

P4P Public Comment Summary - December 2011

Measure	Support	Support with modifications	Do Not Support	Total	P4P Technical Quality Committee and Steering Committee Recommendation
Human Papillomavirus (HPV) Vaccine for Adolescent Females	1	2	1	4	Test as stand alone measure in MY 2011; do not test as part of combo
Patient Experience Domain: Chronic Care Measure(s)	1	0	1	2	Do not add; PAS did not add any chronic care measures
Proportion of Days Covered (PDC) – ACEI/ARB	3	1	1	5	Test for MY 2011
Proportion of Days Covered (PDC) – Statins	3	1	1	5	Test for MY 2011
Proportion of Days Covered (PDC) – Biguanides	2	1	3	6	Do not test individual diabetes drug classes
Proportion of Days Covered (PDC) – DiPeptidyl Peptidase (DPP)-IV Inhibitors	2	1	3	6	Do not test individual diabetes drug classes
Proportion of Days Covered (PDC) – Sulfonylureas	2	1	3	6	Do not test individual diabetes drug classes
Proportion of Days Covered (PDC) – Thiazolidinediones	2	1	3	6	Do not test individual diabetes drug classes
Proportion of Days Covered (PDC) – Diabetes Roll-up	4	1	1	6	Do not test individual diabetes drug classes
Use of Spirometry Testing for COPD (SPR)	2	0	1	3	Test for MY 2011
Appropriate Resource Use	1	0	0	1	
MY 2011 Testing Measures - Total	23	9	18	50	
Measure 16: Generate patient lists by specific conditions	2	0	0	2	Remove for MY 2012
Measure 17: Send patient reminders per patient preference	2	0	0	2	Remove for MY 2012
MY 2012 Measure Deletions - Total	4	0	0	4	
Total Cost of Care - Baseline	1	0	1	2	
Within-PO Performance Variation Measurement	0	0	1	1	Work still underway
Measures 16-20: Any (5) CMS/ONC Menu Set measures	1	0	0	1	Add to MY 2012 measure set
Relative Resource Use (RAS) – Asthma	2	0	1	3	Do not adopt for MY 2012
Relative Resource Use (RCA) – Cardiovascular	2	0	1	3	Do not adopt for MY 2012
Relative Resource Use (RDI) – Diabetes	2	0	1	3	Do not adopt for MY 2012
MY 2012 Measure Additions - Total	8	0	5	13	
Encounter Rate Threshold for MY 2012	1	1	0	2	Remove for MY 2012
P4P Process and Policy Changes - Total	1	1	0	2	
Asthma Medication Ratio	0	1	0	1	Align with HEDIS
Breast Cancer Screening	2	0	1	3	Leave as is
Childhood Immunization Status	1	3	0	4	Leave as is
Immunizations for Adolescents	0	3	0	3	Only recommend Tdap for payment and public reporting
Evidence Based Cervical Cancer Screening	0	2	1	3	Add ICD-9 code 279 for immunodeficiency as an exclusion
Use of Imaging Studies for Low Back Pain	0	1	0	1	Leave as is
Miscellaneous	1	0	0	1	
MUHIT	2	2	1	5	Propose change to eligible population
Survey Measures	0	1	0	1	Work still underway
Value Based P4P	0	1	0	1	
Appropriate Resource Use	0	0	1	1	
MY 2011 Other Comments - Total	6	14	4	24	

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#	Element	Org Name	Feedback Type	Comments	Response
1	Human Papillomavirus (HPV) Vaccine for Adolescent Females	GlaxoSmithKline	Support	<p>GSK strongly supports the testing of the measure of HPV vaccination for adolescent females as part of the measure Immunizations for Adolescents and as a standalone measure. This measure is consistent with ACIP, ACOG, AAP and AAFP guidelines. Virtually all cases of cervical cancer are related to HPV infections and are most prevalent among young persons within the first few years after sexual debut.(1-7) Infections with low-risk HPV types can cause benign or low-grade changes in cells of the cervix, genital warts and recurring respiratory papillomatosis. High-risk HPV types can cause cervical, anal and other genital cancers. High-risk HPV types are detected in 99.7% of cervical cancers. At least 70% of cervical cancers worldwide are due to HPV types 16 and 18. (8,9) References will be sent separately.</p> <p>References for comments previously submitted: 1) Saslow D et al. CA Can J Clinicians 2007;57:7-28. 2) Weinstock H, Berman S, Cates W. Sexually transmitted infections in American youth: incidence and prevalence estimates, 2000. Perspect Sex Reprod Health. 2004;36:6-10. 3) Revzina NV, Diclemente RJ. Prevalence and incidence of human papillomavirus infection in women in the USA: a systematic review. Int J STD AIDS. 2005;16:528-537. 4) Tarkowski TA, Koumans EH, Sawyer M, et al. Epidemiology of human papillomavirus infection and abnormal cytologic test results in an urban adolescent population. J Infect Dis. 2004;189:46-50. 5) Winer RL, Lee SK, Hughes JP, Adam DE, Kiviat NB, Koutsky LA. Genital human papillomavirus: infection incidence and risk factors in a cohort of female university students. Am J Epidemiol. 2003;157:218-226. 6) Trottier H, Franco EL. The epidemiology of genital human papillomavirus infection. Vaccine. 2006;24(suppl 1):S1-S15. 7) Manhart LE, Holmes KK, Koutsky LA, et al. Human papillomavirus infection among sexually active young women in the United States: implications for developing a vaccination strategy. Sex Transm Dis. 2006;33:502-508. 8) Walboomers JM, Jacobs MV, Manos MM, et al. Human papillomavirus is a necessary cause of invasive cervical cancer worldwide. J Pathol. 1999;189:12-19. 9) Bosch FX, de Sanjose S. Chapter 1: human papillomavirus and cervical cancer-burden and assessment of causality. J Natl Cancer Inst Monogr. 2003;(31):3-13.</p>	<p>Thank you for your feedback.</p> <p>TQC/SC: Test HPV but only as a stand alone measure for two reasons:</p> <p>(a) Avoids incomparability of combo rate for males and females due to different number of vaccines.</p> <p>(b) Aligns with HEDIS.</p>
2	Human Papillomavirus (HPV) Vaccine for Adolescent Females	CIGNA HealthCare of California	Support with modification	<p>Provided IHA makes this a standalone measure as HEDIS does we support this measure being added to P4P. We do not support the proposed specification to embed the HPV component for females within the male and female IMA measure. To do so would no longer measure immunizations for adolescents within a PO, it would measure immunizations for adolescents given gender demographic distributions within and across POs. Furthermore, the programming required to deviate so widely from the HEDIS specifications represents an unnecessary burden for plans.</p>	<p>We planned to test this as both a standalone measure and as part of a combination. TQC will discuss whether to proceed with the combination, and if so, whether to calculate separate combinations for males and for females.</p> <p>TQC/SC: Please see Testing Measures response #1.</p>

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3	Human Papillomavirus (HPV) Vaccine for Adolescent Females	Kaiser Permanente	Support with modification	The Permanente Medical Groups (SCPMG and TPMG) support the inclusion of the HPV vaccine measure as a stand-alone measure, but question the utility of combining with the overall adolescent combination. The HPV rates only apply to female adolescents, so the adolescent immunization combo rates would be incomparable between male and female adolescents. A PO's results on the combined measure would be influenced by the proportion of male versus female adolescents.	TQC/SC: Please see Testing Measures responses #1 and 2.
4	Human Papillomavirus (HPV) Vaccine for Adolescent Females	Bristol Park Medical Group/Memorial Care Medical Group	Do NOT Support	1. CDC, ACIP, and AAP support use of HPV4 (quadrivalent, aka Gardasil) OR HPV2 (bivalent, aka Cervarix) for protection of cervical cancer, but the proposed measure only includes the quadrivalent vaccine. 2. Although only anecdotal evidence, there is enormous controversy regarding this vaccine, not necessary in terms of safety, but in terms of its social implications with regards to sexual activity. There are huge disparities in my experience in rates of vaccine refusal among various cultural, religious, and socioeconomic groups. Unless "refusal to vaccinate" could exclude patients from the denominator, I do not feel that calculating compliance rates for this vaccine is a reliable or fair way to measure quality care.	1. We accept both referenced HPV4 and HPV2 codes. 2. Once we get the testing results we can examine if there are regional differences in performance that may be the result of social disparities. Patient refusals are not considered numerator hits or valid exclusions for any of the HEDIS or P4P measures. The intent of the measures is to assess whether the patient received the service. Therefore, patients who refuse services remain in the measure denominators and are not counted in the numerator. TQC/SC: Please see Testing Measures responses #1 and 2.
5	Patient Experience Domain: Chronic Care Measure(s)	GlaxoSmithKline	Support	GSK strongly supports IHA's continued work with CCHRI to identify appropriate patient experience measures and chronic care measures. The impact of chronic illness on people's lives, healthcare expenditures is significant. 49% of Americans have at least one chronic disease.(1) 75 cents of every healthcare dollar is spent on chronic disease.(2) Approximately 54 million people in the U.S. have pre-diabetes.(3) The percent of children and youth who are overweight has tripled since 1980.(4) Life expectancy has recently dropped for the first time in about 100 years.(5) Development and use of patient experience chronic care measures is an important part of addressing patient outcomes and cost. 1) Gerry Anderson, Chronic Conditions: Making the Case for Ongoing Care", analysis of the 2004 Medical Expenditure Panel Survey, November 2007. Published in Profile 2008 Pharmaceutical Industry, by PHRMA. 2) CDC, "Chronic Disease Overview: Cost of Chronic Disease," available at http://www.cdc.gov/nccdphp/overview.htm , accessed August, 2008. 3) CDC, Diabetes At a Glance, January 2008. Downloadable at http://www.cdc.gov/nccdphp/publications/aag/pdf/diabetes.pdf . 4) CDC Obesity Report 11 5. Brown, David. Life Expectancy Drops for some U.S. Women. The Washington Post, April 22, 2008.	Thank you for your feedback.

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6	Patient Experience Domain: Chronic Care Measure(s)	Kaiser Permanente	Do NOT Support	For MY 2011, the CCHRI Executive Committee approved the CCHRI PAS Project Committee's recommendation to replace the chronic care management questions with more generic self-care management questions. The Permanente Medical Groups encourage IHA to follow the CCHRI recommendation.	While P4P hoped to influence CCHRI to include Chronic Care measures, P4P's PAS options are limited by CCHRI's reporting decisions. TQC/SC: No further discussion.
7	Proportion of Days Covered (PDC) – ACEIs/ARBs	GlaxoSmithKline	Support	GlaxoSmithKline strongly supports all of the proposed 2011 testing of the Medication Adherence (PDC) measures developed by PQA. Seeking and following medical advice can help millions avoid chronic illness and prevent complications. For many Americans with chronic diseases, treatment often involves taking medications for long periods of time to avoid the costly complications of unmanaged disease. Unfortunately, only half of patients take their medications as directed.(1) This "non-adherence" increases health care costs, including up to \$100 billion a year in hospital admissions alone.(1) Non-adherence also takes a significant human toll, including increased hospitalizations, nursing home admissions, physician visits, and as many as 125,000 deaths a year.(2) With the popular interest in preventing hospital and nursing home readmissions, improved medication adherence offers significant opportunity with the potential to avoid both initial admissions and costly readmissions. Researchers found significantly lower hospitalization rates for patients with high medication adherence rates – resulting in a \$4 to \$7 reduction in health care costs for every additional \$1 spent on medication.(3) 1) L. Osterberg, Blaschke T. Adherence to medication. N Engl J Med. 2005 Aug 4;353(5): 487-97. New England Healthcare Institute, 2009. 2) McCarthy R, "The Price You Pay for the Drug Not Taken," Bus Health 16:27-33 (1998). 3) Sokol MC, et al., "Impact of Medication Adherence on Hospitalization Risk and Health care Cost," Medical Care (June 2005).	Thank you for your feedback. TQC/SC: Test the PDC-ACEI/ARB measure. (a) This is a Medicare Stars Measure. (b) Staff will ask plans if they have any data on generic Rx filled at external retail chains, and if so, do they share it with POs? (c) Staff to work with PQA on FAQ to explain how to handle order reversals. (d) Concern that all PDC measures will show a bias towards 30-day fills. P4P added data collection elements to capture information to analyze this.
8	Proportion of Days Covered (PDC) – ACEIs/ARBs	Kaiser Permanente	Support	The Permanente Medical Groups (SCPMG and TPMG) support this measure because it aligns with CMS Star Quality Report. For the Medicare population, the denominator should be restricted to Part D members.	Thank you for your feedback. As currently specified, all Medicare Advantage members would be included in the denominator. TQC/SC: Please see Testing Measures response #7.
9	Proportion of Days Covered (PDC) – ACEIs/ARBs	Blue Shield of California	Support	These are non-HEDIS measures. Blue Shield will have to program these measures from scratch. Since specifications are not available at this time, Blue Shield cannot fully estimate the time and resources needed to comply with these measures.	Blue Shield put this measure forward for P4P consideration. Specifications were included in the MY 2011 P4P Manual posted as part of Public Comment on Sept 1. TQC/SC: Please see Testing Measures response #7.

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10	Proportion of Days Covered (PDC) – ACEIs/ARBs	Hill Physicians Medical Group	Support with modification	Clinical Measures which have a prescription component in clinical management/control 1. Examples include use of ACEs/ARBs for nephropathy 2. Asthma The numbers of insured enrollees who fill their prescriptions using \$4 “plans” are affected as noted in this November 2010 NEJM article. http://www.nejm.org/doi/full/10.1056/NEJMp1006189 . Using a “hit” of a prescription fill is rapidly becoming a process measure which clinicians question as more retail chains offer similar programs and add more drugs to the \$4 list. Estimates do not appear to be readily available from the chain pharmacies, but have ranged as high as 10% for insured enrollees.	1. P4P generally aligns with standardized measures where available. In this case, CMS is using three PDC measures for evaluation of Medicare plans. Those 3 measures are for ACEI/ARB, statins and oral diabetes medications (rollup for the diabetes medications, but not a breakout for individual diabetes classes due to frequent switching between classes). TQC will consider whether to continue with testing of the individual diabetes drugs. 2. The concern about the generic prescriptions being missing from drug claims is frequently expressed; however, it seems reasonable that the limitations for these data apply equally to all POs. Therefore, all POs/physicians face the potential loss of some data, but it likely doesn’t bias the measure against any particular PO. Additionally, the plans can work with the pharmacies in their network to minimize the loss of data by requiring the pharmacies to submit the claims but with an adjusted copayment. Some plans have also kept the generic copayments to \$4 to negate any incentive for patients to go outside the system. TQC/SC: Please see Testing Measures response #7.
11	Proportion of Days Covered (PDC) – ACEIs/ARBs	CIGNA HealthCare of California	Do NOT Support	This is a non-HEDIS measure with complex programming required. P4P should align with HEDIS measures whenever possible to reduce the burden on plans participating in the P4P program.	Thank you for your feedback. This measures aligns with the Medicare Stars program. TQC/SC: Please see Testing Measures response #7.
12	Proportion of Days Covered (PDC) – Statins	GlaxoSmithKline	Support	Please see Testing Measures comment # 7.	TQC/SC: Test the PDC-Statins measure. Please also see Testing Measures response #7 items (a)-(d).
13	Proportion of Days Covered (PDC) – Statins	Kaiser Permanente	Support	Please see Testing Measures comment #8.	TQC/SC: Please see Testing Measures response #12.
14	Proportion of Days Covered (PDC) – Statins	Blue Shield of California	Support	Please refer to Testing Measures comment #9.	TQC/SC: Please see Testing Measures response #12.

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15	Proportion of Days Covered (PDC) – Statins	Hill Physicians Medical Group	Support with modification	Please refer to Testing Measures comment #10.	TQC/SC: Please see Testing Measures response #12.
16	Proportion of Days Covered (PDC) – Statins	CIGNA HealthCare of California	Do NOT Support	Please refer to Testing Measures comment #11.	TQC/SC: Please see Testing Measures response #12.
17	Proportion of Days Covered (PDC) – Diabetes Individual Rates	GlaxoSmithKline	Support	Please refer to Testing Measures comment # 7.	TQC/SC: Do <u>not</u> test individual diabetes measures for 3 main reasons: (a) While the individual measures may be helpful to collect from a diagnostic standpoint, the roll-up is more appropriate for public reporting. (b) Medicare Stars did not adopt the individual diabetes measures. (c) Switching drugs is a bigger issue in the individual diabetes measure. The roll-up over estimates adherence since all medications are in the same bucket while the individual rate, under estimates adherence.
18	Proportion of Days Covered (PDC) – Diabetes Individual Rates	Blue Shield of California	Support	Please refer to Testing Measures comment #9.	TQC/SC: Please see Testing Measures response #17.
19	Proportion of Days Covered (PDC) – Diabetes Individual Rates	Hill Physicians Medical Group	Support with modification	Please refer to Testing Measures comment #10.	TQC/SC: Please see Testing Measures response #17.
20	Proportion of Days Covered (PDC) – Diabetes Individual Rates	CIGNA HealthCare of California	Do NOT Support	Please refer to Testing Measures comment #11.	TQC/SC: Please see Testing Measures response #17.
21	Proportion of Days Covered (PDC) – Diabetes Individual Rates	Kaiser Permanente	Do NOT Support	The Permanente Medical Groups (SCPMG and TPMG) do not support this measure because the CMS Star Quality Report does not include PDC for the individual diabetes medication classes. We support only the Diabetes Roll-up.	TQC/SC: Please see Testing Measures response #17.

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22	Proportion of Days Covered (PDC) – Diabetes Individual Rates	Pacific Partners Management Services, Inc.	Do NOT Support	The PDC measure reports on 6 different drug categories (4 of them diabetes-related) as well as a Diabetes Roll-Up measure. Why is the diabetes Rx measure split up into four separate categories? The diabetes roll-up (includes all diabetic medications) seems to be a better measures of diabetic medication compliance. What if a patient switches prescriptions across different diabetic Rx categories within a measurement year? For instance, what if a patient was on a biguanide for the first 6 months then on a sulfonylurea the final 6 months. In the original PQA measure specifications, the patient would be eligible for both categories, but would fail the biguanide PDC because their rate is 50% (measurement period is defined as the index prescription date to end of calendar year per the PQA measure specifications). Overall, the Diabetes Roll-up seems to be a better measure of diabetes medication compliance compared to the separate diabetes Rx categories.	TQC/SC: Please see Testing Measures response #17.
23	Proportion of Days Covered (PDC) – Diabetes Roll-up	GlaxoSmithKline	Support	Please see Testing Measures comment # 7.	TQC/SC: Test the PDC- Diabetes Roll-Up measure. (a) This is a Medicare Stars measures. (b) Please also see Testing Measures response #7 items (a)-(d).
24	Proportion of Days Covered (PDC) – Diabetes Roll-up	Kaiser Permanente	Support	Please see Testing Measures comment #8.	TQC/SC: Please see Testing Measures response #23.
25	Proportion of Days Covered (PDC) – Diabetes Roll-up	Blue Shield of California	Support	Please see Testing Measures comment #9.	TQC/SC: Please see Testing Measures response #23.
26	Proportion of Days Covered (PDC) – Diabetes Roll-up	Pacific Partners Management Services, Inc.	Support	Please see Testing Measures comment #22.	TQC/SC: Please see Testing Measures response #23.
27	Proportion of Days Covered (PDC) – Diabetes Roll-up	Hill Physicians Medical Group	Support with modification	Please see Testing Measures comment #10.	TQC/SC: Please see Testing Measures response #23.
28	Proportion of Days Covered (PDC) – Diabetes Roll-up	CIGNA HealthCare of California	Do NOT Support	Please see Testing Measures comment #11.	TQC/SC: Please see Testing Measures response #23.

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#	Element	Org Name	Feedback Type	Comments	Response
29	Use of Spirometry Testing for COPD (SPR)	CIGNA HealthCare of California	Support	This measure follows the HEDIS specifications and therefore poses no additional burden on plans.	TQC will consider the following: <ol style="list-style-type: none"> 1. No longer a Medicare Stars measure. 2. Potentially small denominator for commercial population at PO level. 3. Limited opportunity for improvement. 4. Feedback from NCQA on the measure is that many physicians are not reimbursed for this service and do not have the equipment in their offices. This is one of the reasons why the rates are low. TQC/SC: Do <u>not</u> test for the 4 reasons listed above.
30	Use of Spirometry Testing for COPD (SPR)	GlaxoSmithKline	Support	GSK strongly supports the addition of Spirometry testing for COPD to the testing group. COPD entails substantial societal costs. 1. Current diagnosis and treatment standards state unequivocally that spirometry is required for the diagnosis of COPD. Disease severity is also determined with spirometry results. From the 2004 American Thoracic Society standards. 2. "The diagnosis (of COPD) requires spirometry...Spirometric classification has proved useful in predicting health status, utilization of healthcare resources, development of exacerbations and mortality in COPD. It is intended to be applicable to populations and not to substitute clinical judgment in the evaluation of the severity of disease in individual patients." The "GOLD" guidelines, a collaboration between the NIH and WHO(3) also recommend the use of spirometry: "A diagnosis of COPD should be considered in any patient who has cough, sputum production, or dyspnea, and/or a history of exposure to risk factors for the disease. The diagnosis is confirmed by spirometry. The presence of a postbronchodilator FEV1 <80% of the predicted value in combination with an FEV1/FVC <70% confirms the presence of airflow limitation that is not fully reversible." 3. Further, it has been reported that FEV1 as a percentage of its predicted value is the single best correlate of mortality in COPD. 4. The role for continued use of FEV1 in evaluation of patients with COPD is also supported by a small but significant correlation of airflow obstruction severity to patient health status. References to follow. References for previous comment: 1) Strassels S, Smith D, Sullivan S, Mahajan P. Costs of treating COPD in the United States. Chest 2001; 119: 344-52 2) Celli BR, MacNeeW. Standards for the diagnosis and treatment of patients with COPD: a summary of the ATS/ERS position paper. European Respiratory Journal 2004;23:932-946. 3) Global Initiative for Chronic Obstructive Lung Disease. Global Strategy for the diagnosis, management, and prevention of chronic obstructive pulmonary disease. National Heart, Lung, and Blood Institute, National Institutes of Health: Bethesda, MD;2005. 4) Celli B. The importance of spirometry in COPD and asthma: effect on approach to management. Chest 2000; 117: 15S-19S.	Thank you for your feedback. TQC/SC: Please see Testing Measures response #29.

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31	Use of Spirometry Testing for COPD (SPR)	Kaiser Permanente	Do NOT Support	The Permanente Medical Groups (SCPMG and TPMG) do not support the inclusion of the spirometry testing measure, as there is not enough evidence that spirometry testing influences positive outcomes for COPD members. Further, CMS has removed this measure from the Star Quality report. The Permanente Medical Groups (SCPMG and TPMG) would support alternative COPD treatment measures in the future.	TQC/SC: Please see Testing Measures response #29.
32	Appropriate Resource Use	Blue Shield of California	Support	Measurement Year 2012 Proposed Measure Additions: - ARU measures: High Cost High Volume Service Areas We need more explanation on what this measure is.	This is not a specific measure, rather a category of measures. These are preference and supply sensitive procedures that have been shown to have wide variation in utilization.

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1	Measure 16: Generate patient lists by specific conditions	CIGNA HealthCare of California	Support		Thank you for your feedback. TQC/SC: Remove measure to fully align with CMS requirements.
2	Measure 16: Generate patient lists by specific conditions	Kaiser Permanente	Support	The Permanente Medical Groups (SCPMG and TPMG) support alignment with the CMS and ONC requirements by deleting Measure 16.	Thank you for your feedback. TQC/SC: Remove measure to fully align with CMS requirements.
3	Measure 17: Send patient reminders per patient preference	CIGNA HealthCare of California	Support		Thank you for your feedback. TQC/SC: Remove measure to fully align with CMS requirements.
4	Measure 17: Send patient reminders per patient preference	Kaiser Permanente	Support	The Permanente Medical Groups (SCPMG and TPMG) support alignment with the CMS and ONC requirements by deleting Measure 17.	Thank you for your feedback. TQC/SC: Remove measure to fully align with CMS requirements.

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1	Total Cost of Care - Baseline	GlaxoSmithKline	Support	GSK supports measuring cost of care alongside quality rather than reporting cost alone because, as IHA notes, measuring total cost alongside quality gives stakeholders a better understanding of the value of care.	Thank you for the comment.
2	Total Cost of Care - Baseline	Kaiser Permanente	Do NOT Support	Due to the nature of the integration between the KP Health Plan and the Permanente Medical Groups, it precludes the PMG's from reporting observed costs PMPY. The PMG's do not "bill," strictly speaking, and our budget system and Medical Service Agreement with KFHP is different than the contract payments other Provider Organizations get from their contract Health Plans. Further, our "fee schedules" are undergoing redesign, and specific services are not carved out in our integrated model, making it virtually impossible to exclude (at a costs-level report) specific categories of services, such as mental health, chemical dependency, and vision services. Further, since the costs can not be broken down to the member, it would not be possible to exclude costs associated with members that may have exceeded \$100,000 at a member-level cost basis.	IHA will work with KP to further explore the feasibility of KP participating in TCC and ARU measurement.
3	Within-PO Performance Variation Measurement	Kaiser Permanente	Do NOT Support	The Permanente Medical Groups (SCPMG and TPMG) do not support adding Measure 22 to the Meaningful Use of Health IT Domain for MY 2012. This measure is not a standard Meaningful Use measure, and we do not support including non-standard measures in this domain. This measure should not be added for MY 2012. The Permanente Medical Groups oppose this measure because this type of measure has never been done before, and IHA should not engage in testing measures by including them in P4P. Health care consumers, purchasers, and health plans will not find this measure useful in evaluating the quality of Physician Organizations. PO's are already involved in performance improvement, and within-PO variation is assessed as part of internal QI efforts, and should not be used for public reporting. Ultimately, the clinical results by PO's are what count, not the variation within a PO.	While we want to align with the CMS Measures of Meaningful Use program, P4P committees felt that we did not want to be strictly limited by that goal. For example, P4P opted to retain the Care Management portion of IT-Enabled Systemness. A similar but less rigorous measure was previously part of Systemness, and purchasers are very interested in continuing to have this type of measure. Our PO survey shows that many POs are not currently measuring variance of physician performance. TQC/SC: More work is needed and will continue.
4	Measures 16-20: Any (5) CMS/ONC Menu Set measures	Kaiser Permanente	Support	The Permanente Medical Groups (SCPMG and TPMG) support the addition of Measures 16-20, as they are in alignment with the CMS requirements.	TQC/SC: Add for MY 2012 to fully align with CMS requirements.

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5	Relative Resource Use (RAS) – Asthma	GlaxoSmithKline	Support	GSK strongly supports adding three of the HEDIS Relative Resource Use measures for Asthma, Cardiovascular and diabetes. Appropriate measures of resource use along with valid quality measures can aid in evaluating a group’s ability to manage specific member populations. Cost information alone is insufficient to make such evaluations. Further, reporting utilization rates alone perpetuates and rewards component management at the expense of managing the whole patient over time. Higher results are often assumed to be bad and low numbers good. However, that assumption may not be true for what they are measuring. For this reason, reporting utilization is also not meaningful in assessing plan performance, patient care or appropriate decision-making. Therefore, measures of successful patient management such as episode-based relative resource use measures are better predictors of quality and plan performance. We strongly recommend that measures of resource use be paired with valid quality measures. This pairing aids in the evaluation of plan or provider ability to manage specific populations. If only cost measures, including relative resource use (RRU), are shown, consumers and purchasers could incorrectly conclude that the plans provide similar quality at different costs. Therefore, quality and cost measures should be displayed and used together.	Thank you for your feedback. TEC/SC: Do not add to measure set for MY 2012.
6	Relative Resource Use (RAS) – Asthma	Blue Shield of California	Support	These are very complex HEDIS measures and are difficult to understand. More time and information are needed for all stakeholders to implement these measures.	TEC/SC: Please see Measure Additions response #3.

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7	Relative Resource Use (RAS) – Asthma	CIGNA HealthCare of California	Do NOT Support	<p>1. Appropriate Resource Use Domain. The RRU measures being considered for P4P reporting are organized under the Appropriate Resource Use Domain. This is misleading in that it illustrates the RRU measure's ratios as comparing a PO's standardized price experience against some "appropriate" benchmark. In truth, the RRU ratios depict the PO's experience as compared against the average of POs. What does this average have to do with "appropriateness?" We feel that reporting Relative Resource Use measures under the Appropriate Resource Use Domain will lead to uninformed decision making on the part of stakeholders. 2. Statistical Significance of POs. For a HEDIS plan's eligible population to be considered statistically significant under the RRU current risk adjustment, the population must exceed 400 members within the clinical condition. A review of Cigna's contribution to PO's eligible populations shows that the majority of POs will NOT be statistically significant under the current model. Even under the newly-proposed HCC Risk Adjustment model being implemented with HEDIS 2012, the eligible population must exceed 150 members, of which Cigna's experience contributes to less than half the POs. IHA understands this concern and has decided to combine the populations of all contributing plans into POs to ensure statistical significance. While this may promote a statistical significance at the PO level, statistically valid plan-level drill down within a PO will be limited. 3. Plan Market Penetration. Related to the Statistical Significance of POs above, once plans' experience are bucketed together within a PO to achieve statistical significance, one must determine the underlying drivers to the resulting PO's RRU performance. If one plans holds the majority of a given PO's make-up, then this plan will skew the PO's RRU results in their direction of resource use. Therefore, an RRU result is no longer a measure of a PO's experience as compared to the average of POs resource use, it instead is a measure of market penetration a given plan has within a PO. 4. IDSS. The currently-proposed P4P manual specification cites the new IDSS xml standard for data submissions as developed by NCQA for reporting of RRU data to NCQA. Will IHA be prepared to accept data in this new format XML standard? Will RRU data be transmitted separately for RRU just as will be the case for HEDIS in 2012? Please advise.</p>	<p>1. Thank you for your feedback. IHA will consider the need for changing the domain name. 2. The RRU results will be aggregated across plans in the same manner that quality results are aggregated. This allows a larger sample size. During the feasibility study, NCQA determined that over half of PO's could reliably report Cardiovascular, Diabetes and Asthma RRU measures using the previous RA methodology. With the new HCC RA Methodology we expect this number to be even larger. 3. The same argument can be made for quality metrics. The aggregation methodology used for the quality measures will also be implemented for RRU measures. 4. Yes, RRU data will be transmitted directly to NCQA in the IDSS format. TEC/SC: Please see Measure Additions response #3.</p>
8	Relative Resource Use (RCA) – Cardiovascular	GlaxoSmithKline	Support	Please see Measure Additions comment #3.	TEC/SC: Please see Measure Additions response #3.
9	Relative Resource Use (RCA) – Cardiovascular	Blue Shield of California	Support	Please see Measure Additions comment #4.	TEC/SC: Please see Measure Additions response #3.

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#	Element	Org Name	Feedback Type	Comments	Response
10	Relative Resource Use (RCA) – Cardiovascular	CIGNA HealthCare of California	Do NOT Support	Please see Measure Additions comment #5.	TEC/SC: Please see Measure Additions response #3.
11	Relative Resource Use (RDI) – Diabetes	GlaxoSmithKline	Support	Please see Measure Additions comment #3.	TEC/SC: Please see Measure Additions response #3.
12	Relative Resource Use (RDI) – Diabetes	Blue Shield of California	Support	Please see Measure Additions comment #4.	TEC/SC: Please see Measure Additions response #3.
13	Relative Resource Use (RDI) – Diabetes	CIGNA HealthCare of California	Do NOT Support	Please see Measure Additions comment #5.	TEC/SC: Please see Measure Additions response #3.

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#	Element	Org Name	Feedback Type	Comments	Response
1	Encounter Rate Threshold for MY 2012	Blue Shield of California	Support	Blue Shield supports the removal of the Encounter Rate threshold as a requirement for clinical measures reporting. Alternative ways to assess data completeness: Blue Shield recommends groups that self-report to begin reporting their registry data. For self-reporters, the health plans do not get an opportunity to review their data, even though the health plans financially reward the groups based on that reported information. We believe if groups report their registries, it can increase data transparency and completeness. Another alternative to increase data completeness is to remove the option of self-reporting all together, and only base the payout on health plans' data.	Thank you for the feedback. IHA is currently revamping their strategic plan, and increasing the scope of work around data sharing is under consideration as part of that process. TQC/SC: Remove Encounter Rate Threshold for MY 2012.
2	Encounter Rate Threshold for MY 2012	CIGNA HealthCare of California	Support with modification	CIGNA supports but if a PO does not submit a threshold like 4.0 encounters than a plan should exclude the PO from payment	The encounter rate threshold criteria will be dropped from clinical data aggregation, but plans can still choose to have a threshold criteria for payment. TQC/SC: Please see Process and Policy response #1.

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#	Element	Org Name	Feedback Type	Comments	Response
1	Childhood Immunization Status	GlaxoSmithKline	Support	<p>1. GSK strongly recommends that the Childhood Immunization Status measure be revised to put back Rotavirus vaccine requirements. These immunization requirements are in HEDIS. The minutes from the IHA meeting where Rotavirus was removed from the measure highlight concerns about shortages of Rotavirus vaccines in 2009. Since that time, any shortage has been resolved. Please see this CDC link that confirms that there is no shortage. The availability of Rotavirus vaccine should also negate the previous concerns about inability to switch between vaccines. http://www.cdc.gov/vaccines/vac-gen/shortages/default.htm</p> <p>2. GSK also strongly recommends that the Childhood Immunization Status Measure be revised to put back Hep A vaccine requirements. We understand that the concern about having a sufficient buffer to allow for the 2nd dose to occur before the child's 2nd birthday. The IHA "P4P Public Comment MY 2010" document listing the public comments and IHA's response, states that IHA would write a formal letter to NCQA requesting a buffer be added to Hep A measure timing requirements. I am wondering if that buffer has been added by NCQA. If not, we respectfully recommend that IHA proceeded to modify the technical specifications for the IHA P4P measure set. Our concern is that because Rotavirus and Hep A are not in the measure, there could be drop in vaccination rates for these diseases. There could be a misperception that Hep A and Rotavirus vaccinations are not ACIP recommended or maybe not needed. This could prompt low vaccination rates for these diseases and pose unintended health risks.</p>	<p>1. TQC will consider whether Rotavirus should be added back into the P4P measure set.</p> <p>2. The hepatitis A issue is that the ACIP requirement is represented differently in the text (which indicates, 'first dose between one and two, and second dose at least six months after the first', and nowhere does it say 'it must be completed by 2') and the standard vaccine table which uses shading (and shortcuts subtly) to indicate 'two doses between one and two.' NCQA is aware of the complaints about this measure but feels that until and unless CDC/ ACIP makes a clarifying statement, NCQA is not in a position to adjust the HEDIS specification on Hepatitis A. CDC is aware of complaints about this measure.</p> <p>TQC/SC: 1. Do not add Rotavirus. Same timing issues still apply.</p> <p>2. Do not add Hepatitis A. Same timing issue would still apply and effort to add an additional grace period would be too burdensome.</p>

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#	Element	Org Name	Feedback Type	Comments	Response
2	Childhood Immunization Status	Pacific Partners Management Services, Inc.	Support with modification	<p>Why are codes in ICD-9 category 345: Epilepsy and recurrent seizures not counted as "Progressive neurologic disorder, including infantile spasms, uncontrolled epilepsy, progressive encephalopathy; defer DTaP until neurologic status clarified and stabilized" (copied from ACIP guidelines, which is the same as a listed official exclusion in the P4P manual: "Progressive neurologic disorder, including infantile spasm, uncontrolled epilepsy"). I understand it is a "precaution" and children with this condition require clearance by a neurologist, but I thought that was why it was excluded from P4P measurement as the neurologist may not clear the child by the second birthday (once again, even though this is a precaution in ACIP, this is listed as an EXCLUSION in table CIS-B in the Draft 2011 manual). My question is why ICD-9 category 345 is not included in Table CIS-B as a "Progressive neurologic disorder, including infantile spasm, uncontrolled epilepsy" when it clearly encompasses ICD-9 codes for these conditions? I have submitted this through the P4P Policy Clarification portal previously (Question 47394 and follow up question 47407) in late June 2011 and was told the following: "We apologize for the confusion. We will research your question, and if changes are made, they will be included in the P4P September Update memo." I cannot find the September memo and the current manual (Posted September 1) does not state why it is listed this way.</p>	<p>NCQA found that "Progressive neurologic disorder" was a precaution rather than an actual contraindication; given that we only exclude conditions based on contraindications, it was removed from the HEDIS 2012 Volume 2 Tech Specs. P4P will follow suite in the November release of the P4P MY 2011 manual.</p> <p>TQC/SC: Issue will be fixed.</p>
3	Childhood Immunization Status and Adolescent Immunization Status	Arch Health Partners	Support with modification	<p>It is so disheartening to have children/teens fully immunized, but after their 2nd/13th birthday, and to see our scores reflect this. In many cases it is just a matter of days. There is a very strong movement in California to have children immunized on an "alternate" schedule. We feel there should be two metrics - one with rates prior to 2nd/13th birthday, and one with rates after 2nd/13th birthday. This is how we look at it internally.</p>	<p>TQC will consider whether to adopt an additional metric which assesses numerator compliance within a certain time period after the 2nd or 13th birthday. If this metric were collected, it would likely not be used for public reporting or payment. We follow the CDC ACIP guidelines for immunizations, which are evidence-based. Most of the CIS measures are recommended by 18 months, so a 6 month "grace period" is already incorporated into the HEDIS and P4P measures. Because of delays in administering immunizations, there are many issues now with higher incidence of disease and resurgence of some diseases. Delayed immunization administration is more prevalent in some geographic areas than others, and California seems to be one of these areas.</p> <p>TQC/SC: 1. Do not add additional grace period. Adding an additional grace period after the 2nd and 13th birthdays would be too burdensome and not in alignment with HEDIS and national guidelines. 2. Only pay and publicly report on Tdap rather than the combination rate of Tdap and meningococcal. Continue to collect Tdap, meningococcal, and combination rate.</p>

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#	Element	Org Name	Feedback Type	Comments	Response
4	Childhood Immunization Status and Adolescent Immunization Status	PAMF - Mills-Peninsula Division/Mills-Peninsula Medical Group	Support with modification	Is there going to be some adjustment the strict adherence to the birthday requirements for the measure to count immunizations given very close to the child's second, 10th, 11th or 13th birthday. I think a relatively short window around the birthdays to account for scheduling difficulties would be appropriate. Furthermore, not counting immunizations given one day after the second birthday actually results in us under-reporting the level of immunization in our country and gives public health officials and policy makers an inaccurate representation of the level of actual protection against vaccine preventable diseases.	TQC/SC: Please see Other Comments response #3.
5	Immunizations for Adolescents	Sutter Regional Medical Group	Support with modification	As you are aware, the parents of pre-teens in California, are being contacted and notified that updated Tdap is necessary for the school year due to the prevalence of pertussis in our communities. When the child arrives for this injection, (s)he often receive the meningitis injection at the visit when the Tdap is administered. The child may not yet be 11 y.o. We feel that it is better to administer the meningococcal vaccine at age 10 ½ years rather than inconvenience our patient & family by expecting them to return for another visit a year down the road. The vaccine is still effective at age 10, and causes no harm. We recommend that the specifications be changed to align meningitis vaccine with the Tdap: due ages 10-13 years of age.	We align our immunization measures (both child and adolescent) with the ACIP recommendations/guidelines for vaccinating children and adolescents. The current ACIP recommends that meningococcal conjugate be given at age 11 or 12 years and a booster dose at age 16 years. TQC/SC: Please also see Other Comments response #3, part 2.
6	Breast Cancer Screening	Pacific Partners Management Services, Inc.	Support	Breast Cancer Screening will require collection of data for three age bands spanning 40-74. I understand that IHA follows the USPTF recommendations, but the USPTF recommends 50-74. P4P changed their specifications to measure age 52-69 (removing 42-51 age group) per this specifications for MY2011. Why are they re-expanding to include 40-50 age group once again? Is this for more consistency with the CMS 5 star measure?	P4P changed the age band to align with both HEDIS and CMS 5 Star measures. TQC/SC: No further discussion.
7	Breast Cancer Screening	Kaiser Permanente	Support	The Permanente Medical Groups (SCPMG and TPMG) support changing the age band for Breast Cancer Screening (MY 2011) to an eligible population of 52 – 69 year old women. The evidence base is stronger for supporting screening in this age band.	The age band recommended for payment and public reporting is for women 52-69 years old. TQC/SC: No further discussion.

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#	Element	Org Name	Feedback Type	Comments	Response
8	Breast Cancer Screening	Kaiser Permanente	Do NOT Support	The Permanente Medical Groups (SCPMG and TPMG) do not support the addition of an 70 – 74 yr. old age band for Breast Cancer Screening (MY 2012), since this would diverge from HEDIS and CMS reporting, and there is not a strong enough consensus on the need for performance reporting of mammography screening in this upper age band.	P4P follows USPSTF recommendations, which were recently updated to include the 70-74 age band. TQC/SC: No further discussion.
9	Evidence Based Cervical Cancer Screening	Pacific Partners Management Services, Inc.	Do NOT Support	After comparing "Evidence-Based Cervical Cancer Screening" for P4P with the CDC and ACOG guidelines for cervical cancer screening, we found that the P4P guidelines are in conflict with these national agencies. According to the P4P manual, pap tests should start at age 21 and occur exactly 1X every 3 years. If they are screened more than 1X every 3 years, the PO is docked for too frequent screening. However, ACOG recommends screening every 2 years for women 21-29 and every 3 years for women over 30 if they have had 3 normal screenings. The CDC guidelines are consistent with the ACOG guidelines in that they recommend screening 1X every 3 years for women over 30 IF they have had a series of normal pap tests. The ACS also recommends waiting until 30 to lengthen the screening interval. So for a 25 year old woman who was last screened in 2009, P4P dictates she should not have a screening again until 2012, but CDC/ACOG recommends a screening in 2011. If her physician follows national guidelines and screens this year, she or he will fail the P4P measure due to too frequent screening for this patient. Thus, a physician following national guidelines will fall out of compliance with P4P. I brought this up during the last Public Commentary period and received the reply that P4P follows USPTF recommendations. However, even the USPTF doesn't specifically endorse screening exactly once every 3 years. They state screening should be done AT LEAST 1X every 3 years with the acknowledgement that "Because sensitivity of a single Pap test for high-grade lesions may only be 60-80%; however, most organizations in the United States recommend that annual Pap smears be performed until a specified number (usually 2 or 3) are cytologically normal before lengthening the screening interval."	TQC understands that there are disagreements among guidelines put out by various societies. The measure is most consistent with the USPTFS recommendations which are generally accepted as evidence-based, unbiased, and conservative. National societies' recommendations have been changing in the past few years, mostly adopting longer screening intervals. ACOG guidelines have changed twice in the past three years. They initially recommended annual pap smears in the 21-30 age range, and leaned towards use of HPV testing in those 30 and above. Their latest guidelines now recommend pap smears every 2 years for ages 21-30 and HPV testing is much less encouraged. USPSTF states: "The USPSTF found no direct evidence that annual screening achieves better outcomes than screening every 3 years. Modeling studies suggest little added benefit of more frequent screening for most women." From a population standpoint, our attention should be focused on those women who have not had any cervical cancer screening in over three years. P4P and other performance measures are not practice guidelines. They measure performance and are based on guidelines. For example, a physician organization would not be "punished" if all physician organizations also adopt a 2-year interval for cervical cancer screening for patients aged 21-30 since their performance is measured relative to the other organizations. Finally, physician discretion is always appropriate in individual circumstances. No performance measure can capture every patient situation, and it is still the responsibility to evaluate any guidelines in the context of an individual patient's presentation. TQC/SC: Support continued use of measure.

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10	Evidence Based Cervical Cancer Screening	PAMF - Mills-Peninsula Division/Mills-Peninsula Medical Group	Support with modification	Inclusion of additional ICD-9 codes for immunocompromised status as an indicator of above average risk for the ECS measure. Currently only ICD-9 codes for HIV are included to account for immunocompromised status. However there are additional etiologies and ICD-9 codes representing them that should also be included so these women will also not be considered "at average risk"	279 is an appropriate code to indicate immunodeficiency. TQC/SC: Add ICD-9 code 279 as an exclusion.
11	Evidence Based Cervical Cancer Screening	Sutter Regional Medical Group	Support with modification	Sutter Medical Foundation Sutter Medical Group 9/13/11 Comments to IHA for MY 2011 Evidence Based Cervical Cancer Screening The specifications for Appropriately Screened vs. Screened Too Frequently appear to contradict each other. In an effort to provide a Screening, there will by definition, either be a period of time in which it appears that the patient was screened too frequently or not screened at all. Example: Pap smear completed on 1/1/09 Due again on 1/1/12 If repeat is completed on 12/31/11, she has been Screened Too Frequently If repeat is completed on 1/2/12, she has Not Been Screened per Guidelines. These make it nearly impossible to comply with both measures. We recommend review & revision of the specifications to allow for Appropriate Screening. Example: Appropriate screening interval – every 2 ½ to 3 ½ years.	The measure looks at the number of pap smears in the measurement period, not the time between pap smears. You are correct, a woman who had a pap test on 1/1/2009 and also on 12/31/2011 would be categorized as Screened Too Frequently. However, if a woman who had a pap test on 1/1/2009 and again on 1/2/2012, she would be considered Appropriately Screened as she met the numerator criteria of having one pap test during the measurement period (i.e., the measurement year or the two years prior to the measurement year). The reverse of this is also true. For MY 2011, if a woman received a pap smear on 12/31/08, she will not be considered overscreened if she receives another pap smear at any time in 2009, 2010, or 2011 because the initial pap smear was completed a day before the measurement period began. These situations should basically even each other out. TQC/SC: Please also refer to Other Comments response #9.
12	Asthma Medication Ratio	Kaiser Permanente	Support with modification	The Permanente Medical Groups (SCPMG and TPMG) support the inclusion of the Asthma Medication Ratio measure for MY 2011. If the Asthma Medication Ratio measure proposed for HEDIS 2013 is added to the measure set, then we recommend that IHA use the HEDIS version of this measure for MY 2012 if there are any differences in the specifications between the IHA version and the HEDIS version.	P4P generally tries to align with standardized national measures, unless there is a compelling reason to deviate. TQC/SC: No further discussion.
13	Low Back Pain	Sutter Gould Medical Foundation	Support with modification	The low back pain measure does not allow a diagnosis of radiculopathy or sciatica to trigger imaging. Based on Up To Date recommendations, plain films should be ordered for radiating pain. Please consider adding this as an exclusion. Thanks.	The exclusions in the HEDIS measure are only those we found we were able to reliably capture through administrative (claims) data. When we field tested this measure we looked for data on the most clinically appropriate indications in which a low back imaging may be necessary; however, some of them are just not coded on claims. Since the HEDIS LBP measure is administrative data only, we restricted the exclusion list. We also found that the exclusions in the HEDIS measure were those that were most commonly seen. TQC/SC: No further discussion.

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14	Miscellaneous	Blue Shield of California	Support	<p>1. Specifications for each proposed measures should be made available at the same time as the public comments period. It is difficult to estimate the amount of time and resources needed to program measures without the specifications. 2. We need to consider if there are too many measures in the Pay for Performance program. Improvement can be diluted when there are too many measures.</p>	<p>1. The MY 2011 testing measure specifications were made available at the same time as Public Comment in the release of the 9/1/2011 P4P manual. 2. Thank you for the feedback; this is part of what the P4P committees consider when approving the P4P measure set each year.</p> <p>TQC/SC: No further discussion.</p>
15	MUHIT	Hill Physicians Medical Group	Support	<p>Meaningful Use Domain: the questions below are related to how the answers will be scored, particularly IPAs. The proposal is to award 75% of the points achieved to a PO if the EMR is NOT ONC certified. 1. What is the cutoff date that the particular EMR must be ONC certified? 12/31/2011? Or 1/1/2011 or anytime in between? Will systems that are only certified for part of the year receive full or only 75% credit? 2. Some POs have only one EMR system, while others (IPAs especially), will allow their physicians to have any EMR, with an overarching HIE strategy in mind. In this situation, some of the EMRs will be ONC certified, while others may not be yet. 2i. How should the POs compete the survey? 2ii. How will their results be scored? 3. In answering the MU questions, is it implied that if the EMR HAS the feature, that the physicians are using it? Wouldn't every ONC certified system have the features? 4. How will this be audited at a. The individual physician level? b. At the PO level? Since this is an attested, self report, which says will be audited?</p>	<p>1. P4P requires that the measure criteria be met by 12/31 of the measurement year, and P4P aligns with CMS criteria for meeting a measure. Per the CMS reporting requirements, POs must use EHR functionality 90 days before the end of the measurement year to meet the measure. Therefore, for MY 2011, use of functionality must be in place by October 1, 2011. 2i. The survey tool has been built to accommodate IPA submitting for both PCPs who use certified software and PCPs who use non-certified software at a measure level. 2ii. Each measure will be scored based on a weighted average of the Total number of PCPs/members for certified vs. non-certified software users. For example, a. 100 out of 100 PCPs meet the criteria = 100% (5 points for certified and 3.75 for non-certified) b. 25 out of 100 certified = (25% * 5) = 1.21, c. 75 out of 100 non-certified = (75% * 3.75) = 2.71, d. Total Number of points = 1.21 + 2.71 = 4.06. 3. Yes, we assume that they are using the functionality and will clarify this in the next release of the manual. 4. We will audit that the count of PCP's meeting the standard is accurate for each PO we audit. Documentation will be required to substantiate the numbers submitted.</p> <p>TQC/SC: No further discussion.</p>
16	MUHIT	Kaiser Permanente	Support	<p>The Permanente Medical Groups (SCPMG and TPMG) support Measure 18 (Chronic Care Mgmt for DM, Depression, and one other Condition) of the Meaningful Use of Health IT Domain for MY 2011.</p>	<p>Thank you for the feedback.</p> <p>TQC/SC: No further discussion.</p>
17	MUHIT	Kaiser Permanente	Support with modification	<p>MUHIT: One issue brought to my attention is that CMS has used the definition of "eligible professional" not "PCP" for reporting. Not all "eligible professionals" are PCPs. We suggest that IHA/NCQA use the same definitions to assure alignment and consistency with all meaningful use reporting. That should be defined and revised in the Survey tool.</p>	<p>PCPs are a subset of CMS's defined "eligible professional" population. Modifying this requirement for P4P would greatly increase the rigor of the measure. We will take this feedback under advisement.</p> <p>TQC/SC: Starting in MY 2012, allow POs to submit either all Primary Care Practitioners or all Eligible Professionals as defined by CMS.</p>

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18	MUHIT	Kaiser Permanente	Support with modification	MUHIT: Will this be requested of Provider Groups who do not see Medicare pts as well as those that do? And will the reporting apply to all patients or just commercial patients?	The MUHIT domain will apply to all POs participating in P4P, regardless of whether they see Medicare patients. The scoring is determined by the percent of the organization's PCPs or PCPs serving a percentage of the organization's commercial HMO/POS members, who are able to meet the intent of the measure. TQC/SC: No further discussion.
19	MUHIT	Arch Health Partners	Do NOT Support	Meaningful use of IT - 2 menu options chosen: I do understand that they are population health measures, but #17 is very difficult to implement. At best, we hope to begin the very specific patient preference data collection required by MU in 2012. We did not select it as one of our menu options. We would rather this was not included in 2011MY, but part of the 5 for 2012MY.	Given how far along we are in the measurement year, it is too late to change the specifications for MY 2011. This topic is up for public comment as a change for MY 2012. TQC/SC: No further discussion.
20	Survey Measures	Kaiser Permanente	Support with modification	P4P Quality Measurement related to Medicare Stars (12 survey-based patient experience and health outcomes measures): If IHA decides to pursue doing their own survey, analyses should be conducted in order to establish reliability before public reporting of the results or for P4P use. The groups should also have the opportunity provide input on these analyses, and the survey instrument and method prior to administration. Concerns relate to 1) HOS measures based on change in self reported status from two-year cohort survey, 2) flu vaccination question wording, and 3) approval from CMS and NCQA on use of CAHPS-like and HOS items.	P4P is still considering these measures and will take your feedback under advisement. Participating Medicare Advantage plans will have the opportunity to participate in the decision making process. Alterations to the standard measures would likely not be made. All necessary approvals will be obtained prior to implementation. TQC/SC: No further discussion.
21	Value Based P4P	Arch Health Partners	Support with modification	Value Based P4P - We strongly believe in the concept, but believe the quality multiplier should be > 1.25 for achieving maximum quality. The investments in quality pay off downstream to the plans (reduced mortality and morbidity), but they are expensive to maintain. We believe there should be at least a 2x, if not greater multiplier.	A Value Based P4P work group will discuss and recommend the appropriate range for the quality multiplier.
22	Appropriate Resource Use	Kaiser Permanente	Do NOT Support	The Permanente Medical Groups do not support inclusion of any of the Appropriate Resource Use measures. The measures "IPR" and "TCC" are not nationally standardized measures, and the PMG's object to the inclusion of non-standard measures in the IHA P4P measure set. (Please also see other comments submitted specifically about the data challenges that would be imposed on the PMG's related to the TCC measure.) The other measures in this domain are described as being based on HEDIS Use of Services measures, but when applying a new risk adjustment methodology, the specifications and results are not comparable to the nationally reported HEDIS measures. There would be confusion as to differences between the HEDIS Use of Services measure results and the P4P versions.	While P4P is committed to using nationally standardized measures, we don't make this a limitation. In the case of resource use/cost measures, there haven't been robust national measures relevant for use in P4P programs. Therefore, P4P developed our own measurement, building on the HEDIS Use of Services metrics.