



Million Hearts® Cardiovascular Disease Risk Reduction Model FAQs

Application/Selection Process

Q1: Please confirm that the selection process is random once a practice has met the basic requirements of the application.

A: Practices will be selected on a first come, first serve basis until 720 applications have been received. There will be basic completeness checks and CMS reserves the right to select practices based on geographic need and diversity factors, such as clinical focus and patient demographics. The randomization process will occur once the 720 practices have been selected.

Q2: If a provider is selected to participate and is in the Intervention Group, will the provider be expected to implement what they documented for the application questions?

A: Yes, practices will be expected to implement what they documented for the application questions. Practices are required to submit data and complete a survey twice a year that will assess how well they have implemented what they proposed in order to allow CMS to monitor performance and implementation of the model.

Q3: Should providers list the number of providers, NP's, and clinical staff (RN's, LPN's, and MA's) and their responsibilities in the "Team Based Care" question? Should their responsibilities be described with respect to the program or overall patient care? Should providers include information about the care of communication and care coordination within and outside the organization?

A: Providers and their responsibilities should be listed in the "Team Based Care" section. Please provide their responsibilities as it relates to their work on the Million Hearts® Cardiovascular

Disease Risk Reduction Model. A brief sentence or two about communication and care coordination within and outside the organization would be helpful if space permits.

Q4: Are Provider Based Clinics eligible for the program?

A: Yes

Q5: Are Method II Critical Access Hospital clinics eligible for the program?

A: Yes

Q6: Should providers in all specialties be included in the question about “total number of providers” or just the providers who are participating in the model?

A: Only list providers who are participating in the model.

Q7: Is there a sample application available?

A: A sample application can be accessed via this link: <http://innovation.cms.gov/Files/x/mh-cdrrm-samplerfa.pdf>.

Q8: If a clinic has not yet opened and cannot provide demographic information for their patients, would the clinic still be eligible for the program?

A: Yes, as long as the clinic has physicians on board, meets the eligibility criteria, and is operational by January 4, 2016, they are eligible to apply.

Q9: If a provider has 23 different practices sites, may we submit an application for the six that are most representative of our organization’s geographic, patient diversity and size differences?

A: Providers may submit an application for the practice sites of their choice that will participate in the model. If they are independent and do not operate on a shared EHR or providers do not readily move back and forth between the sites, these 6 applications may be separate.

Q10: What is the CMS helpdesk email to contact when providers have log-in questions?

A: Providers should contact: CMMIForceSupport@cms.hhs.gov (mailto:CMMIForceSupport@cms.hhs.gov) or call 1-888-734-6433 and select “option 5” for log-in issues.

Q11: Under Practice Characteristics, it asks for the estimated number of Medicare beneficiaries the practice serves. Does this include Medicare FFS and Medicare Advantage beneficiaries or just Medicare FFS?

A: Since the target population for this model is Medicare FFS beneficiaries, and Medicare Advantage beneficiaries are ineligible to participate, providers should only report the number of Medicare FFS beneficiaries.

Q12: When are providers going to be notified if they qualify to participate in the model? Once providers have been notified that they are eligible to participate in the model, can they start using the risk calculator prior to the actual start date?

A: We anticipate that providers would hear back from CMS in November/December. Providers are welcome to use the risk calculator before the model launch; however, that will not have a bearing on the randomization. In addition, they will only be able to be eligible for payment for the risk stratification and care management once the model begins and if they are randomized into the intervention group. The anticipated start date is 1/4/2016.

Q13: In the section of the application that asks about, “estimated number of total patients,” “estimated number of Medicare patients,” and “racial demographics of the patient population,” is the last question referring to only Medicare patients or the total patient population?

A: The last question is referring to the total patient population in the practice.

Q14: With respect to the Patient Population table in the application, if a provider collects data for “Hispanic (Non-White),” should this percent be reported under the “unreported/unknown” column since there is no box indicating where they should be reported?

A: It is fine to report under the “unreported/unknown” column.

Q15: Our practices are Rural Health Clinics and bill Medicare A. It was noticed that such practices are excluded. Could you please confirm?

A: Rural health clinics are not excluded – they are eligible to apply. CMS understands that rural health clinics, critical access hospitals, and Federally-qualified health centers bill Medicare part A. If randomized to the intervention group, rural health clinics, critical access hospital, and Federally-qualified health centers will be required to apply for a Part B billing number so CMS can submit claims on behalf of the organization. CMS will assist practices with this process.

Q16: If we have multiple TINs that will be applying do we need to have a separate application for each TIN?

A: No, you do not need to submit separate applications. If you are applying as one entity you only need to submit one application. In the Organization TIN field, enter the TIN for the umbrella organization. In the supporting spreadsheet, please specify the entire list of TINs and NPIs for participating providers.

Q17: Our practice is already implementing an aggressive quality improvement program for our patients. Should we apply for the Million Hearts Model?

A: We encourage you to apply for the Million Hearts® Cardiovascular Disease Risk Reduction Model as there is no risk to your practice to be involved in either the intervention or control group and you can help with identifying successful prevention and population health interventions for CVD.

Control Group

Q18: Are practices that are selected to be in the “control group” able to proceed with a CVD risk reduction program for their patients, including the possible use of Million Hearts programming and education while also participating as a member of the control group during the five year program?

A: Control group practices can proceed with CVD risk reduction programming, but the programming specific to the Million Hearts® Cardiovascular Disease Risk Reduction Model would not be available to the control group during the five year duration of the model.

Q19: If a provider is selected as a control practice, is the provider prevented from providing risk reduction interventions for their patients?

A: Control group practices should continue to practice in any way they see appropriate for their patients.

ACC/AHA CVD Risk Calculator

Q20: Will practices use an online version of this tool and then be required to transfer the data into their EHR system?

A: Yes. Practices can use whatever version of the tool works best with their work flow. This may be online, a downloadable excel spreadsheet, i-phone app, etc. The expectation is that the patient’s CVD risk score will be captured in the EHR so that it can be reported to CMS every six months.

Reporting

Q21: If providers report PQRS data through Group Practice Reporting Option (GPRO) Web Interface and the metrics are predefined by CMS, would this be sufficient for reporting the PQRS data for the program?

A: Providers may report PQRS data through the GPRO; they are not required to use the model’s PQRS system.

Payment

Q22: How was the payment incentive structure developed for this model?

A: The incentive structure was developed to drive practices to achieve outcomes. Different scenarios were modeled to assess a reasonable risk reduction that is achievable for high risk individuals.

Q23: Are the payments a lump sum made every six months?

A: Yes

Q24: The control group will be paid \$20/beneficiary for each reporting cycle, correct? How frequently will this data need to be reported?

A: Practices in the control group will receive a one-time payment of \$20 per beneficiary. For the control group, practices will report annually in years 1, 2, 3, and 5. For the intervention group, practices will report every six months.

Q25: Will the \$10 be added to ENM payment?

A: Yes, any payments made under the model are paid in addition to payment for any other services that are provided and billed for.

Payment - Risk Score

Q26: Would a provider's aggregate absolute risk reduction for high risk patients need to be between 2% and 10% to earn \$5 PBPM?

A. Yes

Q27: Would a provider's aggregate absolute risk reduction for high risk patients need to be more than 10% to earn \$10 PBPM?

A: Yes

Q28: Does the provider's baseline aggregate absolute risk score then adjust to what was reported during the year? For example, if a provider achieved an aggregate risk score of 49% during the second year, down from 60%, does the provider have to reduce to less than 47% to get paid the PBPM payment after the next reporting milestone?

A: No. The risk reduction is cumulative and the provider's baseline is static. If the baseline is 60%, it will remain 60% over the life of the model. The provider's PBPM will be determined according to its reduction in aggregate absolute ASCVD risk compared to the baseline.

Tool Question

Q29: Can providers participate in this model if they are already involved with other CMS shared saving initiatives?

A: Yes, CMS encourages participation in our model if a practice is already involved with other CMS shared savings initiatives. In most cases, the shared savings initiatives will adjust the shared savings calculations to account for the payments received from this model.

Q30: How do I know if the practice is involved in a CMS shared savings initiatives i.e., MSSP/ACOs?

A: Any entity will be considered a participant in an ACO based upon the following:

- Any provider or supplier that has or bills through a TIN that appears on a SSP certified list of ACO participants.
- An institutional provider or supplier that has a CCN included on a Pioneer ACO's participating provider list.
- A non-institutional provider and supplier that has a TIN/NPI combination included on a Pioneer ACO's participating provider list.

Q31: How will the recoupment calculation work?

A: The recoupment calculator will be performed after the completion of the shared savings calculation by the respective ACO initiative.

Q32: Can a provider participate if they are a part of an ACO?

A: Yes.

Q33: Is there guidance regarding the need for an IRB/ethics review of an institution's participation in the Million Hearts model, seeing as participating sites will be randomized into either "intervention" or "control" groups?

A: The Center for Medicare & Medicaid Innovation (CMMI) evaluation research is in all but very rare cases exempt from the IRB process.

Q34: Can the three mandatory encounters be either face-to-face or non-face-to-face?

A: On page 17 of the RFA, it states, "...To receive the ongoing CVD CM payment, practices will attest to the provision of the following services between each six month reporting period:

- Conduct at least one annual reassessment of the ACC/AHA ASCVD Pooled Cohort 10 Year Risk Score utilizing the Treatment Benefit Equation
- A minimum of two annual follow-up beneficiary encounters"

The annual risk score reassessment would have to be done in person in terms of physical measurements such as blood pressure would be difficult, or impossible, to do remotely. The two follow up beneficiary encounters can be done either face-to-face or remotely. The expectation is that the practice will follow-up with the beneficiary to discuss their progress in risk reduction, modify their risk reduction plan, and/or engage in shared decision making to determine the next best course of action for continuing to reduce or maintain their reduced risk.

In addition, please note that the minimum required **three visits are per year**, not per six month reporting period.

Q35: Two of the data points are related to the patient's cholesterol level. Is it sufficient to use the patient's most recent cholesterol test to report this data, even if the test was conducted four years ago? Given that Medicare only covers cholesterol screening every five years for most patients, would a practice need to use a cholesterol test from the current year to report to CMS?

A: Yes. CMS encourages practices to provide services in line with what is covered by Medicare. If the cholesterol level was obtained in the previous 5 years, it will be acceptable.

Q36: Can the model be integrated with an office documentation system or a stand alone system?

A: We require practices to have at least a basic electronic medical system, but there are multiple options. CMS will provide a stand alone web based portal which will provide all functions that are necessary. The only option that is not allowed is the submission of paper based claims.

ASCVD

Q37: Can you confirm that your high-risk definition is any beneficiary with an ACC/AHA 10-year ASCVD risk score of 30%? Our understanding is that prior guidelines put the high risk score at 7.5%.

A: For the purposes of the Million Hearts® Cardiovascular Disease Risk Reduction Model, CMS is defining "high-risk" beneficiaries as individuals with an ACC/AHA 10-year ASCVD risk score of greater than 30%. The ACC/AHA guidelines still hold true that all individuals should have a risk score less than 7.5%. CMS is attempting to intervene on the critically high risk group. It is expected that practices will provide the necessary care as clinically appropriate for beneficiaries with risk scores between 7.5-29%.