February 4, 2016

Elise Dickenson
Covered California
1601 Exposition Boulevard
Sacramento, CA 95815

Sent via email to Elise.Dickenson@covered.ca.gov

RE: 2017 Qualified Health Plan Contract Attachment 7

Dear Ms. Dickenson:

On behalf of our more than 41,000 physician and medical student members, the California Medical Association (CMA) would like to thank you for considering stakeholder input on Covered California’s 2017 Qualified Health Plan (QHP) contract and, specifically, on Attachment 7 to the contract. CMA recognizes Covered California’s success in providing coverage for millions of previously uninsured Californians as well as its efforts to ensure that coverage is meaningful as reflected by the Triple Aim framework. CMA shares Covered California’s commitment to improving health care quality, promoting better health, lowering costs, and reducing health disparities and makes the following recommendations regarding Attachment 7 to ensure that Covered California consider the impact of these policies on QHP contracted physicians, who are an essential component of California’s health care system.

Need for Physician Collaboration and Meaningful Input in Stakeholder Processes

Throughout its discussion of strategies to promote higher quality and better value, Attachment 7 repeatedly refers to a need for input from “providers” generally. CMA is concerned that Attachment 7 is void of any language requiring that these providers be practicing physicians and recommends that Covered California require the Plan Management Advisory Group and/or the Quality Subcommittee to solicit input from practicing physicians - in addition to medical group and health plan medical directors - as part of implementing new quality rating programs and models of care.

CMA is particularly concerned that Covered California staff may lack an understanding of the current practical realities facing QHP contracted physicians. Health plan representatives who raised concerns regarding difficulties with getting providers to comply with proposed data reporting requirements have been told by Covered California staff to simply write these requirements into the provider contracts. We believe that these comments demonstrate an overly
simplistic view of the problem and that directing plans to simply pass on unfunded, administratively burdensome mandates on physicians could result in unintended consequences.

Complying with health plan data reporting requirements includes navigating unfamiliar web portals and interfaces that host the quality data used to develop a performance rating, locating and thoroughly reviewing chart data, and identifying and correcting errors, all of which take away from time providing patient care. CMA member physicians have reported spending up to five hours to review and correct inaccurate data required by a single payor. Consider that most physicians have numerous contracts and these reporting requirements become a significant factor in deciding whether to take on additional plan contracts. Physicians who become overburdened by unwieldy, costly administrative requirements may be forced to decline these contracts or to terminate existing contracts, leaving QHPs with narrower and potentially inadequate provider networks and patients with limited options for care. It is thus critical that Covered California and QHPs seek input from practicing physicians in order to develop quality measures and data reporting requirements that accurately reflect current modes of medical practice and practical realities facing QHP contracted physicians.

Effective Quality Measures

CMA recognizes the value to patients of having access to quality information when selecting a physician and health plan and wants to ensure that quality rating measures developed by Covered California are meaningful and accurate. We urge Covered California to consider quality rating programs that QHPs already use – both because they have likely been vetted for accuracy and because streamlining reporting requirements would significantly reduce the administrative burden on providers, as physicians contracting with multiple health plans for multiple lines of business already have to comply with significant data reporting requirements. Attachment 7 refers to eValue8 and Truven Analytics as contractors. CMA requests that additional information be provided regarding the qualifications of these contractors, particularly as compared to other quality rating programs in use.

To the extent Covered California intends to employ any quality rating metrics - existing or newly developed - CMA recommends publicizing the specific metrics that will be used in developing quality scores and to allow for comment and input on these metrics from practicing physicians as well as from other stakeholders. Finally, CMA would oppose any quality rating program that fails to provide physicians the opportunity to review, correct and appeal their data prior to publication.

These concerns are grounded in recent experiences CMA has had evaluating and/or collaborating with physician quality rating programs. While the intentions of these programs may be good, the quality of their information often is suspect and misleading. The accuracy of physician quality ratings, CMA has found, depends greatly on data collection methods, the source of the data, the metrics and analytic protocols used, the ability of subject physicians to review and correct errors, and the disclosures that accompany any ratings reports. While CMA cannot comment on the contractors referenced in Attachment 7, we remain concerned that the Exchange has not done enough to minimize the factors we know to undermine the accuracy and integrity of quality ratings.
Promotion of Effective Care Models

CMA supports the aim of Covered California to allow QHPs to develop payment models and models of care that reflect the new ways in which physicians practice medicine and encourages Covered California to include practicing physicians in these conversations. In particular, Covered California should consult closely with practicing physicians in its efforts to adopt a standard definition of Patient Centered Medical Home and in developing standards for telehealth that are consistent with existing California law. It is critical to the success of these new models of care and reimbursement that they are based on practical experience, which can only be gained by seeking input from practicing physicians – rather than relying solely on medical group and health plan medical directors.

CMA urges Covered California to balance its focus on efficiency and innovation with a consideration of consumer choice. In this regard, Covered California should take care not to constructively eliminate the Preferred Provider Organization (PPO) model of care by developing policies and QHP contract terms that will make it untenable for such a plan to operate in the marketplace. While CMA does not oppose the creation of incentives for innovative and cost effective care models, we would oppose contract terms that serve to render the PPO model inoperable.

Healthcare Services Price Transparency

While CMA supports efforts to educate QHP enrollees with regard to the cost of care in order to empower them to make informed healthcare decisions, we oppose any requirement that QHPs disclose or make public a physician’s allowed charges. Forced disclosures of contracted rates negotiated between providers and health plans raise anti-trust concerns and are prohibited by most managed care plan contracts with providers. In addition, negotiated rate information is simply not useful to QHP enrollees in determining the cost of their care. Rather, CMA urges Covered California to require QHPs to disclose all information related to out of pocket costs in ways that are organized to be understandable and meaningful for enrollees in their decision-making.

Thank you again for the opportunity to provide input on the 2017 QHP Contract and on Attachment 7. We look forward to continuing our work with Covered California, the QHPs, and other stakeholders in our ongoing effort to improve access to cost effective, quality healthcare for Californians. Please contact me at (916) 551-2552 or swittorff@cmanet.org if I may offer any additional information or clarify any of CMA’s comments.

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1 CMA urges Covered California to replace the definition of “telemedicine” from Attachment 7 with the definition of “telehealth” from California Business & Professions Code § 2290.5. As defined in state law, telehealth is: “the mode of delivering health care services and public health via information and communication, treatment, education, care management, and self-management of a patient’s health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchrononous store and forward transfers.”
Respectfully submitted,

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California Medical Association

c: California Health Benefits Exchange Board, via email to boardcomments@covered.ca.gov
    Plan Management Advisory Group, via email to qhp@hbex.ca.gov