December 26, 2012

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–9962-NC
P.O. Box 8010
Baltimore, MD 21244–8010
(Sent electronically to http://www.regulations.gov)

Re: Request for Information regarding Health Care Quality for Exchanges (CMS-9962-NC)

Dear Ms. Tavenner,

On behalf of over 220 member children’s hospitals across the country, the Children’s Hospital Association (the Association) appreciates the opportunity to comment on the questions posed in the Request for Information regarding Health Care Quality for Exchanges. We join with our colleagues in other organizations advocating for maternal and child health in our belief that the Affordable Care Act (ACA) offers tremendous potential to improve the health of and quality outcomes for mothers, infants and children. The Association applauds the efforts of the Centers for Medicare and Medicaid Services (CMS) to initiate public discussion on advancing quality measurement in the Exchanges, and we appreciate the outreach to numerous stakeholders by HHS for input on how best to foster and support quality measurement and improvement across the insurance marketplace. We further appreciate the alignment with the National Strategy for Quality Improvement in Health Care. We believe this alignment will promote effective quality measurement while minimizing the burden of data collection and enabling comparability across health plans, providers and insurance markets.

The Association believes that it is imperative that measurement of and reporting on health care quality address all of the patient populations included in the Exchange. There are major opportunities to improve the health and the delivery of health care to children across the United States. Quality measurement provides the tool to assess current care by identifying and closing gaps.

Quality measures must be available and balanced across all of the priority areas outlined in the National Quality Strategy in order to provide robust information to support decision-making. For pediatrics, this means that important efforts to address the gap in
pediatric measures be continued and expanded, including measures that address the needs of children with special health care needs and complex conditions.

Children’s health care presents distinctive challenges for quality measurement. All efforts to measure quality should take into account the unique features of child health and health care and should recognize the importance of pediatric development, dependency, demographics and disparities. Those who develop and use pediatric measures should address the differential epidemiology in children as compared with adults and incorporate patient and family participation in their development and implementation efforts. Measures of patient/family experience with care should be prominent and carry substantial weight. In addition, non-condition-specific measures are needed (e.g., coordination of care for children with special health care needs) because of the relatively small numbers of children with any single condition.

The Pediatric Quality Measurement Program (PQMP) established through the Children’s Health Insurance Program Reauthorization Act (CHIPRA) is the first significant national investment in pediatric quality measurement, and it has made considerable strides forward through identification of the Initial Core Measure Set and through its current efforts to develop additional measures on critically important areas through the PQMP Centers of Excellence, six of which are housed within children’s hospitals. Measures used to monitor and report on quality within the insurance marketplace should draw upon this resource, and funding of the PQMP must be continued following the expiration of the CHIPRA provisions.

The Association’s responses to the specific questions included in the request for information are included below.

Understanding the Current Landscape

*Question 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?*

The Association is aware of a handful of strategies being used by insurance issuers to drive quality improvement. Insurers and providers are testing a range of payment strategies, such as payment bundles, and we look forward to continued efforts to build the evidence base around the effectiveness of various approaches. Many plans have provided patient education materials that reinforce messages being delivered by health care providers around specific issues, including prevention and wellness. More recently, insurance issuers have shown increased interest in assisting insurance issuers to access quality improvement tools, such as toolkits and checklists developed by professional or consumer organizations.
With regard to health outcomes and wellness, input from Association members noted strategies such as annual EPDST audits for well child screening and care. One hospital reported that all payers in its marketplace have policies and procedures for disclosing hospital acquired conditions and harm resulting from hospital-based care, including financial consequences for the provider. Although many health insurance issuers and plans may have strategies in place for preventing hospital readmissions, we are not aware of issuers that have structured programs for preventing readmissions in pediatrics.

**Question 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?**

**Challenges**

Historically and currently, the focus for measure development has coincided with funding sources (i.e., Medicare). As a result, the lack of a robust set of measures appropriate for assessing the quality of care provided to children presents a significant challenge to tracking quality improvement over time consistently across issuers, plans and states for the pediatric population. Measures that are available for the pediatric population are somewhat heavily focused on prevention and well-child care. For example, over half of the initial set of 24 recommended children’s measures for the Medicaid and CHIP program released in December 2009 relate to prevention and health promotion. Although these measures are clearly important, Exchanges need to report on measures across all care needs, including prevention and wellness, acute care, chronic care, and end of life care.

Moreover, there is not a national infrastructure, such as QualityNet to standardize data collection and reporting on pediatric measures. Investment is needed to create platforms and other mechanisms for measure application and reporting at the state, hospital, and health plan level.

In the Medicare program, increased focus on quality and, with that, development of measures suitable for adult populations, has evolved over 40 years. In the absence of pediatric specific measures, some plans and payers are starting to apply measures developed for adults to pediatric populations. Because the epidemiology and etiology of illness and, therefore, evidence-based guidelines differ in children as compared to adults, adult measures cannot simply be assumed to apply to children. Doing so may result in unintended consequences, including worse outcomes for children. This is true even for adult patients seen in children’s hospitals due to certain illnesses. For example, some of the clinical quality measures for meaningful use of Health Information Technology (e.g., certain stroke measures) are not consistent with recommendations for patients with sickle cell disease. When implementing measures designed for most adults to prevent venous thromboembolism, a potent anticoagulant could be inappropriately ordered for a patient receiving care in a pediatric facility due to a congenital illness.
Causes and prevention strategies must be understood for the population to which the measure is being applied and must be appropriately risk adjusted.

Even in adult populations, there remain gaps in the availability of measures. A notable example is the lack of sound cost/value measures. It is critically important that decision making solely based on cost be avoided. Quality metrics must support decision making based on both quality and cost and represent all populations served through the exchange.

A major obstacle to measuring quality improvement over time, especially in areas with high managed care penetration, is that data are often not collected in the same manner as in fee-for-service plans. When capitation payments are made, the payer generally doesn’t request data at the granular level, but rather is focused on the monthly capitation payment. As a result, there are gaps in coding by units of care, creating a divergence between the payer and provider with regard to tracking accountability for improving quality. This may be of particular concern in pediatric care as a result of the high penetration of managed care across states.

An additional challenge with regard to inpatient measures for children is that children present to any given children’s hospital relatively infrequently as compared to adults. As a result, apparent performance is subject to uncontrollable variations and nuances that can confound measurement in either direction.

Another challenge is presented by the updating and improvement of measures over time. Although it is appropriate and important to review and refine measures, the process can create substantial confusion if it is unclear which version(s) of a measure is being used and whether it is comparable to other versions of the same measure. Additionally, there has been a proliferation of measures related to a single topic, creating confusion and inefficiency. It is our understanding that the National Quality Forum has increased its focus on measure harmonization. It is critically important that this issue receive appropriate and aggregate attention as it can only be expected to grow in importance and complexity over time.

Finally, timely data are critical to meaningful quality measurement, reporting and improvement efforts. Measures that are collected only quarterly or annually are of limited use for the purposes of selection and improvement.

**Strategies**

As noted in our introduction, one strategy for mitigating these challenges is continued development of pediatric measures as has begun through the CHIPRA PQMP. Seven PQMP Centers of Excellence work with public and private sector entities to develop, test and validate new measures to improve and strengthen the initial core set as well as to generate measures that can be used for other public reporting and payment initiatives.
Although states’ use of the initial children’s measure core set is improving, it is critically important that states and other payers move beyond selective reporting of core measures to reporting on a full complement of pediatric core set measures. Without national reporting of uniform measures for children, individual plans and providers will continue to be subject to a cacophony of different measures, and children and their families will lack comparable information on their care. Many issuers and plans have their own quality improvement and rating programs, meaning that the same providers can be rated differently depending upon the plan. A consistent and aggregate rating system across the insurance marketplace would provide more comprehensive and consistent information and reduce confusion among consumers.

Certification standards for QHPs should reward plans that collaborate with pediatric providers in the design of innovative delivery and payment reforms focused on the National Quality Strategy priorities and plans that contract with pediatric providers that are participating in delivery models that promote coordinated care (e.g., medical homes). QHP-based incentives can drive the development of delivery reforms that improve quality while controlling costs. For example, QHPs can be required to:

- Contract with pediatric providers that have demonstrated continuous quality improvement.
- Include providers in the design of payment and other contractual incentives aimed at encouraging continuous quality improvement and delivery system innovation.
- Include information about pediatric quality and coordinated and integrated delivery systems in consumer and patient marketing materials.
- Encourage providers to implement integrated and coordinated care models that improve patient experience and outcomes and lower costs (such as medical homes and accountable care organizations) through incentivizing payment policies and other contractual agreements.
- Design payment structures that cover the costs of the full spectrum of primary, specialty and ancillary services, including care coordination and management.

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

States and private entities are engaged in multiple efforts to promote transparency and display health care quality information. An example of the State of California ratings is available at [www.opa.ca.gov/report_card/](http://www.opa.ca.gov/report_card/). However, many, if not most, payer-driven quality designation programs are focused on adult providers at both the physician and the hospital levels. As a result, pediatric providers might be listed on the payer web-site, but cannot earn a “star rating” because those ratings are based on adult measures focused on high volume diagnoses, such as acute myocardial infarction (AMI) or congestive heart failure (CHF), that are not meaningful for children.

As discussed under question 2, measures, reporting and even pay for performance initiatives in some states that have been developed for adult settings have been
“retrofitted” to pediatric populations. Although avoiding readmissions is equally important in pediatrics and adult settings, readmissions are not well studied in pediatrics, and retrofitting the problem and suggested solutions from adult settings to pediatrics has the potential for unintended consequences, such as potentially increasing disparities in care or discouraging appropriate care for patients with chronic illnesses. A study by Gay, et al. (*Pediatrics*, June 2011) is the first description of the epidemiology of 15-day pediatric readmissions and found that almost 80 percent of children with readmissions had an underlying chronic illness. Patients with malignancies were most likely to be readmitted, followed by newborns and patients with neurologic conditions.

Question 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?

There is variability across issuers and states with regard to monitoring the performance of hospitals. One Association member hospital noted that all major issuers have regular meetings with the hospital to review data and outcomes. However, except for one payer, the main focus of those meetings is not hospital-acquired conditions or mortality (which is a less sensitive measure in pediatrics). In that same hospitals, some plans and issuers request concurrent reporting of hospital acquired conditions through their utilization management processes; some payers use claims data to identify and track hospital acquired conditions; and some payers use claims data to trigger a request and/or audit to review actual and potential hospital acquired conditions. With regard to discharge planning, the hospital noted that most payers request daily clinical summaries detailing discharge planning and core coordination; however, no payer has their own post-discharge care program for pediatrics (e.g., bridge to home).

A children’s hospital association in one state noted that there is little real monitoring of quality of care provided with the exception of a focus on safety metrics, primarily those that are likely to or do relate to safety violations.

Some issuers using tiered networks profess that the tiering is based on quality and cost. However, most often the primary driver of selection is cost with minimal focus on quality of care. This is particularly an issue in pediatric settings given the gap in available measures previously described under question 2. This gap is especially critical for children with special health care needs and complex conditions. Children with special health care needs and complex conditions account for a high level of cost but require highly specialized care. With regard to care coordination activities, it is important to adopt measures that indicate whether children with special need conditions are referred to appropriate levels of specialty providers for their care. This will ensure that appropriate care is available to children with low-incidence, rare and serious pediatric conditions.
Applicability to the Health Insurance Exchange Marketplace

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

As noted in the introduction, the Association appreciates the alignment with the National Quality Strategy (NQS) through quality reporting requirements. At the most fundamental level, quality reporting requirements for Exchange plans have the potential to drive consumers and employers to enroll in plans that deliver the highest quality care.

Of the priorities included in the NQS, we believe Exchanges are uniquely and especially positioned to address those priorities that span care settings, including person and family-centered care, care coordination, prevention and affordability. A limitation is the lack of sound measures of care coordination and cost/value, particularly in pediatrics. A balanced approach is needed to ensure that quality reporting covers all of the priority areas and does not overly weight any single priority area.

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?

The CHIPRA initial core measures are relevant to the Exchange marketplace, including those measures related to prevention and health promotion. Pediatric quality measures are included in California’s MediCal, CHIP and Healthy Families program as one example.

As previously noted, existing measures for the pediatric population are not robust in terms of addressing acute and chronic conditions and in measuring the quality of care and outcomes longitudinally. Going forward, measures used in the Exchange marketplace and other programs should draw on the rigorous and promising work underway through the PQMP Centers of Excellence. Patient perception of care coordination and the ability to access the right level of care at the right time should be given priority as initial measures, and some of these measures currently exist. For example, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) health plan survey (child version) includes questions on ability to get care for illness or injury as soon as needed, ability to get appointment for routine care as soon as needed and ease of getting an appointment with a specialist. Insurers should identify, structure their plan and communicate to enrollees when it is appropriate to receive care in the ED versus the urgent care center.

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

As noted under question 2, significant gaps in the availability of quality measures exist across all domains for the pediatric population. It is essential that these gaps be closed in
order to ensure that selection of plans is based on quality as well as cost. Specific gaps include adolescent care (including self-reported experience with care), mental health, and measures for technology dependent children and children with complex conditions. Robust measures for pediatric subspecialties and measures on quality of health (not just medical care) are needed. Additionally, methodologies to address new concepts, such as episodes of care and longitudinal measures are needed to reach the goal of fostering high quality and lower cost within the Exchange marketplace.

There are few obvious outcome measures for children’s care. Because most children are largely healthy, much of the care they receive is focused on ensuring appropriate development and delivering preventive care and counseling. Yet, the quality of care for children with special health care and quality of care for medically complex children is critically important. There may not exist a clear, linear relationship from diagnosis to treatment to health outcome. Relevant health outcomes may occur many years into the future. As a result, there is a critical need to develop process and outcome measures for children from the preconception health of the mother through pregnancy, birth, childhood, adolescence and transition to adulthood. Particular attention should be paid to patient and family experience with care.

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 of narrative reports to assess quality improvement strategies?

Adopting quality improvement strategies to improve quality and reduce costs for all populations (including children) served by plans and issuers should be a basic principle. Strategies should be aligned with the National Quality Strategy and tailored to the populations within the plan. Special attention should be focused on vulnerable patients and families, especially patients and families with special health care needs (e.g., improving care coordination/medical homes for children with complex medical needs).

The Association urges that maternal and child health issues be given high priority in all aspects of quality rating through the Exchanges due to their fundamental impact on lifelong health. Narrative reports can provide useful case studies and context for assessing quality improvement strategies in conjunction with quantitative information.

Question 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?

There are numerous initiatives underway for capturing and displaying quality improvement activities. One example is the Action Registry recently developed through
the National Quality Forum, although this is a new initiative and, therefore, is not fully tested.

Alignment with the EHR incentive programs can provide an important framework for capturing and displaying quality improvement activities. The types of capabilities included in the incentive program are intended to support the National Quality Strategy domains, and alignment with the EHR incentive program (as well as other existing programs) is desirable. For example, the EHR incentive program supports electronic reporting to vaccine registries and syndromic surveillance, which promotes population health. Electronic exchange of information included in the MU criteria supports communication and care coordination. The patient engagement objectives added under Stage 2 (e.g., access to personal health information through a patient portal) provide an important foundation for moving forward. However, the incentive program is relatively early in implementation and is not structured to capture and display quality improvement activities. (Rather, eligible providers and eligible hospitals report dichotomously on whether or not they meet various criteria.) The clinical quality measures included in the meaningful incentive program are largely adult-focused and do not address a range of quality domains for pediatric patients. As a result, the EHR Incentive Program is currently limited with regard to promoting children’s health care quality.

Question 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, managing chronic conditions, ratings of health plan responsiveness and care, health plan members’ complaints and appeals, and health plan telephone customer service)?

Rating systems must address all of the populations served and include measures across all of the priorities outlined in the National Quality Strategy. Additionally, these systems must be able to differentiate quality in plans serving patients with special health care needs. Although the Medicare Advantage five-star quality rating system provides a foundation, the rating categories do not completely align with the National Quality Strategy. For example, the rating system does not seem to include acute care, and perceptions of experience with the plan (ratings of health plan responsiveness and complaints) are somewhat limited. Rating systems should include patient/family, physician and hospital satisfaction on whether the plan promotes quality (including preventive, primary and tertiary care) in terms of coverage and payment.

At the same time, it is important to emphasize that a small number of key measures or sets should be selected and broadly utilized to achieve an optimal balance between informed decision making and resources devoted to measurement.

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?

The Agency for Healthcare Research and Quality has developed resources on best practices for publicly reporting information. See http://www.ahrq.gov/qual/qualix.htm.

As noted under question 3, quality ratings should reflect all of the populations served. Quality ratings should be displayed in a way that is simple and easy to understand for individual consumers and small employers. Ratings should employ plain language and may utilize graphics or other systems that allow consumers to grasp the message easily and quickly. Measures should be reported in a clear, concise manner at an appropriate literacy level, translated in Spanish and other languages and made available in multiple formats (e.g., electronic, paper). Additionally, more detailed information should be readily available to those who wish to access it.

**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?**

Key challenges include small numbers given the need to measure and report on quality across domains and populations. Data collection burden and lack of infrastructure at the state level remain significant challenges. At the same time, reliance on billing and administrative data to monitor quality is problematic.

**Question 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.**

One area in which the Exchange could add great value is through encouraging (or even requiring) health plans to engage in disease management, case management, quality improvement and care coordination through a multi-payer collaborative organized at the provider level. A fund could be created through a small share of premiums that would support systems of care based on best practices. This would be especially useful when all payers would benefit from the infrastructure. The efforts of the health plan community to develop innovative cost control and quality measures to serve plan members could be aligned in one or more broad-based, multi-payer collaborative to promote quality improvement and health plan innovation.

Such an approach would allow health plans to develop innovative payment models, consumer incentives and rewards for quality performance through well-financed initiatives, to measure the value and effect of such innovative strategies on each unique population and to apply these common new methods and process in both the Exchange and outside markets. In crafting participation standards for Qualified Health Plans, baseline standards that protect the ability of participating QHP issuers to adapt their payment and care models in innovative new ways is critical to better serving consumers.
Aligning quality reporting requirements across states also is important. Some states use their “own standards,” which is problematic when those requirements do not align with national standards.

Question 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?

The Association agrees that methods and strategies to track the quality, impact and performance of services for those with accessibility and communication barriers are critically important as are methods and strategies to address disparities in care. Stratification of results according to population characteristics is one approach. As we have noted previously, ensuring that Exchanges address the needs of patients and families with special needs is imperative.

Question 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 and value-based purchasing and other new payment models (for example, Accountable Care Organizations) being implemented by providers?

Recognizing there are methodological challenges, calculation of health plan value should consider the long-term impact of health care. Many adult chronic conditions have their root in childhood. Appropriate measurement and improvement efforts for children will have long-term impact on costs as well as affect other outcomes for adults (such as ability to work). Value based approaches should be designed and tested for all populations served, not simply derived from existing approaches. Careful consideration of scoring methodologies is essential, and there must be adequate provisions for risk adjustment for all populations.

Standardization of benefit plan offerings would allow for more accurate calculation of actuarial value by oversight agencies and reduce the potential for gaming. Gaming of actuarial value by subtle methods is an important potential risk. For example, narrow provider networks that maneuver less healthy enrollees to go out of network in order to keep their existing provider will result in significantly higher cost-sharing for vulnerable enrollees. Moving pharmaceuticals to higher tiers with higher coinsurance also will disproportionately impact enrollees with chronic conditions and special needs. This is not a theoretical issue – it is one that greatly impacts consumers who do not understand their coverage. A recent study of high-deductible health plan members conducted by Kaiser Permanente found that fewer than 20 percent of respondents fully understood the health plan’s cost sharing arrangements.

Although still somewhat nascent, the development of composite measures that reflect the totality of the patient/family experience and focus on outcomes would be of great
value to consumers. Ideally, these measures would reflect a patient/family-centered approach that takes into account the full range of health care needs associated with a condition, episode or encounter.

We appreciate the opportunity to provide input on the questions posed in the Request for Information. We offer our assistance as HHS works towards advancing this effort. If you have any questions on our comments, please contact Ellen Schwalenstocker at 703-797-6045 or ellen.schwalenstocker@childrenshospitals.org.

Sincerely,

M. James Kaufman, PhD
Vice President, Public Policy