CAPG Recommendations for the California Health Benefits Exchange Qualified Health Plan RFP

June 18, 2012

INTRODUCTION

The California Health Benefits Exchange ("the Exchange") has requested CAPG's recommendations to inform the Exchange's RFP selection process for the Qualified Health Plans that will participate in the Exchange, and to provide suggestions on delivery system reform strategies that could be adopted by the Exchange.

The California Association of Physician Groups ("CAPG") is composed of 155 member medical groups and IPAs that have long been committed to providing coordinated and accountable healthcare services through capitated and other population and performance-based payment methodologies. CAPG's member groups have an extensive and impressive history of managing large and diverse patient populations in collaboration with health plans, and delivering outstanding quality and utilization efficiency. CAPG groups are eager to leverage that knowledge and experience to help the Exchange formulate ways to deploy sustainable, patient-centered methodologies that will improve outcomes while suppressing inflation in the cost of coverage and care.

CAPG is uniquely qualified to provide the recommendations set forth herein:

- Since 2006 we have conducted our Standards of Excellence program, in which we annually assess and publicly report the key features and capabilities of coordinated, accountable care demonstrated by our members. The SOE standards are important because they constitute the essential elements of a coordinated patient care delivery system and form the benchmark for accountable care delivery by a provider. A Qualified Health Plan should be required to arrange for and deliver these SOE elements.

- Virtually all of our members participate in the IHA's Pay for Performance Program.

- We have been actively engaged in the development of Medicare Accountable Care Organizations' (ACO) specifications in our work with the Brookings/Dartmouth Collaborative, the Congressional committees that authored the ACO provisions within the Affordable Care Act, and, most recently, with CMS in the development of regulations and rules for both the Pioneer ACOs and Shared Savings ACOs.

- CAPG is proud to have six Pioneer ACOs and two Shared Savings ACOs within its membership.

Please note that CAPG has developed the recommendations set forth below in direct response to the Exchange's guiding mission, vision and values, as follows:

- The vision of the Exchange is to improve the health of all Californians by assuring their access to affordable, high quality care

- The mission of the Exchange is to increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value

- The California Health Benefit Exchange is guided by the following values:

    - Consumer-focused: At the center of the Exchange's efforts are the people it serves, including patients and their families, and small business owners and their employees. The Exchange will offer a consumer-friendly experience that is accessible to all Californians, recognizing the diverse cultural, language, economic, educational and health status needs of those we serve.
    - Affordability: The Exchange will provide affordable health insurance while assuring quality and access.
    - Catalyst: The Exchange will be a catalyst for change in California's health care system, using its market role to stimulate new strategies for providing high-quality, affordable health care, promoting prevention and wellness, and reducing health disparities.
    - Integrity: The Exchange will earn the public's trust through its commitment to accountability, responsiveness, transparency, speed, agility, reliability, and cooperation.
    - Partnership: The Exchange welcomes partnerships, and its efforts will be guided by working with consumers, providers, health plans, employers and other purchasers, government partners, and other stakeholders.
    - Results: The impact of the Exchange will be measured by its contributions to expanding coverage and access, improving health care quality, promoting better health and health equity, and lowering costs for all Californians

CAPG Recommendations

CAPG's recommendations are organized in this document as follows:

A. Care Management Practices

1. Patient-based Complex Care Management
2. Population-based Chronic Illness Outreach and Management
3. Inpatient Care Management
4. Appropriate ER Use
5. Other Care Management Opportunities

B. Health Information Applications

C. Patient Satisfaction and Quality Reporting

D. Delivery System Reform

SPECIFIC QUESTIONS THE EXCHANGE RFP SHOULD INCLUDE FOR QHPs

To be eligible for participation as a Qualified Health Plan, all Exchange applicants should demonstrate the following critical competencies and attributes. Important note: It is vital that these should apply to all products sold through the Exchange, including both HMO and PPO products.

All of the questions below assume that Qualified Health Plans will, for all HMO and some PPO products, contract with and delegate to provider groups the competencies identified below. When a question asks whether a plan will provide a specific service, it is assumed that in most instances the plan will arrange for the delivery of the service by a delegated physician group. Therefore, the questions below should be understood to refer to services provided either directly or by way of a subcontract with a delegated group.

Where a service is not delegated to a physician group, the plan should be asked to include specific detail as to how it will provide the service directly to the patient. For example, if a plan's answer would differ depending upon the type of product they wish to sell through the Exchange, i.e. HMO or PPO, the plan should address and specify all aspects of the difference in their answers to each question.

In addition, for PPO products, which are not subject to or participants in State-mandated or voluntary quality measures, plans should be required to provide detailed evidence of their quality management and reporting methodologies and practices.

The Exchange RFP should pose the following questions to assess and determine each plan's current capabilities to perform as expected:

A. Care Management Practices

The following questions focus on care management practices, with specific attention to: disease management; hospitalists; concurrent review nurses; systems to track readmission reduction; and measures to prevent avoidable emergency room use.

1. Patient-based Complex or Chronic Illness Management

   - Will your plan provide in-house staffing by nurses or other licensed professionals with specified panel management responsibilities for high risk or high complexity care?

   - Will your plan provide a system to identify and enroll high acuity patients in a minimum of three of the following categories:

     - Frequent ER users

- Recent cancer diagnosis
- History of cardiac ischemic event
- History of stroke
- CHF
- COPD
- Atrial fibrillation and/or anticoagulation Rx
- ESRD
- Tertiary referrals
- Palliative Care
- Frail elderly
- Vulnerability to falls
- Dementia
- Special needs children, including CCS enrollees
- Long-term wheelchair users
- Diabetics with A1C > 9
- Major depression
- Chemical dependency
- Recent hospital discharge

- Will your plan provide a care management staff that has electronically retrievable documentation of patient and physician contacts and interventions to facilitate shared responsibilities and rapid response times?

- Will your plan provide high complexity care coordination systems that are applied to all patients – not just capitated enrollees?

2. <u>Population-based Chronic Illness Outreach and Management</u>

- Will your plan provide sophisticated local registry systems, timely point of care reminders and dashboard prompts efficiently integrated with physician workflow?

- Will your plan provide advanced population oversight?

- Will your plan provide effective patient contact methods?

- Will your plan provide attention to behavioral determinants of good self-care?

- Will your plan provide community partnerships to support this population?

- Will your plan provide In-house chronic illness management programs with all of the following features:

    - Electronic registry for eligible patients
    - Ability to funnel timely information for individual patients to frontline offices regarding currency of monitoring studies, out of range values, adverse events

- Periodic feedback reports for individual practitioners for the patient populations under their care
- Ability to identify patients with multiple concurrent diagnoses
- Designated personnel to assist with patients who fail to respond to standard chronic care measures
- Engagement with community resources to supplement traditional office-based care
- Tracking and reporting of measurable indicators
- The above capabilities apply to all of the following, and plans must be required to provide annual evidence of the number of patients enrolled:

    - Diabetes
    - Coronary disease
    - CHF
    - COPD
    - Asthma
    - Osteoporosis
    - Anticoagulation oversight
    - Cancer
    - ESRD
    - Depression
    - Hypertension
    - Rheumatoid arthritis Rx
    - Active systems to identify eligible patients and generate referrals on a regular periodic basis, including specific referral mechanism, i.e. secure email, disk, hardcopy, phone

- Specific additional methods for outreach to patients with chronic conditions:

    - Land line telephone
    - Cell phone voice messages
    - Text messages
    - Social media
    - Interactive website
    - Secure email
    - Mail with general educational information
    - Mail with general educational information plus specific patient information
    - Worksite-posted information in collaboration with employer
    - Worksite in-person professional teaching, i.e. “lunch and learn”
    - Community health workers, i.e. promontories

3. <u>Inpatient Care Management</u>

    - Will your plan provide hospitalists to be used for at least 50% of medical and/or surgical and/or NICU patients?

- Will the hospitalists you provide be employed or contracted? Are there specified response times, performance metrics, communications responsibilities, and incentive opportunities for them?

- Will your plan provide on-site, in-person concurrent review nurses at all hospitals where an average daily census of >12 is maintained? Is this coverage available 24/7?

- Will your plan provide 24/7 telephonic triage and case management available, including for out-of-network admissions?

- Will your plan provide a post-hospital discharge continuity of care program with graduated intensity of patient engagement based upon a severity or complexity profile? Does it apply to adult med-surg patients and NICU patients in defined diagnostic categories or severity profiles? Does it also apply to routine OB, Nursery and Peds?

- Will your plan provide RN and/or MD formal review of all unplanned inpatient readmissions?

    - Concurrent
    - Tracked and reported to a peer oversight committee
    - Identification of potentially avoidable readmissions and engagement of the responsible physicians in peer dialogue

4. <u>Appropriate ER Use</u>

    - Will your QHP provide a plan to improve the appropriateness of ER use?

        - A general educational program
        - Measurement of individual physician performance, with periodic feedback
        - A PCP incentive program to reward convenient after-hours alternatives for avoidable ER use

5. <u>Other Care Coordination Opportunities</u>

    - Will your plan assure that PCPs are given periodic, individual feedback regarding generic drug prescription rates: overall, or with breakdown by drug classification?

    - Will your plan provide clinical experts in-house or under contract to provide guidance on esoteric or highly specialized authorization requests in areas such as:

        - Complex durable medical equipment (i.e. power and custom chairs)
        - Oncology Rx
        - Esoteric genetic testing

- Wound care
- High cost injectables
- Insulin pumps
- Implantable devices

- Will your plan provide an organized palliative care program readily accessible for referral?

- Will your plan provide an organized end of life and/or hospice care program readily accessible for referral?

- Will your plan participate in formal efficiency and quality collaboratives such as the California Quality Collaborative?

- Do your plan and/or its delegated provider groups have formal relationships with local employers to coordinate employee "wellness" activities with mainstream care?

- Do both your plan and its contracted groups have formal disaster plans (earthquake, flood, fire) for provider deployment and continuity of patient care in the event of significant infrastructure disruption? Please provide a copy or executive summary of this plan.

B. Health Information Technology

The following section focuses on highly effective and robust HIT deployment to improve health status and outcomes for individuals and populations, a critical component as information drives intelligent responses and is a powerful and essential tool for quality.

- Will your plan provide Preventive Care and Screening Patient Registries in key preventive care realms (i.e. Women's Health, Childhood IZ's, Adolescent Health, Senior Health), with such specific functionality as action lists (overdue or missing services), retrievable by practitioners at the clinical office? Via paper or electronic information sharing?

- Will your plan provide Chronic Care Registries for diagnosis-based conditions (i.e. diabetes, CHF, asthma, CAD, COPD) which include all of the following features:

  - Real time information (data update cycle < monthly) available to office practitioners
  - Action lists for overdue or missing services generated for practitioners according to peer-developed guidelines
  - Action lists provided to practitioners for patients with measures falling outside target ranges
  - Are these via paper or electronic data sharing?

- Will your plan capture blood pressures in electronically retrievable form from at least 50% of PCP's in adult practice (FP and IM)? (Methods could include EMR extraction, CPT II, or advanced capability registry)

- Will your plan sponsor and support implementation of an Electronic Medical Record (EMR) for member groups? How do you support this effort: policy endorsement by governing body plus decision support for prospective purchasers? Financial incentives or subsidy for deployment?

- Will your plan exchange data in both directions between providers with EMR and centralized data repositories?

- Will your plan provide group-sponsored IT personnel support for implementation at the practice sites?

- Will your plan enable information to be downloaded from patients' Personal Health Records (i.e. portable storage devices, web portals, home monitoring devices, etc)

- Will your plan provide a secure electronic network for timely patient care coordination, including provider-to-provider, provider-to-group and provider-to-plan communication (e.g. consultation reports, referral notes, lab data, imaging reports, hospital discharge summaries)? Is the use of this network required or encouraged?

- Will your plan provide Rx fill confirmations and/or refill notifications in electronic form?

- Will your plan provide Rx fill confirmations and/or refill notifications in electronic form from the centralized PBM's?

- Will your plan incorporate this Rx information into point-of-care notification or dashboard systems?

C. Patient Satisfaction and Quality Reporting

We understand the Exchange is contemplating the development of a quality and performance measurement program for all QHPs. Based upon our experience of it, CAPG urges the Exchange to adopt the existing and highly successful P4P program developed and administered through the Integrated Healthcare Association (IHA).

The IHA's Pay for Performance program has successfully developed and evolved a quality transparency program second to none in the United States. More than two hundred participating physician groups, most of them CAPG members, contribute data on clinical performance measures, effective use of health information technology and patient satisfaction scores to this system. Results are publicly reported on the website of the Office

of the Patient Advocate. This data reflects patient care outcomes for more than 15 million Californians.

These performance measures were developed through a highly collaborative and thoroughly vetted process. We urge the Exchange to make use of this existing system of quality transparency, rather than to attempt to reinvent the wheel.

The following questions focus both on quality measurement and on patient/provider satisfaction with the imperative of responding effectively to individual and family needs in the nation's most diverse state.

- Will your plan require/encourage participation in the IHA Patient Satisfaction (PAS) Survey?

- Will your plan require/encourage participation in the IHA P4P clinical measures exercise?

- What percentage of your provider network participates annually in IHA Pay for Performance program?

- Will your plan require that provider groups share individual physician clinical performance data, including benchmarks, with practitioners?

- Will your plan provide groups/individual practitioners with reports and comparisons regarding their physician-ordered services? (Examples: prescription patterns, consultations, imaging, ancillary services, procedures, durable medical equipment)

- Will your plan provide a formal program under which a medical director (or designated staff professional) engages practitioners in data-based discussions regarding utilization patterns and choices?

- Will your plan insure that >90% of all urgent pre-service authorizations processed within these timeframes?

    - 90% within 72 hours (ICE standard)
    - 90% within 48 hours (surpasses ICE Standard)

- Will your plan survey groups/individual practitioners regarding their satisfaction with plan procedures and performance? Please provide a recent sample.

- Will your plan provide a formal policy statement affirming patients' rights, responsibilities, and privacy assurance? Please provide a recent sample.

- Will your plan require that groups have access to HIPAA compliant, secure, direct electronic communication between patients and practitioner offices? (i.e. in-house system or vendor service)

- Will your plan assess or survey provider office availability of same day access and extended hours for patients on at least an annual basis with retrievable results? Please provide a recent sample.

- Will your plan sponsor cultural education for providers and staff? In what format? Is participation required?

- Will your plan offer spoken language interpretation services supplemental to plans' State-mandated telephonic interpretation services? Please explain.

- Will your plan employ one or more case managers with proficiency in a second language?

- Will your plan have a formal staff function to receive, document, and respond to patient complaints and grievances? Please provide documentation.

- Will your plan survey or monitor timely appointment availability (i.e. number of working days lag time before an appointment can be scheduled, third next available appointment, or similar measure)? Please provide a recent sample report.

- Will your plan send personalized reminders (mail, phone, or e-mail) to patients regarding recommended preventive screenings? Please provide a range of examples.

- Will your plan arrange home visits by physicians, advanced practice nurses, or other professionals for homebound and complex patients for whom office visits constitute a physical hardship or a substantial cost barrier?

- Will your plan have a publicly accessible website which offers group/physician profiles, language capabilities, office communication options, and geographic locations?

- As a matter of policy, will your plan offer shared decision-making protocols (guideline-based, consistently applied, written, spoken, or video materials identifying choices, risks, and benefits) for 2 or more of the following procedures:

    - Breast biopsy and cancer surgery (mandated in CA)
    - Prostate cancer interventions
    - Invasive cardiology procedures
    - Bariatric surgery
    - Spine surgery
    - Knee and hip replacement
    - Cholecystectomy

- Will your plan retrieve patient ethnicity and/or language preference from administrative sources, such as demographic fields on registration or eligibility files?

- Will your plan sponsor a 24 hour telephonic advice line with the capability to notify PCPs of the contact the following day (in addition to customary on-call access to physician)?

D. Delivery Model Reform

The Exchange has the opportunity and declared commitment to be a catalyst for meaningful change and delivery system improvement. This effort may enable new entrants to move into the QHP fold, which would require the adoption of hybrid system structures. The following questions address QHP receptivity and capability to adapt to such evolutionary market changes.

- Would your Plan be able, willing and prepared to serve as an ASO or TPA in support of a multi-specialty medical group that seeks to serve as a QHP?

- Were a collection of multi-specialty medical groups to apply and be selected to serve as QHPs for the entire state, would you be able, willing, and prepared to enter into an ASO agreement with them, and to pay capitation to downstream medical groups contracted with the QHP?

- Would you be open to "Regional Solutions" in the event one model does not fit all?

- Do you foresee any legal challenges to your plan serving as an ASO in support of a multi-specialty medical group or IPA and using your risk contracts with the medical groups and hospitals?

- Would you be able, after a defined period of time, to report to the Exchange where it is realizing its best value and improved health status, based on the performance of competing medical groups and hospitals? Would you, based on such analysis, be willing to drop groups and hospitals from your network that were not performing sufficiently well?

- Would your plan be willing to participate in a "Joint Operations Committee" consisting of Exchange staff, other stakeholders, medical group and hospital representatives and outside consultants to, on a regular basis, review the performance of your Plan and make suggestions for improvements?

- What are the risk adjustment models utilized by your plan to create actuarially sound products and models of reimbursement to provider organizations to create a level playing field?

CONCLUSION

Beyond CAHPS and HEDIS scores, financial and management stability measures and certification standards, CAPG's recommendations focus specifically on: access; coordination and continuity of care; and performance imperatives to achieving the Triple Aim: improving care for individuals and populations while reducing cost.

The Exchange's selected QHPs will need to manage risk, operate centralized systems and acquire and apply knowledge with the cultural imperative over time to constantly improve. To meet this level of performance, QHPs must effectively partner with provider groups to: share data; fund functional improvements; share system functions where feasible; provide expert technical support; and add value and foster local excellence with smart tools and high level expert consultation.

CAPG endorses the use of centralized systems and personnel to assist the frontline practitioner to rise to the aspirations of the "Medical Home." Many of these sophisticated systems, including performance measurement with feedback and incentives, are not affordable in the micro-scale of a small office. With economies of scale and local physician guidance, meaningful improvements can be achieved and sustained on a community-wide level. It is our firm hope that the Exchange and its selected QHPs will support this effort to improve access and quality while lowering the cost of care.

CAPG and its members are committed to working with the Exchange at all levels to make the system work easily for all Californians who count on us for their healthcare every day, to continue our drive to innovate and foster excellence, and to contribute to the ongoing local, regional, statewide and national healthcare conversation.