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Attn: Comments on *Qualified Health Plan Policies and Strategies to Improve Care, Prevention and Affordability*
California Health Benefit Exchange Board
Sacramento, CA

Dear Sir or Madam:

The California Academy of Family Physicians (CAFP) submits this letter in response to the invitation to provide public comment on the California Health Benefit Exchange (HBEX) Board's *Qualified Health Plan Policies and Strategies to Improve Care, Prevention and Affordability* (*QHP Policies and Strategies*). CAFP, representing more than 8,000 family physicians and medical students in California, is a long-standing advocate for health care reform and the HBEX. CAFP appreciates the HBEX Board and staff's work in developing the recommendations in *QHP Policies and Strategies*. We believe that building the HBEX presents a great opportunity to drive change in the delivery and payment of care, health outcomes and cost of care. We believe this can be best accomplished by the promotion, on the HBEX, of the Patient Centered Medical Home (medical home) model and we think the HBEX Board can go further in advancing this model than the current recommendations propose. We describe this and other comments related to network adequacy, essential community providers, the prohibition on contracts that include anti-transparency clauses, quality reporting on provider-level performance and administrative simplification in detail below. We thank you for the opportunity to share our views.

Ensure Adequate Provider Networks through Improved Verification Processes

It is of paramount importance that the HBEX provide adequate access to providers. Strong network adequacy requirements and a system for assuring the requirements are met serve as both a protection to ensure enrollees have minimally acceptable access to providers and a vehicle to improve access. Access to care, specifi ally primary care, directly correlates with better health and lower costs. Robust provider networks will be essential to ensuring a healthy California and a successful HBEX.

CAFP supports the HBEX staff recommendation that the Board adopt the regulatory requirements of the Qualified Health Plan (QHP)'s current regulator (e.g., PPOs regulated by the California Department of Insurance would comply with the Insurance Code and HMOs/PPOs regulated by the Department of Managed Health Care would comply with the Health and Safety Code). We agree that this minimizes administrative and operational burden.

CAFP is concerned with the HBEX staff's recommendation that the HBEX rely on regulators' certification that the QHPs met regulatory network adequacy standards, however. We believe, and our members' experience indicates, that network verification processes historically have been weak. We think that the HBEX can improve on these processes to ensure that regulatory requirements are met. CAFP therefore joins the California Medical Association (CMA) in recommending that the Exchange Board capitalize on the new provider directory functionality of the System for Electronic Rate and Form Filing (SERFF) by integrating the network adequacy verification system currently used in Medicare Advantage (MA).

CAFP agrees with the CMA that using this network adequacy verification system would provide greater assurance that QHPs are meeting regulatory requirements related to network adequacy. The SERFF verification system would build on processes and technologies already utilized by the California state government and health insurance industry. It would provide consumers with better access to plans' provider network information and assure consumers they are getting what they want in a plan. The SERFF system could do this with relatively minimal administrative burden and cost to the state and industry. We urge the HBEX Board to reconsider the recommendation related to network adequacy verification and improve on the verification process by using SERFF.

Essential Community Providers Standards

CAFP supports the Affordable Care Act requirement that QHPs have a sufficient number and geographic distribution of essential community providers (ECPs) to ensure low income, medically underserved individuals reasonable and timely access to a broad range of providers. In keeping with this statutory requirement, CAFP believes that HBEX should define ECPs more broadly by including physicians, clinics and hospitals that have demonstrated service to low income, medically underserved individuals. We agree with HBEX staff that this broader definition increases the pool of ECPs and thereby increases overlap in provider networks for beneficiaries who may "churn" between Medi-Cal and the Exchange. CAFP supports policies that preserve the physician-patient relationship and otherwise ensure continuity of care. We believe the broader definition of ECPs serves that purpose.

CAFP supports the HBEX staff recommendation that Essential Community Providers include physicians, clinics and hospitals that have demonstrated service to Medi-Cal, low-income, and medically underserved populations rather than limiting the definition to 340B and 1927 providers.

CAFP supports the staff recommendation that QHPs demonstrate minimum proportion of network overlap among Qualified Health Plan and Medi-Cal Managed Care, Healthy Families Program networks and/or independent physician providers serving a high volume of Medi-Cal patients in their practices.

Prohibition on Health Plan Provider Contracts that Include Anti-Transparency Clauses

CAFP is concerned with the recommendation on page 155, that the HBEX "[p]rohibit health plan provider contracts that include anti-transparency clauses such as: terms that bar disclosure of provider ratings, or require affiliate participation." As this directive is the only mention made of anti-transparency clauses in *QHP Policies and Strategies*, the definition of anti-transparency clauses and the reason for such a recommendation are not evident. There are no limits to the definition and we are concerned that this prohibits any confidentiality provisions in provider contracts. There is also no evidence that this kind

of interference with provider contracting benefits purchasers or consumers. We think this recommendation is ill-conceived.

CAFP joins the CMA in urging the Exchange Board to reconsider the prohibition on "Anti-Transparency Clauses" in provider contracts. At the very least, we ask that before such a prohibition is adopted, the Board publicly delineate the contractual language it would include in this prohibition and provide an opportunity for public comment.

We also urge the Board to adopt appropriate limits to the prohibition and provider protections. To simply prohibit "anti-transparency" clauses without any concomitant provider protections or, more importantly, precise parameters around what that prohibition entails will inhibit efficient contracting between providers and plans. Indeed, such a failure to provide necessary provider protections will force providers, as well as plans, to expend resources negotiating the line between "anti-transparency" and merely protecting the provider from inaccurate or otherwise unfair reporting.

Provider protections should include, among other things, measures affording physicians due process rights in challenging information prior to their public disclosure, unfettered access to the data upon which they are being profiled and proper patient disclosures to put the reported information in the proper context. The Exchange should engage the provider community in discussions about what should or should not be in a provider contract. Not doing so now will result in more significant issues in 2013 and beyond.

Advance the Patient Centered Medical Home Model on the HBEX

CAFP believes that improving care, health and affordability begins with the medical home model. We agree with the quality and affordability goals articulated in *QHP Policies and Strategies* and believe the medical home is an important tool to achieve these goals. We were pleased to see recognition of the medical home model in *QHP Policies and Strategies* and support the requirement, described on pages 155 and 156, that QHPs articulate strategies that they are engaged in including "[p]romotion of care coordination and medical homes." We think the HBEX Board can and should go further in advancing the medical home model on the HBEX, however.

During the "Quality and Affordability Webinar" on August 1, 2012, Peter Lee, Executive Director of the HBEX, cited the alignment among purchasers in their desire to have QHPs incorporate medical home programs or other structured ways to better deliver primary care. Mr. Lee added that there are "currently about a dozen ways to define what is quote unquote a medical home" and suggested there is a need for a few years to parse out just what is the right model. CAFP respectfully disagrees that the medical home is an undefined or unproven model. On the contrary, the model is well-defined and has a proven record of improving the delivery of care and reducing costs.

The Exchange Board and staff need only look at two papers that lend significant support for this argument: The Medical Group Management Association's (MGMA) *Patient Centered Medical Home Guidelines - A Tool to Compare National Programs*, and Drs. Kevin Grumbach and Paul Grundy's *Outcomes of Implementing Patient Centered Medical Homes* (available at

http://www.pcpcc.net/files/evidence_outcomes_in_pcmh.pdf). MGMA looks at the detailed guidelines for medical homes of the four national organizations that "recognize" medical homes. This document reveals that there is, in fact, limited variation among the four and that a highly-refined medical home concept is very much in existence. Grumbach and Grundy review cost and quality data on groups that have implemented the medical home model. Their review covers the medical homes for more than one million patients in thousands of diverse practice settings, involving both private and public payers. Grumbach and Grundy conclude that investing in medical homes results in improved quality of care and patient experiences and reductions in expensive hospital and emergency department utilization.

CAFP notes, in Grumbach and Grundy's paper, that none of the groups that implemented the medical home model and saw improvements in health and lower costs are in California. As a state, we are behind the curve in medical home adoption and our purchasers, providers and patients are suffering as a result. HBEX can alter this landscape and ensure patient access to medical homes in California in multiple ways. We think, at a minimum, the HBEX Board should require inclusion of medical homes on plans' networks.

Among its specific recommendations for implementing the four-part strategy (i.e., "Require Certain Health Plan Practices"), the HBEX staff proposes that QHPs articulate strategies that they are engaged in related to promotion f care coordination and medical homes and innovations in care that improve care coordination and primary care access, including access in rural geographies. CAFP endorses this proposal and supports this general framework for advancing delivery transformation.

CAFP urges the HBEX Board to go further and adopt the ultimate goal of having each QHP offer all of its exchange beneficiaries the choice of medical home-based care. CAFP urges the Board to adopt an expeditious and realistic timetable for moving toward this ultimate goal. The Board should define benchmarks to mark QHP progress toward this goal that are specific and measureable. CAFP urges the Board to require inclu ion of a minimum number of medical homes on QHPs' networks at the launch of the Exchange in 2014.

CAFP recommends that QHP progress in meeting Board-determined benchmarks – beginning with articulation of the QHP's strategy and progressing toward the goal of offering all the QHP's beneficiaries a choice of medical home-based care – will be a basis for HBEX decisions regarding QHP recertification and decertification. QHPs will be incentivized to align health plan goals with Board objectives, yet each QHPs will have substantial autonomy and flexibility to develop their own, distinct strategies for achieving the Board objectives. Consumers will have an array of choices among QHPs and care delivery options that they can make based on comparative cost and quality information. Competing QHPs will be incentivized to continuously pursue delivery system innovations that improve quality and cost performance of their medical home offerings. An exchange marketplace with these characteristics is fertile with possibility for achieving quality-improving, cost-reducing care delivery transformation in diverse regions of the State.

Provider-Level Quality Reporting

CAFP acknowledges that consumers need more accurate information on quality and cost of care when choosing a provider. This goal is defeated if the information provided is inaccurate, misleading or based on flawed data, however. Reporting faulty data can mislead patients and irreparably harm physicians' professional reputation and livelihood. In our view, reporting at the individual provider level is currently at a nascent stage; we are not aware of reporting programs that circumvent the following:

- Problems with statistical validity. Individual physicians often have too few patients in any specific disease group to support statistically valid comparative measurement. Essentially there is a sample size problem. Also, the threshold for statistical validity may vary depending on the statistics' intended use. A quality reporting program could publicize measures from which consumers derive valid inferences about individual physicians' performance, but these same measures may not permit the valid comparison of individual physicians' performance because a different threshold of statistical validity is required.
- Problems with patient attribution. Patients may see multiple physicians; there is considerable difficulty attributing the quality of a patient's care to a single physician. For example, a patient in a PPO may see an out-of-network physician for a pap smear and that patient may inform her in-network primary care physician. Under many quality reporting programs, the in-network physician would be penalized because no record of the pap smear exists in claims data. We note that this may lead to expensive, duplicative care as physicians try to protect themselves from negative reports. Even in well-functioning medical teams, there are problems attributing quality to one physician or another. Because several physicians may treat the same patient during the course of a single episode of care, it may be inaccurate to attribute to one of these several physicians all care rendered by those in the group.
- Problems with reliance on claims data. Claims data is known to carry significant risks of error when used to rank individual physicians. Claims data is set up for billing, and not for quality measurement. It does not include all relevant clinical information that would be contained in medical charts.
- Problems correcting for patient behavior or differences in patient populations. Many reporting initiatives fail to adjust for patient behavior and penalize physicians who see patients who are less willing or able to adhere to recommended care. We do not want to incentivize physicians to stop seeing patient populations that may skew any report on quality.

We note that individual providers, unlike plans, hospitals and groups, are transient. Capturing accurate information on physician names and locations, let alone quality and cost information, poses considerable difficulty.

We can envision problems with implementation. The HBEX may have executive power to require QHPs to publicize provider level performance data, but as a practical matter, it may have limited ability to enforce the use of any particular methodological standards because of the administrative burden this would create for both QHPs and the HBEX.

Additionally, there is the issue of administrative burden. A difference exists between asking plans, hospitals and large medical groups – with their data systems, management and governance structures and definable lines of work – to report, monitor reports and correct inaccuracies in reports and asking the same of individual physicians, many of whom are in solo or small practices.

CAFP appreciates the HBEX Board's interest in providing consumers with provider-level quality information. Because of the concerns identified above, however, we urge you not to require individual physician-level reporting at this time. We understand that the HBEX Board is considering requiring QHPs to provide some level of quality information at least at the hospital and medical group level, and to describe plans for physician-level reporting (p. 155). We support the exclusion of physician-level reporting at this time. With the robust HBEX that we are all envisioning, an inaccurate individual physician's sub-par report could seriously jeopardize that physician's livelihood. While it is not a staff recommendation, we are concerned by the suggestion, on pages 146 and 147, that "the Exchange may encourage Qualified Health Plans to:

- Participate in statewide multi-payer claims data initiatives to pool data for performance measurement;
- Include measures of overuse and whether care is appropriate for both measurement and payment; and
- Adhere to The Patient Charter for Physician Performance Measurement, Reporting and Tiering."

We urge you to consider the provider community's concerns related to statistical validity, claims data, patient attribution and patient populations before adopting policies that encourage this QHP activity. Again, we support the movement toward information sharing, but we believe the HBEX must ensure the information it is sharing is accurate.

Administrative Simplification and Quality Reporting Program Alignment

CAFP commends the HBEX Board for the recommendations related to administrative simplification. We urge the Board to look for ways to reduce administrative burden and standardize processes. CAFP is especially pleased that the HBEX intends to adopt and build HBEX quality and performance data collection and reporting programs on metrics that are already required by other programs, ranging from HEDIS and CAPHS, NCQA Accreditation requirements and more. We appreciate that the HBEX Board and staff will look for opportunities for administrative simplification in provider level performance metrics going forward. The more that state and federal quality reporting programs can be aligned, the more our physician members can focus on providing high quality care and reducing costs. We urge the HBEX Board to explore ways it can align its quality programs with the Medicare and Medicaid Electronic Health Record incentive programs and the Medicare ACO quality reporting requirements.

We appreciate the opportunity to comment on the *QHP Policies and Strategies*. The HBEX Board and staff are engaging in an important effort to ready the HBEX for a large, newly-insured population in a very short time frame. We have the utmost respect for the work that you are doing. As family physicians, we will continue to champion the health and well-being of our patients as they become purchasers on the HBEX, and we appreciate your attention to our concerns. If you have any questions

about the above comments, please contact our Director of Health Policy, Leah Newkirk, at lnewkirk@familydocs.org or 415.345.8667.

Sincerely,

Steve Green, MD
President