Plan Management Advisory

June 10, 2021

AGENDA

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

2023-2025 Attachment 7 refresh process overview

Margareta Brandt, Quality Improvement Unit Manager

COVERED CALIFORNIA

COVERED CALIFORNIA'S FRAMEWORK FOR HOLDING PLANS ACCOUNTABLE FOR QUALITY CARE AND DELIVERY REFORM

Assuring Quality Care

Effective Care Delivery Strategies

INDIVIDUALIZED, EQUITABLE CARE

- Population Health Management: Assessment and Segmentation
- Health Promotion and Prevention
- Mental Health and Substance Use Disorder Treatment
- Acute, Chronic and Other Conditions
- Complex Care

ORGANIZING STRATEGIES

- Effective Primary Care
- Promotion of Integrated Delivery Systems and ACOs
- Networks Based on Value

Sites and Expanded Approaches to Care Delivery

Appropriate Interventions

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
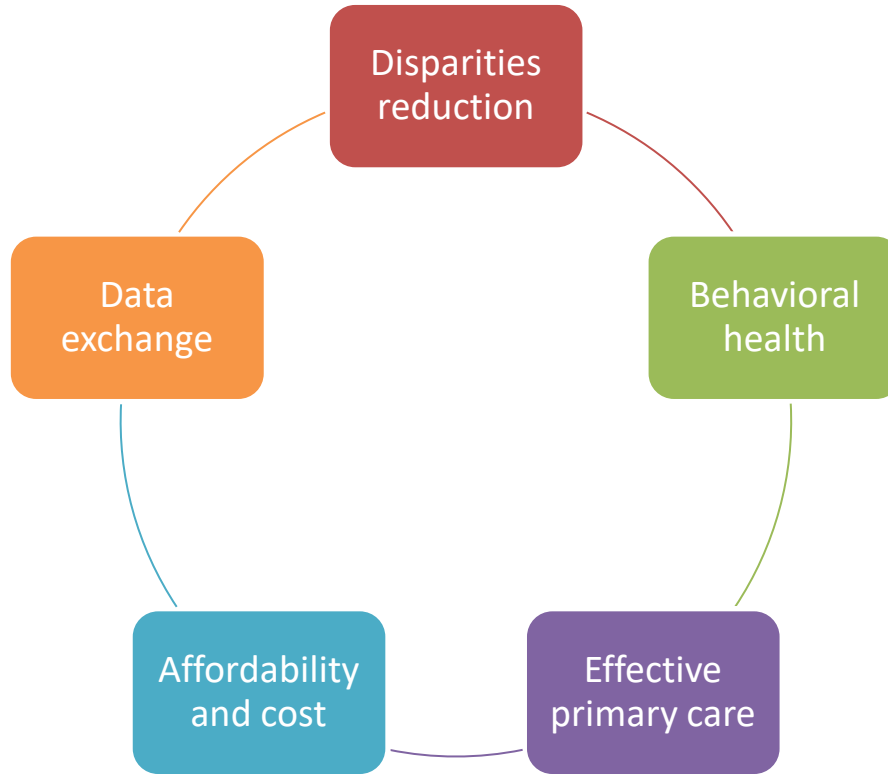
January 2020

COVERED CALIFORNIA'S FRAMEWORK FOR HOLDING PLANS ACCOUNTABLE FOR QUALITY, EQUITY, AND DELIVERY SYSTEM TRANSFORMATION

Domains for Equitable, High-Quality Care

PHYSICAL | BEHAVIORAL | ORAL | SOCIAL

- Population health management
- Health promotion and prevention
- Acute care
- Chronic care
- Complex care

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

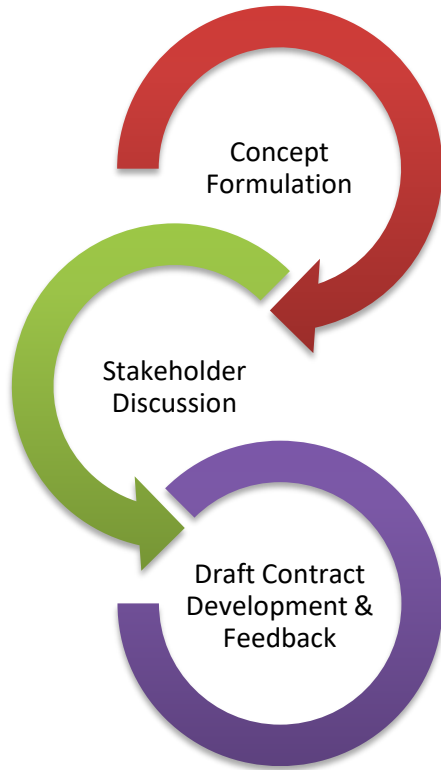**Community Drivers:** Social Influences on Health, Economic and Racial Justice

June 2021

EQUITY, QUALITY, AND DELIVERY SYSTEM REFORM WORKSTREAMS

Workstreams	Activities
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

COVERED CALIFORNIA

PRIORITY AREAS FOR 2023-2025 ATTACHMENT 7

ATTACHMENT 7 REFRESH PROCESS

Concept Formulation

Stakeholder Discussion

Draft Contract Development & Feedback

□ 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 | Sept - Oct 2021 | Nov 2021 – Jan 2022 |

2023-2025 Plan Year

Engage stakeholders through monthly Refresh Workgroup meetings, Plan Management Advisory meetings, and additional ad hoc meetings

Sept 2021: Post first draft for public comment

Oct 2021: Draft updated to reflect public comments

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

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

2023-2025 ATTACHMENT 7 CONSIDERATIONS

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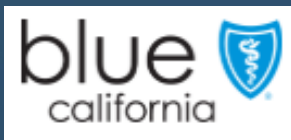
Sherry Novick, MPA, Community Health Lead, National Thrive Local Initiative, Kaiser Permanente

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.

People reporting unmet social needs are

2x

as likely to rate their health as fair or poor.

97%

Of respondents want medical providers to ask about social factors during care visits.

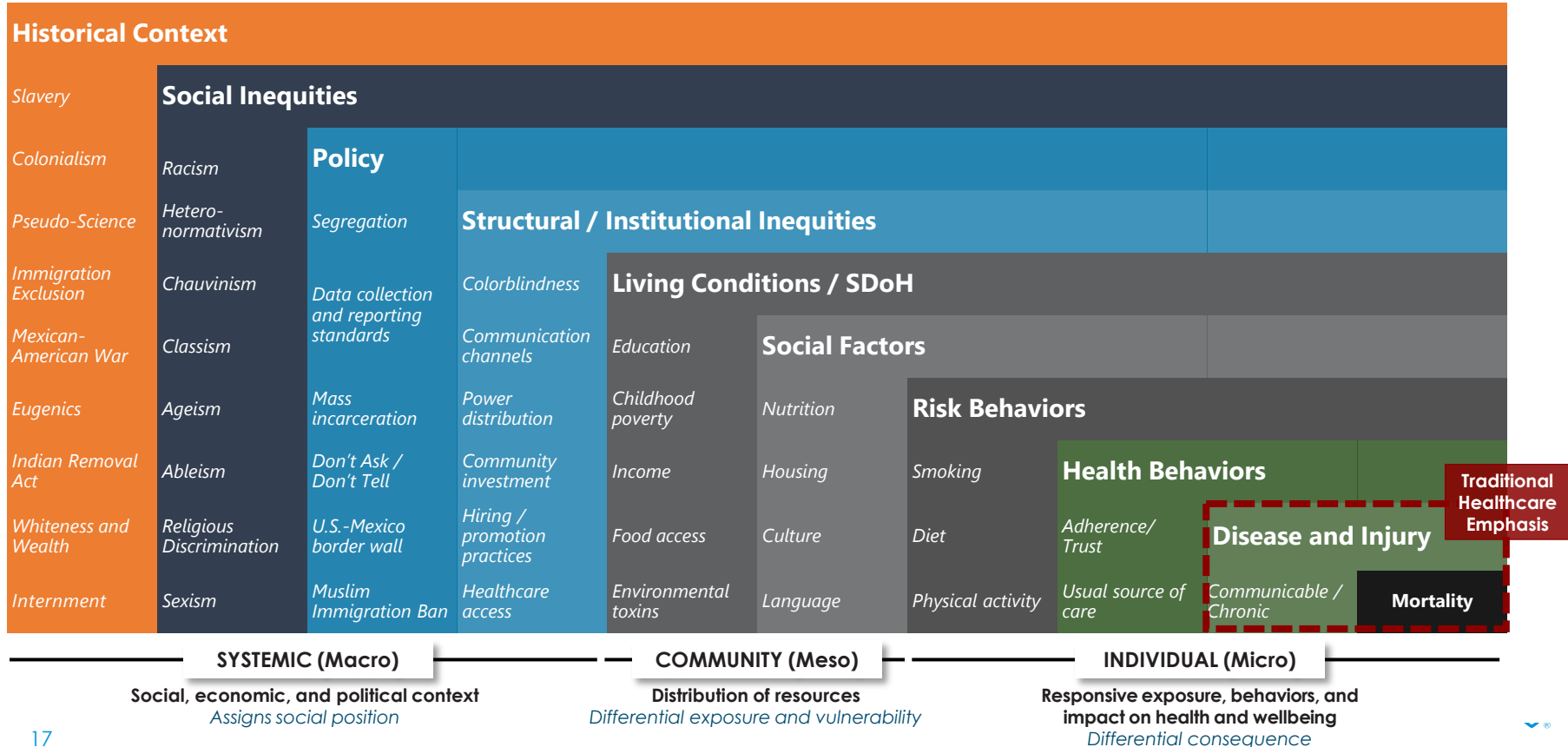*2019 Social Needs in America Study (national data)*

16

UNMET SOCIAL NEEDS ARE A BARRIER TO HEALTH

1 in **4 Americans**

Had a social factor they say was a barrier to health in the past year.

Changing the context of health to center health equity: Opportunities for health systems

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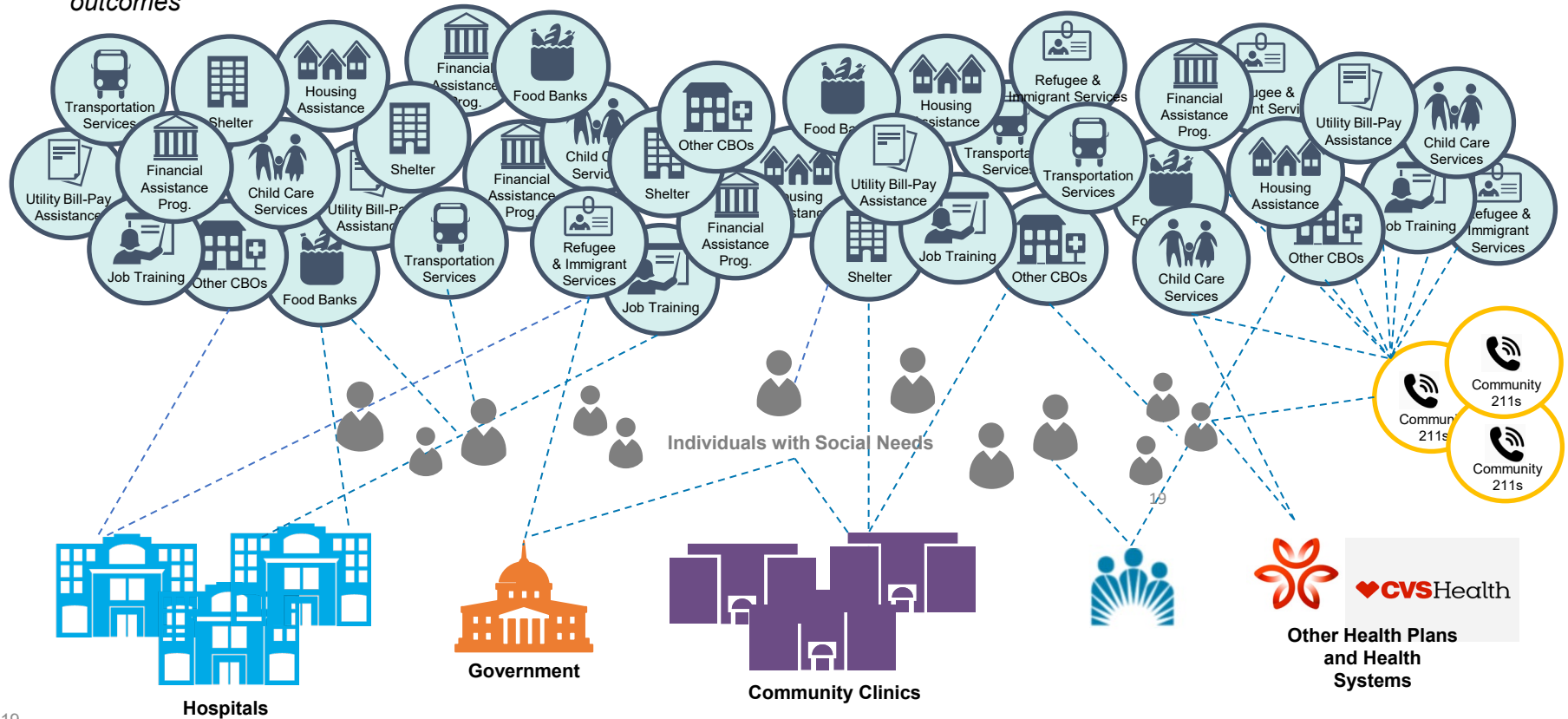
Make a collective impact on care quality and health equity for California's
most vulnerable populations

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

Individuals with Social Needs

Community 211s

Hospitals

Government

Community Clinics

Other Health Plans and Health Systems

19

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.

UNITE CALIFORNIA

Live
In Planning
2022

california.uniteus.com

- 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

Connecting People to Care

Jorge shows up at Sue's organization.

Screening

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.

Referral

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.

Resolution

Feedback

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

UNITE US

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
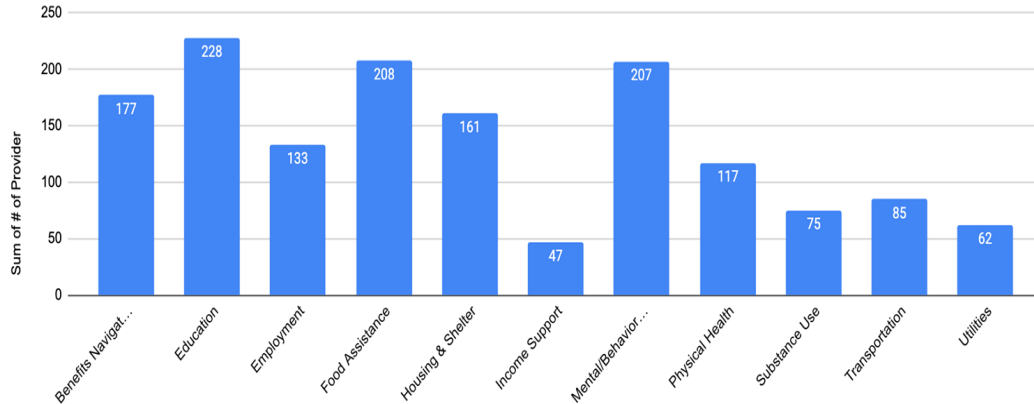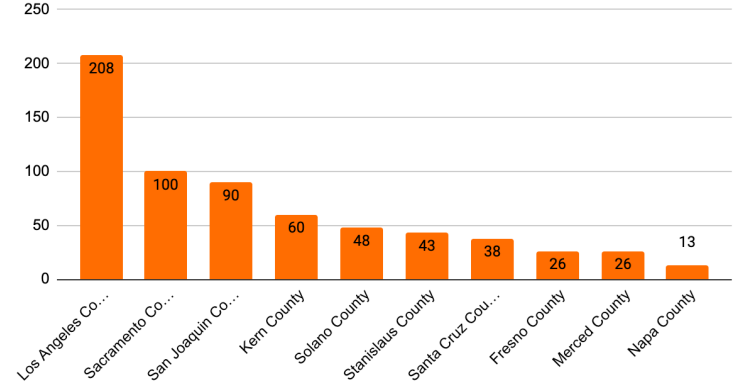
California Network Coverage

>100k
users

Hundreds
in-network partner
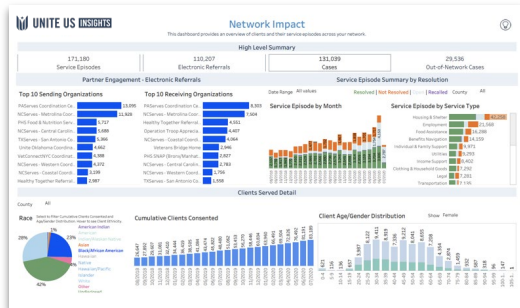locations

>1,500
programs
receiving referrals

Number of Unite California Partners Accepting Referrals by Core Service Type

Service Type	Sum of # of Provider
Benefits Navigat...	177
Education	228
Employment	133
Food Assistance	208
Housing & Shelter	161
Income Support	47
Mental/Behavior...	207
Physical Health	117
Substance Use	75
Transportation	85
Utilities	62

Unite CA Partner Locations Per County (Top 10)

County	Locations
Los Angeles Co...	208
Sacramento Co...	100
San Joaquin Co...	90
Kern County	60
Solano County	48
Stanislaus County	43
Santa Cruz Cou...	38
Fresno County	26
Merced County	26
Napa County	13

UNITE US

How Unite Us Helps Advance Health Equity

UNITE US INSIGHTS

- **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

UNITE US PAYMENTS

- **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

Maternal Health

Child Health & Wellness

Criminal Justice

Behavioral Health

Seniors & Aging

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