December 27, 2012

Rebecca Zimmerman
Centers for Medicare & Medicaid Services
Department of Health and Human Services
PO Box 8010
Baltimore, Maryland 21244–8010

Attention: CMS–9962–NC

Dear Ms Zimmerman:

The child and adolescent health advocacy community represented by the signatories below is pleased to take this opportunity to respond to the Department of Health and Human Services (HHS) and Centers for Medicare and Medicaid Services (CMS) Request for Information (RFI) on health plan quality management in Affordable Insurance Exchanges. Maternal and child health advocates believe that the Affordable Care Act (ACA) offers tremendous potential to improve the health of mothers, infants and children by improving child and perinatal health quality outcomes. We applaud CMS's effort toward this end by initiating public discussion on the current challenges and possible solutions to advance quality measurement.

Firearms. We note that one section of the ACA that generated the RFI includes language barring the Secretary and health plans listing in the Exchanges from collecting and housing information regarding the presence of firearms in the home. Pediatric advocates vehemently reject this component of the ACA and urge HHS to craft policy to improve the quality of care and overall health of infants, children, adolescents and young adults that will limit the harmful impact of this section of the Act. Pediatricians should have no deterrents to ask whether a gun is in the home. In fact, Section 2713 of the ACA requires that insurers offer Bright Futures services for no copay in all non-Grandfathered plans. The Bright Futures guidelines for well-child and well baby visits include anticipatory guidance regarding whether firearms are in the home. Given the importance of such a question to a child's health and their quality of care, we respectfully request you issue clarification to ensure pediatricians do not interpret this provision to mean they may not follow the Bright Futures guidelines. One way to accomplish this would be to explicitly exclude Bright Futures from the definition of a "wellness and health promotion activity" as set forth in sec. 2717(a)(1)(D).

Firearm-related deaths continue as one of the top three causes of death in American youth. While the firearm-associated death rate among youth ages 15 to 19 has fallen from its peak of 27.8 deaths per 100,000 in 1994 to 11.4 per 100,000 in 2009, driven by a decline in firearm homicide rates, nevertheless, firearm-associated death and disability rates remain unacceptably high.[1]

[1] See AAP Council On Injury, Violence, And Poison Prevention Executive Committee, "Firearm-Related Injuries Affecting the Pediatric Population," DOI: 10.1542/peds.2012-2481. *Pediatrics.* 2012; 130; e1416; originally published online October 18, 2012.

Of all injury deaths of individuals 15 through 19 years of age in the United States in 2009, more than one in four (28.7%) were firearm related, and of those younger than 20 years, nearly one in five (19.5%) were firearm related. These firearm deaths result from homicide, suicide, and unintentional injury. Black Americans are particularly affected; injuries from firearms were the leading cause of death among black males 15 through 34 years of age in 2009. Although national data cannot fully document urban and rural differences in the patterns of injuries from firearms that involve children, local data indicate that children in rural areas as well as in urban areas are at risk for firearm-related mortality.[2]

Pediatric advocates support a number of specific measures to reduce the destructive effects of guns in the lives of children and adolescents. The AAP, for example, supports including the regulation of the manufacture, sale, purchase, ownership, and use of firearms; a ban on semiautomatic assault weapons; and the strongest possible regulations of handguns for civilian use.[3]

Quality Improvement. Major opportunities exist to improve the delivery of health care to pregnant women and children in the United States. Quality measurement provides the tool to improve care by identifying and closing care gaps. Measurement for continuous quality improvement can be used to help practice or organizations understand care processes, how performance compares with others, and to track measures in response to changes.[4]

Women's and children's health care present distinctive challenges for quality measurement. Any effort to measure quality should take into account the unique features of maternal and child health and health care and recognize the importance of pediatric development, dependency, demographics, and disparities. Measures must reflect the differential epidemiology in children as compared with adults and include patient and family participation. Those who develop and use perinatal and pediatric measures should acknowledge that much of child and perinatal health care is focused on promoting healthy development and prevention. In addition, non–condition-specific measures may need to be considered (eg, coordination of care for children with special health care needs) because of the relatively low numbers of children with any one condition.[5]

The Children's Health Insurance Program Reauthorization Act (CHIPRA) Pediatric Quality Measurement Program (PQMP) has made considerable strides toward ensuring quality care for children through the identification of the Initial Core Measure Set and current efforts to develop additional measures through CHIPRA-funded Centers of Excellence. In addition, the Medicaid adult core set of measures contains a suite of perinatal measures designed to capture the quality of care provided to pregnant women. We recommend that these measures be incorporated within the Exchanges with an emphasis on the inclusion of robust outcome measures, wherever possible. Additionally, measures of patient experience of care should be prominent and carry substantial weight in relation to other measures. Finally, measures should be reported in a clear,

[2] Ibid.
[3] Ibid.
[4] American Academy of Pediatrics, Steering Committee on Quality Improvement and Management and Committee on Practice and Ambulatory Medicine. Principles for the Development and Use of Quality Measures. *Pediatrics.* February 2008; 121:2; 411-418.
[5] Ibid.

concise manner at an appropriate literacy level, translated in Spanish and other languages, and be made available in multiple forms (e.g., electronic, paper).

Maternal and child health advocates offer the following responses to specific questions posed by HHS:

2) *What challenges exist with quality improvement strategy metrics and tracking quality improvement over time (for example, measure selection criteria, data collection and reporting requirements)? What strategies (including those related to health information technology) could mitigate these challenges?*

There are numerous challenges in measuring quality including risk adjustment, attribution of care to individual physicians, and inadequate systems for collection and analysis of clinical data, particularly process data. Additional concerns abound in pediatric quality measurement, including the unique features of children's healthcare and the often low number of children represented for any one condition. Children present to any given children's hospital with events subject to particular measures relatively infrequently. This makes apparent performance subject to uncontrollable variations and nuances that can confound the measure in either direction.

Also, timely data are critical to meaningful quality measurement efforts. It is best to collect and report data in smaller, more frequent batches such as weekly or monthly instead of the typical quarterly or annually.

In addition, many health plans currently have their own quality improvement and physician rating programs. Physicians or facilities are being rated on multiple criteria from various health plans. Physicians or facilities may be rated differently across the various health plan programs such that a doctor or facility may be highly rated in several plans but poorly rated by another plan due to low number of cases or outliers. An aggregate rating system across all health plans would provide more comprehensive and consistent quality rating.

HHS should consider establishing a suite of measures that can apply to children with special health care needs regardless of the specific condition the child has. In adult medicine, there is greater recognition of similar issues – ie, that few patients come in with hypertension or coronary artery disease alone. Instead, most patients in family or internal medicine have multiple, interacting conditions, and measures for them too should allow assessment of their chronic state regardless of the specific condition.

Additionally, we urge HHS to consider that measures to be assessed be stratified by key child characteristics (race/ethnicity, socioeconomic status, and/or presence or absence of a chronic condition).

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

The Exchange should incorporate the CHIPRA PQMP Initial Core Set of Children's Health Care Quality Measures and additional measures being developed by the PQMP.

10) What are the priority areas for the quality rating in the Exchange marketplace?

The National Quality Strategy (NQS) sets forth comprehensive principles and a solid framework for improving the delivery of health care, patient health outcomes, and population health. In addition to the NQS priorities, health plans should be rated according to both consumer and physician satisfaction and on whether the plan promotes preventive and primary care in terms of coverage and payment (e.g., does the plan cover and pay separately for all recommended Bright Futures recommended services?).

11) What are effective ways to display quality ratings that would be meaningful for Exchange consumers and small employers, especially drawing on lessons learned from public reporting and transparency efforts that states and private entities use to display health care quality information?

The quality ratings display should include the following features: 1) number and types of consumer and provider complaints for the plan; 2) total expected out of pocket costs to the plan member; 3) the premium costs to the employer/member; and time to payment of claims since pediatricians are subject to collections and credit checks due to insurers not paying on time.

15) What factors should HHS consider in designing an approach to calculate health plan value that would be meaningful to consumers? What are potential benefits and limitations of these factors? How should Exchanges align their programs with value-based purchasing and other new payment models (for example, Accountable Care Organizations) being implemented by payers?

Suggested factors include 1) a metric that includes number of member and provider complaints against the plan; 2) the degree or comprehensiveness of coverage; and 3) cost of the plan. Additional features for plan value for pediatric services are outlined in the AAP policy statement, Guiding Principles for Managed Care.[6]

Thank you for the opportunity to provide comments on issues related to health plan quality management in Affordable Insurance Exchanges. We offer our assistance as HHS works toward advancing this effort.

Sincerely,
American Academy of Pediatrics
Children's Defense Fund
Children Now
Georgetown University Center for Children and Families
First Focus
National Assembly on School-Based Health Care
National Health Law Program
New England Alliance for Children's Health
Voices for America's Children

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[6] American Academy of Pediatrics, Committee on Child Health Financing. "Guiding Principles for Managed Care Arrangements for the Health Care of Newborns, Infants, Children, Adolescents, and Young Adults." *Pediatrics*. August 2006; 118:2:828 -833.