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August 4, 2006

Ms. Margaret E. O'Kane
President
NCQA
2000 L Street NW
Washington, DC 20036

Re: Public Comment on Physician Specialty Measures

Dear Peggy:

The Pacific Business Group on Health continues to strongly support NCQA's performance measurement evolution designed to provide consumers and employers with information to help guide choice and distinguish value. It is our belief that the expansion of measurement and public reporting to include physician specialties will be powerful mechanisms that will drive quality and efficiency improvements within the healthcare system. It is in this spirit that we offer our comments on the proposed implementation of physician specialty measures. We have four general comments applicable to each of the initial three specialty measure sets:

Measures should be made more relevant to consumers. The proposed measures represent a good start and will be useful to physicians for process improvement; however, they offer little information to help purchasers or consumers in their decision making. In general, the measures are focused on processes, not outcomes, and seem to be more of a measurement of the physician's documentation capabilities than actual care delivery. For example, it would be much more meaningful to patients if the change in visual acuity as the result of cataract surgery were measured, rather than noting if a physician documented the occurrence of certain tests. Please see the attached Consumer/Purchaser Guidance for the Development of Performance Measures from the Consumer-Purchaser Disclosure Project. We recommend expanding the measures to meet the specifications defined in this document, in particular the criteria defined in items 2) Feasibility and 3) Relevance to consumers and purchasers (important and actionable).

A path to feasibility should be articulated. We are pleased to see the use of G-codes and CPT-II codes being proposed in the measure specifications. We note, however, that the collection of these measures will require physician support for and actual use of these codes. Since it is not clear to us as purchasers how these codes will be implemented, we recommend that the mechanisms for commercial payers to obtain these codes from physicians providing care to their members be clearly articulated.

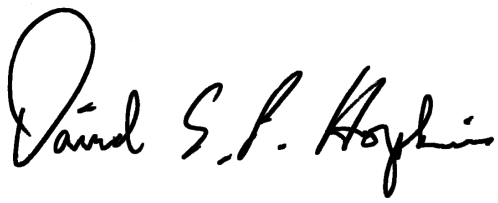
We also note that performance measurement coding is very much in development and many codes do not yet exist to support outcome measurement. Yet many specialty societies collect rich clinical data from their physicians for their registries. As a component of feasibility review, we recommend that NCQA consider the potential use of specialty-specific registries as a means of capturing and reporting on important outcomes.

The novel use of exclusions should be reconsidered. We note that, for the first time, measure sets are being proposed by NCQA with numerator exclusions that are nonspecific and highly subjective. For example, many of the proposed measures contain an exclusion code saying "clinician documented that patient was not an eligible candidate for ___." Such wide-open exclusion criteria enable gaming and may subvert the purpose of measurement in the first place. We recommend that they be dropped.

A systems approach should be reflected in measures relating to surgical care. Safe, high quality, efficient care for surgical patients requires coordination between facility and surgeon. For example, administration of antibiotic or VTE prophylaxis to surgical patients might be most efficiently and dependably accomplished through the use of standing orders implemented by the hospital or ambulatory surgery facility, rather than by relying on physicians to place positive orders for the vast majority of their patients. Thus, the whole construct underlying these measures in the Perioperative Care measure set should be rethought.

Thank you for this opportunity to provide input to NCQA's Physician Specialty Specifications.

Sincerely,



David S. P. Hopkins, Ph.D.
Director of Quality Measurement and Improvement

Cc: Peter Lee

Consumer-Purchaser DISCLOSURE PROJECT Improving Health Care Quality through Public Reporting of Performance

Consumer/Purchaser Guidance for the Development of Performance Measures
Working Draft Outline
May 5, 2006

Improving the quality of our nation's health care requires nationally standardized comparative information about the clinical quality, patient experience, efficiency, and equity of care that is the product of hospitals, physicians, and treatment options. A robust performance "dashboard" allows: 1) consumers to make informed decisions about their health care; 2) insurers and purchasers to make value-based contracting decisions and use differential payments as incentives; and 3) providers' improvement efforts to be supported with better information.

Currently, most measures are developed by provider-lead and/or provider "only" organizations or processes. In order to ensure the needs of consumers and purchasers, as well as those of providers, the undersigned organizations endorse the following guidance for measure development activities.

This measure development guidance reinforces and builds on established criteria for the development of measures, as well as their screening and selection, as reflected in materials such as the Institute of Medicine's Performance Measurement and Priority Conditions reports, the AQA's Parameters for Selecting Performance Measures, and elements of the National Quality Forum's National Framework Report. These reports, however, frequently describe measure criteria either from the provider perspective or as aspirational goals that do not recognize the urgency felt by consumers and purchasers who are largely acting on little to no information. The criteria that follow use similar terms as are found in those reports, but their definition reflects the consumers' and purchasers' sense of urgency and need for measures that can be implemented immediately.

1. **Reasonable scientifically acceptability:** Measures must be scientifically sound, (i.e., precisely specified, sufficiently reliable, valid, risk adjusted, and reflect current evidence base). Consumers and purchasers however do not seek perfection, but rather improvement upon baseline levels of performance transparency. The scientific standard or rigor applied to define "reasonably acceptable" should be assessed based on what consumers themselves would find appropriate.

2. **Feasibility:** Wide-spread adoption of clinical/treatment measures and rapid reporting of performance information necessitates that measures are constructed and specified so that the data needed is readily available and can be collected with limited reporting burden. For the immediate future, this means collection of the data via currently existing payer-based electronic databases **OR,** if additional effort is required of providers, there is evidence that the measure will substantially improve upon performance measures collectible via existing payer-based electronic databases **and** a credible path is articulated by which the data will actually be collected and transmitted by the relevant providers.

3. **Relevance to consumers & purchasers (important and actionable)**: Development of performance measures that are intended to produce comparative information and inform provider selection and payment should be driven by the needs of consumers

and purchasers. (Needs of providers for information to support quality improvement are important considerations that should also inform priorities for measure development.) The level to which measures address consumers' and purchasers' information needs can be assessed by the degree to which measures relate to services that:

- Enable consumer choice because they are non-emergent;
- Show high variation in performance;
- Affect large numbers of patients or total health care spending;
- Shed light on both overall and condition-specific performance; and
- Capture outcomes along with processes associated with those outcomes

Note this list is intended to reflect different important dimensions, rather than criteria that all measures must meet. In determining relevance to consumers, testing of measures, domains and areas of potential measurement with actual consumers should inform ultimate measure development.

4. **Reflect continuum of care/care coordination from patient perspective:** measures should reflect both the cross-section of conditions and procedures addressed by a particular provider, but as importantly the continuum of care coordination among providers. Measures developed for either particular specialties or conditions should specifically reflect the measurement concepts of being comprehensive, longitudinal, multi-level (individual, population-based and systems), and shared accountability (see IOM, *Performance Measurement: Accelerating Improvement*, 2006).