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### **Comments Submitted by:**

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### **General Comments:**

United Health Group is pleased to respond to the NQF's proposed conversion of the 113 NQF –endorsed paper based measures to an electronic eMeasure format.

UnitedHealth Group is dedicated to making our nation's health care system work better. Recognized as America's most innovative health care company by *Fortune* magazine, our highly-diversified and comprehensive array of health and well-being products and services empowers individuals, expands consumer choice, and strengthens patient-provider relationships. Our 80,000 employees serve the health care needs of more than 75 million individuals, develop and advance new health technologies and enhance financial and operational connectivity across the health care system. Our role as a national leader in both private and public health benefits programs and services enables us to continuously foster innovative health solutions aimed at creating a modern health care system that is more accessible, affordable and higher quality for all Americans. Through our relationship with more than 5,000 hospitals and 650,000 physicians and other health professionals, we have a very detailed picture of health care delivery system.

As such, we support NQF's efforts to make these measures computable because this will advance the completeness and applicability of clinically relevant health information that leads to greater quality improvement and cost effectiveness throughout the health system.

**The Larger Context:** UnitedHealth Group has long been concerned that various measures, and the programs that utilize them, are poorly aligned, thereby creating difficulties in standardizing quality measurement and improvement and leading to unnecessary administrative costs. While we support the NQF eMeasure program, the 113 proposed measures need to be understood within the context of existing NQF endorsed measures in general. The recently announced NQF activities related to the new HHS National Quality Strategy (NQS) provides an important opportunity to address this issue. In addition, we believe NQF and multiple stakeholders would be well served by addressing the following concerns, which we lay out according to several broadly organized themes. Some comments may overlap with the HHS NQS and we provide them for added emphasis:

1. **Gaps in NQF measurement:** We urge NQF to call for, encourage development of, and expeditiously endorse measures related to filling the gaps in the assessment of utilization, appropriate use of resources and procedures, health outcomes, specialty care, and disparities. Salient examples include radiology use in emergency rooms, any number of invasive diagnostic and therapeutic procedures, and appropriate site of service measures. We know that NQF is aware of these gaps, but we stress the importance of acting on these as soon as possible in light of the many payment reform activities that need such measures (see next). Expeditious development of these measures would facilitate the inclusion of them in the eMeasures set, meaningful use, and

clinical decision support in EHRs, and could be used for quality improvement, public reporting, and incentive based payments.

2. **Anticipation of measurement needs related to payment reform:** Similar to addressing the gaps noted above, measures related to population health and cost must be promulgated as quickly as possible. Structures such as ACOs, PCMHs, and FQHCs are moving forward and evolving rapidly. Without standard utilization and population health measures each program will develop ad hoc measures as needed, leading to increased complexity, implementation costs, and inability to evaluate results across different programs. The work of the Measures Applications Partnership will be key in this regard.
3. **Further use of existing NQF measures:** Based upon our extensive experience with patients, physicians and hospitals we have been strong proponents of performance measures related to hospital lengths of stay and readmissions. To that end, using the normal scientific development and approval process of the NQF we are pleased to see the inclusion of our proposed all condition-all cause readmission measure (NQF #0329). However, we have come to understand that this measure, while important in and of itself, must be coupled with a measure of risk adjusted average LOS such as NQF #0328. To ensure this measure works appropriately, MS-DRG needs to be enabled in EHR and Health Information Exchange need to be enabled to link patients' admissions in different hospitals. It is important to capture whether patients are receiving inappropriately long hospital stays out of concern for readmission prevention, or whether they are discharged before they are ready as reflected in elevated readmission rates. Understanding the balance between these two and including both of these measures in the eMeasurement program is critical. The ONC-HIT Efficiency Tiger Team recognized the complementary nature of these two rules and recommended both in its report of October 2010. Because eMeasure information can be exchanged in both directions, these two measures would give physicians important information about their patients' hospitalizations. Finally, RAND has completed a study of generally underused NQF measures, which could be used as a guide in incorporating additional measures as part of the eMeasures set.
4. **Further harmonization of existing NQF measures:** Measures that overlap could be further harmonized. For example, there are two pairs of measures applying to both coronary artery disease and ischemic vascular disease (including cardiac revascularization): oral antiplatelet therapy for each (NQF #0067 and 0068) and lipid lowering therapy for each (0074 and 0075). We believe these should be combined into one set of measures.
5. **Decreased use of measures that represent minimal levels of care:** If the eMeasurement program is to be maximally effective, especially during its launch stages, the number of measures in the set should be comprehensive but also not overly burdensome. Given that we have made suggestions for additional measures, we feel compelled to suggest some areas that are of lesser importance and that should be considered for elimination. In a prior review of NQF measures, UnitedHealth Group found that most of the 113 eMeasures were clinically important in managing patient's care properly. However, 15 represent standard of care that would have small opportunity for EBM improvement. Specifically, we suggest removing the measures below.

| NQF# | Measure Name  |
|------|---|
| 001  | Asthma assessment   |
| 013  | Blood pressure measurement  |
| 014  | Prenatal Anti-D Immune Globulin   |
| 061  | Diabetes: Blood Pressure Management   |
| 086  | Primary Open Angle Glaucoma: Optic Nerve Evaluation   |
| 089  | Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care                                 |
| 103  | Major Depressive Disorder: Diagnostic Evaluation  |
| 106  | Diagnosis of attention deficit hyperactivity disorder (ADHD) in primary care for school age children and adolescents  |
| 107  | Management of attention deficit hyperactivity disorder (ADHD) in primary care for school age children and adolescents |
| 246  | Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) Reports  |
| 507  | Stenosis measurement in carotid imaging studies   |
| 511  | Correlation With Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy                               |
| 321  | Peritoneal Dialysis Adequacy/Plan of Care   |
| 323  | Hemodialysis Adequacy/Plan of Care  |

Additionally, we note with interest the Joint Commission has promulgated four criteria that they are using to review and revise its measurement set. These criteria are:

- a. There is a strong evidence base showing that the care process leads to improved outcomes.
- b. The measure accurately captures whether the evidence-based care process has, in fact, been provided.
- c. The measure addresses a process that has few intervening care processes that must occur before the improved outcome is realized.
- d. Implementing the measure has little or no chance of inducing unintended adverse consequences.

As a result of their process, the Joint Commission has recommended that NQF#0151 relating to antibiotics, be removed because it may lead to inappropriate excessive antibiotic use and should be deleted from the eMeasure list.

### Comments on the eMeasures.

- eMeasures produced by the current initiative address the shortcomings identified in the initial HL7 ballot in which the eMeasure (Health Quality Measures Format i.e. HQMF) standard became a Draft Standard for Trial Use (DSTU). This status will close on March 10, 2012 as indicated at (<http://www.hl7.org/dstucomments/showdetail.cfm?dstuid=55>). It is important that the current improvements be balloted to make HQMF a normative standard.
- Patterns within the rules are a critical enhancement that is understated in the documentation submitted for comment. Clarity should be provided by describing their roles and more specificity about the logic required to compute each pattern. Each HL7 HQMF XML pattern and the associated attributes should be identifiable by unique OID and LOINC identifiers that are included in an HL7 ballot.
- HQMF should work in concert with standards for reporting that are robust, flexible and scalable. Flexibility to report at the patient, provider or group level is particularly important if quality improvement and incentives are to be created at these levels. HL7 Quality Reporting Document Architecture (QRDA) addresses these requirements, has been tested by vendors at the Connectathon, and is the preferred reporting output format for quality measures. Proprietary format, not subjected to consensus balloting, should not be promoted.
- Rules should serve multiple purposes, but the current rules are designed primarily for reporting. NQF should consider the various uses of rules and unique requirements of each. Most pressing is point of care clinical decision support (CDS) because it directly addresses implementation, patient safety, quality of care and meaningful use. CDS requires specific triggers to initiate rule processing. These triggers would use subsets of the rule logic and, without more specificity, implementers may vary in which elements of the rule are used for triggering. Such variation is undesirable and can be addressed by constraints within the HL7 logic. Possible strategies could be inclusion of a specific trigger section (XML element) in each rule or tag attributes indicating an element is a trigger. These constraints would enable uniform and simplified implementation.

**Conclusion.** We are supportive of the NQF's work on eMeasures and stand ready to assist in their application through a standardized reporting and feedback process that is used across federal and private programs. We are hopeful that NQF and other standard setting bodies will receive the appropriate resources and direction from Federal Departments and Agencies that are necessary to align related activities so as to achieve our national quality improvement goals and do so in an administratively cost effective way. We would hope that the conduct of the eMeasures program would facilitate coordination between programs such as MU, PQRI, RHQDAPU and future requirements such as ACOs and PCMH.