



May 14, 2010

To: Secretary Kathleen Sebelius
Secretary Timothy Geithner
Secretary Hilda Solis
Room 445-G
Department of Health and Human Services
Attention: DHHS-2010-MLR
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: PPACA Medical Loss Ratio Provisions

Dear Secretaries Sebelius, Geithner, and Solis:

As one of the nation's oldest and largest providers of health care benefits, we understand the critical importance of thoughtful development of minimum loss ratio (MLR) definitions and standards under the Patient Protection and Affordable Care Act (PPACA). These definitions and standards will determine the manner and extent to which health plans invest in activities to improve care quality and safety, reduce fraud, support members with chronic illnesses or complex health conditions, and maintain networks that offer both broad provider choice and affordability.

The MLR definitions also will determine the willingness of health plans to enter new markets and/or remain in existing markets, particularly those markets in which the carrier has a relatively small market share. No other aspect of PPACA will be as influential in shaping the future of the health care marketplace in the United States. Meaningful consumer choice in the individual and small group markets will depend on the ability of plans -- both for-profit and non-profit -- to serve members effectively and to compete fairly without undue risk to solvency.

The statute provides the designated federal agencies with a great deal of flexibility in the MLR section to assure the development of an MLR that does not destabilize the marketplace. We hope that you carefully consider this flexibility and use it to avoid the potential negative impacts of an inappropriately designed MLR. An improperly developed MLR could:

- *Hurt quality and patient safety:* Narrow MLR definitions could lead insurers to eliminate functions like protocol-based care review that improve quality and reduce inappropriate and even harmful care. These activities address and prevent unnecessary surgeries that lead to

the deaths of 12,000 patients annually¹, adverse drug events that result in more than 770,000 injuries or deaths each year² and fraud that threatens the health of consumers and costs at least \$68 billion each year.³

- *Increase premiums:* Under-investment in care quality initiatives, safety activities, and effective provider contracting will increase health care costs which in turn will result in insurers having to increase premiums. Amounts health plans invest in electronic connectivity, chronic care support, critical care coordination, and member health information and cost and quality optimization result directly in consumer cost savings.
- *Reduce competition in the market place:* Inappropriate MLR rules could cause insurers to withdraw from state individual or small group markets and discourage entry into new markets. At one point in the 1990s, residents of 36 of 39 Washington state counties were left without access to individual market coverage because of shortsighted state insurance reforms. CBO also has recognized the possibility of insurers exiting the individual market and the American Academy of Actuaries has expressed solvency concerns stemming from inappropriate MLRs.
- *Narrow provider choice for consumers:* Health plans operate in a variety of ways -- from contracting with individual providers to fully-capitated staff model plans. The MLR must treat analogous activities comparably whether performed directly or through a contracted relationship. Otherwise, the MLR will favor the less prevalent staff model HMO construct and drive the more popular PPO model from the marketplace -- since PPOs will either exit the individual market or convert to the staff model construct.

Recommendations: We recommend that the agencies consider the following recommendations to avoid these types of unintended consequences:

- 1) Provide for a single MLR calculation for an insurer's large group business at the holding company level -- reflecting the multi-state nature of this business that is consistent with the way large employers manage their health care benefits across many different products in varying markets with different costs. If a single large group MLR is not allowed, it would require significant expenditures in systems changes to allocate expenses on a state-by -- state basis. This would have the paradoxical effect of increasing administrative expenses.
- 2) Adopt a quality definition that includes the broad array of insurer functions that support quality by using the Institute of Medicine's six aims for care quality improvement: activities designed to make care more safe, effective, patient-centered, timely, efficient or equitable. In particular, we are concerned that health information technology investments that directly and indirectly support quality be considered, like electronic health records and ICD-10 implementation, as they will enable better research and disease management. Quality also should cover utilization review connected to standard of care measures as identified by the

1 Leape L. Unnecessary surgery. *Annu Rev Public Health.* 1992;13:363-383

2 Classen DC, Pestotnik SL, Evans RS, et al. Adverse drug events in hospitalized patients. *JAMA* 1997;277(4):301-6.; Cullen DJ, Sweitzer BJ, Bates DW, et al. Preventable adverse drug events in hospitalized patients: A comparative study of intensive care and general care units. *Crit Care Med* 1997;25(8):1289-97.; Cullen DJ, Bates DW, Small SD, et al. The incident reporting system does not detect adverse drug events: A problem for quality improvement. *Journal on Quality Improvement* 1995;21(10): 541-8.

3 National Healthcare Anti-Fraud Association, "The Problem of Health Care Fraud."

various medical society guidelines and anti-fraud activities that protect consumers from dangerous unnecessary procedures.

- 3) Adopt NAIC's definitions of claims and claims-related expenses (SAP 85) as permitted claims expenses. This ensures all insurance providers use the same accounting rules for claims, no matter how they are organized, i.e., HMO vs. PPO business models.
- 4) Exclude from premiums the amount of all federal taxes (e.g., income, PPACA) and state taxes (e.g., property), assessments, and regulatory fees that health plans currently pay and/or administer. Plans also should be permitted to account for medical cost plan-related activities required to comply with applicable state and federal law as a reduction to premiums.
- 5) Allow rebates to be provided through premium credits to individuals and employers (on behalf of employees). This avoids expensive administrative costs associated with sending individual checks -- costs that may exceed the value of the rebates.
- 6) Allow three year rolling MLR averages beginning with the initial MLR calculation -- this is necessary to address normal fluctuations in the risk pool and administrative expenses from one year to the next.
- 7) Adopt a modified version of the credibility adjustment used for Medigap, for the individual and small group markets. This also was recommended by the American Academy of Actuaries (May 12th letter from the Chair of the Medical Loss Ratio Regulation Work Group). Otherwise, insurers with a small population in a state may exit the individual market -- disrupting coverage for scores of individuals, and leaving those with high risk conditions without critical coverage in some states where they are unable to either obtain or afford high risk pool coverage that is likely to be more expensive than their current individual market coverage.
- 8) Allow federal preemption of state MLR definitions and methodologies that differ from the NAIC's recommendation. If states adopt an alternative formula, it would be costly and impractical for insurers to comply with different federal and state formulas.

We have attached a more detailed set of comments. We appreciate your consideration of these comments as you prepare MLR definitions that further quality, preserve competition and do not adversely affect affordability. Please contact me if we can be of assistance.

Sincerely,



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VIA HAND DELIVERY

Secretary Kathleen Sebelius
Secretary Timothy Geithner
Secretary Hilda Solis
Room 445-G
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200 Independence Avenue, SW
Washington, DC 20201

Re: Medical Loss Ratios; Request for Comments Regarding Section 2718 of the Public Health Service Act

Dear Secretaries Sebelius, Geithner and Solis:

This letter responds to the Request for Comments Regarding Section 2718 of the Public Health Service Act (PHSA) published at 75 Fed. Reg. 19297 on April 14, 2010.

Aetna is one of the nation's oldest and largest providers of health care benefits and currently provides coverage for more than 36 million Americans. We understand the critical role of the medical loss ratio (MLR) definitions and standards under the Patient Protection and Affordable Care Act (PPACA), and we appreciate the opportunity to provide comments on this important issue. These definitions and standards will determine the manner and extent to which health plans choose to invest in activities to improve care quality and safety, reduce fraud, support members with chronic illnesses or complex health conditions, and maintain networks that offer both broad provider choice and affordability. The MLR rules will also determine the willingness of health plans to enter new markets and/or remain in existing markets, particularly those markets in which the carrier has a relatively small market share. We believe that no other aspect of PPACA will be as influential in shaping the future of the health care marketplace in the United States.

Meaningful consumer choice in the individual and small group markets will depend on the ability of plans – both for-profit and non-profit – to serve members effectively and to compete fairly without undue risk to solvency. As the new MLR requirements go in effect, one of the key elements of ensuring the stability of the health insurance market is appropriate aggregation. Particularly for regional plans with small market share, rules requiring narrow aggregation may

make it too challenging to compete effectively, forcing these plans to leave the market. Another key element of the MLR rules will be the definitions that determine which expenses are considered medical and which are considered administrative. In general, health plan expenditures that are designed to affect patient outcomes and behaviors should be considered medical costs, whereas expenditures that go towards collecting revenue or billing for services should be considered administrative.

We present our response to your request for comments in the priority of what we believe are the key issues underlying your inquiry. We hope that the information provided below in response to the agencies' solicitation of comments will be helpful as you move forward with implementing PPACA. We look forward to commenting further when a proposed rule is issued.

I. **Level of Aggregation**

MLRs should be aggregated at a level that maximizes consumer choice and administrative efficiency. Each insurer holding company should report a single large group MLR (e.g. national). Insurer holding companies would report individual and small group MLRs on a state-by-state basis.

The statutory language of the MLR requirement does not specifically address aggregation for purposes of MLR reporting or rebate payments. Because of the statute's silence, the Department of Health and Human Services (HHS) has substantial discretion to allow aggregation by market segment (individual, small group, large group), as well as aggregation by state or nationally. The regulation would receive deference under settled principles of administrative law.

a. **Large Group Aggregation:**

Concerning large groups, it is our recommendation that the MLR be measured at the holding company level for the largest geographic area covered, e.g. at the national level. Blending large group experience across the holding company level is the most accurate way to assure reasonable distribution across all group clients – and best conforms to the accounting principle of matching costs to associated premiums. Insurers do not currently allocate large group costs on a state by state basis. Any requirement to calculate large group MLRs at the state level would require extensive system changes that would increase administrative costs to employers and could reduce the number of insurers capable of serving this marketplace. Narrowly aggregating for national companies also risks incorrectly attributing administration expenses within component regional or state markets, thus inaccurately reflecting true MLR experience for the group.

Calculating MLRs for large groups raises a number of complexities. Pricing, rating and funding methodologies vary significantly for these groups. This inherent complexity was recognized when Congress appropriately exempted self-insured group health plans from the MLR reporting requirements. We agree that there should be no MLR calculation done for self-insured large employers, as these employers are significantly sophisticated in benefit design given that they hold the risk for their employee populations. For large groups that are fully insured, some are fully prospectively rated (similar to small group practices) but most are rated partially or entirely on their own experience. For these plans, an MLR variation in one year is likely to be reflected in policyholder-specific changes in premium for the following year.

Additionally, a great majority (89 percent) of large groups typically have membership across multiple states. These employers view their experience on an aggregate basis and expect their carriers to do the same. In light of these complications and the fact that larger plans are sophisticated purchasers who typically use brokers and consultants to negotiate tailored rates, MLR regulation would not play a meaningful consumer protection role in the large group market, it would simply add unnecessary administrative costs. In fact, the introduction of MLR calculations on this basis is significantly different than how the marketplace conducts business today. Aggregating at the state-level could produce arbitrary and unfair results, such as different employees of the same employer receiving different rebates based solely on their residency.

b. State and Individual Market MLRs

MLRs for the individual and small group markets should be reported on a state-by-state basis. Measurement on smaller subsets of an issuer's book of business in the individual or small group market (e.g., distinguishing different product variations) runs the risk of penalizing smaller market participants and discouraging innovation in new benefit offerings by measuring experience data that lacks sufficient statistical make-up to produce a credible MLR. In addition, it would run counter to PPACA's requirement to establish "one risk pool." It would also substantially increase the burden on both issuers and state insurance departments to no advantage for the beneficiary.

By defining the small group market to include groups of up to 100 lives, it is likely that in many urban areas, the MLR experienced in this category will reflect coverage provided in two or more states. For small groups with membership in multiple states, the contract situs should determine the state in which the MLR is reported.

II. Credibility Allowances

The American Academy of Actuaries should develop a credibility adjustment for the MLR calculation. Otherwise, the new federal requirements could reduce market competition by forcing insurers with a small market presence to exit some state markets, or preventing their ability to enter new states.

As suggested above, allowing issuers to report their individual and small group MLRs by state at the holding company level would help assure that measurement is made across a meaningful population. However, even this level of aggregation may not be sufficient to produce entirely credible calculations for companies with smaller market shares. Statistical fluctuations in the experience of these smaller books of business would make it more likely that smaller carriers could fail to meet the MLR thresholds. This outcome is inconsistent with a key goal of PPACA to encourage greater participation and competition in the individual and small group markets.

The NAIC has addressed this exact concern in the Medicare Supplement market by establishing a credibility adjustment table that is incorporated in the NAIC Annual Medicare Supplement Refund Calculation form. We would urge adoption of a similar mechanism for the application of the PPACA's MLR requirements, recognizing that smaller measured populations will experience a greater level of statistical fluctuation. The NAIC Medicare Supplement table would need to be updated by the American Academy of Actuaries to reflect the differences between the senior

and under 65 populations, as well as differences between Medicare Supplement plans and comprehensive health care coverage. We support the second proposal recommended in the May 12th letter to the NAIC from the Chair of the Medical Loss Ratio Regulation Work Group of the American Academy of Actuaries proposed methodology of “*Application of Adjustments for Statistical Tolerance*,” where they recommend “*a carrier would add to its actual MLR an adjustment, based on the size of the carrier’s membership in the block of business for which the calculation is prepared, to reflect the potential impact of statistical fluctuation prior to comparison with the applicable minimum MLR standard.*”

Credibility adjustment strikes an appropriate balance between affording consumers the financial protections of the MLR standards and maintaining consumer choice by avoiding penalties against smaller plans caused by random variations in claims experience. The MLR standards are intended to drive value for consumers by assuring more premium dollars go to patient care costs and reducing insurers’ administrative expenses. These standards, however, must guard against the unintended effect of causing volatility that could drive up the cost of health insurance coverage for consumers and reduce their choices in the marketplace.

Credibility adjustments should be included in MLR calculations regardless of the level of permitted aggregation. For plans with a small market share, new market entrants, or insurers offering new products, a credibility adjustment will be particularly important, recognizing that in the initial phases of market entry – or a product life cycle – pricing would be difficult to determine.

III. Potential for Market Destabilization

In order to maintain consumer choice and competition, states and the federal government should lower MLR requirements if certain early warning signs occur. These early warning signals would include (1) reduction in market risk based capital levels (2) product compression or (3) market contraction.

Stringent MLR requirements can increase the potential for destabilization in both the individual and small group markets. According to the American Academy of Actuaries, “[i]mposing unrealistically high medical loss ratio requirements may threaten plan solvency by making it difficult for premiums to cover claims and expenses.” If they perceive a threat to their solvency, carriers will – and should – withdraw from markets in which they cannot meet MLR requirements. The Congressional Budget Office noted the possibility of insurers exiting the individual market as a risk of overly-restrictive MLR standards, and state experience supports this as well. At one point in the 1990s, residents in 36 of 39 Washington State counties were left without access to individual market coverage because of shortsighted state insurance reforms. Recognizing early warning signs is critical to avoid this eventuality. Failure to do so would undermine one of the stated goals of reform – to allow consumers to “keep what they have” – and would decrease choice and competition in market segments that are already relatively underserved today.

For markets to be stable they must include participation by a meaningful number of financially-sound competitive issuers, allow for continuous availability of a number of product choices, and foster relatively stable coverage among individual participants without undue turnover or churn. In addition to reducing consumer choice, market withdrawal could result in high risk individuals left without coverage and providers left with unpaid claims.

MLR standards can threaten the stability of a market in a variety of ways. In particular, the market could destabilize if the MLR standards do any of the following:

- Drive significant market or product withdrawal by existing participants;
- Act as a barrier to new market entrants or the introduction of new products;
- Drive excessive turnover in coverage;
- Cause issuers to take unsustainable actions in order to remain in the market (e.g., cross-subsidizing by coverage in other segments or states); or
- Cause greater-than-necessary fluctuations in annual premiums.

States currently vary significantly on the nature and extent of formal criteria established to avoid destabilization in the individual market. In an effort to encourage competition in health insurance markets, some states recognize that MLR is likely to be relatively low when a product is first brought to market. These states allow for lower MLR requirements for new policies and gradually increase the MLR requirements over the life of the product. For example, California's requirements are more lenient for new products. California generally requires that an established plan's administrative costs not exceed 15 percent of revenues. However, plans still in their "development phase" are allowed to have administrative expenses up to 25 percent.

Once carriers begin to withdraw from a market it is generally very difficult to increase competition. For this reason it is critical that the regulations establish mechanisms to monitor early warning indications of market distress and take appropriate action to adjust MLR standards before significant market withdrawals occur. Those indications might include:

- **Reductions in Solvency or Ratings:** The NAIC has established capital adequacy standards for health insurers through risk based capital rules, including establishing early warning levels. A reduction in reported capital levels by carriers in a market would be a sign of impending market destabilization/withdrawal. Reductions in the ratings of carriers competing in a market would be a similar early warning sign of potential market destabilization.
- **Product Compression:** Another trigger for lowering the MLR should be if at least 10 percent of products are withdrawn from the marketplace. Lack of new product introduction or innovation in the individual market compared to the rest of the market could also trigger changes.
- **Market Contraction:** Another trigger should be if at least 10 percent of enrollees in the marketplace are impacted by one or more insurers exiting the market. In this case the individual market should be considered destabilized and the Secretary should lower the MLR requirements.

Based on Aetna's experience, we also would recommend establishing specific criteria to limit potential market destabilization. Such criteria should recognize that there are substantial administrative costs beyond the issuer's control that could make it difficult for an issuer to maintain a sustainable financial position, such as prevailing commissions, new government requirements or other intermediary costs. Criteria also should allow for adequate flexibility to address exogenous cost drivers, such as variations in seasonal influenza costs. Adequate aggregation or time-averaging so that issuers – particularly those participating in smaller

markets – are not at undue risk of penalty based on annual statistical fluctuations will also preserve market stability. Appropriate aggregation and averaging will avoid a destabilizing, fluctuating pattern of issuers meeting and failing the MLR standards year-to-year. We also recommend ensuring that there is adequate flexibility to permit and encourage new product introductions or new market entrants, and that holding active life reserves, certified by an actuary, is an allowable adjustment.

IV. Actual MLR Experience and Minimum MLR Standards

Market destabilization can be avoided if MLR rules recognize the statistical fluctuations in MLR.

The agencies request information on how health insurance issuers' current MLR for the individual, small group, and large group markets compare to the minimum standards required under PPACA, what factors contribute to fluctuations in MLR, and what warning signs could indicate that a minimum MLR standard could potentially destabilize a market.

MLRs have typically been calculated based on a comparison of clinical claims costs to premium costs. Unlike current MLR calculations based on definitions used by the NAIC and states, the calculations that will be used to determine MLR for purposes of PPACA will more broadly include expenses for activities that are designed to improve health care quality, in addition to clinical costs. This distinction makes it difficult to compare Aetna's current MLR experience to the MLR requirements under PPACA. Additionally, it is common for MLRs to fluctuate depending on the issuer, customer size, changes in market dynamics, and unforeseen medical events such as a flu pandemic.

States generally treat MLRs differently for the individual, small, and large group markets. About 27 states use MLRs in the individual market – but 17 of those have MLRs that are below 60 percent. Twenty-two have MLRs below 70 percent and only one uses an 80 percent MLR according to a recent AHIP analysis. Most states do not use MLRs in the large group market.

However, each state's rules and requirements are borne out of its own specific experience of market dynamics and state characteristics. Issuers' experience with state MLR requirements will not translate directly to the new federal requirements, due to differences in how MLR is defined.

In Aetna's experience, MLRs in the individual market have historically been below the 80 percent minimum standard. MLRs in the small group market are more consistently closer to PPACA's 80 percent benchmark. Large group market MLRs also tend to fall close to the 85 percent minimum standard outlined in PPACA, with historic loss ratios typically trending between 80 and 90 percent. In all cases, there are periods in which individual issuers and/or the industry as a whole have experienced both significantly lower and higher loss ratios.

A variety of factors can cause annual fluctuations in Aetna's MLR:

- **Market Size:** Group and market size can have a considerable impact on MLRs. For instance, a single catastrophic event within a small book of business can result in significantly higher MLR rates. Larger groups – including large governmental and union groups, traditional employer arrangements, and non-traditional groups such as

retirees, rural collectives or correctional facilities – have unique funding arrangements such as split funding, minimum premium plans, and competitive pricing strategies that can influence Aetna’s MLR in these markets.

- ***Projected Versus Actual Events:*** Premiums are generally set based on historical trends and predictions of future medical use and trends. However, unpredictable events such as large scale epidemics and pandemics impacting the general health of the population can drive increases in medical expenditures. Additionally, something as simple as the introduction of a new medical device or prescription drug can drive changes in MLR.
- ***Changes in Administrative or Other Business-Related Costs:*** Markets and groups are far from static. Individuals may leave markets or change carriers. Providers may drop out of networks or increase rates. And new laws and regulations result in changes in benefit levels and administrative costs. All of these changes can result in significant fluctuation in MLRs.

Factors causing fluctuation are currently addressed through various cycles of underwriting. Appropriate aggregation and smoothing of MLR calculations over time, as described above, can help to mitigate large fluctuations that could threaten solvency and harm the marketplace.

V. Defining Activities that Improve Health Care Quality

The definition of quality should include the following: Federal laws and regulations that are related to quality measures and promotion, including measures required in federal health plans (e.g. FEHBP, TRICARE, Medicare, etc.); nationally recognized clinical standard setting bodies (e.g. NCQA) and federal agencies (e.g., physician colleges, AHRQ, CDC, etc.); and those measures that relate to quality as defined in the PPACA.

The attached two charts outline quality measures that relate to specific Federally recognized standard setting bodies (Attachment 1) as well as a summary of quality improvement provisions as defined in PPACA (Attachment 2). These activities should be included in the MLR definition of quality.

PPACA requires reporting on three categories of expenses: “reimbursement for clinical services provided to enrollees”; “activities that improve health care quality”; and “all other non-claims costs, including an explanation of the nature of such costs, and excluding Federal and State taxes and licensing or regulatory fees.” The NAIC’s Statutory Accounting Principles currently provide a framework for reporting of expenses associated with claim activities and plan administration. However, PPACA modifies this framework, most significantly by adding an additional category of expenses associated with health care quality improvement. This has long been recognized as a critical activity of health plans and an appropriate definition will be essential to encourage plans to continue to invest in member health quality, safety and equity.

PPACA prioritizes certain activities designed to encourage specific quality improvement. For example, under the charge of ensuring the quality of care, new PHSA § 2717 includes the following as quality improvement initiatives: quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, patient-centered education and counseling, reduction of medical errors through best practices and HIT,

and wellness and health promotion activities including health risk assessments and telephonic or web-based intervention efforts. PPACA also supports innovation in payment structures, such as through accountable care organizations and programs operated by the Centers for Medicare & Medicaid Services Innovation Center (PPACA §§ 3021, 3022).

PPACA provides for a variety of grants targeting specific quality improvements, including HIT (PPACA § 1561) and medication management services (MTM) (PPACA § 3503). The American Recovery and Reinvestment Act (ARRA) also made significant investments in HIT. These significant investments in HIT are an important starting place for improving our country's capacity to provide high quality and efficient care. Failing to recognize HIT investment under the MLR regulations as a mechanism for quality improvement could discourage private development of electronic medical records and therefore could stilt HIT progress.

The breadth of investment in quality improvement supported by PPACA also reaches to promotion of healthy lifestyles. (See e.g., PPACA § 4108). These provisions together create a meaningful collection of activities that Congress viewed as beneficial to health care quality.

Regarding the attached chart that references various federal quality requirements, we list below those that we want to ensure are among our priorities for inclusion. They include:

Supporting Care Coordination

- ***Disease Management/Care Management/Case Management:*** Programs that assist members living with and managing risks associated with chronic illnesses and/or coordinating treatment and follow-up care for serious injuries or complex care (e.g., transplants); recognized in PPACA sec. 3011, National Strategy to Improve Health Care Quality Priorities; sec. 2717, Ensuring Quality of Care.
- ***Patient Centered Medical Homes:*** An approach to providing comprehensive primary care for children, youth and adults. A Patient-Centered Medical Home is a health care setting that facilitates partnerships between individual patients and their personal physicians and when appropriate, the patient's family; recognized by March 2007 "Joint Principles of the Patient-Centered Medical Home" published by the American Academy of Family Physicians, American Academy of Pediatrics, the American College of Physicians and the American Osteopathic Association.
- ***Discharge Planning:*** Effective discharge planning from one level of care to another can decrease the chances of hospital readmission, help in recovery and ensure medications are prescribed and given correctly. As recognized by Naylor, Mary D. et. al. "Comprehensive Discharge Planning and Home Follow-Up of Hospitalized Elders." *Jama* 1999;281(7):613-620.

Assistance for Members and Providers

- ***Education and Clinical Decision Support:*** On-line, mail and other information resources make credible health information available to members. Note that among their ten rules to inform the redesign of the health care system, the Institutes of Medicine (IOM) specifically recognized the role of telephonic, on-line and other forms of health support beyond hands on care: "Patients should receive care whenever

they need it and in many forms, not just face-to-face visits. This implies that the health care system must be responsive at all times, and access to care should be provided over the Internet, by telephone, and by other means in addition to in-person visits.” *Crossing the Quality Chasm, Institute of Medicine.*

- **Wellness Programs:** Programs designed to improve the overall health of members through increased prevention and screening, improvements in lifestyle, reduction of health risk factors (e.g., weight reduction) and/or changes in behaviors (e.g., smoking cessation) impact patient care. Wellness empowers members to make positive and permanent lifestyle changes to improve their health. Wellness and prevention programs, including web-based intervention efforts, are recognized as quality functions in PPACA in both sec. 2717, Ensuring Quality of Care, and sec. 1311 (g)(1), Rewarding Quality Through Market Based Incentives.
- **Health Counseling and Information Services such as Nurse Lines, Counselor Lines, Employee Assistance Programs:** These programs provide members with access to clinical advice, counseling or crisis intervention. Recent research published in Health Affairs recognizes these initiatives can help prevent condition deterioration that could require hospitalization. (*Health Affairs*, July/August 2009, “Disease Management of Chronically Ill Beneficiaries in Traditional Medicare” by David Bott et. al.)
- **Web-Based Interventions:** Web-based interventions such as electronic records (PHRs, EMRs, etc.) and associated connectivity make member health information available to the patient and other providers in a timely fashion to assist in care decisions.
- **Population Health Quality Improvement:** These activities include programs aimed at reducing racial and ethnic inequality of care, addressing population health risks such as obesity and smoking, improving health risk detection and prevention among women, children and other segments of the population, and providing compassionate end-of-life care. Many of these programs are directly aligned with PPACA’s goals for health improvement, as stated in Sec. 1311 (g) (1), Sec. 3011, and Sec. 3013.

Promote Evidence-Based Decision Making

- **ICD-10:** The adoption of the 10th version of the ICD code set will provide an additional level of detail regarding patient care in order to enhance the ability to maximize quality for patients and to further research that can improve aggregate patient outcomes, as well. In the Final Rule implementing these new coding requirements, HHS stated that they “provide specific diagnosis and treatment information that can improve quality measurements and patient safety, and the evaluation of medical processes and outcomes.” 74 Fed. Reg. 3328, 3330 (January 16, 2009).
- **Utilization Review:** Use of medically approved standards of care recommendations to identify unnecessary or inappropriate services could help to reduce the preventable adverse events that the IOM identifies as a leading cause of death in the

United States. The IOM says: When extrapolated to the over 33.6 million admissions to U.S. hospitals in 1997, the results of these two studies imply that at least 44,000 and perhaps as many as 98,000 Americans die in hospitals each year as a result of medical errors. (American Hospital Association. *Hospital Statistics*. Chicago. 1999.) Deaths due to preventable adverse events exceed the deaths attributable to motor vehicle accidents (43,458), breast cancer (42,297) or AIDS (16,516); (Centers for Disease Control and Prevention; National Center for Health Statistics. Births and Deaths: Preliminary Data for 1998. National Vital Statistics Reports. 47 (25):6, 1999.) Utilization review would support quality definitions included in PPACA:

- Sec. 2717: Implementing activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology;
- Sec. 3011: Enhancing the use of health care data to improve quality, efficiency, transparency, and outcomes; and
- Sec. 3013: Promoting the safety and effectiveness, patient centeredness, appropriateness and timeliness of care, and the efficiency of care.

Align Provider and Member Incentives to Health Care Quality Improvement

- ***Pay for Performance and High Performance Networks:*** These initiatives include the assessment of provider care effectiveness, the formation and support of provider networks based on care quality and efficiency, and payment methodologies designed to incent continuous quality improvement. These initiatives support the quality definitions and priorities identified in PPACA:
 - Sec. 3011: Addressing gaps in quality and health outcomes measures, comparative effectiveness information and data aggregation techniques; and
 - Sec. 2717: Implementing activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine and health information.

Improve Patient Safety and Decrease Medical Errors

- ***Patient Safety, Care Effectiveness and Care Optimization:*** Protocol-driven assessments of member records to identify gaps in care, unnecessary and/or ineffective treatments, potential patient safety risks, e.g., adverse drug interactions, and optimal clinical pathways for effective personal care are vital. Medication and care compliance activities and activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, EBM and HIT are recognized as quality functions in PPACA in sec. 2717 (Ensuring Quality of Care). In awarding grants for quality measure development, PPACA directs the Secretary to give priority to the development of quality measures that allow the assessment of factors including "the safety, effectiveness, patient-centeredness, appropriateness, and timeliness of care." PPACA Sec. 3013.
- ***Health Information Technology, including Electronic Health Records (EHR) and Protocol-Driven Care Review:*** Health information tools allow clinical information to

be shared in real time among patients and providers, reducing the risk of medical errors and unnecessary/duplicative services. These record-sharing mechanisms include personal health records (PHRs), EHRs, and regional health information organizations (RHIOs). Aetna's *Care Engine* technology provides a major enhancement to electronic medical records by continuously reviewing member health activities against more than 10,000 evidence-based care protocols to identify gaps in care, opportunities for care improvement and potential health risks associated with adverse care interactions. The Care Engine technology provides alerts to doctors and patients about opportunities for care improvement and even potentially life-threatening risks. Care Engine use has demonstrated an 8.4 percent decrease in hospitalizations. HIT will also help to support adoption of the 10th version of the ICD code set which will provide an additional level of detail regarding patient care in order to enhance the ability to maximize quality for patients and to further research that can improve aggregate patient outcomes, as well. HIT is recognized as an activity to improve patient safety and reduce medical errors by PPACA in Sec. 2717, Ensuring the Quality of Care, and in sec. 3013, Health Care Quality Improvement: Quality Measure Development.

- **Quality Assurance:** Plans routinely gather, analyze and report health care quality information, including HEDIS and other standardized provider and care quality measures, as part of their core operations. Many of these activities are required by NCQA for plan accreditation, URAC, HEDIS and state departments of health. Quality reporting is recognized as a quality function in PPACA in Sec. 2717 (Ensuring Quality of Care) and in Sec. 3011 (National Strategy to Improve Health Care Quality Priorities).
- **Fraud Prevention:** Fraud units identify providers that are engaging in fraud through a number of ways – false credentials, provision of unnecessary services or failing to provide reported procedures. These efforts protect consumers from providers who have lied about their qualifications or about the level of care necessary or provided. Consumers are safer as a result and enjoy a higher level of quality care. The following are examples of how anti-fraud efforts protect patients and further quality:
 - A GAO report (1992) states “the vulnerability of the health care system to fraud and the financial damage that it can cause is illustrated by a California scheme that has resulted in the loss of millions of dollars...the [rolling] labs provided patients a battery of costly and often unnecessary tests, which were billed to the patients’ insurers.” Anytime individuals undergo unnecessary procedures, they may be put at risk.
 - Fraud prevention has been prioritized by the federal government through the partnering of HHS and the Attorney General to establish the new Interagency Health Care Fraud Prevention and Enforcement Action Team (HEAT) to combat provider fraud and abuse.

VI. Defining Clinical Services

“Clinical services” should be defined based on NAIC’s definitions of claims and claims-related expenses to assure a level playing field among all Issuers.

To assure a level playing field and support the ability of both models to provide quality health services to consumers, all four items listed below – provider reimbursements, payments to third parties, incurred loss plus loss adjustment expenses and other categories of provider payment – should be considered under the category of clinical services costs.

- **Reimbursements to Health Care Providers:** Covers services provided to members, including fee-for-service payments, capitation, quality and other performance incentives.
- **Payments to Third Parties:** Costs associated with arranging favorable provider reimbursement rates, including network access fees and payments to IPAs, PHOs and other intermediaries who arrange for health care services.
- **Other Categories of Provider Payment:** Includes contracting, credentialing, quality, cost and satisfaction measurement and reporting, communication, electronic connectivity and appeals. These costs assure an ongoing level of quality within provider networks.
- **Calculation of Member Medical Services:** Different issuers contract for member medical services in different ways, in particular making greater or lesser use of contracting intermediaries. Intermediary contracting arrangements often include some component of service or administration as part of the claim cost. For issuers that contract directly for services, these costs are more likely to be reflected in general administrative overhead. For example, when a member of a Blues plan accesses services through the network of another Blues plan, the provider charge may include handling fees added by the second plan. Similarly, when an issuer contracts for physician services through an IPO, PHO or other contracting intermediary, or purchases pharmacy services through a Pharmacy Benefit Manager (PBM), some incremental services are likely to be reflected in the claim cost. Group model HMOs tend to present an extreme example of this phenomenon. The capitation paid between the plan and the group covers various administrative activities associated with the group's operation. Contracting through intermediaries is often a very efficient way for issuers to gain access to competitive provider costs and/or to share risk with provider groups. However, it is difficult if not impossible to break out claim and non-claim costs of subcontractors. Issuers should be allowed to maintain these arrangements and, to maintain a level playing field, should be able to allocate as medical expenses the costs they incur directly in contracting for and maintaining negotiated price arrangements with providers. This method is most efficient and recognizes the value provided by these member medical services.
- **Incurred Loss Plus Loss Adjustment Expense:** Incurred Loss and Loss Adjustment Expense, as included in the legislation, are defined in statutory accounting standards and currently reported annually by insurers. The definition of these items should be consistent with the relevant statutory accounting standards (specifically Statutory Accounting Principles (SAPs) 50, 54, 55 and 85) and include actual clinical claims paid, claims incurred but not yet reported or paid, estimated claims to be paid pursuant to actuarial standards (i.e., claim and premium reserves) and the cost containment expenses included as component of claim adjustment expenses and enumerated in SAP 85.

VII. Assumptions and Methodologies in MLR Calculation

Regulations should follow existing methodologies (Statutory accounting standards) for administrative efficiency.

Most issuers today have very robust accounting systems, but these systems would not allow specific costs associated with these activities to be isolated and either directly or indirectly allocated in accordance with reasonable statutory principles. Continuing to follow these standards builds on already established processes and will reduce administrative and financial burdens associated with transferring to a new system.

The calculation of MLR for reporting purposes should match that used for rebating purposes.

The “general rule” of section 2718(a) of the PHSA is that insurers must “submit a report” to HHS regarding the ratio of incurred loss plus loss adjustment expense to earned premiums. This general rule is amplified by the requirement that the “report” include the percentage of premium revenue that such coverage expends on the three categories listed in (a)(1) through (3) (relating to claims, quality and administrative costs). The rebate provision in section 2718(b) builds on the calculation in 2718(a). It is true that section 2718(b) does not specifically refer to the general rule to report incurred loss plus loss adjustment expense to earned premiums. Instead, it simply refers to the ratio of (a)(1) and (2) to premium revenue. However, by referencing (a)(1) and (2) the statute imports into 2718(b) the same method by which (a)(1) and (2) are calculated for purposes of 2718(a), which should include the general rule providing for the use of the loss adjustment expense. This is because (a)(1) and (a)(2) are not stand alone provisions – they are elaborations of the general rule in 2718(a), which requires reporting that takes into account loss adjustment expenses.

This construction is supported by the fact that it would be illogical for Congress to require a report of MLR based on a different calculation method than the rebate requirement. Generally statutes, particularly sections of a statute, are read consistently absent clear evidence to the contrary. Moreover, if the methods in section 2718(a) and (b) were different, an insurer could file a report with the HHS showing it has an 89 percent MLR in the group market, but it might have to pay a rebate if the rebate calculation were below 85 percent. In such a case, the amount and fact of the rebate would be unknown to HHS since the original report, calculated using a different method, would not reveal it. This undermines the ability of HHS to monitor and enforce the rebate provision and cannot be what Congress intended.

VIII. PPACA versus Current Practices

There are several areas in which current practices and practical realities limit the type of information that can be supplied. It is important to insure a level playing field by recognizing the types of costs that each insurance model can track.

The agencies ask about the differences and similarities between the requirements under PPACA compared to current state practices, including which data elements are currently captured by state requirements. The new law’s recognition of “activities that improve quality of care” as a unique category of issuer costs that contributes to medical expenses is likely to require additional segmentation and allocation of expenses compared to current practices.

As described above, subcontractors present a prime example. Because most plans subcontract care for disease management, wellness, behavioral health, and psychiatric services, such subcontracts should be counted as part of expenditures for clinical services or quality improvement. Current practices do not allow insurers to track expenditures of subcontractors or to determine which subcontractor services are clinical or for quality improvement, rather than administrative. Any such requirement would require substantial rethinking of how subcontracts are structured, which could jeopardize the efficiencies enabled by such arrangements. Therefore, subcontracts in their entirety should be considered clinical or quality improvement expenditures.

Illustrating this point, under current Statutory Accounting Principles, “cost containment” expenses can include both quality-related expenses and general administrative expenses. In practice, contracting with a pharmacy benefit management (PBM) company can reduce costs for Aetna – and in turn to consumers – through improved network development. However, what Aetna pays the PBM to manage a network includes the PBM’s general administrative costs associated with running the program. Tracking a subcontractor’s medical versus administrative expenses would be a substantial administrative burden and would cancel out the benefit of such arrangements as a means of increasing efficiency.

Similar issues arise in accounting for physician administrative expenses that may or may not be accounted for separately from clinical costs on a provider’s bill. Different insurers contract with and pay providers in different ways. The type of physician financial arrangement (e.g., staff model HMOs, capitation) determines whether under traditional rules provider administrative costs are attributed to the physician or the insurer and, in turn, determine whether those costs are included in the MLR calculation. Under a methodology that separately accounts for provider administrative costs and requires issuers to count these as administrative costs rather than clinical costs, HMOs with very narrow networks (e.g., staff models) will tend to incur lower administrative expenses under this methodology. On the other hand, issuers with broader networks will incur higher administrative costs.

To assure a level playing field and support the ability of both models to provide quality health services to consumers, provider reimbursements, payments to third parties, IBNR and other categories of provider payment should be considered under the category of clinical services costs.

IX. Clarifications Needed to Facilitate Implementation

Phase in of MLR for New Plans and Products: The timeframe (e.g., multi-year, lifetime, annual) over which included costs and claims occur will have a significant impact on the MLR, since high cost investments and the savings they generate may not accrue in the same time period. In addition, administrative costs for a product vary over time. For instance, launching a new product may require more administrative costs than in later years when the product is simply being maintained. California recognizes the administrative start-up costs of new plans and therefore phases in its administrative spending cap for new products.

Rolling Average for MLR Threshold: The MLR should be calculated on the basis of a rolling average in order to reduce the impact of market fluctuation. Basing the allocation on a three

year rolling calculation would help to smooth out fluctuation in smaller blocks of business. Maine currently allows issuers to meet the state's minimum MLR based on a three year rolling-average, rather than requiring an issuer to issue refunds to members based on failure to meet the standard in a single year. If single years are required for MLR calculations, it would reduce the ability of new insurers to enter a marketplace or of existing insurers to roll out new products. Aetna therefore recommends that reporting, calculation and rebating of MLRs be done on a three year rolling average per state. Beginning in 2011, the Secretary should allow insurers to use a three year rolling average when calculating MLR.

Transitional Rules on Broker Commissions: We also recommend that the Secretary allow a portion of broker commissions to be excluded from premium revenue on a transitional basis. Under this proposal, 90 percent of external commissions would be excluded from premium in the 2011 MLR calculation. This exclusion could be reduced to 66 percent in 2012, 33 percent in 2013, and 0 percent in 2014. Many insurers have contracts with brokers that were established prior to PPACA passage and are in effect for 2010. Some longer term contracts may stretch beyond 2010 into 2011 and 2012. These new MLR levels were established based on changes that would occur in the reformed market of 2014 – such as the elimination of underwriting, an individual mandate, and the establishment of the exchange.

Transitional Rules on Exchange Start up Costs: There will be significant costs related to the start up of exchanges, the new federal web portal, and other new structures created by PPACA. Special consideration of these administrative costs should be addressed in the MLR regulations. Start-up expenses will be high as issuers absorb the administrative burdens of these programs. We urge you to allow the costs of compliance with health care reform legislation to be treated as expenditures on activities that improve health care quality.

X. Reporting Period

MLRs should be reported and calculated on a calendar year basis.

NAIC is given broad authority to set definitions in this section. Most states base MLR calculations on a calendar year basis. PPACA refers to MLR calculations based on the “plan year.” Requiring insurers to calculate and report to states on a calendar year basis and to the federal government on a plan year basis would increase administrative costs, make it difficult to reconcile results, and could lead to confusion for individuals using this information to compare policies. Many groups (even those enrolled in the same product line) could have different plan years. This could result in hundreds of MLR calculations per insurer throughout the year. Further, the individual market traditionally does not use the term “plan year.” Instead, consumers generally have “renewal dates” – with thousands of customers renewing every day of the calendar year. Moreover, customers are accustomed to thinking about insurance in deductible years (usually calendar years), not plan years. To avoid additional administrative costs and confusion, the most appropriate and sensible period should apply – the calendar year. For most insured group business and all individual insurance, there are no separate written plan documents that designate a plan year (most insured ERISA plans simply use the group policy and an SPD supplement). As such, consistent with current regulations, HHS can and should look to the period during which deductibles accumulate, which is typically a calendar year.

XI. Enforcement of MLR and Rebates

The regulation should provide for a fair and administratively efficient mechanism to protect consumers from insurers who fail to comply with MLR requirements. Rebates should take the form of premium credits to current customers. De minimus rebates should be provided to state high risk pools or risk adjustment mechanisms. Federal law should preempt conflicting state MLR formula definitions and methodologies.

The rebate or “penalty” process should provide premium credits to currently enrolled individuals and employers (on behalf of their enrollees). A number of states currently require rebates when issuers fail to meet minimum MLRs, including New York and New Mexico. These states allow premium credits as an administratively efficient way to issue rebates. Issuing rebates to individual members is administratively costly, as insurers must locate former members that have since dropped coverage and changed location as well as perform the administratively costly “cutting of checks.” The administrative cost could exceed the value of the checks to consumers.

A rule that allows insurers to reduce policyholder premiums by applying rebates to outstanding premiums as a means of dealing with distributions would be consistent with the way similar issues have been resolved by state and federal regulators. For example, the Department of Labor (DOL) indicated that plan fiduciaries could use settlement proceeds to pay plan expenses if it would not be cost effective to allocate the proceeds to participant accounts (DOL FAB 2006-01). In order to ensure efficiency, rebates should be distributed as premium credits. Currently enrolled individuals and employers (on behalf of their enrollees) would receive premium credits toward their payments. To require direct payment of rebates to consumers would have the paradoxical impact of increasing administrative costs and consumer premiums. In our experience, a credit could be issued within four months after the MLR report is submitted.

All markets should have a *de minimus* rule under which premium credits would not be made. Instead, an aggregate contribution to the state high risk pool or a risk adjustment mechanism would occur. Some states that currently impose minimum MLRs require payment of penalties to the state high risk pool, rather than to plan members. Providing an aggregate rebate amount to a state entity – such as a high risk pool or risk adjustment mechanism – benefits all consumers in the market, is administratively efficient, and acts as a “penalty” to insurers that fail to meet MLR targets. This mechanism is administratively simpler than creating checks for individual enrollees. We have recommended a *de minimus* rule under which an aggregate contribution to the state high risk pool or risk adjustment mechanism would occur in lieu of low-dollar amount premium credits being issued to individual members.

PPACA MLR reporting and rebate rules are part of the overall Health Insurance Portability and Accountability Act (HIPAA) framework that preempts state laws that prevent the application of the federal law (PHSA § 2723(a)). As a practical matter, if states have different MLR formulas and rebate requirements, these rules would conflict with federal rules. Insurers can only rebate a dollar once. Insurers cannot rebate the same dollar twice. Consistent with the statute and current practice, the PHSA preemption scheme should preempt those state laws to the extent that the state law prevents the application of the federal MLR standard (PHSA § 2724(a)). In addition, on a purely pragmatic level, conflicting state MLR rules would create unnecessary administrative costs and increase consumer premiums and would thus frustrate one of the goals of the PPACA.

XII. Scope of Benefits

The “excepted benefits” framework should be maintained.

The MLR requirements apply to “group and individual health insurance coverage.” Those terms are specifically defined in the PHSa and “excepted benefits” are specifically excluded from those terms (PHSA § § 2722, 2791). This “excepted benefits” framework was maintained with respect to PPACA. As such, the MLR rules do not apply to excepted benefits. Moreover, subjecting these policies to MLR rules could thwart their ability to offer critical products to consumers that allow them to access a quality of health services they could not access without coverage. HIPAA excepted benefits are not subject to Minimum Loss Ratio Rules.

HIPAA excepted benefits include:

- Coverage only for accident, or disability income insurance, or any combination thereof;
- Coverage issued as a supplement to liability insurance;
- Liability insurance, including general liability insurance and automobile liability insurance;
- Workers’ compensation or similar insurance;
- Automobile medical payment insurance;
- Credit-only insurance;
- Coverage for on-site medical clinics; and
- Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

Benefits not subject to requirements if offered separately:

- Limited scope dental or vision benefits;
- Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and
- Such other similar, limited benefits, as are specified in regulations.

Benefits not subject to requirements if offered as independent, noncoordinated benefits:

- Coverage only for a specified disease or illness; and
- Hospital indemnity or other fixed indemnity insurance.

Benefits not subject to requirements if offered as separate insurance policy:

- Medicare supplemental health insurance, coverage supplemental to the coverage provided under chapter 55 of title 10, and similar supplemental coverage provided to coverage under a group health plan.

XIII. Exclusion of State and Federal Costs

The formula to calculate the minimum loss ratio should exclude state and federal assessments, taxes and other costs from premium revenue.

This exclusion should include items such as federal income taxes, federal excise taxes and other federal regulatory related costs. In addition, state premium taxes, income taxes, property taxes and other regulatory and licensing fees and assessments, such as guarantee fund assessments, charity care assessments, high risk pool assessments etc., should be excluded

from premium revenue. This would include items such as New Jersey's HMO surcharge or the costs associated with normalizing risks such as NYS regulation 146 insurer funded reinsurance pool.

The MLR requirement permits insurers to exclude from the non-claim cost category "federal and state taxes and licensing or regulatory fees." PPACA § 1001, adding PHSA § 2718(a)(3). This is broadly worded and, as such, can be construed to cover any federal or state tax directly paid by an insurer (e.g., income taxes), as well as any tax rolled into the insured's premium (e.g., state premium taxes). It is also broad enough to cover "assessments" paid to states to fund various state programs. See Black's Law Dictionary 6th Ed. (1990) (definitions of "tax" and "assess") ("... taxes undoubtedly include assessments, and the right to impose assessments has its foundation in the taxing power of government" Indeed, "assess" is defined as "to tax".); see also *De Buono v. NYSA-ILA Medical and Clinical Services Fund*, 520 U.S. 806, 809 (1997). The statute clearly intends to exclude these items from the calculation. If the items are not excluded, then it would reduce – or eliminate – the ability of insurers to invest in important services that further quality improvement such as health information technology, which would, in turn, frustrate the purposes of the statute to reduce costs and improve quality.

Sincerely,



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The definitions of clinical services and health care quality improvement activities should include the following components:

Health Care Quality Improvement	Activities Supporting Quality Improvement
Support Care Coordination	<p><u>Disease and Care Management:</u> <i>Assists members with chronic illnesses, serious injuries or complex care (e.g., transplants) to access appropriate care services, monitor and maintain their health and/or reduce risks of further complications. Achieves improved medical outcomes and higher levels of satisfaction:</i></p> <ul style="list-style-type: none"> • Effective disease management for asthma resulted in reduction in ER visits, increase in peak flow meter usage, and increase in use of oral corticosteroids.ⁱ • Evidence supports effectiveness of disease management on glycemic control; on screening for diabetic retinopathy, foot lesions and peripheral neuropathy, and proteinuria; and on monitoring lipid concentrations.ⁱⁱ • Aetna’s Health Connections Disease Management, based on evidence-based medicine, helps people with chronic conditions obtain treatment and preventive care they need. It has resulted in 26% reduction in ER visits, 15% reduction in inpatient admissions and 25% reduction in medical and pharmacy costs in a 2005 study on congestive heart failure members.ⁱⁱⁱ • Note: Addressing health care provided to patients with high cost chronic diseases is recognized as a quality function in PPACA in sec. 3011, National Strategy to Improve Health Care Quality Priorities; sec. 2717, Ensuring Quality of Care. <p><u>Patient-Centered Medical Home:</u> <i>is an approach to providing comprehensive primary care for children, youth and adults. A Patient-Centered Medical Home is a health care setting that facilitates partnerships between individual patients and their personal physicians and when appropriate, the patient’s family.</i></p> <ul style="list-style-type: none"> • Quality and safety are hallmarks of the medical home, according to the Joint Principles of the Patient-Centered Medical Home issued by The American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and American Osteopathic Association in March, 2007. • PPACA sec. 2717 references Medical Homes in Ensuring Quality of Care <p><u>Discharge Planning:</u> <i>Effective discharge planning from one level of care to another can decrease the chances of hospital readmission, help in recovery and ensure medications are prescribed and given correctly.</i></p> <ul style="list-style-type: none"> • Nurse-centered discharge: centered discharge planning and home care intervention for at-risk

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	<p>hospitalized elders reduced readmissions, lengthened the time between discharge and readmission and decreased the costs of providing health care.^{iv}</p>
<p>Assist Members and Physicians</p>	<p><u>Education and Clinical Decision Support:</u> <i>Ensures that patients are provided with medical treatments which are best suited to their specific needs, conditions and situations, pursuant to evidence based medicine (EBM); therefore, protecting consumers from undergoing unnecessary procedures that could threaten their health.</i></p> <p><u>Wellness Programs:</u> <i>Empowers members to make positive and permanent lifestyle changes to improve their health.</i></p> <ul style="list-style-type: none"> • Programs include: health counseling; health assessment and screening; incentives for healthy behaviors; wellness programs (e.g., smoking cessation); and provision of third party fitness and wellness programs. • <u>Note:</u> Wellness and prevention programs, including web based intervention efforts, are recognized as quality functions in PPACA in both sec. 2717 (Ensuring Quality of Care) and sec. 1311(g)(1) (Rewarding Quality Through Market Based Incentives) <p><u>Health Counseling and Information Services:</u> <i>Provides members telephone access to doctors, nurses and counselors experienced in providing information on a variety of health topics. This allows members to obtain information to improve their health.</i></p> <ul style="list-style-type: none"> • Several Aetna programs provide members with physician-specific indicators based on adverse events and overall efficiency, and hospital information about specific diagnoses and procedures and empower them to evaluate the overall value and cost of care before they access services. • “Periodic contact [of nurses] with people with [multiple chronic] conditions improves self management or recognition of symptoms early enough to prevent deterioration requiring hospitalization.”^v <p><u>Web-based Interventions</u> <i>that share medical information for providers and patients:</i></p> <ul style="list-style-type: none"> • A study of web-based interventions showed an “Improvement in outcomes for individuals using web-based interventions to achieve the specified knowledge...”^{vi} (Section 2717 of PPACA references web-based interventions in Ensuring Quality of Care)

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	<p><u>Population Health Quality Improvement:</u> <i>Includes a range of activities, such as programs aimed at reducing racial and ethnic inequality of care, addressing population health risks such as obesity and smoking, improving health risk detection and prevention among women, children and other segments of the population, and providing compassionate end-of-life care.</i></p> <ul style="list-style-type: none"> • Population health is one of three components of the recently nominated CMS Administrator Donald Berwick and colleague’s “Triple Aim” vision for improving the healthcare system (along with improving the experience of care and reducing the per capita cost of care). • Speaking about efforts to improve health literacy: “Informed patients have better outcomes; they are more concordant with the people who provide health services; they seek care earlier because they recognize warning signs; they read and comprehend instructions; they understand what their doctors advise them to do and they are not afraid to ask questions when they do not understand.”^{vii} • Patient health education outreach improves health status and quality of care. These activities include mammogram reminders and colorectal screening reminders for at risk populations. Studies have shown that targeted reminders have led to increased screening rates among at-risk patients.^{viii} • These programs are a consistent component of PPACA’s definition of quality: <ul style="list-style-type: none"> ✓ Section Sec 1311(g)(1): “Rewarding quality through market based incentives” includes activities to reduce health and health care disparities, such as through the use of language services, community outreach and cultural competency training in the programs it considers quality improvement. ✓ Section 3011: National Strategy to Improve Health Care Quality Priorities lists as priorities: “Reducing health disparities.” ✓ Section 3013: Supports Quality Measure Development to assess health disparities across health populations and geographic areas.
<p>Promote Evidence Based Decision Making</p>	<p><u>Utilization Review:</u> <i>Ensures that patients are provided with evidence-based medical treatments which are best suited to their specific needs, conditions and situations. This program protects consumers from undergoing unnecessary procedures that could threaten their health; unnecessary surgeries could also be reduced. U.S. estimates of the combined effect of errors and adverse effects that occur because of iatrogenic damage not associated with recognizable error, include 12,000 deaths per year from unnecessary surgery.^{ix} Other rationales for inclusion of utilization review as part of the quality definition include:</i></p> <ul style="list-style-type: none"> • Utilization review that uses medically-approved standards of care can help to identify and reduce

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unnecessary services – which cost the U.S. about \$700 billion according to OMB director Peter Orszag.^x Some experts, such as Elliot Fisher and John Wennberg, estimate that up to 30% of health care is unnecessary.^{xi}

- Utilization review programs (and specifically prior authorization and pre-certification processes) are based on clinical guidelines, EBM, peer review, and are credentialed programs.
- The *DOD Medical Management Guide* issued by the Office of the Assistant Secretary of Defense defines utilization management as a “...key process within Medical Management ...for improving the quality of health care...”^{xii}
- Government contracts with insurers generally require performance of utilization review (e.g., FEHBP, TRICARE, state contracts). Washington State defines the process as “...comparing requests for medical services (“utilization”) to guidelines or criteria that are deemed appropriate for such services, and making a recommendation based on that comparison.”^{xiii}
- The Social Security Administration has stated when describing its history of Medicare and its requirement of utilization review, that “The health care professions had recognized for some time the need for mechanisms which would assure quality care to patients through sound utilization of institutional facilities and professional services.”^{xiv}
- Through a pre-certification process for bariatric surgery, an Aetna member discovered that he needed surgery for a very serious heart condition, and also participated in a physician-supervised nutrition and exercise program that eliminated the need for the bariatric surgery.
- Some Florida Medicaid services are subject to utilization review by a Quality Improvement Organization (QIO) under contract with Florida’s AHCA. The purpose of the utilization review program is to *safeguard against unnecessary and inappropriate medical care* rendered to Medicaid recipients. The following Medicaid services are subject to review by a QIO: inpatient hospital services, home health services, community mental health services, and home and community based waiver services for the developmentally disabled.^{xv}
- Utilization review that uses medically approved standards of care recommendations to identify unnecessary or inappropriate services could also help to reduce the preventable adverse events that the IOM identifies as a leading cause of death in the United States. The IOM says:
 - ✓ When extrapolated to the over 33.6 million admissions to U.S. hospitals in 1997, the results of these two studies imply that at least 44,000 and perhaps as many as 98,000 Americans die in hospitals each year as a result of medical errors.^{xvi}
 - ✓ Deaths due to preventable adverse events exceed the deaths attributable to motor

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vehicle accidents (43,458), breast cancer (42,297) or AIDS (16,516).^{xvii}

- Utilization review would support quality definitions included in PPACA:
 - ✓ Sec 2717: implementing activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology;
 - ✓ Sec 3011: enhancing the use of health care data to improve quality, efficiency, transparency, and outcomes; and
 - ✓ Sec. 3013: promoting the safety and effectiveness, patient centeredness, appropriateness and timeliness of care, and the efficiency of care.

ICD-10: *The adoption of the 10th version of the ICD code set will provide an additional level of detail regarding patient care in order to enhance the ability to maximize quality for patients and to further research that can improve aggregate patient outcomes, as well.*

- According to former Department of Health and Human Services Secretary, Mike Leavitt, “The greatly expanded ICD-10 code sets will fully support quality reporting, pay-for-performance, bio-surveillance, and other critical activities. The updated X12 transaction standards, Version 5010, provide the framework needed to support the ICD-10 codes.”^{xviii}
- Consistent use of "E" codes (external causes of injury and poisoning), facilitated through the use of ICD-10 codes could improve the likelihood of the recognition of medical errors and “might improve the recognition of the magnitude of their effect,”^{xix} according to a 2000 JAMA article.
- New ICD-10 codes can facilitate better disease management through new obesity codes and other more granular diagnosis codes.
- We anticipate that the use of ICD–10–CM, with its greater detail and granularity, will greatly enhance our capability to measure quality outcomes. We acknowledge that quality performance outcome measures are currently used for high-profile initiatives such as the hospital pay-for-reporting program. The greater detail and granularity of ICD–10–CM and ICD–10–PCS will also provide more precision for claims-based, value-based purchasing initiatives such as the hospital-acquired conditions (HAC) payment policy.^{xx}
- ICD-10 is consistent with definitions and priorities for quality as outlined in PPACA:
 - ✓ Sec 3011: Addressing gaps in quality and health outcomes measures, comparative effectiveness information and data aggregation techniques and enhancing the use of

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	<p>healthcare data to improve quality, efficiency, transparency and outcomes</p> <p>✓ Sec 3013: the meaningful use of technology</p> <p><u>Clinical Appeals Programs:</u> <i>Ensures patients access appropriate care in a timely fashion – assuring the best outcomes possible and avoiding unnecessary, dangerous procedures that could threaten health.</i></p> <ul style="list-style-type: none"> • The Agency for Healthcare Research and Quality’s Health Care Utilization Project estimates that unnecessary services result in 37,136 deaths and a cost of 122 billion dollars. • External review systems ensure that services rendered align with medical based protocols. • An external review process is mandatory for NCQA and URAC accreditation
<p>Improve Patient Safety and Decrease Medical Errors</p>	<p><u>Patient Safety, Care Effectiveness and Care Optimization Activities:</u> <i>Includes protocol-based assessments of gaps in care, ineffective/ inappropriate care, potential medical errors (e.g. drug interactions) and optimal treatment pathways based on individual needs.</i></p> <ul style="list-style-type: none"> • Medication and care compliance activities and activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, EBM and HIT are recognized as quality functions in PPACA in sec. 2717 (Ensuring Quality of Care). In awarding grants for quality measure development, PPACA directs the Secretary to give priority to the development of quality measures that allow the assessment of factors including "the safety, effectiveness, patient-centeredness, appropriateness, and timeliness of care." PPACA Sec. 3013 • Adverse drug events result in more than 770,000 injuries or deaths each year.^{xxi} • IOM identifies preventable adverse events as a leading cause of death in the United States and also states that, based on 33.6 million admissions to U.S. hospitals in 1997, 44,000-98,000 Americans die in hospitals each year as a result of medical errors.^{xxii} <p><u>Institutes of Excellence and Critical Case Support:</u> <i>Customized care coordination for members requiring specialized care for critical illnesses or injuries, including identification of regional and national centers of excellence for specialized care and member assistance in accessing care through these centers.</i></p> <ul style="list-style-type: none"> • Without logistical support, these members would have more difficulty utilizing these providers and would experience a lower quality of care. • Research shows that aligning with Leapfrog’s protocol for referrals to facilities that specialize in performing those specific services with frequency, demonstrated that a patient’s risk of dying could

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be reduced by 40%.^{xxiii}

Quality Assurance: *Health plans routinely gather, analyze and report health care quality information, including HEDIS and other standardized provider and care quality measures, as part of their core operations. Many of these activities are required by NCQA for plan accreditation, URAC, HEDIS and state departments of health.*

- Quality reporting is recognized as a quality function in PPACA in sec. 2717 (Ensuring Quality of Care) and in Sec. 3011 (National Strategy to Improve Health Care Quality Priorities).
- The collection and analysis of this data allows health plans to assess the quality of care provided to their members and to develop new programs, procedures and activities to improve that quality. HEDIS reporting by health plans is one of the fundamental sources of care quality measurement in the United States.
- Specific activities include: quality assurance activities; mandates by law/regulation; provider quality measurement, review, and reporting; credentialing; and care effectiveness assessments. NCQA specifically includes credentialing as part of its requirements.

Health Information Technology (HIT), Including Electronic Health Records (EHRs) and Protocol-Driven Care Review: *Health information tools allow clinical information to be shared in real time among patients and providers, reducing the risk of medical errors and unnecessary/duplicative services. These record-sharing mechanisms include personal health records (PHRs), EHRs, and regional health information organizations (RHIOs). The following demonstrate some of the quality improvement that HIT brings:*

- HIT is recognized as an activity to improve patient safety and reduce medical errors by PPACA in sec. 2717 (Ensuring the Quality of Care), and in sec. 3013 (Health Care Quality Improvement: Quality Measure Development).
- Aetna's *Care Engine* technology provides a major enhancement to electronic medical records by continuously reviewing member health activities against more than 10,000 evidence-based care protocols to identify gaps in care, opportunities for care improvement

and potential health risks associated with adverse care interactions. The Care Engine technology provides alerts to doctors and patients about opportunities for care improvement and even potentially life-threatening risks.

- Care Engine use has demonstrated an 8.4% decrease in hospitalizations.
 - ✓ Research has demonstrated higher levels of average quality for hospitals with electronic health records and computerized physician order entry^{xxiv}
 - ✓ VA’s investment in the Veterans Health Information Systems and Technology Architecture is associated with significant value through reductions unnecessary and redundant care, process efficiencies, and improvement in care quality. Conservative estimates quantify VA investments over four years as yielding \$3.09 billion in cumulative benefits net of investment costs.^{xxv}
 - ✓ PPACA sec. 2717 references HIT in Ensuring Quality of Care

Hospital-Based Utilization Review: *has been critical in patient safety—in which medical services and records are specifically reviewed for quality of care and appropriateness of place of service. It has improved quality by decreasing life-threatening errors, implementing activities to prevent hospital admissions, as well as activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, EBM and health information technology are recognized as quality functions in Sec. 2717 (Ensuring the Quality of Care) of PPACA.*

Fraud Prevention: *Fraud units identify providers that are engaging in fraud through a number of ways – false credentials, provision of unnecessary services or failing to provide reported procedures. These efforts protect consumers from providers who have lied about their qualifications or about the level of care necessary or provided. Consumers are safer as a result and enjoy a higher level of quality care. The following are examples of how anti-fraud efforts protect patients and further quality:*

- Under a “rent-a-patient” scheme discovered by Blue Cross and Blue Shield plans, a group of California-based surgery centers and medical management companies paid people as young as 12 to have unnecessary medical procedures. The surgery centers would use prompt-payment laws to pressure insurers to reimburse them within 45 days, before the fraud could be detected.^{xxvi}
- A GAO report (1992) states “the vulnerability of the health care system to fraud and the financial damage that it can cause is illustrated by a California scheme that has resulted in the loss of millions of dollars...the [rolling] labs provided patients a battery of costly and often unnecessary tests, which were billed to the patients’ insurers.” Anytime individuals undergo unnecessary

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	<p>procedures, they may be put at risk.</p> <ul style="list-style-type: none"> • Fraud prevention has been prioritized by the federal government through the partnering of HHS and the Attorney General to establish the new Interagency Health Care Fraud Prevention and Enforcement Action Team (HEAT) to combat provider fraud and abuse. • Programs to identify and prevent fraud and abuse supports the quality definitions and priorities identified in PPACA Sec. 2717, which encourages implementing activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine and health information technology.
<p>Improve Availability, Access and Accuracy of Information</p>	<p><u>Transparency Initiatives:</u> <i>Provides members with clinical quality and efficiency information to make better informed decisions to access providers with a higher level of quality.</i></p> <ul style="list-style-type: none"> • Aetna’s informatics tools provide hospital quality information so that members can make informed provider service decisions; some states require quality ratings for certain procedures (e.g., NY for cardiac surgery). • Research demonstrates that enrollees in consumer directed plans “are more likely than those in comprehensive plans to ask providers about costs, to identify and consider treatment alternatives, and to pay attention to wellness and prevention practices. They are also more likely to check plan coverage before seeking care, discuss costs and options with physicians, ask for less costly drugs, check quality ratings, and ask about service prices.”^{xxvii} • Transparency initiatives support the quality definitions and priorities identified in PPACA Sec 3013, which discusses the experience, quality and use of information provided to and used by patients, caregivers and authorized representatives to inform decision making about treatment options. <p><u>Clinical Pharmacy Activities:</u> <i>Includes therapeutic effectiveness assessments (e.g., P&T Committee), drug interaction monitoring and direct pharmacy services (e.g., mail order delivery, specialty pharmacy delivery). These services facilitate the ability to prevent negative drug interactions, provider prescription errors and other issues that could negatively impact patients’ health.</i></p> <ul style="list-style-type: none"> • In 1993 medication errors are estimated to have accounted for about 7,000 deaths.^{xxviii} Medication errors account for one out of 131 outpatient deaths and one out of 854 inpatient deaths.

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	<ul style="list-style-type: none"> UCLA and Kaiser Permanente researchers found that 84.7% of patients who received their medications by mail at least two-thirds of the time stuck to their physician-prescribed regimen, compared with 76.9 % of those who picked up their medications at traditional “brick-and-mortar” Kaiser Permanente pharmacies.^{xxix} <p><u>Direct Care Delivery:</u> Includes on-site clinics, drug dispensing and other clinical services provided or arranged directly by the health plan.</p> <p><u>Pilot Programs and Research:</u> Insurers establish pilot programs to further wellness and health care quality as well as contribute to academic research to identify best practices and other initiatives to improve quality.</p>
<p>Align Provider and Member Incentives to Health Care Quality Improvement</p>	<p><u>Comparative Effectiveness, Pay for Performance and High Performance Networks:</u> <i>Includes assessment of provider care effectiveness, the formation and support of provider networks based on care quality and efficiency, and payment methodologies designed to incent continuous quality improvement. The following are examples of the quality aspects of these programs:</i></p> <ul style="list-style-type: none"> Aetna has established a high performance network program called the Excel Network, in which specialists who have met certain clinical quality and efficiency standards are recognized. Medicare implements pay for performance to improve quality. The American Recovery and Reinvestment Act (ARRA) contains \$1.1 billion for comparative effectiveness research (CER). CER compares treatments and strategies to improve health. This information is essential for clinicians and patients to decide on the best treatment. It also enables our nation to improve the health of communities and the performance of the health system, overall. These initiatives support the quality definitions and priorities identified in PPACA: <ul style="list-style-type: none"> ✓ Sec 3011: Addressing gaps in quality and health outcomes measures, comparative effectiveness information and data aggregation techniques; and ✓ Sec 2717: Implementing activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine and health information.

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Decrease Waste	<ul style="list-style-type: none">• Some of the above items also decrease waste.
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- ^v Bott, David M., et al. "Disease Management for Chronically Ill Beneficiaries in Traditional Medicare". *Health Affairs*. January/February 2009; 28(1): 96-98.
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- ^{vii} Parker, Ruth M., "Health Literacy: A Policy Challenge for Advancing High-Quality Health Care." *Health Affairs*, July/August 2003; 22(4): 147-153.
- ^{viii} "Effect of Multimodal Reminder Program on Repeat Mammogram Screening." Published online July 14, 2009 in the *American Journal of Preventive Medicine*. Corresponding author: Adrienne C. Feldstein, MD, MS, Center for Health; Baron RC, Rimer BK, Breslow RA, et al. Client-directed interventions to increase community demand for breast, cervical, and colorectal cancer screening: a systematic review. *Am J Prev Med* 2008;35(1S): S34-55; Task Force on Community Preventive Services. Recommendations for client- and provider-directed interventions to increase breast, cervical, and colorectal cancer screening. *Am J Prev Med* 2008;35(1S): S21-5.
- ^{ix} Leape L. Unnecessary surgery. *Annu Rev Public Health*. 1992;13:363-383.
- ^x U.S. Congress. Senate Finance Committee. March 10, 2009. (testimony of Peter Orszag).
- ^{xi} Kaiser Family Foundation U.S. Health Care Costs. July 2009.; John E. Wennberg and others, "Geography and the Debate Over Medicare Reform," *Health Affairs*, Web Exclusive (February 13, 2002), pp. W96–W114; and Elliott Fisher, "More Care Is Not Better Care," *Expert Voices*, Issue 7 (National Institute for Health Care Management, January 2005) .
- ^{xii} Medical Management Guide, Office of the Assistant Secretary of Defense for Health Affairs and Office of the Chief Medical Officer, Population Health and Medical Management Division.
- ^{xiii} ^{xiii} Washington State Department of Labor and Industry, see <http://www.lni.wa.gov/ClaimsIns/Providers/Treatment/UtilReview/default.asp>
- ^{xiv} <http://www.socialsecurity.gov/history/ssa/lbjmedicare4.html>.
- ^{xv} http://ahca.myflorida.com/Medicaid/Utilization_Review/index.shtml.
- ^{xvi} American Hospital Association. *Hospital Statistics*. Chicago. 1999.
- ^{xvii} Centers for Disease Control and Prevention (National Center for Health Statistics). Births and Deaths: Preliminary Data for 1998. *National Vital Statistics Reports*. 47(25):6, 1999.
- ^{xviii} Department of Health and Human Services News Release, "HHS Issues Final ICD-10 Code Sets and Updated Electronic Transaction Standards Rules," January 15, 2009.
- ^{xix} Starfield, Barbara. "Is US Health Really the Best in the World?" *JAMA*. 2000; 284; 483-485.
- ^{xx} 74 Fed. Reg. 3332 (January 16, 2009).
- ^{xxi} <http://www.ahrq.gov/qual/aderia/aderia.htm>.

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^{xxii} American Hospital Association. Hospital Statistics. Chicago. 1999.

^{xxiii} Leapfrog Group, "The Leapfrog Group Fact Sheet, "March 2010. Accessed May 4, 2010 at: http://www.leapfroggroup.org/media/file/FactSheet_LeapfrogGroup.pdf.

^{xxiv} McCullough, Jeffrey S., et al., The Effect of Health Information Technology on Quality in U.S. Hospitals." *Health Affairs Supplement 2010*; 29(4): 647-654.

^{xxv} Byrne, Colene M., et al. "The Value From Investments in Health Information Technology at the US Department of Veterans Affairs." *Health Affairs Supplement 2010*. 29(4): 629-638.

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The Affordable Care Act (ACA) includes a number of new requirements and programs to promote quality healthcare. Many health plans have been participating in similar quality-focused initiatives for some time. The enactment of the ACA provides the government authority to implement quality initiatives across the healthcare system, including Medicare and Medicaid.

Below is a section-by-section description of the quality improvement activities included in the law.

Section 2717: Ensuring the quality of care

- Developing activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance activities, including the use of medical homes
- Implementing activities aimed at preventing hospital readmissions
- Encouraging and implementing activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology
- Establishing wellness and prevention programs. These may include personalized wellness and prevention services, which are coordinated, maintained or delivered by a healthcare provider, a wellness and prevention plan manager, or a health, wellness or prevention services organization that conducts health risk assessments or offers ongoing face to face telephonic or web-based intervention efforts for each of the programs participants

Section 1311: Rewarding quality through market-based incentives

- Implementing activities to reduce health and healthcare disparities, including the use of language services, community outreach and cultural competency training
- Including the activities listed above under “Ensuring the quality of care”

Sec 3011: National Strategy to Improve Healthcare Quality Priorities

- Addressing the health care provided to patients with high cost chronic diseases
- Improving the research and dissemination of strategies and best practices to improve patient safety and reduce medical errors, preventable admissions and readmissions, and health care-associated infections
- Identifying those items with the greatest potential for improving health outcomes, efficiency, and patient centeredness of healthcare
- Reducing health disparities
- Addressing gaps in quality and health outcomes measures, comparative effectiveness information and data aggregation techniques
- Identifying areas in the delivery of healthcare services that have the potential for rapid improvement in the quality of patient care

- Improving federal payment policy to emphasize quality and efficiency
- Enhancing the use of healthcare data to improve quality, efficiency, transparency, and outcomes

Section 3013: Quality Measure Development

- Developing measures that assess:
 - Health outcomes and functional status of patients
 - The continuity, management, and coordination of healthcare and care transitions, including episodes of care for patients across the continuum of providers, healthcare settings and health plans
 - The experience, quality and use of information provided to and used by patients, caregivers, and authorized representatives to inform decision making about treatment options
 - The meaningful use of health information technology
 - The safety and effectiveness, patient centeredness, appropriateness, and timeliness of care
 - The efficiency of care
 - Health disparities across health populations and geographic areas
 - Patient experience and satisfaction
 - The uses of innovative strategies and methodologies