PLAN MANAGEMENT ADVISORY GROUP

March 29, 2016

WELCOME AND AGENDA REVIEW

BRENT BARNHART, CHAIR
PLAN MANAGEMENT ADVISORY GROUP

AGENDA

AGENDA
Plan Management and Delivery System Reform Advisory Group
Meeting and Webinar
Tuesday, March 29, 2016, 1:00 p.m. to 3:00 p.m.

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

March Agenda Items	Suggested Time
I. Welcome and Agenda Review	1:00 - 1:05 (5 min.)
II. 2017 Certification Update	1:05 – 1:25 (20 min.)
III. Review of Draft 2017 Contract	1:25 – 2:45 (80 min.)
Contract Overview	
Attachment 7	
Appendix 2, Measurements and Specifications	
IV. Special Enrollment Period Update	2:45 – 2:55 (10 min.)
V. Wrap-Up and Next Steps	2:55 – 3:00 (5 min.)

2017 CERTIFICATION UPDATE

TAYLOR PRIESTLEY, CERTIFICATION MANAGER
PLAN MANAGEMENT DIVISION

2017 CERTIFICATION TIMELINE UPDATES

Plan Management Advisory Meeting: Benefit Design & Certification Policy recommendation	January 14, 2016
Release draft 2017 QHP & QDP Certification Applications	January 19 – February 9, 2016
January Board Meeting: discussion of benefit design & certification policy recommendation	January 21, 2016
Draft application comment periods end	February 16, 2016
Letters of Intent Accepted	February 1 – February 19, 2016
Final AV Calculator Released	February 2016
February Board Meeting: approval of 2017 Standard Benefit Plan Designs & Certification Policy	February 18, 2016
Applicant Trainings (electronic submission software, SERFF submission and templates)	February 22 -26, 2016
QHP & QDP Applications Open	March 1, 2016
Second Letter of Intent Period for Covered California for Small Business QHP Application	March 18 – April 15, 2016
QHP Application Responses Due	May 2, 2016
Evaluation of QHP Responses & Negotiation Prep	May 3 – June 5, 2016
QHP Negotiations	June 6 – June 17, 2016
Covered California for Small Business (CCSB) QHP Application Submissions Due	June 17, 2016
QHP Preliminary Rates Announcement	July 7, 2016
Regulatory Rate Review Begins (Individual Marketplace QHP)	July 7, 2016
QDP Application Responses Due	June 1, 2016
Evaluation of QDP Responses & Negotiation Prep	June 2 – July 10, 2016
QDP Negotiations	July 11 – July 17, 2016
CCSB QHP Rates Due	July 15, 2016
QDP Rates Announcement (no regulatory rate review)	August 1, 2016

Dates for QHP rate public posting are contingent on CMS approval

REVIEW OF 2017- 2019 QHP ISSUER CONTRACT

ELISE DICKENSON, CONTRACT MANAGER
PLAN MANAGEMENT DIVISION

2017 – 2019 QHP ISSUER CONTRACT

Based on comments received and discussions with the QHP Issuers, Consumer Advocate Groups and CAHP, we've made some additional changes to the contract. Highlights of the revisions include:

2.1.2 (b) Contractor shall comply with **all** Exchange eligibility and enrollment determinations, including those made through CalHEERS and that result from an applicant's appeal of an Exchange determination. Contractor shall also implement appeals decisions and provide the Exchange with evidence that the appeal resolution has been implemented within ten (10) business days of receiving all necessary data elements from the Exchange.

3.1.5 Reviewing the amount of liquidated damages for additional CalHEERS uploads. We are researching this item. The current amount of $50,000 may change.

7.2.4 Remedies in case of QHP Issuer default or breach. Adding an Exchange requirement to notify QHP Issuer and allow the QHP Issuer an opportunity to correct the issue prior to enforcement.

Attachment 14 – 2.2, 2.3 and 2.6 will be new performance standards for 2017. Each performance standard will have a pilot period prior to implementation of the timeframe for assessing performance penalties.

Separation of the 2017 -2019 QHP Issuer Contract into two contracts – one for the Individual Market and one for Covered California for Small Business.

REVIEW OF DRAFT ATTACHMENT 7

DR. LANCE LANG, CHIEF MEDICAL OFFICER
PLAN MANAGEMENT DIVISION

2017 ATTACHMENT 7: REVIEW OF CHANGES POSTED MARCH 4, 2016

- Health Disparities (Article 3)
  - Plans will report percent of enrollees who self identify race/ethnicity for Covered California enrollees only.
  - 80% self identification target by 2019 applies only to Covered California enrollees; Covered California provides health plans with racial/ethnic self report for an average of 73% of enrollees through 834s.
- Care Models - Primary Care (Article 4)
  - "Primary Care Physician" changed to "Primary Care Clinician"
  - Reporting will be separate for Covered California, Medi-Cal, Medicare, and commercial lines of business.
- Care Models – Integrated Healthcare Models (Article 4)
  - Reporting will be separate for Covered California, Medi-Cal, Medicare, and commercial lines of business.
- Hospital Safety (Article 5)
  - Payment strategy applies to general acute hospitals only (critical access hospitals are excluded).
  - Payment strategy can be met by having 6 percent of reimbursement at-risk or through bonus structured payments
- Health and Wellness (Article 6)
  - Utilization of members using wellness visits (prevention, tobacco, and obesity programs) will be reported for Covered California lives, and separately for Medi-Cal, Medicare, and commercial lines of business.
  - Health Assessments – language added to confirm appropriate protections from disclosure are in place, and plans will advise enrollees on how the information will be used.
- Consumer transparency (Article 7)
  - Intent clarified to focus on providing enrollees their specific share of cost for common services based on their benefits.
  - Contractor agrees to monitor care that is provided out of network to ensure that consumers understand that their cost share will likely be higher and are choosing out of network care intentionally.

- **For all Attachment 7 initiatives, performance standards will be measured based on Covered California enrollees only, with the exception of health disparities.**

2017 ATTACHMENT 7: PROPOSED CHANGES TO MARCH 4TH VERSION

- Ensuring Networks are Based on Value (Article 1)
  - Criteria for defining “outlier poor performance” now includes consideration of hospital case mix and services provided in variation analysis
- Primary Care Clinician Selection or Attribution (Article 4)
  - Requirement updated to 30 days calculated from member effectuation
- Hospital Quality (Article 5)
  - Additional clarification on hospitals excluded from the payment reform requirement. In addition to CMS Critical Access Hospitals, the following hospital types will be excluded:
    - Long Term Care hospitals
    - Inpatient Psychiatric hospitals
    - Rehabilitation hospitals
    - Children’s hospitals
- Hospital Patient Safety (Article 5)
  - Language added regarding possible substitution of Hospital Acquired Conditions (HACs) in the event a common data source cannot be found

CONTINUING WORK WITH MULTI-STAKEHOLDER COLLABORATION FOR FINALIZATION OF 2017- 2019 CONTRACT

- Finalize specifications for all metrics
  - First meeting was held March 22 with follow-up scheduled April 14
- Source(s) of performance data and approach to assess and measure variation for Hospital Acquired Conditions (HACs)
- Agree on approach to assign proxy racial/ethnic attributes and agree on timing of claims data that will be used to collect and measure performance related to disparity reduction
  - Presentation to health plans from Rand on March 24
  - Covered California will survey plans to determine next steps including possible coordination of training provided by Rand
- Primary Care meeting scheduled in May
  - Aligning on definition for “Selection of a Personal Care Clinician”
  - Begin discussion of how to define Patient Centered Medical Homes (PCMH) for measurement purposes
- Determining appropriate definition and methodology on how “outlier” will be defined in various measures

COVERED CALIFORNIA INDIVDUAL MARKET QUALITY INITIATIVE MULTI-YEAR STRATEGY TIMELINE

Topic Area	Contract Year Performance Expectation			
	2016	2017	2018	2019
Health disparities	Report baseline of self-reported racial or ethnic identity.	Report proportion of membership with self-reported racial or ethnic identity and receive penalty or credit for performance compared to contract target.	Report proportion of membership with self-reported racial or ethnic identity and receive penalty or credit for performance compared to contract target.	Report proportion of membership with self-reported racial or ethnic identity and receive penalty or credit for performance related to target of 80%.
	Report baseline performance of selected measures by race or ethnicity.	Report performance on selected measures and receive penalty or credit based on negotiated annual intermediate milestone.	Report performance on selected measures and receive penalty or credit based on negotiated annual intermediate milestone.	Report performance on selected measures and receive penalty or credit based on negotiated improvement target.
Network Design Based on Quality	Report baseline criteria for network design.	Report strategy for inclusion of quality criteria in all networks and receive penalty or credit based on criteria and implementation schedule.	Report strategy for inclusion of quality criteria in all networks and receive penalty or credit based on criteria and implementation schedule.	Report strategy for inclusion of quality criteria in all networks and receive penalty or credit based on criteria, implementation schedule, and demonstrated exclusion of outlier performers.
Primary Care	Report percent of Covered California members who have selected a personal care clinician.	Report percent of Covered California members who have selected a personal care clinician and receive credit or penalty based on performance compared to 95% target.	Report percent of Covered California members who have selected a personal care physician and receive credit or penalty based on performance compared to 95% target.	
	Report baseline percent of personal care physicians paid under a payment strategy supporting accessible, data-driven, team-based care.	Report percent of personal care physicians paid under a payment strategy supporting accessible, data-driven, team-based care and receive penalty or credit based on 5-10% targets.		
Integrated Healthcare Models (IHMs)	Report baseline measurement of percent of Covered California enrollees who select or are attributed to IHMs.	Report percent of Covered California enrollees who select or are attributed to IHMs and receive penalty or credit based on negotiated intermediate milestone.	Report percent of Covered California enrollees who select or are attributed to IHMs and receive penalty or credit based on negotiated intermediate milestone.	Report percent of Covered California enrollees who select or are attributed to IHMs and receive penalty or credit based on 2019 negotiated target.

COVERED CALIFORNIA INDIVIDUAL MARKET QUALITY INITIATIVE MULTI-YEAR STRATEGY TIMELINE

Topic Area	Contract Year Performance Expectation			
	2016	2017	2018	2019
Appropriate use of C-Sections	Report rates of low risk (NTSV) C-Sections for each Exchange network hospital.	Receive penalty or no penalty based on reported C-Section rates for all Exchange network hospitals, and receive credit if plan engages hospitals in tracking rates.	Receive penalty or no penalty based on reported C-Section rates for all Exchange network hospitals, and receive credit if plan engages hospitals in tracking rates.	
		Report percent of hospitals and providers contracted under new payment strategy to support only medically necessary care and receive penalty or credit based on performance to 20% target.	Report percent of hospitals and providers contracted under new payment strategy to support only medically necessary care and receive penalty or credit based on performance to 20% target.	Report percent of hospitals and providers contracted under new payment strategy to support only medically necessary care and receive penalty or credit based on negotiated target of all providers paid under new strategy.
Hospital Safety	Report specified HAC rates for each Exchange network acute general hospital.	Receive penalty or no penalty based on reported hospital acquired condition (HAC) rates for each Exchange network hospital, and receive credit if plan engages hospitals in tracking rates.		
		Report percent of hospitals and providers contracted under new payment strategy to place at least 6% of payment at risk for quality performance and receive penalty or credit based on performance to 20% target.	Report percent of hospitals and providers contracted under new payment strategy to place at least 6% of payment at risk for quality performance and receive penalty or credit based on performance to 20% target.	Report percent of hospitals and providers contracted under new payment strategy to place at least 6% of payment at risk for quality performance and receive penalty or credit based on negotiated target of all providers paid under new strategy.

Note: Carrier Performance for each contract year above is determined based on reports submitted to Covered California generally during the following calendar year based on the due date agreed to in the contract that considers requirements needed to appropriately measure performance such as claims completion and common market collection periods.

2017 ATTACHMENT 7: COVERED CALIFORNIA FOR SMALL BUSINESS (CCSB) AND DENTAL MARKETPLACES

Emphasis on enrollment, similar to first three years building Covered California Individual Market:

- CCSB (Health)
  - New 2017 - 2019 Quality Initiatives in Attachment 7 will apply to the Individual Market only, and will not apply to the CCSB line of business.
  - While CCSB enrollment builds, health plans will make good faith efforts to promote the 2017 quality initiatives through collaborative efforts and strategic decisions for its other products and lines of business.
  - Health Plans agree to participate in the advisory and planning process with Covered California to determine future contract requirements.
- Dental (Individual and CCSB Marketplaces)
  - Future quality contract requirements will build on existing dental quality activities such as reduction of health disparities, assessment of member risk and health status, and wellness services, promotion and support, as well as the adoption of Dental Quality Alliance (DQA) measures in 2016.
  - While dental enrollment builds in the individual and small business markets, dental plans will continue to participate in the 2016 advisory and planning process to determine future quality contract requirements in 2018.

REVIEW OF APPENDIX 2: MEASUREMENTS AND SPECIFICATIONS

ALLIE MANGIARACINO, SENIOR QUALITY ANALYST
PLAN MANAGEMENT DIVISION

2017 DRAFT APPENDIX 2 – PUBLIC COMMENT SUMMARY

Measure #	Measure Subject	Concern	Suggestion	Response
General	General	The current measure set will require significant resources (coding, development, testing).	Limit the requested measures only to those that are considered critical at this time and expand gradually in future years.	Covered CA is maximizing overlap with current measures and processes as much as possible, but wants to get a baseline on specific priority areas, even if some are not being collected currently.
General	General	This process requires more review and discussion among stakeholders to arrive at a final set of measures that will be effective in tracking improvement.	Lay out timeline for additional meetings and/or make this a standing work group.	Covered California will hold another work group meeting on 4/14 and will make the measures and specifications work group a standing group that meets with varying frequency depending on need.
1	Health Disparities – Self Identification	80% of Race/Ethnicity self-reported information is required for Covered CA lines of business by end of 2019. Consumers may not self-identify R/E.	Include “decline to state” in the numerator (or remove from numerator and denominator). Or, Change CalHEERS enrollment form to require completion of R/E.	Covered CA is looking into both these options. Information was shared that shows QHPs have, on average 73% of R/E data passed to them already on enrollment forms. Two plans have already reached the 80% goal, which is not required until end of 2019.
3-15	Health Disparities – Reduction Targets	Use of non-standardized measures has risk of inconsistent measurement across plans and useless measurement that cannot be audited/validated.	Need code sets for each ED/hospitalization measure, and collection specifics to ensure apples to apples comparison.	Covered CA is working to identify common code sets.
3-15	Health Disparities – Reduction Targets	Timing for reporting baseline is too early given the upfront work to code and test methodology	Adjust report timing to Q3 2016 for baseline data, and Q3 2017 for first reporting set for performance.	Covered CA has adjusted the reporting timing of the health disparities measures (3-15) and the hospital safety measures (25-35).
3-15	Health Disparities – Reduction Targets	Sample sizes are not big enough to measure disparities and assess improvement.	Instead of ARHQ measures (7, 11-13), use ICD-10 codes. Include an "other" category among the R/E categories. (This is different from "unknown.“)	Covered CA is looking for alternatives to the AHRQ and is developing a list of ICD-10 codes for diabetes, asthma, and hypertension measures.

2017 DRAFT APPENDIX 2 – PUBLIC COMMENT SUMMARY

Measure #	Measure Subject	Concern	Suggestion	Response
3-15	Health Disparities – Reduction Targets	ED utilization is affected by many variables that extend beyond access to alternative sites of care or control of the underlying disease.	Use hospitalization rates only.	ED visits related to the chronic condition indicate poor control and barriers to care. Including both ED visits and hospitalizations accounts for those visits that do not result in hospitalization and could have been prevented.
5	Asthma Medication Ratio	This is not a preferred measure for disparities.	Suggest using Medication Management for People with Asthma (MMA) to align with CMS/AHIP core measures and Medi-Cal external accountability set.	Covered CA opened this for discussion in the work group, and it was group consensus to stay with the AMR.
6	Depression Response at 12 months	This measure is still in development, difficult to measure, and would not yield a large enough sample to measure disparity. This measure is designed to assess physician quality, not health plan quality.	Suggest using Antidepressant Medication Management (AMM)	Covered CA will likely require both, recognizing that measure 6 is relatively new but would be a better precedent for understanding depression management since the AMM relies heavily on medication use and less on outcomes.
16-17	Primary Care	Lack of clarity on process and implementation and concern that PPO consumers will be upset.	Request clarification on: provider's role, contractual impact, required communication/outreach/ID card requirements, member reassignment, and what is meant by primary care payment strategy.	Covered CA will hold a separate meeting with sole focus on primary care definition and rollout strategy, likely the second week of May.
17	Primary Care – PCMH enrollment	Including all lines of business in PCMH strategy is an overreach.	Report PCMH enrollment percentage only for Covered CA lines of business.	Reporting is required for all lines of business for comparison purposes only. Performance standard is only tied to Covered CA lines.
23	NTSV C-Section rate for each network hospital	Potential for disadvantaging plans that exclude a hospital while another plan does not exclude it and provides a rationale.	Suggest Covered California provide rationale for continued inclusion and/or plan for improvement so that the same hospital isn't expected to use different improvement strategies for different carriers.	Covered CA will work with stakeholders to set criteria for defining outlier performance. Improvement resources and technical assistance are available to hospitals for each measure, and Covered California expects improvement efforts to be underway before 2019 when exclusion is required.

2017 DRAFT APPENDIX 2 – PUBLIC COMMENT SUMMARY

Measure #	Measure Subject	Concern	Suggestion	Response
25	Opioid Adverse Events	Very difficult to obtain rates for each hospital for this measure. This measure is developing and it is too early to measure. Also, Medical record review is not administratively feasible and pharmacy reporting will not provide information on admissions.	Covered California should arrange to obtain this data and give it to the plans. Or, Covered California should delay collecting data on this measure.	Covered California and the Appendix 2 workgroup are looking at a common reporting mechanism and evaluating the OSHPD report which includes this measure.
25-35	Hospital Safety – Hospital Acquired Conditions	Concern over ability to have statistically appropriate samples as HACs approach zero. Concern for smaller hospitals, who already have low sample sizes.	Several measures are used to mitigate (SIR, ratio comparing against national benchmark, and rates, and in some cases utilization ratio) Tradeoff is this increases number of measures reported.	Covered CA welcomes suggestions on how to mitigate small numbers issues, both as HACs approach zero for regular sized hospitals, and for smaller hospital whose numbers are already small. (And how to distinguish these two.)
25-35	Hospital Safety – Hospital Acquired Conditions	NHSN data is difficult to find and not provided for each facility.	Exclude LTAC, inpatient psychiatric and rehab facilities, and children's hospitals from reporting.	Covered CA has updated Attachment 7 to reflect this.
25-35	Hospital Safety – Hospital Acquired Conditions	There is lack of clarity on how plans will obtain rates for each hospital.	Set data channels, with a preference for plans obtaining information from a central source.	Covered CA has adjusted the reporting timing of the hospital safety measures (25-35), in order to facilitate reporting from a common source, CDPH, who will report 2015 data in early fall. Covered CA is open to switching the two measures currently not reported by CDPH to measures that are included in CDPH.
36-37	Hospital Safety – Payment Strategy	Universe of at-risk payment metrics could be unwieldy if plans can select anything they want.	Covered California should create a pick list of options for at-risk payments that aligns with Medicare. Specifically exclude measures that are still in development/not standardized and specify which readmission measures can be used.	Covered CA is evaluating and welcomes suggestions for a pick list.
39-40	Utilization of members using tobacco cessation and weight management program	Further specification is needed to enable apples to apples comparison of health plan data.	Define specifications, as best can be done, with administrative data.	Covered CA will work with PBGH to provide more specification for these measure (collection is through eValue8).

SPECIAL ENROLLMENT PERIOD UPDATE

ANNE PRICE, DIRECTOR
PLAN MANAGEMENT DIVISION

PROPOSED SPECIAL ENROLLMENT POLICY GUIDING PRINCIPLES

- Covered California will implement a special enrollment policy that preserves the integrity of the Individual market risk mix and supports long term affordability for all consumers

- The Special Enrollment policy will not be overly burdensome to members
  - Use of electronic verification will be maximized
  - Alternative forms of documentation or attestation may likely be required

- The process for verification does not take an unreasonable length of time so access to care is not jeopardized

- The process must consider technology capabilities and resource limitations

WRAP UP AND NEXT STEPS

BRENT BARNHART, CHAIR
PLAN MANAGEMENT ADVISORY GROUP