ACAP
Association for Community Affiliated Plans

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December 27, 2012

Rebecca Zimmerman
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–9962–NC
PO Box 8010
Baltimore, Maryland 21244–8010

Dear Ms Zimmerman:

The Association for Community Affiliated Plans (ACAP) thanks you for providing us with an opportunity to comment on the *Request for Information Regarding Health Care Quality for Exchanges* published November 27, 2012 in the Federal *Register.* We appreciate your willingness to consider these comments.

ACAP is an association of 59 not-for-profit and community-based Safety Net Health Plans (SNHPs) located in 25 states. Our member plans provide coverage to approximately 9 million individuals enrolled in Medicaid, the Children's Health Insurance Program (CHIP) and Medicare Special Needs Plans for dually-eligible people. Nationally, ACAP plans serve roughly one-third of all Medicaid managed care enrollees. Many Safety Net Health Plans currently are developing plans to serve those individuals that will gain new coverage due to insurance expansions enacted by the Affordable Care Act. Many of our members intend to build qualified health plans that will participate in the FFE operating in their states.

1. **What quality improvement strategies do health insurance issuers currently use to drive health care quality improvement in the following categories: (1) Improving health outcomes; (2) preventing hospital readmissions; (3) improving patient safety and reducing medical errors; (4) implementing wellness and health promotion activities; and (5) reducing health disparities?**

   Safety Net Health Plans use of variety of quality improvement strategies involving member outreach and engagement, working with providers to transform primary care, performance-based reimbursement, and collaboration with purchasers, community-based organizations and other payers. Specific to reducing readmissions, health plans are increasingly adopting evidence-based transition of care programs for both the Medicare and Medicaid populations. Concerning patient safety in Medicaid, payment is not allowed for certain hospital acquired events and serious reportable events.

2. **What challenges exist with quality improvement strategy metrics and tracking quality improvement over time (for example, measure selection criteria, data collection and reporting requirements)? What strategies (including those related to HIT) could mitigate these challenges?**

The largest challenge is the current inability to risk adjust quality measures to reflect the population being served by the plan. While health plans are continuously striving to reduce health care disparities and disparities in quality scores, we know that some differences are associated with overcoming certain social determinants of health. It is for this reason that NCQA in reporting quality measures and ranking health plans only does so for like plans (commercial, Medicare and Medicaid).

Other challenges include:

1. Measures must be reflective of the population being served. Therefore, while we understand the value of quality reporting for consumers and to promote overall improvement, we strongly support no quality measure reporting until at least 2016 when reporting can be done specifically for the population enrolled via the Exchange;
2. A health plan must serve a population for a minimum period of time before accurately reporting on quality measures. Therefore, we support excluding quality reporting for new QHPs on the FFE website until at least year three of plans' participation;
3. Issuers must have the ability to impact the measures used both in terms of the overall number of measures and the clinical outcomes;
4. Need for harmonization of measures across various government-sponsored programs;
5. Need for consistency in measure definition and application (for example, need to avoid state use of HEDIS-like measures and require the use of HEDIS audits to insure consistency);
6. Frequent changes in measure definitions impact ability to trend the data over time;
7. Need for reliable benchmarks based on population served and across all delivery systems (managed care versus fee for service);
8. Some measures do not apply to the populations enrolled in certain health plans. How to address measures with small n values and how to treat non-reportable measures is an issue;
9. The need to test the reliability of each measure with each population being covered;
10. Many measures are based on patient surveys. There are issues with reliability in different populations, the lack of validated surveys in a variety of language (for example, CAHPS has only been validated in English and Spanish), and the use of reading levels beyond the comprehension of all members being served.

A major issue is the need to balance the data collection efforts versus the need for a particular measure. A proliferation of measures that require chart review can result in increased costs of the insurance product. We believe that the development of robust e-measures at the provider level and the leverage of health information exchange are critical to reducing this reporting burden.

**3. Describe current public reporting or transparency efforts that states and private entities use to display health care quality information.**

Unlike the Federally-facilitated Exchanges, not all state Medicaid programs require that plans be accredited. Therefore, the reporting varies by state. Some states also maintain publicly reported health plan report cards. Although most states do require some HEDIS measure reporting for Medicaid Managed Care, there is no similar requirement for Medicaid PCCM programs or the fee for service delivery system.

Increasingly, states are attempting to report on the HHS-determined adult and child core set of measures, many of which build on HEDIS measures. The core measure sets each include CAHPS Health Plan surveys as one of the recommended measures. However, not all of the core measures are appropriate or possible at the plan level since they rely on state public health survey data.

Medicare plans must report data to CMS. A summary of this data is available online through Health Plan Compare and through the STARS data system.

For those plans that are accredited by NCQA, they must publicly report data. Publicly reporting data to NCQA is voluntary for all other plans. The data is accessible in the licensed Quality Compass product. Health Plan rankings and some indication of scores on quality domains is also included on the NCQA website and reported annually by Consumer Reports.

4. **How do health insurance issuers currently monitor the performance of hospitals and other providers with which they have relationships? Do health insurance issuers monitor patient safety statistics, such as hospital acquired conditions and mortality outcomes, and if so, how? Do health insurance issuers monitor care coordination activities, such as hospital discharge planning activities, and outcomes of care coordination activities, and if so, how?**

Many health plans are utilizing PCP performance measurement systems. Concerning monitoring of hospital performance by health plans, there is a great deal of variation between health plans. Moreover, within a health plan, there is variation in reporting requirements based on the volume of members using a particular facility in order to insure reliability of the data reported. In addition, these data are used for quality improvement and may not be publicly available to consumers. Oftentimes, health plans rely on the public reporting done to Medicare (Hospital Compare) and state and local health departments on mortality outcomes and other issues as well as data reported to private entities such as Leapfrog.

In terms of readmissions, there is still debate in the measurement community on the proper measure for readmission. Our understanding is that NQF is doing work to attempt to harmonize the measures. In addition, there is variation based on purchaser. NCQA does require accredited commercial and Medicare plans to report on all readmissions. It is not required by NCQA for Medicaid health plans.

At this time, there is also no agreement on good measures of care coordination, although they are in development on many fronts.

NQF endorsement should be a minimum standard for all measures.

5. **What opportunities exist to further the goals of the National Quality Strategy through quality reporting requirements in the Exchange marketplace?**

   We support (1) the consistent use of NQF-endorsed measures; (2) reliance on the measure reporting done to the approved accrediting bodies; (3) consistency across programs in a particular state; and (4) leverage of Health Information Exchanges to share quality data directly from electronic medical records.

6. **What quality measures or measure sets currently required or recognized by states, accrediting entities, or CMS are most relevant to the Exchange marketplace?**

   We believe the Exchange should rely on the quality measure reporting that is done as part of the accreditation process.

   While both NCQA and URAC now require reporting of measures, if only one measure set is to be used for public reporting, we believe that HEDIS has become an industry standard. If measures are to be reported outside the accreditation process, we believe it should be a measure set comprised of those HEDIS measures that are common to the commercial, Medicare and Medicaid population given the unknown characteristics of the population that will be served by the Exchange. We also believe that great care and consideration should be given to requiring any additional measures that require intensive chart review.

7. **Are there any gaps in current clinical measure sets that may create challenges for capturing experience in the Exchange?**

   As indicated above, the largest challenge is the current inability to risk adjust quality measures to reflect the population being served by the plan. While health plans are continuously striving to reduce health care disparities and disparities in quality scores, we know that some differences are associated with overcoming certain social determinants of health.

   As indicated above, at this time, there is also no agreement on good measures of care coordination, although they are in development on many fronts. There are also limited behavioral health measures, including measures that evaluate the successful integration of physical and behavioral health.

8. **What are some issues to consider in establishing requirements for an issuer's quality improvement strategy? How might an Exchange evaluate the effectiveness of quality improvement strategies across plans and issuers? What is the value in narrative reports to assess quality improvement strategies?**

Since all qualified health plans must be accredited or on their way to accreditation, we strongly support reliance on the standards and reporting that is required through the accreditation process. No additional measures or narrative reports should be necessary.

9. **What methods should be used to capture and display quality improvement activities? Which publicly and privately funded activities to promote data collection and transparency could be leveraged (for example, Meaningful Use Incentive Program) to inform these methods?**

We support leveraging Meaningful Use and Health Information Exchange investments. We also support building off of existing quality improvement requirements of the approved accrediting bodies. Finally, we support the use of the consumer friendly, health plan quality reporting display utilized by the Consumer Reports.

10. **What are the priority areas for the quality rating in the Exchange marketplace? (for example, delivery of specific preventive services, health plan performance and customer service)? Should these be similar to or different from the Medicare Advantage five-star quality rating**

While we have no issue with the quality categories used by STARS, we do have some concerns with the current STARS methodology, as outlined in the attached ACAP Fact Sheet entitled, *Medicare's Quality Incentive System Does Not Adequately Account for Special Needs of Dual-Eligible Populations.*

If one system must be used, we would support the use of the current NCQA domains for quality rating.

More importantly, we believe that plans should report in accordance with the requirements of whichever approved accreditation body they are utilizing instead of adding new and potential more burdensome requirements that have limited value.

11. **What are effective ways to display quality ratings that would be meaningful for Exchange consumers and small employers, especially drawing on lessons learned from public reporting and transparency efforts that states and private entities use to display health care quality information?**

ACAP supports the use of a consistent, consumer friendly report layout and rating system, similar to that used by Consumer Reports. Consideration could be given to utilizing rankings based on categories instead of serial rankings.

12. **What types of methodological challenges may exist with public reporting of quality data in an Exchange? What suggested strategies would facilitate addressing these issues?**

The largest challenge is the current inability to risk adjust quality measures to reflect the population being served by the plan. While health plans are continuously striving to reduce

health care disparities and disparities in quality scores, we know that some differences are associated with overcoming certain social determinants of health.

We strongly support reporting at the issuer level. Reporting for multiple metal levels may result in small denominators and the inability to report meaningful data.

**14. Are there methods or strategies that should be used to track the quality, impact and performance of services for those with accessibility and communication barriers, such as persons with disabilities or limited English proficiency?**

Again, we believe that CCIIO should rely on the standards and requirements of the approved accreditation bodies rather than develop new and/or additional requirements. We also believe that CCIIO should work with AHRQ to develop validated versions of CAHPS in languages other than English and Spanish. We believe that current versions of CAHPS as well as the Medicare HOS surveys need to be shortened and the reading level grade lowered.

**15. What factors should HHS consider in designing an approach to calculate health plan value that would be meaningful to consumers? What are potential benefits and limitations of these factors? How should Exchanges align their programs with value-based purchasing and other new payment models (for example, Accountable Care Organizations) being implemented by payers?**

While we support the concept, much development work still needs to be done to perfect appropriate value measures and cost calculators. For those plans that are NCQA accredited, there is the Relative Resource Unit. However, there are still questions about the reliability of these measures. Therefore, we support the initial use of HEDIS and CAHPS as measures of quality and value.

**Conclusion**

Again, ACAP would like to thank you and your colleagues for your willingness to discuss these issues with us. If you have any additional questions or comments, please do not hesitate to contact me at (202) 341-4101 or dkilstein@communityplans.net.

Sincerely,

Deborah Kilstein

Deborah Kilstein
VP Quality Management and Operational Support