Medicare Care Management Performance Demonstration

Design Report

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Jody Blatt
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By
John C. Wilkin, F.S.A.
C. William Wrightson, Ph.D.
David Knutson
Erika G. Yoshino
Anahita S. Taylor
Kerry E. Moroz

Actuarial Research Corporation
5513 Twin Knolls Road, Suite 213
Columbia, Maryland 21045
410-740-9194 x14
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Design Report

1. Introduction

Section 649 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requires the Secretary of Health and Human Services to "establish a pay-for-performance demonstration program with physicians to meet the needs of eligible beneficiaries through the adoption and use of health information technology and evidence-based outcomes measures." The resulting demonstration, known as the Medicare Care Management Performance (MCMP) Demonstration, provides participating primary care physician practices an initial payment for reporting quality measures to CMS followed by, in each of the three demonstration years, incentive payments for meeting or exceeding specific performance criteria based on these same measures. In addition to improving the quality of care and reducing the cost of care for beneficiaries by providing financial incentives to physicians to achieve efficiencies, specific objectives of the demonstration include: (1) promoting continuity of care, (2) stabilizing medical conditions, (3) reducing adverse health outcomes, and (4) preventing or minimizing acute episodes of chronic conditions that require an emergency room visit or hospitalization.

In the demonstration, payments will be made to physician practices that meet or exceed performance standards established by CMS. The pay-for-performance financial incentives for *clinical quality* encompass using evidence-based outcome measures and electronic submission of the *clinical quality* measures. Specifically, under this three-year demonstration, physicians will be paid to improve quality using evidence-based outcome measures with an additional incentive for the *electronic submission* of these measures from an electronic health record that meets national certification standards. At the beginning of the demonstration, participating physician practices are eligible for a one-time payment for *reporting* data on the quality measures. This payment is contingent upon each physician practice agreeing to participate in the program and providing clinical quality measures data, but not upon their actual scores on the measures. The amount of the payment will be tied to the number of beneficiaries for whom the practice reports the data.

Following each of the three demonstration years, demonstration practices will be required to continue to report *clinical quality* data, but payment of financial incentives by CMS will be contingent upon the performance of the physician practices. Practices that meet quality performance thresholds will receive a separate performance payment for each beneficiary with diabetes, congestive heart failure (CHF), coronary artery disease (CAD), and a smaller payment for all beneficiaries with a chronic condition for achieving a quality standard for preventive care. (Please see section 4 for additional detail.) Payments can vary based on performance. Practices will be eligible for a higher payment if the physician practices submit their *clinical quality* data electronically. The project is expected to launch in July 2007, with physicians being paid the initial payment for reporting baseline data for the period January through December 2006 and performance-

based payments following each of the three years (July through June)of the demonstration[1]. Payments will be paid after the submitted data are processed.

The three-year demonstration project will be launched in four states, with approximately 800 small and medium-sized physician practices participating, including practices in both urban and rural areas. The MCMP project will operate in the same four states as the initial Doctor's Office Quality – Information Technology (DOQ-IT) pilot project (Arkansas, California, Massachusetts, and Utah), thus allowing the Quality Improvement Organizations (QIOs) in those states to provide technical support to participating physicians. Section 649 also specifies other requirements (i.e., duration of demonstration, number of sites, participating physician practice standards, payment methodology, budget neutrality, Report to Congress, etc.). See Appendix A for the legislation.

Mathematica Policy Research (MPR) is the evaluation contractor for the MCMP Demonstration. A comprehensive evaluation of the demonstration will be conducted including site visits and surveys of participants as well as an analysis of claims data from a matched comparison group of DOQ-IT participating practices in non-demonstration states. Research Triangle Inc. (RTI) and its subcontractor the Iowa Foundation for Medical Care (IFMC) are the implementation support contractors that will collect the data on clinical quality measures. Actuarial Research Corporation (ARC) is the financial support contractor for the demonstration and is responsible for collection and analysis of data related to the determination of payments. TrailBlazer Health Enterprise, LLC is the payment contractor for the demonstration and will process and issue checks to practices based on the payment amounts calculated by ARC.

The next section details the data collection process for the demonstration. Section 3 of this report discusses the definition, recruitment, and identification of practices in relation to the MCMP Demonstration. Beneficiary assignment to practices and beneficiary eligibility for participation are discussed in Sections 4 and 5. The payment methodology is described in Section 6. The final section of this report discusses payment management, including procedures for the calculation, documentation, and distribution of physician incentive payments.

2. Data Collection

The success of this demonstration requires the collection, warehousing, and analysis of a large quantity of data. The data will be used as a basis for identifying the physician practices in the comparison states, scoring practices on clinical measures, making performance payments to practices for the implementation of the demonstration, and for the independent evaluation of the success of the demonstration.

The main data sources for the demonstration and evaluation include the following:

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[1] In general, claims incurred between January and July of 2007 will not be used for the demonstration. However, the baseline data will include claims runout through March 2007.

- Demonstration application form,
- QIO supplied data
- Medicare Enrollment Database (EDB) data
- TAP claims data,
- Clinical quality measures data,
- Practice Office Systems Survey,
- Beneficiary and Provider Surveys, and
- Practice site visit

Application Form and QIO-Supplied Data

ARC will be collecting (and storing in a database) information submitted by the practices on the demonstration application form. The information from the application includes data necessary to uniquely identify and describe the practices participating in the demonstration. This includes the following:

- a unique DOQ-IT identification number for each practice;
- the names, Medicare provider identification numbers (PINs), tax identification numbers (TINs), National Provider Identification numbers (NPIs), specialty of each of the physicians in the practice;
- the practice address(es); and
- other descriptive information about the practice.

ARC will transmit these data to MPR, the evaluation contractor. Similar information on the comparison practices will be gotten from the Office Systems Survey which is administered by the QIOs to all DOQ-IT practices across the country. MPR will use this information to help identify comparison practices in non-demonstration states.

EDB Enrollment Data

The EDB contains enrollment data on each beneficiary. This includes such information as a beneficiary's Health Insurance Claim (HIC) number, date of birth, sex, address, whether the beneficiary has joined a Medicare Advantage (MA) plan, has elected hospice care, has both Part A and Part B, has Medicare as the primary payer, has ESRD, or has died. The EDB data will be used to determine the eligibility of the beneficiaries under the primary care of physicians in the participating practices.

TAP Files

The Program Integrity TAP file will be the source of claims data used in assignment of beneficiaries to practices and calculation of claims-based performance measures. TAP claims data have the advantage of being available on a more-timely basis than data from the National Claims History file, but also require that claims be put through a "final action" process that nets out all adjustments before being used. ARC will transmit the claims data to RTI for both the demonstration and comparison group practices.

Clinical Quality Measures Data

Under this demonstration, performance data will be collected during a baseline period and in each of the three demonstration years for 26 clinical quality measures covering treatment related to diabetes, congestive heart failure, coronary artery disease and the provision of specific preventive and screening services. These measures reflect care for the prevention or treatment of conditions common among Medicare beneficiaries that are routinely treated by primary care providers.

These measures (See Appendix E) are a subset of the measures originally developed for the Doctors Office Quality (DOQ) project. The measures have also been used in another CMS 'pay for performance' demonstration, the Physician Group Practice (PGP) Demonstration. Many of the measures being used are copyrighted and/or maintained by the AMA or NCQA. To the extent practical, the measure specifications for the demonstration have been updated to insure consistency with their use in other clinical quality measurement and pay-for-performance programs.

RTI will collect and validate data on the clinical quality measures. For those measures that can be determined from claims data, RTI will calculate the quality measures for both demonstration and comparison group practices. For those measures that can be determined from data that are only available from a patient's clinical chart, RTI will work with its subcontractor, IFMC, to collect such data from the demonstration group practices. These data will be used to determine payment amounts based on clinical quality performance. (*See section 6 for more detail on payment calculation and processing.*)

Beneficiary and Provider Surveys

MPR will be responsible for completing various surveys of beneficiaries and providers, as well as site visits, as part of the evaluation.

Appendix B contains a flow chart that describes the process in which the data will be collected, shared, and analyzed for the MCMP Demonstration.

3. Definition, Recruitment, and Identification of Practices

The recruitment of practices for the MCMP Demonstration is built upon the QIOs' relationships with practices that have been developed through the DOQ-IT project. QIOs in the states of Arkansas, California, Massachusetts, and Utah have recruited a large number of small to medium-sized practices to participate in the DOQ-IT project. Lumetra, the California QIO, was the lead QIO for this effort as part of the initial DOQ-IT pilot program.

For the MCMP Demonstration, the QIOs will recruit approximately 250 practices each in California and Massachusetts and 150 practices each in Arkansas and Utah from among

those participating in DOQ-IT. It is anticipated that approximately 800 practices, consisting of approximately 2,800 physicians will participate in MCMP.

In addition to requiring participation in the DOQ-IT program, there will be other qualifications for practices participating in the demonstration:

- The practice must be solo or small-to-medium sized. For the purposes of this demonstration "small-to-medium sized" is defined as ten or fewer physicians in the practice. While this will not be an absolute requirement (e.g., practices with a few more physicians may be eligible to participate in the   demonstration if space permits), the emphasis will be on recruiting smaller practices.

- The practice must be identified as providing the primary care for at least 50 fee-for-service (FFS) Medicare beneficiaries at the time the demonstration begins. ARC will apply an algorithm for assigning beneficiaries to primary care providers based on historical claims data. (*See section 4 for more information on beneficiary assignment*.) This requirement is being made to ensure that the financial incentive, which is based on the number of beneficiaries assigned to a practice, is sufficient to have an impact on physician behavior. If the number of assigned beneficiaries per practice drops below the initial requirement of 50, the practice will not be dropped from the demonstration. At the same time, practices that are not eligible at the beginning of the demonstration will not be able to join if they meet eligibility criteria at a later date.

- Some of the beneficiaries initially assigned to participating practices will not be eligible for final assignment (i.e., they will not be counted in the 50-beneficiary minimum). Beneficiaries that are in another demonstration, have elected hospice care, joined an MA plan, not enrolled in both Medicare Parts A and B, or have moved out of state will be ineligible to participate in this demonstration.

- The focus of the practice must be primary care. This may include physicians specializing in family practice, internal medicine and geriatrics, as well as those physicians who also practice in a medical subspecialty (e.g., cardiology or endocrinology) and may serve as primary care providers for the patients with CHF, CAD, diabetes, or other chronic conditions. Appendix C contains the complete list of the specialty visit types that were used to assign beneficiaries to providers.

- Participating practices must bill for Medicare services through a carrier and not a fiscal intermediary. The reason for this is that the source of data for assigning beneficiaries to physicians, as well as for calculating the claims-based quality measures, will be the diagnoses, procedures, and specialty data from the physician/supplier claims data file that is constructed from claims billed through carriers.

- Practices may be ineligible to participate if any of the physicians and/or the entire practice is participating in another demonstration that covers the same FFS Medicare beneficiaries. Each circumstance will be individually evaluated to insure that participation in both demonstrations would not jeopardize either the budget neutrality or the validity of the evaluation of either demonstration.

- Practices will be permitted to self-define themselves. This means that they may include one or more locations within the practice or separate out each physical office location as a separate practice. Similarly, while all physicians in a practice will be strongly encouraged to participate in the demonstration, this is not an absolute requirement. Operationally, however, every practice submitting an application must be able to uniquely define their practice and the physicians in it by a combination of tax identification numbers (TINs) and Medicare provider identification numbers (PINs).

- All Practices that are recruited for the demonstration must submit an application form to CMS, which will include the practice's consent to share data between the QIO, CMS, and CMS's contractors.

Application Processing

Once the application is received, it will be reviewed by ARC to insure that it meets the eligibility requirements. Practices that are eligible to participate in the demonstration will be assigned a unique practice identification number and be notified in writing. A letter will be sent to each of the qualifying practices that will include the Terms and Conditions for the participation in the MCMP Demonstration as well as the forms necessary to process electronic payment of the incentives. The Terms and Conditions will spell out the structure and requirements of proposed payment amounts, data collection requirements, and other features of the demonstration. ARC will collect signed letters of agreement to participate in the demonstration.

All practices will be selected prior to the demonstration and it is expected that they will participate for all three years of the demonstration. Practices will not be enrolled after the demonstration has begun.

4. Beneficiary Assignment

ARC will use historical claims data from CY 2006 to identify Medicare beneficiaries associated with practices applying to the demonstration. The resulting number of beneficiaries assigned will be used by CMS to confirm minimum practice size eligibility requirements and will serve as the basis from which subsequent subsets of patients with chronic conditions will be identified for baseline year reporting.

ARC will assign three sets of beneficiaries to each practice as shown in the diagram below:

Medicare Beneficiaries

Specified Chronic Conditions

CHF   CAD

DIAB
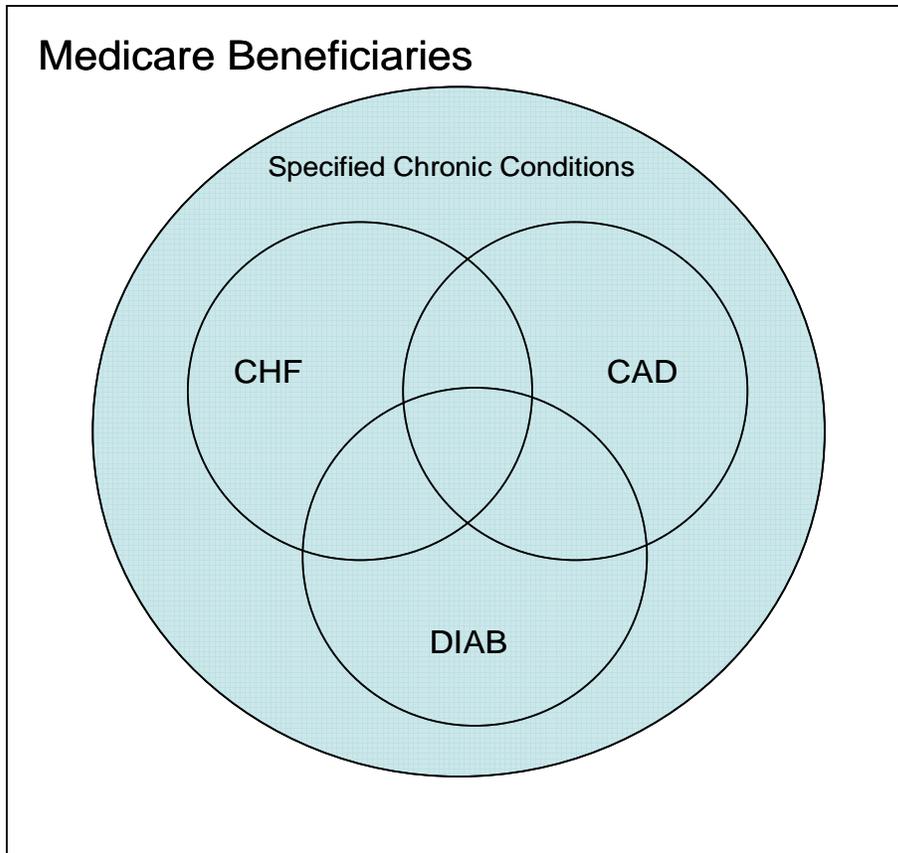
1. All Medicare beneficiaries – The first set of beneficiaries will include all FFS Medicare beneficiaries and will be used to determine that the practice meets the 50-beneficiary requirement.

2. All beneficiaries with one of the specified chronic conditions - The second set of beneficiaries (which is a subset of the first) will be all beneficiaries with an eligible chronic condition. (See Appendix D for a list of the specific diagnosis codes used to define each chronic condition.) This also includes any beneficiary with one of the targeted conditions of congestive heart failure (CHF), coronary artery disease (CAD), or diabetes mellitus (DM). This set will be used as a basis for performance payments for the preventive clinical quality measures.

3. Beneficiaries with one of the targeted conditions (CHF/CAD/DM) - This third set will actually include three separate, and potentially overlapping, subgroups of beneficiaries. That is, a beneficiary with more than one of these conditions will be included in each category for which he/she qualifies. This set will be used as a basis for payments for the disease-specific clinical quality measures.

A beneficiary is considered to have CHF if, during the twelve-month measurement period, the individual has such a diagnosis (not necessarily the principal diagnosis) on at least one inpatient hospital claim or on at least two outpatient claims on different dates, i.e., of claim type outpatient facility and/or physician carrier. A diagnosis of CAD is

determined with the same algorithm, only using the appropriate ICD-9 CM diagnostic codes. A diagnosis of DM is determined in a similar manner except that the measurement period is twenty four months, and one ER visit is sufficient to make the diagnosis. Practices will be eligible for payment on all of the diseases for which a beneficiary qualifies. For example, if a beneficiary has both diabetes and CHF, s/he will be counted in both categories.

The determination for payment on the preventive measures will be based on the second subset of Medicare beneficiaries, (i.e., those with either one of the targeted conditions of CHF, CAD, DM) or with any one or more of the other specified chronic conditions. A beneficiary is considered to have a defined chronic condition if the individual has at least one inpatient hospital claim with a diagnosis for a particular condition or two outpatient claims on different dates with similar conditions. The diagnoses on the two outpatient claims do not need to be exactly the same; they need only be for the same general condition. For example, a beneficiary qualifies for payment if they have one outpatient claim with a diagnosis code 290.40 (Atherosclerotic Dementia, uncomplicated) and one outpatient claim with diagnosis code 294.1 (Dementia in Conditions Classified elsewhere) because they are both classified as relating to Alzheimer's or other Mental Health condition. However, a beneficiary with one outpatient claim with diagnosis code 427.31 (Atrial Fibrillation) and one outpatient claim with diagnosis code 296 (Affective psychoses) would not be counted as having either, because at least two claims for the same chronic condition are required.

This methodology is consistent with what has been done for other CMS projects in an attempt to exclude patients whose claims have one-time coding errors or whose claims have been incorrectly coded with a disease when the intent was to "rule out" the condition. On the other hand, because inpatient claim coding is presumed to be more accurate than physician claim coding, a single mention of a diagnosis on an inpatient claim is sufficient to categorize a beneficiary for demonstration purposes. Appendix D contains the complete list of eligible conditions and their associated ICD 9 CM diagnosis codes.

5. Beneficiary Assignment and Beneficiary Eligibility

For each beneficiary represented in the claims data, ARC will determine which practice provided the plurality of evaluation and management (E&M) services. The algorithm only uses claims for services which most likely reflect primary care. Additionally, those services must have been provided by primary care providers or those medical subspecialists likely to provide primary care (See Appendix C). The underlying assumption is that these physicians, if providing this type of care, are in the best position to manage the overall care and, ultimately, control costs for that beneficiary.

For the purposes of the algorithm, primary care type services are defined as Evaluation and Management (E&M) services billed using the following CPT codes:

99201-99215	Office or other Outpatient Service

99301-99316	Nursing Facility Service
99321-99333	Domiciliary, Rest Home, Boarding Home or Custodial Care Services
99341 – 99350	Home Service
99381-99397	Preventive Medicine Services
99401-99429	Counseling and/or Risk Factor Reduction Intervention

Only the carrier (physician) claims file is used for this algorithm. Each claim with a qualifying CPT code and physician specialty is counted as one visit. The practice providing a particular beneficiary with the greatest number of these visits during the specific reporting period will have that beneficiary assigned to it. Should two or more practices have provided an equal number of visits; the beneficiary will be assigned to the practice with the most recent E&M visit. The underlying assumption is that if a beneficiary changed physicians during the year, then the most recent provider would be the most accurate choice. Therefore, even if a beneficiary is treated by a participating practice during the year, if the most E & M visits during the year were provided by a nonparticipating practice or, if two practices provided the same number of visits but the nonparticipating practice billed for the most recent visit, the beneficiary will not be assigned to the participating demonstration practice.

Exclusionary Criteria

Once the initial list of beneficiaries assigned to each practice has been identified, there will be a second process to finalize the determination of beneficiaries eligible to be counted toward the 50-beneficiary minimum under the demonstration. The initial list of beneficiaries will be filtered through a set of eligibility exclusionary criteria. These criteria include:

- death,
- lack of either Part A or Part B coverage,
- residence outside of the demonstration state,
- Medicare is secondary payer,
- election of hospice coverage, or
- enrollment in an MA or other Medicare coordinated care plan.

Beneficiaries meeting any of the above eligibility exclusionary criteria at the time the initial eligibility check is completed will not be assigned to a provider and will, therefore, not be counted when determining the eligibility of practice to participate in the demonstration.

Once the demonstration is underway, the following criteria will exclude a beneficiary from being eligible for payment in each demonstration year:

- death with more than 6 months remaining in the demonstration year,
- relocation out of the demonstration state for more than 6 months of the demonstration year,

- lack of either Part A or Part B coverage for all or part of the demonstration year,
- Medicare is secondary payer due to working aged / disabled status for more than 6 months of the demonstration year,
- election of hospice coverage for more than 6 months of the demonstration year, or
- enrollment in an MA or other Medicare coordinated care plan for more than 6 months of the demonstration year.

Beneficiaries that are excluded for any of the above reasons will not be assigned to a provider and will, therefore, not be counted when calculating payment.

Each year, the beneficiaries assigned to a practice will be redetermined based on claims data in the most recently completed demonstration year. Thus, a patient assigned to a physician in year 1 of the demonstration may not be assigned in year 2, depending upon which physicians the patient saw during year 2. Similarly, a physician may be assigned a new patient in year 2 that s/he had not been assigned the previous year. Because assignment of a beneficiary is a retrospective process based on services provided to a beneficiary during the previous period, it is reflective of beneficiary behavior rather than having any impact on the beneficiary's actual access to providers.

6. Payment Methodology

The payment model under MCMP will consist of three components (i.e., three types of payment):

1. an initial payment for reporting clinical quality data (not contingent upon actual scores or performance),

2. an annual payment for performance on clinical measures, and

3. an additional bonus to the performance payment for submitting clinical measures data electronically.

Initial Incentive Payment for Reporting Clinical Quality Data:

One of the purposes of the initial payment is to recognize the practices' commitment towards the goals of the demonstration and to provide an up-front incentive, albeit a small one, to invest early on in those changes in practice that are required to achieve the quality goals. In addition, the baseline data collection will provide practices the opportunity to familiarize themselves with the measures and the data collection process before having their payments tied to performance.

The amount of the initial payment will be up to $1,000 per physician and up to $5,000 per practice. This payment is not contingent upon any specific level of performance, but will be tied to the number of beneficiaries for whom the practice is responsible for

reporting baseline data. The per beneficiary payment amount for the reporting the initial baseline data will be twenty dollars. As described in section 4, above, claims from calendar year 2006 will be used to assign beneficiaries to practices for the purposes of determining practice eligibility and reporting baseline period performance measures. Because calculation of performance on the clinical measures requires one year of data and a three-month lag period when claims may be submitted, incentive payments for performance on the clinical measures is, inherently, retroactive and delayed.

Annual Incentive Payment

The key payment incentive is the annual payment for performance on the twenty-six clinical quality measures. The amount of the performance payments will be based on a practice-level score, with practices that meet the performance criteria receiving a per-beneficiary-per-year payment in each diagnosis category: CHF, DM, CAD and preventive services. The per beneficiary payment amount will be seventy dollars for the diabetes, CHF and CAD measures and twenty-five dollars for the preventive services measures. The beneficiary, or patient, count in each category will be based on the number of FFS Medicare beneficiaries with a chronic disease and/or specific condition assigned to the practice and not necessarily the number of beneficiaries reported on for each measure(e.g., CHF, CAD or diabetes; *See sections 4 & 5 above for discussion of the assignment algorithm. See section 6 below for discussion of clinical measure scoring*).

Additional Bonus Payment for Electronic Submission

The third component of the incentive is the additional payment to practices if they are able to submit the clinical quality measure data electronically directly from an electronic health record that meets national certification (CCHIT) standards. Practices will be eligible for a bonus of up to 25% of their annual incentive payment if they are able to submit all of the measures electronically. Because some practices may be able to report only some of the measures electronically, and will have to report other measures by manually abstracting the record from an individual medical chart, the source of each measure (EHR or manual abstraction) will be tracked. Those practices that submit only some of the measures electronically will be eligible for the additional bonus on a prorated basis that depends upon the number of measures submitted electronically.

Payment Calculation and Management Processes

The method for paying practices for their *clinical quality* performance involves three major aspects: scoring, scaling, and payment management. Scoring refers to the choice of measures to assess and the criteria for measuring success, or degrees of success. Scaling refers to the conversion of the measurement of success to a dollar value for payments. Payment management refers to the mechanics of the payment process, including scheduling. This section summarizes the scoring and scaling process that determines payments. This includes the setting of performance thresholds, and the conversion of scores into a dollar amount.

Scoring

Practices participating in the demonstration will be scored based on a potential total of 26 measures: 8 diabetes measures, 7 CHF measures, 6 CAD measures, and 5 preventive services measures. *(See Appendix E for a complete list of measures.)* All measures will be reported on during the baseline period and will count towards performance scoring beginning in the first operational year of the demonstration. There will be no penalty for not submitting any data on any particular measure, but practices that submit data on only some of the measures will be eligible for only the proportion of payment applicable to the measures they report on.

In some situations, a beneficiary will be assigned to a provider for purposes of calculating payment (See sections 4 & 5, above), but may be excluded from calculation of a particular quality measure. Reasons for this include not having a full twelve months of Medicare claims data, (e.g., a beneficiary who ages into Medicare three months into the demonstration year or a beneficiary who is enrolled in hospice for less than six months) or because of other exclusionary criteria specific to the measure specifications. For example, in order to be eligible for the mammography screening measure, a beneficiary must be female and under 70 years of age. In addition, there may be clinical factors that could exclude a beneficiary from a measure. Another example would be that although all assigned diabetic patients might be included in the denominator of the measure of the percentage of patients receiving HbA1c tests, only those who did, in fact, receive HbA1c tests would be included in the denominator of the measure examining how many had their HbA1c levels under good control. Actual scores on each of the measures will be calculated by RTI.

Beneficiaries will be classified into every condition for which they qualify. A patient that is diagnosed with Diabetes and CHF will be counted in both specific disease categories. Any beneficiary counted in a specific disease category will also be included in the broader "chronic disease" category applicable to the preventive services measures. There is no minimum requirement for the number of beneficiaries in any of the disease categories. As long as the practice meets the requirement of 50 Medicare beneficiaries overall, the practice is eligible to receive payment on the number of beneficiaries that meet the criteria for each category.

Practices will earn up to 5 points for meeting standards on each measure. The total number of potential points for each condition will vary based on the number of measures related to that condition. For example, for Diabetes, there are eight separate quality measures and, therefore, the maximum number of quality points is 8 x 5, or 40. Similarly, the maximum number of quality points is 35 and 30 for each beneficiary with CHF or CAD, respectively. The preventive measures include vaccines for flu and pneumonia and screenings for blood pressure, colorectal cancer, and breast cancer. These measures will apply to any beneficiary assigned to the practice that has one of the specified chronic conditions. With a potential for reporting on all five measures, practices are eligible to receive a maximum of 25 quality points for the preventive measures.

For each measure, practices will earn anywhere from zero to five points, depending on how well they perform. The standards chosen are based on the Medicare Health Plan Employer Data and Information Set (HEDIS). A practice will earn the full 5 points for a measure if it achieves a score at or above the 75th percentile of the Medicare HEDIS standard. Practices that achieve a score of at least the 62.5[th] percentile but less than the 75th percentile will earn 4 points.[2] A score above the 50th percentile but less than the 62.5[th] percentile will earn 3 points. A score above the 37.5[th] percentile but less than the 50th percentile will earn 2 points.[3] A score above the 25th percentile but less than the 37.5[th] percentile will earn 1 point. Finally, practices that achieve less than the 25th percentile of the Medicare HEDIS standard for that measure will earn no points.

For the demonstration, the 2006 HEDIS data (available summer 2007) will be used to determine point values. Those values will then be frozen for the course of the demonstration. Appendix E contains a detailed description and specific percentiles of each measure from the 2004 HEDIS dataset. These values are only given as an example of what the point methodology will be.

For clinical measures that are not in the HEDIS data, the *percent* (rather than percentile) of patients in each practice meeting the measure will be used to determine point values. A practice will earn the full 5 points for a measure if it achieves a score at or above 75%. Practices that achieve a score of at least 62.5% but less than 75% will earn 4 points. A score above 50% but less than 62.5% will earn 3 points. A score above 37.5% but less than 50% will earn 2 points.   A score above 25% but less than 37.5% will earn 1 point. Finally, practices that achieve less than 25% for that measure will earn no points.

Scaling

All of the points for each of the measures in a particular category will be added together to calculate an aggregate percentage of total potential points earned for that category. Practices that earn at least 90% of the potential points in a given category will be eligible for the full per beneficiary bonus amount. Practices that earn less than 30 percent of the potential points in the first demonstration year will not receive payment for that category. In the second and third years of the demonstration, practices will be required to earn at least 40% and 50%, respectively, of the potential points within a given category in order to qualify for any payment in that category that year. Practices that achieve at least the minimum score (30%, 40%, or 50% in demonstration years 1, 2, and 3, respectively) but do not achieve at least 90% of the potential points in a category will be paid an amount based on a linear interpolation between 0 and the 100% payment level.

Practices that submit the data on their measures electronically will also be eligible to receive up to a 25% increase in their performance payment. The actual amount of this

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[2] The 62.5[th] percentile will be determined as the midpoint between the 50th percentile and the 75th percentile.
[3] Similarly, the 37.5[th] percentile will be determined as the midpoint between the 25th percentile and the 50th percentile.

bonus for electronic submission will be proportional to the number of measures the practice is able to submit electronically. Practices that submit their data electronically but earn less than 30 percent of the *quality* points will still receive no payment. The payment for electronic submission is proportional to the performance on the *clinical quality* measures. Below are some examples of how the payment may be calculated:

- Example #1 –
  Assume "Practice A" earns 36 out of the potential 40 points, or 90%, for performance on the diabetes measures. Because the practice's composite score in the category is >=90%, it is entitled to the full incentive of $70 for this category. Based on the patient assignment algorithm, the practice provides primary care for 100 diabetic Medicare beneficiaries.

  If none of the measures are submitted electronically, the payment would be:
  $70 per beneficiary x 100 beneficiaries = $7000

  If all of the measures are submitted electronically, the payment would be:
  ($70 per beneficiary x 100 beneficiaries) x 125% = $8750

  If four out of the eight (or half) of the measures are submitted electronically, the payment would be:
  ($70 per beneficiary x 100 beneficiaries) x (1 + (25% x 4/8)) = $7875

- Example #2 -
  Assume "Practice B" reports on only 3 of the 7 CHF measures and earns a total of 8 out of the potential 35 points, or 22.9%. Based on the patient assignment algorithm, the practice provides primary care for 50 Medicare beneficiaries with CHF.

  Because Practice B scored less than the minimum 30% of the potential points, it would not be eligible for any incentive payment in this category, even if the data that were submitted were submitted electronically. Depending upon its score for the other categories, it may or may not be eligible for incentive payments related to performance on the CAD, DM, or preventive services measures.

Payment amounts will not change with an increase in the minimum threshold, however, practices must perform at a higher standard in order to receive any payment in each subsequent year.

Payment Management

The actual scores on each of the clinical measures will be calculated by RTI. Data on scores for each of the measures and whether the measure was submitted electronically or not will be forwarded to ARC for calculation of the payment using the rules described above. With the exception of the initial payment which will be based solely on the reporting of baseline data, payment during the demonstration years will be contingent

upon both the scores on each of the quality measures as well as whether the measure was reported electronically.

Payment for the baseline period and for each demonstration year will be calculated and issued several months after the end of the demonstration year. After allowing for a three-month claims lag, additional time is needed for practices to complete the clinical reporting tool and/or submit the data electronically to the Iowa Foundation for Medical Care, RTI's subcontractor. IFMC will then be responsible for editing the data for completeness and doing an audit on approximately 5% of all submissions. Payment for the baseline reporting data is projected to be calculated and issued by the end of 2007. For each of the three demonstration years, payments are projected to be calculated and issued approximately six to nine months after the end of the demonstration year

Practice-specific payment amount information will be transmitted from ARC to TrailBlazer Health Enterprise, LLC, which will be responsible for processing and issuing checks. TrailBlazers will also be responsible for all reporting and tax functions related to payment. All payments will be issued to demonstration practices electronically.

Appendix A: Demonstration Legislation

MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003

TITLE VI—PROVISIONS RELATING TO PART B
Subtitle D—Additional Demonstrations, Studies, and Other Provisions

SEC. 649. MEDICARE CARE MANAGEMENT PERFORMANCE DEMONSTRATION

(a) ESTABLISHMENT.

(1) IN GENERAL.—The Secretary shall establish a pay-for-performance demonstration program with physicians to meet the needs of eligible beneficiaries through the adoption and use of health information technology and evidence-based outcomes measures for

(A) promoting continuity of care;
(B) helping stabilize medical conditions;
(C) preventing or minimizing acute exacerbations of chronic conditions; and
(D) reducing adverse health outcomes, such as adverse drug interactions related to polypharmacy.

(2) SITES.—The Secretary shall designate no more than 4 sites at which to conduct the demonstration program under this section, of which

(A) 2 shall be in an urban area;
(B) 1 shall be in a rural area; and
(C) 1 shall be in a State with a medical school with a Department of Geriatrics that manages rural outreach sites and is capable of managing patients with multiple chronic conditions, one of which is dementia.

(3) DURATION.—The Secretary shall conduct the demonstration program under this section for a 3-year period.

(4) CONSULTATION.—In carrying out the demonstration program under this section, the Secretary shall consult with private sector and non-profit groups that are under taking similar efforts to improve quality and reduce avoidable hospitalizations for chronically ill patients.

(b) PARTICIPATION.

(1) IN GENERAL.—A physician who provides care for minimum number of eligible beneficiaries (as specified by the Secretary) may participate in the demonstration program under this section if such physician agrees, to phase in over the course of the 3-year demonstration period and with the assistance provided under subsection (d)(2)

> (A) the use of health information technology to manage the clinical care of eligible beneficiaries consistent with paragraph (3); and
> (B) the electronic reporting of clinical quality and outcomes measures in accordance with requirements established by the Secretary under the demonstration program.

(2) SPECIAL RULE.—In the case of the sites referred to in subparagraphs (B) and (C) of subsection (a)(2), a physician who provides care for a minimum number of beneficiaries with two or more chronic conditions, including dementia (as specified by the Secretary), may participate in the program under this section if such physician agrees to the requirements in subparagraphs (A) and (B) of paragraph (1).

(3) PRACTICE STANDARDS.—Each physician participating in the demonstration program under this section must demonstrate the ability

> (A) to assess each eligible beneficiary for conditions other than chronic conditions, such as impaired cognitive ability and co-morbidities, for the purposes of developing care management requirements;
> (B) to serve as the primary contact of eligible beneficiaries in accessing items and services for which payment may be made under the medicare program;
> (C) to establish and maintain health care information system for such beneficiaries;
> (D) to promote continuity of care across providers and settings;
> (E) to use evidence-based guidelines and meet such clinical quality and outcome measures as the Secretary shall require;
> (F) to promote self-care through the provision of patient education and support for patients or, where appropriate, family caregivers;
> (G) when appropriate, to refer such beneficiaries to community service organizations; and
> (H) to meet such other complex care management requirements as the Secretary may specify.

> The guidelines and measures required under subparagraph (E) shall be designed to take into account beneficiaries with multiple chronic conditions.

(c) PAYMENT METHODOLOGY.—Under the demonstration program under this section the Secretary shall pay a per beneficiary amount to each participating physician who meets or exceeds specific performance standards established by the Secretary with respect to the clinical quality and outcome measures reported under subsection (b)(1)(B). Such amount may vary based on different levels of performance or improvement.

(d) ADMINISTRATION

(1) USE OF QUALITY IMPROVEMENT ORGANIZATIONS.—The Secretary shall contract with quality improvement organizations or such other entities as the Secretary deems appropriate to enroll physicians and evaluate their performance under the demonstration program under this section.
(2) TECHNICAL ASSISTANCE.—The Secretary shall require in such contracts that the contractor be responsible for technical assistance and education as needed to physicians enrolled in the demonstration program under this section for the purpose of aiding their adoption of health information technology, meeting practice standards, and implementing required clinical and outcomes measures.

(e) FUNDING.

(1) IN GENERAL.—The Secretary shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the demonstration program under this section.

(2) BUDGET NEUTRALITY.—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary estimates would have been paid if the demonstration program under this section was not implemented.

(f) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as may be necessary for the purpose of carrying out the demonstration program under this section.

(g) REPORT.—Not later than 12 months after the date of completion of the demonstration program under this section, the Secretary shall submit to Congress a report on such program, together with recommendations for such legislation and administrative action as the Secretary determines to be appropriate.

(h) DEFINITIONS.—In this section:

(1) ELIGIBLE BENEFICIARY.—The term ''eligible beneficiary'' means any individual who—

(A) is entitled to benefits under part A and enrolled for benefits under part B of title XVIII of the Social Security Act and is not enrolled in a plan under part C of such title; and
(B) has one or more chronic medical conditions specified by the Secretary (one of which may be cognitive impairment).

(2) HEALTH INFORMATION TECHNOLOGY.—The term ''health information technology'' means email communication, clinical alerts and reminders, and other

information technology that meets such functionality, interoperability, and other standards as prescribed by the Secretary.

Appendix B: Data Collection Flow Chart
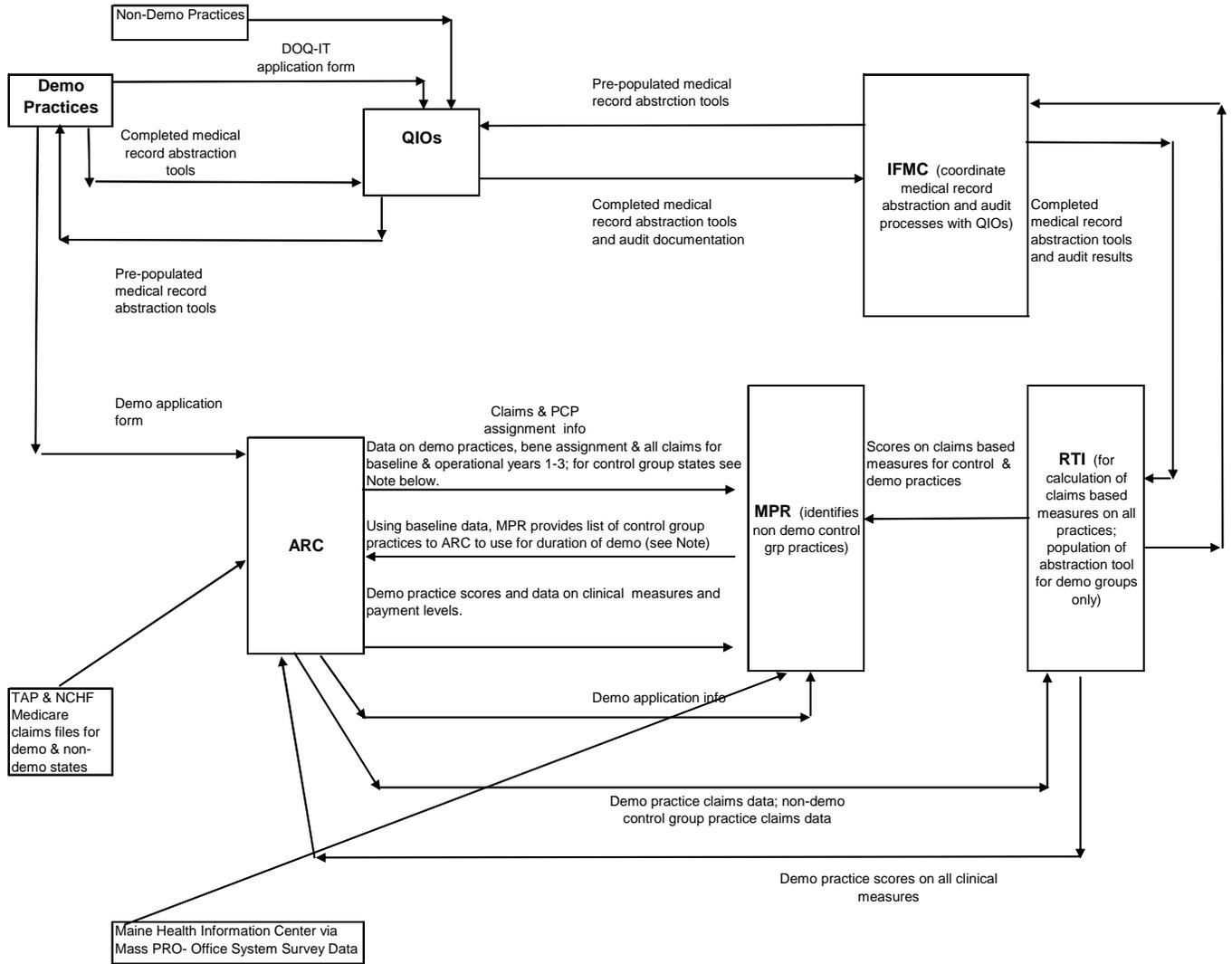
Note:
For non demo control group states: For baseline year, initially benes will be assigned to all practices in control grp states and given with claims to MPR.
MPR will then identify specific control group practices and provide list of practices to ARC. For all future years, ARC will match benes and provide
claims for demo practices and for non demo states only for matched practices.

Appendix C: Physician Specialty and E & M Code Inclusions

The following physician specialties will be eligible to participate in the MCMP demonstration:

General Practice	Nephrology
Allergy/Immunology	Infectious Disease
Cardiology	Endocrinology
Family Practice	Multispecialty clinic or Group Practice
Gastroenterology	Hematology
Internal Medicine	Hematology/Oncology
Pulmonary Disease	Preventive Medicine
Geriatric Medicine	Rheumatology
Osteopathic Medicine	Medical Oncology

The following CPT codes will be used to define Evaluation and Management visits in the MCMP demonstration:

99201 – 99215	Office or other Outpatient Services
99301 – 99316	Nursing Facility Services
99321 – 99333	Domiciliary, Rest Home, Boarding Home or Custodial Care Services
99341 – 99350	Home Services
99381 – 99397	Preventive Medicine Services
99401 – 99429	Counseling and/or Risk Factor Reduction Intervention

Appendix D: Diagnostic Code Inclusions

The following ICD 9 CM codes are arranged by category. Beneficiaries must have at least one inpatient claim OR two SEPARATE outpatient claims on different dates with an ICD 9 CM code in the same category for a practice to be eligible for payment on that beneficiary.

Disease Category	ICD 9 CM Codes
Diabetes Mellitus	250.00 – 250.93, 357.2, 362.01 – 362.07, 366.41, 648.00 – 648.04
Congestive Heart Failure	398.91, 402.01, 402.11, 402.91, 404.01, 404.91, 404.03, 404.13, 404.93, 428.0x, 428.1x, 428.20, 428.21, 428.22, 428.23, 428.30, 428.31, 428.32, 428.33, 428.40, 428.41, 428.42, 428.43, 428.9x
Coronary Artery Disease	410.00 – 414.07, 414.8x, 414.9x, v45.81, v45.82
Alzheimer's and Mental Health	290.xx, 294.xx, 296.xx, 298.0x, 300.4x, 309.1x, 309.28, 310.xx, 311.xx, 331.0x, 331.1x, 331.2x, 331.3x, 331.7x, 331.89, 797.xx
Other Chronic Cardiac or Circulatory Disease	401.0x, 402.00, 430.00 – 432.xx, 434.xx – 438.xx, 440.xx
Kidney Disease	016.0x, 095.4x, 189.0x, 189.9x, 223.0x, 236.91, 250.40, 250.41, 250.42, 250.43, 271.4x, 274.1x, 283.11, 403.01, 403.11, 403.91, 404.02, 404.03, 404.12, 404.13, 404.92, 404.93, 440.1x, 442.1x, 572.4x, 580.0x, 580.4x, 580.81, 580.89, 580.9x, 581.0x, 581.1x, 581.2x, 581.3x, 581.81, 581.89, 581.9x, 582.0x, 582.1x, 582.2x, 582.4x, 582.81, 582.89, 582.9x, 583.0x, 583.1x, 583.2x, 583.4x, 583.6x, 583.7x, 583.81, 583.89, 583.9x, 584.5x, 584.6x, 584.7x, 584.8x, 584.9x, 585.xx, 586.xx, 587.xx, 588.0x, 588.1x, 588.81, 588.89, 588.9x, 591.xx, 753.12, 753.13, 753.14, 753.15, 753.16, 753.17, 753.19, 753.20, 753.21, 753.22, 753.23, 753.29, 794.4x, v56.xx, v45.1x

Lung Disease	491.1x, 491.2x, 491.8x, 491.9x, 492.xx, 493.1x, 493.2x, 493.82, 493.9x
Cancer	14x.xx – 208.xx, 230.xx – 239.xx
Other Chronic Diseases **(Osteoporosis and Arthritis)**	714.0x, 714.1x, 714.2x, 714.30, 714.31, 714.32, 714.33, 715.00, 715.04, 715.09, 715.10, 715.11, 715.12, 715.13, 715.14, 715.15, 715.16, 715.17, 715.18, 715.20, 715.21, 715.22, 715.23, 715.24, 715.25, 715.26, 715.27, 715.28, 715.30, 715.31, 715.32, 715.33, 715.34, 715.35, 715.36, 715.37, 715.38, 715.80, 715.89, 715.90 – 715.98, 733.00, 733.01, 733.02, 733.03, 733.09

Appendix E: Clinical Quality Measures for each clinical area

(Values are based on 2004 HEDIS data for example purposes. Actual values used for the demonstration will be based on the 2006 HEDIS data)

Diabetes Mellitus	Standard	Max Points	Performance	Score
DM-1 HbA1c Management • Percent of patients with one or more A1c test(s)	HEDIS median: 89.6% HEDIS 75th : 92.5% HEDIS 25th : 85.7	5	$x \geq 92.5$ $91.1 \leq x < 92.5$ $89.6 \leq x < 91.1$ $87.7 \leq x < 89.6$ $85.7 \leq x < 87.7$ $x < 85.7$	5 4 3 2 1 0
DM-2 HbA1c Control • Percent of patients with most recent A1c level >9.0% (poor control)	HEDIS median: 21.1 HEDIS 25th : 15.1%* HEDIS 75th : 27.7%*	5	$x \leq 15.1$ $15.1 < x \leq 18.2$ $18.2 < x \leq 21.2$ $21.1 < x \leq 24.5$ $24.5 < x \leq 27.7$ $x > 27.7$	5 4 3 2 1 0
DM-3 Blood Pressure Management • Percent of patients (who received a test) with last BP < 140/90 mm Hg	HEDIS median: 64.2 HEDIS 75th : 69.7% HEDIS 25th : 60.3%	5	$x \geq 69.7$ $66.9 \leq x < 69.7$ $64.2 \leq x < 66.9$ $62.3 \leq x < 64.2$ $60.3 \leq x < 62.3$ $x < 60.3$	5 4 3 2 1 0
DM-4 Lipid Measurement • Percent of patients with at least one low-density lipoprotein (LDL) cholesterol test	HEDIS median: 93.9% HEDIS 75th : 95.9% HEDIS 25th : 90.5%	5	$x \geq 95.9$ $94.9 \leq x < 95.9$ $93.9 \leq x < 94.9$ $92.2 \leq x < 93.9$ $90.5 \leq x < 92.2$ $x < 90.5$	5 4 3 2 1 0
DM-5 LDL Cholesterol Level • Percent of patients with most recent LDL cholesterol < 130 mg/dl	HEDIS median: 73% HEDIS 75th : 78.1% HEDIS 25th : 65.5%	5	$x \geq 78.1$ $75.6 \leq x < 78.1$ $73 \leq x < 75.6$ $69.3 \leq x < 73$ $65.5 \leq x < 69.3$ $x < 65.5$	5 4 3 2 1 0
DM-6 Urine Protein Testing • Percent of patients with at least one test for microalbumin during the year; or who had medical attention for existing nephropathy or microalbuminuria or albuminuria	HEDIS median: 56.4% HEDIS 75th : 65.9% HEDIS 25th : 49.4%	5	$x \geq 65.9$ $61.2 \leq x < 65.9$ $56.4 \leq x < 61.2$ $52.9 \leq x < 56.4$ $49.4 \leq x < 52.9$ $x < 49.4$	5 4 3 2 1 0
DM-7 Eye Exam • Percent of patients who received a dilated eye exam or evaluation or retinal photographs by an optometrist or ophthalmologist	HEDIS median: 66.8% HEDIS 75th : 74.2% HEDIS 25th : 57.4%	5	$x \geq 74.2$ $70.5 \leq x < 74.2$ $66.8 \leq x < 70.5$ $62.1 \leq x < 66.8$ $57.4 \leq x < 62.1$ $x < 57.4$	5 4 3 2 1 0

DM-8 Foot Exam • Percent of patients receiving at least one complete foot exam	75% 50% 25%	**5**	$x \geq 75$ 5 $62.5 \leq x < 75$ 4 $50 \leq x < 62.5$ 3 $37.5 \leq x < 50$ 2 $25 \leq x < 37.5$ 1 $x < 25$ 0

Congestive Heart Failure	Standard	Max Points	Performance	Score
HF-1 Left Ventricular Function Assessment • Percent of patients who have quantitative or qualitative results of LVF assessment recorded	75% 50% 25%	5	$x \geq 75$ $62.5 \leq x < 75$ $50 \leq x < 62.5$ $37.5 \leq x < 50$ $25 \leq x < 37.5$ $x < 25$	5 4 3 2 1 0
HF-2 Left Ventricular Ejection Fraction Testing • Left ventricular ejection fraction testing for patients hospitalized during the year with principal diagnosis of CHF	75% 50% 25%	5	$x \geq 75$ $62.5 \leq x < 75$ $50 \leq x < 62.5$ $37.5 \leq x < 50$ $25 \leq x < 37.5$ $x < 25$	5 4 3 2 1 0
HF-3 Weight Measurement • Percent of patients with weight measurement recorded	75% 50% 25%	5	$x \geq 75$ $62.5 \leq x < 75$ $50 \leq x < 62.5$ $37.5 \leq x < 50$ $25 \leq x < 37.5$ $x < 25$	5 4 3 2 1 0
HF-5 Patient Education • Percent of patients who were provided with patient education on disease management and health behavior changes during on or more visits within a 6-month period	75% 50% 25%	5	$x \geq 75$ $62.5 \leq x < 75$ $50 \leq x < 62.5$ $37.5 \leq x < 50$ $25 \leq x < 37.5$ $x < 25$	5 4 3 2 1 0
HF-6 Beta-Blocker Therapy • Percent of patients who also have LVSD who were prescribed beta-blocker therapy	HEDIS median: 95.9% HEDIS 75th : 98.0% HEDIS 25th : 89.7%	5	$x \geq 98.0$ $96.9 \leq x < 98.0$ $95.9 \leq x < 96.9$ $92.8 \leq x < 95.9$ $89.7 \leq x < 92.8$ $x < 89.7$	5 4 3 2 1 0
HF-7 Ace Inhibitor Therapy • Percent of patients who also have LVSD who were prescribed ACE inhibitor therapy	75% 50% 25%	5	$x \geq 75$ $62.5 \leq x < 75$ $50 \leq x < 62.5$ $37.5 \leq x < 50$ $25 \leq x < 37.5$ $x < 25$	5 4 3 2 1 0
HF-8 Warfarin Therapy for Patients • Percent of patients who also have paroxysmal or chronic atrial fibrillation who were prescribed warfarin therapy	75% 50% 25%	5	$x \geq 75$ $62.5 \leq x < 75$ $50 \leq x < 62.5$ $37.5 \leq x < 50$ $25 \leq x < 37.5$ $x < 25$	5 4 3 2 1 0

Coronary Artery Disease	Standard	Max Points	Performance	Score
CAD-1 Antiplatelet Therapy • Percent of patients who were prescribed antiplatelet therapy	75% 50% 25%	5	$x \geq 75$ $62.5 \leq x < 75$ $50 \leq x < 62.5$ $37.5 \leq x < 50$ $25 \leq x < 37.5$ $x < 25$	5 4 3 2 1 0
CAD-2 Drug Therapy for Lowering LDL Cholesterol • Percent of patients who were prescribed a lipid-lowering therapy (based on current ATP III guidelines)	75% 50% 25%	5	$x \geq 75$ $62.5 \leq x < 75$ $50 \leq x < 62.5$ $37.5 \leq x < 50$ $25 \leq x < 37.5$ $x < 25$	5 4 3 2 1 0
CAD-3 Beta-Blocker Therapy – Prior MI • Percent of patients with prior Myocardial Infarction (MI) who were prescribed beta-blocker therapy	HEDIS median: 95.9% HEDIS 75th : 98.0% HEDIS 25th : 89.7%	5	$x \geq 98.0$ $96.9 \leq x < 98.0$ $95.9 \leq x < 96.9$ $92.8 \leq x < 95.9$ $89.7 \leq x < 92.8$ $x < 89.7$	5 4 3 2 1 0
CAD-5 Lipid Profile • Percent of patients receiving at least one lipid profile during the year	HEDIS median: 71.0% HEDIS 75th : 78.1% HEDIS 25th : 62.6%	5	$x \geq 78.1$ $74.6 \leq x < 78.1$ $71.0 \leq x < 74.6$ $66.8 \leq x < 71.0$ $62.6 \leq x < 66.8$ $x < 62.6$	5 4 3 2 1 0
CAD-6 LDL Cholesterol Level • Percent of patients with mort recent LDL cholesterol<130 mg/dl	HEDIS median: 55.8% HEDIS 75th : 64.1% HEDIS 25th : 43.8%	5	$x \geq 64.1$ $60.0 \leq x < 64.1$ $55.8 \leq x < 60.0$ $49.8 \leq x < 55.8$ $43.8 \leq x < 49.8$ $x < 43.8$	5 4 3 2 1 0
CAD-7 Ace Inhibitor Therapy • Percent of patients who also have diabetes and or LVSD that were prescribed ACE inhibitor therapy	75% 50% 25%	5	$x \geq 75$ $62.5 \leq x < 75$ $50 \leq x < 62.5$ $37.5 \leq x < 50$ $25 \leq x < 37.5$ $x < 25$	5 4 3 2 1 0

Preventive Care	Standard	Max Points	Performance	Score
PC-1 Blood Pressure Screening • Percent of patient visits with blood pressure measurement recorded during the last office visit	75% 50% 25%	**5**	$x \geq 75$ $62.5 \leq x < 75$ $50 \leq x < 62.5$ $37.5 \leq x < 50$ $25 \leq x < 37.5$ $x < 25$	5 4 3 2 1 0
PC-5 Breast Cancer Screening • Percent of women under age 69 who had a mammogram during the current or previous year	HEDIS median: 73.0% HEDIS 75th : 79.9% HEDIS 25th : 67.7%	**5**	$x \geq 79.9$ $76.5 \leq x < 79.9$ $73 \leq x < 76.5$ $70.4 \leq x < 73$ $67.7 \leq x < 70.4$ $x < 67.7$	5 4 3 2 1 0
PC-6 Colorectal Cancer Screening • Percent of patients screened for colorectal cancer during the year	HEDIS median: 52.0% HEDIS 75th : 59.8% HEDIS 25th :43.9%	**5**	$x \geq 59.8$ $55.9 \leq x < 59.8$ $52 \leq x < 55.9$ $47.9 \leq x < 52$ $43.9 \leq x < 47.9$ $x < 43.9$	5 4 3 2 1 0
PC-7 Influenza Vaccination • Percent of patients over age 50 who received an influenza vaccination from September through February of year prior to measurement year	HEDIS median : 73% HEDIS 75th : 78% HEDIS 25th : 68%	**5**	$x \geq 78$ $75.5 \leq x < 78$ $73 \leq x < 75.5$ $70.5 \leq x < 73$ $68 \leq x < 70.5$ $x < 68$	5 4 3 2 1 0
PC-8 Pneumonia Vaccination • Percent of Patients over 65 with a chronic condition who received a pneumococcal vaccination	HEDIS median : 69% HEDIS 75th : 73% HEDIS 25th : 62%	**5**	$x \geq 73$ $71 \leq x < 73$ $69 \leq x < 71$ $65.5 \leq x < 69$ $62 \leq x < 65.5$ $x < 62$	5 4 3 2 1 0