



2023-2025 Attachment 7 Refresh Workgroup

April 1, 2021

AGENDA

Time	Topic	Presenter
10am-10:10	<ul style="list-style-type: none">◆ Welcome and introductions	Thai Lee
10:10-10:45	<ul style="list-style-type: none">◆ Covered California health equity and quality transformation framework<ul style="list-style-type: none">◆ Introduction of Health Equity and Quality Transformation Division◆ Proposed 2023-2025 Attachment 7 and 14 principles and priorities	Alice Chen
10:45-11:00	<ul style="list-style-type: none">◆ Quality Transformation Fund (QTF) progress update	Margareta Brandt
11:00-11:15	<ul style="list-style-type: none">◆ Overview of 2023 – 2025 Attachment 7 refresh workgroup process	Thai Lee
11:15 – 11:45	<ul style="list-style-type: none">◆ Open discussion and feedback	All
11:45-11:50pm	<ul style="list-style-type: none">◆ Wrap up & next steps◆ Adjourn	Thai Lee

Covered California Health Equity and Quality Transformation Framework

Alice Chen, Chief Medical Officer

HEALTH EQUITY AND QUALITY TRANSFORMATION

- Health Equity and Quality Transformation Division (EQT)
 - New division to focus on quality, equity, delivery system transformation
- Division is led by Alice Chen, Chief Medical Officer
 - Ashrith Amarnath, Medical Director
 - Population Care Unit
 - Taylor Priestley, Health Equity Officer
 - Rebecca Alcantar, Senior Health Equity Specialist
 - Kelly Bradfield, Senior Equity Policy Specialist
 - La Toya Holmes-Green, Senior Program Coordinator
 - Quality Improvement Unit
 - Margareta Brandt, Quality Improvement Manager
 - Thai Lee, Senior Quality Improvement Specialist
 - Whitney Li, Senior Evaluation Specialist
 - Kelly Saephan, Senior Quality Improvement Specialist

GUIDING PRINCIPLES FOR DEVELOPING EXPECTATIONS OF HEALTH PLANS – 2020 REVISION

1. Contract expectations are driven by the desire to improve the health of the population, improve care delivered, reduce the cost of care and reduce health disparities by assuring three complementary and overlapping objectives are met by health plans:
 - **Assuring Quality Care:** Ensuring our enrollees receive the right care, at the right time, in the right setting, at the right price.
 - **Fostering Improvements in Care Delivery:** Promoting value-enhancing strategies that have the potential to reform the delivery system in the near and long term.
 - **Promoting Health Equity:** Acknowledging the role of social determinants and systemic racism, Covered California expects its issuers and partners to address the impact of social needs and health disparities experienced by Covered California enrollees.
2. Success will be assessed by outcomes, measured at the most appropriate level, in preference to adoption of specific strategies.
3. Prioritizing requirements that meet multiple objectives and leveraging existing initiatives and mechanisms will reduce administrative burden.
4. Promoting alignment with other purchasers will maximize impact, elevate shared priority objectives and increase efficiency.
5. Enrollees will have access to networks offered through the issuers that are based on high quality and efficient providers.
6. Enrollees will have the tools needed to be active consumers, including tools for provider selection and shared clinical decision making.
7. Payment will increasingly be aligned with value and proven delivery models.
8. Actively monitoring and reducing variations in quality and cost of care will ensure better outcomes across the network for all Covered California Enrollees.

BUILD ON SUCCESS

ORGANIZING PRINCIPLES

ENGAGE STAKEHOLDERS

Quality is central

Equity is quality

Care about cost

Measures that matter

Make quality count

Amplify through alignment

Promote public good

QUALITY IS CENTRAL

- Coverage and access are necessary but not sufficient
- Goal must be to improve health care and health outcomes of individuals and communities in California
- Quality performance is uneven and overall inadequate




EQUITY IS QUALITY

- Ensure that an equity lens is integrated into all our quality work in a meaningful way
- Address disparities as a central objective of our quality agenda
- Stratify (over time) all core measures by race/ethnicity and explore impact of income



CARE
ABOUT
COST

- Address and assess impact on health care affordability through enrollment, subsidies, and benefit design
- Seek to address underlying drivers of high and escalating health care costs



MEASURES THAT MATTER

- Provide focus for plan and provider improvement efforts that maximizes impact and minimizes burden
- Select a parsimonious set of priority core measures that are epidemiologically relevant, evidence-based, actionable, feasible, with opportunity for improvement



MAKE QUALITY COUNT

- For health plans, tie significant financial consequences to core measure set in order to influence health plan premium position and signal the importance of quality, equity and delivery system transformation
- From health plans, translate quality and equity priorities to delivery system incentives and support



AMPLIFY
THROUGH
ALIGNMENT

- Amplify impact and accelerate change by aligning with public and private purchasers, regulatory agencies and quality assurance entities
- Aim to reduce administrative burden



PROMOTE
PUBLIC
GOOD

- Population health improvement is hampered by fragmented system, churn, and lack of ROI for any single entity
- Require investments in infrastructure for “public good” e.g. data exchange, health related social needs
- Partner with multi-stakeholder organizations such as IHA, Cal Hospital Compare, and CQC to create and sustain a culture of quality and equity

**PRIORITY
AREAS**

Disparities reduction

Behavioral health

Advanced primary care

Affordability and cost

Data exchange

QUALITY EQUITY AND DELIVERY SYSTEM REFORM WORKSTREAMS

2023 Refresh EQT Workstreams	QTF (\$)	"A14 2.0" (\$)	A7 outcomes reporting	A7 process reporting
1. Select QTF measures and benchmarks				
2. Determine QTF methodology and amounts				
3. Decide how QTF funds will be invested (with goal of not collecting future QTF penalties)				
4. Identify key non-metric based areas for performance guarantees (e.g. payment reform, HIE participation)				
5. Establish requirements (e.g. coverage of DPP, BH telehealth; PCP assignment; participation in collaboratives)				
6. Designate SELECT areas for reporting that are active areas of engagement (e.g. BH)				
7. Create "Quality Playbook" to capture additional domains in terms of best practices and resources.				
8. Include relevant legal requirements (e.g. enrollee notification, QRS, QIS)				

Quality Transformation Fund Progress Update

Margareta Brandt, Quality Improvement Unit Manager

COVERED CALIFORNIA QUALITY TRANSFORMATION FUND OVERVIEW

- **Covered California is proposing to implement a Quality Transformation Fund (QTF) to penalize plans based on quality performance**
 - Penalty assessments will be based on quality performance; penalty may be up to 4% of premium, phased in over time
 - Example: Year 1 – 1%, Year 2 – 2%, Year 3 – 3%, Year 4 – 4%
 - Plans that perform well will retain their premiums; poor performing plans will be assessed a penalty based on a percent of premium
 - The assessments from poor performing plans will establish a fund to support systemwide quality improvement and delivery system reform; however, the goal is to eliminate fund payments
- Covered California is proposing to develop the measures and methodology to pilot the QTF with no funds at risk in 2022 and implement the first year of money at risk in 2023
- Covered California will publish the QTF measures and methodology separately from the contract for the QTF pilot in 2022

QTF DEVELOPMENT WORKSTREAMS

- **QTF Measure Set**
 - Develop a proposed QTF measure set (in progress)
 - A few measures will be stratified by race/ethnicity initially; all measures will be stratified eventually in a phased approach
 - Review the proposed QTF measure set with DHCS, CalPERS, and other purchasers to promote measure alignment (in progress)
- **Performance Evaluation**
 - Develop proposal for performance evaluation or scoring methodology (the amount of penalty a plan will pay based on their performance on the measure set) (in progress)
 - Model the financial and enrollment impact to plans and consumers based on the performance evaluation proposal (in progress)
- **Fund Distribution**
 - Develop a proposal for how the funds from penalty assessments will be collected and distributed to support quality improvement and delivery system reform in California
- Feedback will be collected for each of the QTF development workstreams through the refresh workgroup and Plan Advisory meetings

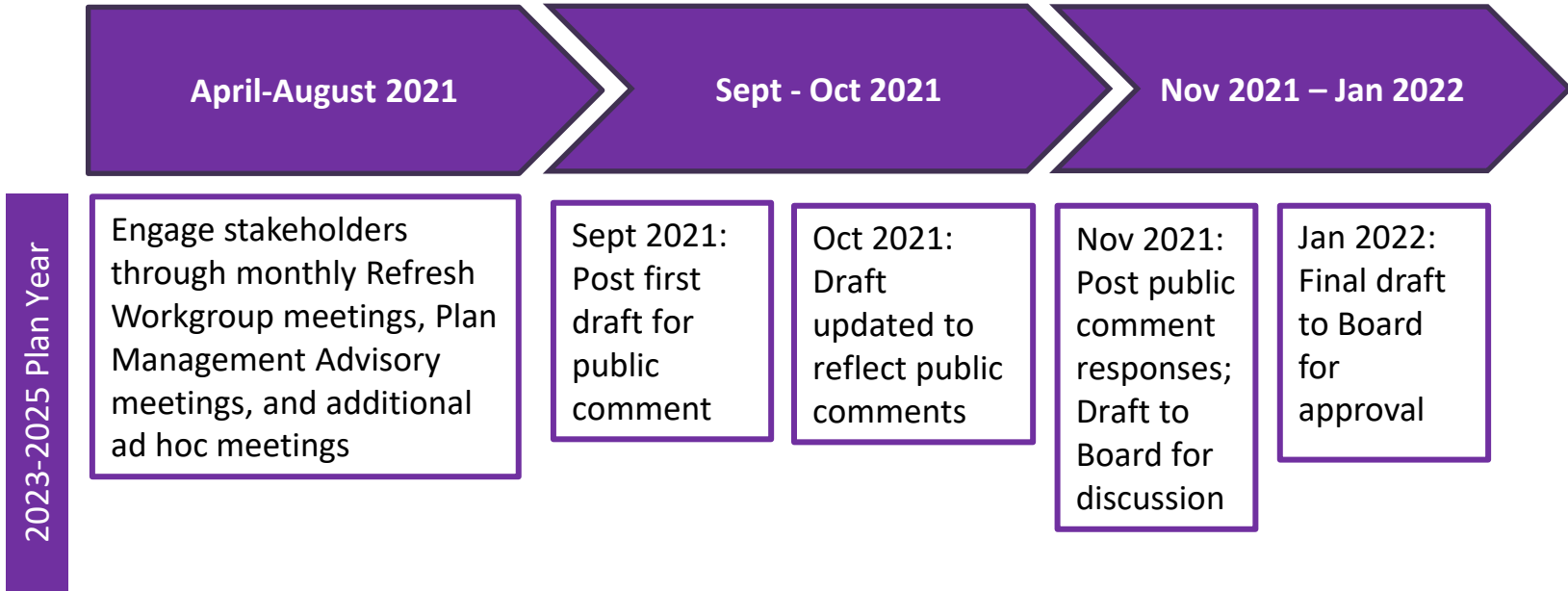
2023-2025 Attachment 7 Refresh Workgroup

Thai Lee, Senior Quality Specialist

REVIEW OF PREVIOUS ATTACHMENT 7 REFRESH PROCESS

- In 2019-early 2020, we conducted public workgroup meetings centered on Health Equity, Behavioral Health, Primary Care, Patient-Centered Social Needs, and Performance Standards
- The workgroups were suspended in April 2020 due to COVID-19 pandemic
- Focus shifted to a 2022 Amendment; transitional year to focus on foundational changes that would lay the groundwork for 2023-2025 Attachment 7 refresh
- Lessons learned from previous workgroups:
 - We were very aspirational in our scope of work
 - Challenging to meaningfully engage with 60+ participants
 - Stakeholders want to be included in discussions early in process

PROPOSED 2023-2025 ATTACHMENT 7 DEVELOPMENT TIMELINE

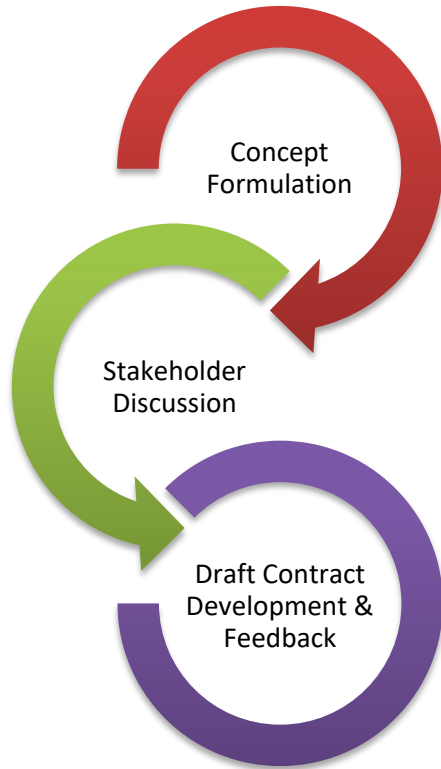


RESOURCES TO GUIDE CONTRACT DEVELOPMENT

- Covered California has laid the groundwork for the 2023-2025 Attachment 7 refresh through such publications as:
 - [2022 Attachment 7 Amendment](#)
 - [2022 Attachment 14](#)
 - 2030 Vision Statements and Guiding Principles (see Appendix A)
 - [Covered CA First Five Years: Improving Access, Affordability, and Accountability](#)
 - [Covered CA Holding Health Plans Accountable for Quality and Delivery System Reform](#)
 - [Current Best Evidence and Performance Measures for Improving Quality of Care and Delivery System Reform](#)
 - [Health Purchaser Strategies for Improving Quality of Care and Delivery System Reform](#)

- These evidence-based and stakeholder driven works will inform and guide the development of the 2023-2025 Attachment 7 contract

PROPOSED APPROACH FOR REFRESH WORKGROUP



- Covered California leadership and staff engage in strategic planning sessions to develop concept proposal for the refresh framework, principles, and priority areas for focus
- Attachment 7 Refresh workgroup
 - Scheduled monthly meetings
 - Forum for large group discussion on proposed changes to Attachment 7, Attachment 14 and the Quality Transformation Fund
 - Learning space to share ideas and best practices among stakeholders
 - Participants will review and give feedback on contract proposals and draft contract language
 - Additional focus group meetings on specific priority areas will be scheduled as necessary to help facilitate contract development

NEXT STEPS AND DISCUSSION

- Feedback on proposed workgroup and contract development process
- Upcoming proposed 2023-2025 Attachment 7 refresh workgroup meetings:
 - May 6
 - June 3
 - July 1
 - August 5
- Submit questions and comments to Thai at thai.lee@covered.ca.gov

Appendix A: Guiding Principles for Developing Expectations of Health Plans & 2030 Vision Statements

GUIDING PRINCIPLES FOR DEVELOPING EXPECTATIONS OF HEALTH PLANS – 2020 REVISION

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CORE ASSUMPTIONS TO COVERED CALIFORNIA'S APPROACH

Covered California remains committed to health equity. Addressing disparities in health care has been integral to Covered California's mission in ensuring consumers receive the right care at the right time, regardless of race, gender, where one lives or other socioeconomic factors.

Alignment, empowerment and support of meaningful improvement at five levels are necessary for fundamental change:

1. **Consumers and patients** – how they are engaged in maintaining good health and in getting best care when needed;
2. **Clinicians and hospitals** – where and how care is provided (physician practices, hospitals and other sites of care);
3. **Plans** – what they do independently and with others to both improve care and improve the health of their members;
4. **Purchasers** - what they do independently and with others to both improve care and improve the health of their employees; and
5. **Communities** – working collaboratively to improve the well-being of community members and address the social determinants of health.

COVERED CALIFORNIA'S OVERARCHING GOALS IN HEALTH PLAN CONTRACTING

1. Ensure that each Covered California enrollee receives the best possible care at the lowest possible cost.
2. Achieve the best possible health and healthcare for all California residents.
3. Establish a process that will ensure continual improvement of California's health system through well-aligned near-term incremental changes and longer-term transformational reforms.
4. Provide a model that can spread broadly and insights and tools that others can adopt to help scale and spread the lessons learned.

DEVELOPING A VISION FOR THE FUTURE

- To help achieve these goals, Covered California's believes it is important to know what we are trying to achieve.
- The 2030 Vision Statements were developed in consultation with a multi-stakeholder group to envision what the future of health system would look like to meet those goals from the perspectives of each of these major constituencies:
 - Consumers and patients
 - Clinicians and hospitals
 - Health plans
 - Purchasers
 - Communities
- See appendix for 2030 Vision Statements

CONSUMERS AND PATIENTS: CURRENT STATE

- *The quality of care received is very inconsistent, varying based on both consumers' personal characteristics and differences in how care is organized and delivered. Some Californians receive consistently high-quality care while others receive care that is either poor or variable quality.*
- There is widespread disparities in the quality of healthcare based on based on race, ethnicity, socioeconomic status, Limited English Proficiency (LEP), disability and geography.
- Lack of clear communications and lack of effort to remove literacy-related barriers that impact patients' access to high quality care.
- Choice of providers and plans is available to many, but lack of information on the quality and cost of treatments, providers and plans makes it difficult for consumers to choose based on meaningful measures of quality and their individual values and preferences.
- There is massive amounts of data that fail to help consumers or patients contributing to uncertainty about how to get help and from whom and about what to do to maintain health or manage illness.
- *Cost and affordability are barriers to access to high quality care at the right time. Care is often delivered where it will be most profitable rather than where it is most needed or most effective. Care is fragmented and poorly coordinated and comes with a high cost and administrative burden.*
- Many consumers feel disrespected and stigmatized with particular challenges due to race/ethnicity, LGBTQ+, language barriers, mental and behavioral health conditions, disability status and education. This contributes to a pervasive lack of trust that makes it less likely they will access and receive effective care.

CONSUMERS AND PATIENTS: 2030 FUTURE STATE

Consumers and Patients Have Access to a Safe, Timely, Equitable, Effective, Affordable and Patient-Centered Health System

- The health system embraces a culture of health equity and puts consumers, patients and caregivers needs first, by understanding their preferences, goals, values and assets foremost in a system built through consumer-centered design. This includes a recognition of the value of community networks and social infrastructure that support patients' social needs to minimize emergency room and hospital admissions.
- Everyone has the information, care and support needed to promote or improve health, seek and obtain care, manage health-related conditions and make health-related decisions. Patients are activated and engaged so that their goals and values guide health decisions-- and the feedback of diverse patients and experiences are valued and integrated in a learning system. Patients own and control their health information.
- The evidence required to make informed choices of treatments, providers and plans is sound, trusted and easy to understand. The safety, quality, effectiveness, efficiency and equity of care are continually improving.
- The health system is affordable, trusted, simple to use, tailored to the needs of each individual and is consuming a declining share of economic resources so that other human needs and wants can be met.
- Patients can expect to be treated with respect, regardless of race/ethnicity and other sociodemographic factors.
- There are programs and services to address social determinants of health and reduce health disparities across communities. A focus on whole-person care ensures that care is coordinated and communicated at the patient level between physical, oral and mental health care and is culturally and linguistically appropriate.

CLINICIANS: CURRENT STATE

- Payment and management systems have imposed considerable administrative burdens on clinicians which undermine professional values, reduce clinician autonomy and prioritize revenue generation, payer status and income rather than patient needs, all of which contribute to physician burnout and decreasing satisfaction.
- A key source of burden on clinicians is lack of alignment among purchasers and payers. Variation in priorities and requirements cascades to variation in provider performance. Primary care clinicians often work with several organized physician groups interfering with their ability to assume the leadership roles that are needed.
- The information needed to deliver care is too often unavailable due to siloed, administratively focused, and often burdensome electronic health records.
- Physicians (especially, but other clinicians as well) carry high levels of debt that force career choices that are often disconnected from the motivations that brought them to health care. Too few clinicians are entering primary care.
- The clinician workforce is maldistributed, with rural and low-income communities often underserved. Physicians increasingly work for corporate medical groups, independent practice associations or health systems rather than on their own or in integrated delivery systems.
- Clinicians are too often paid in ways that do not encourage better care or lower costs (largely through fee-for-service) rather than under payment models that create incentives aligned with patients' needs for affordable, high quality care – such as capitated or value-based payments.
- The clinician workforce is not always reflective of the populations served, contributing to lack of cultural humility and implicit bias in care delivery.
- There is a lack of investment in preventive and primary care which results in an increasing number of Californians with chronic conditions and comorbidities and greater health care costs.



Collaborative, team-based care models are gaining traction, but far from the norm in the practice setting.

CLINICIANS: 2030 FUTURE STATE

Clinicians are Empowered and Supported to Deliver the Best Possible Care for Their Patients

- Physicians and other clinicians are working in settings where they have the training, support, resources, time and information needed to deliver the best possible care to their patients while contributing to improving the health of their community.
- The foundation of this care is accessible, data-driven, team-based primary care that is culturally and linguistically appropriate.
- Primary care clinicians work for and assume a leadership role in managing integrated, coordinated health care systems. A broader range of clinicians, beyond physicians, provide care to patients based on their health needs. Members of the team share information and assist in decision-making based on their unique skills – all with the common goal of providing the safest, best possible care to patients.
- Information systems integrate comprehensive historical and real-time clinical data to support patient-centered collaborative decision-making, health system improvement and accountability, all with minimal administrative work on the part of clinicians.
- Universal access and alternative payment models enable health systems and clinicians to provide care to all who need it and be rewarded financially for improving both health and care.
- The health professional workforce is trusted and valued, collaborative and team oriented, reflects the diversity of the populations health systems serve and works to address racial/ethnic biases. Professional values are prioritized and joy in work has returned.
- Primary care providers partner with community stakeholders and social service organizations to prevent and manage chronic conditions. To support this vision, purchasers and payers must align priorities and requirements around clinician performance.

HOSPITALS: CURRENT STATE

- Hospitals are essential community resources, as the only current place to treat seriously ill patients, deliver technologically advanced interventions and emergency treatment. Some hospitals provide highly specialized, high quality care and often play a vital role in disasters or public health emergencies.
- Hospitals are important educational sites for physicians, nurses and other health professionals.
- Hospitals are increasingly the only source of care for the uninsured but are hard pressed to deliver needed primary and chronic care to the uninsured and are an ineffective way to finance that care.
- Hospitals that are part of an integrated delivery system offer high quality care at low costs and can keep rural and underserved community hospitals financially secure.
- Hospitals' financial models are largely based on fee-for-service payment systems that reward volume and high-margin (often high cost) services and attracting high-paying patients. The result in many communities is an overemphasis on inpatient and specialty care at the expense of primary and community-based care.
- Hospital mergers are leading to anti-competitive practices and higher prices, with no evidence of gains in quality. For many hospitals, financial performance is their priority. Quality and safety are rarely prioritized and remain uneven.
- Hospitals in rural areas are closing leading to concerns about access to critical care in these areas.
- Regulatory requirements and variation in priorities and requirements from purchasers and payers imposed on hospitals contribute to the high cost and variation in performance of hospital-based care in California.

HOSPITALS: 2030 FUTURE STATE

Hospitals and other Facilities are Continuously Refining Their Roles as Components of Health Systems

- Advances in technology, remote monitoring, telemedicine and payment systems have shifted much acute and chronic care to home and community-based facilities, leading to the “right-sizing” of hospitals, while regulatory changes have enabled planning for less costly approaches to meeting surges in demand.
- Variation in access to care and quality of care at the regional and facility level are greatly decreased. Facility-based care is an integrated component of health systems where safety and quality are outstanding; the quality and cost of care are continuously evaluated and transparently reported.
- Value-based payment is fostering the continued redesign of care to reduce costs and improve safety and has led health systems to prioritize the public good.
- Hospitals are incorporating community benefits in their planning processes.
- Universal insurance and excellent access to all levels of service and adequate behavioral health services have shifted routine care for the uninsured from emergency rooms to other settings.
- Health professional education is no longer hospital-focused and is taking place in settings best suited to the learner’s needs.

HEALTH PLANS: CURRENT STATE

- Health plans compete in a complex market where provider consolidation and pricing power is increasing, relationships are in constant flux and contracts must be continuously renegotiated.
- Limited regulation has led to the proliferation of plan designs that are often customized for each purchaser, sometimes with multiple plan designs. This contributes to high administrative costs and consumer, provider and purchaser confusion.
- Provider networks are complex, overlapping and difficult for consumers to understand. Primary care clinicians often work with several organized physician groups interfering with their ability to assume the leadership roles that are needed. The quality and costs of providers in any network – whether overall or for specific conditions – are often times unknown due to inaccurate or incomplete information, forcing consumers to choose based on reputation or price, not meaningful measures of value.
- For some plans, risk avoidance remains an effective strategy for maximizing profits. The complexity of the market means that plans are not competing to improve quality and affordability for consumers.
- Some plans have demonstrated the ability to provide quality care through provider-plan partnerships, innovative care models that include addressing social needs, and leveraging clinical and patient decision-support technology.

HEALTH PLANS: 2030 FUTURE STATE

Health Plan Offerings are Standardized and Anchored in Partnerships with Providers that Improve Value

- Plans compete on value that is defined by quality and affordability.
- Consumers choose coverage through easy-to-use information services that offer a limited number of plans with common standard benefit designs, a common, agreed upon formulary and with distinct well-defined networks of providers.
- Primary care clinicians work for and are supported in providing leadership within only one integrated, coordinated network. These networks are paid under a unified population-based budget and have flexibility on how they pay providers within the network.
- Common benefit designs and uniform billing and administrative systems have markedly reduced administrative costs.
- Comprehensive performance measures at both the provider and plan level enable meaningful competition among a reasonable number of provider-plan partnerships in local health care markets.
- Plans focus on improving care, reducing costs, ensuring consumer satisfaction and promoting health equity.
- Plans are incentivizing health systems and providers to screen for and address the social determinants of health that may also be impacting health outcomes.

PURCHASERS: CURRENT STATE

- Purchasers' efforts to slow healthcare costs are largely ineffective; these mounting costs consume an increasing share of employee compensation and reduce take home pay.
- Purchasers negotiate individually with health insurers over details of benefits, plan design and prices that have little impact on the forces driving rising costs or variable quality. Lack of broad alignment limits purchasers' leverage and impact.
- Some purchasers are aligning to address specific health system challenges or health conditions with success.
- Limited information is available on the relative performance of treatments, providers and plans, or the effectiveness of different policy approaches to improving health or health care.

PURCHASERS: 2030 FUTURE STATE

Purchaser Alignment is Transforming Health Care Delivery and Reduce Health Care Costs

- Public and private purchasers have aligned on effective care delivery models, provider payment strategies, performance measures and health plan design so that meaningful competition leads to ongoing quality improvement (including addressing disparities) and reduction in health care costs.
- Whether through individual or employer-sponsored coverage, consumers are choosing among a limited number of plans with common benefit designs.
- Purchaser alignment enables aggressive negotiation with plans and health systems, further enhancing competition among insurers.
- Quality and cost transparency are contributing to effective competition between plans.
- Health care costs are declining relative to economic growth.
- Information on effective health policies and delivery reforms are driving further improvements in population health, health care quality and costs.

COMMUNITIES: CURRENT STATE

- Inequity in wealth and power, along with structural racism have led to pervasive disparities in health care, health, and wellbeing. As a result, we see a higher burden of illness and mortality experienced by certain groups relative to others based on various demographics, including geography, sexual orientation, gender identity, income level, education level, and race/ethnicity.
- Health care costs continue to increase, constraining individuals' and communities' capacity to invest in other goods and services that could improve health and well-being overall while reducing disparities.
- Communities are resourceful and resilient, and many are motivated to invest in long term solutions that promote health and well-being for residents. Community and non-profit organizations play a crucial role in the health and well-being of residents.

COMMUNITIES: 2030 FUTURE STATE

Communities Support and Improve the Health and Well-Being of All Residents

- Communities are designed, built and redesigned to promote optimal health for all individuals where they are born, live, learn, work, pray and age.
- Communities are supported through policies, systems and environmental changes that improve the health and well-being of community members and ensure equitable access to resources.
- Communities are empowered with the information, leadership and resources that are needed to ensure health equity across social, economic and behavioral determinants of health.
- Access to health care and the quality of health care does not vary by community or individual based on geography, education level, income level and race or ethnicity.
- Health care is consuming a smaller fraction of income.
- Individuals of diverse backgrounds feel respected and valued.