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SIGN-ON DRAFT

DUE June 18, 2012

Steve Larson
Deputy Administrator and Director
Center for Consumer Information and Insurance Oversight
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services

RE: Comments on "General Guidance on Federally Facilitated Exchanges"

Dear Mr. Larson:

We appreciate the opportunity to comment on the "General Guidance on Federally Facilitated Exchanges" released by the Center for Consumer Information and Insurance Oversight (CCIIO) on May 16. The [X] undersigned organizations represent a collaboration of leading consumer, labor, and employer organizations, committed to improving quality and affordability of health care through the use of performance information to inform consumer choice, payment and quality improvement.

It is important for the Federally-Facilitated Exchange program (FFE) to establish strong standards and operating principles. Currently only 13 states and the District of Columbia have either passed legislation required to begin developing a state Exchange, or have programs already in place that grant them "grandfathered" authority to operate an Exchange. Similar legislation is pending in 22 states, and 15 states have failed to pass legislation.[1] Given these numbers, there is a strong likelihood that an FFE will be established in a significant number of states to ensure that all Americans have access to a marketplace for purchasing affordable, comprehensive individual health coverage. **Thus, we are writing to urge HHS and CCIIO to strengthen the language in the FFE guidance to ensure that meaningful quality and cost information will be made available to consumers in time for the FY 2014 start date**. Doing so will not only send a signal that HHS recognizes the significance of providing information – from day one – on quality, together with cost, to help consumers make important health care decisions based on value, but will also be an important tool to contributing to the overall success of the Exchange.

[1] *Status of State Health Insurance Exchange Implementation,* Center on Budget and Policy Priorities, May 1, 2012, www.cbpp.org

Having information on quality and cost is not just critical for consumers. Through the *National Quality Strategy (NQS),* the *Partnership for Patients,* and myriad other efforts, HHS has expressed a strong interest in using strategies that will serve to align its public sector purchasing efforts with those being used in the private sector, in order to meet the three aims of better health, better care, and lower cost. The NQS 2012 Annual Progress Report to Congress describes how federal agencies, as well as state Medicaid agencies and departments of health, are embracing the goals of the NQS, and are tailoring their work to address its domains and priorities. We strongly urge the FFE to do the same.

Beyond the NQS Update, there are numerous examples of how private-sector purchasers and states (in their roles as purchasers for their Medicaid and public employee populations) are successfully using value-based purchasing strategies and proven improvement tools – such as the eValue8 survey to assess health plan performance – to save money and improve outcomes. These strategies all have one thing in common: the use of quality information to hold health plans to high accountability standards, drive quality improvements throughout the system, and encourage consumers to make decisions based on value. We urge CCIIO to align with these efforts and establish quality standards for QHP certification and quality reporting in the FFE guidance, to ensure that 1) consumers purchasing coverage through the FFEs have access to both high-quality health plans and to decision-making information that will ultimately drive improvement and reduced costs to the system; and 2) the FFEs leverage this historic opportunity to drive significant improvements in the overall health care delivery system.

Our comments focus on the two sections of the "Approach to Key Exchange Functions in a Federally-facilitated Exchange" Guidance related to the QHP Certification Process; and Accreditation and Quality Reporting.

QHP Certification Process

We believe that the certification process outlined in the Exchange final rule and reiterated in this guidance has enormous room for improvement in terms of setting a foundation for value purchasing by consumers. The guidance states that HHS will certify as a QHP any health plan that meets all certification standards, including licensure and good standing, network adequacy, inclusion of essential community providers, accreditation, and plan attestation. It goes on to say, however, that HHS will analyze the QHP certification process in future years and may make changes. **As this process is analyzed and refined in Phase Two, we urge HHS to consider adding the following requirements to the certification process:**

- Accreditation that reflects superior ratings of network adequacy and access, patient information programs, clinical quality, patient experience, utilization management, provider credentialing, and quality assurance. Note that we do believe that the accreditation processes designed by NCQA meet these criteria, and are pleased to see NCQA designated as an accrediting entity in

Phase One. Below, we provide additional comments on accreditation related to URAC, and to the Phase Two application process for new accreditation entities.

- Evidence of an issuer/product's emphasis on primary care, prevention, care coordination and use of shared decision-making by patients and providers;
- Evidence of issuer/health plan's use of both consumer incentives (e.g. value-based insurance design, evidence-based benefit design, reference pricing) and provider incentives (e.g. bundled payments, global budgets, quality-based payment); and
- Issuer/health plan's implementation of quality improvement initiatives, delivery system innovation, and reporting of detailed performance data by providers.

We believe that adding these criteria to the FFE process for QHP certification would not conflict with the FFE's alignment with individual states' governance of health insurance products.

Accreditation

We support the guidance's proposal that NCQA be a designated accreditation entity recognized in Phase One. We support URAC being a designated accreditation entity in Phase One as well, assuming it does release its "Health plan Accreditation Program 7.0" as scheduled, and that that program includes reporting on the CAHPS survey as well as a set of clinical performance measures. **For Phase Two, in which applications will be accepted from bodies wishing to be considered as Exchange accreditation entities, we urge HHS to establish high standards for what the accreditation process requires as it relates to quality and value,** including (as noted above) ratings of network adequacy and access, patient experience, patient information programs, clinical quality, utilization management, provider credentialing, and quality assurance.

Quality Reporting

While the primary goal of the Exchange is to organize access to insurance coverage for the millions of Americans who need affordable coverage, the development of these exchanges – both the federally-operated exchange and the individual state exchanges – provides a unique and critical opportunity to address the significant quality and affordability gaps that exist in today's health care delivery system. Our hope was that the FFE guidance would establish – if not a tested quality rating system that would be ready by October, 2013 – at least minimum standards for publicly reporting widely available quality and cost information at the health plan level. Doing so would not only make it possible for FFE consumers to have access to critical information, but would hopefully also set an example that state Exchanges would be motivated to meet.

Instead, the guidance states that in Phase One it will report the Consumer Assessment of Healthcare Providers and Services (CAHPS) patient experience survey, and otherwise use accreditation as a proxy for quality. In Phase Two (i.e. by FY 2017) HHS will develop a quality rating system for use by consumers along with the other comprehensive quality-related provisions required by the ACA. We recognize the

many demands placed on HHS and on states in getting the Exchanges up and running, as well as the complexity of developing the quality rating system that will convey quality and cost information in a way that is meaningful and usable by consumers, and we applaud the inclusion of the CAHPS data in the FFE's data collection and public reporting efforts. Publicly reporting patient experience data will provide consumers with critical information, particularly for those who are entering the health coverage market for the first time.

However, we question why the guidance states that FFEs will not display other available clinical data from the accreditation process, such as that afforded by the Healthcare Effectiveness Data and Information Set (HEDIS). **In the absence of quality rating system that could be publicly reported along with cost information, we urge HHS to reconsider this decision and include HEDIS data in its consumer support tools wherever possible.** Focus groups have shown that when provided with quality and cost information together, consumers are more to choose the highest quality plan they can afford, which can have significant ramifications for overall cost and outcomes.[2] HEDIS, which is collected as part of the NCQA accreditation process in 34 states, includes not just clinical measures, but also Relative Resource Use (RRU) measures that calculate the level of resources – including hospital stays, doctor visits, and drugs – used to treat patients with prevalent chronic illnesses that together account for over 50% of total health care spending.

For Phase Two, we recommend that HHS establish public reporting requirements for a standardized set of quality metrics – via the quality rating system, but with the ability to "drill down" to the specific measures – to ensure comparability across QHPs. All commercial QHPs, irrespective of product type (e.g. HMO, HMO/POS, PPO), and Medicaid QHPs should be required to report on the same measures in the same way. One tool that may be useful for HHS to consider when developing these requirements is the NCQA Physician and Hospital Quality Certification program (PHQ). This program, which has been in place since 2006, assesses whether a health plan uses a quality and cost measurement and reporting structure measures and reports the quality and cost of physicians and hospitals in a way that is standardized, uses sound methodology, is transparent, reflects collaborative practices, and provides information on both quality *and* cost. Currently over 60 health plans have been certified by this program.

In addition, we urge HHS to recognize the distinction between the CAHPS survey, which is a tool for collecting patient experience data, and the consumer experience survey of exchange members as required in the ACA. As noted above, we are strong supporters of publicly reporting CAHPS data as part

[2] "*An Experiment Shows That A Well-Designed Report on Costs And Quality Can Help Consumers Choose High-Value Health Care,*" Judith Hibbard, Jessica Greene, Shoshanna Sofaer, Kirsten Firminger, Judith Hirsch, *Health Affairs* March 2012 vol. 31 no. 3 560-568.

of the consumer assistance tools made available on exchange websites. However, we also urge the collection and public reporting of consumer experience data on individuals' experiences in accessing coverage, such as: 1) accuracy of eligibility and tax credit determinations; 2) effectiveness of the appeals process; 3) and accuracy, timeliness, effectiveness, and ease of access to consumer assistance via call centers, the Navigator program, etc.

Finally, the guidance states that HHS will seek stakeholder input on the most effective ways to align quality reporting and display requirements for QHPs in 2016 and beyond. We look forward to the opportunity to provide such input, but at the same time urge HHS not to wait until the development of the quality rating system is complete to begin reporting quality and cost information that is already available, in a way that meets the quality measurement requirements outlined in the Affordable Care Act. **Presenting the CAHPS and HEDIS data in an easily-understandable way through the web portal, phone, print and navigator-based tools should not be delayed until 2016.**

We envision a future in which Exchanges enable and encourage consumers to make decisions based on quality and value. Many consumers are not aware of the variations in quality or cost of care experienced in our current system. Without this information –and without the understanding of the role they can play in helping to improve the system – consumers may rely simply on cost comparisons to make their health plan decisions. The result may be lower quality care that, in the long run, costs more to the consumer and to the system. **By providing clear information on the importance of quality and cost to both the individual consumer's care and to the system, exchanges can play a role in improving quality and reducing costs across the board, contributing to the overall system transformation that the Affordable Care Act and other programs and initiatives were designed to achieve.**

The consumer and purchaser communities are eager to see FFEs and state Exchanges succeed, and recognize the myriad challenges they face in this endeavor. We welcome the opportunity to discuss our specific comments, and how they can be operationalized in a way that is feasible for HHS to pursue. If you have any questions, please contact either of the Consumer-Purchaser Disclosure Project's co-chairs, Debra L. Ness, President of the National Partnership for Women & Families, or Bill Kramer, Executive Director for National Health Policy at the Pacific Business Group on Health.

Sincerely,
[signators]