group of physicians or nurse practitioners, that provide care as part of a team that may include physician assistants, clinical staff, and other health and social service staff who:

Have experience providing home-based primary care to applicable beneficiaries;

Make in-home primary care visits;

Are available 24 hours a day, 7 days a week to carry out plans of care tailored to an individual patient's needs;

Organized at least in part for the purpose of providing physician services;

Uses electronic health records, remote monitoring, and mobile diagnostic technology;

Furnishes services to an average of 200 or more applicable beneficiaries during each year of the Demonstration;

Reports information about their patients and the health care services provided; and

Reports on required quality measures.

**A.7. What is meant by “home”?**

For the purpose of this demonstration, “home” is simply where the beneficiary resides. A “home” may be a house, apartment, assisted living facility, or any other noninstitutional location. Long-term residence in a nursing facility will not be considered living at home for the purpose of this demonstration.

**A.8. What is a “legal entity”?**

A legal entity is the organization comprised of a physician- or nurse practitioner-led group practice, or groups of practices, that will sign the CMS notice of award, abide by the terms and conditions, provide care to patients, and to whom any incentive payments will be provided should the entity meet the conditions for receiving incentive payments. The legal entity may be an organization that has additional components (e.g., a certified home health agency or a medical center) as long as it has a department that is organized and has experience delivering primary care in the home. Any organization or entity that meets these requirements and those stated in the solicitation would qualify as a “legal entity.”

**A.9. Can a practice or beneficiary participate in the IAH Demonstration and an Accountable Care Organization (ACO), such as the Medicare Shared Savings Program, or testing of the Pioneer ACO model, at the same time?**

No. Practices may only receive incentive payments from one shared savings initiative at any given time.

**A.10. Can nurse practitioners and physician assistants participate in this demonstration?**

Yes. Practices may include physicians, nurse practitioners, and physician assistants. Nurse practitioners and physician assistants must comply with regulations specific to their field of practice and state regarding their scope of practice. A practice must be led by a physician or nurse practitioner or physicians assistants that meet certain requirements.

**A.11. What types of monitoring and diagnostic technology are practices required to use?**

Practices are required to use remote monitoring and mobile diagnostic technology in order to provide timely monitoring and evaluation and to minimize trips to the emergency department or outpatient facilities that are difficult for the target population to reach. Practices may propose varying levels of monitoring and mobile diagnostic technology.

**A.12. What are the different ways my practice can participate?**

There are three different options for participation in the Demonstration:

*Option 1:* Any practice meeting the eligibility criteria may apply as a sole legal entity.

*Option 2:* Multiple primary care practices within a geographic area may form a consortium in order to participate. Any practice that decides to participate in a consortium in a geographic area must provide the Taxpayer Identification Numbers (TINs) of all the applying practices and must designate a single TIN that will act as the agent for the consortium and be responsible for distributing any incentive payments to all the individual practices that comprise the consortium.

All the practices participating in the consortium will be treated by CMS as one IAH practice for the purpose of establishing expenditure targets, evaluating quality, and determining incentive payments.

*Option 3:* Practices with a beneficiary caseload ranging from 200 to 500 beneficiaries may choose to become a part of a national pool of providers. Providers participating in a national pool will waive the right to have savings evaluated as a single practice and all financial targets will be calculated based on the pooled practices. Savings will then be distributed according to (1) practice-level, risk- and frailty-adjusted beneficiary months of enrollment and (2) number of quality measures met at the practice level (see questions E.4. and E.5).

Once a practice elects to participate in a selected option, the practice will remain in that option for the entirety of the Demonstration.

**A.13. Are there circumstances in which a practice can change their participation status?**

No. Practices that select Option 1, participating as a sole legal entity, will remain a sole entity throughout the Demonstration. Practices participating under Option 2, as a consortium, will remain part of that consortium throughout the Demonstration. Practices that choose to participate in Option 3, the national pool, will remain in the national pool throughout the Demonstration.

**A.14. Can practices affiliate with other practices for the purpose of joining the Demonstration?**

Yes. Practices may affiliate to form a consortium, but the consortium must be declared as a separate legal entity as described in Option 2 (question A.12). Any practice that decides to participate in a consortium in a geographic area must provide the Taxpayer Identification Numbers (TINs) of all the applying practices and must designate a single TIN that will act as the agent for the consortium and be responsible for distributing any incentive payments to all the individual practices that comprise the consortium. All the practices participating in the consortium will be treated by CMS as one IAH practice for the purpose of establishing expenditure targets, evaluating quality, and determining incentive payments.

**A.15. My practice meets all of the eligibility requirements, but has less than 200 beneficiaries. Can we join with another practice to form another organization to meet that requirement?**

Yes, a practice that has less than 200 eligible beneficiaries may form a consortium with another practice or practices in order to meet the 200 beneficiary requirement. This consortium must be declared as a separate legal entity for the purpose of the Demonstration.

**A.16. The consortium that my practice was planning on joining is no longer going to be formed. If my practice meets all of the eligibility requirements, can we still participate?**

If your plan to join a consortium changes prior to the single practice and national pool application deadline, your practice may still submit a completed application by Monday, February 6, 2012. However, if the application deadline has passed, your practice will not be considered eligible for the Demonstration.

**A.17. What are the benefits of joining the national pool of providers?**

By joining the national pool, all financial targets for pooled practices will be calculated based on the total size of the pool. Because the Minimum Savings Requirement (MSR) is inversely related to the size of the IAH practice, practices that join the national pool will have a smaller MSR, thus lowering the threshold for these practices to qualify for incentive payments.

**A.18. What are the potential disadvantages of joining the national pool of providers?**

Practices participating in the national pool waive the right to have their savings evaluated as a single practice; based on the distribution of savings among sites in the national pool, this may result in incentive payments that are lower than what a practice would have achieved on its own.

**A.19. How do we notify CMS that we would like to be part of the national pool?**

There is a drop-down menu in the *Information* tab of the Application that allows practices to declare how they will be participating—as a single practice, as part of a legal entity comprised of multiple practices (consortium), or as part of the national pool.

**A.20. If my practice selects Option 3, to participate in the national pool of providers, but grows to greater than 500 eligible beneficiaries during the course of the Demonstration, can we exit the national pool?**

No. All practices that select Option 3, the national pool, will remain in the national pool for the duration of the Demonstration, even if their enrollment exceeds 500 eligible beneficiaries.

**A.21. Can home health agencies participate in the Demonstration? Can home health agencies work with an existing in-home practice?**

A home health agency that has an existing in-home primary care service, directed by a physician or nurse practitioner or physicians' assistant that meets certain requirements, may participate in the Demonstration. Alternatively, home health agencies may establish a relationship with an applying in-home provider practice for providing home health care as recommended by physician practices or receive referrals as usual for providing home health care to IAH beneficiaries.

**A.22. What is the minimum number of beneficiaries an IAH practice must enroll per year?**

Each participating practice or consortium must provide services to an average of at least 200 applicable beneficiaries during each year of the Demonstration. A practice's enrollment may vary over a year, but must reach an average of 200 or more applicable beneficiaries each year.

**A.23. Will CMS provide a beneficiary caseload or will the practice be responsible for its own caseload?**

The practice will be responsible for identifying its eligible caseload and for certifying the eligibility of each applicable beneficiary (an eligible beneficiary must have at least two chronic conditions, two functional impairments, hospitalization in the last 12 months, and use of rehabilitation or other postacute care in the last 12 months). Practices are required to enroll all eligible beneficiaries both at the outset of the Demonstration and all additional beneficiaries who become eligible in the course of the Demonstration. CMS

will verify beneficiary eligibility by checking Medicare claims data (hospitalization and postacute care use in the last 12 months) and by auditing medical records for information regarding functional limitations. CMS will also use claims data to identify all potentially eligible beneficiaries associated with the individual practices to ensure the practices enroll all eligible beneficiaries. CMS reserves the right to audit a practice's medical records to verify eligibility of beneficiaries participating in the Demonstration.

**A.24. What are the eligibility requirements for patients?**

In order to be counted as part of this demonstration, patients must:

Be entitled to Medicare benefits under Part A and be enrolled in benefits under Part B;

Not be enrolled in a Medicare Advantage (MA) plan under Part C;

Not be enrolled in a Program for All-Inclusive Care for the Elderly (PACE) program under SSA Title 18 Sec 1894;

Have two or more chronic conditions;

Have had a hospital admission within the past 12 months;

Have received acute or sub-acute rehabilitation services within the past 12 months (including skilled nursing facility, home health, and inpatient and outpatient rehabilitation services); and

Require assistance of another person (assistance may include supervision, cueing, or hands-on help) for two or more activities of daily living (ADL).

**A.25. How will CMS know that the beneficiaries served by the practices meet the eligibility requirements?**

Each month, practices will provide CMS with a list of the patients they are serving under the IAH Demonstration, and provide information about their patients' chronic conditions and functional impairments. CMS reserves the right to audit the practices' medical records to verify the accuracy of these reports and will check claims records for qualifying hospitalization and rehabilitation or postacute care utilization in the 12 months prior.

**A.26. How are you defining "chronic conditions" for this demonstration?**

For the purpose of this demonstration, a chronic disease or condition is a disease or medical condition that is expected to last for more than 1 year, limits what a person can do, and requires ongoing medical monitoring. CMS will not specify a list of chronic conditions; however, some examples include congestive heart failure, diabetes, chronic obstructive pulmonary disease, ischemic heart disease, stroke, neurodegenerative diseases, and dementias such as Alzheimer's disease.

**A.27. Is each patient required to have a hospitalization and subsequent rehabilitation or postacute care use every year to remain eligible to be counted on a practice's IAH caseload?**

No. CMS hopes that practices will succeed in keeping their patients from returning to the hospital and needing any rehabilitation or postacute care. A beneficiary may continue to be counted in a practice's demonstration caseload as long as the beneficiary continues to have two or more chronic conditions and two or more functional impairments.

**A.28. One of our patients walks with a cane but does not need any additional assistance to use it correctly. Does this meet the ADL requirement for this demonstration?**

No. The use of assistive devices alone does not count as a functional dependency. For this demonstration, patients must need human assistance, including hands-on assistance, cueing, or supervision, with at least two of the following activities of daily living (ADLs): bathing, dressing, transfers, walking, toileting, or eating.

**A.29. What is meant by "forestalling the need for care in institutional settings" in the solicitation?**

CMS anticipates that the IAH Demonstration will lead to reductions in ED use, acute hospital stays, and inpatient rehabilitation or skilled nursing facility care. It is also possible that more timely, appropriate, and coordinated care will help beneficiaries to remain at home rather than seek long-term institutional care. However, as a program designed to focus on Medicare services and costs, the impact on long-term institutionalization and on total Medicare and Medicaid costs for dually eligible beneficiaries will be examined as part of the evaluation but not taken into consideration in determining incentive payments under the IAH Demonstration.

**A.30. How will the beneficiary's privacy in the home be protected?**

Beneficiaries will be guaranteed the same privacy in the home as they receive in a normal physician's office. All federal and state privacy laws apply to this demonstration.

**A.31. Do physicians need informed consent from all of their Medicare patients in order to participate in this demonstration?**

This demonstration does not affect Medicare benefits or payments and does not restrict beneficiaries from using other providers or Medicare covered services. Physician practices are expected to inform beneficiaries of their participation, but the Demonstration does not require a specific patient consent form or process.

**A.32. How will CMS make sure that the participating practices are representative of all IAH practices, even the ones that do not apply or are not selected?**

CMS expects that many IAH organizations will participate in the Demonstration and will provide a sufficient basis for a thorough and fair evaluation of the program.

**A.33. During the Demonstration, who will provide technical assistance to physician practices if they have questions?**

Technical assistance for providing data needed for monitoring patient participation and quality of care will be provided by CMS's design and implementation contractor. CMS' design and implementation contractor will also organize a learning collaborative and training on topics of interest to the practices or reflecting areas where improvements may be needed to achieve savings and meet the quality requirements. Practices will be encouraged to share best practices with other participating practices, and will have the opportunity to learn from other participating providers and experts.

**A.34. Will any practices be given preference over other practices during the application review and selection process?**

If the eligible applicant pool exceeds the 10,000 applicable beneficiary maximum, CMS will select a subset of eligible practices to participate in the Demonstration. Should this occur, practices will be selected to ensure balance among participants for evaluation purposes using the following criteria: location (high-cost area, state and region, urban and rural) and size of practice's patient population (variation will be based upon actual applicant pool), and practice readiness (all criteria met at the time of application submission). CMS may also limit the number of beneficiaries per practice to ensure that the Demonstration does not exceed the statutory maximum size of 10,000 beneficiaries.

## **Quality Measures**

**B.1. How were the quality measures targeted for inclusion in the Demonstration chosen?**

The quality measures were selected based on an extensive review of the literature, consultation with clinical experts, relevance of national quality standards (e.g., National Quality Forum and Agency for Healthcare Research and Quality), and analysis of Medicare claims data. Additionally, some of the measures, which are related to processes of care expected to improve quality and reduce costs, have been established specifically for the IAH Demonstration. Quality measure information will be self-reported electronically by each practice. Some quality measures will be verified or reconciled using claims data.

**B.2. The solicitation states that quality measures were selected, in part, by whether they could be measured on a timely basis and not require a longer period for the availability of data for analysis. Does this mean that Medicare claims will not be the source of data used to determine inpatient utilization?**

Each participating practice will report inpatient utilization directly to the design and implementation contractor on a quarterly basis to allow more timely analysis of utilization rates and to facilitate timely feedback to the practices. Claims data, available on a slower timeframe, will be used to calculate expenditures and to confirm the accuracy of the utilization data provided directly by the practices. Additional information is available in the solicitation.

**B.3. Is there a penalty for not meeting the targets established for the quality measures?**

Practices that do not meet at least three of the six quality measures tied to payment will not receive any incentive payments. Practices can be removed from the Demonstration if they fail to meet the quality measure targets or fail to have an average of at least 200 eligible beneficiaries for 1 year.

**B.4. What types of hospitalizations will practices be required to report?**

Practices will need to provide information on all types of hospitalizations and emergency department visits regardless of the condition for which the beneficiary was admitted or seen. CMS will use this information to track follow-up contact after a patient has been admitted to the hospital and discharged from the hospital and/or emergency department. However, only hospital admissions and emergency department visits for ambulatory care sensitive conditions will be included in the quality measures related to the number of inpatient admissions and number of emergency department visits. Conversely, inpatient readmissions will be calculated based on all types of hospitalizations.

**B.5. What data will be required for quality measures related to hospitalizations and emergency department visits?**

We will require information regarding the patient's admission date, discharge date, and admitting diagnosis.

**B.6. What kind of contact is expected from the practice for Quality Measure 1– “Contact with beneficiaries or primary caregivers within 48 hours upon admission to the hospital and discharge from the hospital and/or emergency department”?**

Upon admission to the hospital, CMS expects the practice to contact the beneficiary, the beneficiary's primary caregiver, or the hospital clinical staff, whether via phone or in person, in order to discuss the current condition of the beneficiary. During this contact, the practice should inform the hospital clinical staff that the patient is receiving home-based care, address any questions or concerns that may have arisen regarding the hospitalization, and plan follow-up care.

Upon discharge from the hospital, CMS expects the practice to provide an in-home visit within 48 hours, to assess the current condition of the beneficiary, and to begin follow-up care.

Upon discharge from the emergency department, CMS expects the practice to provide either an in-home visit to the beneficiary or telephone call to the beneficiary or the beneficiary's primary caregiver. Phone call follow-ups are acceptable as determined by the IAH physician or nurse practitioner. However, phone call follow-ups are not acceptable for medication reconciliation.

These steps are standard for home-based primary care practices, according to input from clinical experts consulted by CMS.

**B.7. How will CMS know that the IAH practice has conducted follow-up by telephone?**

All follow-ups, whether in person or by phone, need to be reported in the quarterly submissions. For auditing purposes, CMS is also requiring practices to note information related to phone follow-ups in the patient's medical record. This information should include the time and date of the call, the name and licensure of the staff member who made the call, and with whom they spoke (patient, caregiver, etc), all information that would normally be recorded by a practice in the course of normal business.

**B.8. What is meant by Quality Measure 2 "Medication reconciliation in the home"?**

One of the focuses of this quality measure is the safe care transitions from institutional settings to the home. Medication reconciliation in the home should occur after a beneficiary returns home from the hospital or ED. The reconciliation should include explaining any newly prescribed medications, as well as reconciling any new medications or dosages with previous ones. Medication reconciliation also includes ensuring that the beneficiary or caregiver understands and is capable of following the medication regime and, if not, making arrangements for medication management assistance as needed.

**B.9. Why are the measures in Quality Measure 7 not tied to incentive payments?**

These measures will be used to evaluate and monitor how different practices approach various aspects of providing in-home care to beneficiaries. These measures are not considered in the incentive payment calculations because CMS wants to focus on a smaller number of key, measurable outcomes and processes specific to the goals of the IAH Demonstration.

**B.10. Is in-home follow-up within 48 hours of discharge from the hospital required to fulfill Quality Measure 1 if the patient is transferred to another inpatient facility from the hospital?**

No; patients who are discharged from the hospital and transferred to another inpatient facility will be not be included in calculations for Quality Measure 1. However, CMS expects that practices will continue to follow these patients until they are back home in

order to maintain high-quality service and to facilitate safe transitions as part of the patient's full plan of care.

## **Application**

### **C.1. Should we complete the application on the computer or print it or fill it in by hand?**

Please complete the application by typing responses or, when available, selecting options from the drop-down menus. The completed application should be printed, signed, and then mailed to CMS, along with an electronic version on CD-ROM. The application materials should be mailed to:

Linda S. Colantino  
Independence at Home Demonstration  
Centers for Medicare & Medicaid Services  
Mailstop WB-06-05  
7500 Security Blvd  
Baltimore, MD 21244

### **C.2. When is the application due?**

For practices applying as a single entity or to be part of the national pool, the application deadline is Monday, February 6, 2012. Practices forming a consortium have an additional 90 days to submit an application, but must submit a Letter of Intent by the initial application deadline.

### **C.3. How do I know when drop-down menus have been provided?**

When you select a cell with a drop-down menu, a box with an arrow will appear to the right of that cell. Click on the arrow to see the list of available options. Select the applicable response by clicking on it.

### **C.4. Can we type in our own answers in boxes with drop-down menus?**

No. Applicants must select one of the options from the drop-down menu. An error message will appear if an answer is typed instead of selected from the menu.

### **C.5. How do I add an extra line?**

Select a cell in the row directly below where you would like a line to be added. Right-click and select "Insert." Next, select "entire row" and click "OK." A new row will appear above the selected cell. Repeat this process until the desired number of rows has been created.

### **C.6. What is meant by "name of legal entity/consortium"?**

This is the legal name of the practice. If several practices have joined together to form a consortium, please give the name of this new legal entity.

**C.7. My practice joined with several others to form a consortium. Whose and what information should be provided?**

Please provide the name of the newly formed legal entity. For the address and TIN, please provide the information for the primary practice in the consortium, as determined by the practices involved. For questions related to practice size, please provide the total number of patients for all of the practices in the consortium.

**C.8. Why are consortium applicants given extra time?**

Practices that choose to apply to participate in the Demonstration as a consortium are required to form a new legal entity. The additional 90 days are to allow for the practices to organize and create this entity. Please see question A.8 for more information regarding legal entities.

**C.9. What needs to be included in the Letter of Intent for consortia?**

Each consortium should send a single Letter of Intent that includes the following:

A statement that the consortium as a whole furnishes services to at least 200 eligible beneficiaries;

A statement that each of the involved practices meets eligibility requirements;

An approximate number of eligible beneficiaries from each individual practice in the consortium, as well as a total number for the entire consortium;

An address of each individual practice;

The name and address that the consortium will use to form the legal entity (if available); and

The name of the consortium representative who will sign the formal IAH application (if available).

Specific instructions for the Letter of Intent can be found in the *Letter of Intent* tab of the application.

**C.10. My practice is part of a consortium and we were able to create a new legal entity before the initial deadline. Do we need to submit a Letter of Intent or can we just submit a completed application?**

Consortium practices that are fully formed prior to the initial application deadline may submit their completed applications by that deadline without a Letter of Intent.

**C.11. In the *Information* tab for “Years Providing In-Home Primary Care Service,” should we provide the number of years that each practitioner has been providing in-home primary care?**

No. Please provide the number of years that the practice (or if a consortium, the multiple practices together) has had an established in-home primary care service available to

patients. Do not provide the sum of the number of years that the individual practitioners have been providing in-home primary care.

**C.12. In the *Practice Eligibility* tab, what should we do if we answered “no” to any of the questions?**

If you answered “no” to any of the questions, please explain your answer and the steps that you will take to address any deficiencies in your current situation prior to the beginning of the Demonstration.

**C.13. My practice currently meets the minimum level of applicable beneficiaries and does not have plans to expand; do we need to describe plans to expand the practice?**

No. Please write “Not Applicable” in the space provided for explaining plans to expand the practice.

**C.14. My practice is in the process of transitioning to electronic health information systems, are we still eligible? How should we answer the question on the application asking us to explain the electronic system we currently have in place?**

Yes, your practice will be eligible to participate in the Demonstration as long as use of the systems has been incorporated by the time the Demonstration begins.

In the application, briefly describe the system your practice will be using and the plans for incorporating the system into your practice.

Please note that if CMS receives applications that would lead to exceeding 10,000 beneficiaries, CMS may use experience with electronic health information systems as one practice selection criterion.

**C.15. Do we need to answer any questions in the *Beneficiary Eligibility* tab?**

No. The *Beneficiary Eligibility* tab lists the eligibility requirements for beneficiaries. There are no questions for providers to answer in this tab.

**C.16. What type of staff should be named in the leadership position within the provider practice?**

For the Demonstration, provider practices should be led by a physician or nurse practitioner or physician’s assistant that meets certain requirements. If nurse practitioners or physician’s assistants are leading the practice, briefly describe any oversight role of nurse practitioners that physicians are required to provide in the state(s) in which the practice will serve Demonstration beneficiaries.

**C.17. Why does CMS require our individual National Provider Identification (NPI) number and Medicare Tax Identification Number (TIN)?**

Practices are required to submit their NPI numbers and TINs so that CMS can verify that the practice is a legal entity, to check that a practice has been completing home visits, and to track utilization and expenditures using Medicare claims data. In addition, this information will also be used for auditing purposes and to ensure that the practice is not enrolled in another shared savings program.

**Data Submission**

**D.1. What data and communication capabilities are required of a physician practice for participation in the Demonstration?**

Practices must have electronic medical records, the ability to use remote monitoring, and mobile diagnostic technology, or a referral arrangement with providers with this capability who will report findings back to the practice. In addition, practices will be required to transmit information about their beneficiaries and quality measure data via the Internet.

**D.2. Are we required to use a specific EHR system?**

No. Practices are expected to operationalize the use of EHR in a way that best suits the needs of their practice; this includes choosing which system to use.

**D.3. How do we demonstrate our capability for remote monitoring and mobile diagnostic technology?**

In your application, describe how your practice will use technology to monitor patients' health status. This technology can include anything from a phone call to portable imaging and laboratory tests to electronic in-home monitoring. Please see question A.11 for examples of remote monitoring technology.

**D.4. What types of feedback will physician practices receive?**

CMS will provide feedback reports at least biannually to the practices summarizing the information provided by the practices regarding their caseload, utilization, and quality performance. These reports will be used to identify needs for technical assistance and to allow practices to see their performance in comparison to the average in the Demonstration. These ongoing reports will not be case mix or risk adjusted. Practices also will receive annual reports about their performance in respect to meeting the quality standards and financial targets established in the Demonstration.

**D.5. How and to whom do practices submit data?**

Practices will submit data electronically to CMS' design and implementation and evaluation contractors.

**D.6. How often should physicians provide information to CMS about their caseload and report information regarding the quality measures?**

Practices must report basic information about their patients each month and information required for monitoring quality quarterly. Most measures will be reported to CMS on a quarterly basis but some, like documenting patient preferences, will be reported on a yearly basis. The electronic reporting system will make it clear which measures need to be reported at what time. The reporting system will be designed to allow practices to submit data on a rolling basis (i.e., as it becomes available for individual patients), but practices may also wait to submit data on a monthly basis.

## **Payment**

**E.1. What has to be done to earn an incentive payment?**

In order to receive an incentive payment, a practice must achieve savings greater than the MSR and meet or exceed at least three of the six quality measures tied to payment. The MSR is a savings percentage that varies by the number of Demonstration beneficiaries that are patients of the practice; that is, the smaller the practice size, the greater the MSR.

**E.2. When can I expect the first incentive payment to be made?**

The first incentive payment will be made in the middle of the second year of the Demonstration. Savings will be determined based on claims data incurred during the first year of operations under the Demonstration, allowing for a claims run-out period. After savings have been determined and quality measure achievement calculated, CMS will provide incentive payments to qualifying practices.

**E.3. How will incentive payments to practices be calculated?**

Incentive payments will be paid to a practice if it produces savings as a result of its IAH Demonstration participation and meets at least three of the six quality measure thresholds. After meeting the MSR, the incentive payments will be calculated as a proportion of the remaining savings achieved by the practice in excess of 5%. If a practice exceeds the MSR at the 5% level of statistical significance, then the practice will receive between 50% to 80% of the remaining savings achieved, depending on the number of quality measure targets met. If, instead, a practice exceeds the MSR at only the 10% level of statistical significance, then the practice will receive between 25% to 50% of the remaining savings achieved, depending on the number of quality measure targets met.

**E.4. How does the number of quality measures met affect the payment of any incentive payments to my practice?**

If a practice does not meet the targets for at least three of the six quality measures, that practice will not receive any incentive payments, regardless of the savings achieved. After the potential incentive payment is calculated based on the MSR and whether it was achieved at the 5% or 10% level of significance, and at least three of the six quality

targets have been achieved, the actual incentive payment to the practice will be based on how many of the quality targets are met. It does not matter which of the quality measures are met.

**E.5. Will I have to share the savings that my practice achieves with other practices participating in the Demonstration?**

For practices entering into the Demonstration under Option 1, as a single practice, a spending target will be set and savings will be measured by comparing actual Medicare expenditures for each practice to its own target. Actual expenditures will be adjusted to take into account each practice's experience resulting from its high-cost beneficiaries.

For practices that select Option 2, and enter the Demonstration as a consortium, CMS will make a single incentive payment to the entity as a whole. It will be up to each consortium to determine how to distribute the payment among its participating practices.

For practices participating under Option 3, the national pool, savings will be determined based on the spending target, actual expenditures, and MSR for all beneficiaries in the national pool. Savings will be distributed to the individual practices according to the individual practice's risk-adjusted beneficiary months of enrollment and the number of quality measures met by the individual practice.

**E.6. What is a risk corridor, and how does it affect payment of any incentive payments?**

CMS has established a risk corridor to identify whether annual savings produced by practices are statistically different from any year-over-year difference that otherwise might be expected due to normal variation in annual expenditures, as required by the statute. The determination of statistically significant differences in year-over-year expenditures is a function of the number of patients in the practice. Practices with fewer patients must produce larger savings in order to pass the test of statistical significance than larger practices because practices with fewer patients offer less statistical power for making this determination. The risk corridor is expressed as a minimum savings requirement (MSR) that each practice must meet to be eligible for an incentive payment.

**E.7. Will participation in this demonstration affect current practice methods of submitting claims or billing Medicare?**

No. Current practice methods of submitting claims or billing Medicare will not be affected by participation in this demonstration. The IAH Demonstration does not change Medicare coverage or payment policies.