April 28, 2014

Marilyn Tavenner, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Baltimore, MD 21244

Submitted via email to: Marketplace_Quality@cms.hhs.gov

Re: **Quality Rating System Scoring Specifications**

Dear Ms. Tavenner:

The Alliance of Community Health Plans (ACHP) is pleased to submit comments on the Quality Rating System (QRS) Scoring Specifications circulated on March 28, 2014.

ACHP is a national leadership organization representing community-based and regional health plans and provider organizations. ACHP members provide coverage and care for more than 18 million Americans in the commercial market, for newly insured families through the exchanges, and for Medicare, Medicaid, and federal, state, and local public employees. Our members are not-for-profit health plans or subsidiaries of not-for-profit health systems. They share longstanding commitments to their communities, close partnerships with providers, and substantial investments in the innovative approaches and infrastructure necessary to provide health care that is coordinated, affordable and high quality. In the 2013-14 National Committee for Quality Assurance (NCQA) rankings of health plans, ACHP plans are all 10 of the nation's top 10 Medicare plans, 5 of the top 10 plans in the commercial rankings and 5 of the top 10 plans in the Medicaid rankings. Thirty-three Medicare plans (contracts) operated by ACHP members received 4, 4.5 and 5 stars in the CMS combined 2014 Medicare Advantage and Medicare Part D star ratings; seven of the 11 5-star plans are ACHP plans.

Introductory comments

ACHP submitted comments on the QRS framework published in the *Federal Register* on November 19, 2013 and we refer CMS to that comment letter, dated January 21, 2014. As we stated then, ACHP strongly supports the long term value of the QRS and appreciates CMS' work in developing the proposed framework. Given our members' long-standing commitment to quality care, our role in developing and implementing quality measurement in health plans, and our advocacy of value-based purchasing in Medicare and other public and private health care programs, we look forward to implementation of an effective system for assessing clinical quality and patient experience in the exchanges.

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ACHP believes the QRS has the potential to play as important a role in the exchanges as the star ratings system plays in Medicare. For that reason, a nationally consistent measurement system, applicable across federal, state, and partnership exchanges, is essential. As CMS continues to develop the methodology, we urge you to ensure that the measures and rating methodology are designed to: 1) provide information that is meaningful for consumers choosing among plan options; 2) be usable by health plans and providers seeking to improve care and the patient experience; and 3) be as consistent as possible with other widely accepted measure sets. We would also emphasize that transparency on the rating methodology, data strategy, and other elements of the QRS is critical for health plans, consumers, and other stakeholders.

3.0 QRS Measure Set and Structure

Hierarchical Structure

As we noted in our January 21st response, ACHP believes that CMS has developed a reasonable and useful hierarchical model for consumers, plans, and purchasers. Overall, the structure reflects the goals of the National Strategy for Quality Improvement in Health Care. We believe it is particularly important for consumers, as well as plans and providers, for the rating system to make accessible the hierarchical aggregations of individual measures. Our member plans' experience is that consumers with heart problems or diabetes, for example, or those interested in adult prevention, need to be able to access consolidated, comparative metrics in the areas that are of interest to them.

ACHP continues to believe that the structure could be simplified to some extent and doing so would improve its usability. We offer the following recommendations:

- We recommend combining the "Access to Preventive Visits" and "Access to Care" composites into a single access composite, particularly in light of our recommendation below to eliminate the well visit measures.
- For clarity, we suggest renaming the summary indicator "Member Experience" to "Member Experience with Care" to better differentiate it from the composite measure, "Member Experience with Health Plan."
- In our January 21 response, we recommended combining the Care Coordination, Clinical Effectiveness, and Patient Safety domains into one domain of "Clinical Care" or "Clinical Treatment." Given our concerns expressed below about weighting, we believe that fewer domains would exacerbate that problem, so we no longer make that recommendation.

Individual measures

With exceptions noted below, ACHP supports the initial set of measures proposed in the notice. We agree that clinical quality and patient satisfaction should be at the core of the rating system. Measures should be evidence-based and meaningful for consumers, health plans, and providers.

ACHP has concerns about the following measures:

- **Relative Resource Use (RRU) Measures**: We urge CMS to drop the proposed relative resource measures ("Relative Resource Use for People with Diabetes, Inpatient Facility Index," and "Relative Resource Use for People with Cardiovascular Conditions, Inpatient Facility Index"). While a value measure is important to consumers, the RRU measures capture cost data too narrowly (only inpatient costs for those with two chronic conditions). Recognizing that problem, NCQA has dropped these measures from its health plan rankings. Additionally, RRU measures use an indexed cost rather than a total cost. This approach does not recognize differences in provider unit costs, which are a major driver of variation in commercial insurance. As a result, a patient with diabetes who is admitted with the same cost-sharing requirements as another patient may face higher costs in a plan that has lower relative resource use. We recommend that CMS continue to work with stakeholders and rating organizations to refine cost-of-care measures that are evidence-based and more relevant for consumers and purchasers.

- **Visit Count Measures**: We do not believe that the visit-count measures are appropriate for inclusion (Adolescent and Child Well-Care Visits). Such measures are not the appropriate metric for access, they will vary under different models of care, and frequency counts could encourage unnecessary use. Increasingly, patients and providers interact through e-visits, access to electronic records, remote monitoring, and other technologies. These new means of providing care may well increase access, serve patients' need for convenience, and help to meet both wellness and treatment protocols, but they would not be captured by a simple count of visits.

- **Diabetes Composite Measure**: ACHP recommends a modification in the diabetes composite measure to better reflect the clinical priority of cardiovascular disease management in diabetic patients. Specifically, we would recommend deleting the proposed "Diabetes Management: HbA1c Control <8.0%" measure and adding two measures to this composite: "Diabetes: Most recent LDL-C Screening," and "Diabetes: DL-C Control <100 mg/dL." These measures are widely collected, reflect evidence-based guidelines for diabetes care, and improvement in these areas can have a significant impact on patient outcomes.

- **Cardiovascular Care Measures**: The two cardiovascular care measures have been dropped by HEDIS and by the Medicare star ratings. We believe they should not be used in the QRS measure set.

4.0 Proposed Scoring Process Detailed Specifications

The proposed scoring methodology is significantly different from the approach used in the star ratings for Medicare Advantage and Part D plans. In the Medicare star ratings system, each measure is assigned a star rating and the measures are grouped into domains, but the domain ratings are not averaged or otherwise used in calculating the overall rating. Rather, the Medicare overall star rating is calculated from a plan's scores on the individual

measures. Those measures are weighted based on CMS' judgment of the significance of the measure to beneficiaries and the efficient and effective administration of the program.

Forty-two measures of clinical effectiveness, prevention, access, efficiency, and consumer satisfaction form the basis of the proposed QRS structure. These measures are all equally weighted. Most, but not all, of the individual measures are combined into composite measures (e.g., cardiovascular care, diabetes care). There are different numbers of measures in the various composites. The composites (and the individual measures that have no composite) are aggregated into 8 quality domains, which in turn are aggregated to 3 summary indicators used to determine the global star rating.

For the QRS, CMS proposes to standardize measure scores using percentile ranks, which will then be used to establish thresholds for ratings on a 1 to 5 scale. ACHP supports CMS' proposed use of national percentiles across all exchange products (HMOs, PPOs) as the basis for assigning ratings on individual measures. This approach provides a national benchmark for performance and gives consumers meaningful comparisons both within their markets and to other markets across the country. Using percentiles rather than thresholds based on absolute performance also provides for normal performance distributions on measures that will reflect both current measure performance and performance improvement.

The global QRS rating would be determined in a staged calculation; the methodology would aggregate the scores as follows:

- first average scores on individual measures into composite measures,
- then average those composites scores into the 8 domains,
- then average scores on the domains into the 3 summary indicators, and
- finally average the summary indicator scores into the global score.

ACHP's most significant concern is that the use of averages at each level gives more influence to measures that are under the composites (and domains and summary indicators) with <u>fewer</u> measures. The problem is exacerbated by the absence of measure weights. That is, a composite that reflects the average of 2 or 3 measures will count the same as a composite made up of the average of 5 or 6 measures – disproportionately reducing the "influence" of the composite with the greater number of measures. This approach loses more and more precision as it moves up the hierarchical structure. While CMS is not proposing to weight measures, *by default* the approach places greater weight on the composites/domains/summary indicators with fewer measures. CMS may want to consider weighting at least the measures or composites to reflect an evaluation of the importance of some measures over others in terms of patient outcomes and other program priorities.

Determining global score thresholds: CMS' proposal to determine star ratings by setting cut points at the 25th, 50th, 75th, and 90th percentiles limits to 10 percent the number of plans that can earn 5 stars. Also, given the lack of weighting in the measurement system, a plan will have to rank in the 90th percentile on almost all of its scores to achieve a global mean score of 90 or above. We believe this will have two effects:

- Over time, higher performing plans will hit a ceiling. They will have smaller marginal gains as they move closer to the maximum score on a measure.

- Lower performing plans will be able to achieve higher marginal gains, but with a system based on relative distributions, they may remain at low star ratings despite their improved performance.

In both cases, the incentive to improve is at least partially offset by the effects of scoring based on relative distributions. We ask CMS to consider possible solutions to this problem. At the high end, one approach may be to reward consistently high performance as is done in the Medicare star ratings program through the "Reward Factor" (formerly called the "I-Factor").

Half-Star Ratings: The Medicare star ratings system has experienced the problem that a single star rating reflects a wide range of scores. Plans with a "high 3" and a "low 3" may represent quite different performance levels, but they both are given the 3 star rating. CMS should consider using half-star ratings to reduce the range of performance within a single star rating and provide a truer picture of a plan's quality.

Prior Year Percentiles: In applying percentiles to determine the star ratings thresholds, we also suggest that, after the initial years, CMS use prior year percentiles rather than current year percentiles. This would allow a fixed target for plans to use in planning their improvement efforts, while allowing for upward adjustment for improvement over time.

ACHP appreciates this opportunity to comment on the proposed scoring specifications. If there are questions or the need for additional information, please contact Howard Shapiro, ACHP Director of Public Policy, at HShapiro@ACHP.org.

Sincerely,

Patricia P. Smith

Patricia P. Smith
President and CEO