PLAN MANAGEMENT ADVISORY GROUP

November 14, 2019

WELCOME AND AGENDA REVIEW

ROB SPECTOR, CHAIR
PLAN MANAGEMENT ADVISORY GROUP

AGENDA

AGENDA
Plan Management and Delivery System Reform Advisory Group
Meeting and Webinar
Thursday, November 14, 2019, 10:00 a.m. to 12:00 p.m.

Webinar link: https://attendee.gotowebinar.com/rt/4171897155750816770

October Agenda Items	Suggested Time
I. Welcome and Agenda Review	10:00 – 10:10 (10 min.)
II. Benefit Design Update	10:10 – 10:20 (10 min.)
III. Covered California's Efforts for Assuring Quality Care and Promoting Delivery System Reform	10:20 – 11:20 (60 min.)
IV. Open Enrollment End Date Implementation Considerations	11:20 – 11:40 (20 min.)
V. Open Forum	11:40 – 12:00 (20 min.)

2021 BENEFIT DESIGN UPDATE

ALLIE MANGIARACINO, SENIOR MARKET INSIGHTS ANALYST
PLAN MANAGEMENT DIVISION

2021 BENEFIT DESIGN WORKGROUP UPDATES

The benefits workgroup has met twice to discuss changes to the benefit design in 2021:

- **Cost-share changes to meet AV requirements:** Tentative preference for increasing the MOOP, deductible, and office visit cost shares to meet AV requirements
  - The workgroup is considering adding the deductible to Outpatient Facility Fee to avoid changes to other service categories (e.g. drugs).
- **Standardize annual wellness exam benefit:** Covered California staff is collecting more data on utilization and issuer coverage policies to continue the discussion on whether to standardize the wellness benefit.
- **Updates to CDT codes and cost sharing in the dental copay schedule:** Covered California staff is collecting input from dental carriers on proposed changes.

Draft 2021 AV Calculator (AVC) and Notice of Benefit and Payment Parameters is not yet available.

- Staff are using the previous year's AVC to estimate potential increases to the AV and to determine preferred changes in advance of the release of the new AVC.

COVERED CALIFORNIA'S EFFORTS FOR ASSURING QUALITY CARE AND PROMOTING DELIVERY SYSTEM REFORM

POPULATION CARE TEAM | PLAN MANAGEMENT DIVISION

COVERED CALIFORNIA

INTRODUCTION

- *Covered California Progress Report: Assuring Quality Care and Promoting Delivery System Reform – 2015-2019* summarizes Covered California's issuers' performance in meeting Attachment 7 requirements
  - Describes a number of initiatives that require concerted, multi-year efforts of health plans across the California delivery system
  - Covered California staff reviewed and assessed the information issuers report annually on their Attachment 7 performance for contract compliance purposes and to assess the success of the Attachment 7 initiative
- *Overview of Covered California's Efforts to Improve Health System Performance – 2015-2019* highlights the key strategies for an effective exchange and summarizes issuer performance in meeting Attachment 7 requirements
- These reports are key milestones in refreshing Attachment 7 for the 2022-2024 contract and part of Covered California's efforts to be transparent

COVERED CALIFORNIA'S QUALITY CARE AND DELIVERY REFORM FRAMEWORK

Assuring Quality Care Domains

INDIVIDUALIZED, EQUITABLE CARE

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

OVERVIEW: KEY OBSERVATIONS

- Estimated that Covered California has saved consumers and the U.S. Treasury $7.5 billion between 2014 and 2018
  - Policy actions to promote market stability, active negotiation with issuers, standard plan benefit designs, and extensive marketing and outreach have contributed to the savings
- The beginning of long-term initiatives to reduce health disparities: expanding the Covered California team to focus on health equity; 80% self-identification reporting by race and ethnicity; and development of health disparities intervention proposals by issuers
- Wide variation in performance across issuers on quality measures with consistent high performance by Kaiser Permanente and Sharp Health Plan
  - Covered California should assess what factors can contribute to better performance among non-integrated systems and how performance can be improved across California
- 60% of Covered California enrollees were cared for in an Integrated Delivery System or an Accountable Care Organization (ACO) in 2018, which represents a 12-percentage point increase from 2015
- Hospital quality and maternity safety collaborative improvement efforts have lead to reductions in hospital acquired infections and low-risk C-sections between 2015 and 2018

HEALTH EQUITY: REDUCING DISPARITIES

INDIVIDUALIZED, EQUITABLE CARE

- For Measurement Year 2018, the majority of issuers were at or above the 80% requirement for enrollee race/ethnicity self-identification
- Issuers submitted proposals for addressing at least one identified disparity measure with a focused intervention based on 3 years of baseline data collection
  - Most issuers selected at least one diabetes or hypertension measure for intervention
  - Intervention activities proposed include enhanced member and provider education, active care team support for at-risk populations, enhanced data collection and analysis, disease registry development, and outreach events
- Identified challenges included small denominators (particularly for the AHRQ PQI admissions measures), variation in data quality and collection processes, varying populations by issuer, and the lack of a formal audit process

IMPLICATIONS FOR THE FUTURE

INDIVIDUALIZED, EQUITABLE CARE

- The beginning of long-term initiatives to reduce health disparities
  - Baseline data using HEDIS samples have limitations
  - Initial interventions to reduce disparities are just launching
  - Evaluations of progress will inform best practices to share
- Expanding the Covered California team to focus on health equity
  - Hiring of team lead by the Health Equity Officer is nearly complete
  - Will be working with issuers and stakeholders to expand evidence base and scope to address social needs
- Importance of integrated and coordinated care
  - The most consistent finding from last few years is remarkable variation in performance with consistent high performance by Kaiser and Sharp including for disadvantaged populations
  - The growth of Accountable Care Organizations for health plans that shared provider networks may duplicate this encouraging finding

CERVICAL CANCER SCREENING
HEALTH PROMOTION AND PREVENTION

Cervical Cancer Screening (HEDIS) The Cervical Cancer Screening measure is the percentage of women 21-64 years of age who were screened for cervical cancer.				
	US Benchmark 2019	**Percent of Enrollees**	**Number of Enrollees**	**Number of Plans**
Plans at 90th Percentile and Above	73 +	35%	477,683	1
Plans at 50th to 90th Percentile	56 to 73	38%	507,707	4
Plans at 25th to 50th Percentile	48 to 56	20%	269,251	6
Plans Below 25th Percentile	Below 48	7%	91,985	2
Covered CA Highest Performer	79			
Covered CA Weighted Average	64			
Covered CA Lowest Performer	42			

Highlights

- The Covered California weighted average across all issuers for preventive care measures for breast, cervical, and colorectal cancer screening and chlamydia screening in women were at or above the US 50th percentile for the 2019 reporting year.
- Wide variation was observed among plans over the past four years, with the integrated delivery system, Kaiser Permanente, frequently reporting performing at or above the 90th percentile for screening measures.
- Overall, variation across plans represents opportunity for improvement.

Data Source: QRS reporting for all national marketplace plans. Weighted average based on enrollment in products eligible for a QRS score in the individual market.

IMPLICATIONS FOR THE FUTURE
HEALTH PROMOTION AND PREVENTION

- Covered California should consider finding another way to promote smoking cessation and obesity management programs including exploring the feasibility of (1) collecting clinical data to improve enrollee identification or (2) better tracking of program availability and participation rates
  - Health plans need alternative ways to identify at-risk enrollees such as through large databases that predict public health risks by census track
- The ability of Kaiser and Sharp to achieve positive results for prevention measures is a clear indicator of what is possible with well-coordinated and integrated care
- Covered California should assess what factors contribute to better performance among network plans and how performance can be improved across California

INITIATION AND ENGAGEMENT WITH TREATMENT

MENTAL HEALTH AND SUBSTANCE USE DISORDER TREATMENT

Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment (IET)

The IET measure is the percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following: *Initiation of AOD Treatment and Engagement of AOD Treatment*.

	US Benchmark 2019	Percent of Enrollees	Number of Enrollees	Number of Plans
Plans at 90th Percentile and Above	32 +	36%	477,683	1
Plans at 50th to 90th Percentile	24 to 32	0%	-	0
Plans at 25th to 50th Percentile	19 to 24	36%	490,372	3
Plans Below 25th Percentile	Below 19	28%	377,175	8
Covered CA Highest Performer	34			
Covered CA Weighted Average	25			
Covered CA Lowest Performer	16			

Highlights

- 2% to 11% increase in Covered California enrollees cared for under a behavioral health model between 2015-2018.
- Kaiser Permanente is among the 90th percentile in the nation for 2019, with wide variation among all plans.
- Health plans are pursuing a broad spectrum of behavioral health integration efforts, including co-location of services, increased coordination with carve-out vendors, and embedded behavioral health staff in primary care clinics.
- Covered California will continue to track performance on these measures and further engage with health plans on how to improve.

Data Source: QRS reporting for all national marketplace plans. Weighted average based on enrollment in products eligible for a QRS score in the individual market.

IMPLICATIONS FOR THE FUTURE

MENTAL HEALTH AND SUBSTANCE USE DISORDER TREATMENT

- Measurement for behavioral health has major gaps; Covered California will consider increasing the use of patient-reported outcome measures
  - Screening and follow-up for depression using PHQ-9 is the highest priority
  - Expanded and improved measures for access need identification and implementation
  - Additional screening tools for anxiety and substance use disorders will follow
- Covered California needs to consider how to promote better measurement and accountability for behavioral health integration, which may involve standardized definitions and use of best practices to support tracking and trending of available services and adoption of behavioral health integration
  - Promising models include collaborative care, co-location and telehealth
- There is significant opportunity for collaboration through the Integrated Healthcare Association and California Quality Collaborative

QRS GLOBAL AND SUMMARY INDICATOR RATINGS – 2019

ACUTE, CHRONIC, AND OTHER CONDITIONS

Issuer	Product Type	Global Rating	Getting the Right Care	Members' Care Experiences	Plan Services for Members
Anthem	EPO	★★	★★	★★	★★★
Blue Shield	PPO	★★★	★★	★★★	★★★
Blue Shield	HMO	★★★	★★	★★★	★★★
CCHP	HMO	★★★	★★★	★★	★★★★★
Health Net	HMO	★★	★★★	★	★★★
Health Net	EPO	One Quality Rating Available	★★	NR	NR
Health Net	PPO	Quality Rating in Future	Quality Rating in Future	Quality Rating in Future	Quality Rating in Future
Kaiser	HMO	★★★★★	★★★★★	★★★	★★★★★
LA Care	HMO	★★★	★★★	★★	★★★
Molina	HMO	★★	★★	★★	★★★
Oscar	EPO	★★	★★	★★★	★★★★★
Sharp	HMO	★★★★	★★★★	★★★	★★★★
Valley	HMO	★★★	★★★★	★	★★★
WHA	HMO	★★	★★	★★★	★★★★
Blue Shield	HMO/SHOP	★★★	★★	★★★	★★★
Health Net	PPO/SHOP*	Quality Rating in the Future*	Quality Rating in the Future*	Quality Rating in the Future*	Quality Rating in the Future*

*Health Net PPO, with expansion into individual market, is a first-year plan and will not be reportable until PY2021.

EFFECTIVE DIABETES CARE

ACUTE, CHRONIC, AND OTHER CONDITIONS

Hemoglobin A1c (HbA1c) Control (<8.0%) (HEDIS)

The Hemoglobin A1c Control measure represents the percent of members 18-75 years of age with diabetes (type 1 or 2) who had HbA1c Control (< 8.0%)

	US Benchmark 2019	Percent of Enrollees	Number of Enrollees	Number of Plans
Plans at 90th Percentile and Above	68 +	37%	495,018	2
Plans at 50th to 90th Percentile	58 to 68	43%	582,871	5
Plans at 25th to 50th Percentile	52 to 58	17%	223,389	4
Plans Below 25th Percentile	Below 52	3%	45,348	2
Covered CA Highest Performer	72			
Covered CA Weighted Average	64			
Covered CA Lowest Performer	49			

Highlights

- Kaiser Permanente and Sharp Health Plan perform among the 90th percentile nationally.
- There is wide variation in performance among plans with most plans performing between the 90th percentile and the 25th percentile for the Comprehensive Diabetes Care: Hemoglobin A1c Control measure.
- The Covered California weighted average for plan performance for the Hemoglobin A1c Control measure falls between the 50th to 90th percentile.

Data Source: QRS reporting for all national marketplace plans. Weighted average based on enrollment in products eligible for a QRS score in the individual market.

CONTROLLING HIGH BLOOD PRESSURE

ACUTE, CHRONIC, AND OTHER CONDITIONS

Controlling High Blood Pressure (HEDIS) The Controlling High Blood Pressure measure is the percentage of members 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled.				
	US Benchmark 2019	Percent of Enrollees	Number of Enrollees	Number of Plans
Plans at 90th Percentile and Above	75 +	35%	477,683	1
Plans at 50th to 90th Percentile	62 to 75	20%	273,647	5
Plans at 25th to 50th Percentile	54 to 62	37%	495,303	5
Plans Below 25th Percentile	Below 54	7%	99,993	2
Covered CA Highest Performer	81			
Covered CA Weighted Average	66			
Covered CA Lowest Performer	44			

Highlights

- Kaiser Permanente is among the 90th percentile nationally for the Controlling High Blood Pressure measure.
- There is wide variation in performance among plans with most plans performing between the 90th percentile and 25th percentile for this measure.
- The ability of integrated delivery systems to achieve such positive results is a clear indicator of what is possible with well-coordinated and integrated care.
- In future years, Covered California should assess what factors contribute to better performance among non-integrated systems and how this performance can be replicated across California.

Data Source: QRS reporting for all national marketplace plans. Weighted average based on enrollment in products eligible for a QRS score in the individual market.

ACCESS TO CARE
ACUTE, CHRONIC, AND OTHER CONDITIONS

Access to Care (CAHPS)
The Access to Care measure is based on four 2019 QHP Enrollee Survey questions that ask enrollees how often they were able to access care as soon as needed.

	US Benchmark 2019	Percent of Enrollees	Number of Enrollees	Number of Plans
Plans at 90th Percentile and Above	80 +	0%	-	0
Plans at 50th to 90th Percentile	75 to 80	0%	-	0
Plans at 25th to 50th Percentile	72 to 75	62%	839,580	4
Plans Below 25th Percentile	Below 72	38%	505,650	8
Covered CA Highest Performer	75			
Covered CA Weighted Average	72			
Covered CA Lowest Performer	57			

Highlights

- In the two priority CAHPS measures, Access to Care and Care Coordination, there is generally more consistency across Covered California's contracted plans but most plans cluster around the national 50th percentile or below the 25th percentile.
- Several plans are performing at 25th to 50th Percentile and most are performing below 25th Percentile for the Access to Care priority CAHPS measure.

Data Source: QRS reporting for all national marketplace plans. Weighted average based on enrollment in products eligible for a QRS score in the individual market.

CARE COORDINATION
ACUTE, CHRONIC, AND OTHER CONDITIONS

Care Coordination (CAHPS)

The Care Coordination measure is based on six 2019 QHP Enrollee Survey questions that ask enrollees how often their care was coordinated among doctors and facilities.

	US Benchmark 2019	Percent of Enrollees	Number of Enrollees	Number of Plans
Plans at 90th Percentile and Above	87 +	0%	-	0
Plans at 50th to 90th Percentile	83 to 87	0%	-	0
Plans at 25th to 50th Percentile	81 to 83	3%	35,962	1
Plans Below 25th Percentile	Below 81	97%	1,309,268	11
Covered CA Highest Performer	83			
Covered CA Weighted Average	79			
Covered CA Lowest Performer	73			

Highlights

- Most plans are performing below the 25th percentile for the Care Coordination priority CAHPS measures.
- Research studies for many years have suggested that insured Californians (across other lines of business) give lower ratings on patient experience of care measures compared to the rest of the nation.
- Nonetheless, Covered California should assess both how important this variation is and consider the use of other complementary measures to assess consumers' experience in ways that could better discriminate good and bad performance.

Data Source: QRS reporting for all national marketplace plans. Weighted average based on enrollment in products eligible for a QRS score in the individual market.

IMPLICATIONS FOR THE FUTURE
ACUTE, CHRONIC AND OTHER CONDITIONS

- Wide variation in performance among plans on clinical measures
- The ability of Kaiser and Sharp to achieve positive results for effective diabetes care and controlling high blood pressure measures is a clear indicator of what is possible with well-coordinated and integrated care
- Covered California should assess what factors contribute to better performance among non-Kaiser plans and how performance can be improved across California
- Covered California plans are underperforming on key satisfaction metrics
  - Low scores on Access to Care and Care Coordination need further evaluation
  - Covered California will assess variation across plans and consider the use of other complementary measures to assess consumers' experience in ways that could better discriminate good and bad performance

COMPLEX CARE

- Issuers are required to address complex care by: coordinating treatment for enrollees with conditions that require high specialized management, such as transplant patients, and appropriately using Centers of Excellence (COEs) for these enrollees; collecting information to monitor enrollee health status; tracking changes in health status; supporting at-risk enrollees requiring transition among plans; and identifying and providing appropriate services for at-risk enrollees
- Most issuers offer voluntary Health Risk Assessments (HRAs) to monitor enrollee health status, but completion rates ranged from 0 to 37.6% with 8 of the 11 issuers reporting under 6% completion in 2018
  - In 2018, 10 issuers generated a personalized report after HRA completion
- All issuers offered some level of live outbound telephonic coaching to members in 2018
- All issuers provided enrollees access to at least two types of COEs - cancer care and transplant centers were most common

IMPLICATIONS FOR THE FUTURE

COMPLEX CARE

- Measurement for the care of patients requiring complex care needs requires further development
- Covered California consultants highlighted important strategies
  - Adopt standardized population stratification based on a hybrid of administrative and survey data including social needs, behavioral health and patient activation
- Covered California needs to assess approaches to working with health plans and other stakeholders to establish best practices for population identification and management including a standardized approach to defining and measuring performance of Centers of Excellence

PROMOTION OF EFFECTIVE PRIMARY CARE

- Since 2017, 99% of enrollees have been matched with a PCP or clinician
- In 2018, 40% of Covered California enrollees were cared for by PCMH-recognized practices, an increase from 25% in 2016
  - Excluding Kaiser, the increase from 2016-2018 is from 3% to 11%
  - The formal PCMH recognition programs largely document process improvement without measuring outcomes
  - Many advanced primary care practices have not sought formal PCMH recognition
  - Covered California is examining alternative approaches to advanced primary care recognition
- 10 of 11 issuers have Positive or Strong Incentives for transitioning from volume-based to value-based primary care payment models such as shared savings or population-based payment

IMPLICATIONS FOR THE FUTURE

EFFECTIVE PRIMARY CARE

- Covered California will look to examine outcomes including utilization, cost and quality that may improve through PCP matching
- Covered California will continue to work with health plans to help all enrollees understand the value of primary care
- Covered California will review the requirement of health plans to increasingly implement value-based payments for primary care providers like shared savings and population-based payment or capitation
- Measurement of advanced primary care practices will need to include outcome measures
  - Evaluation of variation in primary care payment as a proportion of the budget at health plan, medical group or ACOs tied to variation in outcomes will inform next steps in payment reform
- Integration with behavioral health through collaborative efforts will be a major opportunity

INTEGRATED DELIVERY SYSTEMS & ACCOUNTABLE CARE ORGANIZATIONS

- In 2018, 60% of Covered California enrollees were cared for in an IDS or ACO, a 12-point increase from 2015
  - Excluding Kaiser and Sharp Health Plan enrollment, the increase from 2015-2018 is from 21% to 25%
  - Leavitt Partners* reports that 10% of the US population and between 10-15% of Californians were in ACOs in 2018 (excluding integrated delivery systems)
- Most issuers have reported offering technical support, data sharing support, or promoting participation in health information exchanges for providers
- There has been a steady increase in issuers using common components like population health management support and holding providers accountable using standard quality measure sets

* Source: https://www.healthaffairs.org/do/10.1377/hblog20180810.481968/full/

INTEGRATION AND COORDINATION
IMPLICATIONS FOR THE FUTURE

- In 2018, Covered California enrollment in ACOs, excluding integrated delivery systems, exceeds comparisons in Californians and the nation
- Performance variation among ACO models may be attributed to design elements such as the structure of financial incentives, the role of physicians in the leadership structure, the percent of budget spent in primary care and the sophistication of population health and case management strategies
- Covered California will work with health plans to use the performance data from the IHA Commercial ACO measure set to establish correlations with the design elements to determine best practices and inform future contract requirements
  - ACOs will be evaluated to determine if they can replicate the success of integrated systems

NETWORKS BASED ON VALUE

- Issuers are required to report the factors used to select providers and hospitals in the issuer's network
- Hospital selection factors reported by issuers include:
  - A hospital's designation as a Center of Excellence
  - Publicly reported data from Leapfrog or CMS Hospital Compare
  - Cost or prices charged such as a percent of Medicare
  - Participation in collaboratives like CMQCC
- Covered California worked with Cal Hospital Compare to define "outlier poor performers" for issuers to use in hospital contracting decisions and quality improvement efforts with hospitals
  - There is no single composite measure that meets the criteria for outlier poor performers
  - Cal Hospital Compare provides four distinct lists of hospitals with consistently low performance
  - The greater the number of "low performance" lists a hospital appears on, the greater the concern
- Provider selection factors reported by issuers include: provider credentialing, grievances, appeals or member satisfaction results, quality or HEDIS measures, or referral patterns to network hospitals
- To assess relative unit prices and total cost of care, issuers reported: comparing costs of providers and hospitals to other similar providers in the market or region, using case rates, fee schedules or fee schedules based on a percent of Medicare to determine reimbursement rates, annually adjusting payments to providers and hospitals or paying providers as a percent of premium

IMPLICATIONS FOR THE FUTURE

NETWORKS BASED ON VALUE

- Covered California holds health plans accountable to manage variation across their networks
  - The priority will always be supporting outlier poor performers to improve
- Health plans joined Covered California in focusing on a common set of measures in hospital performance for improvement efforts with hospitals and to determine outlier poor performing hospitals
- Covered California is partnering with the Integrated Healthcare Association's California Regional Health Care Cost & Quality Atlas to profile health plan's providers and provider group networks based on the wide variation in clinical quality, satisfaction, and total cost of care
  - Covered California plans to collaborate with others to define or create a standard for low-quality and high-cost providers that could be the basis for targeted improvement or removing such providers from their networks

APPROPRIATE INTERVENTIONS

- Under the current contract, issuers are required to report on: pharmacy utilization management, consumer and patient engagement, addressing overuse of care, and appropriate use of services
- In 2018, 10 issuers considered value in pharmacy management and 10 issuers used at least one third-party value assessment methodology (e.g., ICER Value Assessment Framework)
- All issuers use a systematic, evidence-based process for monitoring off-label use of pharmaceuticals in 2017
- Larger issuers generally provided enrollees provider-specific cost shares of common elective inpatient, outpatient, and ambulatory surgery services and prescription drugs, and real-time tracking of member out of pocket costs through online tools
- Smaller issuers state enrollees can obtain all cost related information, including provider-specific cost shares and real-time OOP costs through a call center
- In 2018, all issuers are participating in Smart Care California either as regular attendees or by implementing the Smart Care guidelines
  - Issuers are approaching completion of implementation for many of the recommended Smart Care California improvements to reduce opioid overuse including limiting the quantity of tablets in first prescriptions, removing barriers to medication-assisted treatment and for drugs used to reverse overdoses

APPROPRIATE INTERVENTIONS
IMPLICATIONS FOR THE FUTURE

- There is good evidence that a very high proportion of care delivered is unwarranted or delivered poorly; some diagnostic tests are overused, and there is limited information available to assess relative efficacy and value of many drugs, devices, and even some surgical interventions
- Covered California plans have had some success but much more can be done
  - Smart Care California will evaluate options to address variation in pharmacy prescribing practices across plans and adopt best practices
  - The analysis of the care patterns in the Covered California claims data warehouse will be greatly expanded now that data submission is mature and legal authority to include financial data has been confirmed through legislation

HOSPITAL SAFETY AND QUALITY

SITES AND EXPANDED APPROACHES TO CARE DELIVERY

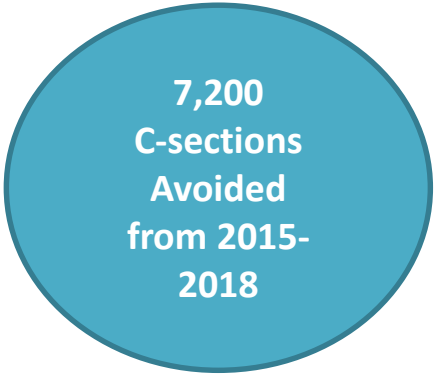
- In 2018, the California Department of Public Health reported there had been a statistically significant reduction in CLABSI, SSI, MRSA, and C. difficile bacteria infection rates at hospitals
- The number of issuers that that participated in Partnership for Patients collaborative for hospital quality and safety increased from two to 10 health plans between 2016-18
- 10 issuers were assessed as having *Full Engagement* or *Engaged* for hospital safety in 2018

12 months 2017-18
Reduction in HAIs
3,392 Infections Saved
$62.2M Cost Savings
251 Lives Saved

MATERNITY CARE

SITES AND EXPANDED APPROACHES TO CARE DELIVERY

- In 2018, the third annual C-section Honor Roll reported that 56% of California hospitals have achieved the national goal of NTSV C-section rates of 23.9% or lower, a 12-point improvement from 2015
  - This translates to 7,200 C-sections avoided between 2015-18
- The number of issuers that participated in Smart Care California collaborative for maternity care increased from six to 11 between 2016-18
- All 11 issuers were assessed as *Full Engagement* or *Engaged* for maternity care in 2018



TELEHEALTH
EXPANDED APPROACHES TO CARE DELIVERY

- For expanded approaches to care delivery, Covered California has the following requirements:
  - Using technology, including telehealth and remote home monitoring, to assist in higher quality, accessible, patient-centered care
- All Covered California health plans offered a telehealth service in 2018, but their capabilities vary
  - The percent of enrollees with a telehealth visit for Covered California issuers ranged from 0% to 71% in 2017 and from 0% to 59% in 2018 with a weighted average of 21% for both years
  - The majority of issuers reported the percent of enrollees with a telehealth visit as under 10% in both 2017 and 2018
  - The issuers with higher rates of telehealth visits are integrated delivery systems or issuers that actively promote the use of telehealth to enrollees

IMPLICATIONS FOR THE FUTURE

SITES AND EXPANDED APPROACHES TO CARE DELIVERY

- Improving hospital quality and safety through reducing HAI and NTSV C-section rates will continue to be areas of focus for Covered California
- The collaborative effort to improve hospital safety and maternity care has been an initial success
  - Additional measures will be included starting with sepsis and adverse drug events as public reporting becomes available
  - Inclusion of volume of procedures as a proxy for quality will be assessed
- Centers of Excellence will be evaluated for services beyond complex care
- Telehealth services could be expanded through the use of technology such as eConsult and Project ECHO to facilitate integration and coordination across specialties and the adoption of team-based care

QUESTIONS & COMMENTS

AB 1309 READINESS UPDATE

JEN JACOBS, DIRECTOR
CUSTOMER CARE DIVISION

AGENDA

- Covered California Readiness
- Carrier Readiness
- Next Steps
- Q & A

COVERED CALIFORNIA READINESS COMMUNICATIONS

In preparation for the implementation of AB 1309, Covered California (CovCA) will be:

- Following the intent of the law and using a Feb. 1 effective date, which will be communicated enterprise-wide
- Developing messaging with internal partners to ensure a consistent consumer-facing voice
- Educating consumers to sign up early and pay
- Creating talking points and information regarding how to access care while waiting for an ID card

COVERED CALIFORNIA READINESS
SERVICE CENTER

The Service Center will be appropriately staffed, including our surge vendor, to take consumer calls up until 11:59:59 p.m.

- The queue will be closed at midnight, however all consumers remaining in the call queue will be assisted
  - CiCi (i.e. chatbot) will be available
  - Live Chat will be available until from 8 A.M. to 6 P.M.
  - Help on Demand and some Agents will match Service Center call operations

CovCA will ensure consumers in queue will have a Feb. 1 effective date

CARRIER READINESS
TIMING CONSIDERATIONS

CovCA continues to investigate individual Carrier timing readiness. The following tables represent averages for each operational activity.

Operational Activity	Expected Timing
834 Processing	24 hours to 3 days
Pay Now Processing	3 hours to 5 days
Paper Invoice Timing	1 to 10 days
Binder Payment Due Dates	Up to 30 days
ID Card Mailing	Within 10 days of receipt of payment
Earliest Date for Access to Care	Once binder payment is received
Consumer Hotline Availability	Majority of Carriers have a hotline in place to assist consumers with access to care issues.

NEXT STEPS

- ☐ Continue internal meetings
- ☐ Continue discussions with Carriers
- ☐ Finalize preparation detail

QUESTIONS & COMMENTS

OPEN FORUM
QUESTIONS & COMMENTS