COVERED CALIFORNIA

MEMORANDUM

January 26, 2016

TO: State Based Marketplaces
State Medicaid Directors
Delivery Reform/Value Promoting Colleagues

FROM: Peter V. Lee, Executive Director

RE: Draft Covered California Delivery Reform Contract Provisions
Comments Welcome and Encouraged

Covered California is focused on achieving the triple aim on behalf of all Californians and we are in the process of updating the contract requirements that will apply to the health plans we select for the three year period going from 2017 through 2019. These efforts are anchored in our recognition that while having a good risk mix is the most important element to keep premium costs down in the short-term, over the long-term the key is changing how care is delivered. To that end, I am happy to share with you and ask for your thoughts and comments on our draft Delivery System Reform contract requirements.

What follows in this memorandum is a summary and linked to this document is the full text of the staff recommendations (Covered California Delivery Reform Draft Recommendations). The board of Covered California will act on the revised/final proposal that they will receive in mid-February. If you have any comments, please make them either directly to me or to Taylor Priestley (taylor.priestley@covered.ca.gov) by February 4th.

We are sharing this document prior to the board adoption for two reasons. First and foremost, many of the concepts here are based on our learnings from colleagues in the marketplace, public and private sectors and we welcome your continued thoughts to improve on what we do and align our efforts with others. Second, as many others are at similar places in their development of contracts, want to share this to inform their work in progress.

These provisions have been informed by good work happening across the nation to promote a higher quality and more cost effective delivery system. Some of the sources of inspiration are others State-Based Marketplaces; Federal contracting for Medicare; state Medicaid programs; state employer purchasing programs (such as CalPERS and the MAS – Find name); efforts by large employers; and coalitions. We hope these same groups find our working draft helpful to their efforts. These recommendations were also the product of a rich collaborative process of consumer advocates, health plans, clinicians and other stakeholders and subject matter experts that have been meeting over the past year to inform these efforts.

In addition, while this section of our contract relates specifically to delivery reform and assuring the Triple Aim is met for our enrollees, Covered California sees the structure of our benefit designs integrally linked to this agenda. For 2017, staff are proposing to the board of Covered California that we continue to have health plans present standard benefit designs that continue to be structured to assure that financial barriers to consumers getting needed care are minimized as much as possible, with such critical features as:

- Out-patient care NOT being subject to any deductible for Silver Tiers and above;
- Even for Bronze plans, three out-patient visits not subject to the deductible (in addition to the free preventive visits); and
- Protecting consumers from high-cost specialty drug costs by limiting their out-of-pocket.

For 2017, we are proposing to build on this structure by lowering the out-of-pocket for primary care and urgent care. For more details see 2017 Standard Benefit Plan Design and 2017 Standard Benefit Plan Design Endnotes.

Covered California and a Quality Delivery System

Covered California has articulated the "guiding principles" behind our delivery system work which are to:

- Promote alignment with other purchasers including CMS, DHCS, CalPERS and employers as much as possible, so there are common focus and requirements across the delivery system (this includes synchronizing our efforts with the CMS requirements on Qualified Health Plans to have a "Quality Improvement Strategy")
- Require, in many cases, health plan's initiatives to both benefit Covered California enrollees AND their entire book of business
- Focus on tracking, trending and reducing healthcare disparities in care of chronic disease by race and ethnicity as well as gender
- Provide assurance that consumers will have access to networks that are based on high quality and efficient providers
- Provide enrollees with the tools needed to be active consumers including both provider selection and shared clinical decision making
- Increasingly align payment with value and fostering proven delivery models
- Minimize the variation in the delivery of quality care and assure that provider meets minimum standards
- Minimize the burden on providers by reducing and focusing measurement on the vital few measures that matter

In meeting these principles, Covered California has proposed organizing its Delivery System Reform requirements in the following nine sections (with a summary of each following):

1. Improving Care, Promoting Better Health and Lowering Costs
2. Provision & Use of Data and Information for Quality of Care
3. Reducing Health Disparities and Assuring Health Equity

4. Promoting Development and Use of Care Models
5. Hospital Quality
6. Population Health: Preventive Health, wellness and At-Risk Enrollee Support
7. Patient-Centered Information and Communication
8. Promoting Higher Value Care
9. Accreditation: NCQA, URAC or AAAHC

Article 1: Improving Care, Promoting Better Health & Lowering Costs

Covered California supports provider networks that are designed based on quality, satisfaction and cost efficiency standards to insure that enrollees have access to quality care. Requirements of the Contracted Health Plan will include:

1. Provider network selection must be on quality in addition cost and other to other plan factors. Health plans must report their methodology in their Application for Certification for 2018.

2. Contracted plans are expected to only contract with providers and hospitals that demonstrate they provide quality care and promote the safety of Covered California enrollees. By contract year 2019, providers with "outlier poor performance" in metrics targeted under Attachment 7 will not be included in the network or contracted plans will report rationale for continuing their participation.

3. Contracted plans must report on their use of "Centers of Excellence" and how enrollees with conditions that require highly specialized management such as transplant or burn patients are directed to providers with documented experience and proficiency based on volume and outcome data.

4. Contracted plans are expected to participate in improvement collaboratives, with two identified as required in 2017 and reporting on others' in which QHPs participate.

Article 2: Provision and Use of Data for Improvements in Quality of Care Delivery

Covered California will be data-driven in assuring that consumers are getting the right care at the right time, this will including coordinating annual reporting of all quality and delivery system reform contract elements and targets having the following requirements on Contracted Health Plans:

1. Provide full and complete contracted claims and clinical data for exchange enrollees as specified in Attachment 7 to use in the Exchange's Enterprise Analytics Solution (EAS).

2. Report HEDIS, CAHPS, and other performance data for each product type as required for use in Covered California's Quality Rating System (QRS).

3. Report work plan and annual progress of the federally-required Quality Improvement Strategy (QIS) through the annual certification application.

4. Report on broader quality improvement and delivery system reform efforts through annual reporting in the Covered California eValue8 Request for Information included in the annual certification application.

Article 3: Reduce Health Disparities and Assure Health Equity

Covered California recognizes that promoting better health requires a focus on addressing health disparities and health equity while recognizing that some disparity results from determinants outside the control of the health care delivery system. Requirements of the Contracted Health Plan will include:

1. Increase self-reported identity annually 2017 and 2018, achieving 85% by year end 2019.

2. Track, trend and improve quality measures by ethnic/racial group and by gender.
    - For ethnic/racial group identification, Plans shall use self-reported data supplemented by proxy measures based on zip code and surname
    - Initial focus: Diabetes, Hypertension, Asthma and Depression

3. Report baseline data in 2017 application for certification.
    - Baseline per cent of self-reported racial/ethnic identity
    - Baseline quality measures based on HEDIS from MY 2015

4. In future years, Contracted Plans must achieve Covered California targets for annual reduction in disparities.

Article 4: Promoting Development and Use of Care Models: Primary Care, Patient Centered Medical Homes (PCMH) and Integrated Healthcare Models (IHM)

Primary care is the foundation of an effective healthcare delivery system. Primary Care redesigned as "Patent Centered Medical Home" (PCMH) is supported by a growing body of evidence that primary care can improve management of total costs of care. Covered California recognizes the importance of primary care in its standard benefits which seek to minimize enrollee cost share for primary care visits and the application of deductibles to such care. Covered California also places great importance on promoting integrated/coordinated care, often referred to as Accountable Care Organizations (ACOs) and is adopting a modified version of the description of an Integrated HealthCare Model (IHM) from CalPERS. Requirements of the Contracted Health Plan will include:

1. For 2017, assure that all enrollees either select or are provisionally assigned to a Personal Care Physician. This requirement is not to be interpreted as requiring that the PCP serve as a gatekeeper, but rather to assure that all enrollees have access to an individual primary care provider.

2. Cooperate in evaluating various PCMH accreditation and certification programs as well as other frameworks for defining a consistent standard for determining the percent of primary care provided by PCMHs for Exchange enrollees and for the Plan's book of business.

3. Apply this standard to determine a baseline that will be included in the Application for Certification in 2018. Covered California will establish a target for 2019 with annual intermediate milestones.

4. Adopt and progressively expand a contracting and payment strategy that creates a business case for PCPs to adopt accessible, data-driven, team-based care (alternatives to face to face visits and care by non-MDs) with accountability for improving triple aim metrics including total cost of care.

5. Describe how the requirements of an integrated healthcare model are met, including reporting on the percent of Covered California and book of business enrollees receive care from the ACO or integrated model of care in the Application for Certification for 2017. Reporting shall include how these models ensure accountability for triple aim metrics including both quality and total cost of care across specialties and institutional boundaries. After establishing baseline enrollment, Covered California shall establish targets for a progressively greater share of enrollees for whom care is provided under these models.

Article 5: Hospital Quality

Covered California and its health plans 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. Requirements of the Contracted Health Plan will include:

1. Report the quality performance of contracted network hospitals including at minimum an agreed set of hospital acquired conditions (HACs) and the C-section rates for low risk pregnancies.

2. Covered California will set annual targets for increasing the number of hospitals that meet the goals for reducing HACs and that achieve the national Healthy People 2020 goal for C-sections of 23.9 percent for low risk first pregnancies.

3. Adopt a payment strategy for hospitals such as that employed by Centers for Medicare and Medicaid Services (CMS), which by 2019 putting at least 6 percent of reimbursement at risk based on quality performance. Each contractor will structure this according to their own priorities including HACs, readmissions, or Hospital satisfaction scores.

4. Additionally, adopt a payment strategy for physicians and hospitals designed such that there is no financial incentive for surgical delivery.

5. Only contract with providers and hospitals that demonstrate they provide quality care and promote the safety of Covered California enrollees. Providers with outlier poor performance on hospital safety or that do not achieve a C-section rate of 23.9 for low risk pregnancies will not be included in the network by 2019 or contracted plans will report rationale for continuing participation.

Article 6: Population Health – Preventive Health, Wellness and At-Risk Enrollee Support

Covered California and Contracted Health Plans recognize that access to care, timely preventive care, coordination of care and early identification of high risk enrollees are central to improving each part of the triple aim. Requirements of the Contracted Health Plan will include:

1. Report the number and percent of members who have utilized preventive care, tobacco cessation, and obesity management services in the annual Application for Certification.

2. Report on any participation in evidence based community health and wellness initiative, such as those recommended by the Community Preventive Services Task Force in 2017, CMS Healthy Communities Initiative or other similar pilots.

3. Report the results of ongoing health assessments and incorporate into monitoring and management through the annual Application for Certification.

4. Report programs to proactively identify and manage at-risk enrollees.

5. Provide support to at-risk enrollees transitioning to or from coverage under Covered California.

6. Assure mental and behavioral health is effectively integrated and delivered.

Article 7: Patient-Centered Information and Support

Consumers must be provided better tools to understand health care costs, quality and to be active participants in making their health care decisions. Requirements of the Contracted Health Plan will include:

1. Report a plan to provide by 2018 either online tools or phone alternatives that allow enrollees to understand their share of cost for medical services in the Application for Certification for 2017.

2. Report on tools provided with the percent of enrollees who utilize tools in the Annual Application for Certification.

3. Report on strategy to inform enrollees by 2019 of the quality performance of providers with emphasis on target metrics for hospital quality defined in Attachment 7.

4. Covered California requires deployment of tools to support enrollees in understanding their medical diagnosis and treatment options to aid in discussion with their provider. Shared decision-making is a powerful evidence-based approach to reducing overuse or misuse of clinical interventions.

5. Contracted plans shall support the use of Choosing Wisely to spark discussion about the need — or lack thereof — for many frequently ordered tests or treatments. Contracted plans shall join Covered California in partnership with DHCS and CalPERS in a statewide multi-stakeholder workgroup to support reduction of overuse through Choosing Wiseley. Targeted conditions include: C-sections, Opioid Prescription and Imaging for Low Back Pain

Article 8: Promoting Higher Value Care

Covered California requires that quality and delivery system improvement strategies include payment models that align across purchasers. Covered California has established requirements for the following initiatives: (1) Advanced Primary Care or Patient-Centered Medical Homes (Article 4); Integrated Healthcare Models (Article 4); appropriate use of C-sections (Article 5); and hospital quality (Article 5). In addition to these requirements, the Contracted Health Plan shall report in the annual Application for Certification on experience with other innovations in payment or market-based incentives. These will include:

1. Participation or alignment with CMMI innovative payment models such as the Oncology or Joint Replacement model; and

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

Article 9: Accreditation

All contracted health plans are required to be accredited by NCQA, URAC or AAAHC.