Qualified Health Plans
Quality and Affordability of Qualified Health Plans

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Qualified Health Plans
Assuring Quality and Affordability

Strategies to Promote Better Quality and More Affordable Care

The Exchange seeks to use "its market role to stimulate new strategies for providing high-quality, affordable health care, promoting prevention and wellness, and reducing health disparities." The impact of the Exchange will be measured by its results in "expanding coverage and access, improving health care quality, promoting better health and health equity, and lowering costs for all Californians." The promise of delivery system reform and health care transformation is to offer significant advances in value – improving health, and enhancing quality and care coordination, while reducing waste and the total cost of care. These are also the three national aims espoused in the National Quality Strategy.

Preliminary Recommendations to Foster Better Health, Quality Care and Lower Costs

A. **Promote alignment** with other purchasers to foster better care, lower costs and improved health.

B. **Collect standardized Information** on health plans performance and care delivery/payment practices to inform future work.

C. **Require certain health plan practices that promote better care or standards of performance** to gain certification by the Exchange.

D. **Use value-elements in its Qualified Health Plan selection** process considering a combination of outcomes (e.g. HEDIS and/or CAHPS scores) and practices (e.g. participation and support for pay-for-performance or medical home initiatives).

E. **Advance Wellness/Prevention** (Separate Board Recommendation Brief)

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Preliminary Recommendations to Foster Better Health, Quality Care and Lower Costs

A. **Promote alignment** with other purchasers to foster better care, lower costs and improved health.

The Exchange should continue its current practice of seeking to work in partnership and collaboration with stakeholders of all types as it pursues its mission, including:

- Review of the contracting requirements for the state's public programs
- Review procurement strategies among public purchasers such as CalPERS and the federal Office of Personnel Management, including efforts to advance delivery system reform issues such as payment and care redesign, patient safety and transparency of performance information.
- Alignment and collaboration with the OPM's qualification of multi-state plans for Exchanges and Center for Consumer Information and Insurance Oversight's (CCIIO's) requirements for the federally facilitated Exchanges
- Support standardization among state-based exchanges to benchmark and compare performance.

To further align purchasing strategies with public and private purchasers, staff recommends the Exchange undertake two formal steps:

a. Participate actively in the formation and oversight of a national network of health benefit exchanges. The Exchange can and should learn from shared experiences and seek to align its value-promoting activity with these other exchanges.

b. The Exchange should join the Pacific Business Group on Health to align its efforts with its public (e.g., CalPERS and the University of California) and private (e.g., Bechtel Corporation, Pitney Bowes and Stanford University, among others) members

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B. Collect standardized Information on health plans performance and care delivery/payment practices to inform future work.

The reporting of clinical quality and patient experience results for standardized performance measures through NCQA is routine for most HMO and PPO plans in California, as well as managed care Medi-Cal plans (see Accreditation and Qualified Health Plan Quality Board Recommendation Brief, Appendix B).

To foster both improvements in measurement and transparency, staff recommends that the Exchange:

a. Require completion of the eValue8 Health Plan RFI to collect data that supports Qualified Health Plan oversight and reporting of plans' quality improvement strategies in accordance with the Affordable Care Act. The Exchange may initially require a subset of modules or questions to be completed, and reserves the right to weigh the scoring of eValue8 responses to be consistent with its Guidelines for Selection and Oversight of Qualified Health Plans.

b. Examine the use of emerging measure sets from the Medicare Shared Savings Program or other measures endorsed by the National Quality Strategy to fill gaps in assessment of key areas such as care coordination, patient, and caregiver engagement.

c. Prohibit health plan provider contracts that include anti-transparency clauses such as: terms that bar disclosure of provider ratings, or require all affiliate participation (i.e. provider demands that all hospitals and medical groups in the system must be in-network).

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Preliminary Recommendations to Foster Better Health, Quality Care and Lower Costs

C. **Require certain health plan practices that promote better care or standards of performance** to gain certification by the Exchange.

The Exchange should be careful about requiring too many elements initially, but at the same time it is critical that from the outset the Exchange clearly articulates and acts on its expectation that Qualified Health Plans actively promote better care, improved health and lower costs. What follows is a list of potential "requirements" that could be refined in future years.

a. Consumer information on provider-level performance.

b. Cost of care information is readily available to their consumers

c. Use eValue8 as a general framework and data collection tool

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D. **Use value-elements in its Qualified Health Plan selection** process considering a combination of outcomes (e.g. HEDIS and/or CAHPS scores) and practices (e.g. participation and support for pay-for-performance or medical home initiatives).

Articulate specific strategies issuers are engaged in with respect to:

- Promotion of care coordination and medical homes;
- Chronic disease management;
- Data-driven outreach to at-risk or underserved populations, or high impact conditions identified through the National Quality Strategy or National Prevention Strategy;
- Payment or oversight programs aimed at reducing hospital acquired infections including, in particular sepsis, central line infection and pressure ulcers, as well as patient safety and avoidable hospital re-admissions;
- Initiatives specifically geared at measuring and addressing health disparities, and
- Demonstrated support for innovations in care that improve care coordination and primary care access, including access in rural geographies.

Designation or differential weighting of specific plan performance elements as core or threshold participation requirements for Qualified Health Plans, or as other issuer selection criteria.

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Strategies to Promote Better Quality and More Affordable Care

The Affordable Care Act calls upon the Exchanges to advance “plan or coverage benefits and health care provider reimbursement structures" that improve health outcomes. The Exchange will use the eValue8 Health Plan Request for Information to elicit information about delivery system reform strategies and collect information in a standardized format.

Health Plan Reporting and Value Differentiation

The 2012 eValue8 Request for Information is made available courtesy of the National Business Coalition on Health and will be available on the Exchange’s website until August 23, 2012. This document is security-protected as a read-only document which does not permit copying or printing.

The Board requests stakeholder feedback on the following:

1. Which modules and/or questions are critical for use in assessing and monitoring Qualified Health Plans?
2. What areas might HBEX weight most to achieve its vision and goals?
3. Should HBEX establish absolute or relative scoring criteria for its QHP standards?
4. Are there additional topics or questions you recommend?
5. Are some modules more important than others to you? If so, identify which ones and explain why they are more important.

Preliminary Recommendation: Require completion of the eValue8 Health Plan RFI to collect data that supports Qualified Health Plan oversight and reporting of plans’ quality improvement strategies in accordance with the Affordable Care Act. The Exchange may initially require a subset of modules or questions to be completed, and reserves the right to weigh the scoring of eValue8 responses to be consistent with its Guidelines for Selection and Oversight of Qualified Health Plans

About the eValue8 Health Plan Request for Information

It incorporates health plan accreditation status, HEDIS and CAHPS performance, while also seeking to measure the utilization, spread and impact of various health plan programs. Using a Web-based platform, it collects information on health plans activities that can foster alignment with national Medicare purchasing strategies through questions in emerging areas such as patient-centered medical homes, patient safety and healthcare acquired conditions.

The modules are organized as follows:

1. Plan Profile
2. Consumer Engagement
3. Provider Measurement and Rewards
4. Pharmaceutical Management
5. Prevention and Health Promotion
6. Chronic Disease Management
7. Behavioral Health

The following slide presents a sample section from Plan Profile that summarizes the plan's activities to address disparities in care and assure cultural competency and an excerpt from Disease Management that summarizes types of member outreach activities.

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eValue8 Section 1.7 Racial, Cultural and Language Competency

1.7.1 Identify the sources of information gathered about commercial members' race/ethnicity, primary language and interpreter need and % of membership for whom such data is captured.

❑Enrollment form,
❑Health Risk Appraisal,
❑Information requested upon Website registration,
❑Inquiry upon call to Customer Service,
❑Inquiry upon call to Clinical Service line,
❑Imputed method such as zip code or surname analysis,
❑Other (detail box, 200 word limit),
❑Data not collected

1.7.2 Provide an estimate of the percent of network physicians, office staff and Plan personnel in this market for which the plan has identified race/ethnicity, and a language spoken other than English?

1.7.3 Indicate how racial, ethnic, and/or language data is used?

❑Assess adequacy of language assistance to meet members' needs,
❑Calculate HEDIS or other clinical quality performance measures by race, ethnicity, or language,
❑Calculate CAHPS or other measures of member experience by race, ethnicity, or language,
❑Identify areas for quality improvement/disease management/ health education/promotion,
❑Share with enrollees to enable them to select concordant clinicians,
❑Share with provider network to assist them in providing language assistance and culturally competent care,
❑Set benchmarks (e.g., target goals for reducing measured disparities in preventive or diagnostic care),
❑Determine provider performance bonuses and/or contract renewals (e.g. based on evidence of disparity outlier status),
❑Analyze disenrollment patterns,
❑Develop disease management or other outreach programs that are culturally sensitive,
❑ Racial, ethnic, language data is not used

1.7.4 How does the Plan support the needs of members with limited English proficiency? Check all that apply.

❑ Test or verify proficiency of bilingual non-clinical Plan staff,
❑Test or verify proficiency of bilingual clinicians,
❑Certify professional interpreters,
❑Test or verify proficiency of interpreters to understand and communicate medical terminology,
❑Train practitioners to work with interpreters,
❑Distribute translated lists of bilingual clinicians to members,
❑Distribute a list of interpreter services and distribute to provider network,
❑Pay for in-person interpreter services used by provider network,
❑Pay for telephone interpreter services used by provider network,
❑Pay for in-person interpreter services for non-clinical member interactions with plans,
❑Negotiate discounts on interpreter services for provider network,
❑Train ad-hoc interpreters,
❑Provide or pay for foreign language training,
❑Formulate and publicize policy on using minor children, other family, or friends as interpreters,
❑Notify members of their right to free language assistance,
❑Notify provider network of members' right to free language assistance,
❑Develop written policy on providing language services to members with limited English proficiency,
❑Provide patient education materials in different languages.
  ❑Percent in a language other than English
  ❑Media
❑Other (describe in detail box below):,
❑Plan does not implement activities to support needs of members with limited English proficiency

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eValue8 Section 1.7 Racial, Cultural and Language Competency, cont.

1.7.5 Indicate which of the following activities the Plan undertakes to assure that culturally competent health care is delivered. Check all that apply.

- ❑ Assess cultural competency needs of members,
- ❑ Conduct an organizational cultural competence assessment of the Plan,
- ❑ Conduct a cultural competence assessment of physician offices,
- ❑ Employ a cultural and linguistic services coordinator or specialists,
- ❑ Seek advice from a Community Advisory Board or otherwise obtain input from community-based organizations,
- ❑ Collaborate with statewide or regional medical association groups focused on cultural competency issues,
- ❑ Tailor health promotion to particular cultural groups,
- ❑ Tailor disease management activities to particular cultural groups,
- ❑ Public reporting of cultural competence programs, staffing and resources,
- ❑ Sponsor cultural competence training for Plan staff,
- ❑ Sponsor cultural competence training for physician offices,
- ❑ Other (describe in detail box below)
- ❑ No activities in 2011

1.7.6 Has the Plan evaluated or measured the impact of any language assistance activities? If yes, describe the detail box below the evaluation results of the specific disparities that were reduced and provide a description of the intervention if applicable

Patient Support Examples from Disease Management Section

6.3.9 For members already participating in the telephone management program (beyond the initial contact) indicate the events that will cause the Plan to call a member outside of the standard schedule for calls. Check all that apply. Please note this refers only to members already participating in the telephone management program.

- ❑Calls are made according to a set schedule only,
- ❑Clinical findings (e.g. lab results),
- ❑Acute event (e.g. ER, inpatient),
- ❑Medication events (e.g. failure to refill, excess use, drug/drug or drug/DX interaction),
- ❑Missed services (e.g. lab tests, office visits),
- ❑Live outbound telephone management is not offered

6.3.10 Indicate the member support elements used in the Plan's live outbound telephone management program. Only select member support items that are both tracked and reportable to the purchaser.

- ❑Patient knowledge (e.g. patient activation measure score),
- ❑Interaction with caregivers such as family members (frequency tracked),
- ❑Goal attainment status,
- ❑Readiness to change score,
- ❑Care plan development, tracking, and follow-up,
- ❑Self-management skills,
- ❑Provider steerage,
- ❑Live outbound telephone management not offered,
- ❑Live outbound telephone management program offered but elements not tracked for reporting to purchaser

Accreditation Standards and Reporting for Qualified Health Plans

The Affordable Care Act requires Qualified Health Plans to be accredited as a condition of certification, but leaves accreditation standards to the states for state-based Exchanges. An accredited health plan must maintain its accreditation for as long as it offers Qualified Health Plans on the Exchange. If not already accredited, a Qualified Health Plan issuer must obtain accreditation within a time period established by the Exchange.

Accreditation Standards and Reporting		
Option A: Require NCQA Health Plan Accreditation as a minimum requirement for inclusion as a Qualified Health Plan in the Exchange	**Option B: Require reporting of CAHPS and HEDIS measures consistent with Medi-Cal Managed Care specifications and an Interim NCQA Health Plan Accreditation by 2014; Commendable NCQA Accreditation required by 2015**	**Option C: Require at least Commendable NCQA Health Plan Accreditation and NCQA Physician Hospital Quality Certification by 2015**
Leverages existing accreditation requirements commonly in use by large purchasers and Medi-Cal Managed Care	Leverages existing accreditation requirements commonly in use by large purchasers and Medi-Cal Managed Care, but provides a transitional glide path for new entrants and regional health plans	Leverages existing accreditation requirements and incorporates specific elements to advance provider performance accountability.
Preliminary Recommendation: To require advanced NCQA accreditation and establish high standard of quality reporting and transparency, Option B		

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Administrative Simplification

The Affordable Care Act requires reduction of administrative burden to improve efficiency and lower costs through both administrative simplification and standardization in health care delivery.

Administrative Simplification Approaches Required by the Affordable Care Act

Eligibility verification and claims status : Standardized approach required by January 1, 2013.	Electronic funds transfers, health care funds transfers and remittance: Establish and adopt transaction standards to move to eliminate paper checks and remittance in physician and other provider practices by January 1, 2014.	Health claims and encounter information, health plan enrollment and disenrollment, premium payment, and referral certification and authorization: standards for these and to submit an inquiry, receive a response and use of standardized forms and definitions due January 1. 2016.
Exchange can promote consistency in claims edit software and payment policies in its contracts with QHPs	Opportunities for Exchange to encourage standardized approach to health plan ID cards.	Exchange can promote transparency of provider level (hospital and group) performance metrics

Exchange should be a catalyst for administrative simplification through its QHP selection and contracting.

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Other Issues

Partnering with Health Plan Issuers to Promote Enrollment

The California Health Benefit Exchange is exploring options to involve health plan issuers in activities to maximize enrollment in health plans offered in the Exchange. This activity is consistent with the Exchange's values of partnership, increasing access to affordable health insurance and being a catalyst for change in California's health care system by using its market role to stimulate new strategies for providing high quality, affordable health care to all Californians. Partnering with health plan issuers to enhance marketing and enrollment will leverage the skills and resources issuers can devote to these areas. Care must be taken to ensure the partnership provides fair and balanced information to consumers.

Preliminary Recommendations to Foster Plan Partnership to Promote Enrollment

A. **Consider current plan investment in marketing and enrollment activities** to understand current resources and methods.

B. **Incentivize issuers to market on behalf of the Exchange** by adding resources targeted to Exchange needs.

C. **Address regulatory and oversight needs** to ensure fair and balanced information is provided.

D. Address technical needs to link issuers to Exchange enrollment processes to provide seamless process for enrollees

E. Facilitate all avenues of enrollment: web-based, telephone, in-person

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Comments and Input Welcome

- Comments welcome on Board Recommendation Brief materials
- Please submit comments on the Stakeholder Input form by COB, Monday, August 6
- Send comments to info@hbex.ca.gov
- See the Stakeholder section of the Exchange Website for response form