PLAN MANAGEMENT ADVISORY GROUP

August 11, 2016

WELCOME AND AGENDA REVIEW

BRENT BARNHART, CHAIR
PLAN MANAGEMENT ADVISORY GROUP

AGENDA

AGENDA
Plan Management and Delivery System Reform Advisory Group
Meeting and Webinar
Thursday, August 11, 2016, 3:00 p.m. to 5:00 p.m.

Webinar link: https://attendee.gotowebinar.com/register/2276312700727263234

August Agenda Items	Suggested Time
I. Welcome and Agenda Review	3:00 - 3:05 (5 min.)
II. Certification Process Update	3:05 – 3:20 (15 min.)
III. Quality Rating System for Open Enrollment 4	3:20 – 3:50 (30 min.)
IV. Primary Care Requirement Implementation	3:50 – 4:20 (30 min.)
V. Benefits Work Group 2018	4:20 – 4:50 (30 min.)
VI. Open Forum	4:50 – 4:55 (5 min.)
VII. Wrap-Up and Next Steps	4:55 – 5:00 (5 min.)

CERTIFICATION PROCESS UPDATE

JAMES DEBENEDETTI, DIRECTOR
PLAN MANAGEMENT DIVISION

2017 CERTIFICATION UPDATES SUMMARY

- Statewide weighted average premium increase is 13.2 percent
- Three-year average increase of 7 percent is lower than pre-Affordable Care Act trends
- Nearly 80 percent of consumers will pay less or see a rate bump of no more than 5 percent if they switch plans
- New benefit changes help consumers save when they access health care (for example, Silver 70 plan savings of $10 for primary care and $55 for urgent care visits)
- All plans required to assign a primary care clinician within 60 days of effectuation

CONTRIBUTORS TO THE RATE INCREASE

- Reinsurance is no longer available: The American Academy of Actuaries estimates this will add between 4 percent and 7 percent to premiums for 2017.

- Specialty drugs: Trends indicate that between 2012 and 2020, nationwide health system payments toward specialty drugs will quadruple ($87 billion in 2012 to $400 billion in 2020), and the percent of overall health care spending attributed to specialty drugs will almost triple (3.1 percent in 2012 to 9.1 percent in 2020). (http://www.pewtrusts.org/~/media/assets/2015/11/specialty-drugs-and-health-care-costs_artfinal.pdf)

- Pent-up demand for health care now being accessed by those who were locked out of the health care system before the Affordable Care Act was enacted.

- Special enrollment by some consumers who may be enrolling in health insurance only after they become sick or need care, which had a significant impact on rates for some carriers.

PRODUCT / NETWORK CHANGE HIGHLIGHTS

- **Anthem** is converting its PPO network to an EPO, which will eliminate coverage for out-of-network services. The provider network will remain the same except for most tier 2 hospitals, which will be removed from the network due to the removal of that benefit tier.

- **Blue Shield** is adding its Trio HMO, which is focused on Accountable Care Organizations (ACOs) which improve integration and coordination of care across providers (primary care, specialty care, hospitals, etc.), resulting in lower costs and better outcomes.

- **Kaiser** is adding a gold coinsurance plan, and expanding its service area to Santa Cruz county in Region 9. This includes collaboration with Watsonville Community Hospital and Dominican Hospital for inpatient and ambulatory specialty care. Phased expansion plans include the opening of three medical offices in January of 2017, and a specialty hub for members to be added by 2020.

- **Molina** is expanding its service area into Orange County, and is partnering with Monarch Health and the Heritage Provider Network, which provides over 2,000 physicians and 29 hospitals. Molina is also in discussions with Inland Faculty Medical Group in the Inland Empire to expand their network of providers.

- **Oscar** is expanding its service area to San Francisco, Santa Clara, and San Mateo counties, with the addition of UCSF Health, Hill Physicians, Sequoia Quality Care Network (and Sequoia Hospital), Verity Health System, and SCCIPA.

QUALITY RATING SYSTEM FOR OPEN ENROLLMENT 4

ALLIE MANGIARACINO, SENIOR QUALITY ANALYST
PLAN MANAGEMENT DIVISION

QUALITY RATING SYSTEM (QRS) REPORTING FALL 2016: CMS MANDATED METHODS

- Four quality ratings – One global rating and three summary indicator ratings
- 5-star scale
- National benchmark applied to all products to determine star ratings
- Uses 31 measures – QRS subset includes 1-year lookback period metrics

Publicly Reported Fall 2016

QHP 1 Global Rating	QHP 3 Summary Indicators	Underlying Measure Topics
Global Rating of Plan	Getting the Right Care	Clinical Effectiveness
		Patient Safety
		Prevention
	Member's Care Experience	Access to Care
		Doctors and Care
		Care Coordination
	Plan is a Good Value, Care is Proven and Safe	Health Plan Customer/Info Services
		Efficient Care/Resource Use

QRS REPORTING CHANGES: FALL 2016 VS. CURRENT REPORTING

QRS Component	Fall 2016	Current (Fall 2015)
Methods Author	CMS	Covered California
Summary Ratings	1 Global Rating 3 Summary Indicators	1 Overall Rating of Member Experience
Measures Set Used for Summary Ratings	29 HEDIS and CAHPS	10 CAHPS
Benchmark	National All-Product Type Benchmarks	Western Region PPO Benchmarks
Ratings Display	5 Stars	4 Stars
QHP Product Scope	On-Exchange Only	On-Exchange and Optionally Off-Exchange

QRS PUBLIC REPORTING

Covered California is one of 9 states that are publicly reporting QRS results in Fall 2016.

- CMS is reporting QRS results in 5 Federally-facilitated Marketplaces states: Wisconsin, Ohio, Pennsylvania, Virginia, and Michigan
- Covered California, as well as Oregon, New York, and Washington represent the State Marketplaces who will be displaying QRS results. Maryland has expressed interest.

CMS Reporting Requirements:

- SBMs must display at least the QRS global rating
- SBMs must include CMS disclaimer language noting that additional consumer testing is being conducted on the display of these ratings
- Covered California QHP issuers may reference QRS results in marketing materials after Covered California review and approval of proposed materials

Beginning in Fall 2017, all Marketplaces will be required to publicly report QRS results.

MARKETING GUIDELINES*: QHP REFERENCES TO QRS RATINGS IN MARKETING MATERIALS

QHP Issuers:

- shall reference specific QHPs or product types and their CMS-assigned quality rating information.
- limit information to the 4 quality ratings reported by Covered California (Global Rating and 3 Summary Indicator Ratings)
- that choose to advertise ratings for QRS summary ratings, may use only the summary indicator titles assigned by Covered California without variation (e.g., “Getting the Right Care”). Additionally, the QHP issuer must always include the QRS global rating alongside the QRS summary indicator rating.
- shall only use a general label in reference to the rating of a specific QHP. For example, “a 5-star plan” can be used only to reference the QRS global rating, unless the summary indicator rating is specified (e.g., “a 5-star plan for [insert summary indicator name]”).
- should not use superlatives (e.g., “highest ranked,” “one of the best”) without additional context. For example, a QHP that is the only one in the State that received a 5-star rating for a specific QRS summary indicator, but received a 3-star global rating, may not be promoted as the highest ranked QHP in the State when other QHPs have a higher global rating.
- shall only advertise QRS ratings (i.e., stars) rather than scores (i.e., numerical value),
- must include the CMS-provided disclaimer on all marketing materials.

*Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2016 (CMS, January 2016 V. 2.0)

CMS CALL LETTER: FUTURE QRS CHANGE SCHEDULE

In July 2016, CMS proposed approach and timeline for QRS updates in future years.

- Refinements to QRS rating methodology proposed in the QRS Call Letter could take effect in the current ratings year. Refinements could take effect later if the proposed changes are significant.
- Refinements to the QRS and QHP Enrollee Survey participation requirements, measure set, or other significant program refinements proposed in the QRS Call Letter could take effect in the following ratings year at the earliest.
- For Fall 2017 QRS: CMS anticipates releasing draft 2017 QRS Call Letter in December 2016 and the final 2017 Call Letter in April 2017.

CMS will not revise the QRS rating methodology this year; several proposed non-methods changes for measurement year 2016:

- Expand beyond beta measures set to include all 42 QRS measures
- Eligible reporting units must have more than 500 enrollees as of July 1 of the prior year and more than 500 enrollees as of January 1 of the ratings year (applies to QRS clinical & Enrollee Survey)
- Align with NCQA HEDIS changes: i) revise low back pain measure, ii) integrate Immunizations of Adolescents (IMA) & Human Papillomavirus Vaccine for Adolescents (HPV) into single measure

TIMELINE: COVERED CALIFORNIA QUALITY REPORTING FALL 2016

Reporting Step	Date
CMS QRS Preview Period	
Health Plans & Covered California	August 15-26
Results Final	August 26
Summary of Results Presented	
Advisory Group	September 8
Board *(Ratings displayed for each plan product)*	September 15
Public Release	1st week in October

NEXT STEPS

QRS Results Preview
- Obtain and review QRS results from CMS
- QHPs to resolve any QRS scores and rating concerns with CMS

Summarize QHP Results
- Produce a summary of QRS results across California QHPs

Public Reporting
- Individual: Produce online results for Plan Selection and Plan Review applications
- Covered California for Small Business (CCSB): Consider producing stand-alone print materials for CCSB products

QRS for 2017 and Beyond
- Covered California will work with CMS and Issuers on lessons learned from the 2016 QRS results and how to improve methodology and consumer displays

PRIMARY CARE REQUIREMENT IMPLEMENTATION

LANCE LANG, CHIEF MEDICAL OFFICER
PLAN MANAGEMENT DIVISION

PRIMARY CARE INITIATIVE IMPLEMENTATION (1 OF 2)

- As part of the strategy to promote team based, data driven, integrated care, enrollees in all products (including PPO and EPO) will either select or be provisionally matched to a Primary Care Physician (PCP) by January 1, 2017 or within 60 days of effectuation into the plan.
- The rationale is to give all enrollees a central point of contact in the health system to help with care navigation and health education, and act as an integrator and coordinator. PPO and EPO enrollees have no requirement to see their PCP before seeing a specialist, and members can change their PCP at any time.
- Covered California is working with stakeholders to develop common consumer messaging and timelines, and to ensure messaging harmonizes with operational and system capabilities to minimize confusion.

Messaging Timeline for PPO/EPO Members

	Covered California	Health Plans
August	***To members:*** PCP message launch through email and direct mail ***Service center:*** Talking points on PCP announcement ***To sales partners:*** PCP announcement through an alert email, briefing, and various webinars	--
September	***To members:*** PCP message follow-up through email and direct mail ***To sales partners:*** PCP announcement through various webinars and a partner briefing	Renewal and open enrollment communications through letters, emails, FAQs for inbound calls, etc.
October	***To members:*** Renewal reminder with PCP language through email and direct mail ***To sales partners:*** PCP announcement through a webinar and a partner briefing	Renewal and open enrollment communications through letters, emails, FAQs for inbound calls, etc.
November	***To members:*** Open enrollment reminder with PCP information through email and direct mail	
December	--	--
January	***To members:*** PCP reminder message through email and direct mail	Member education on PCP assignment

PRIMARY CARE INITIATIVE IMPLEMENTATION (1 OF 2)

In addition, Covered California is developing a document to be a common information platform for stakeholders which will be distributed before open enrollment. The document includes information on rationale and implementation, and is divided into value statements, targeted toward different audiences such as consumers, providers, brokers, and advocates. **Example value statements from drafts are below.**

To Advocates:

TRIPLE AIM AND SYSTEM IMPROVEMENT: PCP matching will improve quality of care, efficiency, and population health overall by giving enrollees a primary care resource who can help them navigate the health system, and act as an advocate, coordinator and integrator for their care.

NO ENROLLEE LEFT BEHIND: PCP matching in all products, including PPO and EPO, will provide a system entry point and built-in orientation for enrollees new to health insurance or for those who just need more guidance.

A RESOURCE TO IMPROVE HEALTH LITERACY: It can be a challenge to understand how health care works, especially for people new to health insurance. A PCP is a resource to help build health literacy for consumers. This enhances and adds value to the healthcare experience whether or not the consumer is new to insurance.

COMFORT, TRUST, AND GOOD FIT: Enrollees can choose any PCP, and are able to base choice on language, gender, areas of health expertise, and other variables that may best fit their situation. Choosing a PCP they can trust is the first step. The more they visit the PCP, the better the relationship and the better their care.

If you would like to review and/or comment on the advocate statements please email lindsay.petersen@covered.ca.gov

2018 BENEFIT DESIGN WORK GROUP

ALLIE MANGIARACINO, SENIOR QUALITY ANALYST
PLAN MANAGEMENT DIVISION

2018 BENEFIT DESIGN WORK GROUP: POSSIBLE TOPICS

Benefit Category	Issue	To be addressed in 2018? Yes/No
Home Health Care	Specify copay as being per day or per visit	Yes
Telehealth visits	Determine whether to standardize copays	Yes
Prediabetes programs	Consider requirement, per USPSTF recommendations, to include diabetes prevention programs (DPP) as a covered preventive service	Yes
Actuarial Value of SBPDs	Consider an AV that is less than or equal to the metal tier AV, i.e. not within 2% of the upper de minimus limit, in order to leave room for fewer changes to benefits in future years.	Yes
VBID for diabetes	Determine whether to implement a VBID program within the SBPD and which services to include	No. Consider for 2019 plan designs.
Remove limitations/restrictions on tobacco cessation therapies	CA state and Federal guidelines state no restrictions should exist on all seven categories of tobacco cessation therapies. Some plans already have no restrictions or limitations.	Yes

WRAP UP AND NEXT STEPS

BRENT BARNHART, CHAIR
PLAN MANAGEMENT ADVISORY GROUP

SUGGESTED AGENDA TOPICS FOR SEPTEMBER MEETING

- Benefits Work Group – 2018 Members, Topics and Timeline
- Primary Care Initiative Implementation – PCMH Definition Update
- Quality Rating System Update
- Healthcare Evidence Initiative (Truven) Discussion
- Special Enrollment Review Policy Update
- Others? Please email Lindsay.Petersen@covered.ca.gov