

Date_of_Comment	Comment_Submitter_Name	Comment_Submitter_Organization	On_Behalf_of_Organization	On_Behalf_of_Email	On_Behalf_of_PhoneNumber	Comment_Type	Question	Comment
Oct 4 2010 4:46PM	Kevin Weiss	American Board of Medical Specialties					Section 4: Resource Use Measure Modules	<p>'Attribution: In our measure development process, we came to the conclusion that no single rule could apply across the entire measure set; rather, decisions on attribution should vary according to the clinical context of the condition. In some situations the measure can clearly be attributed to one individual (e.g. the provider performing a certain procedure). However, many conditions require input from a combination of primary and specialty care physicians and so the concept of multiple attribution is more appropriate in these situations. Attribution rules should be able to vary from measure to measure according to the disease or condition under study.</p> <p>Peer Group Identification and Assignment: The paper states that the two key characteristics of the physician peer group are most often medical specialty and geographic location. We caution against comparing peer groups on the basis of geographic area as it may mask important variations in practice patterns occurring at the local level.'</p>
Oct 4 2010 4:48PM	Kevin Weiss	American Board of Medical Specialties					General Comments on the White Paper	<p>'The American Board of Medical Specialties Research and Education Foundation (ABMS REF) is pleased to have the opportunity to comment on the recent draft of the Resource Use Measurement White Paper. We appreciate the balanced perspectives and thorough coverage of the topic as presented in the paper. We also applaud the emphasis on resource use as only one component of efficiency measurement. In our measure development process, we took great care to create measures that reflect the grouping of resources from the clinical perspective of a condition's progression and treatment. However, resource measures, in isolation, do not measure appropriateness of care and so we strongly agree that any use of these measures for purposes of judgment or accountability should incorporate appropriate measures of quality.</p> <p>We thank you for the opportunity to provide input to these important new processes and look forward to the release of the call for measures later this year.</p> <p>Sincerely,</p> <p>Kevin B. Weiss, MD, MPH</p> <p>President and CEO</p> <p>American Board of Medical Specialties Research and Education Foundation'</p>
Oct 4 2010 4:49PM	Kevin Weiss	American Board of Medical Specialties					Section 5: Limitations, Implications, and Unresolved Questions About Resource Use Measurement	<p>'Reliability Testing: On lines 1537-38 of the paper, reliability is defined as demonstrating the measure results are repeatable and produce the same results for the same population in the same time period. This approach appears to be more of a comment on coding accuracy than the reliability of the measure. As such, we are unclear as to the value of performing this exercise as stated.</p> <p>Validity Testing: There is currently no gold standard of resource use for the numerous health care conditions under consideration. In the absence of universally accepted standards, we have real concerns over potential requirements for validity testing that extend beyond face validity. Calling for this type of testing in the absence of providing standards will result in the NQF receiving numerous applications that are non-comparable.'</p>
Oct 4 2010 5:16PM	Jennifer Pearse	Ingenix					General Comments on the White Paper	<p>'On behalf of Ingenix, we'd like to thank NQF for the opportunity to comment on this topic and applaud NQF for culminating many months of thought and extensive debate into this White Paper. Resource use measurement has been a challenge for both organizations undertaking measurement and those being measured. Careful review and standards will be a major contribution. We provide both general and specific comments below.</p> <p>General Comments:</p> <ol style="list-style-type: none"> <li>1. The five modules identified by NQF: (1) data protocol; (2) measure clinical logic; (3) measure construction logic; (4) adjustments for comparability; and (5) measure reporting all have importance. Modules 2, 3, and 4 form the core of any methodology and should be a major focus of the endorsement process. For Modules 1 and 5, NQF guidelines and recommended practices from a measure developer will have the greatest value. Specific, prescribed approaches will be a challenge given the potentially different applications, data issues and measure focus across organizations.</li> <li>2. Many resource measures will use a common approach for episodes, risk, or other units of measurement. We recommend that NQF consider a process where developers of those methods submit their approach for general review and endorsement. Other organizations could then submit for the relevant module components beyond those core methodologies.'</li> </ol>

Oct 4 2010 5:20PM	Jennifer Pearse	Ingenix	Section 1: Measuring Efficiency and Resource Use in Healthcare	'Comments refer to lines in the draft.  176: This statement does not characterize well the general use of quality and cost/resource use measures in the industry. Following NCQA PHQ 2008 and Patient Charter, most organizations that measure cost of care do so in the context of quality.  177: Resource use measures are evaluated by NCQA PHQ 2008 and Patient Charter.  205-207: A better example would be two visits of a different level (limited and complex) or two very different procedures. The visit and procedure in the example would be counted separately in most (if not all) applications.  221: It is understandable that composites might be considered separately from measures for individual conditions. However, there is significant demand for and use of these measures in the industry. Composites should be a priority.  248-252: Please see comment for 205-207.  269-274: The terms "resource use" and cost of care are used interchangeably in different parts of the paper (and in the industry, in general). It is difficult in these definitions to see a clear difference/similarity/overlap. Same comment for "resource unit" at 276.'
Oct 4 2010 5:27PM	Jennifer Pearse	Ingenix	Section 2: Designing Measures that Acknowledge the Real World While Producing Usable Output	'Comments note line number in draft  403-441: A further dimension is the ability of a measure to be attributed to providers of different types and at different levels. Per capita measures can be attributed in a relatively straightforward way to a plan, a system/ACO, and to a PCP. However, attributing per capita measures to a specialist and other providers presents issues. Episode measures have greater flexibility in this regard - being attributable across the spectrum of provider types.  430-433: The point on not all services grouping to an episode is accurate (although almost 90% of services do group). However, the statement, "Generally, multiple episodes are not designed to relate to one another" is not accurate. Most episode methodologies cover the clinical spectrum and also methods that acknowledge the presence of different episodes and their impact. Most methodologies are designed specifically to relate to one another - that's part of the challenge. The sentence at 435 does acknowledge this design, but if it is true, it is not consistent with the general statement at 430.  452: The leading inpatient hospital DRG methodologies do account for co-morbidities.'
Oct 4 2010 5:36PM	Jennifer Pearse	Ingenix	Section 3: Types of Resource Use Measures: Per Capita, Per Episode, Per Admission, Per Procedure, and Others	'Comments refer to line number in draft.  558-560: This is particularly true if PCPs are involved - may want to make that distinction. Per capita measures will not work well for many specialists.  567-569: Is "powerful" the right term? Maybe a better way to say it is "and" and thus requires a different approach to risk adjustment.  572-576: The relative importance of coupling episode and per capita measures depends on the focus. For PCP or system measurement (e.g. ACO), combining the two approaches has value. This is less so for specialists, where there may be minimal opportunity to impact care outside of the provider's general area of focus. The point also speaks to the importance of appropriateness measures.  585-593: The per procedure discussion describes procedure episodes, especially if extending to pre and post.  596-612: The general points made in this section have merit for systems, plans and PCPs. However, as noted for above, per capita measures have less relevance for many specialists. A distinction should be made between the types of physicians where both per capita and per episode measures make sense.'
Oct 4 2010 5:52PM	Jennifer Pearse	Ingenix	Section 4: Resource Use Measure Modules	'Comments refer to line numbers  747: Although exclusions based on enrollment, benefits, and data can be accomplished as part of cleaning, clinical exclusions are typically accomplished as a later step  816-835: The text is misleading. It is correct that many use annual periods for measurement. However, this approach is coupled with the clinical and methodological logic that recognizes different stages of a condition.  868-873: It is unclear how these last two sentences fit.  893: The use of the term "corrective" seems awkward. In many ways, risk adjustment is a further step in defining a measure - just like the dx codes used for diabetes  1157-1158: Many organizations use peer comparisons for quality  1174: O/E methods actually weight observations by expected cost  1180: Figure 7 - Difficult to understand the tradeoffs with this composite measure. The # of observations could be added. Mean O/E ratio across measures would likely be weighted by # of observations. For the Total O/ E approach - organizations weight by total expected.  1190-1193: Double-counting of services and costs would create significant issues for most applications.  1211: All thresholds have value. However, the claim-line and entity threshold discussions may better fit elsewhere'

Oct 4 2010 5:55PM	Jennifer Pearse	Ingenix				Section 5: Limitations, Implications, and Unresolved Questions About Resource Use Measurement	'Comments refer to line #  1284: Administrative data is also a limitation of quality measures. It should be noted if resource measures are different in this regard.  1326: Also an issue for quality. Are resource measures more or less impacted?  1327: The goal should not be sample size but statistical evidence of real differences.  1348: The term reliability is used here in the context of statistical reliability &ndash; suggest use &ldquo;statistical reliability&rdquo;.  1363: Composite measures that provide insights across multiple conditions have significant value in resource measurement and should noted as an option to address sample size.  1389: Ttransparency is important. However, the terms proprietary and transparent are not the same. Many proprietary tools are available in more transparent ways than public domain tools (e.g., ability to explain the methodology). &ldquo;Proprietary and therefore not transparent&rdquo; is not necessarily true. The more challenging issue is how to make methodologies such as episodes or complex population measures both transparent and understandable.'	
Oct 4 2010 5:58PM	Jennifer Pearse	Ingenix				Section 6: Summary of NQF Evaluation Criteria for Measures of Resource Use	'1514: The use of the term &ldquo;reliability&rdquo; may create confusion with an alternative use of the term.  1538: Is the question around the consistency of software in applying a measure?  1551: NQF will need to provide detailed examples and guidance around this type of validation. What is an example of a gold standard?  1558: Is this test to show that exclusions are done consistently? Is the assessment around whether the exclusions make sense? Detailed guidance and examples needed.  1565: Will quality measures be restricted to NQF endorsed quality rules?  1577: In determining feasibility, this assessment should consider that most organizations use software to support measure implementation. Also, there is often a tradeoff between complexity and validity. More precise approaches for defining resource measures involve more complex approaches'	
Oct 7 2010 5:37PM	Janet Leiker	American Academy of Family Physicians	Janet Leiker	American Academy of Family Physicians	jleiker@a afp.org	913-906- 6000	General Comments on the White Paper	On behalf of the AAFP Commission on Quality and Practice:  This paper is generally well done and complete in its assessment of the area of resource use. There are four areas that we think need additional consideration. These comments have been posted in their respective sections.
Oct 7 2010 5:39PM	Janet Leiker	American Academy of Family Physicians					Section 1: Measuring Efficiency and Resource Use in Healthcare	'On behalf of the AAFP Commission on Quality and Practice  Patient Perspective and Preferences  The paper correctly acknowledges that the &ldquo;value of care&rdquo; must take into account the patient&rsquo;s view in order to be meaningful. For example, going half-way across the Country for surgery at a &ldquo;center for excellence,&rdquo; incurring a lower cost and demonstrating slightly higher quality may have high value for the health plan or employer, but having the procedure done locally with ready access to family and friends for support may have higher value for the patient.  Patient choices and behaviors have significant influence on the cost, quantity and intensity of care. Any method that is designed to assess or influence the cost of care must take into account patient incentives. Patients who are aided by informed medical decision making choose less intervention, less intensity of treatment and lower cost alternatives.  Patients should have incentives to choose and use a &ldquo;usual source of care.&rdquo; There is ample evidence that this alone lowers costs through fewer hospital admissions, fewer emergency department visits and fewer unnecessary tests and procedures. It also aids in providing clear attribution of costs to a primary
Oct 7 2010 5:41PM	Janet Leiker	American Academy of Family Physicians					Section 3: Types of Resource Use Measures: Per Capita, Per Episode, Per Admission, Per Procedure, and Others	'On Behalf of the AAFP Commission on Quality and Practice  Different Approaches are Needed for Different Providers (part 1)  The paper seems to assume that a similar methodology should be used for all providers within a system. The efficiencies of a primary care physician, procedure oriented specialist and a hospital can and must be measured in very different ways. Episode of care (bundled payment) algorithms work extremely well for brief or acute care involving a hospitalization or a procedure (e.g. hip fracture or maternity care). Episodes methods are much more complex and less reliable when the patient has multiple co-morbidities and chronic illness. The framework must acknowledge the limitations of these methods certain care settings and should make recommendations about the best method for each setting.'
Oct 7 2010 5:43PM	Janet Leiker	American Academy of Family Physicians					Section 3: Types of Resource Use Measures: Per Capita, Per Episode, Per Admission, Per Procedure, and Others	'On Behalf of the AAFP Commission on Quality and Practice  Different Approaches are Needed for Different Providers (part 2)  The efficiency of primary care physicians might be best measured by the per capita costs (pmpm calculation of the total medical spend) because of the broad scope of services and the care coordination functions that actually save the system money. Focusing only on the efficiency of a few conditions with low prevalence in the office practice (e.g. CHF or AMI) may give little insight into the overall efficiency of the care provided to a population of patients. In similar fashion, primary care provider quality might best be measured using a composite of common conditions (e.g. diabetes, hypertension, asthma, cardiovascular disease and depression) rather than using the individual cost/quality determinations required by an episode methodology with small numbers for each.  Detailed pmpm cost reports for a wide variety of services (e.g. ED visits, lab testing, pharmacy, physical therapy or imaging) help providers focus on specific actions that may reduce overall costs. When possible these reports should provide comparison data for peers within the same market and similar patient populations.'
Oct 7 2010 5:44PM	Janet Leiker	American Academy of Family Physicians					Section 2: Designing Measures that Acknowledge the Real World While Producing Usable Output	'On behalf of the AAFP Commission on Quality and Practice  Pharmacy Costs  Pharmacy costs and efficiency have commonly been measured using percent generic prescribing or single source drug prescribing rates. The efficiency of drug prescribing is best measured by the pmpm pharmaceutical costs in the population served by a particular physician. Only the pmpm costs will reflect a physician&rsquo;s choice to recommend a treatment regimen that relies on lifestyle modification, over-the-counter medications, or counseling instead of a prescription with unknown benefit.'

Oct 7 2010 5:46PM	Janet Leiker	American Academy of Family Physicians				Section 5: Limitations, Implications, and Unresolved Questions About Resource Use Measurement	On Behalf of the AAFP Commission on Quality and Practice Transparency and Reliability are Keys to Success  Full transparency and disclosure of information about the methodology and algorithms used for efficiency measures will be essential for their effective use and acceptance by the provider community. NQF should not endorse measures that are not available for public scrutiny. The endorsement process should include evaluation of a measure's validity and reliability to assure all that the measure performs well using the variety of data sets currently available. "The American Nurses Association (ANA) notes the document's appropriate use of knee replacement surgery as an example as the numbers of these replacements will likely continue to rise. However, had another example (i.e., hip replacement surgery) been selected the document does not indicate whether there would be differentiation between an open procedure and one that was minimally invasive. Resource use in the OR depends on type of procedure as well as on team communication regarding what supplies, approach, prosthesis, etc. will be used. Identification of 'supply use' is not among the elements to be quantified and (in its absence) true measurement of physician practice patterns will likely not be achieved."	
Oct 7 2010 6:48PM	Rita Munley Gallagher	American Nurses Association	Rita Munley Gallagher, PhD, RN	American Nurses Association	DrRitaMunleyGallagher@ATT.net	301-628-5062	General Comments on the White Paper	"The American Nurses Association (ANA) believes the document will benefit from careful editing to add clarity and eliminate typographical and/or grammatical errors including:  Lines 219-220, a word (possibly 'determine') is missing after 'The ability to...'  Line 341, AQA is no longer an acronym for 'Ambulatory Care Quality Alliance.' It is now just known as 'AQA.'  Line 446, delete 'further.'  There is no text reference to Exhibit 3, which likely belongs around line 526.  Line 536, delete 'the table below'; and add 'Exhibit 4.'  Exhibit 4 ~ What is it?  a) Per capita-patient based 'and'; should be 'diagnosis', not 'diagnoses.'  b) Per admission 'and'; delete extra space between 'for'; and 'acute.'  c) Per procedure 'and'; delete extra space between 'specific'; and 'procedures'; and 'procedures'; should be 'procedure.'
Oct 7 2010 6:51PM	Rita Munley Gallagher	American Nurses Association	Rita Munley Gallagher, PhD, RN	American Nurses Association	DrRitaMunleyGallagher@ATT.net	301-628-5062	General Comments on the White Paper	"The American Nurses Association (ANA) also notes the following instances of typographical and/or grammatical errors:  7.Line 581 'and'; add comma after 'measures';  8. Line 607-608 'and'; recommend changing 'higher or lower outcomes'; to 'better or worse outcomes'; or just 'better outcomes';  9.Lines 614-618 'and'; recommend adding a comma after 'evaluated'; and move the evaluation terms to a footnote ('in terms of importance to measure and report, scientific acceptability of measure properties, usability, and feasibility') or a link to the evaluation terms.'
Oct 7 2010 6:54PM	Rita Munley Gallagher	American Nurses Association	Rita Munley Gallagher, PhD, RN	American Nurses Association	DrRitaMunleyGallagher@ATT.net	301-628-5062	General Comments on the White Paper	'ANA calls attention to the following:  10. Page 63 1c. NQF Quality Measure  a) second line; add space between 'mortality'; and 'function.'  b) third line, add space between 'is'; and 'relevant';  c) fourth line, add space between 'national'; and 'Health';  d) fifth line, add space between ','; and 'and/or';  e) sixth line, add space between 'process,'; and 'structure.'  f) seventh line, add space between 'that'; and 'supports';  11. Page 63 1c. Proposed Resource Use  a) second line; add space between 'mortality,'; and 'function.'  b) third line, add space between 'is'; and 'relevant';  c) fourth line, add space between 'national'; and 'Health';  d) fifth line, add space between ','; and 'and/or';  e) sixth line, add space between 'process,'; and 'structure';
Oct 7 2010 6:56PM	Rita Munley Gallagher	American Nurses Association	Rita Munley Gallagher, PhD, RN	American Nurses Association	DrRitaMunleyGallagher@ATT.net	301-628-5062	General Comments on the White Paper	"The American Medical Association (AMA) appreciates the opportunity to review and provide comments on the NQF's Resource Use Measurement White Paper. The paper provides a comprehensive review of the complex issues surrounding health care efficiency and resource use measurement. The paper is well written and the discussion is presented at a level for all interested stakeholders. The PCPI strongly supports the recommendation throughout the paper that resource use measure developers be transparent in describing in detail the steps and decisions made during the development and specification of the measures. We also agree with the requirement that measure developers carry out validity and reliability testing of the measures in each of the five modules of the resource use measure. In addition, the AMA has long felt that measures of efficiency are multidimensional and should not be separated from quality measurement. To this end, we have outlined a framework for aligning quality measurement with costs of care (A Framework and Empirical Strategies for Assessing Healthcare Efficiency, <a href="http://www.ama-assn.org/ama1/pub/upload/mm/370/exec_summ_efficiency.pdf">http://www.ama-assn.org/ama1/pub/upload/mm/370/exec_summ_efficiency.pdf</a> ).  Below are general comments on two topic areas in the paper, as well as some comments regarding particular language within the paper:'
Oct 8 2010 10:03AM	Mark Antman	American Medical Association	Ardis D. Hoven, MD	American Medical Association	mark.antman@ama-assn.org	312-464-5056	General Comments on the White Paper	

Oct 8 2010 10:04AM	Mark Antman	American Medical Association	Ardis D. Hoven, MD	American Medical Association	mark.antman@ama-assn.org	312-464-5056	General Comments on the White Paper	'Risk Adjustment  While the sections covering risk adjustment outline potential problems or limitations (eg, use of administrative data in risk adjustment methodologies), the white paper provides few recommendations. The paper at a minimum should require efficiency measure developers to include a complete description of the risk adjustment procedures utilized. There should be no &ldquo;black box&rdquo; in this areas. The description should include the model specification, variables, rationale for variable inclusion, data sources, and evidence of the effectiveness for the measures developed, as well as results from application to other measures.  Physician-Level Attribution  The AMA supports measures that appropriately assign responsibility to physicians in those instances when it has been consistently shown that the measure is directly dependent on a physician&rsquo;s actions or the actions of other healthcare professional for which the physician has significant oversight authority. As such we caution the NQF in including statements that suggest that responsibility for &ldquo;procedure specific&rdquo; measures can generally be attributed to an individual physician (Pg 34, lines 1015-1017).' 'Line 662 &ndash; &ldquo;For example, for the purposes of feedback and confidential reporting to physicians, or when measuring large populations or entities, it may be acceptable to use a less powerful risk adjustment approach; whereas, for the same measure when the purpose is public reporting, a more complete and vigorous risk adjustment may be necessary.&rdquo; For the measures to be meaningful and actionable to the attributed physician, in reporting to physicians (as confidential reporting or not) the risk adjustment system should be as rigorous as in any other use of the measures.  Line 740 &ndash; &ldquo;As a result, Medicare has full-year claims data only for some of its beneficiaries and is missing drug claims for a subset of this group.&rdquo; The limitation of not having information from drug claims or patients not being enrolled in drug coverage should be more fully fleshed out in discussions of data protocol, stratification, and risk adjustment.'
Oct 8 2010 10:06AM	Mark Antman	American Medical Association	Ardis D. Hoven, MD	American Medical Association	mark.antman@ama-assn.org	312-464-5056	General Comments on the White Paper	'Line 662 &ndash; &ldquo;For example, for the purposes of feedback and confidential reporting to physicians, or when measuring large populations or entities, it may be acceptable to use a less powerful risk adjustment approach; whereas, for the same measure when the purpose is public reporting, a more complete and vigorous risk adjustment may be necessary.&rdquo; For the measures to be meaningful and actionable to the attributed physician, in reporting to physicians (as confidential reporting or not) the risk adjustment system should be as rigorous as in any other use of the measures.  Line 740 &ndash; &ldquo;As a result, Medicare has full-year claims data only for some of its beneficiaries and is missing drug claims for a subset of this group.&rdquo; The limitation of not having information from drug claims or patients not being enrolled in drug coverage should be more fully fleshed out in discussions of data protocol, stratification, and risk adjustment.'
Oct 8 2010 10:06AM	Mark Antman	American Medical Association	Ardis D. Hoven, MD	American Medical Association	mark.antman@ama-assn.org	312-464-5056	General Comments on the White Paper	'The following are comments on specific sections of the white paper:  Line 189 &ndash; &ldquo;the terms &ldquo;low&rdquo; and &ldquo;high&rdquo; do not capture the relative comparisons between the quadrants. Using &ldquo;lower&rdquo; and &ldquo;higher&rdquo; seems more descriptive of the concepts being illustrated in the exhibit.  Line 567 &ndash; &ldquo;Episode-based measures are by construction generally more homogenous than per capita or patient measures and thus do not require as powerful a risk adjustment.&rdquo; Is there evidence to substantiate this claim? While an episode could be defined as more homogeneous than other types of measures, all episodes need not be. The degree of homogeneity will depend on the condition and the population of patients. The risk adjustment system should also vary by condition and patient population. The example (line 380) of a highly homogeneous measure for patients with comorbidities would still require risk adjustment.'
Oct 8 2010 10:07AM	Mark Antman	American Medical Association	Ardis D. Hoven, MD	American Medical Association	mark.antman@ama-assn.org	312-464-5056	General Comments on the White Paper	'Line 897 &ndash; &ldquo;Risk-adjustment approaches often are defined as the process of adjusting payments to healthcare providers or health plans to account for the health status of the patients or members.&rdquo; Referring to the use of risk adjusting payments is confusing when the focus is on resource use.  Line 1021 &ndash; &ldquo;In one extreme, with plans that assign patients to a primary care physician and explicitly hold the primary care physician accountable for the care the patient receives&mdash;such as HMOs that use gatekeepers&mdash;the attribution of a patient&rsquo;s resource use is relatively straightforward.&rdquo; This might only be applicable for primary care services, or maybe chronic care episodes. But why would attribution be assigned to a gatekeeper for procedure based episodes? Also, what percentage of plans use gatekeepers?'
Oct 8 2010 10:07AM	Mark Antman	American Medical Association	Ardis D. Hoven, MD	American Medical Association	mark.antman@ama-assn.org	312-464-5056	General Comments on the White Paper	'Lines 1034-1037 - It may not be appropriate to rely on the Acumen LLC study cited in this report for justifying the linking of costs of care to a single provider given that the study cited relied on administrative claims. As we know, administrative claims do not necessarily appropriately reflect the care provided to a patient.'
Oct 8 2010 10:09AM	Mark Antman	American Medical Association	Bernard M. Rosof, MD, MACP Physician Consortium for Performance Improvement	Physician Consortium for Performance Improvement	mark.antman@ama-assn.org	312-464-5056	General Comments on the White Paper	'Risk Adjustment  While the sections covering risk adjustment outline potential problems or limitations (eg, use of administrative data in risk adjustment methodologies), the white paper provides few recommendations. The paper at a minimum should require efficiency measure developers to include a complete description of the risk adjustment procedures utilized. There should be no &ldquo;black box&rdquo; in this areas. The description should include the model specification, variables, rationale for variable inclusion, data sources, and evidence of the effectiveness for the measures developed, as well as results from application to other measures.  Physician-Level Attribution  The PCPI supports measures that appropriately assign responsibility to physicians in those instances when it has been consistently shown that the measure is directly dependent on a physician&rsquo;s actions or the actions of other healthcare professional for which the physician has significant oversight authority. As such we caution the NQF in including statements that suggest that responsibility for &ldquo;procedure specific&rdquo; measures can generally be attributed to an individual physician (Pg 34, lines 1015-1017).' 'The Physician Consortium for Performance Improvement&reg; appreciates the opportunity to review and provide comments on the NQF&rsquo;s Resource Use Measurement White Paper. The paper provides a comprehensive review of the complex issues surrounding health care efficiency and resource use measurement. The paper is well written and the discussion is presented at a level for all interested stakeholders. The PCPI strongly supports the recommendation throughout the paper that resource use measure developers be transparent in describing in detail the steps and decisions made during the development and specification of the measures. We also agree with the requirement that measure developers carry out validity and reliability testing of the measures in each of the five modules of the resource use measure. In addition, the PCPI has long felt that measures of efficiency are multidimensional and should not be separated from quality measurement. To this end, we have outlined a framework for aligning quality measurement with costs of care (A Framework and Empirical Strategies for Assessing Healthcare Efficiency, <a href="http://www.ama-assn.org/ama1/pub/upload/mm/370/exec_summ_efficiency.pdf">http://www.ama-assn.org/ama1/pub/upload/mm/370/exec_summ_efficiency.pdf</a> ).  Below are general comments on two topic areas in the paper, as well as some comments regarding particular language within the paper:'
Oct 8 2010 10:09AM	Mark Antman	American Medical Association	Bernard M. Rosof, MD, MACP Physician Consortium for Performance Improvement	Physician Consortium for Performance Improvement	mark.antman@ama-assn.org	312-464-5056	General Comments on the White Paper	'The Physician Consortium for Performance Improvement&reg; appreciates the opportunity to review and provide comments on the NQF&rsquo;s Resource Use Measurement White Paper. The paper provides a comprehensive review of the complex issues surrounding health care efficiency and resource use measurement. The paper is well written and the discussion is presented at a level for all interested stakeholders. The PCPI strongly supports the recommendation throughout the paper that resource use measure developers be transparent in describing in detail the steps and decisions made during the development and specification of the measures. We also agree with the requirement that measure developers carry out validity and reliability testing of the measures in each of the five modules of the resource use measure. In addition, the PCPI has long felt that measures of efficiency are multidimensional and should not be separated from quality measurement. To this end, we have outlined a framework for aligning quality measurement with costs of care (A Framework and Empirical Strategies for Assessing Healthcare Efficiency, <a href="http://www.ama-assn.org/ama1/pub/upload/mm/370/exec_summ_efficiency.pdf">http://www.ama-assn.org/ama1/pub/upload/mm/370/exec_summ_efficiency.pdf</a> ).  Below are general comments on two topic areas in the paper, as well as some comments regarding particular language within the paper:'

Oct 8 2010 10:10AM	Mark Antman	American Medical Association-Physician Consortium for Performance Improvement	Bernard M. Rosof, MD, MACP	Physician Consortium for Performance Improvement	mark.antman@ama-assn.org 312-464-5056	General Comments on the White Paper	<p>'Line 662 &amp;ndash; &amp;ldquo;For example, for the purposes of feedback and confidential reporting to physicians, or when measuring large populations or entities, it may be acceptable to use a less powerful risk adjustment approach; whereas, for the same measure when the purpose is public reporting, a more complete and vigorous risk adjustment may be necessary.&amp;rdquo; For the measures to be meaningful and actionable to the attributed physician, in reporting to physicians (as confidential reporting or not) the risk adjustment system should be as rigorous as in any other use of the measures.</p> <p>Line 740 &amp;ndash; &amp;ldquo;As a result, Medicare has full-year claims data only for some of its beneficiaries and is missing drug claims for a subset of this group.&amp;rdquo; The limitation of not having information from drug claims or patients not being enrolled in drug coverage should be more fully fleshed out in discussions of data protocol, stratification, and risk adjustment.'</p>
Oct 8 2010 10:10AM	Mark Antman	American Medical Association-Physician Consortium for Performance Improvement	Bernard M. Rosof, MD, MACP	Physician Consortium for Performance Improvement	mark.antman@ama-assn.org 312-464-5056	General Comments on the White Paper	<p>'Line 897 &amp;ndash; &amp;ldquo;Risk-adjustment approaches often are defined as the process of adjusting payments to healthcare providers or health plans to account for the health status of the patients or members.&amp;rdquo; Referring to the use of risk adjusting payments is confusing when the focus is on resource use.</p> <p>Line 1021 &amp;ndash; &amp;ldquo;In one extreme, with plans that assign patients to a primary care physician and explicitly hold the primary care physician accountable for the care the patient receives&amp;mdash;such as HMOs that use gatekeepers&amp;mdash;the attribution of a patient&amp;rsquo;s resource use is relatively straightforward.&amp;rdquo; This might only be applicable for primary care services, or maybe chronic care episodes. But why would attribution be assigned to a gatekeeper for procedure based episodes? Also, what percentage of plans use gatekeepers?'</p>
Oct 8 2010 10:10AM	Mark Antman	American Medical Association-Physician Consortium for Performance Improvement	Bernard M. Rosof, MD, MACP	Physician Consortium for Performance Improvement	mark.antman@ama-assn.org 312-464-5056	General Comments on the White Paper	<p>'Lines 1034-1037 - It may not be appropriate to rely on the Acumen LLC study cited in this report for justifying the linking of costs of care to a single provider given that the study cited relied on administrative claims. As we know, administrative claims do not necessarily appropriately reflect the care provided to a patient.'</p>
Oct 8 2010 10:10AM	Mark Antman	American Medical Association-Physician Consortium for Performance Improvement	Bernard M. Rosof, MD, MACP	Physician Consortium for Performance Improvement	mark.antman@ama-assn.org 312-464-5056	General Comments on the White Paper	<p>'The following are comments on specific sections of the white paper:</p> <p>Line 189 &amp;ndash; the terms &amp;ldquo;low&amp;rdquo; and &amp;ldquo;high&amp;rdquo; do not capture the relative comparisons between the quadrants. Using &amp;ldquo;lower&amp;rdquo; and &amp;ldquo;higher&amp;rdquo; seems more descriptive of the concepts being illustrated in the exhibit.</p> <p>Line 567 &amp;ndash; &amp;ldquo;Episode-based measures are by construction generally more homogenous than per capita or patient measures and thus do not require as powerful a risk adjustment.&amp;rdquo; Is there evidence to substantiate this claim? While an episode could be defined as more homogeneous than other types of measures, all episodes need not be. The degree of homogeneity will depend on the condition and the population of patients. The risk adjustment system should also vary by condition and patient population. The example (line 380) of a highly homogeneous measure for patients with comorbidities would still require risk adjustment.'</p>
Oct 9 2010 2:20PM	Frederick Masoudi	ACC/AHA Task Force on Performance Measures	Frederick Masoudi	ACC/AHA Performance Measures TF	fred.masoudi@ucdeanver.edu 303-436-5498	General Comments on the White Paper	<p>'We appreciate the opportunity to comment on this well-written and thoughtful document that addresses a critical topic in the area of measurement. The ACC and AHA are committed to providing the highest quality care to patients and are aware that costs of care cannot be ignored. Indeed, the AHA and ACC have specifically addressed the methodology of measuring health care efficiency (Krumholz et al. J Am Coll Cardiol 2008;52). Rigorous, standardized measures of resource use are instrumental to understanding this central concept of efficiency. However, as discussed in this NQF document, resource use alone does not characterize efficiency. For example, a program that cuts costs without concerns for the consequences on quality is identical from a resource use perspective to another that achieves similar costs savings without adversely affecting quality. Thus, resource use measures in isolation are of little value to patients, providers, or payers. Further, resource use measures alone when used for accountability are likely to pressure providers to avoid patients who will incur the highest costs, such as the elderly and those with numerous illnesses. Although the document touches on these issues, it does not seem to go far enough in requiring that any measure of 'Humana is pleased to have the opportunity to comment. This was a very well done document representing succinctly a wide range of methodologies currently employed. We do have a few general comments and then will include specifics in the respective sections:</p> <p>--The emphasis on evidence-based medicine and the evaluation processes limit the determinations of efficiency and resource use to only that estimated 20% of health care services that are truly evidence-based. The other factors such as patient preferences, provider-patient-family relationship values, employer measures of presenteeism, social values of equity and justice, and cultural values all need to be included in determinations of efficiency and effectiveness of care. That is to say, medicine is not all about science and physiology</p> <p>--The paper accurately describes what might be considered a methodologic Tower of Babel. There are excellent discussions of the attributes of methodologies for measurement, there is no discussion of the appropriateness of one methodology over another; or the circumstances of measurement when one method may be preferred to another.. A timeline should be established</p> <p>--Of particular concern is the like of consensus on the methods of physician attribution. Without that piece, the rest of discussions of consensus on measurement methodology is not going to be as fruitful</p>
Oct 11 2010 1:58PM	Thomas James	Humana Inc.	Tom James	Humana Inc.	tjames@humana.com 502-476-8929	General Comments on the White Paper	<p>Section 1: Measuring Efficiency and Resource Use in Healthcare</p> <p>'Line 177--while AHRQ may have indicated a &amp;quot;jack of validation or evaluation of the measures&amp;quot; of efficiency, I believe that there is sufficient experience with commercial measures from Ingenix, Thomson-Reuters, and Cave Consulting Group as used by commercial health plans, that validation has been achieved in the market place.</p> <p>Line 182--Suggests that efficiency is the sum of cost of each of the five IOM quality attributes which would be a complex computation, that is not validated and would require weighting each of the five IOM quality attributes. While that paragraph starts in that direction, it does not seem to be picked up elsewhere in this document'</p>

Oct 11 2010 2:06PM	Thomas James	Humana Inc.	Section 2: Designing Measures that Acknowledge the Real World While Producing Usable Output	Line 470--makes inferences on contemporary commercial methodologies from a study by Thomas et al ( <a href="http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361048/">http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361048/</a> ) that used statistical methodologies in place more than a decade ago. There have been greater advances in the statistical processes so that this reference and its conclusions are not necessarily correct.  What is not addressed in this section is the need for a standardized attribution methodology so that costs may be attributed in a uniform fashion. This is not mentioned until Module 5 (Line 1010)
Oct 11 2010 2:09PM	Thomas James	Humana Inc.	Section 3: Types of Resource Use Measures: Per Capita, Per Episode, Per Admission, Per Procedure, and Others	Line 562--There is no discussion of the concerns about stacking of episodes of care so that each episode may be appropriate in cost; but that the provider has a greater number of episodes because of poor care coordination. This would raise costs just as a FFS does. Care Coordination and Appropriateness of Care are key elements if episodes of care are a unit
Oct 11 2010 2:14PM	Thomas James	Humana Inc.	Section 4: Resource Use Measure Modules	'Line 719--Inclusion and Exclusion--this is a very good section, describing what we all do in managing data. It does not discuss, however, the issues with pharmacy costs when a person receives medications outside of RxHUB e.g. samples, \$4 prescriptions, drugs mailed from Canada, etc.  Line 254--Measure Clinical Logic--This argument is based upon comparison of treatment of single conditions, and recognizes that many patients have multiple conditions. But rather than this being a flaw, it is an opportunity to build efficiency measures for managing patients/members who do have confounding medical problems. That is real world medicine, so single condition analyses are frequently not appropriate  Line 885 and Line 938--The concept of stratification to account for disparities of care should be used when that is the intended measurement, but does not need to be included in all analyses unlike risk-adjustment which is critical in outcomes determinations and in most cost efficiency measurements (line 892)
Oct 11 2010 2:15PM	Thomas James	Humana Inc.	Section 4: Resource Use Measure Modules	'Line 1127--The Draft includes the 54 specialties that CMS captures (plus "other") whereas most health plans use the 26 ABMS specialty designations. We have found issues in specialties such as dermatology, cardiology, gynecology, and ophthalmology where there are distinct subspecialization that do not have ABMS recognized Boards.  Line 1239--Truncation can be done at a specialty level as some fields such as dermatology have low level costs whereas oncology has higher level costs. We have found it necessary to set levels for "windorsizing" by specialty type that is not described in this section.'
Oct 11 2010 2:17PM	Thomas James	Humana Inc.	Section 5: Limitations, Implications, and Unresolved Questions About Resource Use Measurement	'Line 1273--"a standard must reliably and validly measure what it is intended to evaluate": It seems odd that everyone accepts variation in medical management by physicians and hospitals, but is unwilling to accept any variation in measurement.'
Oct 11 2010 2:21PM	Thomas James	Humana Inc.	Section 6: Summary of NQF Evaluation Criteria for Measures of Resource Use	'Line 1510--Scientific acceptability of measure properties--it would seem to me that it is not just a scientific evaluation but an economic and social value examination. Limiting to the methods employed in pure medical or laboratory science will not get a full picture of the value proposition that also encompasses the economic impact on society and the social good of health care services. This section is too limiting. As a result, the types of measures being submitted will be biased toward aspects of evidence-based medicine and not towards other legitimate interests.ok'
Oct 11 2010 2:25PM	Thomas James	Humana Inc.	Proposed Resource Use Evaluation Criteria (Appendix B)	'A. Conditions for Consideration--Part C should be amended to include among the intended use of the measures to add "development of health care delivery systems"; in addition to public reporting and quality improvement. This would allow health plans to use this information in steerage programs, tiered networks, or development of ACOs (page 61)  B. Measure Focus--Trying to get efficiency measures to meet "one or more of the other five IOM aims of quality, effectiveness, equity, patient-centeredness, safety and timeliness"; will be asking more of efficiency measures than is realistic. There is a tendency to make one set of tools do more than is possible and that will delay the process because of the discussions, and lead to a poorer set of tools (page 63)  C. "For outcome measures and other measures ...and evidence-based, risk-adjustment strategy is specified"--this proposal will limit the types of measures of resource use to those which have a medical model bias and do not necessarily take into account more global economic impacts or patient-preference/social impact models. This is a weakness in the proposal as it is too limiting. (page 66)  D. Feasibility--point 4.c Exclusions is a great point as it limits extraneous information.'
Oct 11 2010 4:31PM	Sam Ho	UnitedHealthcare	General Comments on the White Paper	'We applaud the NQF for developing a white paper on the important topic of resource use measurement, and we appreciate the opportunity to comment.'
Oct 11 2010 4:32PM	Sam Ho	UnitedHealthcare	Section 1: Measuring Efficiency and Resource Use in Healthcare	'We agree with the formulation that resource use measurement must be connected to quality measurement. One example of connecting quality to cost assessment is our UnitedHealth Premium<sup>®</sup> designation program, in which only physicians designated for quality of care are eligible for designation as cost-efficient.'
Oct 11 2010 4:32PM	Sam Ho	UnitedHealthcare	Section 2: Designing Measures that Acknowledge the Real World While Producing Usable Output	'The white paper indicates that NQF would favor if not require resource measures that are connected directly to one or more NQF Endorsed<sup>®</sup> quality measures. We are concerned that this would create too narrow a set of resource use measures. We note that the current NQF Endorsed measures have gaps in terms of appropriateness measures, outcome measures, and in general in the area of specialty and surgical care. Resource use assessment in those areas is necessary as a part of addressing the urgent affordability agenda. Conversely, the framework proposed in the white paper underscores the need for measures that fill gaps in the NQF Endorsed measure set.'
Oct 11 2010 4:33PM	Sam Ho	UnitedHealthcare	Section 3: Types of Resource Use Measures: Per Capita, Per Episode, Per Admission, Per Procedure, and Others	'A requirement for corresponding NQF Endorsed quality measures could result in resource use measures limited to narrow scopes (i.e. specific types or settings of resource use). On the other hand, episode of care techniques are commonly to create composite resource measures, as the white paper appears to anticipate in pages 39-41, for example. It is unclear therefore how the NQF proposed formulation would allow creation of NQF Endorsed composite episode resource measures. Based on UHC's more than 6 years<sup>®</sup> experience in this area (please see the details in the comments that we submitted in the PDF document), we recommend that NQF split the topic composite episode measures out of this paper and into a separate white paper to be developed at a later time. In regards to NQF's multiple types of resource use measures, UHC agrees that measures or combinations of measures should be selected in light of the goal of measurement. In particular, we agree that population measures should supplement episode measures, and we are working towards that end.'

Oct 11 2010 4:33PM	Sam Ho	UnitedHe althcare	Section 4: Resource Use Measure Modules	'The white paper follows standard English usage of the word, reliability. Given recent publicity, the audience of the white paper will surely be familiar with the RAND research on statistical reliability. We recommend that the NQF white paper carefully and clearly defines its meaning of reliability the first time the term is used, and again when necessary, as well as explicitly distinguish it from statistical reliability. The discussion on pp 39 and 40 regarding different methods of O:E construction is misleading. The two methods (mean of O:E vs total O: total E) do indeed yield different results, but the mean O:E is not methodologically sound. Composite O:E ratios must preserve case mix and severity adjustment (and in fact are constructed so as to do that through indirect standardization). The mean O:E method does not do that. Please see the illustration in the PDF document. Therefore the fact that the mean O:E method yields a different result is not relevant. Due to the 1500-character limitation of online submission, more comments are submitted in the PDF document (sections 15&16).'
Oct 11 2010 4:34PM	Sam Ho	UnitedHe althcare	Section 5: Limitations, Implications, and Unresolved Questions About Resource Use Measurement	'In regards to limitations of claims and administrative data, the white paper does not present a balanced view. Sample size is not a limitation specific to claims or administrative data; in fact sample sizes are often larger when drawn from administrative data than chart data due to the high cost of chart abstraction. Similarly, &quot;black box&quot; methodology can be applied to many types of data. Therefore both of these comments should be removed from the section on limitations of claims data, and they should reflect that all data is subject to those potential issues. In addition to EMR data, ICD-10 will increase the utility of claims and administrative data. To be balanced, the report should also mention that chart data itself has been shown to contain errors when compared to a video tape of the actual encounter, and that chart data is inherently incomplete because it reflects only that data developed or collect by one physician.'
Oct 11 2010 4:34PM	Sam Ho	UnitedHe althcare	Proposed Resource Use Evaluation Criteria (Appendix B)	'Generally we agree with the principles for measures of resource use; however they could be improved in several ways. Due to the 1500-character limitation of online submission, more comments are submitted in the PDF document (sections 12-14).'
Oct 11 2010 10:27PM	Barbara Rudolph	The Leapfrog Group	Section 3: Types of Resource Use Measures: Per Capita, Per Episode, Per Admission, Per Procedure, and Others	'Per Episode  Line 572-76 We are concerned, that the suggestion of adding a population-based per capita resource use measure to the episode measure, would be viewed as resolving the issue of the inability to distinguish appropriateness of the service. It does not.  Using Resource Use Measures  Line 614-618 This sentence concludes that measure developers need to provide a measure that provides a complete resource use picture of those being evaluated. While you may be able to build a measure that does this, measure use will be very restricted. This is not even feasible for Medicare databases, which are very large. All Payer Claims Data often is without the self-pay and uninsured patient information. State discharge data often doesn't contain over-the-border activity. There is no database, except the physician-group's databases, that provides all the resource use for individual physicians. Setting the standard of a complete resource use picture of those evaluated means that measures may be submitted, but there will be very limited use of these measures.'
Oct 11 2010 10:28PM	Barbara Rudolph	The Leapfrog Group	Section 5: Limitations, Implications, and Unresolved Questions About Resource Use Measurement	'Line 1290&mdash;The statement that &ldquo;gaps and incomplete clinical information compromise the ability to use administrative data for measurement&rdquo;&mdash;seems to make a conclusion which is not necessarily the case. If we are going to determine cost, it is the only source for the information. Clinical information would not be a better source&mdash;since it doesn't contain the element of interest. Administrative data is the most relevant data for this type of measurement, yet this section implies that it is not. Yes, it has limitations, but those should be addressed more specifically, by condition or by procedure. There is detail in this area that is missing&mdash;and instead the conclusion is drawn that all administrative data is compromised.'
Oct 11 2010 10:30PM	Barbara Rudolph	The Leapfrog Group	Section 6: Summary of NQF Evaluation Criteria for Measures of Resource Use	'Importance to Measure and Report  Line 1494-1497 The addition to the criteria of &ldquo;high or unexplained&rdquo; variation is inappropriate. If there is variation it means that costs can be reduced, and at this particular point, it seems that this is significant. Second, the addition of the requirement for the variation to be &ldquo;unexplained&rdquo; is inappropriate. For example, a recent article in the NEJM[1], titled &ldquo;Low-Cost Lessons from Grand Junction, Colorado&rdquo; refuted criticisms of the Dartmouth Atlas for failing to adjust for regional price variation (a form of &ldquo;explained&rdquo; variation). This article cites three independent observations confirming that Grand Junction provides low-cost healthcare. Second, the University of Wisconsin County Health Rankings show that the population in Grand Junction&rsquo;s Mesa County is far less healthy than those of other US counties with high Medicare costs. And finally, that it is number one in Colorado for the quality of clinical care being provided. The lesson is that sometimes the explained variation is the variation you need to change! Please remove the term &ldquo;unexplained variation&rdquo; from all references in the criteria.
Oct 11 2010 10:31PM	Barbara Rudolph	The Leapfrog Group	Section 6: Summary of NQF Evaluation Criteria for Measures of Resource Use	[1] Bodenheimer, T., and D. West. Low Cost Lessons from Grand Junction, Colorado (2010) NEJM, 363:15, 'Line 1526-1529 The inclusion of &ldquo;5) measure reporting&rdquo; may not be appropriate as stated. I would suggest the following &ndash;&ldquo;guidance on measure reporting&rdquo; Since this is relatively new area of measurement, and it has not been reported publicly to any extent, it is inappropriate for NQF to &ldquo;endorse a method for reporting&rdquo; until there is more research done on this area.  Line 1539&mdash;We would suggest that the two modules for &ldquo;per procedure&rdquo; and &ldquo;per admission&rdquo; should qualify for &ldquo;time-limited&rdquo; status if they have not been fully tested. These types of measures are less likely to be complex, and therefore, should still fall into the category of &ldquo;potential for time-limited status.&rdquo; These measures are likely to have a narrow focus and apply to single providers, limited timeframes, and fairly clean coding and specifications. Given the dearth of resource use measures, NQF should allow these the same leeway that has been given for quality measures, where there are now 100&rsquo;s of measures.  Line 1542-1543&mdash;The wording seems to suggests that each of the individual elements of the measure would require separate testing. I think it should be made clear that only the overall measure validity would need to be completed.'



Oct 11 2010 10:32PM	Barbara Rudolph	The Leapfrog Group	Section 6: Summary of NQF Evaluation Criteria for Measures of Resource Use	'exclusion.&rdquo; This is going a bit too far&mdash;when the denominator is selected, eg., isolated CABG for a procedure, the measure developer should not have to test total CABGs to show why they selected isolated CABG. Likewise, if the measure is for cost of isolated CABG, the measure developer should not have to test CABG with AVR costs. Also, if you are looking at a procedure where there are many appropriate measure exclusions, eg. &ldquo;Elective Deliveries&rdquo;. There are over 100 separate codes that are exclusions from the denominator and some additional from the numerator. This would be impractical and meaningless to test each one.  Usability  Line 1572&mdash;At this point in time we have over 500 quality measures, but only a handful of resource use measures&hellip;and we are in the early stages of developing resource use measures. To add the &ldquo;preference&rdquo; for resource measures linked to quality measures seems premature.'
Oct 11 2010 10:33PM	Barbara Rudolph	The Leapfrog Group	Section 6: Summary of NQF Evaluation Criteria for Measures of Resource Use	'Section on Feasibility  Line 1577&mdash;It seems that a new requirement has been added for resource use measures&mdash;&ldquo;retrievable without undue burden.&rdquo; This is not one of the requirements for other measures, and should not be a requirement for resource use. Measure developers will be caught in a contradictory framework on these measures&mdash;preference for comprehensive measures, complex attributional rules, risk adjustment, testing all exclusions, and then being asked to not make it too complicated, and don&rsquo;t charge too much.'
Oct 11 2010 10:34PM	Barbara Rudolph	The Leapfrog Group	Proposed Resource Use Evaluation Criteria (Appendix B)	'Item D.  In this section, the assumption is made that all resource use measures are complex. I would disagree, it is possible that in at least two domains (per admission, per procedure/condition level) measures would not necessarily be complex. These measures generally might only be attributable to one facility or one provider, would likely be time-limited (eg., inpatient stay, visit or diagnostic test), have clear codes and specifications. I would suggest that these two domains not be considered a priori as complex.  [1] Bodenheimer, T., and D. West. Low Cost Lessons from Grand Junction, Colorado (2010) NEJM, 363:15, NEJM.ORG, Oct. 7, 2010.'
Oct 11 2010 10:35PM	Barbara Rudolph	The Leapfrog Group	Proposed Resource Use Evaluation Criteria (Appendix B)	'1. Importance to Measure  The addition to the criteria of &ldquo;high or unexplained&rdquo; variation is inappropriate. If there is variation it means that costs can be reduced, and at this particular point, it seems that this is significant. Second, the addition of the requirement for the variation to be &ldquo;unexplained&rdquo; is inappropriate. For example, a recent article in the NEJM[1], titled &ldquo;Low-Cost Lessons from Grand Junction, Colorado&rdquo; refuted criticisms of the Dartmouth Atlas for failing to adjust for regional price variation (a form of &ldquo;explained&rdquo; variation). This article cites three independent observations confirming that Grand Junction provides low-cost healthcare. Second, the University of Wisconsin County Health Rankings show that the population in Grand Junction&rsquo;s Mesa County is far less healthy than those of other US counties with high Medicare costs. And finally, that it is number one in Colorado for the quality of clinical care being provided. The lesson is that sometimes the explained variation is the variation you need to change! Please remove the term &ldquo;unexplained variation&rdquo; from all references in the criteria.'
Oct 12 2010 2:09PM	Deborah Mullen	HealthPartners	General Comments on the White Paper	'The document is well organized and thorough. We offer the following comments for consideration for improving the construct of this proposed measurement:  The unit of analysis should include total care for a population as well as condition specific care. Focus on condition specific care and value only does not adequately account for providers and plans that excel at population health and averting onset of chronic disease.  Use of standardized pricing schedules within sector of care (inpatient, outpatient, professional, etc) is a common method for isolating resource use but it has a major limitation. That resulting imputed resource use may still be clouded by unequal levels of payment in different geographies of the country. HealthPartners has developed an algorithm to consistently and thoroughly analyze resource use and we would be happy to share this method with NQF and make it publicly available.  Risk adjustment techniques must be robust enough to achieve a high and reliable levels of performance statistics at the throughout all units of analyses including the highest to the lowest unit (e.g. plan or provider level). To-date, we have not encountered an open source tool that meets these standards. Additionally, open source tools are confounded by how each individual user interprets and applies the specifications. This Benefit differentials among plans will confound results and must be adjusted for to ensure comparability.  Plans or groups that optimally manage patients with chronic disease such that they are able to address secondary health issues need some consideration in the unit of analysis and/or the risk adjustment so these additional services are not counted against them.  Coding completeness and accuracy across the country has variation and will cause a lowest common denominator approach. This will penalize performing plans and providers operating in parts of the country with existing high standards and consistency. We recommend early policy work to ensure administrative uniformity in data collection (see MN AUC standards).
Oct 12 2010 2:28PM	Christine Chen	Pacific Business Group on Health	General Comments on the White Paper	'The Pacific Business Group on Health appreciates the opportunity to comment on the Resource Use Measurement White Paper. This is a timely document given the increasing interest in ensuring greater value for our health care dollars and the critical need to lower costs. We applaud the Steering Committee&rsquo;s work to summarize and assess the current state of resource use measurement, and appreciate its effort to create a document that reflects a balanced perspective. We provide suggestions on how the document can be improved.'
Oct 12 2010 2:29PM	Christine Chen	Pacific Business Group on Health	Section 2: Designing Measures that Acknowledge the Real World While Producing Usable Output	'This section of the document highlights frustration, confusion, and anxiety that arise from implementing a range of resource use measures and methodologies. At the same time, the document should underscore the importance of allowing for flexibility in specifying measurement options to support different stakeholder needs.'

Oct 12 2010 2:29PM	Christine Chen	Pacific Business Group on Health	Section 3: Types of Resource Use Measures: Per Capita, Per Episode, Per Admission, Per Procedure, and Others	'General Comment  While it does mention the findings described in MedPAC's 2009 Report to Congress, the white paper neglects to mention more recent research published by MedPAC in August 2010: "The Reliability of Physician Cost Profiling in Medicare", which is an important reference that sheds light on a number of the issues raised in the white paper.  Line 614-618 (Using Resource Use Measures)  According to the document "users of measures will need to account for perspective and provide a complete resource use picture of those being evaluated". This appears to be an unreasonable requirement as providing a complete picture of a provider's resource suggests that the user must have access to data on how a provider cares for their patients across payers, all conditions, etc. Providing a comprehensive assessment is challenging for Medicare, which has extensive databases, let alone those in the private sector. Also, as a matter of NQF policy, if such were to be required of resource use measures, the same standard should be applied to quality measures, i.e., users of quality measures will need to provide a complete picture of a provider's quality of care across the spectrum of their patients' health  Lines 665-668
Oct 12 2010 2:30PM	Christine Chen	Pacific Business Group on Health	Section 4: Resource Use Measure Modules	  In describing the measure reporting module, the document states: "The last module, reporting, or the analytic functions necessary to report resource use measures reliably and validly, includes steps to calculate a benchmark, attribute results to providers or eligible entity, and provide statistical information necessary to interpret findings when reported."  Conveying performance information to consumers is still in the early stages of development and should not be constrained. We therefore recommend that the word "statistical" be removed. Effectively communicating provider performance to consumers may or may not include "statistical" information (e.g., confidence intervals). This consideration should also be applied to lines 1225-1264.'
Oct 12 2010 2:32PM	Christine Chen	Pacific Business Group on Health	Section 4: Resource Use Measure Modules	'Line 930-936 (Risk-Adjustment Approach)  This section of the document discusses the limitations of administrative and claims data, including the lack of clinical details. This is part of a long-standing debate over whether additional (clinical) data are necessary for risk-adjustment, which will never be resolved to the satisfaction of all stakeholders. Therefore, NQF may need to specify methods to determine when risk-adjustment is sufficient for the need. In addition, this section should cite recent research that shows that by including electronic lab values with administrative data, its ability to adjust for patient risk factors is significantly improved and comparable to clinical data from medical charts and is much more economical than using a full clinical data set. (See "Enhancement of Claims Data to Improve Risk Adjustment of Hospital Mortality")
Oct 12 2010 2:32PM	Christine Chen	Pacific Business Group on Health	Section 4: Resource Use Measure Modules	'Line 947-1001 (Costing Methodology)  This section outlines the benefits of using standardized prices instead of actual prices. We believe that the section should also discuss the benefits of using actual prices for any stakeholder who is paying the bills, in whole or in part. In the private market, providers have demanded higher reimbursements on the basis of their market share rather than quality of care. If resource measures rely on standardized prices, they cannot be employed by consumers and purchasers to hold providers accountable for using oligopolistic powers to extract higher prices.'
Oct 12 2010 2:33PM	Christine Chen	Pacific Business Group on Health	Section 4: Resource Use Measure Modules	'Line 1111-1114 (Peer Group Identification and Assignment)  In the discussion around attribution, it should be added that peer groups can and should be expanded to not only include individuals from the same specialty, but also primary care physicians and those from other specialties. Primary care physicians or other specialists may practice more efficiently for patients with a given condition. This possibility should always be assessed.  Line 1129-1138 (Peer Group Identification and Assignment)  The paper elaborates on the challenges of identifying to which specialty a physician belongs. We encourage the paper to delineate ways in which these challenges can be overcome. For example, Medicare, from which 97% of all eligible physicians accept reimbursement, collects information on the specialties of its enrolled physicians, but the data are often inaccurate. The steering committee white paper should recommend that CMS require accurate, up-to-date reporting of specialty designations of its contracted providers using objective criteria, e.g., board certification, and encourage this information to be made available to other payers and purchasers.'
Oct 12 2010 2:33PM	Christine Chen	Pacific Business Group on Health	Section 5: Limitations, Implications, and Unresolved Questions About Resource Use Measurement	'Line 1285-1298 (Claims and Other Administrative Data Limitations)  This section of the document does not appropriately balance the essential nature of administrative claims data for resource use measurement against its imperfections. Claims data are the most accurate source of data on paid cost and resource use. Unfortunately, the document does not highlight their pivotal role in assessing costs but rather incorrectly suggests that clinical information, which does not contain the necessary elements to perform resource use analysis, would be superior. While administrative data has its limitations, it is also incredibly valuable.'
Oct 12 2010 2:33PM	Christine Chen	Pacific Business Group on Health	Section 6: Summary of NQF Evaluation Criteria for Measures of Resource Use	'Lines 1469 and 1470  Principle 4 should be amended to read: "The justification for and intended purpose of resource use measures is to examine, understand, and ultimately reduce unnecessary costs in care and for use in value-based purchasing."
Oct 12 2010 2:34PM	Christine Chen	Pacific Business Group on Health	Section 6: Summary of NQF Evaluation Criteria for Measures of Resource Use	'Line 1504 (Importance to Measure and Report)  The paper states that "Further, broad comprehensive measures of resource use are preferable, and the health services (or units of resource use) selected for measurement should be conceptually coherent." We believe that this sentence should be reworded to reflect more neutral language. Broad comprehensive resource use measures are not necessarily preferable as different types of resource use measures are more appropriate for different circumstances and audiences; a point made much earlier in the document.  Line 1496 (Importance to Measure and Report)  We do not agree with the addition of "unexplained" variation to the NQF evaluation criteria. Addressing and capturing progress on explained variations such as geographic differences in health care spending remains critical. We therefore encourage the steering committee to remove the reference to "unexplained" variation. This should also be addressed in Appendix B'

Oct 12 2010 2:34PM	Christine Chen	Pacific Business Group on Health	Section 6: Summary of NQF Evaluation Criteria for Measures of Resource Use	'Lines 1565-1575 (Usability)	<p>We appreciate the steering committee's desire to encourage that measures of resource use be implemented in conjunction with measures of quality of care. However, we are concerned about the statement that "resource use measures that are used alongside quality or health outcome measures would be given preference over those that are not." We believe that this practice could stifle innovation in the development of resource use measures, which is still an emerging area. Additionally, there is a dearth of health outcome measures. Giving preference to resource use measure simply because it is accompanied by an endorsed quality measure may also be misguided; some process measures lack a strong link to outcome and will therefore fail to better ensure "efficiency and value of care."</p>
Oct 12 2010 2:35PM	Christine Chen	Pacific Business Group on Health	Proposed Resource Use Evaluation Criteria (Appendix B)	Lines 1577 (Feasibility)	<p>It is proposed that the original NQF criteria around feasibility will now be interpreted to require that "The cost associated with the use of measures for public reporting or quality improvement is considered as part of the criteria." We do not agree with this concept. Because resource use measures are derived from claims data, they are relatively economical to administer. And a resource use measure is derived from claims data, they are relatively economical to administer. We find the white paper to be lacking in understanding of the origin of NQF's measure evaluation criteria, which were developed with a primary focus on measures of process quality and outcomes. In particular, these criteria were developed to stem the tide of narrow and highly-specific quality measures that were being brought to NQF in droves prior to any real testing. The situation with resource use measures is quite different. In particular:</p> <p>Such measures have been in use for a long time by payers to monitor care;</p> <p>They need to be standardized quickly to allow for pairing with already endorsed quality measures for efficiency analysis; and</p> <p>They generally can be described and understood as generic models that are not necessarily condition-specific but are amenable to analysis by condition/procedure when needed.</p>
Oct 12 2010 2:36PM	Christine Chen	Pacific Business Group on Health	Proposed Resource Use Evaluation Criteria (Appendix B)	Proposed Resource Use Evaluation Criteria (Appendix B)	<p>NQF should decide on the strategy it chooses to take in endorsing measures of resource use. Does it make sense to take every conceivable combination of medical condition/procedure and resource type through the endorsement process, or can measures be endorsed in a more generic form that would allow for rapid "Appendix B: Considerations for Consideration, Item D"</p> <p>It is proposed, "Based on existing NQF policy, complex measures are not eligible for time-limited endorsement. Resource use measures are complex in nature and therefore must be fully tested at the time of submission." Yet the white paper cites no evidence for this statement. We do not agree that all resource use measures should be considered complex. Instead, we suggest that two types of resource use measures (i.e., per admission, per procedure/condition level) would not necessarily be complex. These measures are likely to have a narrow focus and apply to single providers, limited timeframes, and fairly clean coding and specifications.'</p>
Oct 12 2010 2:36PM	Christine Chen	Pacific Business Group on Health	Proposed Resource Use Evaluation Criteria (Appendix B)	Proposed Resource Use Evaluation Criteria (Appendix B)	<p>'A second concern is that the effort to amend the current NQF measure evaluation criteria to fit resource use measures seems forced and unnatural. It is difficult to see how the proposed criteria would be applied in practice, and, given this ambiguity, leaves too much discretion with future Steering Committees regarding whether or not the criteria are met. We would strongly urge the White Paper Steering Committee to develop a small number of "use cases" that would help to illustrate how the criteria are intended to be applied. We would suggest the development of "use case" scenarios for each of the following:</p> <p>A simple per capita resource use measure, e.g., emergency room visits per 1,000 population</p> <p>Total annual cost associated with a specific chronic disease, e.g. diabetes</p> <p>An episode-based cost measure, e.g., relative cost for an episode of maternity care (mother + infant), using (a) standardized pricing and (b) actual pricing.</p> <p>Total annual cost of care PMPY for a broad population, e.g., that covered by a particular physician organization</p> <p>NQF's Relative Resource Use measures.'</p>
Oct 12 2010 2:37PM	Christine Chen	Pacific Business Group on Health	Proposed Resource Use Evaluation Criteria (Appendix B)	Proposed Resource Use Evaluation Criteria (Appendix B)	<p>'Appendix B: Proposed Criteria for Usability</p> <p>The report should acknowledge a potential unintended consequence of public reporting of cost and resource use measures, namely that the prevailing public attitude that "more is better" may drive business to inefficient providers. Another unintended consequence is when a provider learns that they are on the high end of efficiency and, as a result, demands higher prices from its payers. NQF will need to decide whether reporting to the general public is necessary, as opposed to reporting to the providers, payers, and purchasers involved in the measurement exercise.</p> <p>Also, Criterion 3c should be changed to read: "List NQF-endorsed quality measures that can be used alongside the resource use measure." As stated earlier, while certainly preferred, we do not agree that this criterion should be an absolute requirement for endorsement.'</p>
Oct 12 2010 3:46PM	Jennifer Faerberg	Association of American Medical Colleges	General Comments on the White Paper	General Comments on the White Paper	<p>'The Association of American Medical Colleges (AAMC) appreciates the opportunity to comment on the Resource Use Measurement White Paper. We commend NQF in producing a well thought out, balanced and informative document on Resource Use. The paper does a great job in highlighting the key elements included in resource use reporting as well as the limitations with various approaches. The document will serve as an excellent guidepost as resource use reporting continues to mature.</p> <p>While we support the paper overall, we do have a few comments and suggestions for refinement.'</p>
Oct 12 2010 3:49PM	Jennifer Faerberg	Association of American Medical Colleges	Section 1: Measuring Efficiency and Resource Use in Healthcare	Section 1: Measuring Efficiency and Resource Use in Healthcare	<p>We were heartened to see that the paper defines efficiency as the relationship of cost of care to quality and not just monetizing resource utilization for purposes of comparison. The AAMC is concerned that the practice of measuring resource use not be utilized to support arbitrary reductions in reimbursement.</p>

Oct 12 2010 3:51PM	Jennifer Faerberg	Association of American Medical Colleges	Section 4: Resource Use Measure Modules	<p>'We strongly agree with the limitations outlined in the paper regarding risk-adjustment. Risk adjustment models based on claims data are problematic as claims data are unable to accurately capture a patient's severity of illness and are subject to the vagaries of billing and coding practices.</p> <p>For resource use measurement to be fair and comparable, the underlying patients should be adjusted for factors such as poverty and severity of illness, which could affect the amount of resources needed to provide quality patient care. The AAMC recommends that the risk adjustment methodologies include patient socio-economic status information. We also believe that patients with substance abuse and mental health disorders should either be removed from the analysis or analyzed separately, as patient compliance is particularly difficult in this patient population. A recent AAMC analysis indicated that income level, patient comorbidities, and substance abuse/mental health disorders may be associated with higher readmission rates. This finding is important because increased readmission rates may result in higher overall episode costs. Thus, adjusting these rates appropriately is critical to obtaining accurate and comparable episode costs.</p>
Oct 12 2010 3:52PM	Jennifer Faerberg	Association of American Medical Colleges	Section 5: Limitations, Implications, and Unresolved Questions About Resource Use Measurement	<p>All resource use measures should utilize risk adjustment methodologies that are transparent and in the public domain. No proprietary or black box systems should be employed.'</p> <p>'Alignment of resource use and quality measures &amp;ndash; Another potential limitation for resource use measurement is the period being measured for both resource use and quality. It would be important to make sure the timeframes are aligned to ensure disparate time periods are not being aggregated. Given the data sources being utilized for the resource use and quality metrics, this could be problematic.</p> <p>Timeliness of information &amp;ndash; In order for resource use information to be actionable it needs to be timely. A limitation for resource use measures is that they often require a long time window to account for analysis time as well as clean periods prior to and post the measurement period. If there is a significant delay between the data collection and reporting, the data becomes less actionable as it is not measuring current practice.'</p>
Oct 12 2010 3:55PM	Jennifer Faerberg	Association of American Medical Colleges	Section 5: Limitations, Implications, and Unresolved Questions About Resource Use Measurement	<p>'The paper does a good job in outlining how resource use measures may be used as well as the various perspectives. A new requirement for the submission of resource use measures will be for measure developers to state their intended purpose and use for their measures on the measure submission form. Our concern is the potential for inappropriate use of the measures therefore leading to unintended consequences. What kind of mechanism, if any, will NQF have to monitor the use of the measures?'</p>
Oct 12 2010 4:04PM	Jennifer Faerberg	Association of American Medical Colleges	Section 4: Resource Use Measure Modules	<p>'As the paper points out determining physician specialty is difficult and therefore identifying peer comparison groups is challenging. We would point out that many specialists in academic medicine are in fact sub-specialists or sub-sub specialists. Many academic clinicians provide unique specialty services that are not performed by others within the same specialty. The UHC-AAMC Faculty Practice Solutions Center&amp;reg;, a product that calculates productivity benchmarks for academic faculty, has benchmark data for over 100 clinical specialties. We would be happy to provide additional information on these benchmarks if that was of interest to the group.'</p>
Oct 12 2010 4:04PM	Jennifer Faerberg	Association of American Medical Colleges	Section 4: Resource Use Measure Modules	<p>'Attribution &amp;ndash; There is an inherent tension in determining the unit of measurement for resource use reporting. While many faculty physicians function in a large group practice, most of the accountability and incentive programs are focused on individual physicians. As we continue to move towards team based medicine we need to be able to measure at the group level.</p> <p>That being said, there are also issues to consider in what constitutes a group. The logic to determine a group practice could focus on the use of Tax ID numbers, however large physician faculty group practices can have a Tax ID for each practice within the overall group as well as a Tax ID for the overall practice.</p> <p>No matter how the groups are constituted, in order for the measures to be useful physicians need to be able to drill down to the individual patient level data to determine who are the attributed patients, which physician they saw and what were the clinical outcomes.'</p>
Oct 12 2010 4:05PM	Jennifer Faerberg	Association of American Medical Colleges	Section 5: Limitations, Implications, and Unresolved Questions About Resource Use Measurement	<p>'Appendix &amp;ndash; It was unclear from the proposed criteria for evaluating resource use measures, how each module within the measure specifications would be evaluated rather than in aggregate. We believe each of the modules should be evaluated independently to ensure they all meet the evaluation criteria.'</p>
Oct 12 2010 4:07PM	Jennifer Faerberg	Association of American Medical Colleges	Section 4: Resource Use Measure Modules	<p>'Costing methodologies - We were heartened to see that the paper defines efficiency as the relationship of cost of care to quality and not just monetizing resource utilization for purposes of comparison. The AAMC is concerned that the practice of measuring resource use not be utilized to support arbitrary reductions in reimbursement.</p> <p>In order for resource use reporting to be effective, the information needs to be actionable. In addition, the measuring of resources must also include a way to measure performance improvement. Utilizing geographic variation for resource use is problematic as it is not actionable at the provider level and has no ability to account for performance improvement therefore minimizing the usability.</p> <p>We appreciate the discussion regarding actual prices and standardized prices, however we recommend utilizing standardized prices in order to provide a level playing field for comparisons. Similarly, we recommend any special payments to teaching hospitals such as IME, DGME and DSH should be excluded from any costing methodology to avoid unfairly penalizing teaching hospitals.'</p>
Oct 12 2010 5:22PM	Steven Brotman	Advanced Medical Technology Association	General Comments on the White Paper	<p>'The Advanced Medical Technology Association (AdvaMed) appreciates this opportunity to review and provide comments on the NQF's Resource Use Measurement White Paper. We believe that the paper provides a wide-ranging review dealing with the complex issues involving health care efficiency and resource use measurement. Additionally, we strongly support the recommendation in the paper that resource use measure developers be transparent in every step of the process during the development and specification of the measures.'</p>
Oct 12 2010 5:23PM	Steven Brotman	Advanced Medical Technology Association	General Comments on the White Paper	<p>'AdvaMed has concerns regarding the use of administrative claims-based data for developing resource-use measures. As noted in the White Paper, it is important to emphasize that claims data lacks robust clinical information and other pertinent patient data, such as those contained in medical records and therefore, provides only limited clinical information. Although administrative data is used for measuring resource utilization, it is important to emphasize the need for complete data on patient encounters with the health care system. As discussed in the &amp;ldquo;Measure Specification Steps by Module&amp;rdquo; section, there may be an incompleteness of resource utilization data for beneficiaries. For example, Medicare may not have comprehensive data on the pharmaceutical utilization, or the utilization of the Medicare Advantage enrollees. To the extent that resource utilization measures will be translated into efficiency measures, it is necessary to have complete data on all encounters with the health care system, including pharmacy, which will better estimate the true value of particular health care interventions or therapies. For example, a new technology may offset drug or post-acute care utilization and if certain benefits are not captured, it will systematically bias the resource utilization measures and the efficiency measures of particular procedures.'</p>

Oct 12 2010 5:24PM	Steven Brotman	Advanced Medical Technolog y Associatio n	General Comments on the White Paper	'AdvaMed believes that it is fundamentally important that measures of cost, or resource use, be considered only when accompanied by measures of quality related to the same health care. Considering episodes of care, resource use must be determined over an appropriate episode of care, which includes a period of time sufficiently long enough to capture all the benefits and costs of the care. One could erroneously draw conclusions about the relative benefits and costs of care if an inappropriate time period is used. We believe that it only makes sense for efficiency &mdash; and measures dealing with efficiency &mdash; to be defined to include both quality and cost, and there should be no reduction in quality.'
Oct 12 2010 5:24PM	Steven Brotman	Advanced Medical Technolog y Associatio n	General Comments on the White Paper	'The White Paper includes the concept of quality outcomes in the definition of efficiency, even though the focus of the paper is on resource-use measures apart from quality measures. However, we recommend the paper include a more specific discussion about the NQF&rsquo;s view regarding the need to combine resource measures with outcomes measures. Otherwise, we question why NQF would endorse resource-use measures without a clear path to combining them with clinical outcomes measures. While we understand payers&rsquo; interest in developing episode-based resource-use measures, it is important that NQF consistently articulate the need to combine resource-use measures with clinical outcomes measures to fully capture effectively measure efficiency.'
Oct 12 2010 5:25PM	Steven Brotman	Advanced Medical Technolog y Associatio n	General Comments on the White Paper	'Although the White Paper notes that efficiency measures should incorporate quality, the body of the White Paper does not address this matter, except for including quality in two of the eleven &ldquo;Principles for Resource Use Measure Evaluation&rdquo; (Pages 50-51). Unfortunately, the White Paper lacks any discussion concerning how resource measures should incorporate outcomes and quality in the design of the measures themselves. Additionally, the paper does not provide any examples of resource measures incorporating quality within the measures. AdvaMed suggests that NQF consider including a discussion and comparison of the advantages and disadvantages (as noted with the other issue areas throughout the White Paper) of approaches such as:  Creating quality/outcome bands, such as shown in Exhibit 1 on page 6, so that efficiency is only compared within the same quality/outcome band. The diagram currently depicts high and low quality fields in the context of cost; however we would suggest showing more quality bands.'
Oct 12 2010 5:25PM	Steven Brotman	Advanced Medical Technolog y Associatio n	General Comments on the White Paper	'Evaluating the reliability criterion for resource-use measures will present particular challenges. Fully capturing the resources associated with a health care episode is complicated by external factors to a greater extent than the quality measures that NQF traditionally has endorsed. As described in the White Paper, using payments associated with particular services as a relative measure of resource use is susceptible to variations in payments across payers. Variations exist not only in the amount of payment across payers for the same service, but also whether different payers will cover a particular service or procedure at all. These variations in payers&rsquo; policies can influence not only the estimated resources associated with providing a particular service, but also whether a service or procedure is performed. We recommend the White Paper acknowledge this challenge with the reliability of resource-use measures when used across different payers.'
Oct 12 2010 5:25PM	Steven Brotman	Advanced Medical Technolog y Associatio n	General Comments on the White Paper	'Including quality and outcomes as an important consideration in selecting peer groups for comparison. This could be added to the discussion of &ldquo;Peer Group Identification and Assignment&rdquo; on pages 37-41. Additionally, the issue of higher cost/better quality technology may be addressed by appropriate peer group comparisons &ndash; e.g., comparing physicians within a specialty in a particular geographic area. To the extent that appropriate practice patterns, including use of the new technology, are established in the specialty, then the comparison group will incorporate the cost.  Addressing quality and outcomes in &ldquo;Setting Thresholds&rdquo; (pages 41-42). This brief discussion mentions that outliers can be due to inappropriate treatment, rare or extremely complicated cases, or coding error. It fails to mention, however, that outliers could be due to the use of new technology or better outcomes/higher quality.  The White Paper should discuss explicitly that adjustments might need to be made to recognize the cost of using new technology that leads to better quality or improved outcomes and it should discuss ways that such adjustments could be made.'
Oct 12 2010 5:26PM	Steven Brotman	Advanced Medical Technolog y Associatio n	General Comments on the White Paper	'AdvaMed understand that different resource use measurement approaches may be applicable in different situations.  Finally, AdvaMed believes that the White Paper should clearly state that the NQF will evaluate and compare alternative resource use measures, in part based on their handling of the difficult issue of controlling for differential quality and outcomes.'
Oct 12 2010 5:26PM	Steven Brotman	Advanced Medical Technolog y Associatio n	General Comments on the White Paper	'The resource utilization measures should include mechanisms to recognize and account for resources associated with and required by new technologies. The implementation of these measures should not deter the use of new technologies and certain therapies which may necessarily require follow-up care protocols to ensure the optimal treatment and health outcomes.  The White Paper should discuss the difficulty of accounting for differences in long-term outcomes in measure development. AdvaMed believes that the importance of this topic warrants creating a new section in this paper to adequately address the issue. Without guidance or direction to the contrary, proposed resource use measures may consider only short-term outcomes &ndash; if they consider outcomes at all. There are treatments and technologies which are more costly up-front, however they show their benefit only over a longer time horizon. As the purpose of the White Paper is to pose important technical issues which measure developers must consider, it would be a serious oversight for the issue of long-term outcomes to be overlooked.'
Oct 12 2010 5:40PM	Lisa Latts	WellPoint Jenna Williams- Bader	WellPoint jenna.willi ams- 9601 bader@an them.com	General Comments on the White Paper  WellPoint agrees with the report as written. The criteria for assessing resource use measures are appropriate.

Oct 12 2010 6:04PM	Rebecca Zimmermann	America's Health Insurance Plans	General Comments on the White Paper	'AHIP Comments on NQF Resource Use Measurement White Paper	AHIP appreciates the opportunity to provide comments on the NQF's Resource Use Measurement White Paper. The White Paper includes a review of types of resource use measures, resource use measure modules (i.e., analytic functions), limitations of resource use measures, and principles and criteria to guide NQF's evaluation of resource use measures for endorsement. We have reviewed the paper with our member health plans and offer the following comments.
				General Comments	
				We appreciate NQF's efforts to develop a framework for reviewing resource use measures and believe that this report represents a first step towards broader availability of endorsed measures of resource use. The availability of endorsed measures will be critical in meeting new legislative requirements enacted by the Patient Protection and Affordable Care Act (ACA), including new value-based payment programs for providers. AHIP and our members support the use of resource use measurement to assess the value of health care services provided to patients. The framework clearly describes NQF's proposed strategy to review resource use measures and establishes high standards that will need to be met.'	
Oct 12 2010 6:05PM	Rebecca Zimmermann	America's Health Insurance Plans	Section 1: Measuring Efficiency and Resource Use in Healthcare	'We recommend adding language in the introduction that acknowledges the role of non-clinical factors, such as economic, social and patient preference.'	
Oct 12 2010 6:05PM	Rebecca Zimmermann	America's Health Insurance Plans	Section 2: Designing Measures that Acknowledge the Real World While Producing Usable Output	'The document cites a report by Thomas, et al, which found variation in categorization of providers as high or low cost depending upon the product being used. Since the publication of this article alternative statistical approaches have been implemented in the market and the report should reflect these advances in methodology[1].	
Oct 12 2010 6:06PM	Rebecca Zimmermann	America's Health Insurance Plans	Section 3: Types of Resource Use Measures: Per Capita, Per Episode, Per Admission, Per Procedure, and Others	'[1]Adams et al.: Incorporating Statistical Uncertainty in the Use of Physician Cost Profiles. BMC Health Services Research 2010:10:57' 'AHIP supports NQF's proposal to review many different types of resource use measures, including per capita population, per-capita patient, per episode, per admission, and per procedure.  For per episode measures, consideration should be given to both episode cost and episode frequency. An increased number of episodes, despite low resource use for a given episode, can lead to increased overall healthcare costs.  Analysis should be conducted on the relationships among the different resource use measures with a specific emphasis on the relationships between these measures and total per capita costs.'	
Oct 12 2010 6:06PM	Rebecca Zimmermann	America's Health Insurance Plans	Section 4: Resource Use Measure Modules	'The report identifies five major analytic functions or modules that must be included in measure specifications, however, the modules appear to favor episode-based measures. It would be helpful if NQF could clarify if the different types of resource use measures required to address all five modules and the application of these modules. For example, a per procedure resource use measure may need to include temporal information in its measure specifications that is defined differently relative to an episode-based resource use measure. Likewise, a per capita measure may not need to set thresholds or remove outliers.  The clinical logic section should be written more broadly to include resource use measures appropriate for patients with multiple chronic conditions in addition to those with single conditions.'	
Oct 12 2010 6:07PM	Rebecca Zimmermann	America's Health Insurance Plans	Section 4: Resource Use Measure Modules	Many resource use measures developed by the same developer will have a common approach to the modules. NQF should consider a process that will streamline review of multiple measures submitted by the same developer.	
Oct 12 2010 6:07PM	Rebecca Zimmermann	America's Health Insurance Plans	Section 4: Resource Use Measure Modules	'The report contains a detailed discussion of the treatment of outliers. The approach to addressing outliers may need to be flexible and not rely on a single rule that is applied universally across all measures. For example, truncation can be performed at the provider specialty level as opposed to the measure level as data have shown that specialties such as dermatology have low costs while oncology can have higher costs.  We agree that stratification by populations can be a useful tool to identify disparities. However, stratification does not need to be included in all analyses, unlike risk-adjustment, which is critical for outcomes and used in most cost efficiency measurements.  The report includes reporting mechanisms as part of the required modules. Reporting requirements are not currently required for NQF review of quality measures and we would like additional clarity on NQF's rationale for including reporting requirements. It would also be helpful for NQF to clarify if the reporting mechanisms will be part of the endorsed measure specifications or if they will be published separately from the specifications, similar to the NCQA PHQ standards. NQF should consider developing criteria to evaluate the reporting mechanisms, including evidence and results from testing the reporting methodology.' 'The report should note that sample size issues are a challenge to all types of measures.'	
Oct 12 2010 6:07PM	Rebecca Zimmermann	America's Health Insurance Plans	Section 5: Limitations, Implications, and Unresolved Questions About Resource Use Measurement	The report should also include language acknowledging that chart based measures have limitations & studies have shown inaccuracies with what is in the medical record compared to video-taped interactions.  In addition to EMR data, ICD-10 will increase the utility of claims and administrative data by adding some clinical data to claims fields.'	
Oct 12 2010 6:08PM	Rebecca Zimmermann	America's Health Insurance Plans	Proposed Resource Use Evaluation Criteria (Appendix B)	'Criterion 1(c) states that a measure must demonstrate an association between the measured resource use and level of performance with respect to one or more of the other five IOM aims of quality. It is unclear if the broader definition of measure focus will include quality as well as resource use. We encourage NQF to review resource use measures as standalone measures. When reporting resource use, quality information should be included where measures are available.  As stated under the "Modules" section, NQF requires the submission of reporting mechanisms as part of the resource use measures, including proposed attribution, sample size, etc. If the reporting mechanisms are to be included in the endorsed measure specifications, NQF will need to develop criteria to evaluate the reporting mechanisms. The criteria should contain a requirement to test the measure and reporting mechanisms.'	

Oct 12 2010 6:08PM	Rebecca Zimmermann	America's Health Insurance Plans			Section 6: Summary of NQF Evaluation Criteria for Measures of Resource Use	<p>'It is unclear if resource use measures will need to meet all the Principles articulated in the report. Measures that meet the majority of the Principles should also be considered for endorsement. Application of the Principles should not hinder the development of new resource use measures given the current lack of availability of such measures.</p> <p>The NQF should ensure that terms included in the Principles are clearly defined. For example, Principle 7 includes the term "comprehensive measures" which requires definition. Further clarification or an example would better illustrate this Principles intent. Additionally, specific terms such as "Transparency" need to be clarified as they could be open to interpretation. In some cases, the individual data underlying the measure cannot be made publicly available due to privacy reasons. NQF should consider adding a Principle that notes the connection between resource use measures and their role in helping achieve the Triple Aim: Better Care, Better Health and Lower Costs.'</p>
Oct 12 2010 6:08PM	Rebecca Zimmermann	America's Health Insurance Plans			Section 6: Summary of NQF Evaluation Criteria for Measures of Resource Use	<p>'We concur with the recommendation that resource use measurement methodologies should be transparent as this will facilitate provider acceptance and participation. As resource use measures are complex, understandability and correct interpretation of results may be a challenge. The language in the report should reflect approaches that can address these challenges and should be part of the measure development process.'</p>
Oct 12 2010 10:56AM	Tracy Spinks	MD Anderson Cancer Center	Joseph Steele, MD	MD Anderson Cancer Center jsteele1@mdanderson.org (713) 745-0874	General Comments on the White Paper	<p>'I looked over the white paper, and it is very informative. It appears that the committee realizes the complexity of accurate resource use measures. It almost seems overwhelming, but I think their suggested approach of a macro/micro one is pretty good.</p> <p>As for Diagnostic Imaging, my concern is that imaging utilization (as a resource) is measured in relation to not only the episode of care, but the complexity of the patient and underlying comorbidities. For example, utilization rates of CT for abdominal pain in the Emergency Center might be completely different (and appropriately so) for a Comprehensive Cancer Center such as MD Anderson—strictly based on the complexity of the patient population. Obviously, hospital utilization rates will also vary based on the patients—we will do far more CTs per patient than a community hospital.</p> <p>The depth of the paper seems to acknowledge and begin to address these issues.'</p>
Sep 14 2010 9:34PM	Yisrael Safeek	Integrity Physicians Solutions			Section 1: Measuring Efficiency and Resource Use in Healthcare	<p>'Janet M. Corrigan, PhD, MBA President and CEO, National Quality Forum</p> <p>Regarding the "Resource Use Measurement White Paper," there are a few points to ponder. It is true that episodes are based on conditions which do not necessarily add up to measure total resources. The paper suggests use of different types of episodes (acute, chronic) as a solution. It would be even better to go one step further and use additional types (minor, major) to optimize the accounting.</p> <p>Second, while it may be preferable to use multiple rather than single attribution to solve the attribution dilemma, this in itself is controversial. Physicians are always personally held responsible for their actions in every other aspect of medicine - legal, competency etc. By stressing individual attribution, we can also emphasize individual accountability. Finally, efficiency of care may be synonymous with value as in the value equation (high quality/low cost), but it does not encompass the five aims of quality from IOM; it is just one. The term accountability of care may be a more fitting as it encompasses quality, cost, and indeed value.</p> <p>I appreciate the opportunity to provide these comments, and look forward to continuing to work with NQF to improve healthcare.</p>
Sep 17 2010 8:21AM	Michael Schuh	Mayo Clinic Jacksonville			Section 2: Designing Measures that Acknowledge the Real World While Producing Usable Output	<p>'Initiating and providing a system of electronic healthcare "homes" would be useful to track and measure outcomes. These homes could be licensed. Natural homes would be primary care providers and medication therapy management pharmacists. Standardized software would be maintained and accessible for measurement of outcomes. If a patient wishes to change "homes", data could be electronically transferred to the new "home". This way there would always be a central location to a patient medical record. Records would be encrypted for privacy.'</p>
Sep 17 2010 8:38AM	Michael Schuh	Mayo Clinic Jacksonville			General Comments on the White Paper	<p>'I noticed a lack of addressing medication use, a priority. I strongly suggest addition of medication education and medication recommendations be added to the Recommended Taxonomies Table. Proper medication use is critical to improved outcomes and lower healthcare costs by keeping patients out of hospitals and avoiding adverse drug reactions which can lead to hospitalizations. Medication Therapy Management (MTM), which specifically includes medication education and medication recommendations by pharmacists in collaboration with physicians, has been shown to improve medication use and improve outcomes.'</p>