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.

Specific Comments

Introduction

- We recommend adding language in the introduction that acknowledges the role of non-clinical factors, such as economic, social and patient preference.

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].

Types of Measures

- 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.

[1] Adams et al.: Incorporating Statistical Uncertainty in the Use of Physician Cost Profiles. BMC Health Services Research 2010:10:57

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.
- 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.
- 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.

Limitations to Resource Use Measures

- The report should note that sample size issues are a challenge to all types of measures.
- 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.

Principles

- 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.

- 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.
- 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.

Comments on the Resource Use Measure Criteria

- 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.