Qualified Health Plan: Selection Process and Contracting Plan Management Advisory Group Discussion

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HMO and PPO Options / Number and Type of Plans

Geographic Coverage by Health Plan:

- Stimulating competition and real choices within a region.
- Avoiding duplicates of very similar plans/products.
- Covered CA must have statewide coverage.

Number of QHP Product Bids per Issuer:

- 2 or 3 per issuer per geographic region.
- Striking the balance between healthy choice but not too many to confuse the consumer
- Plans will vary provider networks and request alternative benefit designs.

Breadth of Provider Networks – Narrow and Broad

Provider Network Access Adequacy Standards

- All networks must meet network adequacy regulatory standards.
- Many QHPs are expected to include narrow networks to achieve affordability.

Essential Community Provider Network Sufficiency

- Meeting 340B percent requirement.
- Sufficiency requirement. Hospitals and non-hospitals needed. Varies by region. Preference to bidders with FQHCs contracted.

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Delivery System Reform Initiatives

Care Redesign and Infrastructure Investment

- Accountable Care Organizations to align incentives and improve data exchange among physician organizations, hospitals and health plans.
- Electronic health record and data exchange adoption that improves clinical processes and reduces duplication of services. Valuing telemedicine/telehealth.
- Evaluating clinical decision support and approaches to deliver right care at right time.
- Patient Centered Medical Homes to improve primary care access and support for special needs populations.

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Delivery System Reform Initiatives

Payment Reform

- Reward providers who deliver high-quality, cost effective care (delivery improvements, adoption of technology, e.g., e-prescribing).
- Increase payments for primary care, rewarding better coordination and more efficient care, recognizing primary care medical home pilots.
- Encourage plan efforts to:
  - Undertake quality-based contracting
  - Expand access through telemedicine / use of trained ancillary providers.

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Multi-year Agreement and Partnership Issues

- Specific multi-year contact criteria with health plans.
- Open to revisions and negotiation of additional terms and timing.
- Tied into re-certification and de-certification processes which have not yet been defined.
- Goal is to try to stabilize rates in 2015 and 2016 by agreeing on an approach to rate analysis in advance.
- Performance guarantees are a related but contested issue.

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Quality and Performance Data Reporting, Monitoring

Require reporting of CAHPS and HEDIS measures required by Medi-Cal Managed Care.

- Establishes a minimum level of quality reporting.
- Raises the bar.

And

Interim NCQA accreditation

Selected Model Contract Terms and Stakeholder Comments

Primary Care and Preventive Services

A. Contractor shall demonstrate to the Exchange that all new Enrollees are assigned to a Primary Care Provider or a Patient-Centered Medical Home within 45 days of enrollment. Contractor may offer an alternative approach to achieving this goal. The Exchange may substitute this requirement with an applicable HEDIS measure.
B. Contractor shall demonstrate to the Exchange that at least XX% of new Enrollees receive a preventive services or equivalent visit within 120 days of enrollment. The Exchange may substitute this requirement with applicable HEDIS measures.

- HEDIS already collecting info (get it from them)
- **Define a new enrollee (new to CC or new to insurance)
- PPO model currently does not support CC requirements (PCP)
- Plans can't *MAKE* an enrollee receive care within 120 days
- Rely on existing CAHPS quality data
- Help CC define evidence-based targets
- Incorporate Young Adult Health Care Survey into reporting

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Network and Essential Community Provider Adequacy

Contractor shall submit to the Exchange, upon request, its criteria for selection of Physician Providers and its standards for the continuing education of Physician Providers and professional health care staff. Contractor shall give access to the Exchange any or all Participating Provider contracts, with or without payment terms, and shall submit copies of such contracts to the Exchange's audit/actuarial firms, including payment terms, in accordance with the audit provisions set forth herein.

- Issuer contracts with Provider are confidential
- State law already addresses continuity of care should provider contract end or terminate
- CC disruption policy goes beyond state and federal law
- Concerns that routine disruptions could cause unspecified costs
- Support for efforts to provide enrollees meaningful access to care

Reporting Quality of Care Assessment

Contractor shall provide periodic reports that describe the types of care provided to Enrollees. Report requirements and formats will be outlined in the Administrative Manual. Examples of these reports include:

- Claims and encounter data; volume by type of provider
- High-cost Enrollee reports
- Health Assessment Completion reports
- Preventive Services Visit reports
- Reports on episodes of care eligible for reinsurance reimbursement
- Out-of-network paid claims reports

- Clarify why we request this information
- Concern that we are not using NCQA measures versus making new ones
- Concern that current contract requirement does not collect specific demographic data
- Consider relying on existing measures for QHPs to report data for the initial open enrollment period.
- Consider aligning quality measurement and quality improvement programs with existing Medicare program.
- Which quality approach is feasible by open 2013 open enrollment and for 2015-2016 operations?

HEDIS Effectiveness of Care Performance Rates

Contractor shall collect and compile National Committee on Quality Assurance (NCQA)-approved Health Plan Employer Data and Information Set (HEDIS) Effectiveness of Care measure performance rates for its Exchange and Medicare populations.

- Issuers request reference to and requirements regarding Medicare populations removed from contract
- Request measure to track early elective deliveries
- New requirements that will require phase-in and alternative reporting in the initial years
- Focus on measures that report children's needs