AMERICA'S ESSENTIAL HOSPITALS

April 21, 2014

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Ave., SW
Washington, DC 20201

Ref: CMS-9949-P: Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond

Dear Ms. Tavenner,

America's Essential Hospitals appreciates the opportunity to submit comments on the above-captioned proposed rule. The association's comments relate specifically to the sections on quality standards for the quality rating system (QRS) in the health insurance marketplaces (exchanges). We applaud the Centers for Medicare & Medicaid Services (CMS) for working to improve the quality of health care, guarantee patients access to care, and achieve better health outcomes. Implementing a quality rating system (QRS) for plans offered in the insurance marketplaces to help accurately guide consumers in their decision making is a commendable goal. However, the quality measures in the system should be NQF-endorsed, reliable, valid, and risk-adjusted where appropriate. CMS must consider the types of measures that will provide meaningful results that are useful to consumers and take into account the different factors that affect providers' performance outcomes. CMS must also remain vigilant in ensuring that essential community providers (ECPs) are included in health plan networks, or these networks can never provide the value they should to consumers.

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America's Essential Hospitals is the leading association and champion for hospitals and health systems dedicated to high-quality care for all, including the most vulnerable. As ECPs, our more than 200 member hospitals fill a safety net role in their communities, serving the uninsured and patients covered by public programs. Specifically, our members provide a disproportionate share of the nation's uncompensated care and devote more than half of their inpatient and outpatient care to uninsured or Medicaid patients. Our members provide this care while operating on margins substantially lower than the rest of the hospital industry—with an average operating margin of -0.4 percent, compared to 6.5 percent for hospitals nationally.[1]

Many previously uninsured patients who seek care at our member hospitals are transitioning into health plans offered through the marketplaces. Maintaining a relationship with their current provider is of utmost importance to these vulnerable patients' health. Essential hospitals are experts at providing the comprehensive care these patients need, which ranges from primary care services and other ambulatory care to complex inpatient services.

Some members of America's Essential Hospitals operate their own qualified health plans (QHPs) that provide affordable coverage through the marketplaces to residents in their communities. In addition, many of our members are included as providers in qualified health plan (QHP) networks on the marketplaces, but as we have expressed previously, some are being excluded from these networks. This exclusion threatens access to care for our hospitals' most vulnerable patients, who could be forced to choose between paying more to maintain their existing provider relationships or seeking care from a provider with less experience caring for the vulnerable.

The QRS, if implemented properly, can be a useful tool for consumers to find plans that include providers who offer high-quality care and with whom they have existing relationships. However, this must go hand in hand with efforts to ensure that ECPs are included in these networks in the first place, so consumers have a range of choices of providers offering primary through quaternary care when deciding on a

[1]America's Essential Hospitals Annual Hospital Characteristics Survey. 2012. Results to be published.

plan. As such, CMS should consider the following when finalizing this rule.

1. CMS should ensure the QRS provides meaningful information and protects consumer access to quality health care.

In the proposed rule and in CMS' November 19, 2013, notice on the QRS (QRS notice), the agency emphasizes that the QRS is intended to improve the consumer experience as well as the accessibility and affordability of care. **CMS should implement the QRS in a way that protects consumer access in the marketplaces to ECPs on whom they already rely for health care services.** The QRS will provide publicly reported information that consumers can use to choose health plans. However, if the appropriate information is not displayed in a manner that is comprehensible and useful to consumers, it can lead to misinformed choices, which in turn affects access to care.

One of the most relevant pieces of information to consumers is the type and number of providers in the QHPs. **CMS should include in the QRS measures that reflect the plan network's composition, including a listing of all providers in the QHP, by type of provider.** Such an approach was supported by the Measure Applications Partnership (MAP) in its report on the QRS.[2]

In addition to knowing which providers are part of a QHP, it is important for enrollees to be assured they will be able to see these providers in a timely manner. To this end, it is critical that the QRS include information on the time that it takes for a beneficiary to be seen by a provider. CMS' proposed QRS measure set contains a measure on access to care from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) health plan survey that asks plan enrollees about wait times. This information is useful to consumers in making decisions about health plans, because meaningful access entails not only the availability of a provider of choice but also receiving care when it is most needed.

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[2]National Quality Forum. Final Report, Measure Applications Partnership Input on the Quality Rating System for Qualified Health Plans in the Health Insurance Marketplaces. January 24, 2014. https://www.qualityforum.org/Publications/2014/01/Input_on_the_Quality_Rating_System_for_Qualified_Health_Plans_in_the_Health_Insurance_Marketplaces.aspx. Accessed April 2014.

The QRS should also report on the scope of vital services offered by providers in the QHP, such as whether the providers offer culturally and linguistically competent care, in addition to other essential community services for low-income, uninsured, and vulnerable populations. The QRS should also include data on which hospitals provide access to a range of primary through quaternary care services, as well as trauma care and public health services. The availability of essential providers offering these specialized services in a QHP should be displayed publicly along with other quality rating information. The availability of these services should also be incorporated as a positive factor in a QHP's overall rating.

Consumers are most interested in knowing whether the plan they select includes the providers with whom they have relationships, and who they know can provide the necessary services for their particular needs. By including information on the availability of these types of services, CMS can ensure consumers will be able to find a plan that will provide them with affordable access to the type of comprehensive and specialized care that only certain providers offer.

2. CMS should include reliable and valid measures that take into account the socioeconomic and demographic factors that complicate care for vulnerable patients.

In the QRS notice, CMS presented the framework for the QRS, including the specific measures under consideration. In the proposed rule, the agency states that it intends to finalize these measures. There are two separate measure sets: one for family and adult self-only plans (the main measure set) and one for child-only plans. The main QRS measure set contains 42 measures, while the child-only set contains 25 measures. A majority, but not all, of the measures in the QRS measure sets are endorsed by the National Quality Forum (NQF). **CMS should narrow this measure set to NQF-endorsed measures that are valid and reliable, are aligned with other existing measures, and are risk adjusted for socioeconomic factors to accurately represent the quality of care being provided by ECPs.** This is consistent with CMS alignment efforts on quality measures across settings and programs.

   a. CMS should adjust the measures for socioeconomic factors to accurately represent the quality of care delivered.

For outcome performance measures in the QRS, CMS should incorporate risk adjustment for socioeconomic factors in its methodology for calculating measures so the results are accurate and reflect differences in the patients being treated across plans. Without proper risk adjustment, a health plan that serves a disproportionate share of lower-income patients with confounding socioeconomic factors may be rated lower for reasons outside of the plan and providers' control. Results on certain measures, such as readmissions measures, can be skewed by factors such as race, homelessness, cultural and linguistic barriers, and low literacy. Patients who do not have a reliable support structure upon discharge are more likely to be readmitted to a hospital or other institutional setting. These readmissions are caused by factors beyond the control of providers and health plans and therefore do not reflect the quality of care being provided. Risk adjusting measures for these factors will ensure that potential enrollees receive accurate information about the plan's performance.

The need to take socioeconomic factors into account has been increasingly suggested for quality measurement programs. For example, the Medicare Payment Advisory Commission made this recommendation for the Medicare Hospital Readmissions Reduction Program.[3] NQF has also convened a panel on this issue that has issued draft recommendations proposing that certain quality measures be risk adjusted for socioeconomic and demographic factors. America's Essential Hospitals believes that including these factors in risk adjustment models will unmask quality excellence at hospitals that serve vulnerable populations. Risk adjustment will help patients identify providers who offer the most appropriate care for their particular circumstances and needs by providing more accurate results on provider quality outcomes to patients. The failure to appropriately risk adjust outcome measures can adversely affect patients' access to appropriate care by prompting them to avoid plans that include ECPs based on misleading, unadjusted performance scores.[4] **For these**

[3]See, e.g., Medicare Payment Advisory Commission. Report to Congress, Medicare and the Health Care Delivery System. June 2013. http://www.medpac.gov/documents/Jun13_EntireReport.pdf. Accessed April 2014.

[4]National Quality Forum. Draft Report, Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors. March 18, 2014:14. http://www.qualityforum.org/Project_Pages/Risk_Adjustment_and_SES.aspx#t=2&s=&p=1. Accessed April 2014.

reasons, CMS should risk adjust the measures in the QRS for socioeconomic factors to protect access to care, particularly for vulnerable patients who receive care from ECPs.

b. CMS should reduce the number of measures in the QRS so that it contains a limited number of cross-cutting measures that accurately represent health plan quality.

In the QRS notice, CMS introduced 42 measures for the main QRS measure set and 25 for the child-only measure set. Now, CMS proposes to finalize these measures and provide measure specifications later this year. **CMS should work with relevant stakeholders to identify a core set of measures that truly reflect the priorities of the QRS and will help to improve health care quality and consumer access to health plans with essential community providers.**

CMS should also include cross-cutting instead of condition-specific measures, because these types of measures are better indicators of quality across a continuum of care. By choosing these types of measures, CMS will ensure that the QRS contains a manageable number of quality measures that will be useful to health plans in making quality improvements and to consumers in making coverage choices. Rather than including a large number of measures that will be burdensome for health plans and confusing for consumers, CMS should focus on establishing a meaningful and succinct set of health plan quality measures that are evidence-based, valid, and reliable.

c. CMS should include only NQF-endorsed measures that have been tested for the marketplace population and should regularly submit measures to MAP for evaluation.

CMS should only consider measures that are NQF-endorsed and MAP-supported. In its report on the QRS, MAP indicated that many measures, such as the breast cancer screening and cervical cancer screening measures, are not NQF-endorsed and are not ready for implementation. The following list represents the other measures that are not currently NQF-endorsed:

- CAHPS–cultural competency (QRS and child-only QRS)
- Adolescent well-care visits (QRS and child-only QRS)

- Adults' access to preventive and ambulatory health services (QRS)
- Children and adolescents' access to primary care practitioners (child-only QRS)
- Adult BMI assessment (QRS)
- CAHPS–aspirin use and discussion (QRS)
- Cholesterol management for patients with cardiovascular conditions: LDL-C control (<100 mg/Dl)(QRS)
- Cholesterol management for patients with cardiovascular conditions: LDL-C screening (QRS)
- CAHPS – coordination of members' health care services (QRS and child-only QRS)
- Annual monitoring for patients on persistent medications (endorsement withdrawn) (QRS)

CMS should not include these measures in the QRS until they are thoroughly vetted and endorsed by the NQF.

The population that will gain coverage through the marketplaces will be substantially different than the populations covered by existing public and private health plans. Accordingly, while the measures may have been previously tested and used for other populations, they should still be rigorously tested for suitability for the marketplace population. Any measures that are proposed for the QRS should be submitted to MAP for review, similar to or as part of the CMS year-end pre-rulemaking measures under consideration. Furthermore, all existing measures, as well as new measures in future years, should be continuously reviewed to confirm that they are still relevant and reliable. NQF endorsement is imperative to ensure measure validity and reliability, because the endorsement process requires that measures be fully vetted and approved through a consensus-building approach that involves the public and interested stakeholders.

d. CMS should not include the all-cause readmissions measure in the QRS.

CMS should remove the all-cause readmissions measure from the QRS measure set. Reducing preventable readmissions is of paramount importance to members of America's Essential Hospitals who are involved in all levels of the provision of health care, from operating health plans to providing care in their hospitals. However, any program

directed at reducing readmissions must target readmissions that are preventable and must also include appropriate risk-adjustment methodology. Readmissions measures can unfairly penalize health plans that serve the nation's most vulnerable populations when they do not take into account external factors that explain higher readmission rates. An all-cause readmissions measure would have to exclude appropriate planned readmissions and include sufficient risk adjustment for socioeconomic factors, as described above. America's Essential Hospitals has previously weighed in on this issue during MAP deliberations. We believe that the current approach to clinically coherent and homogenous measures of readmissions, such as readmissions specific to heart failure, acute myocardial infarction, and pneumonia, offers better pathways to meaningful quality improvement and reduction strategies. All-cause readmission measures do not give us that view nor do they offer meaningful data to the consumer. Due to providers' relative lack of experience implementing all-cause readmissions measures as well as the concerns mentioned above, CMS should not include this measure in the QRS measure set.

3. CMS should provide measure specifications in a timely fashion so that stakeholders can review them and QHP issuers have ample time to prepare for reporting on them.

In the proposed rule, CMS notes that it will publish measure specifications on the U.S. Department of Health and Human Services website later this year for the proposed QRS quality measures. **America's Essential Hospitals urges CMS to publish this information as soon as possible so stakeholders may evaluate their appropriateness for inclusion in the QRS.** Transparency in methodological details should be a key part of public reporting programs. It enables consumers and other affected stakeholders to properly interpret the data. For example, health plans that have no prior experience with data collection and reporting for quality reporting purposes should be afforded sufficient time to understand how the data are to be collected and aggregated at the health plan level. America's Essential Hospitals looks forward to reviewing this technical guidance when CMS publishes it later this year.

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America's Essential Hospitals appreciates the opportunity to submit these comments. If you have any questions, please contact Xiaoyi Huang at 202-585-0127.

Sincerely,

/s/

Bruce Siegel, MD, MPH
President and CEO