March 6, 2019

James DeBenedetti, Director
Plan Management

Dr. Lance Lang, M.D., Chief Medical Officer
Covered California
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Sacramento, CA 95815
Via email: Lance.Lang@covered.ca.gov

Re: Covered California Request for Input to Inform Refreshing Expectations Designed to Promote Accountability and Delivery System Improvements

The California Pan-Ethnic Health Network (CPEHN) and the undersigned organizations, have reviewed Covered California's Request for Input to Inform Refreshing Expectations Designed to Promote Accountability and Delivery System Improvements. Below are our high level comments and recommendations. For more detail, please see the attached document(s).

General Comments:

- **Ranking Covered California's 13 Strategies:** Given the complexity of California's health care needs, we recommend that Covered California continue to prioritize all 13 strategies, but take a closer look instead at the underlying elements of those strategies and prioritize and refresh those strategies.

- **Alignment Across Purchasers:** While we support Covered California working with other purchasers to coalesce around a core set of quality measures, payor alignment should be pursued "as appropriate." Covered California needs to take into account differences in covered populations (e.g. age/conditions in Medicare versus commercial) when deciding which initiatives to pursue. Additionally, we note that some of the quality strategies Covered California is contemplating require tracking patient health outcomes for more than 2 years which may be difficult given the high turn-over rate of Covered

California enrollees. Longer-term measurement of provider quality improvement efforts (e.g. Hospital Acquired Conditions (HACs)) may be easier to do.

- **Public Reporting:** After three years, Covered California has only just begun to share high level data regarding the progress plans are making on quality improvement strategies in Attachment 7. The data that has been shared shows quality improvement has been uneven with large gaps between low and high performers. There is a 40 point spread, for example between the highest and lowest performing plans on certain metrics such as controlling high blood pressure or colorectal cancer screening. Unfortunately the current data does not allow for plan-by-plan comparisons and as a result, public accountability to improve the wide variation between plans on quality improvement, disparities reduction and cost containment strategies is lacking. How then, is a consumer supposed to act on this information without the ability to identify which plans are doing well and which are falling behind? Moving forward, Covered California must include in its QHP contracts requirements for the public reporting of data on cost reduction, quality improvement and disparities reduction efforts.

  Areas for Assessment of Impact: Covered California in its document entitled "Refreshing Contractual Expectations," says it will assess "savings" when deciding on interventions, including "the total cost of health care and savings for specific interventions." We would appreciate greater clarity on Covered California's approach in this area. For example, is Covered California interested in savings for payers or consumers? What counts as savings? For whom? How will these savings impact consumers? Should we expect to see lower premiums? Are there requirements on plans on what to do with the savings they generate? How will Covered California work to ensure these savings are invested in appropriate quality improvement strategies and interventions? Recent evidence suggests that both in California and nationally, reductions in utilization have been correlated with increases in prices that mean consumers, and purchasers more generally, see no savings.[1] In this context, how do savings from specific interventions translate into savings for consumers in terms of lower premium or reductions in the ever-steady creep of the actuarial value calculator?

- **Population-based and Community Health Promotion Beyond Enrolled Population:** Though health care quality is essential to good health, one's race, ethnicity and socioeconomic status is an even stronger indicator of health outcomes. As a result, there are a growing number of multi-payer federal and state initiatives as well as Medicaid-specific initiatives focused on addressing social needs.[2] We strongly support Covered California exploring requirements and standards for community health promotion beyond

[1] Gerard Anderson et al, "It is Still the Prices, Stupid", Health Affairs January 2019. Richard Scheffler and Steve Shortell, "California Dreaming", Petris Center, February 2019.

[2] "Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity," Samantha Artiga and Elizabeth Hinton, Kaiser Family Foundation, May 10, 2018. https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/

enrolled populations. These requirements should be linked to/based on other quality improvement goals, e.g. reducing the prevalence of obesity, or improving the control of diabetes through promotion and support for healthy eating and safe physical activity. Community needs assessments and community health improvement plans should address the upstream determinants of health from issues of affordable housing to early childhood programs, access to healthy food and opportunities for safe physical activities.

Comments on Particular Strategies:

- **Disparities Reduction (Article 3, Attachment 7):** Although we are only just starting to see reports on progress on the current QHP member race and ethnicity self-identification objectives, the next contract should add requirements for self-identification and documentation of age, sex, race, ethnicity, preferred language, sexual orientation, gender identity, disability, and social and behavioral factors consistent with the 2015 Office of National Coordinator for Health IT requirements for certified health IT.[3] Additionally, the next contract should have more specific requirements for the identification of disparities and specific Quality Improvement Plans to reduce those identified disparities. Covered California should also reference and adopt QHP contract requirements and measures from the National Quality Forum's *Roadmap for Promoting Health Equity and Elimiating Disparities* report which include requirements for example, that consumer evaluation tools be culturally and linguistically appropriate and that staff be trained in cultural competancy issues to reduce bias and create a culture of equity.

- **Alternative Sites of Care (Article 4, Attachment 7):** Alternate Sites and Modalities of Care should include telephonic advice/visits, e-visits, e-consults and e-referrals, group visits, in-home monitoring, etc. "Retail clinics" should be stricken as an example as they are the epitome of uncoordinated care. Additionally, while we are supportive of alternate sites and modalities of care, the way the contract is written seems to suggest that telehealth is always the preferred method of delivering care and ditto for remote home monitoring. Is that correct? Are there clinical consequences that should be considered (e.g. sometimes the doctor needs to be in the same room as the patient.)

- **Care Coordination (Article 4, Attachment 7):** Covered California and QHPs should continue to improve coordination for Mental Health Services Act-funded behavioral health services, especially prevention and early intervention programs. There also should be measures about access to and integration of behavioral health, and oral health (at a

[3] U.S. Department of Health and Human Services Office of National Coordinator for Health Information Technology, *2015 Edition Health Information Technology (Health IT) Certification Criteria, 2015 Edition Base Electronic Health Record (EHR) Definition, and ONC Health IT Certification Program Modifications*; Final Rule, 80 Fed. Reg. 62602-62759 (October 16, 2015) https://www.gpo.gov/fdsys/pkg/FR-2015-10-16/pdf/2015-25597.pdf

minimum, for children, but also at least information and referral for adults). Additionally, Covered California could do more to incentivize and/or require electronic exchange of health information (see QHP Application Section 18.5) to support care coordination and quality improvement.[4]

- **Prevention and Wellness/Social Determinants of Health (Article 6, Attachment 7):** We strongly support additional requirements for community needs assessments and community health improvement plans that address the upstream determinants of health; issues of affordable housing including housing stability and housing conditions (e.g. mold and other conditions that contribute to respiratory diseases and remediation strategies such as weatherization) should be prioritized as well as early childhood programs, access to healthy food and opportunities for safe physical activities. If there are new requirements for community needs assessments and community health improvement plans, these should definitely be aligned and coordinated with existing requirements and ongoing community needs assessments, community health improvement plans, and community benefit plans. The requirements for Health Assessments should include requirements that such Health Assessments are available in multiple languages (not only asked if available, with no penalties or need for corrective action, see QHP Application Section 18.9.13, p.101) Similarly, the requirements for outreach and interventions for at-risk enrollees (QHP Application Section 18.11.3, p.105) should include requirements that outreach and intervention materials and services be culturally and linguistically appropriate. Additionally, QHP grievance procedures (QHP Application 7.1, p.28) should be required to be culturally and linguistically appropriate, and be evaluated/audited on that criteria.

Thank you for your time, we look forward to continuing discussions with you on this important issue. For questions about this letter, please contact Cary Sanders at: csanders@cpehn.org.

Sincerely,

California Pan-Ethnic Health Network

Health Access

National Health Law Program

Western Center on Law & Poverty

[4] see Office of National Coordinator for Health IT's proposed rule to improve the interoperability of health information: https://www.healthit.gov/topic/laws-regulation-and-policy/notice-proposed-rulemaking-improve-interoperability-health

Attachment 7 to Covered California 2017 Individual Market QHP Issuer Contract: Quality, Network Management, Delivery System Standards and Improvement Strategy

Preamble

PROMOTING HIGHER QUALITY AND BETTER VALUE

Covered California's "Triple Aim" framework seeks to lower costs, improve quality, and improve health outcomes and reduce health disparities, while ensuring a good choice of plans for consumers. Covered California and Contractor recognize that promoting better quality and value will be contingent upon supporting Providers and strategic, collaborative efforts to align with other major purchasers and payors to support delivery system reform. Qualified Health Plan (QHP) Issuers are integral to Covered California achieving its mission:

> *The mission of the California Health Benefit Exchange 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.*

By entering into this Agreement with Covered California, Contractor agrees to work with Covered California to develop and implement policies and practices that will promote the Triple Aim, impacting not just the Enrollees of Covered California but Contractor's entire California membership. All QHP Issuers have the opportunity to take a leading role in helping Covered California support new models of care which promote the vision of the Affordable Care Act and meet consumer needs and expectations. At the same time, the Contractor and Covered California can promote improvements in the entire care delivery system. Covered California will seek to promote care that reduces excessive costs, minimizes unpredictable quality and reduces inefficiencies of the current system. In addition, Covered California expects all QHP Issuers to balance the need for accountability and transparency at the Provider-level with the need to reduce administrative burdens on Providers as much as possible. For there to be a meaningful impact on overall healthcare cost and quality, solutions and successes need to be sustainable, scalable and expand beyond local markets or specific groups of individuals. Covered California expects its QHP Issuers to support their Providers to engage in a culture of continuous quality and value improvement, which will benefit both Covered California Enrollees and all individuals covered by the QHP Issuers.

This Quality, Network Management, Delivery System Standards and Improvement Strategy outlines the ways that Covered California and the Contractor will focus on the promotion of better care and higher value for Enrollees and for other California health care consumers. This focus will require both Covered California and Contractor to coordinate with and promote alignment with other organizations and groups that seek to deliver better care and higher value. By entering into the Agreement with Covered California, Contractor affirms its commitment to be an active and engaged partner with Covered California and to work collaboratively to define and implement additional initiatives and programs to continuously improve quality and value.

Covered California and Contractor recognize that driving the significant improvements needed to ensure better quality care is delivered at lower cost will require tactics and strategies that extend beyond the term of this agreement. Success will depend on establishing targets based on current performance, national benchmarks and the best improvement science conducting rigorous evaluation of progress and adjusting goals annually based on experience. This Attachment 7 contains numerous reports that will be required as part of the annual certification and contracting process with QHP Issuers. This information will be used for negotiation and evaluation purposes regarding any extension of this Agreement and the recertification process for subsequent years.

ARTICLE 1
IMPROVING CARE, PROMOTING BETTER HEALTH AND LOWERING COSTS

1.01 Coordination and Cooperation

Contractor and Covered California agree that the Quality, Network Management, Delivery System Standards and Improvement Strategy serve as a starting point for what must be ongoing, refined and expanded efforts to promote improvements in care for Enrollees and across Contractor's California members. Improving and building on these efforts to improve care and reduce administrative burdens will require active partnership between Covered California and Contractor, but also with Providers, consumers and other important stakeholders.

1) Covered California shall facilitate ongoing discussions with Contractor and other stakeholders through Covered California's Plan Management and Delivery System Reform Advisory Group and through other forums as may be appropriate to work with Contractors to assess the elements of this Section and their impact, and ways to improve upon them, on:

   (a) Enrollees and other consumers;

   (b) Providers in terms of burden, changes in payment and rewarding the triple aim of improving care, promoting better health and lowering costs; and

   (c) Contractors in terms of the burden of reporting and participating in quality or delivery system efforts.

2) Contractor agrees to participate in Covered California advisory and planning processes, including participating in the Plan Management and Delivery System Reform Advisory Group.

1.02 Ensuring Networks are Based on Value

Central to its contractual requirements of its QHP Issuers, Covered California requirements include multiple elements related to ensuring that QHP Issuers' plans and networks provide quality care, including Network Design (Section 3.3.2), the inclusion of Essential Community Providers (Section3.3.3) and a wide range of elements detailed in this Attachment. To complement these provisions and to promote accountability and transparency of Covered California's expectation that network design and Provider selection considers quality and patient experience in addition to cost and efficiency, the Contractor shall:

1) Include quality, which may include clinical quality, patient safety and patient experience and cost in all Provider and facility selection criteria when designing and composing networks for inclusion in Covered California products

2) Contractor will be required to report to Covered California as part of its annual application for certification for purposes of negotiations, how it meets this requirement and the basis for the selection of Providers or facilities in networks available to Enrollees. This will include a detailed description of how cost, clinical quality, patient reported experience or other factors are considered in network design and Provider or facility selection. Information submitted for the application for certification in 2019 may be made publicly

available by Covered California.

3) Covered California expects Contractor to only contract with Providers and hospitals that demonstrate they provide quality care and promote the safety of Enrollees at a reasonable price. To meet this expectation, by contract year 2018, Covered California will work with its QHP Issuers to identify areas of "outlier poor performance" based on variation analysis. As part of this process, Covered California will engage experts in quality and cost variation and shall consult with Providers throughout California. For contract year 2019, QHP Issuers will be expected to either exclude those Providers that are "outlier poor performers" on either cost or quality from Covered California Provider networks or to document each year in its application for certification the rationale for continued contracting with each Provider that is identified as a "poor performing outlier" and efforts the Provider is undertaking to improve performance. Rationales for continued inclusion of Providers may include the impact on consumers in terms of geographical access and their out-of-pocket costs, or other justification provided by the QHP Issuer. QHP Issuer's rationale for inclusion of outliers on cost or quality will be released to the public by Covered California. Selection of specific measures of cost and quality, as well as criteria for defining "outlier poor performance" in a way that can be implemented consistently across Contractors will be established by Covered California based on national benchmarks, analysis of variation in California performance which shall include consideration of hospital case mix and services provided, best existing science of quality improvement, and effective engagement of stakeholders. Contractor agrees to participate in these collaborative processes to establish definitions. Reports from Contractor must detail implementation of such criteria through contractual requirements and enforcement, monitoring and evaluation of performance, consequences of noncompliance, corrective action and improvement plans if appropriate, and plans to transition patients from the care of Providers with poor performance. Such information may be made publicly available by Covered California.

4) Contractor will report as requested how Enrollees with conditions that require highly specialized management (e.g. transplant patients and burn patients) are managed by Providers with documented special experience and proficiency based on volume and outcome data, such as Centers of Excellence. In addition, to the extent that the Contractor uses Centers of Excellence more broadly, it will report as requested, the basis for inclusion of such Centers of Excellence, the method used to promote consumers' usage of these Centers, and the utilization of these Centers by Enrollees.

5) While Covered California welcomes QHP Issuers' use of Centers of Excellence, which may include design incentives for consumers, the current standard benefit designs do not envision or allow for "tiered" in-network Providers.

1.03 Demonstrating Action on High Cost Providers

Affordability is core to Covered California's mission to expand the availability of insurance coverage and promoting the Triple Aim. The wide variation in unit price and total costs of care charged by Providers, with some Providers charging far more for care irrespective of quality, is one of the biggest contributors to high costs of medical services.

1) Contractor will be required to report to Covered California as part of its application for

Commented [EAC1]: We like the concept of "outlier poor performance" but we have questions about how it is being executed (or not) by the plans.

Commented [EAC2]: Question: was this done? Do plans consistently identify the same providers as "outlier poor performance"? Or do different plans get difference results for the same providers?

Commented [EAC3]: Are plans using the same measures or different measures?

Commented [EAC4]: And are the definitions publicly reported? Who is reviewing them?

Commented [EAC5]: From a patient perspective, coordination of care all too often falls on the family, not the health system. The technical aspects of care also supersede psycho-social supports or psycho-social support is ignored entirely and left to the (overwhelmed) family/friends.

Commented [EAC6]: How are "Centers of Excellence" defined? By what standard? We understand the concept that high volume improves quality. But "Centers of Excellence" seems more like a marketing term than a quality improvement standard.

certification for 2017, and annually thereafter, which will be used for negotiation purposes:

(a) The factors it considers in assessing the relative unit prices and total costs of care;

(b) The extent to which it adjusts or analyzes the reasons for cost factors based on elements such as area of service, population served, market dominance, services provided by the facility (e.g., trauma or tertiary care) or other factors;

(c) How such factors are used in the selection of Providers or facilities in networks available to Enrollees; and

(d) The identification of specific hospitals and their distribution by cost deciles or describe other ways Providers and facilities are grouped by costs such as comparison of costs as a percentage of Medicare costs; and the percentage of costs for Contractor that are expended in each cost decile. Contractor understands that it is the desire and intention of Covered California to expand this identification process to include other Providers and facilities in future years.

2) In its application for certification for 2017, and annually thereafter, which will be used for negotiation purposes, Contractor will be required to report on its strategies to ensure that contracted Providers are not charging unduly high prices, and for what portions of its entire enrolled population it applies each strategy, which may include:

(a) Telehealth;

(b) Use of Centers of Excellence; and

(c) Design of Networks (see Article 1.02)

(d) Reference Pricing; and

(e) Efforts to make variation in Provider or facility cost transparent to consumers and the use of such tools by consumers.

3) For contract year 2019, Contractor will be expected to exclude hospitals and other facilities that demonstrate outlier high cost from Provider networks serving Covered California or to document each year in its application for certification the rationale for continued contracting with each hospital that is identified as a high cost outlier and efforts that the hospital or facility is undertaking to lower its costs.

1.04 Demonstrating Action on High Cost Pharmaceuticals

Appropriate treatment with pharmaceuticals is often the best clinical strategy to treating conditions, as well as managing chronic and life threatening conditions. Covered California expects its Contractor to ensure that its Enrollees get timely access to appropriate prescription medications. At the same time, Covered California is concerned with the trend in rising prescription drug costs, including those in specialty pharmacy, and compounding increases in costs of generic drugs, which reflect a growing driver of total cost of care.

Commented [EAC7]: How is this defined?

Commented [EAC8]: Under what circumstances, if any, is this information useful to a consumer?

Commented [EAC9]: Good idea but how is "outlier" defined? As a percentage of Medicare?

Commented [EAC10]: While we share the concern over escalating prescription drug prices, what is it about the requirements in this section that goes beyond existing state/federal law and plan practice in terms of balancing clinical effectiveness and cost containment? What is the added value of these requirements?

Contractor will be required to report in its annual application for certification for negotiation purposes, a description of its approach to achieving value in delivery of pharmacy services, which should include a strategy in each of the following areas:

1) Contractor must describe how it considers value in its selection of medications for use in its formulary, including the extent to which it applies value assessment methodology developed by independent groups or uses independent drug assessment reports on comparative effectiveness and value to design benefits, negotiate prices, develop pricing for consumers, and determine formulary placement and tiering within Covered California standard benefit designs. Contractor shall report the specific ways they use a value assessment methodology or independent reports to improve value in pharmacy services and indicate which of the following sources it relies upon:

   (a) Drug Effectiveness Review Project (DERP)

   (b) NCCN Resource Stratification Framework (NCCN-RF)

   (c) NCCN Evidence Blocks (NCCN-EB)

   (d) ASCO Value of Cancer Treatment Options (ASCO- VF)

   (e) ACC/AHA Cost/Value Methodology in Clinical Practice Guidelines

   (f) Oregon State Health Evidence Review Commission Prioritization Methodology

   (g) Premera Value-Based Drug Formulary (Premera VBF)

   (h) DrugAbacus (MSKCC) (DAbacus)

   (i) The ICER Value Assessment Framework (ICER-VF)

   (j) Real Endpoints

   (k) Blue Cross/Blue Shield Technology Evaluation Center

   (l) International Assessment Processes (e.g., United Kingdom's National Institute for Health and Care Excellence – "NICE")

   (m) Other (please identify)

2) Contractor shall describe how its construction of formularies is based on total cost of care rather than on drug cost alone

3) Contractor shall describe how it monitors off-label use of pharmaceuticals and what efforts are undertaken to assure any off-label prescriptions are evidence-based;

4) Contractor must describe how it provides decision support for prescribers and consumers related to the clinical efficacy and cost impact of treatments and their alternatives.

1.05 Quality Improvement Strategy

Starting with the application for certification for 2017, Contractor is required under the Affordable Care Act and regulations from CMS to implement a Quality Improvement Strategy (QIS). The core CMS requirement for the QIS is to align Provider and enrollee market-based incentives with delivery system and quality targets.

Contractor agrees to align its QIS with the contractual requirements and initiatives of Covered California and to report on its multi-year strategy and first-year plan for implementing each initiative through the annual certification application submitted to Covered California, which will be used for negotiation purposes during the application process. Contractor understands that the application serves as the reporting mechanism and measurement tool for assessing Contractor QIS work plans and progress in achieving improvement targets with respect to each of Covered California quality and delivery system reform initiatives.

Contractor understands that Covered California will seek increasingly detailed reports over time that will facilitate the assessment of the impacts of each initiative which will include:

Commented [EAC11]: What is required here beyond the CMS requirements?

(a) The percentage, number and performance of total participating Providers;

(b) The number and percent of Enrollees participating in the initiative;

(c) The number and percent of all the Contractor's covered lives participating in the initiative; and

(d) The results of Contractor's participation in this initiative, including clinical, patient experience and cost impacts.

1.06 Participation in Collaborative Quality Initiatives

Covered California believes that improving health care quality and reducing costs can only be done over the long-term through collaborative efforts that effectively engage and support clinicians and other Providers of care. There are many established statewide and national collaborative initiatives for quality improvement that are aligned with priorities established by Covered California with requirements specified below.

1) Effective January 1, 2017, Contractor must participate in two such collaboratives:

(a) CalSIM Maternity Initiative: Sponsored by Covered California, DHCS and CalPERS as well as other major purchasers with support from the California Maternal Quality Care Collaborative (CMQCC) which provides statewide analysis of variation and promotes the appropriate use of C-sections with associated reductions in maternal and newborn mortality and morbidity. https://www.cmqcc.org/ (See Article 5, Section 5.03)

(b) Smart Care California: Sponsored by Covered California, DHCS and CalPERS, this multi-stakeholder work group facilitated by the Integrated Healthcare Association (IHA), will provide guidance and steer the delivery system to drive appropriate use of C-sections, prescription of opioids and low back imaging. A key element of this change is promoting best practices through provider and consumer decision support, for example through the Choosing Wisely campaign

from Consumer Reports.
http://www.iha.org/grants-projects-reducing-overuse-workgroup.html (See Article 7, Section 7.05)

2) Covered California is interested in Contractors' participation in other collaborative initiatives. As part of the application for certification for 2017, and annually thereafter, for negotiation purposes, Contractor will be required to report to Covered California its participation in any of the following collaboratives, or other similar activities not listed:

Commented [EAC12]: So different plans are doing different things—and different providers within the same plan are doing different things? How is CovCA assuring that plans and providers are not just picking the initiatives where they will do well rather than the initiatives needed to improve quality for their own enrollees?

(a) CMMI's Transforming Clinical Practices, administered by:

i. Children's Hospital of Orange County,

ii. LA Care,

iii. National Rural Accountable Care Consortium,

iv. California Quality Collaborative of PBGH, and

v. VHA/UHC Alliance NewCo, Inc.

All five of these collaboratives are coaching accessible, data-driven, team-based care over the course of the grant 2015-2019.
https://innovation.cms.gov/initiatives/Transforming-Clinical-Practices/ (See Article 4, section 4.02)

(b) Partnership for Patients: The CMS Innovation Center (CMMI) implemented this program focused on hospital patient safety, which between 2012 and 2014 resulted in 87,000 fewer deaths, mostly in 2013-14. The 2017 grants to build on this work have been distributed to Hospital Improvement Innovation Networks (HIINs) around the country including several in California.
https://partnershipforpatients.cms.gov/ (See article 5, section 5.02)

Awardees working with California hospitals for 2017 are:

i. Health Services Advisory Group (HSAG) which includes the Hospital Quality Initiative subsidiary of the California Hospital Association.

ii. Dignity Hospitals,

iii. VHA/UHC, and

iv. Children's Hospitals' Solutions for Patient Safety

v. Premiere, Inc.

(c) 1115 Medicaid Waiver Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program

(d) California Joint Replacement Registry developed by the California Healthcare Foundation (CHCF), California Orthopedic Association (COA) and PBGH

(e) California Immunization Registry (CAIR)

(f) Any IHA or CMMI sponsored payment reform program

(g) CMMI ACO Program (including Pioneer, Savings Sharing, Next Gen ACO, and other models)

(h) California Perinatal Quality Care Collaborative

(i) California Quality Collaborative

(j) Leapfrog

(k) A Federally Qualified Patient Safety Organization such as CHPSO

(l) The IHA Encounter Standardization Project

3) When reporting this information to Covered California, such information shall be in a form that is mutually agreed upon by the Contractor and may include copies of reports used by Contractor for other purposes. Contractor understands that Covered California will seek increasingly detailed reports over time that will facilitate the assessment of the impacts of these programs which will include: (1) the percentage of total Participating Providers, as well as the percentage of Covered California specific Providers participating in the programs; (2) the number and percentage of potentially eligible Plan Enrollees who participate through the Contractor in the Quality Initiative; (3) the results of Contractors' participation in each program, including clinical, patient experience and cost impacts; and (4) such other information as Covered California and the Contractor identify as important to identify programs worth expanding.

Commented [EAC13]: Most of this "assessment" is just volume of participation, not impacts on outcomes or disparities.

Commented [EAC14]: And implications for disparities?

4) Covered California and Contractor will collaboratively identify and evaluate the most effective programs for improving care for Enrollees and Covered California may require participation in specific collaboratives in future years.

1.07 Data Exchange with Providers

Covered California and Contractor recognize the critical role of sharing data across specialties and institutional boundaries as well as between health plans and contracted Providers in improving quality of care and successfully managing total costs of care.

1) Contractor will be required to report in its annual application for certification for negotiation purposes, the initiatives Contractor has undertaken to improve routine exchange of timely information with Providers to support their delivery of high quality care. Examples that could impact the Contractor's success under this contract may include:

(a) Notifying Primary Care clinicians when one of their empaneled patients is admitted to a hospital, a critical event that often occurs without the knowledge of either the primary care or specialty Providers who have been managing the patient on an ambulatory basis.

(b) Developing systems to collect clinical data as a supplement to the annual HEDIS

process, such as HbA1c lab results and blood pressure readings which are important under Article 3 below.

(c) Racial and ethnic self-reported identity collected at every patient contact.

2) Contractor will be required to describe its participation in statewide or regional initiatives that seek to make data exchange routine, including, but not limited to the following Health Information Exchanges:

(a) Inland Empire Health Information Exchange (IEHIE)

(b) Los Angeles Network for Enhanced Services (LANES)

(c) Orange County Partnership Regional Health Information Organization (OCPRHIO)

(d) San Diego Health Connect

(e) Santa Cruz Health Information Exchange

(f) CalIndex

3) By June 30, 2018 Contractor must use standard processes for encounter data exchange with its contracted providers, which include:

(a) The use of the 837-P and 837-I industry standard transaction sets for encounter data intake. These standard transaction sets must include appropriate cost sharing and member out of pocket information.

(b) The use of the 277 CA transaction set and industry standard code sets to communicate encounter data that was successfully processed, as well as any encounter data that was rejected and requires resubmission. If Contractor uses a clearing house to process encounter data and the 277 CA is not utilized, the Contractor must provide a daily detailed file to the clearing house of all rejected records and corresponding reasons for rejections. Contractor must ensure its contracted providers receive visibility to the specific reasons the encounter data was rejected to allow for both successful resubmissions and any process improvement needed to minimize future rejections.

4) By June 30, 2018 Contractor agrees to participate in industry collaborative initiatives for improving encounter data exchange processes in California, which include:

(a) The Integrated Healthcare Association Encounter Data Work Group; and

(b) The Industry Collaborative Efforts (ICE) Encounter Data Work Group.

1.08 Data Aggregation across Health Plans

Covered California and Contractor recognize the importance of aggregating data across purchasers and payors to more accurately understand the performance of Providers that have contracts with multiple health plans. Such aggregated data reflecting a larger portion of a

Provider, group or facility's practice can potentially be used to support performance improvement, contracting and public reporting.

1) Contractor will be required to report in its annual application for certification for negotiation purposes, its participation in initiatives to support the aggregation of claims and clinical data. Contractor must include its assessment of additional opportunities to improve measurement and reduce the burden of data collection on Providers through such proposals as a statewide All Payor Claims Database.

   Examples include but are not limited to:

   (a) The Integrated Health Association (IHA) for Medical Groups

   (b) The California Healthcare Performance Information System (CHPI)

   (c) The CMS Physician Quality Reporting System

   (d) CMS Hospital Compare or

   (e) CalHospital Compare

Commented [EAC15]: In another decade, the APCD may (or may not) be operational.

Commented [EAC16]: These measure different things: some apply to doctors, some to hospitals, some to medical groups. So a plan complies if it does one on the list, even if it neglects others?

Commented [EAC17]: Anthem is pulling out of CalHospital Compare: is Covered CA raising this with Anthem?

ARTICLE 2
PROVISION AND USE OF DATA AND INFORMATION FOR QUALITY OF CARE

2.01 HEDIS and CAHPS Reporting

Contractor shall annually collect and report to Covered California, for each QHP Issuer product type, its Quality Rating System HEDIS, CAHPS and other performance data (numerators, denominators, and rates). Contractor must provide such data to Covered California each year regardless of the extent to which CMS uses the data for public reporting or other purposes.

Contractor shall submit to Covered California HEDIS and CAHPS scores to include the measure numerator, denominator and rate for the required measures set that is reported to the National Committee for Quality Assurance (NCQA) Quality Compass and DHCS, for each Product Type for which it collects data in California. The timeline for Contractor's HEDIS and CAHPS quality data must be submitted at the same time as Contractor submits this to the NCQA Quality Compass and DHCS. Covered California reserves the right to use the Contractor-reported measures to construct Contractor summary quality ratings that Covered California may use for such purposes as supporting consumer choice and Covered California's oversight of Contractor's QHPs.

2.02 Data Submission Requirements

Contractor and Covered California agree that the assessment of quality and value offered by a QHP to enrollees is dependent on consistent, normalized data, so that the Contractor and Covered California can evaluate the experience of Contractor's membership, and compare that experience to the experience of Enrollees covered by other QHP issuers, and to the Covered California population as a whole. In order to conduct this assessment, Contractor shall provide certain information currently captured in contractor's information systems related to its participation in the Exchange EAS Vendor in a manner consistent to that which Contractor currently provides to its major purchasers.

Commented [EAC18]: Given what the advocates currently understand about the refusal of the plans to submit data to CovCA, we have lots of questions about this contract provision which is foundational to much of the rest of the work described in this attachment.

1) Disclosures to Enterprise Analytics Vendor:

(a) Covered California has entered into a contract with an Enterprise Analytics Vendor ("EAS Vendor") to support its oversight and management of health exchange. EAS Vendor has provided Contractor with a written list of data elements ("EAS Dataset") and a data submission template that defines the data elements and format for transmitting the data. Contractor shall provide EAS Vendor with the data identified in the EAS Dataset on a monthly basis, which is attached as Appendix 1 to this Attachment 7. The parties may modify the data fields in Appendix 1 to Attachment 7 upon mutual agreement of the parties, and without formal amendment to this Agreement.

(b) To enable the submission of the EAS Dataset to EAS Vendor, Contractor has executed a Business Associate Agreement ("BAA"), and any other agreements that Contractor determines are required for the submission of the EAS Dataset to EAS Vendor. Contractor's obligation to provide any data to EAS Vendor is contingent on a BAA being in force at the time information is to be provided to EAS Vendor. Covered California may, upon request to Contractor, review such BAA and any other agreements between Contractor and EAS Vendor related to

the submission of the EAS Dataset.

2) Disclosures to Covered California:

(a) EAS Vendor must protect the EAS Dataset submitted to it by Contractor pursuant to the BAA and any other agreements entered into with Contractor, applicable federal and state laws, rules and regulations, including the HIPAA Privacy and Security Rules. Any data extract or report ("EAS Output") provided to Covered California and generated from the EAS Dataset shall at all times be limited to de-identified data. Covered California shall not request any Personally Identifiable Health Information from EAS Vendor or attempt to use the de-identified data it receives from EAS Vendor to re-identify any person.

3) EAS Vendor Designation:

(a) Truven Health Analytics ("Truven") is Covered California's current EAS Vendor. In the event that Covered California terminates its contract with Truven during the term of this Agreement, Covered California shall provide notice to Contractor pursuant to section 12.3 of the Agreement. Any such termination of the agreement with Truven shall excuse any performance of Contractor under this section 2.02 effective on the date of termination of the agreement with Truven until a replacement EAS Vendor is designated.

4) Covered California is a Health Oversight Agency:

(a) Covered California continues to maintain that it operates as a Health Oversight Agency as described by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended. As such, Contractor may disclose protected health information to Covered California, or its vendor, in order for Covered California to perform its mandated oversight activities. At such time that Covered California receives technical assistance from the Office for Civil Rights, or otherwise receives guidance from the federal government, that reasonably confirms Covered California's status as a Health Oversight Agency, Contractor shall provide Covered California, or its vendor, with the necessary data elements, including protected health information as permitted by state and federal laws, in order for Covered California to perform its mandated oversight activities.

Commented [EAC19]: "May" or "shall"?

2.03 Quality and Delivery System Reform Reporting

For measurement year 2017, Contractor will be required to respond to questions identified and required by the Exchange in the annual certification application related to quality and delivery system reform requirements in this Attachment 7.

Such information will be used by Covered California to evaluate Contractor's performance under the terms of the Quality, Network Management, Delivery System Standards and Improvement Strategy and in connection with the evaluation regarding any extension of this Agreement and the certification process for subsequent years. The timing, nature and extent of such responses will be established by Covered California based on its evaluation of various quality-related factors.

2.04 Data Measurement Specifications

Contractor shall report metrics specified herein, as mutually agreed upon by both parties, and as requested by Covered California. Covered California and Contractor agree to work collaboratively during the term of this Agreement to enhance the data specifications and further define the requirements.

ARTICLE 3
REDUCING HEALTH DISPARITIES AND ENSURING HEALTH EQUITY

Mitigation of health disparities is central to the mission of Covered California, and the California Language Assistance Act adopted as SB 853 in 2003. In alignment with these principles, Covered California and Contractor recognize that promoting better health requires a focus on addressing health disparities and health equity. Covered California will require Contractor to track, trend and reduce health disparities with the phased approach outlined below.

3.01 Measuring Care to Address Health Equity

Contractor must track and trend quality measures by racial or ethnic group, or both, and by gender for the Contractor's full book of business, excluding Medicare.

1) Identification:

   (a) By the end of 2019, Contractor must achieve 80 percent self-identification of racial or ethnic identity for Covered California enrollees.

   (b) In the application for certification for 2017, Contractor will be required to report the percent of self-reported racial or ethnic identity for Covered California enrollees.

   (c) Covered California and Contractor will negotiate annual targets for self-identification of racial or ethnic identity to be reported in the applications for certification for 2018 and beyond.

   (d) To the extent Contractor does not have self-reported information on racial or ethnic identity, or both, it shall use a standardized tool for proxy identification through the use of zip code and surname to fill any gaps in information.

2) Measures for Improvement:

   (a) Disparities in care by racial and ethnic identity and by gender will be reported annually by QHP Issuers based on its Enrollees. The tool for proxy identification shall be used to supplement self-reported racial or ethnic identity. Contractor agrees to work with Covered California to provide comparison reporting for its other lines of business where comparative data can offer meaningful reference points.

   (b) Measures selected for improvement beginning in plan year 2017 include Diabetes, Hypertension, Asthma (control plus hospital admission rates) and Depression (HEDIS appropriate use of medications).

   (c) Covered California will consider adding additional measures for plan year 2020 and beyond.

3.02 Narrowing Disparities

While Covered California and Contractor recognize that some level of disparity is determined by social and economic factors beyond the control of the health care delivery system, there is agreement that health care disparities can be narrowed through quality improvement activities tailored to specific populations and targeting select measures at the health plan level. Covered California and the Contractor agree that collection of data on clinical measures for the purpose of population health improvement requires development and adoption of systems for enhanced information exchange (see Section 1.07).

1) Contractor reported baseline measurements from plan years 2015 and 2016 on the measures listed in the Measurement Specifications document, based either on self-reported identity or on proxy identification on its Enrollees. Covered California anticipates that this baseline data may be incomplete.

2) Targets for 2019 and for annual intermediate milestones in reduction of disparities will be established by Covered California based on national benchmarks, analysis of variation in California performance, best existing science of quality improvement, and effective engagement of stakeholders.

3.03 Expanded Measurement

Contractor and Covered California will work together to assess the feasibility and impact of extending the disparity identification and improvement program over time. Areas for consideration include:

1) Income

2) Disability status

3) Sexual orientation

4) Gender identity

5) Limited English Proficiency (LEP)

3.04 NCQA Certification

Meeting the standards for Multicultural Health Care Distinction by NCQA is encouraged as a way to build a program to reduce documented disparities and to develop culturally and linguistically appropriate communication strategies. To the extent Contractor has applied for or received NCQA Certification, Contractor must provide this information with its annual application for certification. Covered California may publicly recognize this achievement and include it in information provided to consumers.

ARTICLE 4
PROMOTING DEVELOPMENT AND USE OF EFFECTIVE CARE MODELS

Covered California and Contractor agree that promoting the triple aim requires a foundation of effectively delivered primary care and integrated services for patients that is data driven, team based and crosses specialties and institutional boundaries. Contractor agrees to actively promote the development and use of care models that promote access, care coordination and early identification of at-risk enrollees and consideration of total costs of care. Contractor agrees to design networks and payment models for Providers serving Enrollees to reflect these priorities.

In particular, the Covered California's priority models which align with the CMS requirements under the QIS, are:

1) Effective primary care services, including ensuring that all enrollees have a Primary Care clinician.

2) Promotion of Patient-Centered Medical Homes (PCMH), which use a patient-centered, accessible, team-based approach to care delivery, member engagement, and data-driven improvement as well as integration of care management for patients with complex conditions, and

3) Integrated Healthcare Models (IHM) or Accountable Care Organizations, such as those referenced by the Berkeley Forum (2013) that coordinate care for patients across conditions, Providers, settings and time, and are paid to deliver good outcomes, quality and patient satisfaction at an affordable cost.

4.01 Primary Care

Contractor must ensure that all Enrollees either select or be provisionally assigned to a Primary Care clinician within 60 days of effectuation into the plan. If an Enrollee does not select a Primary Care clinician, Contractor must provisionally assign the Enrollee to a Primary Care clinician, inform the Enrollee of the assignment and provide the enrollee with an opportunity to select a different Primary Care clinician. When assigning a Primary Care clinician, Contractor shall use commercially reasonable efforts to assign a Primary Care clinician consistent with an Enrollee's stated gender, language, ethnic and cultural preferences, geographic accessibility, existing family member assignment, and any prior Primary Care clinician. Contractor will be required to report on this requirement annually in the application for certification for negotiation and evaluation purposes regarding any extension of this Agreement and the recertification process for subsequent years.

4.02 Patient-Centered Medical Homes

A growing body of evidence shows that advanced models of primary care, often called Patient-Centered Medical Homes (PCMH), greatly improve the care delivered to patients and support triple aim goals.

1) Covered California will provide Contractor with necessary data for Contractor to perform analysis on their networks to assess the adoption and growth of advanced primary care among providers. Contractor agrees to use the following recognition programs to determine which network providers meet standards for redesigned primary care:

Commented [EAC20]: Sounds like a nice idea but is this really happening and how does CovCA measure it?

Commented [EAC21]: The most recent report from Scheffler and Shortell cites the increase in DMHC-regulated plans, almost all of which is the shift of PPOs from CDI to DMHC. Please remove references to Berkeley Forum: you have better definitions below.

Commented [EAC22]: Given the turnover in enrollment (40% annually), it is important to sustain this requirement.

a. NCQA Patient-Centered Medical Home recognition
b. The Joint Commission Primary Care Medical Home certification

2) Contractor will be required to describe in its application for certification a payment strategy for adoption and progressive expansion among Providers caring for Enrollees that creates a business case for Primary Care Providers to adopt accessible, data-driven, team-based care (alternatives to face-to-face visits and care provided by non-MDs) with accountability for meeting the goals of the triple aim, including total cost of care.

3) Contractor will be required to report annually:

(a) The number and percent of Covered California enrollees who obtain their primary care in a PCMH.

(b) Covered California will establish targets for 2019 for the percent of Covered California enrollees obtaining primary care in a PCMH based on national benchmarks, analysis of variation in California performance and best existing science of quality improvement and effective engagement of stakeholders.

(c) A baseline of the percent of Primary Care clinicians whose contracts for Covered California Enrollees are based on the payment strategy defined in 4.02(2) for primary care services.

(d) Methods for enrolling or attributing members to a PCMH including whether the plan engages in formal enrollment and or outreach to members based on a risk algorithm.

(e) How Contractor's payment to PCMH practices differs from those payments made to practices that have not met PCMH standards.

4) Contractor agrees to work with Covered California to provide comparison reporting for its other lines of business to compare performance and inform future Covered California requirements where comparative data can offer meaningful reference points. The non-Covered California lines of business data is to support contract negotiations in setting targets and requirements for Covered California-only business and any required data will be submitted as part of Contractor's annual application for certification, which will be used for negotiation and evaluation purposes regarding any extension of this Agreement and the recertification process for subsequent years.

4.03 Integrated Healthcare Models (IHM) or Accountable Care Organizations (ACO)

Covered California places great importance on the adoption and expansion of integrated, coordinated and accountable systems of care and is adopting a modified version of the CalPERS definition for Integrated HealthCare Models also known as Accountable Care Organizations (ACOs):

1) The IHM is defined as:

(a) A system of population-based care coordinated across the continuum including multi-discipline physician practices, hospitals and ancillary Providers.

(b) Having at least Level three (3) integration, as defined by the Institutes of Medicine (IOM), of certified Electronic Health Record (EHR) technology in both a hospital inpatient and ambulatory setting provided either by a Provider organization or by Contractor:

i. Ambulatory level of integration will include, at minimum, electronic charts, a data repository of lab results, connectivity to hospitals, partial or operational point of care technology, electronic assistance for ordering, computerized disease registries (CDR), and e-mail.

ii. Hospital inpatient level of integration will include, at minimum, lab, radiology, pharmacy, CDR, clinical decision support, and prescription documentation.

iii. There must be Stage two (2) (Advanced Clinical Processes) of Meaningful Use of the certified EHR within the IHM including:

a. Health Information and Data,

b. Results Management,

c. Order Entry/Management,

d. Clinical Decision Support

e. Electronic Communications and Connectivity, and

f. Patient Support.

(c) Having combined risk sharing arrangements and incentives between Contractor and Providers, and among Providers across specialties and institutional boundaries, holding the IHM accountable for nationally recognized evidence-based clinical, financial, and operational performance, as well as incentives for improvements in population outcomes. As Providers accept more accountability under this provision, Contractors shall be aware of their obligations in the Health and Safety Code and Insurance Code to ensure that Providers have the capacity to manage the risk.

2) Contractor must provide Covered California with details on its existing or planned integrated systems of care describing how the systems meet the criteria in Article 4.03(1), including the number and percent of Enrollees who are managed under IHMs in its response to the annual application for certification, which will be used for negotiation and evaluation purposes regarding any extension of this Agreement and the recertification process for subsequent years..

3) Targets for 2017-2019 for the percentage of Enrollees who select or are attributed to IHMs will be established by Covered California based on national benchmarks, analysis of

variation in California performance, best existing science of quality improvement, and effective engagement of stakeholders.

4) Contractor agrees to work with Covered California to provide comparison reporting for its other lines of business to compare performance and inform future Covered California requirements where comparative data can offer meaningful reference points. The non-Covered California lines of business data is to support contract negotiations in setting targets and requirements for Covered California-only business and any required data will be required as part of Contractor's annual application for certification.

4.04 Mental and Behavioral Health

Covered California and Contractor recognize the critical importance of Mental and Behavioral Health Services as part of the broader set of medical services provided to Enrollees.

Contractor will be required to report in its annual application for certification on the strategies Contractor has implemented and its progress in:

1) Making behavioral health services available to Enrollees;

2) How it is integrating Behavioral Health Services with Medical Services; and

3) Reports must include documenting the percent of services provided under an integrated behavioral health-medical model for Enrollees and the reports should include the percent for Contractor's overall covered lives, where such information is useful for comparison purposes and informing future Covered California requirements. These reports should also include whether these models are implemented in association with PCMH and IHM models or are independently implemented and will be used for negotiation and evaluation purposes regarding any extension of this Agreement and the recertification process for subsequent years.

4.05 Telehealth and Remote Monitoring

In the annual application for certification, Contractor will be required to report the extent to which the Contractor is supporting and using technology to assist in higher quality, accessible, patient-centered care, and the utilization for Enrollees on the number of unique patients and number of separate servicing provided for telehealth and remote home monitoring. Contractor agrees to work with Covered California to provide comparison reporting for its other lines of business to compare performance and inform future requirements for the exchange where comparative data can offer meaningful reference points. Such information will be used for negotiation and evaluation purposes regarding any extension of this Agreement and the recertification process for subsequent years.

Commented [EAC23]: This assumes that telehealth is always the preferred method of delivering care and ditto for remote home monitoring. Is that correct? Or are there clinical consequences that should be considered? As in sometimes, the doctor needs to be in the same room with the patient.

Reporting requirements will be met through completing the annual application for certification, but contractor may supplement such reports with data on the efficacy and impact of such utilization. These reports must include whether these models are implemented in association with PCMH and IHM models or are independently implemented.

Commented [EAC24]: Retail clinics were added to this section in some document—even though retail clinics are the epitome of uncoordinated care.

ARTICLE 5
HOSPITAL QUALITY

Covered California and Contractor recognize that hospitals have contracts with multiple health plans and are engaged in an array of quality improvement and efficiency initiatives. Hospitals play a pivotal role in providing critical care to those in the highest need and should be supported with coordinated efforts across health plans and purchasers.

5.01 Hospital Payments to Promote Quality and Value

Covered California expects its Contractors to pay differently to promote and reward better quality care rather than pay for volume. Contractor shall:

1) Adopt a hospital payment methodology that incrementally places at least six percent of reimbursement to hospitals for Contractor's Covered California business with each general acute care hospital at-risk or subject to a bonus payment for quality performance. At minimum, this methodology shall include two percent of reimbursement by January 1, 2019 with a plan for satisfying future increases in reimbursement, four percent of reimbursement by January 1, 2021 and six percent by January 1, 2023. Contractor may structure this strategy according to its own priorities such as:

   (a) The extent to which the payments "at risk" take the form of bonuses, withholds or other penalties; or

   (b) The selection of specific metrics upon which performance based payments are made may include, but are not limited to, Hospital Acquired Conditions (HACs), readmissions, or satisfaction measured through the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAPS), but Contractor must use standard measures commonly in use in hospitals and that are endorsed by the National Quality Forum – with the goal of limiting measurement burden on hospitals.

   (c) Contract arrangements with hospitals that participate in Integrated Healthcare Models or Accountable Care Organizations, whether sponsored by the QHP Issuer or by Provider organizations, which include accountability or shared risk for total cost of care shall be considered to have met this requirement.

2) Because there is some evidence that readmissions may be influenced by social determinants beyond the control of the health care system or social supports that a hospital can provide at discharge, if Contractor includes readmissions as a measure under this provision, it shall not be the only measure. Additionally, Contractor must adopt balancing measures to track, address, and prevent unintended consequences from at-risk payments including exacerbation of health care disparities. Contractor shall report what strategies it is implementing to support hospitals serving at-risk populations in achieving target performance. In alignment with CMS rules on payments to hospitals for inpatient hospital services, Critical Access Hospitals as defined by the Centers for Medicare and Medicaid, are excluded from this requirement. In addition, the following types of hospitals are excluded from this requirement:

   (a) Long Term Care hospitals

Commented [EAC25]: Is this still the correct amount? What is the experience with CMMI?

Commented [EAC26]: Given the recent studies on readmissions, is this still an appropriate metric?

Commented [EAC27]: Consumers are not clinicians: lots of good care is pretty unpleasant. If readmissions are not counted, this means only HACs and satisfaction are the measures. Should reimbursement be based on only two measures?

Commented [EAC28]: We appreciate the inclusion of disparities but is it just disparities?

(b) Inpatient Psychiatric hospitals

(c) Rehabilitation hospitals

(d) Children's hospitals

Contractor shall still be accountable for the quality of care and safety of Covered California members receiving care in the aforementioned hospitals. Implementation of this requirement may differ for integrated delivery systems and require alternative mechanisms for tying payment to performance.

3) Report in its annual application for certification for negotiation purposes, for Enrollees, the:

(a) Amount, structure and metrics for its hospital payment strategy;

(b) The percent of network hospitals operating under contracts reflecting this payment methodology;

(c) The total dollars and percent or best estimate of hospital payments that are tied to this strategy; and

(d) The dollars and percent, or best estimate that is respectively paid or withheld to reflect value. The hospital payments to promote value must be distinct from shared-risk and performance payments to hospitalization related to participation in IHMs as described in Article 4.03.

Additionally, Contractor agrees to work with Covered California to provide comparison reporting for Contractor's entire book of business where comparative data can offer meaningful reference points. Such information will be used for negotiation and evaluation purposes regarding any extension of this Agreement and the recertification process for subsequent years.

5.02 Hospital Patient Safety

1) Contractor agrees to work with Covered California to support and enhance acute general hospitals' efforts to promote safety for their patients. Exclusions for this requirement include CMS Critical Access Hospitals as defined by the Centers for Medicare and Medicaid. In addition, the following types of hospitals are excluded:

(a) Long Term Care hospitals

(b) Inpatient Psychiatric hospitals

(c) Rehabilitation hospitals

(d) Children's hospitals

2) Contractor will annually report strategy to improve safety in network hospitals, informed by review of specified HAC rates in all network hospitals. HAC rates will be provided by Covered California from established sources of clinical data such as rates reported by hospitals to the National Healthcare Safety Network (NHSN), or the California Department of Public Health (CDPH). Such information will be used for negotiation and evaluation

purposes regarding any extension of this Agreement and the recertification process for subsequent years.

3) Prior to the application for certification for 2018, target rates for 2019 and for annual intermediate milestones for each HAC measured at each hospital will be established by Covered California, based on national benchmarks, analysis of variation in California performance and best existing science of quality improvement and effective engagement of stakeholders.

4) Covered California has identified an initial set of HACs for focus in 2017. Certain HACs may be substituted for others in the event that a common data source cannot be found. The decision to substitute HACs would be made transparently and collaboratively through the advisory process. The HACs that are currently the subject of the 2017 hospital safety initiatives are listed below:

(a) Catheter Associated Urinary Tract Infection (CAUTI);

(b) Central Line Associated Blood Stream Infection (CLABSI);

(c) Surgical Site Infection (SSI) with focus on colon;

(d) Methicillin-resistant Staphylococcus aureus (MRSA); and

(e) Clostridium difficile colitis (C. Diff) infection.

5) The subject HACs may be revised in future years. Covered California expects to include ADEs including inappropriate use of opioids and blood thinners, hypoglycemia, and Sepsis Mortality at such time as standardized definitions and measurement strategies have been adopted by CMS or by a coalition of Partnership for Patients grantees in California.

6) Covered California expects Contractor to only contract with hospitals that demonstrate they provide quality care and promote the safety of Enrollees. To meet this expectation, by year end 2017, Covered California will work with QHP Issuers and with California's hospitals to identify areas of "outlier poor performance" based on variation analysis of HAC rates. For contract year 2019, as detailed in Article 1.02(3), Contractors must either exclude hospitals that demonstrate outlier poor performance on safety from Provider networks serving Covered California or to document each year in its application for certification the rationale for continued contracting with each hospital that is identified as a poor performing outlier on safety and efforts the hospital is undertaking to improve its performance.

Commented [EAC29]: How has this work progressed?

Commented [EAC30]: Sepsis and opioids both seems timely additions if there are standard measures.

5.03 Appropriate Use of C-Sections

Contractor agrees to actively participate in the statewide effort to promote the appropriate use of C-sections. This ongoing initiative sponsored by Covered California, DHCS and CalPERS as well as major employers is coordinated with CalSIM, and has adopted the goal of reducing NTSV (Nulliparous, Term Singleton, Vertex) C-section rates to meet or exceed the national Healthy People 2020 target of 23.9 percent for each hospital in the state by 2019. In addition to actively participating in this collaborative, Contractor shall:

1) Work collaboratively with Covered California to promote and encourage all in-network hospitals that provide maternity services to enroll in the California Maternity Quality Care Collaborative (CMQCC) Maternal Data Center (MDC).

2) Review information on C-section rate for NTSV deliveries and use it to inform hospital engagement strategy to reduce low risk (NTSV) C-Sections. Such information will also be used for negotiation and evaluation purposes regarding any extension of this Agreement.

3) Adopt a payment methodology progressively to include all contracted physicians and hospitals serving Enrollees, such that by 2019, payment is structured to support only medically necessary care and there is no financial incentive to perform C-sections. Contractor must report on its design and either the number or percent of hospitals contracted, as applicable, under this model in its annual application for certification.

4) Covered California expects Contractor to only contract with hospitals that demonstrate they provide quality care and promote the safety of Enrollees. Beginning with the application for certification for 2019, As detailed in Article 1.02(3), Contractors must either exclude hospitals from networks serving Enrollees that are unable to achieve an NTSV C-section rate below 23.9 percent from Provider networks or to document each year in its application for certification the rationale for continued contracting with each hospital that has an NTSV C-Section rate above 23.9 percent and efforts the hospital is undertaking to improve its performance.

ARTICLE 6
POPULATION HEALTH: PREVENTIVE HEALTH, WELLNESS AND AT-RISK ENROLLEE SUPPORT

Covered California and Contractor recognize that access to care, timely preventive care, coordination of care, and early identification of high risk enrollees are central to the improvement of Enrollee health. Contractor and Covered California shall identify ways to increase access and coordination of care and work collaboratively to achieve these objectives.

6.01 Health and Wellness Services

Contractor shall ensure Enrollees have access to preventive health and wellness services. For the services described below, Contractor must identify Enrollees who are eligible, notify Enrollees of their availability, and report utilization.

1) Necessary preventive services appropriate for each Enrollee. Contractor must report utilization to Covered California on the number and percent of Enrollees who take advantage of their wellness benefit.

2) Tobacco cessation intervention, inclusive of evidenced-based counseling and appropriate pharmacotherapy, if applicable. Contractor must report to Covered California the number and percent of Enrollees who take advantage of the tobacco cessation benefit.

3) Obesity management, if applicable. Contractor must report to Covered California the number and percent of its Enrollees who take advantage of the obesity benefit.

4) To ensure the Enrollee health and wellness process is supported, Contractor must report on its:

   (a) Health and wellness communication processes delivered to its Enrollees and applicable Participating Providers, that take into account cultural and linguistic diversity; and

   (b) Processes to incorporate Enrollee's health and wellness information into Contractor's data and information specific to each individual Enrollee. This Enrollee's data is Contractor's most complete information on each Enrollee and is distinct from the Enrollee's medical record maintained by the Providers.

Contractor will be required to report on each of these four service categories in its annual application for certification. Additionally, Contractor agrees to work with Covered California to provide comparison reporting for its other lines of business to compare performance and inform future requirements for the exchange where comparative data can offer meaningful reference points. The non-exchange line of business data is to support contract negotiations in setting targets and requirements for exchange-only business and any required data will be submitted as part of Contractor's annual application for certification.

For each of the four service categories described above, Covered California will establish targets for 2018 and annual milestones thereafter for the percent of the population that uses annual preventive visits based on national benchmarks, analysis of variation in California performance, best existing science of quality improvement, and effective engagement of stakeholders

Commented [EAC31]: Is this based on the % of enrollees using tobacco? If prevention works, no one should need this intervention because no one smokes or vapes. What about vaping?

6.02 Community Health and Wellness Promotion

Covered California and Contractor recognize that promoting better health for Enrollees also requires engagement and promotion of community-wide initiatives that foster better health, healthier environments and the promotion of healthy behaviors across the community. Contractor is encouraged to support community health initiatives that have undergone or are being piloted through systematic review to determine effectiveness in promoting health and preventing disease, injury, or disability and have been recommended by the Community Preventive Services Task Force.

Contractor will be required to report annually in its application for certification the initiatives, programs and projects that it supports that promote wellness and better community health for Enrollees, and is encouraged to report on such initiatives for Contractor's overall population. Such reports must include available results of evaluations of these community programs for Enrollees, including clinical or other health impacts and efficacy and will be used for negotiation and evaluation purposes regarding any extension of this Agreement and the recertification process for subsequent years.

Such programs may include:

1) Partnerships with local, state or federal public health departments such as Let's Get Healthy California;

2) CMS Accountable Health Communities;

3) Voluntary health organizations which operate preventive and other health programs such as CalFresh; and

4) Hospital activities undertaken under the Community Health Needs Assessment required every three years under the Affordable Care Act.

6.03 Determining Enrollee Health Status and Use of Health Assessments

Contractor shall demonstrate the capacity and systems to collect, maintain, use, and protect from disclosure individual information about Enrollees' health status and behaviors in order to promote better health and to better manage Enrollees' health conditions.

To the extent the Contractor uses or relies upon Health Assessments to determine health status, Contractor shall offer, upon initial enrollment and on a regular basis thereafter, a Health Assessment in all threshold languages to all Enrollees over the age of 18, including those Enrollees that have previously completed such an assessment. If a Health Assessment tool is used, Contractor should select a tool that adequately evaluates Enrollees current health status and provides a mechanism to conduct ongoing monitoring for future intervention(s).In addition, Health Assessments should advise policyholders at the outset on how the information collected may be used, and explain that the member is opting in to receive information from the plan, and that participating in the assessment is optional.

6.04 Reporting to and Collaborating with Covered California Regarding Health Status

Contractor shall provide to Covered California, in a format that shall be mutually agreed upon, information on how it collects and reports, at both individual and aggregate levels, changes in Enrollees' health status. Reporting may include a comparative analysis of health status improvements across geographic regions and demographics.

Contractor shall report to Covered California its process to monitor and track Enrollees' health status, which may include its process for identifying individuals who show a decline in health status, and referral of such Enrollees to Contractor care management and chronic condition program(s) as defined in Section 6.05, for the necessary intervention. Contractor shall annually report to Covered California the number of Enrollees who are identified through their selected mechanism and the results of their referral to receive additional services.

6.05 Supporting At-Risk Enrollees Requiring Transition

Contractor shall have an evaluation and transition plan in place for the Enrollees transitioning into or from employer-sponsored insurance, Medi-Cal, Medicare, or other insurance coverage who require therapeutic Provider and formulary transitions. Contractor shall also support transitions in the reverse direction. The plan must include the following:

Commented [EAC32]: Wonder if DMHC is getting complaints along these lines?

1) Identification of in-network Providers with appropriate clinical expertise or any alternative therapies including specific drugs when transitioning care;

2) Clear processes to communicate Enrollee's continued treatment using a specific therapy, specific drug or a specific Provider when no equivalent is available in-network;

3) Where possible, advance notification and understanding of out-of-network Provider status for treating and prescribing physicians; and

4) A process to allow incoming Enrollees access to Contractor's formulary information prior to enrollment.

6.06 Identification and Services for At-Risk Enrollees

Contractor agrees to identify and proactively manage Enrollees with existing and newly diagnosed chronic conditions, including, diabetes, asthma, heart disease, or hypertension, and who are most likely to benefit from well-coordinated care ("At-Risk Enrollees"). Contractor agrees to support disease management activities at the plan or health care Provider level that meet standards of accrediting programs such as NCQA. Contractor shall provide Covered California with a documented process, care management plan and strategy for targeting and managing At-Risk Enrollees. Such documentation may include the following:

Commented [EAC33]: Ahem, what about mental health, especially depression, which is comorbid with these physicial conditions and makes managing all/any of them harder.

1) Methods to identify and target At-Risk Enrollees;

2) Description of Contractor's predictive analytic capabilities to assist in identifying At-Risk Enrollees who would benefit from early, proactive intervention;

3) Communication plan for known At-Risk Enrollees to receive information prior to Provider visit, including the provision of culturally and linguistically appropriate communication;

4) Process to update At-Risk Enrollee medical history in Contractor's maintained Enrollee health profile;

5) Process for sharing registries of Enrollees with their identified risk, as permitted by state and federal law, with appropriate accountable Providers, especially the enrollee's PCP.

6) Mechanisms to evaluate access within the Provider network on an ongoing basis, to ensure that an adequate network is in place to support a proactive intervention and care management program for At-Risk Enrollees;

7) Care and network strategies that focus on supporting a proactive approach to At-Risk Enrollee intervention and care management. Contractor agrees to provide Covered California with a documented plan and include "tools" and strategies to supplement or expand care management and Provider network capabilities, including an expansion or reconfiguration of specialties or health care professionals to meet clinical needs of At-Risk Enrollees;

8) Data on number of Enrollees identified and types of services provided.

6.07 Diabetes Prevention Programs

Starting January 1, 2018, Contractor must offer a CDC-recognized Diabetes Prevention Lifestyle Change Program, also known as a Diabetes Prevention Program (DPP), to all Enrollees ages 18 and older who meet the participation criteria. The DPP shall be available to all Enrollees in the geographic service area and covered under the $0 preventive services benefit or diabetes education benefit in the Patient-Centered Benefit Design Plans. Contractor's DPP must have pending or full recognition by CDC as a DPP and be accessed either online or in person. A list of recognized programs in California can be found at https://nccd.cdc.gov/DDT_DPRP/Programs.aspx.

ARTICLE 7
PATIENT-CENTERED INFORMATION AND SUPPORT

Empowering consumers with knowledge to support healthcare decision-making is a crucial part of Covered California's mission and naturally promotes the Triple Aim by supporting decisions consistent with the Enrollee's values and preferences and fostering consumer access to care.

Covered California and Contractor agree that valid, reliable, and actionable information relating to the cost and quality of healthcare services is important to Enrollees, Covered California, and Providers.

Thus, Covered California expects that Contractor will participate in activities necessary to provide this information to consumers. The specifics of this phased approach are described in Section 7.01 below.

7.01 Enrollee Healthcare Services Price and Quality Transparency Plan

1) In the application for certification, Contractor will have reported for negotiation and certification purposes, its planned approach to providing healthcare shopping cost and quality information available to all Enrollees. Covered California does not require using a specific form or format and recognizes that the timeline and expectations will differ, based on variables such as Contractor's membership size and current tool offerings. Regardless of how the requirement is fulfilled, the common elements at the end point of each Contractor planned approach must include:

   (a) Cost information:

      i. That enables Enrollees to understand their exposure to out-of-pocket costs based on their benefit design, including real time information on member accumulation toward deductibles, when applicable, and out of pocket maximums. Health Savings Account (HSA) user information shall include account deposit and withdrawal/payment amounts.

      ii. That enables Enrollees to understand Provider-specific consumer cost shares for prescription drugs and for care delivered in the inpatient, outpatient, and ambulatory surgery/facility settings. Such information must include the facility name, address, and other contact information and be based on the contracting rates to give the Enrollee estimates of out of pocket costs that are as accurate as possible.

      iii. Commonly used service information should be organized in ways that are useful and meaningful for consumers to understand.

   (b) Quality information:

      i. That enables Enrollees to compare Providers based on quality performance in selecting a Primary Care clinician or common elective specialty and hospital Providers.

      ii. That is based on quality measurement consistent with nationally-endorsed quality information in accordance with the principles of the Patient Charter for Physician Performance Measurement.

Commented [EAC34]: It is not just "enrollees": it is also those considering enrolling—that is consumers when they are making the decision about whether to enroll or not. Also good for enrollees facing significant health care costs.

iii. That, as an interim step prior to integrating quality measurement into Provider chooser tools, can be provided by linking to:

a. The California Office of the Patient Advocate (www.opa.ca.gov/)

b. The Department of Insurance Healthcare Compare (www.consumerreports.org/cro/health/california-health-cost-and-quality---consumer-reports/index.htm)

c. CMS Hospital Compare Program (https://www.medicare.gov/hospitalcompare/search.html)

d. CMS Physician Quality Reporting System (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html?redirect=/pqri/)

iv. In addition, Contractor must recognize California hospitals that have achieved target rates for HACs and NTSV C-Section utilization as defined in Article 5, Sections 5.02 and 5.03.

(c) Health Insurance Benefit Information. Contractor shall make available personalized benefit-specific information to all enrollees that includes accumulations of expenses applicable to deductible and out-of-pocket maximums.

Commented [EAC35]: Medicare requires that this be done monthly (or when care is used). No reason why most plans cannot provide the information in a timely manner just as Medicare requires.

(d) Contractor agrees to monitor non-emergency care provided out of network to ensure that consumers understand that their cost share will be higher and are choosing care non-emergency out of network intentionally.

(e) If Contractor product enrollment exceeds 100,000 for Covered California business, the cost and quality information shall be provided through an online tool easily accessible across a variety of platforms and made available by 2018. If Contractor enrollment is under 100,000 for Covered California business, the information may be provided by alternative means such as a call center.

Commented [EAC36]: I am not sure this is the right threshold: Anthem is a large organization with considerable capacity but its CovCA enrollment is now probably under 100,000. Not objecting to a threshold: just to asking whether this is the right one.

2) Contractor will be required in its annual application for certification to:

(a) Report the number and percent of unique Enrollees for each of the consumer tools offered for the reporting period of the plan year.

(b) Report user experience with the tool (or equivalent service such as a call center) from a representative sample of users who respond to a survey which includes a user overall satisfaction with rating.

(c) Provide access and log-in credentials for Covered California staff per mutually agreeable terms to safeguard Contractor proprietary information and services.

Contractor agrees to work with Covered California to provide comparison reporting for its other lines of business to compare performance and inform future requirements for the exchange where comparative data can offer meaningful reference points. The non-exchange line of business data is to support contract negotiations in setting targets and

requirements for exchange-only business and any required data will be submitted as part of Contractor's annual application for certification.

7.02 Enrollee Personalized Health Record Information

1) In its application for certification for 2017, Contractor will have reported for negotiation and certification purposes, the extent to which Enrollees can easily access personal health information or have reported its plan to provide such access through such tools as a Personal Health Record (PHR) or other "patient portal".

2) The content of such PHRs includes: medical records, billing and payment records, insurance information, clinical laboratory test results, medical images such as X-rays, wellness and disease management program files, clinical case notes, and other information used to make decisions about individuals.

3) Covered California will establish targets for 2019 and annual milestones thereafter for Enrollee use of personal health information based on national benchmarks, analysis of variation in California performance, best existing science of quality improvement, and effective engagement of stakeholders.

4) Contractor will provide access and log-in credentials for Covered California staff per mutually agreeable terms to safeguard Contractor proprietary information and services.

7.03. Enrollee Shared Decision-Making

Covered California requires deployment of decision-making tools to support Enrollees in understanding their medical diagnosis and treatment options to aid in discussion with their Provider. Educating Enrollees on their diagnosis and alternative treatment options is a powerful evidence-based approach to reducing overuse or misuse of clinical interventions.

Contractor agrees to promote and encourage patient engagement in shared decision-making with contracted Providers.

1) Contractor will be required to report in its annual application for certification specific information regarding the number of Enrollees who have accessed consumer information or have participated in a shared decision-making process prior to reaching an agreement on a treatment plan. For example, Contractor may adopt shared-decision-making practices for preference-sensitive conditions, including breast cancer, prostate cancer, and knee and hip replacements, that feature patient-decision-making aids in addition to physician opinions and present trade-offs regarding quality or length of life.

2) Contractor will be required to report in its annual application for certification the percentage of Enrollees with identified health conditions above who received information that allowed the Enrollee to share in the decision-making process prior to agreeing to a treatment plan.

3) Contractor will be required to report in its annual application for certification participation in these programs and their results, including clinical, patient experience and costs impacts.

4) These reports will be used for negotiation and evaluation purposes regarding any

Commented [EAC37]: Are we there already? Is this section still needed? Are there any plans that do not meet this standard? And if so, what's up with the plan or the contracting providers?

Commented [EAC38]: Agree with the concept but wonder whether this should be revised/updated?

extension of this Agreement and the recertification process for subsequent years.

7.04 Reducing Overuse through Choosing Wisely

Contractor shall participate in the statewide workgroup on Overuse sponsored by Covered California, DHCS and CalPERS. This multi-stakeholder work group facilitated by IHA, will leverage Choosing Wisely decision aids to support efforts to drive appropriate use of:

1) C- Sections for low risk (NTSV) deliveries;

2) Opioid overuse and misuse; and

3) Imaging for low back pain.

Commented [EAC39]: Isn't the right standard here that the plan has the capacity to provide same-day physical therapy for low back pain? That is what is clinically appropriate (and thus required by the timely access standards).

The mechanism for reduction of NTSV C-Sections will be participation in the California State Initiative Model (CalSIM) Maternity Care Initiative, with the target of ensuring all network hospitals achieve rates of 23.9 percent or less by 2020. (See section 5.03)

Improvement strategies and targets for 2019 as well as for annual intermediate milestones in reductions of overuse of opioids and imaging for low back pain will be established by Covered California in collaboration with other stakeholders participating in the workgroup based on national benchmarks, analysis of variation in California performance and best existing science of quality improvement and effective engagement of stakeholders.

7.05 Use of Provider Directory Utility

1) In order to fulfill its obligation to assist Enrollees in making informed decisions when considering health insurance options and in choosing QHPs and their associated network of Providers, Covered California is committed to implementing and participating in the statewide provider directory utility (Statewide Provider Directory) being developed by the Integrated Health Care Association (IHA). Once established, the Statewide Provider Directory will serve as the authoritative source of Provider information for all QHP issuers contracted with Covered California, and will be maintained and updated in a manner designed to allow Contractor and other QHP issuers to satisfy their obligations under California Health and Safety Code §1367.27, California Insurance Code §10133.15 and other applicable state and federal regulations. Specifically, the Statewide Provider Directory will be used by Providers to populate, maintain and continually update demographic, licensure, and other relevant information with respect to such Providers and their participation in the QHPs offered by Covered California. Contractor and other QHP issuers will utilize the Statewide Provider Directory to populate, maintain and continually update product, provider network, and other relevant information with respect to all of their respective QHPs, as well as to provide information regarding the terms and restrictions governing such Providers' participation in the QHPs offered by Contractor through Covered California.

2) Contractor agrees to participate in the Statewide Provider Directory, beginning on the first day of the first month of the full calendar quarter immediately following IHA's launch of the Statewide Provider Directory, currently anticipated to begin in the fourth quarter of 2018. In connection with such participation, Contractor shall:

Commented [EAC40]: I lost track: did this launch? And how much error/lacunae remain? 40%?

(a) Execute such reasonable participation, subscription or other agreements required by Covered California or IHA or their vendors to participate in the Statewide Provider Directory;

(b) Populate, maintain, and continually update the Statewide Provider Directory with all relevant information with respect to its contracted Providers' participation in its QHPs, including all information regarding the terms and restrictions governing such Providers' participation in the QHPs offered through Covered California;

(c) Use the Statewide Provider Directory, as the exclusive platform to populate and maintain the information published in the Statewide Provider Directory concerning its QHPs; and

(d) Work with Covered California, IHA and their respective vendors to ensure that the Statewide Provider Directory serves its primary purpose of effectively and efficiently assisting Enrollees in making informed decisions in selecting QHPs and Providers.

3) At a time and manner mutually agreed upon by Covered California and Contractor, Contractor agrees to report on its strategies to ensure that Contractor, and its contracted Providers, maintain compliance with the provisions of this Section 7.05.

ARTICLE 8
PAYMENT INCENTIVES TO PROMOTE HIGHER VALUE CARE

8.01 Reward-based Consumer Incentive Programs

Contractor may, to the extent permitted by law, maintain or develop a Reward-based Consumer Incentive Program to promote evidence-based, optimal care for Enrollees with identified chronic conditions. To the extent Contractor implements such a program and to the extent such information is known, Contractor shall report participation rates and outcomes results, including clinical, patient experience and cost impacts, to Covered California annually.

Commented [EAC41]: Given the very high cost sharing for most enrollees, is this the right question to ask? It makes sense for large employers with AVs over 90%, e.g. CalPERS, but not much sense for bronze or silver.

8.02 Value-Based Reimbursement Inventory and Performance

Contractor agrees to implement value-based reimbursement methodologies to Providers within networks contracted to serve Covered California. Value-based reimbursement methodologies must include those payments to hospitals and physicians that are linked to quality metrics, performance, costs and value measures and must include the Contractor's entire book of business with the Provider.

1) Among the strategies for which Covered California has established requirements for payment strategies to support delivery system reforms are:

   (a) Advanced Primary Care or Patient-Centered Medical Homes (4.02)

   (b) Integrated Healthcare Models (4.03)

   (c) Appropriate use of C-sections (5.03)

   (d) Hospital Patient Safety (5.02)

Commented [EAC42]: This seems duplicative.

2) In addition to the required payment strategies above, Contractor will be required to report in its annual application for certification an inventory and evaluation of the impact of other value-based payment models it is implementing including, but not limited to:

   (a) Direct participation or alignment with CMMI innovative payment models such as the Oncology or Joint Replacement model; and

   (b) Adoption of new Alternative Payment Models associated with the implementation of the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA)

8.03 Value-Pricing Programs

Contractor agrees to provide Covered California with the details of any value-pricing programs for procedures or in service areas that have the potential to improve care and generate savings for Enrollees. Contractor agrees to share with Covered California, the results of programs that may focus on high cost regions or those with the greatest cost variation(s). These programs may include payment bundling pilots for specific procedures where wide cost variations exist.

Commented [EAC43]: Are these programs aimed at providers or consumers? Isn't it the plan's responsibility to negotiate with the providers?

8.04 Payment Reform and Data Submission

1) Contractor agrees to provide information to Covered California pursuant to this Article 8, understanding that Covered California will provide such information to the Catalyst for

Payment Reform's (CPR) National Scorecard on Payment Reform and National Compendium on Payment Reform.

2) The CPR National Scorecard will provide a view of progress on payment reform at the national level and then at the market level as the methodology and data collection mechanisms allow.

3) The CPR National Compendium will be an up-to-date resource regarding payment reforms being tested in the marketplace and their available results. The Compendium will be publicly available for use by all health care stakeholders working to increase value in the system.

4) Contractor must annually report on the progress and impact of value-oriented payment initiatives imputed to the Purchaser's annual spend for the preceding calendar year, using both the format and calculation methodology in the annual certification application and CPR's Payment Reform Evaluation Framework..

ARTICLE 9
ACCREDITATION

Commented [EAC44]: The idea that plans should be accredited seems pretty basic. What about looking at enforcement actions by the regulators, including fines for lack of compliance?

1) Contractor agrees to maintain a current accreditation throughout the term of the Agreement from one of the following accrediting bodies: (i) Utilization Review Accreditation Commission (URAC); (ii) National Committee on Quality Assurance (NCQA); (iii) Accreditation Association for Ambulatory Health Care (AAAHC). Contractor shall authorize the accrediting agency to provide information and data to Covered California relating to Contractor's accreditation, including, the most recent accreditation survey and other data and information maintained by the accrediting agency as required under 45 C.F.R. § 156.275.

2) Contractor shall be currently accredited and maintain its NCQA, URAC or AAAHC accreditation throughout the term of the Agreement. Contractor shall notify Covered California of the date of any accreditation review scheduled during the term of this Agreement and the results of such review. Upon completion of any health plan accreditation review conducted during the term of this Agreement, Contractor shall provide Covered California with a copy of the Assessment Report within forty-five (45) days of report receipt.

3) If Contractor receives a rating of less than "accredited" in any category, loses an accreditation or fails to maintain a current and up to date accreditation, Contractor shall notify Covered California within ten (10) business days of such rating change and must provide Covered California with all corrective action(s). Contractor will implement strategies to raise Contractor's rating to a level of at least "accredited" or to reinstate accreditation. Contractor will submit a written corrective action plan (CAP) to Covered California within forty-five 45 days of receiving its initial notification of the change in category ratings.

4) Following the initial submission of the CAPs, Contractor shall provide a written report to Covered California on at least a quarterly basis regarding the status and progress of the submitted CAP. Contractor shall request a follow-up review by the accreditation entity at the end of twelve (12) months and submit a copy of the follow-up Assessment Report to Covered California within thirty (30) days of receipt, if applicable.

5) In the event Contractor's overall accreditation is suspended, revoked, or otherwise terminated, or in the event Contractor has undergone review prior to the expiration of its current accreditation and reaccreditation is suspended, revoked, or not granted at the time of expiration, Covered California reserves the right to terminate this Agreement , suspend enrollment in Contractor's QHPs or avail itself of any other remedies in this Agreement, to ensure Covered California is in compliance with the federal requirement that all participating issuers maintain a current approved accreditation.

6) Upon request by Covered California, Contractor will identify all health plan certification or accreditation programs undertaken, including any failed accreditation or certifications, and will also provide the full written report of such certification or accreditation undertakings to Covered California.

Quality, Network Management and Delivery System Standards

Glossary of Key Terms

Accountable Care Organization (ACO) - A healthcare organization characterized by a payment and care delivery model that seeks to tie Provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients. An ACO is intended to provide incentives for participating Providers (i.e. clinics, hospitals and physicians) to collectively share financial risk, working towards common goals to 1) reduce medical costs, 2) reduce waste and redundancy, 3) adhere to best care practices (i.e. evidence-based care guidelines, and 4) improve care quality. Care Management and Population Health Management are critical program components that are intended to enable ACOs to achieve favorable financial outcomes as the result of improved care outcomes.

Bundled Payments (also known as Global Payment Bundles, episode-of-care payment, or global case rates) - An alternative payment method to reimburse healthcare Providers for services that provides a single payment for all physician, hospital and ancillary services that a patient uses in the course of an overall treatment for a specific, defined condition, or care episode. These services may span multiple Providers in multiple settings over a period of time, and are reimbursed individually under typical fee-for-service models. The Payment Bundle may cover all inpatient/outpatient costs related to the care episode, including physician services, hospital services, ancillary services, procedures, lab tests, and medical devices/implants. Using Payment Bundles, Providers assume financial risk for the cost of services for a particular treatment or condition, as well as costs associated with preventable complications, but not the insurance risk (that is, the risk that a patient will acquire that condition, as is the case under capitation).

Care Management - Healthcare services, programs and technologies designed to help individuals with certain long-term conditions better manage their overall care and treatment. Care management typically encompasses Utilization Management (UM), Disease Management (DM) and Case Management (CM). Care Management's primary goal is to prevent the sick from getting sicker, and avoiding acute care events. Care Management is usually considered a subset of Population Health Management.

Complex Conditions - Clinical conditions that are of a complex nature that typically involve ongoing case management support from appropriately trained clinical staff. Frequently, individuals have multiple chronic clinical conditions that complicate management ("polychronic") or may have a complex, infrequent specialty condition that requires specialized expertise for optimal management.

Delivery System Transformation - A set of initiatives taken by purchasers, employers, health plans or Providers, together or individually, to drive the creation and preferred use of care delivery models that are designed to deliver higher value aligned with the "triple aim" goals of patient care experience including quality and satisfaction, improve the health of the populations, and reduce the per capita cost of Covered Services. Generally these models require improved care coordination, Provider and payor information sharing and programs that identify and manage populations of individuals through care delivery and payment models.

Enrollees – Those individuals with coverage through the Issuer received through Covered California.

Patient Centered Medical Home - A health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family. Care is facilitated by registries, information technology, health information Covered California and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner. The medical home is best described as a model or philosophy of primary care that

is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety.

Health Disparities - Healthy People 2020 defines a health disparity as “a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.”9 Racial and ethnic disparities populations include persons with Limited English Proficiency. (LEP).

Health Equity - Healthy People 2020 defines health equity as the “attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.”

Primary Care - The provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health needs, developing a sustained partnership with patients, and practicing in the context of family and community. (IOM, 1978) Contractors may allow enrollees to select Nurse Practitioners and Physician Assistants to serve as their Primary Care clinician. Covered California does not require that Primary Care clinicians serve as a “gatekeeper” or the source of referral and access to specialty care. Covered California recognizes Internal Medicine, Pediatrics and Family Medicine as primary care specialties.

Population Health Management - A management process that strives to address health needs at all points along the continuum of health and wellbeing, through participation of, engagement with and targeted interventions for the population. The goal of a Population Health Management program is to maintain and/or improve the physical and psychosocial wellbeing of individuals through cost-effective and tailored health solutions.

Preventive Health and Wellness Services - The provision of specified preventive and wellness services and chronic disease management services, including preventive care, screening and immunizations, set forth under Section 1302 of the Affordable Care Act (42 U.S.C. Section 18022) under the Section 2713 of the Affordable Care Act (42 U.S.C. Section 300gg-13), to the extent that such services are required under the California Affordable Care Act.

Reference Pricing - A payor contracting, network management and enrollee information process that identifies and differentially promotes delivery system options for care based on transparent display of comparative costs for identical services or procedures, typically after each Provider has passed a quality assessment screen. In some cases, value pricing will identify the individual enrollee’s out-of-pocket costs accounting for plan design and deductible status. While quality is incorporated in the process, typically there is no differentiation based on comparative quality once a threshold performance level is achieved.

Remote Patient Monitoring - A technology or set of technologies to enable monitoring of patients outside of conventional clinical settings (e.g. in the home), which may increase access to care and decrease healthcare delivery costs.

Reward Based Consumer Incentive Program - (aka: Value-Based Insurance Design) individualizes the benefits and claims adjudication to the specific clinical conditions of each high risk member and to reward participation in appropriate disease management & wellness programs. Positive Consumer Incentive

programs help align employee incentives with the use of high-value services and medications, offering an opportunity for quality improvement, cost savings and reduction in unnecessary and ineffective care.

Shared Decision Making - The process of making decisions regarding health care diagnosis and treatment that are shared by doctors and patients, informed by the best evidence available and weighted according to the specific characteristics and values of the patient. Shared decision making combines the measurement of patient preferences with evidence-based practice.

Team Care - A plan for patient care that is based on philosophy in which groups of professional and non-professional personnel work together and share the work to identify, plan, implement and evaluate comprehensive client-centered care. The key concept is a group that works together toward a common goal, providing qualitative comprehensive care. The team care concept has its roots in team nursing concepts developed in the 1950's.

Telehealth - Professional services given to a patient through an interactive telecommunications system by a practitioner at a distant site. Telehealth seeks to improve a patient's health by permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site. This electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment.

Value Pricing - A payor contracting, network management and enrollee information process that identifies and differentially promotes delivery system options for care that provide better value through the identification and transparent display of comparative total cost, out-of-pocket cost for enrollees and standardized quality performance to allow for informed consumer choice and Provider referrals for individual services and bundles of services.

Value-Based Reimbursement - Payment models that rewards physicians and Providers for taking a broader, more active role in the management of patient health, and provides for a reimbursement rate that reflects results and quality instead of solely for specific visits or procedures.

Covered California: Request for Input to Inform Refreshing Expectations Designed to Promote Accountability and Delivery System Improvements

As part of our contracts with Qualified Health Plan (QHP) Issuers, Covered California has set forth specific requirements related to improving quality, lowering costs, promoting better health and reducing health care disparities, both for our enrolled population and more broadly in the health care system. Covered California has focused on prices, benefits, networks, quality, and other factors that assure those with coverage through Covered California get the right care at the right time and that promote delivery system reforms to improve health care for all Californians. Central to Covered California's strategy has been to align its expectations with actions of other payers and purchasers and to anchor its policies in the best evidence available.

Covered California set forth our standards and strategy for quality improvement and delivery system reform in our QHP Issuer Model Contract, specifically within the "Quality, Network Management, Delivery System Standards and Improvement Strategy" section, also known as "Attachment 7" (https://hbex.coveredca.com/insurance-companies/PDFs/QHP-Model-Contract-2017-2019-Amended-for-2017-and-2018.pdf).

Covered California is in the process of revising its quality improvement and delivery system reform standards and requirements. To inform Covered California's efforts, we are conducting independent research and surveying the efforts of other purchasers. In addition, we are seeking input from health plans, providers, advocates, experts and other stakeholders as we propose revisions to contractual terms that take effect in plan year 2021. For additional background on Covered California's Attachment 7 refresh process, please see: *Covered California – Refreshing Contractual Expectations Designed to Promote Accountability and Delivery System Improvements* (https://board.coveredca.com/meetings/2019/01-17%20Meeting/Refreshing-Contractural-Expectations.pdf).

Covered California welcomes written feedback on its current efforts and how it might improve them in the coming years. Please provide comments in any form, but if possible please respond to the questions and topic areas detailed on the pages that follow. **Please insert your responses to the questions directly in this document, adding more space under each question as needed. Save the file with your organization's name and return to QHP@covered.ca.gov by February 15, 2019.**

This questionnaire solicits comments, observations and suggestions in the following areas:

- Covered California's *Guiding Principles for Promoting Better Care and Delivery Reform*
- *Current QHP Issuer Contract Terms: Quality, Network Management, Delivery System Standards and Improvement Strategy*
- *Contractual Expectations Domains and Strategies: Right Care/Accountability and Delivery System Improvement*
- *Enabling Factors that Promote Delivery Reform*

We will not share individual responses, though we may share aggregated themes.

Name:
Organization:
Contact E-Mail:
Phone:

Covered California's Guiding Principles for Promoting Better Care and Delivery Reform

The following are proposed guiding principles for Covered California's efforts to assure its contracted QHP Issuers are held accountable for providing the right care and are promoting needed improvements in the delivery system.

1. Driven by the desire to meet two complementary and overlapping objectives:
    a. **Right Care/Accountability**: Ensure our members receive the right care, at the right time, in the right setting, at the right price.
    b. **Delivery System Improvement**: 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 contracted 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 assuring that each provider meets minimum standards.

Please note your agreement or disagreement with the guiding principles and provide any questions, concerns, or suggested additions you may have.

Guiding principle 1b should be amended to read: Support and incentivize value-enhancing strategies that have the potential to reform the delivery system in the near and long term.

Guiding principle 2 should be strengthened to read: Specific, measureable objectives will be established to improve the health of the population, improve the experience of care including the delivery of culturally competent care, reduce the cost of care, reduce administrative burden, and reduce health care disparities.

Guiding principle 3 should be amended to read: Success will be assessed by outcomes, measured at the most appropriate level and stratified by member demographic data~~, in preference to adoption of specific strategies.~~

Guiding principle 4 should be amended to read: We will promote alignment with other purchasers as much as possible, where appropriate

Guiding principle 6 should be amended to read: Enrollees have the culturally and linguistically appropriate tools needed to be active consumers, including ~~both~~ provider selection, ~~and~~ shared clinical decision making, reporting patient experiences and outcomes, and accessing and utilizing quality improvement data.

Guiding principle 8 should be amended to read: Variation in the delivery of quality care, especially across geographic regions and by size of provider organization, will be minimized by assuring that each provider meets minimum standards.

Current QHP Issuer Contract Terms: Quality, Network Management, Delivery System Standards and Improvement Strategy (Attachment 7 – 2017-2020)

In the current Attachment 7 of the QHP Issuer Contract, Covered California aims to promote care that reduces excessive costs, minimizes unpredictable quality and reduces inefficiencies of the current system (https://hbex.coveredca.com/insurance-companies/PDFs/QHP-Model-Contract-2017-2019-Amended-for-2017-and-2018.pdf). Covered California also expects all contracted issuers to balance the need for provider accountability and transparency with the need to reduce administrative burden on providers. The requirements within Attachment 7 consist of the following focus areas:

- Article 1: Improving Care, Promoting Better Health and Lowering Costs: Ensuring networks are based on value, addressing high cost providers and high cost pharmaceuticals
- Article 2: Provision and Use of Data and Information for Quality of Care: Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers & Systems (CAHPS), Quality Rating System (QRS) reporting and IBM Watson data submissions
- Article 3: Reducing Health Disparities and Ensuring Health Equity: Increasing self-identification of race or ethnicity and measuring and narrowing disparities
- Article 4: Promoting Development and Use of Effective Care Models: Primary care provider (PCP) matching, promotion of patient-centered medical homes (PCMH) and integrated healthcare models (IHMs), supporting primary care through value-based payment, increasing mental and behavioral health integration with medical care, and using telehealth
- Article 5: Hospital Quality and Safety: Payment models to increase value, reducing hospital acquired conditions (HACs) and unnecessary C-Sections
- Article 6: Population Health: Preventive Health, Wellness and At-Risk Enrollee Support: Wellness services, community health, supporting at-risk enrollees, and diabetes prevention
- Article 7: Patient-Centered Information and Support: Price and quality transparency for enrollees, shared decision making, reducing overuse, and using the statewide provider directory
- Article 8: Payment Incentives to Promote Higher Value Care: Increasing value-based reimbursement
- Article 9: Accreditation

Please provide any overarching or specific feedback on the current Attachment 7 that we should consider as we approach the revision.

In this next contract cycle, Article 3: Reducing Health Disparities and Ensuring Health Equity should be strengthened to read: Increasing self-identification of member demographic data (age, sex, race, ethnicity, preferred language, sexual orientation, gender identity, disability, and social and behavior factors) and measuring and narrowing disparities.

Contractual Expectation Domains and Strategies

Covered California is considering reorganizing the initatives and strategies addressed in Attachment 7 into two broad domains with a total of 13 distinct individual strategies:

Right Care/Accountability: We are looking for more transparency into issuer oversight of care delivery, what kinds of problems are being found and how are they being addressed.

1. Chronic Care, General Health Care, and Access
2. Hospital Care
3. Major/Complex Care – Identification of High-Risk or High-Cost Individuals and Getting them the Right Care
4. Mental/Behavioral Health and Substance Use Disorder Treatment
5. Health Equity: Disparities in Healthcare
6. Preventive Services
7. Pharmacy Management

Delivery System Improvements: With these longer term efforts, we seek to redesign care delivery to be more effective in meeting the triple aim, reducing administrative burden, and reducing disparities.

8. Networks Based on Value (narrow or limited physician, hospital, and ancillary provider networks, Centers of Excellence)
9. Promotion of Effective Primary Care (PCP matching or assignment, patient-centered medical home or other models)
10. Promotion of Integrated Healthcare Models (IHMs) and Accountable Care Organizations (ACOs)
11. Alternate Sites of Care Delivery (e.g., telehealth, alternatives to emergency room use, retail clinics)
12. Consumer and Patient Engagement (e.g., quality and cost tools, personal health record, patient shared decision-making)
13. Population-based and Community Health Promotion Beyond Enrolled Population

NOTE: High level questions for input follow – for a detailed outline of questions and some specific issues regarding particular strategies see the Addendum: Detailed Questions – Contractual Expectation Domains and Strategies at the end of this survey.

A. Please comment on these domains as a way to reorganize Attachment 7.

Measureable Progress on Health Equity: Identification and Reduction of Disparities in Healthcare should be moved from Right Care/Accountability to Delivery System Improvements

Under Networks Based on Value, how are “Centers of Excellence” defined? By what standard?

Promotion of Integrated Healthcare Models should also include improved integration of behavioral health and oral health services

Alternate Sites and Modalities of Care should include telephonic advice/visits, e-visits, e-consults and e-referrals, group visits, in-home monitoring, etc. "Retail clinics" should be stricken as an example of: Alternate Sites of Care Delivery as they are the epitome of uncoordinated care.

B. Have we missed any strategies that should be considered or included in our domains?

Health promotion and disease prevention should be added as a category in Right Care/Accountability

Demographic data collection and stratrification, and electronic exchange of health information to support care coordidation and quality improvement should be added to Delivery System Improvements

Payment incentives and techinical assistance, especially to providers and delivery systems that serve low-income populations (QHP Application Section 1.3, p.) and Essential Community Providers (QHP Application Section 17, pp.72-73) should be added to Delivery System Improvements

C. Please provide any comments, observations or recommendations with regard to the 13 strategies articulated. Where relevant, please refer to and/or attach any relevant supporting or reference material.

D. Recognizing these strategies are all "priority" elements, we request your ranking of the 13 strategies from high to low priority for Covered California, looking ahead 2-5 years. If applicable, please include any other strategies identified in the previous question.

Strategy	Your Ranking for Covered California's Prioritization 2021-2023 Contract Rank from Highest to Lowest (1 to 13)
Chronic Care, General Health Care, and Access	
Hospital Care	
Major/Complex Care	
Mental/Behavioral Health and Substance Use Disorder Treatment	
Health Equity: Disparities in Healthcare	
Preventive Services	
Pharmacy Management	
Networks Based on Value	
Promotion of Effective Primary Care	
Promotion of Integrated Healthcare Models and Accountable Care Organizations	
Alternate Sites of Care Delivery	
Consumer and Patient Engagement	
Population-based and Community Health Promotion Beyond Enrolled Population	
Other:	
Other:	
Other:	

Our organizations diasgree with the inclusion of a ranking system for these different strategies. Given the complexity of California's health care needs, we recommend that Covered California continue to prioritize all of the strategies. However we would agree that some of the underlying elements of the strategies should be up for discussion, not the strategies themselves.

E. Are there particularly important challenges you foresee with respect to Covered California promoting improvements in the domains and strategies identified and what could Covered California do to address them?

Covered California could do more to incentivize and/or require electronic exchange of health information (see QHP Application Section 18.5) to support care coordidation and quality improvement; see Office of National Coordinator for Health IT's proposed rule to improve the interoperability of health information: https://www.healthit.gov/topic/laws-regulation-and-policy/notice-proposed-rulemaking-improve-interoperability-health

Enabling Factors that Promote Delivery Reform

Covered California's contractual expectations have included requiring or encouraging contracted QHP Issuers to engage in a range of "enabling factors" that may support the success of particular strategies. Covered California welcomes comments on its potential emphasis/focus on the enabling factors and their potential continued or changed inclusion as a contract requirement.

1. Payment Models (e.g., higher or lower payment, risk-based payments, bonuses or withholds; which may include payment that directly supports greater integration and coordination including budgets to support team-based care and payments that reflect include accountability across specialist and institutional boundaries)
2. Channeling of Members or Patients (e.g. exclusive networks or preferential)
3. Measurement and Data to Inform Impact
4. Data Exchange to Support Improved Clinical Care and Care Coordination
5. Provider-level Coaching or Quality Improvement Efforts to Support the Strategy
6. Alignment Across Payors or Purchasers to Provide Better "Signal Strength" to Provider
7. Benefit Design or Other Consumer-Facing Incentives
8. Public Reporting, Consumer Tools or other Consumer/Patient-Engagement Strategies

A. Please provide any comments on which of these enabling strategies you believe to be most important for Covered California to reflect as a contractual expectation of its QHP Issuers and why?

While there are references to the Health Care Payment Learning Action Network (LAN) framework (see QHP Application Section 19.2.3.3, p.111), the QHP contract should include specific, measureable goals for how QHP providers are paid using LAN Level 3 and Level 4 payments (25%? 50%?); at a minimum, QHPs should identify and report which LAN Levels their network provider payments are in and set specific, measureable objectives to increase from those baselines in the next contract cycle.

See comments on electronic exchange of health information above.

B. Given the importance of Covered California aligning with other purchasers, are there particular enabling factors you believe are more important to be promoted as common goals and standards across purchasers?

While we are generally supportive of alignment across purchasers and populations, Covered California needs to take into account differences in covered populations (e.g. age/conditions in Medicare versus commercial) and the turn-over of Covered California enrollees, 40% of whom leave the marketplace each year.

Where appropriate, Covered California should work with CMS, Medi-Cal at the Department of Health Care Services, large employers, QHPs and other health plans operating in California, and other quality improvement and payment reform stakeholders in California to continue to coalesce around a core set of quality measures across all payers, quality improvement, and payment reform activities and programs, and then establish a periodic review and refreshing of the core set (e.g. retiring those topped out, increasing weights on patient experience measures, etc.); this would catalyze improvement while allowing flexibility to address emerging quality and safety issues, as well as sustain improvement on clinical and health issues that will take longer for improvement (e.g. obesity, diabetes, etc.)

C. Have we missed any enabling factors that should be considered?

The current measures of patient experiences of care and patient-reported outcomes, are still limited in their usefulness; Covered California should consider leveraging the experience and expertise of QHPs, as well as the experience and expertise of patient/consumer stakeholders to develop, test, and validate additional measures of patient experiences of care and patient-reported outcomes, especially for culturally and linguistically diverse patients and consumers.

D. Please provide any comments, observations or recommendations with regard to the enabling factors articulated. Where relevant, please refer to and/or attach any relevant supporting or reference material.

Addendum: Detailed Questions -- Contractual Expectation Domains and Strategies

In this section, please provide any comments or suggestions for us to consider in thinking about each strategy. If you have no comments or considerations for a strategy, please feel free to leave blank. Where relevant, please refer to and/or attach any relevant supporting or reference material.

1. **Chronic Care, General Health Care, and Access**

    a. General comments/observations on this strategy for Covered California as an area of focus:

The focus should continue to be on health care system-level measures that the QHP should be responsible for, i.e. reducing ambulatory-sensitive, avoidable emergency department visits and hospitalizations; there also should be measures about access to and integration of behavioral health, and oral health (at a minimum, for children, but also at least information and referral for adults).

2. **Hospital Care**

    a. General comments/observations on this strategy for Covered California as an area of focus:

    b. We believe improvements have been made in maternity care and hospital safety. Given these improvements, should Covered California continue and broaden this effort to focus on additional hospital quality issues? If so, please specify your suggested areas of focus.

    c. Should Covered California change its focus to address other hospital issues (e.g., total cost of care)?

The focus should continue to be on improving patient safety (getting to zero medical errors); improving hospital discharges, improving transitions of care to/from hospitalization, and reducing avoidable hospital readmissions.

We like the concept of "outlier poor performance" (QHP Attachment 7, Section 1.02, p. 4) but we have questions about how it is being executed (or not) by the plans. The QHP contract states Covered California will work with its QHP issuers to identify areas of "outlier poor performance" based on variation analysis. Has this been done? Do plans consistently identify the same providers as "outlier poor performance"? Or do different plans get difference results for the same providers? Are plans using the same measures or different measures? And are the definitions publicly reported? Who is reviewing them?

3. **Major/Complex Care – Identification of High-Risk or High-Cost Individuals and Getting them the Right Care**

    a. General comments/observations on this strategy for Covered California as an area of focus:

As noted in the current Attachment 7, Contractors must identify and proactively manage Enrolless with existing and newly diagnosed chronic conditions, including asthma. A related requirement is that Contractors provide care and network strategies that focus on supporting a proactive approach to At-Risk Enrollee intervention and care management. Covered California should consider the inclusion of asthma home visiting services as one of the required strategies for Enrollees with poorly controlled asthma. Asthma home visiting services can include asthma education, home environmental asthma trigger assessments, and home environmental trigger remediation by qualified professionals.

4. **Mental/Behavioral Health and Substance Use Disorder Treatment**

    a. General comments/observations on this strategy for Covered California as an area of focus:

    b. What should Covered California focus on to:

i. Improve mental health and substance use access and treatment?

ii. Monitor access, treatment effectiveness, or outcomes for members needing behavioral health or substance use disorder services?

Covered California and QHPs should continue to improve coordination for Mental Health Services Act-funded behavioral health services, especially prevention and early intervention programs.

5. Health Equity: Disparities in Healthcare

a. General comments/observations on this strategy for Covered California as an area of focus:

Although we have not yet had reports on progress on the current QHP member race and ethnicity self-identification objectives, the next contract should add requirements for self-identification and documentation of age, sex, race, ethnicity, preferred language, sexual orientation, gender identity, disability, and social and behavioral factors consistent with the 2015 Office of National Coordinator for Health IT requirements for certified health IT: U.S. Department of Health and Human Services Office of National Coordinator for Health Information Technology, *2015 Edition Health Information Technology (Health IT) Certification Criteria, 2015 Edition Base Electronic Health Record (EHR) Definition, and ONC Health IT Certification Program Modifications*; Final Rule, 80 Fed. Reg. 62602-62759 (October 16, 2015) https://www.gpo.gov/fdsys/pkg/FR-2015-10-16/pdf/2015-25597.pdf

The next contract should have more specific requirements for the identification of disparities, and specific Quality Improvement Plans to reduce those identified disparities

Covered California should reference and adopt QHP contract requirements and measures from the National Quality Forum's *Roadmap for Promoting Health Equity and Eliminating Disparities: The Four I's for Health Equity*, especially from the Culture of Equity and Structural Support for Equity domains

https://www.qualityforum.org/Publications/2017/09/A_Roadmap_for_Promoting_Health_Equity_and_Eliminating_Disparities__The_Four_I_s_for_Health_Equity.aspx

For example, all information and tools used to monitor consumer experience should be required to be culturally and linguistically appropriate (QHP Application Section 7.12, p.30) and that staff be trained in cultural competancy issues to reduce bias and create a culture of equity.

And note that for QHP Application Sections 7.9 and 7.10, p.29, the references should be updated to a "telephonic/video interpreter vendor" (rather than a "language line"); such vendors should meet the federal Department of Health and Human Services Office of Civil Rights requirements for trained health care interpreters

https://www.hhs.gov/civil-rights/for-individuals/section-1557/fs-limited-english-proficiency/index.html

b. To what extent should Covered California and contracted issuers move or shift emphasis toward addressing "upstream" determinants of health? What areas do you think are relevant to specific attention on the part of issuers and providers?

We strongly support additional requirements for community needs assessments and community health improvement plans that address the upstream determinants of health; issues of affordable housing including housing stability and housing conditions (e.g. mold and other conditions that contribute to respiratory diseases) should be prioritized as well as early childhood programs, access to healthy food and opportunities for safe physical activities.

c. Does aligning population health efforts for issuers working in similar geographic areas or within provider or other systems warrant additional focus? Are there important steps or milestones for common work for diverse issuers throughout the state of California or should efforts be focused within/by each issuer?

If there are new requirements for community needs assessments and community health improvement plans, these should definitely be aligned and coordinated with existing requirements and ongoing community needs assessments, community health improvement plans, and community benefit plans.

6. Preventive Services

a. General comments/observations on this strategy for Covered California as an area of focus:

7. Pharmacy Management

a. General comments/observations on this strategy for Covered California as an area of focus:

b. Should Covered California, perhaps working with other state purchasers and issuers, explore adopting coordinated procurement strategies?

8. Networks Based on Value

a. General comments/observations on this strategy for Covered California as an area of focus:

QHP provider networks should also be evaluated based on sufficient availability of “culturally and linguistically appropriate” providers (rather than “appropriate culturally competent providers” currently required in QHP Application Sections 16.2.1.5 at p.62; 16.3.1.5 at p.64;16.4.1.5 at p,67; and 16.5.1.5 at p.70); this should be a requirement for provider networks, not an optional consideration as implied in the current QHP Application.

The evaluation of the cultural and linguistic appropriateness of each network provider should include whether the provider himself/herself, or the provider’s staff, has the cultural and linguistic capability to provide culturally and linguistically appropriate services – for example, the proposed revised QHP Application will ask whether telehealth services are available in languages other than English (Section 18.8, p.88); providers should also report on their own, and their staff’s, cultural and linguistic capabilities, and any changes in such capabilities (see proposed revised QHP Application Section 9.2.10, p.38)

The current QHP Application has general language about hiring bilingual bicultural staff and internal training (QHP Application Section 1,3, p.8); these could be specific, measureable requirements

Similarly, QHP provider networks should also be evaluated whether they have appropriated matched members based on language preference ("what language do you want us to speak to you?" on the Covered California enrollment form)(rather than "language proficiency" in the QHP Application Sections 16.2.2.4 at p.63; 16.3.2.4 at p.66;16.4.2.4 at p,68; and 16.5.2.4 at p.71); this should be a requirement for provider networks, not an optional consideration as implied in the current QHP Application.

b. Should Covered California consider addressing provider concentration and expensive providers? If so, what strategies should be considered?

9. Promotion of Effective Primary Care

a. General comments/observations on this strategy for Covered California as an area of focus:

10. Promotion of Integrated Healthcare Models and Accountable Care Organizations

a. General comments/observations on this strategy for Covered California as an area of focus:

There also should be measures about access to and integration of behavioral health, and oral health (at a minimum, for children, but also at least information and referral for adults).

11. Alternate Sites of Care Delivery

a. General comments/observations on this strategy for Covered California as an area of focus:

12. Consumer and Patient Engagement

a. General comments/observations on this strategy for Covered California as an area of focus:

b. Should Covered California explore requirements and/or standards for consumer engagement?

The requirements for Health Assessments should include requirements that such Health Assessments are available in multiple languages (not only asked if available, with no penalties or need for corrective action, see QHP Application Section 18.9.13, p.101)

Similarly, the requirements for outreach and interventions for at-risk enrollees (QHP Application Section 18.11.3, p.105) should include requirements that outreach and intervention materials and services be culturally and linguistically appropriate

Finally, QHP grievance procedures (QHP Application 7.1, p.28) should be required to be culturally and linguistically appropriate, and be evaluated/audited on that criteria

13. Population-based and Community Health Promotion Beyond Enrolled Population

a. General comments/observations on this strategy for Covered California as an area of focus:

b. Should Covered California, perhaps working with other state purchasers and issuers, explore adopting coordinated population-based or community health interventions?

c. Should Covered California explore requirements and/or standards for community health promotion?

Though health care quality is essential to good health, one's race, ethnicity and socioeconomic status is an even stronger indicator of health outcomes. As a result, there are a growing number of multi-payer federal and state initiatives as well as Medicaidspecific initiatives focused on addressing social needs.2 We strongly support Covered California exploring requirements and standards for community health promotion beyond enrolled populations. These requirements should be linked to/based on other quality improvement goals, e.g. reducing the prevalence of obesity, or improving the control of diabetes through promotion and support for healthy eating and safe physical activity. Community needs assessments and community health improvement plans should address the upstream determinants of health from issues of affordable housing to early childhood programs, access to healthy food and opportunities for safe physical activities.