



**To:** Pay for Performance (P4P) Stakeholders  
**From:** Dolores Yanagihara, P4P Program Director, Integrated Healthcare Association (IHA)  
**Subject:** Proposed Measurement Year 2010 Measure Set

**Public Comment Period for P4P Measurement Year 2010  
September 2 - October 2, 2009**

We invite your review and comment on the attached P4P measure set proposed for Measurement Year 2010 (measurement period January 1 – December 31, 2010, with reporting and payment in 2011). We welcome input on the following:

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

**Comments are due by Friday, October 2 to the NCQA Public Comment Website at the following link:** <http://publiccomments.ncqa.org>

Login instructions:

1. Enter your email address
2. If this is the first time using this public comment tool you will be asked to enter your contact information for your organization
3. Product (drop down menu) – Select **P4P Public Comment 2009**
4. Topic (drop down menu) – Select a specific topic you would like to comment on
5. Indicate whether you support, do not support, or support with modifications
6. Type comments in the comment box and note that **text can not exceed 1800 characters**. If text is greater than 1800 characters it will be deleted prior to IHA and NCQA reviewing your comments. 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. You will not receive an email confirmation of your submission but 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 measurement set (changes highlighted in red) is provided in Appendix A, starting on page 8. Brief supporting information is also provided on the following pages of this document. The changes were developed and recommended by the P4P Technical, Payment, and Executive Committees and reviewed and approved for public comment by the P4P Steering Committee. These Committees will consider all

public comment received, and finalize the Measurement Year 2010 P4P measure set in November 2009.

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 Measurement Year 2010 Measure Set**

The following are the recommendations from the Pay for Performance (P4P) Technical, Payment, Executive, and Steering Committees for the Measurement Year (MY) 2010 P4P measure set. These Committees will review all public comment received and finalize the MY 2010 P4P measure set in November 2009.

#### **1. MY 2009 Proposed Testing Measures**

Testing measures for MY 2009 are those that will be tested in 2010 using 2009 data. We are focused on nationally vetted, standardized measures that would supplement our current chronic care and child health measures. Measures that test successfully in MY 2009 will move directly into the MY 2010 measure set. Please note that this is a change in the measure adoption timeline and reflects the removal of the “transition” year, as approved last year.

##### **a. Clinical Domain**

The P4P Technical Quality, Executive, and Steering Committees are recommending three clinical measures for testing for MY 2009. Draft measure specifications are available in the MY 2009 P4P Manual on IHA’s website ([www.iha.org](http://www.iha.org)).

##### **1) Asthma Medication Ratio**

An asthma medication ratio measure was successfully tested in MY 2007, but in an effort to align with national asthma measure development efforts led by NCQA, P4P decided to not proceed with adoption. Due to delays in NCQA’s measure testing and uncertainty on which measures will be tested, the P4P Committees think it is now appropriate for P4P to move forward. The P4P measure that was previously tested has undergone specification changes so it is being recommended for re-testing in MY 2009 with the modified specifications.

This measure would replace the current Use of Appropriate Medications for People with Asthma measure. It is based on the work of the American Academy of Allergy, Asthma and Immunology and American College of Allergy, Asthma and Immunology Joint Quality Measures Task Force. Although not a current HEDIS measure, this is one of the measures NCQA is considering testing for HEDIS.

##### **2) Childhood Immunization – Combination Rates**

This measure is based on the Childhood Immunization Status Combination Rates reported as part of HEDIS. The measure assesses whether children received various combinations of four diphtheria, tetanus, and acellular pertussis (DTaP) vaccinations; three polio (IPV) vaccinations; one measles, mumps and rubella (MMR) vaccination; two H influenza type B (Hib) vaccinations; three Hepatitis B (Hep B) vaccinations; one

chicken pox (VZV) vaccination; four pneumococcal conjugate (PCV) vaccinations; two Hepatitis A (Hep A) vaccinations; two or three Rotavirus (RV) vaccinations; and two influenza vaccinations on or before the child's second birthday. All of these antigens are recommended by the CDC Advisory Committee on Immunization Practices, AAP and AAFP.

Combinations 3, 7 and 10 are being recommended for testing.

| Combination    | DTaP | IPV | MMR | HiB | Hep B | VZV | PCV | Hep A | RV | Influenza |
|----------------|------|-----|-----|-----|-------|-----|-----|-------|----|-----------|
| Combination 3  | ✓    | ✓   | ✓   | ✓   | ✓     | ✓   | ✓   |       |    |           |
| Combination 7  | ✓    | ✓   | ✓   | ✓   | ✓     | ✓   | ✓   | ✓     | ✓  |           |
| Combination 10 | ✓    | ✓   | ✓   | ✓   | ✓     | ✓   | ✓   | ✓     | ✓  | ✓         |

**3) Childhood Immunization – Hepatitis A and Rotavirus**

Hepatitis A and Rotavirus as individual antigens are also being recommended for testing. These antigens are recommended by CDC for all children by the age of 2 and are included in HEDIS. Influenza is not being recommended for testing as an individual antigen due to the anticipated confounding issues with swine flu vaccinations.

**b. Coordinated Diabetes Care Domain**

The P4P Technical Quality, Executive and Steering Committees are recommending two diabetes care measures for testing in 2010. Draft measure specifications are available in the MY 2009 P4P Manual posted on IHA's website ([www.ihha.org](http://www.ihha.org)).

**1) Blood Pressure Control for People with Diabetes**

This measure was tested in MY 2008, but there was not enough data submitted for robust testing. The P4P Committees deemed it appropriate to keep this measure for testing in MY 2009. A summary of MY 2008 testing results is included in Appendix B.

This is a HEDIS-based measure which assesses the percentage of members 18 – 75 years of age with diabetes (type 1 and type 2) who had their blood pressure in control (< 140/90 and < 130/80 are both collected). The numerator compliance for this measure can be captured using CPT II codes or information from electronic supplemental databases.

While there are ongoing concerns about the ability to electronically collect this data, because of the clinical importance of blood pressure control, the committees felt it was worth pushing POs to create data collection systems. Overcoming barriers to data exchange between POs and plans will also be critical.

**2) Optimal Diabetes Care**

This measure was tested in MY 2008, but there was not enough data submitted for robust testing. The P4P Committees deemed it appropriate to keep this measure for testing in MY 2009. A summary of MY 2008 testing results is included in Appendix B.

This is derived from a similar measure used by the Minnesota Community Measurement Program. It assesses the percentage of patients 18 – 75 years of age with diabetes (type 1 and type 2) who reached all of the following three treatment goals: Hemoglobin A1c (HbA1c) < 8%, blood pressure < 140/90, and LDL < 100. This is an “all-or-none” measure and credit for this measure is achieved when all three components are met for a patient.

## **2. MY 2010 Proposed Measure Additions**

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

### **a. Clinical Domain**

The four clinical measures listed below are being proposed by the P4P Technical Quality, Executive and Steering Committees for addition to the MY 2010 P4P measure set. Since the transition year is being removed after MY 2009, measures that test successfully in MY 2009 will move directly into the MY 2010 measure set. Draft measure specifications for the proposed MY 2010 measure set are posted on the IHA website in the Draft MY 2010 P4P Manual.

#### **1) Adolescent Immunizations (Tdap, meningococcal)**

The Adolescent Immunization Status measure aligns with the HEDIS 2010 Immunizations for Adolescents measure, which assesses the percentage of adolescents 13 years of age who had one dose of meningococcal vaccine (MCV), and one Tdap or Td vaccine by their 13th birthday.

This measure was successfully tested in P4P in 2009 and worked well at the physician organization (PO) level. The testing results showed variation across POs and room for improvement. The distributions were not skewed, and valid results were produced for a larger number of POs. A summary of the testing results is available in Appendix B.

#### **2) Asthma Medication Ratio (AMR)**

This measure is being recommended for testing in MY 2009 and adoption for MY 2010. See description in testing measures section.

#### **3) Childhood Immunization – Combination rate (CIS)**

This measure is being recommended for testing in MY 2009 and adoption for MY 2010. See description in testing measures section.

#### **4) Childhood Immunization – Hepatitis A and Rotavirus (CIS)**

This measure is being recommended for testing in MY 2009 and adoption for MY 2010. See description in testing measures section.

b. Coordinated Diabetes Care Domain

The two coordinated diabetes care measures listed below are being proposed by the P4P Technical Quality, Executive and Steering Committees for addition to the MY 2010 P4P measure set. Since the transition year is being removed after MY 2009, measures that test successfully in MY 2009 will move directly into the MY 2010 measure set. Draft measure specifications for the proposed MY 2010 measure set are posted on the IHA website in the Draft MY 2010 P4P Manual.

1) Blood Pressure Control for People with Diabetes

This measure is being recommended for testing in MY 2009 and adoption for MY 2010. See description in testing measures section.

2) Optimal Diabetes Care

This measure is being recommended for testing in MY 2009 and adoption for MY 2010. See description in testing measures section.

c. IT-Enabled Systemness Domain

The IT-Enabled Systemness measure listed below is being proposed by the P4P Technical Quality and Steering Committees for addition to the MY 2010 P4P measure set. Draft measure specifications are posted on the IHA website in the Draft MY 2010 P4P Manual.

1) Electronic Reporting of Blood Pressure for People with Hypertension

The current Systemness scores are effective for three years, and MY 2009 is the last valid year for the survey for a majority of POs. There is interest in making major modifications to the survey to align with upcoming national initiatives (measures of meaningful use, patient-centered medical home, and health reform in general) but this re-vamping of the survey will not occur until MY 2011. Therefore, MY 2010 will be a bridge year between the old survey and a potential new survey. P4P Committees are recommending extending the effective date of the current Systemness scores through MY 2010, and adding electronic reporting of blood pressure for people with Hypertension. The blood pressure measure would be worth 3 points or 10% of total Systemness. POs would have to meet the criteria for this measure to retain full credit for Systemness.

**3. MY 2009 Proposed Measure Deletions**

a. Clinical Domain

The P4P Technical Quality, Executive and Steering Committees are recommending removal of Use of Appropriate Medications for People with Asthma. This recommendation is based on specification changes in the measure, current high performance on the measure, and the intent to adopt a new asthma measure for MY 2010. The P4P Committees felt it would be wasted effort for POs and plans to make programming changes for the current asthma measure given its potential phase out in one year and its high performance.

#### **4. MY 2009 Proposed Process and Policy Changes**

a. Extreme outlier values will no longer be removed from reporting analysis

Each year, there are a small number of physician organizations (PO) that have extremely low clinical scores that are substantially different than the scores for all other POs. It is likely that these scores do not reflect true performance, rather deficient information systems. Based on this premise, P4P has been removing extreme low outlier scores for public reporting and calculation of P4P awards. Thresholds for outlier scores were determined by the OPA Methods Advisory Group, comprised of PO representatives, OPA, IHA, and statistician/methodologists. Outlier scores have been removed and treated as missing scores.

The OPA Methods Advisory Group is now recommending that P4P discontinue the removal of outliers starting in MY 2009, which is the seventh measurement year of P4P. The advisory group feels that POs have had adequate time to improve their data collection and reporting systems, and that POs that have not successfully done so should be held accountable.

#### **5. MY 2011 Proposed Process and Policy Changes**

a. First year of performance-based contracting

Pay for Performance has been considered an add-on bonus to regular physician organization (PO) compensation by most participating health plans. While the original intention was for P4P bonuses to gradually grow to 5-10% of compensation, in reality, the bonuses have not even reached 1-2% for most POs. Recent efforts to increase the bonus amounts have been unsuccessful.

Furthermore, the healthcare marketplace has changed significantly since P4P started. Affordability problems have worsened and HMO enrollment is being impacted. Variation in resource use by geographic location and physician is now a major part of the national policy discussion. Given these market conditions, there is a need for powerful metrics, incentives, and results, and P4P has an opportunity to build on the common metrics already adopted and to improve on the weaknesses of historic risk sharing. We proposed to do this through transitioning P4P to performance-based contracting.

The concepts behind performance based-contracting are:

- Incorporate performance-based payment as a regular and substantial part of PO compensation, versus the current side-bar bonus structure
- Increase emphasis on efficiency and affordability
- Continue to measure, report, and reward quality achievement and improvement

The move to performance-based contracting would be supported by the following process goals:

1. Expand measure set to integrate quality and efficiency measures with total cost of care by MY 2011
  - a. Quality Measures
    - i. Add inpatient quality measures
    - ii. Add more outcomes/specialty measures, which are currently constrained by electronic data sources and sample size
  - b. Efficiency Measures
    - i. Add Total Cost of Care measure
    - ii. Other more granular measures become “leading indicators” to support quality improvement (not for payment). Examples of leading indicators are: Appropriate Resource Use measures, episode of care measures, measures on overuse of procedures
  
2. Increase overall payment potential to 7% of professional compensation by MY 2013, and eventually to 10%
  - a. Quality Incentive
    - i. Fixed budget, incrementally increasing each year
    - ii. Funded from budgeted capitation increases
    - iii. Potential of 2+% of compensation by MY 2013
  - b. Efficiency Incentive
    - i. Variable budget
    - ii. Funded from gain sharing
    - iii. Potential of about 5% of compensation by MY 2013
  
3. Execute performance-based contract amendments for MY 2011
  - a. Work with key people from plans and a few POs to develop a model contract amendment
  - b. Develop implementation guidelines and obtain widespread buy-in
  
4. Implement tiered co-pay benefit design starting 2012
  - a. Develop and get stakeholders agreement on common criteria for value tiers based on quality and efficiency performance metrics
  - b. Plans create benefit package incorporating variable member co-pays based on the value tier of the PO they select

APPENDIX A

MY 2010 P4P Measurement Set

|   | <b>Year 7 Measures:<br/>2009 Measurement Year /<br/>2010 Reporting Year</b>  | <b>Proposed Year 8 Measures:<br/>2010 Measurement Year /<br/>2011 Reporting Year</b>   |
|---|--|--|
| <b>CLINICAL DOMAIN</b><br><i>MEASURES TO BE<br/>COLLECTED, REPORTED<br/>AND RECOMMENDED FOR<br/>PAYMENT</i> | <ol style="list-style-type: none"> <li>1. Childhood Immunization Status (MMR+VZV)</li> <li>2. Appropriate Testing for Children with Pharyngitis</li> <li>3. Appropriate Treatment for Children with Upper Respiratory Infection</li> <li>4. <del>Use of Appropriate Medications for People with Asthma</del></li> <li>5. Chlamydia Screening in Women</li> <li>6. Evidence-Based Cervical Cancer Screening</li> <li>7. Breast Cancer Screening</li> <li>8. Colorectal Cancer Screening</li> <li>9. Cholesterol Management LDL Screening (Pts. w/ Cardiovascular Conditions)</li> <li>10. Cholesterol Management: LDL Control &lt;100 (Pts. w/ Cardiovascular Conditions)</li> <li>11. Medication Monitoring (ACE/ARBs, digoxin, diuretics)</li> <li>12. Avoidance of Antibiotic Treatment of Adults with Acute Bronchitis</li> <li>13. Use of Imaging Studies for Low Back Pain</li> </ol> | <ol style="list-style-type: none"> <li>1. Childhood Immunization Status – <b>Combination rate or more antigens</b></li> <li>2. Appropriate Testing for Children with Pharyngitis</li> <li>3. Appropriate Treatment for Children with Upper Respiratory Infection</li> <li>4. <del>Use of Appropriate Medications for People with Asthma</del></li> <li>5. Chlamydia Screening in Women</li> <li>6. Evidence-Based Cervical Cancer Screening</li> <li>7. Breast Cancer Screening</li> <li>8. Colorectal Cancer Screening</li> <li>9. Cholesterol Management LDL Screening (Pts. w/ Cardiovascular Conditions)</li> <li>10. Cholesterol Management: LDL Control &lt;100 (Pts. w/ Cardiovascular Conditions)</li> <li>11. Medication Monitoring (ACE/ARBs, digoxin, diuretics)</li> <li>12. Avoidance of Antibiotic Treatment of Adults with Acute Bronchitis</li> <li>13. Use of Imaging Studies for Low Back Pain</li> <li>14. <b>Adolescent Immunizations (Tdap, meningococcal)</b></li> <li>15. <b>Asthma Medication Ratio</b></li> </ol> |
| <b>Clinical PO Encounter Threshold for reporting<sup>1</sup></b>  | <b>4.0</b> Encounters per member per year (using Encounter Rate by Service Type specs)   | <b>4.0</b> Encounters per member per year (using Encounter Rate by Service Type specs)   |
| <i>Clinical Weighting</i>   | 40%  | 40%  |

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

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|  | <b>Year 7 Measures:<br/>2009 Measurement Year /<br/>2010 Reporting Year</b>   | <b>Proposed Year 8 Measures:<br/>2010 Measurement Year /<br/>2011 Reporting Year</b>   |
|--|---|--|
| <b>PATIENT EXPERIENCE DOMAIN</b><br><i>MEASURES TO BE COLLECTED, REPORTED AND RECOMMENDED FOR PAYMENT</i>    | 1. Getting Appointment with a Specialist }<br>2. Rating of Specialist }<br>3. Timely Care and Service composite<br>4. Doctor-Patient Interaction composite<br>5. Care Coordination composite<br>6. Rating of PCP }<br>7. Rating of all Healthcare }<br>8. Office Staff composite<br>9. Health Promotion composite   | 1. Getting Appointment with a Specialist }<br>2. Rating of Specialist }<br>3. Timely Care and Service composite<br>4. Doctor-Patient Interaction composite<br>5. Care Coordination composite<br>6. Rating of PCP }<br>7. Rating of all Healthcare }<br>8. Office Staff composite<br>9. Health Promotion composite  |
| <i>Patient Experience Weighting</i>  | 20%   | 20%  |
| <b>IT-ENABLED SYSTEMNESS DOMAIN</b><br><i>MEASURES TO BE COLLECTED, REPORTED AND RECOMMENDED FOR PAYMENT</i> | 1. Data Integration for Population Management<br>a. Reporting Based on Electronic Information<br>b. Identifying Important Conditions<br>2. Electronic Clinical Decision Support at the Point of Care<br>3. Care Management<br>a. Coordination with Practitioners<br>b. Chronic Care Management<br>c. Continuity of Care<br>5. Physician Measurement and Reporting | 4. Data Integration for Population Management<br>a. Reporting Based on Electronic Information<br>b. Identifying Important Conditions<br>5. Electronic Clinical Decision Support at the Point of Care<br>6. Care Management<br>a. Coordination with Practitioners<br>b. Chronic Care Management<br>c. Continuity of Care<br>4. <b>Electronic Reporting of Blood Pressure for People with Hypertension</b><br>5. Physician Measurement and Reporting |
| <i>IT-Enabled Systemness Weighting</i>   | 20%   | 20%  |

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|  | <b>Year 7 Measures:<br/>2009 Measurement Year /<br/>2010 Reporting Year</b>  | <b>Proposed Year 8 Measures:<br/>2010 Measurement Year /<br/>2011 Reporting Year</b>   |
|--|--|--|
| <b>COORDINATED<br/>DIABETES CARE</b><br><i>MEASURES TO BE<br/>COLLECTED, REPORTED<br/>AND RECOMMENDED FOR<br/>PAYMENT</i>                        | <ol style="list-style-type: none"> <li>1. HbA1c Screening</li> <li>2. HbA1c Poor Control (&gt;9)</li> <li>3. HbA1c Control (&lt;8)</li> <li>4. HbA1c Control (&lt;7)</li> <li>5. LDL Screening</li> <li>6. LDL Control &lt;100</li> <li>7. Nephropathy Monitoring</li> <li>8. Diabetes Registry and related activities</li> <li>9. Diabetes Care Management Program</li> </ol>   | <ol style="list-style-type: none"> <li>1. HbA1c Screening</li> <li>2. HbA1c Poor Control (&gt;9)</li> <li>3. HbA1c Control (&lt;8)</li> <li>4. HbA1c Control (&lt;7)</li> <li>5. LDL Screening</li> <li>6. LDL Control &lt;100</li> <li>7. Nephropathy Monitoring</li> <li>8. <b>Blood Pressure Control for People with Diabetes</b></li> <li>9. <b>Optimal Diabetes Care</b></li> <li>10. Diabetes Registry and related activities</li> <li>11. Diabetes Care Management Program</li> </ol>   |
| <i>Coordinated Diabetes Care Weighting</i>   | 20%  | 20%  |
| <b>EFFICIENCY DOMAIN</b>   | <ol style="list-style-type: none"> <li>1. Inpatient Utilization—Acute Care Discharges PTMY</li> <li>2. Inpatient Utilization—Bed Days PTMY</li> <li>3. Inpatient Readmission Within 30</li> <li>4. Emergency Department Visits PTMY</li> <li>5. Outpatient Surgeries Utilization—% Done in ASC</li> <li>6. Generic Prescribing</li> </ol>  | <ol style="list-style-type: none"> <li>1. Inpatient Utilization—Acute Care Discharges PTMY</li> <li>2. Inpatient Utilization—Bed Days PTMY</li> <li>3. Inpatient Readmission Within 30</li> <li>4. Emergency Department Visits PTMY</li> <li>5. Outpatient Surgeries Utilization—% Done in ASC</li> <li>6. Generic Prescribing</li> </ol>  |
| <i>Efficiency Weighting</i>  | Gain-sharing   | Gain-sharing   |
| <b>REPORTABLE NON-PAYMENT MEASURES</b><br><i>MEASURES TO BE<br/>COLLECTED AND<br/>PUBLICLY REPORTED,<br/>BUT NOT RECOMMENDED<br/>FOR PAYMENT</i> | <ol style="list-style-type: none"> <li>1. Medicare Measures: <ol style="list-style-type: none"> <li>a. Breast Cancer Screening</li> <li>b. Diabetes Care HbA1c Screening</li> <li>c. Diabetes Care HbA1c Poor Control</li> <li>d. Cholesterol Management LDL Screening (<i>Pts. w/ Cardiovascular Conditions and Diabetics</i>)</li> <li>e. Cholesterol Management: LDL Control &lt;100 (<i>Pts. w/ Cardiovascular Conditions and/or Diabetes</i>)</li> <li>f. Nephropathy Monitoring for Diabetic Patients</li> <li>g. Colorectal Cancer Screening</li> </ol> </li> </ol> | <ol style="list-style-type: none"> <li>1. Medicare Measures: <ol style="list-style-type: none"> <li>a. Breast Cancer Screening</li> <li>b. Diabetes Care HbA1c Screening</li> <li>c. Diabetes Care HbA1c Poor Control</li> <li>d. Cholesterol Management LDL Screening (<i>Pts. w/ Cardiovascular Conditions and Diabetics</i>)</li> <li>e. Cholesterol Management: LDL Control &lt;100 (<i>Pts. w/ Cardiovascular Conditions and/or Diabetes</i>)</li> <li>f. Nephropathy Monitoring for Diabetic Patients</li> <li>g. Colorectal Cancer Screening</li> </ol> </li> </ol> |

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|   | <b>Year 7 Measures:<br/>2009 Measurement Year /<br/>2010 Reporting Year</b>   | <b>Proposed Year 8 Measures:<br/>2010 Measurement Year /<br/>2011 Reporting Year</b> |
|---|---|--|
| <p><b>TRANSITION MEASURES</b><br/><i>MEASURES TO BE COLLECTED BUT NOT PUBLICLY REPORTED OR RECOMMENDED FOR PAYMENT. THESE MEASURES HAVE BEEN TESTED AND APPROVED FOR ADDITION TO THE P4P MEASURE SET IN THE FOLLOWING YEAR.</i></p> | <p><u>Clinical:</u><br/>1. Adolescent Immunizations (Tdap, meningococcal)</p>   | <p align="center">None</p>   |
| <p><b>TESTING MEASURES</b><br/><i>MEASURES TO BE COLLECTED FOR TESTING AND ANALYSIS</i></p>   | <p>1. Asthma Medication Ratio<br/>2. Childhood Immunizations – HEDIS Combinations 3, 7, and 10<br/>3. Childhood Immunizations – Hep A and Rotavirus<br/>4. Blood Pressure Control for People with Diabetes<br/>5. Optimal Diabetes Care</p> | <p align="center">TBD</p>  |

**APPENDIX B**

**2009 Testing Results for Commercial HMO/POS**

**Blood Pressure Control in Diabetics**

**Table 1: Self-Reporting PO Results**

| Control Level | N* | PO 1 Rate | PO 2 Rate | PO 3 Rate | PO 4 Rate | PO 5 Rate |
|---------------|----|-----------|-----------|-----------|-----------|-----------|
| 130/80        | 5  | 4.0       | 29.0      | 26.5      | 30.6      | 5.5       |
| 140/90        | 5  | 7.4       | 21.2      | 49.3      | 63.7      | 10.8      |

\*N = the number of POs that submitted data

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

| Control Level | N** | Mean | Min | 25 <sup>th</sup> | 50 <sup>th</sup> | 75 <sup>th</sup> | Max |
|---------------|-----|------|-----|------------------|------------------|------------------|-----|
| 130/80        | 7   | 0.8  | 0.1 | 0.2              | 0.7              | 1.1              | 1.8 |
| 140/90        | 14  | 0.8  | 0.0 | 0.2              | 0.3              | 0.8              | 4.2 |

\*\*N = the number of POs for which the plan could report data

**National benchmark:**

HEDIS performance on the Comprehensive Diabetes Care Blood Pressure Control Measure for 2008 ranged between 0.2% and 38.9% for blood pressure control < 130/80 and between 0.4% and 72.1% for blood pressure control < 140/90. These HEDIS rates, which are based on Hybrid methodology, are comparable to the P4P testing results reported by POs.

**Optimal Diabetes Care**

**Table 1: Self-Reporting PO and Health Plan Reported Results**

|                      | # of POs | Mean | Min | 25 <sup>th</sup> | 50 <sup>th</sup> | 75 <sup>th</sup> | Max  |
|----------------------|----------|------|-----|------------------|------------------|------------------|------|
| PO Self-Reported     | 46       | 28.3 | 3.1 | 23.5             | 30.7             | 34.4             | 42.8 |
| Health Plan Reported | 8        | 1.0  | 0.1 | 0.2              | 0.7              | 1.7              | 2.6  |

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

Minnesota's Optimal Diabetes Care measure assesses the percentage of patients with diabetes (type 1 and type 2) ages 18 – 75 who reached all of the following five treatment goals: Hemoglobin A1c (HbA1c) < 7%, blood pressure < 130/80 mm Hg, LDL < 100mg/dL, daily aspirin use (ages 41 – 75), and documented tobacco-free status. Credit for this measure is achieved when all five components are met for a patient. MN Community Measurement ranged between 3% and 34% for performance on the five components. Since the proposed P4P measure has fewer components and less stringent control criteria, we would expect P4P results to be higher than Minnesota's results.

**APPENDIX B**

**Adolescent Immunization Status**

**Table 1: Tdap/TD Self-Reporting and Health Plan Reported Results**

|                | # of POs | Mean | Min  | 25 <sup>th</sup> | 50 <sup>th</sup> | 75 <sup>th</sup> | Max  |
|----------------|----------|------|------|------------------|------------------|------------------|------|
| Self Reporting | 9        | 45.2 | 16.7 | 46.7             | 47.9             | 52.3             | 59.8 |
| Plan Reported  | 135      | 38.6 | 10.1 | 29.2             | 40.2             | 47.4             | 67.6 |

**Table 2: MCV Self-Reporting and Health Plan Reported Results**

|                | # of POs | Mean | Min | 25 <sup>th</sup> | 50 <sup>th</sup> | 75 <sup>th</sup> | Max  |
|----------------|----------|------|-----|------------------|------------------|------------------|------|
| Self Reporting | 9        | 30.4 | 7.4 | 27.1             | 28.3             | 36.2             | 47.5 |
| Plan Reported  | 132      | 28.9 | 4.8 | 20.8             | 28.6             | 38.2             | 60.8 |

**Table 3: Combination Self-Reporting and Health Plan Reported Results**

|                | # of POs | Mean | Min | 25 <sup>th</sup> | 50 <sup>th</sup> | 75 <sup>th</sup> | Max  |
|----------------|----------|------|-----|------------------|------------------|------------------|------|
| Self Reporting | 9        | 26.3 | 3.6 | 24.0             | 25.1             | 32.6             | 45.0 |
| Plan Reported  | 130      | 22.4 | 3.6 | 14.3             | 22.0             | 30.0             | 48.7 |

**National Benchmark:**

The CDC reports a national rate of 64% for 13-year-olds receiving the Tdap/Td vaccination and 32.6% for MCV.