Advancing Equity, Quality and Value
2026-2028 QHP Issuer Model Contract Update

April 4, 2024

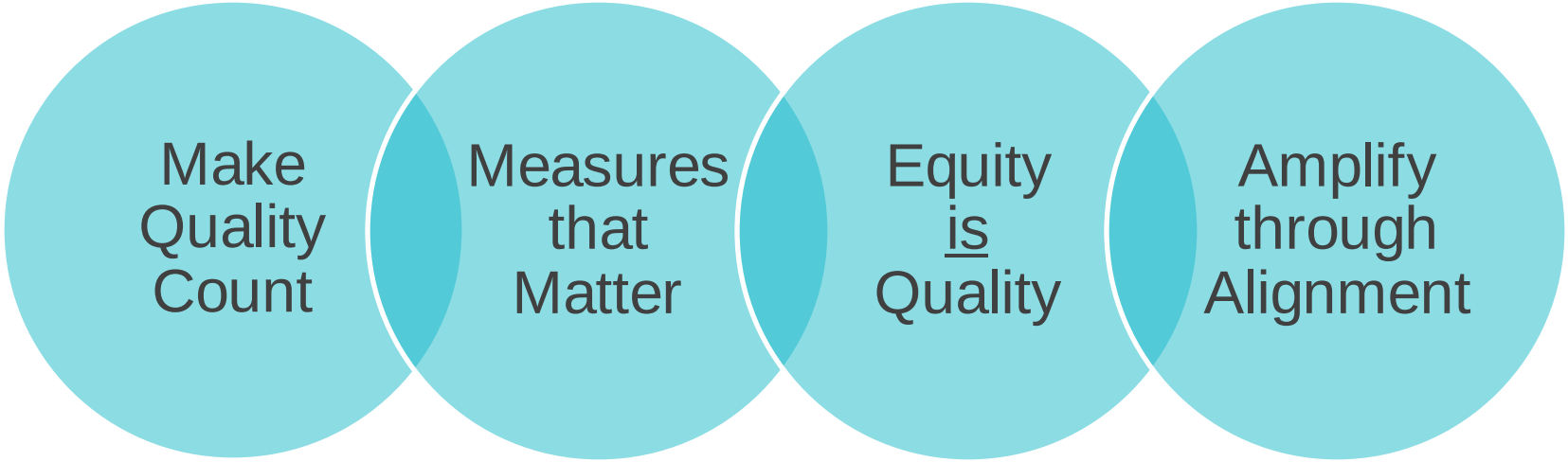
AGENDA

Time	Topic	Presenter
9:00-9:05	Welcome and Introductions	Charles Raya
9:05-9:35	Quality Transformation Initiative	Joy Dionisio
9:35-10:05	Quality Transformation Initiative: Health Equity Methodology	Mayra Miranda
10:05-10:25	Removal from the Exchange “25/2/2” Program	Peg Carpenter
10:25-10:30	Wrap Up & Next Steps	Taylor Priestley

Quality Transformation Initiative (QTI)

Joy Dionisio, MPH
Senior Equity and Quality Specialist
EQT

QUALITY TRANSFORMATION INITIATIVE



0.8% to 4% premium at risk for

a small set of clinically important measures

stratified by race/ethnicity

selected in concert with other public purchasers*

*Public purchasers includes CalPERS and DHCS/Medi-Cal

2023-2025 QTI MEASURES

Core Measures*	Clinical Context
Blood Pressure	Key risk factor for cardiovascular disease (heart attacks and strokes), the leading cause of death in the United States
Diabetes (A1c control)	~50% Californians have prediabetes or diabetes, which is a leading cause of blindness and amputation and key risk factor for cardiovascular disease
Colorectal Cancer Screening	Cancer is the second leading cause of death after heart disease, and colorectal cancer is the second leading cause of cancer death after lung cancer. Screening reduces the risk of developing and dying from CRC cancer by 60-70%
Childhood Immunizations	Childhood immunizations prevent 10.5m diseases annually. For every $1 spent on immunizations, there is as much as $29 in savings
Reporting only	Depression Screening and Follow-Up for Adolescents and Adults
Reporting only	Medication Treatment for Opioid Use

*All measures will be stratified by race/ethnicity

OVERVIEW OF ANTICIPATED 2026-2028 QTI UPDATES

- QTI Measure Set Adjustments
  - Revisions based on CMS QRS and NCQA Changes
  - Alternative Core Measure considerations
  - Re-evaluation of reporting only measures
  - Add language to align specifications with QRS
- Benchmarks and QTI Payments
  - Flexibility in benchmark adaptations
  - Revision of percent-at-risk for new contract period
- New Entrants Overview
  - Scoring approach for new entrants
  - Determining percent-at-risk

PROPOSED QTI MEASURE SET UPDATES: ANTICIPATING CMS QRS AND NCQA CHANGES

2023-2025 QTI Measure Set Attachment 4 Section 1.01.1	2026-2028 Proposed QTI Measure Set
1. Controlling High Blood Pressure (CBP)	1. Blood Pressure Control for Patients with Hypertension (BPC-E)
2. Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control <8%	2. Glycemic Status Assessment for Patients with Diabetes (GSD) >9%
3. Colorectal Cancer Screening (COL)	3. Colorectal Cancer Screening (COL-E)
4. Childhood Immunization Status (Combo 10) (CIS 10)	4. Childhood Immunization Status (CIS-E)
*5. Depression Screening and Follow-Up for Adolescents and Adults (DSF)******	5. Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)
*6. Pharmacotherapy for Opioid Use Disorder (POD)******	*6. Pharmacotherapy for Opioid Use Disorder (POD)******

***Reporting Only

COVERED CALIFORNIA

OPTIMIZING THE QTI MEASURE SET: ADAPTING TO CHALLENGES AND OPPORTUNITIES

Current Measure Challenges

- Childhood Immunization Status (Combo 10)
- Pharmacotherapy for Opioid Use Disorder (POD)

Opportunities for New Measures

Alignment Considerations

Covered California, DHCS, CalPERS

- CMS
- NCQA

Proposed Changes

CHALLENGES WITH CHILDHOOD IMMUNIZATION STATUS (COMBO 10)

	Childhood Immunization Status (Combo 10)
Measure specification	The measure calculates a rate for each vaccine (10 total vaccines) and one combination rate for children up to two years of age
MY2021 Plan Performance Report	7 out of 11 plan products scored below the 50th percentile
Alignment	CalPERS and DHCS core sets
Challenges	- Caregiver vaccine fatigue after COVID-19 - Influenza vaccine is the most challenging for this age-range - CDC allowable catch-up schedule is not captured in CIS-10 measure - **Covered California's pediatric population is small** ❑ A greater reliance is placed on the compliance of each individual due to the limited number in the eligible population ❑ Subset of QHPs do not report CIS10 due to small denominator

WHY RETAIN A PEDIATRIC MEASURE IN THE QTI MEASURE SET

- Given California's ranking among the lowest in the nation for children's healthcare, including a pediatric measure is crucial
- Incorporating a pediatric measure emphasizes the importance of alignment with other California public purchasers, even though Covered California has a relatively small pediatric population.

California

Ranking Highlights[a]

How Health Care Performance Changed in California[b]

Prevention & Treatment	2023 Scorecard				
Adults with all age- and gender-appropriate cancer screenings	2020	65%	69%	76%	43
Adults with age-appropriate flu and pneumonia vaccines	2021	40%	42%	54%	35
Adults vaccinated against COVID-19 with a booster	2022	52%	42%	63%	9
Diabetic adults without an annual hemoglobin A1c test	2021	16%	10%	4%	48
Children without all recommended vaccines	2021	31%	28%	12%	37
Children with a medical home	2020–21	41%	46%	55%	46
Children without a medical and dental preventive care visit	2020-21	46%	38%	26%	50
Children who did not receive needed mental health care	2020–21	21%	20%	11%	38
Adults age 18 and older with any mental illness who did not receive treatment	2019–20	63%	55%	41%	49

The Commonwealth Fund

Source: Commonwealth Fund 2023 Scorecard on State Health System Performance

RE-EVALUATING REPORTING ONLY MEASURES

	Pharmacotherapy for Opioid Use Disorder (POD)
Measure specification	The percentage of new opioid use disorder (OUD) pharmacotherapy events with OUD pharmacotherapy for 180 or more days among members age 16 and older with a diagnosis of OUD.
CMS QRS Benchmark	This measure is expected to have a benchmark by 2026
Challenges	- Measure is episode-based and complex - Measure requires several steps to detect the eligible population - Adherence reporting causes false patient fallout - Limits number of patients to be tracked by measure as it is currently reported
Proposed Change	Keep as reporting only for 2026-2028

ALIGNING SPECIFICATIONS WITH QRS

2023-2025 ATTACHMENT 4	SUMMARY OF PROPOSED CHANGES
1.01.1 2023-2025 QTI Measure Set ❑ The QTI Core measures will be scored using CMS Marketplace Quality Module within CMS' Health Insurance and Oversight System	❑ Add language to indicate that measure specifications will align with QRS measure adjustments to specifications

BENCHMARKS AND QTI PAYMENTS

2023-2025 ATTACHMENT 4	SUMMARY OF PROPOSED CHANGES
1.02 Benchmarks and QTI Payments ❑ Benchmarks will remain fixed during the term of this Agreement ❑ For MY 2023, the full per measure payment amount is equal to 0.8 percent of Contractor's total Gross Premium per product divided equally by each reportable QTI Core Measure for that product, increasing by 1 percentage point each year in MY 2024 and MY2025	❑ Benchmarks will remain fixed but will allow mid-cycle benchmark re-evaluation and updates if necessary ❑ The amount at risk will remain steady or decrease with introduction of health equity accountability, then incrementally increase

APPROACH FOR NEW ENTRANTS: PERCENT AT RISK AND HEALTH EQUITY ACCOUNTABILITY

2023-2025 ATTACHMENT 4 CURRENT CHALLENGE	PROPOSED SOLUTION
❑ New entrants are immediately subject to the same percent at-risk as existing QHPs for the year they are QTI eligible ❑ New entrants in plan year 2026 and later are immediately subject to health equity accountability	Graduated risk introduction: **Year 1 of QTI Eligibility (3rd Year of QHP Operation):** Introduce at lower percent at-risk, supporting easing into the program ❑ Subject to health equity accountability: QTI performance will be assessed using stratified measure results. **Year 2:** Incrementally increase the at-risk percentage OR full alignment with at-risk percentage for previously contracted QHPs

QTI PROGRAM REQUEST FOR FEEDBACK

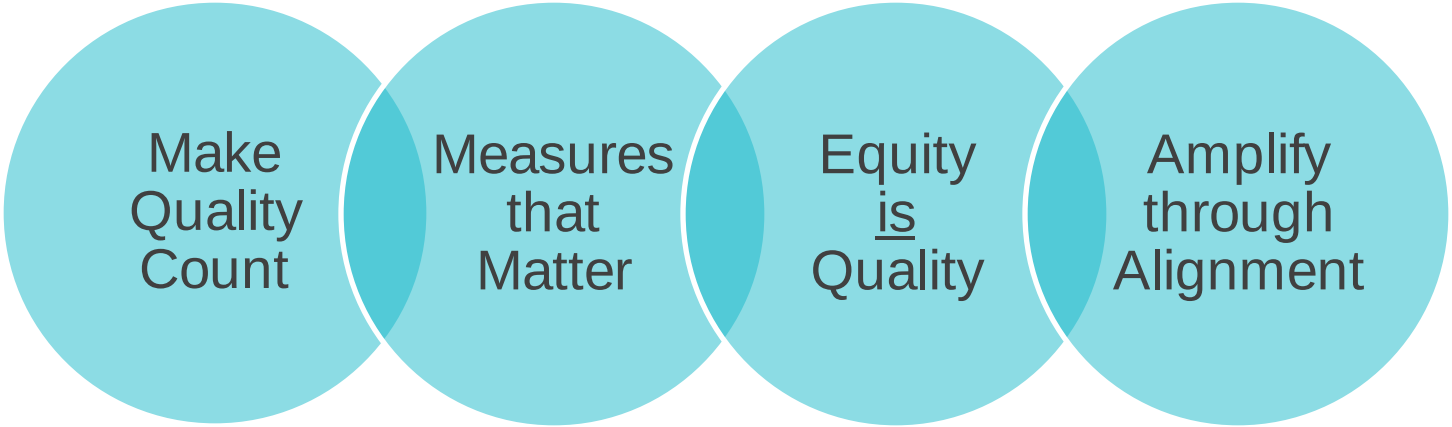
- To address challenges associated with the Childhood Immunization Status (Combo 10) measure, are there recommendations for new measures for its replacement?
- Input on proposed change to maintain Pharmacotherapy for Opioid Use Disorder (POD) as a reporting-only measure
- Input on the proposed change to keep the amount at risk steady or decreased for all QHPs while introducing health equity accountability, followed by a gradual increase in succeeding years
- Input on the proposed approach for new entrants, involving a graduated risk introduction, starting them at the lower percentage-at-risk in their first year of QTI eligibility, immediately subject to health equity accountability

QUALITY TRANSFORMATION INITIATIVE (QTI) PROPOSED HEALTH EQUITY METHODOLOGY

S. Monica Soni
Chief Medical Officer, Chief Deputy Executive Director

Mayra Miranda
Senior Equity and Quality Specialist

THERE IS NO QUALITY WITHOUT EQUITY



Delivering on Covered California's vision to improve the health of all Californians, this proposed methodology aligns with efforts occurring at DMHC, DHCS/Medi-Cal, and CalPERS

CURRENT CONTRACT REQUIREMENTS

Attachment 4, Article 1.01.2 Health Disparities Reduction Requirements:

- ❑ Intent to stratify the QTI core measure set by race and ethnicity
- ❑ Public reporting on Contractor's scores on all QTI measures stratified by race and ethnicity
- ❑ Disparities reduction requirements will be tied to payments

Covered California proposes the following:

- ❑ Refine and test health equity methodology
- ❑ Direct sharing of stratified performance with Contractor for learning and feedback before publicly reporting
- ❑ Payments connected to Health Equity Methodology for some measures no sooner than 2026

OUR COMMITMENT

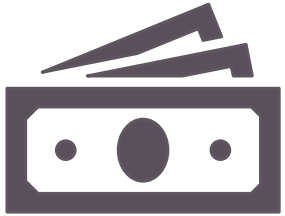
Covered California appreciates that success necessitates:

- Accuracy and completeness of race and ethnicity data
- Evidence-based approach to minimum population threshold
- Early visibility into QHP performance at subpopulation level
- Iterative, bi-directional learning
- Collaboration in a safe environment

APPROACHES TO ACCOUNTABILITY FOR DISPARITIES REDUCTION

Dashboards and Public Reporting

Improvement Plans

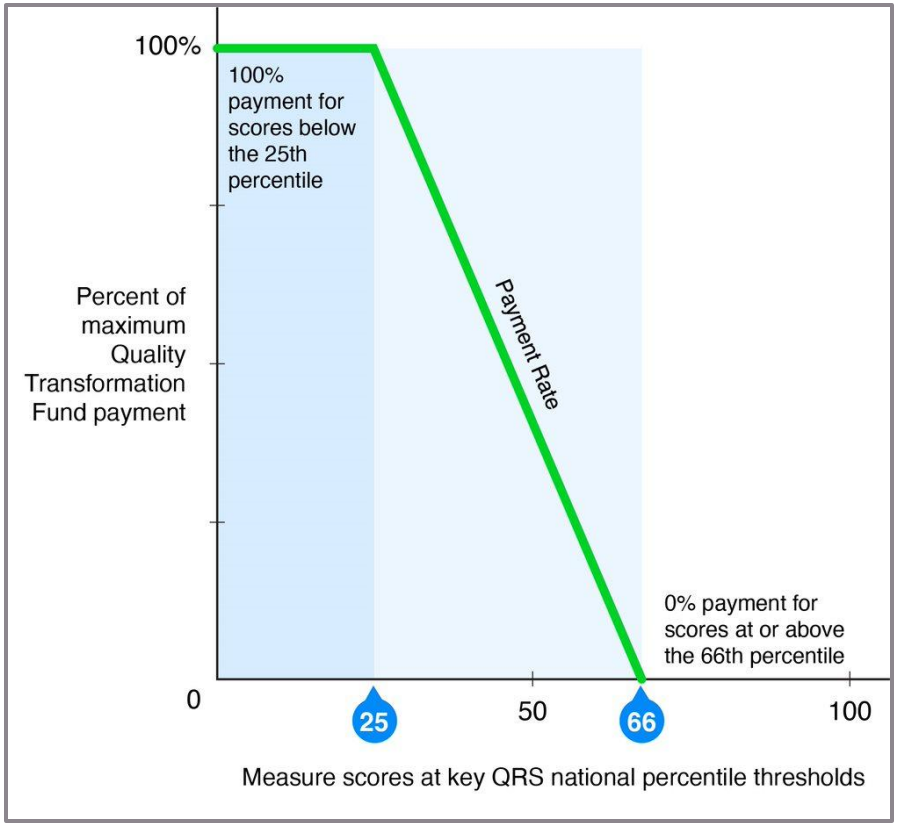


Financial Incentives

KEY STRUCTURES OF PROPOSED METHODOLOGY

1. Stratified measure results replace “all-population” measure results for eligible measures
2. Assessment of QTI payments for these measures will be based on performance of stratified subpopulations
3. QRS measure national benchmarks define performance thresholds
4. Health plans accountable to ensure all subpopulations reach the national 66th percentile score for all QTI core measures
5. To be a reportable race/ethnicity group must meet minimum denominator size established
6. Subpopulations that do not meet minimum denominator size will be grouped into "All Other Members"

ASSESSING SUBPOPULATION PERFORMANCE

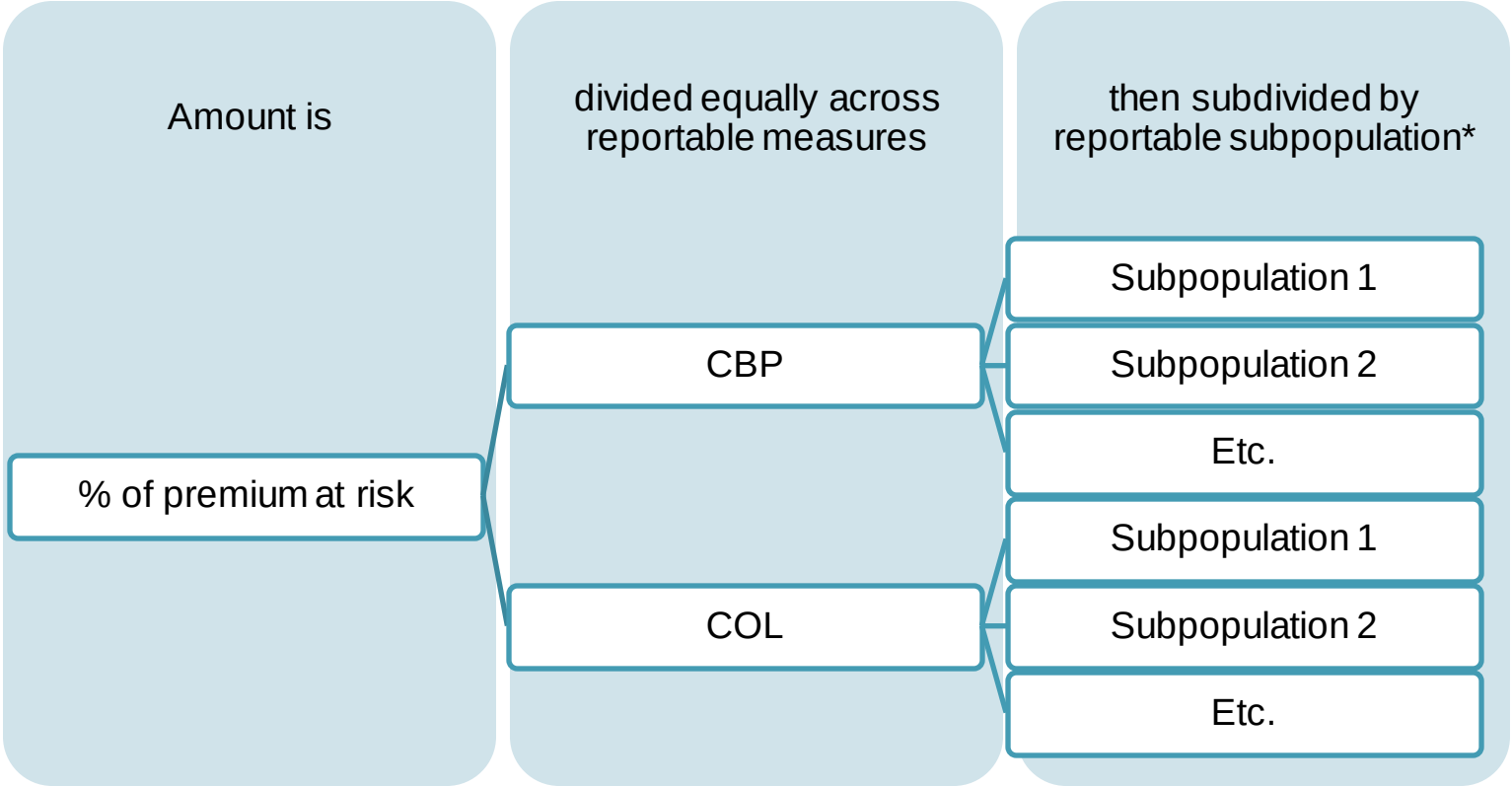


- Each reportable subpopulation performance would be separately evaluated
- Graduated performance scoring along 25th to 66th percentile slope would apply to each reportable subpopulation

ALLOCATING FINANCIAL INCENTIVE AT SUBPOPULATION LEVEL

- Amount at-risk would be apportioned at the race/ethnicity group level
  - i.e., same amount of premium at risk divided by the 4 QTI core measures, then subdivided by reportable group
- Payment amount apportioned based on QHP-specific race/ethnicity denominator size
  - e.g., if sub-population represents 30% of total population, amount at risk for that group is maxed at 30% of total pool for that measure

WEIGHTING BY SUBPOPULATION SIZE



*Each Subpopulation is weighted by denominator size

EVALUATING MINIMUM SUBPOPULATION SIZE

- What is reliability testing?
  - Industry standard to determine denominator size by measure
- Why did Covered California conduct reliability testing?
  - No current national standard on minimum denominator size by subpopulation
  - To ensure sound health equity methodology for any financial accountability program
- What did Covered California's reliability analysis find?
  - Able to stratify administrative measures
  - Able to stratify some hybrid measures
  - High accuracy and precision with use of 100 as minimum denominator size

ESTABLISHING A MINIMUM DENOMINATOR SIZE

- Based on Covered California reliability testing applying a subpopulation minimum denominator size rule of 100:
  - Allows accuracy and precision of the variation across plans
  - Captures true underperformance
- For most issuers, there would be sufficient volume to assess quality for Asian, Hispanic / Latino, and White subpopulation
  - Two years of data may need to be pooled to achieve the 100 for these subpopulations
- However, in some instances, a denominator size of less than 100 achieves the industry standard of 0.7 reliability

ENSURING NO ONE IS LEFT BEHIND

- Although using a denominator sizes of 100 likely captures only Asian, Hispanic / Latino, and White, Covered California is committed to preventing erasure of other members
- Covered California recommends the creation of an additional group for financial accountability and assessment, “All Other Members”. This group would be comprised of:
  - American Indian/Alaska Native
  - Black/African-American
  - Multi-race
  - Native Hawaiian/Pacific Islander
  - Other-race
- When these subpopulations are pooled, they achieve the same reliability threshold of >/= 0.7
- Of note, if any of the above subpopulations achieve a minimum denominator size of 100, they would be separately assessed

CONSOLIDATION OF “ALL OTHER MEMBERS”

- Although the interventions needed to address quality for this group are not homogenous, creating this single, reportable category ensures that groups that often have the largest disparities are not erased
- Financial accountability for "All Other Members" will allow continued focus and investment
- Covered California is conducting additional statistical analysis to assess inclusion of members with Unknown race or ethnicity in All Other Members group
- Issuer-specific information on the composition of their "All Other Members" group will be available to ensure tailored interventions

DISTRIBUTION OF "ALL OTHER MEMBERS"

- Across all issuers, the breakdown of "all other members" is:
  - American Indian / Alaska Native 1-3%
  - Black or African American 14-17%
  - Native Hawaiian/Pacific Islander <.1%
  - Other race* 67-68%
  - Two or more races 13-15%

With current hybrid measures (which use a sample size of 411), AI/AN, Black/AA and NH/PI have median counts of <10 per measure and could not be assessed on their own or as a grouped category, even if pooling two years of data. The transition to ECDS should allow more robust assessment.

*Other race indicates that the member identifies as some other race that does not align with the OMB summary level categories (i.e., may include people who identify as Middle Eastern or North African)

ALL OTHER MEMBERS GROUP SCORES: CONTROLLING BLOOD PRESSURE (CBP) EXAMPLE

The all-QHPs CBP scores for each of the race categories show close alignment although the "two or more races" group scores moderately higher.

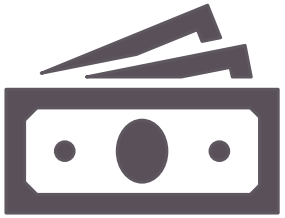
Covered California All-Health Plans (MY2022)	Denominator CBP (MY2022)	Rate CBP (MY2022)
American Indian or Alaska Native	20	50%
Black or African American	182	49%
Other Race	424	50%
Two or More Races	115	55%
All Other Members Total	741	51%

*Native Hawaiian/Pacific Islander omitted as too few members

ACCOUNTABILITY FOR SMALLER SUBPOPULATIONS

Dashboards and Public Reporting

Improvement Plans



Financial Incentives

Covered California will ensure gaps in performance do not widen, **especially for historically marginalized populations**, by using additional tools to monitor and address disparities. However, subpopulation weighting could be changed if disparities worsen through course of program.

ELIGIBLE QTI MEASURES

- By the 2026-2028 contract cycle, we anticipate being able to move to financial accountability for at least 2 stratified QTI measures. The remainder will be assessed at the all-population level
- With the current QTI measure set, the controlling blood pressure (CBP) and colorectal cancer screening (COL) hybrid measures meet reliability threshold for financial accountability at stratified level
- If measures are adjusted for 2026-2028 contract cycle, Covered California will re-assess which meet reliability thresholds for financial accountability at stratified level

EXTERNAL FEEDBACK ON PROPOSED METHODOLOGY

Covered California conducted consultations with national experts from RAND, NCQA, Blue Cross Blue Shield of Massachusetts, Henry Ford Health, as well as Consumer Advocates

- ❑ Agreement on use of reliability thresholds to determine minimum denominator size for financial accountability programs
- ❑ Strong support for using national all-population benchmark to mitigate against perverse incentives
- ❑ Support for inclusion of small subpopulations, but advised to ensure “All Other Members” should be grouped as currently organized
- ❑ Further statistical analysis recommended to assess “All Other Members” subpopulation

SUMMARY OF PROPOSED METHODOLOGY

1. Stratified measure results replace “all-population” measure results for eligible measures
2. Assessment of QTI payments for these measures will be based on performance of stratified subpopulations
3. QRS measure national benchmarks define performance thresholds
4. Health plans accountable to ensure all subpopulations reach the national 66th percentile score for all QTI core measures
5. To be a reportable race/ethnicity group must meet minimum denominator size established
6. Subpopulations that do not meet minimum denominator size will be grouped into "All Other Members"

WHAT SUCCESS LOOKS LIKE

★★★ Receipt of high-quality care for all members regardless of subpopulation size

Embrace of an equity-centered approach to meet diverse needs with tailored interventions

Greatest financial accountability for subpopulations least served by current quality improvement approaches

Deep engagement and monitoring by Covered California to ensure disparities do not increase

QTI HEALTH EQUITY METHODOLOGY REQUEST FOR FEEDBACK

- Input on use of QRS 66th percentile as benchmark for all sub-population results
- Should Covered California set a lower minimum denominator size for measures that achieve the industry standard of 0.7 reliability with a denominator size of less than 100?
- Recommendations for oversight approaches to ensure performance gaps do not increase for sub-populations included in All Other Members

Removal from the Exchange "25/2/2" Program Updates

Peg Carpenter
Senior Equity and Quality Specialist
EQT

MAKING QUALITY COUNT: CONTRACT PROVISIONS ON QUALITY

For existing carriers: “25/2/2” allows for selective contracting and removal from marketplace for consistent poor performance on quality measures.

Quality Transformation Initiative: assesses quality improvement payments up to 66th percentile national performance.

2023-2025 REMOVAL FROM THE EXCHANGE "25/2/2" POLICY AND METHODOLOGY

Assessment Structure	Composite measure score on QRS Clinical Quality Management Summary Indicator measures compared to MY 2018 25th percentile individualized composite benchmark for each product. • **Monitoring Period**: If an issuer has one or more products that falls below the 25th percentile individualized composite benchmark for its product-reportable subset of the QRS Clinical Quality Management Summary Indicator measures for **two consecutive** years. • **Remediation Period**: The product is required to meet or exceed the 25th percentile individualized composite benchmark within the **following two years**, or it will not be certified for the Plan Year following the performance assessment of the last year of the remediation period. • **Removal from Exchange**: If the product does not perform above the 25th percentile individualized composite benchmark for **four consecutive years**.
25th Percentile Benchmark	Covered California uses the 25th percentile score for each of the QRS Clinical Quality Management Summary Indicator measures from the QRS national percentile data. An unweighted average of these scores is computed to establish the 25th percentile composite benchmark excluding Non-Reportable (NR) scores and measures without a 2018 benchmark.
Annual Assessment	If the issuer product meets the CMS eligibility criteria to report QRS measures scores, it will be assessed for this 25/2/2 program as early as Measurement Year 2021. Product performance will be assessed annually.

2023-2025 QHP ISSUER MODEL CONTRACT ARTICLE 5.2.3

Measure Source: Inclusion and Exclusion	Covered California follows the CMS QRS Clinical Quality Management Summary Indicator measure set (which includes QTI core measures). Covered California follows the CMS QRS guidelines for reportable clinical quality measures. For each year of assessment, only QRS reportable measures that were also QRS reportable measures in the baseline benchmark year (Measurement Year 2018) are used in the scoring. If any measure with a 2018 benchmark is sunset by CMS QRS, Covered California excludes that measure from the composite scoring methodology during the assessment process.
Benchmark Year	Measurement Year (MY) 2018 is currently used as the most current benchmark year for the 2023-2025 QHP Issuer Contract due to COVID (CMS suspended QRS in MY 2019 and COVID impacted MY 2020 performance).
Scoring Calculation	All measures that comprise the QRS Clinical Quality Management Summary Indicator are equally weighted in calculating the 2018 25th percentile composite benchmark and each product's annually revised clinical composite score.

25/2/2 INDIVIDUAL MEASURE RESULTS FOR MY 2022

25-2-2 MY 2022 Assessment Results

Identifier		Measure Acronym	QRS Clinical Quality Management Summary Indicator Measures	MY 2018 25th Percentile	Anthem HMO	Anthem EPO	Blue Shield HMO	Blue Shield PPO	Chinese Community HMO	Health Net HMO	Health Net PPO	Kaiser HMO	L.A. Care HMO	Molina HMO	Oscar EPO	Sharp HMO	Valley HMO	Western HMO
			MY 2018 Individualized Composite Benchmark	**0.515**	**0.517**	**0.515**	**0.517**	**0.517**	**0.524**	**0.517**	**0.517**	**0.537**	**0.515**	**0.509**	**0.517**	**0.517**	**0.547**	**0.508**
			MY 2022 Composite Score		**0.571**	**0.554**	**0.575**	**0.597**	**0.541**	**0.595**	**0.539**	**0.74**	**0.569**	**0.537**	**0.578**	**0.658**	**0.626**	**0.579**
S1D1C2M2	S1M2	AMM	Antidepressant Medication Management	0.588	0.627	0.586	0.549	0.598	NR	0.609	0.58	0.733	0.649	0.535	0.688	0.748	0.629	0.605
S1D3C6M16	S1M16	BSC	Breast Cancer Screening	0.650	0.701	0.607	0.707	0.701	0.596	0.689	0.516	0.799	0.666	0.561	0.587	0.804	0.612	0.704
S1D3C6M17	S1M17	CCS	Cervical Cancer Screening	0.481	0.477	0.568	0.632	0.617	0.608	0.643	0.572	0.754	0.526	0.467	0.620	0.614	0.494	0.63
S1D3C6M18	S1M18	COL	Colorectal Cancer Screening	0.467	0.562	0.533	0.602	0.581	0.529	0.574	0.438	0.726	0.427	0.382	0.501	0.579	0.455	0.564
S1D1C3M6	S1M6	CBP	Controlling Blood Pressure	0.538	0.631	0.543	0.56	0.511	0.426	0.61	0.58	0.758	0.626	0.513	0.603	0.785	0.545	0.583
S1D1C3M7	S1M7	PDC	Proportion of Days Covered (RAS Antagonists)	0.729	0.674	0.682	0.694	0.719	0.816	0.768	0.729	0.801	0.752	0.7	0.777	0.819	0.773	0.768
S1D1C3M8	S1M8	PDC	Proportion of Days Covered (Statins)	0.681	0.609	0.625	0.631	0.666	0.701	0.694	0.682	0.777	0.685	0.616	0.752	0.791	0.731	0.743
S1D1C4M13	S1M13	PDC	Proportion of Days Covered (Diabetes All Class)	0.678	0.688	0.661	0.692	0.681	0.837	0.768	0.713	0.765	0.737	0.688	0.766	0.802	0.778	0.733
S1D1C4M9	S1M9	CDC	Comprehensive Diabetes Care: Eye Exam (Retinal) Performed	0.406	0.46	0.384	0.511	0.453	0.405	0.491	0.26	0.757	0.487	0.450	0.37	0.669	0.494	0.491
S1D1C4M10	S1M10	CDC	Comprehensive Diabetes Care: Diabetes Hemoglobin A1c (HbA1c)	0.521	0.684	0.599	0.637	0.64	0.66	0.601	0.557	0.631	0.579	0.513	0.611	0.675	0.628	0.596
S1D3C7M19	S1M19	PPC	Prenatal and Postpartum Care: Postpartum Care	0.658	0.781	0.788	0.704	0.754	NR	0.819	0.71	0.886	0.839	0.798	0.804	0.805	0.922	0.784
S1D3C7M20	S1M20	PPC	Prenatal and Postpartum Care: Timeliness of Prenatal Care	0.774	0.737	0.819	0.741	0.822	NR	0.904	0.864	0.949	0.892	0.786	0.753	0.899	0.902	0.811
S1D3C8M23	S1M23	CHL	Chlamydia Screening in Women	0.402	0.476	0.44	0.535	0.482	NR	0.476	0.415	0.61	0.586	0.533	0.521	0.623	0.59	0.468
S1D3C8M24	S1M24	FVA	Flu Vaccinations for Adults Ages 18-64	0.432	0.439	0.475	0.495	0.522	0.55	0.449	0.49	0.573	0.433	0.42	0.496	0.546	0.554	0.492
S1D3C8M25	S1M25	MSC	Medical Assistance With Smoking and Tobacco Use Cessation	0.483	NR	0.417	NR	NR	0.351	NR	NR	NR	0.452	NR	NR	NR	NR	0.598
S1D3C9M26	S1M26	ADV	Annual Dental Visit	0.161	0.276	0.319	0.216	0.405	0.144	0.218	0.404	NR	0.281	0.032	0.237	0.111	0.201	0.031
S1D3C9M47	S1M47	IMA	Immunizations for Adolescents Combination 2	0.174	0.338	0.232	0.295	0.234	NR	0.296	0.146	0.552	0.294	0.211	0.263	0.355	NR	0.138
S1D3C9M30	S1M30	WCC	Weight Assessment and Counseling for Nutrition and Physical Acti	0.586	0.676	0.612	0.628	0.614	0.415	0.649	0.61	0.896	0.662	0.748	0.642	0.645	0.702	0.664
S1D3C9M31a	S1M31a	W15	Well-Child Visits in the First 30 Months of Life (First 15 Months)	0.661	0.513	0.64	0.525	0.754	NR	0.483	0.515	0.758	0.333	NR	0.542	0.602	NR	NR
S1D2C5M15	S1M15	PCR	Plan All-cause Readmissions (reverse scored)	0.234	0.51	0.546	0.574	0.587	NR	0.573	0.459	0.592	0.48	0.713	0.446	0.638	NR	0.589
			Total Individual Measures Underperforming:		**5**	**8**	**5**	**3**	**6**	**1**	**7**	**0**	**3**	**10**	**4**	**2**	**2**	**2**

TRENDED MEASURES BELOW THE 25TH PERCENTILE

All **14*** QHPs remain in **good standing** based on composite performance

- All Qualified Health Plan (QHP) issuer products have maintained the minimum threshold of reportable measures.
- Several Clinical Quality Measures remain below the 25th percentile for some QHP issuer products.
- There has been meaningful improvement from MY 2021 to MY 2022, although not across all issuer products.

Numerator represents the **total number of Clinical Quality Measures currently below the 25th percentile** for the QHP Issuer Product. Denominator represents the **total number of reportable scores** for the QHP issuer product.

QHP Products	Measure Year 2021	Measure Year 2022
Anthem EPO	8/20	5/20 ↓
Anthem HMO	4/18	8/19 ↑
Blue Shield HMO	4/20	5/19 ↑
Blue Shield PPO	4/19	3/19 ↓
Chinese Community HMO	5/14	6/13 ↑
Health Net HMO	2/19	1/19 ↓
Health Net PPO	5/19	7/19 ↑
Kaiser HMO	0/18	0/18 =
L.A. Care HMO	3/20	3/20 =
Molina HMO	10/19	10/18 =
Oscar EPO	10/19	4/19 ↓
Sharp HMO	2/19	2/19 =
Valley HMO	2/17	2/17 =
Western HMO	3/19	2/19 ↓

* Health Net Life PPO is no longer offered in Plan Year 2023. Oscar EPO is no longer offered in Plan Year 2024. IEHP HMO, Bright HMO and Aetna HMO are not included; they do not have MY 2022 QRS reportable results.

2026 - 2028 PROPOSED PROGRAM: CALIBRATING MEASURES & BENCHMARKS

Measure Source: Inclusion and Exclusion	Covered California will follow the CMS QRS guidelines for reportable clinical quality measures. For the 2026-2028 QHP Issuer Model Contract, Covered California will use the **most current reportable clinical measures** as published within QRS proof sheets by CMS through the CMS Marketplace Quality Module at the time of contracting. For each year of assessment, only QRS reportable measures that were also QRS reportable measures in the chosen benchmark year will be used in the scoring. If any measure with a benchmark is removed from QRS by CMS, Covered California will exclude that measure from the composite scoring methodology during the assessment process. If CMS adds measures to the QRS Clinical Quality Management Summary measures set, Covered California will incorporate into 25/2/2 program accountability once benchmarks are available.
Static Benchmark Year	Covered California will use the **latest available benchmark year** at the time of contracting. Annually, an unweighted average of these QRS national measure scores for which there are reportable scores available is computed to establish the 25th percentile composite benchmark for that year.
Composite Scoring Calculation	The 25th percentile composite benchmark and each product's clinical composite score are calculated by averaging measure scores. Reportable measure scores are summed and divided by the count of reportable measure scores. The product's clinical composite score is compared to the matched QRS 25th percentile composite benchmark score to determine if the 25th percentile composite benchmark is achieved.

2026 - 2028 PROPOSED PROGRAM: CALIBRATING MEASURES & BENCHMARKS

New Entrants	For new products offered by Covered California in Plan Year 2023 or later, the product is subject to 25/2/2 assessment with the first Plan Year the product meets CMS eligibility criteria to report QRS measures scores and QRS star ratings.
Annual Assessment	Product performance is assessed annually. If an issuer product(s) composite score falls below the applicable 25th percentile composite benchmark for two consecutive years beginning **MY 2021**, the 2-year remediation period and 4-year removal from the exchange policy will apply.
Half-Scale Rule	Consistent with CMS QRS scoring methodology, a minimum of 50% of the measures from the QRS 25th national percentile benchmark measures set must be reportable for a composite score to be calculated.
Future Adjustments	Covered California will follow the CMS QRS guidelines on reportable measures to determine the inclusion or exclusion and revision of clinical quality measures in the 25th percentile composite benchmark and each product's annual clinical composite score for the 2026-2028 QHP Issuer Model Contract. Measures may be added to the assessment as benchmark scores become available to capture complete clinical quality performance. For any new clinical measures, Covered California will use the first benchmark year available from CMS QRS Clinical Quality Management Summary Indicator national percentile data.

2026 - 2028 PROPOSED UPDATES: MINIMUM PERFORMANCE LEVEL (MPL) ACTION PLAN

Continuous Monitoring

- ❑ Covered California will continue to assess patterns of poor performance for each measure.
- ❑ Each clinical measure falling beneath the 25th percentile for 2 consecutive years will require a Minimum Performance Level (MPL) action plan developed by the QHP Issuer and submitted to Covered California.

Collaboration & Support

- ❑ The MPL action plan must include:
  - ❑ Which Quality Collaboratives from Attachment 1 Article 4.05 are involved.
  - ❑ Detailed outline of quality improvement and health equity efforts and infrastructure across the organization to support measure improvement.
  - ❑ Timeline for implementing interventions to raise scores above the minimum.

Quality Improvement

- ❑ The MPL action plan must detail:
  - ❑ QHP issuer's root cause or gap analysis for each required clinical measure.
  - ❑ Factors contributing to repeated poor quality performance
  - ❑ Improvement strategy for each measure
- ❑ QHP Issuer must demonstrate it has identified and deployed best practices to close care gaps and improve value, both projected performance and real time changes.

25/2/2: CONTRACTING BASED ON QUALITY EVOLUTION

2023-2025	2026-2028
❑ 2018 static benchmark year	❑ New static benchmark year, likely MY2024
❑ Sunset measures removed	❑ Sunset measures removed
❑ No new clinical measures added	❑ New clinical measures added as benchmarks are published
❑ Monitoring and remediation required to composite performance only	❑ Monitoring and remediation required for composite performance only
❑ Quality Improvement Plan required for composite performance only	❑ Minimum Performance Level Action Plan required for each clinical measure falling beneath the 25th percentile for 2 consecutive years.

25/2/2 PROGRAM REQUEST FOR FEEDBACK

- Input regarding the addition of new measures (once benchmarks available) to remain aligned with CMS QRS clinical measures
- Feedback on proposed update to benchmark year
- Feedback on the proposed Minimum Performance Level (MPL) Action Plan

Wrap-up and Next Steps

Please submit feedback on today's topics, questions, and suggestions for future meetings to EQT@covered.ca.gov

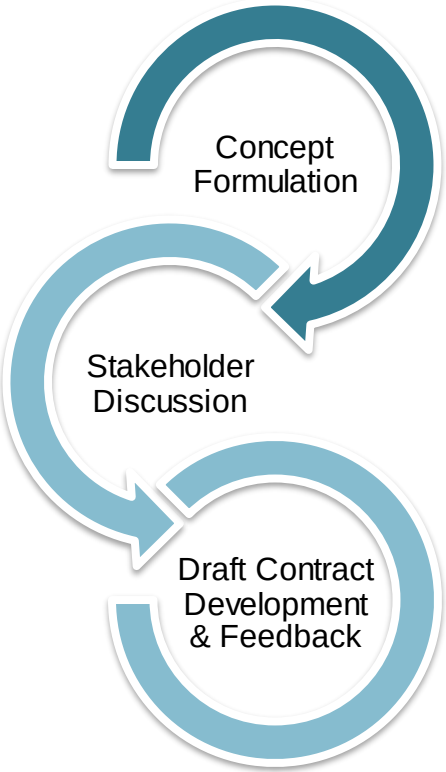
Thank you!

Appendix

2026-2028 Advancing Equity, Quality & Value Contract Update Workstreams

Model Contract *with PMD*	Attachment 1	Attachment 2 *with PMD*	Attachment 4	Workgroups
• Essential Community Providers (ECPs) • Article 5	• Articles 1-6	• Performance standards	• Quality Transformation Initiative	• Contract Update Workgroup

Proposed Approach for Contract Update 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
- Contract Update workgroup
  - Scheduled monthly meetings
  - Forum for large group discussion on proposed changes to Attachments 1, 2 and 4
  - 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 can be scheduled as necessary to help facilitate contract development

2026 QHP ISSUER MODEL CONTRACT UPDATE TIMELINE

- **February 2024** Plan Management Advisory meeting – preview timeline
- **March 2024** – kick off external contract update workgroup
- **Late summer 2024** – first public comment period
- **Sept/October 2024** – second public comment period
- **January 2025** – Board discussion of proposed model contract
- **March 2025** – anticipated Board approval of proposed model contract

2026 Contract Development Guiding Principles

Equity is quality

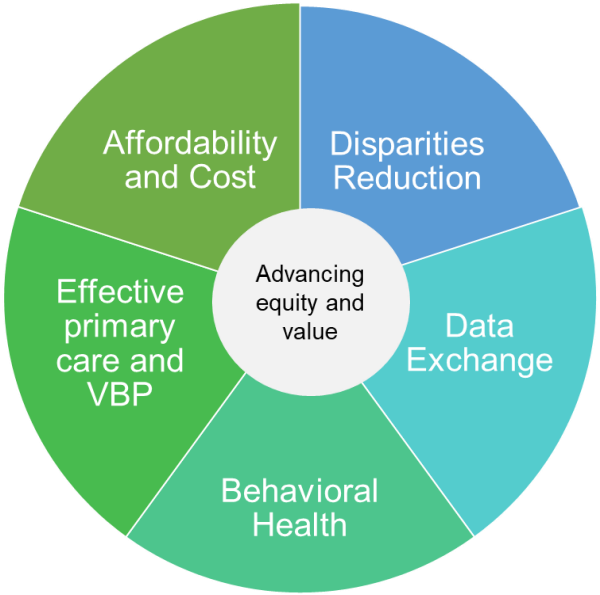
Center the member

Make it easy to do right

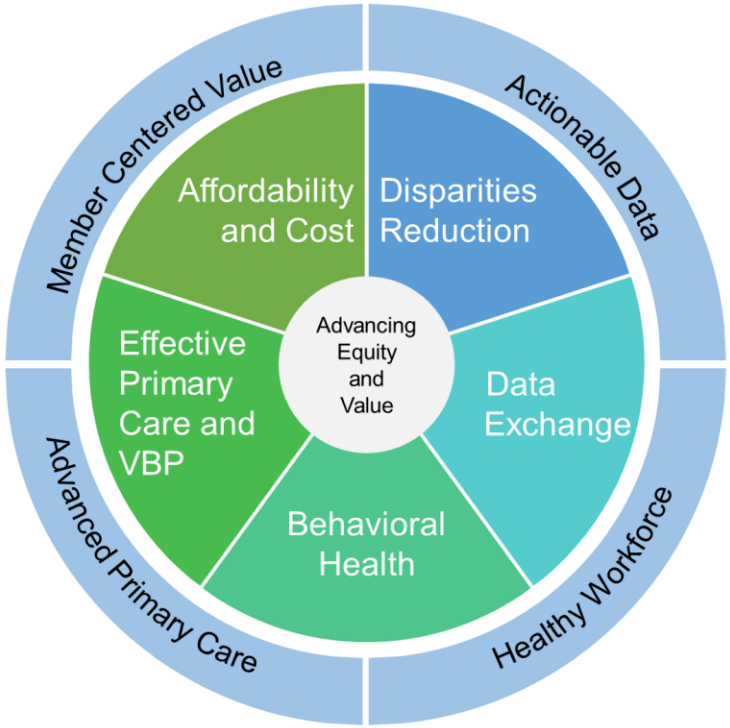
Amplify through alignment

Focused scope for high impact

2026-2028 Strategy Builds Upon 2023-2025 Focus Areas



2023-2025



2026-2028