TO: Board of Directors, Colorado Health Benefit Exchange

FROM: COHBE Staff

DATE: December 14, 2012

SUBJECT: Response to RFI on Quality Improvement in Exchanges

On November 23, the U.S. Department of Health and Human Services (HHS) posted a Request for Information seeking comment on 15 questions regarding quality improvement through the Exchanges. This memorandum outlines the Colorado Health Benefit Exchange's answers to HHS.

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?

COHBE recommends leaving this question to the health plans.

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?

One of the major challenges to quality improvement is the quality of the data used to collect and report quality metrics. Most administrative measures are based on claims data, which is only as good as the data the providers used to submit the claim. Claims systems were designed for billing not for quality measurement. In addition, many of these measures were developed based on what we could measure rather than what was really important to improve quality of care. Clinical measures are more important and more accurate but are impractical to collect due to the expense. "Clinically enhanced" administrative measures are a mixture of the two and more accurate but there aren't enough measures. Using electronic measures derived from electronic medical records are a hopeful future solution as more practices develop EMR capabilities.

Tracking over time is possible on a plan level but the more stable the group the more accurate the measurement will be. In populations such as an individual business or Medicaid, where members can rotate in and out, it becomes more difficult to measure changes over time that can be attributed to health plan actions. This may apply to QHPs on the exchanges as well if there is a lot of year over year churn.

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

COHBE does not currently see this as being applicable.

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? Applicability to the Health Insurance Exchange Marketplace

COHBE does not currently see this as being applicable.

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

The selection of quality measures is important, because current initiatives have shown that what gets measured gets the attention and improves. Any measure required by the state or federal exchanges for participation, or those measures required for reporting to consumers, will get the focus and will likely improve. To further the goals of the National Quality Strategy, the federal government should align metrics for reporting and participation while focusing on measures of patient safety, patient engagement, coordination of care etc.

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

COHBE believes that all the performance measures currently in common use are relevant to the Exchange marketplace including but not limited to those for chronic disease, prevention, satisfaction, use of services, and safety. If COHBE had to prioritize, it would look at measures for chronic disease, prevention and screening, medication management, care coordination and patient safety.

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

Specific satisfaction measures about the purchasing process, the service delivered by the plans for enrollment and any other specific exchange-type activity would be helpful. COHBE supports the development and testing of a Health Exchange Specific CAHPS survey. In addition, measures of patient engagement will be important for the population purchasing insurance through the exchange.

Given the regulatory environment and limits to MLR, COHBE would also recommend making MLR transparent for each health plan and gathering and comparing utilization and cost data, especially when consumers choose high deductible plans. There are currently gaps in standardized measures for cost and utilization. COHBE supports the development and use of these measures.

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?

Both the individual exchange and the SHOP exchange will bring the consumer to an unprecedented level of choice for purchasing health insurance. Consumers are not used to shopping for health insurance and don't yet know what is important, other than what it costs, how is the plan's customer service and that their provider is in the network. It will be incumbent upon us to find ways to gather and display data that will help consumers understand how the health plans are focused on quality and how that might impact the individual consumer. It would be helpful to have both global and general measures of quality for the consumer, as well as the ability to search and compare on specific measures and data that might be relevant to a particular consumer. For example, an individual might want to compare how potential health plans manage particular disease states and what sort of outcomes individuals in the plan with that disease might have.

It is also valuable to develop a strategy that considers special populations that will be served across the exchanges such as measuring care for those traditionally underserved, minorities, those previously uninsured, etc.

In addition, much of the "quality activity" today is not measured by today's performance metrics, including programs that are mandated in the ACA, such as innovative reimbursement models, efforts at coordination of care between settings and providers, etc. These are the programs that allow and indeed require the plans to demonstrate innovation. It is important that consumers have an opportunity to view these programs and therefore a narrative report with standardized questions and elements, including limited space for reporting, will be critical.

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 plans should be required to submit data to the Exchange, but there is also an opportunity to leverage data from other sources, including Meaningful Use, and possibly all payer claims databases in states that have them.

The information needs to be conveyed in an objective way so consumers have the ability to choose plans and do side-by-side comparisons.

Information must be available to consumers via many mediums such as the internet, mobile technology, and print. COHBE supports the consideration of requiring plans to make available quality metrics on provider level data that can be delivered and available to consumers at the point of care through mobile applications.

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)?

The Medicare Advantage Stars program is a good baseline for quality rating. Additional metrics need to be added to focus on women's care/pregnancy, children's measures, and an exchange-specific CAHPS survey. Quality results should be rolled up in to domains that are easy to understand, with the ability to drill down to individual metrics.

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?

Cost and quality should be displayed in exchanges. The federal government should review and call on the work of Judith Hibbard to display information in ways that is engaging and understandable for consumers. There needs to be the ability to compare across plans, link to external reference sites and sites for further information, link directly to programs for enrolled members, and of course fully accessible for low medical literacy, different languages, etc. There should be some sort of training program so navigators are well versed in the quality data and know how to direct consumers to appropriate programs after enrollment. Data must be available at point of care and wherever consumers may need to access the data.

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?

Quality information is typically difficult to understand for those not in the business. There needs to be a roll up that is comprehensive and understandable as well as the ability to drill down to specific individually meaningful measures.

The timing will be a problem. Because of timing issues, data will always lag behind what is reported to consumers by two years, assuming plans will have to report HEDIS data in the early part of the calendar year for which enrollment would start. The same problem exists in the MCare Stars program.

For this reason, COHBE would suggest that CMS/CMMI consider changing the schedule by which quality data is collected and consider asking NCQA to do the same for commercial health plans. For example, If HEDIS data was collected from 6/1/13 – 5/31/14, data collection occurred by 12/31/14 and was reported to NCQA in January 2015. Data could be reported to the exchanges in Q1 or Q2 2015 and available for open enrollment 10/15 leading to only a 15 month lag instead of two years. There is no reason that quality data needs to be collected on a calendar year basis. More concurrent data would be more meaningful to consumers and provide great accountability for QHPs. There would need to be some consideration however on the effects of an annual enrollment process on this - if the population from the later half of the year is significantly different from the population at the beginning of the next year, this would be a problematic strategy. Data from the first few years of the exchange should help us understand the turnover better.

13. Describe any strategies that states are considering to align quality reporting requirements inside and outside the Exchange marketplace, such as creating a quality rating for commercial plans offered in the non- Exchange individual market.

Colorado is not considering anything in this area.

14. Are there methods or strategies that should be used to track the quality, impact and performance of services for those with accessibility and communication barriers, such as persons with disabilities or limited English proficiency?

This topic is a critical aspect of the exchange. Enrollment data should include gathering information on this for both allowing the plans opportunities to meet their needs as well as the opportunity to track and trend.

For health equity, racial and ethnic minority status should also be requested on a voluntary basis and indirect data analysis can be used to predict status on those who elect not to report. R/E minorities are proportionally uninsured and should be well represented in the exchanges. Addressing the needs of these populations will be critical to reducing health disparities, a critical part of the National Health Strategy and National Prevention Strategy.

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?

The value question, both how to measure it and how to communicate it, is a critically important one that many are trying to address. The approach needs to be developed through a collaborative, transparent process that involves representation from all stakeholders. It needs to be based on what the evidence-based literature shows is most meaningful and effective for communicating to consumers and needs to be forward looking so it not only responds to what consumers believe provides value today, but pushes the envelope to help consumers understand what will be valuable in the future. There is no right answer to this yet; CMS could be central in developing an industry-leading approach.

Displaying and gathering information on VBP is important but there is no clear way yet to display the information in an objective format. This is where the narrative part of the display is most likely to come in. Requiring this information and displaying it will help drive more programs in this area for QHPs.