PLAN MANAGEMENT ADVISORY GROUP

September 8, 2016

WELCOME AND AGENDA REVIEW

JAMES DEBENEDETTI, DIRECTOR
PLAN MANAGEMENT DIVISION

AGENDA

AGENDA
Plan Management and Delivery System Reform Advisory Group
Meeting and Webinar
Thursday, September 8, 2016, 10:00 a.m. to 12:00 p.m.

Webinar link: https://attendee.gotowebinar.com/rt/6132192224704601089

September Agenda Items	Suggested Time
I. Welcome and Agenda Review	10:00 - 10:05 (5 min.)
II. Covered California Enrollment System Updates	10:05 – 10:35 (30 min.)
III. Quality Rating System for Open Enrollment 4	10:35 – 11:05 (30 min.)
IV. Benefits Work Group 2018	11:05 – 11:35 (30 min.)
V. Open Forum	11:35 – 11:50 (15 min.)
VI. Wrap-Up and Next Steps	11:50 – 12:00 (10 min.)

COVERED CALIFORNIA ENROLLMENT SYSTEM UPDATES

TAYLOR PRIESTLEY, CERTIFICATION MANAGER
LAUREN SCHAUB, BUSINESS ANALYST
PLAN MANAGEMENT DIVISION

Please see slide deck, “Covered California Enrollment System Updates”

QUALITY RATING SYSTEM FOR OPEN ENROLLMENT 4

DR. LANCE LANG, CHIEF MEDICAL OFFICER
PLAN MANAGEMENT DIVISION

QUALITY RATING SYSTEM (QRS) REPORTING FALL 2016: CMS METHODS

- Four quality ratings – One global rating and three summary indicator ratings
- 5-star scale
- National benchmark applied to all products to determine star ratings
- Uses 31 measures – QRS subset includes 1-year lookback period metrics

Publicly Reported Fall 2016

QHP 1 Global Rating	QHP 3 Summary Indicators	Underlying Measure Topics
Global Rating of Plan	Getting the Right Care	Clinical Effectiveness
		Patient Safety
		Prevention
	Member's Care Experience	Access to Care
		Doctors and Care
		Care Coordination
	Plan is a Good Value, Care is Proven and Safe	Health Plan Customer/Info Services
		Efficient Care/Resource Use

BACKGROUND AND UPDATES FOR 2016 FALL ENROLLMENT

- CMS produced QRS ratings for 310 Marketplace products nationwide based on 31 HEDIS and CAHPS measures. Nine Marketplaces will pilot reporting QRS results in Fall 2016 (5 FFMs, California, Oregon, Washington and New York).

- Covered California has reported Member Experience with Care in past years in advance of the CMS pilot. The pilot now also includes a broader mix of 31 quality measures: 60% are clinical, 30% are drawn from the enrollee survey and 10% measure resource use. The survey and resource use measures are combined to create two sub-scores, one focusing on experience with care and the other on plan functions. A third sub-score measures clinical performance based on HEDIS. The CMS QRS scoring formula weights the three sub-scores equally to create a summary score.

- Covered California had concerns with the CMS approach for this pilot:
  - The resource use metrics focused on pediatrics which represents a very small fraction of enrollment. The results therefore were not scored for 8 QHPs, and didn't adequately represent resource use in the exchange population.
  - Historical precedents for summary scores all place greater emphasis on clinical performance.

- Covered California has developed a different approach for this year using all CMS data except for the 3 resource use measures* which were removed.

*__Removed measures:__ Appropriate Testing for Children With Pharyngitis, Appropriate Treatment for Children With Upper Respiratory Infection, Use of Imaging Studies for Low Back Pain

COVERED CALIFORNIA FALL 2016 METHODOLOGY

Covered California revised several aspects of the CMS QRS rating formula to better reflect health plans' performance to assist consumers in their health insurance choices. Covered California:

1. Removed the 3 resource use (also known as "efficient care") measures.
2. Reallocated the sub-score weights, to follow the approaches taken by the major U.S. healthcare performance rating programs (Medicare, Consumer Reports, etc.):
   - Two-thirds of QRS weight is assigned to clinical care and one-third to member-reported experiences

3. Provides consumers with 3 topics* that accompany the summary quality rating to convey 3 major aspects of health plan performance that matter to consumers:
   - Clinical care
   - Member experience with their doctors and care
   - Member experience with health plan customer services

COVERED CALIFORNIA

*CMS reports these 3 topics but organizes some information differently and includes efficient care measures

QRS REPORTING CHANGES (UPDATED FROM 8/11): FALL 2016 VS. CURRENT REPORTING

QRS Component	Fall 2016	Current (Fall 2015)
Methods Author	***Covered California Adjusted*** CMS Methodology	Covered California
Summary Ratings	1 Summary Rating and 3 Topic Ratings	1 Rating of Member Experience of Care
Measures Set Used for Summary Ratings	28 HEDIS and CAHPS	10 CAHPS
Benchmark	National All-Product Type Benchmarks	Western Region PPO Benchmarks
Ratings Display	5 Stars	4 Stars
QHP Product Scope	On-Exchange Only	On-Exchange and Optionally Off-Exchange

NUMBER OF PRODUCTS IN EACH QRS RATING LEVEL BY YEAR

	# Products	1 Star	2 Star	3 Star	4 Star	5 Star
Fall 2016 QRS (31 Q.) *Tentative*	17*	1	6	2	1	1
Fall 2015 Global Ratings of Health Plan (1 Q.)	12	1	5	3	3	1-4 Star Scale Only

*Six of the seventeen QHP products do not have a reportable Summary Rating (Anthem HMO, Anthem EPO, Health Net EPO, OSCAR, Blue Shield HMO/Individual and Blue Shield HMO/SHOP)

MARKETING GUIDELINES*: QHP REFERENCES TO QRS RATINGS IN MARKETING MATERIALS

Guidelines are currently in review by Covered CA marketing department. At a minimum, QHP Issuers that choose to use the QRS Ratings in marketing materials:

- shall reference specific QHPs or product types and their Covered California assigned quality rating information.
- limit information to the 4 quality ratings reported by Covered California (Global Rating and 3 Summary Ratings)
- may use only the quality rating titles assigned by Covered California without variation (e.g., “Getting the Right Care”). Additionally, the QHP issuer must always include the QRS global rating (e.g., “Quality Rating”) alongside the QRS summary indicator rating.
- shall only use a general label in reference to the rating of a specific QHP. For example, “a 5-star plan” can be used only to reference the QRS global rating, unless the summary indicator rating is specified (e.g., “a 5-star plan for [insert summary indicator name]”).
- should not use superlatives (e.g., “highest ranked,” “one of the best”) without additional context. For example, a QHP that is the only one in the State that received a 5-star rating for a specific QRS summary indicator, but received a 3-star global rating, may not be promoted as the highest ranked QHP in the State when other QHPs have a higher global rating.
- shall only advertise QRS ratings (i.e., stars) rather than scores (i.e., numerical value),
- must include the CMS-provided disclaimer on all marketing materials.

*Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2016 (CMS, January 2016 V. 2.0)

TIMELINE: COVERED CALIFORNIA QUALITY REPORTING FALL 2016

Reporting Step	Date
CMS QRS Preview Period	
Health Plans & Covered California	August 15-26
Results Final	August 26
Summary of Results Presented	
Advisory Group	September 8
Ratings updated in CalHEERS	1st week in October

NEXT STEPS

Public Reporting

- Individual: Produce online results for Plan Selection and Plan Review applications
- Covered California for Small Business (CCSB): Consider producing stand-alone print materials for CCSB products

QRS for 2017 and Beyond

- Covered California will work with CMS and Issuers on lessons learned from the 2016 QRS results and how to improve methodology and consumer displays

2018 PATIENT-CENTERED BENEFIT PLAN DESIGNS

ALLIE MANGIARACINO, SENIOR QUALITY ANALYST
PLAN MANAGEMENT DIVISION

STRATEGY FOR PATIENT-CENTERED BENEFIT PLAN DESIGNS

Organizational Goal

Covered California should have benefit designs that are standardized, promote access to care, and are easy for consumers to understand **= PATIENT-CENTERED**.

Principles

- Multi-year progressive strategy with consideration for market dynamics: changes in benefits should be considered annually based on consumer experience related to access and cost
- Adhere to principles of value-based insurance design by setting cost shares based on the value of clinical services
- Set fixed copays as much as possible and utilize coinsurance for services with high price variation to encourage members to shop for services
- Apply a stair-step approach for setting member cost shares for a service across each metal level, e.g. a primary care visit is $35 in the Silver tier, $30 in Gold, $15 in Platinum

2018 BENEFIT DESIGN: POSSIBLE TOPICS

Benefit Category	Issue	To be addressed in 2018? Yes/No
Home Health Care	Specify copay as being per day or per visit	Yes
Telehealth visits	Determine whether to standardize copays	Yes
Prediabetes programs	Consider requirement, per USPSTF recommendations, to include diabetes prevention programs (DPP) as a covered preventive service	Yes
Actuarial Value of SBPDs	Consider an AV that is less than or equal to the metal tier AV, i.e. not within 2% of the upper de minimus limit, in order to leave room for fewer changes to benefits in future years.	Yes
Remove limitations/restrictions on tobacco cessation therapies	CA state and Federal guidelines state no restrictions should exist on all seven categories of tobacco cessation therapies. Some plans already have no restrictions or limitations.	Yes
Inpatient Services	Consider removal of inpatient physician copay in the Platinum and Gold Copay plans	Yes
Services for pain management	Start the discussion on access/barriers to pain management services such as acupuncture and physical therapy, in alignment with other state efforts. (For example mitigation of opioid overuse/misuse.) Possible action for 2018 depending on findings.	Yes
Consolidate Platinum/Gold/CCSB Silver Plans	Consider eliminating Copay and Coinsurance Design plans (i.e. one plan design per metal level)	Yes
CCSB Alternate Plan Designs	Decide whether to continue to allow proposed alternate benefit designs in CCSB	Yes

PROPOSED 2018 PAYMENT PARAMETERS AND DRAFT AV CALCULATOR

- Maximum out-of-pocket (MOOP) limit: $7,350 (2.8%/$200 increase from 2017)
  - Silver 94 and Silver 87: $2,450 ($100 increase)
  - Silver 73: $5,850 ($150 increase)
- Dental MOOP limit for stand-alone dental plans: $350 (no change)
- Extended de minimis range for Bronze and Bronze HDHP plans: -2% / +5% AV
  - Must cover and pay for at least one major service before the deductible, other than preventive services
  - NOTE: Covered California's Bronze currently covers first three non-preventive visits at copay amount; lab tests and rehabilitation/habilitation services are not subject to deductible
  - Major services that may be covered before the deductible: primary care, specialty visits, inpatient services, generic/preferred brand/specialty drugs, ED visits
- Draft AV Calculator methodology:
  - Uses 2015 claims from individual and small group market, trended to 2018 (3.25% medical trend, 11.5% drug trend)
  - Includes claims from HMO, PPO, and EPO (previous calculator only used PPO claims)
  - Projects to the anticipated 2018 demographic distribution for the expected enrolled population.

STARTING POINT: 2017 PLAN DESIGNS IN 2018 AVC

- Platinum, Gold, and Bronze plans: AV is within de minimis range
  - With expanded de minimis for Bronze, there is an opportunity to rework the Bronze plan
  - Options: Eliminate “100% coinsurance” for some benefits, lower deductible, remove deductible from some services
  - Continue offering copay and coinsurance designs for Gold and Platinum?
- Silver, CCSB Silver plans, and Silver CSR plans: AV increased 4-8%
  - Need to alter benefits significantly to get within de minimis range
  - Continue offering CCSB Silver plans?

TIMELINE

Date	Event	Description
August 11	Plan Advisory Meeting	Discuss potential issues to address for designing 2018 benefits
September 8	**Plan Advisory Meeting**	**Planning and stakeholder input on process for designing 2018 benefits**
October – December	**Design 2018 benefits**	**Make changes to meet AV requirements, edits to endnotes as necessary**
January 2017	Board Meeting	Present proposed 2018 plan designs for Board discussion
February 2017	Board Meeting	Present proposed 2018 plan designs for Board approval, pending final AVC and payment parameters
March-April 2017	Final changes	Make final changes as necessary per final AVC and payment parameters

NEXT STEPS

- Establish process for 2018 benefit design development
- Test various plan design scenarios in the 2018 AV Calculator
- Address benefit design issues (e.g. home health care, IP physician fees, etc.) and determine whether to make changes in plan design and/or endnotes
- Provide comments to HHS within 30-day window

WRAP UP AND NEXT STEPS

JAMES DEBENEDETTI, DIRECTOR
PLAN MANAGEMENT DIVISION

SUGGESTED AGENDA TOPICS FOR OCTOBER MEETING

- 2018 Benefit Design - Update
- Primary Care Initiative Implementation – PCMH Definition Update
- Healthcare Evidence Initiative (Truven) Discussion
- Special Enrollment Review Policy Update
- Others? Please email Lindsay.Petersen@covered.ca.gov