19 Covered California Quality Improvement Strategy

The Patient Protection and Affordable Care Act (§1311-(g)-(1)) requires periodic reporting to the Exchange of activities a contracted health plan issuer has conducted to implement a strategy for quality improvement. This strategy is defined as a multi-year improvement strategy that includes a payment structure that provides increased reimbursement or other incentives for improving health outcomes, preventing readmissions, improving patient safety, wellness and health promotion activities, or reduction of health and health care disparities. Per the final rule issued by the Centers for Medicare and Medicaid Services (CMS) on May 27, 2014, issuers must implement and report on a quality improvement strategy or strategies consistent with the standard of section 1311(g) of the ACA.

Attachment 7 of the Covered California Qualified Health Plan (QHP) Issuer Contract embodies the Exchange's vision for reform and serves as a roadmap to delivery system improvements. Beginning with the 2017 QHP Issuer Contract, QHP issuers have been engaged in supporting existing quality improvement initiatives and programs that are sponsored by other major purchasers including the Department of Health Care Services (DHCS), the California Public Employees' Retirement System (CalPERS), the Pacific Business Group on Health (PBGH), and CMS. These requirements are reflected in the 2017 contract and will be in all successive contracts through 2019 2020. QHP Cc ertification and participation in the Exchange will be conditional on Applicant developing a multi-year strategy and reporting year-to-year activities and progress on each initiative area.

The Covered California Quality Improvement Strategy (QIS) meets federal requirements for State-based Marketplaces (SBMs) and also and serves as the foundational improvement plan and progress report for QHP certification and contractual requirements. Applicants currently contracted with the Exchange are required to complete the QIS as part of the Application process. Reporting is divided into two parts:

- Applicant information
- Implementation plans and progress reports for the QIS for Covered California Quality and Delivery System Reform:
    - Provider Networks Based on Quality
    - Reducing Health Disparities and Assuring Health Equity
    - Promoting Development and Use of Care Models - Primary Care
    - Promoting Development and Use of Care Models - Integrated Healthcare Models (IHM)
    - Appropriate Use of Cesarean Sections
    - Hospital Patient Safety
    - Patient-Centered Information and Support

New Entrant Applicants: New entrant Applicants are not required to complete the QIS as part of the 2019 2020 Application but must review Attachment 7 with the understanding that engagement in the QIS and Attachment 7 initiatives will be contractually required and measured in the future if Applicant joins the Exchange.

Currently Contracted Issuers: The QIS will be evaluated by the Exchange as part of the annual application for ~~re~~certification and final approval by the Exchange may require follow-up meetings or documentation as necessary. Currently contracted Applicants should describe updates to the previous QIS submissions. Note new and revised questions throughout this section.

19.1 Applicant Information

All questions are required for new entrant Applicants. Question 19.1.3 is required for currently contracted Applicants.

19.1.1 Confirm Applicant has reviewed Attachment 7 and will comply with contractually required ~~the~~ quality improvement initiatives ~~will be contractually required~~ if selected by the Exchange.

Single, Pull-down list.
1: Confirmed
2: Not confirmed

19.1.2 Describe any concerns or limitations Applicant may have with the quality improvement initiatives detailed in Attachment 7.

1000 words

19.1.3 Complete this section and designate one contact for medical management and one contact for network management.

Type of QIS Submission	*Single, Pull-down list.* 1: New QIS 2: N/A
QIS Medical Management Contact's Name	*20 words.*
QIS Medical Management Contact's Title	*20 words.*
QIS Medical Management Contact's Phone Number	*20 words.*
QIS Medical Management Contact's Email	*20 words.*
QIS Network Management Contact's Name	*20 words.*
QIS Network Management Contact's Title	*20 words.*
QIS Network Management Contact's Phone Number	*20 words.*
QIS Network Management Contact's Email	*20 words.*

19.1.4 Indicate the health plan product types the Applicant offers for the Exchange. If Applicant offers more than one product type, Applicant will complete Section 19 for each product type.

Multi, Checkboxes. Trigger question to populate additional Section 19 questions for each product type.

1. HMO
2. PPO
3. EPO
4. Other

19.2 Implementation Plans and Progress Reports for the Quality Improvement Strategy (QIS) for Covered California Quality and Delivery System Reform

Questions required only for currently contracted Applicants.

19.2.1 QIS for Provider Networks Based on Quality

Federal QIS Topic Area: Activities to improve patient safety and reduce medical errors

2017 QHP Issuer Contract Attachment 7, Section 1.02

QIS Goal ~~for end of 2019~~: Applicant should have 1) clear network quality criteria that are used to screen providers and hospitals for inclusion in network, and 2) possible removal of outliers based on inability to meet quality criteria or lack of effort toward improvement.

19.2.1.1: -Submit as attachments the following documents related to use of quality criteria in network contracting:

1. (File titled Provider Network): All quality measures and criteria used to develop provider networks. Include patient safety and patient-reported experience (noting any measures that are new). An explanation of the assessment process, including source of quality assessment data, specific measures and metrics, and thresholds for inclusion and exclusion in the network. If applicable, describe which criteria are prioritized above other criteria to determine the provider network.

Single, Pull-down list.

1.Attached

2.Not attached

2. (File titled Hospital Network): All quality measures and criteria used to develop hospital networks. Include patient safety and patient-reported experience (noting any measures that are new). An explanation of the assessment process, including source of quality assessment data, specific measures and metrics, and thresholds for inclusion and exclusion in the network. If applicable, describe which criteria are prioritized above other criteria to determine the hospital network.

Single, Pull-down list.
1.Attached
2.Not attached

19.2.1.2: Describe updates in Applicant's ability to build networks based on quality since the previous~~last~~ -QIS submission. Applicant may submit any supporting documentation as an attachment. ~~Include~~ Address each of the following in the narrative:

- ~~All quality measures and criteria used to develop 1) provider networks, and 2) hospital networks. Include patient safety and patient-reported experience (noting any measures that are new).~~
- ~~Explain the assessment process, source of quality assessment data, specific measures and metrics, and thresholds for inclusion and exclusion in the network.~~
- ~~If applicable, describe which criteria are prioritized above other criteria to determine the provider network.~~
- ~~Describe if Centers of Excellence are included in network, and if so the basis for inclusion. Also note if they are promoted among members and if utilization is tracked.~~
- Progress in 201~~7~~8 toward the end goal and any further implementation plans for 2019~~8~~ with milestones for 2019 and 2020 identified.
- Known or anticipated barriers in implementing QIS activities and progress of mitigation activities.

5~~10~~00 words.
Attachments permitted

19.2.1.3 Describe if Applicant includes Centers of Excellence ~~are included~~ in network, ~~and if so~~ the basis for inclusion,~~. Also note~~ how~~if~~ they are promoted among members and how~~if~~ utilization is tracked.
Submit an attachment that lists the providers, hospitals and facilities the Applicant uses as Centers of Excellence. For each facility, indicate the condition(s) (cancer, transplants, burns, etc.) for which the facility is used as a Center of Excellence.
200 words.

Single, Pull-down list.
Attachment required.
1: Yes, COE List attached
2: Not attached

19.2.2 QIS for Reducing Health Disparities and Ensuring Health Equity

Federal QIS Topic Area: Activities to reduce health and health care disparities.
2017 QHP Issuer Contract Attachment 7, Section 3.01 and 3.02

QIS Goal ~~for end of 2019~~: Applicant will 1) continue to ~~Reach~~achieve 80% of Exchange members self-reporting their race/ethnicity, 2) collect, track, trend, and reduce health disparities in management of diabetes, asthma, hypertension, and depression.

19.2.2.1: Provide the percent of Exchange members for whom self-reported data is captured for race/ethnicity in Attachment E QIS Run Charts. Self-identification may take place through the enrollment application, web site registration, health assessment, reported at provider site, etc. The percentage should exclude members who have "declined to state" either actively or passively. Enter the percentage reported in the Certification Applications for 2017, 2017~~7~~8 and 2018~~8~~9 as well.

Single, Pull-down list.

1. Attached
2. Not attached

19.2.2.2: Describe progress on ~~updates~~ increasing or maintaining the percent of Exchange members who self-report race/ethnic information~~on progress made since the last QIS submission, and planned activities to achieve Applicant's aims~~. Applicant may submit~~-~~ any supporting documentation as an attachment. ~~Include~~ Address each of the following in the narrative~~as applicable~~:

- Updates in efforts to increase self-reported race/ethnic information including whether there are barriers to self-report.~~.~~
- Update ~~whether~~ if or how the Rand proxy method using geocoding and surname is used to supplement self-report.~~.~~
- Any plans to implement or test new programs to increase self-identification.
- ~~Updates in ability to compile, track and trend data for understanding disparity gaps in the four key disease areas.~~
- ~~Planning/implementation of interventions to reduce known disparity gaps.~~
- ~~Development of market-based incentives to reduce disparities and assure health equity.~~
- ~~Progress in 2017 toward the end goal and any further implementation plans for 2018.~~
- ~~Known or anticipated barriers in implementing QIS activities and mitigation activities.~~

5~~10~~00 words.
Attachments permitted

19.2.2.3 Confirm Applicant submitted a quality improvement plan to address health care disparities on March 1, 2019 to the Exchange.

Single, Pull-down list.
1. Submitted
2. Not submitted

19.2.3 QIS for Promoting Development and Use of Care Models – Primary Care

Federal QIS Topic Area: Activities for improving health outcomes
2017 QHP Issuer Contract Attachment 7, Sections 4.01 and 4.02

QIS Goal ~~for end of 2019~~: 1) Continue to match at least 95% of enrollees with a primary care physician 2) increase proportion of providers paid under a payment strategy that promotes advanced primary care.

19.2.3.1 Report, by product, the percentage of members in Applicant's Exchange business who either selected a Primary~~Personal~~ Care Physician (PCP) or were matched with a Primary~~Personal~~ Care Physician in 2018~~7~~ in Attachment E QIS Run Charts. If Applicant had no Exchange business in 2018~~7~~, report full book of business excluding Medicare. Enter the percentage reported in the Certification Applications for 2017, 2018~~7~~ and 2019~~8~~ as well. Report data by product (HMO, PPO, EPO).

Single, Pull-down list.
1. Attached
2. Not attached

19.2.3.2 Report the number and percentage of Exchange members who obtain their primary care with a provider or clinic that has received PCMH recognition from NCQA, The Joint Commission, or the Accreditation Association for Ambulatory Health Care (AAAHC) in Attachment E QIS Run Charts. For currently contracted Applicants, enter the percentage reported in the Certification Application for 2018 and 2019~~8~~ as well. If Applicant did not have Exchange business during the prior calendar year, report on the full book of business.

Single, Pull-down list.
1. Attached
2. Not attached

19.2.3.3 Report all types of payment ~~-~~methods~~models~~, including fee for service (FFS) and capitation, used for primary care services and number of providers paid under each model in Attachment E QIS Run Charts. If Applicant has adopted a model consistent with a Level 3 or 4 alternative payment model (APM) as outlined in the Health Care Payment Learning Action

& Action Network (HCP LAN) Draft White Paper on Primary Care Payment Models or aligned with Center for Medicare & Medicaid's (CMMI's) Comprehensive Primary Care Plus program as part of its strategy to advance primary care in California, include a description of the model, including any alternative payments such as care management fees and payments based on quality, in the attachment. Applicants may include any newly adopted models that are planned or in progress but not yet implemented among providers (include timeline for beginning the payment model). Enter the number and percentage of providers paid under each model reported in the Certification Applications for 2017, 2018~~7~~ and 2019~~8~~ as well.

References:
HCP LAN Primary Care Payment Models Draft White Paper: http://hcp-lan.org/workproducts/pcpm-whitepaper-draft.pdf
CMMI Comprehensive Primary Care Plus:
https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus

Single, Pull-down list.
1. Attached
2. Not attached

19.2.3.4: Describe updates on progress made since the ~~last~~ previous QIS submission in each part of the primary care goals, and planned activities. Applicant may submit any supporting documentation as an attachment. ~~Include in~~Address each of the following in the narrative:

- Updates in year ~~two~~ three of the PCP matching initiative, including an implementation status report, feedback on the consumer experience, complaints, positive feedback, unanticipated challenges, and suggestions (if applicable).

- If contracted physician organizations have made progress in adopting Level 3 or 4 APMs described in the LAN Draft White Paper (above). Describe the predominant payment structure used among contracted groups and their progress towards implementing APMs (if applicable).

- Describe any support (financial, staffing, educational, etc.) that Applicant or multi-insurer collaborative is providing to primary care providers to support their efforts towards accessible, data-driven, team-based care. ~~Describe any specific educational support that Applicant or multi-insurer collaborative is providing to PCMH practices to help support their efforts at transformation.~~

- How Applicant is encouraging enrollees to use PCMH-recognized providers ~~with PCMH recognition~~or accessible, data-driven, team-based care providers.~~?~~

- Progress in 2017~~7~~8 toward the end goal and any further implementation plans for 2019~~8~~ with milestones for 2019 and 2020 identified~~.~~

- Known or anticipated barriers in implementing QIS activities and progress of mitigation activities.

1000 words.

Attachments permitted

19.2.3.5: What other innovative methods is Applicant considering for increasing support for primary care providers, such as increasing the percent of revenue or premium allocated towards primary care services? Describe.

200 words.

19.2.4 QIS for Promoting Development and Use of Care Models – Integrated Healthcare Models (IHM)

Federal QIS Topic Area: Activities for improving health outcomes

2017 QHP Issuer Contract Attachment 7, Section 4.03

QIS Goal ~~for end of 2019~~: Applicant will increase IHM presence in its Exchange network by providing various types of support to providers to elevate their processes and practice toward this goal. ~~By~~ If ~~increasing~~ expanding its network, Applicant will also increase the proportion of Exchange enrollees receiving care in an IHM.

An IHM is defined as a system of population-based care coordinated across the continuum including multi-discipline physician practices, hospitals and ancillary providers that has combined risk sharing arrangements and incentives between Applicant and providers, holding the IHM accountable for nationally recognized evidence-based clinical, financial, and operational performance, as well as incentives for improvements in population outcomes.

~~19.2.4.1 Using the definition for IHMs in Appendix H 2017 QHP Contract Attachment 7, provide~~

19.2.4.1 Using this definition for IHMs, adapted from Appendix H 2017 QHP Contract Attachment 7, report the number and percentage of Exchange members and total California members who are managed under an IHM in Attachment E QIS Run Charts. For currently contracted Applicants, enter the percentage reported in the Certification Application for 2017, 2018 and 2019 as well. If Applicant did not have Exchange business during the prior calendar year, report on the full book of business.

Single, Pull-down list.
1. Attached
2. Not attached

Attachment(s) Appendix H 2017 QHP Applicant Contract Attachment 7.pdf

~~details on existing or planned integrated systems of care. State the following:~~

	~~Response~~
~~Line of business for which the IHM is or will be available (Exchange, Commercial non-Exchange, Medicare, Medicaid, other)~~	~~*Multi, Checkboxes.*~~ ~~1: Exchange,~~ ~~2: Commercial non-Exchange,~~ ~~3: Medicare,~~ ~~4: Medicaid,~~ ~~5: other,~~ ~~6: N/A~~
~~Product for which the IHM is or will be available~~	~~*Multi, Checkboxes.*~~ ~~1: HMO,~~ ~~2: EPO,~~ ~~3: POS,~~ ~~4: Other,~~ ~~5: PPO~~
~~Location (California Rating Region)~~	~~*Multi, Checkboxes.*~~ ~~1: Region 1,~~ ~~2: Region 2,~~ ~~3: Region 3,~~ ~~4: Region 4,~~ ~~5: Region 5,~~ ~~6: Region 6,~~ ~~7: Region 7,~~ ~~8: Region 8,~~ ~~9: Region 9,~~ ~~10: Region 10,~~ ~~11: Region 11,~~ ~~12: Region 12,~~ ~~13: Region 13,~~ ~~14: Region 14,~~ ~~15: Region 15,~~ ~~16: Region 16,~~ ~~17: Region 17,~~ ~~18: Region 18,~~ ~~19: Region 19,~~ ~~20: No planned or existing systems in any region~~

	~~Response~~
~~Indicate whether the IHM is founded on an existing provider organization or if it joins multiple providers/groups together under the IHM.~~	~~*100 words.*~~
~~Number of California members in the product who are managed under the IHM~~	~~*Integer.*~~
~~Percent of California members in the product who are managed under the IHM~~	~~*Percent.*~~
~~Number or percent of California members in the product who are managed under the IHM unknown~~	~~*Yes/No.*~~
~~Number of Exchange members in the product who are managed under the IHM~~	~~*Integer.*~~
~~Percent of Exchange members in the product who are managed under the IHM~~	~~*Percent.*~~
~~Number or percent of Exchange members in the product who are managed under the IHM unknown~~	~~*Yes/No.*~~

~~Note: Completion of this question may be assisted by referring to a compilation of ACO Best Practices by the Pacific Business Group on Health (PBGH). The Exchange will be engaging stakeholders in reviewing, editing and potentially adopting this compilation in 2018. Refer to Appendix T Draft Summary of ACO Best Practice.~~

19.2.4.2 Provide as attachments the following documents related to IHMs:

1. (File titled Provider 1a): Applicant's IHM business model including measures used to track progress and success of IHM providers and the payment model for the IHM. ~~methodology for documentation on the Triple Aim (quality, enrollee experience, total cost of care), measures in use and weighting of measures or measurement domains, if used for performance payments in IHM. Describe any applicable performance threshold requirements. Indicate the measures that are used for measurement and reporting, and those measures that are used for determination of gainsharing or performance rewards~~.

Single, Pull-down list.

1.Attached

2.Not attached

2. (File titled Provider 1b): Example of Applicant report to ~~the~~ its IHM providers on its quality of care and financial performance, including benchmarking relative to performance improvement goals or market norms.

Single, Pull-down list.

1.Attached

2.Not attached

3. (File titled Provider 1c): Copy of Applicant's IHA Align Measure Perform (AMP) Commercial ACO report (formerly known as the IHA-PBGH Commercial ACO Measurement & Benchmarking Initiative), if Applicant participates in the program.

   As noted in Attachment 7, Section 4.03, 4), the Exchange will use the Commercial ACO Measure Set as updated by the IHA as the basis for analysis of variation in performance of different ACO or IHM models, beginning in plan year 2018.

Single, Pull-down list.

1.Attached

2.Not attached

3.N/A

19.2.4.3 Describe updates on progress made since the ~~last~~ previous QIS submission o~~i~~n each component~~part~~ of the IHM goals, and planned activities. Applicant may submit any supporting documentation as an attachment. ~~Include~~ Address each of the following in the narrative:

- Progress in 2018 toward the end goal and any further implementation plans for 2019 with milestones for 2019 and 2020 identified.
- How Applicant expects to evolve its model, based on progress or outcomes to date.
- ~~Any specific educational support that Applicant or multi-insurer collaborative is providing to IHMs to help support their efforts at transformation, such as coaching or learning collaboratives.~~
- ~~Other support (financial, technical, personnel).~~
- Other activities conducted since the ~~last~~ previous QIS submission to promote IHMs, or activities that will be conducted.
- ~~Progress 2017 toward the end goal and any further implementation plans for 2018.~~
- Known or anticipated barriers in implementation of QIS and progress of mitigation activities.

1000 words.
Attachment permitted

19.2.4.4: Describe how Applicant is providing support for integration and coordination of care through coaching, funding, implementation of information systems, technical assistance, or other means where no provider organization is accepting accountability.
200 words.

~~19.2.4.4 Does Applicant evaluate the success of its IHM model based on the Commercial ACO Measure Set as updated by the Integrated Healthcare Association (IHA)? If so, describe how the IHM (or ACO model) in Applicant's network is held accountable to high performance on the Commercial ACO Measure Set and how Applicant expects to evolve its model based on these results. See Appendix U IHA Commercial ACO Measure Set.~~

~~*1000 words.*~~

19.2.5 QIS for Appropriate Use of Cesarean Sections

Federal QIS Topic Area: Activities for improving health outcomes
2017 QHP Issuer Contract Attachment 7, Section 5.03

QIS Goal ~~for end of 2019~~: Applicant will: 1) Progressively adopt physician and hospital payment strategies so that~~, by end of 2019,~~ revenue for labor and delivery only supports medically necessary care and no financial incentive exists to perform a low-risk Nulliparous Term Singleton Vertex (NTSV) Cesarean Section (C-Section). 2) Promote improvement work through the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center (MDC), so that all maternity hospitals achieve an NTSV C-Section rate of 23.9% or ~~lower, or~~lower or are at least working toward that goal. 3) By end of 2019 include NTSV C-Section rate into contracting criteria so that all hospitals either meet the 23.9% goal, or if ~~not~~not, the plan has rationale for continued inclusion.

19.2.5.1 Report number of all network hospitals reporting to the CMQCC's MDC in Attachment E QIS Run Charts. A list of all California hospitals participating in the MDC can be found here:
https://www.cmqcc.org/sites/default/files/CMQCC_County_Participation_List_12.04.17.pdf .
Enter the percentage reported in the Certification Applications for 2017, 201~~7~~8 and 2019~~8~~ as well.

Single, Pull-down list.
1. Attached

2. Not attached

19.2.5.2 Provide a description of all current payment models for maternity services across all lines of business, and specifically address whether payment differs based on vaginal or C-Section delivery. Report models and number of network hospitals paid using each payment strategy in Attachment E QIS Run Charts. Enter the percentages reported in the Certification Applications for 2017, 201~~7~~8 and 201~~8~~9 as well.
References:
http://www.iha.org/sites/default/files/files/page/c-section_menu_of_payment_and_contracting_options.pdf.

Single, Pull-down list.
1. Attached
2. Not attached

19.2.5.3 Describe updates on progress made since the last QIS submission with regards to promoting appropriate use of Cesarean-Sections (C-Sections). Applicant may submit any supporting documentation as an attachment. ~~Include~~ Address each of the following in the narrative ~~if applicable~~:

- Progress in 2018 toward the end goal and any further implementation plans for 2019 with milestones for 2019 and 2020 identified.
- Updates to hospital participation in CMQCC and hospital engagement in maternity care quality improvement, particularly those with a~~n~~ NTSV rate higher than 23.9%.
- ~~Hospitals that have newly achieved a NTSV C-Section rate of 23.9% or less or have achieved improvement in NTSV rates.~~
- Updates as to how NTSV C-section rate or other maternal safety factors are considered in maternity hospital network.
- How Applicant is using the data from CMQCC to work with hospitals that have a NTSV C-Section rate higher than 23.9%, especially hospitals with a high volume of births.
- Collaborations with other QHP Issuers on approaching hospitals to suggest CMQCC involvement or alignment on a payment strategy to not incentivize ~~low-risk~~ NTSV C-Sections and support only medically necessary care.
- List any known or anticipated barriers in implementing QIS activities and progress of mitigation activities.

1000 words.

19.2.6 QIS for Hospital Patient Safety

Federal QIS Topic Area: Activities to improve patient safety and reduce medical errors
2017 QHP Issuer Contract Attachment 7, Section 5.01 and 5.02

QIS Goal~~ for end of 2019~~: Applicant will: 1) Adopt a hospital payment methodology that~~, by 2019,~~ places 2% of payment to acute general hospitals either at risk or ~~tied~~ subject to a bonus payment for quality performance. 2) Promote hospital involvement in improvement programs so that all hospitals achieve infection rates (measured as a standardized infection ratio or SIR) of 1.0 or lower for the five Hospital Acquired Condition (HAC) measures outlined in Attachment 7 or are working to improve by end of 2019. The five HACs are:

- Catheter Associated Urinary Tract Infections (CAUTI)
- Central Line Associated Blood Stream Infections (CLABSI)
- Clostridium Difficile Infection (CDI)
- Methicillin-resistant Staphylococcus Aureus (MRSA)
- Surgical Site Infection of the Colon (SSI Colon)

19.2.6.1 Report, across all lines of business, the percentage of hospital reimbursement at risk for quality performance and the quality indicators used in Attachment E QIS Run Charts. In the details section of the spreadsheet, describe the model used to put payment at risk, and note if more than one model is used. “Quality performance” includes any number or combination of indicators, including HACs, readmissions, patient satisfaction, etc. In the same sheet, report quality indicators used to assess quality performance. Enter the percentages reported in the Certification Applications for 2017, 201~~7~~8 and 201~~8~~9 as well.

Single, Pull-down list.
1. Attached
2. Not attached

19.2.6.2 Report the number of hospitals contracted under the model described in question 19.2.6.1 with reimbursement at risk for quality performance in Attachment E QIS Run Charts. Enter the numbers reported in the Certification Applications for 2017, 201~~7~~8 and 201~~8~~9 as well.

Single, Pull-down list.
1. Attached
2. Not attached

19.2.6.3 Describe updates on progress promoting hospital safety ~~made~~ since the last ~~QIS~~ previous submission~~ with regards to promoting hospital safety~~. Applicant may submit any supporting documentation as an attachment.

Note: In addition to hospital HAC rates in Appendix S, refer to the following publicly available references, which describe free coaching programs available to hospitals:

- Information on Partnership for Patients: https://partnershipforpatients.cms.gov/
- Hospital participation in Hospital Improvement Innovation Networks (HIINs): https://partnershipforpatients.cms.gov/about-the-partnership/hospital-engagement-networks/thehospitalengagementnetworks.html
- Hospital HAC rates can be reviewed individually at http://calhospitalcompare.org/.

~~Include~~ Address each of the following in the narrative ~~if applicable~~:

- Progress in 2018 toward the end goal and any further implementation plans for 2019 with milestones for 2019 and 2020 identified.
- Updates to strategy for promoting HIIN participation among the non-participating network hospitals, especially those with a standardized infection ratio (SIR) above 1.0 for the five designated Hospital Acquired Conditions (HACs). Refer to Appendix S1 CAUTI Rates, Appendix S2 CLABSI Rates, Appendix S3 CDI Rates, Appendix S4 MRSA Rates, and Appendix S5 SSI Colon Rates.
- Updates on efforts to re-contract ~~to tie~~ hospital payments ~~to quality~~ placing ~~to meet~~ 2%~~-~~ either at risk or subject to a bonus payment for quality performance ~~by end of 2019~~.
- Collaborations with other QHP Issuers on approaching hospitals to suggest improvement program involvement ~~and/~~or alignment on a payment strategy to tie hospital payment to quality.~~.~~

1000 words.

Attachments permitted

19.2.7 QIS for Patient-Centered Information and Support

Federal QIS Topic Area: Activities for improving health outcomes

2017 QHP Issuer Contract Attachment 7, Sections 7.01 and 7.02

QIS Goal ~~by end of 2019~~: Applicant ~~is able to~~can supply consumers with 1) provider-specific cost shares for common inpatient, outpatient and ambulatory services, 2) costs of prescription drugs, 3) member specific real-time understanding of accumulations toward deductibles, maximum out of pockets, and 4) quality information on network providers.

19.2.7.1 Fulfilling the QIS Requirement: Respond as applicable based on anticipated Exchange enrollment:

If Applicant has or anticipates having Exchange enrollment more than~~of over~~ 100,000 members, describe plans to ensure~~, by 2019~~, members will have online access to:

1) Provider specific cost shares for common inpatient, outpatient and ambulatory services, (either as a procedure or as an episode of care). (Waived for Applicants with only HMO products.)
2) Access to costs for prescription drugs and member specific real-time understanding of accumulations toward deductibles, maximum out of pockets.
~~*(Note in response if these requirements have already been fulfilled.)*~~

If Applicant has or anticipates having Exchange enrollment of fewer than 100,000 members~~ in Plan Year 2018~~, describe how Applicant will ensure~~, by 2019~~, members have access to:
1) Provider specific cost shares for common inpatient, outpatient and ambulatory services, (either as a procedure or as an episode of care). Information does not need to be provided online. *(Waived for Applicants with only HMO products.)*
2) Access to costs for prescription drugs and member specific real-time understanding of accumulations toward deductibles, maximum out of pockets.
~~*(Note in response if these requirements have already been fulfilled.)*~~
~~*200 words.*~~

Confirm Applicant continues to meet this requirement and there have been no changes since previous Application for Certification.

1. Confirmed
2. Not Confirmed; Details
   Details limited to 100 words.

If confirmed, questions 19.2.7.2 and 19.2.7.3 not required. Trigger question.

19.2.7.2 If Applicant offers online consumer support tools that require login, provide sample login information~~ in lieu of screenshots~~.

50 words.

19.2.7.3 Describe any quality ~~related~~ information currently included with cost information. If quality information is not included, describe feasibility for inclusion by 2020~~19.~~

200 words.

19.2.7.4 If Applicant ~~already~~ has cost tools available to members, report number and percent of unique enrollees for the Exchange line of business who used the tool in 2018~~7~~.

100 words.

19.2.7.5 Based on the utilization reported in 19.2.7.4, how does Applicant intend to increase or maintain engagement with the tool.

200 words.