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VIA ELECTRONIC MAIL
http://regulations.gov

Marilyn B. Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9962-NC
P.O. Box 8010
Baltimore, MD 21244-8010

Re: CMS–9962–NC, Request for Information Regarding Health Care Quality for Exchanges

Dear Ms. Tavenner:

I am writing on behalf of the Adventist Health Policy Association (AHPA). We represent 80 hospitals and several hundred affiliated health care facilities (nursing homes, outpatient centers, urgent care centers, and others) across 17 states. One of our AHPA members (Florida Hospital) is the nation's largest Medicare provider.

We have read the notice requesting information on health plan quality management in the Exchanges and appreciate the opportunity to comment. Below, you will find our answers to the questions raised by the Centers for Medicare and Medicaid Services (CMS) in the notice.

Understanding the Current Landscape

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?

(1) Health insurers mostly rely on a few incentives negotiated with hospitals that reflect some of the Value-Based Purchasing (VBP) initiatives at the national level. (2) Insurers work directly with their contracted medical staff but generally do not have incentives with hospitals for reduced readmissions. They do have care coordinators who work directly with the patient to help reduce readmissions. (3) Few health insurers have made this a priority in their contracts. Payments to hospitals are either per diem or DRG-based so the consequences are borne by the hospital. (4) Insurance companies do provide some incentives on wellness and health

promotion. They generally limit themselves to the national criteria on screenings. The overall investment in prevention is nominal as there is no long term incentive for prevention. The enrollee will be covered by another insurance company when the benefits of meaningful prevention will be realized. (5) Insurance companies have not engaged in systematic reductions of health disparities. Given the realities of employer-sponsored health insurance, it would be difficult to deal with reducing health disparities as this is a population-based and long- term issue.

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 health information technology) could mitigate these challenges?

Quality improvement metrics are generally process-oriented and are based on statistical approaches that do not recognize normal variance. Another existing challenge with quality improvement strategy metrics is that these metrics do not sufficiently account for major demographic factors that could impact measures. We believe that the use of quality measures would be more meaningful if CMS looked at the improvement of quality by an institution or group of physicians and compared it to their past performance. Furthermore, the quality improvement criterion currently being used is based upon a consensus model that may not objectively demonstrate quality. AHPA recommends a more rigorous approach to determining quality, one that is based on statistical correlation as opposed to general agreements. It is our view that the emerging "harms" model approach is a step in the right direction.

We recommend that CMS focus on those critical factors that actually make a difference in outcomes. For instance, a measure of quality of care could be the percentage of cardiac arrests codes outside of the Intensive Care Unit (ICU). A hospital that is providing high quality health care over time should be reducing such events. Hospitals should be able to aggregate their data on a quarterly basis and have a rolling four quarter trend.

What we believe is sorely lacking in health care is objective evaluation of what is occurring in the physician's office or the outpatient diagnostic and treatment centers. Rates of normal cardiac catheterizations, outpatient surgical complications, and rates of tests ordered by disease state should all be evaluated as potential quality indicators. Insurance companies have some of this data in their claims systems but other data will need to be obtained from the medical record. A current challenge for physicians is the implementation of an electronic medical record and the interoperability of that record with hospitals.

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

Most public reporting and transparency efforts are done by entities such as Healthgrades and the Leapfrog Group. The problem with these entities is the vast differences in how each define quality. The National Quality Forum (NQF) criterion, while it may have a consensus, is not necessarily indicative of objective measures of quality.

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?

We do not see such activity taking place in any meaningful way by the insurance companies at the hospital level. Few insurance companies incorporate quality incentives in contracts.

Applicability to the Health Insurance Exchange Marketplace

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

AHPA recommends an alignment of metrics across all insured groups. However, we believe that CMS should first ensure that what is being measured and reported is meaningful and related to quality outcomes.

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

It is our view that serious reportable events or "Never Events" are the only measures reasonable to institute. We believe that other measures do not have a high correlation to outcomes. Rates of central line-associated infections and hospital-acquired pneumonia objectively measure harms and would be better indicators of quality.

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

It is our view that the current quality measures are not necessarily indicative of quality and have insufficient norms based on the insured population. We believe that a hospital should be measured against itself for improvement in quality.

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?

We believe that there needs to be better and more objective measures of quality. The number of measures should be smaller in number and better correlated with patient outcomes.

Another issue to be considered by CMS is that data may not be available for the new populations covered by the Exchanges. These populations not previously insured may have more underlying conditions that will affect outcomes not currently addressed by the quality measures. AHPA

therefore recommends that CMS institute Serious Reportable Events or "Never Events" as the only measure to be used in the Exchanges.

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?

Health insurance companies have claims data that could be used once metrics are established. In some states, hospitals report all their administrative data to a state agency that makes it publically available. Many hospitals are already tracking data related to quality measures and other processes that are assumed to be related to quality.

A concern about transparency is that it creates yet another vehicle for malpractice attorneys to create actions and leverage settlements. An area to be considered would be to leverage the data being gathered and analyzed by Patient Safety Organizations (PSO) and have insurance companies participate in those. The display of quality improvement activities could be worked out in a manner that does not violate privacy protections offered by the PSO.

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 system (for example, staying healthy: screenings, tests and vaccines; managing chronic (long-term) conditions; ratings of health plan responsiveness and care; health plan members' complaints and appeals; and health plan telephone customer service)?

Assuming the data is available, the priorities for outpatient services should be:

- Number of complications that result from a procedure or diagnostic test;
- Number of readmissions to a hospital or nursing home;
- Percent of patient visits seen by the physician (will vary by specialty);
- Number of emergency room visits by population served;
- Clinical appropriateness of referral

On a more subjective basis, customer surveys on wait time for appointments, interaction with staff, and physician ability to listen to the patient should also be considered priorities. We do not think that using the current Medicare structure is necessarily appropriate for insurance companies serving non-Medicare patients. What is valued by a younger population is not necessarily valued by an older one.

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?

The most effective way to display quality ratings is to have the information available to search engines on the Internet. We recommend for CMS to include a general explanation of how the data was gathered and what it means to the consumer.

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?

Comparisons will not be meaningful unless the same population is being compared. It is our view that adjustments need to be made for social and economic factors as well as ethnicity, regardless of whether the group has historically been insured or not. These limits must be noted when the data is posted.

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?

Value is a very difficult item to calculate. It generally means a fair price in return for goods or services. In health care, the value is determined by the individual. Some individuals may consider the price paid for health insurance fair because it protects them from facing large medical bills if they get sick. Others may not consider health insurance valuable because they are healthy and not worried about getting sick. Therefore, younger people will be less likely to consider their plans valuable. Value will be seen in the amount of services covered by health insurance plans and the out of pocket costs for services or items received.

From a consumer perspective, factors like being able to see a physician in a timely manner, a clear explanation of benefits, timely payment of claims, and/or not having to appeal claims, will be used to calculate value. It is our view that more technical items such as VBP will not make a significant difference, especially in the early years of the Exchanges.

We appreciate the opportunity to comment and hope you will see our remarks as they are intended: proactive input on the important issues that will improve quality and reduce costs in our health system.

Sincerely,

Richard E Morrison

Richard E. Morrison
President