



**2023-2025 Attachment 7 Refresh Workgroup**

June 3, 2021

# AGENDA

Time	Topic	Presenter
10:00am-10:05	<ul style="list-style-type: none"><li>◆ Welcome and introductions</li></ul>	Thai Lee
10:05-10:25	<ul style="list-style-type: none"><li>◆ Quality Transformation Initiative (formerly known as Quality Transformation Fund)<ul style="list-style-type: none"><li>◆ Goals</li><li>◆ Design principles</li><li>◆ Measure set criteria</li></ul></li></ul>	Alice Chen
10:25-11:10	<ul style="list-style-type: none"><li>◆ Covered California primary care initiatives<ul style="list-style-type: none"><li>◆ Overview of state and national primary care initiatives</li><li>◆ Review of Covered California primary care requirements</li><li>◆ California Quality Collaborative - Advanced Primary Care: A Shared Standard</li><li>◆ Discussion</li></ul></li></ul>	Margareta Brandt Peter Robertson, California Quality Collaborative (CQC) Dolores Yanagihara, Integrated Healthcare Association (IHA)
11:10-11:30am	<ul style="list-style-type: none"><li>◆ Open discussion</li><li>◆ Wrap up &amp; next steps</li><li>◆ Adjourn</li></ul>	Thai Lee

# Quality Transformation Initiative

Alice Hm Chen, MD, MPH  
Chief Medical Officer

- **Covered California is proposing to implement a Quality Transformation Initiative (QTI, formerly know as 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 QTI with no funds at risk in 2022 and implement the first year of money at risk in 2023
- Covered California will publish the QTI measures and methodology separately from the contract for the QTI pilot in 2022

## QRS Getting the Right Care Summary Indicator Performance

Health Plan	% 2020 Enrollees	2016	2017	2018	2019	2020
Anthem EPO	5%	2	NA	3	2	2
Anthem HMO	1%	3	-	-	-	NA
Anthem PPO	-	2	-	-	-	-
Blue Shield HMO	5%	NA	NA	NA	2	3
Blue Shield PPO	20%	2	2	3	2	3
CCHP HMO	0.4%	3	3	3	3	3
Health Net EPO	0.1%	NA	2	3	2	3
Health Net HMO	12%	3	3	3	3	3
Health Net PPO	3%	-	NA	NA	NA	3
Kaiser HMO	36%	5	4	5	5	5
LA Care HMO	5%	1	3	4	3	4
Molina HMO	3%	2	3	3	2	2
Oscar EPO	5%	NA	NA	3	2	2
Sharp HMO	1%	4	4	5	4	4
Valley HMO	1%	3	3	5	4	4
Western HMO	1%	3	3	3	2	2

- QHP performance, as measured by QRS, has not consistently improved over time.
- In 2020, 4 of 11 health plans (14% enrollees) received 2 stars for Getting the Right care.
  - 3 received 3 stars
  - 3 received 4 stars
  - 1 received 5 stars

- Create the “business case for quality and equity” by scaling quality and equity performance penalties to a magnitude that motivates improvement, particularly at the lower end of performance.
- Encourage enrollees to choose higher performing plans.
- Select a parsimonious set of measures aligned to the extent possible with other major purchasers to more effectively signal critical areas of attention for the delivery system.
- Utilize funds to drive improvements, reduce disparities and narrow quality gaps across providers.

Quality performance is tied to financial consequences.	Plans can both avoid the penalty and potentially gain enrollment with better performance.
A high standard of performance is expected.	Excellence – not average performance – is the goal.
Penalties are higher at lower levels of performance.	Higher penalties incentivize more improvement; the lowest levels of performance are unacceptable.
Reward attainment rather than improvement.	We are aiming for achievement, not relative improvement.
Plans should be held to the same standards.	All enrollees deserve to receive the same high level of quality; as a general rule, plans should be treated equally.
Select measures that matter.	Prioritize quality measures that are clearly linked to important clinical health outcomes as well as can be targeted for disparity reduction.
Focus on a select set of established, commonly used quality and equity measures.	Use of a small set of aligned measures across purchasers reduces administrative burden on health plans and providers.
Funds derived from the financial penalty will be used to support improvement rather than rewards for high performance.	Transformational improvement requires investment. Redistribution of penalty to high performing plans would be unlikely to spur additional improvement more broadly.

- **Epidemiologically relevant:** target conditions that are key drivers of morbidity and mortality for Californians, with significant racial/ethnic disparities in outcomes
- **Outcomes focused:** select measures with clear linkage to clinical outcomes
- **Established:** minimize administrative burden by relying on nationally endorsed metrics that, as much as possible, are shared across multiple measure sets
- **Actionable:** choose measures where improvement is clearly amenable to health care intervention
- **Parsimonious:** focus on a select subset of measures to achieve impact
- **Aligned:** strive to align measure sets and measure specifications to allow maximal synergy across health plans and providers



# Primary Care Initiatives

Margareta Brandt  
Quality Improvement Manager

# STATE AND NATIONAL PRIMARY CARE INITIATIVES

## State initiatives

- CQC Advanced Primary Care standards
- Covered California pilot of Advanced Primary Care measure set with CQC
- Covered California study of primary care spend with IHA
- Blue Shield multi-payer primary care payment model analysis by IHA
- CHHS Office of Health Care Affordability
- CHCF primary care investment coordinating group (PICG)
- CAFP sponsored SB 402 Multi-payer Payment Reform Collaborative legislation

## National initiatives

- PBGH national primary care payment reform workgroup
- Milbank Memorial Fund primary care spend analysis
- Primary Care Collaborative attributes of advanced primary care
- CMS Primary Care First program
- Health Care Payment Learning and Action Network (HCP LAN)
- National Academies report, *Implementing High Quality Primary Care: Rebuilding the Foundation of Health Care* (NASEM 2021)\*

# EFFECTIVE PRIMARY CARE 2022 CONTRACT REQUIREMENTS

- ❑ PCP matching for all enrollees
- ❑ Promotion of advanced primary care through quality improvement and technical assistance, encourage participation in primary care improvement collaboratives
- ❑ Increasing primary care payment tied to shared savings and population-based payment models (using HCP LAN APM categories)
  - Performance subject to penalty through Attachment 14 performance standards
- ❑ Pilot advanced primary care measure set to measure the performance of primary care practices
  - Collaborate with California Quality Collaborative (CQC) and Integrated Healthcare Association (IHA) to implement the pilot
  - Submit data to IHA to support implementation

# EFFECTIVE PRIMARY CARE PROPOSED 2023-25 CONTRACT REQUIREMENTS

## Proposed continued requirements

- PCP matching for all enrollees
- Promotion of advanced primary care through quality improvement and technical assistance

## Proposed new or enhanced requirements

- Increasing primary care payment to support advanced primary care functions, including care management fees, incentives for quality performance, and payment tied to shared savings and population-based payment models
- Implementation of advanced primary care measure set to measure the performance of primary care practices
- Improvement requirements for low quality primary care practices (may be implemented in 2024 or 2025 based on measure set analysis)
- Reporting on primary care spend or collaborate with Covered CA to measure primary care spend
- Primary care spend target or floor requirement (may be implemented in 2024 or 2025 based on primary care spend analysis)

# MEASURING EFFECTIVE PRIMARY CARE USING THE CQC ADVANCED PRIMARY CARE MEASURE SET

Covered California is pursuing the use of the CQC Advanced Primary Care measure set beginning in 2022. The measure set:

- Recognizes the importance of **patient outcomes and experience of care**, deemphasizes process-orientated approaches (e.g., PCMH) to identify effective primary care
- **Identifies practices providing advanced primary care** and concentration within Covered California's contracted health plan networks
- **Leverages existing statewide data infrastructure** supported by the requirement that health plans participate in IHA beginning in 2022

The pilot period will inform future requirements for health plans to address the variation in performance of their contracted primary care practices



June 3, 2021

# Advanced Primary Care Pilot

Peter Robertson,  
California Quality Collaborative

Dolores Yanagihara,  
Integrated Healthcare Association



California Quality  
Collaborative

# Advanced Primary Care - A Shared Standard

## Purpose:

Create a **shared standard** that emphasizes a **high quality, lower-cost** primary care experience centered around the **patient**

## Objectives:

- Enable purchasers and patient to recognize and identify practices providing Advanced Primary Care (APC) and to **pay for it differently**
- Utilize a patient centered and outcome focused measurement framework to readily **identify practices that are delivering APC**
- Provide clear **guidance** to providers to attain APC



## Resources

Advanced Primary Care: Defining A Shared Standard

- [Technical Brief](#)
- [One-Pager](#)

# Advanced Primary Care - A Shared Standard

## Development Process

- 18+ month **multi-stakeholder** process driven by CQC's Steering Committee
- **Aligned** efforts with other National and Regional initiatives
- **Evidence based** and informed by CQC's experience during multi-year Practice Transformation program.

The Advanced Primary Care standard includes 2 components:

### *Define*

#### Attributes

Patient's experience of care across a set of highest order care processes

### *Identify*

#### Measures

Indicator of implementation of attributes



# Attributes of Advanced Primary Care

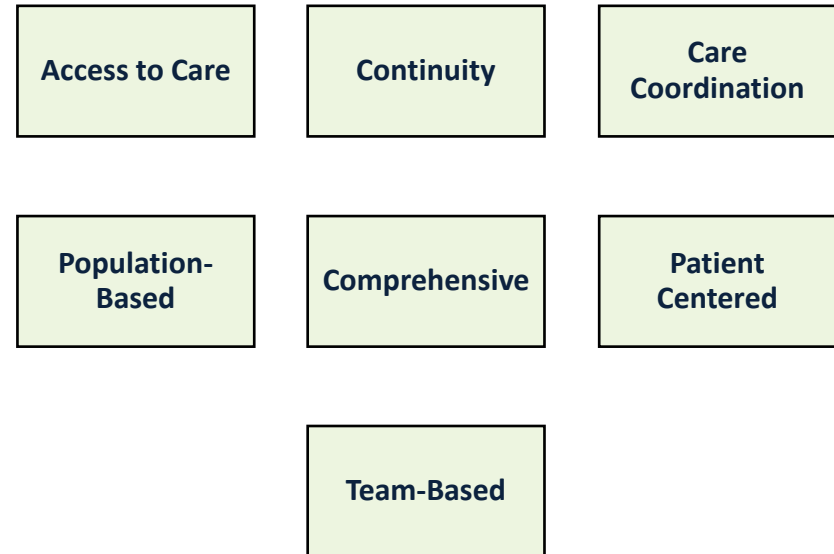
The attributes define advanced primary care:

- From the **patient perspective** and how the **patient experiences** care
- **Agnostic to the method**, or ‘the how’, each attribute was achieved

“I can get the care and information from my primary care team when I need it and in the way that best meets my needs”

A patient’s description of primary care that embodies a **patient centered** approach that addresses both **access** and **continuity** of care.

## Attribute Domains

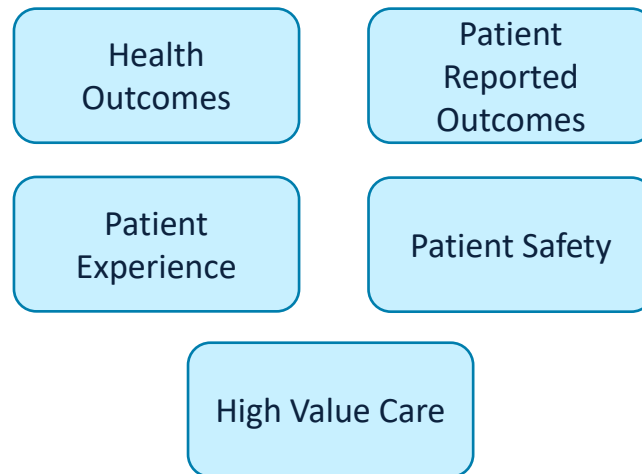


# Advanced Primary Care - Measure Selection Criteria

## Individual measures were selected to:

- Reflect patients experience of care & their individual health outcomes
- Aligned around a suite of quality domains representing high quality/value of care (Reflecting incorporation of the **attributes** within a practice)
- Assess the entire spectrum of primary care (**Pediatrics & Adults**)
- Minimize reporting burden (*Aligned across Payers and with National & Regional quality programs*)

## Quality Domains



# Advanced Primary Care – Measure Set

Measure	NQF ID	Population
Asthma Medication Ratio	1800	Pediatric/Adult
Childhood Immunization Status (Combo 10)	0038	Pediatric
Colorectal Cancer Screening	0034	Adult
Concurrent Use of Opioids and Benzodiazepines	3389	Adult
Controlling High Blood Pressure	0018	Adult
Diabetes HbA1c Poor Control (>9%)	0059	Adult
Immunizations for Adolescents	1407	Pediatric
Patient Experience (CG-CAHPS)	0005	Pediatric/Adult
Depression Remission at 6 months*	0711	Pediatric/Adult
Emergency Department Visits	-	Pediatric/Adult
Inpatient Utilization/ Acute Hospital Utilization	-	Pediatric/Adult
Total Cost of Care (Standardized Pricing)	1604	Pediatric/Adult

\* Phased implementation approach. In 2021, pilot will adopt the CMS developed Depression Screening and Follow-up measure (NQF ID: 0418)

CQC's Advanced Primary Care measure set is aligned with primary care payment models in development or in use within California, including:

- IHA's Value Based Payment Model for Primary Care
- Blue Shield's Pay-for-value PPO program
- CMS Primary Care First alternative payment model

# Covered California Pilot - Guiding Principles

1. Leverage existing data infrastructure within IHA
  - Utilize claims feeds and supplemental data currently reported by Health Plans and Provider Organizations as part of IHA's Align.Measure.Perform suite of programs
  - Minimize any new data collection specific to pilot
2. Assess practice performance across commercial lives
  - Plan to aggregate practice data across purchasers (e.g., Covered California and non-Covered California members) and health plans
  - Provide more actionable data to all stakeholders and reduce the impact of small numbers
3. Encourage participation of other purchasers

# Covered California Pilot – Timeline & Next Steps

2021



Defining & testing practice attribution model

Finalize & disseminate program mechanics

2022



Start of pilot measurement year

MY 2022 data submission to IHA

End of pilot measurement year

2023



Complete MY 2022 data submission to IHA

Pilot results available

# Practice Attribution

## Multi-Stage Attribution Model



### Stage 1: Member to Physician

- Utilize Covered California member PCP assignment
- When not available, attribute based on algorithm
- Aggregate member data across health plans to increase panel

### Stage 2: Physician to Practice

- Test and determine methodology
- Try combination of physician and practice identifiers and location information

# Practice Attribution

- Test and determine methodology for practice attribution
  - Investigate billing provider information and its relationship to rendering providers
  - Explore consistency of various potential methods using combo of identifiers and location
  - Consider against panel size for sufficient reliability

## Examples of Practice Attribution Methodology

### CMS TCPI Program<sup>1</sup>

- TIN *and*
- Zip-Code+4 extension

### CQC/IHA/CCI – PTI<sup>2</sup>

- TIN *or*
- NPI Level 2 *or*
- PO Internal Identifier

### PBGH – CHPI<sup>3</sup>

- 2 or more physicians (same specialty)
- Common address (primary & secondary address units)

1. Centers for Medicare & Medicaid Services, Transforming Clinical Practice Initiative
2. Practice Transformation Initiative
3. California Healthcare Performance Information System

# Pilot Challenges

- Small numbers
  - Practices may be excluded from the analysis due to low member attribution
- Supplemental data
  - Individual measures that require supplemental clinical data may have low performance, e.g., Depression Screening, Blood Pressure Control
- Patient Experience
  - PAS results currently only generated at Health Plan and Provider Organization level
  - PAS investigating methodology to assign practice level results (minimum n)



# Depression Screening Data Collection

- There is currently no established data stream for collecting depression screening results
- The CMS depression screening measure is currently self-reported by some provider organizations for AMP, but not at the practice level
- There is a claims-based version of the CMS depression screening measure
  - Relies on G-codes to determine screening, results, and appropriate follow-up
- Health plan claims data submitted to IHA includes these G-codes
  - Increasing number over time
  - Majority for Commercial members, including some Covered CA members
  - BUT still < 1% of members with these G-codes

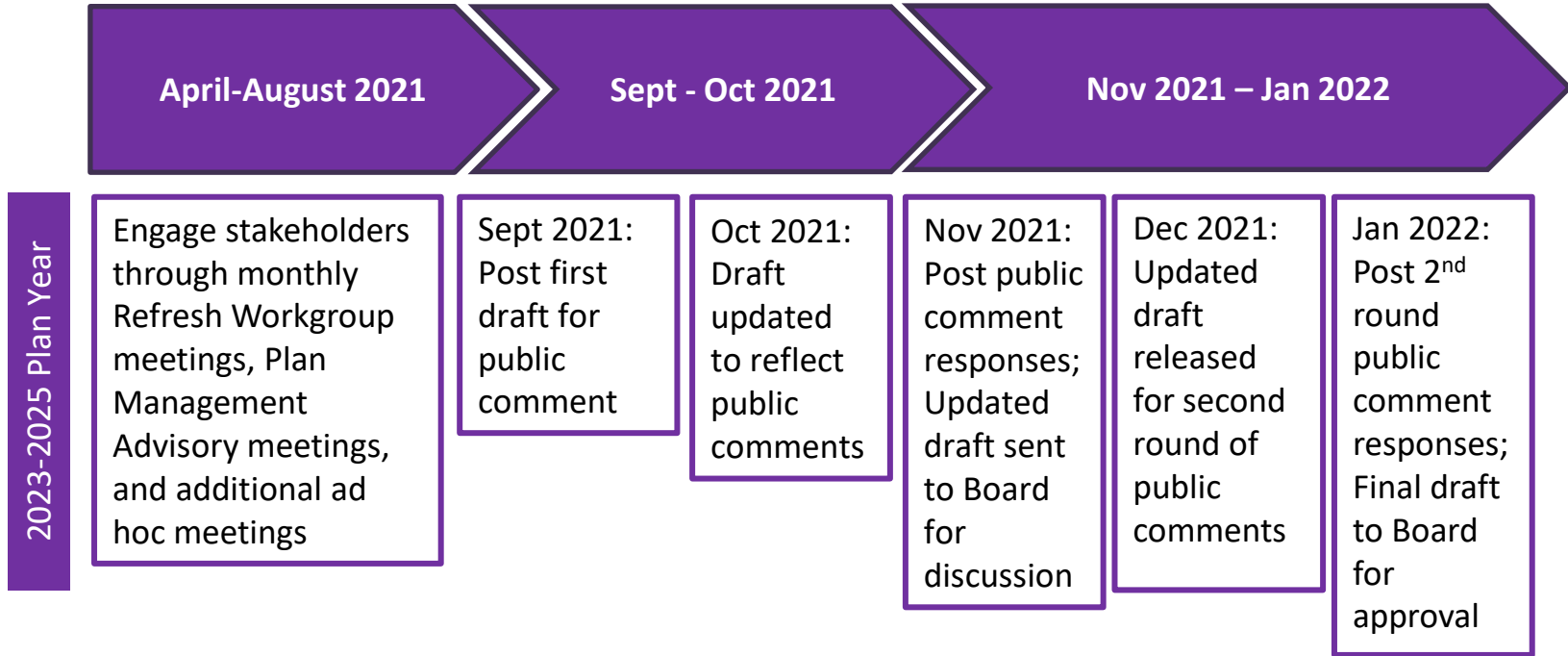
## Next Steps

- Follow up attribution and implementation discussions with QHPs
- Data submission discussions with remaining QHPs

# Open discussion & Next steps

Thai Lee, Senior Quality Improvement Specialist

# PROPOSED 2023-2025 ATTACHMENT 7 DEVELOPMENT TIMELINE



# NEXT STEPS AND DISCUSSION

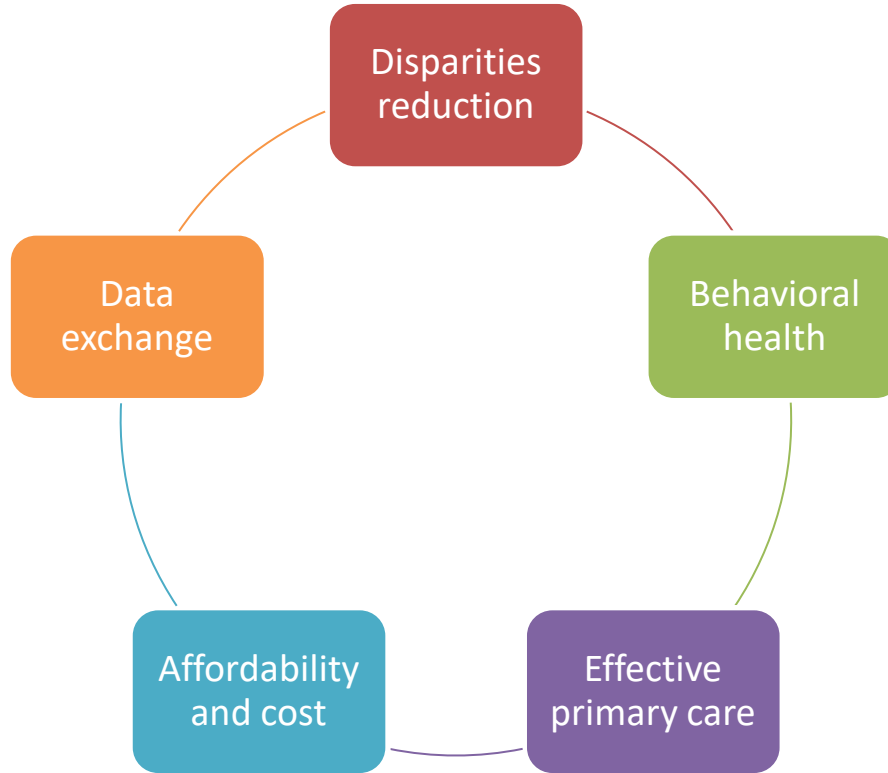
- Upcoming proposed 2023-2025 Attachment 7 refresh workgroup meetings:
  - July 1
    - Behavioral health
    - Data exchange
  - August 5
    - Affordability and cost
  
- Topics to be scheduled
  - QTI measures and methodology
  - Alignment opportunities with DHCS, CalPERS
  
- Submit questions and comments to Thai at [thai.lee@covered.ca.gov](mailto:thai.lee@covered.ca.gov)

# Appendix

# COVERED CALIFORNIA'S FRAMEWORK FOR HOLDING PLANS ACCOUNTABLE FOR QUALITY, EQUITY, AND DELIVERY SYSTEM TRANSFORMATION

Domains for Equitable, High-Quality Care	Care Delivery Strategies	Goals
<p>PHYSICAL   BEHAVIORAL   ORAL   SOCIAL</p> <ul style="list-style-type: none"> <li>• Population health management</li> <li>• Health promotion and prevention</li> <li>• Acute care</li> <li>• Chronic care</li> <li>• Complex care</li> </ul>	<ul style="list-style-type: none"> <li>• Effective primary care</li> <li>• Appropriate, accessible specialty care</li> <li>• Integrated delivery systems and ACOs</li> <li>• Networks based on value</li> <li>• Leveraging technology</li> <li>• Cultural and linguistic competence</li> </ul>	<ul style="list-style-type: none"> <li>• Improvement in health status</li> <li>• Elimination of disparities</li> <li>• Evidence-based care</li> <li>• Patient-centered care</li> <li>• Affordability for consumers and society</li> </ul>
<h3>Key Levers</h3> <p>Covered California recognizes that promoting change in the delivery system requires <b>aligning</b> with other purchasers and working with all relevant payers in a way that improves value for consumers and society while minimizing administrative burden on plans and providers.</p> <ul style="list-style-type: none"> <li>• Benefit design</li> <li>• Measurement for improvement and accountability</li> <li>• Data sharing and analytics</li> <li>• Payment reform</li> <li>• Consumer empowerment</li> <li>• Quality improvement collaboratives</li> <li>• Technical assistance</li> <li>• Certification and accreditation</li> </ul>		
<p><b>Community Drivers:</b> Social Influences on Health, Economic and Racial Justice</p>		

# PRIORITY AREAS FOR 2023-2025 ATTACHMENT 7





# IMPLEMENTING HIGH QUALITY PRIMARY CARE: REBUILDING THE FOUNDATION OF HEALTH CARE (NASEM 2021) (1 OF 2)

Objective One: Pay for primary care teams to care for people, not for doctors to deliver services.

## Actions

1. Action 1.1: Payers—Medicaid, Medicare, commercial insurers, and self-insured employers—should evaluate and disseminate payment models based on the ability of those models to promote the delivery of high-quality primary care, as defined by the committee, and not on their ability to achieve short-term cost savings.
2. Action 1.2: Payers—Medicaid, Medicare, commercial insurers, and self-insured employers—using a fee-for-service (FFS) payment model for primary care should shift primary care payment toward hybrid (part FFS, part capitated) models, making them the default method for paying for primary care teams over time. For risk-bearing contracts with population-based health and cost accountabilities, such as those with accountable care organizations, payers should ensure that sufficient resources and incentives flow to primary care. Hybrid reimbursement models should:
  - a. pay prospectively for interprofessional, integrated, team-based care, including incentives for incorporating non-clinician team members and for partnerships with community-based organizations;
  - b. be risk-adjusted for medical and social complexity;
  - c. allow for investment in team development, practice transformation, and the infrastructure to design, use, and maintain necessary digital health technology; and
  - d. align with incentives for measuring and improving outcomes for attributed populations.

Source: <https://www.nap.edu/catalog/25983/implementing-high-quality-primary-care-rebuilding-the-foundation-of-health>

# IMPLEMENTING HIGH QUALITY PRIMARY CARE: REBUILDING THE FOUNDATION OF HEALTH CARE (NASEM 2021)

Objective One: Pay for primary care teams to care for people, not for doctors to deliver services.

## Actions

3. Action 1.3: The Centers for Medicare & Medicaid Services should increase the overall portion of spending going to primary care by:
  - a. accelerating efforts to improve the accuracy of the Medicare physician fee schedule by developing better data collection and valuation tools to identify overpriced services, with the goal of increasing payment rates for primary care evaluation and management services by 50 percent and reducing other service rates to maintain budget neutrality; and
  - b. restoring the Relative Value Scale Update Committee to the advisory nature as originally intended by developing and relying on additional independent expert panels and evidence derived directly from practices.
4. Action 1.4: States should implement primary care payment reform by:
  - a. using their authority to facilitate multi-payer collaboration on primary care payment and fee schedules and,
  - b. measuring and increasing the overall portion of health care spending in their state going to primary care.

Source: <https://www.nap.edu/catalog/25983/implementing-high-quality-primary-care-rebuilding-the-foundation-of-health>