2026-2028 Contract Update:
Attachment 1: Article 4 Delivery System and Payment Strategies to Drive Quality

May 2, 2024

AGENDA

Time	Topic	Presenter(s)
9:00-9:10	Welcome and Introductions	Charles Raya
9:10-9:35	Attachment 1: Article 4 – Advanced Primary Care	Barbara Rubino
9:35-9:45	Attachment 1: Article 4 – Promotion of Integrated Delivery System (IDS) & Accountability Care Organizations (ACO)	Peg Carpenter
9:45-10:10	Attachment 1: Article 4 – Networks Based on Value	Peg Carpenter
10:10-10:20	Attachment 1: Article 4 – Participation in Quality Collaboratives	Peg Carpenter & Steph Carlson
10:20-10:30	Wrap Up & Next Steps	Charles Raya

ARTICLE 4 - DELIVERY SYSTEM AND PAYMENT STRATEGIES TO DRIVE QUALITY

2023-25 ATTACHMENT 1 REQUIREMENTS

Article 4: Delivery and Payment Strategies to Drive Quality

Advanced Primary Care

- ❑ Issuers must match enrollees with PCPs and report the number of enrollees who select a PCP vs. those who are assigned a PCP
- ❑ Issuers must implement a quality measure set for advanced primary care in collaboration with the California Quality Collaborative (CQC) and the Integrated Healthcare Association (IHA). Issuers must submit data to IHA to implement the measure set
- ❑ Issuers must report on primary care payment models using the Health Care Payment Learning and Action Network Alternative Payment Model (HCP LAN APM) categories and increase the number of PCPs paid through shared savings and population-based payment models
- ❑ Issuers must report total primary care spend compared to overall spend by HCP LAN category and a description of the payment models for their 5 largest physician groups

2023-25 ATTACHMENT 1 REQUIREMENTS

Article 4: Delivery and Payment Strategies to Drive Quality

Promotion of Integrated Delivery Systems (IDSs) and Accountable Care Organizations (ACOs)

- ❑ Issuers must report the number of enrollees in IDS and ACO systems and increase the number of enrollees cared for under IDS and ACO systems
- ❑ Issuers must report the characteristics of the issuer's IDS and ACO systems such as payment model, leadership structure, quality incentive programs, data exchange processes, etc. and newly report the percent of spend under ACO and IDS contracts compared to overall spend
- ❑ Issuers must participate in the Integrated Healthcare Association (IHA), submit data for the IHA Commercial HMO and ACO measure sets (as applicable), and report performance on the measure sets to Covered California annually

2023-25 ATTACHMENT 1 REQUIREMENTS

Article 4: Delivery and Payment Strategies to Drive Quality

Networks Based on Value

- ❑ Issuers must report how cost, quality, patient safety, patient experience, or other factors are considered in network design and provider and facility selection and review
- ❑ Issuers must report on their network payment models by HCP LAN categories and associated subcategories
- ❑ Issuers must participate in the IHA Align.Measure.Perform (AMP) program for physician groups and report AMP performance results to Covered California annually or allow IHA to submit results to Covered California
- ❑ Issuers must adopt a hospital payment methodology for each general acute care hospital in its QHP networks that ties payment to quality performance
- ❑ Issuers must report its strategies to improve the appropriate use of opioids in its network hospitals
- ❑ Issuers must adopt value-based payment strategies structured to support only medically necessary care with no financial incentive to perform C-sections

2023-25 ATTACHMENT 1 REQUIREMENTS

Article 4: Delivery and Payment Strategies to Drive Quality

Participation in Quality Collaboratives

- ❑ Issuers must report participation in any collaborative initiatives that are aligned with Covered California's requirements and expectations for quality improvement, addressing health disparities, and improving data sharing

4.01 Advanced Primary Care

Dr. Barbara Rubino
Associate Chief Medical Officer

2023-25 ATTACHMENT 1 REQUIREMENTS

Article 4: Delivery and Payment Strategies to Drive Quality

Advanced Primary Care

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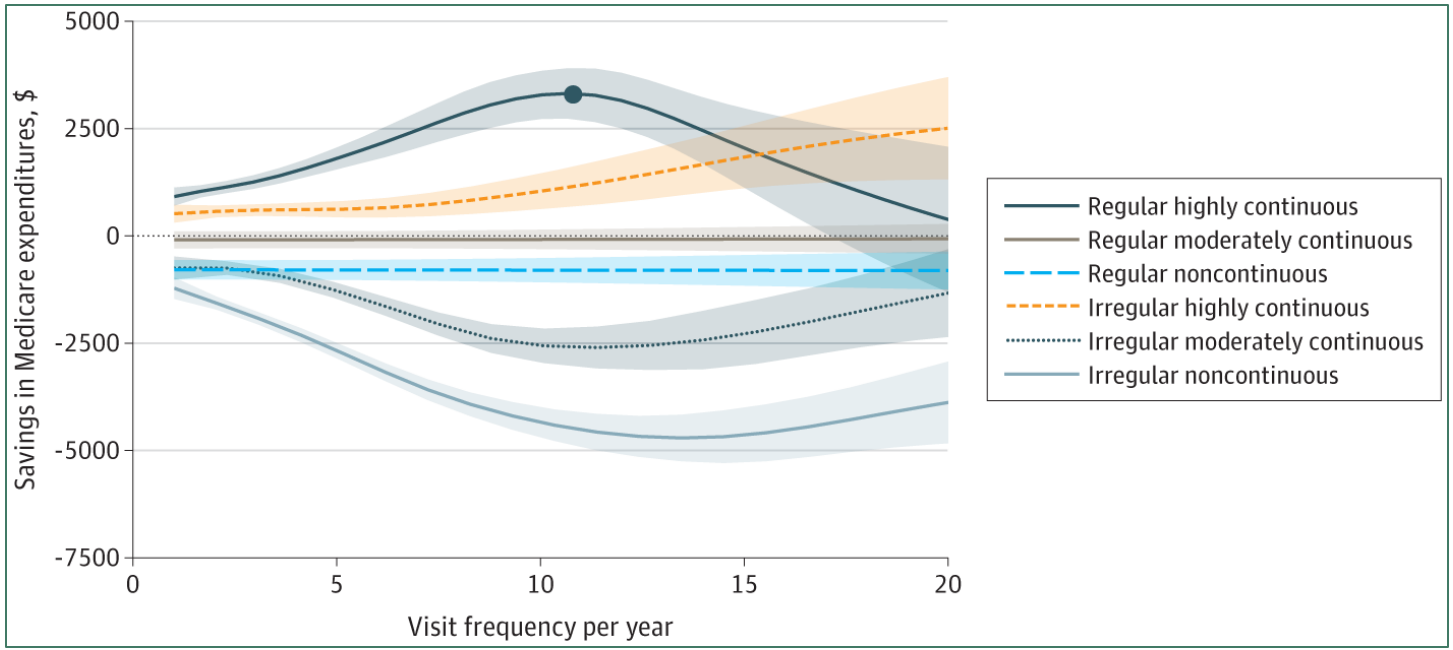
IMPACT OF DISCONTINUOUS PRIMARY CARE

August 21, 2023 | JAMA Network Open | Health Policy

Primary Care Continuity, Frequency, and Regularity Associated With Medicare Savings



- Increasing primary care visit frequency (up to a point) in the setting of a **highly continuous** PCP relationship has a cost-savings effect
- Increasing primary care visit frequency in an irregular, noncontinuous way leads to increased healthcare costs

IMPACT OF DISCONTINUOUS PRIMARY CARE

December 27, 2023 | JAMA Network Open | Health Policy

Virtual Visits with Own Family Physician Versus Outside Family Physician and Emergency Dept Use

Table 2. Patient Outcomes in Matched Cohort

Outcome	Patients with virtual encounter, No. (%) (N = 1 885 966)		RD, % (95% CI)	RR (95% CI)
	Physician outside enrolling group (n = 942 983)	Own enrolling physician (n = 942 983)		
ED visit within 7 d				
Any	30 748 (3.3)	18 519 (2.0)	1.3 (1.2-1.3)	1.66 (1.63-1.69)
High acuity	7042 (0.7)	4836 (0.5)	0.2 (0.2-0.3)	1.46 (1.40-1.51)
Low acuity	7759 (0.8)	4084 (0.4)	0.4 (0.4-0.4)	1.90 (1.83-1.97)
ED visit				
Day 1	12 661 (1.3)	6372 (0.7)	0.7 (0.6-0.7)	1.99 (1.93-2.05)
Day 2	6566 (0.7)	3539 (0.4)	0.3 (0.3-0.3)	1.86 (1.78-1.93)
Within 30 d	57 674 (6.1)	41 342 (4.4)	1.7 (1.7-1.8)	1.40 (1.38-1.41)
Mean (SD)	8.9 (9.1)	10.4 (9.2)	NA	HR = 1.41 (1.39-1.43)
ED visit for high-acuity motor vehicle accident day 3-30[a]	129 (<0.1)	97 (<0.1)	<0.1	1.33 (1.02-1.73)
In-person visit within 7 d				
With any family physician	57 208 (6.1)	45 828 (4.9)	1.2 (1.1-1.3)	1.25 (1.23-1.26)
With same physician	29 043 (3.1)	39 102 (4.1)	1.1 (1.0-1.1)	0.74 (0.73-0.75)
With own enrolling physician	9915 (1.1)	39 102 (4.1)	3.1 (3.1-3.1)	0.25 (0.25-0.26)
With physician in own group	11 532 (1.2)	38 994 (4.1)	2.9 (2.9-3.0)	0.30 (0.29-0.30)
Virtual visit within 7 d				
With any family physician	83 681 (8.9)	44 470 (4.7)	4.2 (4.1-4.2)	1.88 (1.86-1.90)
With same physician	40 100 (4.3)	39 251 (4.2)	0.1 (0.0-0.2)	1.02 (1.01-1.04)
With own enrolling physician	19 658 (2.1)	39 251 (4.2)	2.1 (2.0-2.1)	0.50 (0.49-0.51)
With physician in own group	20 924 (2.2)	38 882 (4.1)	1.9 (1.9-2.0)	0.54 (0.53-0.55)

- Patients who had a virtual encounter with an outside family physician were **66% more likely** to visit an emergency department within 7 days as compared with those who had a virtual visit with their own family physician.
- *Note: A separate analysis for virtual visits with family physicians in D2C telemed companies increased the risk from 66% to 3x.*

COVERED CALIFORNIA

ASSESSING IMPACT OF PCP ASSIGNMENT/SELECTION

- Using CovCA all plan claims database, we investigated the association between PC Assignment & healthcare utilization
  - All CovCA plans provide an Assigned PCP NPI for each enrollee
    - May be Selected PCP, or may be Assigned (if not selected)
- We matched rendering provider on claims to the Assigned PCP on the enrollee file to determine if the patient used:
  - Their assigned PCP
  - Some other plan-identified PCP
  - No PCP but some other healthcare service
  - No healthcare service/ no claims
- Each of the above is mutually exclusive

ANALYSIS: PRIMARY CARE SELECTION & HEALTHCARE UTILIZATION

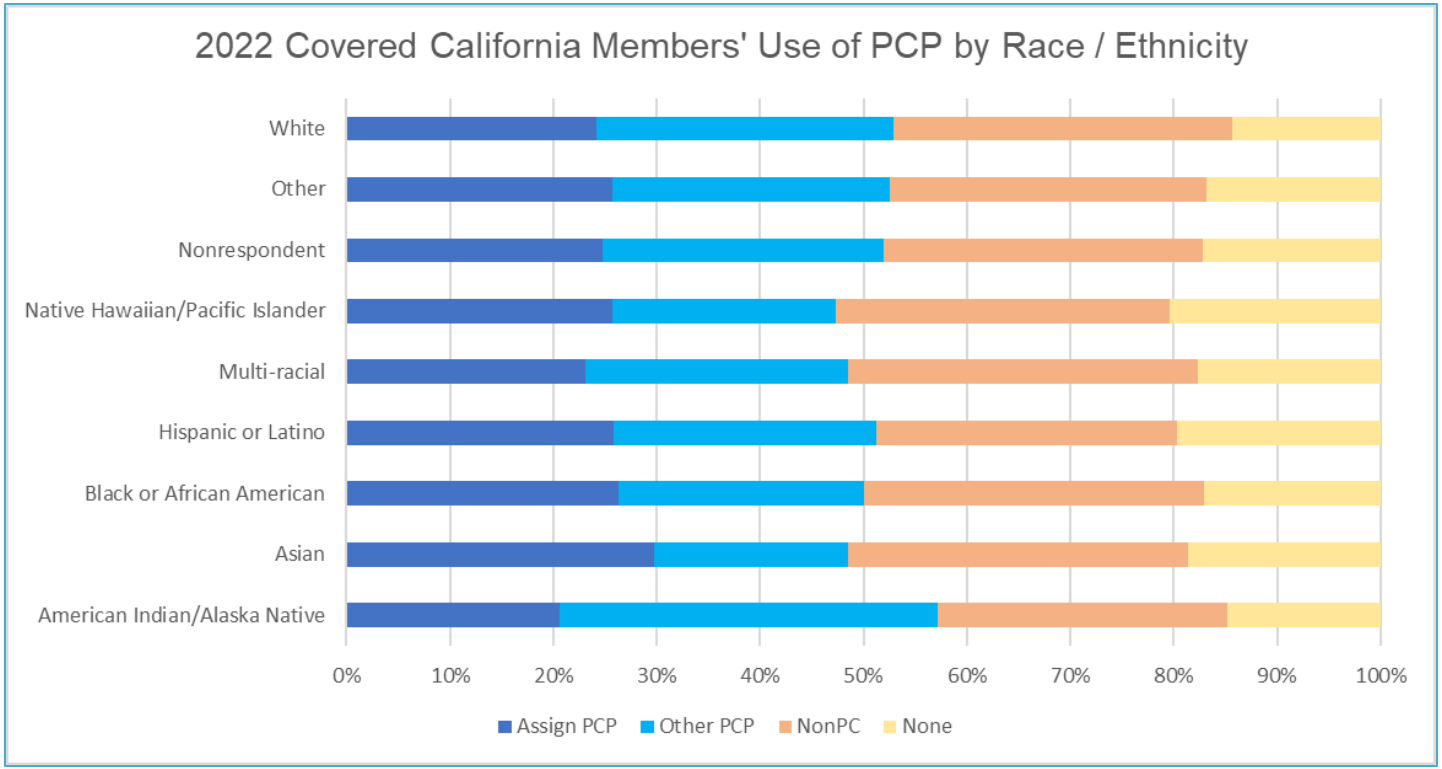
Members Enrolled >3 months in 2022

	HMO	PPO/EPO	Overall
Used Assigned PCP	32%	11%	26%
Used Other PCP	18%	46%	26%
Used only Non-PCP service (i.e. spec only)	32%	28%	31%
No utilization	18%	14%	17%

Members Enrolled in 2022 > 12 months

	HMO	PPO/EPO	Overall
Used Assigned PCP	37%	13%	30%
Used Other PCP	19%	50%	28%
Used only Non-PCP service (i.e. spec only)	31%	27%	30%
No utilization	14%	11%	13%

ANALYSIS: PRIMARY CARE SELECTION & HEALTHCARE UTILIZATION



CONTINUITY OF CARE INDEX: A VALID & EVIDENCE-BASED MEASURE

- Included in CMS' Core Quality Measures Collaborative (CQMC) P4QM Measure Set in 2021
  - Endorsed by NQF, measure steward is the American Board of Family Medicine
- Validated in 2022 in the Annals of Family Medicine
- Strong evidence behind continuity of care measurement:
  - CoC leads to reduction in ER visits, hospitalizations, healthcare costs, and survival
    - Disruption of continuity via loss of a PCP increases costs & utilization

CONTINUITY OF CARE MEASURE DESCRIPTION

The calculation

- Relies on claims data
- Numerator: Number of patients with Continuity index of 0.7 or more
  - Continuity index calculated by looking at % of visits with the same provider
    - Ranges from 0 to 1, 0 = all visits with different provider, 1 = all visits with the same provider
- Denominator: Number of patients with continuous enrollment 12 months with 2 or more visits to any primary care clinician

LIMITATIONS OF THE MEASURE

It is provider-centric

- Does not account for team-based care
  - No method to account for RN visits, pharmacists, etc.
- Difficult to reconcile with PCP workforce shortage

It is visit-based

- Does not account for work done outside of traditionally scheduled visits or encounters
- Evolving models of care
- Use of technology, portals, e-visits not captured in original measure specifications

ANALYSIS: CONTINUITY OF CARE INDEX IN COVERED CALIFORNIA

- **Methods:** We applied the continuity of care index to the Covered California population (2022) with 12+ months of continuous enrollment
  - Evaluated the % of plan-designated PCPs with a continuity index of >0.7 or 70%
    - 70% threshold for continuity is what has been validated in literature and endorsed in NQF and CQCM specifications
  - We rolled up results to the QHP level, and assess what portion of each QHP's designated PCPs had achieved 70% or more continuity

- **Initial Results: Individual QHP results ranged from 41% to 82%**
  - HMOs average continuity is 68%
  - PPOs average continuity is 64%

OHCA'S ALTERNATIVE PAYMENT MODELS ADOPTION GOALS

- ❑ Promote the shift of payments based on fee-for-service (FFS) to APMs that provide financial incentives for equitable high-quality and cost-efficient care
- ❑ Convene health care entities and organize an APM workgroup, set statewide goals for the adoption of APMs, measure the state's progress toward those goals, and adopt contracting standards healthcare entities can use
- ❑ Set benchmarks that include, but are not limited to, increasing the percentage of total healthcare expenditures delivered through APMs or the **percentage of membership covered by an APM**

DRAFT OHCA APM ADOPTION GOALS

Revised APM Adoption Goals

Revised APM Adoption Goals for Percent of Members Attributed to HCP-LAN Categories 3 and 4 by Payer Type				
	Commercial HMO	Commercial PPO	Medi-Cal	Medicare Advantage
2026	65%	25%	55%	55%
2028	75%	35%	60%	65%
2030	85%	45%	65%	75%
2032	90%	55%	70%	85%
2034	95%	60%	75%	95%

- Two-year interim goals leading to a 10-year goal.
- Reinforces public reporting on interim goals.
- Recognizes different starting and ending points for payers.
- Recognizes that all arrangements must include a link to quality.
- Creates a glidepath that more than triples Commercial PPO members attributed to HCP-LAN Categories 3 and 4 from 16% in 2021.

These revised adoption goals are also under discussion with sibling state departments.

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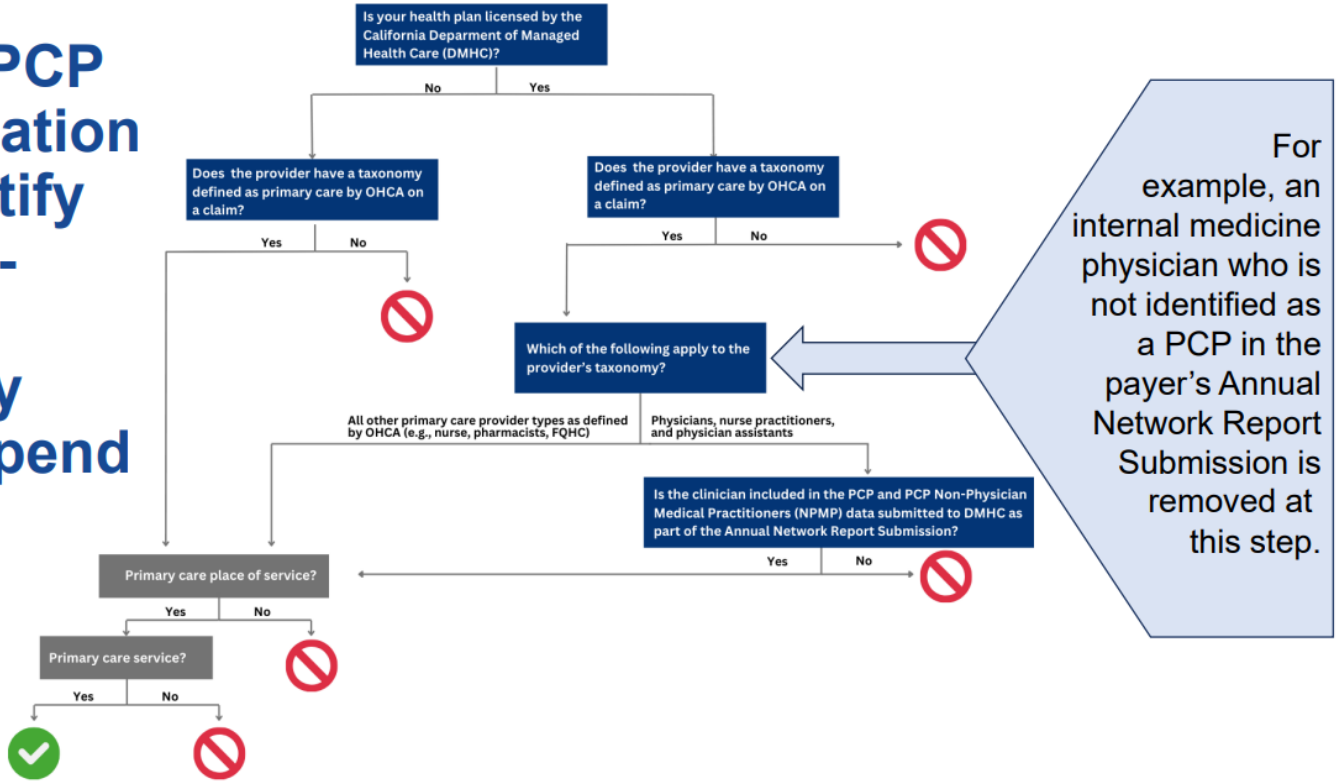
HCAI Department of Health Care Access and Information

COVERED CALIFORNIA

https://hcai.ca.gov/wp-content/uploads/2024/04/April-2024-Board-Meeting-Presentation.pdf

DRAFT OHCA PRIMARY CARE SPEND METHODOLOGY

Using PCP Designation to Identify Claims-based Primary Care Spend



Draft Primary Care Investment Benchmark Recommendation

Relative Improvement Benchmark: All payers* increase primary care spending by 0.5 percentage points to 1 percentage point per year, depending on current level of investment.

Rationale for Level:
- Consistent with other state approaches and experiences.
- Acknowledges payers are at different starting levels.
- Offers gradual reallocation of spending.
- Focus on shifting spend from specialty care and toward primary care.

AND

Absolute Benchmark: California allocates 15% of total medical expense to primary care by 2034 across all payers and populations.

Rationale for Level:
- Internationally, high performing health systems spend 12% to 15% of total spending on primary care.[1]
- States that invest more on primary care tend to spend less on avoidable hospitalizations and ED use.[2]
- Slightly higher than other states, recognizing California's healthcare delivery goals, delivery system, younger population, and time horizon.

*Payers at or above 15% of total medical expense may refrain from continued increases if not aligned with care delivery or affordability goals.

Sources: Jabbarpour, et al. (2019, July). *Investing in Primary Care: A State-Level Analysis*. Patient-Centered Primary Care Collaborative. https://www.graham-center.org/content/dam/rgc/documents/publications-reports/reports/Investing-Primary-Care-State-Level-PCMH-Report.pdf.; National Academies of Sciences, Engineering, and Medicine. (2021). *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*. Washington, DC: The National

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https://hcai.ca.gov/wp-content/uploads/2024/04/April-2024-Board-Meeting-Presentation.pdf

Delivery System and Payment Strategies to Drive Quality

4.01 ADVANCED PRIMARY CARE: PROPOSED CHANGES

Covered California seeks to measure achievement of and progress towards advanced primary care to promote access, care coordination, and quality while managing the total cost of care. To that end, Covered California proposes:

Encouraging Use of Primary Care – retain the reporting requirement for the proportion of enrollees who select versus are assigned a primary care clinician. However, remove from Attachment 2 Performance Standard 9 (Healthcare Evidence Initiative Data (HEI) Submission)

Measuring Advanced Primary Care – deploy continuity of care assessments and other novel analytics via HEI to measure advanced primary care. Benchmarks and improvement targets will be included in Attachment 2 as a new Performance Standard

Payment to Support Advanced Primary Care – align with Office of Health Care Affordability (OHCA) and require reporting on the adoption of HCP LAN Alternative Payment Models assessed using percent of members as well as primary care spend. Given level of oversight from OHCA, propose retirement of Performance Standard 5 (Primary Care Payment) and 6 (Primary Care Spend)

ADVANCED PRIMARY CARE REQUEST FOR FEEDBACK

- Input on retaining the reporting requirement for the proportion of enrollees who select versus are assigned a primary care clinician and retirement from HEI Performance Standard 9 (HEI Submission) in Attachment 2
- Input on deploying a continuity of care assessment and other novel analytics via HEI to measure advanced primary care and establishing benchmarks and improvement targets as new Performance Standards in Attachment 2
- Input on aligning with OHCA methodology for required reporting on adoption of HCP LAN Alternative Payment Models using percent of members as well as primary care spend methodology, and retirement from Performance Standard 5 (Primary Care Payment) and 6 (Primary Care Spend) in Attachment 2

4.02 Promotion of Integrated Delivery Systems (IDSs) and Accountable Care Organizations (ACOs) & 4.03 Networks Based on Value

Peg Carpenter
Senior Equity & Quality Specialist

COVERED CALIFORNIA

2023-25 ATTACHMENT 1 REQUIREMENTS

Article 4: Delivery and Payment Strategies to Drive Quality

Promotion of Integrated Delivery Systems (IDSs) and Accountable Care Organizations (ACOs)

- ❑ Issuers must report the number of enrollees in IDS and ACO systems and increase the number of enrollees cared for under IDS and ACO systems
- ❑ Issuers must report the characteristics of the issuer's IDS and ACO systems such as payment model, leadership structure, quality incentive programs, data exchange processes, etc. and newly report the percent of spend under ACO and IDS contracts compared to overall spend
- ❑ Issuers must participate in the Integrated Healthcare Association (IHA), submit data for the IHA Commercial HMO and ACO measure sets (as applicable), and report performance on the measure sets to Covered California annually

2023-25 ATTACHMENT 1 REQUIREMENTS

Article 4: Delivery and Payment Strategies to Drive Quality

Networks Based on Value

- ❑ Issuers must report how cost, quality, patient safety, patient experience, or other factors are considered in network design and provider and facility selection and review
- ❑ Issuers must report on their network payment models by HCP LAN categories and associated subcategories
- ❑ Issuers must participate in the IHA Align.Measure.Perform (AMP) program for physician groups and report AMP performance results to Covered California annually or allow IHA to submit results to Covered California

PERCENT OF MEMBERS PARTICIPATING IN ACO/IDS

PPO/EPO	Anthem	BSC	Health Net	Oscar
MY2019	16%	13%	8%	10%
MY2020	15%	11%	8%	8%
MY2021	42%	13%	7%	10%

Historic Covered California data shows high variability and unclear impact of current contract requirement with high administrative reporting and processing burden

HMO	Anthem	BSC	Health Net	LA Care	Molina	Sharp	VHP	WHA
MY2019	n/a	100%	79%	21%	28%	100%	33%	100%
MY2020	100%	100%	79%	26%	32%	100%	32%	100%
MY2021	100%	100%	72%	7%	26%	100%	31%	100%

https://hbex.coveredca.com/data-research/plan-performance-reports/published-reports/2023/

Delivery System and Payment Strategies to Drive Quality

4.02 PROMOTION OF IDS AND ACO & 4.03 NETWORKS BASED ON VALUE: PROPOSED CHANGES

To reduce administrative burden and maximize alignment with OHCA and other public purchasers, Covered California proposes:

Promotion of Integrated Delivery Systems (IDS) and Accountable Care Organizations (ACO): Removal of IDS and ACO enrollment and descriptive reporting requirements

Networks Based on Value: Align with OHCA on required reporting on the adoption of HCP LAN Alternative Payment Models assessed using percent of members and retirement of Attachment 2 Performance Standard 7 (Payment to Support Networks Based on Value- reporting on total network spend and the percent of spend within each HCP LAN APM category)

4.02/4.03 - REQUEST FOR FEEDBACK

- ❑ Input on removal of IDS and ACO enrollment and descriptive reporting requirements

- ❑ Input on aligning with OHCA in reporting adoption of HCP LAN Alternative Payment Models using percent of members and retirement of Attachment 2 Performance Standard 7 (Payment to Support Networks Based on Value)

4.03 Networks Based on Value – Hospital and Maternity Care

Peg Carpenter
Senior Equity & Quality Specialist

2023-25 ATTACHMENT 1 REQUIREMENTS

Article 4: Delivery and Payment Strategies to Drive Quality

Networks Based on Value – Hospital and Maternity

- ❑ Issuers must adopt a hospital payment methodology for each general acute care hospital in its QHP networks that ties payment to quality performance
- ❑ Issuers must report its strategies to improve the appropriate use of opioids in its network hospitals
- ❑ Issuers must adopt value-based payment strategies structured to support only medically necessary care with no financial incentive to perform C-sections

HOSPITAL SAFETY AND PAYMENTS BASED ON QUALITY

- Upon review of performance for MY2019-MY2021, percent of hospitals with payment tied to quality ranged from 0%-100% without consistency in performance by product
- Data shows high variability and unclear impact of current contract requirement with high administrative reporting and processing burden

PERCENT OF HOSPITAL PAYMENT AT RISK FOR QUALITY PERFORMANCE		
Date	Value	Goal
MY2019	0%	2%
MY2020	0%	2%
MY2021	0%	2%
HOSPITALS WITH PAYMENT TIED TO QUALITY	0%	

PERCENT OF HOSPITAL PAYMENT AT RISK FOR QUALITY PERFORMANCE		
Date	Value	Goal
MY2019	2%	2%
MY2020	2%	2%
MY2021	2%	2%
HOSPITALS WITH PAYMENT TIED TO QUALITY	95%	

PERCENT OF HOSPITAL PAYMENT AT RISK FOR QUALITY PERFORMANCE		
Date	Value	Goal
MY2019	0%	2%
MY2020	6%	2%
MY2021	6%	2%
HOSPITALS WITH PAYMENT TIED TO QUALITY	6%	

https://hbex.coveredca.com/data-research/plan-performance-reports/published-reports/2023/

Delivery System and Payment Strategies to Drive Quality

4.03 HOSPITAL QUALITY, VALUE AND PATIENT SAFETY: PROPOSED CHANGES

Covered California seeks to foster collaboration among network hospitals to not only comply with the transparency requirements but also to improve healthcare value. To amplify OHCA's focus on total cost of care, Covered California seeks to enable sharing of best practices, providing technical assistance, and facilitating discussions on how to work with underperforming hospitals to resolve resource inefficiencies. Therefore, Covered California proposes:

Hospital Value: Update CMS Price Transparency Language; shift from individual hospital intervention plans to demonstrating collaborative engagement with poor performing hospitals

Hospital Payments to Promote Quality and Value: Retirement of this section

Hospital Patient Safety: Require Cal Healthcare Compare participation for patient safety oversight

Alignment with DHCS and Medi-Cal's Bold Goals

Medi-Cal provides health insurance coverage for about 40 percent of all births in the state each year, therefore aligning and amplifying DHCS' efforts are paramount

MATERNITY CARE: AMPLIFY THROUGH ALIGNMENT

Workforce: Expand and Diversify the Perinatal Workforce in alignment with DHCS

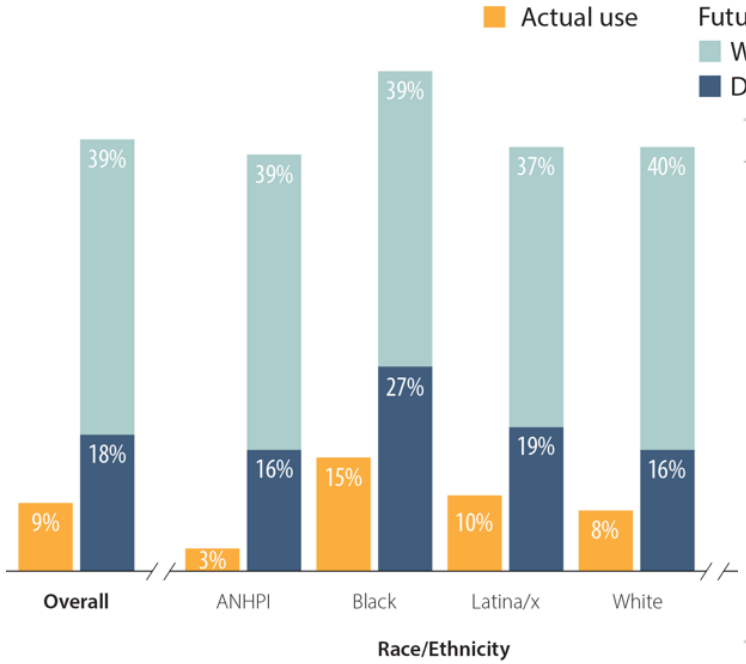
- As the country grows more diverse, the health care workforce has grown increasingly unrepresentative of the women it serves
- By 2030, the number of obstetricians is expected to decrease by 7% while demand is projected to increase by 4%
- In 2022, 46,000 California women ages 18-44 lived in counties with no hospitals with obstetrics care or birth centers, and an additional 76,000 lived in counties with only one hospital with obstetrics care or a birth center
- Doula/Midwife access is associated with improved maternal health outcomes, including lower odds of Cesarean sections and preterm births. Yet, only about 6% of women who give birth receive doula/midwifery care
  - Doulas/Midwives can also play a particularly important role in understanding a community's traditions and providing culturally appropriate care

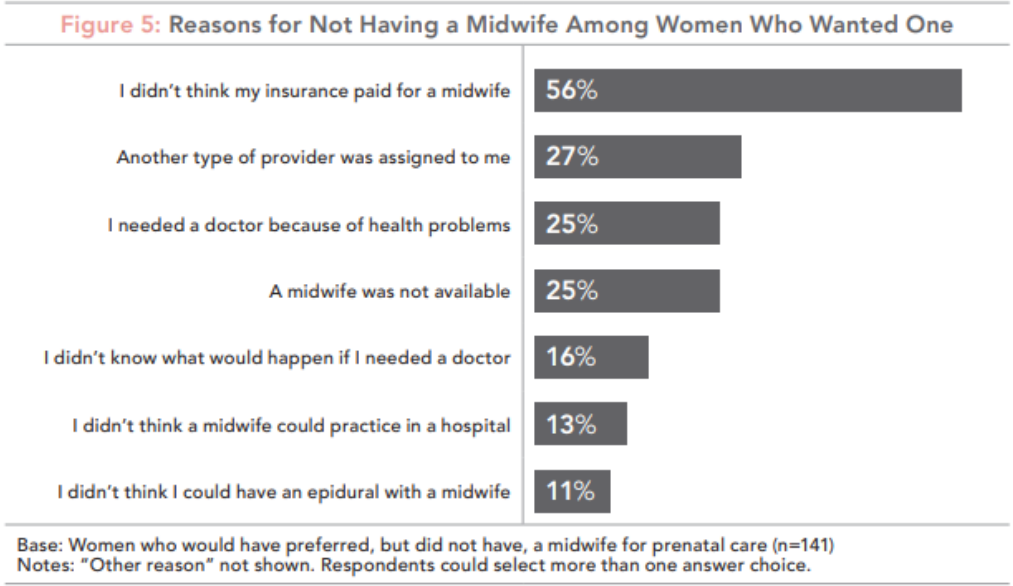
Alternative Models: Modernizing maternal health care and improving our understanding of social determinants of health in pregnant and postpartum patients

- Emphasis is placed on community birth centers and the integration of more midwives and doulas, to improve quality and outcomes for birthing individuals, promoting culturally competent care and reducing disparities
- Sixty cents of every dollar spent on maternity care pays for hospital facility services. Shifting from a fee-for-service model to alternative payment models requires a significant culture change among providers and institutions, with an increased focus on quality, equity, and respectful care

https://www.whitehouse.gov/wp-content/uploads/2022/06/Maternal-Health-Blueprint.pdf
https://www.chcf.org/publication/maternity-care-ca-2023-edition/
https://www.catalyze.org/wp-content/uploads/2017/04/2013-The-Cost-of-Having-a-Baby-in-the-United-States.pdf

MIDWIFE & DOULA USE: ACCESS BARRIERS





https://nationalpartnership.org/health-justice/maternal-health/listening-to-mothers-ca/report/
https://www.chcf.org/publication/infographic-overmedicalization-childbirth/

MATERNITY CARE HONOR ROLL

Background: Every year approximately 420,000 babies are born in California, and childbirth is the number one reason for hospitalization in the U.S. and California. For mothers, overuse of cesarean sections (c-sections) can result in higher rates of complications like hemorrhage, transfusions, infection, and blood clots. The surgery also brings risks for babies, including higher rates of infection, respiratory complications, neonatal intensive care unit stays, and lower breastfeeding rates

- ❑ The 2023 Maternity Honor Roll recognizes 107 hospitals that met or surpassed the statewide target aimed at reducing births via c-section in first-time mothers with low-risk pregnancies
- ❑ **Roughly 50% (103 of 210) of** Covered California Hospitals made the Maternity Care Honor Roll in 2023

Maternity Hospital Honor Roll

	Plan Product	MY2020	MY2021
Anthem	HMO	31%	42%
	EPO	49%	48%
Blue Shield	HMO	47%	51%
	PPO	49%	52%
Chinese Community	HMO	33%	33%
Health Net	HMO	54%	49%
	PPO	42%	49%
	EPO	46%	50%
Kaiser Permanente	HMO	59%	63%
LA Care	HMO	32%	38%
Molina Healthcare	HMO	45%	45%
Oscar Health Plan	EPO	47%	56%
Sharp Health Plan	HMO	57%	57%
Valley Health Plan	HMO	67%	67%
Western Health Advantage	HMO	33%	50%

https://calhospitalcompare.org/wp-content/uploads/2023/07/Fact-Sheet-w-List-of-Honor-Roll-Hospitals_Maternity-Honor-Roll_CHC_2023.pdf

COVERED CALIFORNIA BIRTHS & C-SECTION RATES

Populations	Number of Births	% C-sections
All Covered California Population	**13,235**	34%
American Indian/Alaska Native	35	37%
Asian	2,347	38%
Black or African American	306	40%
Hispanic or Latino	3,245	34%
Multi-racial	329	31%
Native Hawaiian/Pacific Islander	4	0%
Nonrespondent	3,005	35%
Some other race	998	36%
White	3,482	32%

HEI August 2022 - July 2023

Delivery System and Payment Strategies to Drive Quality

4.03 NETWORKS BASED ON VALUE – MATERNITY CARE

To enhance maternal health, long-term improvement relies on collaboration, data sharing, and engaging healthcare providers. Therefore, Covered California proposes:

Maternity Care:

- ❑ Continued direct data collection on maternal mental health and stratification;
- ❑ Redoubling participation in high-quality collaboratives such as Cal Healthcare Compare; and
- ❑ Expansion of maternity health equity focus specifically workforce and participation in DHCS improvement initiatives, including expansion of doulas

4.03: HOSPITAL/MATERNITY - REQUEST FOR FEEDBACK

- ❑ Input on retirement of individual hospital intervention plans and shift to collaborative engagement with poor performing hospitals
- ❑ Input on retirement of Hospital Payments to Promote Quality and Value section
- ❑ Input on requiring Cal Healthcare Compare participation for patient safety oversight and maternity quality improvement
- ❑ Input on tracking volume of in-network doulas

4.05 Participation in Quality Collaboratives

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2023-25 ATTACHMENT 1 REQUIREMENTS

Article 4: Delivery and Payment Strategies to Drive Quality

Participation in Quality Collaboratives

- ❑ Issuers must report participation in any collaborative initiatives that are aligned with Covered California's requirements and expectations for quality improvement, addressing health disparities, and improving data sharing

QUALITY COLLABORATIVES: BENEFITS

Performance Optimization: Collaboratives focus on metrics aligned with regulatory standards, aiding health plans in meeting compliance requirements. Through data analysis and sharing of best practices, health plans can identify performance gaps, and implement targeted high impact improvements

Driving Affordability: Quality collaboratives drive efficiency in healthcare delivery, reducing waste and lowering costs—a benefit that aligns with the management of chronic conditions and preventive care, which are the focus areas of clinical quality performance

Innovation: Participation fosters a culture of learning, sharing, and collaboration, enabling health plans to engage in large-scale quality improvement initiatives that contribute to better performance

Reputation & Trust: Active improvement efforts enhance a health plan's reputation, building trust among stakeholders and amplify efforts through alignment. Moreover, strategies aimed at engaging patients directly contribute to higher patient satisfaction levels

Alignment with Value-Based Care: Quality collaboratives support health plans in the transition adoption and alignment with value-based care by fostering a culture of continuous improvement. They provide the tools, resources, and partnerships necessary to succeed in a value-based healthcare landscape

Strategic Partnerships Advocacy: Through networking and collective advocacy within collaboratives, health plans can influence and engage in initiatives that support quality improvement and member experience, facilitated by rapid feedback loops for timely strategy adjustments

https://www.milbank.org/wp-content/uploads/2024/03/Haft-Jones-Article_final.pdf

QUALITY COLLABORATIVES: CHALLENGES

Cost: Mandatory participation often requires plans to contribute membership fees. In previous assessments, Covered California found plans were contributing $30,000-$620,000 in dues. This is increasingly burdensome for smaller issuers

Variable benefit: Issuers with regionally focused or smaller networks reported benefiting less from collaboratives due to the perception of having unique relationships with their provider groups that were often not accounted for. Smaller or regional issuers report that larger plans may sway direction given size and footprint and their voices are often overlooked in collaboratives leading to disengagement

2023 PARTICIPATION IN QUALITY COLLABORATIVES

	Leapfrog	Symphony Provider Directory	Health Care Payments Data (HPD) System	Cal Hospital Compare	California Maternal Quality Care Collaborative (CMQCC)	California Right Meds Collaborative	Integrated Healthcare Association	NCQA Colonoscopy Learning Collaborative Overview	California Improvement Network (CIN)*	American Joint Replacement Registry (AJRR) for California	Collaborative Healthcare Patient Safety Organization (CHPSO)	California Quality Collaborative (CQC)
Aetna	✓	✓	✓				✓			✓		✓
Anthem	✓			✓			✓					✓
BSC		✓	✓	✓	✓	✓	✓					✓
CCHP		✓	✓									
Health Net	✓	✓	✓	✓	✓		✓		✓			✓
IEHP												
Kaiser	✓	✓		✓	✓		✓					✓
LA Care		✓		✓	✓	✓	✓	✓	✓			✓
Molina		✓	✓	✓	✓		✓		✓			✓
Sharp	✓	✓	✓	✓	✓		✓		✓	✓	✓	
VHP				✓								✓
WHA	✓			✓	✓		✓					

Required Participation for IHA, Symphony and Cal Hospital Compare

Delivery System and Payment Strategies to Drive Quality

4.05 PARTICIPATION IN QUALITY COLLABORATIVES: PROPOSED CHANGES

In response to growing financial burden and feedback from issuers, Covered California proposes:

- ❑ Reducing the list of required collaboratives
- ❑ Continuing to track participation
- ❑ Continuing to track cost
- ❑ Encouraging high-quality engagement through possible use of Attachment 2 penalty funds to help support participation dues and memberships for issuers

4.05 REQUEST FOR FEEDBACK

- ❑ In response to feedback on administrative burden, provide input on reducing the number of required collaboratives and initiatives
- ❑ In response to feedback on financial burden, provide input on proposal to utilize Attachment 2 penalties in part or whole to support cost of required quality collaborative memberships and participation
- ❑ Input on highest value collaboratives to have required participation

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!