

MY 2010 P4P Public Comment Summary with Responses

#	Element	Org Type	Feedback Type	Comments	P4P Response after vetting with Technical Quality Committee
Proposed MY 09 Testing Measures					
1	Asthma Medication Ratio (AMR)	Health Plan	Support		
2	Asthma Medication Ratio (AMR)	Health Plan	Support	No issues with this measure, however, note that the HEDIS version of this measure is not yet final. Once finalized it will be important to align the measures if differences exist.	NCQA will leverage P4P's experience with testing this measure when developing it for HEDIS. Additionally, if the measure is adopted for HEDIS with differences, P4P will consider aligning with HEDIS.
3	Asthma Medication Ratio (AMR)	Health Plan	Support	Until it is known what new asthma measure NCQA is intending to test, it is best to wait until that decision is made so that P4P and HEDIS can be aligned. It would be an unnecessary burden on plans to test a measure for P4P only to have it change if NCQA decides to implement a different measure.	See response #2
4	Asthma Medication Ratio (AMR)	Physician Specialty Group	Support with modifications	We support replacing the existing asthma measure with this one, which was developed, tested, modified by Kaiser-Permanente, and provided to NCQA. NCQA acknowledges that existing measure needs to be replaced, although budget constraints resulted in delays. Without substantial testing external to Kaiser-Permanente, we approve in concept, but we do see a potential problem if it becomes a payable measure for 2010. This measure does not facilitate quality improvement as directly as the previous measure which identified individual patients in need of intervention. This means physician organizations will need to spend additional resources to build asthma registries to identify patients in need of services.	A similar measure was tested by P4P once already and a modified version will be tested again in 2010. The measure identifies patients with more reliever meds than is advisable when compared to total (controller + reliever) asthma meds, which can be used directly for quality improvement. In addition, measure results indicate a good link to outcomes. TQC members felt that while this measure is not perfect it is a significant improvement over the old Asthma medication ratio measure.

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5	Asthma Medication Ratio (AMR)	Physician Organization	Support with modifications	Our PharmD had concerns about the definition of “inhaler/injection dispensing event” (p. 66 of 2010 draft manual), which states that an inhaler with a 90-days supply is considered one dispensing event. Is this definition for both reliever medications and controller medications? It seems inaccurate and problematic to do this for controller medications.	P4P generally aligns with the HEDIS definitions, which does not differentiate between for dispensing events for controllers and relievers. We will review the definitions used by Kaiser when testing the measure and determine whether a change is needed. TQC members felt that while this measure is not perfect it is a significant improvement over the old Asthma medication ratio measure. The issue of the refills for the controller is a wash because it is in both the numerator and denominator. There are ways to get this more precise but testing showed it to be error prone and could cause more problems. The target for this is .5 and not 1 to 1 to account for issues like these.
6	Asthma Medication Ratio (AMR)	Physician Organization	Support with modifications	The minimal optimum ratio should be defined.	The minimal ratio is outlined in the specifications: patients with ratios ≥ 0.5 experience significantly fewer asthma exacerbations.
7	Blood Pressure Control for Patients With Diabetes (CBPD)	Health Plan	Support		
8	Blood Pressure Control for Patients With Diabetes (CBPD)	Physician Specialty Group	Support with modifications	We support including BP. We acknowledge that groups without the ability to electronically capture these values will lag behind those with more advanced HIT. Without the electronic tracking, organizations will suffer a “double hit.” They will lose on both the diabetes domain and the IT-systemness, and this seems an excessive penalty. Suggest a potential middle ground for percent of population for which BP reports are available as the applicable measure.	This measure can be collected via registries or CPT II codes, not just with a sophisticated EMR. P4P has been emphasizing the importance of being able to collect and measure blood pressure control for 3 years, and has taken a phased approach to adding measures of blood pressure control e-capture and reporting. The proposed MY 2010 Systemness measure aligns with the suggested middle ground.
9	Blood Pressure Control for Patients With Diabetes (CBPD)	Health Plan	Do NOT Support	Concern over the ability to capture this data, as it is not available at this time.	P4P is aware of the challenges of collecting CPT II codes or registry data for blood pressure reporting. However, P4P's TQC and Steering Committees deemed this measure important enough to approve despite the challenges. P4P has been broadcasting this as an upcoming measure for 3 years, and has taken a phased approach to adding measures of blood pressure e-capture and reporting. P4P also incentivizes data sharing via a payment differential recommendation.

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10	Blood Pressure Control for Patients With Diabetes (CBPD)	Health Plan	Do NOT Support	This measure is not suited for administrative reporting due to the lack of CPT II codes in the data and it should not be considered for testing in MY 2009.	See response #9
11	Blood Pressure Control for Patients With Diabetes (CBPD)	Physician Organization	Do NOT Support	We still have challenges to get our IPAs to use CPT II codes, which is a new concept for many.	P4P is aware of the challenges of collecting CPT II codes for blood pressure reporting. However, P4P's TQC and Steering Committees deemed this measure important enough to approve despite the challenges. You may also use a registry or other supplemental data.
12	Blood Pressure Control for Patients With Diabetes (CBPD)	Physician Organization	Do NOT Support	1. Blood Pressure Control for Patients With Diabetes measure unfairly disadvantages PO's who do not have a universal EMR. 2. PO's are encouraged to get patients to goal and then stop further testing until the next measurement year. 3. Recommend setting a median state Blood Pressure goal prior to adding it to the measure set.	This measure can be collected via registries or CPT II codes, not just with a sophisticated EMR. P4P selects standardized quality measures; it is up to an organization to decide how to execute them in way that best serves their patients. NCQA tested taking averages and other methods of collection and it did not appear to make a difference; using the most recent reading is the easiest to collect. P4P may consider selecting statewide targets for measures.
13	Blood Pressure Control for Patients With Diabetes (CBPD)	Health Plan	Do NOT Support	Should IHA still go forward with these measures, the following notation should be removed from the specifications for these measures: "When identifying the most recent BP reading notated during the measurement year, do not include BP readings that meet the following criteria. BPs taken during an acute inpatient stay or an ED visit, BPs taken during an outpatient visit whose sole purpose to have a diagnostic test or surgical procedure performed (e.g., sigmoidoscopy, removal of a mole), BPs obtained the same day as a major diagnostic or surgical procedure (e.g., stress test, administration of IV contrast for a radiology procedure, endoscopy), BP readings taken by the member". This notation is only appropriate when doing medical record review and should not be present for administrative reporting.	P4P added the noted language to controlling high blood pressure because levels may be falsely elevated due to pain experienced in ER, Urgent Care and Inpatient. This came directly from Public Comment last year. Additionally, it should be possible to capture this information administratively. This language comes from HEDIS chart review but is applicable to registries/EHR's.
14	Optimal Diabetes Care (ODC)	Health Plan	Support		

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15	Optimal Diabetes Care (ODC)	Health Plan	Support with modifications	Recommend composite of A1c and LDL, BP data is not available	In response to concerns over POs inability to capture blood pressure this measure was modified so that it now has two combination rates: Rate 1: HbA1c <8, LDL-C<100, and Nephrology and Rate 2 will include all the criteria in Rate 1 plus Blood Pressure Control 140/90. Rate 1 will be recommended for payment and reporting.
16	Optimal Diabetes Care (ODC)	Physician Organization	Support with modifications	We recommend that all exclusions for the HbA1c measure be eliminated.	Exclusions were carefully selected by NCQA in order to avoid including people in the denominator for whom this level of control is not appropriate.
17	Optimal Diabetes Care (ODC)	Physician Specialty Group	Support with modifications	1. All of these values have consensus merit, although they are not necessarily equally weighted. As we have commented earlier, "all or nothing" scoring, i.e., "zero" score unless all 3 are within boundaries, is likely to be misleading. Under that absolute scheme, a patient with HbA1C 12, BP 160/100, LDL 200 scores the same as a patient with HbA1C 7.0, BP 120/80, & LDL 105. That becomes reporting without clinical common sense. While perhaps more complicated on the Excel sheet, we believe it would be more sensible to report the % of patients with 0, 1, 2, or all 3 measures in range. Organizations which hit 3 of 3 will still stand out appropriately. 2. Additionally, should the bundled reporting proposal prevail, the specifications are different for the "bundle" than for the individual measures for blood pressure control (130/80 v 140/90) and A1C control (poor control = 9 v 8). This inconsistent message may cause some confusion for physicians trying to meet guideline targets. We would endorse more uniform standards.	See response #15. TQC members felt that from a practice perspective the safer level is BP <140/90. Similar to the Minnesota Community Project from which this measure is based there are only two reporting options: 0 and 3.
18	Optimal Diabetes Care (ODC)	Health Plan	Do NOT Support	As this measure is an "all or none" measure where a member must meet all 3 control levels to be included in the numerator, and blood pressure control is one of the 3 levels that must be met, for the reasons stated in the Blood Pressure Control for People with Diabetes measure, this measure should not be tested in MY 2009. There will be no members who will meet all 3 levels due to the lack of administrative data for the blood pressure control.	See response #15.

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19	Optimal Diabetes Care (ODC)	Physician Organization	Do NOT Support	1. This is currently not a HEDIS measure and our clinicians prefer to use nationally-vetted HEDIS measures. 2. It is also very difficult to achieve all 3 of these goals, especially if the blood pressure is not captured systematically, since a missing blood pressure equates to "non-compliance" with this measure.	See response #15. While this is not a HEDIS measure, all three parts are comprised of HEDIS measures. Additionally, P4P has other non-HEDIS measures as part of the measure set. P4P is aware of the challenges of collecting CPT II codes or registry data for blood pressure reporting. However, P4P's TQC and Steering Committees deemed this measure important enough to approve despite the challenges.
20	Optimal Diabetes Care (ODC)	Physician Organization	Do NOT Support	1. Including Blood Pressure in the Optimal Diabetes Care measure unfairly disadvantages PO's who do not have a universal EMR. 2. PO's are encouraged to get patients to goal and then stop further testing until the next measurement year. 3. Recommend setting a median state Blood Pressure goal prior to including it into the Optimal Diabetes Care measure.	See response #12 and #15.
21	Optimal Diabetes Care (ODC)	Health Plan	Do NOT Support	Should IHA still go forward with these measures, the following notation should be removed from the specifications for these measures: "When identifying the most recent BP reading notated during the measurement year, do not include BP readings that meet the following criteria. BPs taken during an acute inpatient stay or an ED visit, BPs taken during an outpatient visit whose sole purpose to have a diagnostic test or surgical procedure performed (e.g., sigmoidoscopy, removal of a mole), BPs obtained the same day as a major diagnostic or surgical procedure (e.g., stress test, administration of IV contrast for a radiology procedure, endoscopy), BP readings taken by the member". This notation is only appropriate when doing medical record review and should not be present for administrative reporting.	See response #13
22	Childhood Immunization Status Combination Rates (CIS)	Health Plan	Support		
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24	Childhood Immunization Status Combination Rates (CIS)	Health Plan	Support		
25	Childhood Immunization Status Combination Rates (CIS)	Physician Organization	Support with modifications	Combo 10: Why does this measure include influenza vaccination when influenza vaccination is being excluded from the Hep A & Rotavirus testing measure due to “anticipated confounding issues with swine flu vaccinations?”	TQC removed combination 10 which included the flu vaccine.
26	Childhood Immunization Status Combination Rates (CIS)	Physician Organization	Support with modifications	<p>1. Our concern is the HepB given at birth because it is not available information. It is hard to match the immunization to the newborn due to global payment. It will require a lot of manual work with attestations.</p> <p>2. Recommend removal of combination 10 because of H1N1 this year and the supply of influenza vaccine is questionable which undermines the ability to be effective in all cases.</p> <p>3. Additional recommendation is the deadline for HepA needs to be extended due to recommended guidelines. There should be a 6 month leeway to allow for up to 30 months.</p>	<p>This information is needed for clinical decision of whether to vaccinate and can be collected via registry. Data collection progress has been made.</p> <p>See Response #25.</p> <p>The timing requirements for the Hepatitis A vaccine align with the ACIP guidelines. The recommended immunization schedule for persons age 0-6 years, indicates that two doses of Hepatitis A should be administered between 12 and 24 months. While the TQC acknowledged that this measure will never be a 100% they believe it will affect PO's equally.</p>

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27	Childhood Immunization Status Combination Rates (CIS)	Physician Specialty Group	Support with modifications	<p>1. Hepatitis B remains a serious challenge for comparative reporting, since the first dose is commonly administered in the birth hospital, with notoriously poor transfer of data from inpatient to ambulatory care systems. This measure dramatically favors groups which control hospitals, an acknowledged structural advantage unlikely to change in the immediate future. The challenge of sharing this claims trace needs to be met eventually, but candidly, this is not the most important priority for hospital-group-Plan HIT interface. (For both clinical and financial impact, that would more likely be continuity of care pre- and post-hospitalization plus rapid ER follow-up to the medical home physician and group.) Meanwhile, there is a near certainty that variability in group Hep B compliance will be related to hospital inpatient practices and billing procedures, not clinical appropriateness of ongoing children's' ambulatory preventive health oversight.</p> <p>2. We have objections of a similar theme regarding the multiple combinations. In current situations, compounded by the grim economy, many families are obliged to change coverage as a sequence of employment vagaries. They may choose to procure IZ's in alternative locations (community clinics, retail outlets) and/or postpone them. The quirky influenza vaccine supply now and in multiple recent years really exacerbates this problem, rendering Combo 10 particularly undesirable. Bottom line, for Hep B and Combos 7 & 10: We have no objection to testing to develop useful baseline trends, but we resist conversion to report/pay measure until this multi-provider situation is resolved. We would suggest "stick with the basics" of the first 2 year core vaccinations.</p>	<p>This information is needed for clinical decision of whether to vaccinate and can be collected via registry. Data collection progress has been made.</p> <p>See Response #25.</p>
28	Childhood Immunization Status Combination Rates (CIS)	Physician Organization	Do NOT Support	Performance on combination rates may be poor due to parents choosing to vaccinate children only for certain diseases. An increasing number of parents are wary about giving too many vaccinations because of fears of autism (even if unsubstantiated).	P4P does not allow patient refusal as a reason for exclusion from the denominator in any given measurement. Please refer to letter "Excluding Patients Who Decline Services" posted on IHA website for more detailed response.

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29	Childhood Immunization Status Hep A and Rotavirus (CIS)	Health Plan	Support		
30	Childhood Immunization Status Hep A and Rotavirus (CIS)	Health Plan	Support		
31	Childhood Immunization Status Hep A and Rotavirus (CIS)	Physician Specialty Group	Support with modifications	<p>1. Our pediatric leaders offered a strong consensus that rotavirus vaccine does not belong on the P4P list at all. Its clinical utility is controversial at best, and the cost is a major obstacle to both providers and recipients. The recall of the original rotavirus vaccine casts a continuing pall upon the reputation of this vaccine in the public eye. Unfortunately, that experience impugns the safety of other more important preventive offerings.</p> <p>2. A rigid second-birthday deadline for the two doses of Hep A is problematic. All of the other vaccines have their last recommended date of administration at 18 mos. or earlier. According to the current CDC/ACIP vaccine schedule the two doses of Hep A are to be given between 12 and 23.999 mos. We generally give the second Hep A at the 2yr WCC, which is in accordance with any reasonable interpretation of the schedule. But this visit is nearly universally shortly after the second birthday. So we would get a zero on this measure, even though we were following the CDC guidelines. Basically we need a reasonable grace period for Hep A since giving it at the 2yr WCC is correct. I would suggest 6 mos since the other vaccines have at least this long (i.e., two HepA by 30 mos.).</p>	<p>The ACIP guidelines, which are supported by AAP and AAFP, recommend vaccinating all kids against Rotavirus.</p> <p>See response #26.</p>
32	Childhood Immunization Status Hep A and Rotavirus (CIS)	Physician Organization	Do NOT Support	<p>1. It is difficult to give 2 doses of Hepatitis A by the age of 2 years because the vaccine is not licensed for children less than 1 year of age. The strict dosing intervals for Rotateq make it difficult to perform well on the measure (i.e., the child needs to receive all doses by 32 weeks of age).</p>	See response #26.

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				2. In addition, since the "transition year" is no longer offered for P4P, this puts medical groups at a complete disadvantage since by 2010, no pursuit of patients needing the Rotavirus vaccine can be done since all these patients will have been older than 8 months of age (after which the vaccine is not indicated as there is no catch-up period).	Rotavirus is part of the standard immunization guidelines and should be given regardless of whether or not it is a P4P measure.
MY 2010 Measure Additions					
33	Adolescent Immunizations (Tdap, meningococcal) (IMA)	Health Plan	Support		
34	Adolescent Immunizations (Tdap, meningococcal) (IMA)	Health Plan	Support		
35	Adolescent Immunizations (Tdap, meningococcal) (IMA)	Health Plan	Support		
36	Adolescent Immunizations (Tdap, meningococcal) (IMA)	Physician Organization	Support with modifications	There are patients who are medically indicated to receive the Td vaccine before the age of 10 or 11 (outside of the P4P criteria). Therefore, to count towards P4P, the physicians would need to revaccinate at age 11 or 12, which is medically unnecessary. There needs to be an accommodation for these instances.	The age requirement for the Tdap/Td vaccines aligns with the ACIP guidelines which indicates that the vaccine should be administered between the ages 11-12. The age range in the specifications is 10-12 to account for the Boostrix vaccine.
37	Adolescent Immunizations (Tdap, meningococcal) (IMA)	Physician Organization	Support with modifications	Even though recommended by 12, the catch-up is to age 13. Our recommendation is for a grace period of 2 years to allow time for the immunization.	P4P and HEDIS measures don't accommodate the "catch up" schedule on missed vaccinations.
38	Adolescent Immunizations (Tdap, meningococcal) (IMA)	Physician Specialty Group	Support with modifications	Widespread California practice has been to give Menactra vaccine anytime between 14-15 yrs old. ACIP recommends age 11-12, so this would be change of practice. Recommend extending age cut-off.	Yes, this would be a change in practice. P4P guidelines align with ACIP recommendations.

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39	Asthma Medication Ratio (AMR)	Health Plan	Support	No issues with this measure, however, note that the HEDIS version of this measure is not yet final. Once finalized it will be important to align the measures if differences exist.	See response #2
40	Asthma Medication Ratio (AMR)	Health Plan	Support with modifications	Until it is known what new asthma measure NCQA is intending to test, it is best to wait until that decision is made so that P4P and HEDIS can be aligned.	See response #2
41	Asthma Medication Ratio (AMR)	Health Plan	Support with modifications	We support this measure contingent on there being a sound number of participants in testing as well as there being valid & consistent results across reporting entities.	Per P4P policy, this measure will only be adopted upon successful and thorough testing by P4P. Please note that this measure has also been tested by Kaiser in conjunction with AAAI.
42	Asthma Medication Ratio (AMR)	Physician Organization	Support with modifications	1. We would like to keep the existing measure because we have not received any good information on the new test measure to adequately test. 2. The AMR measure does not give you an actionable list of how to make sure the patients are well cared for and may require the build of an asthma registry to identify patients that are in poor control.	This measure has been thoroughly specified and has already been tested by Kaiser in conjunction with AAAI. Per P4P policy, this measure will only be adopted if successfully tested by the P4P program. The measure identifies patients with more reliever meds than is advisable when compared to total (controller + reliever) asthma meds, which can be used directly for quality improvement. In addition, measure results indicate a good link to outcomes.
43	Blood Pressure Control for People with Diabetes (BPCD)	Health Plan	Support	We support the intent of this measure and would like to see data submission / collection processes implemented to capture this element in administrative data. However, it is key to point out that most results for this measure will primarily be reported by and financial awards paid to self reporting POs only.	See response #9
44	Blood Pressure Control for People with Diabetes (BPCD)	Physician Organization	Support with modifications	1. The Blood Pressure Control for People with Diabetes measure unfairly disadvantages PO's who do not have a universal EMR. 2. PO's are encouraged to get patients to goal and then stop further testing until the next measurement year. 3. Recommend setting a median state Blood Pressure goal prior to including it into the measure set.	See response #12

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45	Blood Pressure Control for People with Diabetes (BPCD)	Physician Specialty Group	Support with modifications	We acknowledge that groups without the ability to electronically capture these values will lag behind those with more advanced HIT. Without the electronic tracking, organizations will suffer a “double hit.” They will lose on both the diabetes domain and the IT-systemness, and this seems an excessive penalty. Suggest a potential middle ground for percent of population for which BP reports are available as the applicable measure.	See response #8
46	Blood Pressure Control for People with Diabetes (BPCD)	Physician Organization	Support with modifications	1. I realize why BP is included as a measure, but I challenge that there isn't great correlation of BPs taken in the office to long-term cardiovascular outcome in diabetes. A better measure might be home BP readings. 2. Emerging data suggests that it might be much more clinically important to simply put a hypertensive patient on medication, rather than shooting for a numerical treatment target; again the research isn't all that great about treating to a specific target number. The correlation is lower BPs to better outcomes, but this might be an effect of an individual's natural biology, rather than treatment.	Home measurements do not count, as the guidelines on home blood pressure monitoring are not straight forward. NCQA is encouraging guideline agencies to be more specific. This measure is built on evidence-based guidelines that recommend treating to target.
47	Blood Pressure Control for People with Diabetes (BPCD)	Physician Organization	Support with modifications	The results from the pilot should be evaluated and perhaps tested again for MY 2010. Measure addition should be evaluated for 2011.	This will be the second year that we test this measure. P4P has also been announcing that this measure is coming for 3 years.
48	Blood Pressure Control for People with Diabetes (BPCD)	Physician Organization	Do NOT Support	Capturing blood seems biased toward self contained self contained medical groups as this information is not easily available for IPAs. This should not be a requirement until everyone has an EHR.	This measure can be collected via registries or CPT II codes, not just with a sophisticated EMR. While data availability may be easier in medical groups vs. IPAs, the ability to collect and exchange data is important for all POs, and has been emphasized by P4P.
49	Blood Pressure Control for People with Diabetes (BPCD)	Health Plan	Do NOT Support	Concern over the ability to capture this data, as it is not available at this time	See response #9
50	Blood Pressure Control for People with Diabetes (BPCD)	Health Plan	Do NOT Support	This measure is not suited for administrative reporting due to the lack of CPT II codes in the data and it should not be considered for adoption in measurement year 2010.	See response #9

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51	Blood Pressure Control for People with Diabetes (BPCD)	Health Plan	Do NOT Support	Should IHA still go forward with these measures, the following notation should be removed from the specifications for these measures: "When identifying the most recent BP reading notated during the measurement year, do not include BP readings that meet the following criteria. BPs taken during an acute inpatient stay or an ED visit, BPs taken during an outpatient visit whose sole purpose to have a diagnostic test or surgical procedure performed (e.g., sigmoidoscopy, removal of a mole), BPs obtained the same day as a major diagnostic or surgical procedure (e.g., stress test, administration of IV contrast for a radiology procedure, endoscopy), BP readings taken by the member". This notation is only appropriate when doing medical record review and should not be present for administrative reporting.	See response #13
52	Optimal Diabetes Care (ODC)	other	Support with modifications	Quality measurement has been identified as a tool to help achieve improved quality of care and improved health outcomes. Through measurement, healthcare quality can be assessed, analyzed, and improved. Results of such measurement can identify areas for improvement, as well as areas of strength, for a given healthcare professional, plan, or system. Those identified areas needing improvement can be evaluated and analyzed to isolate processes or practices that, with change, can lead to better care. Performance evaluation can help lead to improvements in quality of care by ensuring that patients are receiving appropriate care, which can include appropriately ordering and monitoring results of lab tests, imaging studies, medical and surgical procedures, counseling, or medication use. Measurement also provides a means of accountability, ensuring that there is a responsible party for a patient's care. To support quality-focused competition in healthcare, measures should overcome, and not reinforce, fragmentation in care delivery and narrow silo budgeting.	Tobacco and aspirin use were dropped from the composite due to data collection issues around these two metrics. Collecting blood pressure was thought to be difficult enough and the program did not want to overshadow blood pressure by asking organizations to also collect tobacco and aspirin use. Additionally, the composite is a collection of measures that are already in the measure set, or being considered as new standalone measure. This could possibly be considered in the future when data collection and exchange is stronger.

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				Measures should support the overall goal of improved long-term patient outcomes, accommodate patient preferences, and give physicians and patients flexibility to choose the optimal treatment to achieve high quality outcomes for the individual. We applaud the IHA for continuing to test the incorporation of the Optimal Diabetes Measure adopted from Minnesota Community Measurement. We strongly urge IHA to consider implementing all five indicators of the Optimal Diabetes Measure, rather than the revised three indicator version currently proposed. Tobacco has been shown to be harmful to health and is of particular danger to people with diabetes. All late complications of diabetes such as cardiovascular disease, foot problems, kidney and eye disease are worsened by smoking. Experts agree that appropriate use of medicines plays a central role in both the quality of healthcare patients receive as well as t [missing text - exceeded character limit on Web form]	
53	Optimal Diabetes Care (ODC)	Health Plan	Support with modifications	Recommend composite of LDL and A1c, BP data is not available	See response #15
54	Optimal Diabetes Care (ODC)	Health Plan	Support with modifications	We support the intent of this measure. As the all or nothing scoring aspect of this measure includes the blood pressure screening measure, it is key to point out that most results for this measure will be primarily reported by and financial awards paid to self reporting POs only.	See response #15
55	Optimal Diabetes Care (ODC)	Physician Specialty Group	Support with modifications	We acknowledge that groups without the ability to electronically capture these values will lag behind those with more advanced HIT. Without the electronic tracking, organizations will suffer a "double hit." They will lose on both the diabetes domain and the IT-systemness, and this seems an excessive penalty. Suggest a potential middle ground for percent of population for which BP reports are available as the applicable measure. See qualified support above, including standardizing individual targets.	This measure can be collected via registries or CPT II codes, not just with a sophisticated EMR. In response to concerns over POs inability to capture blood pressure this measure was modified so that it now has two combination rates: Rate 1: HbA1c <8, LDL-C<100, and Nephrology and Rate 2 will include all the criteria in Rate 1 plus Blood Pressure Control 140/90. Rate 1 will be recommended for payment and reporting. The proposed MY 2010 Systemness measure aligns with the suggested middle ground.
56	Optimal Diabetes Care (ODC)	Health Plan	Do NOT Support	This measure is not suited for administrative reporting due to the lack of CPT II codes in the data needed for the blood pressure component and it should not be considered for adoption in measurement year 2010.	See response #15

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57	Optimal Diabetes Care (ODC)	Physician Organization	Do NOT Support	1. Including Blood Pressure in the Optimal Diabetes Care measure unfairly disadvantages PO's who do not have a universal EMR. 2. PO's are encouraged to get patients to goal and then stop further testing until the next measurement year. 3. Recommend setting a median state Blood Pressure goal prior to including it into the Optimal Diabetes Care measure.	See response #15
58	Optimal Diabetes Care (ODC)	Physician Organization	Do NOT Support	1. For optimal care it is 'all or none'. It gets confusing with the difference in the blood pressure for control with diabetes and the blood pressure for optimal diabetes care. 2. Capturing blood seems biased toward self contained self contained medical groups as this information is not easily available for IPAs.	See response #15
59	Optimal Diabetes Care (ODC)	Health Plan	Do NOT Support	Should IHA still go forward with these measures, the following notation should be removed from the specifications for these measures: "When identifying the most recent BP reading notated during the measurement year, do not include BP readings that meet the following criteria. BPs taken during an acute inpatient stay or an ED visit, BPs taken during an outpatient visit whose sole purpose to have a diagnostic test or surgical procedure performed (e.g., sigmoidoscopy, removal of a mole), BPs obtained the same day as a major diagnostic or surgical procedure (e.g., stress test, administration of IV contrast for a radiology procedure, endoscopy), BP readings taken by the member". This notation is only appropriate when doing medical record review and should not be present for administrative reporting.	See response #13
60	Childhood Immunization Status Combination Rates (CIS)	Health Plan	Support with modifications	We support this measure contingent on there being a sound number of participants in testing as well as there being valid & consistent results across reporting entities.	Per P4P policy, these measures will only be adopted upon successful and thorough testing.
61	Childhood Immunization Status Combination Rates (CIS)	Physician Organization	Support with modifications	Combo 10 Why does this measure include influenza vaccination when influenza vaccination is being excluded from the HepA & Rotavirus testing measure due to "anticipated confounding issues with swine flu vaccinations?"	See response #25.

#	Element	Org Type	Feedback Type	Comments	P4P Response after vetting with Technical Quality Committee
62	Childhood Immunization Status Hep A and Rotavirus (CIS)	Physician Organization	Support with modifications	<p>1. We recognize the importance of timely immunizations for all children and follow the guidance of the CDC and ACIP. The list of recommended immunizations for children continues to grow, yet physicians report difficulty with parental adherence with the current schedule of immunizations that prevent life threatening illness. The list of recommended immunizations for children continues to grow, yet physicians report difficulty with parental adherence with the current schedule of immunizations that prevent life threatening illness.</p> <p>2. We do not support the inclusion of the rotavirus as a required vaccination for all children by the age of two, and recommends that combinations 7 and 10 be changed. It is our position that the inclusion of rotavirus to the measurement set promotes inappropriate utilization. Physicians should assess the need for this vaccination based on a child's risk of exposure to rotavirus. Groups at increased risk for rotavirus infection are those with increased exposure to virus. This includes children who attend childcare centers, children in hospital wards, caretakers and parents of children in childcare or hospitals, and children and adults with immunodeficiency-related diseases. We believe that this population should appropriately receive the rotavirus vaccination. Rotavirus is currently not one of the reported vaccine-preventable diseases in California.</p>	<p>See response #28</p> <p>The ACIP guidelines, which are supported by AAP and AAFP, recommend vaccinating all kids against Rotavirus.</p>
63	Childhood Immunization Status Hep A and Rotavirus (CIS)	Health Plan	Support with modifications	We support this measure contingent on there being a sound number of participants in testing as well as there being valid & consistent results across reporting entities.	See response #60
64	Systemness: Electronic Reporting of Blood Pressure-Hypertension	Health Plan	Support		
65	Systemness: Electronic Reporting of Blood Pressure-Hypertension	Health Plan	Support	This data would need to come from an EHR or other means as BP data is not available from the health plan	See response #9

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66	Systemness: Electronic Reporting of Blood Pressure-Hypertension	Physician Organization	Support	10% capture rate seems fair; anything more would not be.	
67	Systemness: Electronic Reporting of Blood Pressure-Hypertension	Physician Organization	Support with modifications	We concur with the importance of including blood pressure as part of the diabetes and IT Systemness measures. An unintended consequence of these measures highlights the gap between IPAs and medical groups. The perceived “gap” is not reflective of the care provided. We would like this highlighted in the results.	While data availability may be easier in medical groups vs. IPAs, the ability to collect and exchange data is important for all POs, and has been emphasized by P4P.
68	Systemness: Electronic Reporting of Blood Pressure-Hypertension	Health Plan	Support with modifications	Would like the Blood Pressure collected and reported to plans for credit - to drive to use of CPT II codes, could those be mandatory?	A standard format for sharing supplemental data is being finalized, and will include mapping to CPT II codes for blood pressure.
69	Systemness: Electronic Reporting of Blood Pressure-Hypertension	Physician Specialty Group	Support with modifications	Yes—this is the most important as well as the most controllable physiological parameter. Without the ability to track and recall...lessons we have learned long ago with registries...we’re unable to provide the population based care we need to offer. We acknowledge that groups without the ability to electronically capture these values will lag behind those with more advanced HIT. Without the electronic tracking, organizations will suffer a “double hit.” They will lose on both the diabetes domain and the IT-systemness, and this seems an excessive penalty. Suggest a potential middle ground for percent of population for which BP reports are available as the applicable measure. P4P succeeded fabulously to accelerate the acquisition of HIT...and let’s continue to nudge the infrastructure to incorporate BP reporting.	See response #8
70	Systemness: Electronic Reporting of Blood Pressure-Hypertension	Physician Organization	Do NOT Support	IT Enabled Systemness Domain adds electronic reporting of blood pressure. This will cause the medical groups to be penalized twice for the groups that do not have the ability to measure the information electronically. Capturing blood seems biased toward self contained self contained medical groups as this information is not easily available for IPAs. This should not be a requirement until everyone has an EHR.	See response #48

#	Element	Org Type	Feedback Type	Comments	P4P Response after vetting with Technical Quality Committee
Proposed MY 2009 Measure Deletions					
71	Use of Appropriate Medications for People With Asthma (ASM)	Health Plan	Support		
72	Use of Appropriate Medications for People With Asthma (ASM)	Physician Specialty Group	Support	Support Removal.	
73	Use of Appropriate Medications for People With Asthma (ASM)	Health Plan	Support		
74	Use of Appropriate Medications for People With Asthma (ASM)	Health Plan	Support		
75	Use of Appropriate Medications for People With Asthma (ASM)	Physician Organization	Support		
76	Use of Appropriate Medications for People With Asthma (ASM)	Physician Organization	Support		
77	Use of Appropriate Medications for People With Asthma (ASM)	Physician Organization	Do NOT Support	Why is the current Asthma measure being deleted prior to completion of testing and adoption of the new Asthma Medication Ratio measure? In doing so, PO's who have been working on the measure in good faith this year will not be fairly rewarded.	It is non-traditional to remove a measure at this time, and P4P would not have proposed it if it weren't for the extensive programming changes required this year. Since P4P intends to replace the measure for MY 2010, and the measure is already high performing (i.e., the 25th percentile score is >90%), P4P recommends removing the measure.

#	Element	Org Type	Feedback Type	Comments	P4P Response after vetting with Technical Quality Committee
Other Comments					
78	Measure Adoption	Physician Organization	Do NOT Support	<p>1. Removal of the “transition year” is problematic especially since “testing measures” are introduced very late in the year and we will not know the results of “testing” until 2010. The “testing measures” should be renamed “transition measures” since they will become measures the following year. Once again, this puts medical groups at a distinct disadvantage. There is not enough time for appropriate “gearing up” for the measure (i.e., review of coding practices to make sure we capture valid P4P codes, programming the new specifications, testing the programming, providing information to clinicians, adjusting internal guidelines, etc). The dissatisfaction with performance may be linked to the above. 2. In addition, P4P should only use HEDIS nationally-vetted measures. This is important for the Asthma Medication Ratio measure, the Optimal Diabetes Care measure, and the Evidence-Based Cervical Cancer Screening measure, which are not currently HEDIS measures. Practicing physicians express concern that these measures have not been vetted at the highest level.</p>	Removal of the transition year was part of last years public comment and was approved by the P4P committees. P4P relies on a measure selection framework when selecting measures that looks at importance, scientific acceptability, feasibility, and usefulness. Ideally all measures will have been nationally vetted or, as is the case of the Asthma Medication Ratio measure, tested by a nationally recognized organization and up for consideration by NCQA for adoption.
79	Measure Adoption	Physician Organization	Do NOT Support	New Test-Implement cycle: Encourages potential misuse of resources for an unproven metric.	P4P's test measures have all been vetted, typically by nationally recognized entities like NCQA. None of the P4P test measures are unproven metrics. P4P also tests these measures again to see if there is something unique in California or for Self Reporting PO's. Additionally, PO testing is optional.
80	Evidenced Based Cervical Cancer Screening	Physician Organization	Support with modifications	Our Physician Organization as a whole has voiced much concern regarding the Evidence Based Cervical Cancer Screening measure, specifically, the sub-measure of Screened Too Frequently. After careful review of many of the medical society guidelines, specifically the American Cancer Society, the American College of Obstetrics and Gynecology, and the USPSTF, we believe that the USPSTF guidelines are the outlier guidelines since the other societies are more in alignment than the USPSTF. However, since IHA has selected to follow the USPSTF recommendations we find that in order to adhere exactly to these guidelines the sub-measure of 'Screened Too Frequently' is not appropriately defined by IHA. Our opinion is based on the actual recommendations of the USPSTF which state the following:	P4P and NCQA follow the USPSTF guidelines and acknowledge that they do not align with ACS and ACOG on some recommendations. Per USPSTF, the data are limited to determine the benefits of ACS and ACOG strategies. We acknowledge that USPSTF's summary of recommendations does recommend "screening at least every 3 years," but if you read the further into the clinical considerations, they indicate that they "found no direct evidence that annual screening achieves better outcomes than screening every 3 years."

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				For the recommended intervals of conducting cervical cancer screening - AT LEAST EVERY 3 YEARS The IHA measure set states that more than one pap smears is 'too many' thereby penalizing the MD for more than one screening in the three year period. We request you amend the sub-measure to reflect the exact language of the USPSTF and discard the sub-measure penalties if more than one screening is performed on the patient.	
81	Evidenced Based Cervical Cancer Screening	Physician Organization	Support with modifications	We were happy to see that IHA added exclusions for the ECS measure, but there are other symptoms that a woman may present that warrant a cervical cancer screening to rule out early cancer. Those symptoms include menorrhagia (unusual vaginal bleeding) (626.2, 627.0, 627.1), dysparenia (painful intercourse) (625.0), and vaginitis (099.2). Since it would be inappropriate for a clinician not to do pap smear with these symptoms, we think these should be on the list of exclusions because they define "symptomatic" as opposed to "asymptomatic".	TQC reviewed these exclusions and found them to be too infrequent and inappropriate exclusions for ECS.
82	Evidenced Based Cervical Cancer Screening	Physician Organization	Support with modifications	1. Our concern is with the non-payment of P4P bonuses for the screened too frequently (STF) category in the ECCS measure. Many PCP's are adding the HPV High Risk screening to their Pap smears. If the Pap shows the patient has HPV, the PCP notifies her that she now needs yearly Pap tests. However, we are not able to exclude the patient from the measure because her Pap test has come back normal. 2. In addition, many GYNs refuse to refill oral birth control for patients unless they do a yearly Pap test.	TQC added HPV as an exclusion for ECS.

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83	Evidenced Based Cervical Cancer Screening	Physician Organization	Support with modifications	<p>1. Changes to cervical cancer screening that affects MY2009 and MY2010. We endorse the measure’s intentions of encouraging appropriate screening for cervical cancer, identifying under-screening, and discouraging overuse. However, we recommend that IHA consider removing the “over-screening” standard to the population under 30 years of age for several reasons: A) there may be other rationale for more frequent screening in this population such as multiple sexual partners. B) physicians rarely identify multiple sexual partners in coding practices and C) multiple sexual partners is not listed as an exclusion in the proposed measure specifications. Current American College of Obstetricians and Gynecologist (ACOG) screening guidelines differ from the U.S. Preventive Services Task Force (USPSTF) guidelines for the population under 30 years of age. USPSTF recommendations state:</p> <p>“The American College of Obstetricians and Gynecologist (ACOG) identifies additional risk factors that might justify annual screening, including a history of cervical neoplasia, infection with HPV or other STDs, or high-risk sexual behavior, but data are limited to determine the benefits of these strategies.”</p> <p>2. The ACOG guidelines state: “Women of any age who are immuno-compromised, are infected with HIV, or were exposed in utero to DES should be screened annually.”</p> <p>3. Both PCPs and obstetrician and gynecology (OB/GYN) physicians contribute to prevention and screening measures. Patients can self-refer to OB/GYNs under current California law. While the PCP may adhere to the USPSTF guidelines, if a patient self-refers to an OB/GYN, PCPs may be held accountable for patients for whom they are not providing care.</p>	<p>In MY 2009 P4P has broken out the measure so that women under 30 will be collected separately. While P4P will not report this measure by age band publicly, organizations will be able to use this information for their internal needs. A-C: Currently, the USPSTF's guidelines do not make recommendations based on the number of sexual partners. As with all P4P measures, clinicians still need to use their best judgment when caring for their patients. USPSTF commonly states counter arguments in their guidelines, as they did in the referenced quote from ACOG.</p> <p>TQC added HPV as an exclusion for ECS.</p> <p>The USPTSTF guidelines apply to all physician specialties. Coordination of services and monitoring over-use is expected to occur across the entire organization and not just amongst PCP's.</p>
84	Evidenced Based Cervical Cancer Screening	Physician Organization	Do NOT Support	<p>Evidence based cervical cancer screening measure requires an inordinate amount of administrative data to be accurate (ie hysterectomy status). This data often exists only in paper form and is extremely labor intensive to collect. I propose that only those who have recent hysterectomies, with system generated data, be included in the "too frequently" screened denominator.</p>	<p>Despite the high level of effort required for this measure, clinical evidence warrants the adoption of this measure given the prevalence of over-screening at this time. Instructions are to look back as far as possible for hysterectomy, and it is up to the PO to determine what is possible. This is not a new requirement, as hysterectomies were a required exclusion in the former cervical cancer screening measure.</p>

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85	Encounter Rate by Service Type	Physician Organization	Support with modifications	<p>1. The Encounter Data by Service type requirements (now 4.0) to qualify for inclusion into the P4P program are troubling in that health plans are moving away from interim reporting. Instead, medical groups may be presented with an unpleasant surprise at the end of a reporting year - you have not met the minimum encounter data threshold.</p> <p>2. We have found DDD to be unresponsive to our concerns re data submission discrepancies (what we send vs. what they transmit". They have no accountability in this effort, yet they can put medical groups at tremendous financial risk. Medical groups need to be given regular updates of their progress in meeting the encounter thresholds throughout the MY, with an opportunity to correct and improve - and with appropriate responsiveness from DDD. Concern about the Encounter Data by Service type requirements (now 4.0) to qualify for inclusion into the P4P program due to health plans moving away from interim reporting. Concern about unresponsiveness in regards to data submission discrepancies. Consider providing regular updates of progress in meeting the encounter thresholds throughout the measurement year, with an opportunity to correct and improve data.</p>	<p>The intent of standardizing the metrics was not to discontinue interim reporting. This will be an agenda item during the next Health Plan Data Collection Team meeting.</p> <p>DDD offers an on-line tool called the Encounter Reconciliation System (ERS), which can be used to track the status of encounter submission and transmission.</p>
86	PO Master	Health Plan	Support	Please automate the PO Master rather than in excel workbooks.	This is not possible at this time.
87	Supplemental Data	Physician Organization	Support	Now that our group is using an AEHR and electronic prescribing I am wondering if the P4P pharmacy outcomes should allow for self reporting via the AEHR prescribing modules. It is my understanding that currently this data can only be reported via pharmacy claims data which is usually at the plan level or requires the plans to provide accurate data to the groups. Electronic prescribing would likely provide a more accurate assessment of the physicians' behavior. I think groups with AEHRs should be able to self report via the AEHR data.	EHR/EMR data falls under the category of supplemental data, which P4P allows as long as it goes through the audit review process and meets the criteria specified. These criteria are outlined in the MY 2009 P4P manual on page 17 under the required data elements section. Pharmacy EMR data is allowed, although the prescribing module must track <u>filled</u> prescription in order to meet the specifications.
88	Diabetes Registry	Physician Organization	Support with modifications	Diabetes Registry (scoring) we support the components of this measure, yet recommends a change in the scoring / weighting of in this measure. The blood pressure element is worth 2 out of 5 points and the other elements are worth one point each. Our recommendation is that the blood pressure has a value/weight of 1 point as the other components of the measure.	The scoring for this measure was purposefully set high to stress the importance of engaging in this type of management for patients with diabetes. P4P is aiming for breakthrough change in the management of diabetes, and blood pressure control is a vital component.

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89	IT Enabled Systemness	Physician Organization	Support with modifications	IT Systemness (scoring) - we recommend that IHA consider looking at a tiered scoring/ weighting rather than an "all of none" approach. The expectation to achieve 27 out of 27 points to obtain a score of 20 is confusing. We recommend adjusting the scoring the total points equal the total possible points for the measure.	We recognize that the current scoring system is confusing but it was set up this way to accommodate updates/changes to this domain. A conversion factor is necessary to assure that the number of points equals the domain weighting that year and to allow us to add/remove measures.
90	Patient-Centric Reporting	Physician Specialty Group	Do NOT Support	We would like to preface our comments by reinforcing a suggestion made by several parties recently. Currently, scores are reported for each group as an equivalent reporting unit regardless of size of network and covered lives. Derivative statistics (means, medians, percentiles, standard deviations, confidence intervals, etc.) are calculated for each measure using each group as an equivalent unit in the denominator. Some large groups report geographic subunits separately, others as an amalgamated score. This display remains useful for many purposes, but does not deliver an accurate picture of the healthcare experience for our California population. We would strongly suggest reporting also with population-weighted figures. Beyond the more accurate representation of our collective service quality to the people we serve, it can also help define priority target communities for the assistance we all recognize to be necessary.	IHA analyzed this and found that there was no substantial difference at the quartile level, but there is an increase when measuring across all POs. We will seek further input from TQC.
Proposed MY 2009 Policy Changes					
91	Extreme outlier values will no longer be removed from reporting	Health Plan	Support	Agree with rationale for this, however, this will impact trending ability and will impact mean from a pure analytical standpoint.	Outlier values have always been included in the final PO and payout reports, so they can be consistently included or excluded from analyses.
92	Extreme outlier values will no longer be removed from reporting	Physician Specialty Group	Support		
93	Extreme outlier values will no longer be removed from reporting	Health Plan	Support		

#	Element	Org Type	Feedback Type	Comments	P4P Response after vetting with Technical Quality Committee
94	Extreme outlier values will no longer be removed from reporting	Physician Organization	Support		
95	Extreme outlier values will no longer be removed from reporting	Health Plan	Support with modifications	We support the policy change but would like to see additional information. We are in receipt of the outlier count by measure for 2008MY but would like to see counts by measure trended over at least 3 years to gain a better comfort level.	This information will be provided to TQC.
96	Extreme outlier values will no longer be removed from reporting	Physician Organization	Do NOT Support	We disagree with this in instances where the capture of the data is not available without an EHR. The reporting is not the same if there is a low population for the measure and there are a few outliers. The outliers should continue to be removed because it may not be indicative of poor performance but could be related to a lack of data.	None of the P4P measures require HER.