



**To:** Pay for Performance (P4P) Stakeholders  
**From:** Dolores Yanagihara, P4P Program Director, Integrated Healthcare Association (IHA)  
**Subject:** Proposed Changes to the P4P Program

**2010 P4P Public Comment Period  
September 1 - October 1, 2010**

We invite your review and comment on the proposed changes to the P4P Program. We welcome input on the following:

- proposed measures (testing measures, additions, deletions)
- detailed specifications for the proposed measures
- proposed process and policy changes
- measurement areas you believe should be considered for future inclusion in P4P
- anything else related to the P4P program

**Comments are due by Friday, October 1st to the NCQA Public Comment Website at the following link: <http://publiccomments.ncqa.org>**

Login instructions:

1. Enter your email address
2. If this is the first time using this public comment tool you will be asked to enter your contact information for your organization
3. Product (drop down menu) – Select **P4P Public Comment 2010**
4. Topic (drop down menu) – Select a specific topic you would like to comment on
5. Indicate whether you support, do not support, or support with modifications
6. Type comments in the comment box and note that **text can not exceed 1800 characters**. If you are copying and pasting into the comment box, you must hit enter in order for the character counter tool at the bottom left hand side of the page to count the number of characters in your comments.
7. Once you submit, a page will open up letting you know that your comment has been received. You may also print your comments from this page for your own records, if you like.
8. After you submit a comment, you may continue to add comments to other topics by selecting the “Add More Comments” button.

For your convenience, a summary of proposed changes to the measure set (changes highlighted in red) is provided in Appendix A, starting on page 11. Brief supporting information is also provided in the following pages of this document.

Feedback from physician organizations, health plans and other stakeholders helps shape the direction of the P4P program, and is critical to the success of the program. Thank you for your continued interest and support of P4P.

**Summary of Proposed Changes to the P4P Program**

The following are recommendations from the P4P Technical, Efficiency, Payment, and Executive Committees that were reviewed and approved for public comment by the P4P Steering Committee. These Committees will review all public comment received and finalize changes in November 2010.

**1. Measurement Year 2010 Proposed Measure Additions**

The measures listed below are being proposed for addition to the Measurement Year (MY) 2010 P4P measure set. These measures were successfully tested in 2010 for performance in MY 2009. A summary of testing results is included in Appendix B. Since the “transition year” has been removed, measures that test successfully move directly into the current year measure set, i.e., measures successfully tested in 2010 are added to the MY 2010 measure set. Measure specifications for the proposed MY 2010 measure set are posted on the IHA website in the MY 2010 P4P Manual.

Public reporting and payment measures for MY 2010 are those that will be measured for the period January 1 through December 31, 2010, with reporting and payment in 2011.

a. Clinical Domain

1) Asthma Medication Ratio

This measure assesses the percentage of members 5-50 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medication of .50 or greater during the measurement year.

This measure tested well for MY 2009 and evidence shows it correlates well with outcomes. There is variation in performance across physician organizations (PO), and room for improvement. This measure would replace the previous “Use of Appropriate Medications for People with Asthma” measure which was removed from the measure set in 2009. It is based on the work of the American Academy of Allergy, Asthma and Immunology and American College of Allergy, Asthma and Immunology Joint Quality Measures Task Force.

Although not a current HEDIS measure, NCQA acknowledged that the current HEDIS asthma measure will eventually be retired and a replacement measure introduced. The Asthma Medication Ratio measure is their top candidate for this replacement measure. This type of measure has also been used by Kaiser and Medi-Cal.

2) Childhood Immunization Status – All Antigens

This measure is based on the Childhood Immunization Status (CIS) Combination Rates reported as part of HEDIS. It is an “all or none” measure that assesses the percentage of children that have received all of the antigens currently collected for P4P by their 2<sup>nd</sup> birthday. All of these antigens are recommended by the CDC Advisory Committee on Immunization Practices, AAP and AAFP.

	DTaP	IPV	MMR	Hib	Hep B	VZV	PCV
CIS – All Antigens	✓	✓	✓	✓	✓	✓	✓

The measure tested well for MY 2009 and performance rates showed a reasonable amount of variation across POs and room for improvement.

Other immunization measures that were tested but **not** recommended include Hepatitis A, Rotavirus and another combination. These measures were not recommended due to feedback from stakeholders on timing, dosing, and availability issues.

b. Coordinated Diabetes Care Domain

1) Blood Pressure Control for People with Diabetes <140/90

This is a HEDIS-based measure which assesses the percentage of members 18 – 75 years of age with diabetes (type 1 and type 2) who had their blood pressure in control (<140/90.) The numerator compliance for this measure can be captured using CPT II codes or information from electronic supplemental databases.

This measure was tested for MY 2008 and MY 2009. The committees recognize that there continue to be issues with data collection, but felt physician organizations have been given sufficient time to implement a system for collecting blood pressure data. The clinical importance of blood pressure control was also considered with this recommendation.

The committees recommended **not** moving forward with <130/80 because evidence from the ACCORD trial and subsequent studies confirm that <130/80 could be harmful to some patients.

2) Optimal Diabetes Care – Combination 1

This measure is derived from a similar measure used by the Minnesota Community Measurement Program, and it assesses the percentage of patients 18 – 75 years of age with diabetes (type 1 and type 2) who reached all of the following three treatment goals: Hemoglobin A1c (HbA1c) < 8%, LDL < 100, and Nephropathy Monitoring. This is an “all-or-none” measure and credit for this measure is achieved when all three components are met for a patient.

This measure was tested for MY 2008 and MY 2009. This measure has clinical importance and tested well.

Optimal Diabetes Care Combination 2 is also proposed for collection for MY 2010 but is not recommended for public reporting and payment. Combination 2 includes all of combination 1 in addition to blood pressure control <140/90. This combination may be added to the measurement set in future years.

**2. Measurement Year 2010 Proposed Testing Measures**

Testing measures for MY 2010 are those that will be tested in 2011 using 2010 data. Measures that test successfully will move directly into the MY 2011 measure set. Please note that this is a change in the measure adoption timeline and reflects the removal of the “transition year” as previously approved.

a. Clinical Domain

There are no new clinical measures recommended for testing for MY 2010.

b. Patient Experience Domain

The patient experience continues to be a very important measurement area for P4P Stakeholders, and P4P committees have expressed an interest in enhancing the current Patient Experience Domain, particularly around the care experience and outcomes of people with chronic conditions. The committees also indicated that any efforts to expand the current domain should be in alignment with national efforts.

Upcoming national efforts include development of a Patient Centered Medical Home (PCMH) version of the Clinician and Group CAHPS Survey by a research team sponsored by the Agency for Healthcare Research and Quality (AHRQ) in collaboration with NCQA. This survey is expected to address the following domains: communication, self-management support, whole person orientation, coordination, comprehensiveness, and shared decision-making.

CCHRI is currently working with AHRQ to be a survey test site. In early 2011, there will be an opportunity for some POs to test the PCMH survey – focused on chronically ill patient populations. Areas of most interest to P4P are self-management support, functional status, and team care, as well as the role of IT in effective patient communication.

We would like your feedback on these areas or other areas that are of interest for P4P Stakeholders to enhance the current Patient Experience Domain. Additionally, we are interested in your feedback about the patient experience work focusing on chronically ill patient populations. If testing of new areas/measures is successful for MY 2010, these new areas/measures may be considered for addition to the MY 2011 measure set.

c. Appropriate Resource Use Domain

The P4P committees are recommending testing Total Cost of Care for MY 2010. Measure specifications are available in the MY 2010 P4P Manual posted on IHA's website.

1) Total Cost of Care

As part of the move toward Performance Based Contracting (see Section 5 - MY 2011 Proposed Process and Policy Changes), P4P committees recommend the addition of the Total Cost of Care measure. Total Cost of Care is based upon actual costs associated with care for membership attributed to a PO, including all covered professional, pharmacy, hospital, and ancillary care, as well as other administrative payments and adjustments. The results will be adjusted for health status, geography, and possibly other factors such as affiliation with teaching hospital or other market impacts.

Specifications for this measure were developed by the P4P Technical Efficiency Committee. There is a growing national consensus which supports measurement of total costs, and we expect there will be one or more nationally standardized, endorsed total cost measures in 2011, which may be considered for use in P4P.

The Total Cost of Care measure is scheduled for testing in 2010 and 2011, with baseline results being produced for MY 2011, and incentive payments made starting for MY 2012.

### 3. Measurement Year 2011 Proposed Measure Deletions

#### a. IT-Enabled Systemness Domain

The P4P committees are recommending deletion of the following IT-Enabled Systemness Measures for MY 2011:

- Measure 1: Data Integration for Population Management
- Measure 2: Electronic Clinical Decisions Support at the Point of Care
- Measure 4: Electronic Reporting of Blood Pressure for Patients with Hypertension
- Measure 5: Physician Measurement and Reporting

This recommendation is based on the intent to replace these measures with the Centers for Medicare and Medicaid Services (CMS) and Office of the National Coordinator's (ONC) functional measures of meaningful use of electronic health records (EHR). See the description in Section 4 - MY 2011 Proposed Measure Additions.

### 4. Measurement Year 2011 Proposed Measure Additions

The measures listed below are being proposed by the P4P committees for addition to the MY 2011 P4P measure set. Measure specifications for the proposed MY 2011 measure set are posted on the IHA website in the Draft MY 2011 P4P Manual.

Public reporting and payment measures for MY 2011 are those that will be measured for the period January 1 through December 31, 2011, with reporting and payment in 2012.

#### a. Meaningful Use of Health IT Domain

##### MY 2011 Recommendations

The IT-Enabled Systemness Domain has been renamed to Meaningful Use of Health IT effective MY 2011. The current Systemness Domain has been in place for four years and the committees agreed it was time to evolve the domain. During this same time period, CMS committed to dedicate unprecedented resources to support the adoption and use of EHRs. In addition to the adoption of EHRs, CMS is also supporting the implementation of "meaningful use" measures designed to improve clinical outcomes by leveraging technology.

To support the implementation of technology and eliminate redundancy, the P4P committees recommend aligning with the CMS and ONC regulations of meaningful use measures. Promoting health IT adoption and use will also allow the addition of measures requiring clinically enriched data to the P4P measure set in future years.

To allow flexibility, CMS and ONC established both a "core" and "menu" set of objectives. In order to qualify as a meaningful EHR user, an eligible provider must successfully meet the measure for each objective in the core set and all but five of the objectives in the menu set.

For MY 2011, the P4P recommendation is to adopt all of the 15 core CMS and ONC objectives. The measures will be adopted as specified by CMS at the individual physician level.

Although alignment with national standards is valuable, the committees agreed that maintaining components of the current Systemness standards that exceed the new national standards is

important. Care Management for diabetes, depression, and one other condition – Measure 3B in the current Systemness – is not represented in the CMS/ONC measures of meaningful use. The P4P committees recommend that this Chronic Care Management measure also be retained.

The methodology for scoring at the PO level and detailed specifications for the proposed measures are included in the Draft MY 2011 P4P Manual on the IHA website.

The MY 2011 proposed measures are:

- Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines
- Implement drug-drug and drug-allergy interaction checks
- Generate and transmit permissible prescriptions electronically (eRx)
- Record demographics: preferred language, gender, race, ethnicity, and date of birth
- Maintain an up-to date problem list of current and active diagnoses
- Maintain active medication list
- Maintain active medication allergy list
- Record and chart changes in vital signs: height, weight, blood pressure, calculate and display BMI, and plot and display growth charts for children 2-20 years, including BMI
- Record smoking status for patients 13 years old or older
- Implement one clinical decision support rule relevant to specialty or high clinical priority, along with the ability to track compliance with that rule
- Report ambulatory quality measures to CMS or the State
- Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies), upon request
- Provide clinical summaries for patients for each office visit
- Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, diagnostic test results), among providers of care and patient authorized entities electronically
- Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities
- Chronic Care Management for members identified in the patient population with diabetes, depression, or one other clinically important condition

#### MY 2012 Recommendations

P4P committees reviewed the menu set objectives and agreed that 8 of these objectives are particularly important for P4P, and recommended that these 8 objectives be added to P4P for MY 2012.

The menu set objectives recommended for addition to the measure set for MY 2012 are:

- Implement drug formulary checks
- Incorporate clinical lab-test results into certified EHR technology as structured data
- Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach

- Send reminders to patients per patient preference for preventive/follow up care
- Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, medication allergies)
- Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate
- Perform medication reconciliation for patients received from another setting of care or provider of care or at relevant encounters
- Provide summary of care record for each transition to another setting of care or referral to another provider of care

The committee felt it was important to give advance notice since eligible providers will be selecting menu set objectives to satisfy CMS requirements for 2011. This advance notice will allow POs to focus on the menu set objectives to be added to the P4P measure set in MY 2012.

For Consideration and Feedback

In addition to the recommendations above, the P4P Steering Committee discussed the importance of not losing the current Systemness standards related to population health management, which POs have found valuable for improving health care quality for their members. They suggested seeking stakeholder feedback on whether menu set objectives related to population health management be included for MY 2011, rather than waiting for MY 2012.

The menu set objectives that most closely align with registries and population health management are:

- Generate lists of patients by specific conditions
- Send reminders to patients per patient preference for preventive/follow-up care

We would like input on moving these two menu set objectives into the measure set in MY 2011 rather than waiting until MY 2012.

b. Total Cost of Care Baseline Measurement

The P4P committees are recommending Total Cost of Care as a payable measure for MY 2012. Baseline measurement would be established based on MY 2011. See Section 2 – MY 2010 Proposed Testing Measures for information about the Total Cost of Care measure and Section 5 – MY 2011 Proposed Process and Policy Changes for information on the use of Total Cost of Care in Performance Based Contracting.

**5. Proposed Process and Policy Changes**

a. Encounter Rate Threshold of 4.25 for MY 2011

The encounter rate threshold for MY 2009 was 4.00 encounters per member per year (PMPY), and will remain the same for MY 2010. The goal is to continue to raise the bar for encounter submission and capture, without excluding more than 5% of enrollment. MY 2009 data was utilized to perform an analysis to determine how much of the enrollment would be excluded at different thresholds. This analysis shows that 4.25 encounters PMPY is an appropriate threshold for MY 2011.

b. Domain Weighting for MY 2011

The P4P measure set has been re-structured around the following priority conditions: diabetes, cardiovascular, respiratory, musculoskeletal, maternity, and prevention. These areas were selected based on clinical importance and potential of addressing resource use variation, including overuse of high cost procedures. Each of these selected areas will eventually include measures of clinical quality, as well as resource use metrics.

This restructuring of the measure set included the Coordinated Diabetes Care (CDC) Domain being absorbed into the Clinical Domain as one of the priority conditions. The weighting of the CDC Domain, which was 20%, will be re-distributed to other domains. The committees felt that it made sense to add weight to the Clinical Domain since most of the CDC measures are clinical. They also felt adding weight to the HIT domain will further encourage adoption of the measures. The following P4P domain weightings are being recommended for MY 2011:

Clinical Domain – 50%  
Patient Experience Domain – 20%  
Meaningful Use of Health IT Domain – 30%

c. Performance Based Contracting for MY 2012

Beginning in Measurement Year 2012, P4P committees recommend implementing Performance Based Contracting.

**Objectives:**

The purpose of Performance Based Contracting is to revitalize/retool the P4P program against the backdrop of affordability. The objectives of this strategic initiative are as follows:

- Reorder priorities to emphasize cost control (affordability)
- Continue to promote quality
- Standardize health plan efficiency measures and payment methodology
- Increase the amount of incentive potential

**Current Incentive Environment:**

Currently in California, two separate measurement/incentive pools exist — one for the IHA P4P quality measures, and one for non-IHA health plan utilization measures. All participating health plans use the IHA P4P quality measures, which include Clinical, Coordinated Diabetes Care, IT-Enabled Systemness, and Patient Experience measures. Incentives representing about 1% of PO professional compensation are paid out for performance on these standardized quality measures. In addition, each health plan has its own non-standardized utilization measures. Incentives representing about 2% of PO professional compensation are paid out for these utilization incentives. Incentive payments for these two categories of measures (quality and utilization) equal about 3% of professional compensation when aggregated across all P4P participating health plans.

**Proposed Incentive Environment with Performance Based Contracting:**

Under Performance Based Contracting, achievement of three key activities is expected:

- 1) Harmonize/standardize the utilization metrics and bring utilization incentives under the P4P umbrella

There is a desire to harmonize and standardize the utilization metrics being used by health plans. The key utilization metric proposed is a Total Cost of Care measure, which is scheduled for testing in 2010 and 2011, baseline results for MY 2011, and used for incentive payments starting with MY 2012 (see Section 2 – MY 2010 Proposed Testing Measures for more information).

Underlying key indicators to inform POs about their performance relative to peers in specific aspects of care will continue to be provided. These measures include P4P's current Appropriate Resource Use measures (inpatient acute care discharges per thousand members year (PTMY), bed days PTMY, all-cause readmissions within 30 days, ED Visits PTMY, % Outpatient procedures done in preferred facility, and generic prescribing for seven therapeutic areas) and other metrics used by plans and/or are nationally endorsed by the National Quality Forum.

2) Integrate quality and utilization incentives

Performance Based Contracting will integrate incentives for quality and utilization. Cost efficiency performance will establish the base amount of incentive payment, and quality performance will adjust the base amount. In other words, there will be a single incentive structure which is based on a PO's cost and quality performance.

Cost efficiency performance will be measured by attainment and improvement on Total Cost of Care (TCC) and trend.

Quality performance will be measured by a composite of Clinical, Patient Experience, and Meaningful Use of Health IT measures. Quality performance will act as a multiplier and be applied on a "sliding" scale to the sum of the incentive amount earned based on cost efficiency, assuming the PO meets a minimum quality threshold.

3) Increase amount of incentive potential

The goal is to increase the incentive potential to 7% of professional compensation by 2015. Current PO incentive payments average about 3% of PO professional compensation when combining the IHA P4P quality incentives and the various health plan utilization incentives. Nationally, the average performance incentive payment is about 7%. As part of Performance Based Contracting and measurement of Total Cost of Care, it is expected that larger incentive payouts will be possible through expanded gain-sharing.

**Next Steps:**

To determine the impact of the proposed Performance Based Contracting incentive method, results will be modeled and shared with P4P committees and stakeholders for further vetting. Necessary adjustments will be made and tested before finalizing the recommendation.

**Summary:**

Performance Based Contracting establishes a standardized way to measure both quality and cost of care to enable the uniform calculation of value. It is proposed that this integrated "value score" serve as the basis for determining incentive payments to POs by health plans. The value score can also be used to engage in other value-based purchasing activities, such as creating competition among physician groups through network tiering with differential copayments and engaging consumers in value-based healthcare decisions.

## 6. Measurement Year 2011 Proposed Testing Measures

Testing measures for MY 2011 are those that will be tested in 2012 using 2011 data. We are focused on nationally vetted, standardized measures that would supplement our current measure set. Measures that test successfully for MY 2011 will move directly into the MY 2012 measure set.

### a. Clinical Domain

The P4P committees are giving advanced notice of one testing measure recommended for MY 2011. Additional testing measures may be added at a later date.

#### 1) Controlling High Blood Pressure <140/90

This measure assesses the percentage of patients 18–75 years of age who had a diagnosis of hypertension and whose BP was controlled adequately during the measurement year. Exclusions for this measure include: all patients with evidence of end-stage renal disease, all patients who are pregnant, and all patients who had an admission to a nonacute inpatient setting during the measurement year. The numerator compliance for this measure can be captured using CPT II codes or information from electronic supplemental databases.

This measure is proposed for testing for MY 2011 contingent on an appropriate administrative only measure specification. It is a current HEDIS hybrid measure and the committees agreed it was a good measure, especially since it is being included as one of the “core” clinical measures in the CMS Measures of Meaningful Use. It is not being tested for MY 2010, because there were concerns about it being specified as a hybrid measure and the denominator criteria which only requires one diagnosis of hypertension. The measure will be tested for MY 2011 if NCQA is able to modify it to an administrative only measure.

APPENDIX A

Proposed MY 2011 P4P Measurement Set

	<p><b>Year 8 Measures: 2010 Measurement Year / 2011 Reporting Year</b></p>	<p><b>Proposed Year 9 Measures: 2011 Measurement Year / 2012 Reporting Year</b></p>
<p><b>CLINICAL DOMAIN</b> <i>MEASURES TO BE COLLECTED, REPORTED AND RECOMMENDED FOR PAYMENT</i></p> <p><b>MY 2011 -</b> <i>RESTRUCTURED INTO PRIORITY CONDITIONS</i></p>	<ol style="list-style-type: none"> <li>1. Childhood Immunization Status – <b>Combination of all Antigens</b></li> <li>2. Appropriate Testing for Children with Pharyngitis</li> <li>3. Appropriate Treatment for Children with Upper Respiratory Infection</li> <li>4. Chlamydia Screening in Women</li> <li>5. Evidence-Based Cervical Cancer Screening</li> <li>6. Breast Cancer Screening</li> <li>7. Colorectal Cancer Screening</li> <li>8. Cholesterol Management LDL Screening (Pts. w/ Cardiovascular Conditions)</li> <li>9. Cholesterol Management: LDL Control &lt;100 (Pts. w/ Cardiovascular Conditions)</li> <li>10. Medication Monitoring (ACE/ARBs, Digoxin, and Diuretics)</li> <li>11. Avoidance of Antibiotic Treatment of Adults with Acute Bronchitis</li> <li>12. Use of Imaging Studies for Low Back Pain</li> <li>13. Adolescent Immunizations – Combination of Tdap and Meningococcal</li> <li>14. <b>Asthma Medication Ratio</b></li> </ol>	<p><u>Cardiovascular</u></p> <ol style="list-style-type: none"> <li>1. Medication Monitoring (ACE/ARBs, Digoxin, and Diuretics)</li> <li>2. Cholesterol Management LDL Screening</li> <li>3. Cholesterol Management: LDL Control &lt;100</li> </ol> <p><u>Diabetes</u></p> <ol style="list-style-type: none"> <li>1. HbA1c Screening</li> <li>2. HbA1c Poor Control &gt;9%</li> <li>3. HbA1c Control &lt;8%</li> <li>4. HbA1c Control &lt;7%</li> <li>5. LDL Screening</li> <li>6. LDL Control &lt;100</li> <li>7. Nephropathy Monitoring</li> <li>8. Blood Pressure Control for People with Diabetes &lt;140/90</li> <li>9. Optimal Diabetes Care Combo 1 (LDL&lt;100, HbA1c&lt;8%, Nephropathy Monitoring)</li> </ol> <p><u>Maternity</u></p> <p><u>Musculoskeletal</u></p> <ol style="list-style-type: none"> <li>1. Use of Imaging Studies for Low Back Pain</li> </ol> <p><u>Prevention</u></p> <ol style="list-style-type: none"> <li>1. Childhood Immunization Status – Combination of all antigens</li> <li>2. Adolescent Immunizations – Combination of Tdap and meningococcal</li> <li>3. Chlamydia Screening in Women</li> <li>4. Evidence-Based Cervical Cancer Screening</li> <li>5. Breast Cancer Screening</li> <li>6. Colorectal Cancer Screening</li> </ol> <p><u>Respiratory</u></p> <ol style="list-style-type: none"> <li>1. Asthma Medication Ratio</li> <li>2. Appropriate Testing for Children with Pharyngitis</li> <li>3. Appropriate Treatment for Children with Upper Respiratory Infection</li> <li>4. Avoidance of Antibiotic Treatment of Adults with Acute Bronchitis</li> </ol>

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	Year 8 Measures: 2010 Measurement Year / 2011 Reporting Year	Proposed Year 9 Measures: 2011 Measurement Year / 2012 Reporting Year
<b>PO Encounter Threshold for reporting<sup>1</sup></b>	4.00 Encounters per member per year (using Encounter Rate by Service Type specs)	<b>4.25</b> Encounters per member per year
<i>Clinical Weighting</i>	40%	<b>50%</b>
<b>COORDINATED DIABETES CARE</b> <i>MEASURES TO BE COLLECTED, REPORTED AND RECOMMENDED FOR PAYMENT</i>	<ol style="list-style-type: none"> <li>1. HbA1c Screening</li> <li>2. HbA1c Poor Control &gt;9%</li> <li>3. HbA1c Control &lt;8%</li> <li>4. HbA1c Control &lt;7%</li> <li>5. LDL Screening</li> <li>6. LDL Control &lt;100</li> <li>7. Nephropathy Monitoring</li> <li>8. <b>Blood Pressure Control for People with Diabetes &lt;140/90</b></li> <li>9. <b>Optimal Diabetes Care Combo 1 (LDL&lt;100, HbA1c &lt;8%, Nephropathy Monitoring)</b></li> <li>10. Diabetes Registry and related activities</li> <li>11. Diabetes Care Management Program</li> </ol>	<b>MOVED TO CLINICAL DOMAIN AS ONE OF THE PRIORITY CONDITIONS</b>
<i>Coordinated Diabetes Care Weighting</i>	20%	
<b>PATIENT EXPERIENCE DOMAIN</b> <i>MEASURES TO BE COLLECTED, REPORTED AND RECOMMENDED FOR PAYMENT</i>	<ol style="list-style-type: none"> <li>1. Getting Appointment with a Specialist</li> <li>2. Rating of Specialist</li> <li>3. Timely Care and Service composite</li> <li>4. Doctor-Patient Interaction composite</li> <li>5. Care Coordination composite</li> <li>6. Rating of PCP</li> <li>7. Rating of all Healthcare</li> <li>8. Office Staff composite</li> <li>9. Health Promotion composite</li> </ol>	<ol style="list-style-type: none"> <li>1. Getting Appointment with a Specialist</li> <li>2. Rating of Specialist</li> <li>3. Timely Care and Service composite</li> <li>4. Doctor-Patient Interaction composite</li> <li>5. Care Coordination composite</li> <li>6. Rating of PCP</li> <li>7. Rating of all Healthcare</li> <li>8. Office Staff composite</li> <li>9. Health Promotion composite</li> </ol>
<i>Patient Experience Weighting</i>	20%	20%

<sup>1</sup>PO Encounter Threshold refers to the average number of encounters per member per year required for data to be included in clinical data aggregation and public reporting. For the purposes of payment, individual health plans may use a different encounter threshold. Please see P4P Manual for more information.

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	<p><b>Year 8 Measures: 2010 Measurement Year / 2011 Reporting Year</b></p>	<p><b>Proposed Year 9 Measures: 2011 Measurement Year / 2012 Reporting Year</b></p>
<p><b>IT-ENABLED SYSTEMNESS DOMAIN</b> <i>MEASURES TO BE COLLECTED, REPORTED AND RECOMMENDED FOR PAYMENT</i></p> <p><i>MY 2011 – RENAMED TO MEANINGFUL USE OF HEALTH IT</i></p>	<ol style="list-style-type: none"> <li>1. Data Integration for Population Management               <ol style="list-style-type: none"> <li>a. Reporting Based on Electronic Information</li> <li>b. Identifying Important Conditions</li> </ol> </li> <li>2. Electronic Clinical Decision Support at the Point of Care</li> <li>3. Care Management               <ol style="list-style-type: none"> <li>a. Coordination with Practitioners</li> <li>b. Chronic Care Management</li> <li>c. Continuity of Care</li> </ol> </li> <li>4. <b>Electronic Reporting of Blood Pressure for People with Hypertension</b></li> <li>5. Physician Measurement and Reporting</li> </ol>	<ol style="list-style-type: none"> <li>1. <b>Use of CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines</b></li> <li>2. <b>Implement drug-drug and drug-allergy interaction checks</b></li> <li>3. <b>Generate and transmit permissible prescriptions electronically (eRx)</b></li> <li>4. <b>Record demographics: preferred language, gender, race, ethnicity, date of birth</b></li> <li>5. <b>Maintain an up-to date problem list of current and active diagnoses</b></li> <li>6. <b>Maintain active medication list</b></li> <li>7. <b>Maintain active medication allergy list</b></li> <li>8. <b>Record and chart changes in vital signs: Height, Weight, Blood Pressure, Calculate and display BMI, Plot and display growth charts for children 2-20 years including BMI</b></li> <li>9. <b>Record smoking status for patients 13 years old or older</b></li> <li>10. <b>Implement one clinical decision support rule relevant to specialty or high clinical priority, along with the ability to track compliance with that rule</b></li> <li>11. <b>Report ambulatory clinical quality measures to CMS or the States</b></li> <li>12. <b>Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies), upon request</b></li> <li>13. <b>Provide clinical summaries for patients at each office visit</b></li> <li>14. <b>Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, diagnostic test results), among providers of care and patient authorized entities electronically</b></li> <li>15. <b>Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities</b></li> <li>16. <b>Chronic Care Management</b> <ol style="list-style-type: none"> <li>a. <b>Diabetes</b></li> <li>b. <b>Depression</b></li> <li>c. <b>Other Condition</b></li> </ol> </li> </ol>

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	Year 8 Measures: 2010 Measurement Year / 2011 Reporting Year	Proposed Year 9 Measures: 2011 Measurement Year / 2012 Reporting Year
<i>IT-Enabled Systemness Weighting</i>	20%	30%
<b>EFFICIENCY DOMAIN</b>	<ol style="list-style-type: none"> <li>1. Inpatient Utilization—Acute Care Discharges PTMY</li> <li>2. Inpatient Utilization—Bed Days PTMY</li> <li>3. Inpatient Readmission Within 30</li> <li>4. Emergency Department Visits PTMY</li> <li>5. Outpatient Procedures Utilization—% Done in Preferred Facility</li> <li>6. Generic Prescribing (7 therapeutic areas)</li> </ol>	<ol style="list-style-type: none"> <li>1. Inpatient Utilization—Acute Care Discharges PTMY</li> <li>2. Inpatient Utilization—Bed Days PTMY</li> <li>3. Inpatient Readmission Within 30</li> <li>4. Emergency Department Visits PTMY</li> <li>5. Outpatient Procedures Utilization—% Done in Preferred Facility</li> <li>6. Generic Prescribing (7 therapeutic areas)</li> <li>7. <b>Total Cost of Care (baseline)</b></li> </ol>
<i>Efficiency Weighting</i>	Gain-sharing	Gain-sharing
<b>REPORTABLE NON-PAYMENT MEASURES</b> <i>MEASURES TO BE COLLECTED AND PUBLICLY REPORTED, BUT NOT RECOMMENDED FOR PAYMENT</i>	<ol style="list-style-type: none"> <li>1. Medicare Measures: <ol style="list-style-type: none"> <li>a. Breast Cancer Screening</li> <li>b. Diabetes Care HbA1c Screening</li> <li>c. Diabetes Care HbA1c Poor Control &gt;9%</li> <li>d. Diabetes Care HbA1c Control &lt;8%</li> <li>e. Cholesterol Management LDL Screening (Pts. w/ Cardiovascular Conditions and Diabetics)</li> <li>f. Cholesterol Management: LDL Control &lt;100 (Pts. w/ Cardiovascular Conditions and Diabetes)</li> <li>g. Nephropathy Monitoring for Diabetic Patients</li> <li>h. Colorectal Cancer Screening</li> </ol> </li> </ol>	<ol style="list-style-type: none"> <li>1. Medicare Measures: <ol style="list-style-type: none"> <li>a. Breast Cancer Screening</li> <li>b. Diabetes Care HbA1c Screening</li> <li>c. Diabetes Care HbA1c Poor Control &gt;9%</li> <li>d. Diabetes Care HbA1c Control &lt;8%</li> <li>e. Cholesterol Management LDL Screening (Pts. w/ Cardiovascular Conditions and Diabetics)</li> <li>f. Cholesterol Management: LDL Control &lt;100 (Pts. w/ Cardiovascular Conditions and Diabetes)</li> <li>g. Nephropathy Monitoring for Diabetic Patients</li> <li>h. Colorectal Cancer Screening</li> </ol> </li> </ol>
<b>TESTING MEASURES</b> <i>MEASURES TO BE COLLECTED FOR TESTING AND ANALYSIS</i>	<u>Patient Experience</u> <ol style="list-style-type: none"> <li>1. <b>Measures that focus on Chronically Ill Patient Populations</b></li> </ol> <u>Efficiency</u> <ol style="list-style-type: none"> <li>2. <b>Total Cost of Care</b></li> </ol>	<u>Clinical</u> <ol style="list-style-type: none"> <li>1. <b>Controlling High Blood Pressure</b></li> </ol>

## APPENDIX B

## 2010 Testing Results for Commercial HMO/POS

**Blood Pressure Control in People with Diabetes <140/90****Table 1: Self-Reporting PO and Health Plan Reported Results**

	# of POs	HEDIS Mean	P4P Mean	10th%	25th%	50th%	75th%	90th%
PO Self-Reported	37	65.14%	44.10%	0	0.26	57	81.8	84.32
Health Plan Reported	175	65.14%	0.66%	0	0	0	0	0.66

**National benchmark:**

HEDIS performance on the Comprehensive Diabetes Care Blood Pressure Control in People with Diabetes <140/90 for 2009 ranged between 0.1% and 83.7%.

**Optimal Diabetes Care****Table 2a: Self-Reporting PO Results**

	# of POs	P4P Mean	10th%	25th%	50th%	75th%	90th%
Combination 1	36	34.82%	18.83%	27.25	38.89	43	45.98
Combination 2	36	20.04%	0	0.06	25.36	37.58	39.95

**Table 2b: Health Plan Reported Results**

	# of POs	P4P Mean	10th%	25th%	50th%	75th%	90th%
Combination 1	175	14.91%	0.13	4.15	16.18	23.76	27.82
Combination 2	175	0.21%	0.00	0.00	0.00	0.00	0.13

**Benchmark: Minnesota (MN) Community Measurement Program Results**

Minnesota's Optimal Diabetes Care measure assesses the percentage of patients with diabetes (type 1 and type 2) ages 18 – 75 who reached all of the following five treatment goals: Hemoglobin A1c (HbA1c) < 7%, blood pressure < 130/80 mm Hg, LDL < 100mg/dL, daily aspirin use (ages 41 – 75), and documented tobacco-free status. Credit for this measure is achieved when all five components are met for a patient. MN Community Measurement ranged between 3% and 44% for performance on the five components. Since the proposed P4P measure has fewer components and less stringent control criteria, we would expect P4P results to be higher than Minnesota's results.

## APPENDIX B

**Childhood Immunization Status – All Antigens****Table 3: Self-Reporting PO and Health Plan Reported Results**

	# of POs	HEDIS Mean	P4P Mean	10th%	25th%	50th%	75th%	90th%
PO Self-Reported	39	73.37%	70.26%	33.82	62.22	78.05	85.83	88.08
Health Plan Reported	105	73.37%	32.26%	10.91	19.88	30.23	41.86	54.72

***National Benchmark:***

HEDIS performance on the Childhood Immunization Status – All Antigens for 2009 ranged between 15.58% and 89.80%.

**Asthma Medication Ratio****Table 4a: Self-Reporting PO Results**

Age	# of POs	P4P Mean	10th%	25th%	50th%	75th%	90th%
5-11	23	63.88%	55.38	59.07	65.12	67.95	77.36
12-50	20	64.36%	37.75	58.67	66.46	74.38	81.58
5-50	23	63.76%	53.22	58.65	64.89	69.98	75.64

**Table 4b: Health Plan Reported Results**

Age	# of POs	P4P Mean	10th%	25th%	50th%	75th%	90th%
5-11	119	55.04%	41.57	46.76	54.31	62.99	70.27
12-50	68	61.37%	50.00	53.37	60.36	68.55	75.56
5-50	125	56.46%	43.59	49.18	55.95	63.92	70.67

***National Benchmark:***

This measure is not being collected in any other comparable programs, and benchmark data is not available. The measure is being considered for future HEDIS implementation.