

May 25, 2010

Mr. Lou Felice
Chair, Health Reform Solvency Impact Subgroup
c/o National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, MO 64108-2662

Re: Medical Loss Ratios – Section 2718 of the Public Health Service Act

Dear Mr. Felice:

The Joint Commission is offering comments on the classification of quality improvement and patient safety activities under the definitions to be used to create medical loss ratios consistent with the newly enacted health care reform legislation, The Patient Protection and Affordable Care Act of 2010 (PPACA). Since the beginning of the last century, The Joint Commission has taken a leadership role in promoting advances in quality improvement. Our mission is to continuously improve health care for the public by evaluating health care organizations and inspiring them to excel in their quest to provide safe and effective care of the highest quality and value. Thus we want to ensure that the approach to calculating medical loss ratios does not inadvertently create a chilling effect on legitimate and promising quality improvement activities that can lead to better patient outcomes and enhance the efficiency of care delivery. Our interest in how medical loss ratios are calculated is also driven by our firm belief that high quality care is the most cost-effective care.

The Joint Commission accredits or certifies over 17,000 health care organizations and programs that cover the full continuum of care. For example, our accreditation programs apply to an array of providers and settings in the areas of ambulatory care, acute care, behavioral care, clinical laboratory services, long term care, durable medical equipment suppliers, and home health organizations. As health plans in the envisioned state-based insurance exchanges carry out quality improvement activities in areas of patient safety, preventable hospital readmissions and coordination of care – as envisioned by PPACA in Section 1311 – such plan activities will ultimately involve many of the providers and suppliers that are Joint Commission accredited.

In addition, The Joint Commission is a world leader in raising the bar on quality and patient safety. Our standards, educational programs, publications and consulting are also looked to world-wide for their state of the art guidance and application in a variety of health care delivery situations. As one indicator of the global recognition of our

leadership in advancing patient safety solutions, we are the only World Health Organization designated collaborating center on patient safety.

A number of years ago, The Joint Commission developed a robust program of performance measurement that included the first national, standardized set of evidence-based quality of care measures for hospitals--measures that are now the basis of today's Medicare reporting program for hospitals, codified in law, and referenced in PPACA. Many of the measures in our hospital program will, because of language in both the American Responsibility and Recovery Act and the Patient Protection and Affordable Care Act, become integrated into the definitions of "meaningful use" of electronic health records required to be met in order that Medicare certified hospitals receive incentive payments for adoption of electronic health record systems. But the overwhelming contribution of The Joint Commission's program on measurement has been the documented and extraordinary effect it has had on dramatically increasing the adherence by our nation's hospitals to critical processes of care that are closely related to improved patient outcomes. Few other programs to improve provider performance have had such a profound and national effect.

Recently, The Joint Commission launched a new initiative, the Center for Transforming Healthcare, which will help shape the future of health care delivery by developing and deploying durable and generalizable solutions to pressing quality and safety problems. Together with a key group of the nation's leading hospitals and health systems, the Center identifies and tests quality improvement interventions and solutions by using the same robust process improvement tools that other industries have long relied on to improve quality, safety and efficiency. The Joint Commission then spreads these proven interventions to all its accredited organizations.

We applaud the NAIC's effort to develop clear and concise definitions in the "exposure draft blank and instructions" that have been recently proposed. The Joint Commission understands very well the challenge that the NAIC faces in trying to appropriately define quality improvement activities for the purpose of calculating medical loss ratios. It is imperative that expenses allowed for quality improvement efforts are expenses designed to have a positive effect on patient and population health. Activities with little opportunity to make a difference in health outcomes should be excluded as legitimate costs in order to protect insurance premiums from unreasonable cost increases.

At the same time, it is important that there be sufficient latitude in the definition of allowable quality improvement expenses to encourage and support innovative approaches to quality improvement. While we want to strive toward as much evidenced-based quality improvement as possible, we do not have a large portfolio of activities that meet that test, and evaluations to demonstrate cost-effective implementation of many quality

improvement strategies is expensive. Unfortunately, this country has not made substantial investments in systematically identifying scientifically-based quality improvement efforts that have also been tested and evaluated for their effectiveness, which is precisely why The Joint Commission launched the aforementioned Center for Transforming Healthcare and lobbied heavily for inclusion of Section 3501 .in PPACA to fund similar types of empirically-based quality improvement work. The Joint Commission’s quality improvement and patient safety work in its new Center is illustrative of the significant resources it takes to develop cost-effective, well tested and durable quality solutions.

Consequently, many quality improvement strategies are reasonable for insurers to engage in because of their likelihood to result in better care and services, but cannot yet meet a rigorous requirement that they are evidenced-based. Until such time as there is more empirical evidence, insurers should not be discouraged from engaging in activities with a generally accepted, strong and close causal relationship between the quality improvement expenditures and the anticipated population or enrollee outcome. The Joint Commission does support, however, the draft NAIC language that would require that quality improvement activities be designed in a manner that can be objectively measured and verified. In this way, insurers will be able to prospectively evaluate which of their strategies are effective should results appear to be of questionable value. *We would suggest strengthening this language to add the concept that the strategies should be well designed in their methodology, approach and plan for execution to achieve their specific intended purpose.*

Quality improvement activities that The Joint Commission recommends for inclusion in “Expenses for Health Care Quality and Improvements” are:

- Performance measurement and reporting activities that include data analysis, timely feedback of results, and the use of performance information in quality improvement strategies. It is important to note here that for many measures, medical chart abstraction or record review is still a necessity and should be considered an allowable cost for quality improvement.
- Costs for accreditation/certification expenses, including the costs associated with compliance with accreditation requirements. Accreditation is associated with risk reduction and has been shown to correlate with better adherence with the clinical processes that underlie many performance measures.
- Quality improvement activities referenced in Sections 2717 and 1311 of PPACA.

Lastly, we would like to caution that the proposed category of “Other costs approved by the Secretary, in consultation with the NAIC, which in her discretion upon an adequate

showing that the costs improve the quality of health care...” could be used to create a very high bar for deciding legitimate costs for conducting quality improvement strategies.

The Joint Commission appreciates the NAIC’s efforts and willingness to reach out for public input to inform the medical loss ratio dialogue. We urge you to develop unambiguous definitions wherever possible, but to also consider both including the specific items listed above and a safe harbor for well designed quality improvement activities where there is a broad consensus that they are strongly associated with better individual and population outcomes. These strategies will ultimately provide the most value for the public and thereby have a positive effect on overall health care costs.

Please do not hesitate to contact me or Margaret VanAmringe, Vice –President for Public Policy and Government Relations in our Washington Office. She can be reached by telephone at 202.783.6655 or by email at mvanamringe@jointcommission.org

Sincerely,



Mark R. Chassin, MD, MPP, MPH
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