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May 14, 2010

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The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
Room 445-G
200 Independence Avenue SW
Washington, DC 20201

Vernice Davis Anthony
Greater Detroit Area Health Council

Marc H. Bennett
HealthInsight
(Nevada & Utah Partnerships for
Value-Driven Healthcare)

Kent Bottles
Institute for Clinical
Systems Improvement

The Honorable Hilda L. Solis
Secretary
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

Nancy Clarke
Oregon Health Care Quality
Corporation

Thomas C. Evans
Iowa Healthcare Collaborative

The Honorable Timothy F. Geithner
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue NW
Washington, DC 20220

Karen Wolk Feinstein
Pittsburgh Regional Health Initiative

David S. P. Hopkins
California Cooperative Healthcare
Reporting Initiative

Lisa Letourneau
Quality Counts

RE: DHHS-2010-MLR (Response to Request for Comments
Regarding Section 2718 of the Public Health Service Act, Federal
Register Vol. 75, No. 71, p. 19297, April 14, 2010)

Mary McWilliams
Puget Sound Health Alliance

Elizabeth Mitchell
Maine Health Management Coalition

Dear Secretary Sebelius, Secretary Solis, and Secretary Geithner:

Betsy Mulvey
New York Quality Alliance

Cindy Munn
Louisiana Health Care Quality
Forum

Christopher Queram
Wisconsin Collaborative for
Healthcare Quality

The Network for Regional Healthcare Improvement (NRHI) appreciates the opportunity to provide input as the Departments of Health and Human Services, Labor, and Treasury begin the process of rulemaking to implement Section 2718 of the Public Health Service (PHS) Act, which was added by Sections 1001 and 10101 of the Patient Protection and Affordable Care Act (P.L. 111-148).

Barbra Rabson
Massachusetts Health Quality
Partners

Thomas R. Williams
Integrated Healthcare Association

As a result of the amendments in PPACA, Section 2718(b) of the PHS Act establishes standards for the minimum percentage of premium revenues that must be spent by health insurance issuers on (1) reimbursement for clinical services provided to enrollees and (2) “activities that improve health care quality.” Section 2718(c) directs the National Association of Insurance Commissioners (NAIC) to define which activities constitute activities that improve health care quality, subject to the certification of the Secretary of HHS. **We urge that in your rulemaking, you ensure that “activities that improve**

Harold D. Miller
President and CEO

health care quality” are defined so as to include financial contributions which health insurance issuers make to support the activities of non-profit, multi-stakeholder, Regional Health Improvement Collaboratives in the communities where the health insurance issuers’ enrollees reside.

Non-profit, multi-stakeholder Regional Health Improvement Collaboratives have been formed in dozens of states and metropolitan regions to improve the quality and reduce the cost of healthcare services in their communities. These Collaboratives bring together four types of stakeholders – healthcare providers (physicians, hospitals, and other providers), payers (health plans, state Medicaid agencies, etc.), purchasers (both businesses and state and local government employee healthcare purchasing agencies), and consumers – to collaboratively design and implement important programs and initiatives such as:

- public reports on the quality of care delivered by physicians and hospitals in the community;
- education for consumers on how to select high-quality healthcare providers and services;
- technical assistance for healthcare providers on ways to improve the quality of care they deliver;
- redesign of payment and delivery systems to support higher-quality care.

The types of programs operated by Regional Health Improvement Collaboratives are directly consistent with other provisions of PPACA. For example, Section 3015 requires collection and reporting of quality data and provides for grants to “multi-stakeholder entities that coordinate the development of methods and implementation plans for the consistent reporting of summary quality and cost information,” which is precisely the role that many Regional Health Improvement Collaboratives play in their communities. Section 3501 authorizes federal funding for local quality improvement collaboratives to provide technical support to health providers to improve the quality of care they deliver, which is again one of the key roles that Regional Health Improvement Collaboratives play in their communities.

The importance of the work Regional Health Improvement Collaboratives do has been nationally recognized. Twenty-four Collaboratives have been designated as Chartered Value Exchanges (CVEs) by HHS and receive technical assistance from the Agency for Healthcare Research and Quality. Seventeen of the Collaboratives participate in the Robert Wood Johnson Foundation’s Aligning Forces for Quality program. The leading Regional Health Improvement Collaboratives in the country are members of the Network for Regional Healthcare Improvement, which provides a mechanism for Collaboratives to share best practices among themselves and to work jointly on national quality improvement issues.

Despite the critical role that Regional Health Improvement Collaboratives have played and will continue to play in improving healthcare quality, there has been no

federal financial support for their work to date. The Collaboratives rely primarily on contributions from local healthcare stakeholders to support the quality measurement and quality improvement programs they operate. In particular, health insurance issuers have been major sources of funding for Collaboratives, since these issuers serve as efficient mechanisms for equitably distributing the burden of financial support for community quality improvement initiatives across all of the healthcare providers and recipients in the community. (In many cases, these contributions are referred to locally as “dues,” even though the Collaboratives are 501(c)(3) entities, simply as a way of reinforcing the need for all stakeholders in the community to contribute.) The loss of these contributions from health insurance issuers would jeopardize the continued viability of the programs operated by Collaboratives at a time when those programs are needed more than ever.

Consequently, it is essential that in your regulations regarding “activities that improve health care quality” under Section 2718 and in the definition established by the National Association of Insurance Commissioners, there be nothing which precludes or discourages health insurance issuers from contributing funds to support the work of non-profit Regional Health Improvement Collaboratives. We would urge that the definition explicitly identify such contributions as an “activity that improves health care quality” so that there is no ambiguity about that.

We appreciate the opportunity to provide these comments, and we would be happy to answer any questions or provide any additional information that you would find helpful. We would be pleased to work with you to help establish an appropriate definition of quality improvement activities to ensure that the critical work of Regional Health Improvement Collaboratives is not jeopardized.

Please feel free to contact me if we can be of assistance as you implement the provisions of the law.

Sincerely,

A handwritten signature in black ink, appearing to read 'H. Miller', written in a cursive style.

Harold D. Miller
President and CEO

cc: NRHI Members