



## **2023-2025 Attachment 7 Refresh Workgroup**

September 2, 2021

# AGENDA

Time	Topic	Presenter
10am-10:05	<ul style="list-style-type: none"><li>◆ Welcome and introductions</li></ul>	Thai Lee
10:05-10:55	<ul style="list-style-type: none"><li>◆ Overview of draft 2023 – 2025 Attachment 7</li></ul>	EQT Staff
10:55-11:25	<ul style="list-style-type: none"><li>◆ Quality Transformation Initiative (QTI) update</li></ul>	Alice Chen
11:25-11:30pm	<ul style="list-style-type: none"><li>◆ Wrap up &amp; next steps</li><li>◆ Adjourn</li></ul>	Thai Lee

# Overview of Draft 2023-2025 Attachment 7

Alice Hm Chen, MD, MPH  
Chief Medical Officer

# OVERVIEW

- ❑ 2020 vision statements serve as north star for quality and equity work
- ❑ 2022 included substantive review and refresh of Attachment 7
- ❑ 2023 significant as the beginning of a new, three-year contract cycle
- ❑ In recognition that improvement is necessarily iterative and ongoing, initial provisions for 2023 will be followed by amendments in 2024, 2025
- ❑ Covered California's approach includes:
  - Building on seven years of experience and investment
  - Increased focus on data and outcomes over narrative reporting
  - Intentional alignment with other public purchasers
  - Implementation of Quality Transformation Initiative

# 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>		

# PRINCIPLES AND STRATEGIC FOCUS AREAS

Quality is central

Equity is quality

Measures that matter

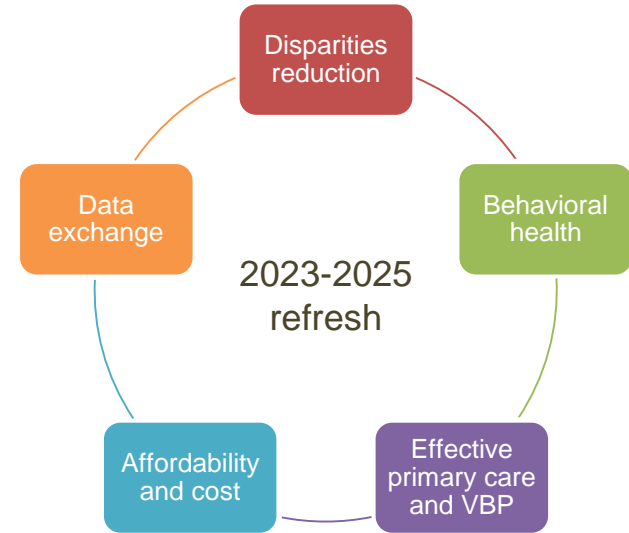
Make quality count

Amplify through alignment

Promote public good

Care about cost

## STRATEGIC FOCUS AREAS



Alignment with DHCS/CalPERS  
Quality Transformation Initiative  
Data analytics/Healthcare Evidence Initiative

# 2023-25 EQT REFRESH WORKSTREAMS

## Attachment 7 Implementation

- Establish implementation or activity requirements

## Attachment 7 Process Reporting

- Designate select areas for reporting with a focus on priority areas

## Quality Playbook

- Simplify Attachment 7 by transitioning some requirements to the Quality Playbook as best practices and resources

## Quality Transformation Initiative

- Select QTI measures and benchmarks
- Determine QTI methodology and premium at risk
- Determine how QTI funds will be invested

## Attachment 14

- Identify key areas for performance guarantees in addition to QTI

# Disparities Reduction Proposed Requirements

Rebecca Alcantar, Senior Health Equity Specialist  
Taylor Priestley, Health Equity Officer



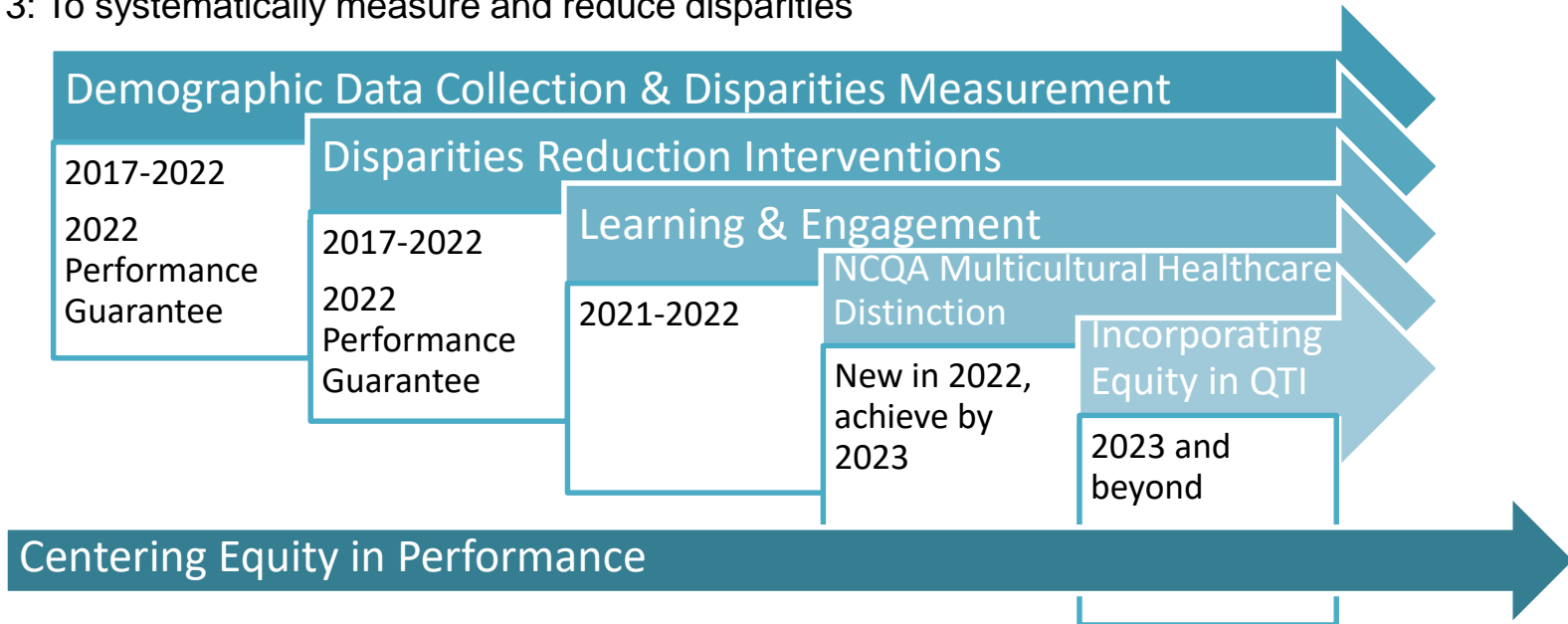
# DISPARITIES REDUCTIONS GOALS

Covered California's multi-year disparities reduction initiatives have been in place since 2017 and seek to achieve the following goals:

Goal 1: To improve disparity data capture to support measurement and

Goal 2: To improve structure and rigor for disparities intervention development in order to

Goal 3: To systematically measure and reduce disparities



# PROGRAM AND POLICY CONTEXT

Covered California is actively engaged with or tracking the following initiatives:

- ❑ DMHC: AB 133 Health Quality and Equity Measures development
- ❑ NCQA: HEDIS measure race/ethnicity stratification requirements 2022-2024; evolution of Multicultural Health Care Distinction to Health Equity Accreditation effective 2023
- ❑ National Quality Forum (NQF) Measure Applications Partnership (MAP) Health Equity Advisory Group
- ❑ Health Care Payment Learning and Action Network (HCP-LAN) Health Equity Advisory Team (HEAT)

# 2022 CURRENT VS 2023-25 PROPOSED REQUIREMENTS

## Disparities Reduction

2022 Current Requirements	2023-25 Proposed Requirements
<b>Article 1.01 Demographic Data Collection</b> Achieve 80% self-identification of race and ethnicity data for Covered California members.	(1) Continue race/ethnicity data collection. Consider increased penalty (7.5% in 2022). Propose increased penalty for HEI data performance guarantees. (2) Expand demographic data collection to preferred language. Phase in threshold requirement based on current state. Consider phased in penalty.
<b>Article 1.02 Identifying Disparities in Care</b> Submit patient-level HEDIS hybrid measure data stratified by race and ethnicity.	Expand measure set to initial QTI measures set given centrality of disparities reduction in QTI development. Consider stratification by other demographics.
<b>Article 1.03 Disparities Reduction Intervention</b> Meet a mutually agreed upon intervention population improvement target in quality based on the mutually agreed-upon health disparities intervention proposal.	Update intervention performance level to proposed expectations for multi-year gap reduction. Maintain or consider increased penalty (7.5% in 2022) with transition to QTI accountability.

# 2022 CURRENT VS 2023-25 PROPOSED REQUIREMENTS

## Disparities Reduction

2022 Current Requirements	2023-25 Proposed Requirements
<p><b>Article 1.04 Statewide Focus Health Equity Collaborative Efforts</b> Participate in collaborative efforts to identify and align statewide disparity work. Covered CA will convene these discussions or identify venues for collaborative development of aligned activities.</p>	<p>Remove; incorporate outcomes of 2021-2022 statewide focus disparity effort in disparities reduction or other applicable section(s).</p>
<p><b>Article 1.05 Culture of Health Equity Capacity Building</b> Achieve NCQA Multicultural Healthcare Distinction by year-end 2023; early achievement by year-end 2022 eligible for performance credit.</p>	<p>Submit NCQA Multicultural Healthcare Distinction evidence of compliance by 2023. Propose penalty if distinction is not achieved by year-end 2023.</p>

# AREAS OF EXPLORATION

- ❑ Continuing alignment effort with DMHC and DHCS/CalPERS priority quality and equity measures
- ❑ Continuing alignment effort with NCQA implementation of race/ethnicity stratified HEDIS measures 2022-2024
- ❑ Determining timing of transition of disparities measurement and reduction requirements to QTI accountability
- ❑ Evolving the disparities data collection and measurement requirements
- ❑ Assessing the need for additional cultural and linguistic competency requirements or Quality Playbook recommendations to supplement current contractual requirements and NCQA Health Equity Accreditation standards

# Behavioral Health Proposed Requirements

Margareta Brandt, Quality Improvement Manager

# BEHAVIORAL HEALTH GOALS

- To ensure enrollees have access to and receive timely and effective behavioral health care
- To ensure enrollees receive evidence-based behavioral health care
- To use appropriate, effective measures to track behavioral health quality with a focus on outcomes measures
- To strengthen and expand integration of behavioral health with primary care
- To improve behavioral health outcomes for enrollees

# PROGRAM AND POLICY CONTEXT

Covered California is actively engaged in the following initiatives:

- ❑ Joint Purchaser Behavioral Health Project
- ❑ CQC Advanced Primary Care workgroup (incorporating integrated behavioral health)

Covered California is actively tracking the following initiatives:

- ❑ DHCS' Children and Youth Behavioral Health Initiative
- ❑ DHCS' Behavioral Health Continuum Infrastructure Program
- ❑ AB 457: Protection of Patient Choice in Telehealth Provider Act
- ❑ AB 935: Mothers and Children Mental Health Support Act
- ❑ SB 221: Timely access to behavioral health care
- ❑ SB 428: Coverage for adverse childhood experiences screenings



# 2022 CURRENT VS 2023-25 PROPOSED REQUIREMENTS

## Behavioral Health

2022 Current Requirements	2023-25 Proposed Requirements
<p><b>Article 4.01 Access to Behavioral Health Services</b></p> <ul style="list-style-type: none"><li>• Submit NCQA behavioral health network management reports</li><li>• Monitor depression treatment penetration rates and general behavioral health utilization rates</li></ul>	<p><i>Minor updates will be made in 2023. Larger revisions will be made in 2024 and 2025 based on the Joint Purchaser Behavioral Health project and data gathered through the implementation of 2022 requirements.</i></p>
<p><b>Article 4.02 Offering Telehealth for Behavioral Health Services</b></p> <ul style="list-style-type: none"><li>• Offer telehealth for behavioral health services</li><li>• Monitor telehealth utilization and report annually</li></ul>	
<p><b>Article 4.03 Quality of Behavioral Health Services</b></p> <ul style="list-style-type: none"><li>• Monitor QRS results and report annually</li><li>• Monitor depression screening and follow up rates and report annually</li></ul>	
<p><b>Article 4.04 Appropriate Use of Opioids</b></p> <ul style="list-style-type: none"><li>• Implement SmartCare guidelines for appropriate use of opioids</li><li>• Monitor the following measures: MAT Prescriptions, Use of pharmacotherapy; Concurrent Use of Opioids and Benzodiazapines; Use of Opioids at High Dosage; Concurrent Use of Opioids and Naloxone</li></ul>	
<p><b>Article 4.05 Integrating Behavioral Health Services with Medical Services</b></p> <ul style="list-style-type: none"><li>• Report how behavioral health integration is being promoted; percent of enrollees receiving services in integrated models; whether collaborative care model codes are reimbursed</li><li>• Monitor utilization of collaborative care model claims codes using HEI and report annually</li></ul>	

# AREAS OF EXPLORATION

- ❑ Requiring the use of PHQ-2/PHQ-9 tools with the implementation of the Depression Screening and Follow-Up Plan (NQF #0418) to support future implementation of patient-reported outcome measures (PROMs) for depression
- ❑ Requiring reimbursement or coverage of Collaborative Care Model services
- ❑ Looking to the results of the new Joint Purchaser Behavioral Health Project
  - Focus of project is access, quality, and equity with an emphasis on screening and treatment for mild to moderate conditions
  - Results are expected in Spring 2022 for inclusion in the 2024-2025 amendment
  - Key questions will assess current state and ask how purchasers can drive change around: unmet need, barriers to access, provider network adequacy, and current measures and measurement gaps

# Advanced Primary Care (APC) and Integrated Delivery Systems (IDS) Proposed Requirements

Margareta Brandt, Quality Improvement Manager

# ADVANCED PRIMARY CARE AND IDS GOALS

- ❑ To ensure access to effective primary care – defined as equitable, coordinated, comprehensive, longitudinal – as the foundation of a high functioning health care delivery system
- ❑ To support effective primary care and integrated care through sufficient payment and the spread of alternative payment models such as population-based payment and shared savings
- ❑ To promote alignment of payers and providers through common measures and goals to improve quality and reduce cost

# PROGRAM AND POLICY CONTEXT

Covered California is actively engaged in the following initiatives:

- ❑ CQC development of Advanced Primary Care measure set
- ❑ CQC Advanced Primary Care workgroup
- ❑ Covered CA – IHA primary care spend analysis
- ❑ CHCF primary care investment coordinating group (PICG)
- ❑ PBGH national primary care payment reform workgroup

Covered California is actively tracking the following initiatives:

- ❑ Blue Shield multi-payer primary care payment model analysis by IHA
- ❑ CHHS Office of Health Care Affordability
- ❑ CAFP sponsored SB 402 Multi-payer Payment Reform Collaborative
- ❑ CMS Primary Care First program
- ❑ HCP LAN focus on health equity in primary care payment models
- ❑ National Academies report, *Implementing High Quality Primary Care: Rebuilding the Foundation of Health Care* (NASEM 2021)

# 2022 CURRENT VS 2023-25 PROPOSED REQUIREMENTS

## Primary Care and Integrated Systems

2022 Current Requirements	2023-25 Proposed Requirements
<p><b>Article 7.01 Encouraging Use of Primary Care</b></p> <ul style="list-style-type: none"><li>• All enrollees select or are assigned a PCP</li></ul>	<ul style="list-style-type: none"><li>• Continue requirement for all enrollees to select or be assigned a PCP</li><li>• Require reporting of percentage of enrollees select vs. are assigned PCP</li><li>• Continue to explore options for evaluating the impact of PCP matching</li></ul>
<p><b>Article 7.02 Promotion of Advanced Primary Care</b></p> <ul style="list-style-type: none"><li>• Promote and support advanced primary care models</li><li>• Covered California strongly encourages health plans to support or provide quality improvement and technical assistance to primary care practices</li></ul>	<p><i>This will be incorporated into 7.03 Measuring Advanced Primary Care</i></p>
<p><b>Article 7.03 Measuring Advanced Primary Care</b></p> <ul style="list-style-type: none"><li>• Pilot the advanced primary care measure set with CQC</li><li>• Submit data to IHA to support the pilot</li></ul>	<ul style="list-style-type: none"><li>• Continue and strengthen requirements to implement and report on the advanced primary care measure set</li><li>• Continue to require IHA data submissions</li></ul>

# 2022 CURRENT VS 2023-25 PROPOSED REQUIREMENTS

## Primary Care and Integrated Systems

2022 Current Requirements	2023-25 Proposed Requirements
<p><b>Article 7.04 Payment to Support Advanced Primary Care</b></p> <ul style="list-style-type: none"><li>• Report on primary care payment models using HCP LAN categories</li><li>• Adopt and progressively expand the number and percent of primary care clinicians paid through the HCP LAN population-based payment and alternative payment models built on a fee for service structure such as shared savings each year</li></ul>	<ul style="list-style-type: none"><li>• Continue reporting on primary care payment models using Health Care Payment Learning and Action Network Alternative Payment Model (HCP LAN) categories</li><li>• Require reporting of primary care spend as a percentage of overall budget, and by HCP LAN category</li><li>• Newly require issuers to report a description of the payment models for its 5 largest medical groups or IPAs as defined by the number of providers</li><li>• Continue Attachment 14 standard for progressively expanding the number and percent of primary care clinicians paid through the HCP LAN population-based payment and alternative payment models</li></ul>
<p><b>Article 8.01 Enrollment in IDSs and ACOs</b></p> <ul style="list-style-type: none"><li>• Meet a threshold for the number of enrollees cared for within an ACO or IDS model each year</li><li>• Report on characteristics of IDS and ACO systems</li></ul>	<ul style="list-style-type: none"><li>• Continue reporting on number and percent of enrollees who are cared for within an ACO or IDS</li><li>• Enhance reporting requirements using structured format to report the details of each ACO or IDS, including the number and type of partner organizations, one-sided or two-sided risk sharing, and amount of payment at risk</li></ul>

# 2022 CURRENT VS 2023-25 PROPOSED REQUIREMENTS

## *Primary Care and Integrated Systems*

2022 Current Requirements	2023-25 Proposed Requirements
<p><b>Article 8.02 Measuring IDS and ACO Performance</b></p> <ul style="list-style-type: none"><li>• Participate in the IHA and submit data to IHA for use in the IHA Commercial ACO Measure Set and Commercial HMO Measure Set, as applicable for its delivery system model</li><li>• Submit results to Covered California</li></ul>	<ul style="list-style-type: none"><li>• Continue to require IHA data submissions</li></ul>



# AREAS OF EXPLORATION

- ❑ Continuing to explore options for evaluating the impact of PCP matching such as tracking how many enrollees have a visit with their selected or assigned PCP
- ❑ Developing improvement requirements for issuers contracted with low quality or low value primary care practices, based on results of the advanced primary care measure set
- ❑ Encouraging enrollee selection or assignment of high quality or high value primary care practices, based on results of the advanced primary care measure set
- ❑ Developing a primary care spend target or floor requirement, based on the Covered CA primary care spend analysis with IHA
- ❑ Comparing performance on the QTI measure set for IDS/ACO and non-IDS/ACO enrollees

# Affordability and Cost Proposed Requirements

Thai Lee, Senior Quality Improvement Specialist

# AFFORDABILITY AND COST GOALS

*Covered California will enhance its focus on affordability and cost in 2023 and future years*

- ❑ To ensure high-value qualified health plan networks through measuring the quality and cost performance of physician groups and hospitals; health plans should not only contract with higher performers, but also work to improve performance of lower performers
- ❑ To ensure affordability for high-value drugs and services and improve access to effective treatments using tools such as value-based insurance design (VBID)
- ❑ To explore effectiveness and impact of cost transparency initiatives

# PROGRAM AND POLICY CONTEXT

Covered California is actively engaged in the following initiatives:

- ❑ State and federal subsidies help consumers obtain high value health insurance at an affordable cost
- ❑ Covered California's patient-centered benefit design ensures that benefits are the same, depending on metal tier, across different health plans; and that there are no surprise costs
- ❑ Covered California's Quality Transformation Initiative includes focus on diabetes, with HbA1C <8% (NQF #0575) as a proposed measure

Covered California is actively tracking the following initiatives:

- ❑ AB 97 (Nazarian) – Assembly bill prohibiting a deductible from being applied to insulin prescriptions. Other cost sharing measures such as copayments and coinsurance are not addressed.
- ❑ SB 568 (Pan) – Senate bill requiring health plan contracts and health insurance policies to eliminate the deductible for outpatient prescription drugs and some covered benefits that are used to treat chronic conditions.
- ❑ IRS Notice 2019-45 (June 2019) expands the list of allowable preventive services without a deductible in High Deductible Health Plans (HDHPs) to include chronic diseases such as insulin and other glucose lowering agents.
- ❑ Massachusetts health exchange insulin VBID (PY2021) – Requires health plan issuers to offer at least one of each class of insulins in vial and pen injector formulations at the Tier 1 copay amount corresponding to each metal tier standard plan before deductible applies.

# 2022 CURRENT VS 2023-25 PROPOSED REQUIREMENTS

## Affordability and Cost

2022 Current Requirements	2023-25 Proposed Requirements
<p><b>Article 9.01 Designing and Managing Networks Based on Value</b></p> <ul style="list-style-type: none"><li>• Include quality and cost in the evaluation and selection criteria for all providers and all facilities when designing and managing networks</li></ul>	<ul style="list-style-type: none"><li>• Enhance reporting requirements for quality criteria used in determining networks, along with results of analysis for all contracted hospitals and provider groups</li><li>• Newly require issuers to report their network payment models using the HCP LAN APM categories; issuers must report the percent of spend within each HCP LAN APM category compared to its overall budget</li></ul>
<p><b>Article 9.02 Hospital Networks Based on Value</b></p> <ul style="list-style-type: none"><li>• Work with Cal Hospital Compare, California hospitals, and Covered California to profile and analyze variation in performance on hospital quality measures</li><li>• Report on engagement efforts with network hospitals to hold them accountable for performance</li><li>• Report the rationale for continued contracting with each hospital performing in the lowest decile</li><li>• Report on how hospital and facility costs are managed</li></ul>	<ul style="list-style-type: none"><li>• Alone or in collaboration with other Covered California issuers, analyze and address quality and safety performance of hospitals that are in the lowest tier of performance as determined by Cal Hospital Compare</li><li>• Issuers that contract with these lowest tier hospitals must develop an intervention plan that may include quarterly performance reviews, tying hospital payment to quality and safety, providing technical assistance for specific quality and safety domains, or excluding hospital from network if poor performance persists; the intervention plan must be submitted to and approved by Covered California</li></ul>

# 2022 CURRENT VS 2023-25 PROPOSED REQUIREMENTS

## Affordability and Cost

2022 Current Requirements	2023-25 Proposed Requirements
<p><b>Article 9.03 Physician Networks Based on Value</b></p> <ul style="list-style-type: none"><li>• Work with IHA, provider groups, and Covered California to profile and analyze variation in performance on provider quality measures</li><li>• Participate in the IHA Align.Measure.Perform (AMP) program for physician groups and report AMP performance results for each QHP contracted physician group annually</li><li>• Report on engagement efforts with contracted physician groups as well as independent physicians to hold them accountable for performance</li><li>• Report on analysis of performance variation, provision of technical assistance to poor performers, and management of costs for contracted physician groups</li></ul>	<ul style="list-style-type: none"><li>• Continue to require IHA data submissions and participation in IHA Align.Measure.Perform (AMP) program for physician groups and report AMP performance results for each QHP contracted physician group annually</li><li>• Issuers that contract with provider groups in the lowest quartile of AMP performance must develop an intervention plan that may include quarterly performance reviews, tying provider payment to quality and safety, providing technical assistance for specific quality and safety domains, or excluding provider group from network if poor performance persists; the intervention plan must be submitted to and approved by Covered California</li></ul>
<p><b>Article 11.01 Demonstrating Action on High Cost Pharmaceuticals</b></p> <ul style="list-style-type: none"><li>• Reporting requirement on how plans consider cost and quality on high-cost pharmaceuticals in their formularies</li></ul>	<ul style="list-style-type: none"><li>• Move to quality playbook</li><li>• Exploring options for addressing high cost pharmaceuticals</li></ul>

# AREAS OF EXPLORATION

- ❑ Addressing cost barriers for high value drugs
  - ❑ Focus on diabetes
    - Require at least one of each class of insulin in vial and pen injector formulation
      - Tier 1 versus no cost share
    - Minimize cost share for glucometers and test strips
      - Tier 1 versus no cost share
    - Minimize cost share for metformin and sulfonylureas
      - Tier 1 versus no cost share
- ❑ Analyzing other high-value drugs or services that Covered California could pursue for Attachment 7 beyond 2023
  - IRS Notice 2019-45 list: cardiovascular drugs, anti-depressants
- ❑ Continuing to review the federal cost transparency initiatives and other efforts to look for opportunities for alignment

# Data Exchange Proposed Requirements

Whitney Li, Senior Evaluation Specialist



# DATA EXCHANGE GOALS

- ❑ To broadly align with and augment federal and state requirements for data exchange
- ❑ To enhance bi-directional QHP issuer participation for Health Information Exchanges (HIEs)
- ❑ To enhance the Healthcare Evidence Initiative (HEI) and transparent use of data for QHP issuer monitoring, accountability, and promotion of quality performance
- ❑ To identify use cases for HIE participation and collaboration among providers, issuers, and California Trusted Exchange Network (CTEN) member organizations in support of priority areas for disparities, behavioral health, advanced primary care and cost and affordability initiatives

# PROGRAM AND POLICY CONTEXT

Covered California is actively engaged with or tracking the following initiatives:

- ❑ California Health & Human Services Agency Data Exchange Framework Stakeholder Advisory Group
- ❑ AB 133 (2021) – State bill requiring health plans sign onto the CA Health & Human Services Agency Data Exchange Framework and share minimum required data elements. Promotes secure electronic health data exchange among health care providers, consumers of health care, and other individuals.
- ❑ AB 1810 (2018) and AB 80 (2020) – State bills advancing data collection, management, use, access, and development of public information for the OSHPD All Payer Claims Database. Promotes visibility on health care spending, identification of opportunities to improve health care system and facilitation of linkages with other economic, environmental, social, and clinical data sets.

Covered California is actively tracking the following initiatives:

- ❑ CMS FFM Rules 9115-F & 9123-P
  - The Interoperability and Patient Access Rule (CMS-9115-F) was finalized in Spring 2020 and represents the first phase of CMS efforts to advance electronic access to information.
  - The Reducing Provider and Patient Burden by Improving Prior Authorization Processes, and Promoting Patients' Electronic Access to Health Information Rule (CMS-9123-P) is effective January 2023 and builds on the first phase by including technical additions for Patient Access APIs. It also adds new requirements for FFM to implement Provider Access APIs and payer-to-payer enrollment data transfer.

# 2022 CURRENT VS 2023-25 PROPOSED REQUIREMENTS

## Data Exchange

2022 Current Requirements	2023-25 Proposed Requirements
<p><b>Article 6.03 Care Coordination (ADT)</b></p> <ul style="list-style-type: none"><li>• Report issuer support and monitoring of hospitals in application of the Medicare Condition of Participation to notify primary care providers of Admission, Discharge, Transfer (ADT) events</li></ul>	<ul style="list-style-type: none"><li>• Continue reporting requirement for implementation of ADT notifications</li></ul>
<p><b>Article 15.01 Data Submission</b></p> <ul style="list-style-type: none"><li>• Submit timely and appropriate data for the Healthcare Evidence Initiative (HEI)</li></ul>	<ul style="list-style-type: none"><li>• Continue HEI requirements</li></ul>
<p><b>Article 15.02 Data Exchange with Providers</b></p> <ul style="list-style-type: none"><li>• Report on activities to support data exchange with providers including:<ul style="list-style-type: none"><li>• Efforts to improve routine data exchange with providers</li><li>• Participation in statewide or regional data exchange initiatives including Health Information Exchanges (HIEs)</li><li>• The % of the individual clinicians and hospitals that participate in HIEs</li></ul></li><li>• Use standard processes for encounter data exchange with contracted providers (837-P, 837-I standard transaction sets)</li></ul>	<ul style="list-style-type: none"><li>• Newly require participation in an HIE and proposing to strengthen the definition of participation through:<ol style="list-style-type: none"><li>1. Membership in the California Trusted Exchange Network (CTEN)</li><li>2. Issuer receipt of information and sending information to HIEs (bi-directional exchange of information with HIEs)</li></ol></li><li>• Move standard processes for encounter data exchange with contracted providers to the quality playbook</li><li>• Proposing to add a reporting requirement of participation in data exchange initiatives that enhance health equity, demographic and social risk factor data capture, alternative payment models, and integrated behavioral health strategies</li></ul>

# 2022 CURRENT VS 2023-25 PROPOSED REQUIREMENTS

## Data Exchange

2022 Current Requirements	2023-25 Proposed Requirements
<p><b>Article 15.03 Data Aggregation Across Health Plans</b></p> <ul style="list-style-type: none"><li>• Report on participation in aggregation of data across health plans such as the statewide All Payor Claims Database</li></ul>	<ul style="list-style-type: none"><li>• Move data aggregation reporting requirements to the quality playbook</li></ul>
<p><b>Article 15.04 Patient Access Application Programming Interface</b></p> <ul style="list-style-type: none"><li>• Implement and maintain a secure, standards-based Interoperability and Patient Access API consistent with the CMS Patient Access final rule (CMS-9115-F) for Federally Facilitated Marketplaces (FFM)</li><li>• Report the % of patients accessing their Patient Access API</li></ul>	<ul style="list-style-type: none"><li>• Newly require issuers to participate in payer-to-payer data exchange at enrollment and educate consumers about opt-in to approve data transfer from prior to new health plan consistent a part of the new CMS FFM requirement of Reducing Provider &amp; Patient Burden by Improving Prior Authorization Processes, and Promoting Patients' Electronic Access to Health Information (CMS-9123-P) (effective starting January 2023)</li><li>• Continue to require issuers to maintain a secure, standards-based Interoperability and Patient Access API requirement and update as needed to continue aligning with CMS</li><li>• Move requirement to report the % of patients accessing APIs to the quality playbook and revise the language to a best practice of tracking member access to optimize usage and improve usability of APIs</li></ul>

# AREAS OF EXPLORATION

- ❑ Establishing QHP Issuer-Provider HIE contract requirements
  - QHP issuers to provide incentives for providers contracted with the issuers to join HIEs
  - QHP issuers to require designated providers to participate in HIE per a minimum set of data exchange functions
  - Requiring QHP issuers to implement and maintain a Provider Access API to facilitate the exchange of current patient data from payers to providers (based on a section of the CMS FFM Requirement that is effective 1/2023)
- ❑ Researching specific use cases of HIE data for plans
- ❑ Aligning with CalPERS and DHCS on future data sharing requirements
- ❑ Continuing interviews and engagement of Subject Matter Experts and incorporating feedback and lessons into retiring, revising, and developing requirements

# Quality Transformation Initiative Update

Alice Hm Chen, MD, MPH  
Chief Medical Officer

- **Covered California is developing a Quality Transformation Initiative (QTI) to spur substantive improvements in health plan clinical quality**
  - QTI ties significant financial consequences (penalties) to health plan quality performance on a select set of measures
  - Penalty amount based on level of quality performance; may be up to 4% of premium annually, phased in over time:
    - Proposed: Year 1 – 1%, Year 2 – 2%, Year 3 – 3%, Year 4 – 4%
  - 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, with the first measurement year at risk in 2023

### QHP 5-Year Quality Performance Trend on QRS Getting the Right Care Summary Indicator

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 15 QHPs (13% enrollees) received 2 stars for Getting the Right care.
  - 6 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

# DESIGN CONSIDERATIONS

Category	Design Component	Proposed Approach
<b>INCENTIVE STRUCTURE</b>	Form of financial incentive/disincentive	Penalty
	Magnitude of penalty	1-4% of QHP premium, scaled up 1% each year from 2023 through 2026
	Threshold required to avoid all performance penalty	75 <sup>th</sup> percentile nationally for QRS measures
	Unit of accountability	QHP across all regions
<b>PERFORMANCE MEASURES</b>	Measure sources	QRS measures at launch, may add HEI or self-reported measures over time
	Number of measures	No more than 12 that span relevant subpopulations and are aligned with DHCS and CalPERS
	Measure Weights	Equal

Category	Design Component	Proposed Approach
PERFORMANCE EVALUATION	Application of penalty	<ul style="list-style-type: none"> <li>Penalty is applied based on achievement only (not improvement)</li> <li>Penalty is assessed on annual quality performance</li> </ul>
	Achievement benchmarks	<p>QRS Measures:</p> <ul style="list-style-type: none"> <li>Full penalty at 25<sup>th</sup> percentile</li> <li>Continuous graded penalty between 25<sup>th</sup>-50<sup>th</sup> and between 50<sup>th</sup>- 75<sup>th</sup></li> <li>Penalty weighted such that 2/3 applied in 25<sup>th</sup>-50<sup>th</sup> percentile range, 1/3 applied in the 50-75<sup>th</sup> percentile range</li> <li>Avoid penalty at 75<sup>th</sup> percentile</li> </ul> <p>Non QRS Measures:</p> <ul style="list-style-type: none"> <li>Behavioral health measures: benchmarks to be established</li> <li>Race/ethnicity disparities gap reductions: measure methodology and benchmarks to be developed</li> </ul>

Category	Design Component	Proposed Approach
<b>SCORING RULES</b>	Individual Measure Scoring	Each measure is scored against reference norm (percentile) and penalty shares are summed across measures
	Measure Weights	Equal (e.g. 0.1 for each of 10 measures)
	Penalty Scaling 25 <sup>th</sup> -75 <sup>th</sup> Span	Compute penalty proportional to position in percentile range (e.g., if 25 <sup>th</sup> -50 <sup>th</sup> is 50%-60% span and QHP score is 55% then half of penalty assigned plus penalty component in 50 <sup>th</sup> -75 <sup>th</sup> span)
	Penalty Maximum	<ul style="list-style-type: none"> <li>Penalty maximum is based on measure weight</li> <li>This maximum penalty is applied for scores below 25<sup>th</sup> percentile</li> </ul>
	Missing Measures	Reapportion upweighted measure weights to reportable measures
	Rounding	Round all percentile and measure scores to whole numbers (e.g., 66%)

## CANDIDATE MEASURES (1 OF 3)

Candidate QTI Measures	Medi-Cal Managed Care Accountability Set	CalPERS	NCQA R/E Stratification	Advanced Primary Care measure set
Cervical Cancer Screening (NQF #0032)	X (MPL)	X	X	
Colorectal Cancer Screening (NQF #0034)		X		X
Diabetes HbA1c<8% (NQF #0575)	Diabetes HbA1c>9% (MPL)	X	X	Diabetes HbA1c>9%
Controlling High Blood Pressure (NQF #0018)	X (MPL)	X	X	X
Immunizations for Adolescent Combo 2 (NQF #1407)	X (MPL)	X		X
Child Immunization Combo 3 (NQF #0038)	Combo 10 (MPL)	X		Combo 10

MPL – Minimum Performance Level

## CANDIDATE MEASURES (2 OF 3)

Candidate QTI Measures	Medi-Cal Managed Care Accountability Set	CalPERS	NCQA R/E Stratification	Advanced Primary Care measure set
Breast Cancer Screening (NQF #2372)	X (MPL)	X		
Chlamydia Screening (NQF #0033)	X (MPL)	X		
Asthma Medication Ratio (NQF #1800)	X	X		X
Depression Screening & Follow-up (NQF #0418)*	X			X
Follow-up Post Mental Health Hospitalization (NQF #0576)		X		
Pharmacotherapy for Opioid Use Disorder (NQF #3400)*				

\*Non-QRS measure

MPL – Minimum Performance Level



Candidate QTI Measures	Medi-Cal Managed Care Accountability Set	CaIPERS	NCQA R/E Stratification	Advanced Primary Care measure set
All-cause Readmission (NQF #1768)	X	X		
Coordination Composite (NQF #0006)				
Access Composite (NQF #0006)				
Weight Assessment and Counseling for Children and Adolescents (NQF #0024)	X (MPL)	X		

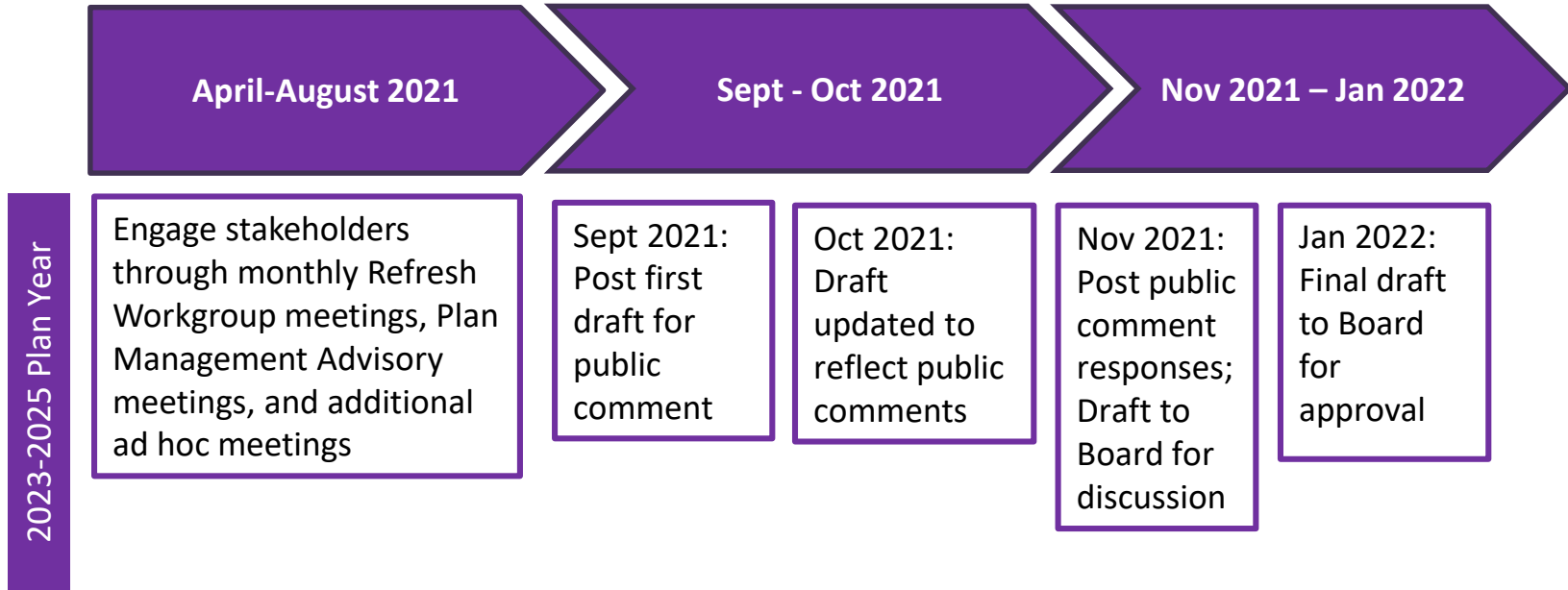
MPL – Minimum Performance Level

- Covered California will develop the final measure set with no more than 12 measures (from the candidate list)
- Covered California will finalize the QTI methodology and measures by January 2022
- First performance measurement year would be 2023, with a maximum penalty of 1% of premium to be assessed in late 2024 once performance results are available
- QTI measure set and structure will be assessed annually and adjusted if needed

# Next steps & open discussion

Thai Lee, Senior Quality Specialist

# PROPOSED 2023-2025 ATTACHMENT 7 DEVELOPMENT TIMELINE



## NEXT STEPS AND DISCUSSION

- ❑ 2023-2025 Attachment 7 draft will be released for public comment the week of September 6<sup>th</sup>
- ❑ Two supplemental documents will also be released
  - Summary of changes to 2023-2025 Attachment 7
  - Crosswalk of 2022 to 2023-2025 Attachment 7
- ❑ There will be a three-week or four-week public comment period following the release of the contract; exact dates to be determined

Submit questions and comments to Thai at [thai.lee@covered.ca.gov](mailto:thai.lee@covered.ca.gov)

**Thank you**