

Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

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Submitted via [regulations.gov](http://www.regulations.gov)

January 21, 2014

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-3288-NC
P.O. Box 8010
Baltimore, MD 21244-8010

RE: Comments on CMS-3288-NC; Qualified Health Plan Quality Rating System

I write on behalf of the Tribal Technical Advisory Group (TTAG) of the Centers for Medicare and Medicaid Services (CMS) regarding the notice titled “Patient Protection and Affordable Care Act; Exchanges and Qualified Health Plans, Quality Rating System (QRS), Framework Measures and Methodology” (CMS-3288-NC) and published by CMS in the November 19, 2013, Federal Register. This notice requested comments on the list of proposed QRS quality measures that qualified health plan (QHP) issuers would have to collect and report, the hierarchical structure of the measure sets, and the elements of the QRS rating methodology. In addition, this notice sought comments on proposals to ensure the integrity of QRS ratings and on priority areas for future QRS measure enhancement and development.

TTAG advises CMS on Indian health policy issues involving Medicare, Medicaid, the Children’s Health Insurance Program, and any other health care programs funded (in whole or part) by CMS. In particular, TTAG focuses on providing policy advice to CMS regarding improving the availability of health care services to American Indians and Alaska Natives (AI/ANs) under these Federal health care programs, including through providers operating under the health programs of the Indian Health Service (IHS), Indian Tribes, tribal organizations, and urban Indian organizations (referred to as I/T/Us or Indian health care providers).

We appreciate the opportunity to provide comments on QRS, which we believe will serve as an important tool that allows consumers to make informed decisions when comparing QHPs. Though we applaud CMS for its efforts to encourage the delivery of higher-quality health

care services, expand access to care, and improve health outcomes for QHP members, we have concerns that QRS, as proposed, does not include measures that adequately address the special needs and circumstances of AI/ANs. These comments outline our specific concerns and provide recommendations to address these issues.

Statutory Authority and Summary of Notice

The Patient Protection and Affordable Care Act (ACA) requires the Secretary of the Department of Health and Human Services (HHS) to develop a number of reporting requirements to support the delivery of quality health insurance offered in the Exchanges. Specifically, sections 1311(c)(3) and (c)(4) of ACA direct the HHS Secretary to develop: (1) a system that rates QHPs based on their relative quality and price; and (2) an enrollee satisfaction survey system that assesses the level of enrollee experience with QHPs. CMS has promulgated regulations at 45 CFR 155.200(d) that direct Exchanges to oversee implementation of QRS, and it has issued regulations at 45 CFR 156.200(b)(5) that direct QHP issuers to report health care quality information to an Exchange.

In CMS-3288-NC, CMS indicates that QRS should provide ratings of QHPs based on health care quality, health outcomes, cost of care, and consumer experience. To support this objective, CMS intends, for the initial years of QRS implementation, to have all QHP issuers report product-level performance data in general areas such as clinical effectiveness of care, patient safety, care coordination, prevention of disease and illness, access to care, member experience, plan services and efficiency, and cost reduction. According to CMS, QRS ratings should demonstrate sound, reliable, and meaningful information on the performance of QHPs to support informed decisions by consumers.

Recommendations

1. Information on Access to I/T/U Providers

In CMS-3288-NC, CMS cites the level of access to health care provided through QHPs as an important component of QRS. To ensure access to care for consumers, QHPs must have adequate networks of health care providers. CMS previously has recognized that the concept of network adequacy includes several components, such as geographic accessibility, the ability to deliver the care needed by consumers, and the ability to offer culturally competent care.¹ In this notice, CMS has indicated that QRS should reflect the goals of the National Strategy for Quality Improvement in Health Care, which, among other priorities, seeks to

¹ CMS, "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans," *Federal Register* 76, no. 136 (July 15, 2011): 41866-927. <http://www.gpo.gov/fdsys/pkg/FR-2011-07-15/pdf/2011-17610.pdf>

promote health care that is “timely, accessible, and consistent with individual and family preferences and values.”²

In addition, an ACA initiative central to ensuring access to quality health care for all QHP members is the required inclusion of “essential community providers” (ECPs) in plan networks. Under section 1311(c)(1)(C) of ACA, the HHS Secretary is to certify that health plans to be offered through an Exchange meet certain ECP requirements. CMS promulgated regulations at 45 CFR 156.235 that established requirements for inclusion of ECPs in QHP provider networks. And in an April 5, 2013, letter sent to issuers, CMS issued directives outlining how QHPs can satisfy ECP requirements. (TTAG submitted comments on March 17, 2013, on an earlier draft of the CMS letter to issuers.) Ensuring compliance by issuers with the ECP requirements, whether through QHPs offered through State-based Exchanges or Federally-facilitated Exchanges, is key to facilitating access to quality health care.

Network adequacy is an issue of critical significance to AI/ANs. Many AI/ANs rely on I/T/U hospitals and clinics, which operate in some of the most isolated and sparsely populated areas of the United States, as their sole source of health care.³ In addition to geographic concerns, I/T/Us often are the only providers in a plan service area with the capacity to deliver health care AI/ANs in a culturally competent manner.⁴ Therefore, for AI/ANs to have the ability to make informed decisions when comparing QHPs--one of the fundamental tenets of QRS set forth by CMS--they require timely and accurate information regarding the availability of, and level of access to, I/T/Us in their networks.

To address the need for timely and accurate information on the inclusion of I/T/U providers in QHP networks, CMS should add the following individual QRS measures to the list shown in Table 2 of CMS-3288-NC:

- Number of I/T/U providers in the geographic area served by the QHP;
- Number of I/T/U providers in the geographic area served by the QHP that are included as in-network providers; and
- Percentage of I/T/U providers in the geographic area served by the QHP that are in-network providers.

2. Information on AI/AN Member Experience

² HHS, *2013 Annual Progress Report to Congress: National Strategy for Quality Improvement in Health Care* (Washington, DC: July 2013), 12. <http://www.ahrq.gov/workingforquality/nqs/nqs2013annlrpt.pdf>

³ The Kakakanek Hospital, operated by the Bristol Bay Area Health Corporation, for example, is located 329 air miles from the nearest non-I/T/U facility in Anchorage, Alaska.

⁴ Whether because of a lack of trust, a history of abuse and discrimination, or the inability of non-I/T/U providers to offer culturally competent care, many AI/ANs will not enroll in a QHP unless they can have access to their own I/T/U provider.

In addition to the level of access to health care, CMS in CMS-3288-NC cites member experience with QHPs as a key part of QRS. According to CMS, “because we believe that QHP consumer experience is an important part of rating the overall quality of a QHP, we intend to use some of the information collected” from the enrollee satisfaction survey system in QRS.⁵ As part of this system, CMS has developed a draft version of the QHP Enrollee Survey, which, among other goals, seeks to help consumers make informed decisions when comparing QHPs.

For AI/ANs, the issue of QHP enrollment raises important concerns. To ensure that QHPs help AI/ANs understand and obtain these protections, TTAG, in comments filed on December 2, 2013, recommended that CMS add to the QHP Enrollee Survey an AI/AN-specific section with the following topics:

- Whether AI/AN members are aware of the availability of I/T/Us as in-network providers in the QHP;
- Whether and why the QHP ever refused to pay a bill, in full or in part, for services provided at an I/T/U;
- Whether AI/AN members have ever had cost-sharing in any circumstances in which ACA exempts them, and, if so, whether and how they resolved the dispute with the QHP, as well as the availability of resources in the event of an unresolved dispute; and
- What interaction AI/AN members have experienced with QHP personnel regarding AI/AN-specific issues.

By adopting these recommendations, CMS will have the information necessary to add the following individual QRS measures to the list shown in Table 2 of CMS-3288-NC:

- Percentage of AI/AN members who are aware of the availability of I/T/Us as in-network providers in the QHP;
- Percentage of claims denied by the QHP, in full or in part, for services provided at an I/T/U;
- Percentage of AI/AN members who have ever had cost sharing in any circumstances in which ACA exempts them;
- Percentage of AI/AN members who have entered disputes with the QHP over cost sharing, as well as the percentage of resolved disputes; and

⁵ CMS, “Patient Protection and Affordable Care Act; Maximizing January 1, 2014, Coverage Opportunities,” *Federal Register* 78, no. 223 (Nov. 19, 2013): 69418-26. <http://www.gpo.gov/fdsys/pkg/FR-2013-11-19/pdf/2013-27649.pdf>

- Percentage of AI/AN members who positively rate their experience with QHP personnel.

3. AI/AN-Specific CAHPS Measures

QRS, as proposed by CMS in CMS-3288-NC, includes 13 Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey measures, which address issues such as member experience with QHPs, providers, and health care services, including preventive care. These measures, however, might not reflect the special circumstances and needs of AI/ANs. In 2004-2005, CAHPS developed the American Indian Survey to help establish benchmarks for AI/AN patient experiences, whether at I/T/U or non-I/T/U facilities.⁶ This survey produces the following AI/AN-specific measures:

- Getting care quickly;
- Getting needed care;
- How well health professionals communicate;
- Courteous and helpful office staff;
- Guidance about your personal health;
- Perceived discrimination because of tribal affiliation;
- Shared decision making;
- Coordination of care;
- Patients' rating of the doctor or nurse; and
- Patients' rating of the clinic.⁷

We recommend that CMS add the existing AI/AN-specific measures identified above to the list of individual QRS measures shown in Table 2 of CMS-3288-NC. In addition, we encourage CMS to ensure that sufficient numbers of AI/ANs are surveyed to generate statistically valid samples and findings.

Conclusion

Thank you for the opportunity to provide these comments on QRS. We appreciate the continuing efforts by CMS to help ensure that QHPs meet the unique needs of AI/ANs and that AI/ANs understand and obtain the special protections afforded to them by ACA. TTAG

⁶ "Development of the CAHPS American Indian Survey," *CAHPS: Consumer Assessment of Healthcare Providers and Systems*, last modified June 1, 2013, <https://cahps.ahrq.gov/surveys-guidance/american-indian/about/Development-AI-Care-Survey.html>.

⁷ "Quality Measures from the American Indian Survey," *CAHPS: Consumer Assessment of Healthcare Providers and Systems*, last modified June 1, 2013, <https://cahps.ahrq.gov/surveys-guidance/american-indian/about/index.html>.

remains willing to assist CMS in these endeavors. Please contact Jackie Engebretson at JEngebretson@nihb.org if you have any questions on the issues addressed in these comments.

Sincerely,

A handwritten signature in black ink, appearing to read "Valerie Davidson". The signature is fluid and cursive, with a long, sweeping flourish extending from the end.

Valerie Davidson
Chair, TTAG

Cc: Dr. Yvette Roubideaux, Director, IHS
Stacy Bohlen, Executive Director, NIHB
Kitty Marx, Director of Tribal Affairs, CMS