January 21, 2014

Marilyn Tavenner, Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-3288-NC  
P.O. Box 8016  
Baltimore, MD 21244-8016

Filed via www.regulations.gov

Re: Patient Protection and Affordable Care Act; Exchanges and Qualified Health Plans, Quality Rating System (QRS), Framework Measures and Methodology - CMS-3288-NC

Dear Ms. Tavenner:

The Alliance of Community Health Plans (ACHP) is pleased to respond to the Notice with comment referenced above and published in the Federal Register on November 19, 2013.

ACHP is a national leadership organization that brings together innovative health plans and provider groups that are among America's best at delivering affordable, high-quality coverage and care in their communities. Member plans provide coverage for more than 16 million Americans in the commercial market, for newly insured families through the exchanges, and for Medicare, Medicaid, and federal, state, and local public employees. Members also provide administrative services for self-insured employers. The community-based and regional health plans and provider organizations that belong to ACHP improve the health of the communities they serve and are on the leading edge of patient care coordination, patient-centered medical homes, accountable health care delivery, information technology use, and other innovations to improve affordability and the quality of care that patients receive. In the 2013-14 NCQA rankings of health plans, ACHP plans are all 10 of the nation's top ten Medicare plans, 5 of the top ten plans in the commercial rankings, and 5 of the top ten 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 strongly supports the long term value of the Quality Rating System (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. Over time, we encourage CMS to use the Triple Aim framework to guide evolution of the rating system, balancing measures of patient experience, outcomes, and costs. To the extent that outcomes measures are developed and incorporated, and costs appropriately captured, patients will be better able to assess value as they choose among health plans.

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. In reviewing the proposed framework, we emphasize five themes: First, the measures and rating methodology should be designed to serve a dual purpose: providing information that is meaningful for consumers choosing among plan options and usable by plans and providers seeking to improve care and the patient experience. Second, the QRS should be aligned with the Medicare Advantage (MA) star rating system to the extent feasible. Third, it will be important for CMS to set out its long-term direction for the QRS while recognizing that in the initial year(s), as enrollment is growing, it will be necessary to accommodate the practical need for obtaining appropriate sample sizes. Fourth, decisions on quality measures and other elements of the system should be evidence-based. Finally, transparency on the rating methodology, data strategy, and other elements of the QRS is critical for health plans, consumers, and other stakeholders.

QRS Framework and Structure

ACHP appreciates CMS’ development of the QRS Framework and Structure and believes that it sets out a reasonable and useful hierarchical model for consumers, plans, and purchasers. We have some specific comments below. 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 framework to provide 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.

The proposed framework and structure is a way to accomplish that objective, allowing consumers to start with overall plan metrics, examine domains and composites in specific health areas relevant to the consumer, and assess performance on individual measures. As in the Medicare star ratings, CMS should consider whether and how measures and domains should be weighted in calculating the ratings, and we urge CMS to consult with health plans and other stakeholders in developing proposed weights. We encourage CMS to continue to make the process of developing and updating the framework and structure both transparent and evidence-based.

ACHP believes that the structure could be simplified to some extent and doing so would improve its usability. We suggest that the Care Coordination, Clinical Effectiveness, and Patient Safety domains be combined into one domain of “Clinical Care” or “Clinical Treatment.” There is alignment among all these measures of clinical quality, and the fact that there are no composite measures in two of these three areas further suggests the need
for combining them. Secondly, and particularly in light of our recommendations below to eliminate the well visit measures, we recommend combining the Access to Preventive Visits and Access to Care composites into a single access composite. Finally, 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.

**Reporting**

ACHP supports CMS’ proposal for product-level reporting for populations inside and outside the Marketplace, especially in the early years of implementing the QRS. More granular reporting, such as reporting at each metal level, will not be feasible until enrollment reaches a point where the sample sizes support robust measurement. In addition, it will be valuable to learn from consumer and plan experience with the product-level reporting before making decisions about whether and how to change in the future.

While there should be a nationally uniform methodology to determine ratings for all health plans, in order for ratings information to be meaningful to consumers, the comparisons presented should reflect the plan’s performance compared with other choices that consumers have in the market; accordingly, we support the display of comparisons at the regional level. Because a consumer is choosing among options in a market area, the most meaningful comparison for that person is among plans available in the state or region.

**Rating Methodology**

As CMS works to propose a rating methodology, ACHP recommends that it align as closely as possible with rating methodologies used for the MA star rating system. That is the best way to minimize complexity for plans and providers and confusion for consumers using the measures, and in particular the composite, domain and plan summary aggregations noted above. Consumers and families should know that, in general, a rating such as four or five stars has the same meaning for the Marketplaces as it does for Medicare, and hopefully for other purchasers. We look forward to commenting more completely on this issue when CMS issues further guidance on the methodology.

**Data Strategy**

As with the rating methodology, ACHP recommends that CMS align the data strategy as closely as possible with the data strategy used for the MA star rating system, and that it be as transparent as possible. We support the proposal to display the global ratings on a simple, 5-star scale.

ACHP members have been committed to reducing health disparities in their communities, and believe that adjusting quality ratings for socio-economic status would be counterproductive to that effort. All participants in the health plan and provider community need to meet the challenge of reducing disparities, and not implicitly accept poorer outcomes for patients most in need of care. Measures should not be adjusted for performance that does not meet that responsibility.
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. We repeat our theme stressing the need for evidence-based measures that are meaningful for consumers and plans.

With regard to specific measures, ACHP has concerns in three areas. First, we believe that CMS should not include 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.

Second, 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 and help to meet both wellness and treatment protocols but they would not be captured by a simple count of visits.

Finally, 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.

ACHP appreciates this opportunity to comment on the notice and would be happy to respond to questions or provide additional information on these issues. If you have any questions, please contact me or Howard Shapiro, ACHP Director of Public Policy, at HShapiro@ACHP.org.

Sincerely,

Patricia P. Smith
President and CEO