Plan Management Advisory

June 10, 2021
<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Presenter</th>
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<tbody>
<tr>
<td>10:00am-10:05</td>
<td>Welcome and introductions</td>
<td>Rob Spector</td>
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<tr>
<td>10:05-10:20</td>
<td>2023-2025 Attachment 7 refresh process overview</td>
<td>Margareta Brandt</td>
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<td>10:20-10:45</td>
<td>Addressing patient social needs</td>
<td>Taylor Priestley</td>
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<td></td>
<td>• Overview of Covered California Attachment 7 requirements</td>
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<td>• Considerations in setting future requirements</td>
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<tr>
<td>10:45-11:45</td>
<td>Community Connections Partnership – collaboration to integrate health systems, health plans, and social services providers</td>
<td>Gil Duran, Jennifer Powell, Sherry Novick, Moira Kenney</td>
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<td>11:45-12:00pm</td>
<td>Open discussion, Wrap up &amp; next steps, Adjourn</td>
<td>Rob Spector</td>
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2023-2025 Attachment 7 refresh process overview

Margareta Brandt, Quality Improvement Unit Manager
COVERED CALIFORNIA’S FRAMEWORK FOR HOLDING PLANS ACCOUNTABLE FOR QUALITY CARE AND DELIVERY REFORM

<table>
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<tr>
<th>Assuring Quality Care</th>
<th>Effective Care Delivery Strategies</th>
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<td>INDIVIDUALIZED, EQUITABLE CARE</td>
<td>ORGANIZING STRATEGIES</td>
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<tr>
<td>• Population Health Management: Assessment and Segmentation</td>
<td>• Effective Primary Care</td>
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<td>• Health Promotion and Prevention</td>
<td>• Promotion of Integrated Delivery Systems and ACOs</td>
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<td>• Mental Health and Substance Use Disorder Treatment</td>
<td>• Networks Based on Value</td>
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<td>• Acute, Chronic and Other Conditions</td>
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<td>• Complex Care</td>
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Key Drivers of Quality Care and Effective Delivery

Covered California recognizes that promoting change in the delivery system requires aligning with other purchasers and working with all relevant payers to reform health care delivery in a way that reduces burdens on providers.

- Benefit Design
- Measurement for Improvement Choice and Accountability
- Payment
- Patient-Centered Social Needs
- Patient and Consumer Engagement
- Data Sharing and Analytics
- Administrative Simplification
- Quality Improvement and Technical Assistance
- Certification, Accreditation and Regulation

Community Drivers: Community-Wide Social Determinants, Population and Public Health, and Workforce

January 2020
Covered California’s Framework for Holding Plans Accountable for Quality, Equity, and Delivery System Transformation

### Domains for Equitable, High-Quality Care

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<tr>
<th>PHYSICAL</th>
<th>BEHAVIORAL</th>
<th>ORAL</th>
<th>SOCIAL</th>
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<tr>
<td>Population health management</td>
<td>Health promotion and prevention</td>
<td>Acute care</td>
<td>Chronic care</td>
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### Care Delivery Strategies

- Effective primary care
- Appropriate, accessible specialty care
- Integrated delivery systems and ACOs
- Networks based on value
- Leveraging technology
- Cultural and linguistic competence

### Goals

- Improvement in health status
- Elimination of disparities
- Evidence-based care
- Patient-centered care
- Affordability for consumers and society

### Key Levers

Covered California recognizes that promoting change in the delivery system requires **aligning** with other purchasers and working with all relevant payers in a way that improves value for consumers and society while minimizing administrative burden on plans and providers.

- Benefit design
- Measurement for improvement and accountability
- Data sharing and analytics
- Payment reform

- Consumer empowerment
- Quality improvement collaboratives
- Technical assistance
- Certification and accreditation

### Community Drivers: Social Influences on Health, Economic and Racial Justice

June 2021
## Quality Transformation Initiative (QTI, formerly known as QTF)
- Select QTI measures and benchmarks
- Determine QTI methodology and amounts
- Decide how QTI funds will be invested (with the goal of not collecting future QTI penalties)

## Attachment 14 2.0
- Identify key non-metric based areas for performance guarantees (e.g., payment reform, HIE participation)

## Attachment 7 Implementation Requirements
- Establish requirements (e.g., behavioral health telehealth coverage; NCQA Multicultural Healthcare Distinction; PCP assignment)

## Attachment 7 Process Reporting
- Designate select areas for reporting that are active areas of engagement (e.g., behavioral health)

## Quality Playbook
- Create “Quality Playbook” to capture domains with best practices and resources
PRIORITY AREAS FOR 2023-2025 ATTACHMENT 7

Disparities reduction

Data exchange

Behavioral health

Affordability and cost

Effective primary care
Attachmate 7 Refresh Process

- Covered California leadership and staff engage in strategic planning sessions to develop concept proposals for the 2023-25 contract, with a focus on the priority areas

- Attachment 7 Refresh workgroup
  - Scheduled monthly meetings
  - Forum for large group discussion on proposed changes to Attachment 7, Attachment 14, and the Quality Transformation Initiative
  - Learning space to share ideas and best practices among stakeholders
  - Participants will review and give feedback on contract proposals and draft contract language
  - Additional focus group meetings on specific priority areas will be scheduled as necessary to help facilitate contract development
2023-2025 ATTACHMENT 7 DEVELOPMENT TIMELINE

April-August 2021
Engage stakeholders through monthly Refresh Workgroup meetings, Plan Management Advisory meetings, and additional ad hoc meetings

Sept - Oct 2021
Sept 2021: Post first draft for public comment
Oct 2021: Draft updated to reflect public comments

Nov 2021 – Jan 2022
Nov 2021: Post public comment responses; Updated draft sent to Board for discussion
Dec 2021: Updated draft released for second round of public comments
Jan 2022: Post 2nd round public comment responses; Final draft to Board for approval
NEXT STEPS

- 2023-2025 Attachment 7 refresh workgroup meetings:
  - May 6: Health disparities reduction
  - June 3: Primary care and QTI goals, principles, and measure set criteria
    - July 1 (tentative)
      - Behavioral health
      - Data exchange
  - August 5
    - Affordability and cost

- Topics to be scheduled
  - QTI measures and methodology
  - Alignment opportunities with DHCS, CalPERS, CMS, etc.

- Submit questions and comments to Thai at thai.lee@covered.ca.gov
Addressing patient social needs

Taylor Priestley, Health Equity Officer
2022 ATTACHMENT 7 REQUIREMENTS

Article 14: Patient-Centered Social Needs

- Issuers must screen all enrollees receiving plan-based services (such as complex care management or case management) for at least housing instability and food insecurity; report aggregated counts of members screened and positive screens for housing instability and food insecurity.

- Maintain community resources inventory by region served to support linkage to appropriate social services; submit documented process for referrals for housing instability and food insecurity.
Patient-Centered Social Needs

- Ensure social needs screening reaches all enrollees with unmet needs impacting health; not limited to those already identified as high risk or complex
- Increase support for provider and care team member screening and exchange of screening and referral data with health plans
- Maximize effective referrals and follow-up to ensure identified needs are met
- Avoid unnecessary burden on patients, providers, plans, and community-based organizations, e.g., complexity, duplication of effort, data collection and reporting
Community Connections Partnership

Gil Duran, MPH, Social Determinants of Health Initiatives Manager, Blue Shield of California

Jennifer Powell, MPH, System Director – Community Impact and Operations, CommonSpirit Health/Dignity Health

Sherry Novick, MPA, Community Health Lead, National Thrive Local Initiative, Kaiser Permanente

Moira Kenney, PhD, Regional Network Director, West Coast, Unite Us
What is the **Community Connections Partnership**?

**A unique collaboration:** Launched in 2020 by Kaiser Permanente, Blue Shield of California, Dignity Health — and dozens of community groups.

**A shared goal:** Addressing the social *and* health factors that contribute to negative health outcomes, from inadequate living conditions and poor nutrition to social isolation.

**A new approach:** Unite Us software integrates the activities of major health systems and social service providers through a single, shared electronic platform.
Even before COVID-19, people struggled with unmet social needs

- **68%** Had at least one social factor they needed help within the past year.
- **97%** Of respondents want medical providers to ask about social factors during care visits.
- **2x** as likely to rate their health as fair or poor.

1 in 4 Americans had a social factor they say was a barrier to health in the past year.

*2019 Social Needs in America Study (national data)*
Changing the context of health to center health equity: Opportunities for health systems

### Historical Context

- Slavery
- Colonialism
- Pseudo-Science
- Immigration Exclusion
- Mexican-American War
- Eugenics
- Indian Removal Act
- Whiteness and Wealth
- Internment

### Social Inequities

- Racism
- Heteronormativism
- Chauvinism
- Classism
- Ageism
- Ableism
- Religious Discrimination
- Sexism

### Policy

- Segregation
- Data collection and reporting standards
- Mass incarceration
- Don’t Ask / Don’t Tell
- U.S.-Mexico border wall
- Muslim Immigration Ban

### Structural / Institutional Inequities

- Colorblindness
- Communication channels
- Power distribution
- Community investment
- Hiring / promotion practices
- Healthcare access

### Living Conditions / SDoH

- Education
- Childhood poverty
- Power distribution
- Community investment
- Hiring / promotion practices
- Healthcare access

### Social Factors

- Nutrition
- Smoking
- Housing
- Culture
- Diet
- Language

### Risk Behaviors

- Adherence/Trust
- Usual source of care
- Communicable / Chronic
- Mortality

### Health Behaviors

### Traditional Healthcare Emphasis

#### Systemic (Macro)
- Social, economic, and political context
- Assigns social position

#### Community (Meso)
- Distribution of resources
- Differential exposure and vulnerability

#### Individual (Micro)
- Responsive exposure, behaviors, and impact on health and wellbeing
- Differential consequence

Sources: CDPH, OHE, WHO, Socioecological Model and BARHII Conceptual Framework
Why form this new partnership?

Find new ways to address the social factors that contribute to negative health outcomes, from inadequate living conditions and poor nutrition to social isolation.

Make a collective impact on care quality and health equity for California’s most vulnerable populations

What brought each of our systems to this strategy?
Referrals are Not New: The Current Approach

Healthcare providers, health plans and community-based organizations are not systematically connected to one another, creating lack of visibility, patchwork solutions for individual community members, limited coordination, missed opportunities and uneven outcomes.
Community-wide infrastructure connecting healthcare and social services

On-the-Ground Expertise
We deploy our 260+ person implementation team to each community to build quality and accountable coordinated networks of health and community services.

Technology Platform
Our flexible and scalable platform helps all network partners track every step of each patient’s total health journey inside and outside their four walls.
Live In Planning 2022

- Health and human service providers across the state unified on one platform adapted to local context and need

- Client demographics, social needs, and outcomes tracked longitudinally across county networks

- Service partners access real-time analytics to support service delivery and outcomes

[california.uniteus.com]
Connecting People to Care

Jorge shows up at Sue’s organization.

Sue screens Jorge and identifies that he has additional needs.

Unite Us supports screening and assessments (PEARL, PRAPARE, etc.) on the platform as requested by network partners.

Sue uses Unite Us to gain digital consent and electronically refer Jorge to multiple community partners. Through the platform, she can seamlessly communicate with the other providers in real time and securely share Jorge’s information.

As Jorge receives care, Sue receives real-time updates and tracks Jorge’s total health journey.
We enable secure, meaningful data exchange across sectors.

**Certifications**
- HITRUST
- SOC 2 Type 2
- NIST

**Regulations**
- HIPAA
- 42 CFR Part 2
- FERPA

**Access and Permissions**
- Organization, program, and user-level roles and permissions to satisfy HIPAA/NIST standards
- Personalized onboarding for each partner
- BAAs, where applicable

**Infrastructure**
- Hosted via AWS’ fully certified and compliant cloud servers
- Native permissions engine
- Data secured and encrypted at rest and in transit
- Audited technical, physical, and administrative safeguards
- Annual penetration testing and audit by third party
- Continuous vulnerability monitoring and alerting
- USA based data centers
Multi-layered Security Controls

Unite Us Consent
- Informed consent to share information with the network
- Digital signature, client-directed, opt-out option, document stored in Face Sheet

Role Based Access
- Tailored access for all users based on their role within an organization
- Records are not shared with every organization on the platform - organizations can only see details on the clients they serve, subject to their individual viewing permissions

Service Type Viewing Permissions
- Additional restrictions limit who has access to certain types of information
- For example, a house provider will not be able to access details around a primary care doctor visit

Sensitive Organizations Configuration
- Enhanced protections around inherently sensitive records, such as information regarding survivors of sexual violence, SUD treatment, HIV status, or legal services
California Network Coverage

- >100k users
- Hundreds in-network partner locations
- >1,500 programs receiving referrals

Number of Unite California Partners Accepting Referrals by Core Service Type

Unite CA Partner Locations Per County (Top 10)
How Unite Us Helps Advance Health Equity

- **Network and outcome data** functions like a real-time community health needs assessment, identifying gaps and overlaps in services and informing targeted investments accordingly.
- **Health Equity Report** disaggregates data by race, gender, and geography, facilitating actionable data-driven decision making and introducing disparities reduction as a KPI.
- **Social Opportunity Indices** can proactively identify and predict the needs of high risk, high need populations.

- **Reimburse CBOs for high quality care to shift investments** to underfunded social services and drive supply of resources to match demand; build capacity of evidence-based programs as well as locally developed initiatives.
- **Match social care bundles with complex needs**, providing targeted support to underserved populations (e.g., Black maternal health).
- **Track funds or pair grants dollars to referral outcomes** to understand investment impact.
Licensing and Pricing Overview

Who can join at no cost?

- **Community-Based Organizations (CBOs)** join the network with unlimited licenses. CBOs are defined as 501c3 entities primarily providing services that are not clinical in nature.

- **Safety net clinics**, including Federally Qualified Health Centers, look-alikes, Certified Community Behavioral Health Clinics, and other types of health centers, join with unlimited licenses. They may be interested in technical integrations or other services offered by Unite Us.

- **County Departments, City Governments, and Public Health Care Systems/County Health Care Agencies** receive 25 web-based licenses for free. County governments are entitled to three departments before additional license fees apply.
Building a California Network that Spans Populations and Policy Priorities

County Partnerships

Opportunities to Support State Priorities

- ACEs Aware
- CalAIM - (ILOS, etc.)
- Aging Master Plan - Aging and Disability Resource Centers
Attachment 7

Unite Us Supports Attachment 7 Articles and Requirements

● Resource Directory
  ○ Unite Us provides full access to all the benefits of a comprehensive resource directory, with the added accountability and outcome tracking of a **secure, closed-loop referral platform**

● Data Collection
  ○ UU has capacity to **segment data by relevant demographics**; Health Equity Dashboard service delivery segmentation by demographic groups
  ○ UU can partner with plans on health disparities reduction intervention proposal via development of targeted networks or via a SCI bundle aimed at addressing chronic disease and reducing disease disparities

● Population Health Management Strategy
  ○ UU can support population health strategy through care coordination and/or **network hub support (NHS)** for high need, high risk populations
  ○ Predictive analytics and Community Health Maps support annual needs assessments
Lessons learned...

Importance of community engagement

Need to address CBO capacity

Need for continual network build

Bigger picture for health systems and CBOs alike: Importance of interoperability and integration
Where can I get more information?

For more information about Unite Us or to join the network, go to:

https://uniteus.com/join

For more information about the Community Connections Partnership or to join us, contact:

Sherry Novick - sherry.l.novick@kp.org
Gil Duran - Gil.Duran@blueshieldca.com
Jennifer Powell - jennifer.powell@commonspirit.org
Open discussion
Thank you for attending today’s meeting