

June 14, 2010

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

Re: Comments to Part III of Blanks Proposal

Dear Mr. Felice:

We are writing in response to the Subgroup's request for comments on June 9, 2010 in regard to Part III of the Blanks proposal. This portion of the proposal relates to the definition of activities that improve quality as set forth in PPACA Section 2718.

As stated in our prior responses and comments, we believe that the definition of activities that improve quality should be informed by the considerable literature on the subject, including the collaborative work of academic institutions, the government, health care providers and payors. For example in seminal works published by Institute of Medicine, such as *Crossing the Quality Chasm* and *To Err is Human*, quality improvement was viewed as having various components not presently accounted for in the draft Blanks document. While some standards are touched upon, the full role of the payor in improving the health quality is not fully acknowledged. A fuller treatment of the core components of quality in health care -- such as safety, effectiveness; patient-centeredness; timeliness; efficiency; equality; elimination of waste; technology; data; and system redesign, including as driven by payment modalities -- is required in order to ensure proper accounting for the role of the payor.

Many of these core components of quality are embedded in PPACA. Section 2717 -- the basis for Blanks' definitions -- provides what one kind of quality report must address. Entire other sections of the new law address the role of system redesign, payment adjustments, data, technology, patient-focus; waste and readmission reduction in driving quality -- the exact kinds of programs payors engage in now but which are not accounted for in the Blanks. Indeed PPACA, for example, requires entire administrative simplification efforts. HHS, when addressing such efforts recently in the context of ICD-10, noted extensively the driving force behind the adoption of the new technology was to improve the quality of care and health care system in United States. We think such guidance, along with the literature on the subject, should inform the Blanks in a way that it does not in the present draft.

We believe that the best approach would to develop a broad definition of quality that would allow for flexibility and enable innovation over time. Expenses for quality initiatives could then be evaluated in the aggregate and with a focus on efficacy of total

program. However, if the Sub-group feels it is necessary to break out various categories (columns) of expenditures it should at a minimum expand upon the current list to include, among other things, initiatives to reduce inefficiencies, eliminate waste, improve effectiveness of services, and ensure equitable delivery of services. In addition to the addition of these columns, we would modify Part III of the existing draft as follows:

SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 3

This exhibit is intended to provide disclosure of expenses by major type of activity that improves health care quality, as defined below, as well as the amount of those expenses that is used for other activities, and reported separately for the Individual, Small Group and Large Group amounts.

Improving Health Care Quality Expenses – General Definition:

Quality Improvement (QI) expenses are expenses, other than those billed or allocated by a provider for care delivery (i.e., clinical or claims costs), that are designed to improve health care quality for health plan enrollees, ~~and~~ advance the delivery of patient-centered medical care, or otherwise improve the way care is delivered. Qualifying QI activities are primarily designed to achieve the following goals, including those referenced in ~~set out in Section 2717 of PPACA;~~ improvement must be capable of being objectively measured and produce results and achievements that can be verified to:

- Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reducing health disparities among specified populations;
- Prevent hospital readmissions;
- Improve patient safety and reduce medical errors, lower infection and mortality rates, or;
- Increase wellness and promote health activities
- Reduce inefficiencies
- Eliminate waste.
- Improve effectiveness of services
- Ensure equitable delivery of services
- Other activities that may be approved by the Secretary in his or her discretion, in consultation with NAIC.

QI Standards: 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~~ or accepted technology or technological developments which are designed to advance safety, efficiency, and patient-centered care which is timely, effective and equitable. ~~They should not be designed solely or primarily to control or contain cost.~~

COLUMNS:

Column 1 – Improve Health Outcomes

Expenses for the direct interaction of the insurer, providers and the enrollee (e.g., face-to-face, telephonic, web-based interactions or other means of communication between and among patients and their providers) to improve health outcomes for the patient under the plan or coverage. This category can include costs for associated activities such as:

- Effective case management (not just general case management), Care coordination, and Chronic Disease Management, including:
 - Patient centered intervention such as:
 - Making/verifying appointments,
 - Medication and care compliance initiatives,
 - Arranging and managing transitions from one setting to another (such as hospital discharge to home or to a rehabilitation center), and
 - Reminding insured of physician appointment, lab tests or other appropriate contact with specific providers;
 - Incorporating feedback from the insured to effectively monitor compliance;
 - Providing coaching to encourage compliance with evidence based medicine;
 - Activities to identify and encourage evidence based medicine;
 - Use of the medical homes model as defined for purposes of section 3602 of PPACA); and
 - Medication and care compliance initiatives, such as checking that the insured is following a medically effective prescribed regimen for dealing with the specific disease/condition and incorporating feedback from the insured in the management program to effectively monitor compliance;
- Expenses associated with identifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence based medicine;
- Quality reporting and documentation of care;
- Health information technology expenses to support these activities (report in Column 5 - see instructions) including:
 - Data extraction, analysis and transmission in support of the activities described above, and
 - Activities designed to promote sharing of medical records to ensure that all clinical providers have access to consistent and accurate records from all participants in a patient's care; and

- ~~Other expenses as may be approved by the Secretary in her or his discretion, in consultation with the NAIC, upon an adequate showing that the costs improve the quality of healthcare as set out in the first paragraph above; the burden shall be on the proponent to show that the expenses meet these criteria.~~

Column 2 – Activities to Prevent Hospital Readmission

Expenses for implementing activities to prevent hospital readmissions, including:

- Comprehensive discharge planning (e.g., arranging and managing transitions from one setting to another, such as hospital discharge to home or to a rehabilitation center) in order to help assure appropriate care that will, in all likelihood, avoid readmission to the hospital;
- Post discharge reinforcement of care instructions by an appropriate health care professional; and
- Health information technology expenses to support these activities (report in Column 5 – see instructions) including.
 - Data extraction, analysis and transmission in support of the activities described above, and
 - Activities designed to promote sharing of medical records to ensure that all clinical providers have access to consistent and accurate records from all participants in a patient's care; and
- ~~Other expenses as may be approved by the Secretary in her or his discretion, in consultation with the NAIC, upon an adequate showing that the costs are designed to prevent hospital readmissions. The burden shall be on the proponent to show that the expenses meet these criteria.~~

Column 3 – Improve Patient Safety and Reduce Medical Errors

Expenses for implementing activities to improve patient safety and reduce medical errors under the patient's plan or coverage through:

- The appropriate identification and use of best clinical practices;
- Activities to identify and encourage evidence based medicine;
- Activities to lower risk of facility acquired infections;
- Health information technology expenses to support these activities (report in Column 5 – See instructions), including:
 - Data extraction, analysis and transmission in support of the activities described above, and
 - Activities designed to promote sharing of medical records to ensure that all clinical providers have access to consistent and accurate records from all participants in a patient's care; or
 - ~~Other expenses as may be approved by the Secretary in her or his discretion, in consultation with the NAIC, upon an adequate showing that the costs improve patient safety or reduce medical~~

errors. The burden shall be on the proponent to show that the expenses meet these criteria.

Column 4 – Wellness & Health Promotion Activities

Programs that provide interaction with the enrollee (e.g., face-to-face, telephonic or web-based interactions or other forms of communication between and among patients and their providers) that promote:

- Wellness assessment;
- Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements;
- Coaching programs designed to educate members on clinically effective methods for dealing with a specific chronic disease or condition; and
- Coaching or education programs and health promotion activities designed to change member behavior (e.g., smoking, obesity); or
- Health information technology expenses to support these activities (Report in Column 5 – See instructions).
- 24hr Nurse Hotline

Column 5 – HIT Expenses for Health Care Quality Improvements

The PPACA also contemplates “Health Information Technology” as a function that may in whole or in part improve quality of care, or provide the technological infrastructure to enhance current QI or make new QI initiatives possible. Include HIT expenses required to accomplish the activities reported in Columns 1 through 4 that are designed for use by health plans, health care providers, or patients for the electronic creation, maintenance, access, or exchange of health information in the following ways;

1. Monitoring, measuring, or reporting clinical effectiveness including reporting and analysis costs related to maintaining accreditation by nationally recognized accrediting organizations such as NCQA or URAC; or costs for public reporting of quality of care, including costs specifically required to make accurate determinations of defined measures (e.g., CAHPS surveys or chart review of HEDIS measures and costs for public reporting mandated or encouraged by law;
2. Advancing the ability of patients, providers, insurers or other systems to communicate patient centered clinical or medical information rapidly, accurately and efficiently to determine patient status, avoid harmful drug interactions or direct appropriate care – this may include Personal Health Records accessible by patients and appropriate providers to monitor and document an individual patient’s medical history;
3. Tracking whether a specific class of medical interventions or a bundle of related services leads to better patient outcomes; or
4. Other expenses as may be approved by the Secretary in her or his discretion, in consultation with the NAIC, upon an adequate showing

that the costs support the activities described in columns 1 through 4 or otherwise support monitoring, measuring, or reporting health care quality improvement. The burden shall be on the proponent to show that the expenses meet these criteria.

[Add Column 6-10 to include separately expenses to:]

- Reduce inefficiencies
- Eliminate waste.
- Improve effectiveness of services
- Ensure equitable delivery of services
- Other activities that may be approved by the Secretary in his or her discretion, in consultation with NAIC.

~~Exclude: Costs associated with maintaining a compliant claims adjudication system, including cost directly related to upgrades in HIT that are required to be made in order to comply with new administrative simplification standards and code sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d-2, as amended, including the new ICD-10 requirements. (Discuss—Exclude as administrative or include as Fed requirement)~~

Expense Allocation: A separate, non-public supplemental filing (Supplemental QI Expenses Exhibit) must be made by the insurer to provide a description of the method utilized to allocate QI expenses to each State and to each line and column on Part 3. Additionally, companies reporting QI expenses in columns 1 through 4 must include a detailed description of such expenses. These will be reviewed for adherence to the definition and standards of QI and may be specifically incorporated into, or excluded from, the instructions for QI for future reporting purposes.

~~Note: 24 Hour Nurse Hotlines: Expenses for 24 hour nurse hotlines should be included in Improve Health Outcomes, Activities to Prevent Hospital Readmissions, Improve Patient Safety and Reduce Medical Errors, and Wellness & Health Promotion Activities. Any other expenses for 24 hour nurse hotlines (e.g., answering member questions) should be excluded from Improving Health Care Quality Expenses and instead included in Claims Adjustment Expenses.~~

The following items are broadly excluded as not meeting the criteria of this section:

- 24 Hour Nurse Hotlines (except as noted above);
- Utilization Review;
- Fraud Prevention activities;
- Network Management;
- Provider Contracting;

- Accreditation Fees;
- Costs associated with calculating and administering individual enrollee or employee incentives. This includes rewards or bonuses associated with wellness or health promotion programs (e.g., reductions in individual enrollee or group health plan copays, deductibles or premiums based on achieving specified health outcomes or engaging in specified health promotion activities); and
- Any function not expressly included in Columns 1 through 5;