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 no later than **Monday, August 6, 2012**.

Name	Organization	Email	Phone
Alana Ketchel	**Pacific Business Group on Health (PBGH)**	**aketchel@pbgh.org**	**415-615-6304**

Input Requested	Comments
Section 5E: Provider Network Access: Adequacy Standards	To achieve the Exchange's quality and affordability goals, Exchange enrollees will need access to high quality providers even if outside their current care geography. For example, for high cost procedures like transplants, patients will need access to Centers of Excellence and other providers ("super specialists") that perform high volumes of these procedures and have demonstrated good outcomes. The Exchange should encourage flexibility in the application of Geographic Access Rules set by DMHC and CDI to ensure that patients can access super specialists that will deliver the highest value care. The Exchange should also permit issuers to offer travel support benefits that enable access to these super specialists for high cost procedures.
Section 6A: Strategies to Promote Better Quality and More Affordable Care	For the Exchange to successfully serve as a "catalyst" for better health care delivery, it will need to pursue a carefully targeted set of strategies to improve quality and affordability of care. We describe below those strategies which the employer purchaser community believes to be the critical path for improvement. The Exchange should do more than just "encourage" but must "require" participating plans to adopt these strategies to achieve measurable change. Leading employers and health plans across California are already engaged in each of the following recommended strategies. The Exchange should not lower the bar to meet the "lowest common denominator" but should set the bar high to provide clear guidance and strong incentives to all health plans to adopt practices that lower costs and improve the value of health care for Californians. As the largest purchaser in California, we believe the Exchange not only has the ability but the responsibility to provide high value products for its customers and set a new tone for the health care market that emphasizes transparency, quality and affordable choices.

Input Requested	Comments
	1. Promote Alignment: a. PBGH strongly believes that for the Exchange to be most effective as a catalyst, it must align its practices with public and private purchasers that are pursuing strategies to improve health and health care. To do this, the Exchange should pursue the key value-based purchasing practices outlined below in the areas of advancing performance measurement, cost and quality transparency and care delivery innovations. (Pg. 154, 1b) 2. Collect Standardized Information: a. PBGH supports the recommendation that plans be required to complete the eValue8 Health Plan RFI to support QHP oversight and reporting of quality improvement strategies. The Exchange should use this information for plan selection, plan engagement and benchmarking. (Pg. 154, 2a) b. The Exchange should also collect information that will directly support consumer choice of plans. (Pg. 150) Key categories include: (1) health improvement (e.g. programs to help to quit smoking, cholesterol management, weight management/nutrition, etc.) (2) disease management (e.g. programs to address asthma, cancer, diabetes, etc.) (3) how to save money (e.g. provider and medical services shopping, discounted services like a gym membership, savings opportunities for medications) and (4) care management services (e.g. health coach, 24 advice nurse, health risk assessment/counseling, complex patients program, etc.)[1]. c. PBGH strongly supports the prohibition of health plan provider contracts that include anti-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. (Pg. 154, 2c) 3. Require certain health plan practices that promote better care or standards of performance: a. The Exchange should require QHPs to provide Exchange customers with hospital and medical-group level performance information that is as comprehensive as possible. (Pg.

[1] More details on information required to support consumer choice of plans is provided in a Pacific Business Group on Health analysis which can be found here: http://pbgh.org/storage/documents/Plan_Choice_Rules_Consumer_Decision_Support_Installments_I_and_II_071912.pdf

Input Requested	Comments
	155, 3a) Metrics should include benchmarks and performance thresholds for clinical outcomes, functional status, appropriateness, patient experience, care coordination and care transitions, and cost and resource use. In the early years, the medical group performance dataset should draw upon the Patient Assessment Survey (PAS) patient experience and Integrated Health Association (IHA) clinical measures. The Exchange should leverage PBGH's work with the CA Office of the Patient Advocate (OPA) to summarize this information and present individual elements in a hierarchy that is most useful to consumers. b. Consumers also need information about provider performance at the *individual provider* level in order to make good health plan and provider choices. To get a breadth of measures, data will have to be aggregated across payers (numbers can be too small at the issuer level). Therefore, the Exchange should require plans to participate in statewide aggregated claims data initiatives such as the California Healthcare Performance Information System (CHPI). (Pg. 147) Simply asking QHPs to identify their plans for physician-level reporting is inadequate; we should begin pooling provider-level performance information to make it available to consumers. (Pg. 155, 3a) c. PBGH supports the recommendation that health plans must articulate how they will make information on total costs and the consumer's share of cost available to consumers at a provider level. (Pg. 155, 3b) The Exchange should select those plans that provide cost information and explanation necessary for consumers to make informed choices about their care providers based on the cost and quality of services. The Exchange must make consumers aware of the relationship between cost and quality so cost is not viewed as a proxy for quality. 4. Use value-elements in its Qualified Health Plan selection process: a. Staff recommendations shy away from requiring plans at the outset to adopt practices that are known to reduce costs and improve quality. This is a missed opportunity. We recognize that standards for QHPs should mature as more information is gathered about best practices, but the Exchange should start by requiring plans to adopt the following strategies that have already been shown to be effective in California: i. Reference Pricing. Reference pricing is a health care benefit design in which payers set a cap on payment for selected clinical services that are equivalent in quality but vary in price. If a patient seeks clinical services from a provider whose charges are at or below that cap, regular benefits apply. If the patient instead

Input Requested	Comments
	seeks a provider that offers services at rates above that cap, the patient would pay some or all of the difference. CalPERS implemented reference pricing with Anthem Blue Cross and realized significant cost savings. Safeway also instituted reference pricing and saw movement away from expensive providers without impacting outcomes[2]. The Exchange should spread these practices across California by requiring plans to implement some form of reference pricing. ii. Bundled or Global Payment. Bundled or global payments eliminate the perverse incentives of fee-for-service payment by providing contracted provider entities with a budget to deliver care, making lower cost services and care coordination more attractive. There are a number of examples of how global payment has been successfully implemented. In California, CalPERS contracted with Blue Shield of California to offer a limited-network HMO and significantly decreased per member per month costs.[3] iii. Intensive Outpatient Care for High Cost Patients. Multiple efforts around California target these high-need populations by providing team-based intensive primary care. For example, recognizing the need to better serve patients with multiple chronic conditions while reducing their cost of care, CalPERS, Pacific Gas and Electric Company, and Boeing introduced an Intensive Outpatient Care Program with demonstrated success in Humboldt County[4]. Boeing has also demonstrated success with this model in Washington state[5]. The Exchange should do more than just encourage but should require plans to participate in these kinds of efforts given the need for immediate improvement in the way these patients access and receive care. b. Beyond the above, PBGH supports the staff's recommendation that plans should articulate specific strategies they are engaged in regarding (1) promoting care coordination and medical homes (2) payment programs aimed at reducing adverse

[2] Catalyst for Payment Reform. "Action Brief: From Reference Pricing to Value Pricing". http://www.catalyzepaymentreform.org/uploads/CPR_Action_Brief_Reference_Pricing.pdf
[3] Catalyst for Payment Reform. "Action Brief: Implementing Global Payment". http://www.catalyzepaymentreform.org/uploads/CPR_Action_Brief_Global_Payment.pdf.
[4] Pacific Business Group on Health. "Pacific Business Group on Health, Partners Receive $19 million Grant from Center for Medicare and Medicaid Innovation to Improve Health for 23,000 Chronically-Ill Californians". http://www.pbgh.org/storage/documents/CMMI_Grant_06.15.12.pdf.
[5] Milstein, Arnold and Kothari, Pranav P. "Are Higher-Value Care Models Replicable?" *Health Affairs Blog*. October 20th, 2009. Available online: http://healthaffairs.org/blog/2009/10/20/are-higher-value-care-models-replicable/.

Input Requested	Comments
	events (3) addressing health care disparities and (4) innovations that improve care coordination and primary care access. (Pg. 155, 3d) The Exchange should consider scoring plans based on their efforts in these areas in the first year - it will be easier for the Exchange to start with a high bar at the outset than to ramp up requirements over time. c. The Exchange should use designation or differential weighting for performance to select those plans that provide the highest value to consumers. (Pg. 156, 3e) In particular, the Exchange should give heavy weight to the eValue8 elements that have the greatest impact on affordability and quality: consumer engagement, provider measurement and rewards, and chronic disease management. In addition to these critical few strategies to promote quality and affordability, the Exchange should actively support the expansion of available measures to fill gaps in information on outcomes, patient experience and care coordination.(Pg. 155, 2b) The Exchange must also help speed the development of standardized measures of total cost, appropriateness of care and resource use to improve cost transparency. PBGH appreciates the opportunity to respond to staff's recommendations and will be pleased to provide more detail as requested.