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Physician Group Practice Transition Demonstration Quality Measurement and Reporting Specifications

Version 3

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SECTION 1
INTRODUCTION

The Physician Group Practice (PGP) Demonstration rewarded large physician groups for improving the quality and cost efficiency of care. The Demonstration completed its fifth performance year and ended March 31, 2010. The Affordable Care Act states that the Secretary of the Department of Health and Human Services may enter into a shared savings agreement with the organizations participating in the PGP Demonstration. The Centers for Medicare & Medicaid Services (CMS) has worked with the participating organizations to revise the Demonstration terms and conditions to operate the Demonstration for two additional years beginning on January 1, 2011.

A two-year Demonstration, termed the PGP Transition Demonstration, will

- provide CMS with additional performance data and insight into the sustainability of results to consider when designing and refining the Medicare Shared Savings Accountable Care Organization (ACO) Program that is mandated in section 3022 of the Affordable Care Act,

- continue a successful Demonstration and provide additional opportunities for groups to generate shareable savings for the Medicare Trust Funds, and

- provide CMS the opportunity to test additional quality measures using a methodology that encourages continual improvement.

The timeline for the PGP Transition Demonstration will be as follows:

- Three base years: January 1, 2008–December 31, 2010

- Performance year 1 (PY1): January 1–December 31, 2011

- Performance year 2 (PY2): January 1–December 31, 2012

1.1 Pay for Performance

Groups that are eligible to share in savings will be eligible to share 50 percent of the difference between target and actual expenditures. The total performance payments earned will be based on performance on the quality measures and efficiency, with the percentage based on quality equal to 80 percent in PY1 and 90 percent in PY2. The actual quality payment is determined based on how the PGP performed in quality measurement for the year.

1.2 Bonus Incentives

The PGP sites that elect to participate in the Leading Quality Group and are eligible to share in savings for the given performance year will have the opportunity to earn an additional 10% in shared savings for performance on (1) a patient experience of care measure and (2) composite quality measure scores. The patient experience of care measure may utilize the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Clinician and Group

survey. The Composite Quality Measures are an aggregate of the composite quality scores for the chronic disease modules under the PGP Transition Demonstration.

The additional 10% of shared savings payments will be outside the maximum shared savings that is currently set at 5% of total target expenditures, and will increase the sharing rate to up to 60% for groups that are eligible to share savings. These two additional performance measurements will each account for 5% of the additional 10% in shared savings. The formula for calculating the leading quality performance payment is as follows:

Leading Quality Performance Payment =	(Score on Patient Experience of Care Measure* 0.05* Target Minus Assigned Beneficiary Expenditures) + (Aggregated Composite Quality Measures*0.05* Target Minus Assigned Beneficiary Expenditures)

Thus, if the PGP is eligible to share in savings for PY1 and scores 100% on each of these two additional measures, they will receive the full 10% of the leading quality performance payment. This also suggests that if the PGP was not eligible to share in savings (i.e., if target minus assigned beneficiary expenditures were below the MSR), then the leading quality performance payment would be zero.

At the end of each reconciliation cycle, the total earned performance payment for PGPs that elect to participate in the Leading Quality Group is the sum of: (1) performance payment for efficiency, (2) the performance payment for quality, and (3) the leading quality performance payment, as follows:

Total Earned Performance Payment =	(Performance Payment for Efficiency) + (Performance Payment for Quality) + (Leading Quality Performance Payment)

1.3 Organization of This Report

The following sections of this report describe in more detail the methods for measuring the Demonstration quality indicators and calculating the PGP quality performance payments. The specific quality measures to be used in the Demonstration and their measurement processes are described in section 2. Procedures for claims-based analysis of quality measures are presented in section 3. Procedures for collecting, measuring, and auditing medical record-based or hybrid measures are included in section 4. Section 5 describes the Leading Quality Group option. Section 6 describes the warehousing of data produced for the Demonstration during quality measurement. Finally, section 7 includes the timeline for implementing the quality measurement procedures during each year of the Demonstration.

Detailed measurement specifications for the 41 quality measures used in the PGP Transition Demonstration are included in the Appendix by topic. These include (1) flow charts for data capture, (2) data abstraction definitions, (3) medication lists (where applicable), (4) an algorithm for electronic health record (EHR) abstraction, and (5) a document for mapping the PGP's EHR to the data abstraction tool.

SECTION 2
MEASURING AND SCORING QUALITY PERFORMANCE

2.1 Overview of the Quality Measurement Process

This section summarizes the consensus reached by the PGP Transition Demonstration Quality Workgroup and CMS between fall 2010 and winter 2011. The quality measures for the PGP Transition Demonstration are a combination of quality measures used in the 2010 Group Practice Reporting Option (GPRO) under the Physician Quality Reporting System (PQRS), the Meaningful Use initiative, and measures that are considered to have special clinical relevance and importance for the Medicare population. The number of quality measure modules and quality measures, therefore, has increased, and the nine modules are as follows: Diabetes Mellitus (DM), Heart Failure (HF), Coronary Artery Disease (CAD), Hypertension (HTN), Preventive Care (PREV), Chronic Obstructive Pulmonary Disease (COPD), Care of Frail Elderly (FE), Transitions of Care/Care Coordination (TCCC), and Meaningful Use Core Clinical Quality Measures (MU). **Table 2-1** lists the 41 specific quality measures included in the PGP Transition Demonstration.

The majority of quality measures in the PGP Transition Demonstration have been endorsed by the National Quality Forum. Among the measures' stewards are the National Committee for Quality Assurance (NCQA), the American Medical Association-Physician Consortium for Performance Improvement (AMA-PCPI), and Quality Insight of Pennsylvania in conjunction with CMS. A brief description of each quality measure is included below.

Diabetes Mellitus

DM-2: Hemoglobin A1c Poor Control in Diabetes Mellitus

Description: Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent hemoglobin A1c greater than 9.0%.

DM-3: High Blood Pressure Control in Diabetes Mellitus

Description: Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent blood pressure in control (less than 140/90 mmHg).

DM-5: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus

Description: Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent LDL-C level in control (less than 100 mg/dL).

DM-6: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients

Description: Percentage of patients aged 18 through 75 years with diabetes mellitus who received urine protein screening or medical attention for nephropathy during at least one office visit within 12 months.

DM-7: Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient

Description: Percentage of patients aged 18 through 75 years with diabetes mellitus who had a dilated eye exam.

DM-8: Diabetes Mellitus: Foot Exam

Description: Percentage of patients aged 18 through 75 years with diabetes who had a foot examination.

Heart Failure

HF-1: Left Ventricular Function (LVF) Assessment

Description: Percentage of patients aged 18 years and older with a diagnosis of heart failure who have quantitative or qualitative results of LVF assessment recorded.

HF-2: Left Ventricular Function (LVF) Testing

Description: Percentage of patients with LVF testing during the current year for patients hospitalized with a principal diagnosis of heart failure (HF) during the measurement period.

HF-3: Weight Measurement

Description: Percentage of patients aged 18 years and older with a diagnosis of heart failure who had a weight measurement recorded during the last office visit.

HF-5: Patient Education

Description: Percentage of patients aged 18 years and older with a diagnosis of heart failure who were provided with patient education on disease management and health behavior changes during one or more visit(s) within 12 months.

HF-6: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)

Description: Percentage of patients aged 18 years and older with a diagnosis of heart failure who also have LVSD (LVEF < 40%) and who were prescribed beta-blocker therapy.

HF-7: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)

Description: Percentage of patients aged 18 years and older with a diagnosis of heart failure and LVSD (LVEF < 40%) who were prescribed ACE inhibitor or ARB therapy.

HF-8: Warfarin Therapy for Patients with Atrial Fibrillation

Description: Percentage of all patients aged 18 years and older with a diagnosis of heart failure and paroxysmal or chronic atrial fibrillation who were prescribed warfarin therapy.

Coronary Artery Disease

CAD-1: Oral Antiplatelet Therapy Prescribed for Patients with CAD

Description: Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed oral antiplatelet therapy.

CAD-2: Drug Therapy for Lowering LDL-Cholesterol

Description: Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed a lipid-lowering therapy (based on current ACC/AHA guidelines).

CAD-3: Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)

Description: Percentage of patients aged 18 years and older with a diagnosis of CAD and prior MI who were prescribed beta-blocker therapy.

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

Description: Percentage of patients aged 18 years and older with a diagnosis of CAD whose most recent LDL cholesterol test was < 100 mg/dL.

CAD-7: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)

Description: Percentage of patients aged 18 years and older with a diagnosis of CAD who also have diabetes mellitus and/or LVSD (LVEF < 40%) who were prescribed ACE inhibitor or ARB therapy.

Hypertension

HTN-2: Blood Pressure Control

Description: Percentage of patients with most recent BP < 140/90 mmHg.

HTN-3: Plan of Care

Description: Percentage of patient visits for patients aged 18 years and older with a diagnosis of HTN with either systolic blood pressure ≥ 140 mmHg or diastolic blood pressure ≥ 90 mmHg with documented plan of care.

Preventive Care and Screening

PREV-5: Screening Mammography

Description: Percentage of women aged 50 through 69 years who had a mammogram to screen for breast cancer within 24 months.

PREV-6: Colorectal Cancer Screening

Description: Percentage of patients aged 50 through 75 years who received the appropriate colorectal cancer screening.

PREV-7: Influenza Immunization for Patients ≥ 50 Years Old

Description: Percentage of patients aged 50 years and older who received an influenza immunization during the flu season (September through February).

PREV-8: Pneumonia Vaccination for Patients 65 Years and Older

Description: Percentage of patients aged 65 years and older who have ever received a pneumococcal vaccine.

Chronic Obstructive Pulmonary Disease (to be added in next version of document)

COPD-1: Tobacco Use Assessment/Cessation Intervention

Description: Tobacco Use assessment/cessation intervention measure pair:

1a. Percentage of patients aged 18 years and older with a diagnosis of COPD who were queried about tobacco use one or more times during the measurement period or year prior to the measurement period.

1b. Percentage of patients aged 18 years and older with a diagnosis of COPD who were identified as tobacco users and received a tobacco use cessation intervention at least once during the measurement period or year prior to the measurement period.

COPD-2: Spirometry evaluation

Description: Percentage of patients aged 18 years and older with a diagnosis of COPD who had spirometry evaluation results documented.

COPD-3: Bronchodilator Therapy

Description: Percentage of patients aged 18 years and older with a diagnosis of COPD and who have an $FEV_1/FVC < 70\%$ and have symptoms who were prescribed an inhaled bronchodilator.

Care of Frail Elderly

FE-1: Screening for Future Fall Risk

Description: Percentage of patients aged 65 years and older who were screened for future fall risk at least once during the measurement period.

FE-2: Osteoporosis Management in Women Who Had a Fracture

Description: Percentage of females 65 years of age and older who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat or prevent osteoporosis in the six months after the fracture.

FE-3: Monthly INR Monitoring for patients on Warfarin

Description: Average percentage of monthly intervals in which patients with claims for warfarin do not receive an INR test during the measurement period.

Transitions of Care/Care Coordination

TCCC-1: Post-discharge medication reconciliation

Description: Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g., hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care who had reconciliation of the discharge medications with the current medication list in the outpatient medical record documented.

TCCC-2: 30-day post-discharge provider visit

Description: The rate of provider visits within 30 days of discharge from an acute care hospital per 1,000 discharges among eligible beneficiaries assigned to the PGP.

TCCC-3: All cause readmissions (any primary diagnosis)

Description: The rate of readmissions within 30 days of discharge from an acute care hospital per 1,000 discharges among eligible beneficiaries assigned to the PGP.

TCCC-4: Ambulatory care sensitive condition: Diabetes, short-term complications admission rate

Description: Admission rate among 18 years and older with a principal diagnosis for short-term diabetes complications.

TCCC-5: Ambulatory care sensitive condition: COPD admission rate

Description: Admission rate among 18 years and older with a principal diagnosis for COPD.

TCCC-6: Ambulatory care sensitive condition: Congestive heart failure admission rate

Description: Admission rate among 18 years and older with a principal diagnosis for CHF.

TCCC-7: Ambulatory care sensitive condition: Bacterial pneumonia admission rate

Description: Admission rate among 18 years and older with a principal diagnosis for bacterial pneumonia.

TCCC-8: Ambulatory care sensitive condition: Uncontrolled diabetes admission rate

Description: Admission rate among 18 years and older with a principal diagnosis for uncontrolled diabetes, without mention of a short-term or long-term complication.

Meaningful Use Core Clinical Quality Measures

MU-1: Adult weight screening and follow-up

Description: Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented.

MU-2: Hypertension: Blood pressure measurement

Description: Percentage of patient visits for patients aged 18 years and older with a diagnosis of hypertension who have been seen for at least 2 office visits, with blood pressure (BP) recorded.

MU-3: Tobacco assessment/cessation intervention

Description: Preventive Care and Screening Measure Pair:

a. Percentage of patients aged 18 years or older who have been seen for at least 2 office visits, who were queried about tobacco use one or more times within 24 months.
b. Percentage of patients aged 18 years and older identified as tobacco users within the past 24 months and have been seen for at least 2 office visits, who received cessation intervention.

Table 2-1
Quality Measures for the PGP Transition Demonstration

Measure title	Measure crosswalk
Diabetes mellitus	
DM2—HbA1c poor control > 9.0%	NQF 59
DM3—Blood pressure control	NQF 61
DM5—LDL control	NQF 64
DM6—Urine protein testing	NQF 62
DM7—Dilated eye exam	NQF 55
DM8—Foot exam	NQF 56
Heart failure	
HF1—Left Ventricular Function Assessment	NQF 79
HF2—Left ventricular EF testing—Hospitalized	GPRO HF-2 (CMS)
HF3—Weight measurement	CMS
HF5—Heart failure patient education	NQF 82
HF6—Beta blocker therapy for LVSD	NQF 83
HF7—ACEI or ARB for LVSD	NQF 81
HF8—Warfarin therapy for patients w/HF and AF	NQF 84
Coronary artery disease	
CAD1—Oral antiplatelet therapy	NQF 67
CAD2—Drug therapy for lowering LDL > 130 mg/dl	NQF 74
CAD3—Beta blocker therapy prior MI	NQF 70
CAD6—LDL level < 100 mg/dl	NQF 64 with CAD denominator
CAD7—ACEI or ARB for patients w/DM & CAD	NQF 66
Hypertension	
HTN2—Blood pressure control	NQF 18
HTN3—Plan of care	NQF 17
Preventive care	
PREV5—Screening mammography	NQF 31
PREV6—Colorectal screening	NQF 34
PREV7—Influenza vaccination—50 years & over	NQF 41
PREV8—Pneumococcal vaccination—65 years & over	NQF 44

(continued)

Table 2-1 (continued)
Quality Measures for the PGP Transition Demonstration

Measure title	Measure crosswalk
COPD [1]	
COPD1—Tobacco Use Assessment/Cessation Intervention	NQF 28 with COPD denominator
COPD2—Spirometry evaluation	NQF 91
COPD3—Bronchodilator therapy	NQF 102
Care of Frail elderly [1]	
FE1—Screening for future fall risk	NQF 101
FE2—Osteoporosis Management in Women Who Had a Fracture	NQF 53
FE3—Monitoring INR monitoring for patients on Warfarin	NQF 555
Transitions of care/care coordination [2]	
TCCC1—Post-discharge medication reconciliation	NQF 97
TCCC2—30-day post-discharge provider visit	CMS
TCCC3—All cause readmissions (any primary diagnosis)	CMS
TCCC4—Ambulatory sensitive conditions admissions: Diabetes, short-term complications	NQF 272
TCCC5—Ambulatory sensitive conditions admissions: COPD	NQF 275
TCCC6—Ambulatory sensitive conditions admissions: Congestive heart failure	NQF 277
TCCC7—Ambulatory sensitive conditions admissions: Bacterial pneumonia	NQF 279
TCCC8—Ambulatory sensitive conditions admissions: Uncontrolled diabetes	NQF 638
Meaningful use core clinical quality measures [1]	
MU1—Adult weight screening and follow-up	NQF 421
MU2—Hypertension: blood pressure measurement	NQF 13
MU3—Tobacco assessment/cessation intervention	NQF 28

[1] Pay for Reporting in PY1.

[2] Pay for Reporting in PY1 and PY2.

The PGP Transition Demonstration will include two 12-month performance periods that are expected to span from January 1, 2011, to December 31, 2012 (PY1 and PY2). The quality measures modules will be phased in under the following timeframe:

Performance Year 1	Pay for Performance: DM, HF, CAD, HTN, PREV
	Pay for Reporting Only: COPD, FE, TCCC, MU
Performance Year 2	Pay for Performance: DM, HF, CAD, HTN, PREV, COPD, FE, MU
	Pay for Reporting Only: TCCC

In PY1, all quality measures in the new modules for COPD, FE, TCCC, and MU will be rewarded under pay for reporting. PGPs will earn 100% of the dollars associated with these modules in PY1 for satisfactory reporting (i.e., completing all required eligible cases). For PY2, the COPD, FE, and MU will move to pay for performance, and the eight TCCC measures will remain as pay for reporting only.

2.2 Benchmarking Quality Performance

The PGP Transition Demonstration performance methodology will include a minimum and maximum threshold for each measure. The rationale for the minimum is that CMS believes there is a minimal acceptable level of quality performance that justifies an incentive payment. The minimum for all PY1 pay for performance measures will be set at 50%; that is, the sum of numerator hits divided by the sum of denominator hits must be greater than or equal to a performance score of 50.00% in order for the measure to have a score calculated. Measures that have performance under the minimum will receive 0% of the quality measure score for that measure. The baseline scores for the COPD, FE, TCCC, and MU are not known, so setting minimums is not possible at this time. The minimum will be set at 50% of the best-performing PGP group when transitioning to pay for performance. Note that, for the quality measures in which the performance scores are an indication of low quality of care (e.g., HbA1 control, all-cause readmission), in order for CMS to measure and reward for high quality, these performance scores must be expressed in the reverse direction. For these measures, the proportion of hospitalization and readmissions will be subtracted from 100.00%.

The maximum (or benchmark) for each pay for performance measure will be as follows:

1. The median of the PGP score for the measure if the median score was >90 percent.
2. A score of 90% if the best-performing PGP group score is >90% but the median performance is <90%.
3. The best-performing PGP group's score if the median performance and the best-performing PGP group's score are <90%.

This scoring methodology creates an incentive for all groups to move to very high levels of performance. All other PGPs will receive a portion of the score for the measure on the basis of how their performance compared with the maximum on the measure, provided that their performance is above the minimum.

The benchmarks will be updated each year on the basis of the previous year's performance. Hence, the results from PY1 will be used for PY2. For PY1 pay for performance measures, results from the PGP Demonstration PY5 quality measurement reporting process will be used for measures with similar specifications. For PY1 measures that have different specifications than the quality measures used under the initial PGP Demonstration, PY5 results will be recalculated or the PGP TD baseline data collection results will be used to set the benchmarks.

In the PGP Transition Demonstration, each module of quality measures will be weighted equally, regardless of the number of measures within the module.

2.3 Calculating Quality Scores and Final Reconciliation

This section provides a hypothetical example of how quality performance will be calculated in the PGP Transition Demonstration. Tables 2-2 and 2-3 provide an example of the methodologies described above.

Table 2-2 shows an example of the quality performance reconciliation methodology for the pay for performance modules in PY1. The first and second columns denote the module and the measure. The third column shows the benchmark, and the fourth column is the PGP's own quality performance for each measure. The fifth column is the quality measure score earned by the PGP compared with the benchmark (note that this PGP had a quality measure score of 0% in DM8 because it did not meet the 50% minimum). The sixth column is the average score for each module across all of the measures.

Table 2-2
Quality performance and scores for each measure and module

Modules (A)	Quality Measures (B)	Benchmark (C)	PGP's Quality Measure Performance= [Sum(numerator)/ Sum(denominator)] (D)	Quality measure score = % of benchmark (E) = (D)/(C)	Module score (unweighted) (F) = average of (E) within each module
Diabetes	DM-2	90.00%	91.87%	100.00%	83.19%
Diabetes	DM-3	80.83%	80.83%	100.00%	83.19%
Diabetes	DM-5	90.00%	92.65%	100.00%	83.19%
Diabetes	DM-6	90.00%	95.63%	100.00%	83.19%
Diabetes	DM-7	80.04%	79.37%	99.16%	83.19%
Diabetes	DM-8	71.25%	45.00%	0.00%	83.19%
Heart Failure	HF-1	97.44%	98.30%	100.00%	99.21%
Heart Failure	HF-2	92.11%	95.30%	100.00%	99.21%
Heart Failure	HF-3	90.92%	87.98%	96.77%	99.21%
Heart Failure	HF-5	93.95%	97.09%	100.00%	99.21%
Heart Failure	HF-6	97.94%	98.91%	100.00%	99.21%

(continued)

Table 2-2 (continued)
Quality performance and scores for each measure and module

Modules (A)	Quality Measures (B)	Benchmark (C)	PGP's Quality Measure Performance= [Sum(numerator)/ Sum(denominator)] (D)	Quality measure score = % of benchmark (E) = (D)/(C)	Module score (unweighted) (F) = average of (E) within each module
Heart Failure	HF-7	95.73%	94.32%	98.53%	99.21%
Heart Failure	HF-8	92.20%	91.42%	99.15%	99.21%
Coronary Artery Disease	CAD-1	92.58%	93.00%	100.00%	98.13%
Coronary Artery Disease	CAD-2	97.67%	97.61%	99.94%	98.13%
Coronary Artery Disease	CAD-3	92.67%	92.04%	99.32%	98.13%
Coronary Artery Disease	CAD-6	90.00%	82.23%	91.37%	98.13%
Coronary Artery Disease	CAD-7	90.00%	92.64%	100.00%	98.13%
Hypertension	HTN-2	79.95%	79.95%	100.00%	96.60%
Hypertension	HTN-3	77.85%	72.56%	93.20%	96.60%
Preventive Care	PC-5	88.58%	88.58%	100.00%	92.92%
Preventive Care	PC-6	76.78%	71.78%	93.49%	92.92%
Preventive Care	PC-7	90.00%	88.58%	98.42%	92.92%
Preventive Care	PC-8	90.00%	71.78%	79.76%	92.92%

Table 2-3 shows the unweighted and weighted results using the proposed methodology. It also assumes that the PGP completed and earned the full 100% for the new modules that are pay for reporting in PY1. With nine modules, each module will carry one-ninth of the weight (i.e., weight=0.1111). Column A contains the unweighted module scores; column B is the 0.1111 weight applied for each module; column C is the weighted result for each module; and the last row contains the overall quality score for the PGP calculated across all nine modules.

Table 2-3
Unweighted, weighted, and overall quality scores calculated

Topic	Unweighted module score (A) = last column in Table 1	Weight of each module (B) = 1 module / total number of modules	Weighted module score (C) = (A) x (B)
Diabetes	83.19%	0.1111	9.24%
Heart failure	99.21%	0.1111	11.02%
Coronary artery disease	98.13%	0.1111	10.90%
Hypertension	96.60%	0.1111	10.73%
Preventive care	92.92%	0.1111	10.32%
COPD	100.00%	0.1111	11.11%
Frail elderly	100.00%	0.1111	11.11%
Transitions of care	100.00%	0.1111	11.11%
MU core measures	100.00%	0.1111	11.11%
Overall (sum)	n/a	1.0000	**96.66%**

Finally, the overall quality score will be used to settle the final financial reconciliation in each performance year. As previously noted, the share of savings based on quality of care for the financial reconciliation will be 80% in PY1 and 90% in PY2.

2.4 Physician Quality Reporting System Incentives

In addition to the incentives that a PGP may earn under the Demonstration, PGPs will earn their Physician Quality Reporting System (PQRS) incentive payments on the basis of their performance on the Demonstration quality measures and will continue to be eligible to participate in the GPRO eRx initiative, subject to the PQRS rules and regulations. A PGP will earn 100% of the PQRS dollars if its overall quality score is greater than 90%. If the PGP's overall quality score is less than 90%, their PQRS dollars will be scaled with the maximum equal to 90%. That is, a PGP that has an overall quality score equal to 85% will earn 94% (0.85/0.90) of the PQRS dollars.

2.5 Quality Measurement Process

Denominator populations for the quality measures will be taken from the same assigned beneficiary population used in the PGP Transition Demonstration for financial reconciliation, although limited to the assigned beneficiaries with full-year Medicare eligibility and at least two office or other outpatient evaluation and management visits at the PGP. Without complete, full-year data, a beneficiary might be classified as not receiving a treatment or test required for a quality indicator when in fact the service had been received, but not recorded in Medicare claims data if it was provided outside the time period covered by Medicare eligibility.

As a result, a PGP's assigned beneficiaries who became eligible for Medicare after January 1 of a performance year will not be included in that year's quality measurement

calculations. Similarly, beneficiaries who died in the middle of the performance year will not be included in the quality performance calculations. Subsets of each PGP's remaining assigned beneficiaries then will be used for the denominators for each quality measure, based on disease status and other characteristics. In sum, the PGP's assigned beneficiaries included in the quality performance payment analysis will be a subset of those included in the financial performance payment calculations, because the latter will include all assigned beneficiaries (both full-year and part-year).

Two types of measurement processes will be used to calculate quality performance in the PGP Transition Demonstration: claims data analysis (8 quality measures) and medical records or hybrid data analysis (33 quality measures). The procedures to be used for each process are reviewed in the next two sections of this report.

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SECTION 3
QUALITY MEASUREMENT—MEDICARE CLAIMS

This section includes specifications for determining the denominator populations for quality measurement as well as for measuring the eight quality indicators calculated using Medicare administrative claims. The denominator identification and claims data analyses described in this chapter will be conducted by RTI International staff once per performance year.

3.1 Claims Data Cleaning Procedures

Three of the seven types of Medicare administrative claims data will be used for the claims-based quality analysis: 1) Part B carrier (physician/supplier) claims, 2) outpatient claims, and 3) inpatient claims. They are viewed as having more reliable data on diagnoses, as containing the procedure codes relevant to the PGP Transition Demonstration quality measures, and also as representing the vast majority of claims. For Part B carrier claims, diagnosis data will only be used from claims with 'source' codes 1–5, which indicate that the provider is considered a reliable source of diagnosis data. The other four types of Medicare claims (skilled nursing facility, home health, durable medical equipment [DME], and hospice) will not be used in the quality analysis.

Denied line items and denied claims will be selectively deleted from the claims databases using the standard approaches that RTI uses for other CMS projects. Most quality measures will be calculated using claims data for a single 12-month period (January 1 to December 31). For measures requiring a 2-year look-back period, data from the prior year will also be used.

During the PGP Transition Demonstration, the standard cutoff point for pulling claims for quality measurement will be 3 months after the end of the 12-month performance period. The reduction from a 6-month to a 3-month claims run-out for quality measurement is necessary to align the PGP Transition Demonstration incentives with the PQRS incentive payments. After 3 months, the claims data are considered to be 98% complete and Medicare enrollment largely updated. Hence, with the performance period spanning from January 1 to December 31, claims and Medicare denominator files will be assessed after March 31 of the following year.

Claims for services provided to beneficiaries after the first date of hospice admission will be deleted from the claims database. The PGP Transition Demonstration truncates a beneficiary's participation in the Demonstration on the first day of the month after the date of first hospice admission.

3.2 Variables to Be Used by Types of Claims

The claims-based quality measures will be calculated using a limited set of the variables available in Medicare claims files. The most relevant variables used by type of claims are listed below, with their field numbers and variable definitions from the Medicare National Claims History data dictionary.

Inpatient Claims
16. Claim Thru Date
58. Claim Principal Diagnosis Code
201. Claim Diagnosis Code
205. Claim Procedure Code
232. Revenue Center Healthcare Common Procedure Coding System (HCPCS) Code
234–238. Revenue Center HCPCS Modifier Codes

Outpatient Claims
16. Claim Thru Date
58. Claim Principal Diagnosis Code
161. Claim Diagnosis Code
165. Claim Procedure Code
193. Revenue Center Healthcare Common Procedure Coding System Code
194–198. Revenue Center HCPCS Modifier Codes

Carrier (Physician/Supplier Part B) Claims
16. Claim Thru Date
51. Claim Principal Diagnosis Code
112. Claim Diagnosis Code
118. Carrier Line Performing NPI number
121. Line Provider Tax Number
124. Line CMS Provider Specialty Code
134. Line Last Expense Date
135. Line HCPCS Code
136-137. Line HCPCS Modifier Codes
163. Line Diagnosis Code

3.3 Calculating Denominators and Numerators

Regardless of whether a measure is strictly calculated from Medicare administrative claims or intended for medical record abstraction, the process for quality measurement begins by identifying the denominator population for the topic (e.g., DM, COPD). Denominators for each claims-based measure will include 100% of the full-year assigned beneficiaries who meet the criteria for that quality measure. Numerators for each claims-based quality measure will include all beneficiaries in the denominator population who also satisfy the quality performance criteria for that measure. Detailed specifications for the denominator and numerator calculations for the all quality measures are included in the Appendices.

3.4 Claims-Based Quality Measures

The PGP Transition Demonstration will include eight quality measures that will be strictly calculated from Medicare claims data (claims-based-only measures) by RTI and reported to the PGPs and CMS. These eight measures include one measure from the FE topic and seven measures from the TCCC topic:

1. Monitoring INR when on Coumadin (FE topic)
2. 30-day post discharge provider visit
3. All cause readmissions—Any primary diagnosis
4. Ambulatory sensitive conditions admissions: Diabetes, short-term complications
5. Ambulatory sensitive conditions admissions: COPD
6. Ambulatory sensitive conditions admissions: Uncontrolled diabetes
7. Ambulatory sensitive conditions admissions: Congestive heart failure
8. Ambulatory sensitive conditions admissions: Bacterial pneumonia

3.5 Procedures for Claims Data Checking and Validation

In addition to the standard claims data quality checks being applied to the entire PGP Transition Demonstration, the following procedures will be used to check the validity of claims-based quality measures.

Observation counts for each type of claim file (inpatient, outpatient, and carrier) will be created and documented for all participating PGPs to ensure that each PGP is correctly represented in the Medicare claim system. This procedure will check that correct identification numbers are used and dates have been filtered correctly.

Claims files will be screened to ensure that the relevant fields contain valid data. Diagnosis and procedure code fields will be checked against known codes to ensure that the claims data contain recognized codes. The percentage of diagnosis and procedure codes recognized will be documented and maintained for each period.

RTI will check the quality measures calculated for each PGP against data from prior years (where available) and against data from other PGPs to determine whether the observed levels are reasonable. This will provide a check against coding problems at the PGPs. If unusual levels are observed for individual quality measures, frequencies of the codes used (or not used) to calculate the quality performance percentages will be analyzed to find potential coding errors.

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SECTION 4
QUALITY MEASUREMENT—MEDICAL RECORD ABSTRACTION

Thirty-three of the 41 quality measures in the PGP Transition Demonstration will require medical record abstraction by the PGPs. As noted, medical records abstraction will also begin with RTI using Medicare claims data to identify the full-year assigned beneficiaries for each PGP that meets the disease and other criteria for each of the condition modules (DM, HF, CAD, HTN, PREV, COPD, FE, TCCC, and MU) and is thus eligible for the denominator populations for the specific quality measures in each module.

4.1 Quality Measurement Using Medical Record Abstraction

For medical record abstraction, RTI and the Iowa Foundation for Medical Care (IFMC) will provide a random sample of eligible assigned beneficiaries to each PGP for each topic. The samples of beneficiaries for analysis will be drawn in sequence from a random sample of 615 beneficiaries identified by RTI through claims data as meeting the disease and other characteristics required for each of the condition modules. For the PREV module, four separate random samples of 615 beneficiaries will be drawn, one for each quality measure (mammography, colorectal cancer screening, flu shot, and pneumococcal vaccination), because these measures are defined by demographic characteristics that differ between the measures. The target sample size for statistical reliability will be 411 beneficiaries for each individual quality measure. A 50% oversampling (i.e., 615 beneficiaries) is used to account for variations in the exclusions relevant for some individual measures within each overall condition module (such as inability to confirm the diagnosis or to find the patient's medical record). Denominator inclusion and exclusion criteria for some individual quality measures may mean that reaching the target sample size of 411 beneficiaries is not possible for some PGPs, even when all of their full-year assigned beneficiaries are considered. For example, measure HF8 requires patients to have both HF and paroxysmal or chronic atrial fibrillation. Some PGPs may not have a total of 411 patients meeting those criteria. In that case the PGP's entire patient population eligible for the given measure will be used for the quality performance calculations.

Numerators can be calculated in two ways: medical records only or hybrid. For the medical records-only method, the PGP will abstract medical records for all 411 beneficiaries selected for each measure (or the total available population if the PGP does not have at least 411 who are eligible). Data will be recorded in the abstracting tool described below in section 4.2 and forwarded to IFMC for review and processing.

For the hybrid method, RTI will prepopulate certain data elements in the data abstraction tool with information readily available through Medicare claims. These data elements can include a numerator hit for the measure for the individual patient. For the same data elements where no evidence of a numerator hit was found in the claims, PGPs will have the option to use a hybrid approach to complete the numerators for these measures. This will require the PGPs to search their medical records and internal clinical data systems to try to document additional health services data that would satisfy the numerator criteria for those beneficiaries. For example, RTI will search through the available Medicare data for evidence of influenza vaccination for patients who are randomly sampled into the PREV7 module. However, because not all flu shots are billed to Medicare, the PGP may have other documentation that shows the patients have received a flu shot during the flu season of interest. After presenting evidence of

satisfactory quality performance (positive numerator hits) for one or more of the individual beneficiaries on the list, the measured performance of the PGP would be increased accordingly for quality performance payment calculations.

4.2 Refining the GPRO Abstraction Tool and Developing a User's Guide for PGPs

The abstraction tool that will be used in the PGP Transition Demonstration for medical record abstraction will be based on the GPRO tool used for PQRS data collection and similar to the PGP-Performance Assessment Tool (PAT) that was used in the original Demonstration but with enhanced features. This electronic data collection PGP Transition Demonstration PAT (PGP TD-PAT) is used for abstracting data from medical records or PGP internal clinical data systems for quality measurement. The abstraction tool used by PGPs will be tailored specifically to include additional topics and measures under the PGP Transition Demonstration.

The abstraction tool will be prepopulated with each beneficiary's available demographic information, visit data, laboratory test data, vaccinations, and other data from Medicare claims information supplied by RTI. The tool and prepopulated data will be distributed to each participating group by IFMC. After abstraction has been completed, the PGP will transmit the tool's database to IFMC for data cleanup and validation. The data will then be transmitted to RTI for further analysis and determination of PGP performance payments.

4.2.1 Minimum Hardware and Software Requirements

This section describes the minimum hardware and software requirements to run the PGP Transition Demonstration PAT.

Technology

The PAT was created using C# on Microsoft's .NET 3.5 framework. The database file is Access 2003, but it does not require Microsoft Access to be present on the machine.

Software

The following are the software requirements to run the PAT:

- Microsoft .NET Framework 3.5 Service Pack 1,
- The PAT application, and
- The PAT database and related files (located on local machine or shared directory). The tool can only be opened if there is an available database.

Compatible Operating System

- Windows XP SP2
- Windows 7

Hardware

Hardware	Specifications
Processor	400 MHz Pentium processor or equivalent (minimum); 1 GHz Pentium processor or equivalent (recommended)
RAM	96 MB (Minimum); 256 MB (recommended)
Hard disk space	Up to 500 MB for .NET 3.5 SP1 ~15 MB for the database and log file
Display	800 x 600, 16-bit colors (minimum); 1024 x 768 high color, 32-bit (recommended)
CD or DVD drive	Required if the application is going to be installed from a CD

Internet Connection

The automatic update feature of the PGP Transition PAT requires an internet connection.

4.2.2 Importing Data

Although the abstraction tool will not support direct interface with an electronic health record (EHR), or directly import data from other databases, documentation of the database structure, expected values, lengths, types, and relationships will be provided in detail to the participating PGPs. This information is included in the *EHR-to-PGP Transition Demonstration PAT mapping document* in the Appendix. This will allow the PGPs to write software programs to import data from their EMRs or other clinical systems into the abstraction database. PGPs will need to use a "push" method to import their data into the database. That is, they will need to connect to the database and use a program or algorithm to push their data into the database; the abstraction tool will have no ability to pull data in from a PGP's data files or data systems. All values from PGP's data systems that do not include the expected values for each field in the abstraction tool must be converted to the value format outlined in the database structure presented in the Appendix.

4.2.3 Reporting

The PAT will contain a number of reports to provide users and administrators with mechanisms for checking the progress of the abstraction. A list of these reports, and a brief description of each, is included below:

1. Patient summary report—displays all the information provided for the selected patient

2. Batch print summary report—enables users to print several patient summary reports

3. Totals report—displays the total number of completed and incomplete records per topic and determines whether the minimum requirement is met

4. Measure rate report—displays the rates of all the clinical quality measures of a group practice

5. Prefilled elements report—a patient-level report that shows the original and new values of the prefilled elements

6. Log viewer utility—displays all activities performed by the users; can be used to help determine the cause of data entry issues or track user activities

4.3 Training and Technical Assistance for PGPs

Training for medical record abstracting using the abstraction tool will be conducted via WebEx. WebEx is an Internet-based global conferencing tool that allows remote sites to attend meetings and view demonstrations in real time. Participants join meetings by logging onto a predetermined Web site and calling a conference telephone number.

IFMC will provide an annual training session for participating PGPs. Training will include instruction on using the abstraction tool and on methods for abstracting medical records efficiently using the tool. IFMC will post a recorded WebEx training session on its Web site so that training of new employees or refresher training can occur at the PGPs at any time.

IFMC will provide technical assistance for participating PGPs in the following areas:

- installation and use of the abstraction tool

- use of QualityNet Exchange for transmitting data from PGPs to IFMC

- database structure of the abstraction tool and guidance on EHR or clinical system interfacing and data uploading

- annual upgrades for the abstraction tool and database; IFMC will distribute the new databases along with any updates to the abstraction tool to each PGP each year

4.4 Audit and Validation

All 33 quality measures under medical record abstraction or hybrid abstraction will be subjected to audit and validation. Note that the audit process is not applicable to the eight claims-based measures. There are two reasons for this distinction. First, medical records and PGP clinical or administrative systems are internal databases under the control of the PGPs, and correctable by them as part of the audit process, whereas Medicare claims are an external database from the PGP perspective and not correctable by them. Second, claims data may include records for services provided to beneficiaries by non-PGP providers that are not auditable under the Demonstration.

The audit process will be used to determine eligibility for payment for the medical records-based measures. For audit and validation of medical record data, a random sample of 30 beneficiaries whose medical records were abstracted by the PGP will be selected from the pool of beneficiaries with a confirmed diagnosis or abstracted in the condition module.

The audit process will include up to three phases, depending on the results of the first two phases. Each initial sample will include 30 beneficiaries per module, but only 8 randomly selected beneficiaries' medical records will be audited for mismatches during the first phase of the audit. A mismatch represents a discrepancy between 1) the numerator inclusions or denominator exclusions in the data submitted by the PGP and 2) IFMC's determination of their appropriateness on the basis of supporting medical records information submitted by the PGP. If there are no mismatches, the remaining 22 of the 30 beneficiaries' records will not be audited. If there are mismatches, the second phase of the audit will occur, and the other 22 beneficiaries' records will be audited. The third phase, involving corrective action, is undertaken only if mismatches are found in more than 10% of the medical records in the second phase. The following steps describe the three audit phases in more detail.

Phase 1

Step 1: Random sample of 30 beneficiaries per condition module selected by RTI for the audit sample.

Step 2: Medical records data for beneficiaries included in the audit sample sent via QNET from RTI to PGPs and IFMC.

Step 3: PGPs send portions of the selected beneficiaries' medical records in hard copy to IFMC to support each numerator inclusion and denominator exclusion for each quality measure. Information available to the healthcare provider at the point of care is considered appropriate to use to satisfy documentation requirements. Any written note or document included in the medical record that includes all of the necessary data required to fully document a numerator inclusion or denominator exclusion will be considered acceptable.

Example: To validate a numerator inclusion for a beneficiary for measure CAD2 (Drug Therapy for Lowering LDL Cholesterol), the PGP would need to provide documentation noting the patient was prescribed a lipid-lowering agent.

Example: To validate a denominator exclusion for a beneficiary for CAD-2, the PGP would need to provide documentation noting the patient was excluded from the denominator because of liver disease or another medical or patient reason.

Step 4: IFMC will assess and validate the medical records information provided by the PGP on the randomly selected 8 of the 30 sampled beneficiaries for each measure, then provide a written report on the results to RTI and the PGP. If no mismatches are found for a given module, the audit process for that module will terminate at this point and Phase 2 will not be conducted.

Phase 2

Step 5: If one or more mismatches are found at the measure level in the first 8 records, then the medical records for the remaining 22 beneficiaries in the module's audit sample will be assessed and validated. A written report on the results will be provided to RTI and the PGP.

Step 6: Agreement rates for the entire sample of 30 records will be calculated by IFMC and provided to RTI and each respective PGP.

Step 7: If the mismatch rate is ≤10% for the 30 records audited, then the audit process will terminate at this point and Phase 3 will not be conducted. The quality performance levels reported by the PGP will be accepted without modification.

Step 8: If >10% mismatches are found in the 30 records assessed in Phase 2, then the PGP will review its medical record abstracting procedures with IFMC. The PGP will revise its data submitted for the given measure or condition module as needed, and Phase 3 will be conducted.

Phase 3

Step 9: Another random sample of 30 beneficiaries for the module in question will then be drawn for that module and the audit process will be repeated, starting with Step 1. If a specific error was identified in Phase 2, the sample of patients will be selected to target the error. If again >10% mismatches are found across the 30 cases, then the PGP will not be given credit for meeting the quality target for any measures for which this mismatch rate still exists.

Each PGP's audit and validation results will remain confidential. Only CMS, RTI, and IFMC staff will review the audit data and written assessments. The audit process will examine the following questions regarding the PGP's submitted data records regarding the sampling and denominator inclusion criteria:

- Was this record appropriately included in the numerator?

  Example: DM-8 (Foot Exam)—if documentation supporting that denominator inclusion criteria are met, and indicating that a complete foot exam was provided one or more times in the measurement period, then the record will be included in the numerator and denominator. It is not necessary to ascertain whether any denominator exclusions exist.

- Was this record appropriately excluded from the denominator?

  Example: HF-6 (Beta Blocker Therapy—for a record to be removed from the denominator correctly, documentation must be present to support a history of Class IV (congestive) heart failure or a history of 2nd- or 3rd-degree (AV) block without a pacemaker or one of the other denominator exclusions listed in the measure specifications.

4.5 Additional Education and Training Provided to PGPs

During the course of the Demonstration, RTI and IFMC will identify topics regarding medical records abstraction or EHR extraction of data that may require additional education, training, or clarification for PGP staff.

Education and training will be provided in written format, with opportunities for discussion through telephone conferences. The telephone conferences will be held before the due date for submission of the data for the following measurement period. For example, to assist PGPs in reducing the mismatch rate in the next round of data collection, training efforts might include information regarding audit mismatch trends identified across PGP sites during the prior year's data collection.

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SECTION 5
LEADING QUALITY GROUP

5.1 Overview

This section outlines the "Leading Quality Group" option that will be incorporated into the PGP Transition Demonstration. The goals of this option are to encourage the PGPs to continue to be leaders in quality measurement and reporting, and for CMS to gain knowledge about how these results can help an organization transform its care delivery processes. The PGP sites will have the opportunity to individually elect to participate in this Leading Quality Group at the start of the Demonstration period.

The PGP sites will have the opportunity to earn an additional 10% in shared savings for performance on a patient experience of care measure and composite quality measure scores, with the understanding that CMS can publicly report these results. This will increase the sharing rate to up to 60% for groups that are eligible to share savings. The additional 10% of shared savings payments will be outside the maximum shared savings, which is currently set at 5% of total target expenditures. This ensures that groups that share in savings receive the additional 10% for these quality components, regardless of whether they hit the shared savings threshold.

5.1.1 Patient Experience of Care Measure

CMS will use the patient experience of care measure that will be used for the Medicare Shared Savings Program (MSSP). Additional details will be available once the Notice of Proposed Rulemaking for the MSSP is released. PGP sites will earn performance payments for reporting in PY1 and based on improvement targets in PY2. We are proposing that CMS will contract directly with a vendor to administer the survey to the PGP samples, at least for the first performance year. PGPs that elect to participate in the Leading Quality Group will also be required to report to CMS how they utilize the survey results to transform their care delivery processes.

5.1.2 Composite Quality Measures

We will use composite quality measures for the chronic disease modules being utilized under the PGP TD—DM, HF, CAD, HTN, and COPD. All composite scores will be pay for performance in the first year except for COPD, which will be pay for reporting in PY1 and will transition to pay for performance in PY2. Performance payments will be based on improvement targets for the composite quality measures.

Additionally, the Demonstration terms and conditions will include permission for CMS to publicly report the results on the composite quality measures. CMS will make an effort when publicly reporting the results to put them in context as composite measures that are new and progressive for quality measurement.

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SECTION 6
WAREHOUSING DATA

RTI will maintain a data warehouse that contains information collected on all aspects of the PGP Transition Demonstration. Fields for beneficiary identification numbers and PGP code numbers will be used to link all of the files. This will enable analysis of trends and cross-sectional associations to be conducted across PGPs, across other variables of interest, and across time, both during the Demonstration and for the subsequent evaluation.

The data warehouse will contain three types of information: 1) Medicare claims data used for financial and quality measure calculations; 2) medical records abstraction data and related data from PGPs' internal clinical or administrative data systems used for quality measure calculations; and 3) results of PGP financial performance, quality performance, and performance payment calculations. Each is discussed in turn below.

6.1 Medical Claims Data

A subset of Medicare claims will be included in the data warehouse. Data for each PGP assigned beneficiary will be stored in the data warehouse for the base year and each performance year. The HICNO variable is the beneficiary identification number that links across the claims files, and links the claims files to the medical records and PGP internal clinical/administrative systems data files. These files will include the variables used to calculate the denominator populations and claims-based quality measures, as well as to prepopulate the elements in the PAT.

6.2 Medical Records and PGP Internal Clinical and Administrative Systems Data

The RTI data warehouse will also include information collected from PGPs' medical records and internal clinical and administrative data systems through the PAT. Data for each PGP assigned beneficiary selected for medical records abstracting will be stored in the data warehouse for the base year and each performance year. These files will include the variables used to calculate the medical records-based quality measures for the PGPs. The HICNO variable will link these data to the Medicare claims data for each beneficiary and also enable analysis across PGPs and over time.

6.3 PGP Demonstration Performance and Performance Payment Calculations

The data warehouse will also include a record of all of the calculations conducted for determining PGP financial performance, quality performance, and performance payments under the Demonstration. These data will include the following information:

- calculations involved in determining cost performance payments and maximum quality performance payments for each performance year
- PGP performance on each quality measure for each Demonstration year
- PGP performance on audits for medical records-based quality measures for each Demonstration year

- PGP performance on the Leading Quality Group measures, if applicable

- calculations involved in determining actual quality performance payments for each performance year

- data on annual earned performance payments, withheld amounts, paid performance payments, and accrued loss carry-forwards for each PGP for each performance year

- calculations involved in determining the final settlement payments at the conclusion of the Demonstration for each PGP

6.4 Data Warehouse Storage and Security Requirements

The PGP Demonstration data warehouse will be stored on a server within RTI's computer network. All of the data will be stored as SAS files, so that a common database and statistical analysis language will facilitate analysis across the claims data, medical records and PGP internal clinical and administrative systems data, and performance payment calculation data. PAT data will also be stored in the original Microsoft Access database format.

RTI will use file and folder naming conventions to organize the data files in a manner that maximizes the speed and reliability with which the data warehouse files can be identified and retrieved. The naming conventions will build upon internal standards that RTI programmers have established through years of experience with these types of data.

RTI will focus on two goals for protecting the security of the PGP Transition Demonstration data warehouse information: first, to protect against unauthorized access; and second, to protect against irreversible changes to these data. To address the first concern, access to the data warehouse will be restricted in three different ways. At the broadest level, the data on RTI's servers are protected by RTI's network security, which severely limits access by those outside of the network. At the next level, within the network, RTI has a system of share and folder permission rights that, for a given share or folder, permit access to it only for those who require such access. Thus, only a very limited number of RTI staff will have access to the folder containing the PGP data warehouse. Finally, at the most specific level – particular data warehouse files – RTI will apply encryption and password protection when appropriate under the Data Use Agreement to be developed between RTI and CMS.

The second concern, protecting against irreversible changes to the data, will be first addressed by applying internal standards by which RTI programmers already abide. RTI programmers work according to standards for naming and organizing source code and documentation files, and these standards will provide for audit trails to be maintained for all changes made to the data contained in the PGP data warehouse. This second concern will also be addressed by preparing a tape backup of the data warehouse information after each Demonstration year to provide a historical record. The tapes will be stored in a secure location.

SECTION 7
TIMELINE FOR QUALITY DETERMINATION

This section presents an annual timetable for quality determination in the PGP Transition Demonstration under a best case scenario. This scenario assumes no delays in data availabilities from CMS, and few or no complications in data analysis runs. This timeline is expected to align with PQRS payment distributions in late fall of each year.

Month	Activities
January 1 to December 31	Performance period
March 31	End of claims run-out for quality measurement
End of April	Claims for assigned beneficiaries ready for quality measurement processing
May to mid-June	Running quality assignment algorithm; identifying denominator for each topic; prepopulate the PGP TD-PAT
Mid-June	Send prepopulated PAT to PGPs
July	PGPs collecting information
Mid-August	Completed abstraction tool due from PGPs
End of August	Audit samples sent to PGPs
End of third week of September	Audit documentation due to IFMC
Mid-October	IFMC conduct audit of PGPs' documentation
End of October	Finalize claims-based results; finalize chart-based quality results after audit