

Appropriate Resource Use Measures

For P4P MY 2009

Overview

In recognition of the growing issue of affordability of the HMO product in California and the consequent potential demise of the delegated model, the P4P Executive and Steering Committees charged IHA with quickly developing standardized appropriate resource use measures to be implemented as part of the Pay for Performance program. These types of measures are currently being used for incentive payments by individual plans and physician groups. The goal of incorporating them into P4P is to align measurement across plans to allow consistent identification of unwarranted variation in care delivery. They will also provide an opportunity to address these areas to ensure more appropriate use of limited healthcare dollars in delivering quality care.

Measure Development and Testing

Measures were selected by a multi-stakeholder group of P4P committee and IHA board members, based on the resource use measures currently in use and the potential of standardization of these measures to impact the delivery of appropriate, quality care. The detailed specifications on the following pages were developed by a technical work group of participating physician organizations and health plans, with technical support from Thomson Reuters Healthcare and NCQA.

Appropriate Resource Use Measures

- Inpatient Readmissions within 30 Days
- Inpatient Utilization—Acute Care Discharges
- Inpatient Utilization—Bed Days
- Outpatient Surgeries Utilization—% Done in ASC
- Emergency Department Visits
- Generic Prescribing

Use of Measure Results

Thomson Reuters Healthcare will run these measures using the claims and encounter data submitted by participating health plans. For each physician organization (PO), each of the measures will be calculated in two ways:

1. **Unadjusted results for each contracted health plan.** Unadjusted rates will be run on each health plan's data for each contracted PO. The intention is for each health plan to apply their actual costs for the PO to the utilization results provided and share any savings generated by a PO's improvement over its previous year's performance. Since a PO is being compared to its own performance over time, risk adjustment is not being applied.
2. **Risk-adjusted results aggregated across all contracted health plans.** A PO's results for each measure will be aggregated across all contracted plans and risk-adjusted. This will allow a PO to understand how their utilization compares to other POs.

Which Services Count

Report all services the organization actually paid or expects to pay. *Do not include* services and days denied for any reason. In cases where a member is enrolled retroactively, count all services that the organization has paid or expects to pay for.

Timeline

The Appropriate Resource Use measures **will** be part of the MY 2009 P4P measure set. **Baseline results are being calculated based on MY 2008 performance.**

Inpatient Readmissions Within 30 Days (IRN)

SUMMARY OF CHANGES FOR P4P MY 2009

- Added to MY 2009 Appropriate Resource Use Measure set.
- Thomson Reuters will run this measure for MY 2009. Health plans and POs are not expected to report this measure.

MODIFICATIONS FROM HEDIS

- Non-HEDIS measure. This measure is the NQF-endorsed Inpatient Readmission measure submitted by PacifiCare.

Description

The number of inpatient readmissions within 30 days of discharge during the measurement year.

Definition

Index Discharge Date Each date of discharge with a discharge status of alive from an acute care hospital.
There can be multiple Index Discharge Dates for a member.

Eligible Population

Product line Commercial HMO/POS

Ages All ages

Continuous enrollment

...for self-reporting POs This measure is based on plan level data and is not feasible for PO reporting.

...for health plans Date of discharge through 30 days after discharge in the health plan and in the PO (parent level).

Allowable gap No gaps in enrollment

Anchor date

...for self-reporting POs This measure is based on plan level data and is not feasible for PO reporting.

...for health plans None.

Benefit Medical.

**Event/
diagnosis**

Step 1 Identify all acute inpatient discharges from January 1 to December 1 of the measurement year using both a valid CMS DRG and Inpatient revenue codes. Refer to Table IRN-A: Codes to Identify Inpatient Discharges.

The denominator for this measure is based on discharges, not members. Include all discharges for each member from January 1 to December 1. This means that a readmission is also an index discharge for another potential readmission within 30 days.

Step 2 Apply CMS DRG Grouper to the inpatient claims data.

Step 3 *Skilled Nursing Facility.* Exclude discharges to a skilled nursing facility. Refer to Table IRN-B: Codes to Identify SNF.

Step 4 *Maternity exclusion.* Exclude maternity and pediatric discharges. Refer to Table IRN-C: Codes to Identify Maternity Discharges.

Step 5 *Discharged to another acute care hospital.* Exclude readmission to another acute care facility within a day of discharge.

Step 6 *Discharged deceased.* Exclude discharges of members who were discharged deceased.

Table IRN-A: Codes to Identify Inpatient Discharges

CMS-DRG	
DRG Codes	001–977

AND

Revenue Code	
Inpatient Codes	100–219

Table IRN-B: Codes to Identify SNF

Description	UB Type of Bill	POS
SNF	21x, 22x	31, 32

Table IRN-C: Codes to Identify Maternity Discharges

Description	CMS-DRG
Maternity	370-375

Administrative Specification

Denominator The eligible population based on discharges.

Note: All discharges that occur from January 1 to December 1 of the measurement year are included in the denominator.

Numerator Identify all admissions within 30 days from an index discharge date.

Case Mix Adjustment Calculation

Step 1 Run logistic regression analysis to model readmission probability (0,1) as a function of case mix of the index discharge case (case mix can be represented by CMS DRG Relative Weight)

Equation: $\text{Logit (Readmission)} = a + b * \text{Relative Weight from CMS DRG grouper}$

Step 2 Calculate readmission probability for each index case (expected readmission)

Equation: $P_i = e^{(a+bx_i)} / 1 + e^{(a+bx_i)}$

Step 3 Calculate expected readmission rate for each PO.

Equation: $\text{Expected Readmission Hosp}_A = (P_{A1} + P_{A2} + P_{A3} \dots P_{An}) / N_{POA}$

N_{POA} : The total number of discharges in the denominator for the calculation of the observed rate for PO_A

Step 4 Calculate Observed Readmission Rate for each PO.

Equation: $\text{Observed Readmission Rate}_{POA} = \text{Total Number of Readmissions}_{POA} / \text{Total Numbers of Index Discharges}_{POA}$

Step 5 Calculate Expected/Observed Readmission Rate Ratio for each PO

Equation: $\text{Observed/Expected Ratio}_{POA} = \text{Observed Rate}_{POA} / \text{Expected Rate}_{POA}$

Inpatient Utilization—Acute Care Discharges (IPU)

SUMMARY OF CHANGES FOR P4P MY 2009

- Added to MY 2009 Appropriate Resource Use Measure set.
- Removed maternity-related discharges (DRGs 370-375) from Table IPU-A.
- Removed unknown DRGs 469-470.
- Added reliability statistics.
- Added exclusion for members affected by Coordination of Benefits.
- Added outlier criteria of <30 or >70 discharges PTMY.
- Thomson Reuters will run this measure for MY 2009. Health plans and POs are not expected to report this measure.

MODIFICATIONS FROM HEDIS

- Based on HEDIS Use of Services specifications.
- Added risk adjustment.

Description

This measure summarizes utilization of **non-maternity related** acute inpatient services. The final reported metrics are:

- Total **non-maternity related** inpatient discharges PTMY (by plan)
- Risk-adjusted **non-maternity related** inpatient discharges PTMY (across all plans)
- **Reliability statistics**

Risk adjustment will be performed using concurrent DxCG Relative Risk Score.

Administrative Specifications

Product lines	Commercial HMO and POS
Member years	<p>Determine the PO's total member months for a particular health plan using a specified day of each month (e.g., the 15th or the last day of the month), to be determined according to the health plan's administrative processes. The day selected must be consistent from member to member, month to month, and year to year.</p> <p>Use the member's PO affiliation on the specified day of each month to determine to which PO the member months will be contributed.</p> <p>For each PO, calculate member years by dividing total member months by 12.</p>
Discharges	<p>Refer to the codes in Table IPU-A to identify total inpatient discharges.</p> <p>Note: The codes in Table IPU-A do not include maternity, newborn, mental health, or chemical dependency discharges. Newborn care rendered after the baby has been discharged home from delivery and is subsequently re-hospitalized should be included.</p>

Table IPU-A: Codes to Identify Total Inpatient Discharges

Principal ICD-9-CM Diagnosis	OR	CMS—DRG
001-289, 317-999, V01-V29, V40-V86		1-369, 376-423, 439-455, 461, 463-468, 471, 473, 475-520, 524-579
<i>WITH</i>		
UB Type of Bill	OR	Revenue Code
11x, 12x, 41x, 84x		100 - 219

Exclusions (required)

- The measure does not include mental health or chemical dependency services. Exclude from all categories claims and encounters that contain any of the following codes.
- Members who require Coordination of Benefits because the health plan is not the primary payer. Health plans will provide this information.

Table IPU-B: Codes to Identify Exclusions

Principal ICD-9-CM Diagnosis	WITH	Secondary ICD-9-CM Diagnosis
960-979		291-292, 303-305

Inpatient Discharges Calculation

- Step 1** Identify qualifying discharges as defined in tables IPU-A and IPU-B.
- Step 2** Calculate Total Inpatient Discharges PTMY by Plan (Observed Rate). For each PO, sum qualifying discharges (as identified in step 1) and divide by total PO member years. Multiply this value by 1,000. Separate rates will be calculated for each health plan. Resulting rates will be used for two purposes: 1) Each health plan may use their plan-specific rates as the basis for shared savings payments, and 2) As the Observed Rates to be used in the calculation below.
- Step 3** Remove outliers. Remove all members from all POs with total discharges of <30 or >70 PTMY.
- Step 4** Perform Risk Adjustment. Member level Relative Risk Scores (RRS) will be calculated by running the DxCG Relative Risk software. Appropriate Relative Risk Score “bins”, which define members of similar risk, are calculated by running a logistic regression model to identify bin cut points. Collect members into appropriate bins based on RRS value.
- Step 5** Calculate Expected Inpatient Discharges PTMY (Expected Rate). The expected rate for each member is the arithmetic mean of all rates for members attributed to each bin, based on discharges across all plans and POs. Sum expected rates across all members in PO.
- Step 6** Calculate Population Rate PTMY. Across all members (i.e., across all plans and POs) calculate the Population Rate as the sum of all discharges divided by the sum of all member years, multiplied by 1,000.
- Step 7** Calculate Risk-Adjusted Inpatient Discharges PTMY. Risk-Adjusted Inpatient Discharges PTMY = [Observed Rate/ Expected Rate] * Population Rate.

One Risk-Adjusted Inpatient Discharges PTMY rate is calculated per PO (i.e., based on data aggregated across all plans).

Inpatient Utilization—Bed Days (IPBD)

SUMMARY OF CHANGES FOR P4P MY 2009

- Added to MY 2009 Appropriate Resource Use Measure set.
- Separated out ALOS calculation for maternity related discharges.
- Removed bed days associated with maternity related discharges (DRGs 370-375).
- Removed unknown DRGs 469-470.
- Added exclusion for members affected by Coordination of Benefits.
- Added outlier criteria of <30 or >70 discharges PTMY.
- Added Winsorization of LOS at 3 standard deviations from the mean across all plans and POs for each DRG.
- Thomson Reuters will run this measure for MY 2009. Health plans and POs are not expected to report this measure.

MODIFICATIONS FROM HEDIS

- Based on HEDIS Use of Services specifications.
- Added risk adjustment.

Description

This measure reports total bed days **associated with non-maternity related discharges** and Average Length of Stay (ALOS) associated with **both non-maternity related and maternity related** discharges. The final reported metrics for each PO are:

- Total **non-maternity related** bed days per thousand member year (PTMY) (by plan)
- Risk-adjusted total **non-maternity related** bed days PTMY (across all plans)
- **Non-maternity related** ALOS (by plan)
- Risk-adjusted **non-maternity related** ALOS (across all plans)
- **Risk-adjusted maternity ALOS (across all plans)**

Risk adjustment for total bed days will be performed using concurrent DxCG Relative Risk Score. Risk adjustment for ALOS will be performed using CMS-DRG mix. The ALOS measures are not intended as payable measures, rather they are provided as additional information.

Administrative Specifications

Product lines Commercial HMO and POS

Member years Determine the PO's total member months for a particular health plan using a specified day of each month (e.g., the 15th or the last day of the month), to be determined according to the health plan's administrative processes. The day selected must be consistent from member to member, month to month, and year to year.

Use the member's PO affiliation on the specified day of each month to determine to which PO the member months will be contributed.

For each PO, calculate member years by dividing total member months by 12.

Discharges Refer to the codes in Table IPU-A to identify total **non-maternity** inpatient discharges.

Note: The codes in Table IPU-A do not include **maternity**, newborn, mental health, or chemical dependency discharges. Newborn care rendered after the baby has been discharged home from delivery and is subsequently re-hospitalized should be included.

Table IPBD-A: Codes to Identify Total Non-Maternity Inpatient Discharges

Principal ICD-9-CM Diagnosis		CMS—DRG
001-289, 317-999, V01-V29, V40-V86	OR	1-369, 376-423, 439-455, 461, 463-468, 471, 473, 475-520, 524-579
WITH		
UB Type of Bill		Revenue Code
11x, 12x, 41x, 84x	OR	100 - 219

Exclusions (required)

- The measure does not include mental health or chemical dependency services. Exclude from all categories claims and encounters that contain any of the following codes.
- Members who require Coordination of Benefits because the health plan is not the primary payer. Health plans will provide this information.

Table IPBD-B: Codes to Identify Exclusions

Principal ICD-9-CM Diagnosis		Secondary ICD-9-CM Diagnosis
960-979	WITH	291-292, 303-305

Total Bed Days Calculation

Step 1 Identify qualifying discharges as defined in tables IPU-A and IPU-B.

Step 2 **Remove outliers.** Remove all members from all POs with total discharges of <30 or >70 PTMY. Note: This will result in the same population as Step 3 of the Inpatient Discharges Calculation.

- Step 3** *Sum Bed Days.* For each qualifying discharge, sum the number of approved days hospitalized during the measurement year. Winsorize each stay at 3 standard deviations from the mean across all plans and POs for each DRG.
- Step 4** *Calculate Total Bed Days PTMY by Plan (Observed Rate).* Divide the number by total PO member years and multiply by 1,000. Separate rates will be calculated for each health plan. Resulting rates will be used for two purposes: 1) Each health plan may use their plan-specific rates as the basis for shared savings payments, and 2) As the Observed Rates to be used in the calculation below.
- Step 5** *Perform Risk Adjustment.* Member level Relative Risk Scores (RRS) will be calculated by running the DxCG Relative Risk software. Appropriate Relative Risk Score “bins,” which define members of similar risk, will be calculated by running an OLS regression model to identify bin cut points. Collect members into appropriate bins based on RRS value.
- Step 6** *Calculate Expected Bed Days PTMY (Expected Rate).* The expected rate for each member is the arithmetic mean of all rates for members attributed to that bin based on discharges across all plans and POs. Sum expected rates across all members in PO.
- Step 7** *Calculate Population Rate PTMY.* Across all members (i.e., across all plans and POs) calculate the Population Rate as the sum of all bed days divided by the sum of all member years, multiplied by 1,000.
- Step 8** *Calculate Risk-Adjusted Bed Days PTMY.* Risk-Adjusted Bed Days PTMY = [Observed Rate/ Expected Rate] * Population Rate.

One Risk-Adjusted Bed Days PTMY rate is calculated per PO (i.e., based on data aggregated across all plans).

Average Length of Stay Calculation

- Step 1** *Calculate ALOS by Plan.* For members with a qualifying discharge, the average length of stay is the mean Winsorized LOS of all member level discharges. Winsorization bounds are set at 3 times the standard deviation for all discharges attributed to a DRG. Separate rates will be calculated for each health plan. The sum of these rates is the Observed Rate to be used in the calculation below.
- Step 2** *Calculate Expected ALOS for Each CMS-DRG.* Collect member-level ALOS values into CMS-DRG-specific “bins”. The expected ALOS for each DRG is the arithmetic mean of all ALOS values attributed to that DRG-bin, based on discharges across all plans and POs.
- Step 3** *Calculate Population Level ALOS (Population Rate).* The population level ALOS is defined as the arithmetic mean ALOS scores across all members within each DRG bin.
- Step 4** *Calculate Expected Inpatient Discharges PTMY (Expected Rate).* The expected rate for each member is the arithmetic mean of all rates for members attributed to that bin based on discharges across all plans and POs. Sum expected rates across all members in PO.
- Step 5** *Calculate Risk-Adjusted ALOS.* Risk-Adjusted ALOS = [Observed Rate/ Expected Rate] * Population Rate.

One Risk-Adjusted ALOS rate is calculated per PO (i.e., based on data aggregated across all plans).

Outpatient Surgeries Utilization—% Done in ASC (OSU)

SUMMARY OF CHANGES FOR P4P MY 2009

- Added to MY 2009 Appropriate Resource Use Measure set.
- Added exclusion for members affected by Coordination of Benefits.
- Thomson Reuters will run this measure for MY 2009. Health plans and POs are not expected to report this measure.

MODIFICATIONS FROM HEDIS

- Based on HEDIS Use of Services specifications.
- Added risk adjustment.

Description

This measure summarizes utilization of outpatient/ambulatory surgeries and procedures. A total of two metrics will be reported for each PO:

- The percentage of outpatient surgeries performed in free-standing ambulatory surgery centers (ASC) (by plan)
- Risk-adjusted percentage of outpatient surgeries performed in free-standing ASCs (across all plans)

Risk adjustment will be performed using concurrent DxCG Relative Risk Score.

Calculations

Product lines	Commercial HMO and POS.
Member years	<p>Determine the PO's total member months for a particular health plan using a specified day of each month (e.g., the 15th or the last day of the month), to be determined according to the health plan's administrative processes. The day selected must be consistent from member to member, month to month, and year to year.</p> <p>Use the member's PO affiliation on the specified day of each month to determine to which PO the member months will be contributed.</p> <p>For each PO, calculate member years by dividing total member months by 12.</p>

Total outpatient surgery/procedures Use Table OSU-A to identify outpatient surgeries. Identify encounters using Option A or Option B. Option A is the preferred method for this measure, though when necessary, the organization should use Option A *and* Option B.

Report only outpatient surgeries performed at a hospital outpatient facility or at a free-standing surgery center.

Do not report office-based surgeries in this category.

Count multiple outpatient surgeries on the same date of service as one ambulatory surgery.

ASC Refer to the codes in Table OSU-C to identify surgeries in ASCs.

Table OSU-A: Codes to Identify Outpatient Surgeries

Option A

CPT	AND	POS
All codes included in the CMS 2008 ASC Approved HCPCS Codes and Payment Rates file* and 92953, 92970, 92971, 92975, 92980, 92982, 92986, 92990, 92992, 92993, 92995, 92996, 93501-93533, 93600-93652		22, 24

Option B

ICD-9-CM Procedure	AND	UB Revenue	AND	UB Type of Bill
01-86, 88.4, 88.5, 98.5		0320, 0321, 0323, 036x, 0480, 0481, 049x, 075x, 079x		13x, 83x

* The CMS 2008 ASC Approved HCPCS Codes and Payment Rates file are available on the CMS Web site (<http://www.cms.hhs.gov/ASCPayment/>). Use the file that was valid at the end of the measurement year.

Exclusions (required)

- The measure does not include mental health or chemical dependency services. Exclude from all categories claims and encounters that contain any of the codes in Table OSU-B.
- Members who require Coordination of Benefits because the health plan is not the primary payer. Health plans will provide this information.

Table OSU-B: Codes to Identify Exclusions

CPT	Principal ICD-9-CM Diagnosis	ICD-9-CM Procedure
90801-90899	290-316	94.26, 94.27, 94.6
Principal ICD-9-CM Diagnosis	WITH	Secondary ICD-9-CM Diagnosis
960-979		291-292, 303-305

Table OSU-C: Codes to Identify Outpatient Surgeries Performed in ASC

POS	UB Type of Bill	UB Revenue
24	83x	049x

OR

Plan-specific code identifying non-hospital affiliated ASCs

Current Procedural Terminology © 2008 American Medical Association. All rights reserved.

Percent of Outpatient Surgeries in ACS

Step 1 Calculate *Observed Percent Outpatient Surgeries Performed in Ambulatory Surgery Centers (% ASC)*. The Observed % ASC is the ratio of numerator/denominator for members collected for each PO. Separate rates will be calculated for each health plan. Resulting rates will be used for two purposes: 1) Each health plan may use their plan-specific rates as the basis for shared savings payments, and 2) As the Observed Rates to be used in the calculation below.

The denominator for this measure is all members having at least one qualifying outpatient surgery/ambulatory procedure as defined in tables OSU-A and OSU-B. The numerator is the subset of members satisfying the criteria given in table OSU-C, identifying those outpatient surgeries/procedures performed in a free-standing Ambulatory Surgery Center.

Step 2 Run *Regression Model*. For each procedure satisfying the numerator criteria, set a flag variable to 1. For all other values set the flag to 0. Run the following logistic regression model:

$$\text{prob(ASC)} = \text{RRS} + \text{Gender} + \text{Age}$$

Output the predicted probabilities for each member and collect them for each PO. Note: Gender and/or age will be included in the model only if they are statistically meaningful.

Step 3 Calculate *Expected Percent Outpatient Surgeries Performed in Ambulatory Surgery Centers (% ASC)*. The Expected % ASC for each PO is the member-level mean of all predicted probabilities for that PO.

Step 4 Calculate *Population Rate*. The Population % ASC is the ratio of numerator/denominator across members in the population (i.e., across all plans and POs).

Step 5 Calculate *Risk Adjusted % ASC*. Risk Adjusted % ASC rate = [Observed Rate/ Expected Rate] * Population Rate.

One Risk Adjusted % ASC rate is calculated per PO (i.e., based on data aggregated across all plans).

Emergency Department Visits (EDV)

SUMMARY OF CHANGES FOR P4P MY 2009

- Added to MY 2009 Appropriate Resource Use Measure set.
- Added exclusion for members affected by Coordination of Benefits.
- Added outlier criteria of <60 or >250 ED Visits PTMY.
- Thomson Reuters will run this measure for MY 2009. Health plans and POs are not expected to report this measure.

MODIFICATIONS FROM HEDIS

- Based on HEDIS Use of Services specifications.
- Added risk adjustment.

Description

This measure summarizes the utilization of emergency department visits. The final reported metrics for each PO are:

- Total emergency room visits PTMY (by plan)
- Risk-adjusted emergency room visits PTMY (across all plans)

Risk adjustment is performed using concurrent DxCG Relative Risk Score.

Calculations

Product lines	Commercial HMO
Member years	<p>Determine the PO's total member months for a particular health plan using a specified day of each month (e.g., the 15th or the last day of the month), to be determined according to the health plan's administrative processes. The day selected must be consistent from member to member, month to month, and year to year.</p> <p>Use the member's PO affiliation on the specified day of each month to determine to which PO the member months will be contributed.</p> <p>For each PO, calculate member years by dividing total member months by 12.</p>
ED visits	Use Table EDV-A and EDV-B to identify ED visits. Count once each visit to an ED that does not result in an inpatient stay, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit.

Table EDV-A: Codes to Identify ED Visits

CPT	<i>OR</i>	UB Revenue
99281-99285		045x, 0981
<i>OR</i>		
CPT	<i>AND</i>	POS
10040-69979		23

Exclusions (required)

- The measure does not include mental health or chemical dependency services. Exclude from all categories claims and encounters that contain any of the codes in Table EDV-B.
- ED visits that result in an inpatient admission should also be excluded.
- **Members who require Coordination of Benefits because the health plan is not the primary payer. Health plans will provide this information.**

Table EDV-B: Codes to Identify Exclusions

CPT	Principal ICD-9-CM Diagnosis	ICD-9-CM Procedure
90801-90899	290-316	94.26, 94.27, 94.6
Principal ICD-9-CM Diagnosis	<i>WITH</i>	Secondary ICD-9-CM Diagnosis
960-979		291-292, 303-305

Emergency Department Utilization Calculation

- Step 1** *Identify Emergency Department (ED) Utilization Rate.* Using tables EDV-A and EDV-B, count emergency department visits for each member.
- Step 2** *Calculate Total ED Utilization Rate PTMY by Plan (Observed Rate).* For each PO, sum qualifying ED visits (as identified in step 1) and divide by total PO member years. Multiply this value by 1,000. Separate rates will be calculated for each health plan. Resulting rates will be used for two purposes: 1) Each health plan may use their plan-specific rates as the basis for shared savings payments, and 2) As the Observed Rates to be used in the calculation below.
- Step 3** *Remove Outliers.* Remove all members from all POs with ED utilization rate of <60 or >250 PTMY.
- Step 4** *Perform Risk Adjustment.* Member level Relative Risk Scores (RRS) will be calculated by running the DxCG Relative Risk software. Appropriate Relative Risk Score “bins”, which define members of similar risk, will be calculated by running an OLS regression model to identify bin cut points. Collect members into appropriate bins based on RRS value.
- Step 5** *Calculate Expected ED Utilization Rate PTMY (Expected Rate).* The expected ED utilization rate for each member is the arithmetic mean of all rates for members attributed to that risk bin based on ED visits across all plans and POs. Sum expected rates across all members in PO.
- Step 6** *Calculate Population ED Utilization Rate PTMY.* Across all members (i.e., across all plans and POs) calculate the Population Rate as the sum of all utilizations divided by the sum of all member years, multiplied by 1,000.

Step 7 Calculate Risk-Adjusted ED Utilization Rate PTMY. Risk-Adjusted ED Rate PTMY is calculated as $[\text{Observed Rate} / \text{Expected Rate}] * \text{Population Rate}$.

One Risk-Adjusted ED Rate PTMY rate is calculated per PO (i.e., based on data aggregated across all plans).

Generic Prescribing (GRX)

SUMMARY OF CHANGES FOR P4P MY 2009

- Added to MY 2009 Appropriate Resource Use Measure set.
- Removed cost-based measures.
- Expanded therapeutic classes to include Anti-Ulcer Agents, Cardiac-Hypertension, Cardiovascular, Asthma, Allergy-oral, Diabetes-oral, and Anxiety/Sedation (sleep aids)
- Thomson Reuters will run this measure for MY 2009. Health plans and POs are not expected to report this measure.

MODIFICATIONS FROM HEDIS

- Non-HEDIS measure.

Description

The level of generic prescribing will be measured as a simple prescription rate. This will be measured for ten specific therapeutic classes (Nasal Steroids, SSRIs/SNRIs, Statins, **Anti-Ulcer Agents, Cardiac-Hypertension, Cardiovascular, Asthma, Allergy-oral, Diabetes-oral, and Anxiety/Sedation (sleep aids)**) individually and as a composite, as well as overall for all prescriptions except self-injectible drugs.

Generic status will be identified through *RED Book™*. Published and maintained by Thomson MICROMEDEX, the *RED Book™* is a nationally recognized source of drug product information, presenting descriptive information for over 200,000 healthcare products. The *RED Book™ Expanded* database classification system supplies a unique 6-digit code identifying drugs with common active ingredients, master dosage form, strength, and route of administration that assists in the identification and comparison of products with common generic ingredients, formulations, and therapeutic classifications. Updates with new product and/or pricing information are performed more than 65,000 times per year.

We are also exploring the impact and feasibility of using plan-defined definitions of brand and generic. This would be based on how a prescription was paid and would accommodate plan-specific contracting arrangements that price brand name drugs at generic-like rates.

Eligible Population

Product line	Commercial HMO/POS
Ages	All ages
Continuous enrollment	None. Since the denominator of this measure is based on prescriptions, not members, there is no continuous enrollment requirement.
Benefit	Member must have pharmacy benefits coverage on the fill date of the prescription. The measure will be based on all pharmacy claims received by participating health plans for members enrolled with the PO at any point in the measurement year. Pharmacy claims will only be attributed to a PO if the member was enrolled with the PO on the fill date on the pharmacy claim.
Measurement Period	Calendar Year. The measurement period will be January 1, 2009 to December 31, 2009.

Measure Definition 1 – Therapeutic Class Generic Prescribing Efficiency

A total of **ten** therapeutic class measures will be calculated. These **ten** will be combined together to produce Overall Therapeutic Class measures to be used for P4P reporting and incentive payment purposes (see measure definition 2 below).

Therapeutic Class Generic Prescribing Efficiency =

$$\frac{\text{Number of Prescriptions for Generic Rx in Therapeutic Class X}}{\text{Number of Prescriptions for All Rx in Therapeutic Class X}}$$

Denominator— Therapeutic Class The steps for identifying the denominators are as follows:

- Step 1** Identify all paid pharmacy claims for members enrolled with the PO at any point during the measurement year.
- Step 2** Ensure the member was enrolled with the PO on the fill date and had pharmacy benefits coverage.
- Step 3** Identify NDC codes of prescriptions belonging to one of the ten therapeutic classes: Nasal Steroids, SSRI/SNRIs, Statins, **Anti-Ulcer Agents, Cardiac-Hypertension, Cardiovascular, Asthma, Allergy-oral, Diabetes-oral, and Anxiety/Sedation (sleep aids)**. These are the prescriptions counted in the denominator.
- Step 4** Exclude prescriptions with any other NDCs.

Numerator— Therapeutic Class

- Step 1** For all prescriptions in the denominator, determine whether the prescription was filled with a generic version of the drug for that therapeutic class.
- Step 2** **To determine if the drug is a generic version, using the NDC code on the pharmacy claim, examine the generic formulation code in Thomson Micromedex's RED Book™ database.**
- Step 3** **If RED Book™ indicates that the prescription was filled with a generic version of the drug, the prescription will be counted in the numerator.**

Measure Definition 2 – Composite Therapeutic Class Generic Prescribing Efficiency

This is a composite of the **ten** therapeutic class measures above (see measure definition 1). This composite is intended for P4P reporting and incentive payment purposes.

Composite Therapeutic Class Generic Prescribing Efficiency =

$$\frac{\text{Total Number of Prescriptions for Generic Rx in any of above Therapeutic Classes}}{\text{Number of Prescriptions for All Rx in any of above Therapeutic Classes}}$$

**Denominator—
Overall
Therapeutic
Class** Sum the denominators of the **ten** therapeutic class measures in measure definition 1 above.

**Numerator—
Overall
Therapeutic
Class** Sum the numerators of the **ten** therapeutic class measures in measure definition 1 above.

Measure Definition 3 – Overall Generic Prescribing Efficiency

This measure will be provided to physician organizations for internal use, but is not intended for P4P reporting or incentive payment purposes.

Overall Generic Prescribing Efficiency (Scripts) =

$$\frac{\text{Number of Prescriptions for All Generic Rx}}{\text{Number of Prescriptions for All Rx}}$$

**Denominator—
Overall
Prescribing** The steps for identifying the denominators are as follows:

Step 1 Identify all paid pharmacy claims for members enrolled with the PO at any point during the measurement year.

Step 2 Ensure the member was enrolled with the PO on the fill date and had pharmacy benefits coverage.

Step 3 Identify the NDC code for the drug filled on the prescription.

Step 4 Identify and exclude claims for self-injectible drugs.

Step 5 All other paid pharmacy claims are included in the denominator.

Notes The measures use the drug filled (as indicated on the pharmacy claim). This may be different from the drug prescribed by the physician (e.g., if a generic substitution was made at the pharmacy).

**Numerator—
Overall
Prescribing** The steps for identifying the numerator are as follows:

Step 1 For all prescriptions in the denominator, determine whether the prescription was filled with a generic version of the drug.

Step 2 To determine if the drug is a generic version, using the NDC code on the pharmacy claim, examine the generic formulation code in Thomson Micromedex's *RED Book*[™] database.

Step 3 If *RED Book*[™] indicates that the prescription was filled with a generic version of the drug, the prescription will be counted in the numerator.