



September 4, 2009

Dear Physician Group:

We are writing to invite your physician group's participation in the 2010 California ***Patient Assessment Survey (PAS)*** Group Survey project, a statewide effort to produce comparative performance information on patient experience. The PAS is sponsored by the California Cooperative Healthcare Reporting Initiative (CCHRI)—a statewide collaborative of health plans, provider organizations, and purchasers. The methods and survey instrument for the 2010 project will remain the same as last year:

PAS Group Survey. The 2010 PAS project represents the ninth consecutive year that CCHRI has conducted a patient experience survey at the *physician group-level*. The survey is open to all groups who serve commercially-insured, adult, managed care populations. As in past years, the seven largest California network-model health plans continue to use the results of the PAS Group Survey in their formulas for calculating financial rewards to medical groups through the IHA Pay-for-Performance (P4P) Program (see Attachment A). **Groups that do not participate in the 2010 PAS will automatically fail to qualify for 20% of the IHA bonus dollars.**

PAS Doctor Survey. For the 2010 project, physician groups are offered the option to participate in additional drill down surveying of their *individual physicians* using the same methods as those applied at the group level. The Doctor Survey provides groups with information to better guide their quality improvement work and earn points (and potential bonus dollars) under the Systemness domain of the IHA P4P program (see Attachment E).

Provider After Hours Access Survey. CCHRI will also be taking advantage of the processes established by PAS to solicit group participation in the Provider After Hours Access Survey, which uses telephone interviews with physician offices to evaluate protocols around emergency instructions and after hours urgent care availability. Groups who wish to participate in the Provider After Hours Access Survey can sign up through the PAS registration site, and submit a single data file for both the PAS and After Hours projects (see Attachment F).

The registration process, period and data specifications remain the same as last year and are as follows:

- ▶ **Registration for the 2010 PAS will occur between September 10th and September 25th, 2009.** The online registration will permit groups to register for the PAS Group Survey, the PAS Doctor Survey and the Provider After Hours Access Survey. The questions on the registration site remain the same as last year.
- ▶ The CCHRI website www.cchri.org/programs/programs_pas.html will serve as the portal to all PAS project information, the PAS Registration Site, and the CSS Survey Vendor site—to which groups will be able to upload data submissions and submit/confirm logos and medical director signatures.
- ▶ Similar to last year, your medical-group specific logon identifier and password is needed for registration and data submission. This logon identifier and password may found in the email transmitting this registration packet. If you cannot locate your logon identifier or password, please contact Julie France at jfrance@pbqh.org or at 714-735-8754.

- ▶ A list of project requirements required for a number of project tasks, including registration and data submissions to the vendor is included as Attachment B to this registration package.
- ▶ As soon as you have completed the registration, you can immediately logon to the survey vendor's website via the PAS registration website and upload data submissions and submit/confirm logos and signatures for producing the files from which your group's patient sample is drawn. The data specifications may be found as Attachment M to this registration packet. These data specifications remain the same as last year and should be given to your IT department so that they can begin preparing for the data submission.
- ▶ The PAS Participation Agreements for both the Group and Doctor Surveys are embedded in the online registration site and will require electronic consent as a last step in the registration process. Copies are included in this package for review prior to registration (see Attachments G and H).
- ▶ This year, groups are required to sign a Business Associate Agreement (BAA) with the survey vendor. A copy is included in this registration package. Please refer to your invitation email (or the CCHRI website) for an editable version of the BAA you can fill out, sign and send directly to the survey vendor—the Center for the Study of Services (CSS). (See Attachment I).
- ▶ Each group will be required to complete an online survey after completing the registration to provide information on medical group coding practices and physician specialty types that will inform the survey vendor's data quality assurance process.
- ▶ CCHRI will hold three informational conference calls regarding the PAS survey process and data submission requirements. **The first call will be held on Thursday, September 17th from 10:00am-11:00am**, and will review the 2010 project requirements and pricing. Please see Attachment L for a full list of informational calls.

In addition to garnering potential financial bonuses, the PAS survey results can be used by your group to identify areas for improvement, help focus your quality improvement investments, examine trends in performance over time, and compare your performance to your peers. Once again, participating health plans will be subsidizing the costs of the Group Survey, which makes the costs of gathering this information lower than any independent survey effort. Please note, physician groups will be responsible for covering all costs of additional surveying conducted through the Group & Doctor Survey (see Attachment K).

Similar to last year, the PAS survey will be sent to patients in the first quarter of 2010, with results reported back to participating provider groups in June 2010 (see Attachment L for detailed project timeline). Please contact Julie France at jfrance@pbgh.org (714.735.8754) with any questions you may have about the registration process. We look forward to your participation in PAS project.



David Hopkins, Ph.D.
CCHRI Administrator

Enclosures:

- Attachment A: PAS Measures in IHA Pay for Performance Measures Set
- Attachment B: Project Requirements
- Attachment C: Alternative Language Surveying for Group Survey
- Attachment D: Group Survey Information Sheet
- Attachment E: Doctor Survey Information Sheet
- Attachment F: After Hours Survey Information Sheet
- Attachment G: 2010 Participation Agreement: Group Survey and After Hours Survey
- Attachment H: 2010 Participation Agreement: Doctor Survey
- Attachment I: Business Associate Agreement
- Attachment J: Schedule of Informational Calls
- Attachment K: Fee Schedule
- Attachment L: Project Timeline
- Attachment M: Data File Specifications

Attachment A: PAS Measures in the IHA Pay for Performance Measures Set (Measurement Year 2009, payout year 2010)

PAS measures account for 20 percent of weighting in the IHA program.

IHA P4P Measures	Individual Questions Items from 2010 PAS
<p>Doctor-Patient Interactions</p> <p>MDINTERACT Composite measure (6 items)</p>	<ul style="list-style-type: none"> • How often did this doctor <u>listen carefully</u> to you? (Q #10 / #9) • How often did this doctor <u>explain things</u> in way that was easy to understand? (Q #9 / #8) • How often did this doctor <u>spend enough time</u> with you? (Q #13 / #12) • How often did this doctor show <u>respect for what you had to say</u>? (Q #14 / #13) • How often did this doctor give you easy to understand instructions about taking care of these health problems or concerns? (Q #11 / #10) • How often did this doctor seem to know the important information about your health history? (Q #12 / #11)
<p>Overall Ratings of Care (2 separate items)</p>	<ul style="list-style-type: none"> • Rate <u>this doctor</u> (0-10 scale) (Q #32 on PCP version only) • Rate all your health care from the <u>other doctors or providers</u> you visited at this doctor's office (0-10 scale) (Q #38 / #36)
<p>Specialty Care (2 separate items)</p>	<ul style="list-style-type: none"> • When you tried to make an appointment to see a specialist, how often did you get an appointment as soon as you needed it? (Q #37 on PCP version only) • Rate <u>this doctor</u> (i.e., specialist) (0-10 scale) (Q #32 on Specialist version only)
<p>Coordination of Care</p> <p>COORD composite measure (2 items)</p>	<ul style="list-style-type: none"> • How often did someone from this doctor's office follow up to give you the results of your blood test, x-ray or other test? (Q #20 / #19) • How often did this doctor seem informed and up-to-date about the care you got from specialists? (Q #19 / #18)
<p>Timely Care and Service</p> <p>ACCESS Composite measure (5 items)</p>	<ul style="list-style-type: none"> • When you called your personal doctor's office to get an appointment for <u>care you needed right away</u>, how often did you get an appointment as soon as you thought you needed it?" (Q #4 on PCP version only) OR When you made an appointment with this doctor, how often did you get an appointment as soon as you thought you needed it?" (Q #4 on Specialist version) • When you called <u>your doctor's office with a medical question during regular office hours</u>, how often did you get an answer to your medical question that same day? (Q #7 / #6) • When you made an <u>appointment for a check-up or routine care with your doctor</u>, how often did you get an appointment as soon as you thought you needed it?" (Q #5 on PCP version only) • When you phoned this doctor's office <u>after regular office hours</u>, how often did you get an answer to your medical question as soon as you needed? (Q #8 / #7) • How often did your visits to your doctor's office start within <u>15 minutes</u> of your appointment? (Q#6 / #5)

Attachment A: PAS Measures in the IHA Pay for Performance Measure Set (Measurement Year 2009, payout year 2010)

IHA P4P Measures	Individual Questions Items from 2010 PAS
Office Staff Composite (2 items)	<ul style="list-style-type: none"> • In the last 12 months, how often were clerks and receptionists at this doctor’s office as <u>helpful</u> as you thought they should be? (Q#34) • In the last 12 months, how often did clerks and receptionists at this doctor’s office treat you with courtesy and respect? (Q#35)
Health Promotion Composite (2-year) (2 items)	<ul style="list-style-type: none"> • In the last 12 months, did you and this doctor talk about a healthy diet and healthy eating habits? (Q#17/Q#16) • In the last 12 months, did you and this doctor talk about the exercise or physical activity you get? (Q#18/ Q# 17)

When two question numbers are listed; the first denotes the number on the 2010 PCP Survey Version and the second denotes the number on the 2010 Specialist Survey version.

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Attachment B

Project Requirements and Password

Password

Similar to last year, PAS participants will need a unique user name and password to complete key project steps, including registration, data submissions and logo confirmation. The unique user name and password for your physician group may be found in the body of the email transmittal of this PAS registration packet. Your unique user name and password was sent to the individual on record as the primary PAS contact for your group. Please keep this username and password throughout the survey period.

If you cannot locate your password, please contact Julie France at jfrance@pbgh.org or at 714.735.8754.

2010 Project Requirements for Physician Groups

Requirement	How and When
Register for the PAS Group Survey, and optionally, the PAS Doctor Survey and CCHRI After Hours Survey.	Go to http://www.cchri.org/pas_registration September 10 – September 25, 2009
Electronically agree to the terms and conditions in the 2010 Participation Agreement.	Electronic “sign-off” is the last step in the online registration process
Submission, or confirmation, of the physician group logo and executive signature—to be printed on the survey cover letter and instrument.	Go to http://www.cchri.org/pas_registration September 10 – October 9, 2009
Completion of online survey regarding the group’s coding practices and provider specialties.	Go to http://www.cchri.org/pas_registration September 10 – October 9, 2009
Submission of data files on all eligible patients, patient visits and providers, from which the survey sample will be drawn. All data submissions must meet the data quality criteria identified by PAS.	Go to http://www.cchri.org/pas_registration to download data specifications and the data checking tool no later than November 2. Data submissions due between November 2 and November 20, 2009 Final data corrections due: December 4th
Payment of participation fees for all survey options selected by the physician group.	Each group’s estimated fees will be calculated during the registration process. 100% of group survey fees are due January 15, 2010 . First half of doctor survey fees are due February 19, 2010 and remaining half are due August 2, 2010.

For your group’s protection, you are required to sign a Business Associate Agreement (BAA) with CSS, the survey vendor for the PAS project. A copy of the standard BAA can be downloaded from http://www.cchri.org/pas_registration. Groups who wish to use their own BAA will be charged a fee of \$250.

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Attachment C

Alternative Language Surveying for Group Survey

For the Group Survey, groups can choose to conduct alternative language surveying in Spanish, Chinese, or Vietnamese. You may choose from the options below during the registration process. The fees listed below are in addition to the cost of participating in the Group Survey.

Fees for Alternative Language Surveying	
Option 1: Double Stuff Survey Packets for Entire Sample of Patients Survey mailings “double stuffed” to include written survey materials in both English and one alternative language (among the above listed options). The double stuffing will occur for the entire group sample of 900 patients.*	\$1,640 per reporting unit
Option 2: Double Stuff Survey Packets for Patients of Selected Physicians Survey mailings “double stuffed” to include written survey materials in both English and one alternative language (among the above listed options). The double stuffing will occur only for patients associated with the providers selected for double-stuffing.*	\$1.82 per patient receiving double-stuffing
Follow up phone interviews in Spanish	No additional cost
Follow up phone interviews in Chinese, and Vietnamese	\$1,000 per reporting unit

*If you elect any of the above alternative language options, please inform the IT staff at your group responsible for programming the data submission. Each group will be required to flag physicians selected for alternative language surveying in the data submission due by November 20, 2009.

Attachment D Group Survey Information Sheet

Background

Since 2001, the California Cooperative Healthcare Reporting Initiative (CCHRI), a statewide collaborative of health plans, provider organizations and associations, consumers and purchasers, has conducted an annual survey to assess ***patient experience with the care delivered by the patient's medical group***. The Patient Assessment Survey (PAS) reflects the commitment of plans, purchasers, consumers and provider organizations to the joint administration of a statewide patient experience survey, in an effort to reduce redundancy and confusion regarding measurement and public reporting of performance results.

PAS is conducted under the auspices of the California Collaborative Healthcare Reporting Initiative, with oversight provided by the CCHRI Executive Committee and guidance from the CCHRI PAS Project Committee—composed of representatives of each participating health plan and ten physician groups. In 2009, eight major California health plans, 145 unique physician organizations (reporting on 184 units), and the 50 healthcare purchasers represented by the Pacific Business Group on Health (PBGH) collaborated in the PAS project. The 2009 participating groups served 11.6 million commercially insured HMO and POS patients, or 94.4% of the total HMO/POS commercial population in California. The participating health plans in 2009 were Aetna, Anthem Blue Cross, Blue Shield, CIGNA, Health Net, Kaiser Foundation Health Plan, PacifiCare Health Systems (UnitedHealthcare), and Western Health Advantage.

PAS in the IHA Pay for Performance Program

Each year a subset of question items from the PAS survey are selected for inclusion in the IHA Pay-for-Performance (P4P) program. Like other P4P measurement domains, IHA puts forth for public comment the potential measures it will include from the PAS. The P4P Steering Committee approves all final measures included in the P4P measurement set by year end, with significant input from the Technical Committee and stakeholders during the public comment period. The PAS measures selected for payment, their associated questions and weights can be found on the IHA website at www.ih.org, organized by measurement year. It is ultimately up to each health plan to determine thresholds for payment for P4P patient experience measures.

Physician Group Eligibility

All physician groups that serve commercially-insured, adult HMO and POS patients are eligible to participate for Measurement Year 2009.

Unit of Analysis

The unit of analysis is in most cases the unique physician group. However, some physician groups elect to survey multiple subunits and, in those cases, those smaller reporting units are the unit of analysis.

Survey Instrument

PAS builds off of a national research effort to create a standardized tool for measuring patient experience with care received in the ambulatory care setting. Specifically, the PAS significantly overlaps with the Clinician and Group CAHPS survey (CG-CAHPS), developed through a collaboration between the Agency for HealthCare Research and Quality (AHRQ), RAND, Harvard University and the American Institute for Research (AIR). The CG-CAHPS has been endorsed by the National Quality Forum (NQF) as the national standard. Differences between the emerging national CG-CAHPS survey and the California PAS survey reflect issues that are of particular interest to the California stakeholders and/or that support the IHA Pay-for-Performance program. One distinction is that PAS has developed both primary care physicians (PCP) and Specialist versions of the survey. These two versions overlap substantially.

Performance Domains

The key performance domains assessed in P4P include:

- ▶ Patient access to care (primary and specialty, non-urgent and urgent);
- ▶ Coordination of care;

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- ▶ Doctor-patient interactions (i.e., communication);
- ▶ Office staff;
- ▶ Health Promotion;
- ▶ Specialty care access and ratings; and
- ▶ Overall ratings of care

Patient Population Surveyed

A sample of 900 adult, commercially-insured HMO and POS patients who: 1) have had at least one visit between January and October of the measurement year; and 2) are enrolled in the medical group as of October 31 of the measurement year, are randomly sampled from each group. The sample is stratified, with 450 of the patients being drawn from patients with visits with their assigned PCP, and the other 450 patients being drawn from those with visits with a specialist.

Physician Group Registration

For the 2009 Measurement Year, CCHRI will send invitations to all physician groups operating in California that have at least 1000 managed care enrollees. Registration will begin on September 10, 2009 and physician groups will be required to formally register by September 25, 2009. Registration will occur via an online registration form found at http://www.cchri.org/pas_registration. If physician groups have any questions about the registration process, they should contact Julie France at jfrance@pbgh.org or at 714.735.8754.

During the registration process, groups will be provided with information on various survey options and the associated fees. Groups will be required to provide up-to-date contact information as well on data on member enrollment and geographic locations served. Groups will also be required to agree to the terms outlined in the CCHRI PAS Participation Agreement and to download and sign a Business Associate Agreement with the survey vendor for the project, the Center for the Study of Services (CSS).

In addition to signing up to participate in the PAS Physician Group Survey, groups will have the opportunity to elect supplemental survey options, including:

- ▶ Surveying distinct sub-units or practice sites of the medical group as separate reporting units, each with a unique sample of 900 patients.
- ▶ Alternative language surveying, in which groups elect to double stuff the patient survey packages with a survey translated into an alternative language of their choice (Spanish, Chinese, or Vietnamese). Double stuffing facilitates responses by patient populations who may not be fluent in English. (See Fee Schedule at www.cchri.org/programs/programs_pas.html for additional fees.)
- ▶ Doctor Survey participation, in which groups elect to conduct additional surveying at the physician level using the PAS survey instrument, processes and methods. This supplemental project is designed to facilitate group's quality improvement work. In addition, pediatricians may be included in the doctor survey process. (See Fee Schedule at www.cchri.org/programs/programs_pas.html for additional fees.) In 2009, 33 physician groups elected to participate in the Doctor Survey in addition to the Group Survey. In the context of the IHA P4P program (Systemness Domain, measure 5), POs can earn 4 points for measuring physician level patient experience and/or clinical performance, reporting it to physicians, and offering financial incentives or other incentives of monetary value based on performance
- ▶ Provider After Hours Access Survey participation, in which telephone interviews are conducted to assess protocols around after hours care for a sample of primary care physician offices (No additional fees).

Physician Group Requirements

In addition to formally registering, groups must adhere to the following requirements. Deadlines will be specified during the registration process and failure to meet the deadlines will forfeit the group's participation in the PAS project and thus eligibility for any P4P bonus dollars associated with the PAS performance measures.

- ▶ Register to participate via http://www.cchri.org/pas_registration no later than September 25th, 2009.

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- ▶ Sign off on the Participation Agreement at the time of registration.
- ▶ Submit (or confirm) the physician group logo and executive signature, to be printed on the survey cover letter and instrument. Due by October 9, 2009.
- ▶ Download, sign and mail BAA to survey vendor by October 9, 2009.
- ▶ Provide accurate information on the group's coding practices and provider specialties, as requested in an online survey hosted by the survey vendor. Groups may access this vendor site directly after registration (September 10-October 9th, 2009).
- ▶ Submit data files on all eligible patients, patient visits and providers, from which the patient sample will be drawn. After registering, groups will be provided with a set of data specifications that define the layout of the files and the information required within each field. All data submissions must meet the data quality criteria identified by PAS. An inability to meet the defined criteria will forfeit a group's participation in PAS (November 2-November 20th, 2009).
- ▶ Pay participation fees associated with the survey options elected by the physician group. See Attachment K for fees. Due by January 15, 2010.

Sampling

After final approval of the data files submitted by each group, the survey research firm draws a total sample of 900 patients for each reporting unit. The sample is stratified by visits to Primary Care Physicians (n=450 PCP visits) and Specialty Care Physicians (n=450 specialist visits), and within strata, patients are randomly selected. For patients with an assigned PCP, the visit must be with the assigned PCP to be eligible for inclusion in the sample. Patients without assigned PCPs are "assigned" by the survey vendor to the most frequently visited PCP. In drawing the sample of patients, only one eligible adult from each household is included.

To increase the likelihood of responding, sampling is prioritized by the most recent date of visit. Patient visits are grouped into three periods: January-April, May-July and August-October. Starting with the most recent period (August-October) visits are randomly selected from the enrollment files of each group.

Survey Fielding

The standard survey protocol consists of two mailed surveys, including a cover letter which outlines an option to complete the survey via the survey vendor web site using a unique web ID contained in the letter. The cover letter is printed using the logo of the patient's physician group and signed by the group's medical director. The first mailing occurs in late January. The second occurs in late February and is sent only to those patients from whom there is no prior response (via web or mail). Those patients who do not respond after the second mailing are contacted via phone in late March. Mail, web and phone interviews are available in English and Spanish for all patients and all mailed cover letters include a message in Spanish inviting patients to request a Spanish version of the survey via a toll-free number.

Groups are also provided the option to field the survey in English and an alternative language (Chinese, Spanish, or Vietnamese). Patients receiving the alternative language survey receive a cover letter in English with a translation in the alternative language printed on the back of the letter, in addition to a copy of the survey instrument in the alternative language.

Response File Preparation

Upon completion of the survey fielding, the survey vendor conducts data cleaning, including removing duplicate interviews, merging the response data with the original sample data, and conducting consistency checks between question items. Response data files from mail, web and telephone interview sources are cleaned for out-of-range responses for each question. Cases with out-of-bound ages (<18) are dropped from analysis. All responses are kept for analysis in which the patient either confirms the physician visit or, for PCP patient interviews, provides the name of another PCP in the physician group and confirms that they had had a visit with the physician in the past year. If the respondent indicates a physician that can not be matched to the physician group's provider file, then the respondent's survey is dropped from analysis.

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Analysis of the Survey Data

Each medical group's results are adjusted for patient case-mix to control for differences across physician groups. In 2009, the case-mix adjustment model controlled for:

- ▶ Age
- ▶ Gender
- ▶ Education level
- ▶ Race/ethnicity-primary language of respondent
- ▶ Presence of chronic conditions
- ▶ Single item physical health status
- ▶ Single item mental health status
- ▶ Specialty type of physician that patient rated (44 categories)
- ▶ Survey response mode (mail, internet, or phone)
- ▶ Language in which survey was completed
- ▶ Body Mass Index (BMI)

Reports

Groups receive the following reports of their results:

P4P Results (May): Each group receives its own results on the P4P set of items, along with a set of percentile showing the distribution of scores statewide.

Medical Group Report (June): Each group receives a report which displays their results for all question items in various formats and as compared to other physician groups in their region. This report also describes all survey methods and processes.

Excel File (June): Each group receives an Excel file which provides comparative results on each question items for all medical groups in their region.

Additionally, the results of the survey are made publicly available for use by consumers through the California Department of Managed Health Care's Office of the Patient Advocate consumer website (www.opa.ca.gov/report_card) each October. Performance results will not be publicly reported for any question or composite measure that achieves a reliability score of less than 0.70.

Key Timelines (please visit the CCHRI website at www.cchri.org/programs/programs_pas.html for detailed timeline)

- ▶ September 10, 2009: Registration site live.
- ▶ September 10, 2009: Data checking tool available on the survey vendor's website via the CCHRI website.
- ▶ September 25, 2009: Registration deadline. Participation agreement due (via electronic consent during the registration process).
- ▶ October 9, 2009: Deadline for groups to submit/confirm group logos/signatures, complete online survey on coding practices and physician specialties and mail signed BAS.
- ▶ November 20, 2009: Data files and attestation due to survey vendor.
- ▶ January-April, 2010: Survey fielding.
- ▶ May 2010: Results for P4P items to groups, plans, and IHA.
- ▶ June 2010: Medical group report including all survey items, comparative results, and raw data to medical groups.
- ▶ July 2010: Individual doctor report including all survey items, comparative results, and raw data to medical groups.

For More Information

Go to www.cchri.org/programs/programs_pas.html or contact Julie France at jfrance@pbgh.org or at 714.735.8754.

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Attachment E

Doctor Survey Information Sheet

To support physician group quality improvement efforts, CCHRI is offering groups the option of additional surveying of patients to produce doctor-level results, using the same survey tools being applied at the group level. Groups can choose among three unique surveys, respectively designed to evaluate care provided by primary care practitioners, specialists, or pediatricians.

Although the IHA Pay-for-Performance (P4P) bonus program is predicated on results of the Group Survey, groups have indicated that the doctor-level “drill down” option will serve to better guide their one-on-one quality improvement work with physicians. Effective with MY 2007 of the IHA program, under the “*Systemness Measure 5: Physician Measurement and Reporting*,” POs can earn 4 points for measuring physician level patient experience and/or clinical performance, reporting it to physicians, and offering financial incentives or other incentives of monetary value based on performance.

For the Doctor Survey, the group designates the physicians for whom patient samples will be drawn. Groups can survey across a broad range of physician specialties. The survey instrument used will depend on the physician:

- ▶ PCP Survey: Family practitioners and internal medicine physicians designated as the adult’s PCP
- ▶ Specialist Survey: Adult specialists, excluding hospital-based physicians and urgent care physicians
- ▶ Child Survey: Pediatricians designated as the PCP for visits with children under the age of 14

The survey will be administered using a two-wave mail protocol (and no phone follow-up). The same sampling rules that are used in the Group Survey apply: Eligible patients are those who have had a visit with their PCP or with a specialist whom the medical group has included in the doctor-level survey. Patient visits with a PCP who is not the patient’s PCP will be excluded.

Distinct from the Group Survey, which limits the survey sample to HMO or POS patients over the age of 18, the Doctor Survey allows for reporting on physicians serving members in any product line (HMO, POS, PPO; commercial or Medicare). However, special arrangements must be made if a medical group wishes to create a unique sample of Medicare-only patients.

For each physician you would like to report on, a sample of 100 patients will be selected for inclusion in the survey mailing. A mail-out sample size of 100 patients per doctor typically yields between 30 and 35 survey responses per physician, *averaged across all medical groups*. However, response rates for individual doctors can range substantially. Historically, the number of responses per doctor has ranged from a low of 10 to a high of 50+. There is some indication that physicians who serve patients of diverse cultures/language mix see lower response rates.

In order to increase the likelihood of receiving a threshold number of responses per doctor, groups will have the option to increase the number of patients in the mail sample to 135 per doctor. Specifically, the group has the option of designating a subset of select doctors to have a larger patient sample. This option does entail an additional fee (see below). A group’s decision to increase the mailed sample size from 100 to 135 for select physicians will depend on a number of variables, including:

- ▶ The way in which your group wishes to use the results. If results are being used as a basis for physician compensation, we recommend a minimum of 20-25 responses per doctor. Tying the survey results to physician reimbursement may increase the importance of achieving a minimum number of responses per doctor, and thus make it worth the additional cost of enlarging the mail sample size.
- ▶ Your group’s historical experience with physician level survey efforts. Groups who have participated in past years may wish to consider the 135 patient sample size for select physicians that have historically experienced low response rates. Groups without historic information may wish to choose the standard sample size of 100 for this year, and make adjustments in future years as necessary.

In some cases, low numbers of responses may also result from the relatively small size of some physician patient panels—with some physicians not having 100 patients that meet the eligibility criteria for inclusion in the survey sample. As an interim step in the project, the survey vendor will apprise the group of each doctor’s sample size after receiving your data submission. Groups will then have the opportunity, if they so choose, to

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de-select from the doctor-level survey those physicians whose eligible patient samples fall below 100. Likewise, if a physician was targeted for a 135 sample size, but the data submission shows that they do not have enough eligible patients to meet this mark, the group can choose to transfer the doctor to the 100 sample size option.

Fees for Doctor Survey participation are detailed below. Although the per unit fees for the Doctor Survey and alternative language surveying are final, each group's total fees (based on the number of doctors participating) will not be finalized until we are able to see your data submission and calculate exactly how many doctors are eligible among those you have designated for participation.

You will be required to flag physicians selected for inclusion in the Doctor Survey as part of the physician group's data submission due by November 20, 2009.

Doctor Survey*		Total
Fixed fee for each reporting unit	\$2,050	\$2,050
(A) Per practitioner fee for a sample size of 100	\$214 X No. of Docs Surveyed	+
(B) Per practitioner fee for a sample size of 135	\$273 X No. of Docs Surveyed	+
Preliminary Total		=

*For PCP, Specialist and Child Surveys

Alternative Language Surveying in the Doctor Survey

As with the Group Survey, you can also choose to conduct alternative language surveying at the physician-level in Spanish, Chinese, or Vietnamese. You may select either all, or a subset of providers to receive double stuffing. You will be required to flag physicians selected for alternative language surveying in the physician group's data submission due by November 20, 2009.

The additional fees are listed below.

Fees for Doctor Survey Alternative Language		Total
Survey mailings "double stuffed" to include written survey materials in both English and one alternative language among the above listed options. (The Child Survey will not be available in Chinese, or Vietnamese)	\$182 X No. of doctors with sample size of 100 \$246 X No. of doctors with sample size of 135	+
Preliminary Total		=

Attachment F Provider After-Hours Access Survey Information Sheet

The California Cooperative Healthcare Reporting Initiative (CCHRI) is coordinating the 2010 Provider After-Hours Access Survey Project. The project, conducted on behalf of participating California health plans for their Commercial populations, will report results by July 31, 2010. Results will be used for reporting to multiple entities, including purchasers, the Department of Managed Health Care and the National Committee for Quality Assurance. There are no additional fees for physician groups to participate in this survey.

Project Goals

The goals for the Provider After-Hours Access Survey Project are to:

- ▶ Improve patient satisfaction;
- ▶ Provide information for quality improvement activities by physician groups and health plans;
- ▶ Develop and implement a process to determine physician office use of appropriate emergency instructions and physician availability after-hours for urgent care issues;
- ▶ Standardize measurement of after-hours care across all participating plans, and minimize intrusion into the provider's practice by consolidating multiple, independent plan surveys into one, integrated data collection project across the participating plans;
- ▶ Provide participating health plans with performance measures and descriptive analyses that will satisfy NCQA Accreditation Standards. Plans to supplement results with review of complaint and member satisfaction data;
- ▶ Enable plans to perform analyses of data and reporting against internal plan standards for access;
- ▶ Support plan identification of performance improvement opportunities; and
- ▶ Assure quality of data collected and reported within a mutually agreed upon standard for data accuracy.

Description

The telephone survey documents after-hours physician availability and access to appropriate emergency and urgent care information. The after-hours phone calls will be completed for up to fifty primary care office sites in each of the participating provider organizations. (These after-hours calls will supplement access information obtained from the PAS project.) A designated number of health plans will equally share the costs for fielding this portion of the project and receive a data file containing individual call outcomes for each phone interview attempted or completed. Provider organizations will receive a standardized report containing group-specific and comparative results; they will also receive a file with raw data from each interview or attempted interview. The reporting unit for this is the physician group level.

Process

1. Groups are invited to register for the Provider After-Hours Access Survey as part of the 2010 Patient Assessment Survey (PAS) registration process.
2. The same data file submitted to the PAS Survey Vendor will also be used to draw the sample of primary care offices for the After Hours Survey. Physicians with a PCP flag and at least one visit in the PAS sample will be included in the After Hours sample data.
3. A random sample will be drawn to allow completion of 50 calls per group
4. Survey calls are completed after normal business hours.
5. Responses are categorized based on predetermined (by After Hours project team) values that also determine if the response will qualify as an appropriate response.
6. Results are summarized and reported by physician group and health plan files are produced.

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Methodology

- ▶ A target of 50 completed primary care physician surveys are attempted per physician group.
- ▶ Surveys will be conducted using a telephone interviewing methodology. The interviews will be conducted after normal business hours between 6:30 p.m. and 9:00 p.m. from April to June 2010.
- ▶ Survey questions are tailored for situations in which the interviewer reaches a live person, a recording or an auto attendant.
- ▶ If a phone number appears more than once in a particular sample set, that phone number is only called only one time in an effort to not burden the answering service. All physicians in the sample with the same number will receive the same score based on that one call.

Physician offices may be considered ineligible for participation in the survey if the physician is deceased, no longer in practice (at that location); on an extended leave of absence, or incorrectly identified as a PCP. Offices are also excluded if the office is no longer open at the phone number listed or the phone number is incorrect.

Attachment G

**CCHRI and Participating Provider Group Letter of Participation
2010 Patient Assessment Survey Group Survey and After Hours Survey**

Consent to be provided electronically during online registration

The [\[insert legal name of Medical Group\]](#) (hereinafter referred to as "Provider Group") and the California Cooperative Healthcare Reporting Initiative (hereinafter referred to as "CCHRI"), through its fiscal agent the Pacific Business Group on Health (hereinafter referred to as "PBGH"), propose to undertake the collection and public reporting of performance data through the 2010 Patient Assessment Survey project (hereinafter referred to as PAS) and, per the Provider Group's selection of this option at the time of online registration, the CCHRI Provider After Hours Access Survey (hereinafter referred to as After Hours). CCHRI has contracted with the Center for the Study of Services (hereinafter referred to as "Survey Vendor"), to collect and analyze the data and to prepare reports from the projects. The provisions governing each of the two projects will apply only to each project the Provider Group elects to participate in via the online registration for the PAS and After Hours Surveys.

The PAS and After Hours Surveys will involve medical groups and IPAs across California in an effort to coordinate the collection and reporting of consumers' experiences with receiving care at the provider group level. The PAS survey tool and protocol are informed by the national Clinician-Group CAHPS (CG-CAHPS) developed by the Agency for Healthcare Research and Quality and endorsed by the National Quality Forum. The survey concerns data collection and public reporting of results for the adult (ages 18 and older), Commercial HMO and POS population only. Information will be collected on those patients who have had an encounter between January 1 and October 31, 2009. The After Hours Survey concerns data collection and reporting for the Provider Group primary care offices' commercial HMO and POS populations.

Provider Group acknowledges that the PAS and After Hours projects are a cooperative venture directed by the CCHRI Executive Committee and project managed by PBGH, with provision for input by designated provider group representatives through the CCHRI PAS Project Committee and the CCHRI After Hours Committee. The decision-making body is the CCHRI Executive Committee within the parameters of authority that are granted to it by the full set of CCHRI stakeholders ("CCHRI All-Participant Membership Group") (committee charter and rosters available at www.cchri.org).

Provider Group and PBGH agree to the following:

1. Provider Group will, according to the CCHRI timetable (at www.cchri.org), produce and submit patient and provider-level data files (i.e., the sample frame) to the Survey Vendor for the purposes of drawing a random sample of 900 patients, based on the data specifications defined by the CCHRI PAS Project Committee and provided to Provider Organization. The same provider-level data files will be used to draw a sample of 50 primary care offices for the After Hours Survey. The Provider Group will provide the Survey Vendor a copy of its Provider Group logo and the name and signature of the medical director for the sole purpose of producing customized patient survey packets. The Provider Group will provide accurate information on medical group enrollment, coding practices and number of physicians of different specialty type per the PAS Survey registration and data submission process.
2. The Provider Group data submission will undergo a set of data quality checks undertaken by Survey Vendor, and if problems are found, the Provider Group will make the necessary corrections and resubmit the file to Survey Vendor. If at the close of the data submission period (All initial submissions are due November 20, with final corrections made no later than December 4, 2009), Survey Vendor determines that Provider Group's data submission is compromised substantially such that the omissions or inclusions would likely introduce bias by having a non-comparable patient population from which to draw a sample (e.g., too few records relative to size of enrolled HMO adult population), the Provider Group will be dropped from the project and there will be no results for the Provider Group (i.e., no data will be collected for public reporting, use by CCHRI partners, or the IHA Pay-for-Performance program). Data quality checks will be conducted between November 2 and December 4, 2009, and all problems must be corrected and final data file submissions received by December 4, 2009. The data quality checks must be completed and a group's file submission deemed to have "passed" to be included in the 2010 PAS project.
3. Provider Group agrees to: (1) have survey data collected and analyzed by the Survey Vendor according to the project timeline; (2) meet all deadlines established by the project administrators, and (3) publication of

Patient Assessment Survey (PAS) 2010

the results of the 2010 PAS and After Hours projects in the CCHRI public and internal reports. As part of the 2010 PAS data analysis, CCHRI will include in the model case mix adjustment for age, gender, education, health status, mental health status, body mass index, race/ethnicity--primary language spoken, language in which the survey was completed, presence of chronic conditions, response mode (i.e., mail, phone, or web), response language, and specialty type of physician being rated. The CCHRI PAS Project Committee will review and approve the data analysis plan. Reports are produced according to the decisions, reporting format guidelines and disclosure criteria set forth by the CCHRI Reporting Committee and the CCHRI Executive Committee. The only condition in which the Provider Group's results will not be publicly published is if the Provider Group's overall ratings AND composite measures fall below a minimum reliability of 0.70. Should a Group's reliability fall below 0.70 for any overall rating or composite measure, the Provider Group's results will continue to be included in the CCHRI internal reports to be shared with all participating groups and plans (with a symbol denoting that the reliability is less than 0.70).

4. Group's with response rates historically lower than 25% will be required to have and pay for a larger than the standard 900 outgo sample, to achieve a minimum number of completes to produce reliable estimates for public reporting and financial incentive payments.
5. Provider Group shall designate a primary contact person who is responsible for interfacing with CCHRI staff in the conduct of the project, and such person shall have final and binding authority for the Provider Group. The contact person shall be responsible for communicating updates and issues related to the 2010 PAS and After Hours projects to other interested parties within Provider Group.
6. Provider Group agrees to pay its cost of participation if any of its patients are surveyed, even if the CCHRI Executive Committee decides to exclude Provider Group's results from the public or internal reports (i.e. because of data incomparability or incompleteness). The participation fee is per reporting unit, unless other payment arrangements have been made between CCHRI and Provider Group. Payment will be made within 30 days of receipt of a CCHRI invoice.

The Provider Group participation fee must be paid in full no later than December 31, 2009, and is based on commercial HMO and POS enrollment, as follows:

- ▶ Under 30,000 enrollees: \$4,715
- ▶ Between 30,000 – 100,000 enrollees: \$5,775
- ▶ Over 100,000 enrollees: \$6,830

There are no additional fees for participation in the After Hours Survey.

7. CCHRI and PBGH shall maintain the confidentiality of Provider Group's individual patient records in accordance with Confidentiality of Medical Information Act, Cal Civ. Code sec. 56 et. seq., and with the Health Insurance Portability and Accountability Act of 1996, and regulations found at 456 C.F.R. sec. 160-164, as applicable.
8. Provider Group shall execute a Business Associate Agreement (BAA) with Survey Vendor to ensure that data confidentiality safeguards are established pursuant to HIPPA. The BAA will be available at www.cchri.org. If the Provider Group wishes to use a BAA other than the standard BAA used by the Survey Vendor it may do so, but the Provider Group will be charged \$250 to pay for the document review.
9. CCHRI will produce and distribute the following products for each Provider Group:
 - ▶ Summary of PAS and After Hours scores that will be reported publicly (for PAS, per the Final Report referenced below);
 - ▶ Results on the P4P designated survey questions;
 - ▶ The **CCHRI PAS 2010 Final Group Reports** (distributed to all CCHRI participants)
 - ▶ A data file containing de-identified patient-level results for Provider Group's members only (for the purposes of conducting additional analyses);
 - ▶ The After Hours Summary Medical Group Report; and
 - ▶ The After Hours results detail file.
10. CCHRI will produce and distribute the following products to each participating health plan:
 - ▶ An Excel file that contains group level results for the PAS scores that will be reported publicly;

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- ▶ The **CCHRI PAS 2010 Aggregate Report** (contains results for all provider groups statewide);
 - ▶ PAS data file containing patient-level results only for the Provider Groups with which the respective health plan contracts. Plans will only receive patient-level data files that have been “de-identified” by removing all contact information (i.e., name, address, phone, zip) and any other personal identifying information (i.e., date of birth). To support plan-specific enrollee analyses, patient-level data would identify the plan’s own enrollees—with a health plan identification variable (e.g., plan=Blue Cross)—patients who are enrolled in all other plans are de-identified (e.g., plan= “other”); and
 - ▶ A Health Plan Results file for the After Hours Survey.
11. For the purposes of additional consumer reporting of comparative performance results, CCHRI will share its publicly reported PAS 2010 results with specific entities, namely the DMHC Office of the Public Advocate (OPA), the Pacific Business Group on Health, CalPERS, and the Integrated Healthcare Association (IHA) for their use. The results for the specific items rewarded under the IHA Pay-for-Performance program will also be shared with IHA for aggregation with clinical data, to be provided to the health plans for use in determining bonus payments to Provider Groups as part of the Pay-for-Performance program. In addition, Provider Group authorizes the CCHRI Executive Committee or its designee to review the individual reporting plans and processes used by the OPA, PBGH, CalPERS and IHA to determine whether those plans and processes are consistent with the “Guidelines for the Use of CCHRI Data by Consumer Reporting Entities” (available online at www.cchri.org). If the CCHRI Executive Committee or its designee determines that said entity followed CCHRI’s guidelines, then Provider Group agrees that CCHRI may provide said entity(s) with results according to that entity’s specifications for the sole purpose of carrying out that entity’s consumer reporting and Pay-for-Performance plan.
 12. CCHRI is interested in supporting the research efforts of the Agency for Health Care Research and Quality (AHRQ) in the development and refinement of national, standardized quality measurement tools for assessing patient experience with care at the health plan, medical group/practice site, physician, and hospital levels. AHRQ has funded this work through its CAHPS initiative. For the purposes of assisting AHRQ with the development of CAHPS-related survey tools and methods, Provider Group authorizes CCHRI to share a PAS de-identified patient level data file with AHRQ, and the CAHPS grantees. For any such research purposes, the data file would be de-identified by removing all patient, provider group, and health plan identifiable information. In addition, contingent upon the approval of and conditions established by the PAS Project Committee, CCHRI may share a PAS de-identified, patient level data file with the National CAHPS Benchmarking Database (NCBD).
 13. Except as otherwise stated in this Agreement, use of Provider Group’s data from the PAS 2010 and the After Hours Survey is under the control of CCHRI, which may grant permission for use by other entities. Entities other than the consumer reporting entities specifically listed in #10 and the research entities listed in #11 above that wish to use results other than those publicly reported by CCHRI, must request permission from the CCHRI Executive Committee. All such requests must be made in writing and submitted to the CCHRI Executive Committee for review and approval.
 14. Provider Group will be financially responsible for any costs (time or materials) incurred by the Survey Vendor that are related to submission of Provider Group information (e.g. data files, medical group logos and signatures) after the deadlines established by CCHRI, or that is related to correction of errors made by the Provider Group. The Survey Vendor will not draw patient samples or prepare mailing materials until a file is certified as having passed the data quality checks. It is the responsibility of the group to meet all deadlines associated with having the data file approved. The Provider Group will also be financially responsible for any customized data runs or analyses of the data.

Patient Assessment Survey (PAS) 2010
Attachment H
CCHRI and Provider Group Letter of Participation
2010 PAS Doctor Survey Project

Consent to be provided electronically during online registration

The [\[insert legal name of Medical Group\]](#) (hereinafter referred to as "Provider Group") and the Pacific Business Group on Health ("PBGH") jointly propose to undertake the collection and provider group reporting of physician-specific patient reported performance data through the 2010 **PAS Doctor Survey Project** ("Doctor Survey"). PBGH has contracted with the Center for the Study of Services Inc. ("Survey Vendor") to collect, analyze and report the survey data.

This work involves California Provider Groups in an effort to administer a survey to capture patient-reported experiences of care and service with their physician. The survey will be conducted with a sample of adult members and/or the parents/guardians of child members who are patients of physicians affiliated with the participating Provider Groups. Survey results are reported to the Provider Group and to the designated recipients listed in Section 4 and Section 5 below. Except as stated herein, survey results are not reported to any other persons or entities.

Provider Group and PBGH agree to the following:

1. Provider Group shall designate a primary contact person who is responsible for interfacing with PBGH staff in the conduct of the Doctor Survey. The contact person shall be responsible for communicating updates and issues related to the 2010 Doctor Survey to other interested parties within the Provider Group.
2. Provider Group shall, according to the 2010 Doctor Survey timetable (available on CCHRI website at www.cchri.org) produce and submit patient-level data files to Survey Vendor for the purpose of drawing a random sample of patients to be surveyed, based on the data specifications defined by PBGH and provided to Provider Group and available at www.cchri.org starting September 10, 2009. Provider Group authorizes PBGH to use the Provider Group name and logo and the patients' names and addresses in communications to solicit Provider Group patients to participate in the survey. Additionally, Provider Group shall provide a copy of its Provider Group logo and the name and signature of the Provider Group representative for the sole purpose of producing customized patient survey packets.
3. Provider Group shall execute a Business Associate Agreement (BAA) with Survey Vendor to ensure that data confidentiality safeguards are established pursuant to HIPPA. The BAA will be available at www.cchri.org. If the Provider Group wishes to use a BAA other than the standard BAA used by the Survey Vendor, it may do so, but the Survey Vendor will charge the Provider Group \$250 to pay for the document review.
4. Provider Group agrees to have its patient data collected and analyzed by Survey Vendor according to the Doctor Survey timeline and agrees to the publication of the results to be used by the Provider Group. For purposes of this clause, any Provider Group-specific results shall be shared with other Doctor Survey-participating Provider Groups only under the condition that no findings shall disclose the identity of the Provider Group, any individual physician or any patient/member.
5. Provider Group authorizes PBGH to publish findings of this Doctor Survey provided that no findings shall disclose the identity of the Provider Group, any individual physician or any patient/member. For purposes of this clause, PBGH agrees that Survey Vendor shall only disclose physician-specific or patient-specific data that has been "de-identified" by removing all personal identifying information collected through the project, specifically patient name, mailing address, zip code, patient home phone, and day and month of birth. The only patient specific information remaining for analysis are gender and birth year.
6. Provider Group agrees to pay PBGH the Doctor Survey administration fee per the 2010 Doctor Survey Fee Schedule of \$2,050 per participating Provider Group and \$214 per doctor selected for participation

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in the Doctor Survey. Provider Group agrees to pay one-half (50%) of the fee no later than February 19, 2009, and the second half of the fee within 30 days of receipt of the Doctor Survey Reports listed below (per the project timeline final fees are due August 2, 2010). The Provider Group will also be financially responsible to the Survey Vendor for any customized data runs or analyses of the data.

7. Confidentiality of individual patient records will be maintained in accordance with California Civil Code Section 56 *et seq.* (Confidentiality of Medical Information Act) by all parties at all times, in accordance with the HIPAA, and in accordance with any more restrictive, applicable law.
8. PBGH shall produce and distribute the following Doctor Survey Reports to Provider Group:
 - ▶ Provider Group Performance Profile Report, which is the Provider Group's affiliated physician results and comparisons to the results of the participating Provider Groups in the Doctor Survey. The participating Provider Group results shall be blinded – no participating Provider Group names shall be disclosed in this Profile. No patient-level information (or patient personal identifying information) shall be included in this report.
 - ▶ Physician-specific Performance Profile Reports, which is the personalized physician reports that compare the physician's results to the results of other physicians in that Provider Group, except that each report shall be identifiable only as to the physician to which it is provided, with other physicians' identities being de-identified. No patient-level information (or patient personal identifying information) shall be included in this report.
 - ▶ Electronic Data File Report, which is the physician-level results for the Provider Group's physicians only (Excel format). Report includes a database of all of the Provider Group's physician-level survey results. No patient-level information (or patient personal identifying information) shall be included in this report. The report includes reference normative results based on all of the participating provider groups.
9. Provider Group agrees to not publicly disclose any comparative participating Provider Group results.
10. These data confidentiality terms shall survive the termination or expiration of this Agreement.

Attachment I HIPAA Business Associate Agreement for the 2010 Patient Assessment Surveys (PAS)

To be downloaded from www.cchri.org, customized for the Provider Group, signed and mailed to CSS

This Addendum (the "Addendum") is entered into as of [\[Insert Date\]](#), 2010, as a result of the Pacific Business Group on Health-Survey Vendor Agreement (the "Survey Vendor Agreement") which agreement is between PBGH and the Survey Vendor (CSS or Center for the Study of Services).

This Addendum is by and between [\[insert name of Medical Group\]](#) ("Covered Entity") and Center for the Survey of Services ("Business Associate"). Covered Entity and Business Associate are sometimes referred to herein individually as a "Party" and collectively as the "Parties".

Covered Entity wishes to disclose certain information to Business Associate pursuant to the terms of the Agreement, some of which may constitute Protected Health Information (defined below). Both Parties are committed to complying with the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Regulation") under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Pub. L. No. 104-191. This Addendum sets forth the terms and conditions pursuant to which Protected Health Information that is provided by, or created or received by, Business Associate from or on behalf of Covered Entity will be handled by Business Associate and third parties during the term of the Agreement and after its termination. Appendix III, which is attached hereto and incorporated herein by reference, specifies the Protected Health Information of Covered Entity that is the subject of this Business Associate Agreement. The Parties agree as follows:

I. Definitions

Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, and applicable regulations found at 45 C. F. R. sec. 160 et seq. Seq., hereinafter the "Privacy Rule".

II. Use of Protected Health Information

Except as otherwise stated in this Agreement, Business Associate may use or disclose Protected Health Information on behalf of Covered Entity solely to provide the services, or perform the functions, described in the Agreement, provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity.

III. Rights and Responsibilities of the Parties

A. Responsibilities of Business Associate: *The Business Associate shall have the following responsibilities:*

1. Business Associate agrees to not use or disclose Protected Health Information other than as permitted or required by the Survey Vendor Agreement or as Required By Law.
2. Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement.
3. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement.
4. Business Associate agrees to report to Covered Entity any use or disclosure of the Protected Health Information not provided for by the Survey Vendor Agreement of which it becomes aware.
5. Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by Business Associate on behalf of Covered Entity agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.
6. Business Associate agrees to make internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity available to the Covered Entity, or to the Secretary, in a time

Patient Assessment Survey (PAS) 2010

and manner designated by the Covered Entity or designated by the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.

7. Business Associate agrees to maintain for a period of six (6) years an accounting of all disclosures of PHI that are required to be maintained under § 164.528 of the HIPAA Regulations. Such accounting will include the date of the disclosure, the name of the recipient, a description of PHI disclosed and the purpose of the disclosure.
8. Business Associate agrees to provide to Covered Entity or, if agreed to by Covered Entity, an Individual, such information to be provided in a time and manner specified by the Covered Entity and such information to be provided to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528.

B. Responsibilities of Covered Entity: *The Covered Entity shall have the following responsibilities*

1. Covered Entity shall notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 CFR § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of Protected Health Information.
2. Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, to the extent that such changes may affect Business Associate's use or disclosure of Protected Health Information.
3. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of Protected Health Information that Covered Entity has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of Protected Health Information.
4. Any notices required under this section shall be made promptly in writing to Business Associate.
5. Covered Entity shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.

IV. Term and Termination

A. Term. The Term of this Agreement shall be effective as of the Effective Date specified below, and shall terminate when all of the Protected Health Information provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this Section.

B. Termination for Cause. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall either:

1. Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity;
2. Immediately terminate this Agreement if Business Associate has breached a material term of this Agreement and cure is not possible; or
3. If neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

C. Future Confidentiality Upon Termination.

1. Except as provided in paragraph (2) of this section, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the

Patient Assessment Survey (PAS) 2010

Protected Health Information, or, if it is infeasible to return or destroy Protected Health Information, protections shall be extended to such information.

2. In the event Business Associate determines that return or destruction is not feasible for any reason, then the provisions of this Business Associate Agreement shall continue to apply for so long as such Protected Health Information is in Business Associate's possession.

V. Miscellaneous

- A. Regulatory References. A reference in this Agreement to a section in the Privacy Rule means the section as in effect or as amended.
- B. Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy Rule.
- C. Survival. The respective rights and obligations of Business Associate under Section III of this Agreement shall survive the termination of this Agreement.
- D. Interpretation. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule.
- E. Interpretation. Any ambiguity in this Amendment shall be resolved to permit Physician to comply with the HIPAA Regulations.
- F. Conflict of Terms. Whenever the terms of the Agreement and this Amendment are in conflict, the terms of this Amendment shall control.
- G. Other Terms Remain in Force. Except as expressly modified by the terms of this Amendment, all of the terms and conditions set forth in the Agreement shall remain in full force and effect.
- H. Effective Date. This Amendment shall be effective on **[Insert Date]**.

IN WITNESS WHEREOF, the parties have executed this Amendment as of the date(s) set forth below.

Center for the Study of Services

[Insert Medical Group Name]

By: Paul Kallaur

By: _____

Its: Healthcare Research Director

Its: _____

Date: _____

Date: _____

Please submit a signed copy of this agreement to:

Jeff Burkeen
Center for the Study of Services
1625 K ST NW, 8th Floor
Washington, DC 20006
202-454-3005

Patient Assessment Survey (PAS) 2010

Attachment J

Schedule of Informational Calls

<p>Registration Period Informational call to answer questions about survey options, process and pricing</p>	<p>September 17: 10:00-11:00 PST Call Number: 1-800-615-2830 Passcode: 415-615-6358#</p>
<p>Data Submission Period Informational calls on PAS data submission process (review data specifications and file submissions)</p>	<p>October 22: 1:00-2:30 PST Call Number: 1-800-615-2830 Passcode: 415-615-6358#</p> <p>November 12: 1:00-2:30 PST Call Number: 1-800-615-2830 Passcode: 415-615-6358#</p>

Patient Assessment Survey (PAS) 2010
Attachment K: 2010 PAS Fee Schedule

Group Survey	
Group Size*	2010 Group Fees
Under 30,000 enrollees (commercial HMO and POS enrollees)	\$4,715
30,000 – 100,000 enrollees	\$5,775
Over 100,000 enrollees	\$6,830

*Groups electing to have subunits of their group surveyed will pay the “fee” based on the size of each subunit.

Group Alternative Language Surveying	
Option 1: Double Stuff Survey Packets for Entire Sample of Patients Survey mailings “double stuffed” to include written survey materials in both English and one alternative language (among the above listed options). The double stuffing will occur for the entire group sample of 900 patients.*	\$1,640 per reporting unit
Option 2: Double Stuff Survey Packets for Patients of Selected Physicians Survey mailings “double stuffed” to include written survey materials in both English and one alternative language (among the above listed options). The double stuffing will occur only for patients associated with the providers selected for double-stuffing.*	\$1.82 per patient receiving double-stuffing
Follow up phone interviews in Spanish	No additional cost
Follow up phone interviews in Chinese, or Vietnamese	\$1,000 per reporting unit
Group Survey Oversample (for low response rate groups only)	
Per additional patient sampled	\$1.82 X No. additional patients
Follow up phone interviews with non-respondents	\$15.97 per non-respondent patient (from add on sample)

Doctor Survey	
Fixed fee for each reporting unit	\$2,050
(A) Per practitioner fee for a sample size of 100	\$214 X No. of Docs Surveyed
(B) Per practitioner fee for a sample size of 135	\$273 X No. of Docs Surveyed

Doctor Survey Alternative Language	
Survey mailings “double stuffed” to include written survey materials in both English and one alternative language among the above listed options. (The Child Survey is not available in Chinese, or Vietnamese.)	\$182 X No. of doctors with sample size of 100 \$246 X No. of doctors with sample size of 135

After Hours Survey	
Physician offices contacted via phone to assess after hours protocols being followed.	No additional charge

Patient Assessment Survey (PAS) 2010

Attachment L

PAS 2010 Project Timeline

Task	Date
PAS Registration Information emailed to Groups	September 1
PAS Registration Site Live	September 10
Web site with medical group logos and signatures "live"	September 10 (once registered)
Online Survey on Coding Practices and Physician Specialties "live". Data file specifications sent to groups.	September 10 (once registered)
Informational call to answer questions about survey options, process, pricing	September 17
★ Group registration deadline	September 25
Data Specifications and Data Checking tool available	September 25
★ Submit/confirm organizational logos and signatures	October 9
★ Complete Online Survey on Coding Practices and Physician Specialties	October 9
★ Groups Submit Signed Business Associates Agreement (BAA)	October 9
Informational calls on PAS data submission process, data quality (QA) reports and Doctor Survey physician lists	October 22 and November 12
★ Use Data Checking Tool (via downloadable tool)	November 2 – November 20
★ Data Submissions Due	November 2 – November 20
Groups receive: <ul style="list-style-type: none"> ▪ All: Data quality reports ▪ Doctor Survey participants: physician visit counts 	No later than November 25
★ Data corrections due	December 4
★ Doctor Survey participants approve doctor lists via CSS website	December 11
Sample finalized by vendor	December 18
★ Participation fee due	December 31, 2009
Group Survey 1 st wave survey mailed	Friday, January 22, 2010
Doctor Survey 1 st wave survey mailed	February 5, 2010
PBGH Invoice #1: 100% Group Survey	December 15, 2009
★ Fees for Invoice #1 Due (100% Group Survey)	January 15, 2010
PBGH Invoice #2: 50% Doctor Survey	January 15, 2009
★ Fees for Invoice #2 Due (50% Doctor Survey)	February 19, 2010
Group 2 nd wave survey mailed	February 19
Doctor 2 nd wave survey mailed	March 12
Phone follow-up for Group Survey begins	March 12
Survey fielding ends	April 30
P4P results sent to groups	May 17
Group Survey reports sent to groups	June 21
Doctor Survey reports sent to groups	July 5
PBGH Final Invoice for Remaining 50% of Doctor Survey Fees	July 9
★ Fees for Final Invoice Due (Remaining 50% Doctor Survey)	August 2

★Denotes action item for the medical group

Attachment M

PAS AND AFTER HOURS SURVEY DATA FILE SPECIFICATIONS

**DATA FILE DUE TO SURVEY VENDOR BETWEEN NOVEMBER 2 TO NOVEMBER 20, 2009.
DATA FILE SPECIFICATIONS REMAIN IDENTICAL TO LAST YEAR**

BACKGROUND

Each participating medical group is to submit three unique fixed-length ASCII text files to the survey vendor using the file specifications detailed below. (The technical specifications begin on page 8). This format assumes one data record per line of text. The three files are:

Table A) Patient Visit File: Contains records of every eligible encounter for eligible patients between January 1, 2009 to October 31, 2009.

Table B) Patient File: Contains a unique record for each patient who had at least one eligible encounter. All patients in this file should be matched to one or more records in the visit file based on their patient ID.

Table C) Active Provider File: Contains a unique record for each provider. This table should include records for all active providers of the specialty types defined in Appendix 1, even if there is no match between the provider and an eligible patient visit.

The Center for the Study of Services (CSS), the data vendor for the project, will match the three files to develop the sample frame to be used for the 2010 Patient Assessment Survey (PAS). The three files are linked together using the Patient IDs and the Physician IDs. The information contained in these files will be used to draw the sample for the Group Survey and the Doctor Survey (for participating groups).

For the Group Survey, CSS will draw a total sample of 900 patients. CSS will first randomly select 450 patients who had visits with their assigned PCP. The group will note each patient's assigned PCP in the data submission. If the Assigned PCP field is blank, CSS will assign a PCP based on the primary care provider most frequently visited by the patient. CSS will then draw an additional sample of 450 patients who had visits with a specialist — regardless of whether the patient had an assigned PCP.

After Hours Survey

For groups who choose to participate in the After Hours Survey, the after hours contact information is collected in the Active Provider File (Table C). Please fill in these if you choose to participate. (The After Hours Survey is a separate survey project but given the overlap in group participation we are including these fields in the PAS submission to consolidate data collection.)

File Naming Convention

The naming convention for the three files should be Table_[A/B/C]_[5-digit DMHC Code]. For example a medical group with DMHC Code 10001 would submit the following set of files:

Table_A_10001.txt, Table_B_10001.txt and Table_C_10001.txt for Patient Visits, Patients and Active Providers respectively.

Technical note: the file name extension (e.g., .txt, .dat, etc.) will be ignored and may be any extension or may be excluded altogether. However, the format of the files must be fixed length ASCII text. No other format will be accepted.

Due Dates and Re-Submissions

PAS is going to strictly enforce deadlines for receipt of data file submissions this year.

- First submissions must occur between **November 2 and November 20, 2009**.
- Groups will receive data quality reports via email within two business days of the submission.
- Final corrections must occur no later than **December 4**, so early submissions are encouraged.
- Groups that cannot make file corrections resulting in an approved file will **not be permitted to participate** in the 2010 project, and will **forfeit their eligibility for Pay for Performance bonuses** tied to the PAS project.

Patient Assessment Survey (PAS) 2010

Contacts

Jeff Burkeen of CSS for questions around the data specifications and file submissions (jburkeen@cssresearch.org or 202-454-3005).

Julie France of PBGH for PAS group and doctor survey information on project participation, survey options and fees (jfrance@pbgh.org 714.735.8754).

Cathie Markow of PBGH for information on Provider After Hours Access Survey participation (cmarkow@pbgh or 415 615-6359).

Generating an Accurate Data Submission

There will be no source code audit for 2010. However, in order to ensure that comparable samples are being drawn from each medical group, CSS will apply a Quality Assurance (QA) process after receipt of your data submission between November 2 and November 20, 2009. The QA system will use a series of data quality checks to determine if your submission is meeting the core parameters of the project. **Groups will be excluded from participation if their final data submission does not meet the criteria listed below labeled “required”. Such exclusion will preclude eligibility for the PAS portion of financial bonuses awarded through the Pay for Performance program.**

- **Required Flag.** Groups must pass all data quality checks labeled as “required”. Failure to pass required checks will result in exclusion from participating in the 2010 PAS Project.
- **Investigate Further Flag.** This is a warning flag that something may be wrong with the data. Groups will be asked to explore any issues that resulted in the flag and submit corrected data if an error in the data collection process is discovered.

Data Quality Criteria	Statistic
Patient Visits (Table A)	
All required visit <u>categories</u> . Illness, preventive care, outpatient, ophthalmology and obstetric visits should <u>all</u> be represented in the visit file.	<p>Required. There should be visits in each of the following visit categories, per the defined CPT codes (or internal codes converted to the defined CPT codes):</p> <ul style="list-style-type: none"> ▪ Illness ▪ Preventive care ▪ Outpatient ▪ Ophthalmology ▪ Obstetric
All eligible visits. Include <u>every</u> visit for each eligible patient. There should be a record for every patient visit—so that some patients will have <u>multiple</u> visit records in the Patient Visit File (and not just the most recent visit per patient).	<p>Required. For each group, the ratio of visits to patients (the number of visit records divided by the number of patients) should be greater than 2.0 but fewer than 10.0 (A ratio larger than 10 may indicate too few patients submitted)</p> <p>Investigate Further. If there is unequal distribution of visits across periods: Visits will be divided into 3 periods: January-March, April-June, July-October. No single period should have more than 45% of submitted visits.</p>
Visits with required specialty types.	<p>Required. Per Appendix 1, there must be valid visits linked to providers representing <u>all</u> required specialty types listed in Appendix 1.</p>
POS insured visits	<p>Required. If the group indicated they had POS insured patients during the registration process, there must also be visits coded with commercial POS insurance in the patient visit file (Table A, Field 11).</p>

Patients (Table B)	
All commercial HMO and POS patients 18 years and older with eligible visits must be included in the data submission.	Required. The number of valid patient-doctor relationships represented in the data should be 20% or more of the overall adult commercial enrollment.
	Investigate Further. If more than 35% of submitted patients are not assigned to a PCP included in the Active Provider file.
Active Providers (Table C)	
All providers of the required specialty types must be included. Include only active providers.	Required. Per Appendix 1, all of the required specialty types listed must be represented in the Active Provider file (Table C, Field 11) and be linked to valid patient visits.
	Required. At least 65% of providers who are listed on the group's roster (Table C, Field 15) should be linked to valid patient visits.
	Required. Family Practice and Internal Medicine physicians should make up at least 90% of the set of physicians flagged as PCPs (Table C, Field 10).
	Investigate Further. If anyone <i>non-PCP</i> specialty type makes up more than 20% of valid providers (with visits).
Additional data quality checks	
Missing data	To Be Invalidated. Any records with missing data that is needed to evaluate the file criteria (e.g., patient age, date of visit, insurance coverage, physician specialty, etc.) will be invalidated. Out-of-range values in these required fields (e.g., a gender entry that is not 'M' or 'F', a month of birth that is not 1-12, etc.) will also invalidate the affected records.
	Investigate Further: If more than 30% of addresses or more than 60% of phone numbers are missing or unusable.
Duplicate Patient IDs in the patient file or duplicate Provider IDs in the provider file.	To Be Invalidated. Records with duplicate IDs in the patient file (Table B, Field 7) or the provider file (Table C, Field 9) will be invalidated. However patient and provider IDs are expected to appear multiple times in the visit file (Table A) to reflect multiple patient visits with the same provider.
Use of PCP Flag	To Be Invalidated. Providers whose specialty is Family/General Practice, Internal Medicine, Nurse Practitioner or Physician Assistant and serve as PCPs with assigned panels of patients are required to be flagged as PCPs (Table C, Field 10). These provider types will be invalidated if this flag is missing or if they are coded as non-PCPs.

Legitimate Exemptions

The Online Survey of Data Procedures, to be completed prior to data submission, allows groups to indicate whether they cannot provide specific categories of patient visits or provide visit data for all required specialties. Project managers will follow up with groups and grant exemptions on a case-by-case basis. (In some cases, the data can be obtained by conversion or other means.)

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If a group believes they cannot meet any of the other requirements listed in the table above, the group should contact Jeff Burkeen at jburkeen@cssresearch.org or 202-454-3005 preferably prior to the start of the data submission period which commences November 2. The group should provide an explanation as to why it cannot meet the criteria and note if this was an issue in the previous PAS survey.

Essential Final Checks Prior to Data Submission

1. Before exporting the files into the final text format, make sure that the patient and provider IDs, respectively, have a consistent format across all three tables so that CSS will be able to link the tables together based on these IDs. Specifically, run the following checks:
 - Link (join) Table A (Patient Visits) with Table B (Patients) on the Patient ID and count the number of visit records in which there is a match with a patient ID (should be close to 100%).
 - Link (join) Table A (Patient Visits) with Table C (Active Providers) on the Provider ID and count the visit records in which there is a match with a provider ID (should be close to 100%).
 - Link (join) Table B (Patients) with Table C (Active Providers) to make sure the PCP ID in Table B matches a Provider ID in Table C. The percentage of matches should meet your expectations based on your PCP assignment policies – if nearly all of your adult patients are assigned a PCP then the match should be close to 100%.
 - If IDs do not match in suggested percentages, then check for missing patient and provider records and/or check that the IDs are formatted consistently and that the ID field lengths are correct.
2. A format checking tool will be available beginning October 1, 2009 on both the CSS and CCHRI web sites. It is highly recommended that you download and install the tool and check your files prior to submitting them for the full quality assurance (QA) process. The QA system is automated and will not process files that do not meet the format/length/naming specifications.

The format checking tool will also be available www.cchri.org/programs/programs_pas.html. The tool will also be available from the main menu at www.cssresearch.org/pas (after you log in with your DMHC Code and passcode).

Instructions for Submitting Data Files

Web site option

This will be the preferred means of submitting data for the 2010 PAS. The Web page for uploading data will create a secure connection between the CSS Web site and your Web browser using Secure Socket Layer (SSL) encryption (the same encryption used by commercial web sites for placing orders, viewing accounts, paying bills, etc.). After the files are selected and uploaded, they will be automatically transferred to the CSS internal network, behind the CSS network firewall. No part of the data files will reside on the Web site.

Once the data is in the CSS network, then the QA system will automatically check the data and generate a data quality report, which will inform each group if its data has been accepted for the PAS or if the data failed to meet specific data quality criteria and thus needs to be corrected. No part of the enrollment data will be included in the reports sent back to the group, only summary information to help identify and correct any issues that may be discovered. The reports will be sent via email with 2 business days of data submission. A data submission link will become available on the main menu of the CSS web page beginning Nov. 2, 2009 (requires a log in with your DMHC Code and passcode).

Web Link: www.cssresearch.org/pas

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E-mail or Surface Mail Options

Groups will still have the option of submitting data via email or by CD if they prefer, however the generation of QA reports may be delayed by an additional day from the day of receipt. Once CSS staff receive the data files they will load them into the QA system via the secure Web site and the QA system will then generate the QA report.

- *E-mail via encrypted e-mail:* CSS will work with groups to accept encrypted e-mail attachments through services such as Zixmail. Please contact CSS to work out the details of using this approach.
- *E-mail via standard e-mail:* If a group chooses to submit via standard e-mail then the file should be compressed (zipped), password protected, and attached to an email to data@cssresearch.org. The password to the zipped file should be sent in a separate email to jburkeen@cssresearch.org.
- *Surface Mail:* To mail the files by CD, please send the CD to the following address after November 2, 2009:
Jeff Burkeen
CSS - 8th Floor
1625 K ST NW
Washington, DC 20006

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Summary Data Requirements

✓	Survey Options	Information Needs	Table A Patient Visit Table	Table B Patient Demographic Table	Table C Provider Table
	Group Survey Must participate to be eligible for health plan bonuses under IHA P4P Program		A unique record for <u>all</u> patient visits: <ul style="list-style-type: none"> ▪ Made between 1/1/09 and 10/31/09 ▪ By HMO and POS members ▪ By members age 18 and older on 10/31/09 ▪ For defined visit types (see page 8) 	A unique record for <u>all</u> members that are: <ul style="list-style-type: none"> ▪ 18 years or older as of 10/31/09 ▪ Enrolled in HMO and POS ▪ Enrolled in Commercial product ▪ Enrolled with provider group on 10/31/09 ▪ Had <u>one or more eligible encounters</u> from 1/1/09 to 10/31/09 	A unique record for <u>all</u> provider types <u>active</u> as of 10/31/09: <ul style="list-style-type: none"> ▪ All active providers with required specialty types (see Appendix 1). ▪ Includes staff, network and contract providers.
	Alternative Language Surveying Is the medical group planning to survey its members in a language other than English? If so:	Identify the language(s); Will the alternative language survey be provided to <u>all</u> patients chosen for the survey, or <u>only patients of select physicians</u>? If the latter, obtain a list of the doctors whose patients will be surveyed in each language			If alternate languages will only be provided to patients of selected physicians, use Field 14 to indicate the language option for each provider. Each provider may be coded with any one of the four alt. language options.
	After Hours Survey Is the medical group participating in the After Hours Survey? If so:	Make sure you include pediatricians in Table C, the Active Provider File.			Include Pediatricians and fill in the optional After Hours contact information (fields 16-19).
	Sub-Unit Reporting Is the medical group going to sample and report results for subunits? If so:	Which subunits does the medical group want to report on separately? Groups can identify subunits in the Visit Table <u>or</u> the Provider Table depending on whether individual physicians deliver care across multiple subunits (use Visit Table) or if each physician is accountable for delivering care at one subunit only (use Provider Table).	Complete Field 9 Allows sampling of visits for a single physician across multiple subunits.		Complete Field 2 All sampled visits are associated with the provider's assigned subunit only.

✓	Survey Options	Information Needs	Table A Patient Visit Table	Table B Patient Demographic Table	Table C Provider Table
	<p>Doctor Survey Is the medical group participating in the Doctor Survey (in addition to the Group Survey?) If so:</p>	<p>Obtain the list of doctors your group wants included in the Doctor Survey.</p> <p>Does your group want to survey members with PPO or Medicare coverage (in addition to HMO & POS)?</p> <p>Does your group want to enlarge the doctor sample size from 100 to 135?</p>	<p>May also include (by group choice):</p> <ul style="list-style-type: none"> ▪ Pediatric visits by members under 14 ▪ Visits by PPO or Indemnity members ▪ Visits by Medicare patients 	<p>May also include (by group choice):</p> <ul style="list-style-type: none"> ▪ Pediatric patients under 14 ▪ PPO or Indemnity members ▪ Medicare members 	<p>Use Field 12 to flag physicians participating in Doctor Survey and to denote sample size of 100 or 135 for physicians participating in Doctor Survey</p> <p>Fill in physician <i>practice/location</i> in Field 13.</p>

TABLE A: PATIENT VISIT FILE

Includes:

1. A separate record for every eligible visit. For example, if a member had three visits to Physician Smith and two visits to Physician Jones there should be five visit records in the file for that member.
2. Visits that meet ALL of the following criteria:
 - Visits made between January 1, 2009 and October 31, 2009.
 - Visits made by members with Commercial HMO or POS coverage
 - Visits made by members who are age 18 or older as of October 31, 2009.
 - Visits of each type listed below, including those documented in your system using internal or proprietary coding. You should include all of the visit codes below in your visit queries. If your group uses additional or different codes to represent the required visit types, you must convert them to the comparable standard CPT code and include them in the data submission. If you're not sure whether other codes should be converted, please contact Julie France at jfrance@pbgh.org 714.735.8754.

Visit Type	CPT Codes Typically Used	Internal Codes (notes section)
Illness office visits	99201-99205, 99211-99215	
Preventive care visits	99385-99387, 99395-99397, 99401-99404, 99411-99412, 99420, 99429 (Doctor Survey participants choosing to include Pediatricians should also include codes 99381-99384, 99391-99394)	
Outpatient consults	99241-99245	
Ophthalmology visits	92002-92014	
Obstetric visits	59400, 59510, 59610, 59618	

Doctor Survey Participant Notes

Groups participating in the Doctor Survey may choose to include the following for their Doctor Survey samples only. Check with the PAS project contact or Medical Director of your group to determine whether to include the visit types listed below.

- Visits made by patients under the age of 14 (if surveying Pediatricians)
- Visits made by PPO or Indemnity patients
- Visits made by Medicare patients

Reminders:

- If your group uses internal codes to represent the required visit types (illness, outpatient consult, preventive care, ophthalmology, obstetric), you will need to convert your internal codes to at least one of the standard CPT codes listed above in each category or they will be invalidated.
- Do not filter by place-of-service code. The survey vendor will be responsible for further screenings and exclusions.
- Before exporting the files into the final text format, make sure that the patient and provider IDs in the visit file match the correct records in the patient and provider tables, respectively. (See Essential Final Checks on Page 4).

- Large groups with subunits (excludes most groups) whose physicians provide services across subunits should use Field 2 to identify the subunit at the visit level. (Groups who wish to associate each provider with one subunit only should code the subunit in Table C – Providers instead.)

Table A – Patient Visit File Data Layout

Field #	Variable	Specifications	Data Format
1	Medical Group ID (DMHC - Department of Managed Health Care)	Medical Group's CA DMHC Code. Used to organize data by participating medical groups. Use 5 digit DMHC code.	Columns: 1 - 5 Width: 5 Type: Numeric Code
2	Medical Group Name	Name of Medical Group. Used as quick reference; will not be used in cover letters or reports and may be abbreviated	Columns: 6 - 35 Width: 30 Type: Alpha
3	Visit Service Code	CPT 5-digit code; if other codes are used for required visit types, they must be converted to corresponding CPT codes.	Columns: 36 - 40 Width: 5 Type: Numeric Code
4	Physician ID for Patient Visit	Physician identifier for provider with whom patient had visit. Used to match visits to the provider record in the Active Provider file. (Table A and Table C are linked together by CSS using the Physician ID)	Columns: 41 - 70 Width: 30 Type: Alpha-Numeric
5	Date of Visit – Month (Patient visit with physician listed in Field 4)	Visits January 1, 2009 – October 31, 2009. Use 2 digit Month codes (e.g. 01-10). Used to identify a unique visit.	Columns: 71 - 72 Width: 2 Type: Numeric Code
6	Date of Visit – Day (Patient visit with physician listed in Field 4)	Visits January 1, 2009 – October 31, 2009. Use 2 digit Day codes (e.g. 01-31). Used to identify a unique visit.	Columns: 73 - 74 Width: 2 Type: Numeric Code
7	Date of Visit – Year (Patient visit with physician listed in Field 4)	Visits January 1, 2009 – October 31, 2009. Use 4 digit Year Codes (2009). Used to identify a unique visit.	Columns: 75 - 78 Width: 4 Type: Numeric Code
8	Patient ID or Record Number	Patient identifier assigned by Medical Group. Used to match visits to the patient record in the Patient Demographic file. (Table A and Table B are linked together by CSS using the Patient ID.)	Columns: 79 - 93 Width: 15 Type: Alpha-Numeric

Table A – Patient Visit File Data Layout (cont.)

Field #	Variable	Specifications	Data Format
9	Medical Group Subunit Code	Group subunit where the visit took place. <u>Optional field</u> for groups who have registered for multiple subunit samples and wish to identify subunits at the visit level. Assign numeric code for each subunit (e.g., 01, 02, 03, ...). Leave blank if not applicable.	Columns: 94 - 95 Width: 2 Type: Numeric Code
10	Health Plan Used for Visit	Name of health plan covering visit. Use legal name of health plan. Do not use acronyms or aliases. If using numeric codes, convert the codes to plan names. Used to evaluate results by health plan.	Columns: 96 - 135 Width: 40 Type: Alpha
11	Insurance Product Used for Visit	Use the following codes: 1 = HMO 2 = POS 3 = PPO 4 = Indemnity/Other Categories 1 (HMO) or 2 (POS) are the only eligible categories for the PAS Group Survey reporting. Categories 3 and 4 may be used for Doctor Survey only.	Columns: 136 Width: 1 Type: Numeric Code
12	Type of Coverage	Use the following codes: 1 = Commercial 2 = Medicare Category 1 (Commercial) is the only eligible category for the PAS Group Survey. Category 2 may be used for Doctor Survey only.	Columns: 137 Width: 1 Type: Numeric Code
13	Place of Service Code*	2-digit CMS place of service indicator (e.g., 11=office, 21=inpatient hospital).	Columns: 138 - 139 Width: 2 Type: Numeric Code
14	Primary Diagnosis of Encounter	ICD-9** code that reflects the primary diagnosis made during the encounter. If not available, leave blank.	Columns: 140 - 149 Width: 10 Type: Alpha-Numeric
15	Secondary Diagnosis of Encounter	ICD-9** code that reflects the secondary diagnosis made during the encounter. If not available, leave blank.	Columns: 150 - 159 Width: 10 Type: Alpha-Numeric

*A complete list of Place of Service Codes are available from CMS. Go to the following Web site and choose "POS Database":
www.cms.hhs.gov/PlaceofServiceCodes/

** ICD-9: International Classification of Diseases, Ninth Revision

TABLE B: PATIENT FILE

Includes:

Members who meet **ALL** of the following criteria:

- Had one or more encounters from January 1, 2009 to October 31, 2009. (Patients who match one or more visits in Table A, based on the Patient ID)
- 18 years or older as of October 31, 2009
- Enrolled in HMO or POS
- Enrolled in Commercial products
- Enrolled with provider group on October 31, 2009

Excludes Members:

- Without any visits between January 1, 2009 and October 31, 2009. (No matches in Table A.)

Doctor Survey Participant Notes

Groups participating in the Doctor Survey may choose to include the following members, who will be included in the Doctor Survey samples only. Check with the PAS project contact or Medical Director of your group to determine whether to include the members types listed below. Note that visits for these patients should also be included in Table A.

- Patients under the age of 14 (if surveying Pediatricians)
- PPO-only or Indemnity-only patients
- Medicare patients

Reminders:

- Include all members based on the above eligibility criteria. The survey vendor will be responsible for further screenings and exclusions.
- Patients with dual insurance coverage may be included, as long as at least one visit was covered under an HMO or POS product.
- **There should be one unique record and one unique Patient ID for each patient. If there are multiple attributes for a patient (e.g., multiple addresses) provide the primary attribute for the patient. Duplicate patient records with the same patient ID will be excluded from the survey.**

Table B – Patient File Data Layout

Field #	Variable	Specifications	Data Format
1	Medical Group ID (DMHC – Department of Managed Health Care)	Medical Group's CA DMHC Code. Used to organize data by participating medical groups. Use 5 digit DMHC code.	Columns: 1 – 5 Width: 5 Type: Numeric Code
2	Medical Group Name	Name of Medical Group. Used as quick reference; will not be used in cover letters or reports and may be abbreviated	Columns: 6 – 35 Width: 30 Type: Alpha
3	Last Name (Patient)	Include last name only. Exclude first name or middle initial. Used for addressing correspondence to patients.	Columns: 36 – 65 Width: 30 Type: Alpha
4	First Name (Patient)	Include first name only. Exclude middle name or initial. Used for addressing correspondence to patients.	Columns: 66 – 95 Width: 30 Type: Alpha
5	Middle Initial (Patient)	Include middle initial only. Used for addressing correspondence to patients.	Columns: 96 Width: 1 Type: Alpha
6	Suffix (Patient, If Any)	Include any degrees, titles, Sr. Jr., etc. Exclude any part of name. Used for addressing correspondence to patients.	Columns: 97 – 106 Width: 10 Type: Alpha
7	Patient ID or Record Number	Unique patient identifier assigned by Medical Group -- not an episode identifier. <u>Must match Patient IDs in Table B.</u> Used by CSS to match patient record to Patient Visit file.	Columns: 107 - 121 Width: 15 Type: Alpha-Numeric
8	Mailing Address Line 1 (Patient)	First line of patient's primary mailing address (e.g.100 Main St, Apt 2). Survey will be mailed to this address. (Apartment numbers can be in either line 1 or 2)	Columns: 122 - 151 Width: 30 Type: Alpha-Numeric

Table B – Patient File Data Layout (cont.)

Field #	Variable	Specifications	Data Format
9	Mailing Address Line 2 (Patient)	Use if necessary for apartment or for a long address, otherwise leave blank; do <u>not</u> duplicate information in line 1.	Columns: 152 - 181 Width: 30 Type: Alpha-Numeric
10	City (Patient)	Use full name of city as recognized by Postal Service.	Columns: 182 - 211 Width: 30 Type: Alpha
11	State (Patient)	Use standard US Postal Service abbreviation (e.g., CA)	Columns: 212 - 213 Width: 2 Type: Alpha
12	Zip code (Patient)	5-digit zip code. (Use leading zeros as appropriate.)	Columns: 214 - 218 Width: 5 Type: Numeric Code
13	Home Phone (Patient)	Include area code. Provide full telephone number without any punctuation. (e.g. 4159991212) Used for follow-up phone survey with patients who are mail non-respondents.	Columns: 219 – 228 Width: 10 Type: Numeric Code
14	Date of Birth – Month (Patient)	Use 2 digit Month codes (e.g. 01-12) Used to confirm patient eligibility.	Columns: 229 - 230 Width: 2 Type: Numeric Code
15	Date of Birth – Day (Patient)	Use 2 digit Day codes (e.g. 01-31) Used to confirm patient eligibility.	Columns: 231 - 232 Width: 2 Type: Numeric Code
16	Date of Birth – Year (Patient)	Use 4 digit Year Codes (e.g. 1970) Used to confirm patient eligibility.	Columns: 233 - 236 Width: 4 Type: Numeric Code
17	Gender (Patient)	Use the following codes: F = female M = male; Used for salutation in patient correspondence	Columns: 237 Width: 1 Type: Alpha
18	Primary Care Physician (PCP) ID	Patient's PCP as of October 31, 2009. Use physician ID used in provider table (Table C). If patient is not assigned to PCP, leave blank and CSS will make PCP assignment based on most frequently visited PCP.	Columns: 238 - 267 Width: 30 Type: Alpha-Numeric

TABLE C. ACTIVE PROVIDER FILE

Please see Appendix 1 for the defined set of specialty types that must be represented in the data submission and their associated codes. **The submission will not pass the Quality Assurance process if the complete set of required specialty types is not included.**

Includes:

All providers (including contract providers) who practice one of the required specialties and were active as of October 31, 2009, regardless of whether there is a match with a patient visit.

Note: Providers who have not had an encounter in the past 3 years are not considered “Active” for the PAS and should not be included.

Excludes:

Providers whose primary specialty is:

- Pediatric subspecialty
- Hospital-based physicians: radiologists, pathologists, anesthesiologists, emergency medicine

Doctor Survey Participant Notes:

Determine the following with the PAS project contact or Medical Director for your group:

- Flag participating physicians in Field 12.
- Pediatricians may be included in the Doctor Survey. Include their patients (under 14) and visits in table A and B.
- Larger sample: to increase the doctor sample size from 100 to 135 (for an additional fee), use code 2 in Field 12.
- Physician practice/location in Field 13 is required.
- If you plan to include a doctor who has dual specialties (see note in reminders), we recommend you choose just one of the specialties for purposes of the Doctor Survey. Flagging both records is highly likely to result in insufficient patient sample size for both specialties.

Reminders:

- Multiple attributes: There should be one unique physician ID for each record in Table C. Duplicate provider records with the same physician ID will be invalidated. For other attributes (e.g., two practice locations), enter the primary attribute for the provider in a single record. (Dual specialty status is the only rationale for including two records for any one provider and each specialty record will require a separate, unique ID - see note on next page).
- New Affiliation Codes: Use Field 15 to code each provider’s affiliation based on whether the provider is typically included in your group roster (as provided to health plans, for example). This replaces the staff/network/contract coding scheme used last year.
- PCPs: Use Field 10 to flag all PCPs that have assigned panels of patients. Providers with specialties Family Practice (07), Internal medicine (09), Nurse Practitioner (14) or Physician Assistant (24) should be flagged as PCPs or they will be invalidated.

- Alternative Language: Use Field 14 to flag providers whose patients are to receive alternative language surveys (group must have registered for alternative language option). Each provider may be coded with any one of the four alternative language options. Groups who registered to have all patients in the sample receive an alternative language do not need to code providers.
- After Hours participants: Fill in optional contact information and include pediatricians.
- Large groups with subunits (excludes most groups): use Field 2 if you wish to associate each provider with one subunit only. (Groups whose physicians provide services across multiple subunits and want to capture that mobility should code the subunit in Table A – Visits instead.)
- Practices: If necessary, provider records may be included with the name of a practice abbreviated to 30 characters in the Last Name field (leave First Name blank). Groups are required to identify individual physicians if possible.
- Dual Specialties: If any providers have dual specialties, you may submit separate records for each specialty. However, each record must have a unique physician ID (e.g. Dr. Jones specializes in Family Practice and Pulmonology. Her unique physician ID for Family Practice is 12345 and her physician ID for Pulmonology is 12345A. In the provider file there would be two records for Dr. Jones, one with ID “12345” and Specialty “07”, the other record would have ID “12345A” and Specialty “26”.) Note that each ID must have corresponding visit records in Table A for each specialty to be represented in the sample. (Continuing the example, some visit records with Provider ID 12345 and some with Provider ID 12345A.) If one of the specialties serves as a PCP, make sure to flag the correct physician ID with the PCP flag.
- Physician Last Name: In field 4 please delete any unnecessary text appended to the last name, such as “Smith, a medical corporation” or “Jones, License # ...” as this will get printed on the surveys sent to their patients
- Groups not participating in the After Hours survey: fields 16 through 19 do not need to be included in Table C You may either fill those columns with blanks or end the provider file at the end of Field 15 (at position 184).

Table C – Active Provider File Data Layout

Field #	Variable	Specifications	Data Format
1	Medical Group ID (DMHC - Department of Managed Health Care)	Medical Group's CA DMHC Code. Used to organize data by participating medical groups. Use 5 digit DMHC code.	Columns: 1 - 5 Width: 5 Type: Numeric Code
2	Medical Group Subunit Code	Group subunit to which the doctor is assigned. <u>Optional field</u> for groups who have registered for multiple subunit samples and wish to associate each provider with a specific subunit. Assign numeric code for each subunit (e.g., 01, 02, 03, ...). Leave blank if not applicable.	Columns: 6 - 7 Width: 2 Type: Numeric Code
3	Medical Group Name	Name of Medical Group. Used as quick reference; will not be used in cover letters or reports and may be abbreviated.	Columns: 8 - 37 Width: 30 Type: Alpha
4	Physician Last Name (or abbreviated practice name)	Include last name only. Do not include professional suffix (MD, DO, etc.) Delete any unnecessary text appended to the last name. (If a practice name, abbreviate to 30 characters.)	Columns: 38 - 67 Width: 30 Type: Alpha
5	Physician First Name	Include first name only. Exclude middle initial. (If a practice name, leave blank – enter abbreviated practice in field 4.)	Columns: 68 - 97 Width: 30 Type: Alpha
6	Physician Middle Initial	Include middle initial only.	Columns: 98 Width: 1 Type: Alpha
7	Physician Name Suffix	Include any Sr. Jr., etc.	Columns: 99 - 108 Width: 10 Type: Alpha
8	Physician Professional Suffix	Include MD, DO, etc.	Columns: 109 - 118 Width: 10 Type: Alpha

Table C – Active Provider File Data Layout (cont.)

Field #	Variable	Specifications	Data Format
9	Physician ID	Unique physician identifier. Used to match physician record with visit records (Table A, Field 5) and patients' PCP assignment (Table B, Field 18).	Columns: 119 - 148 Width: 30 Type: Alpha-Numeric
10	PCP Indicator	Use the following codes: PCP = 1 Non-PCP = 2 Flag to indicate if physician serves as a primary care provider (PCP) with assigned panel of members. FP and IM doctors, NPs and PAs not flagged as PCPs will be invalidated.	Columns: 149 Width: 1 Type: Numeric Code
11	Physician Specialty	Use 2-digit specialty code only from Appendix 1. Used to analyze medical group and project-wide results by PCP/specialist categories and for case-mix adjustment.	Columns: 150 - 151 Width: 2 Type: Numeric Code
12	Doctor Survey Participant	<u>Doctor Survey participants.</u> Use the following codes to indicate which physicians will participate in the Doctor Survey: 1 = Include physician in Doctor Survey at 100 sample size 2 = Include physician in Doctor Survey at 135 sample size Blank = Physician will <u>not</u> be included in Doctor Survey If not applicable, leave blank.	Columns: 152 Width: 1 Type: Numeric Code
13	Physician Practice/Location	<u>Doctor Survey participants.</u> Name of physician's practice or location. <u>Required</u> for physicians who are flagged for participation in the Doctor Survey. If not applicable, leave blank.	Columns: 153 - 182 Width: 30 Type: Alpha-Numeric

Table C – Active Provider File Data Layout (cont.)

Field #	Variable	Specifications	Data Format
14	Alternative Language Survey to be included in addition to English Survey	If you registered for an <u>optional alternative language</u> survey at the provider level, indicate which language should be included for patients of each provider. Codes: Spanish=1, Chinese=2, Vietnamese=3. If not applicable, leave blank.	Columns: 183 Width: 1 Type: Numeric Code
15	Provider Affiliation with Medical Group/IPA	Use the following codes: 1 = Provider is included in group roster 2 = Provider is <u>not</u> included in group roster. (Applies to providers affiliated by a letter of understanding.) Provider Flag to identify each provider's affiliation with the medical group.	Columns: 184 Width: 1 Type: Numeric Code
16*	City (Provider)	<u>After Hours Participants:</u> Use full name of city recognized by Postal Service.	Columns: 185 - 214 Width: 30 Type: alpha
17*	State (Provider)	<u>After Hours Participants:</u> Use full name of city recognized by Postal Service.	Columns: 215 - 216 Width: 2 Type: alpha
18*	Zip code (Provider)	<u>After Hours Participants:</u> 5-digit zip code. Use leading zeros as appropriate.	Columns: 217 - 221 Width: 5 Type: Numeric Code
19*	Phone Number (Provider)	<u>After Hours Participants:</u> 10-digit number including area code. Do not include formatting characters such as parenthesis, dashes or spaces. (e.g. 7149940540)	Columns: 222 - 231 Width: 10 Type: Numeric Code

*Regarding optional After Hours fields: Groups who are not participating in the After Hours survey do not need to include fields 16 through 19. Either these columns can be included and filled with blanks, or the table can end at field 15 (position 184). (Note: other optional fields in the *middle* of any file must be filled with blanks if not applicable.)

Appendix 1: List of Required Specialties

For 2010, all of the *Required Specialty Types* listed below must be represented in the Table C data submission, using the codes in the left column. (For pairs of specialties highlighted in yellow, either code will meet the requirement.) In addition, all required specialty types should be represented with visits in Table A. **The submission will not pass the Quality Assurance process if the required specialty types are not included.**

Required Specialty Types		
01	Allergy/Immunology	
03	Cardiology	
05	Dermatology	
06	Endocrinology	
07	Family/General Practice	
08	Gastroenterology	
09	Internal Medicine	
10	Infectious Disease	
12	Nephrology	
13	Neurology	
15	Obstetrics/Gynecology	Quality check will ascertain if group has either OB/GYNs or Gynecologists only, but group should continue to use the two distinct codes for each specialty type.
41	Gynecology Only	
16	Oncology/Hematology	
17	Ophthalmology	
19	Orthopedist	Quality check will ascertain if group has either Orthopedic Surgeons or Orthopedists, but group should continue to use the two distinct codes for each specialty type.
32	Surgery Orthopedics	
20	Otolaryngology (ENT)	
25	Podiatry	
26	Pulmonology	
27	Rheumatology	
29	Surgery General	
30	Surgery Cardiac/Thoracic	Quality check will ascertain if group has any among following surgical types: Cardiac, Thoracic or Vascular, but group should continue to use the two distinct codes for each specialty type.
36	Surgery Vascular	
33	Surgery Plastic/Reconstructive	
34	Surgery Neurological	
37	Urology	
Optional Specialty Types *		
14	Nurse Practitioner (NP)	
24	Physician Assistant (PA)	
49	NP or PA working in OB/GYN	
50	NP or PA working in Pediatrics	May be included for Doctor Survey only
21	Pediatrician / Adolescent Medicine	For After Hours and Doctor Survey Only

* These specialty types may be included, but are not required.

Specialty Types Excluded from Group Survey**		
2010 Code	Specialty Type	
38	Acupuncture	May be included for Doctor Survey only
--	Addiction Medicine	
--	Anesthesiologists	
--	Audiology	
02	Behavioral Medicine	May be included for Doctor Survey only
04	Chiropractor	May be included for Doctor Survey only
--	Counselor	
48	Dental	May be included for Doctor Survey only
47	Emergency Medicine	May be included for Doctor Survey only
40	Genetics	May be included for Doctor Survey only
39	Geriatric Medicine	May be included for Doctor Survey only
42	Infertility/Reproductive Endocrinology.	May be included for Doctor Survey only
11	Neonatal Care	May be included for Doctor Survey only
--	Nuclear Medicine	
--	Nutrition	
46	Occupational Medicine	May be included for Doctor Survey only
18	Optometry	May be included for Doctor Survey only
43	Oral-maxillofacial Surgery	May be included for Doctor Survey only
44	Pain Management	May be included for Doctor Survey only
--	Pathologists	
--	Pediatric Subspecialists	
22	Perinatology	May be included for Doctor Survey only
23	Physical Medicine	May be included for Doctor Survey only
--	Psychiatry	
--	Public Health	
45	Radiation Oncology	May be included for Doctor Survey only
--	Radiologists	
--	Rehabilitation Medicine	
--	Sleep Medicine	
28	Social Worker	May be included for Doctor Survey only
--	Speech Therapy	
31	Surgery Colon/Rectal	May be included for Doctor Survey only
35	Surgery Transplant	May be included for Doctor Survey only
99	Urgent Care	

** These specialty types will not be included in the Group Survey sample for 2010. Specific specialties may be included in the Doctor Survey as indicated above. Groups may include all specialties in the submission, and the Survey Vendor will remove them if necessary.