ConsumersUnion
POLICY & ACTION FROM CONSUMER REPORTS

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Centers for Medicare and Medicaid Services:

Consumers Union, the policy and advocacy division of Consumer Reports, submits the following comments on the Centers for Medicare & Medicaid Services (CMS) Request for Information Regarding Health Care Quality for Exchanges [CMS-9962-NC].

With the strong public concern about the cost of health insurance and health care, quality and safety concerns can be overlooked in implementation of the Affordable Care Act (ACA). Yet, the law recognizes that as a nation we must not simply cut costs or improve access, but also ensure high quality care - "Patient Protection" is embodied in the title of the ACA, after all. The Exchanges are the key new platform from which to launch the National Quality Strategy and to drive strong, meaningful quality measurement across all markets and industry actors—plans, hospitals, ambulatory surgery centers, physicians and other providers. Moreover, the Exchanges can help drive reduction of racial, ethnic and other disparities that continue to plague our health care system. While there will be variability among the states, a baseline should be developed to establish a minimum standard for each state with regard to quality and safety measurement. States would be allowed to go beyond that minimum standard, which should take into account the issues raised below.

Overall, we think the quality/safety reporting in the Exchanges should cover two categories of ratings or measures. First, we urge that Exchanges provide measures that inform consumers whether issuers are operating in a manner that would facilitate enrollees in getting the care they need, responding to complaints or appeals, and running a business that truly serves its customers; we call this *insurer quality*. Secondly, we recommend that Exchanges provide measures that inform consumers whether the health care providers within the insurers' networks are providing care of high quality and safety; we call this *provider quality and safety*. Our comments focus more on provider quality and safety.

Further, we segment some of our comments on the issue of measuring quality information into: (1) information to be collected (from Exchanges, insurers, providers, and consumers); and (2) how such information is displayed for consumers so that it is usable.

We strongly recommend for the Secretary not develop a new enrollee experience survey system to make available to Exchange consumers, but instead use and build on the existing survey platforms that currently provide information about health plans and health care providers. However, in order to address health disparities, issuers will have to collect patient demographic data as an essential precursor to measurement and reporting. Thus, we urge that Qualified Health Plans be required to, at a minimum, follow the HITECH Act meaningful use requirements for race, ethnicity and language data. We also encourage seeking more input from enrollees/patients about their health

care experiences by adding new questions, such as questions about medical harm and their experiences with Exchanges, as discussed below. For all consumer-facing measures, consumer testing is important to establish which measures consumers really value and will use.

INSURER QUALITY

This category should include measures such as adequacy of the health care provider network, response times for addressing complaints, fairness in appeals processes (with a measure indicating how many appeals of denial of care are overturned on appeal), adequacy of the insurer's health care provider network, linguistic access, and consumer experience with the plan and providers as indicated by the Consumer Assessment of Health Providers and Systems (CAHPS) survey. All participating issuers should be required to administer and submit CAHPS results, including CAHPS supplemental cultural competency and health literacy measures. The Exchange report to consumers on insurer quality should also include information from state insurance regulators regarding consumer complaints and actions taken against insurers as a result of those complaints and for violations of laws and regulations.

Consumer testing should be used to determine the most meaningful way of displaying summary data about insurer quality. Research to date suggests that consumers conflate insurer quality with provider quality, so clarifying those distinctions will be important. These should be put together in an easy to read format that is more likely to show variations among plans. Summary scores should be adjusted for "skewness" to avoid a clustering of scores at either the high or low end. For example, if stars or some indication of best to worst are used, displaying with at least five increments can avoid the majority falling within a meaningless middle rating. Further, , information should be displayed graphically, such as in bar charts, with underlying data available in online versions of the report.

HEALTH CARE PROVIDER QUALITY AND SAFETY

Initially, measures should be pulled from already publicly available sources within the state and federal government. As new measures are added, they should be folded into the reports to consumers. Most of the measures mentioned below are currently reported on Hospital Compare. Some states may have more public information than others, and in those states, Exchanges should use the data available in the state. On a national scale, numerous existing measures could be easily used to inform consumers about the quality and safety of an issuer's network. Again, we recommend consumer testing to determine the most meaningful way of displaying summary data about provider quality and safety. These consumer-facing measures should be in a consumer-friendly format and made available on interactive websites, as well as in print form upon request. All underlying data about the measures should be available online to drill down to for those consumers who want more detail.

We strongly recommend providing outcome measures whenever possible, as process measures do not give consumers meaningful information on health care provider performance. Process measures should only be used when they can be strongly linked to outcomes and any process measures used should be retired once there is evidence of widespread adoption of the practices. HEDIS, for example, continues to report on practices that, while once not widely used, have become standard practice and therefore no longer seem needed to shift to "best practices" nor are informative about variation in quality of care. CMS has recently decided to remove some process measures in which all providers have achieved close to 100 percent compliance.

We also recommend including patient experience with providers from HCAHPS surveys in this group of quality measures. In the area of safety, we encourage HHS to begin developing patient experience survey questions that specifically ask questions about patients' experiences with medical harm, such as whether they got infections or experienced medical or medication errors. There is a good deal of evidence that these events are significantly underreported by hospitals, and tapping into patients' experiences in a standardized way could enhance the picture of provider safety.

Specific responses to several of the questions in the RFI follow.

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

Since the national focus is on attempting to further the National Quality Strategy goals, measures should align under each of the goals and should be reported to consumers under these categories, with underlying data available online. This should not take years of discussion – simply begin fitting existing measures under each of these goals and do the same with new measures as they are rolled out. To reiterate, we recommend using outcome measures rather than process measures because we believe these more accurately reflect provider and plan quality, and are more meaningful to consumers. Below we have attempted, by way of example, to identify existing measures well-suited to evaluating health care providers' success at meeting established goals. We also identify where new measures are needed.

- NQS GOAL: Making care safer by reducing harm caused in the delivery of care.
  Existing:
    - CMS Inpatient Prospective Payment System (IPPS) 30-day readmission rates and for heart attack, heart failure, and pneumonia
    - Hospital-acquired infections - this should include all measures as they become available; the measure list is growing with a phased-in schedule. This will be a source eventually for safety information from non-hospital providers such as outpatient surgical centers and dialysis centers.
    - HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) Survey composite scores on: Communication about medicines (questions 16 and 17) and discharge information (questions 19 and 20)

- Inappropriate Outpatient imaging - how often a hospital provides specific imaging tests for Medicare beneficiaries under circumstances where they may not be medically appropriate.
- CMS IPPS 30-day death (mortality) rates for heart attack, heart failure, and pneumonia
- Other complications measures published pursuant to CMS IPPS regulations (currently these include hospital acquired conditions and certain AHRQ Patient Safety Indicators)

Needed:

- Outpatient surgery center measures, the same as for hospital facilities as appropriate, or other relevant safety measures such as subsequent admission to hospitals.
- Measures indicating medical errors that occur while patients are hospitalized; current measures should be expanded and enhanced with more information than provided by hospital acquired conditions, which only cover Medicare patients. Studies showing that at least one in four patients is harmed while hospitalized warrant significant work in this area.
- Safety measures for physicians should be developed. This could begin with information from state medical boards and the National Practitioner Data Bank, which holds significant data on problem physicians that should be available to consumers. In a 2011 Consumer Reports national survey, almost 9 in 10 consumers (88%) said the public should have access to federally collected information about problems with doctors.
- Measures that indicate whether handoffs between providers relay information about errors (such as serious bedsores or falls) and infections, paired with whether the patient is subsequently readmitted.

- NQS GOAL: Ensuring that each person and family are engaged as partners in their care.

  Existing:

  - HCAHPS Survey question: Nurse communication (questions 1, 2, 3, 4) and doctor communication (Questions 5, 6, 7)
  - CAHPS Clinician and Group Surveys on Patient Centered Medical Home

  Needed:

  - More measures to assess patient-centered care. Generally, these should rely primarily on patient surveys – as an advocate who works with our Safe Patient Project aptly noted: "Only recipients of care get to declare if the care was Patient-Centered."
  - Public display, again by race, ethnicity and primary language, of whether hospitals and their providers meet the core criteria for "meaningful use" under the HITECH Act.

- NQS GOAL: Promoting effective communication and coordination of care.

  Existing:

  - HCAHPS questions: Nurse communication (questions 1, 2, 3, 4) and doctor communication(Questions 5, 6, 7); discharge information (Questions 19 and 20)

- CAHPS Clinician and Group Surveys contain numerous questions about communication in the non-hospital setting; these should be tapped for assessing communication and coordination.

Needed:

- More measures are needed to assess coordination of care. Questions regarding the hospital hierarchy (often a barrier) and specific team-oriented care would be helpful. Also, questions and assessments about handoffs to other providers such as rehab facilities or nursing homes are needed. These should be outcome based whenever possible or directly linked to outcomes – for example, a measure could include readmission information paired with process measures regarding handoff procedures.

- NQS GOAL: Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
  Existing:
  - CMS current 30-day death (mortality) rates for heart attack, heart failure, and pneumonia
  - CMS 30-day readmission rates for heart attack, heart failure, and pneumonia
  - Several NCQA prevention measures may fit under this category

Measures are needed for the remaining two goals, but we have a few comments regarding these goals: "Working with communities to promote wide use of best practices to enable healthy living" and "Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models." Measures for the latter goal could be addressed by adding an "affordability" question to existing enrollee surveys, like CAHPS. Further, to the extent that these "new delivery models" are allowed to report different quality measures than other health care provider models, creating a comparable quality/safety report to consumers will be hindered.

And, in addition to furthering the National Quality Strategy, the quality reporting requirements for the Exchange should also seek to further the goals of the National Stakeholder Strategy for Achieving Health Equity[1], the National Prevention Plan[2], Healthy People 2020[3], and the Action Plan to Reduce Racial and Ethnic Health Disparities[4]. Without holistically considering how to achieve the important goals of these national plans/strategies in the context of Exchanges, we will miss a golden opportunity

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[1] U.S. Department of Health and Human Services, *National Stakeholder Strategy for Achieving Health Equity* (2011): http://minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=286

[2] U.S. Department of Health and Human Services, *National Prevention Strategy* (2010): http://www.healthcare.gov/prevention/nphpphc/final-intro.pdf

[3] U.S. Department of Health and Human Services, *Healthy People 2020*: http://www.healthypeople.gov/2020/about/disparitiesAbout.aspx

[4] U.S. Department of Health and Human Services, *Action Plan to Reduce Racial and Ethnic Health Disparities* (2011): http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

for gathering more robust, comparable information to drive systemic improvements and establish a truly concerted, national effort for improving our nation's health and well being.

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

In addition to the suggestions in question 5 above, we want to highlight a specific set of measures we believe are essential to provide to Exchange customers: maternity-related measures. Maternity care is high-cost constellation of services, as recognized by the Summary of Benefits Coverage example aggregating an "average maternity cost." Pregnancy presents the opportunity for longer term planning than many other medical conditions, and consumers in the Exchange population would welcome a clear presentation of issuer/provider quality performance on maternity measures, as well as the cost information afforded by the Summary of Benefits Coverage. Since the availability of these quality measures currently varies by state, the reports should include all that is available in the state, such as cesarean-section rates, infections related to c-sections or vaginal births, and early elective delivery before 40 weeks (completion of the 39th week of gestation). The National Quality Forum (NQF) has endorsed the latter measure and many groups have acknowledged it as an important measure of quality (e.g. The Joint Commission, the LeapFrog Group, March of Dimes, AHRQ). This is a process measure that we support because it is closely linked to outcomes.

Furthermore, reports to consumers should include information about disciplinary and corrective actions taken by state licensing agencies regarding hospitals, doctors and other relevant providers, e.g. how many times a hospital has been sanctioned (especially for safety concerns) and how many times the state medical board has taken adverse action regarding a physician's license. These are key elements of quality and safety and the Exchange offers an opportunity to put this oft hidden important information before consumers. Ideally, this information would be presented in the website quality report; at a minimum, the Exchange should provide a direct link to the regulator sites where consumers can look up information about health care providers. A 2011 Consumer Reports national survey found that only one-quarter of respondents (26%) said they would know where to file a complaint about a medical error they experienced at a hospital. New York's hospital profiles website provides an excellent example of bringing all information about a hospital together and allowing comparisons among hospitals. The New York Profiles include complaints and regulatory actions under the "surveillance" tab.

We have recently read that CMS and private health plans are considering sharing with each other the names of providers they have suspended under CMS' "Center for Program Integrity." These efforts are aimed at cutting back on waste, fraud and abuse. However, consumers must not be left out of the equation. Any provider suspended by CMS or a private insurer should be flagged in the Exchange information that is available to consumers. The Exchange offers a "one stop" opportunity for consumer information that is generally hidden except from all but the most tenacious consumers.

Question 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?

As stated above, quality improvement strategies should be based on outcome measures and should build on useful, current measures including elements that explicitly identify and address health disparities. If priorities must be made, our preference is to begin with safety measures, since provider changes in behavior can be fostered by public reporting and in many cases can save lives. Also, consumers readily understand the relevance of this information and studies and surveys have shown they value safety information.

We do not see any value in narrative reports to assess quality improvement strategies. These types of reports, without quantitative measures, are vague, subjective and are often used to evade close scrutiny about outcomes. If made consumer-facing, narrative reports would likely just be confusing.

Question 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

Consumers are very interested in **provider** quality and would benefit from provider-specific measures, as well as summary measures that assess the overall quality of a plan's network, using evidence-based outcomes measures, as described above. We also strongly recommend one or more insurer quality measures of network adequacy, accounting for not only provider quality, but also time-quantified and geographic access, access by new patients, and affordability of out-of-network services (not captured by actuarial value measures).

Consumers would also benefit from trust-worthy measures of the "consumer friendliness" of issuers, such as those elements contained in CAHPS surveys, but they may need some guidance on using measures of this sort. In addition, measures should be equally accessible for and inclusive of plan members with limited English proficiency, with lower health literacy, and with disabilities.

As described above, it will be important to distinguish *insurer quality* from *provider quality and safety*. While these two quality categories are inter-related, and provider characteristics are found in CAHPS, a particular provider can also be in more than one issuer's network.

We are still early in the evolution of evidence-based, consumer-tested measures—perhaps too early for any clear definitive "best practices." We urge a federal commitment to conducting additional research about the best methods of conveying this critical information to consumers in a usable and actionable fashion.

Question 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?

The number one methodological challenge to reports to consumers on quality and safety is that of ensuring the accuracy of the information behind the reports. While failure to validate should not be an excuse to withhold quality and safety information, reports must aim to incorporate a reliable validation component into every measurement effort. Reporting of health care-acquired infections in some states has provided a model for validation recently issued by CDC that removes subjectivity and returns to the underlying patient records as a check on reporting. Early efforts at hospital infection validation revealed significant underreporting by providers and studies have found self reporting by providers to be inaccurate.

We believe that data from hospital billing or administrative records are an untapped source for quality reports. IN the past these records have been used for various reports to consumers, however, there has been much criticism about using this data. Further, generally national reports that are provider-specific include only Medicare patients and national reports that include all patients are only provided in by state aggregates, which are meaningless to consumers and providers alike. It is time for AHRQ to end agreements with states that prevent provider-specific data from being published. For decades, providers and researchers have designated this information as inaccurate and often successfully halted meaningful use of the data within these records. There should be a national effort, including validation, to ensure that this data is accurate for numerous reasons:

- For decades this data has been used to assess quality, it is not simply used for billing.
- It is a rich source – our only readily accessible source – of information relating to each patient's stay in a hospital and should be accurate.
- Inaccuracies on these records represent a form of fraud – both for billing and for accuracy in reflecting the same information as is provided in the patient records relating to diagnoses and treatments.

Differing definitions amongst various data sources is also an ongoing challenge in quality reporting, but one that we can overcome. Recent state statutes mandating health care-acquired infection measure reporting, for example, have rested on use of CDC's National Healthcare Safety Network (NHSN), allowing for a uniform set of definitions and a streamlined mechanism for reporting. Once a national health care-acquired infection reporting program was ready to begin, that standardized system was solidly in place. We suggest that a national "floor" for measures be based on those currently available through federal programs such as Hospital Compare and IPPS measures. States collecting more information from health care providers and insurers should be encouraged to go above and beyond that floor in their reports to consumers. Calculation of any composites or "value" scores should be clearly explained and the underlying data should be available.

We note that different people seek different information, and different levels of detail. We thus recommend that Exchanges provide quality information in various formats, with

an interactive website that allows consumers to link to and drill down to the underlying data and to compare various plans.

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?

Calculating the value of health plans (inside and outside of the Exchange) should continue to align with the goals of the National Quality Strategy (NQS). We recommend composite measures, with clear definitions and access to the underlying measures and data making up each composites score available online. Many consumers will want to simply view a composite because they have difficulty interpreting too much information; others will have specific interests or be innate researchers with high tolerance for and interest in the underlying components of the composite. The latter group could then drill down for more detail.

We recommend composite measures for at least the following categories:

1. Insurance plan issues, such as those under "Insurer Quality" above.
2. NQS safety measures.
3. NQS person and family engagement.
4. NQS communication and coordination of care
5. NQS prevention and treatment practices for the leading causes of mortality

We appreciate the opportunity to comment on this Request for Information. For questions, please contact Lisa McGiffert (lmcgiffert@consumer.org) or Betsy Imholz (bimholz@consumer.org).