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

Re: Comments on Draft Physician Practice Connections Version 2 Draft Standards

Dear Peggy:

The Pacific Business Group on Health applauds NCQA's continued leadership in the adoption of standards and measures that assess and promote better delivery of care at the physician level. The Physician Practice Connections standards are rapidly becoming the "industry standard" for assessing structural capacity of physicians' offices. As they stand today, they appropriately address care management needs for the severely ill, the chronically ill, and the well, at-risk population subsets. We believe that PPC needs to build on the foundation established to also encompass care delivered across all specialties and across treatments/conditions. In addition, PPC needs to be broad enough to support evolving technology and clinical advances, yet with depth enough to provide meaningful instruction as practitioners and practice sites use these standards as a roadmap for practice reengineering.

Our specific comments on each individual standard are provided in the attached Public Comment Submission Form. Our review of the Draft Standards materials leaves us with some general comments that I will outline below.

Need to Assure Applicability Across Specialties and for Various Treatments
The standards, as written, apply well to systematic treatment of the chronically ill and well/at-risk populations. For some specialties, these standards will not be applicable and/or meaningful. It is reasonable to anticipate that unique sets of standards may be necessary for groups of providers or as they relate to particular treatments (e.g. those treating more acute conditions, those procedure-based). In particular, the "Care Management" and other broad areas would need to be reconsidered to assess how the elements translate across specialties or if new standards are required.

Scoring and Transparency
The scoring algorithms as outlined frequently award credit based on "batches" of elements. This scoring does not adequately distinguish performance among practices since completing 100% of the targeted activities may get the same "score" as completing 75% of the practices. Moreover, we encourage NCQA to continue its research related to weighting of the elements within and between areas. Within every standard, there are elements more critical to success than others. NCQA is well positioned to evaluate the empirical evidence around weighting and impact of varying activities and is encouraged to take the lead in developing a scoring algorithm that not only reflects excellence when it exists, but that also provides greater weight to the activities and capabilities with the most opportunity to make a difference.

Additionally, "batch scoring" does not support specific reporting of the elements that may be critical to consumers for decision-making, payers for building incentive programs, and health plans for developing select networks. These stakeholders must have access to data that is

specific enough to adequately address their needs. PBGH supports creating a scoring algorithm that reflects credit per weighted element vs. credit per batch of elements, and provides for transparency of the actual practices each provider/practice site completes.

Capability Scoring
NCQA, with complete understanding of the evolving information technology vendor and capability space, awards partial credit throughout the document for practices with the technological capability, even if the technology is not yet implemented. While we understand and respect this approach, we urge NCQA to consider some required follow up within a reasonable timeframe to assure that implementation is inevitable. Capability with no implementation ultimately equals no positive action, and unutilized system capability is not uncommon among health care practice sites (and other users of evolving technology for that matter).

Comprehensive Automated Workflow Platform
A systematic approach to care management and treatment enables a full array of functionality checks (e.g. what should be done, when it should be done, and by whom it should be done). This document addresses in thorough detail what should be done but does not universally address a timeframe or a responsible person (which may be a provider or the patient). Please consider, for all standards, how an automated system can best operationalize those factors most critical to delivering desired results; accountability and timeframes. Accountability allows for training and improvement while indicating a timeframe supports the availability of alerts and follow-up decision support.

We believe NCQA is the right organization to influence, define, communicate, institute, and monitor these standards. Further, NCQA should play a continuous role in adapting an increasing body of knowledge about capability and process into the standards, thereby facilitating ongoing continuous quality improvement. Where there is a lack of empirical evidence for weighting the value of elements, demonstrating elements' impact on health, and/or establishing an efficiency quotient, NCQA should leverage its expertise and political posture to advance the science. PBGH and its members remain interested in the subsequent phases of this work and as the process moves forward, we will continue to encourage NCQA to provide needed leadership in terms of measuring and reporting on performance measures that promote the systematic, efficient, and effective provision of care.

Thank you for this opportunity to provide input to NCQA's Physician Practice Connection standards.

Sincerely,

Peter V. Lee
President & CEO

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