Consumer-Purchaser
DISCLOSURE PROJECT
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January 14, 2013

Rebecca Zimmerman
Centers for Medicare &Medicaid Services
Department of Health and Human Services

RE: CMS-9962-NC: RFI Regarding Health Plan Quality Management in Affordable Insurance Exchanges

Dear Ms. Zimmerman:

The 24 undersigned organizations represent a collaboration of leading consumer, labor, and employer organizations committed to improving quality and affordability of health care through the use of performance information to inform consumer choice, payment, and quality improvement. We appreciate the opportunity to respond to this Request for Information on the ways in which Exchanges can most effectively provide information to consumers about the quality of care delivered through Qualified Health Plans (QHPs).

Exchanges have the potential to significantly transform the health care marketplace, but to do so requires providing consumers and employers with meaningful information on how health plans and providers perform on measures of clinical quality and patient experience. Today, many consumers are not aware of the variations in quality and value and how these significant variations affect care delivery and outcomes. However, as one expert recently noted, Exchange consumers will likely show a "…willingness to pay for value. Price will be a concern for the consumer and insurer, but it will be hard for health care companies to differentiate on price alone. Insurers will need to differentiate through quality, benefits and customer experience." [1] **This speaks to the well-recognized need for consumers to have clear information on both the importance of quality information, and on variations in quality**. Exchanges' role in improving quality and reducing costs across the board, and contributing to the system transformation that the Affordable Care Act was designed to achieve, requires the availability of quality and cost information – and ways to engage consumers in using it – from day one.

Consumers and purchasers look forward to Exchanges serving as a model for efficiently organizing access to insurance coverage for the millions of Americans who need affordable coverage, and we believe that a critical component to making this coverage most efficient is by improving quality of care delivered. Exchanges create an incredible opportunity for the market to address the significant quality and affordability gaps that exist in today's health care delivery system. We cannot stress enough our request that HHS recognize the potential for Exchanges to serve as transformational tools, and the

[1] Vaughn Kauffman, U.S. Health care payer advisory leader, PricewaterhouseCoopers, December 18 2012 webinar.

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imperative for designing them in a way that drives improvements in quality of care which will serve to increase affordability across the entire system. **Making robust information on quality and cost of care available, and delivering it in a way that activates consumers to make decisions based on value, is crucial to the success of the Exchange model.**

Our responses to the questions below reflect our belief that there is an urgent need for Exchanges to be designed to meet the needs of their members, primary among those needs being useful information on quality, access, and affordability, as well as easy-to-use decision support tools.

1. *What quality improvement strategies do health insurance issuers currently use to drive health care quality improvement in the following categories: (1) improving health outcomes; (2) preventing hospital readmissions; (3) improving patient safety and reducing medical errors; (4) implementing wellness and health promotion activities; and (5) reducing health disparities?*

   Health plans employ a number of different improvement strategies, many of which include a financial incentive that falls into one of the following categories:

   - making performance publicly accessible and transparent
   - quality bonuses (either retrospective or prospective as part of the contracting process)
   - putting compensation at risk
   - providing grants for quality improvement activities
   - establishing variable cost sharing or "tiering" for patients

   Many of these strategies, while critical to improving quality, speak more to internal quality improvement processes and are not visible to consumers. However, the first bullet – making performance publicly accessible and transparent – speaks directly to the needs of consumers, and reflects the fact that making quality and cost information publicly available is already happening to a significant degree in the private sector. To not report on this information in the Exchanges would represent a regression on the level of transparency now available in many markets. In addition to public reporting of performance, we believe that it is important for consumers to have access to information on whether, and if so, which, of these additional strategies listed above, are in use by QHPs.

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?*

   In our current environment one of the biggest challenges facing consumers and purchasers is the lack of outcome measures and the glut of process measures clogging many performance measurement programs, most of which do not provide meaningful information. As noted in the question, the fact that the quality measurement enterprise is so process-measure heavy is due to challenges related to data collection and reporting, including lack of interoperable HIT that makes it difficult, at the very least, to develop measures that collect data from different settings (e.g. hospital, ambulatory, lab, pharmacy, home health) in an effort to provide a comprehensive picture of patient's health and wellness over time. There is also a severe lack of publicly reported measures using registry-based data that would provide the field with information on change in

quality/improvement over time. On top of these challenges is the significant time lag between when the data is collected and when it is made available for accountability purposes, making it difficult to improve systems (e.g. Medicare readmissions information available in 2012 is using 2010 data). Finally, physician- and team-level measures and data are still mostly unavailable to consumers to use. One concrete strategy that we urge CMS to pursue for the Federally-facilitated Exchanges as well as incentivize state Exchanges to use is allowing health plans to survey members using the CAHPS tool after only six months, rather than 12 months of being enrolled in the plan. This will allow for collection and reporting of critical patient experience information in a more timely manner.

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

   There are a number of examples of health care quality information being made publicly available, and designed with consumers in mind:

   - Consumers' CHECKBOOK/The Center for the Study of Services created the State Exchange Health Plan Comparison Tool which is modeled after the web portal currently used in the Federal Employees' Benefits Health Program (FEHBP). This tool allows consumers to view, easily and quickly, information on cost and patient experience quality data on a number of different health plans. The tool also lets consumers select health plans based on whether or not their providers are in the health plan's network, and allows the user to drill down for more granular information on how patients with various chronic conditions rated the plans.

   - Louisiana provides Coordinated Care Network customers with useful information that is designed in such a way as to prevent customers from becoming overwhelmed. The CCN provides access to enrollment assistors who provide unbiased interpretations of network options.

   - Minnesota's Web portal allows consumers to compare provider reimbursement rates. The portal lists the average amount health plans pay to 110 Minnesota health care providers for 103 common medical procedures.

   - In Wisconsin, BadgerCare created an easy to use, consumer-friendly web site that includes a report card on plan performance; developed a streamlined health plan selection and enrollment process; and used brokers, community partners, and other navigators to assist consumers in making informed decisions by providing information on eligibility for programs and subsidies.

   - Colorado Business Group on Health is working with Bridges to Excellence to publicly report individual physicians, as well as purchasers and plans that have BTE distinction in cardiovascular care and diabetes care: http://www.coloradohealthonline.org/cbgh/index.cfm/programs/bte/

- The New Jersey Health Care Quality Institute produced a surgery safety report: http://www.njhcqi.org/njhcqinews.php?mode=view&id=630&type=3 and a hospital price transparency report: http://www.njhcqi.org/njhcqinews.php?mode=view&id=311&type=3

- Niagara Health Quality Coalition produces a New York state hospital report card: http://www.myhealthfinder.com/newyork11/index.php and physician profiles: http://www.nydoctorprofile.com/

- Oregon Health Care Quality Corporation (a recently-named QE) offers significant transparency on provider performance: http://q-corp.org/quality-reports/providers

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

   Having information on quality and cost is not just critical for consumers. Through the National Quality Strategy (NQS), the Partnership for Patients, and myriad other efforts, HHS has expressed a strong interest in using strategies that will serve to align its public sector purchasing efforts with those being used in the private sector, in order to meet the three aims of better health, better care, and lower cost. The NQS 2012 Annual Progress Report to Congress describes how federal agencies, as well as state Medicaid agencies and departments of health, are embracing the goals of the NQS, and are tailoring their work to address its domains and priorities. We strongly urge CMS to design quality reporting efforts that go in the same direction as the NQS priorities as well. This means focusing on measures that will indicate whether the three-part aim is being met by making transparent measures of performance on outcomes, cost and resource use, patient safety, and patient experience.

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

   Before discussing specific measures that may be most relevant to the Exchange marketplace, we urge Exchanges and CMS to think about quality reporting initiatives from the perspective of what information consumers want and need, and how they use this information. Exchanges and CMS need to design their quality initiatives closely in concert with the development of the web portal, the navigator program, and other consumer assistance tools, to ensure that the quality measurement efforts will support and contribute to the use of this information by consumers. The bottom line is that if consumers are expected to use this information, then they should be included in all discussions related to creating the system. CMS can accomplish this by using focus groups of consumers, as they have done when exploring efforts to re-design the data display and other aspects of www.hospitalCompare.hhs.gov

   Evidence indicates that consumers make decisions based on information related to choice of provider, and data on patients' experiences of care and outcomes. Having this information as it

pertains to people with similar health status and conditions as their own makes it even more useful and meaningful.[2] Thus, while we support the use of standard measures of health plan quality – such as the National Committee for Quality Assurance's HEDIS instrument – we also urge that Exchanges be required to collect and report on a comprehensive set of provider-specific measures that include data on:

- patients' experiences of care
- outcomes (including functional status, readmissions and mortality, and patient safety and healthcare-acquired conditions)
- clinical processes tightly linked to outcome
- appropriateness of care
- cost and resource use

These measures should be stratified by race, ethnicity, language, gender, and disability (RELGD) in order to identify and address disparities in care. Note that for the pediatric population there is a limited number of outcome measures, since most of the content of care for this population is preventive and intended to avoid outcomes that may never occur. In this area we strongly support the inclusion of population health measures such as vaccinations, and child obesity rates.

The measure sets should evolve as more measures that resonate with those who receive and pay for care become available. This evolution is particularly important to keep in mind as more attention is being paid to the development of measures using patient-reported data, see below. We also urge the use of measures for which public and private sector purchasers and payers are aligned in data collection and reporting, to further promote this type of alignment across sectors.

We strongly urge that state Exchanges be required to collect and report data on patients' experiences of care, and that patient-reported and patient-generated data measures become a core component of the Exchanges quality initiatives. These measures should be implemented across all settings for which measures are available, using tools such as the Consumer Assessment of Healthcare Providers and Services (CAHPS) surveys, which are specified for collecting clinician-level and facility-level data and in the future, data at the patient-centered medical home level. We also suggest consideration of other patient-generated data measures that capture information on patients' perceptions of their care and outcomes. Evidence shows that having actionable data on patients' experiences of care leads to improved health outcomes.[3] Patient-reported and generated data in general are critical for improving overall quality of care, particularly for the highest cost, most complex patients.

Wherever possible, measures – whether patient-reported or clinical quality – should be reported at the individual-physician level. Physicians may operate as part of a team, but patients and consumers most often make health plan choices based on the individual physicians in the QHP's network.

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[2] Note that the Consumers' CHECKBOOK/Center for the Study of Services selection tool linked above on page 3 follows this model.

[3] M. Meterko, Ph.D., et al., "Mortality Among Patients with Acute Myocardial Infarction: The Influences of Patient-Centered Care and Evidence-Based Medicine," Health Services Research. 2010 Oct;45(5 Pt 1):1188-204.

Having individual physician-level information intuitively fits with the way many consumers make health care choices.

Provider- and setting-level measures are critical to helping consumers make informed decisions about which QHP will provide the best quality and value. To facilitate dissemination of this information, states should provide links on their web portals to other sources of quality data, such as CMS, the Agency for Healthcare Research and Quality (AHRQ), the Leapfrog Group (particularly the recently released Hospital Safety Score data), the Joint Commission, and others that use nationally recognized measures to assess quality and performance.

In addition to the use of a nationally standardized minimum set of consumer-tested, quality measures**, Exchanges should be empowered to add additional measures based on local, regional, and private sector innovations in quality measurement**. One example of a tool for assessing health plan quality that is widely used by private sector purchasers is *eValue8*, which provides evidence-based data on health plan quality in critical areas such as consumer engagement, disease management and health promotion, and behavioral health (we discuss *eValue8* in more detail under question 8 below). Additionally, many states have already-established initiatives to improve quality in specific areas, such as statewide public/private sector collaboratives around improving maternity care outcomes (e.g. lower c-section rates, reducing early elective deliveries, etc). In these states, we urge CMS to require that Exchange QHPs report on those measures as well. Recognition of demographic and geographic differences in consumer needs and the nature of local delivery systems, as well as differences in experience with data collection across health plans and states, will strengthen the quality component of the Exchanges.

Finally, we suggest requiring the use of a of a number of clinical measures on which both commercial and Medicaid plans perform poorly nationwide as an incentive for issuers to encourage improvement strategies among the provider community. These could include such measures as scores on certain child/adolescent vaccinations, and follow-up care for child prescribed ADHD meds. This would align with efforts already underway at NCQA, which is requiring both child/adolescent measures and the ADHD follow-up measure for the new ACO accreditation.

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

There are a significant number of gaps in current clinical measure sets, most recently identified and catalogued by the Measure Applications Partnership (MAP) in its work to develop "families" of measures for patient safety, care coordination, and cardiac and diabetes care. **The most glaring gaps are in the areas of patient-reported measures (including patient experience), cost and resource use, and care coordination and transition measures. However, the existence of these gaps does not belay the fact that public reporting of performance in areas where we <u>do</u> have measures is critical.** For example, reporting patient experience via the CAHPS family of measures will provide meaningful information while the field works to develop additional measure of patient experience. In the end, Exchanges should not be reporting less information than is required by other HHS programs, such as Medicare Advantage.

In addition to gaps with measuring clinical performance and patient experience, there are gaps in measuring experience with the Exchange itself. In our comments to the Secretary in July 2012 on the development of a patient experience tool, we highlighted the following as issues/questions that should be included in any survey of Exchange consumers (as well as those who pursue purchasing coverage through an Exchange but do not complete the transaction) in order to continuously improve the way this marketplace operates:

- accuracy of eligibility and tax credit determinations;
- accessibility and effectiveness of consumer support tools
- evidence of bias in communications
- appeals process for both eligibility determination and coverage
- Identifying where consumers are primarily accessing information
- Effectiveness of marketing and outreach efforts
- Measures of patient-reported outcomes

8. *What are some issues to consider in establishing requirements for an issuer's quality improvement strategy? How might an Exchange evaluate the effectiveness of quality improvement strategies across plans and issuers? What is the value in narrative reports to assess quality improvement strategies?*

To evaluate the effectiveness of quality improvement strategies across plans, Exchanges will need to collect standardized information on plan activities that seek to control costs, minimize waste, ensure patient safety, close gaps in care and improve patient experience, health and health care. Some of this information can be gathered through the plan accreditation process, but the assessment of quality improvement strategies is neither sufficient nor consistently captured. This is why healthcare purchasers are requiring issuers to complete the *eValue8* Health Plan Request for Information (RFI). This RFI allows Exchanges to collect data that supports reporting of plans' quality improvement strategies in accordance with the Affordable Care Act. **We recommend that CCIIO look at what states like California and Maryland are doing to incorporate eValue8 into their Exchange quality measure reporting, and require Exchanges to capture relevant sections of *eValue8* across issuers as a key part of the quality improvement evaluation strategy.**

Also critical to an issuer's quality improvement strategy are the quality of its provider network and the affordability of benefits. Therefore, Exchanges should collect quality information on provider-level performance as well as information on the cost of care (total cost and the member portion). As noted above in question 5, these metrics should mirror those that are publicly reported, and include benchmarks and performance thresholds for clinical outcomes, functional status, appropriateness, patient experience, care coordination and care transitions, and cost and resource use. Tracking these metrics over time combined with information on plan quality improvement strategies will shed light on how Exchanges are advancing affordability and quality, per the aims of the National Quality Strategy.

CCIIO should encourage quantitative reporting to indicate the scope and impact of quality improvement programs such as member engagement, the volume of providers, etc. Narrative

content is prone to distortion and is not conducive to comparison across issuers, significantly limiting the utility of information.

9. *What methods should be used to capture and display quality improvement activities? Which publicly and privately funded activities to promote data collection and transparency could be leveraged (for example, Meaningful Use Incentive Program) to inform these methods?*

   CCIIO should ensure its quality improvement evaluation activities align with Affordable Care Act Measurement Initiatives among other public and private sector measurement efforts to minimize reporting burden and forge a uniform path for measurement and valuation:
   - Meaningful Use Incentive Program – CCIIO should take advantage of opportunities to align with incentives for "meaningful use" of electronic medical records
   - Medicare Shared Savings Program – CCIIO should ensure performance measures accommodate new contractual structures such as Accountable Care Organizations and Patient-Centered Medical Homes so that their performance can be evaluated
   - Measures Application Partnership – this group is drawing consensus around what is important to measure for the purposes of program monitoring, payment and public reporting. Exchange quality reporting requirements should draw from this effort.

   CCIIO should leverage the following activities to collect and report quality improvement information:
   - All-Payer Claims Databases / Medicare Qualified Entity Program – plans should be encouraged to pool information into all-payer claims databases as these entities are uniquely qualified to aggregate, analyze and report performance information in a manner that is meaningful for consumers, purchasers and providers
   - eValue8 RFI – As discussed above eValue8 is a tool to collect benchmark and ongoing information on important plan quality improvement strategies in concert with accrediting bodies
   - System for Electronic Rate and Form Filing (SERFF) – Since plans are already familiar with using SERFF to report information, the SERFF should be leveraged as much as possible to collect information in a uniform way and minimize reporting burden

10. *What are the priority areas for the quality rating in the Exchange marketplace? (for example, delivery of specific preventive services, health plan performance and customer service)? Should these be similar to or different from the Medicare Advantage five-star quality rating system (for example, staying healthy: screenings, tests and vaccines; managing chronic (long-term) conditions; ratings of health plan responsiveness and care; health plan members' complaints and appeals; and health plan telephone customer service)?*

    Quality rating activities should be geared towards helping consumers understand the overall value of plans, thus creating a high-value marketplace for consumers and facilitate effective decision making among consumers. **It is critical that any measurement activity result in a summary of product value that is meaningful to consumers**. Some of the priority areas for rating plan quality for consumer plan choice include:

Clinical ratings	Summary ratings for preventive and chronic care
Plan service	Summary rating that is a composite of ratings for customer service, cost information services and paying claims
Access to care	Summary rating that is a composite of ratings for ease of getting appointments and getting needed care, tests or treatment
Doctor communications and care	Includes composite ratings for doctor communications and care, patient and doctor sharing decisions, health promotion, an indicator that care is coordinated and an indicator that health care is highly rated
Patient-reported information	Information gleaned from the patient on outcomes (including functional status), understanding of transition instructions and self-care methods, etc.
Provider-level quality	Whether the plan provides members with hospital and physician-specific quality ratings (clarify physician-level vs. medical group, PCMH, ASO, other organizational levels)
Accreditation scores	Information collected by NCQA to support accreditation

Further analysis should be completed to determine what subset of information should be displayed on Exchange websites as opposed to what information is used by Exchanges for plan management and oversight purposes.

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 web portals offer a significant opportunity for exchanges to provide critical and usable information to consumers that will facilitate better understanding of health care coverage and quality of care. **The success of the portals at meeting this opportunity rests upon exchanges requiring QHPs to publicly report the types of quality measures described above**. Assuming this foundation is in place, exchanges can subsequently best leverage this opportunity by:

- Providing multiple approaches – and the appropriate decision-support tools – for consumers to navigate through the information according to their learning and usage style.
- Placing information on quality and cost (value) up front and center, and developing tools that are intuitive and intelligent enough to provide alternative layers of decision support to meet the diversity of consumer needs and capabilities.
- Reflecting consumer preferences, and allowing consumers to screen plans by those that have their provider(s) in the QHP's network.
- Establishing display methods to help consumers easily distinguish among various benefit and cost levels, particularly in states where there are many participating QHPs.
- Collaborating with regional public reporting efforts and employer-based efforts, to incorporate their experience and expertise regarding how to best communicate quality and cost to

consumers, including assessing what consumers need to know to make the best decisions possible.

- Reporting the availability of QHPs' disease management programs; cost saving opportunities; patient coaching; shared decision-making programs; and prevention and care coordination initiatives, to assist decision-making by those who have multiple chronic conditions.
- Making available composite measures that reflect aspects of enrollee plan experience, such as claim denials, enrollment and disenrollment, complaints, and external appeals outcomes, with the option to drill down for more specific information if interested.
- Allowing consumers to use the web portal to report back on their experiences with the exchange, their health plan, and their provider(s). One of the biggest challenges facing exchanges will be the lack of historical experience for some of the QHPs. Establishing a vehicle for consumer self-reporting is a way to quickly build this type of portfolio.
- Developing innovative strategies for providing quality "proxies" in cases where data metrics are not available. For example, having a "people like me…chose this health plan" tool, which includes information on quality and cost to help guide decision-making.

In developing the content and design of the Web portal, Exchanges should assume no audience knowledge of health insurance and low heath literacy levels. Recognizing this is essential in the Exchange's efforts to maximize accessibility and understanding for all users. **Toward that end, CMS should require that Exchanges include end-users in the web portal design and testing, to ensure usefulness and navigability to consumers.**

13. *Describe any strategies that states are considering to align quality reporting requirements inside and outside the Exchange marketplace, such as creating a quality rating for commercial plans offered in the non-Exchange individual market.*

The California and Maryland Exchanges will both be using the *eValue8* RFI as a tool to collect information on health plan quality improvement activities which is in direct alignment with purchaser activities outside the Exchange. The RFI is fielded around the country by regional employer coalitions. For example, in California, six issuers already use eValue8 under the auspices of the Pacific Business Group on Health.

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?*

The health system has waited too long to share meaningful information that can guide consumer and provider decision-making. Measures have been implemented inconsistently and information provided is not actionable by consumers or purchasers to improve care. **The Exchanges, as the largest purchasers in their state, have a critical role to play in accelerating the collection of standardized information to calculate health plan value. By providing clear guidance on how Exchanges should consistently implement a quality measurement framework, CCIIO will ensure information is collected in a way that is comparable and allows for value-based differentiation.**

To be most effective at creating a meaningful quality measurement program, Exchanges should align their programs with existing value-based purchasing efforts in the following ways:

- Collect standardized information and make it transparent
  - Issuers should be required to complete the eValue8 Health Plan RFI to support QHP oversight and reporting of quality improvement strategies. Exchanges should use this information for plan selection, plan engagement and benchmarking.
  - Prohibit provider contracts that include transparency clauses, such as restrictions on the use of administrative data for performance reporting. Without this requirement, Exchange consumers will not have access to critical information they need to make choices about care providers and plans. These anti-transparency clauses constitute a serious weakness in the current performance infrastructure.
  - Require QHPs to disclose the percentage of total dollars disbursed in Fee-for-Service (FFS) payments versus other value-based payments, and provide the value-based payment "split" using categories specified in the survey developed by the *Catalyst for Payment Reform*. Doing so would provide CCIIO and the state Exchanges a sense of what percentage of payments across the country are being made in the cause of value, which would be enormously useful when disclosed publicly to employers, consumers, and policymakers.

- Use information to improve quality and affordability of health care
  - Information should be used to help consumers identify high-value plans that meet their needs – performance information should be summarized and communicated to consumers at the time of plan choice
  - Exchanges should also leverage information for plan selection, to contract with plans that provide the highest value to consumers
  - Exchanges should also use information to identify and spread plan practices that were successful at reducing costs and maintaining quality, such as reference pricing, revised payment models, and care models that better manage the needs of high-need populations.

- Actively support the expansion of measures to fill gaps
  - CCIIO should collaborate with ongoing public and private sector efforts to fill gaps in information on outcomes, patient experience and care coordination as well as on total cost, appropriateness of care and resource use to improve cost transparency. For example, Exchanges could test the collection and use of these measures.

On behalf of the millions of Americans represented by the undersigned organizations, we appreciate the opportunity to provide comments on the Health Insurance Exchange health plan quality measurement RFI. If you have any questions, please contact either of the Consumer-Purchaser Disclosure Project's co-chairs, Debra L. Ness, President of the National Partnership for Women & Families, or Bill Kramer, Executive Director for National Health Policy at the Pacific Business Group on Health.

Sincerely

American Hospice Foundation
Business Healthcare Group of Southeast Wisconsin
Childbirth Connection
Citizen Advocacy Center
Employers' Coalition on Health
The Empowered Patient Coalition
Health Care Incentives Improvement Institute
Health Policy Corporation of Iowa
Iowa Health Buyer's Alliance
Lamaze International
Mid-Atlantic Business Group on Health
Minnesota Health Action Group
National Business Coalition on Health
National Family Caregivers Association
National Partnership for Women & Families
New Jersey Health Care Quality Institute
Northeast Business Group on Health
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The Leapfrog Group