QUALITY TRANSFORMATION INITIATIVE (QTI): PROPOSED HEALTH EQUITY METHODOLOGY

THERE IS NO QUALITY WITHOUT EQUITY

Make Quality Count

Measures that Matter

Equity is Quality

Amplify through Alignment

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

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

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)****

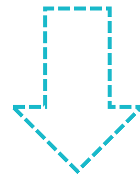
***Reporting Only

COVERED CALIFORNIA

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



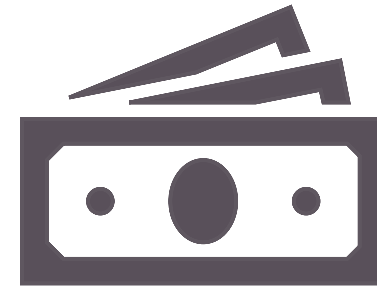
Covered California proposes the following:

- ❑ 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

APPROACHES TO ACCOUNTABILITY FOR DISPARITIES REDUCTION

Dashboards and Public Reporting

Improvement Plans

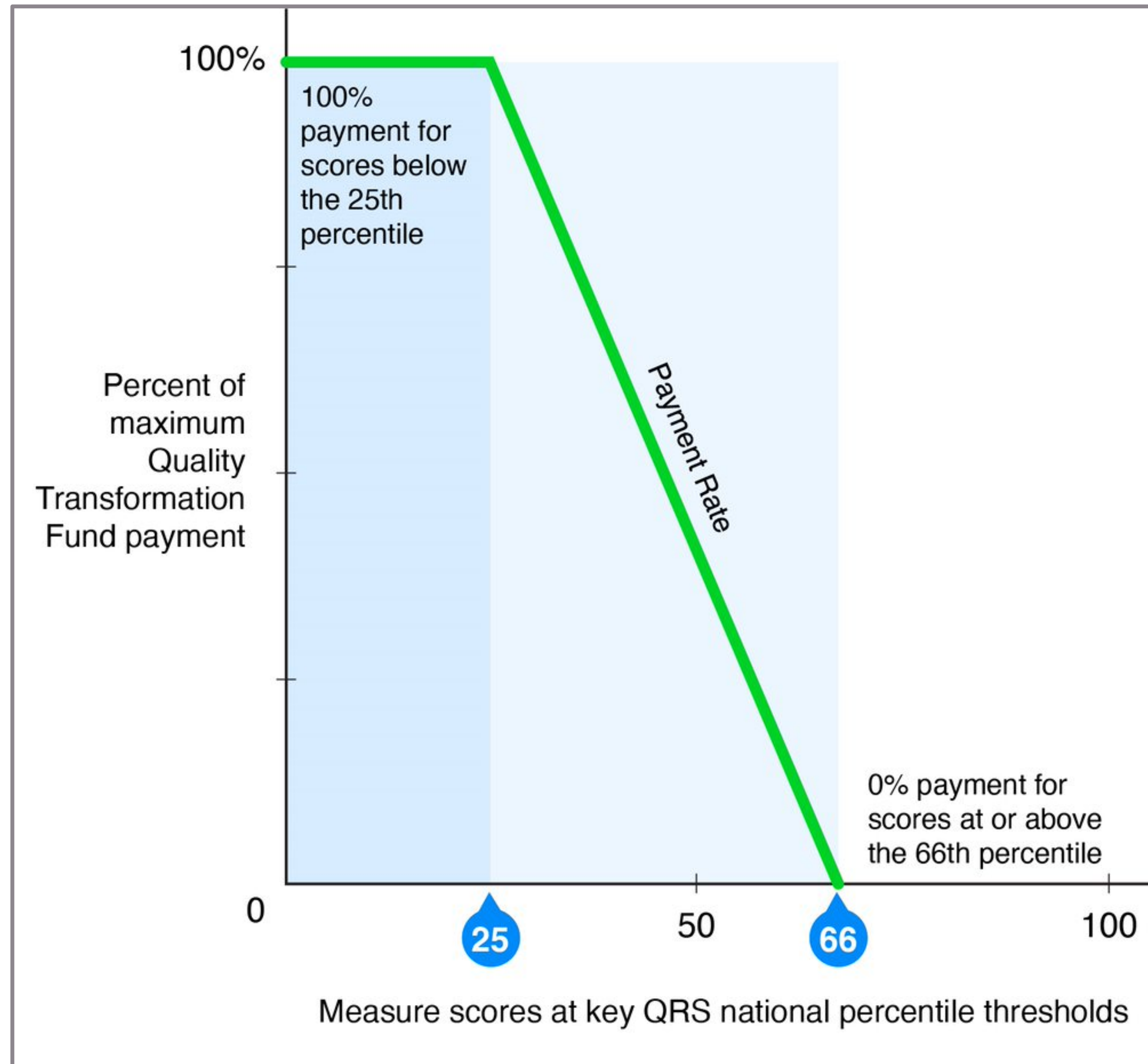


Financial Incentives

STRUCTURE 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

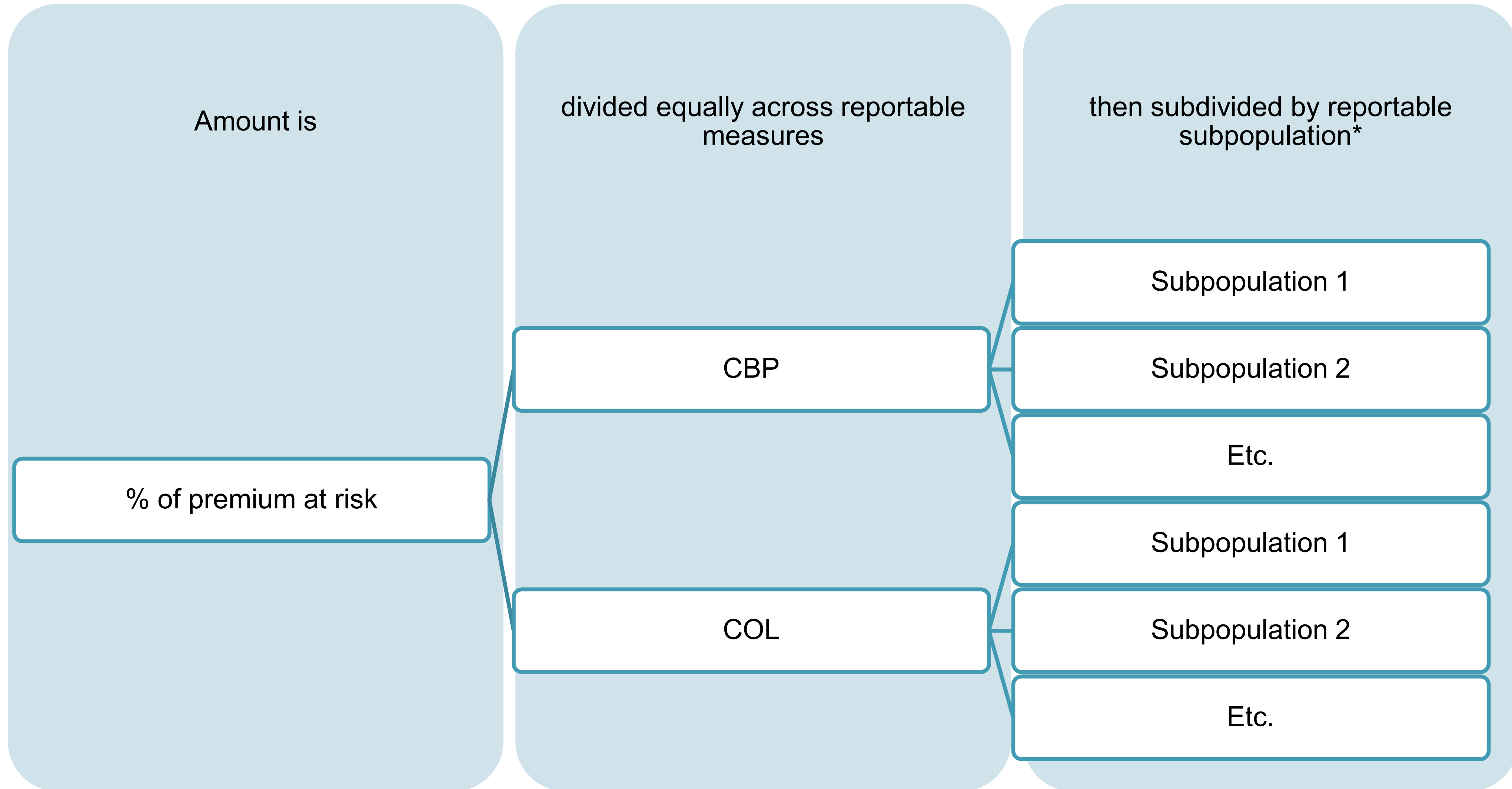


- Each reportable subpopulation performance would be separately evaluated
- Graduated performance scoring along 25th to 66th percentile slope would apply to each reportable subpopulation

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 across the 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

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 for hybrid measures
- 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

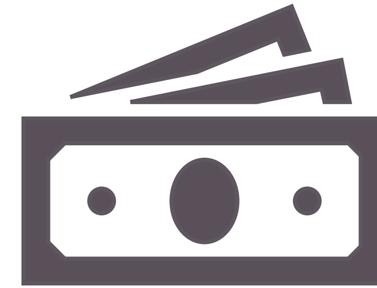
DISTRIBUTION OF “ALL OTHER MEMBERS”

- 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)

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 through the HCP-LAN State Transformation Collaboratives 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

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