

Additional Information

- A. The PAT is neither an electronic nor personal health record. Rather it is a tool to facilitate the collection and scoring of clinical quality measures necessary for the implementation of P4P demonstrations.

Critical to the implementation of these demonstrations is the ability to link Medicare beneficiaries and all of the services they receive to providers via claims data in order to determine which beneficiaries physicians must report on. The first step in this process is to use claims data to identify those physicians and practices responsible for the plurality of a beneficiary's primary care services. CMS has developed a detailed "assignment" algorithm that uses claims data from PAT files for this purpose. In order to link patients to providers and identify all of the services they received, the beneficiaries' Health Insurance Claim (HIC) number is used. There is no other number that can be used to reliably link all services that a beneficiary receives. Data Use Agreements are in place to cover this work and to ensure that all information is treated appropriately.

Once beneficiaries have been assigned to a practice, we then identify all of the claims for those beneficiaries. Again, HIC is the only means by which all services to a particular patient can be linked. Diagnostic and procedure code data on all of these beneficiaries' claims are used to (1) calculate those clinical quality measures that can be calculated using claims data (e.g., whether a mammogram was received), as well as (2) determine which beneficiaries are eligible for other clinical quality measures that require data from the patient medical chart (either electronic or paper) that is maintained by physician.

To facilitate this process, CMS has developed, through a contract with RTI, International, the PAT. To make reporting easier for the physicians, PAT is pre-populated with the names and identifying information of patients that have been "assigned" to them and for whom they must report clinical quality measure data. In addition, PAT is pre-populated with the dates of Medicare-covered visits that might help the physician find relevant data in the patient's records. For example, PAT would be pre-populated with the dates of office and lab visits so that the physician might more easily find information in the chart and determine whether the patient had a flu shot or the results of a lab test. Thus, while this data collection process does not involve the collection of HIC, the HIC is used, in part, to identify patients for whom practices must report and ensure that the clinical quality measures information provided by the practice is matched to the correct patient.

This data collection was initially covered under its own system of records but is now maintained under the Office of Research, Development, and Information's master system of records.

While the PAT software is publicly available and practices can download it from our demonstration bulletin board, the data that is unique to each practice and which includes the personally identifiable beneficiary data is not. That data is encrypted and then sent separately to

each practice via Quality Net Exchange (“QNet”), a secure system for transmitting data that is approved for and used by the QIOs. In addition, each practice is separately provided a unique “key” that is required in order to “open up” and load their practice specific database into PAT. If a practice is inadvertently sent the wrong database, they would not be able to un-encrypt or load that data as the key they had would not match the database; every key is unique. In addition, all users of QNet must be pre-registered and approved and only those users with appropriate designated access can use the tool.

RTI uses CMS’ mainframe computers to store all claims data. The pre-populated PAT data is stored at RTI’s Waltham, Massachusetts facility on a secured server. Only specifically identified programmers with extensive training on handling CMS claims have access to the data. Once collected, the final data is stored in the form of a file that records, for each clinical quality measure, whether a patient is in the numerator and/or denominator of that measure. Thus it is a series of yes/no type fields (“1” / “0”) and does not in any way resemble an electronic medical record.

- B. As noted above, the Medicare HIC number is the only number that allows CMS to link all services received by a beneficiary and then uniquely assign beneficiaries to a physician participating in the demonstration. All use of claims data under these demonstrations are covered under Data Use Agreements.