Plan Management Advisory Workgroup Meeting

September 10, 2020

AGENDA

Time	Topic	Presenter
10:00 – 10:10	Welcome and Agenda Review	Rob Spector
	~~QRS Update~~ Postponed	
10:10 – 10:25	Summary of HMA report: National Accreditation Bodies and Fit for Covered California	Taylor Priestley Whitney Li
10:25 – 10:40	Summary of HMA report: NCQA Multicultural Health Care Distinction	Taylor Priestley Rebecca Alcantar
10:40 – 11:50	Overview of 2022 Attachments 7 and 14 Amendment Proposed Requirements	Margareta Brandt
11:50 – 12:00	Open Forum	All

SUMMARY OF HMA REPORT: NATIONAL ACCREDITATION BODIES AND FIT FOR COVERED CALIFORNIA

Taylor Priestley
Whitney Li

KEY QUESTIONS & BACKGROUND

Key Questions: Are all accreditations equal? To what extent do accreditation standards of different accrediting bodies align with Covered California's Framework for Holding Plans Accountable for Quality Care and Delivery Reform?

- The Affordable Care Act, through the Federal Health Insurance Exchange regulation, requires Qualified Health Plan accreditation and accepts accreditation by all three accrediting bodies (National Committee for Quality Assurance (NCQA), Utilization Review Accreditation Commission (URAC), and Accreditation Association for Ambulatory Health Care (AAAHC).

HMA METHODOLOGY

- HMA reviewed accreditation bodies' structure, requirements, and processes.
- HMA assessed the organization, methodology, evaluation topics, and the types of documentation collected.
- HMA evaluated accreditation bodies on the rigor of health plan performance and measurement.
- Critical ("must pass") elements and areas that have potential to yield documentation that could be provided as a part of the Covered California-Issuer contracting process were identified.
- HMA assessed whether accreditation can serve as an accountability mechanism for core health plan functions:
  - Utilization management
  - Chronic disease and complex care management (previously categorized as disease management)
  - Grievances and appeals
- HMA assessed the level of alignment of the three accrediting entities with Attachment 7 and a focus on Health Equity, Quality Improvement, Network Performance, and Delivery System Reform.

HMA FINDINGS: CORE HEALTH PLAN FUNCTIONS

- All three accrediting bodies assess utilization management policies, procedures, and information provided to members and providers.
- NCQA and URAC incorporate these elements as utilization management requirements. Both specify mandatory, “must pass” requirements for accreditation to a greater degree than AAAHC.
  - NCQA and URAC conduct additional file reviews of utilization management decisions.
- None of the three accrediting bodies evaluate a stand alone set of disease management standards. Instead, disease management concepts are incorporated into requirements for population health, quality management, or member relations.
  - NCQA outlines a Population Health Management strategy that includes population segmentation and a structured plan to meet the care needs of members.

HMA FINDINGS: RIGOR, ENDORSEMENTS & MARKET REACH

- To assess each accrediting body's market reach, HMA compared lists of Issuers accredited in addition to identifying state and federal agency endorsements.
- HMA also reviewed Quality Rating System scores for QHP Issuers accredited by each accrediting body.
- NCQA standards and scoring rely heavily on demonstrated quality outcomes.
  - HEDIS and CAHPS data are required submissions as a part of the accreditation process.
  - The standards include a Population Health Management domain that is unique to NCQA.
- AAAHC has limited standards in utilization management and disease (not population health) management. AAAHC does not conduct file review for case management and utilization management.
- URAC lacks complex care management standards. Furthermore, URAC's requirements in population health management do not include a population segmentation approach and structured plan.

HMA CONCLUSIONS & RECOMMENDATIONS

- NCQA is the best fit for Covered California's goals of achieving health plan quality and ensuring rigor in core areas of health plan control.
- NCQA requires more rigorous documentation in its assessment of compliance with standards. NCQA conducts the vast majority of Issuer accreditations nationally and performance measurement tools have been integrated into its accreditation process. These elements align with Covered California's goal to ensure core health plan competencies and focus on population health management and complex care management.
- NCQA sets a base standard of assurance on core contractual requirements.
  - Covered California could request final audit reports.
  - This would provide Covered California and QHP Issuers value in assuring contract compliance, decreasing administrative burden, and allowing Covered California to set higher standards.

SUMMARY OF HMA REPORT: NCQA MULTICULTURAL HEALTH CARE DISTINCTION

Taylor Priestley
Rebecca Alcantar

BACKGROUND AND REPORT METHODOLOGY

2019 HMA evidence review recommends Covered CA contracting requirements:

- Align with the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS standards).
- Implement organizational culture of equity and utilize culturally specific models that promote equity in health care outcomes.

June 2020: Covered California contracted with HMA to evaluate the benefits and drawbacks of requiring the NCQA Multicultural Healthcare Distinction for all issuers for health equity capacity building and establishing a culture of equity.

- Question: Does Distinction in Multicultural Health Care lead to meaningful adoption of a culture that prioritizes and incorporates equity in setting goals and objectives, budgeting, staffing or other business processes?

HMA Methodology: Literature review, issuer interviews, NCQA Multicultural Health Care Distinction standards crosswalk with Attachment 7 and California's Health Care Language Assistance Act, Senate Bill 853.

NCQA DISTINCTION IN MULTICULTURAL HEALTH CARE PROCESS

- Nine to twelve month process to achieve distinction
- Standards and guidelines in five key areas: Race/Ethnicity & Language Data, Language Services, Practitioner Network Cultural Responsiveness, Cultural Linguistically Appropriate Services (CLAS) Standards Program, and Reducing Health Care Disparities.
- Organizations submit evidence of meeting the NCQA Distinction standards by completing a survey.
- Organizations must score a minimum of 70 out of 100 points to receive Distinction.
- Distinction is awarded for two years.
- Issuers with the Distinction can submit certification to Covered California through the annual certification application.

HMA INTERVIEW FINDINGS

Respondents from the four organizations with Distinction approve of the process NCQA uses for Distinction in MHC and the value add to their organizations.

Benefits	Challenges
Distinction has resulted in stable and ongoing resources (funding and staffing) to advance equity and address disparities.	Distinction scope is limited to race/ethnicity and language disparities
Distinction provides a framework and impetus for plans to push their equity work further.	Burden of data collection
Distinction formalizes processes, including establishing and maintaining structures for documenting, addressing and eliminating disparities that might not otherwise be prioritized.	Mixed responses on whether Distinction should be required and, if so, for what lines of business

Additional effort should be relatively modest, and HMA does not believe it would be enough to discourage QHP participation.

HMA ASSESSMENT OF ALIGNMENT WITH ATTACHMENT 7

Requirement	Attachment 7	Distinction in MHC
Demographic Data	3.01: Race/ethnicity and gender data collected, allows estimation of race/ethnicity using indirect proxy methods.	• Data collected: race/ethnicity, language and CLAS (SB 853) data • Does not prescribe estimation method, but method should be validated.
Disparities Measurement	3.01: Requires selection and reporting of clinical areas for improvement, with these areas chosen by Covered California (asthma, depression, hypertension, diabetes).	• Requires organizations to use language data to analyze at least one clinical performance measure by language. • Use of Data to: Assess Disparities, Monitor & Assess Services, and Measure CLAS and Disparities. • Added benefit to leverage NCQA auditing and scoring to drive implementation and adherence to the workplan.
Reducing Disparities	3.02: Focus is on disparities measures and annual intermediate milestones identified in disparities plan.	Focus is on access and availability of language services, developing, implementing, and evaluating annual work plans to address CLAS.
Expanded Measurement	3.03: Potential to expand to income, disability status, sexual orientation, gender identity, and limited English proficiency (LEP).	No expanded measurement. Measurement focused on race/ethnicity and limited English proficiency (LEP).

HMA SUMMARY OF EVIDENCE SUPPORTING DISTINCTION

Literature Review: Achieving health equity requires policy-level changes and resource allocation or reallocation.

Interviews: All issuers with Distinction agree on the value add and market advantage the Distinction provides to their organizations. Respondents gave mixed responses on whether Distinction in MHC should be required.

Alignment with Attachment 7 and SB 835 CLAS Act:

- Strong alignment with Attachment 7, Article 3: Reducing Disparities and SB 835.
- Distinction supports Covered California disparity reduction requirements rather than conflicting with it.
- Distinction offers a more detailed and prescribed process and structure for approaching the improvement efforts and sets a stricter standard for identifying the number of languages required for translation.
- Distinction process fits with Covered California's Quality Improvement requirements and does not add burden once the Distinction process is used to identify action areas.

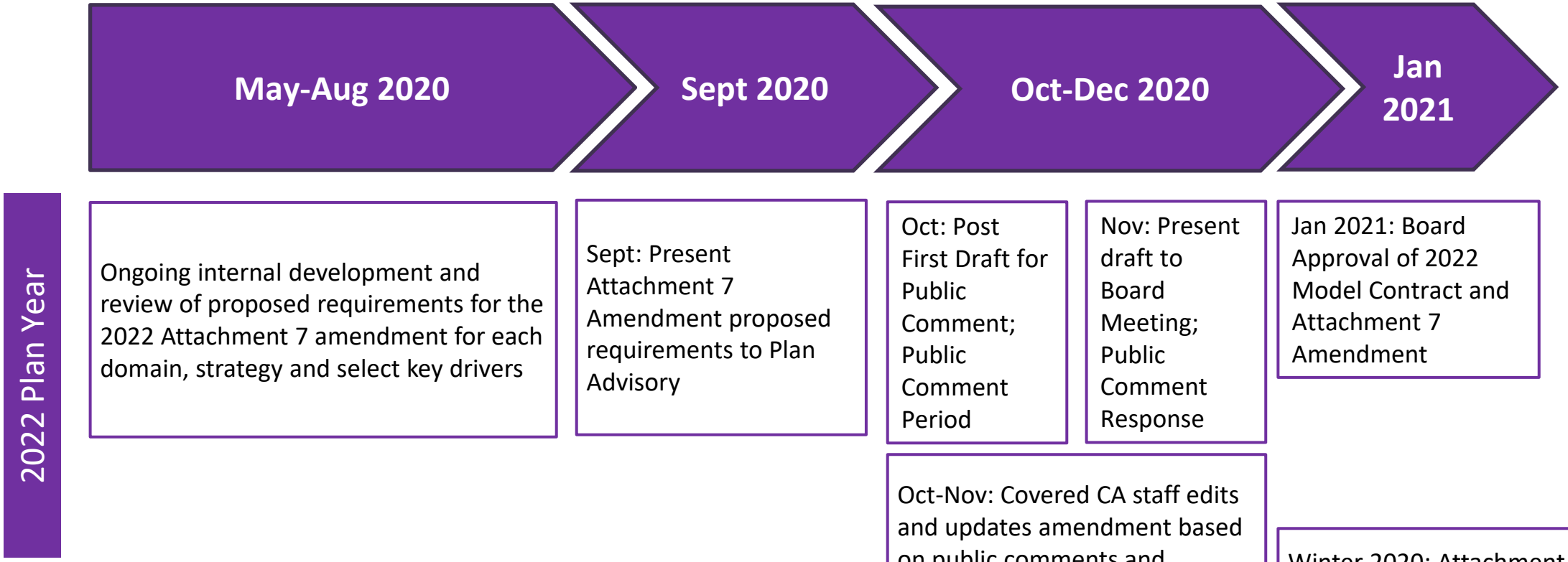
HMA CONCLUSIONS AND RECOMMENDATIONS

- There is significant alignment between Covered California's Reducing Health Disparities and Ensuring Health Equity (Article 3) contract requirements
- The Distinction offers a more detailed and prescribed process and structure for approaching improvement efforts
- Covered California should require health plans to achieve NCQA Distinction in Multicultural Health Care.
  - This change would support the creation of a necessary and consistent infrastructure for improving CLAS and narrowing disparities across QHP Issuers and can impact health plans' resource allocation (staffing, funding) to deliberately address disparities and health equity, increasing infrastructure and reinforcing organizational commitment to this work.

OVERVIEW OF 2022 ATTACHMENTS 7 AND 14 AMENDMENT PROPOSED REQUIREMENTS

Margareta Brandt

PROPOSED 2022 ATTACHMENT 7 AMENDMENT TIMELINE



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

Assuring Quality Care

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

Effective Care Delivery Strategies

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

APPROACH TO 2022 AMENDMENT

- 2022 is a transitional year to focus on a narrowed set of QHP issuer requirements to lay the foundation for more transformational requirements in 2023
- 2022 Attachment 7 Amendment will be developed using the criteria of reducing burden, focusing on priorities, considering feasibility, and implementing foundational elements in preparation for 2023 and beyond
  - These criteria will guide adding requirements, enhancing current requirements and removing other requirements
- Covered CA staff will continue to engage issuers and stakeholders in the development of the 2022 Attachment 7 amendment through the Plan Management Advisory group

2022 ASSURING QUALITY CARE (1 OF 3)

The following are recommended requirements for the 2022 Attachment 7 amendment:

Individualized Equitable Care

- Requirement remains for 80% capture of on-Exchange members race/ethnicity self-identification data; propose updating the demographic data collection reporting from issuer self-report to Healthcare Evidence Initiative (HEI) data submission
- For the disparities reduction requirements, Covered CA is currently researching and assessing options to address existing measure set limitations with disparities measurement and reporting
  - Potential options include: development of disparities measurement using HEI data, supplemental data submission by QHP Issuers
- Proposing a new requirement for issuers to participate in a collaborative effort to identify and align statewide disparity work
  - Identifying a statewide focus and aligning disparities reduction efforts across organizations will increase the impact of Covered CA and issuer's efforts to improve health equity in California
- Previously optional, proposed required achievement or maintenance of NCQA Multicultural Health Care Distinction by year-end 2022

Population Health Management

- Submit copy of NCQA Population Health Management Plan: Standard 1 (Population Health Management Strategy) and Standard 2 (Population Stratification and Resource Integration) to demonstrate population assessment and segmentation approach

Health Promotion and Prevention

- Require issuers to continue reporting on tobacco use cessation program and weight management program utilization
- Report strategies to improve rates of *Medical Assistance with Smoking and Tobacco Use Cessation* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* measures

2022 ASSURING QUALITY CARE (2 OF 3)

The following are recommended requirements for the 2022 Attachment 7 amendment:

Behavioral Health

- Submit NCQA Health Plan Accreditation Network Management reports for the elements related to the issuer's behavioral health provider network
- Offer telehealth for behavioral health services and provide Enrollee education about how to access telehealth services; Covered CA will monitor utilization of telehealth services through HEI
- Annually report *Depression Screening and Follow Up (NQF #0418)* measure results for Covered CA enrollees (audited by the issuer's HEDIS auditor); Covered CA will engage with issuers to review their performance
- Covered CA will monitor the following measures through HEI and engage with issuers to review their performance:
  - *Antidepressant Medication Management (NQF #0105)*
  - *Follow-Up After Hospitalization for Mental Illness (7-Day Follow-Up) (NQF #0576)*
  - *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (NQF #0004)*
  - *Use of Pharmacotherapy for Opioid Use Disorder (NQF #3400)*
  - *Concurrent Use of Opioids and Benzodiazepines (NQF #3389)*
  - *Use of Opioids at High Dosage in Persons Without Cancer (NQF #2940)*
  - *Concurrent Use of Opioids and Naloxone*
- Measure and report the number of active X waiver licensed prescribers in network and the number of total X waiver licensed prescribers in their network
- Report how issuers are promoting the integration of behavioral health services with medical services, report the percent of Enrollees cared for under integrated models, and whether the issuer reimburses for the Collaborative Care Model claims codes

2022 ASSURING QUALITY CARE (3 OF 3)

The following are recommended requirements for the 2022 Attachment 7 amendment:

Acute, Chronic and Other Conditions

- No new requirements

Complex Care

- Describe methods to ensure, support, and monitor contracted hospitals' compliance with Medicare Condition of Participation rules to have electronic information exchange to notify primary care providers of ADT events
- Continue requirements for at-risk enrollee engagement and Centers of Excellence

2022 EFFECTIVE CARE DELIVERY (1 OF 2)

The following are recommended requirements for the 2022 Attachment 7 amendment:

Effective Primary Care

- Continue to match enrollees with PCPs and report the number of enrollees who select a PCP vs. those who are assigned a PCP
- Report the quality improvement and technical assistance being provided to physician groups to implement or support advanced primary care models
- Continue to require primary care payment reporting and increase the number of PCPs paid through shared savings and population-based payment models
- Pilot a quality measure set for advanced primary care to assess the prevalence of high-quality, advanced primary care practices within the issuer's network in collaboration with the California Quality Collaborative (CQC) and the Integrated Healthcare Association (IHA)

Promotion of Integrated Delivery Systems (IDS) and Accountable Care Organizations (ACOs)

- Participate in the Integrated Healthcare Association (IHA) and submit data for the IHA Commercial HMO and ACO measure sets (as applicable)
- Report the characteristics of the issuer’s HMO, IDS, and ACO systems such as payment model, leadership structure, quality incentive programs, data exchange processes, etc.
- Continue to require reporting the number of enrollees in IDS and ACO systems and increase the number of enrollees cared for under IDS and ACO systems

2022 EFFECTIVE CARE DELIVERY (2 OF 2)

The following are recommended requirements for the 2022 Attachment 7 amendment:

Networks Based on Value

- Continue to require issuers to include quality and cost in all provider and facility selection criteria
- Continue to require issuers to notify poor performing hospitals and engage these hospitals in improvement efforts to reduce variation in performance across contracted hospitals
- Participate in the IHA Align Measure Perform (AMP) program and report contracted physician group performance results to Covered CA
- Work collaboratively with Covered CA and other issuers to define poor performing physician groups, notify poor performers, and engage these physician groups in improvement efforts to reduce variation in performance across contracted physician groups

Sites & Expanded Approaches to Care Delivery

- Continue requirements for tracking and reducing hospital associated infections (HAI) and NTSV C-sections to improve hospital quality and safety
- Continue to require issuers to track and report on telehealth utilization and payment

Appropriate Interventions

- Continue requirements for participation in collaborative quality initiatives such as Smart Care California
- Continue requirements for issuers to ensure Enrollee have access to cost and quality information as well as shared decision making tools

2022 KEY DRIVERS OF QUALITY CARE & EFFECTIVE DELIVERY

The following are recommended requirements for the 2022 Attachment 7 amendment:

Accreditation

- ☐ Achieve, or be in the process of achieving, NCQA Accreditation

Data Sharing and Analytics

- ☐ Implement and maintain a secure, standards-based Patient Access Application Programming Interfaces (API) consistent with the Federally Facilitated Marketplace (FFM) rule
- ☐ Continue requirements to support data exchange with providers and data aggregation across plans

Patient-Centered Social Needs

- ☐ 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 listing by region served to support linkage to appropriate social services, submit documented process for referrals for each housing instability and food insecurity

Measurement for Improvement, Choice and Accountability

- ☐ Development of a priority set of quality performance outcome measures, in alignment with key purchasers, to incentivize delivery of high-quality care

2022 ATTACHMENT 14 HIGH-LEVEL PROPOSAL

- The current Attachment 14 includes 5 groups of performance standards
  - Group 1 – Customer Service
  - Group 2 – Operational
  - Group 3 – Quality, Network Management and Delivery System Reform
  - Group 4 – Covered CA Customer Service
  - Group 5 – Dental Quality Alliance (DQA) Pediatric Measure Set
- Covered CA is considering a transition from the current focus on customer service and operational performance within the Attachment 14 performance standards to an increased focus on quality performance in 2022
  - Covered CA is proposing to transition Groups 1, 2 and 4 to reporting only, with the exception of the Healthcare Evidence Initiative (HEI) performance standard
  - Covered CA is proposing to focus the funds at risk within Attachment 14 on Group 3 and the HEI performance standards
  - Within the Group 3, Covered CA is proposing to place the greatest emphasis on the Quality Rating System (QRS) performance standards

FEEDBACK AND NEXT STEPS

Feedback

- Please send questions and comments to Margareta Brandt at margareta.brandt@covered.ca.gov by September 18, 2020
- Covered CA will use the feedback to update the proposed Attachment 7 requirements prior to releasing the 2022 draft Attachment 7 for public comment in October

Next Steps

- Release of 2022 draft Attachment 7 for public comment in early October; public comment period closes by the end of October
- Review and discussion of draft Attachment 7 during the October Plan Advisory meeting

OPEN FORUM

THANK YOU