Physician Group Practice Transition Demonstration
Design Overview
July 14, 2011

Performance Period The Physician Group Practice Transition Demonstration (PGP TD) will be rebased and extended for an additional 2 years with revised terms and conditions. The performance period started January 1, 2011.

Beneficiary Assignment The PGP TD will continue to utilize retrospective beneficiary assignment. PGPs will have the option to elect to use a methodology that involves two passes or the initial PGP methodology that involves one pass. Patients will be assigned to the physician group's tax identification numbers using either: (1) two stage primary care services E&M code algorithm that assigns based on primary care specialties first and then all specialties second for patients without a primary care visit; or (2) plurality of office and other outpatient service E&M codes regardless of specialty.

Baseline and National Target Amount The baseline expenditures will be an average of risk-adjusted Parts A and B per capita expenditures for beneficiaries assigned to the physician group using the selected beneficiary assignment methodology in the three years prior to the start of the agreement period. We will apply credibility weighting to the baseline such that the most recent year will be weighted 60 percent, the next year weighted 30 percent, and the earliest year weighted 10 percent. The per capita amounts will be trended forward based on the national average growth rate provided by the CMS Office of the Actuary (OACT). The target expenditure for each performance year will be the group's baseline expenditure amount plus the absolute per capita dollar equivalent of national FFS expenditure growth from the base period to the performance year. The national FFS expenditure increment will be provided by OACT and will be risk-adjusted by the site-specific annual average risk score.

Risk Adjustment The CMS-Hierarchical Conditions Category (CMS-HCC) prospective risk adjustment models will be used to calculate beneficiary risk scores. Prospective risk adjustment uses prior year diagnoses to risk adjust current year's expenditures. The CMS-HCC risk scores will be adjusted for coding pattern changes. First, the normalized risk scores will be used to adjust for year-to-year FFS coding pattern changes. Each year's FFS normalization factor will be the factor as published by CMS in the Medicare Advantage Final Notice. Second, a $\pm$ 0.4 percent cap will be placed on the annual risk score growth during the performance years. For the PGP Transition Demonstration, we will apply a cap of $\pm$ 0.4 percent relative to the base year for the first performance year and $\pm$ 0.8 percent relative to the base year for the second performance year.

Minimum Savings Requirement The shared savings methodology will include a sliding scale to define the minimum savings requirement (MSR) based on the number of assigned beneficiaries. The MSR is calculated to produce a 95-percent (one-sided: bonuses) or 90-percent (two-sided: bonuses and losses) confidence interval for demonstration savings (target minus actual performance year expenditures).

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Shared Savings The shared savings methodology will include a sliding scale to define the minimum savings requirement (MSR) based on the number of assigned beneficiaries using a 95% one sided (90% two sided) statistical test. Groups that exceed the MSR will be eligible to share 50% of the difference of target minus actual expenditures. The total performance payments earned will be based on performance on the quality measures and efficiency, with the percent based on quality equal to 80% in year 1 and 90% in year 2. A 25% portion of any earned performance payments will be withheld until the end of the two-year performance period. If a PGP has target minus assigned beneficiary expenditures less than the negative of the MSR, the accrued loss for that performance year will be equal to 50% of target minus assigned beneficiary expenditures. Shared savings payments will be capped at 5% of total target expenditures.

Quality Measures The PGP TD will include the quality measures outlined in Attachment 1. The quality performance scoring methodology will include a maximum and a minimum that will be established for each measure and updated annually. The maximum will be based on actual performance of the PGPs during the prior year. The maximum (or benchmark) for each measure will be:

1. The median of the scores for the measure from the prior performance period if the median score was >90 percent.
2. A score of 90 percent if the best performing PGP group score is >90 percent but the median performance is <90 percent.
3. The best performing PGP group's score if the median performance is <90 percent.

The PGPs will have their measure performance divided by the maximum for that measure to produce their individual quality measure score, provided the performance is above the minimum. The minimum quality measure score for the measures in modules that were used in the initial PGP Demonstration will be 50 percent. For the new modules, the minimum will be set at 50 percent of the best performing PGP group when they transition to pay for performance. The actual performance must exceed the minimum or the score for that measure is 0 percent. Individual quality measure scores will be averaged to produce a module quality score. Each module quality score will be averaged to produce an aggregated overall PGP quality score that will be applied to the annual shared savings. In PY 1, the measures in the new quality modules will be pay for reporting and the PGPs will receive 100 percent on these measures. The COPD, Care of Frail Elderly, and Meaningful Use for Core Clinical Quality Measures will transition to pay for performance in PY2.

PGPs will earn their PQRI incentive payments based on performance on the demonstration quality measures and will continue to be eligible to participate in the GPRO eRx initiative, subject to the PQRI rules and regulations. A PGP will earn 100% of the PQRI dollars if their overall quality score is greater than 90%. If the PGPs' overall quality score is less than 90%, their PQRI dollars will be scaled with the maximum equal to 90%.

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"Leading Quality Group" The PGP sites all elected to participate in an optional "Leading Quality Group." Participation in this group will offer them an additional 10 percent in shared savings for performance on a patient experience of care measure and composite quality measure scores, including that CMS can publicly report these results. This increases the sharing rate to up to 60 percent for groups that are eligible to share savings. The additional 10 percent of shared savings payments will be outside the maximum shared savings that is currently set at 5 percent of total target expenditures. Performance payments will be based on meeting improvement targets on results from the Consumer Assessment of Healthcare Providers and Systems Clinician and Group survey and composite (all or nothing) quality measures for the chronic disease modules being utilized under the PGP Transition Demonstration - DM, HF, CAD, HTN, and COPD.

Data Sharing CMS will continue to provide the PGPs with aggregate and beneficiary-level data. CMS will continue to work with the sites to refine the data provided to ensure it is useful and enhancing care coordination and the health care operations of the PGPs. PGPs must provide a data analysis plan for how they will use the data prior to receiving the beneficiary level data sets.

Public Reporting The Demonstration terms and conditions will include that CMS may publicly disclose site-specific annual quality and financial performance results.

Transition Options The PGPs will have the option to transition to the Medicare Shared Savings Program or an initiative in the Innovation Center when they are available. We will reconcile a performance period for the PGP TD if an organization participates in the Demonstration for a complete year. If the PGP elects to transition to another shared savings program during the middle of a performance year, we will make an effort to work with that program to make arrangements to reconcile on the complete year. As other shared savings programs are not defined at this time, this will be evaluated on a program-specific basis.

Attachment 1: Quality Measures for PGP Transition Demonstration

Diabetes Mellitus DM2 - HbA1c Poor Control > 9.0% DM3- Blood Pressure Control DM5 - LDL Control DM6 - Urine Protein Testing DM7 - Dilated Eye Exam DM8 - Foot Exam
Heart Failure HF1 - Left Ventricular Function Assessment HF2 - Left Ventricular EF Testing - Hospitalized HF3 - Weight Measurement HF5 - Heart Failure Patient Education HF6 - Beta-Blocker Therapy for LVSD HF7 - ACEI or ARB for LVSD HF8 - Warfarin Therapy for Patients w/HF and AF
Coronary Artery Disease CAD1 - Oral Antiplatelet Therapy CAD2 - Drug Therapy for Lowering LDL > 130 mg/dl CAD3 - Beta Blocker Therapy Prior MI CAD6 - LDL Level < 100 mg/dl CAD7 - ACEI or ARB for Patients w/DM & CAD
Hypertension HTN2 - Blood Pressure Control HTN3 - Plan of Care
Preventive Care PC5 - Screening Mammography PC6 - Colorectal Screening PC7 - Influenza Vaccination - 50 years & over PC8 - Pneumococcal Vaccination - 65 years & over
COPD * Spirometry Evaluation Smoking Cessation Counseling Received Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy

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Frail Elderly *
Screening for Falls in the Elderly
Osteoporsis Management
Monitoring INR when on Coumadin
Transitions of Care/Care Coordination **
Post Discharge Medication Reconciliation
30 day Post Discharge Provider Visit
All Cause Readmissions - Any Primary Diagnosis
Ambulatory Sensitive Conditions Admissions: Diabetes, Short-term Complications
Ambulatory Sensitive Conditions Admissions: Uncontrolled Diabetes
Ambulatory Sensitive Conditions Admissions: COPD
Ambulatory Sensitive Conditions Admissions: Congestive Heart Failure
Ambulatory Sensitive Conditions Admissions: Bacterial Pneumonia
Meaningful Use Core Clinical Quality Measures *
Adult Weight Screening and Follow-Up
Hypertension: Blood Pressure Measurement
Tobacco Assessment / Cessation Intervention

* Pay for Reporting in PY1
** Pay for Reporting in PY1 and PY2