

Attachment 7. Quality, Network Management and Delivery System Standards

Quality, Network Management and Delivery System Standards

Preamble

PROMOTING HIGHER QUALITY AND BETTER VALUE

The mission of Covered California (the “Exchange”) is to increase the number of insured Californians, improve health care quality and access to care, promote better health, lower costs, and reduce health disparities through an innovative and competitive marketplace that empowers consumers to choose the health plan and providers that offer the best value. The Exchange’s “Triple Aim” framework seeks to improve the patient care experience including quality and satisfaction, improve the health of the population, and reduce the per capita cost of health care services. The Exchange and Contractor recognize that promoting better quality and value will be contingent upon smooth implementation and large enrollment in the Exchange.

Qualified Dental Plan issuers (“QDP issuers” or “Contractor”) are central partners for the Exchange in achieving its mission. By entering into an agreement with the Exchange (“Agreement”), Contractor agrees to work in partnership with the Exchange to develop and implement policies and practices that will promote the Triple Aim, impacting not just the Enrollees of the Exchange but the Contractor’s California membership. QDP Issuers have the opportunity to take a leading role in helping the Exchange support new models of care which promote the vision of the Affordable Care Act and meet consumer needs and expectations. At the same time, the Contractor and the Exchange can promote improvements in the entire care delivery system. The Exchange will seek to promote care that reduces excessive costs, minimizes unpredictable quality and reduces inefficiencies of the current system. For there to be a meaningful impact on overall oral healthcare cost and quality, solutions and successes need to be sustainable, scalable and expand beyond local markets or specific groups of individuals. The Exchange expects its QDP partners to engage in a culture of continuous quality and value improvement, which will benefit all Enrollees.

These Quality, Network Management and Delivery System Standards outline the ways that the Exchange and the Contractor will focus on the promotion of better care and higher value for the Plan Enrollees and for other California health care consumers. This focus will require both the Exchange and the Contractor to coordinate with and promote alignment with other organizations and groups that seek to deliver better care and higher value. By entering into the Agreement with the Exchange, Contractor affirms its commitment to be an active and engaged partner with the Exchange and to work collaboratively to define and implement additional initiatives and programs to continuously improve quality and value.

Article 1. Improving Care, Promoting Better Health and Lowering Costs

1.01 Coordination and Cooperation. Contractor and the Exchange agree that the Quality, Network Management and Delivery System Standards serve as a starting point for what must be ongoing, refined and expanded efforts to promote improvements in care for Enrollees and across Contractor's California members. Improving and building on these efforts to improve oral health care and reduce administrative burdens will require active partnership between both the Exchange and the Contractor, but also with Providers, consumers and other important stakeholders.

(a) The Exchange shall facilitate ongoing discussions with the Contractor and other stakeholders through the Exchange's Plan Management and Delivery System Reform Advisory Group, Dental Technical Workgroup, and through other forums as may be appropriate to work with Contractors to assess the elements of this Section and their impact, and ways to improve upon them on:

- (i) Enrollees and other consumers;
- (ii) Providers in terms of burden, changes in payment and rewarding the triple aim of improving care, promoting better health and lowering costs; and
- (iii) Contractors in terms of the burden of reporting, participating in quality or delivery system efforts.

(b) The Contractor agrees to participate in Exchange advisory and planning processes, including but not limited to participating in the Plan Management and Delivery System Reform Advisory Group, and Dental Technical Workgroup.

1.02 Participation in Collaborative Quality Initiatives. The Exchange and Contractor will collaboratively identify and evaluate the most effective programs for improving care for enrollees and the Exchange and Contractor may consider participation by Contractor as a requirement for future certification.

1.03 Reducing Health Disparities and Assuring Health Equity. Covered California and the Contractor recognize that promoting better health requires a focus on addressing health disparities and health equity. Because of this, Contractor agrees to work with the Exchange to identify strategies that will address health disparities in meaningful and measurable ways. This shall include:

(a) Participating in Exchange workgroups and forums to share strategies and tactics that are particularly effective;

(b) Working with the Exchange to determine how data can best be collected and used to support improving oral health equity including the extent to which data might be better collected by the Exchange or the Contractor and how to assure that the collection and sharing of data is sensitive to Enrollees' preferences. In working with the Exchange, Contractor agrees to report how it plans to collect and use data on demographic characteristics, including but not limited to:

- (i) Race
- (ii) Ethnicity
- (iii) Gender
- (iv) Primary language
- (v) Disability status

Article 2. Provision and Use of Data and Information for Quality of Care

2.01 Dental Utilization Reporting. Contractor shall submit to the Exchange dental utilization data to include the measure numerator, denominator and rate for the required measure set. The Exchange reserves the right to use the Contractor-reported measures scores to construct Contractor summary quality ratings that the Exchange may use for such purposes as the Exchange's plan oversight management.

2.02 Data Submission Requirements to the Exchange. Contractor shall submit a complete data set, inclusive of all member and provider identified data, claims, and encounter data, on a quarterly basis to the Exchange or the Exchange's designated recipient to be used by the Exchange as it determines to be necessary. Such submissions will conform to all applicable Federal and State personal health information and related privacy laws, rules and regulations, and shall comply with the terms and conditions set forth in the Agreement by and between Contractor and the Exchange. Contractor will bear the full cost of data collection, extraction and submission; provided, however, that except as expressly set forth in this Attachment or the Agreement, Contractor will not be required to pay for any expenses related to the analysis of that data in order to comply with the terms of this Agreement. When data is submitted to a vendor for the Exchange, that vendor will be a Business Associate of the Contractor and shall protect the information provided to the extent required under applicable laws, rules and regulations.

Working with Contractors, the Exchange will develop data file formats that will be required of Contractor to support oversight requirements, including actuarial review, clinical quality improvement, network management and fraud and waste reduction, delivery system reform goals, consumer information and research. Additional data and expanded file formats may be requested in the future in support of the Exchange contributing data to statewide collaborative efforts to advance development of an all payer claims database.

Specific data submission areas may include:

- Plan and Product
- Member
- Member History
- Providers (all providers with paid claims, including non-contracted)
- Professional Claims

If Contractor is unable to produce such information in the file format requested by the Exchange, Contractor shall coordinate with the Exchange with a plan to address data gaps or format preferences prior to the Contractor's submission of such information. For any non-paid claims for capitated services, the Contractor shall provide full and complete encounter data.

2.03 Determining Enrollee Health Status and Use of Risk Assessments. Contractor shall demonstrate the capacity and systems to collect, maintain and use individual information about Exchange Plan Enrollees' oral health status and behaviors in order to promote better oral health and to better manage Enrollees' oral health conditions. Contractor shall demonstrate the use of Risk Assessment to identify members in need of dental treatment services including but not limited to preventive and diagnostic services.

To the extent the Contractor uses or relies upon Risk Assessments to determine oral health status, Contractor shall offer, upon initial enrollment and on a regular basis thereafter, a Risk Assessment to all Plan Enrollees, including those Plan Enrollees that have previously completed such an assessment. If a Risk Assessment tool is used, Contractor should select a tool that adequately evaluates Plan Enrollees current oral health status and provides a mechanism to conduct ongoing monitoring for future intervention(s).

2.04 Reporting to and Collaborating with the Exchange Regarding Health Status. Contractor shall provide to the Exchange, in a format that shall be mutually agreed upon, information on how it collects and reports, at both individual and aggregate levels, changes in Exchange Plan Enrollees' oral health status. Reporting may include a comparative analysis of oral health status improvements across geographic regions and demographics.

Contractor shall report to the Exchange its process to monitor and track Plan Enrollees' oral health status, which may include its process for identifying individuals who show a decline in oral health status, and referral of such Plan Enrollees to Contractor care management and chronic condition program(s) as defined in Section 4.03, for the necessary intervention. Contractor shall annually report to the Exchange the number of Plan Enrollees who are identified through their selected mechanism and the results of their referral to receive additional services.

Contractor agrees to work with the Exchange to standardize: (1) indicators of Plan Enrollee risk factors; (2) oral health status measurement; and (3) oral health assessment questions across all Contractors, with the goal of having standard measures used across the Exchange's Contractors in a period of time mutually agreed upon by Contractor and the Exchange.

Article 3. Preventive Health and Wellness

3.01 Health and Wellness Services. Contractor is required to actively outreach and monitor the extent to which Exchange Plan Enrollees obtain preventive health and wellness services within the Enrollee's first year of enrollment. Contractor shall submit information annually to the Exchange related to Plan Enrollees' access to preventive health and wellness services. Specifically, Contractor shall assess and discuss the participation by Plan Enrollees in necessary diagnostic and preventive services appropriate for each enrollee.

Contractor shall annually submit to the Exchange documentation of a health and wellness communication process to Exchange Enrollees and Participating Providers.

3.02 Community Health and Wellness Promotion. The Exchange and Contractor recognize that promoting better health for Plan Enrollees also requires engagement and promotion of community-wide initiatives that foster better health, healthier environments and the promotion of healthy behaviors across the community. Contractor shall report annually in a mutually agreed upon form the initiatives, programs and/or projects that it supports that promote wellness and better community health that specifically reach beyond the Contractors' Enrollees. Such programs may include, but are not limited to, partnerships with local or state public health departments and voluntary health organizations which operate preventive and other health programs.

Contractor shall develop and provide reports on how it is participating in community health and wellness promotion. Report information should be coordinated with existing national measures, whenever possible.

Article 4. Access, Coordination, and At-Risk Enrollee Support

The Exchange and Contractor recognize that access to care, coordination of care and early identification of high risk enrollees are central to the improvement of Enrollee health. Traditionally, Primary Care Providers (PCP) have provided an entry point to the system (access), coordination of care and early identification of at risk patients, and the Exchange strongly encourages the full use of PCPs by Contractors. Contractor and the Exchange shall identify further ways to increase access and coordination of care and agree to work collaboratively to achieve these objectives.

4.01 Encouraging Consumers' Access to Appropriate Care. Contractor is encouraged to assist Exchange Enrollees in selecting a primary care dentist or Federally Qualified Health Center that provides dental care within sixty (60) days of enrollment. In the event the Enrollee does not select a primary care dentist within the allotted timeframe, Contractor may auto-assign the enrollee to a primary care dentist and the assignment shall be communicated to the Plan Enrollee. In the event of an auto-assignment, Contractor shall use commercially reasonable efforts to make the primary care dentist assignment consistent with an Enrollee's stated gender, language, ethnic and cultural preferences, if known, and should consider geographic accessibility and existing family member assignment or prior provider assignment.

4.02 Promoting Development and Use of Care Models Contractor shall report annually, in a format to be mutually agreed upon between Contractor and Exchange, on: (1) the number and percentage of Exchange Plan Enrollees who have selected or been assigned to a primary care dentist, as described in Section 4.01. In the event that the reporting requirements identified herein include Protected Health Information, Contractor shall provide the Exchange only with de-identified Protected Health Information as defined in 45 C.F.R. Section 164.514. All information provided to the Exchange in this section shall be treated by the Exchange as confidential information.

Contractor shall not be required to provide the Exchange any data, information or reports that would violate peer review protections under applicable laws, rules and regulation.

4.03 Identification and Services for At-Risk Enrollees. Contractor agrees to identify and proactively manage the Plan Enrollees with existing and newly diagnosed need for dental treatment beyond diagnostic and preventive dental services and Plan Enrollees with chronic conditions and who are most likely to benefit from well-coordinated care ("At-Risk Enrollees"). As described in Section 2.04, Contractor shall determine the health status of its new enrollees including identification of those with chronic conditions or other significant dental needs within the first one hundred twenty (120) days of enrollment, provided the Exchange has provided timely notification of enrollment. The Exchange will work with Contractor to develop a documented process, care management plan and strategy for targeting these specific Enrollees. Such documentation may include the following:

- (a) Methods to identify and target At-Risk Enrollees;
- (b) Description of Contractor's predictive analytic capabilities to assist in identifying At Risk Plan Enrollees who would benefit from early, proactive intervention;
- (c) Communication plan for known At-Risk Enrollees to receive information prior to provider visit;
- (d) Process to update At-Risk Enrollee dental history in the Contractor maintained Plan Enrollee health profile;

(e) Mechanisms to evaluate access within provider network, on an ongoing basis, to ensure that an adequate network is in place to support a proactive intervention and care management program for At-Risk Enrollees;

(f) Care and network strategies that focus on supporting a proactive approach to at-risk Plan Enrollee intervention and care management. Contractor agrees to provide the Exchange with a documented plan and include “tools” and strategies to supplement and/or expand care management and provider network capabilities, including an expansion and/or reconfiguration of specialties or health care professionals to meet clinical needs of At Risk Enrollees.

Article 5. Patient-Centered Information and Communication

5.01 Provider Cost and Quality. Contractor shall provide the Exchange with its plan, measures and process to provide Plan Enrollees with current cost and quality information for network providers. Contractor shall report how it is or intends to make provider specific cost and quality information available by region, and the processes by which it updates the information. Information delivered through Contractor's Provider performance programs should be meaningful to Plan Enrollees and reflect a diverse array of Provider clinical attributes and activities, including, but not be limited to: provider background; quality performance; patient experience; volume; efficiency; price of services; and should be integrated and accessible through one forum providing Plan enrollees with a comprehensive view.

5.02 Enrollee Cost Transparency. The Exchange and Contractor acknowledge and agree that information relating to the cost of procedures and services is important to enrollees, the Exchange, the Contractor and providers. The Exchange also understands that Contractor negotiates Agreements with providers, including dental practice groups and other clinical providers, which may result in varied provider reimbursement levels for identical services and or procedures. In the event that Contractor's provider contracts result in different provider reimbursement levels that have an impact on Plan Enrollee costs within a specific region, as defined by paid claims for Current Dental Terminology (CDT) services, Contractor agrees to provide the Exchange with its plan, measures and process to assist Plan Enrollees in identifying total cost and out-of-pocket cost information for the highest frequency and highest cost service(s) and or procedure(s). When available, this pricing information shall be prominently displayed and made available to both Plan Enrollees and contracted Contractor providers if provided. This information shall be updated on at least an annual basis unless there is a contractual change that would change enrollee out-of-pocket costs by more than 10%. In that case, information must be updated within thirty (30) days of the effective date of the new contract.

5.03 Enrollee Benefit Information. Contractor shall provide Plan Enrollees with current information regarding annual out-of-pocket costs, status of deductible, status of benefit limit if applicable, and total oral health care services received to date.

Article 6. Promoting Higher Value Care

Reserved for future use

Quality, Network Management and Delivery System Standards

Glossary of Key Terms

Active Purchaser - Health care purchasers, typically employers or employer coalitions, that proactively define and manage performance expectations through their health plan contracts or direct contracting arrangements with providers. These expectations include a range of service models including (but not limited to) benefit design and incentives, health and wellness, service delivery for enrollees, transaction processing, delivery system performance and reform, health information technology adoption and use, quality of care for enrollees, and other innovation models. Further, these expectations may also include active development, financial support, and contractual expectations for collaborative participation in accordance with applicable laws, rules and regulations, among multiple payers and/or providers that collectively serve a specific geographic area and/or multiple purchasers.

Care Management - Healthcare services, programs and technologies designed to help individuals with certain long-term conditions better manage their overall care and treatment. Care management typically encompasses Utilization Management (UM), Disease Management (DM) and Case Management (CM). Care Management's primary goal is to prevent the sick from getting sicker, and avoiding acute care events. Care Management is usually considered a subset of Population Health Management.

Delivery System Transformation - A set of initiatives taken by purchasers, employers, health plans or providers, together or individually, to drive the creation and preferred use of care delivery models that are designed to deliver higher value aligned with the "triple aim" goals of patient care experience including quality and satisfaction, improve the health of the populations, and reduce the per capita cost of health care services. Generally these models require improved care coordination, provider and payer information sharing and programs that identify and manage populations of individuals through care delivery and payment models.

Population Health Management - A management process that strives to address health needs at all points along the continuum of health and wellbeing, through participation of, engagement with and targeted interventions for the population. The goal of a Population Health Management program is to maintain and/or improve the physical and psychosocial wellbeing of individuals through cost-effective and tailored health solutions.

Preventive Health and Wellness Services - The provision of specified preventive and wellness services and chronic disease management services, including preventive care, screening and immunizations, set forth under Section 1302 of the Affordable Care Act (42 U.S.C. Section 18022) under the Section 2713 of the Affordable Care Act (42 U.S.C. Section 300gg-13), to the extent that such services are required under the California Affordable Care Act.

Reference Pricing - A payor contracting, network management and enrollee information process that identifies and differentially promotes delivery system options for care based on transparent display of comparative costs for identical services or procedures, typically after each provider has passed a quality assessment screen. In some cases, value pricing will identify the individual enrollees out of pocket costs accounting for plan design and deductible status. While quality is incorporated in the process, typically there is no differentiation based on comparative quality once a threshold performance level is achieved.

The information set forth in this Attachment shall not limit the Exchange's right to obtain information in accordance with the terms set forth in the Agreement and/or applicable laws, rules and regulations.