



## **Plan Management Advisory Workgroup Meeting**

May 14, 2020

# AGENDA

Time	Topic	Presenter
10:00 – 10:10	Welcome and Agenda Review	Rob Spector James DeBenedetti
10:10 – 11:00	Overview and Timeline of Proposed 2022 Attachment 7 Amendment	Margareta Brandt Taylor Priestley
11:00 – 11:45	Discussion of Potential QHP Contract Changes for 2021	James DeBenedetti
11:45 – 12:00	Open Forum	All

# Overview and Timeline of Proposed 2022 Attachment 7 Amendment

Margareta Brandt  
Taylor Priestley

# 2022 ATTACHMENT 7 AMENDMENT

- Proposal: Delay the Model Contract and Attachment 7 refresh to 2023-2025 and implement an amendment to the Model Contract and Attachment 7 for 2022. The 2022 Attachment 7 amendment will focus on continuing to progress in the foundational elements of the refresh.
  
- Rationale: The COVID-19 crisis disrupted many of our work processes and the work processes of contracted issuers and stakeholders. The refresh efforts would have taken time and resources away from our organization, issuers and stakeholders that were needed to respond to the crisis. Covered California felt that given the unprecedented situation, we should delay the refresh efforts one year.

# 2023-2026 ATTACHMENT 7 REFRESH WORKGROUP

- Proposal: Suspend Attachment 7 Refresh Workgroup until Fall/Winter 2020, after the 2022 amendment process is complete. Consider recommendations for 2022 amendment in Plan Management Advisory group in Summer/Fall 2020.
  
- Rationale: Suspending the Attachment 7 Refresh Workgroup will enable stakeholders, issuers and staff to focus on the 2022 Amendment and COVID-19 response activities. Foundational work and discussions of alignment opportunities for the 2023 Attachment 7 refresh will continue.

# PROPOSED APPROACH TO 2022 AMENDMENT

- 2022 is a transitional year to focus on a narrowed set of QHP issuer requirements to lay the foundation for more transformational requirements in 2023
- 2022 Attachment 7 Amendment will be developed using the criteria of reducing burden, focusing on priorities, considering feasibility, and implementing foundational elements in preparation for 2023 and beyond
  - These criteria will guide adding requirements, enhancing current requirements and removing other requirements
- Develop the measures and methodology for the Quality Transformation Fund (QTF) to pilot in 2022 with no funds at risk and implement the first year of money at risk in 2023 (see Appendix 1 for details and feedback requested)
- Covered California staff will continue to engage issuers and stakeholders in the development of the 2022 Attachment 7 amendment through the Plan Management Advisory group

# 2022 ATTACHMENT 7 AMENDMENT DEVELOPMENT

Potential cross-cutting recommendations across domains & strategies are organized by themes:

**Data Sharing & Analytics**

**Measurement for Improvement, Choice & Accountability**

**Access to High Value Care**

**Patient and Consumer Engagement**



Recommendations for 2022 are reviewed internally and with external stakeholders at Plan Advisory meetings and other ad hoc meetings



2022 recommendations are finalized using criteria:

**Feasibility**

**Minimize burden**

**Integral or foundational to 2023 and 10-year vision**

**Focusing on priorities**

## Examples of Potential Cross-cutting Recommendations

- **Data Sharing & Analytics:** Increased use of Health Evidence Initiative data (IBM Watson) for monitoring issuer progress and compliance; require issuer participation in IHA and require issuers to share IHA reports with Covered CA
- **Measurement:** Enhanced use of QRS measures to conduct analysis and track issuer progress; develop process for requiring use of and reporting on priority HEDIS measures not collected through QRS (e.g. behavioral health measures)
- **Access to High Value Care:** Require enhanced reporting and monitoring of behavioral health access; require use of and promotion telehealth; strengthening primary care payment reform requirements
- **Patient and Consumer Engagement:** Require enhanced member communication and education on the availability of telehealth, behavioral health services and preventive services

# CRITERIA FOR 2022 AMENDMENT RECOMMENDATIONS

## Feasibility

- Consider the amount of effort to issuers or others to implement, cost, availability of data & measurement, other dependencies, etc.
- opportunity for alignment with others
- availability of funding, training, or other support

## Integral or Foundational to 2023 and 10-year Vision

- Consider if the recommendation is a next step towards what is likely to be proposed for new model contract in 2023 and/or key step towards the 10 year vision (see Appendix 2)
- Does recommendation support necessary infrastructure for potential priority areas?
- Does recommendation address existing gaps in reaching these future objectives?

## Minimize Burden

- Consider the burden related to implementation effort, cost, data & reporting, creation or modification of workflows, impact to providers, opportunities to leverage alignment, etc.

## Focusing on Priorities

- Consider how the recommendation relates to foundational elements of the refresh: Quality Transformation Fund, Behavioral Health, Health Disparities, Shared Decision Making, Primary Care Payment, Population Health Management
- Consider if the recommendation is important or crucial to the success of the cross-cutting recommendations



# PROPOSED 2022 ATTACHMENT 7 AMENDMENT TIMELINE



# QUESTIONS AND OPEN DISCUSSION

Please send questions and comments to:

Margareta Brandt, *Senior Quality Specialist*

[Margareta.Brandt@covered.ca.gov](mailto:Margareta.Brandt@covered.ca.gov)

# APPENDIX 1: QUALITY TRANSFORMATION FUND

# ESTABLISH A COVERED CALIFORNIA “QUALITY TRANSFORMATION FUND”

- **Similar to Risk Adjustment, have a Quality Transformation 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 than 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?

**Reminder: Send comments to: [PMDContractsUnit@covered.ca.gov](mailto:PMDContractsUnit@covered.ca.gov) by May 22.**

# **APPENDIX 2: Envisioning the Future of Health and Healthcare**

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

# 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](mailto:margareta.brandt@covered.ca.gov)).

# Potential QHP Contract Changes for 2021

James DeBenedetti



# MARKETING MATTERS

- California's experience shows that a stable individual insurance market does not just happen on its own — investments in marketing and outreach are key factors in attracting and retaining a healthier risk pool, lower premiums, and encourage health insurance companies to participate in the market with greater certainty and potential returns.
- Covered California's experience is that 40 percent of its enrollees leave the marketplace each year, which is a “natural” part of the individual market. This churn means continual outreach is necessary to retain enrollment and to newly enroll people who lose employer-based insurance, parental coverage, or coverage from public programs.

# WITH A COMMON RISK POOL – RELYING ON INDIVIDUAL CARRIERS’ ACTIONS RISKS TRAGEDY OF THE COMMONS

- ❑ Consumers, Covered California and carriers benefit by spending **efficiently** on marketing and enrollment. Marketing spending adds costs to premium but when well-spent greatly reduces total costs by improving the risk mix.
- ❑ Covered California invests a significant portion of its assessment on plans in marketing and outreach, but carriers’ own investments vary widely.
- ❑ All carriers benefit from marketing that promotes shopping, enrollment and retention. If all plans decided to “ride of the coat-tails” of Covered California or other plans – there would be less investment, less enrollment, worse risk mix and higher costs – a true tragedy of the commons.

# COVERED CALIFORNIA'S CONTRACTUAL EXPECTATIONS – PLANS NOT MEETING THE MARK

- For several years, Covered California has expressly called on – without formally requiring – health plans to spend an amount equal to 0.6% of premium on marketing:
  - The majority of that spend – 65% – is supposed to be “Direct Response” marketing with call to action to consumers to enroll in Open Enrollment, get subsidies or go to Covered California.
  - The reality is most plans have sought credit for “brand” marketing that is often focused on “selling the plan” and promoting the brand for all consumers and all lines of business.

# COVERED CALIFORNIA PROPOSED MARKETING REQUIREMENT – FOR 2021 PLAN YEAR

- Beginning with Open Enrollment 2021, issuers will be required to spend a minimum of 0.4% of premium on Direct Response marketing or fund Covered California marketing with any amount less than that minimum.
  - The target removes the overall marketing requirement equal to 0.6% of premium and continues the Direct Response target of the past four years. It allows issuers to make any investment decisions they see fit relative to Brand Marketing.
  - Issuers would be required to project their planned Direct Response marketing when submitting rates for 2021.
  - Issuers that plan to spend less than 0.4% on Direct Response marketing would have their health plan assessment increased by the difference between their planned spending and the target minimum.
  - Issuers spending would be audited annually and reconciled with the target investment. To the extent plans do not spend the target amount, the underspending would be paid to Covered California for it to use in marketing in the next plan years.

# DEFINITION OF DIRECT RESPONSE MARKETING

To meet the Direct Response (DR) requirement, marketing materials should include:

- A call to action to generate immediate sales, leads, or drive traffic. DR marketing assets/materials, including TV, radio, collateral, digital, social, OOH, print must clearly promote the Individual Market and should include messaging about open enrollment, open enrollment deadlines, and/or the availability of financial help.
- Co-branded materials that clearly include both Covered California's logo and website.

# FOR 2022 NEED TO CONSIDER POLICIES TO ADDRESS EQUITY AND SUSTAINABILITY IN AGENT COMMISSIONS

- ❑ Covered California currently has no requirement concerning the amount issuers must spend on commission payments to agents and brokers.
- ❑ In 2019, Covered California agreed to not establish a “minimum commission” for two years while it researched and assessed the issue. This decision was based, in part, on the three issuers with the lowest commission levels agreeing to not reduce commissions through 2021.
- ❑ Covered California is actively considering establishing minimum commissions effective 2022 based on the belief that the independent agent community is a vital source of support, enrollment and retention for California’s consumers and that the differences in agent commissions runs the risk of either the Tragedy of the Commons or of free-riders in some plans benefiting from the agent services that would not be possible if all paid the lowest of commissions.

# OPEN FORUM

**THANK YOU**