

**Comments to the Department of Health and Human Services,
Centers for Medicare & Medicaid Services**

**RE: Patient Protection and Affordable Care Act; Exchanges and Qualified Health Plans,
Quality Rating System (QRS), Framework Measures and Methodology**

CMS-3288-NC

**Submitted by Community Catalyst
January 21, 2014**

Community Catalyst respectfully submits the following comments to the Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS) in response to the notice with comment CMS-3288-NC, which seeks comments on the proposed Quality Rating System (QRS) measures that qualified health plan (QHP) issuers would be required to collect and report.

Community Catalyst is a national non-profit advocacy organization dedicated to securing access to quality, affordable health care for all. Since 1997, Community Catalyst has been working to build the consumer and community leadership required to transform the American health system. With the belief that this transformation will happen when consumers are fully engaged and have an organized voice, Community Catalyst works in partnership with national, state, and local consumer organizations, policymakers, and foundations, providing leadership and support to change the health care system so it serves everyone – especially vulnerable members of society.

We greatly appreciate the opportunity to provide comments on the QRS framework. While we have been concerned about the delay in development of a quality rating system for QHPs, we view this framework as a positive step toward a timely standard for patient-focused quality ratings that are easily understandable for consumers.

However, we have a few areas of concern regarding the incremental approach used in this draft framework. By basing the QRS on existing practices, it may reinforce some of the current weaknesses of quality ratings. We see the QRS framework as an opportunity to advance meaningful measures of quality that are easy for consumers to understand and to use in choosing a health plan. We provide recommendations in this comment letter to further this goal.

We have focused our comments on a few areas in which Community Catalyst has particular expertise to share with HHS. Below are comments on consumer engagement efforts and transparency, as well as quality measures specific to health equity, children's health, and substance use disorders/mental health.

We recommend that CMS consider expanded consumer engagement efforts to inform the development and use of the QRS.

There are three distinct areas in which consumer engagement and transparency could be improved:

- 1) **We recommend that CMS include consumer engagement in the further development of the QRS framework.** While we appreciate the opportunity to provide comment on this framework, many advocates and community-based providers may not have the capacity to respond through formal comments.

We suggest that CMS directly reach out to stakeholders, including state consumer health advocates, to directly engage them in the process of creating a QRS for QHPs. More in-depth settings, such as focus groups and listening sessions, can be valuable to gather input from groups that have been working to improve quality and consumer empowerment on the ground. This input could also be achieved through conference calls and surveys of community-based groups. Additionally, the process for gathering consumer input should be robust enough to capture differences in attitudes based on income, race, and health status.

- 2) **We recommend that CMS include consumer engagement as specific quality measures.** There is an opportunity in developing the QRS framework to go beyond the customer service measures available in CAHPS. Some examples below include measures that will lead to more information about consumer activation and empowerment.

John Wasson, at Dartmouth Medical School, has developed a web-based tool (www.howsyourhealth.org) for patient self-assessment to provide data on overall health and chronic conditions. The tool allows patients to assess their confidence in managing their health conditions, and also helps patients work with their physicians in their treatment. For more information, see “Quality Matters: Patients Gain Information and Skills to Improve Self-Management Through Innovative Tools” at <http://www.commonwealthfund.org/Newsletters/Quality-Matters/2010/December-January-2010/In-Focus.aspx>.

Judith Hibbard’s research on patient activation also provides a helpful measure of patient care and patients’ roles in improving outcomes. This measure helps to improve patient coaching and education in self-management of chronic care needs. Because research shows that the more activated patients have better health outcomes, there are new strategies to integrate patient engagement in care delivery systems. In an emerging area of the quality field, a new goal of increasing patient activation as a measureable outcome can lead to improved health outcomes. More information is available in Health Affairs, “What the Evidence Shows About Patient Activation: Better Health Outcomes And Care Experiences; Fewer Data On Costs” at <http://content.healthaffairs.org/content/32/2/207.abstract>.

- 3) **We recommend that the QRS focus on quality measures that matter most to patients, and that the way in which data is presented to consumers is meaningful.** The most critical work of the QRS framework is to ensure that consumers have a clear understanding of what goes into the quality measures so they are useful in choosing a health plan.

Some of the proposed measures rely mainly on process and interim outcomes that may not be meaningful to consumers. One example, from a recent conference sponsored by the Trust for America’s Health and the Robert Wood Johnson Foundation on integrating population health and clinical care, illuminates this idea. A program goal aimed at reducing amputations had

significantly more resonance with consumers than a goal of meeting a certain percentage of the population having hemoglobin controlled. The latter is one of the proposed measures in the QRS.

Below are a few examples of measures that would be meaningful to consumers:

- Measures of member experience:
 - How long is wait time for appointments
 - How far is travel to clinicians
 - How likely are enrollees to report that they are confident that they have the knowledge and resources to manage their health
- Measures of primary care system / coordination:
 - How likely is a person to be admitted or readmitted to the hospital for treatment that could be provided in a doctor's office or community setting
- Measures of clinical quality:
 - Of those admitted to a hospital, how likely are they to develop a preventable complication or infection during their stay
- Measures of plan efficiency / affordability:
 - Does the plan exceed the required medical loss ratio (MLR)

While some of the above examples are similar to those in the proposed QRS, in the framework they are not expressed in consumer-friendly language. We recommend that CMS use consumer-tested language to ensure measures are meaningful and easy to understand.

Finally, we recommend that the QRS be collected and reported at the metal tier level, not only at the product level, as proposed. The consumer experience will be different for plans at different metal levels, and this information will be critical in determining how well QHPs are meeting consumer needs.

We recommend that CMS begin to hold insurers accountable for longer-term investments in population health and health equity as the QRS evolves over time.

It is difficult to address population health and health equity through current methods of quality reporting because year-by-year enrollment in private health plans makes a long-term return on investment difficult. However, population health, as defined by a specific group—e.g. reducing racial and ethnic disparities in outcomes, access to care, patient empowerment—is entirely possible, but largely missing from the proposed QRS framework.

We recommend a measure, related to population health, tied to creating programs to identify “hot spots” and implement clinical interventions to reduce incidence of frequent emergency department visits and hospital admissions.¹

Health equity is a critical part of improving population health over time. Collecting, analyzing and reporting data on health outcomes by race, ethnicity, primary language, gender identity and sexual orientation is crucial to understanding how quality differs between demographics. Data

¹ The Hot Spotters: Can we lower medical costs by giving the neediest patients better care? Atul Gawande. http://www.newyorker.com/reporting/2011/01/24/110124fa_fact_gawande

regarding race and ethnicity is usually not collected properly, and in many cases not collected at all. But reliable data is essential to identify the type and severity of disparities, causes, interventions needed, and track results.

The HHS Office of Minority Health (OMH) has released standards to more consistently measure race, ethnicity, sex, primary language, and disability status, as required by Section 4302 of the ACA.² The ACA requires that, once established, these data collection standards be used, to the extent practicable, in all national population health surveys. It also requires all federally funded programs and activities collect data on disparities. **We recommend CMS include reporting on the OMH measures in the QRS.**

We recommend that QHPs report and publicly post their progress in improving health outcomes of enrollees by race, ethnicity, primary language, gender identity and disability. These reports should also include data on related complaints and appeals to help consumers make decisions on health plans that improve quality by making progress in decreasing health disparities.

Measures should include an index of disparity to measure differences across populations, particularly among different racial and ethnic groups. This index can be used to prioritize areas in need of improvement by targeting measures of health performance that have the most variation across race and ethnicity.³

Finally, we recommend that CMS stratify data and reporting not only along sex and race but also along sex-race groups (e.g., being able to compare the care the African-American women receive to the care that white men receive). When data is only reported along one of those dimensions, we can lose track of the continued ways that women's care can be inferior to men's - the classic example is treatment for heart attack or high blood pressure.

We recommend CMS require QHPs to measure quality of pediatric services as an area of focus distinct from adult quality measurement.

Children's interaction with the health care system is different from adults' use of health care. Children represent a fundamentally distinct population on four dimensions: development, dependency, differential epidemiology, and demographics. Because of these differences, the children's health advocacy community is deeply concerned about access to appropriate pediatric services—particularly pediatric subspecialties—within the adult and family QHPs. As such, we **urge CMS to adopt a requirement that adult and family QHPs report data stratified by pediatric and adult groups.**

The age cut-offs for these groups are an issue for debate; while age 18 might make an appropriate cut-off for inclusion in the pediatric group, some would argue that because the Bright Futures guidelines extend to age 21, this would be a more appropriate age cut-off. Additionally, the earliest years of life are particularly crucial with regard to development and prevention, so

² <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208>

³ See Keppel et al., "Measuring Progress in Healthy People 2010"; and J. Pearcy and K. Keppel, "A Summary Measure of Health Disparity," *Public Health Reports* 117, no. 3 (2002): 273–280.

stratification of an age 0-5 group may be epidemiologically appropriate. Broadly speaking, stratification of pediatric quality reporting will enable us to understand whether children's experience of care is improving alongside adults'.

Children's health quality measurement has historically lagged behind measurement of adult quality of care, and reporting stratified by age will help us to measure pediatric quality in QHPs. However, some adult quality measures may not be appropriate to the pediatric setting, and the adult measures may fail to address some nuances of pediatric services. As such, **we urge CMS to incorporate the ongoing measure development and testing work of the Centers of Excellence and Demonstration Projects funded through CHIPRA into the development of the QRS.** Incorporating pediatric-specific measures into this reporting will enable consumers to make more educated decisions about pediatric care and will facilitate the quality improvement process with respect to children's health.

We recommend CMS include outcomes related to substance use disorders in the QRS framework.

We are concerned that there is no mention of treatment or outcomes related to substance use disorders in the proposed QRS measures and structure. This is particularly troubling in the context of the new regulations implementing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008. In addition, measures related to addictive illness are critical because they are among the most pervasive illness⁴ affecting health and healthcare costs.⁵

Although behavioral health measures have been endorsed by some of the authorities relied upon in the QRS, those measures were not included. For example, the National Quality Forum endorses [Measure 004](#) which provides:⁶

- **Initiation of AOD Treatment.** The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.
- **Engagement of AOD Treatment.** The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

We also recommend implementing some of the measures included in [the National Outcome](#)

⁴ In 2012, 22.3 million people met the criteria for substance use disorders. [SAMHSA, National Survey on Drug Use and Health](#). Substance abuse prevalence rates are 10% for the general population and 50% for persons with disabilities, [U.S. Department of Health & Human Services, office of Disability, About 22 percent of general health care patients report they have a co-morbid substance use condition](#) of some level of severity.

⁵ Untreated or inadequately treated SUDs cause other illnesses and/or increase the severity of the illness and health care costs, [Clark, Ph.D., Connell, M.S., Samnaliev, Ph.D., Substance Abuse and Healthcare Costs Knowledge Asset, March 2010](#). The National Center on Addiction and Substance Abuse at Columbia University, [Shoveling Up the Impact II, The Impact of Substance Abuse on Federal State and Local Budgets](#) May 2009. However health care costs decline by up to 22% to 55% following SUD treatment. Harwood, Lui, Chong, Gilani, [SAMHSA, National Evaluation Data Services, Cost Effectiveness and Cost Benefit Analysis of Substance Abuse Treatment](#).

⁶ See https://www.qualityforum.org/News_And_Resources/Press_Releases/2012/NQF_Endorses_Behavioral_Health_Measures.aspx

Measures (NOMs) system—developed jointly by SAMHSA and the states and the District of Columbia. It tracks and measures real-life outcomes for people in recovery from mental health and substance abuse disorders.

Lastly, the following measures are critical to effective care for SUDs and should be included in the QRS based on the MHPAEA, because they are comparable to the physical health measures listed. These measures were also recommended as high priority and published in 2005 by the NQF in *Evidence-Based Treatment Practices for Substance Use Disorders workshop convened by the NQF*:

1. Appropriate treatment levels for substance use disorders, such as prevention, outpatient, intensive outpatient, short and long term residential, and recovery support services.
2. Recovery Management Services to assist patients with SUDs in achieving and maintaining long term stable recovery.
3. Screening Brief Intervention and Referral to Treatment (SBIRT) and other alcohol and drug prevention services.
4. Medication Management for substance use disorders and co-occurring mental health disorders.

Thank you for the opportunity to submit comments on the QRS Framework Measures and Methodology. We welcome the opportunity to provide additional input on these issues. Please feel free to contact Christine Barber with any questions at cbarber@communitycatalyst.org.

Respectfully submitted,



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