PLAN MANAGEMENT ADVISORY GROUP

August 13, 2015

AGENDA

AGENDA
Plan Management and Delivery System Reform Advisory Group
Meeting and Webinar
https://attendee.gotowebinar.com/register/3700058205961202433
Thursday, August 13, 2015, 10:00 a.m. to 12:00 p.m.

	August Agenda Items	Suggested Time
I.	Welcome and Agenda Review (Brent Barnhart)	10:00 - 10:05 (5 min.)
II.	2016 Preliminary Individual Rates (Anne Price)	10:05 – 10:25 (20 min.)
III.	2016 Contract Update (Becky Thomas)	10:25 - 10:45 (20 min.)
IV.	Dental Contract Quality Measures Update (Taylor Priestley)	10:45 -10:55 (10 min.)
V.	Health Plan Quality Reporting 2015 (Dr. Lance Lang)	10:55 - 11:30 (35 min.)
VI.	2017 Certification Process and Timeline (Anne Price)	11:30 - 11:50 (20 min.)
VII.	Wrap-Up and Next Steps (Brent Barnhart)	11:50 – 12:00 (10 min.)

2016 CONTRACT UPDATE

BECKY THOMAS, MANAGER, CONTRACT AND PLAN MANAGEMENT
COVERED CALIFORNIA PLAN MANAGEMENT DIVISION

2016 Qualified Health Plan (QHP) Issuer Contract Update

- Dental Quality Alliance (DQA) Pediatric Measures have been added to the reporting requirements in Attachment 14 which now will require QHPs to report annually on pediatric dental measures

- Staff received QHP and stakeholder comments that were due August 12th

- Staff is in the process of scheduling calls with the carriers to review comments

- Revisions based on the feedback will be made and the final 2016 QHP Issuer Contract will be sent to the Health Plans for signature in September

Covered California Health Plan Contract Timeline

ACTIVITY	DATE
2016 Contracting Strategy Shared with Plan Advisory – Solicit Comments and Suggestions	JULY 2015
Covered California Meetings with Qualified Health Plans	AUGUST 2015
Develop Potential Recommended Changes for 2017 Contract (This needs to occur in the Fall of 2015 to include in the 2017 application)	SEPTEMBER – OCTOBER 2015
Plan Advisory Meeting to Share 2017 Contract Recommendation – Solicit additional Input and Comments	OCTOBER 2015
2017 Contract Recommendation to the Covered CA Board	OCTOBER 2015
2017 Contract Approval from the Covered CA Board	NOVEMBER 2015
2017 Contract Requirements incorporated into 2017 Certification/Recertification Applications	DECEMBER 2015 – JANUARY 2016

DENTAL CONTRACT QUALITY MEASURES

TAYLOR PRIESTLEY, CERTIFICATION PROGRAM MANAGER
COVERED CALIFORNIA PLAN MANAGEMENT DIVISION

DENTAL CONTRACT QUALITY MEASURES UPDATE

- Covered California is recommending replacing the current pediatric utilization measures in the Qualified Dental Plan (QDP) contract with the Dental Quality Alliance (DQA) Pediatric Measure Set for 2016
- Additionally, staff is recommending that these measures be added to the QHP contract for the “embedded” pediatric dental benefits.
- The DQA measures are national performance measures that have been developed collaboratively and tested by the multi-stakeholder alliance
- Five measures have been endorsed by the National Quality Forum and the dental sealant measure has been included in the CMS 2015 Core Set of Children’s Health Care Quality Measures for Medicaid and CHIP
- Previous measures in the QDP contract were derived from the Healthy Families Program, which has since been transitioned to Medi-Cal

DENTAL CONTRACT QUALITY MEASURES UPDATE

- Pediatric measures to be included in both the QDP and QHP contract include the following:

Utilization of Services	Percentage of all enrolled children under age 21 who received at least one dental service within the reporting year.
Oral Evaluation	Percentage of enrolled children under age 21 who received a comprehensive or periodic oral evaluation within the reporting year.
Sealants 6 – 9 years of age	Percentage of enrolled children in the age category of 6-9 years at "elevated" risk (i.e., "moderate" or "high") who received a sealant on a permanent first molar tooth within the reporting year.
Sealants 10 – 14 years of age	Percentage of enrolled children in the age category of 10-14 years at "elevated" risk (i.e., "moderate" or "high") who received a sealant on a permanent second molar tooth within the reporting year.
Topical Fluoride for Children at Elevated Caries Risk	Percentage of enrolled children aged 1-21 years who are at "elevated" risk (i.e. "moderate" or "high") who received at least 2 topical fluoride applications within the reporting year.
Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children	Number of Emergency Department (ED) visits for caries-related reasons per 100,000 member months for all enrolled children.
Follow-Up After ED Visit by Children for Dental Caries	The percentage of caries-related ED visits among children 0 through 20 years in the reporting year for which the member visited a dentist within (a) 7 days and (b) 30 days of the ED visit.

** Covered California measures would be adjusted to include children up to age 19 consistent with the required essential health benefits*

COVERED CALIFORNIA HEALTH PLAN QUALITY REPORTING, FALL 2015: REPORTING UPDATE

DR. LANCE LANG, CHIEF MEDICAL OFFICER
COVERED CALIFORNIA PLAN MANAGEMENT DIVISION

WHERE WE HAVE BEEN: COVERED CALIFORNIA HEALTH PLAN QUALITY REPORTING

- Covered California has produced quality ratings based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey for open enrollment 2013 and 2014 that was based on **commercial, non-exchange** health plan surveys because individual product-only surveys were not available
- 4 star scale: 75th percentile and above earns top rating
- Regional PPO benchmark applied to all products to determine star ratings

Publicly reported 2013, 2014

Qualified Health Plan (QHP) Global Rating	Domains	Composites/Measures	# of Questions
Global Rating of Plan (Star Rating)	Access to Care	Getting Needed Care	2
		Getting Care Quickly	2
	Doctors & Care	Rating of All Health Care	1
		Rating of Personal Doctor	1
		Rating of Specialist	1
	Plan Service	Customer Service	2
		Rating of Health Plan	1

NOTE: FINAL 2015 QUALTY RATINGS ARE NOT PRESENTED IN THESE SLIDES

WHAT COVERED CALIFORNIA HEALTH PLAN QUALITY REPORTING LOOKS LIKE TODAY

Current sample quality reporting fact sheet for Region 15 & 16

REGIONS 15 & 16 — Los Angeles County	Quality Rating
Anthem Blue Cross of California EPO, HMO	★★★
Blue Shield of California PPO	★★★
Health Net HMO, HCSP	★★★
Kaiser Permanente HMO	★★★★
L.A. Care Health Plan HMO	★★
Molina Healthcare HMO	★★

COVERED CALIFORNIA

NOTE: FINAL 2015 QUALTY RATINGS ARE NOT PRESENTED IN THESE SLIDES

WHERE WE ARE GOING: COVERED CALIFORNIA QUALITY REPORTING

For 2015 Open Enrollment, Covered California will report QHP CAHPS Survey results from the CMS-mandated beta test of the Quality Rating System (QRS)

- The ACA directed HHS to develop a QRS for QHPs offered through the Marketplace.
- QHPs, with at least 500 enrollees as of July 1, 2014, required to collect CAHPS data for each product (e.g. HMO, EPO, PPO)
- CMS set a target survey sample of 1,000 enrollees for each QHP product; samples included individual and small group and on-exchange and off-exchange enrollees.
- The CMS 2015 beta test may lead to refinements of the QRS scoring specifications and methodology for 2016.
- Beginning in 2016, the federal and state-based Marketplaces will be required to prominently display online QHP quality ratings based on the QRS.

2015 QHP ENROLLEE SURVEY RESPONDENTS

The QHP Enrollee Survey used CAHPS-based measures to assess member experience for the July-December 2014 measurement period

The majority of results are based on individual exchange enrollees

- 13% of respondents are from Covered California Small Business (CCSB)
- 17% of respondents are individual off-exchange
- 70% of respondents are individual exchange

Overall 21% survey response rate (2,957 completes)

- Average 211 surveys completed per carrier reporting unit

All QHP products have reportable results

- Twelve products will be reported (11 individual and 1 CCSB-only)
- Two EPO products (Blue Shield and Anthem) will not be reported as the products are not available in 2016

FINDINGS TO DATE

Five of the ten survey questions have lower issuer-level reliability largely due to smaller sample sizes (see table on the following slide)

- Due to these findings, staff needs to evaluate whether to use all ten questions or fewer
- Highest priority should be given to those questions that accurately reflect the consumer experience, and not unduly penalize a plan due to poor response rate

No adjustment recommended for Small Business enrollees

- Using survey response for small business does not impact the individual scores, so no adjustment is needed

No adjustment recommended for off-exchange enrollees

- Using survey response for off-exchange does not impact the individual scores, so no adjustment is needed

There are meaningful differences in scores across carriers

- Global rating of scores range between 6.1 to 7.8 between carriers

FINDINGS TO DATE: RELIABILITY & SAMPLE SIZE

CAHPS Question	Reliability	N>100
Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to **rate your health plan** in the last 6 months?	↑	↑
Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to **rate the specialist**?	↓	↓
Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to **rate all your health care** in the last 6 months?	↑	↑
Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to **rate your personal doctor**?	↓	↓
In the last 6 months, when you needed care right away, how often did you **get care as soon as you needed**?	↓	↓
In the last 6 months, how often did you get an appointment for a **check-up or routine care** at a doctor's office or clinic as soon as you needed?	↑	↑
In the last 6 months, how often did you get an appointment to **see a specialist as soon as you needed**?	↓	↓
In the last 6 months, how often was it easy to get the **care, tests, or treatment** you needed?	↑	↑
In the last 6 months, how often did your health plan's **customer service** staff treat you with **courtesy and respect**?	↑	↓
In the last 6 months, how often did your health plan's **customer service** give you the **information or help you needed**?	↓	↓

Very low plan-level reliability due to smaller differences among plans and small sample sizes

Low plan-level reliability due to small samples sizes

IMPLICATIONS FOR FALL 2015 QHP RATINGS

Smaller sample sizes

- Report summary star rating using a subset of the 10 survey questions
- No domain level reporting (e.g., Access, Plan Service, Doctors & Care)

Similar results for Small Business vs. Individual and for off-exchange vs. exchange

- Use CMS standard case-mix adjustment formula (health status, age, education, language, chronic conditions/medications, and survey mode)

Meaningful differences in carrier scores

- Expect distribution across spectrum of stars ratings
- Actual star ratings distribution contingent on regional/national benchmarks

NEXT STEPS AND QUESTIONS TO ADDRESS

Produce summary plan-level star ratings

- Obtain final QHP scored results and benchmark data from CMS this month

Evaluate if any differences in star ratings per alternative ways to score global rating

- Covered California will test a variety of scenarios using different combinations of measures to determine if any differences in the QHP global star ratings

Public Reporting

- Individual: Produce online results for CalHEERS and Shop & Compare
- Covered California for Small Business (CCSB): Consider producing stand-alone print materials for CCSB products
- Five of six CCSB plans have reportable results (no results for Health Net given new products for this market)

Next Step for 2016 and Beyond

- Covered California will work with CMS and issuers on lessons learned from the 2015 beta test

RECOMMENDED CHANGES TO PRELIMINARY APPROACH FOR 2015 REPORTING

Preliminary Approach Discussed April Board Mtg.	Preliminary Direction
Report the same 10 measures used in last 2 years	Use fewer measures per limits of smaller survey sample sizes
Expand from a 4-star rating to a 5-star rating system-use 25th, 50th, 75th, & 90th percentiles to create the 5 performance categories	Due to CalHEERS limitations, continue with 4-star system
Report ratings at the product type level (HMO, PPO, EPO)	Yes
Blend the national and HHS western region results to create the benchmark (50:50)	Test once benchmark data is available
Report the global rating in the health plan compare summary online and in print	Yes
Report the 3 domain ratings (Access, Plan Service, Doctors & Care) publicly	Domain ratings not doable given fewer measures per limits of smaller survey sample sizes

TIMELINE: COVERED CALIFORNIA QUALITY REPORTING FALL 2015

Reporting Step	Date
Preliminary findings	
Advisory Group	August 13
Board Meeting	August 20
Preliminary star ratings results	
Health plans	August 27
Advisory Group	September 10
Final scores	
Board	October 8
Public release	1st week in October

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QUALITY REPORTING: CLINICAL MEASURES

- The clinical measures' results from the CMS 2015 beta test will be available to issuers and Covered California in Fall 2015 for non-public internal use only. These measures are not included in Covered California's quality reporting for 2015 Open Enrollment.

- The Health Plan Quality Reporting for 2016 will be based on both clinical (HEDIS) and member experience (CAHPS) measures according to forthcoming CMS specifications.

- Clinical measures for public reporting will be available to issuers and Covered California late summer 2016

2017 CERTIFICATION PROCESS

ANNE PRICE, DIRECTOR
COVERED CALIFORNIA PLAN MANAGEMENT DIVISON

2017 Plan Year Discussion Points

- Given the comprehensive review of benefits that was done for 2016, staff recommends there be minimal changes for the 2017 plan year and the focus for 2017 plan year changes be related to the new entrant policy and contract requirements directly impacting the delivery of care for Covered California consumers.

- We anticipate that the AV calculator will be updated with exchange specific claims data and will need to adjust benefits accordingly. CMS releases the preliminary rates in November, so we will know more at that time.

- Areas to be discussed include the following:
  - Network and benefits: Non-standard benefits, tiered networks and non--essential health benefits.
  - Alternative Benefit Designs (ABDs): discussion as to the pros and cons of allowing ABDs to be offered and requirements.
  - Update of QHP requirements in Attachment 7 to focus effort on targeted areas of improvement and innovation

- What should the forum be for accomplishing the 2017 certification and benefit design work – ad hoc or using the scheduled plan advisory time?

2017 Certification Approval Timeline – For Discussion

Activity	Date
Review and Prioritize Changes for 2017 Plan Year	**August - November**
September Plan Advisory Meeting	September 10, 2015
October Plan Advisory Meeting	October 15, 2015
October Board Meeting – **Recommend Principals for 2017 Certification and QHP Requirements**	October 22, 2015
CMS Payment Notice (will include preliminary AVs)	Early November
November Plan Advisory Meeting	November 10, 2015
November Board Meeting – **Status Update 2017 Certification and QHP Requirements**	November 19, 2015
December Plan Advisory - **Review of Board Recommendation**	December 10, 2015
December Board Meeting - **Recommendation of 2017 Certification Policy and QHP Requirements*** Comments on 2017 Federal AV updates due to CMS (estimated November to mid December)	December 17, 2015
January Plan Advisory - **Review of Final Board Recommendation**	January 2016 (Date TBD)
January Board Meeting **- Approval of 2017 Certification Policy and QHP Requirements**	January 2016 (Date TBD)
Final 2017 changes to AV calculator released	February 2016

QUESTIONS, WRAP-UP, AND NEXT STEPS

BRENT BARNHART, CHAIR,
PLAN MANAGEMENT ADVISORY GROUP