CPPP CENTER for PUBLIC POLICY PRIORITIES
WORKING FOR A BETTER TEXAS™

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Via email: chiefclerk@tdi.state.tx.us and companylicense@tdi.state.tx.us

Re: Proposed Rules Relating to Health Care Collaboratives, 28 TAC Chapter 13, Subchapter E.

Dear Ms. Waitt, Mr. Hunt, and Mr. Danzeiser:

Thank you for the opportunity to comment on TDI's proposed rule related to Health Care Collaboratives.

The Center for Public Policy Priorities supports efforts to improve the quality of health care delivered to Texans while lowering costs, and we believe that new models of care delivery and payment, including Health Care Collaboratives (HCCs), have potential to improve care coordination, foster patient engagement, and increase quality. It is essential that HCCs and other models are more than just a new way to organize and pay providers. We believe HCCs need to be designed, operated, and monitored with a focus on better meeting the needs of enrollees and patients.

Our primary concern with the rules as proposed is that they do not sufficiently hold HCCs accountable for achieving the goals envisioned in Texas Insurance Code Chapter 848. The goal behind allowing more clinical and financial integration of providers is to enable HCC participants to deliver better coordinated care to patients across various health care settings (ex:

primary care physician's offices, specialist's offices, hospitals, etc.). To facilitate this goal, HCCs allow health care providers to consolidate in ways that may otherwise be prevented by anti-trust protections. Evidence from health care provider consolidations shows that quality too often declines despite pledges that quality improvements will result. To ensure that HCCs do not just provide an end-run around anti-trust protections but deliver real value to Texas consumers in the form of less fractured health care delivery, HCCs must be held accountable for delivering better coordinated and higher quality care. The way to hold HCCs accountable is through reporting on quality metrics.

As we suggested in our comments on the draft HCC rule, we recommend that TDI develop a set core set of standard quality measures that all HCCs will report on at renewal. The key consumer protection and tool for accountability is that HCCs report on the same set of standard measures. If HCCs can pick the measures that they report on (as is allowed under §13.413(h)(6)(C) and §13.482(b)(1)), each HCC will pick the measures on which they score well and avoid others that show room for improvement. This is not the point of performance measures and would inhibit regulator's ability to ensure the public is benefiting from provider consolidation and integration through HCCs. Requiring HCCs to report on standard quality measures that support the goals in TIC Chapter 848 (and hopefully publicly displaying the results) is vital for:

1. Oversight of pro-competitive benefits (§13.413(h)(6)),
2. Monitoring HCC progress on promoting evidence-based medicine, patient engagement, coordination of care, and quality reporting (§13.482(a)), and
3. Ensuring that cost savings do not come from limiting medically necessary services (a trend that could show up in quality measure reporting).

We recognize the difficulty in setting uniform quality measures for HCCs when HCCs could take so many different forms. And it is often difficult to get providers to agree on quality measures. We recommend the following, to assist TDI with this important task:

- If TDI does not have the expertise needed in this area, it should partner with the Department of State Health Services or an agency that does have expertise in quality measures.
- Use measures that have been validated and have broad acceptance by the provider community, such standards endorsed by the National Quality Forum.
- Start small. Choose a few measures from the specific domains that are goals in TIC §848.057(a)(2): patient safety, patient engagement, care coordination, reduction of potentially preventable events.
- Use the 33 standard quality measures in the Medicare Accountable Care Organization regulation as a starting point.[1] The Center for Medicare and Medicaid Services chose the ACO measures to align with the Physician Quality Reporting System, and the Electronic Health Record (EHR) Incentive Programs, so they will be familiar to providers and some HCC participants may already be reporting them. We recommend that TDI at least use ACO measures 1-7 from the Clinician and Group Consumer Assessment of Health Care Providers

[1] Centers for Medicare and Medicaid Services, Guide to Quality Performance Standards for Accountable Care Organizations Starting in 2012, http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO-Guide-Quality-Performance-2012.PDF.

and Systems (CG CAHPS) that measure the patient/caregiver experience, as well as ACO measure 8, the risk-adjusted 30-day hospital readmission rate, which measures coordination of care (or another NQF-endorsed, readmission-based measure). TDI should consider other measures that are part of Medicare ACO's care coordination domain.

- It is possible that not all standard measures will apply to narrowly focused HCCs. If a standard measure does not apply to an HCC, the HCC should explain why to TDI and OAG and replace that measure with another in the same domain (ex: patient experience, care coordination, etc.).
- TDI should still require HCCs to report on other quality measures that the HCC determines is appropriate that go beyond the scope of the core set of standard measures.

We urge TDI to incorporate a core set of standard HCC quality measures into the proposed rules as outlined below. We believe that TDI and OAG have sufficient authority to do this under TIC §848.151. Furthermore, we believe that the statute clearly envisions TDI and OAG taking into account an HCC's actual performance in delivering quality and coordinated care in §848.060(b)(2)(D) and (E), which can be evaluated in part by the use of standard quality performance measures.

§13.402 (21) Definition of pro-competitive benefit

We believe that the definition of pro-competitive benefit should link to the goals quality and coordinated care outlined in Chapter 848 and be clear that the benefit is to the patients of the HCC. We think that provider use of electronic health records, for example, is not itself a benefit for patients. EHRs are a tool that can result in benefits for patients like reduction of duplicative tests, fewer prescription errors, and remote patient access one's medical record, as well as benefits for providers like improved efficiency in records maintenance, improved coding and billing, etc. When showing that pro-competitive benefits outweigh the risks of provider consolidation, HCCs should not be able to propose expanding EHRs as a pro-competitive benefit, for example, and then measure the percentage of HCC providers using them. Instead, the HCC should propose reduction of duplicative tests, for example, as the pro-competitive benefit, and measure improvement in that outcome.

Recommendation: We recommend that you revise the definition as follows (benefits modeled after HCC requirements in TIC 848.057(a)(2)(A)):

> *(21) Pro-competitive benefit--A benefit to patients obtained from clinical or financial integration by the establishment and operation of the HCC in the form of increased provider collaboration, improved quality-based health care outcomes, improved patient safety, improved patient engagement, improved coordination of services, reduced potentially preventable events, or incentives that reduce health care costs without jeopardizing patient quality of care.*

§13.413(h)(6). Contents of application related to pro-competitive benefits

Applicants should be required to identify the pro-competitive benefits that support the goals in TIC 848.

Recommendation:

(6) identification of pro-competitive benefits the applicant anticipates will result from the establishment of the HCC:

HCC applicants should be required to use the set of standard HCC quality measures proposed above to support the assessment of their pro-competitive benefits as is appropriate. For example, if the applicant anticipates that the HCC will improve the coordination of care, it should use the TDI-defined standard measures from the care coordination domain in its renewal application, along with other appropriate measures.

Recommendation:

(6)(C)(ii) the standard or standards to be used by the HCC in tracking progress toward achieving the pro-competitive benefit. To the degree possible, the HCC shall use measures from the HCC core set of standardized quality measures for each domain in which the applicant anticipates a pro-competitive benefit, in addition to other relevant standards; and

It will take time for some pro-competitive to be achieved. We support the use on interim benchmarks in §13.413(h)(6)(C)(iii) when benefits will take more than one year to be achieved.

As is laid out in Chapter 848, cost control measures should not jeopardize the quality of patient care.

Recommendation: If an HCC proposes a pro-competitive benefit under §13.413(h)(6)(D), it should lay out the reference point, standards, and time frame (as is done in (C)) that it will use to demonstrate that alternative payment methods either led to improvements in or at least did not result in diminished quality of care.

§13.415. Documents to be Available for Quality of Care and Financial Examinations

The title does not reference renewal applications (found in §13.424), but several provisions ((a)(2)-(4), (12), (16), and (17)) reference information, for example satisfaction surveys, that must be submitted with renewal applications that are not found in §14.413 (Content of the Application) or §13.424 (Certificate of Authority Renewal Requirements).

Recommendation: Clarify which documents must be available at the HCC's office or provided to TDI upon request linked to examinations and which documents must be submitted as part of a complete renewal application. Requirements for the renewal application should probably be listed in §14.413 or §13.424 to reduce confusion and should be reflected Form 492, Original/Renewal Application for Certificate of Authority.

As noted at the outset in our comments, we believe that HCCs should be held accountable for improving the quality of care and better coordinating care, in part, by measuring and reporting on a core set of quality measures defined by TDI. These data are essential for TDI to perform the evaluations of quality of care, promotion of evidence-based medicine, promotion of patient engagement, and coordination of care at renewal as is required under TIC 848.060(b)(D) and (E).

This section should require that HCCs make the quality measure data, documentation of data validation, etc., available during examinations. A requirement to submit these measures for evaluation upon renewal should be added in this section (or in whichever section TDI lists renewal requirements that show HCC outcomes). This section could establish the standard set of HCC quality measures by referencing the Medicare ACO regulation (or a subset of it), or the core set of measures could be established in §13.482. This section should also specifically require HCCs to have for examinations and submit upon renewal the results of the CAHPS survey and other quality measures required under §13.482(b)(1).

Recommendation: insert new subsection (18), and move (18) to (19):

> (18) standard quality measures: for renewal applications only, results of the CAHPS survey and other quality measures required under §13.482(b)(1) and the core set of standard quality measures required under the Medicare Accountable Care Organization final regulation [or a subset of these or other standard measures as defined by TDI].
> (19) other documents and information: any records requested pursuant to Insurance Code §848.153.

Recommendation: We recommend the use of a standard patient experience of care survey like CAHPS as opposed to a patient "satisfaction survey," referenced in §13.415(a)(16).

§13.424. Certificate of Authority Renewal Requirements

As noted above, this section does not contain or reference many requirements for renewal applications found in §13.415.

Recommendation: We recommend moving requirements for renewal applications into this section to increase clarity. All requirements for the renewal application should also be listed on Form 492.

§13.482. Quality Assurance and Quality Improvement

§13.482(a) does not mention patient safety or the reduction potentially preventable events, but those goals are incorporated in TIC 848. Promoting patient safety and reducing preventable events are important parts of quality improvement programs.

Recommendation: We recommend that you list patient safety and the reduction of potentially preventable events in (a), either by listing it as its own subsection or adding it to (1), *promote evidence-based medicine and best practices, <u>including practices or processes to improve patient safety and reduce the occurrence of potentially preventable events.</u>*

We strongly support the requirement in (b) that HCCs will have to use the appropriate CAHPS survey unless TDI grants permission otherwise. As expressed in these comments and our comments on the draft rule, we believe that uniform evaluation tools are critical for consumer protection. We believe that this section can be strengthened as described below.

Recommendations:

1. As repeated throughout these comments, we urge TDI to establish a uniform set of quality measures that all HCCs report on. If a standard measure does not apply to an HCC, the HCC should explain why to TDI and OAG and replace that measure with another in the same domain (ex: patient experience, care coordination, etc.). We think it probably makes more sense to establish the measures in the section on information that must be submitted upon renewal, since TDI is clearly supposed to evaluate an HCC's perform on delivering high-quality and coordinated care. But the core set of standard measures could also be established in this section (potentially under (b) or (e)), as long as doing so does not impact public reporting on quality measures (see below).
2. HCCs should have to publicly post (or TDI should post) HCC's CAHPs measures and other quality measures. We realize that quality improvement activities are confidential under the statute. Measures are not in themselves quality improvement activities. How an HCC acts on the results of its measures may be confidential, but the measures are not and should be made public to bring transparency to HCCs, similar to public reporting of HMO quality indicators. We urge TDI to move the requirement for HCCs to use CAHPs and other quality measures out of this subsection if that is needed to ensure that quality measures are made public.
3. NQF (listed in (b)(3)) endorses quality measures, but AHRQ (listed in (b)(2)) does not. AHRQ has a database of quality measures, but they are not "AHRQ standards." We are not sure what (B) points to. We recommend that (C) be changed to *National Quality Forum <u>endorsed</u> standards*.

Sec. 13.482(c)(1). We support the requirement that HCCs have a process in place to evaluate the health needs of its enrolled populations. We think this section of the rule could be strengthened by requiring that the evaluation occur at least annually, include considerations of diversity in the HCC's patient population, and is used by the HCC to create a plan to address the needs of its population. One way to help ensure network adequacy is to require the HCC to demonstrate how they will update their network in response to the findings of the needs assessment.

Sec. 13.482(c)(2-4). We support the requirements that HCCs have processes and written standards in place to help providers communicate clinical information understandably and promote patient engagement. HCCs should be required to provide a detailed explanation of how its providers will communicate clinical knowledge and evidence-based medicine to enrollees in a way that is understandable to them. For example, the HCC should explain how it will ensure information is conveyed at the appropriate literacy level and in the beneficiary's primary language. This can be done by providing examples of the materials that HCCs will use as part of its application. The HCC should also provide information on its use of decisions aids to help engage patients in treatment decisions. HCC applications and QI processes should lay out whether providers will use decision aids developed by the Agency for Healthcare Research and Quality, other entities, or develop its own. The HCC should also specify how it will identify and incorporate the patient's values and preferences.

We urge TDI to monitor HCCs in this area at renewal and during quality of care exams to ensure that the HCC is following the processes set out in the application. Among other things, CAHPS measures

how enrollees feel providers communicate and their experience with shared decision making. Monitoring CAHPS results at renewal will help TDI monitor and improve patient engagement.

Recommendation: We suggest the following specific additions to sec. 13.482(c):

> (c) The patient engagement process should include:
>
> (1) evaluating the health needs of its enrolled population, including considerations of diversity in its patient population, and a plan to address the needs of its patient population;
>
> (2) communicating clinical knowledge and evidence based medicine to patients and patient representatives clearly and understandably;
>
> (3) promoting patient engagement, through shared-decision making and independent care plans that take into account the patients unique needs, preferences, values, and priorities; ~~and~~
>
> (4) establishing written standards for patient communications, and
>
> (5) establishing a process for patients to access their medical records.

Quality improvement should be the cornerstone of HCCs. Quality and performance measurement are key elements of accountability; without such measurement, TDI, OAG, and the public cannot be sure that quality care is delivered, whether quality improves overtime, and whether HCCs are facilitating coordinated care or just provider consolidation. Nor can we be sure that an HCC isn't sacrificing quality as a means to contain costs.

Thank you for the opportunity to comment on these important rules. If you have any questions about our comments, please contact Stacey Pogue, senior policy analyst with the Center for Public Policy Priorities at 320-0222 x. 117 or pogue@cppp.org.

Sincerely,

Stacey Pogue
Senior Policy Analyst