Attachment 7 Refresh Workgroup Meeting: 2022-2024 Attachment 14 - Performance Standards Proposals

March 5, 2020

AGENDA

Time	Topic	Presenter
10am-10:05	Welcome and Introductions	Thai Lee
10:05- 10:20	Presentation: CalPERS • CalPERS performance standards and monitoring • Opportunities for alignment	Kristin Owens
10:20-10:35	Presentation: Department of Health Care Services • DHCS performance standards and monitoring • Opportunities for alignment	Nathan Nau
10:35-11:00	Presentation: Covered California • Current Attachment 14 performance standards and monitoring • Contracting to promote value and reward quality	James DeBenedetti
11:00-11:55	Group discussion on Attachment 14 performance standards proposed changes and alignment opportunities	All
11:55-12pm	Next Steps	Thai Lee

Monitoring and Measuring Health Plan Performance

Kristin Owens, Manager

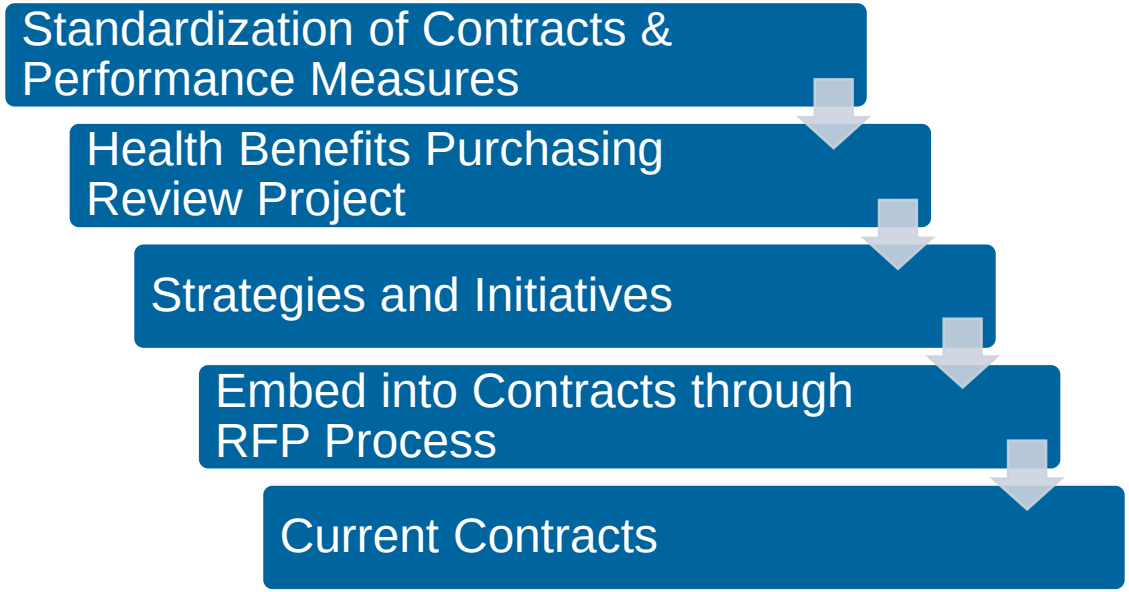
Health Plan Contracts & Compliance

Health Plan Research & Administration

CalPERS Health Benefits Program

The CalPERS Health Benefits Program is a nationally recognized leader in the health care industry. We put our expertise and influence to work to help us deliver quality, affordable health care for our 1.5 million members, and the 1,200 employers that contract with us.

Performance Measures Background and History

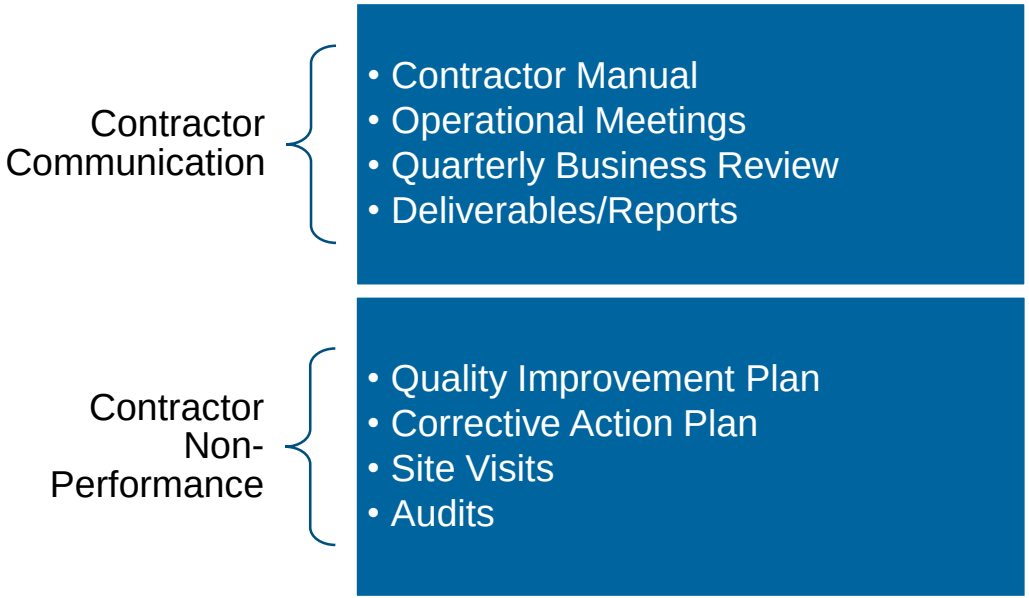


Performance Standards

The majority of our performance monitoring is focused on **8** key service categories:

Administration and Account Management Support
Member Services
Pricing and Payments
Provider Claims Administration
Systems and Data
Provider Networks
Medical Management Services
Pharmacy Benefits

How CalPERS Monitors Contractors



Alignment Opportunities

Questions?

Department of Health Care Services

Nathan Nau
Managed Care Quality and Monitoring Division

Program Monitoring

- Annual Network Certifications
- Annual Timely Access Survey
- Quarterly Monitoring
  - PCP and specialty counts
  - Grievances and Appeals
  - SFHs and IMRs
  - Out of network access request
- Program Evaluations

Clinical Monitoring

- Managed Care Accountability Set
- Quality Improvement Activities
- Disparities Report
- CAHPS Survey
- Facility Site Review
  - Facility review
  - Medical record review
  - Physical accessibility
- Value Based Purchasing

Preventative Services

- Contract Management
  - WPC and Health Homes
- Annual Preventative Services Unitization Report
- External Quality Review Organization
  - Plan Specific Evaluation Reports
  - Network validation
  - Recommendations for program improvement

Data Analytics

- Encounter Data
  - Quarterly metrics
  - Stoplight reports
  - Dashboards
- Provider Data
- Program Data
- Default algorithm

Questions?

Contracting to Promote Value and Reward Quality

James DeBenedetti, Director, Plan Management Division

March 5, 2020

COVERED CALIFORNIA – PROMOTING VALUE

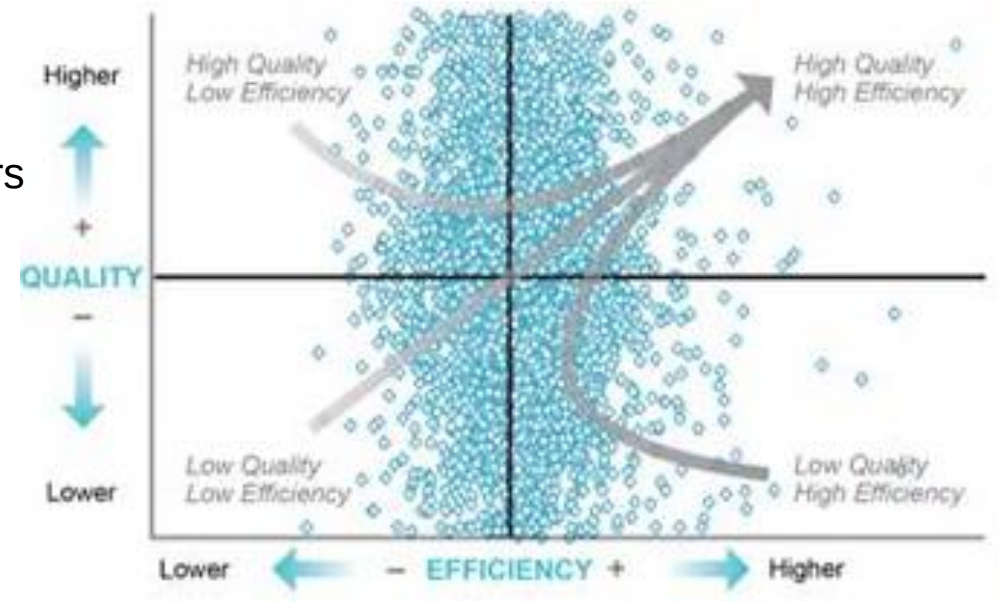
Covered California Mission: The mission of Covered California is to increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and Providers that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

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

- Are some weighted higher than others?
- 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).

Next Steps

NEXT STEPS

Please send comments or questions regarding today's presentation to PMDContractsUnit@covered.ca.gov

Questions regarding Attachment 7 Refresh can be sent to Thai Lee at Thai.Lee@covered.ca.gov

Upcoming workgroup sessions will focus on elements of 2022-2024 Attachment 7 contract refresh.

Proposed meeting dates are: April 2, May 7, June 4, July 2, August 6
Meeting topics and materials will be distributed at a later time and are subject to change.