



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

**2011 P4P Public Comment Period  
September 1 - September 30, 2011**

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, September 30, 2011 to the P4P Public Comment Website at the following link:** <http://publiccomments.ncqa.org/home.aspx>

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 2011**
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 cannot 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. 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 Quality, Technical Efficiency, Payment, and Executive Committees that were reviewed and approved for public comment by the P4P Steering Committee. The P4P Committees will review all public comment received and finalize changes in November 2011.

### 1. Measurement Year 2011 Measure Additions

The measure listed below is being proposed for addition to the Appropriate Resource Use domain for the Measurement Year (MY) 2011 P4P measure set. This measure was tested in early 2011 for performance in 2008 and 2009, using data received from three health plans. More comprehensive testing, including data from more plans and an additional year of data (2010) is currently underway. A summary of testing results will be included as Appendix C, when it is available in mid-September.

#### a. Total Cost of Care – Baseline

The Total Cost of Care (TCC) measure captures all of the costs associated with the medical care for the membership of a physician organization (PO) for one year. TCC is calculated by summing the total contracted amount paid to all providers for the care of all members in a PO -- including covered professional, pharmacy, hospital, and ancillary care -- then dividing that amount by the number of member years. Both capitation and fee for service payments are included. Payments for the following items are excluded: mental health, chemical dependency, acupuncture, chiropractic, dental, and vision services, and P4P quality incentives. Outlier cases are handled by truncating costs per member per PO per year at \$100,000. TCC is risk adjusted to account for the health status of the member population using Verisk's Relative Risk Score methodology. Furthermore, to account for geographic and market-specific pricing differences, TCC results are assessed by region.

Measuring total cost of care alongside quality gives stakeholders a better understanding of the value of care delivered, and robust data for the purpose of provider comparison. Aligning total cost of care measurement and incentives across P4P's participating health plans will maximize impact, and incentivize POs to control their overall cost growth.

In the future, the California P4P Program will place an even greater emphasis on both cost and quality as it transitions to "Value Based P4P" (formerly referred to as Performance Based Contracting). Under this new paradigm, TCC will be used in a shared savings incentive model that incorporates both the quality and cost of health care services. Base shared savings amount will be determined by PO cost performance evaluated against targets for both TCC amount and TCC year-over-year trend. Quality performance will be used to modify the shared saving amount up or down. This shared savings incentive model is in alignment with the move nationally towards Accountable Care Organizations.

IHA is currently seeking comment on establishing the Total Cost of Care baseline measurement for MY 2011. There will be a special public comment period later in 2011 specific to the transition to Value Based P4P.

## 2. Measurement Year 2011 Proposed Testing Measures

Testing measures for MY 2011 are those that will be tested in 2012 using 2011 data. Measures that test successfully will move directly into the MY 2012 measure set. Testing is considered successful when the specifications produce results that are reasonable compared to known benchmarks, show variation in performance across POs, and have room for improvement.

### a. Clinical Domain

Proportion of Days Covered (PDC) – PDC is a method for measuring medication adherence – an area that is not currently measured in P4P. Adherence with medication therapy is generally low, approximately 50% to 65% on average, for common chronic conditions such as hypertension and diabetes. Studies have shown that higher levels of medication adherence are associated with significantly reduced risk of hospitalization, ER visits, and death.

The PDC measures being proposed for P4P are NQF-endorsed, and were developed by the Pharmacy Quality Alliance. These measures are used by the Centers for Medicare and Medicaid Services (CMS) as patient safety measures for Medicare Prescription Drug Plans. CMS has also proposed adding the PDC measures to the Medicare Advantage Stars measure set.

These measures assess the percentage of members 18 years of age and older who meet the PDC threshold of 80% for select medications during the measurement period. Members are required to fill at least two prescriptions for a medication within the same drug class to be included in the measure. A performance rate is reported separately for each drug class, and as a roll-up for diabetes medications.

#### 1) Proportion Days Covered – ACEIs/ARBs

This measure assesses the percentage of members who met the PDC threshold of 80% for ACEIs, ARBs, or ACEI/ARB combinations during the measurement period.

#### 2) Proportion Days Covered – Statins

This measure assesses the percentage of members who met the PDC threshold of 80% for statins or statin combinations during the measurement period.

#### 3) Proportion Days Covered – Biguanides

This measure assesses the percentage of members who met the PDC threshold of 80% for biguanides during the measurement period.

#### 4) Proportion Days Covered – Sulfonylureas

This measure assesses the percentage of members who met the PDC threshold of 80% for sulfonylureas during the measurement period.

#### 5) Proportion Days Covered – Thiazolidinediones

This measure assesses the percentage of members who met the PDC threshold of 80% for thiazolidinediones during the measurement period.

6) Proportion Days Covered – DiPeptidyl Peptidase (DPP-IV) inhibitors

This measure assesses the percentage of members who met the PDC threshold of 80% for DPP-IV inhibitors during the measurement period.

7) Proportion Days Covered – Diabetes Roll-up

This measure assesses the percentage of members who met the PDC threshold of 80% for biguanides, sulfonylureas, thiazolidinediones, or DPP-IV inhibitors. The diabetes roll-up is calculated as a weighted average of the individual classes of oral diabetes medications.

8) Immunizations for Adolescents (IMA) - Human Papillomavirus (HPV) Vaccination for Adolescent Females

P4P currently uses a HEDIS-based measure to assess the percentage of adolescents 13 years of age who have one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13<sup>th</sup> birthday. For MY 2011, HEDIS will begin measuring the percentage of female adolescents who have received doses of quadrivalent HPV vaccine, as recommended by the Advisory Council on Immunization Practices. HEDIS will collect this measure as a standalone measure due to sampling issues associated with the hybrid data collection methodology. Since P4P uses only electronic data, the sampling issue does not apply.

Therefore, P4P proposes testing this measure as both a standalone measure (for females only) and as part of the combination rate with the existing Immunizations for Adolescents (IMA) measure.

P4P committees raised the challenge of getting children of this age vaccinated three times in a year, as well as the pushback from some parents on vaccinating against HPV at such an early age; however, they agreed that the measure should be tested.

9) Use of Spirometry Testing for COPD (SPR)

This is a HEDIS-based measure which assesses the percentage of members 40 years of age and older during the measurement year with a new diagnosis of or newly active chronic obstructive pulmonary disease (COPD) who received appropriate spirometry testing (2 years before to 6 months after) to confirm the diagnosis. This measure is also used by Medicare Advantage Star Ratings and has been proposed for CMS ACO.

The P4P committees believe that COPD is worth addressing, but had the following concerns about the measure: health plans have found that there can be data capture issues since spirometry is often not coded separately; the identification of newly diagnosed COPD is challenging and there is a potential for overutilization of testing; false positives can be generated by use of a single diagnosis; and the spirometry guidelines are vague. Despite these concerns, the P4P committees agreed that P4P should align with other national initiatives using the measure, and test the measure for P4P.

b. Patient Experience Domain: Chronic Care Measures

Patient experience continues to be an important measurement area for P4P stakeholders, and P4P committees would like to enhance the current Patient Experience domain, particularly around the care experience and outcomes of people with chronic conditions. It is important that any expansion be in alignment with national efforts.

IHA is continuing to work with CCHRI to identify survey questions, focused on chronically ill patient populations, that are feasible and reliable. The survey team from CCHRI and CAHPS has determined that there is not a proven screener/gate method for patients to self-identify as chronically ill and complete a subset of items that are relevant to chronic care. An alternative being considered is using the ICD-9 codes in the visit records to draw samples. This may require a standalone survey specifically for chronically ill patients.

Addition of chronic care measures to the P4P measure set is contingent on these measures being added to PAS. CCHRI is assessing if there is an opportunity to do further testing of the self-care management measures in a chronic care only population; however, it is unlikely that any measures will be tested for MY 2011.

We would like your feedback on adding chronic care measures – specifically related to self-care management – to the P4P Patient Experience domain. We are also interested in hearing your ideas on other areas that are of interest for P4P Stakeholders to enhance the current Patient Experience domain.

c. Call for Additional Appropriate Resource Use (ARU) Measures

IHA has worked with stakeholders to develop the existing ARU measures, which function as indicators of potential areas on which POs can focus to reduce inappropriate health care resource use. As P4P moves toward the measurement of Total Cost of Care as the key resource use measure for performance incentives, it is important to provide additional information for POs to identify underlying key drivers of total costs.

IHA is therefore seeking suggestions for new ARU measures to be tested for MY 2011. Measures that focus on high cost/high volume procedures or services are of particular interest. Potential measures should be in widespread use at the PO level, with detailed specifications that would be available to IHA at no cost.

If you are aware of measures that meet these criteria, please submit them to IHA during this public comment period. Please provide a brief description of the measure, along with where and how the measure is currently being used.

**3. Measurement Year 2012 Proposed Measure Deletions**

a. Meaningful Use of Health IT Domain

The P4P committees are recommending deletion of the following Meaningful Use of Health IT (MUHIT) measures for MY 2012:

- Measure 16: Generate patient lists by specific conditions
- Measure 17: Send patient reminders per patient preference

To support the implementation of technology and eliminate redundancy, P4P transitioned from IT-Enabled Systemness to the Meaningful Use of Health IT (MUHIT) domain for MY 2011. MUHIT aligns with the CMS and ONC Measures of Meaningful Use requirements.

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

Measures 16 and 17 are two CMS menu set measures that are focused on population health management. These two menu set measures were adopted for P4P, in addition to the 15 core measures, at the November 2010 P4P Steering Committee meeting. The intent of adopting these measures was to maintain population health management, which has been the foundation of the P4P IT measures, and which was lost in the P4P program transition from IT-Enabled Systemness to MUHIT.

This created a situation where a provider can be in full compliance for CMS, but not meet all of the MUHIT criteria for P4P. Therefore, to fully align with the CMS and ONC requirements, for MY 2012, the P4P committees recommend deleting the requirement for POs to comply with the two population health management measures in the menu set and allow POs to select any five menu set measures (see section 4.b. below).

#### **4. Measurement Year 2012 Proposed Measure Additions**

The measures listed below are being proposed by the P4P committees for addition to the MY 2012 P4P measure set. Public reporting and payment measures for MY 2012 are those that will be measured for the period January 1 through December 31, 2012, with reporting and payment in 2013.

##### **a. Within-PO Performance Variation Measurement**

For the past several years, P4P has rewarded POs that measure and incentivize individual physician level performance within their PO. With the transition to Meaningful Use of Health IT starting in MY 2011, the “Physician-Level Measurement and Reporting” measure will no longer be part of P4P. Purchasers have expressed strong interest in continuing this type of measurement, and suggested a P4P measure of the amount of physician level performance variation within a PO, along with the average performance across all physicians in the PO. The P4P Executive and Steering Committees agreed that it could be valuable to measure within-PO variation and assess whether POs have systems in place to reduce variation.

There are many technical challenges to be worked out, including the development of standardized specifications. IHA has created a plan to address the technical challenges, including convening NCQA and PBGH to assess the status of key specifications for individual MD measurement (which measures used, MD inclusion criteria, patient attribution, sample size requirements, etc.), surveying POs about their current initiatives on physician level measurement, and then doing a pilot test of potential measures.

IHA is seeking stakeholder comment on adding to the MUHIT domain, a measure of within-PO physician performance variation and having a system in place to reduce variation.

b. Meaningful Use of Health IT Domain

For MY 2012, the P4P committees recommend that in addition to the 15 core measures, POs be required to select any five of the ten menu set measures to get full credit for the P4P MUHIT domain.

Measures 16-20: Any five (5) CMS/ONC menu set measures

These five measures would replace the two population health management menu set measures currently required for P4P (see section 3.a. above) and would bring P4P into full alignment with CMS and ONC Meaningful Use requirements.

c. Relative Resource Use Measures

For MY 2012 the P4P recommendation is to add three of the HEDIS Relative Resource Use measures, for the following chronic conditions:

- 1) Relative Resource Use (RAS) – Asthma
- 2) Relative Resource Use (RCA) – Cardiovascular
- 3) Relative Resource Use (RDI) – Diabetes

The HEDIS Relative Resource Use (RRU) measures focus on high-cost conditions that have corresponding HEDIS Effectiveness of Care (i.e., clinical quality) measures. Standardized costs are used to measure an organization's total resource use for members with a given chronic condition during a measurement year. The RRU measures are risk adjusted using HCCs. An index of cost for each measure is reported in five service categories: Inpatient Facility, Evaluation and Management, Surgery and Procedure, Total Medical Cost, and Ambulatory Pharmacy. When used with corresponding clinical quality measures, RRU measures provide information about the efficiency or value of an organization's services. Please see the [HEDIS Relative Resource Use Brochure](#) on the NCQA Web site for more information.

NCQA pilot tested the diabetes RRU measure at the PO level in California using 2009 data from two P4P health plans. Pilot test results are available in Appendix B. The testing showed that health plan HEDIS programming could successfully be leveraged to produce PO level results, and that POs have sufficient sample size to have valid results for the diabetes RRU measure. Results at the PO level were consistent with what NCQA has observed at the health plan level, and significant variation in resource use was seen.

P4P is currently doing additional testing of the RRU measures for asthma, cardiovascular disease, and diabetes, and results will be shared with the Technical Efficiency Committee this Fall. Adding the RRU measures to P4P offers an opportunity to align P4P measurement with health plan HEDIS measurement. IHA is seeking stakeholder comment on adding the RRU measures for asthma, cardiovascular disease, and diabetes to P4P for MY 2012.

## 5. Proposed Process and Policy Changes

### a. Encounter Rate Threshold for MY 2012

The Steering Committee has recommended removal of the Encounter Rate threshold as a requirement for reporting for clinical measures. The original intent of using an Encounter Rate threshold was to serve as a proxy of data completeness, but it has also been erroneously interpreted as a target level of patient-physician interactions (i.e., “We are targeting 4.25 encounters per patient per year”). Results for POs with poor data completeness will already be low; to disqualify these POs from any clinical measurement was seen as overly punitive. Furthermore, as the health care industry moves towards increased coordination of care and new modes of delivery and communication (including phone, email, and team care) that are not generally captured by conventional encounter data, the continued use of encounter rate may not be relevant or appropriate for the future health care delivery environment.

The Encounter Rate by Service Type metrics would continue to be calculated and collected, but no threshold would be applied during the clinical data aggregation process.

Removing the Encounter Rate threshold presents two primary consequences for POs and health plans that participate in P4P:

- 1) Previously, if a PO did not meet the encounter rate threshold, the health plan’s numerators and denominators for the PO were not included in the PO’s aggregated clinical scores. Removal of the encounter rate threshold provides more data for measurement by including all contracted health plans’ numerators and denominators for the PO in the PO’s aggregated clinical scores.
- 2) Self-reporters: In prior measurement years, PO self-reported scores could qualify for use in P4P only if the PO met the encounter rate threshold for all contracted health plans, with the potential exception of up to one plan. As a result of the removal of the encounter rate threshold requirement, all POs would be able to self-report, regardless of the encounter rate with any plan that it contracts with.

IHA is seeking stakeholder feedback on the recommendation to remove the Encounter Rate threshold, as well as input on alternative ways of assessing data completeness.

APPENDIX A

Measurement Year (MY) 2011 and Proposed MY 2012 P4P Measurement Set

	Year 9 Measures: Measurement Year 2011/ Reporting Year 2012	Proposed Year 10 Measures: Measurement Year 2012/ Reporting Year 2013
<b>PO Encounter Threshold for reporting<sup>1</sup></b>	4.25 Encounters per member per year (using Encounter Rate by Service Type specs)	Encounter Threshold to be removed as a clinical quality requirement, effective MY 2012.
<b>CLINICAL DOMAIN</b> <i>MEASURES TO BE COLLECTED, REPORTED AND RECOMMENDED FOR PAYMENT</i>	<p><u>Cardiovascular</u></p> <ol style="list-style-type: none"> <li>Medication Monitoring (ACEIs/ARBs, Digoxin, and Diuretics)</li> <li>Cholesterol Management: LDL Screening</li> <li>Cholesterol Management: LDL Control &lt;100</li> </ol> <p><u>Diabetes</u></p> <ol style="list-style-type: none"> <li>HbA1c Screening</li> <li>HbA1c Poor Control &gt;9%</li> <li>HbA1c Control &lt;8%</li> <li>HbA1c Control &lt;7%</li> <li>LDL Screening</li> <li>LDL Control &lt;100</li> <li>Nephropathy Monitoring</li> <li>Blood Pressure Control for People with Diabetes &lt;140/90</li> <li>Optimal Diabetes Care Combo 1 (LDL&lt;100, HbA1c &lt;8%, Nephropathy Monitoring)</li> </ol> <p><u>Musculoskeletal</u></p> <ol style="list-style-type: none"> <li>Use of Imaging Studies for Low Back Pain</li> </ol> <p><u>Prevention</u></p> <ol style="list-style-type: none"> <li>Childhood Immunization Status – Combination of all Antigens</li> <li>Adolescent Immunizations – Combination of Tdap and meningococcal</li> <li>Chlamydia Screening in Women</li> <li>Evidence-Based Cervical Cancer Screening</li> <li>Breast Cancer Screening – Ages 50-69</li> <li>Colorectal Cancer Screening</li> </ol> <p><u>Respiratory</u></p> <ol style="list-style-type: none"> <li>Asthma Medication Ratio</li> <li>Appropriate Testing for Children with Pharyngitis</li> <li>Appropriate Treatment for Children with Upper Respiratory Infection</li> <li>Avoidance of Antibiotic Treatment of Adults with Acute Bronchitis</li> </ol>	<p><u>Cardiovascular</u></p> <ol style="list-style-type: none"> <li>Medication Monitoring (ACEIs/ARBs, Digoxin, and Diuretics)</li> <li>Cholesterol Management: LDL Screening</li> <li>Cholesterol Management: LDL Control &lt;100</li> <li>Proportion of Days Covered: ACEIs/ARBs</li> <li>Proportion of Days Covered: Statins</li> </ol> <p><u>Diabetes</u></p> <ol style="list-style-type: none"> <li>HbA1c Screening</li> <li>HbA1c Poor Control &gt;9%</li> <li>HbA1c Control &lt;8%</li> <li>HbA1c Control &lt;7%</li> <li>LDL Screening</li> <li>LDL Control &lt;100</li> <li>Nephropathy Monitoring</li> <li>Blood Pressure Control for People with Diabetes &lt;140/90</li> <li>Optimal Diabetes Care Combo 1 (LDL&lt;100, HbA1c &lt;8%, Nephropathy Monitoring)</li> <li>Proportion of Days Covered: Biguanides, Sulfonylureas, Thiazolidinediones, DPP-IV inhibitors, Diabetes roll-up</li> </ol> <p><u>Musculoskeletal</u></p> <ol style="list-style-type: none"> <li>Use of Imaging Studies for Low Back Pain</li> </ol> <p><u>Prevention</u></p> <ol style="list-style-type: none"> <li>Childhood Immunization Status – Combination of all Antigens</li> <li>Adolescent Immunizations – Combination of Tdap and meningococcal, and HPV</li> <li>Chlamydia Screening in Women</li> <li>Evidence-Based Cervical Cancer Screening</li> <li>Breast Cancer Screening – Ages 50-69</li> <li>Colorectal Cancer Screening</li> </ol> <p><u>Respiratory</u></p> <ol style="list-style-type: none"> <li>Asthma Medication Ratio</li> <li>Appropriate Testing for Children with Pharyngitis</li> <li>Appropriate Treatment for Children with Upper Respiratory Infection</li> <li>Avoidance of Antibiotic Treatment of Adults with Acute Bronchitis</li> <li>Spirometry Testing for COPD</li> </ol>

<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.

	<b>Year 9 Measures: Measurement Year 2011/ Reporting Year 2012</b>	<b>Proposed Year 10 Measures: Measurement Year 2012/ Reporting Year 2013</b>
<i>Clinical Weighting</i>	50%	50%
<b>MEANINGFUL USE OF HEALTH IT DOMAIN</b> <i>MEASURES TO BE COLLECTED, REPORTED AND RECOMMENDED FOR PAYMENT</i>	<ol style="list-style-type: none"> <li>1. Use of CPOE for medication orders <b>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. Implement drug-drug and drug-allergy interaction checks</li> <li>3. Maintain an up-to date problem list of current and active diagnoses</li> <li>4. Generate and transmit permissible prescriptions electronically (eRx)</li> <li>5. Maintain active medication list</li> <li>6. Maintain active medication allergy list</li> <li>7. Record demographics: Preferred language, Gender, Race, Ethnicity, Date of birth</li> <li>8. 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</li> <li>9. Record smoking status for patients 13 years old or older</li> <li>10. Report ambulatory clinical quality measures to CMS or the States</li> <li>11. Implement one clinical decision support rule <b>relevant to specialty or high clinical priority, along with the ability to track compliance with that rule</b></li> <li>12. Provide patients with an electronic copy of their health information</li> <li>13. Provide clinical summaries for patients at each office visit</li> <li>14. Capability to exchange key clinical information</li> <li>15. Protect <b>electronic</b> health information created or maintained by the certified EHR technology</li> <li>16. Generate patient lists by specific conditions</li> <li>17. Send patient reminders per patient preference</li> <li>18. Chronic Care Management for Diabetes, Depression, and one other Clinically Important Condition</li> </ol>	<ol style="list-style-type: none"> <li>1. 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</li> <li>2. Implement drug-drug and drug-allergy interaction checks</li> <li>3. Maintain an up-to-date problem list of current and active diagnoses</li> <li>4. Generate and transmit permissible prescriptions electronically (eRx)</li> <li>5. Maintain active medication list</li> <li>6. Maintain active medication allergy list</li> <li>7. Record demographics: Preferred language, Gender, Race, Ethnicity, Date of birth</li> <li>8. 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</li> <li>9. Record smoking status for patients 13 years old or older</li> <li>10. Report ambulatory clinical quality measures to CMS or the States</li> <li>11. Implement one clinical decision support rule relevant to specialty or high clinical priority, along with the ability to track compliance with that rule</li> <li>12. Provide patients with an electronic copy of their health information</li> <li>13. Provide clinical summaries for patients at each office visit</li> <li>14. Capability to exchange key clinical information</li> <li>15. Protect electronic health information created or maintained by the certified EHR technology</li> <li><del>16. Generate patient lists by specific conditions</del></li> <li><del>17. Send patient reminders per patient preference</del></li> <li><del>16-20. Any (5) CMS/ONC Menu set measures</del></li> <li>21. Chronic Care Management for Diabetes, Depression, and one other Clinically Important Condition</li> <li>22. Within-PO Performance Variation</li> </ol>
<i>Meaningful Use of Health IT Weighting</i>	30%	30%

	<b>Year 9 Measures: Measurement Year 2011/ Reporting Year 2012</b>	<b>Proposed Year 10 Measures: Measurement Year 2012/ Reporting Year 2013</b>
<b>PATIENT EXPERIENCE DOMAIN</b> <i>MEASURES TO BE COLLECTED, REPORTED AND RECOMMENDED FOR PAYMENT</i>	<ol style="list-style-type: none"> <li>1. Timely Care and Service Composite for PCPs</li> <li>2. Timely Care and Service Composite for Specialists</li> <li>3. Doctor-Patient Interaction Composite for PCPs</li> <li>4. Doctor-Patient Interaction Composite for Specialists</li> <li>5. Care Coordination Composite</li> <li>6. Overall Rating of Care</li> <li>7. Office Staff Composite</li> <li>8. Health Promotion Composite</li> </ol>	<ol style="list-style-type: none"> <li>1. Timely Care and Service Composite for PCPs</li> <li>2. Timely Care and Service Composite for Specialists</li> <li>3. Doctor-Patient Interaction Composite for PCPs</li> <li>4. Doctor-Patient Interaction Composite for Specialists</li> <li>5. Care Coordination Composite</li> <li>6. Overall Rating of Care</li> <li>7. Office Staff Composite</li> <li>8. Health Promotion Composite</li> </ol>
<i>Patient Experience Weighting</i>	20%	20%
<b>APPROPRIATE RESOURCE USE DOMAIN</b> <i>MEASURES TO BE COLLECTED, INTERNALLY REPORTED AND RECOMMENDED FOR PAYMENT</i>	<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. Total Cost of Care (baseline)</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 Days</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. Total Cost of Care</li> <li>8. Relative Resource Use—Asthma</li> <li>9. Relative Resource Use—Cardiovascular</li> <li>10. Relative Resource Use—Diabetes</li> <li>11. High Cost High Volume Service Areas</li> </ol>
<i>Appropriate Resource Use Weighting</i>	Shared savings	Shared savings

	<p align="center"><b>Year 9 Measures: Measurement Year 2011/ Reporting Year 2012</b></p>	<p align="center"><b>Proposed Year 10 Measures: Measurement Year 2012/ Reporting Year 2013</b></p>
<p><b>MEDICARE MEASURES</b> MEASURES TO BE COLLECTED, PUBLICLY REPORTED, AND RECOMMENDED FOR PAYMENT</p>	<p><u>Clinical</u></p> <ol style="list-style-type: none"> <li>1. Breast Cancer Screening – Ages 50-69</li> <li>2. <del>Diabetes Care: HbA1c Screening</del></li> <li>3. Diabetes Care: HbA1c Poor Control &gt;9% (Stars C17)</li> <li>4. <del>Diabetes Care: HbA1c Control &lt;8%</del></li> <li>5. Diabetes Care: LDL Screening (Stars C04)</li> <li>6. Diabetes Care: LDL Control &lt;100 (Stars C18)</li> <li>7. Nephropathy Monitoring for Diabetic Patients (Stars C16)</li> <li>8. Cholesterol Management: LDL Screening (Stars C03)</li> <li>9. <del>Cholesterol Management: LDL Control &lt;100</del></li> <li>10. <del>Blood Pressure Control (&lt;140/90) for Diabetic Patients</del></li> <li>11. <del>Optimal Diabetes Care (Combo 1) for Diabetic Patients</del></li> <li>12. Colorectal Cancer Screening (Stars C02)</li> <li>13. Medication Monitoring (ACE/ARBs, Digoxin, Diuretics, Anticonvulsants) (Stars C06)</li> </ol>	<p><u>Clinical</u></p> <ol style="list-style-type: none"> <li>1. Breast Cancer Screening – Ages 40-69 (Stars C01)</li> <li>2. Diabetes Care HbA1c Poor Control &gt;9% (Stars C17)</li> <li>3. Diabetes Care LDL Screening (Stars C04)</li> <li>4. Diabetes Care LDL Control &lt;100 (Stars C18)</li> <li>5. Nephropathy Monitoring for Diabetic Patients (Stars C16)</li> <li>6. Cholesterol Management: LDL Screening (Stars C03)</li> <li>7. Colorectal Cancer Screening (Stars C02)</li> <li>8. Medication Monitoring (ACEI/ARBs, Digoxin, Diuretics, Anticonvulsants) (Stars C06)</li> <li>9. At Least One Primary Care Doctor Visit in the Last Year (Stars C13)</li> <li>10. Glaucoma Testing (Stars C05)</li> <li>11. Osteoporosis Management (Stars C14)</li> <li>12. Eye Exam to Check for Damage from Diabetes (Stars C15)</li> <li>13. Rheumatoid Arthritis Management (Stars C20)</li> <li>14. Spirometry Testing for COPD (Stars C21)</li> </ol> <p><u>CAHPS Survey</u></p> <ol style="list-style-type: none"> <li>1. Annual Flu Vaccine (Stars C07)</li> <li>2. Pneumonia Vaccine (Stars C08)</li> <li>3. Doctors Who Communicate Well (Stars C25)</li> <li>4. Getting Appointments and Care Quickly (Stars C26)</li> <li>5. Ease of Getting Needed Care and Seeing Specialists (Stars C24)</li> <li>6. Overall Rating of Health Care Quality (Stars C28)</li> </ol> <p><u>HOS Survey</u></p> <ol style="list-style-type: none"> <li>1. Osteoporosis Testing (Stars C11)</li> <li>2. Monitoring Physical Activity (Stars C12)</li> <li>3. Improving or Maintaining Physical Health (Stars C09)</li> <li>4. Improving or Maintaining Mental Health (Stars C10)</li> <li>5. Improving Bladder Control (Stars C22)</li> <li>6. Reducing the Risk of Falling (Stars C23)</li> </ol>

	<p align="center"><b>Year 9 Measures: Measurement Year 2011/ Reporting Year 2012</b></p>	<p align="center"><b>Proposed Year 10 Measures: Measurement Year 2012/ Reporting Year 2013</b></p>
<p><b>TESTING MEASURES</b> <i>MEASURES TO BE COLLECTED FOR TESTING AND ANALYSIS</i></p>	<p><u>Clinical Domain</u></p> <ol style="list-style-type: none"> <li>1. Proportion of Days Covered—ACEI/ARBs</li> <li>2. Proportion of Days Covered—Statins</li> <li>3. Proportion of Days Covered—Biguanides, Sulfonylureas, Thiazolidinediones, DPP-IV inhibitors, Diabetes Roll-up</li> <li>4. HPV Vaccination for Adolescent Females</li> <li>5. Spirometry Testing for COPD</li> </ol> <p><u>Patient Experience Domain</u></p> <ol style="list-style-type: none"> <li>1. Chronic Care Measure(s)</li> </ol> <p><u>Appropriate Resource Use Domain</u></p> <ol style="list-style-type: none"> <li>1. Relative Resource Use—Asthma</li> <li>2. Relative Resource Use—Cardiovascular</li> <li>3. Relative Resource Use—Diabetes</li> <li>4. High Cost High Volume Service Areas</li> </ol> <p><u>Medicare Measures—Clinical</u></p> <ol style="list-style-type: none"> <li>1. At Least One Primary Care Doctor Visit in the Last Year (Stars C13)</li> <li>2. Glaucoma Testing (Stars C05)</li> <li>3. Osteoporosis Management (Stars C14)</li> <li>4. Eye Exam to Check for Damage from Diabetes (Stars C15)</li> <li>5. Rheumatoid Arthritis Management (Stars C20)</li> <li>6. Spirometry Testing for COPD (Stars C21)</li> </ol> <p><u>Medicare Measures – CAHPS Survey</u></p> <ol style="list-style-type: none"> <li>1. Annual Flu Vaccine (Stars C07)</li> <li>2. Pneumonia Vaccine (Stars C08)</li> <li>3. Doctors Who Communicate Well (Stars C25)</li> <li>4. Getting Appointments and Care Quickly (Stars C26)</li> <li>5. Ease of Getting Needed Care and Seeing Specialists (Stars C24)</li> <li>6. Overall Rating of Health Care Quality (Stars C28)</li> </ol> <p><u>Medicare Measures – HOS Survey</u></p> <ol style="list-style-type: none"> <li>1. Osteoporosis Testing (Stars C11)</li> <li>2. Monitoring Physical Activity (Stars C12)</li> <li>3. Improving or Maintaining Physical Health (Stars C09)</li> <li>4. Improving or Maintaining Mental Health (Stars C10)</li> <li>5. Improving Bladder Control (Stars C22)</li> <li>6. Reducing the Risk of Falling (Stars C23)</li> </ol>	<p align="center">To be determined</p>

**APPENDIX B**

**Pilot Test Results for Relative Resource Use (RRU) for Diabetes**

Two health plans participated in the pilot, accounting for 16% of total non-Kaiser HMO enrollment in California. The two health plan pilot participants submitted relative resource use (RRU) results for 192 Physician Organizations for MY 2008, and 58% of POs had reportable results based on public reporting criteria. This number will increase using aggregated results from all health plans and with the new risk adjustment methodology now being used, which enables reliable reporting for smaller sample sizes.

More than 60% of POs with reportable results showed high quality, but these groups were evenly split between the categories of high utilization of resources and low utilization of resources, as illustrated in Figure 1. Therefore, variation exists as well as room for improvement.

**Figure 1: Count of POs by Quadrant: Total Medical RRU**

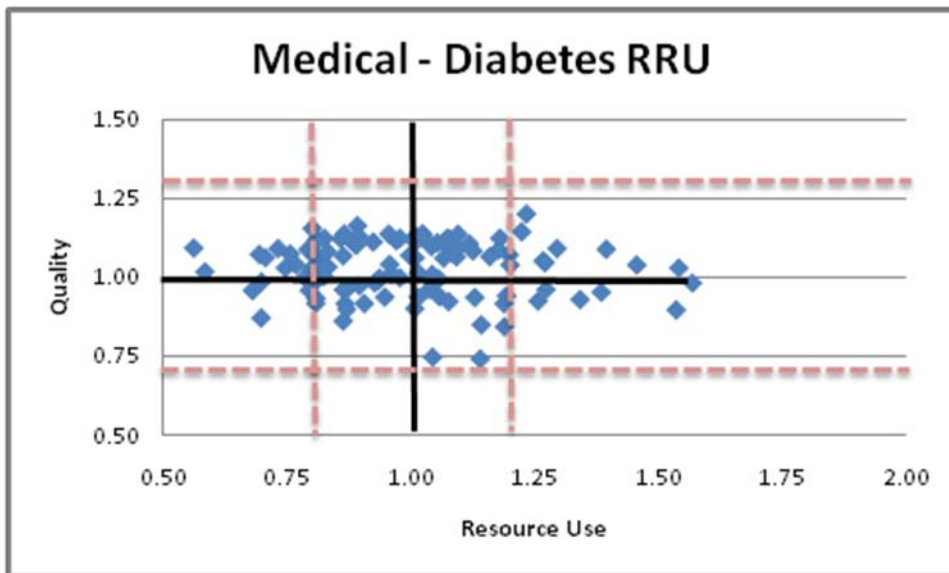
*(POs with reportable Quality and RRU results and >400 sample size and 90% confidence interval)*

Medical	Frequency	Percent
High Quality/Low Resource Use	36	32.4%
High Quality/High Resource Use	35	31.5%
Low Quality/Low Resource Use	20	18.0%
Low Quality/High Resource Use	20	18.0%

The scatter plot in Figure 2 graphically displays spread of POs across the quadrants.

**Figure 2: Display of POs by Quadrant: Total Medical RRU**

*(Note: the solid black lines delineate the average performance on Quality and Resource Use across all POs, and the red dashed lines delineate the 90% confidence interval)*



Some individual POs exhibit a wide degree of variance in quality and cost, as shown in Figure 3. While these results are preliminary and based on data from only two plans, they suggest that there is little, if any, correlation between resource use and quality. Furthermore, the results infer that some POs achieve similar levels of quality (A and B) at vastly different levels of resource use.

**Figure 3: Blinded Physician Organization Data: Total Medical RRU**

<b>Medical Group</b>	<b>Quality Quality Composite</b>	<b>Resource use Total Medical Index Ratio</b>
Medical Group A	1.03	1.54
Medical Group B	1.02	0.58
Medical Group C	0.84	1.19
Medical Group D	0.87	0.7

Following are the key findings from the pilot:

1. POs have sufficient sample size to report NCQA's RRU measures at least for diabetes and cardiovascular disease.
2. The pilot results are consistent with what NCQA has observed at the health plan level:
  - Variation in both quality and resource use across organizations
  - Wider variation in resource use than in quality
  - No overall correlation between resource use and quality

Other considerations:

1. Standard prices provide a fair comparison of weighted utilization.
2. Using the same measure at the health plan and PO level aligns P4P incentives.
3. Leveraging health plan data limits data collection effort and ensures reliability of audited data.

## **APPENDIX C**

### **Testing Results for Total Cost of Care**

Testing results for the Total Cost of Care measure will be available mid-September and inserted here.