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Center for Medicare and Medicaid Services
Department of Health and Human Services,
Attention: CMS-**3288–NC**
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Submitted via http://www.regulations.gov

Comments of Consumers Union
CMS–3288–NC: Patient Protection and Affordable Care Act;
Exchanges and Qualified Health Plans, Quality Rating System (QRS),
Framework Measures and Methodology
January 21, 2014

Consumers Union, the policy and advocacy division of Consumer Reports, appreciates the opportunity to comment on the notice entitled "Patient Protection and Affordable Care Act; Exchanges and Qualified Health Plans, Quality Rating System (QRS), Framework Measures and Methodology." We understand that this is a first step in providing a framework for development of measures to enable consumers to choose among the Qualified Health Plan (QHPs) products offered in health insurance Marketplaces. The stated goals are two-fold: to help consumers make sound choices based not simply on price but also on overall "value" that encompasses quality, and also to facilitate regulatory oversight of QHP quality. We also appreciate CMS' ongoing commitment to expand and improve the assessment of the quality of health plans and their provider networks.

We strongly agree with the approach to base the QRS on consumer experience, health care outcomes, and cost of care, as stated in the Background section. We also acknowledge that good outcome and other measures are currently inadequate and will need development. CMS has made headway in developing provider measures, for example improving readmission measures to cover both all cause hospital-wide readmissions and measures broken out by procedure. Similarly, CMS can and should play a leadership role in improving plan quality measurement. Due to the lack of outcome measures, consumer experience measures are especially critical. In addition, studies have shown that consumers highly value patient experience measures about health plans.[1]

While we appreciate that limitations in available data circumscribe some possibilities in the QRS currently, Consumers Union believes that more is currently available than is captured in the proposed framework. Below, we suggest how the QRS could be enhanced both now and in the future to work better for consumers.

[1] See, e.g., http://dvha.vermont.gov/administration/best-practices-in-reporting-quality-report.pdf

Emphasize Outcome Measures

It is well established that process measures are not as valuable as outcome measures, particularly when measuring provider performance. However, most of the clinical measures appear to be process, rather than outcome, measures. CMS can play a vital role in health status improvement by ensuring that more and better outcome data is collected and folded into the QRS.

A key area where outcome measures can be augmented is with respect to the patient safety domain.

Safety Measures Should be Added and Enhanced

The opportunity, at long last, to engage consumers in thinking about and using quality and safety information is upon us. This will be of particular importance to the many people in the exchanges who have chronic conditions and who will likely be choosing a plan based on the quality and safety of its providers. Multiple studies and Consumers Union's own experience indicate that patient safety information is of great interest to consumers making health care decisions.[2]

We applaud the proposal's indication that patient safety is a CMS priority and understand that you intend to develop the domain in the future. Yet, there are just two safety measures proposed ("all-cause readmissions" and "monitoring for patients on persistent medications"). We believe that there are individual measures that could easily be added to the health plan safety domain now to give consumers a fuller picture of the safety of a health plan's network. For example, hospital infection rates, infection mortality rates, and certain maternity measures are readily available.

Moreover, these measures and others already collected and reported could easily be pulled into composite safety scores. Components of such a composite score could include, for example, Hospital Compare measures on hospital-acquired infection and mortality rates, and information that plans hold regarding rates of C-sections and early elective deliveries – two measures that are widely accepted as indicators of safety, the latter supported by a wide array of diverse organizations such as the March of Dimes and the American Hospital Association.

We also are concerned that there are no patient safety scores in the child-only QRS structure. This needs to be addressed as soon as possible. We suggest at least adding an "all cause readmissions" score for the child-only QRS, similar to what is proposed for the adult Patient Safety domain.

[2] See, e.g., "Looking for Answers: How Consumers Make Health Care Decisions in Massachusetts," a survey for Blue Cross Blue Shield of Massachusetts (April 2007). In this study, from an array of quality and cost information questions, consumers rated the infection rate of the hospital as most important.

If this safety information cannot be added now, such measures should be added as soon as possible. In the meantime, health plans and the Exchanges should at least be required to provide prominent links to existing CMS quality sites where consumers can look up the infection and mortality rates and other measures of their health plan's providers. We urge CMS to see this as an opportunity to introduce the Hospital Compare and Physician Compare websites to a whole new group of consumers who may not even know this information is available. Particularly in locales in which product designs are more standardized and premium prices less varied, quality and safety measures become critical as differentiators.

Measures Indicating Consumer Cost Should be Embellished

Consumers care very much about the cost of health insurance and the cost of using services once they are enrolled. As with patient safety information, cost information is good way to get consumers to begin thinking about value.

While the background discussion notes the importance of cost information, currently there are no meaningful cost measures in the notice. The framework includes one measure that evaluates how well a plan informs its members about the cost of treatment. The CAHPS "Plan Information on Costs" referenced in the QRS' "Plan Service" domain reflects responses to two questions: "How often were you able to find out from your health plans how much you would have to pay for specific medicines?" and "How often were you able to find out from your health plan how much you would have to pay for a health care service or equipment?"

We support including this measure, but it is a narrow one that does not send a strong cost signal to the consumer. In order to get consumers to use quality data and shop based on value, they must have readily accessible summary measures on costs.

We strongly recommend that the framework establish and provide a summary measure of *all* out-of-pocket costs, reflecting the cost-sharing provisions of the plan and measured across the Essential Health Benefits. This summary measure could be derived actuarially, based on the cost-sharing provisions of the plan but should be denominated in dollars (not an AV percentage), so that it can readily be interpreted by the consumer.

As soon as possible, a composite measure or other consumer signal should be developed that makes it easy for consumers to understand how to weigh summary information about out-of-pocket cost, provider and plan quality, network adequacy and premium, in order to assess value.

Add a Robust Measure Of Network Adequacy

The key measure missing from the high level approach proposed by CMS is a summary measure of network adequacy. In addition to paying claims, responding to complaints etc., health plans have a core responsibility to create a sufficient network of high quality providers so that enrollees can access needed services on a timely basis, including specialty care. While the proposed approach includes some retrospective CAHPS access

measures that would indicate past network adequacy, if these measures are not at the product level they tell us nothing about how broad or narrow the specific product 's network is, nor do they convey in summary form the quality of the providers that are actually in the plan network. Much more robust consumer signals are needed.

With narrower networks increasingly being used as a premium-control measure, network adequacy becomes an even more important piece of quality information. State regulators have responsibility for overseeing network adequacy standards, but Exchanges bear a responsibility to give consumers a clear sense of the availability of providers for their products. We urge providing this network adequacy measure at the product level, since within the same plan a network at the platinum level may be far more generous than at the bronze level, which is one reason the plan was able to offer the lower premium at the bronze level.

Ensure Meaningful Measures on Cultural and Linguistic Competency

Capturing data by race, ethnicity and primary language spoken is foundational to tracking access by and adequate health care to communities of color, many members of which do not speak English or have limited English proficiency. In some states, such as California, these populations comprise a very substantial percentage of the subsidy-eligible population. We urge CMS to require plans to collect data in this manner in support of CMS goals to promote equitable access and improved population health.

We strongly support your proposal to use the CAHPS Cultural Competency measure set for both the QRS and Child-only QRS. We understand it primarily addresses the important issue of access to interpreters. We urge that CMS require Marketplaces to use the certified Spanish translation of the survey and provide certified translations in other non-English languages as well.

Additional measures that would be important for non-English speaking consumers include availability of plan forms, websites and phone service in the language relevant to them.

Ensure Measures for People with Disabilities

We do not see any QRS measures geared to consumers with mobility and sight impairments in the notice, although we understand that CAHPS has some questions along these lines. Access to both plan and provider services for consumers with these impairments is critical to the adequacy of networks and value of the plan to them.

Allow for a Range of Meaningful Measures, and for States to Go Further

Consumers Union supports having the QRS measures go beyond those adopted by National Quality Forum, as proposed. While 76% of the proposed measures are those adopted by NQF's deliberative process, other measures tested and accepted by CMS, in the states, and by private sector efforts are worthy of inclusion. For example, we suggest inclusion of a measure for outpatient imaging overuse, as shown on the CMS Hospital Compare website. Consumer Reports has also chosen to include that measure

in our hospital ratings as a valid indicator of inappropriate use of resources. See p. 38, "Abdominal and Chest CT Scan" in description of our hospital ratings. http://www.consumerreports.org/health/resources/pdf/how-we-rate-hospitals/How%20We%20Rate%20Hospitals.pdf

Furthermore, we urge that CMS allow flexibility for state Marketplaces to go farther if their QRS development is at a more advanced stage. For example, in California a great deal of work has gone into developing sound quality measures, including a requirement that QHPs complete portions of the eValue8 Health Plan RFI module on cultural competence and disparities reduction. These innovations should be encouraged.

Make Domain Names and Groupings More Intuitive for Consumers

Consumers Union strongly supports the need to maximize the "approachability and understandability" of the domains. To that end, we suggest some adjustments to the proposed groupings and labels to make them more intuitive for consumers. The summary indicator "Plan Efficiency, Affordability and Management" sweeps several different topics into one bucket. We recommend disaggregating them, and some rearrangement and re-naming.

First, we urge CMS to remove the word "Management," which may be confusing to consumers. Secondly, the domain sub-part "Plan Service" should be moved to the "Member Experience" summary indicator since it is based on a composite of "Member Experience with Health Plan" measures (encompassing CAHPS customer service score, global rating of health plan by the member, and plan information on costs score, as reported by members). Keeping most CAHPS measures in the "Member Experience with Health Plan" indicator would allow consumers to access that information easily, and make clearer that this summary indicator currently labeled "Plan Efficiency, Affordability and Management" is based on objective evidence.

In addition, in that same summary indicator and one domain thereunder, we recommend not using the word "efficiency." It could be interpreted in many different ways, and has negative connotations for many consumers as prioritizing cost over quality and access to needed services. Similarly, "affordability" does not seem to be the right word for what this indicator is intended to convey. Consumers think of "affordability" as evaluating whether something is within their means. We do not see how the stated measures indicate affordability for consumers and thus suggest deleting the word. We suggest labeling the summary indicator and domain something like "Appropriate Care and Good Value" to more clearly indicate what is covered without engendering misimpressions or negative impressions. The best way to ensure getting the words right, of course, is by testing them with actual consumers—a step we highly recommend.

Develop New Measures Where Lacking

Consumers Union supports your suggestion to develop a QRS applicable to other Marketplace offerings in addition to one for full QHPs, including stand-alone dental plans. This would be a major innovation that would aid consumers spending their scarce resources for additional coverage.

In addition, we recommend including in the QRS under an efficiency or value domain (however denominated) a measure of health care cost and resource use. For example, CMS should consider using the NQF-endorsed "Total Cost of Care" and "Total Resource Use Index" measures developed by HealthPartners. These measures are aimed at pinpointing ways to make health care (in contrast to health insurance) more affordable without sacrificing quality or consumer experience. When used in combination and with other quality indicators, these measures can yield more comprehensive and revealing results than cost measures alone. Combined with other quality measures, they can give consumers an idea of how plans manage their resources to provide the highest quality along with a responsible use of clinical resources.

Summary Measures Should Be Augmented By Additional Detail and Fixed Cut-Points

We support the use of rolled-up, global ratings and summary indicators for each QHP as they are important for consumers who are looking for a quick overview of health plan quality. Summary measures reduce the cognitive load for consumers and increase the likelihood that they will use the information.

However, global ratings alone are not enough. We support providing these ratings in a way that allow consumers to view the specific measures on multiple levels, including drilling down to each individual measure—for example, displaying the global rating next to product cost on the plan choice web page with the ability to click through for more detailed breakouts. Also, the ability to sort specific measures by plan would allow consumers to zero in on performance topics that are most important to them. For example, an enrollee with behavioral health family concerns, would be best served by being able to put plans side-by-side to see which does the best job on behavioral health topics.

We support breaking out summary ratings over a wider range of "scores" to show differentiation. Too many of the current CMS ratings use a 3-star scale that puts all but a few providers in the "average" or middle category which fails to provide consumers with enough basis to distinguish among them. In addition, cognitive research has shown that stars may not be the best way to visually engage and send the right signals to consumers. Consumers Union urges CMS to adhere to the most current research and best practices in displaying the data, and to provide another open comment period when you develop the final calculations and display.

Moreover, Consumers Union recommends the use of fixed cut-points (developed with clinically-relevant and/or measure-specific targets in mind) for individual measures, rather than using the average to benchmark the ratings. For example, using the "average" as a benchmark will result in misleading ratings (plans rated higher than they should be) in cases where the mean performance of a measure is low. By fixing the ratings to a standard, consumers and plans will be able to interpret the ratings in a more meaningful way, plans will be incentivized to do better, and overall quality and health status is more likely to improve. For a description of the cut-points Consumer Reports uses in its plan ratings, see http://www.consumerreports.org/health/resources/pdf/how-we-rate-hospitals/How%20We%20Rate%20Hospitals.pdf

Do Not Permit Methodological or Logistical Issues To Unduly Limit Public Data

While Exchange product-level quality data is an important ultimate goal, this should not be over-emphasized. QRS data, like all quality data, will always be "historical" both due to time lags in data collection, because the population measured is ever changing, and because QHP products may vary from year to year. The Exchange population is not a static cohort; someone who is in the Exchange today may be Medicaid-eligible or employed with job-based coverage tomorrow. Also, QHP products may vary from year to year.

The notice explains that summary scores will not be publicly displayed when a plan lacks certain information in the measures making up the composite score. This could become the exception that swallows up the rule. For such plans, alternative quality ratings must be developed, such as having all individual measures publicly displayed and downloadable. In fact, all the QRS data-- the scores that make up the composites, the composites, and the final scores-- should be released to the public in a downloadable form on data.gov.

Further, we recommend a clear "low enrollment" notation in the public report when composite ratings are not available because the plan has too few enrollees to provide sufficient quality information – low enrollment may be an important issue for some consumers in choosing a plan. In addition, validation of the data is extremely important to assure the public that these are reliable and accurate reflections of the plan's quality. We understand that CAHPS and some other measures are audited, and urge auditing all data that goes into the QRS scores and measures.

Provider Level Information Should be Available as Quickly As Possible

The comment indicates that, "We believe it's important that measures, in the initial years, be specified for health plans (rather than specified for health care providers) to ensure reliable data, reduce QHP burden and facilitate consumer use and comprehension."

While health plans have a responsibility for creating networks of high quality providers-- and thus assuring the quality and safety of the care given by their hospitals, physicians and other caregivers-- consumers are very interested in provider level information for providers in their health plan's network.[3] We strongly recommend rapid movement towards provider level information that is available for consumers who want to "drill down" on the summary measures.

[3] http://dvha.vermont.gov/administration/best-practices-in-reporting-quality-report.pdf

Conclusion

Consumers Union offers these comments based on our experience, but the best way to find out how consumers interpret certain language and react to displays of quality measures is to test alternate displays with consumers. We, therefore, urge CMS to undertake consumer testing with an array of consumer audiences, including those with lower incomes, and thus subsidy-eligible, and with those for whom English is not their primary language. However, this testing should not delay the use of QRS measures. Instead, we recommend that the testing of the consumer-facing form of the quality measures be tested concurrently with the final measure development. Once the high level domains are known, presentation to consumers, as well as drill down options can be tested.

On behalf of Consumers Union, I thank you for the opportunity to comment on these important regulations and would be happy to answer any questions.

Sincerely,

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