

**California Health Benefit Exchange: Stakeholder Questions**  
**Qualified Health Plan Policies and Strategies to Improve Care, Prevention and Affordability**

The California Health Benefit Exchange welcomes your input on Qualified Health Plan policies and strategies under consideration. The policies and strategies are laid out in a Board Recommendation Brief available on the Exchange [website](#). Please use the table below to provide your input. We welcome data and references as well as written comments. Please submit your comments to the Exchange at [info@hbex.ca.gov](mailto:info@hbex.ca.gov) no later than **Monday, August 6, 2012**.

Name	Organization	Email	Phone
Edward Schor, MD	The Lucile Packard Foundation for Children's Health		

Input Requested	Comments
<b>Section 3: Guidelines for Selection and Oversight of Qualified Health Plans and the Development of the Small Employer Health Options Program</b>	
<b>Section 4: Core Minimum Qualified Health Plan Certification Requirements and Regulator Partnerships</b>	
<b>Section 5: Plan and Network Design Issues</b>	
<b>Section 5A: Active Purchaser: Number and Mix of Exchange Plans</b>	Pediatric patients should have access to out-of-plan pediatric subspecialists as though they were within-plan subspecialists, e.g., same co-payment fees and without delay, if pediatric subspecialists are not readily available within their plan.
<b>Section 5B: Rating Issues: Family Tiers, Age, Geography, Tobacco and Wellness</b>	
<b>Section 5C: Plan Design Standardization</b>	
<b>Section 5D: Premium Subsidies and Cost Sharing Reductions</b>	
<b>Section 5E: Provider Network Access: Adequacy Standards</b>	Traditional access standards do not include separate access standards for children/youth. Network adequacy standards in the Exchange should include specific standards for children/youth, including

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	<p>access to pediatric and pediatric subspecialty services, such as regional pediatric centers and pediatric subspecialists. Children in need of specialty services should have access to a comprehensive array of pediatric subspecialty services as a fully covered option. The current panel of regional pediatric centers and pediatric subspecialists empanelled by the California Children's Services program or an equivalent paneling process that is built on the current state CCS standards for pediatric care should be accessible to children regardless of the health plan they choose. Plan networks that depend on adult-oriented specialists are not appropriate or acceptable for children and youth and should not meet the pediatric network access standard. In addition, evaluation of network adequacy should include assessment of the patient:provider ratio and location of providers, including pediatric providers, who are accepting <u>new</u> patients..</p>
<p><b>Section 5F: Provider Network Access: Essential Community Provider Standards</b></p>	<p>Support the inclusion of traditional safety net health care providers who have served low-income, uninsured, Medicaid and Health Families children and adults. Definition of provider to these populations should be set at 10% of active practice by the number of patients seen rather than as a proportion of income generated.</p> <p>Essential Community Providers should be paid at the same rate as other eligible providers, but should be able to bill for the HRSA defined wrap-around services at a rate equivalent to that they currently receive through Section 330 payments.</p> <p>Pediatric sub specialists should be incentivized in underserved areas with higher reimbursement rates.</p>
<p><b>Section 6: Assuring Quality and Affordability</b></p>	<p>In general, all of the options seem sound, but we must note that little in this section addresses issues specific to children and youth, yet their health care utilization and expenditure patterns are very different from those of adults. Plan metrics should include those specifically developed for children and youth, as well as those that address children/youth with special health care needs. Standardized data collection is essential, but so is the timely, public availability of that data. Quality metrics, including those that are specific to children and youth and to children/youth with special health care needs, should be prominently displayed along with other characteristics of plans offered through the exchange. Minimum quality standards, including those specific to children/youth and those with special health care needs, should be applied to allow a plan to be offered. Collection and publication of data on the experiences of patients, families, <u>and</u> providers with each health plan should be required and collected not by the plans but by a neutral third party. Assessments of plan quality and affordability should include family experiences and perceptions, including assessment of the impact of family out-of-pocket expenses for child treatment.</p>

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	<p>Health plans should be incentivized and should provide incentives to practices to achieve certification as a level 3 patient-centered medical home; in addition, medical homes for children should be characterized as family-centered and reflect the importance of family involvement in children’s care and care coordination.</p>
<p><b>Section 6A: Strategies to Promote Better Quality and More Affordable Care</b></p>	<p>Health plans should be responsible for the completion of a standardized, patient- or family-completed (depending on plan member age and/or competency) health risk assessment instrument (approved by the Exchange Board) within one year of enrollment in the health plan and that plan should be part of the patient’s medical record. Health risk assessment instruments should capture information appropriate to plan members’ age and special health care needs.</p> <p>Health plans should cover a defined, age-appropriate package of wellness services.</p> <p>Health plans should be accountable for achieving designated community health benchmarks in order to offer plans in any given region. Health benchmarks should include those specific to children and youth and to children/youth with special health care needs. Responsibility should be jointly shared by all health plans operating in a region, and penalties and incentives should be applied equally. Health plans may subcontract with local public health agencies to assist in achieving these benchmarks, but such subcontracting does not relieve them of responsibility for achieving benchmarks.</p> <p>Health plans covering children (0-18) should be required to cover dental and vision services. They may subcontract the management of these benefits, but retain responsible for their availability and for associated quality metrics that are specific to children/youth, including those with special health care needs.</p> <p>Health plans in the exchange should be required to use the federal medical necessity definition under EPSDT, including access to habilitation as well as rehabilitation services, to determine the amount, duration, and scope of occupational, respiratory, speech, and physical therapy services; durable medical equipment; and medical supplies, including hearing aids, to be provided to pediatric populations.</p>
<p><b>Section 6B: Accreditation Standards and Reporting for Qualified Health Plans</b></p>	

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<b>Section 6C: Promoting Wellness and Prevention</b>	
<b>Section 6D: Administrative Simplification</b>	
<b>Section 7: Other</b>	
<b>Section 7A: Aligning the Exchange with Medi-Cal and other State Funded Health Programs</b>	<p>I found no mention of mental health services for children. I assume parity of mental health services with medical services is required. Children should be able to receive up to 10 mental health visits per year without having a DSM diagnosis.</p> <p>The document doesn't address the importance of the federal EPSDT medical necessity definition and benefit package as the gold standard for children, nor does it address the importance of the CCS program in ensuring access to high-quality pediatric subspecialty care for children with complex and/or acute conditions who are low-income or whose family out-of-pocket expenses for the CCS condition exceed 20% of family income. Children who move from CCS to coverage through the Exchange should be assured of continued access to their CCS-approved pediatric centers and subspecialists for continuity and quality of care.</p>
<b>Section 7B: Supplemental Benefits: Dental and Vision</b>	<p>Preventive dental services should be a fully-covered benefit without co-payment or deductibles for enrollees 0-18 years. Eye examinations, refraction and provision of eye glasses should be similarly covered for children and youth. Standards for access to dental and vision services should reflect the often increased needs for these services (e.g. greater frequency of dental and/or vision exams) among children with special health care needs.</p>
<b>Section 7C: Multi-State Plans</b>	
<b>Section 7D: Consumer Operated and Oriented Plans (CO-OPs)</b>	
<b>Section 7E: Partnering with Health Plan Issuers to Promote Enrollment</b>	