



COVERED
CALIFORNIA

PLAN MANAGEMENT ADVISORY GROUP

March 7, 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, March 7, 2019, 10:30 a.m. to 12:30 p.m.

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

March Agenda Items

Suggested Time

- | | |
|---|-------------------------|
| I. Welcome and Agenda Review | 10:30 - 10:35 (5 min.) |
| II. 2020 Certification Update | 10:35 – 10:45 (10 min.) |
| III. 2020 Benefit Design Update | 10:45 - 11:00 (15 min.) |
| IV. Policies Promoting Accountability and Delivery Reform | 11:00 - 12:25 (85 min.) |
| V. Open Forum | 12:25 – 12:30 (5 min.) |

2020 CERTIFICATION UPDATE

MEILING HUNTER, LEAD CERTIFICATION PROGRAM SPECIALIST
PLAN MANAGEMENT DIVISION

2020 QHP/QDP Certification Applications

- Certification Applications went live on March 1, 2019.
- Application Update - Covered CA has amended the marketing expectation in the Individual Marketplace Applications to :

“Upon contingent certification, the expectation for all Applicants is to invest at least 0.6% of their individual market gross premium revenue collected (on and off exchange) on marketing and spend at least 65% of their acquisition marketing funds on DR tactics. Applicants that do not meet this expectation must provide an alternate proposal, including supporting evidence and documentation, on the Applicant’s equivalent market strategies, and explain how it will better meet Covered California’s expectations for enrollee acquisition and retention.”

2020 Certification Update – Proposed Milestones

Release draft 2020 QHP & QDP Certification Applications	December 2018
Draft application comment period	December 14 – 28, 2018
Plan Management Advisory: Benefit Design & Certification Policy recommendation	January 2019
January Board Meeting: Discussion of Benefit Design & Certification Policy recommendation	January 17, 2019
Letters of Intent Accepted	February 1 – 15, 2019
February Board Meeting	February 21, 2019
Final AV Calculator Released*	February 2019
Applicant Trainings (electronic submission software, SERFF submission and templates*)	March 1, 2019
QHP & QDP Applications Open	March 1, 2019
March Board Meeting: Approval of 2020 Patient-Centered Benefit Plan Designs & Certification Policy	March 14, 2019
QHP Application Responses (Individual and CCSB) Due	May 1, 2019
Evaluation of QHP Responses & Negotiation Prep	May - June 2019
QHP Negotiations	June 2019
QHP Preliminary Rates Announcement	July 2019
Regulatory Rate Review Begins (QHP Individual Marketplace**)	July 2019/TBD
QDP Application Responses (Individual and CCSB) Due	June 1, 2019
Evaluation of QDP Responses & Negotiation Prep	June – July 2019
QDP Negotiations	July 2019
CCSB QHP Rates Due	July 24, 2019
QDP Rates Announcement (no regulatory rate review)	August 2019
Public posting of proposed rates	July 2019
Public posting of final rates (per CCIIO's proposed rate filing timeline)	September – October 2019

* Final SERFF template dependent on CMS release

** TBD = dependent on CCIIO rate filing timeline requirements

2020 BENEFIT DESIGN UPDATE

ALLIE MANGIARACINO, SR. MARKET INSIGHTS ANALYST
PLAN MANAGEMENT DIVISION

2019 PLANS IN THE DRAFT 2020 AV CALCULATOR

Due to AV requirements, the benefit workgroup considered a number of potential changes to cost shares for the 2020 benefit plan designs.

	Bronze		Silver				CCSB Silver		
	HDHP	Standard	Silver	Silver 73	Silver 87	Silver 94	Copay	Coins	HDHP
AV Target	60	60	70	73	87	94	70	70	70
Deviation Allowance	+/-2.0%	+/-2.0%	+/-2.0%	+/-1.0%	+/-1.0%	+/-1.0%	+/-2.0%	+/-2.0%	+/-2.0%
2019 AV	61.62	60.94	71.84*	73.90*	87.85*	94.21	71.57*	71.90*	70.47
2020 AV - Baseline	62.93	62.39	73.33*	75.40*	88.55*	94.54	73.08*	73.39*	71.49

	Gold		Platinum	
	Copay	Coins	Copay	Coins
AV Target	80	80	90	90
Deviation Allowance	+/-2.0%	+/-2.0%	+/-2.0%	+/-2.0%
2019 AV	78.06	81.80	88.90	91.73
2020 AV - Baseline	79.28	82.75	89.63	92.18

*Final AV includes additive adjustment for drug copay accumulation

Red text: AV is outside de minimis range

Blue text: AV is within de minimis range

PROPOSED COST SHARE CHANGES: PLATINUM, GOLD, SILVER

Platinum Coinsurance and Copay Plans: Increase MOOP from \$3,350 to \$4,500

Individual-only Gold Coinsurance and Copay Plans:

- Increase MOOP from \$7,200 to \$7,850
- Increase cost shares for specialist visit, labs, x-rays, Tier 3 drugs, ED visit

Individual-only Silver Plan:

- Increase MOOP from \$7,550 to \$7,850
- Increase medical deductible from \$2,500 to \$4,000
- Increase pharmacy deductible from \$200 to \$300
- Increase cost shares for labs, x-rays, imaging, drugs*, ED visits

***Note:** One-dollar increases to Tier 1 drugs have a significant AV impact. New Tier 1 cost shares that are not multiples of 5 reflect a cost share increase made to prevent other AV increases to commonly-used services.

PROPOSED COST SHARE CHANGES: SILVER CSR

Silver 73 Plan:

- Increase MOOP from \$6,300 to \$6,550
- Increase medical deductible from \$2,200 to \$3,700
- Increase pharmacy deductible from \$175 to \$275
- Increase cost shares for labs, x-rays, imaging, drugs*, ED visits

Silver 87 Plan:

- Increase MOOP from \$2,600 to \$2,700
- Increase medical deductible from \$650 to \$1,400
- Increase pharmacy deductible from \$50 to \$100
- Increase cost shares for labs, x-rays, drugs*, ED visits

Silver 94 Plan: No changes

***Note:** One-dollar increases to Tier 1 drugs have a significant AV impact. New Tier 1 cost shares that are not multiples of 5 reflect a cost share increase made to prevent other AV increases to commonly-used services.

PROPOSED COST SHARE CHANGES: BRONZE

Bronze:

- Increase MOOP from \$7,550 to \$7,850
- Decrease member coinsurance from 100% to 40%
- Decrease office visit copays by \$10
- Decrease Tier 1 drug cost share from 100% member coinsurance (up to \$500) after the pharmacy deductible to \$18* after pharmacy deductible

***Note:** One-dollar increases to Tier 1 drugs have a significant AV impact. New Tier 1 cost shares that are not multiples of 5 reflect a cost share increase made to prevent other AV increases to commonly-used services.

PROPOSED COST SHARE CHANGES: CCSB-ONLY PLANS

NEW CCSB-only Gold Plans:

- \$7,850 MOOP
- \$250 medical deductible (no pharmacy deductible)
- \$25 primary care visits / \$50 specialist visits
- Medical deductible applies to ED visits, inpatient admissions, skilled nursing facilities, and medical transportation

CCSB-only Silver Plans:

- Increase MOOP from \$7,550 to \$7,850
- Increase medical deductible from \$2,000 to \$2,250
- Increase pharmacy deductible from \$200 to \$300
- Increase cost shares for office visits, x-rays, imaging, drugs*, ED visits
- Applied the medical deductible to ED visits

***Note:** One-dollar increases to Tier 1 drugs have a significant AV impact. New Tier 1 cost shares that are not multiples of 5 reflect a cost share increase made to prevent other AV increases to commonly-used services.

CHANGE: MEDICAL TRANSPORTATION

Covered California proposes removing the deductible from Medical Transportation (Emergency and Non-Emergency) in the following plan designs*:

- Individual-only Silver plan
- CSR Silver plans

This change will not impact the plan design AV.

*The plan design documents presented for Board discussion on 2/21 indicated removal of the deductible from medical transportation on the CCSB-only plan designs as well. We are proposing to retain the deductible to align with the deductible applying to ED services. The plan design documents presented today reflect this change.

BRONZE HDHP

Plan Management convened the 2020 Benefit Design Workgroup to discuss options for resolving the Bronze HDHP actuarial value (AV) issue and developed the following path forward:

- The Bronze HDHP presented in the plan design documents has a MOOP/deductible of \$6,950 and meets the AV requirements at 61.97%. The IRS will release the annual limit for the MOOP in May.
- Continuing to work internally and with stakeholders to find a solution for offering a Bronze HDHP that meets all requirements

BRONZE HDHP ENROLLMENT

Total California Bronze HDHP Enrollment				
Individual		Small Group		Total
On-Exchange	Off-Exchange	On-Exchange	Off-Exchange	
95,220	71,130	1,506	67,796	235,652

Covered California Metal Level Enrollment % by Income			
Federal Poverty Level (FPL)	Bronze HDHP	Bronze	Silver
100-150%	3.6%	5.4%	25.4%
150-200%	14.8%	18.3%	38%
200-250%	18.1%	19.6%	14.5%
250-300%	17.4%	18.2%	9%
300-400%	23.0%	21%	8.2%
400% and above	9.8%	7.5%	1.7%
Not available	13.4%	10.1%	3.2%
TOTAL	100%	100%	100%

Covered CA Metal Level Enrollment by Age		
Age	Bronze HDHP	Bronze
Less than 18	10.3%	9%
18-25	8.3%	8.9%
26-34	21%	18.5%
35-44	17.6%	16.5%
45-54	18.3%	20.6%
55-64	23.9%	25.8%
65 and older	0.6%	0.8%

2021 VALUE-BASED INSURANCE DESIGN (VBID) PILOT

Covered California is exploring a pilot VBID program for select regions for the 2021 plan year for the most prevalent chronic conditions, including diabetes, chronic obstructive pulmonary disease (COPD), and hypertension. Specifics of the program will be developed over the next few months and will be informed by:

- VBID-X – National Workgroup on VBID for the Exchanges
- Issuer VBID programs (i.e. already in place or in the development stage)
- Input from researchers, stakeholders, etc.

COVERED CALIFORNIA'S POLICIES PROMOTING ACCOUNTABILITY AND DELIVERY REFORM REVISED JAN 22, 2019

LANCE LANG, MD, CHIEF MEDICAL OFFICER
PLAN MANAGEMENT DIVISION

INTRODUCTION

- Beginning with the inaugural 2014 plan year, Covered California set forth our standards and strategy for quality improvement and delivery system reform in our QHP Issuer Model Contract, updated in 2017. The “Quality, Network Management, Delivery System Standards and Improvement Strategy” of Covered California’s current issuer contract is available online at <https://hbex.coveredca.com/insurance-companies/PDFs/Att-7-QHP-Update-for-2018.pdf>.
- As Covered California assesses the performance of our QHP issuers for the contracting period commencing in 2017, we also plan to refresh our quality improvement and delivery system reform standards and requirements. In doing so, Covered California’s efforts should be informed by a clear picture of the potential impacts, as well as performance benchmarks and efforts of major national and California purchasers.
- To inform our efforts, we are engaging in four related and complementary efforts that will be used to engage health plans, providers, advocates and other stakeholders as we propose revisions to contractual terms that take effect in plan year 2021. Covered California intends to share summary findings and seek initial feedback from stakeholders in early 2019.

COVERED CALIFORNIA EARLY RESULTS

- The early results collected from QHP issuers are based on available data, most results are for plan year 2017
- Covered California will continue to work with QHP issuers to standardize reporting across issuers to ensure data validity and accuracy

COVERED CALIFORNIA ATTACHMENT 7 REQUIREMENTS

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The requirements within Attachment 7 consist of the following focus areas:

- Article 1: Improving Care, Promoting Better Health and Lowering Costs: Ensuring networks are based on value, addressing high cost providers and high cost drugs
- Article 2: Provision and Use of Data and Information for Quality of Care: Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers & Systems (CAHPS), Quality Rating System (QRS) reporting and IBM Watson data submissions
- Article 3: Reducing Health Disparities and Ensuring Health Equity: Increasing self-identification of race or ethnicity and measuring and narrowing disparities
- Article 4: Promoting Development and Use of Effective Care Models: Primary care provider (PCP) matching, promotion of patient-centered medical homes (PCMH) and integrated healthcare models (IHMs), supporting primary care through value-based payment, increasing mental and behavioral health integration with medical care, and using telehealth

COVERED CALIFORNIA ATTACHMENT 7 REQUIREMENTS

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- Article 5: Hospital Quality and Safety: Payment models to increase value, reducing hospital acquired conditions (HACs) and unnecessary C-Sections
- Article 6: Population Health: Preventive Health, Wellness and At-Risk Enrollee Support: Wellness services, community health, supporting at-risk enrollees, and diabetes prevention
- Article 7: Patient-Centered Information and Support: Price and quality transparency for enrollees, shared decision making, reducing overuse, and using the statewide provider directory
- Article 8: Payment Incentives to Promote Higher Value Care: Increasing value-based reimbursement
- Article 9: Accreditation

COVERED CALIFORNIA EARLY RESULTS: OVERVIEW

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- Strong evidence that, across plans, consumers are likely to receive quality care, with all plans achieving three stars or better for measurement year 2017, ranging from solid to exceptional performance
- Incremental increases in payment linked to value or shared risk; progressive adoption of payment reforms among larger network plans with market power
 - Blended case rates for maternity
 - Value-based contracting with hospitals
 - Accountable Care Organizations (ACO) or Integrated Healthcare Models (IHMs) with accountability for the triple aim
- All QHP issuers have adopted core hospital performance measures in managing low risk C-sections and hospital acquired conditions (HACs) either in contracting or performance management
 - Significant increased participation in California Maternal Quality Care Collaborative (CMQCC) and Partnership for Patients programs
 - Significant improvement in low-risk C-Section and HAC rates

COVERED CALIFORNIA EARLY RESULTS: OVERVIEW

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- 99% of enrollees have a PCP
- Significant investment in supporting providers in advanced primary care practice transformation
 - Less progress with primary care payment reform and PCMH recognition
- Significant growth in enrollment in IHM/ACO models for network QHPs, and advances in standardization of measuring ACO performance that will permit comparing ACO models
- Good start on reducing disparities in care
 - Improving capture of self-identified racial and ethnic identity
 - Three years of baseline data for chronic conditions and depression
 - Strategies to reduce disparities in early implementation

EARLY RESULTS FOR 2016-2018 PERFORMANCE PERIOD: QUALITY RATING SYSTEM (QRS) SCORES

- QHP issuers are required to collect and report to Covered California, for each product type, its QRS HEDIS, CAHPS and other performance data
- QHP issuers showed steady improvement over three years for a subset of important measures, including HbA1c levels, diabetes medication adherence, and colorectal cancer screening (next slides)

Global Quality Ratings by Reportable Products for Individual & CCSB Markets						
	# Products with No Global Rating	1 Star ★	2 Star ★★	3 Star ★★★	4 Star ★★★★	5 Star ★★★★★
2018 QRS	3*	0	0	6	4	2
2017 QRS	4*	0	3	6	1	1
2016 QRS	5*	1	7	2	1	1

* No global rating if a newer product and not eligible for reporting or insufficient sample sizes to report results for at least 2 of the 3 summary indicator categories

EARLY RESULTS FOR 2016-2018 PERFORMANCE PERIOD: DIABETES CONTROL

Why it matters?

- Diabetes is marked by high blood glucose (blood sugar) due to the body's inability to make or use insulin; hemoglobin A1c (HbA1c) tests indicates the average level of blood sugar
- The target HbA1c level for people with diabetes is 8% or lower; lower HbA1c levels indicate better diabetes control
- If not managed, diabetes can lead to heart disease, stroke, hypertension, blindness, kidney disease, diseases of the nervous system, amputations and premature death

HbA1c < 8% HEDIS Measure			
	2016	2017	2018
US 90th Percentile for national marketplace plans			0.69
US 50th Percentile for national marketplace plans			0.59
Covered CA Weighted Average	0.59	0.60	0.63
Covered CA Best Performing Plan	0.75	0.70	0.73
Covered CA Lowest Performing Plan	0.38	0.47	0.52

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.

EARLY RESULTS FOR 2016-2018 PERFORMANCE PERIOD: DIABETES MEDICATION ADHERENCE

Why it matters?

- Proper diabetes management is essential to control blood glucose, reduce risks for complications and prolong life
- Diabetes can be managed by taking medications as instructed, eating a healthy diet, being physically active and quitting smoking

Diabetes Medication Adherence HEDIS Measure			
	2016	2017	2018
US 90th Percentile for national marketplace plans			0.80
US 50th Percentile for national marketplace plans			0.71
Covered CA Weighted Average	0.66	0.69	0.72
Covered CA Best Performing Plan	0.77	0.80	0.87
Covered CA Lowest Performing Plan	0.51	0.50	0.61

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.

EARLY RESULTS FOR 2016-2018 PERFORMANCE PERIOD: CONTROLLING HIGH BLOOD PRESSURE

Why it matters?

- High blood pressure increases the risk of heart disease and stroke, which are the leading causes of death in the United States
- Controlling high blood pressure is an important step in preventing heart attacks, stroke and kidney disease, and in reducing the risk of developing other serious conditions

Controlling High Blood Pressure HEDIS Measure			
	2016	2017	2018
US 90th Percentile for national marketplace plans			0.77
US 50th Percentile for national marketplace plans			0.61
Covered CA Weighted Average	0.66	0.63	0.66
Covered CA Best Performing Plan	0.85	0.86	0.82
Covered CA Lowest Performing Plan	0.49	0.43	0.43

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.

EARLY RESULTS FOR 2016-2018 PERFORMANCE PERIOD: COLORECTAL CANCER SCREENING

Why it matters?

- Treatment for colorectal cancer in its earliest stage can lead to a 90 percent survival rate after 5 years
- Many adults ages 50–75 do not get recommended screenings; colorectal cancer screening of asymptomatic adults in this age group can catch polyps before they become cancerous or detect colorectal cancer in its early stages, when treatment is most effective

Colorectal Cancer Screening HEDIS Measure			
	2016	2017	2018
US 90th Percentile for national marketplace plans			0.68
US 50th Percentile for national marketplace plans			0.54
Covered CA Weighted Average	0.54	0.55	0.59
Covered CA Best Performing Plan	0.82	0.80	0.78
Covered CA Lowest Performing Plan	0.28	0.35	0.34

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.

EARLY RESULTS FOR 2016-2018 PERFORMANCE PERIOD: ACCESS TO CARE

Why it matters?

- This QRS survey measure is based on enrollee responses to the QHP Enrollee Survey
- This measure indicates whether enrollees had access to urgent or immediate care as soon as needed, were able to get a routine care appointment when needed, were able to get tests when needed, and were able to access a specialist when needed

Access to Care QHP Enrollee Survey Measure			
	2016	2017	2018
US 90th Percentile for national marketplace plans			0.84
US 50th Percentile for national marketplace plans			0.80
Covered CA Weighted Average	0.71	0.70	0.72
Covered CA Best Performing Plan	0.78	0.79	0.81
Covered CA Lowest Performing Plan	0.56	0.60	0.67

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.

EARLY RESULTS FOR 2017-2018 PERFORMANCE PERIOD: INCREASES IN PAYMENT LINKED TO VALUE OR RISK

Requirement

- QHP issuers are required to change how hospitals are paid to promote quality:
 - Adopt a payment method that ties 2% of hospital payments to quality performance
 - Adopt a payment method with no financial incentive for hospitals to perform low risk C-Sections

Results: Hospital Payment Method

- Issuers can tie value-based payments to patient satisfaction, clinical measures, safety, readmissions, or any combination. As of 2017, 6 issuers had implemented value-based payments for hospitals, ranging from 23% of network hospitals to 100% of network hospitals.
- These hospital value-based payments provide the foundation for issuers to meet the requirement that 2% of hospital payments for each in-network hospital is tied to value by the end of 2019

Results: Low Risk C-Section Payment Method

- As of 2017, 6 issuers had actively re-contracted payments for low-risk C-Sections while 4 issuers had begun the process.

EARLY RESULTS FOR 2017 PERFORMANCE PERIOD: IMPROVED HOSPITAL MATERNITY CARE

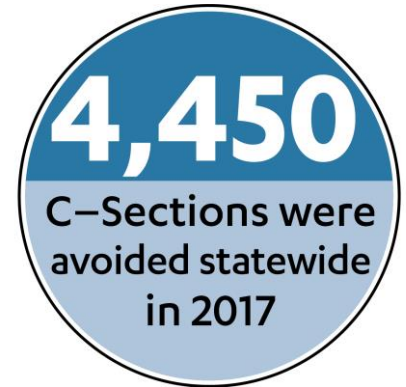
Requirement

Covered California requires QHP issuers to:

- Encourage hospitals to submit data to the California Maternal Quality Care Collaborative (CMQCC) and participate in free coaching programs to improve quality
- Track low-risk C-Section rates with the possibility of excluding a hospital from network if the hospital is a low performer and not working to improve

Results

- Hospital participation in the CMQCC data collection and improvement collaborative is now nearly universal partly due to QHP issuer encouragement and inclusion in contracting discussions with hospitals
- Rates of low-risk C-Sections for low risk first time pregnancies are coming down steadily and the number of hospitals achieving the Healthy People 2020 target of 23.9% or less is growing
- 4,450* C-Sections were avoided statewide in 2017



* A proportionate share of deliveries for Covered California enrollees is approximately 66 fewer C-sections in 2017, not including enrollment through the off-exchange individual market, nor Covered California enrollees who are covered by Medi-Cal for pregnancy

EARLY RESULTS FOR 2017 PERFORMANCE PERIOD: IMPROVED HOSPITAL SAFETY ...page 1 of 2

Requirement

Covered California requires QHP issuers to:

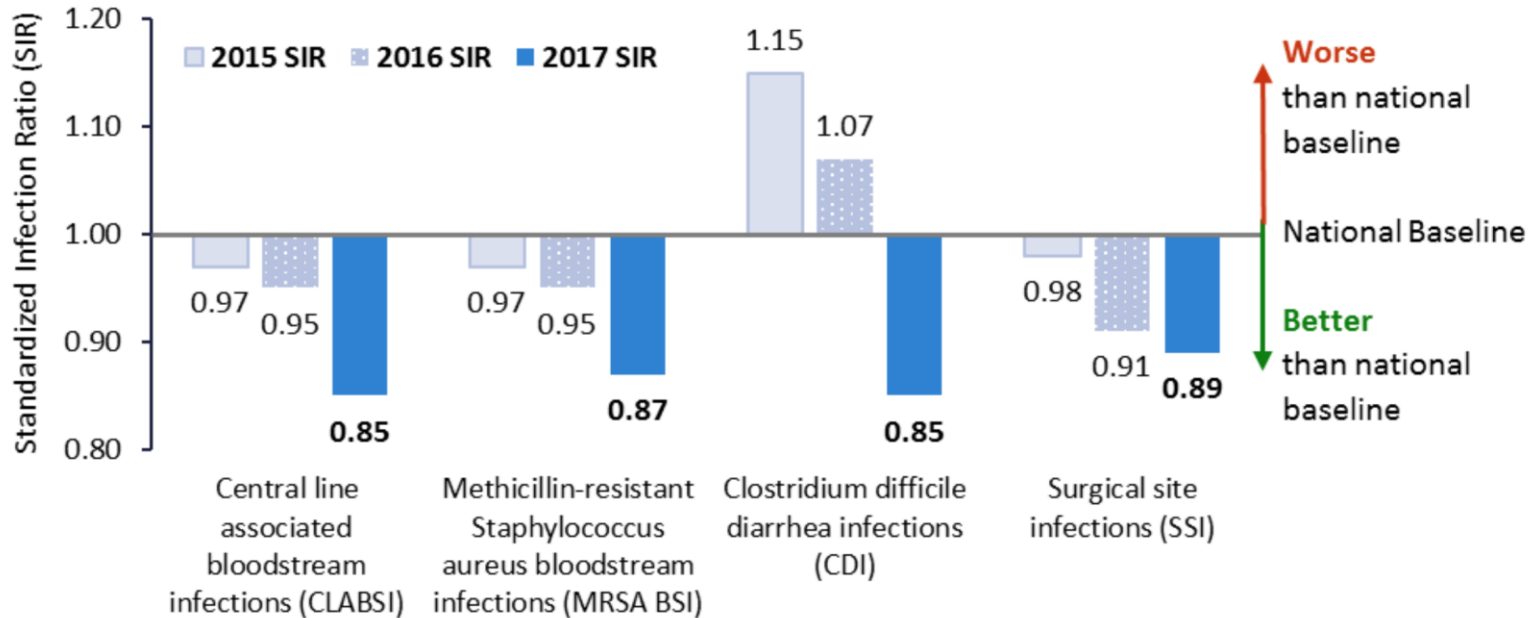
- Encourage hospitals to participate in free coaching programs to improve HAC rates
- Track specified HAC rates with the possibility of excluding a hospital from network if the hospital is a low performer and not working to improve
 - Catheter associated urinary tract infection (CAUTI)
 - Central line associated blood stream infections (CLABSI)
 - Methicillin-resistant staph (MRSA)
 - Clostridium difficile bacterial infection (CDI)
 - Surgical site infection of the colon (SSI Colon)

Results

- Hospital participation in Partnership for Patients improvement collaboratives is now nearly universal
- Rates of avoidable HACs are decreasing (next slide)

EARLY RESULTS FOR 2017 PERFORMANCE PERIOD: IMPROVED HOSPITAL SAFETY ...page 2 of 2

Figure I. Healthcare-Associated Infection Incidence in California Hospitals, 2015-2017



Source: California Department of Public Health (CDPH), October 2018

EARLY RESULTS FOR 2017 PERFORMANCE PERIOD: PROMOTING ACCESS TO PRIMARY CARE

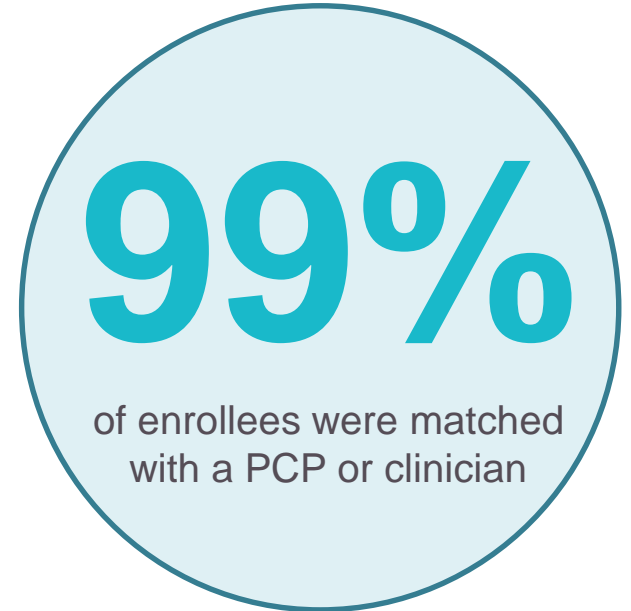
Requirement

Covered California requires that all enrollees are matched to a primary care provider (PCP) or other primary care clinician (such as a nurse practitioner) within 60 days of enrollment

- This requirement effectively applied to PPO and EPO plans as HMO plans already assign enrollees to a PCP as part of their business model

Results

- In 2017, virtually all (99%) of Covered California enrollees (N=1.34 million) were matched with a PCP, a nearly 30-percentage point increase from 2016 (N=1.34 million)



EARLY RESULTS FOR 2016-2017 PERFORMANCE PERIOD: PROMOTING EFFECTIVE PRIMARY CARE ...page 1 of 2

Requirement

- Covered California requires QHP issuers to have an increasing number of enrollees who obtain their care in a patient-centered medical home (PCMH) model with advanced primary care

Results

- Enrollment in PCMH-recognized practices has increased slightly between 2016 and 2017

% Cared for in a Patient-Centered Medical Home		
	2016	2017
All Enrollment	25%	32%
<i>Kaiser</i>	100%	100%
<i>Non-Kaiser</i>	3%	6%

EARLY RESULTS FOR 2016-2017 PERFORMANCE PERIOD: PROMOTING EFFECTIVE PRIMARY CARE ...page 2 of 2

Results

- Covered California is reviewing the current PCMH recognition programs to assess lack of provider interest
- Some have commented that the programs are process-oriented, burdensome, and costly
- Some providers that meet the PCMH recognition requirements may not be pursuing formal recognition
- QHP issuers remain committed to promoting the elements of advanced primary care: accessible, data-driven, and team-based care
- 5 issuers have made significant investments in coaching to support providers in achieving advanced primary care

EARLY RESULTS FOR 2015-2017 PERFORMANCE PERIOD: SIGNIFICANT ENROLLMENT GROWTH IN ACO

Requirement

- Covered California requires QHP issuers to have an increasing number of enrollees who are attributed to or cared for in integrated healthcare models (IHMs) or accountable care organizations (ACOs)

Results

- Significant growth in enrollment in IHMs/ACOs for QHP issuers with EPO and PPO networks

% Cared for in an IHM/ACO		
	2015	2017
All Enrollment	46%	55%
<i>Kaiser</i>	<i>100%</i>	<i>100%</i>
<i>Non-Kaiser</i>	<i>29%</i>	<i>38%</i>

- Covered California is supporting advances in standardizing the measurement of ACO performance that will permit comparing ACO models

EARLY RESULTS FOR 2015-2017 PERFORMANCE PERIOD: UNDERSTANDING DISPARITIES

Requirement

- Covered California requires QHP issuers to achieve 80% self-identification of racial and ethnic identity (R/E) by 2019 and encourage use of various data collection methods beyond the enrollment form to identify membership, to understand disparities in care.
- Covered California requires QHP issuers to submit data by R/E group on 14 disease control and management measures for four conditions: diabetes, asthma, hypertension and depression. Issuers submit data for all lines of business excluding Medicare. This work helps “track, trend, and improve” care across R/E groups.

Results

- In 2017, 9 of 11 QHP issuers have seen increases in the self-identification rate over 2015
- 6 QHP issuers have met and exceeded the 80% target a year early; 3 have exceeded 95%
- QHP issuers have increased identification rates due to improved data collection and incorporation of best practices in asking enrollees for R/E information
- Covered California is working with QHP issuers to analyze early condition-specific data and to address challenges related to data quality, small denominators, and data interpretation

EARLY RESULTS FOR 2017 PERFORMANCE PERIOD: ACHIEVING VALUE IN DRUG SPEND

Requirement

- QHP issuers are required to report whether and how value is considered in formulary selection, whether and how formularies are constructed assessing for total cost of care, and how off-label pharmaceutical use is monitored

Results

- 7 of 11 QHP issuers (covering **1,159,510** or **86%** of enrollees in 2017) have a process for analyzing drug efficacy in the context of total cost of care and outcomes, and actively uses those results
- All QHP issuers have a systematic, evidence-based approach for monitoring the off-label use of pharmaceuticals

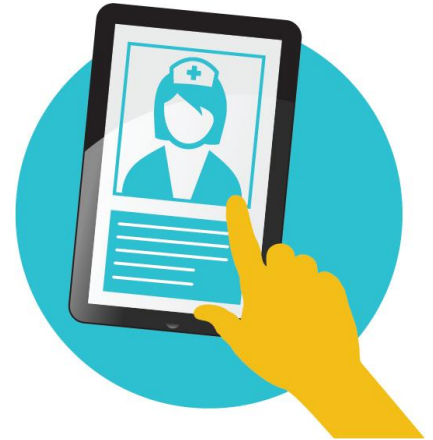
EARLY RESULTS FOR 2017 PERFORMANCE PERIOD: ACCESS TO TELEHEALTH SERVICES

Requirement

- QHP issuers are required to report the extent to which they support and use technology to assist in providing higher quality, accessible, patient-centered care to enrollees

Results

- 10 of 11 QHP issuers (covering **1,329,150** or **99%** of enrollees in 2017) offer telehealth services
- 5 of 11 QHP issuers (covering **775,250** or **58%** of enrollees in 2017) offer primary care telehealth visits at the same cost of a primary care visit or less
- 4 of 11 QHP issuers (covering **553,900** or **41%** of enrollees in 2017) offer primary care telehealth visits at no cost share



EARLY RESULTS FOR 2017 PERFORMANCE PERIOD: CONSUMER DECISION SUPPORT TOOLS

Requirement

- QHP issuers are required to offer tools that enable enrollees to look up provider-specific cost shares of common elective inpatient, outpatient, and ambulatory surgery services and prescription drugs, and accumulations toward deductibles and maximum out of pockets (MOOPs)
- QHP issuers with fewer than 100,000 members with Covered California can provide this information to enrollees through another method such as a call center

Results

- 9 of 11 QHP issuers (covering **1,327,350** or **99%** of enrollees in 2017) provide an online tool with cost information to consumers, including 4 issuers with fewer than 100,000 enrollees



EARLY RESULTS FOR 2017 PERFORMANCE PERIOD: MEMBER PORTAL TOOLS

Requirement

- Covered California requires QHP issuers to report on enrollee access to personal health information and the tools offered through their member portals

Results

- All QHP issuers offer the following services through their member portal:
 - premium payment
 - provider search
 - selecting or changing a PCP
 - managing prescription drugs
- 7 of 11 QHP issuers (covering **1,152,230** or **86%** of enrollees in 2017) offer access to personal health information through their member portal

PROPOSED GUIDING PRINCIPLES FOR DEVELOPING EXPECTATIONS OF HEALTH PLANS 2021-2023 ...page 1 of 2

1. Driven by the desire to meet two complementary and overlapping objectives:
 - **Right Care/Accountability:** Ensure our members receive the right care, at the right time, in the right setting, at the right price.
 - **Delivery System Improvement:** Promoting value-enhancing strategies that have the potential to reform the delivery system in the near and long term.
2. Seek to improve the health of the population, improve the experience of care, reduce the cost of care, reduce administrative burden, and reduce health care disparities.
3. Success will be assessed by outcomes, measured at the most appropriate level, in preference to adoption of specific strategies.
4. We will promote alignment with other purchasers as much as possible.

PROPOSED GUIDING PRINCIPLES FOR DEVELOPING EXPECTATIONS OF HEALTH PLANS 2021-2023 ...page 2 of 2

5. Consumers will have access to networks offered through the QHP issuers that are based on high quality and efficient providers.
6. Enrollees have the tools needed to be active consumers, including both provider selection and shared clinical decision making.
7. Payment will increasingly be aligned with value and proven delivery models.
8. Variation in the delivery of quality care will be minimized by ensuring that each provider meets minimum standards.

FRAMEWORK FOR RIGHT CARE/ACCOUNTABILITY AND DELIVERY SYSTEM IMPROVEMENT EXPECTATIONS

- Covered California has organized the complementary and mutually reinforcing strategies to support these expectations in two domains:

Right Care/Accountability Strategies	Delivery System Improvement Strategies
Chronic Care, General Care, and Access	Networks Based on Value
Hospital Care	Promotion of Effective Primary Care
Major/Complex Care	Promotion of Integrated Healthcare Models and Accountable Care Organizations
Mental/Behavioral Health and Substance Use Disorder Treatment	Alternate Sites of Care Delivery
Preventive Services	Consumer and Patient Engagement
Health Equity: Disparities in Healthcare	Population-Based and Community Health Promotion Beyond Enrolled Population
Pharmacy Utilization Management	

EXPECTATIONS DEVELOPMENT APPROACH: REFRESHING COVERED CALIFORNIA'S STRATEGY

1. Outside Consultants: review and synthesis of the available evidence base for Right Care and Delivery System Improvement Strategies, organized in the following projects:
 - *Benchmarking (PwC)*: Identify relevant benchmarks and data sources to provide valid comparison points for current expectations and performance standards for QHP issuers and Covered California's populations overall.
 - *Purchaser Strategy/M Measurement Review (PwC)*: Review activities and initiatives of other large health purchasers to identify key areas of focus, strategies and performance measures that Covered California should consider for potential adoption or alignment.
 - *Best Evidence Value-Enhancing Strategies (HMA)*: Synthesize the evidence for each value-enhancing strategy and evaluate its potential effectiveness in terms of cost, quality of care, improved health, reduction in health disparities, and provider burden.

EXPECTATIONS DEVELOPMENT APPROACH: REFRESHING COVERED CALIFORNIA'S STRATEGY page 2 of 2

2. QHP Issuers: Covered California seeks to understand each issuer's intended direction, investment strategy, and perspective on how best to ensure right care is being delivered and it is fostering delivery change.
3. Other Stakeholders: Covered California seeks input from diverse stakeholders, including providers, consumers, purchasers, and regulators.

EXPECTATIONS DEVELOPMENT APPROACH: TIMELINE



EXPECTATIONS DEVELOPMENT NEXT STEPS

- **Engagement**

- Covered California will convene meetings of subject matter experts and stakeholders specific to the various topics. For more information, please refer to *Refreshing Contractual Expectations* available at <https://board.coveredca.com/meetings/2019/01-17%20Meeting/Refreshing-Contractual-Expectations.pdf>.

- **Public Comment**

- Covered California will solicit feedback throughout the expectations refresh initiative. Comments in response to *Request for Input* available at <https://board.coveredca.com/meetings/2019/01-17%20Meeting/Request-for-Input.pdf> are requested by February 15, 2019.

OPEN FORUM AND NEXT STEPS

ROB SPECTOR, CHAIR
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