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Marilyn Tavenner
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RE: Request for Information Regarding Health Care Quality for Exchanges; 77 Federal Register 70786-70788 (November 27, 2012)

Attention: CMS-9962-NC

Dear Ms. Tavenner:

The Network for Regional Healthcare Improvement (NRHI) appreciates the opportunity to submit comments on your November 27, 2012 Request for Information regarding the quality improvement and reporting strategies which should be required of Qualified Health Plan (QHP) issuers participating in Health Benefit Exchanges.

Background

NRHI works to help communities across the country build the capabilities needed for all stakeholders to take unified action to create lower-cost, higher-quality healthcare and to improve the health and productivity of their residents, with a particular focus on communities that have created Regional Health Improvement Collaboratives (RHICs). RHICs are non-profit, multi-stakeholder, community-based organizations that are working to improve the quality and reduce the costs of health care in dozens of metropolitan regions and states across the country. Many RHICs are also designated as Chartered Value Exchanges (CVEs) by HHS and AHRQ.

Regional Health Improvement Collaboratives have the most extensive experience in the nation in successfully implementing performance measurement and public reporting efforts for a wide range of measures and for patients associated with multiple payers, and in ensuring the reports are used to actually improve the quality of

care in a community. A number of RHICs have been collecting and publicly disseminating measures of the quality of healthcare services in their communities for multiple years, and a growing number of them also measure and report on patient experience and the cost of care. RHICs are also actively working to encourage and assist providers to make improvements in the quality of healthcare in their communities.

Because of the central role that Regional Health Improvement Collaboratives play in measuring and improving healthcare quality and value in their communities, they could be significantly impacted by what HHS and CMS require of QHP issuers in terms of quality measurement and improvement requirements in the Exchanges. RHICs' deep expertise and extensive experience in quality reporting and improvement also makes them uniquely qualified to provide input on those requirements.

Overarching Recommendations Regarding Quality Measurement and Improvement Requirements for Issuers in Exchanges

We urge that **any regulations you develop with regard to Exchanges or QHP issuers be explicitly designed to support community-based, multi-payer, multi-stakeholder initiatives that measure and improve the quality of care delivered by healthcare providers**. There are several important reasons for this:

1. High Value Health Care is Delivered by Healthcare Providers, not Health Plans

The quality of healthcare is determined primarily by what healthcare *providers* do, not what health plans do, and the quality of healthcare that an individual citizen receives depends first and foremost on which doctors and hospitals they use, not which health plan pays for their care. Reporting on the "quality" of health plans using aggregated measures of the quality of care delivered by the providers in a health plan's network can actually be misleading for consumers, since it implies that the quality of the consumer's care depends primarily on which *health plan* the consumer chooses, rather than which *provider* the consumer chooses. Similarly, the existence of a "quality improvement" initiative operated or supported by a health plan that does not involve the providers a consumer uses or that does not support improvements in the specific aspects of care the consumer needs could also cause that consumer to receive lower-quality care than they would otherwise.

In a growing number of communities around the country, Regional Health Improvement Collaboratives are measuring and reporting on the quality of care delivered by physicians and hospitals, providing training and technical assistance to providers in how to improve quality and reduce costs, designing and coordinating the implementation of changes in payment systems and benefit designs to support higher-value healthcare, and educating consumers about how to choose the highest-value providers and services using the quality and cost measures published by the RHIC. Because these initiatives focus directly on the source of care and because they combine the membership and funds from many different health plans and payers, they

can have far more impact than what an individual health plan can achieve. However, the success of the RHIC's initiatives depends on having participation by all health plans.

Consequently, **we recommend that in the regulations you develop, health plans should be measured on the extent to which they (a) have high-value healthcare providers in their networks, with high-value providers identified based on quality and cost measures derived from multi-payer data and published by multi-stakeholder Collaboratives; (b) contribute data to multi-stakeholder Collaboratives to enable them to measure the quality and cost of care; (c) enable and encourage their members to use high-value providers through value-based benefit designs that rely on the Collaboratives' cost and quality measures; and (d) support community multi-stakeholder initiatives designed to improve the quality and cost of healthcare, including multi-payer provider payment reforms.**

2. Multi-Payer Approaches to Quality Measurement and Improvement Are Essential

The quality and cost of the care delivered by healthcare providers should be measured using data from *all* payers, not just data from the plan's own members. In most cases, measures of healthcare quality based solely on the processes or outcomes of care for members of an individual health plan will be unreliable and potentially misleading because of the small number of patients involved. It is particularly important to have data from all payers in order to disaggregate quality measures and determine whether disparities exist for minorities and other population subgroups.

Moreover, if different health plans each generate their own measures of the quality and cost of providers using separate sets of data and different measures, it will be confusing for both consumers and providers as well as expensive for both plans and providers, so multi-payer quality measurement is the preferred approach.

Similarly, multi-payer approaches to quality *improvement* are also essential. A physician or hospital will not and should not improve the way it delivers care for only one health plan's members, so a provider cannot improve care delivery unless all payers have implemented supportive payment systems and benefit designs. If each health plan in a community supports only its own unique quality improvement initiatives or payment reforms, no matter how well designed they are, it can actually impede efforts to improve the quality of care and it will increase administrative costs for providers as well as health insurance plans. In markets where a single provider dominates the market, efforts to control costs are also more likely to be successful if all payers are participating in common payment reform and cost measurement systems.

Fortunately, there are a growing number of multi-payer initiatives around the country seeking to develop the necessary coordination among payers and the necessary critical mass of participating patients to ensure success of quality measurement and improvement programs. This includes quality and cost measurement and reporting programs that combine data from multiple payers, and multi-payer

payment reforms to support higher-value care. CMS has taken historic steps in this direction itself through the way it designed the Comprehensive Primary Care Initiative, which has as many as 11 different payers participating in each of seven different regions. The single most important element for the success of multi-payer efforts is having all payers participate, and the Exchanges can help encourage that.

Consequently, **we recommend that the highest level of recognition in Exchanges be given to health insurance issuers that participate in multi-payer quality measurement and improvement initiatives**. Exchanges should encourage competition among health insurance issuers on things such as the extent of coverage, administrative costs, and customer service, while encouraging *collaboration* on quality measurement, quality improvement, and payment reform.

3. Regional, Multi-Stakeholder Approaches to Quality Measurement and Improvement are Also Essential

Quality measurement and improvement activities are far more likely to be successful if all of the stakeholders – physicians, hospitals, employers, and patients, as well as health plans – are working together to agree on priorities, to select appropriate measures and goals, and to design and implement effective improvement strategies. Even if all payers are working together on a common measurement and quality improvement strategy, the strategy could fail if it is not also supported by the key providers or by patients.

This kind of multi-stakeholder engagement can only happen effectively at the state or regional level, since most providers and even most payers operate exclusively or primarily in metropolitan regions or states. Health care is a fundamentally regional enterprise, and every region of the country is different in terms of the number, types, and relationships of healthcare purchasers, payers, and providers, in terms of the types of healthcare quality and cost problems their communities are facing, and in terms of the causes of and solutions to those problems. These differences mean that *which* quality and cost improvement issues should be priorities for a particular region and *how* that region can most effectively address those issues will differ, potentially dramatically, from region to region.

Although it is desirable to use common, nationally endorsed quality measures and requirements for quality improvement activities wherever possible, there should also be the flexibility to use different quality measures and quality improvement programs where appropriate to respond to state and regional priorities. The need for this flexibility will be particularly important for Exchanges, since there will likely be considerable variability across the country in the number of individuals purchasing insurance through the Exchanges, the types of healthcare needs those individuals will need to address, and the number of choices of QHPs they will have. In addition, in selecting national quality measures and requirements for quality improvement strategies, preference should be given to those quality measures and quality improvement strategies that are already being used in multiple regions and states.

Consequently, **we recommend that where there is an existing community quality measurement and reporting and/or quality improvement strategy that has been developed by a multi-stakeholder Regional Health Improvement Collaborative, the issuer of a Qualified Health Plan should be encouraged or required to support that existing strategy and to participate in programs developed to achieve the goals of the strategy**.

Responses to Specific Questions

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?**

One of the most important strategies that many health insurance issuers use to help improve health care quality in all of the categories listed is supporting the quality improvement initiatives of multi-stakeholder Regional Health Improvement Collaboratives. RHICs have designed cutting-edge initiatives in each of the areas described above (examples can be found on the NRHI website at http://www.nrhi.org/performanceimprovement.html); because they involve all payers and because the providers have been involved in the design, these initiatives are far more likely to be successful than improvement initiatives designed solely by individual health insurance issuers.

In many ways, the single most important thing that health plans can do to support quality improvement in all of the categories listed above is to change the way they pay providers so as to remove the significant barriers to quality improvement that are created by the current fee-for-service payment system. As noted earlier, this cannot be done effectively by any one health insurance issuer on its own; *successful* payment reform requires *multi-payer* payment reform, so participation by all health insurance issuers in coordinated payment reform initiatives is critical.

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?**

One of the biggest challenges in measuring healthcare quality at any point in time is getting accurate and timely data for enough of a provider's patients in order to generate reliable measures of the quality of care. In most cases, no individual health insurance issuer has enough patients to generate a reliable measure of quality using claims data, so it is essential that if claims-based quality measures are going to be used, all payers need to submit their claims data to a Regional Health Improvement

Collaborative or other data aggregator. If QBP issuers do not contribute data to these measurement systems, it will not only reduce the reliability of the measures of quality in the community, it will also be impossible to determine whether the quality of care for the QBP members is higher or lower than what is received by others in the community.

Tracking quality improvement of providers over time is even more difficult to do with just a subset of payers participating, because most patients change health plans more frequently than they change providers. In order to reliably measure the quality of a provider's care over time, the measures need to be based on data on all of the provider's patients (or as many of them as possible) not just those who happen to be covered by a particular health plan in a particular year.

A growing number of Regional Health Improvement Collaboratives are improving both the reliability of measures and the ability to use more outcome-oriented measures by establishing systems to collect clinical data directly from providers, rather than relying on claims data. For example, Minnesota Community Measurement, Quality Quest for Health of Illinois, The Health Collaborative in Cincinnati, and the Wisconsin Collaborative for Healthcare Quality publicly report on a number of clinical measures that many health plans do not have access to because the RHICs collect the data directly from providers' clinical records. Because the data are based on all of the provider's patients, including those without insurance, they are not affected when patients change insurance carriers and they allow more accurate measurement of disparities in care than data based just on insured patients. Moreover, these measurement systems are not dependent on electronic health records, so they can be used for all providers in the community. Exchanges could serve as a mechanism for providing funding to support these measurement programs.

For those communities that are working to measure and report on the cost of care delivered to their citizens, access to claims data from all payers is essential, and so it will be important that QBP issuers make their claims data available to the community's measurement and reporting organization. This will also enable the cost of care delivered to Exchange participants to be accurately measured and to allow the differences between the costs of care for those participants and those insured by employers or other programs to be determined.

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

As noted earlier, Regional Health Improvement Collaboratives have the most extensive experience in the nation in successfully implementing public reporting efforts for a wide range of measures and for patients associated with multiple payers, and in ensuring the reports are used to actually improve the quality of care in a community. A number of RHICs have been collecting and publicly disseminating measures of the quality of healthcare services in their communities for multiple years, and a growing number of them also measure and report on patient experience and the cost of care. A

list of these can be found on the NRHI website at http://www.nrhi.org/performancemeasurement.html.

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?**

The most effective way to monitor the performance of providers is to do so using measures of quality and cost that have been developed, collected, and reported through a collaborative effort of the payers, providers, purchasers, and patients in the community. The use of different measures and separate monitoring efforts by individual health insurance issuers increases administrative costs for both the insurance plans and for providers and also reduces the ability of providers to focus their improvement efforts and to make real progress in improving the quality and reducing the cost of care.

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

Unless there are effective ways to measure the quality and cost of healthcare, it is impossible to know where opportunities exist for improvements in the quality of healthcare and for reductions in healthcare costs or whether progress is being made on those opportunities. Consequently, it is appropriate that Exchanges support effective measurement of progress toward the goals of the National Quality Strategy.

The best, fastest, and most cost-effective approach to measurement and reporting is to build on the extensive quality measurement and reporting infrastructure which has already been developed in many regions around the country by Regional Health Improvement Collaboratives such as the Albuquerque Coalition for Healthcare Quality (www.abqhealthcarequality.org), Aligning Force for Quality – South Central Pennsylvania (www.aligning4healthpa.org), Better Health Greater Cleveland (www.betterhealthcleveland.org), the California Cooperative Healthcare Reporting Initiative (www.cchri.org), the Greater Detroit Area Health Council (www.gdahc.org), Healthy Memphis Common Table (www.healthymemphis.org), HealthInsight (www.healthinsight.org), the Integrated Healthcare Association (www.iha.org), the Iowa Healthcare Collaborative (www.ihconline.org), the Kansas City Quality Improvement Consortium (www.kcqic.org), the Louisiana Health Care Quality Forum (www.lhcqf.org), the Maine Health Management Coalition (www.mehmc.org), Massachusetts Health Quality Partners (www.mhqp.org), the Midwest Health Initiative (www.mhi.org), Minnesota Community Measurement (www.mncommunitymeasurement.org), the Oregon Healthcare Quality Corporation (www.q-corp.org), the Puget Sound Health

Alliance (www.pugetsoundhealthalliance.org), and the Wisconsin Collaborative for Healthcare Quality (www.wchq.org).

The measurement systems these Collaboratives have developed are non-proprietary and the methodologies are publicly available. Indeed, the Collaboratives proactively encourage providers, consumers, purchasers, and other interested parties to participate in the development of the measurement and reporting systems and to ensure the accuracy of the measures, so that the results will be trusted by all parties.

Not only are these Regional Health Improvement Collaboratives already collecting and publicly reporting an extensive array of quality measures, they are also actively using them to encourage improvements in the quality of healthcare in their communities consistent with the National Quality Strategy. Indeed, in many cases, the measures have been developed specifically to support a local quality improvement initiative, rather than the other way around.

This type of synergy between measurement/reporting initiatives and quality improvement initiatives at the local level is precisely what the National Quality Strategy calls for and what HHS should support through its Exchange requirements and other programs. In regions where Regional Health Improvement Collaboratives have already established quality measurement and reporting programs and/or quality improvement goals and initiatives, it is important that Exchanges support those programs, goals, and initiatives. There are two reasons for this:

- First, the practical reality is that healthcare providers can only implement a limited number of quality measurement and improvement initiatives while still keeping up with patient care responsibilities, so inconsistencies or conflicts between national and regional priorities and requirements may force providers to shift resources and attention away from an important local quality improvement initiative they have worked hard to develop in order to improve on national measures, even though the local initiative could achieve greater impacts on the ultimate goal of improved healthcare quality and lower costs.
- Second, measurement and reporting is not an end in itself, but a means to an end, namely, improving the quality and cost-effectiveness of health care delivery. The keys to quality improvement are (1) having healthcare providers measure their performance, (2) enabling healthcare providers to compare their performance to others, and (3) providing assistance to under-performing providers so that they can improve. Consequently, the quality measurement, quality reporting, and quality improvement initiatives of Regional Health Improvement Collaboratives are *all* needed to ensure that the overall goals of the National Quality Strategy are achieved.

Moreover, a key role that a growing number of Regional Health Improvement Collaboratives are playing is helping healthcare providers and purchasers analyze data to identify opportunities to improve the quality and reduce the cost of healthcare in their communities. They are helping providers conduct exploratory analyses of data to

identify where over- or under-utilization of key services exists and to develop strategies for rectifying those problems in the most cost-effective ways possible. Moreover, if the provider develops a proposal to a payer for changes in payment to support changes in care delivery, the payer can trust that the data supporting the proposal are accurate because they come from a common, objective, trusted source of information, i.e., the Regional Health Improvement Collaborative. This kind of local analysis and priority-setting should be encouraged and supported by the Exchanges.

6. What quality measures or measure sets currently required or recognized by states, accrediting entities, or CMS are most relevant to the Exchange marketplace?

As noted earlier, every region of the country faces different types of healthcare quality and cost problems, and the causes of those problems and the solutions to them will differ from region to region. These differences mean that the most appropriate quality and cost measures will also differ from region to region.

Although it is desirable to use common, nationally endorsed quality measures and requirements for quality improvement activities wherever possible, there should also be the flexibility to use different quality measures and quality improvement programs where appropriate to respond to state and regional priorities. The need for this flexibility will be particularly important for Exchanges, since there will likely be considerable variability across the country in the number of individuals purchasing insurance through the Exchanges, the types of healthcare needs those individuals will need to address, and the number of choices of QHPs they will have. In addition, in selecting national quality measures and requirements for quality improvement strategies, preference should be given to those quality measures and quality improvement strategies that are already being used in multiple regions and states.

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

The single biggest gap is the paucity of measures on outcomes. Most of the measures that are being used by payers today are process measures, not outcome measures, e.g., they measure whether a patient received a specific set of medications, not whether they avoided another heart attack, and they measure whether appropriate surgical procedures were used in the hospital, not whether the patient experienced an infection or was able to walk again. Not only is there evidence that good performance on many types of process measures does not necessarily improve outcomes, process measures can actually impede efforts to reduce costs and improve quality by locking in less-than-optimal approaches to care.

Because of the active involvement by providers, several Regional Health Improvement Collaboratives have been able to develop and successfully use measures of patient outcomes, rather than merely processes. For example Minnesota Community

Measurement is using a measure of the remission rate from depression in conjunction with a major, successful community initiative to improve the treatment of individuals with depression.

A key challenge in obtaining more outcome measures is not just defining them, but finding cost-effective ways to collect the data. Outcomes often cannot be measured using either claims data or clinical data; they must be collected directly from patients. In order for patient-reported information to be objective, reliable, and comparable, it will need to be collected by neutral community organizations, such as Regional Health Improvement Collaboratives, rather than either providers or payers. Exchanges could provide funding to support the development of community initiatives to collect patient-reported outcome data and then use the results to show whether plans have the highest-value providers in their networks.

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 in narrative reports to assess quality improvement strategies?

As noted earlier, no matter how well designed their individual quality improvement strategies are, if each health plan pursues a different strategy from others, it will increase administrative costs for providers and potentially impede their efforts to improve the quality of care. A physician or hospital will not and should not improve the way it delivers care for only one health plan's members, so a provider cannot improve care delivery unless all payers are supporting a common approach to quality improvement and unless all payers have implemented a payment system and benefit design that supports quality improvement.

Consequently, two of the most important things that Exchanges can require is that health insurance issuers participate in multi-payer quality improvement initiatives organized by Regional Health Improvement Collaboratives and that they participate in coordinated payment reform initiatives that remove the barriers to quality improvement.

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?

A simple way for the Exchanges to measure and report on health plan issuers' quality improvement activities would be to list all of the key quality measurement and improvement initiatives that are being undertaken by a Regional Health Improvement Collaborative or other multi-stakeholder effort in the community, and ask the Collaborative or activity sponsor to indicate whether each health plan issuer is fully participating in that initiative. In particular, health plans that are not providing data on a

complete or timely basis to community quality measurement and reporting systems should be rated poorly in the Exchanges.

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: screenings, tests and vaccines; managing chronic (long-term) conditions; ratings of health plan responsiveness and care; health plan members' complaints and appeals; and health plan telephone customer service)?

As noted earlier, different regions of the country face different types of healthcare quality and cost problems. These differences mean that *which* quality and cost improvement issues should be priorities for a particular region and *how* that region can most effectively address those issues will differ from region to region.

In addition, as also noted earlier, reporting on the "quality" of health plans using aggregated measures of the quality of care delivered by the providers in a health plan's network can be actually be misleading for consumers, since it implies that the quality of the consumer's care depends on which *health plan* the consumer chooses, rather than which *provider* the consumer chooses.

Consequently, the quality of health plans should be measured on the extent to which they (a) have high-value healthcare providers in their networks, with high-value providers identified based on quality and cost measures derived from multi-payer data and published by multi-stakeholder collaboratives; (b) contribute data to multi-stakeholder collaboratives to enable them to measure the quality and cost of care; (c) enable and encourage their members to use high-value providers through value-based benefit designs; and (d) support community multi-stakeholder initiatives designed to improve the quality and cost of healthcare, including multi-payer payment reforms.

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?

Many Regional Health Improvement Collaboratives have invested a considerable amount of time and resources to develop and maintain quality reporting websites and to encourage consumers to use them. (Examples of these can be found on the NRHI website at http://www.nrhi.org/performancemeasurement.html.) Many of these websites have been developed and improved using extensive consumer research supported by AHRQ and the Robert Wood Johnson Foundation.

It is critical that Exchanges support and use these existing quality reporting efforts, rather than duplicating or conflicting with them. For example, an Exchange

could work with the RHICs in its state to show how the providers available through a particular issuer or QBP rank on quality and cost using the quality and cost scores and ratings from the RHICs' public reporting websites.

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?

The single biggest methodological challenge in public reporting is the difficulty of obtaining reliable measures on individual providers, and the only way to overcome this is by basing measures on as many patients as possible. Consequently, it is critical that Exchanges only use multi-payer quality measures and that they require health insurance issuers participating in Exchanges to contribute data to multi-payer measurement and reporting programs in the state or region.

A growing number of Regional Health Improvement Collaboratives are improving both the reliability of measures and the ability to use more outcome-oriented measures by establishing systems to collect clinical data directly from providers, rather than relying on claims data. For example, Minnesota Community Measurement, Quality Quest for Health of Illinois, The Health Collaborative in Cincinnati, and the Wisconsin Collaborative for Healthcare Quality publicly report on a number of clinical measures that many health plans cannot generate because they are collected directly from providers' clinical records. Because the data are based on all of the provider's patients, including those without insurance, they are not affected by changes in insurance and they allow more accurate measurement of disparities in care than data based just on insured patients. Moreover, these measurement systems are not dependent on electronic health records, so they can be used for all providers in the community. Exchanges could serve as a mechanism for funding these all-patient quality measurement programs in order to help patients choose high-value providers and then choose the health plans that have those providers in their networks.

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.

The most effective way to align quality reporting requirements inside and outside the Exchanges is to have a single Regional Health Improvement Collaborative collect and report quality measures for providers based on all of the providers' patients, rather than just for the members of certain health plans. Health plans can then be rated based on whether they have the highest-value providers in their networks.

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?

In addition to reporting on the quality of care for all patients, some Regional Health Improvement Collaboratives are reporting on whether there are differences or disparities in the quality of care for different types of patients. (Examples are available on the NRHI website at http://www.nrhi.org/performancemeasurement.html#quality_disparities1.) The ability to do this depends on having data on enough patients, particularly those in the specific subgroups, to allow valid measures to be generated and compared at a disaggregated level.

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

It will be very important to distinguish the value delivered by a health plan from the value of the services delivered by the healthcare providers it contracts with. A number of communities are working actively to measure and improve the quality and cost of healthcare services in their community, and the Exchanges should encourage consumers to use health plans that support these efforts, particularly plans which participate in multi-payer payment reforms developed by the community on a multi-stakeholder basis. The Exchanges should primarily focus on measuring the value that the plan itself contributes beyond the healthcare services of providers, e.g., the magnitude of administrative costs, the quality of customer service for members, etc. To the extent that the Exchanges use any ratings of the value of healthcare services delivered by providers in the health plans' networks, those ratings should be based on the community's quality and cost measures for providers that are derived from data on all patients.

More generally, HHS can support the development of higher-value healthcare in communities through two separate and complementary strategies:

1. HHS should support the creation and operation of non-profit, multi-stakeholder Regional Health Improvement Collaboratives in each community that (a) measure and help providers improve the quality and cost of healthcare and (b) educate and assist consumers to choose and use high-value providers and services, and
2. Through the Exchanges and other mechanisms, HHS should encourage consumers to choose health insurance plans which (a) support the work of multi-stakeholder Regional Health Improvement Collaboratives, (b) have benefit designs that enable and encourage their members to use providers and services that are measured as high value by Regional Health Improvement

Collaboratives, and (c) implement multi-payer payment reforms that enable and reward providers for delivering high-value care.

Thank you for the opportunity to provide input on this important topic. We would be happy to answer any questions you have or provide any additional information. Please let us know if we can be of any assistance to you as you develop the quality-related requirements for insurers participating in the Exchanges.

Sincerely,

Harold D. Miller
President and CEO

cc: Gary Cohen, Director, Center for Consumer Information and Insurance Oversight
Patrick Conway, Director, Center for Clinical Standards and Quality