



**COVERED**  
**CALIFORNIA**

**PLAN MANAGEMENT ADVISORY GROUP**

July 18, 2019

# WELCOME AND AGENDA REVIEW

ROB SPECTOR, CHAIR  
PLAN MANAGEMENT ADVISORY GROUP

# AGENDA

## AGENDA

Plan Management and Delivery System Reform Advisory Group

Meeting and Webinar

Thursday, July 18, 2019, 1:00 p.m. to 3:00 p.m.

Webinar link: <https://attendee.gotowebinar.com/rt/4171897155750816770>

### July Agenda Items

### Suggested Time

- |  |                        |
|--|------------------------|
| I. Welcome and Agenda Review   | 1:00 - 1:05 (5 min.)   |
| II. Current Best Evidence and Performance Measures<br>for Improving the Quality of Care and Delivery System Reform | 1:05 – 2:50 (115 min.) |
| III. Open Forum  | 2:50 – 3:00 (10 min.)  |

# COVERED CALIFORNIA ATTACHMENT 7 REFRESH

# Guiding Principles for Developing Expectations of Health Plans 2021-2023

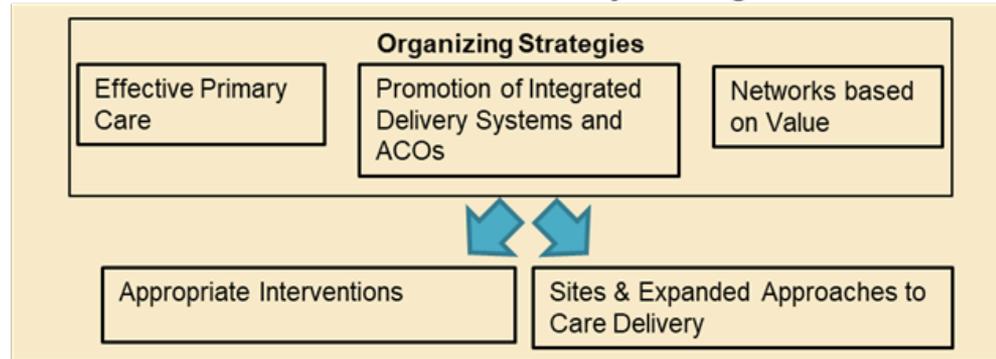
1. Driven by the desire to meet two complementary and overlapping objectives:
  - **Assuring Quality Care:** Ensure our members receive the right care, at the right time, in the right setting, at the right price.
  - **Effective Care Delivery:** Promoting value-enhancing strategies that have the potential to reform the delivery system in the near and long term.
2. Seek to improve the health of the population, improve the experience of care, reduce the cost of care, reduce administrative burden, and reduce health care disparities.
3. Success will be assessed by outcomes, measured at the most appropriate level, in preference to adoption of specific strategies.
4. We will promote alignment with other purchasers as much as possible.
5. Consumers will have access to networks offered through the QHP issuers that are based on high quality and efficient providers.
6. Enrollees have the tools needed to be active consumers, including both provider selection and shared clinical decision making.
7. Payment will increasingly be aligned with value and proven delivery models.
8. Variation in the delivery of quality care will be minimized by ensuring that each provider meets minimum standards.

# Quality Care & Delivery Reform Framework

## Assuring Quality Care Domains

- Individualized Equitable Care
- Health Promotion and Prevention
- Mental Health and Substance Use Disorder Treatment
- Acute, Chronic and other Conditions
- Complex Care

## Effective Care Delivery Strategies



## Key Drivers of Quality Care and Effective Delivery

Covered California recognizes that promoting change in the delivery system requires aligning with other purchasers and working with all relevant payers to reform health care delivery in a way that reduces the burden on providers

- Benefit Design & Network Design
- Measurement & Public reporting
- Payment
- Patient-Centered Social Determinants
- Patient and Consumer Engagement
- Data Sharing and Analytics
- Administrative Simplification
- Quality Improvement
- Certification, Accreditation & Regulation
- Learning & Technical Assistance

Community Drivers: Workforce, Community-wide Social Determinants, Population & Public Health

# CURRENT BEST EVIDENCE AND PERFORMANCE MEASURES FOR IMPROVING QUALITY OF CARE AND DELIVERY SYSTEM REFORM

# Introduction

- HMA: Evidence Review
  - Reviewed relevant literature, case studies, other evidence for specified strategies.
  - Evaluated potential effectiveness of each strategy in terms of **savings, quality of care, improved health, provider burden, administrative burden and potential to reduce health disparities.**
  - Identified value-enhancing strategies for Covered California to consider adopting based on evidence or value of potential impact.
- PwC: Measures & Benchmarks
  - Identified measures & benchmarks, state & national comparison points, and data sources for current expectations and performance standards.
- PwC: Review of Purchaser Strategies
  - Reviewed activities and initiatives of other large health purchasers to identify key areas of focus, strategies and performance measures for Covered California to consider adopting.

# Summary of Recommendations: HMA - Current Best Evidence

- ❖ Ensure issuers' network strategies deliver both cost effective and high-quality care.
- ❖ Issuers and providers should be required to identify and effectively manage care for high-risk or high-cost individuals.
- ❖ Require or encourage issuers to contract with Accountable Care Organizations (ACOs) or comparable vehicles for care integration that meet criteria for delivering higher value.
- ❖ Require issuers to invest in and promote enrollment in primary care practices that reflect best evidence in delivery and promotion of high-value care.
- ❖ Insurers could promote the use of non-clinical providers where they have been demonstrated to improve access to care, address social determinants of health, health disparities, and support more effective engagement of patients and families.
- ❖ Covered California could actively monitor and assess its issuers' activities in channelling patients to alternate sites and expanded approaches to care.
- ❖ Covered California could actively consider and assess its issuers strategies to engage consumers in making choices regarding their provider, treatment and source of care.

# Summary of Recommendations: PwC - Measures & Benchmarks

- ❖ Establish and apply clear principles to guide the selection and updating of measures and benchmarks required by Covered California.
- ❖ Covered California should continue to leverage existing data collection measures and processes
- ❖ In the absence of nationally standardized and already collected measures, for key domains Covered California should use its claims and encounter data to develop additional measures.
- ❖ Given the broad lack of alignment across purchasers and measurement system sponsors, Covered California should make best efforts to align in ways that address priority concerns and that will foster better alignment in the future.
- ❖ Covered California should work to improve analysis and response rates to existing sources and build on those surveys to better capture patients' perspectives of their experience getting coverage and care.
- ❖ Covered California should update its measurement requirements of health plans.
- ❖ Given the inconsistency of consensus and national standards in many critical domains, Covered California will need to either develop new measures or adopt some in limited use while promoting adoption of national standards.

# ASSURING QUALITY CARE DOMAINS

# Health Equity: Reducing Disparities HMA Evidence and Considerations

- HMA Current Best Evidence Review Findings
  - Incorporating equity into overall quality strategy will enhance ability to achieve equity gains
  - Using payment to improve quality shows mixed results on disparities
  - Screening can provide an entry to better care
  - Disparities reduction requires a multi-pronged approach
  - Engaging supportive service providers enhances outcomes
  - Patient engagement improves outcomes and patient satisfaction
- HMA Suggested Considerations for Covered California
  - Align disparities data collection and analysis with other state efforts as part of its requirement of issuers to collect relevant demographic and clinical data needed to assess access, quality and outcomes by race, ethnicity, gender, and other patient characteristics.
  - Engage with issuers and their providers to align with the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS standards).
  - Utilize the Mapping Medicare Disparities tool created by the HHS Office of Minority Health; the tool's interactive map identifies areas of disparities between subgroups of Medicare beneficiaries (e.g., racial and ethnic groups) in health outcomes, utilization, and spending.
  - Require issuers to use their contracting mechanisms to require providers to implement organizational-level efforts to implement a culture of equity and utilize culturally specific models that promote equity in health care outcomes.
  - Implement multiple strategies to reduce health disparities.

# Health Equity: Reducing Disparities PwC Measurement

- PwC Measures & Benchmarks Takeaway
  - There are a wide range of measures available to assess health equity, although many have significant issues with credibility and data quality. PwC recommends Covered California maintain its current measures that focus on high volume conditions and consider expanding its scope of areas for measurement beyond race and ethnicity.
- PwC Measures & Benchmark Recommendations for Covered California
  - Recommend Covered California maintain its current health equity measures.
  - Continue to improve demographic and socioeconomic status member data collection.
  - Continue to track disease control by race/ethnicity and other demographic factors, such as income.
  - To increase QHP disparity measure credibility, consider multiple year averaging or rolling year average reporting. Examples of existing measures that use multiple years of data include:
    - Quality Rating System
    - Medicare Shared Savings Program
  - Consider adding tracking measures beyond racial/ethnic disparity:
    - Stratified outcome analysis by socioeconomic status
    - Provider access measures by region/geographic sub area
    - Consideration of rural and urban geographies and market characteristics

# Health Promotion & Prevention HMA Evidence and Considerations

- HMA Current Best Evidence Review Findings
  - The United States Preventive Services Task Force provides evidence-based, best practice recommendations for preventive services across the individuals' lifespan.
  - A range of evidence-based tobacco cessation interventions are available; a combination of individual and population interventions holds greatest promise for improving health outcomes and reducing health care costs.
  - A range of evidence-based interventions to prevent and reduce obesity prevalence are available; a combination of individual and population interventions holds greatest promise for improving health outcomes and reducing health care costs.
- HMA Suggested Considerations for Covered California
  - Ensure optimal rates of provider screening for obesity in children and adolescents 6 years and older and offer or refer them to comprehensive, intensive behavioral interventions to promote improvements in weight status per USPSTF recommendations.
  - Cultivate and reimburse evidence-based therapeutic interventions in provider networks that are implemented by a multi-disciplinary team that combine behavioral, nutrition, and physical activity to assist members in losing and maintaining weight loss.
  - Support the targeting of lifestyle interventions combined with pharmacotherapy and other more aggressive interventions for patients with obesity-related complications who can benefit the most from weight loss. Bariatric surgery should be a benefit option for patients with BMI  $\geq 40$  kg/m<sup>2</sup> and those with BMI  $\geq 35$  kg/m<sup>2</sup> and severe obesity-related comorbidities.
  - Review CDC strategies to reduce obesity at the community level; identify at least one strategy to implement in the issuer's geography in collaboration with local government, public health, healthcare providers, advocacy organizations, coalitions and/or other organizations.

# Health Promotion & Prevention PwC Measurement

- PwC Measures & Benchmarks Takeaway
  - Qualified Health Plans (QHP) have room to improve Healthcare Effectiveness Data Information Set (HEDIS) scores for standard preventive measures.
  - Measures related to improving personal behaviors are less standardized and benchmark data less available.
- PwC Measures & Benchmark Recommendations for Covered California
  - Use QHP national benchmarks reported from QRS.
  - For measures that Covered California compares to Quality Compass scores, set QHP benchmark at the 50th, 75th, or 90th percentiles for commercial and Medicaid.
  - Recommend new measures: Adults' Access to Preventive/Ambulatory Health Services (AAP).
  - Consider analyzing Covered CA encounter data to assess utilization of tobacco cessation and weight management program services or evaluate prevalence using CHIS survey data.

# Mental Health & Substance Use Disorder Treatment

## HMA Evidence and Considerations

- HMA Current Best Evidence Review Findings
  - Increasing the use of evidence-based practices, including consistent utilization of screening, assessment tools (such as PHQ-9), and performance measurement standards improves the quality of mental health and substance use disorder identification and treatment processes.
  - Telehealth modalities, from apps to computer-assisted treatments and virtual visits, have been regarded as potential solutions to behavioral health access issues.
  - Integrated behavioral healthcare, especially in primary care settings, increases behavioral health access and improves treatment outcomes.
- HMA Suggested Considerations for Covered California
  - Improve access to behavioral health services: Covered California can encourage issuers to remove or decrease prior authorizations, step therapy and other treatment limits, consistent with MHPAEA requirements. Covered California could also require issuers to monitor behavioral health penetration rate.
  - Enhance behavioral health treatment quality: Covered California can enhance treatment quality by enforcing more stringent reporting requirements for issuers of provider network quality and performance measures.
  - Increase the prevalence of integrated behavioral health services: Covered California can encourage issuers to remove administrative barriers to integrating mental health and substance use disorder services into primary care by decreasing burdensome documentation requirements and adopting the proposed billing codes for Collaborative Care services.

# Mental Health & Substance Use Disorder Treatment PwC Measurement

- PwC Measures & Benchmarks Takeaway
  - While there are some Healthcare Effectiveness Data Information Set (HEDIS) clinical measures, there are not yet established measures to evaluate behavioral health integration in primary care that are reliable for improving quality.
- PwC Measures & Benchmark Recommendations for Covered California
  - Continue to report QRS mental health and substance use disorder measures.
  - Track additional HEDIS mental health and substance use disorder endorsed measures:
    - Opioid safety, prescribing, and treatment, adherence
    - Follow-up after Emergency Department visits
  - Adopt new measures:
    - Access to mental health/substance use disorder providers
    - HEDIS measure: Mental Health Utilization (MPT)
  - Consider analyzing QHP data to develop baseline values:
    - Utilization and expenditure of mental health and substance use disorder services
    - Prevalence of mental health and substance use disorder diagnoses and comorbid conditions
    - Formulary tiering
  - Consider potential of telehealth to expand access to mental health and substance use disorder treatment.
  - Consider strategies to increase provider use of mental health/substance use disorder screening tools, such as educating providers on reimbursable screening and collaborative care procedure codes.
  - Consider future development of behavioral health parity measures, e.g., time/distance and reimbursement level.

# Acute, Chronic and Other Conditions PwC Measurement

- HMA was not asked to do a separate review; instead, HMA's related evidence reviews are presented in Chapters 3, 5, 7, 10.
- The domain of Acute, Chronic and Other Conditions currently has several gaps, particularly for cancer care, orthopedics, pregnancy, and surgical volume measures.
- PwC Measures & Benchmark Takeaways
  - Preliminary analysis indicates the National Healthcare Effectiveness Data Information Set (HEDIS) scores at the 90th and 75th percentiles are comparable for QHPs and Commercial plans.
- PwC Measures & Data Recommendations for Covered California
  - Recommend Covered California maintain its current acute, chronic, and other conditions measures.
  - Use QHP national benchmarks reported from QRS.
  - For measures that Covered California compares to Quality Compass commercial scores, set QHP benchmark at the 50<sup>th</sup>, 75<sup>th</sup>, or 90<sup>th</sup> percentiles for commercial and Medicaid.
  - Consider analyzing QHP data to develop baseline values:
    - Utilization and expenditure of services
    - Prevalence of diagnoses and comorbid conditions
  - Recommend adding endorsed measures for chronic conditions, such as cardiovascular disease and diabetes (statin therapy), rheumatoid arthritis (disease-modifying drug therapy), and Chronic obstructive pulmonary disease (COPD) (pharmacotherapy management).
  - Consider strategies to increase the use of health risk assessments to aid identification of enrollee health conditions, such as educating providers on reimbursable procedure codes (e.g. 96160, 96161).

# Complex Care HMA Evidence and Considerations

- HMA Current Best Evidence Review Findings
  - Stratification/segmentation based on both quantitative and qualitative data is crucial for identifying high-risk or high-cost individuals and should be applied prospectively for maximum impact.
  - Hybrid segmentation models that supplement claims analysis with survey data (such as from tools that assess SDOH and patient activation) are most predictive.
  - High-risk and high-cost patients have heterogeneous needs. Segmentation helps identify impactable individuals and sub-populations to target resources and interventions.
  - Using comprehensive needs assessments as part of the identification and care planning process helps segment individuals and target clinical and non-clinical interventions to holistically address medical, behavioral health, and social service needs.
  - Complex Care Management is a patient-centered approach to improving care and reducing costs for individuals identified as high-risk and/or high-cost.
  - Managing care transitions for high-risk patients reduces costs and improves care.
  - Electronic alerts to a patient's primary care provider from the emergency department and hospital admission teams is the key to effective transitions management.

# Complex Care HMA Evidence and Considerations

- HMA Suggested Considerations for Covered California
  - Methods to identify at-risk enrollees could encompass both quantitative and qualitative data.
  - Issuers could be required to identify and develop tailored interventions for one or more subsets of the high-risk or high-cost population.
  - Comprehensive health assessments should follow identification of a potentially high-risk or high-cost individual.
  - Issuer engagement of high-risk or high-cost enrollees should require demonstration of core components of an effective Complex Care Management program and measurement of impacts.
  - Improved care transitions should be supported by specific programming and health information exchange.

# Complex Care PwC Measurement

- PwC Measures & Benchmarks Takeaways
  - Qualified health plans (QHP) offer care management to members identified with conditions of concern. The proportion of members identified as “at risk” and the services that are offered to these enrollees vary substantially, likely due to varying definitions of at-risk enrollees.
  - While almost all QHPs report use of Centers of Excellence, there is limited reporting on efforts to direct members to those facilities and limited information on their comparative quality and value.

# Complex Care PwC Measurement

- PwC Measures & Benchmarks Recommendations for Covered California
  - Consider strategies to increase the use of health risk assessments to aid identification of enrollee health conditions, such as educating providers on reimbursable procedure codes (e.g. 96160, 96161).
  - Continue to require issuers to describe how high needs, high cost populations are identified, the number of members and conditions for the high need, high cost group, and what care management programs are in place for each subpopulation. Consider requiring issuers to describe specific utilization and cost measures they track for high needs, high cost populations.
  - Recommend additional measures: inpatient and Emergency Department (ED) use, and ED follow-up.
  - Require improved reporting on QHP issuer Center of Excellence selection criteria and member utilization of Centers of Excellence. This may be most appropriate for all members rather than just QHP members.
  - Consider requiring each health plan to provide its Center of Excellence benchmarks by condition/treatment to demonstrate the scope of Center of Excellence activity and the metrics that the plan is using to manage its contracted Centers of Excellence.
  - Determine best-practice evaluation and selection of Centers of Excellence, analyze the extent to which the health plans have identified the same or different providers as Centers of Excellence for each condition, and consider alignment of Center of Excellence requirements across health plans.

# EFFECTIVE CARE DELIVERY STRATEGIES

# Networks Based on Value HMA Evidence and Considerations

- HMA Current Best Evidence Review Findings
  - Narrow/limited networks are an effective mechanism to lower premium costs without impacting quality, though quality is not broadly a consideration in their design.
  - Tiered networks may be an effective tool to lower expenditures with fewer restrictions on consumer choice but the design matters; the trade-off between complexity and consumer benefit (quality improvement, cost savings) is not yet clear.
  - Reference pricing results in higher use of lower-price facilities for large group plans; relatively untested in small group and individual markets. While there is no evidence that providers raise prices on other services as a consequence of reference pricing, reference pricing has yet to demonstrate that it can lower premiums.
  - Large employers have found savings and quality improvement combining bundled payment and Centers of Excellence. However, no standards exist for designating Centers of Excellence.

# Networks Based on Value HMA Evidence and Considerations

- HMA Suggested Considerations for Covered California
  - The evidence supports maintaining Covered California's current strategy around narrow networks. Covered California should continue to require issuers to report how they include quality in their network design and review the metrics to ensure they are meaningful.
  - The evidence on tiered networks is still nascent and not yet robust enough to support tiered provider networks. Covered California should continue to monitor the evidence related to tiered networks.
  - Data is not conclusive as to the impact of reference pricing outside of expenditure reductions for select large group plan experiments. Before widely rolling out a reference pricing program, especially given the administrative burden involved in changing the standard benefit design, Covered California should gather more evidence on the long-term cost, quality and access impacts of reference-based pricing.
  - Covered California could require its plans to disclose the standards they use for their Center of Excellence programs along with available evaluation data to begin to draw connections between program design and success. In addition, plans could report on effective mechanisms to incentivize consumers to select Center of Excellence providers.

# Networks Based on Value PwC Measurement

- PwC Measures & Benchmarks Takeaways
  - QHP network value can be assessed using access and quality measures to compare QHPs to commercial plans to determine to what extent narrow networks are impacting enrollees.
  - While almost all QHP issuers report use of Centers of Excellence, there is limited reporting on efforts to direct members to those facilities and limited information on their comparative quality and value.
- PwC Measures & Benchmark Recommendations for Covered California
  - Covered California should leverage existing HEDIS measures to compare quality and access of QHPs to Commercial plans to understand the relative value of QHP narrow networks.
  - Recommend adding measures for PCP-to-member and total physician-to-member ratios. To the extent ratios are available by rating region or county, it may highlight areas with more prevalent access issues.
  - Continue using Cal Hospital Compare, California Department of Public Health hospital rankings, Leap Frog, CMS hospital ratings, OPA/IHA physician ratings and other available metrics. Continue efforts with IHA, providers, and issuers to assess the value of each QHP provider network.
  - Continue to adopt HCP LAN APM payment definitions and collect data consistent with that framework. Covered California could update its data collection process to be more consistent with the HCP LAN APM framework.
  - Establish benchmarks for HCP LAN APM categories 3 (shared savings/risk) and 4 (population-based payment).

# Promotion of Effective Primary Care HMA Evidence and Considerations

- HMA Current Best Evidence Review Findings
  - Primary care is foundational to an effective health care system and evidence supports that more primary care is associated with lower health care spending and higher quality.
  - Some Advanced Primary Care models have demonstrated the potential of effective primary care to improve health and reduce costs and have played a key role in ACO efforts to reduce the total costs of care. Since not all primary care promotion efforts have demonstrated success, the focus should be on supporting those elements of advanced primary care that show the greatest impact and potential.
  - The percent of total US health care spending on primary care is estimated to be below 8%; the average primary care spending rate across other developed countries is 12%. Some states, like Oregon and Rhode Island, have established primary care spending targets, which have led to increased primary care spending.
- HMA Suggested Considerations for Covered California
  - Covered California should continue to require issuers to contract with providers that meet advanced primary care standards and report on the cost, quality and patient-experience of those enrollees in such practices compared to those who are not.
  - Covered California should continue to require issuers to utilize alternative payment models that support advanced primary care and set standards for payment to advanced primary care providers, allowing flexibility to recognize a range of advanced primary care models such as national accreditation or practices that meet standards set by Covered California.

# Promotion of Effective Primary Care PwC Measurement

- PwC Measures & Benchmarks Takeaways
  - Covered California's current required measures are largely structural measures that may be insufficient for evaluating primary care effectiveness.
  - Covered California should consider analysis of its own administrative data to develop resource and utilization baseline values for future benchmarking.
- PwC Measures & Benchmark Recommendations for Covered California
  - Use QHP national benchmarks reported from QRS.
  - For measures that Covered California compares to Quality Compass commercial scores, set QHP benchmark at the 50th, 75th, or 90th percentiles for commercial and Medicaid.
  - Recommend Healthcare Effectiveness Data Information Set (HEDIS) measures: Adult Access to Care and Hospitalization for Potentially Preventable Complications; Integrated Healthcare Association (IHA) Align Measure Perform (AMP) measure: Encounter Rate by Service Type.
  - Consider analyzing QHP data to develop baseline values:
    - Utilization and expenditure of services
    - Prevalence of diagnoses and comorbid conditions
    - PCP visits per thousand
    - Percent enrollees with PCP or no visit
    - Emergency Department visits and admits with ambulatory care sensitive conditions

# Promotion of IDS & ACOs HMA Evidence and Considerations

- HMA Current Best Evidence Review Findings
  - ACOs have successfully generated savings over time and shown improvement in select quality measures.
  - There is strong evidence that ACOs with risk-based contracts, that are physician-led and have two-sided risk contracts are associated with greater savings and improved quality results. Other factors such as use of advanced primary care providers, care management, and behavioral health integration also deserve attention.
- HMA Suggested Considerations for Covered California
  - Covered California could encourage the use of integrated models by leveraging plans' value-based payment mechanisms. To advance the savings and quality of care potential, value-based payment programs to promote integrated health care model development should gradually encourage two-sided risk contracts (both shared savings and shared risk), incorporate entities with experience in risk-based contracting, and embrace physician-led models.
  - Given that the level of ACO enrollment is important to an ACO's ability to produce savings and implement quality initiatives, Covered California could encourage plans to implement strategies to drive ACO participation, where members desire to participate.
  - Covered California could assess the extent to which it could use benefit designs to create cost-sharing incentives for consumers to seek care from the ACO.

# Promotion of IDS & ACOs PwC Measurement

- PwC Measures & Benchmarks Takeaways
  - Despite mixed results of ACO models, increases in integration of care is generally believed to be a worthy goal, and tracking progress in the use and effectiveness of integrated models aligns with the strategies of other payers.
- PwC Measures & Benchmark Recommendations for Covered California
  - Continue to monitor percentage of enrollees cared for in IDS or ACO models.
  - Continue requiring QHPs to report IHA ACO Commercial measures since they are consistent with the priorities of major purchasers and aligned with the existing IHA AMP Commercial HMO measure set and other national ACO initiatives and priorities (e.g., CMS CQMC).
  - Have plans report on shared saving parameters and correlate that with achievements in terms of cost and quality.
  - Monitor premium trends as IDS or ACO adoption continues to assess effectiveness.

# Appropriate Interventions HMA Evidence and Considerations

- HMA Current Best Evidence Review Findings Related to Patient Engagement
  - Provider price and quality transparency tools are little used and are not alone associated with significant savings. Positive impacts require issuers to adopt strategies to encourage use including targeted engagement, member outreach and supporting provider engagement with their patients in using the tools.
  - Decision aids, while not in wide use, can be effective for fostering shared-decision making between consumers and providers and promoting appropriate utilization without adverse outcomes.
  - Evidence on the efficacy of personal health records (PHR) is limited but improved data sharing technology and patient-centered functionality may increase future value.
- HMA Suggested Considerations for Covered California
  - Consider requiring plans to encourage broad uptake of PHR's and to engage in clinical note-sharing as part of providers' standard practice. By fostering clinical note-sharing, plans can help foster a culture of sharing this information so that patient portals will include more valuable information and promote greater engagement in treatment and self-care decisions.

# Appropriate Interventions PwC Measurement

- PwC Measures & Benchmarks Takeaways
  - Increased consumer and patient engagement is desirable, but the definitions and measurement are not standardized and the technologies used to drive and track these issues are under-developed.
  - Preliminary analysis indicates that nationally Healthcare Effectiveness Data Information Set (HEDIS) scores at the 90th and 75th percentiles are comparable for Qualified Health Plans (QHP) and Commercial plans.
  - Given the wide variations in pharmacy needs among different populations and fast pace of change, benchmarks from other sources may have limited relevance.
  - Covered California should leverage its own drug data to understand its population's pharmacy characteristics and changes over time.

# Appropriate Interventions PwC Measurement

- PwC Measures & Benchmark Recommendations for Covered California
  - Consumer and Patient Engagement
    - Use QHP national benchmarks reported from QRS.
    - For measures that Covered California compares to Quality Compass commercial scores, set QHP benchmark at the 50th, 75th, or 90th percentiles for commercial and Medicaid.
    - Consider strategies to increase provider use of SDM and consumer tools. However, reporting of the use of these strategies is not well-developed and burdensome. Consider removing data reporting requirements while maintaining reporting of strategies employed by the QHPs to support and encourage the use of the tools.
  - Appropriate Use of Services: QRS HEDIS Measures
    - Recommend Covered California maintain its measures.
    - Use QHP national benchmarks reported from QRS.
    - For measures that Covered California compares to Quality Compass commercial scores, set QHP benchmark at the 50th, 75th, or 90th percentiles for commercial and Medicaid.
  - Pharmacy Utilization Management
    - Use QHP national benchmarks reported from QRS.
    - For measures that Covered California compares to Quality Compass commercial scores, set QHP benchmark at the 50th, 75th, or 90th percentiles for commercial and Medicaid.
    - Recommend new measures:
      - Generic prescribing (% of scripts/dollars)
      - Consider generic analysis for select therapeutic classes
  - Consider analyzing QHP data to develop baseline values
    - Develop baseline pharmacy cost and utilization metrics.
    - Analyze pharmaceutical spending associated with specific conditions and diseases (e.g., HIV, diabetes and other chronic conditions).
    - Track the introduction of new specialty drugs and biologics.
    - Monitor impact of drug policy issues that emerge.

# Sites & Expanded Approaches to Care Delivery

## HMA Evidence and Considerations

- HMA Current Best Evidence Review Findings
  - Research has demonstrated significant variation in costs for the same services provided in different care settings.
  - Telehealth has been as effective as in-person visits for a broad range of the conditions studied. Impacts of telehealth on costs depend significantly on the nature of services provided and whether telehealth serves to deter costlier downstream care.
  - Retail clinics can provide effective, convenient options to patients for a limited range of services. For those services for which the quality of care has been assessed, retail clinics appear to be equivalent to other settings, at a lower cost per episode of care.
    - Patients like the experience, though there may be a lack of continuity between the care they receive in a retail clinic and from a regular primary care provider.
    - There is some evidence that retail clinics may increase utilization and spending slightly for low-acuity conditions when patients seek care they would not otherwise have received.
  - Like retail clinics, urgent care clinics provide an important alternative to the emergency room and enhance access to primary care. Urgent care clinics can handle a significant portion of emergency visits at a much lower cost. Limited studies on the quality of care and patient experience in urgent care clinics suggest it is on par with that in other settings.
  - Birth Centers show promise for improving health outcomes, addressing disparities and lowering costs.

# Sites & Expanded Approaches to Care Delivery

## HMA Evidence and Considerations

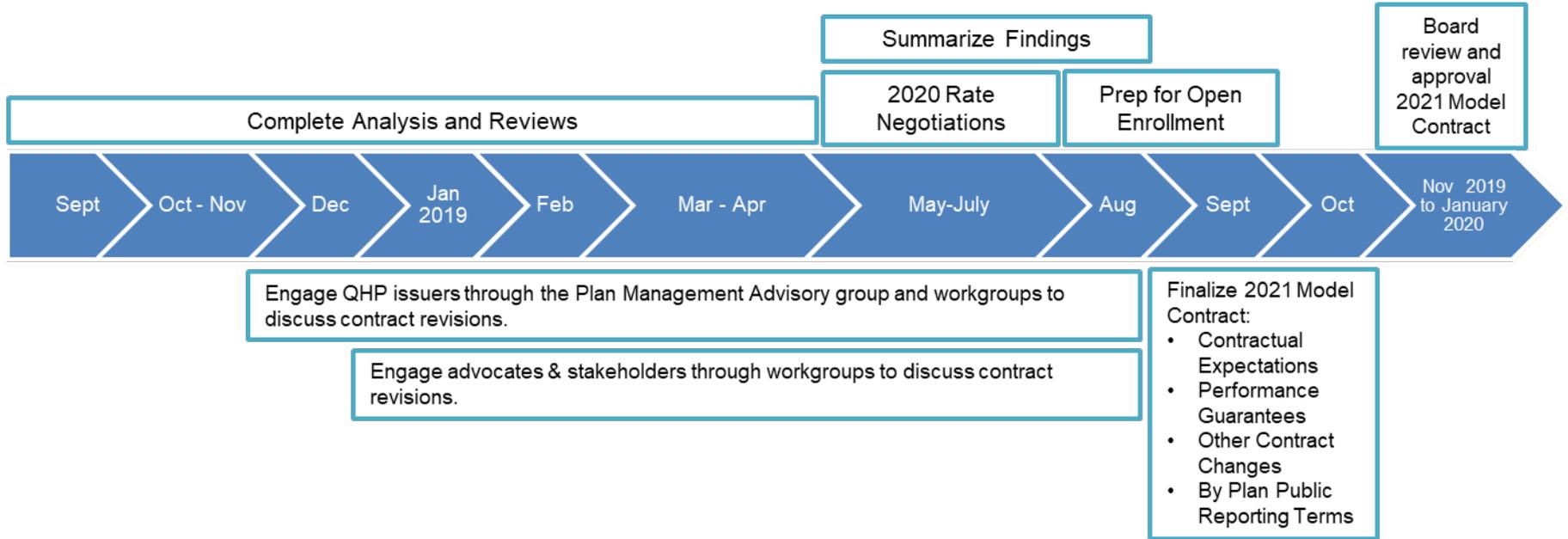
- HMA Suggested Considerations for Covered California
  - Consider options to encourage plans to impose payment neutrality requirements for the same services provided in different care settings.
  - Monitor how plans provide coverage for and promote telehealth services that foster access to specialty care and reduce costlier downstream care.
  - Strategies that may facilitate appropriate use of retail clinics: ensuring retail clinics are included in plan provider directories, educating members about what services retail clinics can provide, and lowering cost sharing for visits to retail clinics over other settings.
    - To mitigate the lack of continuity of care, Covered California could require participating issuers to require retail clinics to send documentation of the patient visit to the patient's primary care doctor, with the patient's permission.
    - To enhance access to retail care further, Covered California may want to meet with major retail clinic companies to ascertain under what factors they would open clinics in underserved areas and determine if Covered California can help to enable those factors.
  - Evaluate the extent to which covered populations are receiving pregnancy-related care. If significant, Covered California could consider encouraging plans to contract with birth centers as a promising source of high-quality and cost-effective care, particularly among low-income women with diverse racial backgrounds.

# Sites & Expanded Approaches to Care Delivery PwC Measurement

- PwC Measures & Benchmarks Takeaways
  - Current Covered California required reporting leverages federal and state surveillance systems to monitor the quality of QHP network hospitals without adding health plan data collection burden.
  - Telehealth and other alternative sites of care can fill some of the gaps driven by inadequate access to providers, and their use is growing rapidly for some services and populations. Covered California should continue to monitor their use and effectiveness.
- PwC Measures & Benchmark Recommendations for Covered California
  - Consider setting HAC performance targets for absolute infection rates in addition to the relative performance represented in the current SIR-based measures.
  - Consider the total number of “harms” when selecting future measures or when setting targets.
  - Consider adding the following measures:
    - Sepsis CMS Core SEP-1 quality measure
    - Hospital readmission rates
    - Excess Days in Acute Care (EDAC)
    - Influenza Vaccination Coverage Among Healthcare Personnel
  - Monitor OSHPD’s development of the all-payer version of the patient safety indicators (PSI) based on data from California hospitals.
  - Adverse drug events (ADEs) are an important source of patient harm, however there is no easy access to clinical ADE data at the hospital level and there are no national measurement standards. OSHPD is currently working with Hospital Quality Institute (HQI) on this issue. Covered California should monitor OSHPD’s progress and assess whether these measures should be considered in the future. At the national level, the Medicare Patient Safety Monitoring System (MPSMS) tracks ADEs through a sample of clinical charts.

# NEXT STEPS

# Timeline



## Attachment 7 Refresh Workgroups

- ❖ Covered California is convening a dedicated workgroup of subject matter experts and stakeholders to discuss contract revisions.
- ❖ Participants include issuers, provider organizations, advocates
- ❖ Proposed workgroup dates:
  - July 31
  - Aug 14
  - Aug 28
  - Sept 11
  - Sept 25

# QUESTIONS & COMMENTS

# OPEN FORUM AND NEXT STEPS

ROB SPECTOR, CHAIR  
PLAN MANAGEMENT ADVISORY GROUP