Plan Management Advisory Workgroup Meeting

March 19, 2020

AGENDA

Time	Topic	Presenter
10:00 – 10:05	Welcome and Agenda Review	James DeBenedetti
10:05 – 10:15	2021 Health and Dental Benefit Design	Jan Falzarano
10:15 – 10:25	2021 Certification Update	Jan Falzarano
10:25 – 10:35	Attachment 7 Refresh Process & Timeline Update	Thai Lee
10:35 – 11:10	Attachment 7 Refresh: 10-year Visions for Consumers, Providers, Health Plans, Purchasers and Communities	Margareta Brandt Taylor Priestley Ashrith Amarnath
11:10 – 11:45	2022-2024 Attachment 14 Performance Standards Proposals • Contracting to Promote Value and Reward Quality • Feedback & Discussion	James DeBenedetti
11:45 – 12:00	Open Forum	All

2021 Health and Dental Benefit Design

Jan Falzarano, Deputy Director, Plan Management Division

AV CALCULATOR AND NOTICE OF BENEFIT AND PAYMENT PARAMETERS

- The final AV Calculator (AVC) was released on March 6, 2020.
- The Proposed Notice of Benefit and Payment Parameters (NBPP) was released in late January 2020. The final NBPP has not been released as of March 13, 2020.
- The plan designs will likely be finalized after the March 2020 Board meeting due to the later timeline for finalizing the NBPP.

	2018	2019	2020	2021
Maximum annual limitation on cost-sharing	$7,350 / $14,700	$7,900 / $15,800	$8,150 / $16,300	$8,550 / $17,100
Increase from previous year	2.8%	7.0%	3.2%	4.9%
CSR 73 Maximum annual limitation	$5,850 / $11,700	$6,300 / $12,600	$6,500 / $13,000	$6,800 / $13,600
CSR 87 Maximum annual limitation	$2,450 / $4,900	$2,600 / $5,200	$2,700 / $5,400	$2,850 / $5,700
CSR 94 Maximum annual limitation	$2,450 / $4,900	$2,600 / $5,200	$2,700 / $5,400	$2,850 / $5,700

PLAN DESIGN CHANGES SINCE JANUARY BOARD MEETING

- Various cost share changes to the CCSB Platinum, Gold, and Silver plans in response to stakeholder feedback
- Increased the MOOP in several plans to the maximum-allowed amount in 2021 (per the Proposed Notice of Benefit and Payment Parameters (NBPP), released on January 31st)
  - Removed some cost-share increases in lieu of the higher-than-expected MOOP limit (e.g. Bronze, Silver 87, Gold plans)
- Changed the medical transportation cost share in the CCSB Gold Coinsurance and CCSB Silver plans from a copay to coinsurance to align with the ED facility fee cost share
- Changed the home health cost share in the CCSB Gold Coinsurance plan from a copay to coinsurance to align with the convention for copay and coinsurance plans
- Updated actuarial values (AV) based on review by Milliman
- No changes to the dental plan designs

BRONZE PLANS

- Covered California is working towards a legislative solution likely through the budget process to address the Bronze AV de minimis range (+5/-2%).
- Endnote #31 addresses the Bronze AV issue: “The Bronze and Bronze HDHP are contingent upon meeting the actuarial value requirements in state law.”

FINAL PLAN DESIGNS

- The plan designs presented to the Board for action in March will still be draft versions until the NBPP is released.
- AV Certification will be completed once the NBPP is available.
- In the event the IRS MOOP limit is less than Covered California's projections, the plan designs will go before the Board again in June.

2021 Qualified Health Plan Certification Policy

Jan Falzarano, Deputy Director, Plan Management Division

CERTIFICATION UPDATE

- The Applications have not had any material changes since the January Board meeting.

- Individual and Small Business Certifications Applications went live on March 2, 2020 and are due on May 1, 2020.

PROPOSED CERTIFICATION MILESTONES

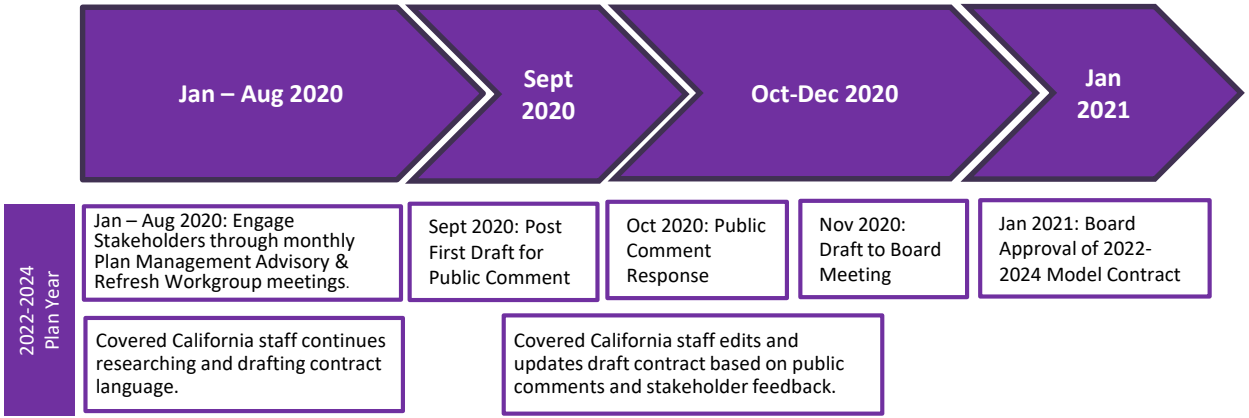
Release draft 2021 QHP & QDP Certification Applications	December 6, 2019
Draft application comment periods end	December 20, 2019
Plan Management Advisory: Benefit Design & Certification Policy recommendation	January 9, 2020
January Board Meeting: Discussion of Benefit Design & Certification Policy recommendation	January 16, 2020
Letters of Intent Accepted	February 3-~~17~~ 21, 2020
Final AV Calculator Released	~~February~~ March 2020
Applicant Trainings (electronic submission software, SERFF submission and templates*)	February - March 2020
March Board Meeting: Anticipated approval of 2020 Patient-Centered Benefit Plan Designs & Certification Policy	March 2020
QHP & QDP Applications Open	March 2, 2020
QHP & QDP Application Responses (Individual and CCSB) Due	May 1, 2020
Evaluation of QHP Responses & Negotiation Prep	May - June 2020
QHP Negotiations	June 2020
QHP Preliminary Rates Announcement	July 2020
Regulatory Rate Review Begins (QHP Individual Marketplace)	July 2020
Evaluation of QDP Responses & Negotiation Prep	June – July 2020
QDP Negotiations	July 2020
CCSB QHP Rates Due	July 2020
QDP Rates Announcement (no regulatory rate review)	August 2020
Public posting of proposed rates	July 2020
Public posting of final rates	September – October 2020

* Final SERFF template dependent on CMS release

Update on Attachment 7 Refresh Timeline and Process

Thai Lee, Senior Quality Specialist

2022-2024 ATTACHMENT 7 & MODEL CONTRACT DEVELOPMENT TIMELINE



- ❑ March 5, 2020: Attachment 7 refresh workgroup discussed proposed changes to Attachment 14 Performance Standards. Received initial feedback from QHPs and advocates.
- ❑ April 2, 2020 workgroup to focus on Individualized Equitable Care & Patient Centered Social Needs
- ❑ Ongoing work: engagement with external SMEs and alignment with other purchasers (CalPERS, DHCS) on different domains and strategies of Attachment 7

ATTACHMENT 7 REFRESH PROCESS

- Contract proposals are presented to Refresh Workgroup participants
  - Feedback is taken into consideration and proposals are updated accordingly
  - Continuous engagement with stakeholders contribute to edits and updates on proposals as appropriate
- Updated proposals are presented to Plan Management Advisory participants
  - Feedback is taken into consideration and proposals updated accordingly
- When ready, draft proposals will be presented to board members

ATTACHMENT 7 REFRESH WORKGROUP MEETINGS

Date	Contract Elements to be Discussed
April 2	Individualized Equitable Care Patient-centered Social Needs Community wide Social Determinants of Health
May 7	Mental Health and Substance Use Disorder Treatment
June 5	Acute Chronic and other Conditions Complex Care Health Promotion and Prevention Population Health Management
July 2*	Promotion of Integrated Delivery Systems Effective Primary Care Networks Based on Value
August 6	Sites and Expanded Approaches to Care Delivery Appropriate Interventions Certification, Accreditation and Regulation
September 3	Attachment 14 Performance Standards
October 1	Key Drivers Summary

*date subject to change

2022-2024 ATTACHMENT 14 PERFORMANCE STANDARDS

- Proposal: Attachment 14 to become a standing agenda item for Plan Management Advisory Meetings
  - PMA participants will discuss concepts and changes to performance standards
  - Staff will incorporate recommendations into new Attachment 14 contract for 2022-2024
  - Beginning in May/June meeting

- Questions or comments regarding this addition to the Plan Management Advisory workgroup?

Envisioning the Future of Health and Healthcare

2030 Vision Statements to Inform Covered California's Model Contract and Attachment 7 Refresh 2022-2024

Margareta Brandt, Senior Quality Specialist
Taylor Priestley, Health Equity Officer
Ashrith Amarnath, Medical Director

CORE ASSUMPTIONS TO COVERED CALIFORNIA'S APPROACH

Fundamental change can only be achieved by empowering and supporting meaningful improvement at five levels that required aligned action:

1. **Consumers and patients** – how they are engaged in maintaining good health and in getting best care when needed;
2. **Clinicians and hospitals** – where and how care is provided (physician practices, hospitals and other sites of care);
3. **Plans** – what they do on their own and with others to both improve care and improve the health of their members;
4. **Purchasers** - what they do on their own and with others to both improve care and improve the health of their employees; and
5. **Communities** – working collaboratively to improve the well-being of community members and address the social determinants of health.

COVERED CALIFORNIA'S OVERARCHING GOALS IN HEALTH PLAN CONTRACTING

1. Ensure that Covered California's enrollees receive the best possible care at the lowest possible cost.
2. Achieve the best possible health and health care for California residents.
3. Establish a process that will ensure continual improvement of California's health system through well-aligned near-term incremental changes and longer-term transformational reforms.
4. Provide a model that can spread broadly and insights and tools that others can adopt to help scale and spread the lessons learned.

DEVELOPING A VISION FOR THE FUTURE

- To help achieve these goals, Covered California's believes that it is important to know what we are trying to achieve.
- This process began with an initial draft vision for what the future health system would have to look like to meet those goals from the perspectives of each of these major constituencies:
  - Consumers and patients
  - Clinicians and hospitals
  - Health plans
  - Purchasers
  - Communities

CONSUMERS AND PATIENTS: 2030 FUTURE STATE

Consumers and Patients Have Access to a Safe, Timely, Equitable, Effective, Affordable and Patient-Centered Health System

The health system puts consumers, patients and caregivers needs first, by understanding their preferences, goals, values and assets foremost in a system built through consumer-centered design. Everyone has the information, care and support needed to promote or improve health, seek and obtain care, manage health-related conditions and make health-related decisions. Patients own and control their health information. The evidence required to make informed choices of treatments, providers and plans is sound, trusted and easy to understand. The safety, quality, effectiveness, efficiency and equity of care is continually improving. The health system is affordable, trusted, simple to use, tailored to the needs of each individual and is consuming a declining share of economic resources so that other human needs and wants can be met.

CONSUMERS AND PATIENTS: CURRENT STATE

- Widespread disparities based on race, ethnicity, socioeconomic status and geography.
- Best in the world care for some, poor quality care or no care at all for many others.
- Massive amounts of data that fails to help consumers or patients. Uncertainty about how to get help and from whom. Lack of information about choices in testing or treatment or how to think about those choices based on individual values and preferences. Pervasive lack of trust.
- Confusion about what to do to maintain one's health or manage illness. Numerous barriers to staying healthy. Powerful socioeconomic forces impair good health.
- Lack of information on the quality and cost of treatments, providers and plans.
- Care is increasingly unaffordable and comes with an overwhelming administrative burden.
- Choice in health plan and health care providers available to many, especially through employer-sponsored coverage and Medicare.

CLINICIANS: 2030 FUTURE STATE

Clinicians are Empowered and Supported to Deliver the Best Possible Care for Their Patients

Physicians and other clinicians are working in health systems where they have the training, support, resources, time and information needed to deliver the best possible care to their patients while contributing to improving the health of their community. The foundation of this care is accessible, data-driven, team-based primary care. A broader range of clinicians, beyond physicians, provide care to patients based on their health needs. Information systems integrate comprehensive historical and real-time clinical data to support patient-centered collaborative decision-making, health system improvement and accountability, all with minimal administrative work on the part of clinicians. Universal access and alternative payment models enable health systems and clinicians to provide care to all who need it and be rewarded financially for improving both health and care. The health professional workforce is trusted and valued, collaborative and team oriented, and reflects the diversity of the populations health systems serve. Professional values are prioritized and joy in work has returned.

CLINICIANS: CURRENT STATE

- Clinicians' work too often prioritizes administrative tasks and productivity rather than patient care. Professional values are undermined by payment and management systems that prioritize revenue generation and discriminate based on payer status and income rather than patient needs.
- The information needed to deliver care is too often unavailable due to siloed, administratively focused, and often burdensome electronic health records.
- Physicians (especially, but other clinicians as well) carry high levels of debt that force career choices that are often disconnected from the motivations that brought them to health care. Too few clinicians are entering primary care.
- The balance between primary and specialty care is tilted toward specialty resulting in unwarranted testing and intervention that drives up cost and often does more harm than good.
- The clinician workforce is maldistributed, with rural and low-income communities often underserved.
- Physicians increasingly work for corporate medical groups, independent practice associations or health systems rather than on their own.
- Although some clinicians make excellent incomes, professional satisfaction is often low and burnout increasing.
- Collaborative, team-based care models are gaining traction, but far from the norm in the practice setting.

HOSPITALS: 2030 FUTURE STATE

Hospitals and other Facilities are Continuously Refining Their Roles as Components of Health Systems

Advances in technology, remote monitoring, telemedicine and payment systems have shifted most acute and chronic care to home and community-based facilities, leading to the “right-sizing” of hospitals. Facility-based care is an integrated component of health systems where safety and quality are outstanding; the quality and cost of care are continuously evaluated and transparently reported. Value-based payment is fostering the continued redesign of care to reduce costs and improve safety and has led health systems to prioritize the public good. Universal insurance and excellent access to all levels of service have eliminated hospital emergency departments as the main access point to care for uninsured patients. Health professional education is no longer hospital-focused and is taking place in settings best suited to the learner’s needs.

HOSPITALS: CURRENT STATE

- Hospitals are essential community resources, as the only current place to treat seriously ill patients, deliver technologically advanced interventions and emergency treatment. Some hospitals provide highly specialized, high quality care.
- Hospitals are important educational sites for physicians, nurses and other health professionals.
- Hospitals are increasingly the only source of care for the uninsured, but are hard pressed to deliver needed primary and chronic care to the uninsured and are an ineffective way to finance that care.
- Hospitals' financial models are largely based on fee-for-service payment systems that reward volume and high-margin (often high cost) services and attracting high-paying patients. The result in many communities is a medical arms race that has led to unnecessarily extravagant and expensive facilities.
- Hospital mergers are leading to anti-competitive practices and higher prices, with no evidence of gains in quality. For many hospitals, financial performance is their priority. Quality and safety are rarely prioritized and remain uneven.
- Hospitals in rural areas are closing leading to concerns about access to critical care in these areas.
- Hospitals are large employers and are politically powerful.

HEALTH PLANS: 2030 FUTURE STATE

Health Plan Offerings are Standardized and Anchored in Partnerships with Providers that Improve Value

Plans compete on value that is defined by quality and affordability. Consumers choose coverage through easy-to-use information services that offer a limited number of plans with identical benefit designs, each with well-defined networks of providers paid under a unified population-based budget, using a common, agreed upon formulary. Common benefit designs, uniform billing and administrative systems have markedly reduced administrative costs. Comprehensive performance measures at both the provider and plan level enable meaningful competition among a reasonable number of provider-plan partnerships in local health care markets. Plans focus on improving care, reducing costs, ensure consumer satisfaction and promoting health equity.

HEALTH PLANS: CURRENT STATE

- Health plans compete in a complex market where provider consolidation and pricing power is increasing, relationships are in constant flux and contracts must be continuously renegotiated.
- Limited regulation has led to the proliferation of plan designs that are often customized for each purchaser, sometimes with multiple plan designs. This contributes to high administrative costs and consumer, provider and purchaser confusion.
- Provider networks are complex, overlapping and difficult for consumers to understand. Primary care clinicians often work with several organized physician groups interfering with their ability to assume the leadership roles that are needed. The quality and costs of providers in any network – whether overall or for specific conditions – are unknown, forcing consumers to choose based on reputation or price, not meaningful measures of value.
- For some plans, risk avoidance remains an effective strategy for maximizing profits. The complexity of the market means that plans are not competing to improve quality and affordability for consumers.
- Some plans have demonstrated the ability to provide quality care through provider-plan partnerships, innovative care models that include addressing social needs, and leveraging clinical and patient decision-support technology.

PURCHASERS: 2030 FUTURE STATE

Purchaser Alignment is Transforming Health Care Delivery and Reducing Health Care Costs

Public and private purchasers have aligned on effective care delivery models, provider payment strategies, performance measures and health plan designs. Whether through individual or employer-sponsored coverage, consumers are choosing among a limited number of plans with identical benefit designs. Purchaser alignment enables aggressive negotiation with plans and health systems, further enhancing competition among insurers. Quality and cost transparency have fostered enhanced competition between plans. Health care costs are declining relative to economic growth. Information on effective health policies and delivery reforms are driving further improvements in population health, health care quality and costs.

PURCHASERS: CURRENT STATE

- Purchasers' efforts to slow healthcare costs are largely ineffective; these mounting costs consume an increasing share of employee compensation and reduce take home pay.
- Purchasers negotiate individually with health insurers over details of benefits, plan design and prices that have little impact on the forces driving rising costs or variable quality. Lack of broad alignment limits purchasers' leverage and impact.
- Some purchasers are aligning to address specific health system challenges or health conditions with success.
- Limited information is available on the relative performance of treatments, providers and plans, or the effectiveness of different policy approaches to improving health or health care.

COMMUNITIES: 2030 FUTURE STATE

Communities Support and Improve the Health and Well-Being of All Residents

Communities are designed, built and redesigned to promote optimal health for all individuals where they are born, live, learn, work, pray and age. Communities are supported through policies, systems and environmental changes that improve the health and well-being of community members and ensure equitable access to resources. Communities are empowered with the information, leadership and resources that are needed to ensure health equity across social, economic and behavioral determinants of health. Access to health care and the quality of health care does not vary by community or individual based on geography, education level, income level and race or ethnicity. Health care is consuming a smaller fraction of income. Individuals of diverse backgrounds feel respected and valued.

COMMUNITIES: CURRENT STATE

- Pervasive disparities in health care, health, and well-being affect California's population, influenced by numerous factors, including individual and community characteristics such as geography, income level, culture, education level, social cohesion, civil participation and access to resources.
- Health care costs continue to increase, constraining individuals' and communities' capacity to invest in other goods and services that could improve health and well-being overall while reducing disparities.
- Communities are resourceful and resilient, and many are motivated to invest in long term solutions that promote health and well-being for residents. Community and non-profit organizations play a crucial role in the health and well-being of residents.

FEEDBACK ON VISION STATEMENTS

- In articulating these vision statements, Covered California's goal is to stimulate thoughtful discussion and to provide specific ideas to consider as starting point for action.
- We recognize that bringing in partners and stakeholders to further develop and shape this vision is imperative, as a *shared* vision is the foundation for transformational change.
- We look forward to working with others to further strengthen and refine these ideas.
- Please provide feedback on the vision statements to Margareta (margareta.brandt@covered.ca.gov).

2022-2024 Attachment 14 Performance Standards Proposals: Contracting to Promote Value and Reward Quality

James DeBenedetti, Director, Plan Management Division

COVERED CALIFORNIA – PROMOTING VALUE

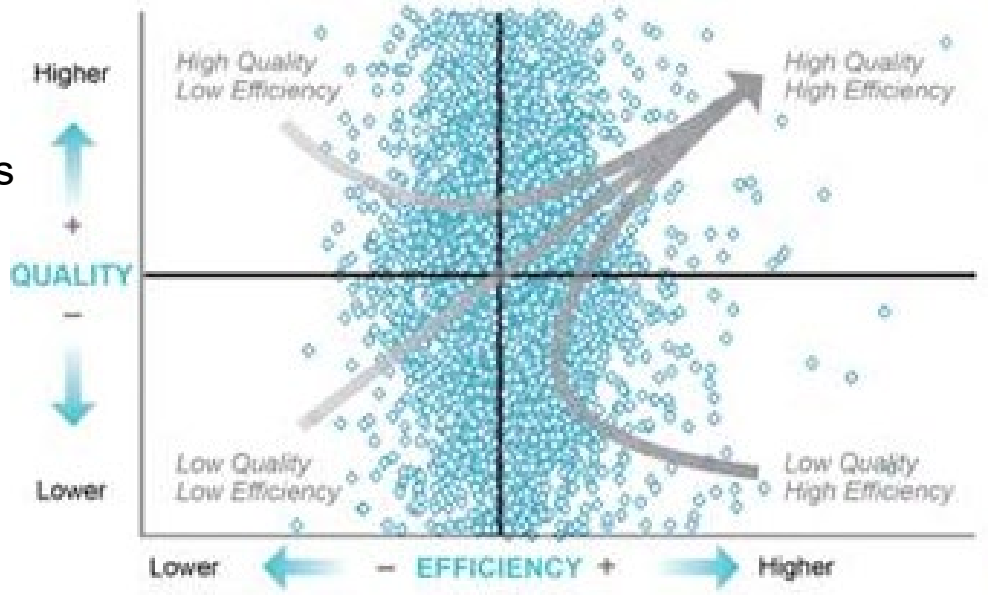
Covered California Mission: The mission of Covered California is to increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and Providers that give them the best value.

Market Reality: Currently virtually the only aspect of value consumers have to consider is the price of their coverage and out-of-pocket costs. There is wide variation in quality among Covered California's plans and very little financial incentive for plans to improve or encouragement of consumers to select better quality plans.

COVERED CALIFORNIA'S GOAL IN REFRESHING INCENTIVES

Covered California want consumers to be encouraged to select better quality and wants its carriers to have real and substantial financial motivation to improve quality.

- Improve health outcomes by assuring consistent high performance.
- Reduce variation by either supporting improvement or channeling consumers to better quality providers.
- Reward Plans for high quality and improved performance.
- Focus on the quality domains the matter most.



PERFORMANCE STANDARDS - CURRENT APPROACH

- **Penalties and Credits are assessed based on Performance Standards in four different areas:**
  - **Group 1** – Customer Service
  - **Group 2** – Operations
  - **Group 3** - Quality, Network Management and Delivery System Standards
  - **Group 4** - Covered California Customer Service (Credits can be applied to QHP Penalties)

LIMITATIONS OF CURRENT APPROACH

- Total amount at risk is 10% of Total Participation Fees, or 0.35% of Gross Premium.
  - Amount at risk in 2018 was $34.8 million.
- Current methodology allows for:
  - Credits for positive performance within a domain to offset penalties across all performance categories; and
  - Credits related to Covered California performance on service domains.
- Due to offsets, total amount collected from 2015-2018 was only $101,000.
- Current approach does not meaningfully reward quality.
- Carriers already have strong self-interest to perform well at some tasks, even without penalties (e.g., call abandonment rates).

MAKING VALUE MATTER TO CONTRACTED PLANS: CONCEPTS FOR 2022 REFRESH

Covered California has reviewed both what it has done over the past 6 years and other purchasers strategies that go beyond “standard” performance guarantees to either steer enrollment to or pay more to carriers providing better quality care (see Appendix 1). Based on this review, Covered California is considering:

- Eliminating or dramatically limiting performance elements subject to performance guarantees.
- Developing and applying clearer policies for including carriers and dropping/excluding carriers during a contract period.
- Bolstering transparency on quality performance to encourage better informed plan and provider selection.
- Establishing a “Quality Adjustment Fund” that would move premiums (and hence “price position”) among carriers based on quality performance.

NEW APPROACHES FOR CONSIDERING QUALITY IN INCLUSION AND EXCLUSION OF APPLICANTS

As an active purchaser, Covered California operates under a mandate to assure health plans offer consumers networks composed of consistently high quality providers.

- For 2022 and beyond, all plans applying (existing and new) will need to meet minimum quality performance standards and expectations as a basis for inclusion.
- Clearer policies on decertification and termination of contract if minimum performance standards and expectations are not met.
- Issues to consider:
  - Performance standards may vary - for example, based on the number of plans in a region.
  - How to have standards that are region specific but do not appear to be “setting a lower bar” for rural versus non-rural areas.
  - How to deal with new entrant plans that do not have existing quality metrics to evaluate.

NEW APPROACH – IMPROVE TRANSPARENCY

- **For Shopping Consumers:**
  - Use a more prominent display of global quality scores;
  - Make more prominent and assess usage of the “sort by quality” feature; and
  - Design and promote search and filter functions for performance domains that may be more relevant to individual consumers (e.g., by health condition)
- **For the public, consumer advocates, and others:**
  - Continue and expand regular release of by-plan performance measures and other quality performance metrics.

NEW APPROACH – STEERAGE BY COVERED CALIFORNIA

- **Steer consumers by having higher quality plans "preferentially" displayed:**

  Examples:

  - Order of display: Three stars and above (ranked by cost), then two stars (ranked by cost), then one star (ranked by cost).
  - Weighted algorithm with, for example, 20% by quality and 80% by cost to consumer.
- **NOT recommended for consideration/development:**
  - Difficult for consumers to understand and not transparent to many consumers.
  - Relies on Covered California applying its judgement on "how much weight" to give quality.
  - Consumers who are primary concerned about price may be confused or feel mislead by not seeing lower cost options without effort.

RECOMMENDED NEW APPROACH: ESTABLISH A COVERED CALIFORNIA "QUALITY ADJUSTMENT FUND"

- **Similar to Risk Adjustment, have a Quality Adjustment Fund to move money among plans based on quality performance.**
  - Zero sum pool of penalty assessments and performance payments based on quality (similar to risk adjustment); up to 4% of premium, phased in over time.
    Example: Year 1 – 1%, Year 2 – 2%, Year 3 – 3%, Year 4 – 4%. In this example, hypothetically this leads to a premium increase or decrease of $18 per member per month (based on 4% of the 2020 Statewide Average Premium of $445).
  - Plans that perform "well" will retain their premiums; "low/poor" performing plans on key quality metrics are assessed based on a percent of premium; and "high/exceptionally" performing plans would receive the funds from low performers.
  - Material improvement by a plan may offset some or all of the amount assessed on it for that year.

SAMPLE QUALITY METRICS AND SCORING

Measures that matter – outcomes focused measurement.
Sample measure sets as based on our Experience Report:

1. Rating of All Health Care
2. Rating of Health Plan
3. Breast Cancer Screening Ages 50-74*
4. Cervical Cancer Screening Ages 21-64*
5. Colorectal Cancer Screening Ages 50-75*
6. Controlling High Blood Pressure*
7. Diabetes: Hemoglobin A1c (HbA1c) Control (<8%)*
8. Alcohol & Drug Disorders: Initiation & Engagement Ages 13+
9. Antidepressant Medication Management*
10. Follow-up After Hospitalization for Mental Illness
11. All-Cause Hospital Readmissions*
12. Care Coordination*
13. Access to Care*

**Integrated Healthcare Association AMP Measures*

New measures may add to or replace old measures based on better data collection methods or increased industry acceptance of a new metric. Potential candidates include:

- Risky behaviors (smoking, obesity)
- Health Equity (e.g., diabetes A1c<8 gap narrowed, or metric for whatever aligned focus is for disparities work)
- Network (e.g., advanced primary care, # outliers cost/quality)
- Payment (e.g., primary care spend target, hospital payments)

QUALITY METRICS AND SCORING – IMPLEMENTATION ISSUES AND CONSIDERATIONS

Suggestions for improving the structure of the Quality Adjustment Fund:

- Phased in timing, up to 4% premium at risk, etc.

Need to develop criteria for selection of measures and how applied:

- Are there any measures that should be added to the list of 13 priority measures?
- Are there any measures that should be removed from the list?
- Should some measures be weighted more that others? If so, which measures?
- Is performance based on absolute scores or compared to a national average?
- How to best align with other purchasers?
- Does this apply to on and off exchange consumers?

Other considerations:

- Measurement year and payment year need to be determined in manner that allows for appropriate budgeting and understanding of price position.
- Given that the Quality Adjustment Fund would be administered on a rating region basis, how to address issues such as the fact quality performance is generally not measured by region?
- How can Plans use the Quality Adjustment Fund to move underlying provider contracts toward higher quality performance?

FEEDBACK AND OPEN DISCUSSION

Send comments to:

PMDContractsUnit@covered.ca.gov

Appendix 1

REWARDING QUALITY AND VALUE - FEDERAL EMPLOYEES HEALTH BENEFITS

The Federal Employees Health Benefits (FEHB) program compares carrier performance on 18 HEDIS measures (differently weighted) to the NCQA nationwide commercial results; points are assigned (1-5 scale) for each measure based on the carrier result relative to nationwide percentile scores.

Quality Penalty - The maximum performance penalty is 1% of premium.

Consumer Choice: carrier quality ratings (outstanding-poor) are reported for 8 priority measures on the federal employees plan choice tool.

Quality Improvement - An Improvement Increment Score is awarded for substantial year-to-year improvement. Carrier can offset an unfavorable baseline quality score by earning improvement points, on a maximum of 3 measures, that equate to 10% of the total quality score.

REWARDING QUALITY AND VALUE - MEDI-CAL MANAGED CARE

Medi-Cal Managed Care Plans (MCPs) are rewarded with a greater percentage of assigned enrollees (those who do not choose an MCP) based on eight performance measures (six HEDIS and two safety net measures). Enrollees are auto-assigned to MCPs using performance points which are computed for each measure based on whether MCP's relative performance is superior, equivalent, or inferior to the all-MCP performance.

Quality Bonus/Penalty –The incentive relates to increased new enrollee auto-assignments; there are no bonus/penalty payments.

Consumer Choice – The incentive does not involve consumer decision support when choosing a MCP.

Quality Improvement – For any of the eight measures, an improvement point is awarded if the MCP's performance has improved over the previous year or for continued strong performance. No point is awarded if the MCP's performance is unchanged. A point is deducted if the MCP's performance has deteriorated. The MCP's base quality performance points are adjusted per these performance gains/losses.

REWARDING QUALITY AND VALUE - MEDICARE ADVANTAGE

Medicare Advantage (MA) calculates star ratings using a maximum of ~ 47 measures (33 medical and 14 drug) which are differentially weighted. The 1-5 stars are assigned based on a carrier's performance relative to the MA nationwide quality measure results.

Quality Bonus – Health plans earning at least 4-stars qualify for bonus payments that equate to an extra 5% a year per member -- these monies must be used to pay for extra benefits.

Consumer Choice – Based on quality performance, a plan may:

- receive a high or low performing icon -- displayed on the consumer Medicare Plan Finder.
- 5-star plans can enroll new members during all 12 months – not limited to 2-month Open Enrollment.

Quality Improvement - For each measure, significant improvement or decline is calculated from year to year; the number of improved measures net of the declined measures is calculated. The net result may be used to adjust the carrier's star rating depending upon its baseline rating (e.g., carrier ratings of 1-2 stars are not adjusted for improvement).

FEEDBACK AND OPEN DISCUSSION

Send comments to:

PMDContractsUnit@covered.ca.gov

OPEN FORUM

THANK YOU