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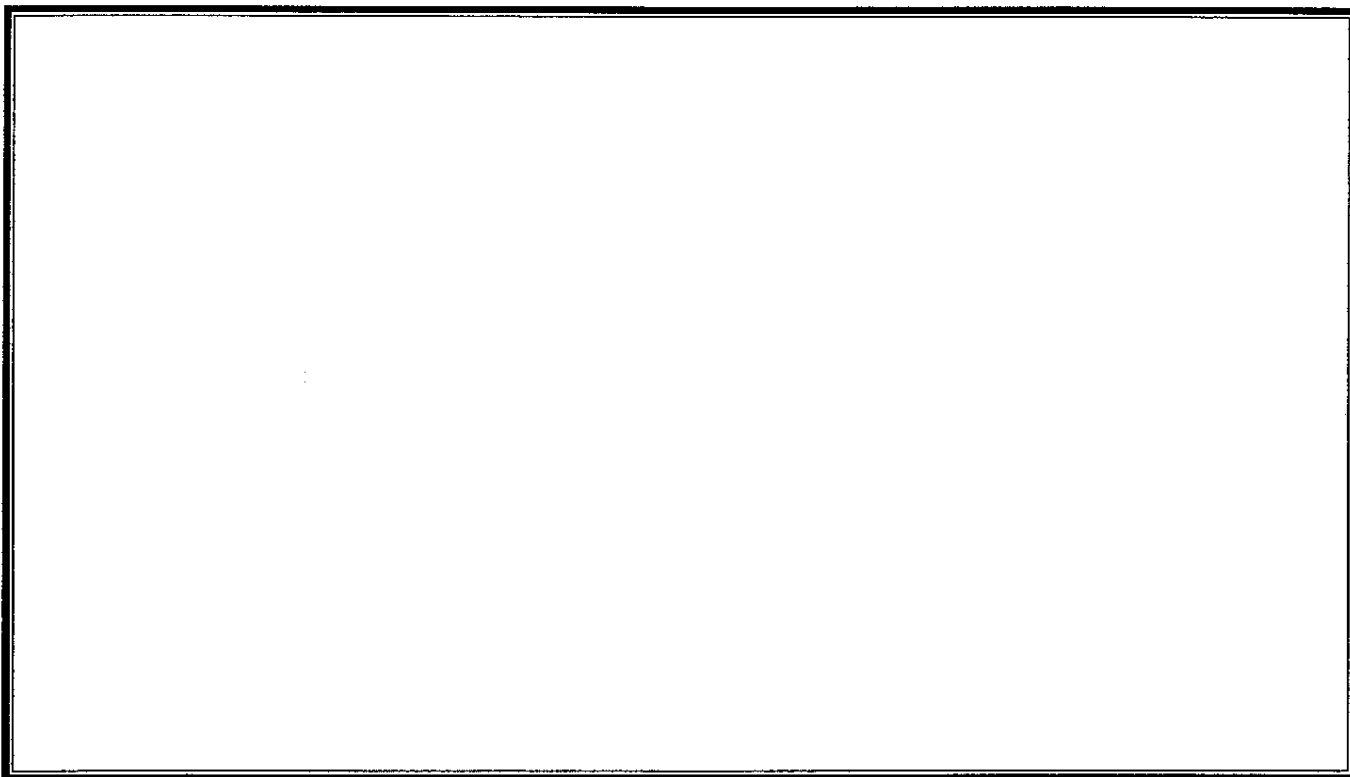
To: Todd Feus

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From: Kanta Patel

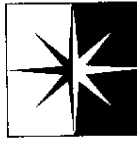
Subject: Comment on June 7 NAIC Blanks (E) WG Draft

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June 15, 2010

Mr. Lou Felice
Chair, Health Care Reform Solvency Impact Subgroup

Re: Comment on June 7 NAIC Blanks (E) Working Group Draft

Mr. Felice:

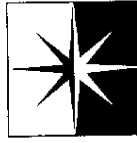
The New America Foundation is a nonpartisan policy think tank dedicated to promoting ideas and programs which will improve the quality of the health care of our nation. We are very proud of the significant achievement of the Patient Protection and Affordable Care Act and are looking forward to working with your organization moving forward to implement key pieces of the law. We respectfully submit the following comments for your consideration regarding the role of quality improvement in calculation of the Medical Loss Ratio (MLR).

Overall, we recognize that there is the sincere need to balance being specific while avoiding the temptation of being overly prescriptive. The underlying problem with the field of quality improvement is that it is relatively new and is still a growing field. And while there is much consensus around certain areas of health care, there are still conflicts, questions and opacities which may complicate some of the MLR draft recommendations.

For example, in the overall definition of quality improvement (QI) standards on page 15 of the draft document: "QI expenses should be based on standards developed independent of any particular health insurer, and be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies or government agencies. They should not be designed solely or primarily to control or contain cost."

There are two potential problems with these standards:

- What is the process by which conflicts in evidence are dealt with?
 - For example, there are a number of conflicting evidence guidelines around prostate cancer and the appropriate treatment for congestive heart failure -- what would some recommendations be for expenses which have only partially been accepted as best clinical practices?
- There is still a great deal we don't have guidelines for that are identified with standard practice. For instance, what if a health insurer requires hospitals to monitor prescription of low dose aspirin after a myocardial infarction? This is primarily identified as standard of care but it is not something that has a literature



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of quality behind it – would this then be counted as a “non quality” process? A potential solution might be to incorporate language around measures that are endorsed by the National Quality Forum, which is a clearinghouse for quality metrics, etc.

We would also like to point out some comments and concerns around the definitions on pages 15-17 of the draft document:

Column 1 – Improve Health Outcomes

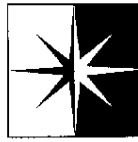
- Effective Case Management – We appreciate the intent here but would like to further understand how one distinguishes between “effective” case management and “general” case management, and where the burden of proof is to distinguish the two.
- Additionally, there is a great deal of back and forth in the quality community right now around the Patient Centered Medical Home. A significant number of activities could be referenced to National Committee for Quality Assurance (NCQA) as being legitimate parts of the NCQA definition. Many current administrative costs now need to be considered clinical since NCQA is proposing to add in requirements for the medical home (in fact, the NCQA is requesting public comment on some of these changes – available at: <http://ncqa.org/tabid/1196/Default.aspx>).

Column 2 – Activities to Prevent Hospital Readmissions

- A general question: how are these costs accounted for now? We ask because there are a great number of activities that are potentially part of “preventing hospital readmissions,” including but not limited to:
 - Coordination between inpatient and outpatient practitioners through secure communication channels, which could be in the form of additional personnel, health information technology infrastructure, etc.
- Several instances refer to an “appropriate health care professional” – so is there a sense of what appropriate is? And since the burden of proof in this section is on the proponent, how are these decisions or determinations likely to be made? We would strongly suggest that there be a minimum type of health professional identified for this set of activities.

Column 3 – Improve Patient Safety and Reduce Medical Errors

In the landmark Institute of Medicine Report “To Err is Human”, the health care community finally realized the true scope of the potential for errors in medicine – this



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column represents the promise of PPACA in emphasizing a shared goal to reduce errors and improve patient safety. However, there are activities which are vague and potentially confusing to completely isolate in this category. For example “appropriate identification and use of best clinical practices” could potentially include preauthorizations as well as chart audits. Additionally, the role of health information technology (HIT) is a very important one in the reduction of medical errors. However, HIT is also a very broad category, and data extraction and analysis are often an automated function of many integrated electronic health records. What category are the software updates and start up costs associated with achieving these functionalities considered?

Column 5 – HIT Expenses for Quality Improvement

While there is some language here about “exclude” costs, there is a significant amount of latitude afforded to the other definitions (1-4). Is it possible that the expense of setting up an electronic health record or personal health record constitute one of these HIT expenses? It would seem so, but if that is the case, then wouldn't setting up any sort of electronic health record be able to suffice as a “clinical cost” and not an administrative cost? What is the current division of costs associated with establishing an integrated electronic medical record? If, for example, in the process of linking a nurse hotline to a health record, how do costs associated with integrating a clinical reminder or generating an email notice become classified?

It is our intention to make sure that the role of quality improvement is retained and definitely not minimized. We hope that we can be helpful in shedding greater light on some of the more complicated areas where the practice of applying these standards could be confusing or unintentionally misclassified.

We look forward to being helpful in any way and commend the working group for being so thoughtful and transparent in its proceedings.

Sincerely,

A handwritten signature in black ink, appearing to read 'K. Patel', with a long horizontal flourish extending to the right.

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