Comments to the Board - External

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February 18, 2016 Board Meeting

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February 17, 2016

Diana Dooley, Chair, Board of Directors
Peter Lee, Executive Director
Covered California
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Via-email to: boardcomments@covered.ca.gov

Re: Proposal to Verify Eligibility for Special Enrollment Periods: OPPOSE

Dear Ms. Dooley and Mr. Lee,

Our organizations very strongly oppose the staff proposal to require consumers to produce a paper document to demonstrate eligibility for a special enrollment period trigger.

Today Covered California relies on self-attestation of eligibility for a special enrollment period. The proposal to require consumers to produce a paper document will significantly reduce enrollment during special enrollment periods, endanger the risk mix and damage the organizational reputation of Covered California as a consumer-centered organization.

Paper Documents Are a Barrier to Enrollment
There is an ample academic literature of peer-reviewed studies over fifty years demonstrating that a requirement for applicants to produce paper documents to apply for a public program is a barrier to enrollment. Indeed, many state budget proposals have relied on precisely this barrier to reduce enrollment during bad budget years.

Many of the Medicaid improvements included in the Affordable Care Act were premised on this literature. Medi-Cal has moved away from reliance on paper documents, requiring documents in those infrequent instances in which electronic verification produces an inconsistency. This proposal by staff would make the barriers to enrollment in Covered California substantially greater than the barriers to enrollment in Medi-Cal (or obtaining other public program assistance, such as unemployment insurance).

In a number of instances, no paper document exists to demonstrate eligibility for a special enrollment period trigger. Examples include:

- Loss of employment: no state or federal law requires an employer to terminate an employee in writing. While high wage professionals may be receive written documents regarding termination, low and moderate wage workers often do not.
- Loss of employer coverage: Workers can also lose employer coverage due to changes in hours worked or taking leave or employer termination of coverage. In these instances, workers would not necessarily have documents.
- Moving to a different region: A consumer who moves in with a family member or has another living situation may not have a written document demonstrating their new address.
- Release from incarceration: again documents may not be available.
- Wrongly denied Covered California coverage: often little documentation is provided by Covered California when a consumer is wrongly told they are ineligible for Covered California or incorrectly denied Covered California coverage: such consumers are entitled to a special enrollment period.

The proposal, as we understand it, would deny eligibility when no paper document exists even if the consumer wanted to produce one. We also note that some of the discrepancies identified by the plans may arise from the fact that in a number of instances, no paper document exists to be produced.

Special Enrollment Periods are Under-Enrolled

There is some peer-reviewed literature that indicates that special enrollment periods are under-enrolled. This literature looked at various data sources to determine how frequently consumers face life changes or work transitions that would make them eligible for a special enrollment trigger. This literature suggests that the volume of enrollment during special enrollment periods should be roughly comparable to the volume of enrollment during open enrollment. By this measure, special enrollment periods are under-enrolled.

Short periods of uninsurance were common prior to the Affordable Care Act. Those who were uninsured for periods of less than six months incurred higher expenses than those uninsured for years. There is no reason to think that the changes in life circumstance or work situations that precipitate brief periods of uninsurance have been eliminated or limited by the Affordable Care Act. Covered California should be a resource for consumers facing periods of uninsurance of less than a year: with this proposal, Covered California makes it difficult for consumers to use the program for shorter term coverage.

Reliance on Un-validated, Non-Public Sources of Information

The staff proposal relies on information provided confidentially by individual plans. It is not validated by any other source. It is not public. And it is provided by many of the same health plans who generally opposed guaranteed issue and would prefer to deny coverage based on risk factors, something which is no longer legal.

It is not correct that purchasers or plans require verification of eligibility in every instance. For example, many employers allow a worker to add a dependent or drop a dependent without requiring marriage certificates, birth certificates, divorce papers or other documents. We are dismayed that Covered California staff are rushing to judgment on a policy that will inhibit enrollment based on this information which has been neither independently validated nor shared with any other entity.

The information that staff shared with us was not surprising and did not provide clear evidence of wrongdoing on the part of those enrolling during Special Enrollment Periods. It is more likely that someone who has health needs would take all the needed steps to secure coverage despite the lack of widespread information about Special Enrollment Periods and other hurdles than those who were essentially healthy, especially those facing relatively brief periods of uninsured.

Verification of Loss of Medi-Cal Coverage
The staff hopes that loss of Medi-Cal coverage can be verified electronically so that these individuals would not be required to provide documentation but cannot assure this. Prioritizing determination of loss of coverage necessarily delays other fixes, including the failure of Covered California and the Medi-Cal program to facilitate the transition of those losing Medi-Cal coverage to Covered California. Tens of thousands of Californians have gone without coverage because of the failure to fix this operational problem. Any attempt to require documentation should exclude this population as this is information that should already be in the CalHEERS system. Furthermore, requiring such documentation would violate the mandate of Welfare and Institutions Code Section 15926 (h) (1) that prohibits the requirement of duplicative or unnecessary information when moving an individual from one insurance affordability program to another.

Conditional Eligibility
For other data elements requiring documentation (again used only when there is an inconsistency with electronic data), applicants are granted conditional eligibility and given 95 days to provide documentation. By contrast, the Covered California staff proposal would not grant conditional eligibility. Instead staff propose that during times other than Open Enrollment coverage would not be effectuated until paper documents are provided and verified by Covered California. If the Board requires verification of eligibility for special enrollment periods, whether electronically or through documentation, applicants should receive conditional eligibility and be given up to 95 days to provide documentation.

Inappropriate Role for Health Plans
Staff proposes having health plans collect documents during special enrollment periods. This has been described as a “mail house” function. This seems an inappropriate role for the health plans which have a vested interest in keeping out those applicants they deem high risk. If the Board is going to require documentation at all, electronic verification should be used first and only when an inconsistency arises between what the applicant reports and what can be verified electronically should documentation be required. Any required information or documents should be submitted directly to Covered California which is the arbiter of eligibility for Advanced Premium Tax Credits, not the health plans.

No Other Effort at Electronic Verification
Today both Covered California and the Medi-Cal program relies largely on electronic verification of information, seeking paper documents only when there is an inconsistency between what the consumer reports and what the electronic data sources indicate. Even in cases of inconsistency, there are instances such as change of income or employment where self-attestation is used.
The staff proposal makes no effort to rely on electronic verification, even in instances in which information is readily available. Examples for which electronic verification could be done:

- Moving: the United States Postal Service sells the list of addresses to commercial vendors. This appears to be the most up-to-date source of addresses.

- Termination of coverage: the plan knows when coverage is terminated for an individual enrollee. Yet there is no effort to require the plan to determine whether an individual has lost coverage.
- Birth, Marriage and Death: The California Department of Public Health is the repository for birth, death and marriage certificates.

Provider Fraud
We do not condone provider fraud such as providers inducing consumers to move, or appear to move, to obtain coverage in order to obtain treatment. Every plan has a provider fraud unit. So does Medi-Cal. If provider fraud is an abuse, then go after the providers but do not slam the door shut in the face of consumers. Plans can terminate contracts with providers that assist in fraudulent enrollment: if plans do not already include such provisions in their contracts, the QHP contract should be revised to require such provisions.

Organizational Reputation Damage
One of the primary values of Covered California is to be consumer-focused. Covered California has a national reputation as being consumer-friendly. This proposal, if implemented, will damage the organizational reputation of Covered California for years to come by creating bureaucratic paperwork barriers that have been severely limited in other public programs, including Medi-Cal. We also note that the Federally-facilitated Marketplace does not require paper documentation for SEPs.

Conclusion
Our organizations stand ready to work with Covered California as we have during its entire history. Consumer advocates have worked through many difficult problems with Covered California.

We oppose reliance on paper documents. There is an ample evidence base that a requirement for paper documents is a barrier to enrollment. There is evidence that special enrollment periods are under-enrolled, not over-subscribed. Creating barriers to enrollment will reduce enrollment, may impair the risk mix and will damage Covered California's reputation among consumers.

For these reasons, we are opposed to the staff proposal to require paper documents.

Asian Americans Advancing Justice – Los Angeles
California Labor Federation
California Pan-Ethnic Health Network
California School Employees Association
Centro Binacional para el Desarrollo Indígena Oaxaqueño
Children's Defense Fund – California
Children Now
Coalition for Humane Immigrant Rights of Los Angeles
Consumers Union
Health Access California
Korean Community Center of the East Bay
Maternal and Child Health Access
National Health Law Program
Project Inform
SEIU
South Asian Network
The Children's Partnership
Western Center on Law and Poverty

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February 16, 2016

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Marty Morganstern,
Art Torres,
Covered California Board
Via email to boardcomments@covered.ca.gov

Dear Jennifer Kent and Covered California Board,

We write to you as members of the Health Consumer Alliance to follow-up on our November 17, 2015 letter raising concerns about the persistent problems in transitioning consumers between Medi-Cal and Covered CA. The Health Consumer Alliance (HCA) is a partnership of community-based legal services organizations serving low-income health consumers in all 58 counties. We help consumers navigate barriers to enrollment and access to services and meet regularly with DHCS and Covered California staff to ensure that consumers are able to access and maintain health coverage.

Since our last letter and despite the formation of the AB 1296 sub-workgroup on Transitions and continuing advocacy efforts, there has been little meaningful progress in ensuring consumers' rights and health coverage are protected as required by law. These issues have gone on far too long without focused attention or decisive action on the part of either agency.

Of particular urgency is the transition from Medi-Cal to Covered California for Medi-Cal beneficiaries who experience an increase in income or a change in family size that puts them over the income level for MAGI Medi-Cal and instead potentially eligible for coverage under Covered California. Over our protests, DHCS issued All County Welfare Director Letter 15-33, which fails to instruct counties on how to transition this population to Covered California without a break in aid, provides a discontinuance notice of action that fails to meet basic due process requirements, and fails to include crucial information to consumers about how to avoid loss of health coverage. We asked both in our November 17 letter and repeatedly in the AB 1296 Transitions workgroup that DHCS issue updated guidance and an errata to ACWDL 15-33, that consumers receive a legally sufficient notice, and that Covered California service center staff be trained to assist these consumers. However, our requests have not yielded any progress. In addition, as of the date of this letter, the Transitions workgroup meetings have been cancelled twice during this critical time such that over a month has passed since our last meeting. In the meantime, not only were many beneficiaries cut off without notice because the SAWS had not

implemented the ACWDL 15-33 notice of action, those that have or will receive the ACWDL 15-33 notice are not adequately informed of the legal basis for their Medi-Cal termination or how to timely transition without a break in coverage.

For example, a 57 year-old, Hispanic male in Orange County resident contacted the Legal Aid Society of Orange County in January 2016 after having his Medi-Cal terminated in December 2015 because his income was too high. LASOC evaluated his case and found that he should be eligible for Covered CA with subsidies. Although the consumer contacted Covered CA around January 15, for coverage effective February 1, 2016, had he received proper notice about transition timing, he could have called in December to have Covered CA coverage starting January 1.

Contrary to DHCS, CWDA and Covered California's assurances that their staff were informed of correct transition standards, we learned that many counties do not know what state and federal regulations require. Specifically, they confirmed that they were unaware that if a consumer enrolls in a Covered California plan before their Medi-Cal ends, the effective date of coverage begins on the day immediately following the loss of Medi-Cal. See 45 C.F.R. § 155.420(b)(2)(iv); 10 C.C.R. § 6504(h)(3). Many of the county representatives are still operating under the erroneous belief that consumers losing Medi-Cal eligibility must pick a plan by the 15th of the month to get next-month Covered California coverage. This lack of knowledge of the regulations regarding special enrollment is not unexpected because DHCS has issued no guidance to the counties that explains how Covered California regulations affect individuals losing Medi-Cal.

Similarly, Covered California's customer service center uses job aids ("Job Aid: Special Enrollment" April 24, 2015 and "Plan Selection" October 7, 2015) that make no mention of the effective date of coverage for consumers who enroll in Covered California before losing Medi-Cal eligibility. To the contrary, Covered California notices issued through CalHEERS (NODO1 notices) simply inform applicants that they have 60 days to pick a plan, and make no mention of the fact that failure to act more quickly will result in a coverage gap for those transitioning from Medi-Cal due to an increase in income. Covered California is making a slight change in the notices to be more accurate but implementation timing is at the discretion of CalHEERS. Greater changes in notices and programming are not expected until September 2016 with CalHEERS Release 16.9. Updated task guides and training modules are also promised but without firm timelines.

The absence of clear policy guidance, training, and legally sufficient notices are the crux of your agencies' failure to uphold your obligations to ensure transition without a break in coverage as a required by law. Consumers cannot exercise rights they do not know about. Likewise, consumer rights cannot be protected if Medi-Cal eligibility program staff at the state and local levels are unaware of what the law requires.

We request that DHCS and Covered California immediately do the following:

1) Issue policy letters and job aids to instruct county eligibility workers and service center representatives to timely advise consumers about when and *how* to transition from Medi-Cal to

Covered California without a break in health coverage and assist consumers to make this transition when the consumer wishes to do so.

2) Issue updated Medi-Cal notice language to inform consumers of their rights to transition programs without a break in coverage, including specific time frames for the implementation so that it can be released in time for CalHEERS 16.2 release and SB 1341 transition (March 7).
3) Instruct all SAWS and counties to use the approved "modified" NOA language until such time as the programming is in place to comply with the new ACWDL.
4) Develop policies and procedures for Covered California service center representatives to identify, advise, and timely enroll consumers losing Medi-Cal into a Covered California qualified health plan without a break in health coverage.

Both state and federal law require that those consumers who transition from Medi-Cal to Covered California be able to do so without a break in coverage. Welf. & Inst. Code § 15926(h)(1); 42 C.F.R. § 435.1200(e). Only by implementing the steps outlined above will California consumers be afforded the protections provided by these statutes and regulations.

We would like the opportunity to discuss this matter and our recommendations about how best to protect consumers from losing vital health coverage. Please contact Cori Racela at (310) 736-1646 or racela@healthlaw.org or Jen Flory at (916) 282-5141 or jflory@wclp.org by March 2 so that we may set up a meeting.

Sincerely,

The Health Consumer Alliance

California Association of Health Plans

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February 4, 2016

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VIA ELECTRONIC MAIL:
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Re: 2017 Quality Initiatives

Dear Ms. Price:

The California Association of Health Plans ("CAHP") represents 48 public and private health care service plans that collectively provide coverage to over 25 million Californians. We write today on behalf of all our member plans to provide feedback on the 2017 Quality Initiatives. We appreciate the opportunity to provide input on these initiatives and we are available to discuss any of the items outlined in this letter at your earliest convenience.

General Comments:

Intersection of Attachment 7 & Appendix H

The recently released Qualified Health Plan (QHP) 2017-2019 draft contract Attachment 7 contains the updated quality initiatives that have been proposed by Covered California. However, the recently released QHP 2017 certification document Appendix H also contains requirements that appear related to the Quality Improvement Strategy contained in the QHP Application for Plan Year 2017. This has caused some confusion among plans and we request clarification on the intersection of these two documents for both current QHPs and those plans that intend to bid in 2017. While this comment letter is specific to the quality initiatives outlined in Attachment 7 of the QHP contract, we realize that most of them will also be applicable to Appendix H of the QHP certification so we request that Covered California acknowledge that as it reviews these comments.

The first area of clarification has to do with how the contract and the certification are linked and how they interact. It appears to be a new approach for Covered California to require the completion of eValue8 components as part of the certification. Plans request more detail on what data will be collected upon certification and what data will be collected during the contract period and how Covered California envisions using all of this data.

Additionally, current QHPs will have to report based on the current Attachment 7 in April of 2015 and it appears that in order to be part of the 2016-2019 certification process those same plans would have to complete the new Attachment 7 by May 2nd. This reporting is very resource intensive and the same staff that is working on the current year reporting would also have to

gather and report the data for the certification process. This type of overlap presents significant operational challenges for current QHPs and we request that Covered California reconsider submission timelines of some of the elements in Attachment 7 or Appendix H for these plans. If Covered California needs to have a baseline for quality it should start with the current Attachment 7 reporting.

The second area of clarification has to do with the scope of the eValue8 tool. Plans are not clear on what eValue8 components are being required for 2016 reporting. Plans were under the impression that Covered California intends to limit the scope of reporting based on the eValue8 tool both in 2015 and 2016-2019, but that has not been made clear in either the certification or the contract. We request that Covered California clearly state what portions of eValue8 will be required and that it be consistent across plans.

Plans would also like to note that some of the proposed reforms will result in significant new costs associated with re-opening provider contracts, potentially adding physician bonuses, and creating resources to produce additional reports. These costs will likely be significant enough to impact premiums. We request that Covered California work with plans and other stakeholders to acknowledge the potential impacts on affordability and develop quality initiatives that will have the most positive impact for consumers. We look forward to working with you on the mutually important goals of improving quality and access and keeping coverage affordable.

Reporting on Other Lines of Business

CAHP's member plans are concerned about the requirement to report on all other lines of business under the drafted Attachment 7. We request that Covered California work with plans to further discuss the scope of this request.

Comments by Section:

Section 1.02- Assuring Networks are Based on Value

Plans have concerns about the scope of the current requirements in this section. The expectation that plans include both cost and quality factors in all provider and facility selection does not take into account region variation of physician distribution and facility resources. In addition, cost data is often better developed compared to quality data in terms of broad based, statistically valid data for a wide variety of specific chronic disease conditions and acute care issues. Reporting on conditions which require highly specialized management should be accompanied by a comprehensive list of those conditions which Covered California considers highly specialized.

We suggest that prior to the required reporting with the 2018 Application for Certification, a more specific, evidence based model, which objectively measures both quality of care and the promotion of safety, be proposed by Covered California if it expects plans to only contract with providers and hospitals which demonstrate both. We also request that Covered California provide models which are specific to contracting with medical specialists, primary care physicians, and specialty acute care facilities such as children's hospitals, academic health centers, large tertiary care centers and even District hospitals. We believe that more discussion with plans on the specific goals of this section will help Covered California and plans develop a model that can better achieve the desired result.

Section 1.03- Participation in Quality Collaborative Initiatives

Plans are concerned that the requirement to report on quality initiatives would include reporting on hospitals that are not under contract with the plan. We request that this section be updated to be clear that plans are only required to report for those hospitals that are under contract. Additionally, we would like to request clarification in this section that plans are only required to report on those initiatives in which they are participating, and not in all initiatives. In general, plans are supportive of plan participation in organized Collaboratives; however plans must have flexibility to determine the most appropriate Collaboratives. We request that Article 1.03 be amended to delete *"shall include, but not be limited to the following (a) and (b)*", which includes a list of 14 different Collaboratives. Covered California may require plans to participate in a certain number, possibly two or three Collaboratives; however plans need the flexibility to choose the most appropriate Collaboratives for the plan and their enrollees.

Section 2.02- Data Submission Requirements

As was noted in our previous comment letter on the 2016 QHP contract, dated January 12, 2016, wording has been removed that required "mutual agreement" for finalization of the EAS Dataset. We acknowledge that agreement has been retained for the timing, but it is essential that threshold of mutual agreement be reinstated for the EAS dataset so that QHPs can adjust fields to reflect the data contained within their systems and comply with provider contracts. We again request that this language be updated in the 2017-2019 contact.

Section 2.04- Quality Improvement Strategy

CMS has adopted the approach of requiring Health plans to select a maximum of two goals from a list of activities established by CMS. We suggest that Covered California align with these existing requirements in order to streamline the process, make it comparable, and avoid duplication or confusion. We support the efforts of Covered California to make sure that we can meet federal requirements through the QIS outlined here and want to work collaboratively to ensure the program is designed to meet this goal.

Section 3.01- Measuring Care to Address Health Equity

Plans are concerned about the requirement for a plan to achieve an 85% completion rate of the racial/ethnic identity of members. This is a self-reported field on the enrollment application and is not something that health plans have control over. Even with the ability to use other data sources to obtain this information we are concerned that 85% is an unreasonable level to hold health plans accountable for when they have to rely on optional self-reporting for the majority of the data. We suggest that if Covered California wants this data it could make the field mandatory on the application, include an option for "decline to state" for those who do not wish to self-report their race/ethnicity, and provide this data to carriers.

Section 3.04 NCQA Certification

Plans request clarification on the Multicultural Health Distinction by NCQA. If this is not required what will Covered California do with this information? Will certified plans receive special acknowledgement?

Section 4.01-Primary Care Physician Selection

Plans are concerned that the wording of this section and the new definition of Primary Care Physician (PCP) on page 30 will be confusing both to enrollees and providers. A PCP is typically used as a gatekeeper. However, Covered California's definition on page 30 specifies that it does not require a PCP to be a gatekeeper. It appears that section 4.01 attempts to make a distinction by using the term *"Personal Care Physician"* rather than *"Primary Care Physician"*. Plans would prefer that Covered California include the more general term *"Provider of Choice"* to provide greater distinction from the well-known PCP as gatekeeper concept. Alternately, Covered California could use both terms and say *"Personal Care Physician or Provider of Choice"*. We believe that this will align the definition on Page 30 to reflect the terminology used in section 4.01, and avoid conflicting with the existing definition of "Primary Care Provider" in the main contract.

Plans also request clarification on the requirement to assign a Personal Care Physician taking into account the *"ethnic and cultural preference",* does this mean *"racial and ethnic"?*

Section 4.02- Patient Centered Medical Home (PCMH)

While plans support the use of a PCMH model and integrated models of care, we oppose a requirement that a specific percentage of Covered California enrollees receive care from a PCMH provider. Many high quality provider and clinics and FQHC offices do not have the sophistication or infrastructure to become PCMH certified. However, these providers must be able to remain in a plan's network to ensure their patient's continuity of care and ensure a plan continues to have an adequate network of providers. We request that this requirement be deleted from the contract.

Section 4.03- Integrated Healthcare Models

Plans generally support an ACO or Integrated Model of Care, however Covered California needs to give plans flexibility in the most effective way to meet these requirements. In addition, plans must be able to retain these providers in their network for the same reasons as stated in the PCMH certification comments.

Section 4.05- Mental & Behavioral Health

Plans request additional clarification on the requirements in this section to ensure that mental and behavioral health is being integrated for Covered California members. Specifically, plans would like to know at what level Covered California expects the plans to report and what provider types would be included in order to demonstrate that a plan meets the requirements under this section.

Section 4.06- Telemedicine and Remote Monitoring

As was noted in under our general comments, plans would like further discussion with Covered California on collecting data for all lines of business.

Section 5.01- Appropriate Use of C-Sections

Plans are very concerned about the requirement in 5.01, subdivision 4, to contract only with hospitals that demonstrate a C-Section rate above 23.9%. This type of policy may create access issues in some areas where there are a limited number of hospitals and it would be detrimental to provider networks in those areas. Additionally, plans are not always able to get this type of information from hospitals and may not be able to demonstrate to Covered California what the current C-Section rate is for a particular facility.

This type of a policy will unnecessarily limit the ability of plans to contract with certain hospitals yet it will not increase the ability of plans to force hospitals to make changes necessary to lower the C-Section rate. We request that Covered California have a discussion with plans on other incentives that have been used successfully with providers to drive behavior changes and increase quality.

If Covered CA expects plans to actively participate in the statewide effort to promote appropriate use of C sections then it should work with plans to develop a payment methodology. However, we suggest that Covered California first attempt to engage hospitals directly about reforms and not impose such tasks on QHPs. Additionally, if Covered California intends to move forward with this policy in some form then it must be explicit in the contract that QHPs are only required to take such an action for Covered California products and that this does not impact the ability of a plan to contract with that hospital for any other line of business.

Section 5.02- Hospital Patient Safety

Plans support the requirements in this section in concept; however, there needs to be collaboration between Covered California, state regulators, plans, and providers. Plans should not be penalized if hospitals do not achieve targeted performance rates. Plans should have the flexibility to design the most effective strategy to meet these requirements. This should be a contracting decision between the plan and its network providers, including facilities.

Section 6- Population Health- Preventive Health, Wellness, and At-Risk Enrollee Support

Plans support the goals of improving the triple aim through preventive health, wellness, and at-risk enrollee support. In order to achieve this goal, Covered California will need to work closely with the plans in the development of additional reporting and monitoring requirements. Additionally, significant lead time is needed to meet new reporting and monitoring requirements.

Section 6.01- Health and Wellness Services

Plans request clarification of the requirement in this section to take *"into account cultural and linguistic diversity"*. It is not clear how Covered California would assess if plans are taking diversity *"into account"* and what is meant by *"cultural"* or *"linguistic"* diversity? We request that these concepts be further defined and that Covered California provide more detail on how it will measure them.

6.06 Identification and Services for At-Risk Enrollees

Plans request clarification of the requirement for *"the provision of culturally and linguistically appropriate communication"*. We request that Covered California clarify the scope of the information that should be communicated and how it defines culturally and linguistically appropriate.

Section 7.01- Enrollee Healthcare Services Price & Quality Transparency Plan

Plans suggest that Covered California look at existing resources to meet the requirement under this section to provide cost and quality information to consumers. There are several tools already available, such at the Office of the Patient Advocate consumer tool, which already provide this data to consumers. It would be duplicative and potentially confusing to enrollees if plans offer a different tool. Additionally, there is likely not enough data per individual provider at the health plan level to calculate reliable rates.

There is significant concern about plans publishing specific cost estimates and quality ratings on providers. Plans are often unable to obtain all of the relevant data that would allow them to provide the exact cost of a specific episode or service/exact procedure code. We believe this is information that the enrollee should request and receive directly from providers. There are too many variables in what will determine the final cost of the services such as specific services received, facilities used, other providers involved, length of stay, etc. Plans are concerned that they will be held liable for the estimated costs when the actual costs for services are higher that the estimated costs.

Additionally, there is the potential of litigation from providers if bad ratings are posted and confusion for consumers if the ratings vary across plans. We request that Covered California remove this requirement from the contract and rely on existing aggregated sources for cost and quality data.

Lastly, this section requires plans to provide numbers and other information about consumers who use these tools. Even if plans could create the tools, such a requirement is not feasible because few people respond to such surveys.

Section 7.05 - Reducing Overuse Through Choosing Wisely

Section 1.03 already mandates participating in two collaborative quality initiatives. It is not clear what else QHPs would have to do to comply with Section 7.05. We suggest that these sections be combined. In addition, Section 1.03 is unclear in that it lists numerous additional collaboratives (in addition to CalSIM Maternity and Statewide Workgroup on Overuse) and it is difficult to discern whether QHPs are required to participate in all of those listed, or merely report on which ones they participate in as was noted in our comments on that section.

Section 8- Payment Incentives to Promote Higher Value Care

Plans support the reduction of overused or misused clinical interventions and look forward to collaborating with Covered California, DHCS, and CalPERS in a multi-stakeholder workgroup**.**

We want to thank you for taking the time to review these comments and we look forward to additional discussion with Covered California and the stakeholder Quality Subcommittee on these comprehensive and important quality initiatives. Please let me know if you need more detail or would like to discuss any of the items outlined in this letter.

Sincerely,

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Director of State Programs

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February 16, 2016

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Re: 2017-2018 QHP Contract- Attachments 7 & 14

Dear Ms. Price:

The California Association of Health Plans ("CAHP") represents 46 public and private health care service plans that collectively provide coverage to over 26 million Californians. We write today on behalf of our member plans to provide feedback on the proposed 2017-2019 contract; specifically to provide input on Attachments 7 & 14.

Health plans are committed to working with Covered California, providers, and other stakeholders on identifying key areas for improvement and increasing access to quality affordable coverage. What Covered California has proposed in these Attachments is extensive and contains a lot of detail that has not previously been shared with stakeholders. Health plans need more than just a few business days to review the robust new requirements contained in these Attachments.

Covered California's goals of transparency and a strong stakeholder process would be best served by giving plans and other stakeholders adequate time to review, analyze, and comment on these attachments. These attachments contain detailed provisions that may have unintended consequences for plans, providers, and consumers.

We respectfully request that Board approval of the entire contract, specifically the Attachments, be delayed at least another month so that all stakeholders have the opportunity to work with Covered California and understand the scope and impact of all of these proposed changes and initiatives.

Delaying the Board decision, or limiting the scope of the approval so that there is flexibility for additional changes to the recently released Attachments, will not unnecessarily delay implementation of important quality initiatives but it will allow time to ensure that the requirements are in line with our shared goals of improved quality and affordable coverage. As of the writing of this letter the final contract and Attachments have not made available, which makes Board approval in two days seem premature. There is a lot of detail in these documents and taking time to make sure that we get it right serves all the stakeholders in this process.

We have provided detailed comments by section in the excel format requested by Covered California, and we look forward to continued discussions on how to implement quality improvement activities that leverage what is already being done by plans and providers and sets reasonable expectations that do not compromise the ability of plans to contract with a variety of providers and have complete networks. Specifically, plans are concerned about requirements that would force a plan to rate providers and/or stop contracting with providers that don't meet specific quality benchmarks; this may have negative impacts on plan networks and plan provider relationships. Additionally, plans would appreciate additional discussion with Covered California on requirements to report on other lines of business and we request additional discussion on the specifics of this requirement.

We appreciate you taking the time to review these comments along with our comments on the quality initiatives dated February 4th, and our spreadsheet of comments on the entire contract dated February 8th. Please note that while items addressed in our previous comments may not have been included in the attached spreadsheet we request that Covered California consider all of our previous input as it reviews these comments. We look forward to working with you as the 2017 contract and its Attachments are finalized and implemented. We are available at your convenience to discuss any of the items outlined in this letter.

Sincerely,

Athena Chapman
Director of State Programs

cc:
Brandon Ross, Covered California
Elise Dickenson, Covered California

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

California Medical Association

February 17, 2016

Mr. Peter Lee
Executive Director
Covered California
1601 Exposition Blvd.
Sacramento, CA 95815

VIA ELECTRONIC MAIL:
peter.lee@covered.ca.gov

Re: 2017-2019 QHP Contract- Attachments 7 & 14

Dear Mr. Lee:

The California Association of Health Plans ("CAHP") representing 46 public and private health care service plans that collectively provide coverage to over 26 million Californians; the California Hospital Association (CHA), on behalf of its more than 400 member hospitals and health systems; and the California Medical Association (CMA) representing more than 41,000 physician and medical student members appreciate the opportunity to provide feedback on the proposed 2017-2019 contract and its attachments.

CAHP, CHA, and CMA are all committed to the goals of quality coverage at an affordable price that covers the cost of care, and we look forward to continued work with Covered California and other stakeholders on robust quality initiatives. However, we are concerned that the stakeholder process on the most recent versions of the contract and its attachments does not reflect the importance and scope of the proposed changes and new quality initiatives. The work required to achieve these goals should not be oversimplified and rushed. Therefore, we strongly urge Covered California and its Board to delay taking action on the contract and its attachments at the February 18 Board meeting.

Plans and providers are an integral part of Covered California's effort to drive delivery system reform and improve the quality of care for consumers. Covered California has not provided sufficient time for us to review and provide meaningful feedback on the 2017 contract and attachments. The first draft of Attachment 7 was released on January 21, just hours before the Board meeting where it was presented for discussion. The quality subcommittee meeting - where Attachment 7 would have been discussed - was canceled and not rescheduled; denying stakeholders an opportunity for dialogue on the proposed quality initiatives and the potential impacts to providers, plans, and consumers. The second version of Attachment 7 was discussed on February 11 and the final version was released late that evening, allowing only one business

day for stakeholders to review and provide comments on an extensive attachment. A similar process was followed with other portions of the contract and appendices. Processes like these do not display or effectuate meaningful stakeholder input.

While we believe that the proposed initiatives are intended to improve the consumer experience and drive higher quality in the health care system we also believe that unintended consequences may be possible because of the deficiencies in the stakeholder engagement process. The technical aspects of the contract and its attachments would have benefited from technical expertise to which CAHP, CHA, and CMA have access. However, the current process did not provide opportunity for our members –Covered California's infrastructure – to engage in that dialogue with both the larger stakeholder community and Covered California staff. We understand that Covered California has presented conceptual information to stakeholders about the development of its quality initiatives. However, in order to operationalize these requirements, Covered California needs to better understand plans' and providers' perspectives and the impact of these initiatives on consumers and networks.

Again, we believe that a delay in Board action is the most prudent course. Delaying approval of the contract by the Board will not delay the recertification or new entrant process. It is unclear why Covered California believes that a delay in this process is detrimental. In fact, it seems unreasonable to ask the Board to approve a contract and attachments that - as of the writing of this letter (one day before the Board vote) - have not been finalized or made public. Plans, providers, and consumers will be greatly impacted by the changes in the contract and its attachments – without a reasonable amount of time for review and discussion we cannot confirm that these initiatives can be implemented and will achieve the desired quality improvement. Plans and providers bear the responsibility of implementing these changes; Covered California should acknowledge that our feedback is integral to its success, and should not finalize contract requirements to which stakeholders have not been given access.

We appreciate your taking the time to consider our request, and we look forward to a more in-depth discussion on these issues so that we may achieve our shared goals of improved quality for Covered California consumers.

Sincerely,

Athena Chapman
Director of State Programs
California Association of Health Plans

Amber Kemp
Vice President, Health Care Coverage
California Hospital Association

Stacey Wittorff, Esq.
Associate Director, Center for Health Policy
California Medical Association

cc:
Anne Price, Director of Plan Management, Covered California
Diana Dooley, Board Chair, Covered California
Genoveva Islas, Board Member, Covered California
Paul Fearer, Board Member, Covered California
Marty Morgenstern, Board Member, Covered California
Art Torres, Board Member, Covered California

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

February 16, 2016

Peter V. Lee
Covered California
Executive Director
Peter.Lee@covered.ca.gov

Subject: Draft 2017-19 Qualified Health Plan Certification Application, Appendix 2 to Attachment 7: Measurement Specifications

Dear Mr. Lee:

On behalf of our more than 400 member hospitals and health systems, the California Hospital Association (CHA) is providing comments to Covered California on its draft 2017-19 Qualified Health Plan (QHP) Certification Application, Appendix 2 to Attachment 7: Measurement Specifications ("Appendix 2"), released on February 8, 2016. Please consider these comments as a supplement to the comments we submitted on February 8 and today, in response to Qualified Health Plan (QHP) Certification Application for Plan Year 2017 and Quality, Network Management and Delivery System Standards ("Attachment 7"). We are extremely disappointed that Covered California did not provide Appendix 2 to Attachment 7 for stakeholder input when it released the Attachment 7 for comment on January 21, 2016 and have prepared comments quickly to meet Covered California's compressed time frame.

We appreciate that Covered California indicated at its February 11 Plan Management and Delivery System Reform Advisory meeting that the Board will adopt the Qualified Health Plan (QHP) Certification Application for Plan Year 2017 and not Appendix 2 to Attachment 7: Measurement Specifications (Appendix 2), and that plenty of time will be allowed to thoroughly review and improve the draft metric specifications. As this is not reflected in the draft contract, CHA requests that Covered California 1) provide this clarification in the final contract, as it is our understanding the Appendix 2 is, in fact, part of the QHP contract; and 2) table this proposal to allow for a meaningful stakeholder process to thoroughly vet the proposed measures as well as the technical specifications and data collection methodologies. It would be premature for the Board to approve this proposal absent this level of stakeholder engagement. **Going forward, CHA believes a robust and transparent stakeholder process would improve Covered California's ability to identify and implement meaningful and appropriate quality measures that could serve as the basis for value-based purchasing and public reporting programs.**

CHA supports Covered California's goal of moving from paying for volume to paying for value and stands ready to work with interested stakeholders to achieve this goal. As stated in our February 8 and February 16 comment letters, we recommend Covered California engage in a robust stakeholder process. Building consensus and shared understanding will ensure transparency on the methodology for performance standard calculation for hospitals, physicians and health plans. **We believe strongly that this process should allow *sufficient time* for thoughtful input, analysis, modeling and education of hospitals and health systems. Such a process should be transparent and inclusive of hospital representatives, CHA and other interested stakeholders. We do not believe the measures outlined in Appendix 2 reflect such a process.**

To highlight the complexity of this issue, an overview of items that will require additional review and input is outlined below.

CHA believes that Covered California must focus on a narrow set of consensus-based and nationally endorsed quality measures that align the efforts of the public and private sectors, leading to accelerated improvement and demonstrated results. **Several measures identified in Appendix 2 need further information and discussion, including adverse drug events, health care-associated infections, and a standardized approach to reporting race and ethnicity data that will not only aid in identifying disparities but may also be used for appropriate measure risk adjustment. Without additional detailed definitions, baseline and performance period time frames, further delineated patient populations, shared understanding of risk adjustment methodologies and transparent criteria for the exclusion of certain providers — among other things — we will have again missed an opportunity for alignment. Moreover, Covered California has not identified appropriate physician-level measures that would complement efforts to accelerate change in maternity care, particularly related to decreasing C-section rates.**

For example, section 1.02 of Article 7 for contract year 2019 indicates that contractors will be expected to either exclude those hospitals that are "outlier poor performers" on either cost or quality from provider networks, or to annually document the rationale for continued contract with each hospital identified as such in its application for certification. **Appendix 2 identifies potential measures for use in this section, but there is neither discussion of nor agreed upon methodology to determine a consistent approach for all health plans. Alignment in this area of performance is essential.**

In addition, Covered California proposes to include excessive anticoagulation among patients receiving Warfarin, hypoglycemia in inpatients receiving insulin, and opioid adverse events in patients treated with naloxone as quality metrics. **CHA believes the proposed adverse drug event measures are prematurely included in this program.** This data collection is only just beginning through the voluntary Partnership for Patients initiative and is focused on quality improvement, not public reporting or pay-for-performance. We have been unable to confirm that the three measures are endorsed by the National Quality Forum (NQF) and ask that Covered California only include NQF-endorsed measures in its quality program. In addition, these data are not currently used in the Centers for Medicare & Medicaid Services (CMS) public reporting programs or national pay-for-reporting programs. As such, CHA is concerned that the level of hospital resources dedicated to data collection for this measure is significantly lower than those devoted to the rigorous data collection for other measures — such as hospital-acquired conditions — that are currently required in national pay-for-performance and public reporting programs. Data integrity is of concern in these early stages of reporting.

As a matter of principle, CHA urges Covered California to adopt measures only after they have been publicly reported for at least one year. This will allow time to establish the data's integrity, as the data on Hospital Compare, while imperfect, undergoes a fairly rigorous validation process — a critically important factor when measures move from pay for reporting to pay for performance.

Moreover, Appendix 2 discusses neither which measures are applicable to different types of hospitals, nor the challenges of the reliability and validity of measures in the absence of sufficient volume at the provider level. For example, using data for 2013, the Centers for Disease Control and Prevention was only able to establish a central line-associated bloodstream infection standardized infection ratio for 290 hospitals; presumably, the volume at remaining hospitals was too low to determine this ratio. The stakeholder process should include additional discussion about these issues and consideration of approaches to determining performance of hospitals with a low patient volume. For example, Covered California may wish to consider the approach taken by CMS in calculating the

standardized infection ratio; in light of differences in patient population, however, additional dialogue is warranted.

This provision should separate hospitals that primarily or exclusively serve pediatric populations, since national pediatric benchmarks may not exist and adult benchmarks may be inappropriate. Appendix 2 does not address this issue. For example, surgical site infection with a focus on colon is not relevant to pediatric patients; C. Difficile infections in children are less common than in adults, and there is limited high-quality evidence to guide the management of pediatric C. Difficile infection. This document does not currently identify any pediatric-sensitive measures, nor does it address the important differences in the applicability of measures in unique settings including inpatient psychiatric facilities, freestanding inpatient rehabilitation facilities and long-term acute care hospitals.

As stated in our February 8 and February 16 letters, we believe a number of principles — including, but not limited to, the following — should be adhered to as part of the QHP contracting process.

- **Use a Common and Parsimonious Set of Measures.** All measures used by QHPs should be identical (numerator, denominator, risk adjustment, data collection methods, data source etc.), regardless of the program in which they are used. The proliferation of measures, data sources and risk adjustment methodologies for the sake of differentiation wastes limited financial and personnel resources. In the April 2015 Institute of Medicine report titled *Vital Signs: Core Metrics for Health and Health Care Progress*, researchers concluded that the vast — and constantly growing — number of quality measures that providers are required to track "limits their overall effectiveness." Therefore, the Institute proposed a more streamlined approach for assessing performance. We should not miss this opportunity to lead the nation in demonstrating that a parsimonious set of high-impact measures — instead of a proliferation of measures that dilute performance — can drive performance at an accelerated rate. We understand that this provision would limit QHPs to measures under consideration for pay-for-performance, HAC measures listed in section 5.02 (except adverse drug events), Medicare readmissions measures (discussed below) and HCAHPS measures, but we do not believe additional measures should be added to this list without additional input from the provider community. We urge Covered California to establish a work group to discuss selection of measures as discussed above.

- **Use NQF-Endorsed Measures.** All measures should, at a minimum, be endorsed by the NQF, a consensus-based entity that evaluates quality measures based on their importance, scientific acceptability, feasibility to collect and usability. Measures endorsed by the NQF are typically suitable for public reporting. Each of the measures noted above is currently NQF-endorsed. However, not all measures are suitable for pay-for-performance programs; we urge Covered California to work with stakeholders to ensure that only the most robust, reliable and valid measures are adopted into those programs.

- **Evaluate Additional Risk Adjustment.** As stated in our February 8 letter, CHA has continually expressed disappointment that, despite overwhelming evidence, CMS has failed to adjust the Medicare readmissions measures for sociodemographic factors that influence a readmissions rate. **It is our understanding in reading Attachment 7 that Covered California intends to use nationally-recognized measures such as Medicare readmissions measures. However, Appendix 2 does not list readmissions measures under consideration. If Covered California wishes to use readmission measures, they should be clearly defined and include appropriate sociodemographic status adjusters.**

As noted in Appendix 2, Covered California is very interested in robust data collection on race and ethnicity. CHA supports these efforts but seeks further dialogue to ensure this data is reported, on both claim level and encounter data, consistently with National Uniform Billing Committee processes. Though we believe Covered California's proposal is in alignment, we request additional clarity. This data is an important component in the development of measures' risk stratification and may be used where appropriate for risk adjustment — along with income, education and other factors evidence suggests are predictors of health outcomes. However, we do not wish to create competing data collection efforts that will be administratively burdensome to providers and health plans.

- **Considerations for Small and Rural Hospitals.** As noted above, critical access hospitals are not currently subject to risk-based programs under Medicare and were excluded because they often have insufficient volume or patient mix for valid and reliable measurement. There must be appropriate exclusions for small and/or rural hospitals that are essential to provider networks but that may not be appropriate hospitals for inclusion in a value-based purchasing program, similar to Medicare. **We ask that Covered California consider that these hospitals may need an additional year to identify appropriate methodologies to meet the goals of the program without unintended consequences.**

Finally, without a robust set of agreed upon measures, we cannot move to the next step of pay-for-performance. This is critical to Covered California's work, and as such it is imperative that the conversations begin immediately. **Performance-based programs should promote "carrot, not stick" payment methodologies. Hospitals should be rewarded for both achievement and improvements, and QHPs should focus on that type of approach to accelerate improvement.**

For the reasons above, CHA requests that Covered California 1) clarify in the final contract that the Board is not adopting Appendix 2 and that plenty of time will be allowed to thoroughly review and improve the draft metric specifications; and 2) allow for a meaningful stakeholder process to thoroughly vet the proposed measures as well as the technical specifications and data collection methodologies. We appreciate your consideration of our recommendations and look forward to our continued partnership. If you have any questions, please contact me at (916) 552-7543.

Sincerely,

Amber Kemp
Vice President, Health Care Coverage

cc: Lance Lang, Chief Medical Officer, Covered California
Anne Price, Director, Plan Management, Covered California

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

February 16, 2016

Peter V. Lee
Covered California
Executive Director
Peter.Lee@covered.ca.gov

Subject: Second Draft Qualified Health Plan (QHP) Certification Application for Plan Year 2017

Dear Mr. Lee:

On behalf of our more than 400 member hospitals and health systems, the California Hospital Association (CHA) welcomes the opportunity to provide comments to Covered California on its second draft Qualified Health Plan (QHP) Certification Application for Plan Year 2017 Attachment 7, Quality, Network Management and Delivery System Standards ("second draft") released on February 11, 2016.

As our February 8 comments reflect, we have a shared commitment to achieving the triple aim of improved patient care including quality and satisfaction, improved population health, and a reduction in per capita health care program costs. CHA appreciates Covered California's continued focus and attention in moving our health care system from paying for volume to paying for value. CHA appreciates its partnership with Covered California and looks forward to continued collaboration with Covered California, its QHPs and other providers in developing policies that will achieve this shared goal.

With that said, CHA wishes to express our deep concern regarding some of the most recent changes proposed to Attachment 7 and the limited time allowed for stakeholder input and discussion. Moreover, there are a number of questions that remain unanswered and the lack of clarity regarding QHP and provider requirements is of great concern as we move forward.

While we appreciate the vision and leadership that Covered California aspires to achieve, we do not believe the current process supports the needs of Covered California or other stakeholders in being able to fully vet and consider both the opportunities and challenges of the proposed policies outlined in Attachment 7. CHA is particularly concerned with the most recent additions outlined in section 1.03 related to high cost providers. The issues of quality and cost measurement are important but they are also very complex and deserve greater scrutiny. A 5-day comment period is woefully inadequate for evaluation of such polices and we urge Covered California to reconsider its approach.

In reviewing comments of other stakeholders including our own, it is clear there is confusion regarding these complex and often overlapping provisions. We have identified areas that if not addressed will lead to overly burdensome and costly data collection, multiple competing health plan priorities and a downstream effect that will divert precious health care dollars away from direct patient care. This is contrary to the goals and vision that Covered California has outlined.

We urge Covered California to revisit the process for input so that these policies can be more fully vetted and issues can be addressed in a way that accelerates improvement, reduces costs and improves the health of all Californians. We believe the current path we are on will result in a number of false starts that will frustrate providers and health plans, leading to costly reworks and potentially unintended consequences

that with an improved and strategic approach may be avoided. One way to accomplish this is to consider a more phased approach and realistic implementation timeline to allow for a more robust discussion, planning, testing and implementation. Starting small and building on our success over time will engender cooperation and collaboration at all levels – a key success factor in achieving our shared goals.

We stand ready to work with Covered California in addressing a number of outstanding issues that have yet to be resolved and are detailed in our comments noted below.

I. Draft Qualified Health Plan (QHP) Certification Application for Plan Year 2017

While the second draft of the QHP Certification Application for Plan Year 2017 does not appear to have been released for additional public comment, Covered California indicated at its February 11 Plan Management Advisory and Delivery System Reform Advisory Group meeting that it does not intend to change the proposed Section 4.4.5 requirement that plans describe any contractual agreements with participating providers that preclude the plan from making contract terms transparent to plan sponsors and members. The proposal also requires that plans agree to make commercially reasonable efforts to exclude any contract provisions that would prohibit disclosure of such information to Covered California. **CHA is disappointed that Covered California refused to acknowledge that provider contracts and payment terms are proprietary, confidential and competitive. CHA does not support this provision as it raises anti-trust concerns.**

There is no policy reason for Covered California to have this detailed information since it is negotiating with the QHPs on premium rates; detailed proprietary contract information from specific providers is not necessary for the purpose of negotiating premiums. In addition, Covered California may obtain aggregated information from its QHPs that sufficiently satisfies any legitimate policy purpose, without requiring access to individual proprietary provider contracts. We have no confidence this sensitive information will remain confidential and will not be used by other parties inappropriately or for anti-competitive reasons.

II. Attachment 7. Quality, Network Management and Delivery System Standards

1.02 Assuring Networks are Based on Value

CHA is very concerned about the addition of section 1.03 and its relationship to sections 1.02 and the related nature of section 1.07. As we discuss in our comments, Covered California uses the terms cost, charge and price interchangeably throughout the document. There are areas throughout the attachment where cost and quality information are linked. The expectation that plans include both cost and quality factors in all provider and facility selection does not take into account region variation of physician distribution and facility resources. We suggest that prior to the required reporting with the 2018 Application for Certification, Covered California engage with stakeholders, including CHA, to develop a more specific, evidence-based model, which objectively measures both quality of care and the promotion of safety, if it expects QHPs to only contract with providers and hospitals which demonstrate both. CHA is concerned that without additional dialogue, we will find ourselves in a place where lower cost equals lower quality, or vice versa, despite evidence to the contrary. In addition, the language in each of the three sections (1.02, 1.03 and 7.01) is confusing and must be clarified to ensure shared understanding and consistent approaches that achieve their intended purpose. More specifically:

2) Contractor shall disclose to Covered California, with its Application for Certification for 2017, how it meets this requirement and the basis for the selection of providers or facilities in networks available to Covered California enrollees. This shall include a detailed description of how cost, clinical quality, patient reported experience or other factors are considered in network design and provider facility selection. Such information may be made publicly available by Covered California.

In order to facilitate understanding of the methodologies used by QHPs in developing networks, CHA respectfully requests that this information be made available to hospitals and physicians. In addition, hospitals and physicians should have embargoed data provided for review to identify errors that require corrections prior to public release to any entity. If the QHP methodology excludes a provider from the network, both the methodology and the data should be transparent to the provider. Understanding expectations of QHPs in their quality goals for network design and facility selection will bring greater transparency to the process. Further, knowing the source and year of the data is also important.

3) Covered California expects Contractor to only contract with providers and hospitals that demonstrate they provide quality care and promote the safety of Covered California Enrollees at a reasonable price. To meet this expectation, by contract year 2018, Covered California will work with its contracted plans 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 California's providers. For contract year 2019, Contractors will be expected to either exclude those providers that are outlier poor performers on either cost or quality from provider networks or to document each year in its Application for Certification the rationale for continued contract with each provider that is identified as a poor performing outlier and efforts the provider is undertaking to improve performance. Such reports will detail contractual requirements and their enforcement, monitoring and evaluation of performance, consequences of noncompliance and plans to transition patients from the care of providers with poor performance. Such information may be made publicly available by Covered California.

As we have previously shared, CHA appreciates the opportunity to engage in the development of a methodology on performance standards for providers, and looks forward to working with Covered California in its development. **However, CHA remains concerns that the process to date for stakeholder input has not been sufficient to support the tremendous work that lies ahead and we urge Covered California to begin this work in earnest as soon as possible. Several key principles should be considered as a framework for analysis and there must be sufficient time for thoughtful input, analysis, modeling and education of hospitals and health systems. We encourage a transparent process inclusive of providers, CHA and other interested stakeholders.**

In addition, Section 1.02 is the first of several sections where Covered California proposes to exclude providers from contracting with QHPs if metrics are not achieved and the methodologies for arriving at those metrics are not yet known. CHA believes these provisions, noted in 1.02, as well as other places in Attachment 7 are worthy of additional dialogue. More specifically, should Covered California proceed, we believe they are also obligated to measure the impact to consumers on their access to care and their out-of-pocket costs. More specifically, Covered California may wish to consider an independent evaluation that is both qualitative and quantitative to measure the impact of access to care for patients and on plan networks as a whole. We are particularly concerned about our low volume providers (small, rural or critical access hospitals) that are essential in meeting the needs of patients in their communities, but due to low volume, the metrics may exclude them meeting a threshold for inclusion in a network, creating access issues in many parts of the state. While well intentioned, we believe these policies need additional refinement and discussion.

1.03 Demonstrating Focus on High Cost Providers

Section 1.03 asserts that the "wide variation in unit price and total costs of care charged by providers, with some providers charging far higher for care irrespective of quality, is one of the biggest contributors to high costs of medical services." The section requires plans to report the factors it considers in assessing the relative unit prices and total costs of care, the distribution of providers and facilities by cost deciles, and strategies to assure that contracted providers are not charging unduly high prices. However, as noted in more detail in our comments in Section 1.07, Covered California fails to clearly define costs, charges and prices. These definitions can vary widely and may refer to the charges billed to the QHP, the amount payable to the provider from the QHP, or the expense incurred by the hospital to deliver the health care services to the patient. The charges billed by the hospital are often much higher than the amount paid by the QHP, and the expense incurred by the hospital to deliver the health care services can be higher or lower than the amount paid by the QHP, depending on the services provided and the contractually negotiated rates that are negotiated between the hospital and the QHP. **Due to these significant discrepancies, CHA urges Covered California to reconsider its approach. Prior to proceeding, Covered California must engage in further discussions with stakeholders, including CHA, to ensure there are clear definitions and a consistent approach in collecting data related to cost, charges and price in order to ensure uniform reporting. Much of this information is already publicly available. CHA supports Covered California's efforts to increase transparency, but in order to provide meaningful information to consumers and comparative analytics, it is vital that the data are standardized and consistent.**

This section also states that the Contractor will be expected to exclude hospitals and other facilities that demonstrate outlier high cost from provider networks serving Covered California or to document the rationale for continued contracting with each hospital and efforts the hospital is undertaking to lower its costs. Pricing is often inconsistent across the hospital industry, because hospitals operate under different circumstances based on the unique range of services they offer, continuing emergence of new medical technology, workforce shortages, government underfunding and patient demographics. It can also vary regionally based on legislative mandates and market demand for labor, supplies (e.g. pharmacy costs), real estate and other costs. Unfunded mandates such as seismic requirements, for example, result in much higher costs. In addition, we are very concerned about variation in the approach for defining a high cost provider. This is a problematic provision that was added with little time for stakeholder input. **For these reasons, CHA does not support requiring QHPs to exclude hospitals that are perceived to be high cost outliers from provider networks. We ask that Covered California remove this provision in its entirety until additional input can be gathered and considered.**

1.06 Participation in Collaborative Quality Initiatives

In our February 8 comments, we requested that Covered California revise its list of quality collaboratives listed in Section 1.03 (Section 1.06 in the second draft) to ensure that any hospital engagement network (HEN), including those not listed, would be counted for participation, including the Children's Hospitals' Solutions for Patient Safety HEN and quality collaboratives associated with the state's 1115 Medicaid Waiver Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program. **CHA appreciates that Covered California has added Children's Hospitals' Solutions for Patient Safety HEN and quality collaboratives associated with the state's 1115 Medicaid Waiver PRIME program to the list of quality collaboratives. Since Covered California did not incorporate our previous recommendation that it revise the list of quality collaboratives to ensure that any HEN, including those not listed, be counted for participation, we more specifically request that Covered California add Premiere, Inc. to the list of HENs that would count toward a hospital's participation in a quality collaborative.**

As we noted in our February 8 comments, CMS' recently proposed *CMS-9937-P Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017* rule further implements provisions of the Affordable Care Act (ACA) that mandate certain patient safety and quality improvement requirements in order to contract with a QHP through health insurance exchanges. **We believe CMS' approach, though not yet finalized, to allow participation in both a quality collaborative and a federally qualified patient safety organization (PSO) outlined in the proposed rule is an important next step in meeting the ACA's requirement. We strongly urge Covered California to add participation in a federally-qualified Patient Safety Organization (for example, CHPSO) to the list of quality collaboratives in Section 1.06, as an interim step toward the anticipated final requirements.**

PSOs — like CHPSO — carry out a variety of patient safety activities with the goal of improving patient safety and the quality of health care delivery. PSOs are able to collect, aggregate and analyze patient safety events and information that are protected under privilege and confidentiality standards. The patient safety evaluation system provisions set forth in the ACA and implemented in regulation align with the triple aim and the goals laid out in the National Quality Strategy.

We believe it would be premature to add CMS' proposed rule language to this section of Attachment 7. However, the ACA requirement for PSO participation is an important step in achieving the goals that Covered California has set forth. CHA and CHPSO believe that the regulatory framework used to implement this section of law should strongly encourage hospital participation in federally-qualified PSOs, while retaining flexibility for continued and ongoing work in the important quality collaborative work outlined in this section.

Covered California goes a step further and proposes to collect information about provider participation, but notes that in the future it will seek additional information.

> Contractor will provide Covered California information regarding their participation in each collaboration. **Such information shall be in a form that shall be mutually agreed to by the Contractor and may include copies of reports used by the 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 should 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.
>
> Covered California and Contractor will collaboratively identify and evaluate the most effective programs for improving care for enrollees and participation in specific collaboratives may be required in future years.

Annual attestation of participation in these programs should be sufficient to meet Covered California requirements, and CHA encourages health plans to consider a simple attestation process when fulfilling these requirements. Notably, many quality improvement initiatives are restricted to only a certain number of hospitals due to limited funding for participation. Throughout the year, and over the course of many years, hospitals will likely move from one initiative to another, or to PSO participation, as they seek to continually improve both performance and patient care. As new initiatives are developed, hospitals must have flexibility to prioritize the areas that are most critical for their quality improvement

efforts. The list of collaboratives should not remain static, and should be added to or reduced, as appropriate, in consultation with stakeholders. Hospital attestation allows for flexibility and will limit the administrative burden on both QHPs and hospitals.

As we have previously shared, while we understand and appreciate the request for additional information by Covered California in future years, we do not agree with collecting data without a clear objective and understanding of its intended use. Rather, a more prudent approach would be to understand participation in various collaboratives and together design a strategic approach to gathering information on hospital performance. CHA does not support requiring QHPs to duplicate already ongoing data collection. We stand ready to work with stakeholders to achieve Covered California's goals in a way that limits administrative burden and costly and unnecessary data collection efforts that will only waste limited financial and personnel resources.

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. Contractor shall report in its annual Application for Certification 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 PCPs when one of their empaneled patients is admitted to a hospital, a critical event that often occurs without knowledge of either the primary care or specialty care 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 encounter.

CHA supports the exchange of patient data to between QHPs and providers to ensure better care coordination. California hospitals remain committed to EHR implementation and using technology to achieve the best patient outcomes. CHA appreciates Covered California's focus on this area but we believe additional refinements to this section are needed to better align efforts already underway in the state.

More specifically, the *Office of the National Coordinator for Health Information Technology Data Brief of April 2015* identified that 68 percent of non-federal acute care hospitals in California responding to the ONC/American Hospital Association annual survey had electronically exchanged health information with outside ambulatory providers or hospitals in 2014. This is statistically lower than the national average of 76 percent. While we are making headway, and we agree more work needs to be done, this work must be aligned with currently specified goals.

CHA does not support QHPs developing new approaches to health information exchange that will divert precious and scarce resources from current efforts. Any new QHP effort will require hospital and provider resources to achieve. A more strategic approach would be for Covered California, in collaboration with QHPs and other stakeholders to assess the current initiatives

underway in the state and to identify within that list of ongoing work a few key priority areas for accelerated development that both providers and health plans would work on together. Creating strategic alignment with ongoing work will only accelerate change. CHA supports the goals that Covered California is promoting, but encourages Covered California to adopt processes that do not place unrealistic requirements on providers or demand the use of technology that is not supported currently.

1.08 Data Aggregation across Health Plans

Covered California and Contractor recognize the importance of aggregating data across purchasers and payers to be 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.

Contractor shall report in its annual Application for Certification its participation in initiatives to support the aggregation of claims and clinical data. Contractor should 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 Payer Claims Database.

Examples to date have included:

(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
(f) Hospital Quality Institute (HQI)

Critical to the work of Attachment 7 is having reliable and valid data aggregators, for both administrative claims data as well as the data needed to construct accurate and reliable quality measures. CHA respectfully requests that Covered California add (f) Hospital Quality Institute (HQI) to the list of examples for inclusion under Section 1.08. HQI is a demonstrated leader in quality improvement in the state, and a trusted source of quality information for hospitals.

Established in April 2013 to realize statewide impact of improving patient safety and quality care for all Californians, HQI has worked tirelessly to accelerate the rate of improvement, and to advance California as a national leader in quality performance. HQI consists of several programs focusing on quality improvement and patient safety including but not limited to CHPSO, the federally qualified patient safety organization, the state's HEN and Patient Safety First. Each program works separately as well as integrated with each other so that reporting redundancy is eliminated, multiple contacts are minimized, and hospital staff focus on improvement goals with the entire support network of HQI.

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 by 2019 places at least 6 percent of reimbursement for Contractor's entire book of business with each hospital at-risk for quality performance. Each contractor may structure this strategy according to their own priorities such as:

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

    b. The metrics that are the basis of such value-payments, such as HACs, readmissions, or satisfaction measured through the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). Contractor is required to select standard measures commonly in use in hospitals and that are endorsed by the National Quality Forum.

CHA appreciates the additional clarification Covered California has provided about the application of this provision to the Contractor's entire book of business, as this was not clear in the first draft. As we have previously noted, we urge a phased approach to the implementation of this requirement to allow sufficient ramp up time for providers and QHPs. This is essential for California's critical access hospitals that are currently not subject to the Medicare fee-for-service risk-based programs. Critical access hospitals and other small or low volume providers should be considered for exclusion from certain proposed measures and payment requirements as there will be insufficient volume for valid and reliable measurement and risk-adjustment. In our previous comments we noted that our understanding is that this provision would only apply to general short-term acute care hospitals and would exclude children's hospitals, inpatient psychiatric facilities, inpatient rehabilitation facilities and long-term acute care hospitals that are contracted with QHPs, asking Covered California to clarify. As this has not been clarified in the second draft, we request that the final draft include this level of specificity.

In addition, CHA supports Covered California's move toward contracts that focus on quality performance that incentivize both hospitals and physicians to work together to improve quality. However, before proceeding, it is imperative that we have an agreed upon set of parsimonious quality measures from which providers and health plans would choose from that that would be the basis for the programs to proceed. Unfortunately, this section does not refer to a draft *Appendix 2 to Attachment 7: Measurement Specifications (Appendix 2)* which we believe is the beginning of such a list of measures for consideration for these programs. CHA urges Covered California to incorporate a forthcoming Appendix 2 following additional stakeholder input.

CHA understands the desire for QHPs and hospitals to work together to design mutually agreeable risk contracts and believes that a number of principles — including, but not limited to, the following — should be adhered to as part of the QHP contracting process.

- **Use a Common and Parsimonious Set of Measures.** All measures used by QHPs should be identical (numerator, denominator, risk adjustment, data collection methods, data source etc.), regardless of the program in which they are used. The proliferation of measures, data sources, and risk adjustment methodologies for the sake of differentiation wastes limited financial and personal resources. In the April 2015 Institute of Medicine report, titled *Vital Signs: Core Metrics for Health and Health Care Progress*, researchers concluded that the vast — and constantly growing — number of quality measures that providers are required to track "limits their overall effectiveness." Therefore, the Institute proposed a more streamlined approach for assessing performance. We should not miss this opportunity to lead the nation in demonstrating that a

parsimonious set of high-impact measures — instead of a proliferation of measures that dilute performance — can drive performance at an accelerated rate. We urge Covered California to establish a workgroup to discuss selection of measures for inclusion in these programs and believe Appendix 2 is the appropriate starting place for the discussion but that additional dialogue is needed.

- **Use NQF-Endorsed Measures.** All measures should, at a minimum, be endorsed by the NQF, a consensus-based entity that evaluates quality measures based on their importance, scientific acceptability, feasibility to collect and usability. Measures endorsed by the NQF are typically suitable for public reporting. Each of the measures noted above is currently NQF-endorsed. However, not all measures are suitable for pay-for-performance programs; we urge Covered California to work with stakeholders to ensure that only the most robust, reliable and valid measures are adopted into those programs.

- **Promote "Carrot, Not Stick" Payment Methodologies.** CHA believes that hospitals should be rewarded for both achievement and improvements, and that QHPs should focus on that type of approach to accelerate improvement. CHA does not support penalty programs — particularly a methodology such as the Medicare HAC program that will always, by design, penalize 25 percent of hospitals regardless of their improvements over the performance period.

- **Evaluate Additional Risk Adjustment.** CHA continually expressed disappointment that, despite overwhelming evidence, CMS has failed to adjust the Medicare readmissions measures for sociodemographic factors that influence a readmissions rate. It is our understanding in reading Attachment 7 that Covered California intends to use nationally-recognized measures such as Medicare readmissions measures, however there are no readmission measures currently specified in Appendix 2 and therefore we would like to have additional dialogue regarding such measures for consideration under these programs. We urge Covered California to work with providers to evaluate appropriate sociodemographic status (SDS) adjusters for readmission measures that may be under consideration. Should Covered California intend to proceed with using Medicare readmissions measures based on QHP claims data, we welcome additional discussion on the significant limitations of these measures that would make them inappropriate for application to the QHP population.

- **Considerations for Small and Rural Hospitals (Low Volume).** As noted above, critical access hospitals are not currently subject to risk-based programs under Medicare and were excluded because they often have insufficient volume or patient mix for valid and reliable measurement. There must be appropriate exclusions for low-volume, small and/or rural hospitals that are essential to provider networks but that may not be appropriate hospitals for inclusion in a value-based purchasing program, similar to Medicare. We ask Covered California to consider that these hospitals may need an additional year to identify appropriate methodologies to meet the goals of the program without unintended consequences.

5.02 Hospital Patient Safety

1) Contractor shall report in its Application for Certification for 2017 baseline rates of specified Hospital Acquired Conditions (HACs) for each of its network hospitals. In order to obtain the most reliable measurement, minimize the burden on hospitals and in the interest of promoting common measurement, Contractor shall employ best efforts to base this report on clinical data

such as is reported by hospitals to the National Healthcare Safety Network (NHSN), California Department of Public Health (CDPH) and to CMS under the Partnership for Patients initiative.

As we noted in our February 8 comments, CHA applauds Covered California for recognizing that QHPs should not develop new measures or data collection efforts to meet this section's intended goals. **However, we are disappointed that Covered California did not remove the language "employ best efforts" from the above to ensure that: a) all QHPs use the HAC measures already required by CMS and CDPH; and b) that QHPs do *not* create an alternative data collection mechanism, but rather employ current data collection efforts to streamline reporting for hospitals and ensure that a robust data validation effort is part of this process. We urge Covered California to establish a workgroup to advise on measure selection for use in public reporting and performance-based programs such as those described in 5.02 and 5.03 and 7.01(b). We believe coming to stakeholder consensus on a list of measures for consideration is the first step in this important discussion.**

1) Prior to its 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.

2) The HACs that are the subject of these initiatives are:

    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. Adverse Drug Events (ADE) with focus on hypoglycemia, inappropriate use of blood thinners, and opioid overuse; and

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

3) The subject HACs may be revised in future years; Covered California expects to include sepsis mortality at such time as the standardized CMS definition and measurement strategy has been tested and validated.

As we've previously shared, while we appreciate Covered California's selection of existing measures that are reported at the state and federal level through the Centers for Disease Control and Prevention's NHSN, we firmly believe it is premature to include the proposed adverse drug event measure, which should instead be considered in future years. This data collection is only just beginning through the voluntary Partnership for Patients initiative, which is focused on data collection for the purposes of quality improvement. This data is not currently used in CMS national pay-for-reporting programs and, therefore, CHA is concerned that the level of hospital resources dedicated to data collection for this measure is significantly lower than the resources devoted to the rigorous data collection for HACs that are currently required in national pay-for-performance and public reporting programs. In addition, opioid overuse is being addressed through a statewide workgroup. **CHA urges Covered California to adopt measures only after they have been publicly reported for at least one year.** The data on Hospital Compare, while imperfect, undergo a fairly rigorous validation process, which is critically important when measures move from pay-for-reporting to pay-for-performance.

CHA is disappointed that Covered California has not included consideration in this provision for hospitals that serve primarily or exclusively pediatric populations, since national pediatric benchmarks may not exist and adult benchmarks may be inappropriate. For example, surgical site infection *with a focus on colon* is not relevant for pediatric patients; C. Difficile infections in children are less common than adults and there is limited high-quality evidence to guide the management of pediatric C. Difficile infection. **We request that Covered California provide clarity on this in its final draft, as well as provide clarity on how this provision would apply to inpatient psychiatric facilities, free standing inpatient rehab facilities and long-term acute care hospitals.**

5) Covered California expects Contractor to only contract with hospitals that demonstrate they provide quality care and promote the safety of Covered California enrollees. **To meet this expectation, by contract year 2018, Covered California will work with its contracted plans and with California's hospitals to identify area of "outlier poor performance" based on variation analysis of HAC rates.** For contract year 2019, Contractors will be expected to 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.

CHA appreciates Covered California's willingness to work with California's hospitals and CHA in defining outlier or poor performance. As we have previously shared, we do not believe that currently available methods to identify "outlier poor performance" are able to adjust adequately for factors such as socioeconomic status, geography, complexity of illness, comprehensiveness of services, wages, post-hospitalization costs, etc. Additionally, there is no evidence that "exclusion" of poor performers is a rational approach to improving care. CHA is concerned that this policy may have the effect of reducing access. Therefore, this process should be open and transparent, and dedicated analytic resources should be made available to understand the impacts of various metrics on providers.

Lastly, CHA urges Covered California to seek public comment on the identification of additional measures going forward in this process. In addition, similar to section 5.01, Covered California should only adopt measures that are endorsed by the National Quality Forum (NQF) — we urge you to reconsider the language in this section to reflect this important measure characteristic.

5.03 Appropriate Use of C-Sections

As we have previously noted, CHA fully supports Covered California's goal of appropriate use of C-sections and strongly believes that a similar payment provision for contracted OB/GYN physicians is critical in making this policy truly effective. While hospitals play a critical role in lowering C-section rates, hospitals do not make those medical decisions — this is a decision made by the physician and the patient. California, unlike other states, cannot employ physicians and thus alignment can be more challenging. A payment policy that ignores the necessary alignment between hospitals and physicians — the majority of whom are not employed by hospitals in California — is short-sighted and must be reconsidered. **We appreciate that Covered California has acknowledged this in the second draft by applying its proposed payment strategy to physicians. CHA strongly believes that any proposal to exclude hospitals from networks or other actions should apply to not only a hospital but also to physicians.** CHA is disappointed that Covered California did not include this recommendation in its second draft. Adoption of a physician-level metric, similar to that for hospitals, must be a top priority for Covered California and the QHPs.

4) Covered California expects Contractor to only contract hospitals **and physicians** that demonstrate they provide quality care and promote the safety of Covered California enrollees. Effective with the Application for Certification for 2019, contractor shall either exclude hospitals **and physicians** from provider networks for purposes of maternity services or to document each year in its Application for Certification the rationale for continued contract with each hospital that demonstrates a C-section rate for NTSV deliveries that is substantially above 23.9 percent.

CHA does not believe that hospitals should be automatically excluded from provider networks if they are unable to achieve an NTSV C-section rate below 23.9 percent. We request that the standard for consideration for exclusion including a statistically significant difference from the 23.9 percent target, rather than falling 'below 23.9 percent'; realizing that C-section volume will impact the validity of this measurement. We appreciate that Covered California is permitting plans to document in their 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, as this may be important for patients to access appropriate care in their local communities.

Lastly, we see that in addition to NTSV C-Sections, Covered California is also requiring an overall C-Section rate to be reported. We are concerned that two C-Section rates may be confusing to consumers and we respectfully request additional dialogue on this issue as this was a last minute addition to Attachment 7 that we believe should be considered more fully before it is implemented.

7.01 Enrollee Health Care Services Price and Quality Transparency Plan

In the Application for Certification for 2017, Contractor will report its planned approach to providing healthcare shopping cost and quality information available to all members enrolled in Contractor's Covered California population. Covered California recognizes that timeline and expectations will differ, based on variables such as Contractor membership size and current tool offerings. Regardless of how the requirement is fulfilled, the common elements at the end point of each Contractor plan submission will include:

a) Cost information:

i. Enable consumers to view their cost share for common elective specialty, and hospital services and prescription drugs specific to their plan product. Also provide real time information on member accumulation toward deductible(s), when applicable, and out of pocket maximums. Health Savings Account (HSA) users' information shall include account deposit and withdrawal/payment amounts.

ii. Allowed charges for all network providers, including the facility and physician cost, for common elective specialty, and hospital services, or comparable clear statement of patient's specific share at each provider. Commonly used service information should be organized in ways that are meaningful for consumers to understand.

iii. Provider-specific costs for care delivered in the inpatient, outpatient, and ambulatory surgery/facility settings; such information shall include the facility name, address, and contact information.

CHA appreciates the important role that cost and quality information play in engaging consumers in their health care, and we believe price transparency will require the commitment and active participation of all stakeholders. CHA was part of a national taskforce convened by Healthcare Financial Management Association that addressed the price transparency issue, and put forth recommendations for consideration. One of the important contributions the taskforce makes in its report, titled *Price Transparency in Health Care*, is providing a clear set of definitions for terms such as charge, cost and price. As previously stated, we ask Covered California to more clearly define its definitions of the allowed charges and provider-specific costs described above. We urge Covered California to consider this nationally-recognized set of common definitions so that all parties agree to what is being asked and can comment specifically on this proposal. Absent a set of common definitions, we offer our comments based on our understanding and welcome additional dialogue.

First, CHA appreciates the recognition that it is incumbent on health plans to provide consumers with understandable information related to their out of pocket costs, because providers do not have timely access to this information. CHA fully supports section iii.

In California, unlike other states, a hospital's chargemaster is public and reported to the California Office of Statewide Health Planning and Development. As such, we believe requesting this information would be duplicative. Providing consumers allowable charge information, alongside out of pocket costs, may cause confusion. While there has been an historical relationship between charges and prices for health care services, that relationship has become less relevant as new payment models have emerged. Moreover, there must be additional consumer education on the differences in hospital charges that are a result of the unique services provided. For example, some hospitals have higher cost structures due to their commitment to teaching or to providing high-cost services such as trauma or burn care. We do not believe charges are an appropriate proxy for price, nor do we support the release of confidentially-negotiated rates between providers and hospitals. CHA stands ready to work with Covered California and the QHPs on developing a strategy to provide important and useable data and to do so in a way that is consistent across all plans.

b) Quality information:

i. Enable consumers to compare providers based on quality performance in selecting a personal care physician or for common elective specialty and hospital services.

ii. Covered California expects Contractor to base quality measurement on nationally endorsed quality information, in accordance with the principles of the Patient Charter for Physician Performance Measurement.

iii. As an interim step prior to integrating quality measurement into provider chooser tools, quality information 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 shall recognize California hospitals that have achieved target rates for Hospital Acquired Conditions (HACs) and NTSV C-section utilization as defined in Article 5, Sections 5.02 and 5.03.

CHA is pleased that Covered California has eliminated its initially proposed requirement that QHPs provide consumers with *internally* developed quality ratings specific to physician and facility by the end of 2019. As we have previously stated, we are concerned with an approach that encourages each individual QHP to develop its own internal quality rating system for providers and facilities. In future years, CHA urges Covered California to adopt one approach that all QHPs may use in providing quality information to consumers.

Covered California consumers are shopping for their health insurance through the exchange; many may change plans from year to year. We believe one methodology for both providers and consumers would consistently result in accurate information. CHA is committed to working with our partners in developing **a single approach** that makes sense for consumers and providers, which would reduce unnecessary costs and administrative burden for both health plans and providers.

CHA appreciates the opportunity to provide comments to Covered California on the second draft. We prepared comments quickly to meet Covered California's compressed timeframe to review and provide comment. Should we identify other areas of concern, we will submit our comments to Covered California in an expeditious manner. If you have any questions, please contact me at (916) 552-7543.

Sincerely,

Amber Kemp
Vice President, Health Care Coverage

cc: Lance Lang, Chief Medical Officer, Covered California
Anne Price, Director, Plan Management, Covered California

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

February 8, 2016

Peter V. Lee
Covered California
Executive Director
Peter.Lee@covered.ca.gov

Subject: Draft Qualified Health Plan (QHP) Certification Application for Plan Year 2017

Dear Mr. Lee:

On behalf of our more than 400 member hospitals and health systems, the California Hospital Association (CHA) welcomes the opportunity to provide comments to Covered California on its draft Qualified Health Plan (QHP) Certification Application for Plan Year 2017 ("Draft") and Attachment 7, Quality, Network Management and Delivery System Standards ("Attachment 7") released on January 21, 2016. We appreciate the opportunity Covered California has provided to hospitals and other stakeholders to engage in this process.

Before providing specific comments, we would like to note our shared commitment to achieving the triple aim of improved patient care experience including quality and satisfaction, improved population health, and a reduction in per capita health care program costs. We recognize the impact Covered California has on improving the health of *all* Californians. CHA appreciates its partnership with Covered California and looks forward to continued collaboration with Covered California, its QHPs and other providers in developing policies that will achieve this shared goal. We also support the important role that the Hospital Quality Institute (HQI) has played – and will continue to play – in efforts to improve hospital safety. We fully support opportunities for Covered California and HQI to collaborate on the performance improvement initiatives outlined in Attachment 7, as well as data sharing and reporting requirements. We welcome further discussions about this collaboration, as well as on our comments below.

I. Draft Qualified Health Plan (QHP) Certification Application for Plan Year 2017

Section 3 of the Draft precludes tiered hospital and physician networks or preferred and non-preferred hospital and physician networks from being offered by QHPs. **CHA supports this policy as it is ineffective in an integrated health care delivery model and forces patients to base decisions on finances, rather than clinical quality and outcomes.**

Section 4.4.5 of the Draft requires plans to describe any contractual agreements with participating providers that preclude the plan from making contract terms transparent to plan sponsors and members, and to agree to make commercially reasonable efforts to exclude any contract provisions that would prohibit disclosure of such information to the Exchange. **As we have stated in our previous comments, provider contracts and payment terms are proprietary, confidential and competitive. There is no policy reason for Covered California to have this detailed information since it is negotiating with the health plan issuer on premium rates; detailed proprietary contract information from specific providers is not necessary for the purpose of negotiating premiums.** In addition, Covered California may obtain aggregated information from its contracted health plan issuers that sufficiently satisfies any legitimate policy purpose, without requiring access to individual proprietary provider contracts. We have

no confidence this sensitive information will remain confidential and will not be used by other parties inappropriately or for anti-competitive reasons.

Section 5 requires plans to demonstrate that its QHP proposals meet requirements for geographic sufficiency of its essential community provider (ECP) network and includes the ECP categories that will meet this requirement. CHA appreciates that Covered California is dedicated to inclusion of ECPs who serve the low-income and medically underserved communities in the provider networks offered by its QHPs. **CHA emphasizes the importance of cultivating meticulous lists and requests that Covered California commit to annually review the lists with CHA and other provider associations to ensure accuracy.**

II. Attachment 7. Quality, Network Management and Delivery System Standards

CHA appreciates Covered California's continued focus and attention in moving our health care system from paying for volume to paying for value. In doing so, CHA also believes that we must focus on a narrow set of consensus-based and nationally-endorsed quality measures that align the efforts of the public and private sectors, leading to accelerated improvement and demonstrated results. Further, we believe payment methodologies implemented by QHPs should focus on rewarding providers for achievement and improvement in performance. CHA does not support payment approaches that implement arbitrary payment reductions based on undefined or subjective metrics. Such approaches undermine a provider's ability to dedicate limited financial and personnel resources to quality improvement efforts that will lead us to our shared goals.

Attachment 7 presents a number of opportunities for alignment; we offer the following specific comments for consideration. In addition, we respectfully request additional clarity in a number of areas that we believe will promote shared understanding of the intended policies and requirements of health plans, hospitals and physicians.

1.02 Assuring Networks are Based on Value

b. This shall 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. Such information may be made publicly available by Covered California. Contractor may provide this information with its Application for Certification for 2017**.** Covered California may, at its discretion, make such information available to Enrollees and interested individuals.

CHA respectfully requests that this information be made available to hospitals and physicians, at a minimum. In addition, hospitals and physicians should have embargoed data provided for review to identify errors that require corrections prior to public release. Understanding expectations of health plans in their quality goals for selection in network design and facility selection will ensure transparency in the process. Further, knowing the source and year of the data is also important.

e. Covered California expects Contractor to only contract with providers and hospitals that demonstrate they provide quality care and promote the safety of Covered California Enrollees. To meet this expectation, by contract year 2018, Covered California will work with its contracted plans 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 California's hospitals. For contract year 2019, Contractors will be expected to either exclude those hospitals that are outlier poor performers on either cost or quality from provider networks or to document each year in its Application for Certification the rationale for continued contract with each hospital that is

identified as a poor performing outlier. Such reports will detail contractual requirements and their enforcement, monitoring and evaluation of performance, consequences of noncompliance and plans to transition patients from the care of providers with poor performance. Such information may be made publicly available by Covered California.

CHA appreciates the opportunity to engage in the development of a methodology on performance standards for hospitals, and looks forward to working with Covered California in its development. Several key principles should be considered as a framework for analysis. **We believe strongly that this process should begin as early as possible to allow sufficient time for thoughtful input, analysis, modeling and education of hospitals and health systems. We encourage a transparent process inclusive of hospital representatives, CHA and other interested stakeholders.**

1.03 Participation in Collaborative Quality Initiatives.

Effective in 2017, Contractor shall be required to 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 by 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. www.chhs.ca.gov/PRI/_CalSIM%20Maternity%20Initiative%20WriteUp%20April%202014.pdf (See Article 5, Section 5.01)

b) Statewide Workgroup on Overuse: Sponsored by Covered California, DHCS and CalPERS, this multi-stakeholder work group facilitated by Integrated Healthcare Association (IHA), will leverage Choosing Wisely decision aids to support efforts to drive appropriate use of C-sections, prescription of opioids and low back imaging. www.iha.org/grants-projects-reducing-overuse-workgroup.html (See Article 7, ~~Section 7.04~~ Section 7.05~~)~~

In reviewing the section noted above, we have noted some confusion in the field about the requirements for hospital participation in various quality collaboratives. First, CHA understands the requirement above as applying to QHPs. CHA also understands Covered California's goal of 100 percent of California maternity hospitals submitting data to CMQCC, and supports this partnership. However, we are unclear if Covered California intends for hospitals to participate in the Statewide Workgroup on Overuse and request additional clarity regarding.

In section 7.05, Covered California states that improvement strategies and targets for 2019 must be established to address reduction in the overuse of opioids and imaging for low-back pain. These issues, while important for hospitals, will be most impactful if addressed at the ambulatory setting. We ask that Covered California further clarify the applicable entity for this requirement. Should Covered California intend to require hospital participation, CHA wishes to understand in greater detail requirements of participation and to be fully involved in developing improvement strategies and targets as discussed in section 7.05.

In addition, we understand the section after Section 1.03(b) which perhaps should be labeled separately as (c), reflects Covered California's interest in participation rates of providers, rather than a requirement that hospitals participate in all of the collaboratives listed on page 5.

We ask that Covered California revise its list of quality collaboratives on page 5 to ensure that any hospital engagement network (HEN), including those not listed, would be counted for participation. In

addition, we request the inclusion of the Children's Hospitals' Solutions for Patient Safety HEN in addition to the other HENs listed in Section 1.03. We request that Covered California also consider quality collaboratives associated with the state's 1115 Medicaid Waiver Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program to be considered for inclusion in Section 1.03.

In addition, CMS' recently proposed *CMS-9937-P Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017* rule further implements provisions of the Affordable Care Act that mandate certain patient safety and quality improvement requirements in order to contract with a QHP through health insurance exchanges. The comments below reference our comments to CMS on Subpart D §156.1110, establishment of the patient safety standards for QHP issuers. **Notably, we believe CMS' approach, though not yet finalized, to allow participation in both a quality collaborative and a federally qualified patient safety organization (PSO) outlined in the proposed rule is an important next step in meeting the ACA's requirement. We encourage Covered California to consider adopting as an interim step toward those final requirements by adding participation in a Federally-Qualified Patient Safety Organization (for example, CHPSO) to the list of quality collaboratives in Section 1.03.**

PSOs — like CHPSO — carry out a variety of patient safety activities with the goal of improving patient safety and the quality of health care delivery. PSOs are able to collect, aggregate and analyze patient safety events and information that is protected under privilege and confidentiality standards. The patient safety evaluation system provisions set forth in the ACA and implemented in regulation align with the triple aim and the goals laid out in the National Quality Strategy.

We believe it would be premature to add CMS' proposed rule language to this section of Attachment 7. However, the ACA requirement for PSO participation is an important step in achieving the goals that Covered California has set forth. CHA and CHPSO believe that the regulatory framework used to implement this section of law should strongly encourage hospital participation in federally-qualified PSOs, while retaining flexibility for continued and ongoing work in the important quality collaborative work outlined in this section.

Covered California goes a step further and proposes to collect information about provider participation, but notes that in the future it will seek additional information.

> Contractor will provide Covered California information regarding their participation in each collaboration. **Such information shall be in a form that shall be mutually agreed to by the Contractor and may include copies of reports used by the 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 should 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.
>
> Covered California and Contractor will collaboratively identify and evaluate the most effective programs for improving care for enrollees and participation in specific collaboratives may be required in future years.

Annual attestation of participation in these programs should be sufficient to meet Covered California requirements, and CHA encourages health plans to consider a simple attestation process. Notably, many quality improvement initiatives are restricted to only a certain number of hospitals due to limited funding for participation. Throughout the year, and over the course of many years, hospitals will likely move from one initiative to another, or to PSO participation, as they seek to continually improve both performance and patient care. As new initiatives are developed, hospitals must have flexibility to prioritize the areas that are most critical for their quality improvement efforts. The list of collaboratives should not remain static, and should be added to or reduced as appropriate in consultation with stakeholders. Hospital attestation allows for flexibility and will limit the administrative burden on both QHPs and hospitals.

While we understand and appreciate the request for additional information by Covered California, we do not agree with collecting data without a clear objective and understanding of its intended use. Rather, a more prudent approach would be to understand participation in various collaboratives and together design a strategic approach to gathering information on hospital performance. CHA does not support requiring health plans to duplicate already ongoing data collection. We stand ready to work with stakeholders to achieve Covered California's goals in a way that limits administrative burden and costly and unnecessary data collection efforts that will only waste limited financial and personnel resources.

5.01 Appropriate Use of C-Sections

CHA fully supports Covered California's goal of appropriate use of C-sections. According to a report issued by the California Maternal Quality Care Collaborative (CMQCC), the rate of cesarean deliveries in the United States as a whole rose by 50 percent between 1998 and 2008. The increasing rate of cesarean deliveries in the United States is attributed to an increase in first-birth cesareans done in the course of labor as well as a decline in vaginal births after a prior cesarean. We feel that there are concrete quality improvement activities that can be performed to address the differences in cesarean delivery rates among hospitals and through collaborative efforts by HQI, CMQCC and CalSIM.

3) Adopt a payment methodology progressively to include all contracted hospitals **and physicians** such that by 2019 there is no financial incentive to perform C-sections. Contractor shall report on its design and the percent of hospitals **and physicians** contracted under this model in its Application for Certification for 2017 and annually thereafter.

First and foremost, we are concerned about creating a disincentive to provide medically appropriate care, and that this language, if not clarified, may create a disincentive for delivery by medically-necessary C-sections — and lead to inadequate payment for medically necessary C-sections. Hospitals are working hard to reduce the C-section rate in California. CHA urges Covered California to consider clarifying language outlining payment designs that promote medically-necessary care for mothers while incentivizing vaginal delivery when medically appropriate. More specifically, CHA understands Covered California does not wish to dictate the manner in which this payment is designed and we agree that providers and health plans should have the flexibility to negotiate a hospital specific rate that incentivizes vaginal delivery while not penalizing hospitals for medically necessary and appropriate C-Sections. One option is to consider a blended hospital-specific rate for C-sections and vaginal deliveries. Another option may be to establish one bundled rate that includes both the physician and hospital component. For the reasons noted below, we believe it is premature for QHPs to consider a bundled or episode approach to the payment of maternity care, rather we encourage and support methodologies that will reward achievement and

improvements in the lowering of the low-risk C-section rates, while maintaining adequate payment for medically necessary C-sections.

In addition, we believe strongly that a similar payment provision for contracted OB/GYN physicians is critical in making this policy truly effective and propose the above changes to item 3. While hospitals play a critical role in lowering C-section rates, hospitals do not make those medical decisions — this is a decision made by the physician and the patient. California, unlike other states, cannot employ physicians and thus alignment can be more challenging. A payment policy that ignores the necessary alignment between hospitals and physicians — the majority of whom are not employed by hospitals in California — is short-sighted and must be reconsidered.

4) Covered California expects Contractor to only contract hospitals **and physicians** that demonstrate they provide quality care and promote the safety of Covered California enrollees. Effective with the Application for Certification for 2019, contractor shall either exclude hospitals **and physicians** from provider networks for purposes of maternity services or to document each year in its Application for Certification the rationale for continued contract with each hospital that demonstrates a C-section rate for NTSV deliveries that is substantially above 23.9 percent.

Adoption of a physician-level metric, similar to that for hospitals, must be a top priority for Covered California and the QHPs. CHA strongly believes that any proposal to exclude hospitals from networks or other actions (discussed below) should apply to not only a hospital but also to physicians.

Finally CHA wishes to express concerns about the above language citing "substantially above" 23.9 percent. All hospitals with labor and delivery must understand the target goal. However, "substantially above" is vague and subjective. It is problematic for hospitals to face a possible scenario of coming to the end of a measurement performance year and then be told they would be excluded from a network because of a QHP's subjective interpretation of what constitutes "substantially above." Further, we believe that the baseline, performance year, volume thresholds for exclusions, and other important factors are clear and transparent in setting the target. Finally, we do not believe hospitals should be automatically excluded; we believe the language below is more appropriate.

> *For contract year 2019, Contractors will be expected to either **exclude hospitals and physicians** that are unable to achieve the target C-section rate from provider networks or to document each year in its Application for Certification the rationale for continued contracting with each hospital and physician that is identified as a poor performing outlier on safety and efforts the hospital is undertaking to improve its performance.*

5.02 Hospital Patient Safety

1) Contractor shall report in its Application for Certification for 2017 baseline rates of specified Hospital Acquired Conditions (HACs) for each of its network hospitals. In order to obtain the most reliable measurement, minimize the burden on hospitals and in the interest of promoting common measurement, Contractor shall employ best efforts to base this report on clinical data such as is reported by hospitals to the California Department of Public Health and to CMS under the Partnership for Patients initiative.

CHA applauds Covered California for recognizing that QHPs should not develop new measures or data collection efforts to meet this section's intended goals. **However, we urge you to remove the language "employ best efforts" to ensure that: a) all QHPs use the HAC measures already required by CMS**

and CDPH; and b) that QHPs do *not* create an alternative data collection mechanism, but rather employ current data collection efforts (i.e. National Healthcare Safety Network) to streamline reporting for hospitals and ensure that a robust data validation effort is part of this process. We urge Covered California to establish a work group to advise on measure selection for use in public reporting and performance-based programs such as those described in 5.02 and 5.03 and 7.01(b).

2) Prior to its 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.

3) The HACs that are the subject of these initiatives are:

    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. Adverse Drug Events (ADE) with focus on hypoglycemia, inappropriate use of blood thinners, and opioid overuse; and~~

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

4) The subject HACs may be revised in future years; Covered California expects to include Sepsis Mortality at such time as the standardized CMS definition and measurement strategy has been tested and validated.

CHA appreciates Covered California's selection of existing measures that are reported at the state and federal level through the Centers for Disease Control and Prevention's National Healthcare Safety Network. However, we believe it is premature to include the proposed adverse drug event measure, which should instead be considered in future years. This data collection is only just beginning through the voluntary Partnership for Patients initiative, which is focused on data collection for the purposes of quality improvement. This data is not currently used in CMS national pay–for-reporting programs, and, as such, CHA is concerned that the level of hospital resources dedicated to data collection for this measure is significantly lower than the resources devoted to the rigorous data collection for HACs that are currently required in national pay-for-performance and public reporting programs. In addition, opioid overuse is being addressed through a statewide workgroup. As a matter of principle, CHA urges Covered California to adopt measures only after they have been publicly reported for at least one year. The data on Hospital Compare, while imperfect, undergoes a fairly rigorous validation process, which is critically important when measures move from pay-for-reporting to pay-for-performance.

Additionally, there should be separate consideration in this provision for hospitals that serve primarily or exclusively pediatric populations, since national pediatric benchmarks may not exist and adult benchmarks may be inappropriate. For example, surgical site infection *with a focus on colon* is not relevant for pediatric patients; C. Difficile infections in children are less common than adults and there is limited high-quality evidence to guide the management of pediatric C. Difficile infection. Therefore, we request clarity as to how the requirements of this section would apply to hospitals that serve primarily

pediatric patients. In addition, we request clarity on how this provision would apply to inpatient psychiatric facilities, free standing inpatient rehab facilities and long-term acute care hospitals.

5) Covered California expects Contractor to only contract with hospitals that demonstrate they provide quality care and promote the safety of Covered California enrollees. **To meet this expectation, by contract year 2018, Covered California will work with its contracted plans and with California's hospitals to identify area of "outlier poor performance" based on variation analysis of HAC rates.** For contract year 2019, Contractors will be expected to either exclude hospitals that demonstrate outlier poor performance on safety from provider networks 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.

CHA appreciates Covered California's willingness to work with California's hospitals and CHA in defining outlier or poor performance. We do not believe that currently available methods to identify "outlier poor performance" are able to adjust adequately for factors such as socioeconomic status, geography, complexity of illness, comprehensiveness of services, wages, post-hospitalization costs, etc. Nor is there evidence that "exclusion" of poor performers is a rational approach to improving care. CHA is concerned that this policy may have the effect of reducing access. Therefore, this process should be open and transparent, and dedicated analytic resources should be made available to understand the impacts of various metrics on providers.

Lastly, CHA urges Covered California to seek public comment on the identification of additional measures going forward in this process. In addition, similar to section 5.03, Covered California should only adopt measures that are endorsed by the National Quality Forum (NQF) — we urge you to reconsider the language in this section to reflect this important measure characteristic.

5.03 Hospital Payments to Promote Quality and Value

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

1) Adopt a hospital payment methodology that by 2019 places at least 6 percent of reimbursement to hospitals at-risk for quality performance. Each contractor may structure this strategy according to their own priorities such as:

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

    b. The metrics that are the basis of such value-payments, such as HACs, readmissions, or satisfaction measured through the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). Contractor is required to select standard measures commonly in use in hospitals and that are endorsed by the National Quality Forum.

CHA supports Covered California's move toward contracts that focus on quality performance that incentivize both hospitals and physicians to work together to improve quality. While the current six percent of payments proposed to be at risk in this section is somewhat similar to the amount of Medicare hospital fee-for-service inpatient payments currently at risk, an important difference is that the Medicare payments were phased in over a three-year period. Further, the payments proposed in this section encompass three very different programs.

CHA understands this to mean six percent of all payments to the hospital for Covered California patients, rather than six percent of payments for a total health plan population, but we seek additional clarity on this definition. In addition, CHA urges a phased approach to the implementation of this requirement to allow sufficient ramp up time for providers and QHPs. This is essential for California's critical access hospitals that are currently not subject to the Medicare fee-for-service risk-based programs like hospital value-based purchasing, readmissions and the HAC reduction program. Critical access hospitals and other small or low volume providers should be considered for exclusion from certain proposed measures as there will be insufficient volume for valid and reliable measurement and risk-adjustment. Further, it is our understanding that this provision would only apply to general short-term acute care hospitals and would exclude children's hospitals, inpatient psychiatric facilities, inpatient rehabilitation facilities and long-term acute care hospitals that are contracted with QHPs — we ask Covered California to clarify.

CHA understands the desire for plans and hospitals to work together to design mutually agreeable risk contracts. However, we believe a number of principles — including, but not limited to, the following — should be adhered to as part of the QHP contracting process.

- **Use a Common and Parsimonious Set of Measures.** All measures used by QHPs should be identical (numerator, denominator, risk adjustment, data collection methods, data source etc.), regardless of the program in which they are used. The proliferation of measures, data sources, and risk adjustment methodologies for the sake of differentiation wastes limited financial and personal resources. In the April 2015 Institute of Medicine report, *Vital Signs: Core Metrics for Health and Health Care Progress*, researchers concluded that the vast — and constantly growing — number of quality measures that providers are required to track "limits their overall effectiveness." Therefore, the Institute proposed a more streamlined approach for assessing performance. We should not miss this opportunity to lead the nation in demonstrating that a parsimonious set of high-impact measures — instead of a proliferation of measures that dilute performance — can drive performance at an accelerated rate. We understand that this provision would limit QHPs to measures under consideration for pay-for-performance, HAC measures listed in 5.02 (except adverse drug events), Medicare readmissions measures (discussed below) and HCAHPS measures, but do not believe additional measures should be added to this list without additional input from the provider community. We urge Covered California to establish a work group to discuss selection of measures as discussed above.

- **Use NQF-Endorsed Measures.** All measures should, at a minimum, be endorsed by the NQF, a consensus-based entity that evaluates quality measures based on their importance, scientific acceptability, feasibility to collect and usability. Measures endorsed by the NQF are typically suitable for public reporting. Each of the measures noted above are currently NQF-endorsed. However, not all measures are suitable for pay-for-performance programs; we urge Covered California to work with stakeholders to ensure that only the most robust, reliable and valid measures are adopted into those programs.

- **Promote "Carrot, Not Stick" Payment Methodologies.** CHA believes that hospitals should be rewarded for both achievement and improvements, and that QHPs should focus on that type of approach to accelerate improvement. **CHA does not support penalty programs — particularly a methodology like the Medicare HAC program that will always, by design, penalize 25 percent of hospitals regardless of their improvements over the performance period**.

- **Evaluate Additional Risk Adjustment.** CHA has continued to express our disappointment that, despite overwhelming evidence, CMS has failed to adjust the Medicare readmissions measures

for sociodemographic factors that influence a readmissions rate. It is our understanding in reading Attachment 7 that Covered California intends to use nationally-recognized measures such as Medicare readmissions measures. In doing so, we hope that Covered California will work with providers to evaluate appropriate sociodemographic status (SDS) adjusters and to encourage CMS to make these changes at the national level. **Should Covered California intend to proceed with using Medicare readmissions measures based on QHP claims data, we would welcome additional discussion on the significant limitations of these measures that would make them inappropriate for application to the QHP population.**

- **Considerations for Small and Rural Hospitals.** As noted above, critical access hospitals are not currently subject to risk-based programs under Medicare, and were excluded because they often have insufficient volume or patient mix for valid and reliable measurement. There must be appropriate exclusions for small and/or rural hospitals that are essential to provider networks, but may not be appropriate hospitals for inclusion in a value-based purchasing program, similar to Medicare. We ask that Covered California consider that these hospitals may need an additional year to identify appropriate methodologies to meet the goals of the program without unintended consequences.

7.01 Enrollee Health Care Services Price and Quality Transparency Plan

In the Application for Certification for 2017, Contractor will report its planned approach to providing healthcare shopping cost and quality information available to all members enrolled in Contractor's Covered California population. Covered California recognizes that timeline and expectations will differ, based on variables such as Contractor membership size and current tool offerings. Regardless of how the requirement is fulfilled, the common elements at the end point of each Contractor plan submission will include:

a) Cost information:

iii. Enable consumers to view their cost share for common elective specialty, and hospital services and prescription drugs specific to their plan product. Also provide real time information on member accumulation toward deductible(s), when applicable, and out of pocket maximums. Health Savings Account (HSA) users' information shall include account deposit and withdrawal/payment amounts.

iv. Allowed charges for all network providers, including the facility and physician cost, for common elective specialty, and hospital services, or comparable clear statement of patient's specific share at each provider. Commonly used service information should be organized in ways that are meaningful for consumers to understand.

v. Provider-specific costs for care delivered in the inpatient, outpatient, and ambulatory surgery/facility settings; such information shall include the facility name, address, and contact information.

CHA appreciates the important role that cost and quality information play in engaging consumers in their health care, and we believe price transparency will require the commitment and active participation of all stakeholders. CHA was part of a national taskforce convened by Healthcare Financial Management Association that addressed the price transparency issue, and put forth recommendations for consideration. One of the important contributions the taskforce makes in its report, titled *Price Transparency in Health Care*, is providing a clear set of definitions for terms such as charge, cost and price. As a first step, we ask Covered California to more clearly define its definitions of the allowed charges and provider-specific

costs described above. We urge Covered California to consider this nationally-recognized set of common definitions so that all parties agree to what is being asked and can comment specifically on this proposal. Absent a set of common definitions, we offer our comments based on our understanding and welcome additional dialogue.

First, CHA appreciates the recognition that it is incumbent on health plans to provide consumers with understandable information related to their out of pocket costs, because providers do not have timely access to this information. CHA fully supports section iii.

In California, unlike other states, a hospital's chargemaster is public and reported to the California Office of Statewide Health Planning and Development. As such, we believe requesting this information would be duplicative. Providing consumers allowable charge information, alongside out of pocket costs, may cause confusion. While there has been an historical relationship between charges and prices for health care services, that relationship has become less relevant as new payment models have emerged. Moreover, there must be additional consumer education on the differences in hospital charges that are a result of the unique services provided. For example, some hospitals have higher cost structures due to their commitment to teaching or to providing high-cost services like trauma or burn care. We do not believe charges are an appropriate proxy for price, nor do we support the release of confidentially-negotiated rates between providers and hospitals. CHA stands ready to work with Covered California and the QHPs on developing a strategy to provide important and useable data and to do so in a way that is consistent across all plans.

b) Quality information:

iii. Covered California expects Contractor with over 100,000 enrollees to provide consumers with internally developed quality ratings specific to physician and facility by the end of 2019,

iv. Nationally endorsed quality information, in accordance with the principles of the Patient Charter for Physician Performance Measurement, will be accepted as an interim step for plans with enrollments over 100,000 until provider-specific quality information specific to Covered California experience can be provided and may be a longer term solution for smaller plans. Sources for national or state quality information for tool inclusion are:

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

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

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

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

v. In addition, Contractor shall recognize California hospitals that have achieved target rates for NTSV C-Section utilization and Hospital Acquired Conditions (HACs) as defined in Article 5, Sections 5.01 and 5.02.

CHA is concerned about the approach outlined in section b) that encourages each individual QHP to develop its own internal quality rating system for providers and facilities. While we agree that providing quality information is important, and are pleased to see Covered California list nationally-recognized and publicly available data for use in this process, we disagree with the approach. **CHA urges Covered California adopt one approach all QHPs may use in providing quality information to consumers.**

Covered California consumers are shopping for their health insurance through the exchange; many may change plans from year to year. We believe one methodology for both providers and consumers would consistently result in accurate information. CHA is committed to working with our partners in developing **a single approach** that makes sense for consumers and providers, which would reduce unnecessary costs and administrative burden for both health plans and providers.

Finally, CHA appreciates the above language in Section 7.01 iii which clearly states that Covered California will recognize in a positive way hospitals that achieve their targets. We understand this approach to be one that promotes positive recognition for important work throughout the year. CHA fully supports this approach and believes consumers will appreciate this simple designation.

We believe some may argue that rather than promoting achievement, an alternative approach would be to perhaps grade hospitals on their performance (average, below average, poor, etc.). As previously stated, we would not support multiple methodologies for the array of quality performance data for QHPs. Any alternative approach should be considered through a stakeholder engagement and public comment process.

CHA appreciates the opportunity to provide comments to Covered California on the Draft and Attachment 7. We appreciate your consideration of the above recommendations, and look forward to our continued partnership. If you have any questions, please contact me at (916) 552-7543.

Sincerely,

Amber Kemp
Vice President, Health Care Coverage

cc: Lance Lang, Chief Medical Officer, Covered California
Anne Price, Director, Plan Management, Covered California

California LGBT Health & Human Services Network

Elise Dickenson
Covered California
1601 Exposition Blvd.
Sacramento, CA 95815

February 4, 2016

Dear Ms. Dickenson,

The California Lesbian, Gay, Bisexual, and Transgender Health and Human Services Network is a statewide coalition of more than 50 nonprofit direct service providers, community centers, researchers, and policy experts serving LGBT communities. We appreciate the opportunity to comment on the 2017-2019 Draft QHP Issuer Model Contract.

The contract with Qualified Health Plans (QHPs) is an important tool in our efforts to improve health care quality, lower costs, and reduce health disparities. Evidence indicates that LGBT people experience worse health outcomes with regards to alcohol, drug, and tobacco use, safety and violence, mental health, cancer, and HIV/AIDS as compared to the non-LGBT population. These disparities are even greater for LGBT people who are also members of other groups disadvantaged because of their race, ethnicity, or other aspects of their identity.

Attachment 7 includes many important ways in which Covered California will work with plans to create a high-performing health delivery system. In particular, we strongly support Article 3: Reducing Health Disparities and Assuring Health Equity. Tracking disparities, designing and implementing measures for improvement, and evaluating progress are critical to achieving health equity. While we would love to see sexual orientation and gender identity included as required measures immediately, we understand that's not currently feasible and look forward to working with Covered California and the health plans to expand disparity identification in the future.

We applaud the steps taken in Attachment 14 to incentivize quality and improvement. However, high quality mental health services should be one of the performance standards that QHPs are held to. Mental and behavioral health are recognized as critically important in Attachment 7, Article 4.05, but without a performance standard in Attachment 14 or a required report in Attachment 13, there is no guarantee that QHPs will place much-needed emphasis on ensuring that they provide excellent mental and behavioral health services. We recommend adding a mental and behavioral health performance standard in Attachment 14, as detailed in the attached comments spreadsheet.

We look forward to working with you as California continues to lead on improving our health care system and working toward health equity. To discuss these recommendations further, please contact Kate Burch at 510-873-8787 or kburch@health-access.org.

Sincerely,

Kate Burch

Kate Burch
Network Director

California Medical Association
Physicians dedicated to the health of Californians
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February 4, 2016

Elise Dickenson
Covered California
1601 Exposition Boulevard
Sacramento, CA 95815

Sent via email to Elise.Dickenson@covered.ca.gov

RE: 2017 Qualified Health Plan Contract Attachment 7

Dear Ms. Dickenson:

On behalf of our more than 41,000 physician and medical student members, the California Medical Association (CMA) would like to thank you for considering stakeholder input on Covered California's 2017 Qualified Health Plan (QHP) contract and, specifically, on Attachment 7 to the contract. CMA recognizes Covered California's success in providing coverage for millions of previously uninsured Californians as well as its efforts to ensure that coverage is meaningful as reflected by the Triple Aim framework. CMA shares Covered California's commitment to improving health care quality, promoting better health, lowering costs, and reducing health disparities and makes the following recommendations regarding Attachment 7 to ensure that Covered California consider the impact of these policies on QHP contracted physicians, who are an essential component of California's health care system.

Need for Physician Collaboration and Meaningful Input in Stakeholder Processes

Throughout its discussion of strategies to promote higher quality and better value, Attachment 7 repeatedly refers to a need for input from "providers" generally. CMA is concerned that Attachment 7 is void of any language requiring that these providers be practicing physicians and recommends that Covered California require the Plan Management Advisory Group and/or the Quality Subcommittee to solicit input from practicing physicians - in addition to medical group and health plan medical directors - as part of implementing new quality rating programs and models of care.

CMA is particularly concerned that Covered California staff may lack an understanding of the current practical realities facing QHP contracted physicians. Health plan representatives who raised concerns regarding difficulties with getting providers to comply with proposed data reporting requirements have been told by Covered California staff to simply write these requirements into the provider contracts. We believe that these comments demonstrate an overly

simplistic view of the problem and that directing plans to simply pass on unfunded, administratively burdensome mandates on physicians could result in unintended consequences.

Complying with health plan data reporting requirements includes navigating unfamiliar web portals and interfaces that host the quality data used to develop a performance rating, locating and thoroughly reviewing chart data, and identifying and correcting errors, all of which take away from time providing patient care. CMA member physicians have reported spending up to five hours to review and correct inaccurate data required by a single payor. Consider that most physicians have numerous contracts and these reporting requirements become a significant factor in deciding whether to take on additional plan contracts. Physicians who become overburdened by unwieldy, costly administrative requirements may be forced to decline these contracts or to terminate existing contracts, leaving QHPs with narrower and potentially inadequate provider networks and patients with limited options for care. It is thus critical that Covered California and QHPs seek input from practicing physicians in order to develop quality measures and data reporting requirements that accurately reflect current modes of medical practice and practical realities facing QHP contracted physicians.

Effective Quality Measures

CMA recognizes the value to patients of having access to quality information when selecting a physician and health plan and wants to ensure that quality rating measures developed by Covered California are meaningful and accurate. We urge Covered California to consider quality rating programs that QHPs already use – both because they have likely been vetted for accuracy and because streamlining reporting requirements would significantly reduce the administrative burden on providers, as physicians contracting with multiple health plans for multiple lines of business already have to comply with significant data reporting requirements. Attachment 7 refers to eValue8 and Truven Analytics as contractors. CMA requests that additional information be provided regarding the qualifications of these contractors, particularly as compared to other quality rating programs in use.

To the extent Covered California intends to employ any quality rating metrics - existing or newly developed - CMA recommends publicizing the specific metrics that will be used in developing quality scores and to allow for comment and input on these metrics from practicing physicians as well as from other stakeholders. Finally, CMA would oppose any quality rating program that fails to provide physicians the opportunity to review, correct and appeal their data prior to publication.

These concerns are grounded in recent experiences CMA has had evaluating and/or collaborating with physician quality rating programs. While the intentions of these programs may be good, the quality of their information often is suspect and misleading. The accuracy of physician quality ratings, CMA has found, depends greatly on data collection methods, the source of the data, the metrics and analytic protocols used, the ability of subject physicians to review and correct errors, and the disclosures that accompany any ratings reports. While CMA cannot comment on the contractors referenced in Attachment 7, we remain concerned that the Exchange has not done enough to minimize the factors we know to undermine the accuracy and integrity of quality ratings.

Promotion of Effective Care Models

CMA supports the aim of Covered California to allow QHPs to develop payment models and models of care that reflect the new ways in which physicians practice medicine and encourages Covered California to include practicing physicians in these conversations. In particular, Covered California should consult closely with practicing physicians in its efforts to adopt a standard definition of Patient Centered Medical Home and in developing standards for telehealth that are consistent with existing California law.[1] It is critical to the success of these new models of care and reimbursement that they are based on practical experience, which can only be gained by seeking input from practicing physicians – rather than relying solely on medical group and health plan medical directors.

CMA urges Covered California to balance its focus on efficiency and innovation with a consideration of consumer choice. In this regard, Covered California should take care not to constructively eliminate the Preferred Provider Organization (PPO) model of care by developing policies and QHP contract terms that will make it untenable for such a plan to operate in the marketplace. While CMA does not oppose the creation of incentives for innovative and cost effective care models, we would oppose contract terms that serve to render the PPO model inoperable.

Healthcare Services Price Transparency

While CMA supports efforts to educate QHP enrollees with regard to the cost of care in order to empower them to make informed healthcare decisions, we oppose any requirement that QHPs disclose or make public a physician's allowed charges. Forced disclosures of contracted rates negotiated between providers and health plans raise anti-trust concerns and are prohibited by most managed care plan contracts with providers. In addition, negotiated rate information is simply not useful to QHP enrollees in determining the cost of their care. Rather, CMA urges Covered California to require QHPs to disclose all information related to out of pocket costs in ways that are organized to be understandable and meaningful for enrollees in their decision-making.

Thank you again for the opportunity to provide input on the 2017 QHP Contract and on Attachment 7. We look forward to continuing our work with Covered California, the QHPs, and other stakeholders in our ongoing effort to improve access to cost effective, quality healthcare for Californians. Please contact me at (916) 551-2552 or switorff@cmanet.org if I may offer any additional information or clarify any of CMA's comments.

[1] CMA urges Covered California to replace the definition of "telemedicine" from Attachment 7 with the definition of "telehealth" from California Business & Professions Code § 2290.5. As defined in state law, telehealth is: "the mode of delivering health care services and public health via information and communication, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and ashynchronous store and forward transfers."

Respectfully submitted,

Stacey Wittorff, Esq.
Associate Director
Center for Health Policy
California Medical Association

cc: California Health Benefits Exchange Board, *via email to boardcomments@covered.ca.gov*
Plan Management Advisory Group, *via email to qhp@hbex.ca.gov*

CPEHN
California Pan-Ethnic Health Network

February 4, 2016

Anne Price, Director
Plan Management

Dr. Lance Lang, M.D.
Chief Medical Officer
Covered California
1501 Exposition Way
Sacramento, CA

Re: Prioritizing Health Disparities Reduction in Covered California Qualified Health Plan Contracting

Dear Ms. Price and Dr. Lang,

The California Pan-Ethnic Health Network, representing California's communities of color, the majority of Californians, has participated in the Covered California Plan Management Committee and its quality workgroup. The Covered California Qualified Health Plan contract and its attachments offer Covered California the opportunity to lead the nation in disparities reduction by taking health disparities into account throughout the entirety of the quality initiatives.

We ask that Covered California ensure health equity is an integral component of the key quality improvement provisions included as part of Attachments 7 and 14. For too long quality improvement and disparities reduction have been treated as separate objectives. This approach is not feasible in a state like California where a majority of Covered California enrollees, and the majority of the state's residents, are racially and ethnically diverse. Disparities in access to care are pervasive which is why the Centers for Medicare and Medicaid Services (CMS) is now recommending that agencies evaluate disparities impacts and integrate equity solutions across all CMS programs.[1] We ask that Covered California do as CMS recommends by evaluating disparities impacts and integrating equity solutions across its quality initiatives. Reducing disparities is also identified as a key priority in the HHS Disparities Action Plan, Healthy People 2020, the 2013 HHS Language Access Plan (HHS Language Access Plan), the CMS Strategy, the CMS Quality Strategy, and key provisions in the Affordable Care Act (ACA).

We appreciate the steps Covered California has taken to ensure health equity is prioritized as part of Covered California's 2017 contract with QHPs including the

[1] "The CMS Equity Plan for Improving Quality in Medicare," September 2015. https://www.cms.gov/About-CMS/Agency-Information/OMH/OMH_Dwnld-CMS_EquityPlanforMedicare_090615.pdf

new requirements under *Article 3. Reducing Health Disparities and Assuring Health Equity.* The steps that are recommended will move Covered California forward from collecting demographic information to requiring contracting health plans to improve quality and reduce health disparities advancing the quadruple aim of lower costs, better care, better health, and reduced disparities, though we have serious questions about the exceedingly slow pace of progress toward a goal that Covered California has been enunciating since at least 2011, five years ago.

There is a clear rationale for prioritizing and integrating health equity in quality improvement initiatives. Most quality improvement strategies will not automatically benefit all segments of the population equally. For example, an intervention that improves quality at the same rate for all racial and ethnic groups leaves existing disparities constant. Without an explicit focus on disparities reduction, other quality interventions such as pay-for-performance programs may have the unintended consequence of worsening health care disparities by creating pressure for providers to avoid caring for people who are perceived to be high-risk patients.[2] We recognize that some quality initiatives, such as reduction of Health Acquired Conditions, should not vary by race, ethnicity, income, gender or geography: even in such an instance, data should be collected to assure that low-income communities of color receive treatment comparable with those from more affluent communities. The solution is to ensure that the proposed quality improvement efforts measure disparities and improvements in them while incorporating adequate safeguards such as pay-for-improvement to avoid cherry picking of easy patients, patient dropping and harming of poorly resourced organizations that care for predominantly vulnerable populations.[3]

General Recommendations:

- **Make Impact on Equity an Integral Component of all Covered California Quality Improvement Efforts.** According to the HHS Disparities Action Plan, creating objectives for health care programs that contribute to the reduction of health disparities will shift the balance from addressing health issues in silos to creating population-wide health improvements for communities experiencing health disparities.[4] As this is a multi-year contract, Covered California should be moving along these lines to ensure all of its quality improvement initiatives improve health and reduce healthcare disparities rather than worsen disparities or leave existing disparities in place.

- **Conduct a Disparities Impact Assessment in order to Ensure Quality Initiatives will not Unintentionally Harm Vulnerable Populations.** CMS in its Equity Plan for Improving Quality in Medicare recommends utilizing Disparities Impact Statements to ensure that vulnerable populations are included in pilot programs, and that disparities are

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[2] "Quality improvement efforts under health reform: How to ensure that they help reduce disparities – not increase them," RM Weinick, R Hasnain-Wynia – Health Affairs, 2011. http://www.ncbi.nlm.nih.gov/pubmed/21976324

[3] Chien AT, Chin MH, David A, Casalino L. Pay-for-performance, public reporting and racial disparities in health care: how are programs being designed? Med Care Res Rev. 2007;64:283S-304S

[4] HHS Action Plan to Reduce Racial and Ethnic Health Disparities. Washington D.C.: US Department of Health and Human Services, Office of Minority Health [cited January 29, 2016]. Available from: http://minorityhealth.hhs.gov/npa/files/plans/hhs/hhs_plan_complete.pdf

not worsened as a result of new quality initiatives.[5] Federal agencies including the Substance Abuse and Mental Health Services Administration and the Health Resources and Services Administration currently use these tools to monitor programs' impact on health disparities.

- **Adopt National Quality Forum Recommendation on Risk Adjustment when Assessing Hospital Quality Performance and Payment Incentives.** CPEHN is supportive of efforts by Covered California to improve the quality of care and patient safety for Covered California enrollees such as those contemplated in Articles 1 and 5. However we urge Covered California to adopt the most recent recommendations of the National Quality Forum when assessing provider quality and performance incentives and determining whether to require QHPs to exclude contracts with certain providers.[6] Hospitals and providers that serve a large racially and ethnically diverse population are more at risk of underperforming on quality measures such as hospital readmission rates because they are caring for a sicker population. An analysis of CMS data from the Medicare Hospital Readmissions Reduction Program showed that safety-net hospitals often under-resourced and overstretched were nearly 60% more likely to be penalized for readmissions rates than non-safety hospitals for all three years of the program.[7] A homeless patient who is discharged from a safety-net hospital and has little or no financial resources may fare worse after discharge for example, when compared to a more affluent patient discharged from a hospital in West Los Angeles. Implementing a policy to exclude or penalize those hospitals or providers based on poor performance on certain measures like readmissions rates could lead to unintended consequences, such as hospital closures in areas where few providers operate today. These trends, in turn, could worsen health disparities rather than alleviate them among Covered California enrollees who live in low-income areas.[8]

- **Include a standard definition of Health Disparities and Healthcare Disparities in Covered California's Glossary of Key Terms:** In order to ensure health care disparities reduction initiatives and solutions are targeted to the most vulnerable communities, we urge Covered California to include a standard definition of the term(s): *health disparities* and *healthcare disparities* in the Glossary of Key Terms in Attachment 7. The Healthy People 2020 definition below includes the additional population categories Covered California is considering including in future years as well as the addition of geographic location as requested by Covered California Board Member Islas:

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[5] The CMS Equity Plan for Improving Quality in Medicare. Washington, D.C. Centers for Medicare and Medicaid Services Office of Minority Health, September 2015. [Cited February 2, 2016]. Available from: https://www.cms.gov/About-CMS/Agency-Information/OMH/OMH_Dwnld-CMS_EquityPlanforMedicare_090615.pdf

[6] "Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors," National Quality Forum, August 2014.

[7] Andrew S. Boozary, MD, MPP; Joseph Manchin III; Roger F. Wicker, JD, "The Medicare Hospital Readmissions Reduction Program, Time for Reform," The Journal of the American Medical Association (JAMA), Viewpoint, July 28, 2015.

[8] "Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors," National Quality Forum, August 2014.

- ***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).

- ***A Healthcare Disparity***: The Institute of Medicine defines healthcare disparity as "Differences in the quality of health care that are not due to access-related factors or clinical needs, preferences or appropriateness of intervention."

Conclusion:
California has the opportunity to lead the nation by ensuring that health equity is not only important but central to *all of your* quality improvement strategies and to the exchange's ability to achieve its mission of reducing health disparities in our state. We seek concrete, enforceable contract conditions to require QHPs in Covered California to reduce the health disparities of its members by meeting concrete disparities reduction goals in specific target areas starting in 2017 and publicly reporting on the results of those efforts.

We strongly urge you to take action now to ensure the 2017 QHP contract requirements provide an important and meaningful step towards reducing rather than holding constant or even worsening persistent health disparities. Please contact myself or Cary Sanders, Director of Policy Analysis, if you have any further questions at (510) 832-1160.

Sincerely,

Sarah de Guia, JD
Executive Director/CPEHN

Cc: Members, Covered California Board

[9] Healthy People 2020. Washington, DC: U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion [cited January 29, 2016]. Available from: http://www.healthypeople.gov/

CPEHN Detailed Recommendations by Section:

Article 1. Improving Care, Promoting Better Health and Lowering Costs:

1.02 Assuring Networks are Based on Value.
CPEHN supports Covered California's efforts to improve the quality of care and patient safety for Covered California enrollees. However we urge Covered California to adopt the most recent recommendations of the National Quality Forum when assessing provider quality and determining whether to require QHPs to exclude contracts with poor performing providers so as not to further exacerbate disparities by penalizing hospitals and providers that care for a large racially, ethnically diverse population.[10]

Recommendations:

- **Adopt National Quality Forum Recommendations for Risk Adjustment by Socioeconomic Status or Other Sociodemographic Factors.** A large body of evidence shows that socioeconomic factors influence health outcomes, which has the potential to impact certain performance measures. The National Quality Forum now recommends adjusting for sociodemographic (SES) factors in some quality performance assessments to avoid penalizing providers caring for low-income populations.

- **Require Hospitals to Address Disparities:** While we are supportive of risk adjustment in certain situations, all hospitals should be required to identify and implement disparities reduction strategies. CMS' "Guide to Preventing Readmissions among Racially and Ethnically Diverse Medicare Beneficiaries," released in 2015, includes recommends for hospital leaders to address disparities in readmissions rates. We urge Covered California to require hospitals and providers to follow the new CMS Guidelines and other national recommendations to address health disparities in readmissions rates.

1.03 Participation in Collaborative Quality Initiatives.
We applaud Covered California for requiring QHPs to participate in Collaborative Quality Initiatives with the Department of Health Care Services (DHCS), CalPERS as well as other major purchasers. As with all quality initiatives, we urge Covered California to conduct a health disparities assessment of quality data to ensure that quality improvements in the various Collaborative Quality Initiatives are actually decreasing health disparities, not holding disparities constant or making disparities worse.

Recommendation:

- **Conduct a Health Disparities Assessment (HDA) to ensure disparities are not widening or remaining constant.** The approach endorsed by Weinick et al. (2011) is parallel to the Centers for Disease Control (CDC) endorsed approach to conducting health impact assessments. It would start with identifying relevant policies and potential disparities that could be affected; assessing risks and benefits, including those incurred by racially and ethnically diverse

[10] "Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors," National Quality Forum, August 2014.

populations that would be most affected by the policies under consideration; and developing recommendations to mitigate any potential exacerbation of disparities.[11]

- **Amend 1.03 b. as follows:**
  (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 Initiatives. (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 <u>including a health disparities assessment across clinical, patient experience and cost impacts.</u>

Article 2. Provision and Use of Data and Information for Quality of Care.

2.01 HEDIS and CAHPS Reporting.
We applaud Covered California for requiring QHPs to report their HEDIS and CAHPS scores to Covered California annually. We urge Covered California to first take the necessary steps to ensure the appropriate collection of key demographic factors including: race, ethnicity, gender, primary language, and sexual orientation/gender identity. Second, we urge Covered California to require all performance data reported to Covered California be stratified by those key demographic factors. . Additionally Covered California should publicly report in aggregate on the performance of all their plans by key demographic factors including gender, race, ethnicity, primary language, sexual orientation and gender identity.

2.02 Data Submission Requirements. We appreciate that the "EAS Dataset" includes multiple fields for gender, race, ethnicity and primary language of Covered California enrollees. We urge Covered California to ensure the EAS dataset also includes fields for sexual orientation and gender identity (SOGI). Although CMS has not yet authorized SOGI questions to be included in the single, streamlined application, providers should not be deterred from collecting and reporting this information to health plans and the exchange.

2.03 eValue8 Submission. We would encourage Covered California to continue to require QHPs to submit the eValue8 Health Disparities questions and to publically report on the results of those surveys.

2.04 Quality Improvement Strategy.
Covered California has an important opportunity over the next several years to ensure better integration of health equity in exchange Quality Improvement Strategies (QIS) and to ensure such strategies are not holding disparities constant or inadvertently worsening disparities. We urge Covered California to ensure disparities reduction is central to Covered California's Quality

[11] "Quality improvement efforts under health reform: How to ensure that they help reduce disparities – not increase them," RM Weinick, R Hasnain-Wynia – Health Affairs, 2011. http://www.ncbi.nlm.nih.gov/pubmed/21976324

Improvement Strategies (QIS) by conducting a health disparities assessment as part of each QIS and ensuring health disparities are identified and addressed.

Recommendation:

- **Ensure health disparities will be addressed as part of all Covered California Quality Improvement Strategies (QIS).**

    - **Amend 2.04 as follows:**
      (a) The percentage, number and performance of total participating providers;

      (b) The number and percent of Covered California enrollees participating in the initiative disaggregated by gender, race, ethnicity, primary language and other sociodemographic factors;

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

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

Article 3. Reducing Health Disparities and Assuring Health Equity.
CPEHN strongly supports the initiatives outlined in Article 3. Reducing Health Disparities and Assuring Health Equity. These initiatives will go a long way in ensuring Covered California is not just measuring health care disparities but reducing them. With regards to narrowing disparities, we urge Covered California to ensure a clear, enforceable requirement for year over year improvement in health disparities reduction starting with the 2017 contract year. Even a plan with data on a small portion of its members, should still be able to identify disparities using proxy methods and show improvement in disparities reduction in some areas. We offer a few additional recommendations to strengthen this section.

3.01 Measuring Care to Address Health Equity.
As stated above, Covered California must ensure a clear, enforceable requirement for year over year improvement in health disparities reduction starting with the 2017 contract year. Even the smallest plans should be able to use proxy data to track and trend disparities and identify solutions for targeting those disparities. Moving forward, we strongly support Covered California's goal of requiring plans by 2019 to achieve 85 percent self-reported racial/ethnic identity as this is the gold standard for data collection per the National Quality Forum.[12] Self-reported data goals for race/ethnicity should also include data on primary language. In future years, we would hope these goals would include strengthening self-reported data on sexual orientation and gender identity. Data on language proficiency specifically, is vital to eliminating racial and ethnic disparities as racially

[12] "NQF Commissioned Paper: Healthcare Disparities Measurement," February 2012. file:///C:/Users/csanders/Downloads/HDCCCS_MemoandCommissionedPaper%20(1).pdf

and ethnically diverse patients with Limited English proficiency (LEP) are more likely than their English speaking White counterparts to suffer from adverse events, and these adverse events tend to have greater clinical consequences.[13] We also urge Covered California to ensure demographic data is disaggregated for smaller, racial/ethnic and LEP populations in order to target disparities reduction efforts in those communities. There is already clear guidance from the Institute of Medicine (IOM)/National Quality Forum (NQF) and Hospital Research & Education Trust (HRET) to help providers to achieve demographic data collection goals and additional opportunities to improve the collection of demographic data through the adoption of Stage 2 Meaningful Use requirements. Covered California and health plans should be encouraged to provide software and technical support to providers to improve the collection and reporting of Electronic Health Record data.

Recommendations:

- **Require QHPs to Track and Trend Quality Measures by Primary Language as well as by Race/Ethnicity.**

    - **Amend 3.01 as follows:**
      Contractor shall be required to track and trend quality measures by ethnic/racial group, primary language and by gender for the Contractor's entire population.

- **Data should be disaggregated for smaller racial, ethnic, Limited English Proficient (LEP) subpopulations.**
- **Covered California and health plans should be encouraged to provide incentives for the adoption of software and technical support to providers to improve the collection and reporting of Electronic Health Record data.**

3.02 Narrowing Disparities.
We strongly support Covered California's requirement for health plans to report baseline measurements from Measurement Year 2015 in the Application for Certification for 2017 and to hold plans accountable for clear, enforceable year-over-year improvement in health disparities reduction in those areas starting in 2017. All Covered California health plans should be required to achieve health disparities reduction efforts in 2017 to the best of their abilities given the current data they have. Even a plan with data on a small portion of their members, should still be able to stratify that data and/or use proxy methodology in order to identify and target disparities reduction activities to the best of its abilities in some areas starting in 2017. There is no reason to wait till 2018 or 2019 to hold QHPs accountable for achieving concrete disparities reduction goals when plans have been required to collect this data since 2003. The time to act is now.

3.03 Expanded Measurement.
We strongly support extending Covered California's disparity identification and improvement

[13] Divi C, Koss RG, Schmaltz SP, et al., Language proficiency and adverse events in US hospitals: a pilot study, *Int J Qual Health Care,* 2007; 19(2):60-7. Available at: http://www.ncbi.nlm.nih.gov/pubmed/17277013

program over time to include income, disability status, sexual orientation and gender identity. It is well established in the academic literature that income is correlated with health outcomes but it is rare that disparities reduction efforts by health plans can take income into account. We urge Covered California to consider adding geographic region as well.

Recommendation:

- **Add Geographic Location to the list for Expanded Measurements as part of Covered California's disparities identification and improvement program.** California's Central Valley has some of the worst air pollution in the country and nationally, according to a 2011 World Health Organization (WHO) report. The report found that five of the ten worst performing cities in the U.S. are located in the Central Valley. Residents of the Central Valley experience higher asthma rates and incidences of Valley Fever, amongst other conditions. At the federal level, Healthy People 2020 is currently planning to assess health disparities in the U.S. population by tracking rates of illness, death, chronic conditions, behaviors, and other types of outcomes in relation to demographic factors including: race and ethnicity, gender, sexual identity and orientation, disability status or special health care needs, and geographic location (rural and urban).[14] Adding geographic location to the list for expanded measurement will ensure attention and resources are dedicated to reducing disparities in geographic regions throughout the state.

3.04 NCQA Certification. We support encouraging groups to meet the standards for Multicultural Health Care Distinction by NCQA as it will help them to achieve the ambitious health disparities reduction goals outlined above.

Article 4. Promoting Development and Use of Effective Care Models

4.01 Primary Care Physician Selection. CPEHN supports PCP assignment as long as there is continuity of care. We appreciate the efforts of Covered California to ensure provider selection is consistent with Enrollee's "stated gender, language, ethnic and cultural preferences, and will consider geographic accessibility and existing family member assignment or prior provide assignment."

4.02 Patient Centered Medical Home. CPEHN supports encouraging the use of Patient Centered Medical Homes. We encourage Covered California to require QHPs to evaluate how well PCMH teams are addressing the needs of Covered California's culturally and linguistically diverse consumers.

4.03 Integrated Healthcare Models (IHM). CPEHN appreciates Covered California's support of the adoption and expansion of integrated, coordinated and accountable systems of care also known as Accountable Care Organizations (ACOs). We support (c) "holding hospitals and physicians accountable for nationally recognized evidence-based clinical, financial, and operational

[14] Healthy People 2020, HHS Office of Disease Prevention and Health Promotion. [Internet. Last accessed 2/3/16]. Available at: http://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities

performance, as well as incentives for improvements in population outcomes."

4.04 Mental and Behavioral Health. There is ample data documenting disparities in mental and behavioral health outcomes (see 11/13/16 CPEHN letter to Covered California). CPEHN recommends that Covered California require QHPs to include as part of its report on the availability and integration of behavioral and mental health services, the effectiveness of strategies and progress in reaching Covered California's diverse enrollees including culturally and linguistically diverse enrollees, women and LGBTQ.

4.05 Telemedicine and Remote Monitoring. CPEHN supports the use of telemedicine and remote monitoring, particularly in geographically underserved regions and for older patients as these strategies have demonstrated success.

Article 5. Hospital Quality

CPEHN supports hospital quality measures aimed at reducing C-Section rates, improving patient safety and promoting quality and value. Consumer advocates have fought for decades to require better reporting of Hospital Avoidable Complications and adverse events. As the literature can attest, hospital acquired infections should not vary based on race/ethnicity, gender or income, thus performance should likewise not be risk adjusted.[15]

With respect to appropriate use of C-sections, we support Covered California's participation in the broader efforts with the Department of Health Care Services, Department of Public Health, CalPERS and the Health and Human Services Agency to reduce inappropriate C-section use. If there are racial and ethnic disparities in the use of C-sections, once the data has been risk-stratified, that would raise very serious questions in our mind about whether care is appropriate or not: we know of no clinical reason why the use of C-section should vary by race and ethnicity.

We have strong concerns however about Section 5.03 Hospital Payments to Promote Quality and Value. As mentioned above, hospitals and providers that serve a large racially and ethnically diverse population are more at risk of underperforming on quality measures such as hospital readmission rates because they are caring for a sicker population. A homeless patient who is discharged from a safety-net hospital and has little or no financial resources may fare worse after discharge that an affluent patient discharged from a hospital in West Los Angeles. Implementing a policy to exclude or penalize those hospitals or providers based on poor performance on certain measures like readmissions rates could lead to unintended consequences, such as hospital closures in areas where few providers operate today. These trends, in turn, could worsen health disparities rather than alleviate them among Covered California enrollees who live in low-income areas.[16]

Recommendations:

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[15] Accounting for Social Risk Factors in Medicare Payment, National Academy of Sciences 2016.

[16] "Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors," National Quality Forum, August 2014.

- **Covered California should adopt the latest National Quality Forum recommendations on risk adjustment when assessing hospital quality performance, particularly with regards to payment incentives.** A large body of evidence shows that socioeconomic factors influence health outcomes, which has the potential to impact certain performance measures. The National Quality Forum now recommends adjusting for sociodemographic (SES) factors in some quality performance assessments to avoid penalizing providers caring for low-income populations.

- **Covered California should require hospitals to address disparities.** While we are supportive of risk adjustment in certain situations, all hospitals should be required to identify and implement disparities reduction strategies with regards to readmissions rates. CMS' "Guide to Preventing Readmissions among Racially and Ethnically Diverse Medicare Beneficiaries," released in 2015, includes recommendations for hospital leaders to address disparities in readmissions rates. We urge Covered California to require hospitals and providers to follow the new CMS Guidelines and other national recommendations to address health disparities in readmissions rates.

Article 6. Population Health: Preventive Health, Wellness and At-Risk Enrollee Support
CPEHN supports Covered California's efforts to improve population health by encouraging access to tobacco cessation, obesity management, and preventive care as well as identification of at-risk enrollees at the point of transition. In addressing each of these, disparities should be taken into account. While California does better than the nation on many of these measures, that is not true of all Californians, and particularly not true of low-income communities of color which are the overwhelming majority of Covered California enrollment. Covered California should require plans to provide information on participation rates in these services by gender, race/ethnicity, primary language, and LGBTQ status along with strategies for decreasing potential disparities. CPEHN appreciates the reporting requirement in Section 6.01 4) a) that plans report on the health and wellness communication processes employed that "take into account cultural and linguistic diversity," of enrollees being served. Covered California should require that these programs be provided in a plan's threshold languages. Additionally we support efforts to encourage contractors to support community health initiatives that have been recommended by the Community Preventive Services Task Force (CPSTF) and to include a comparative analysis of health status improvements across geographic regions and demographics.

Recommendations:

- **Covered California should require QHPs to provide information on enrollee participation rates by gender, race/ethnicity, language, and LGBTQ status in programs aimed at improving population health.**
- **Covered California should require QHPS to provide population health programs including programs on preventive health, wellness and at-risk enrollee support in a plan's threshold languages.**

- **Covered California should encourage contractors to support community health initiatives that have been recommended by the Community Preventive Services Task Force (CPSTF) and to include a comparative analysis of health status improvements across geographic regions and demographics.**

6.06 Identification and Services for At-Risk Enrollees:: We appreciate Covered California encouraging plans to plans document their communication plan for known At-Risk Enrollees to receive information prior to provider visit, including the provision of culturally and linguistically appropriate communication. We urge that Covered California go one step further by making the sharing of this information a contract requirement.

Recommendation:

- **Require QHPs to document their communication plan for known At-Risk Enrollees to receive information prior to provider visit, including the provision of culturally and linguistically appropriate communication.**

Article 7. Patient-Centered Information and Support.

CPEHN supports Covered California's requirement that QHPs participate in activities necessary to provide healthcare decision-making information to consumers relating to the cost and quality of healthcare. Empowering consumers with knowledge to support healthcare decision-making is a crucial part of Covered California's mission to improve health and eliminate health disparities. We urge Covered California to require QHPs to ensure these types of healthcare decision-making tools are provided in a consumer friendly and culturally and linguistically appropriate manner. We are also very supportive of efforts to require participation in the statewide workgroup on Overuse sponsored by Covered California which will leverage Choosing Wisely decision aids to support efforts to drive appropriate use of C- Sections for low risk (NTSV) deliveries, opioid overuse and misuse, and imaging for low back pain.

Recommendation Section 7.01:

- **Require QHPS to provide healthcare decision-making tools in a consumer friendly and culturally and linguistically appropriate manner.**

  Amend 7.01 Enrollee Healthcare Services Price and Quality Transparency a) and c) as follows:

  a) ii. Allowed charges for all network providers, including the facility and physician cost, for common elective specialty, and hospital services, or comparable clear statement of patient's specific share at each provider. Commonly used service information should be organized in ways that are meaningful for consumers to understand and provided in a culturally and linguistically appropriate manner.

  c) ii. User experience with the tool (or equivalent service such as a call center) from a representative sample of racially and ethnically diverse users who respond to a

survey which includes a user overall satisfaction with rating.

Article 8. Payment Incentives to Promote Higher Value Care. CPEHN joins other consumer advocates in expressing our concerns about reward-based consumer incentive programs. If they are not accessible to all consumers and culturally and linguistically appropriate to the populations being served these types of programs risk worsening disparities and can become a form of back-door underwriting based on health status. These types of programs also run the risk of running afoul of anti-discrimination laws if they have disparate impact on members of a protected group. We urge Covered California to require QHPs to conduct a health disparities assessment prior to the development or implementation of any reward-based consumer incentive program and to report the results of that assessment to Covered California.

Recommendations:

- **Require QHPs to conduct a health disparities assessment prior to the development or implementation of any reward-based consumer incentive program and report the results of that assessment to Covered California.**

    - **Amend 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 Plan Enrollees with identified chronic conditions. To the extent Contractor implements such a program for Plan Enrollees and to the extent such information is known, Contractor shall conduct a health disparities impact assessment and report participation rates and outcomes results, including clinical, patient experience and cost impacts stratified by age, gender, race, ethnicity, primary language, sexual orientation and gender identity to Covered California.

      Amend 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 will include those payments to hospitals and physicians that are linked to quality metrics, including metrics related to reduction of health disparities, performance, costs and/or value measures.

Definitions:

We urge Covered California to include definitions for the following terms in the Glossary of Key Terms at the end of Attachment 7:

- ***Health disparities:*** We recommend Covered California adopt the Healthy People 2020 definition of health disparities which 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."[17] The definition should clarify that racial and ethnic disparities populations include persons with Limited English Proficiency. (LEP).

- ***Healthcare Disparity***: The Institute of Medicine defines healthcare disparity as "Differences in the quality of health care that are not due to access-related factors or clinical needs, preferences or appropriateness of intervention."

- ***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."[18]

- ***Cultural and linguistic access:*** HHS' Office of Minority Health established a blueprint for health and health care organizations through the development of National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Healthcare. OMH endorses the following definition of cultural and linguistic competence: "Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities." (Adapted from Cross, 1989). This also includes providing communications in a plan's threshold languages.

- ***Language Access Services:*** The key to providing meaningful access to care for limited English proficient (LEP) persons is to ensure effective communication between the provider/organization and the LEP person. An LEP person cannot speak, read, or understand the English language at a level that permits effective interaction with clinical or nonclinical staff at a healthcare organization. Language assistance services must be made freely available to each person with LEP who seeks services and are to be provided by bilingual staff that can communicate directly with patients/ consumers in their preferred language.

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[17] Healthy People 2020. Washington, DC: U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion [cited January 29, 2016]. Available from: http://www.healthypeople.gov/

[18] U.S. Department of Health and Human Services, Office of Minority Health. National Partnership for Action to End Health Disparities. The National Plan for Action Draft as of February 17, 2010 [Internet]. Chapter 1: Introduction. Available from: **http://www.minorityhealth.hhs.gov/npa/templates/browse.aspx?&lvl=2&lvlid=34**.

- ***Limited English Proficiency (LEP):*** Individuals who do not speak English as their native language and speak English less than "very well."

CPEHN
California Pan-Ethnic Health Network

February 16, 2016

Anne Price, Director
Plan Management

Dr. Lance Lang, M.D.
Chief Medical Officer
Covered California
1501 Exposition Way
Sacramento, CA 95815
Via electronic submission

Re: Comments on Appendix 2 to Attachment 7: Measurement Specifications

Dear Ms. Price and Dr. Lang:

The California Pan-Ethnic Health Network (CPEHN) appreciates the additional detail in Appendix 2 to Attachment 7 regarding measurement specifications for Covered California's quality improvement initiatives. The measures and required stratification by race/ethnicity will go a long way towards ensuring QHPs are meeting concrete disparities reduction goals in specific target areas starting in 2017. While the proposed measures are a strong start, we offer a few additional recommendations to strengthen quality improvement and health disparities reduction efforts:

- **Ensure health equity is an integral part of all quality improvement strategies:** We urge Covered California to ensure health equity is an integral component of the key quality improvement provisions included in Attachment 7. One way to ensure this is to require QHPs to stratify other metrics by race/ethnicity including:
    - ***Measure 14 Primary Care Selection*** Stratifying primary care provider selection by race/ethnicity will help Covered California and QHPs to develop targeted outreach and education to boost provider selection rates in all communities including enrollee communities that are racially and ethnically diverse.
    - ***Measures 25-35 In-Patient Safety Measures.*** Identifying and tracking disparities in in-patient patient safety measures will help to ensure there are no glaring disparities. For example, if Covered California were to uncover racial and ethnic disparities in the use of C-sections, this information could help to ensure there is targeted education and outreach to those communities to help lower C-section rates in those communities.
    - ***Measures 38-40 Wellness Measures***. Stratification of these measures could be used to gauge how well individual communities are taking advantage of wellness services including wellness benefits, weigh management and tobacco cessation programs while encouraging plans to develop more targeted outreach and enrollment to their racially and ethnically diverse members.

- **Require QHPs to report overall rates with all race/ethnicities to see how each plan is doing overall**: We appreciate Covered California's requirement that QHPs report rates by race/ethnicity for metrics 3-13 dealing with diabetes, hypertension, asthma and behavioral health. We urge Covered California to require QHPs to report their overall rates with race and ethnicity categories in order to see how each plan is doing overall and in comparison with their racially/ethnically diverse enrollees.

- **Add additional behavioral health metrics.** While we appreciate that Covered California is moving forward with health disparities reduction efforts in behavioral health as part of the 2017 QHP contract, we would urge California to consider including additional measures related to behavioral health screening and follow-up care, specifically: 1) Screening for Clinical Depression and Follow-up plan and/or 2) Follow-up after Hospitalization for Mental Illness. These measures found in the 2016 QRS Measure and Adult Core Set for Medicaid are an important gauge of how well plans are integrating behavioral health services for all of their enrollees.

- **Stratify all measures, especially health disparities reduction measures by Primary Language:** Lastly we encourage Covered California to require QHPs to stratify primary language in addition to race/ethnicity as part of health disparities reduction efforts. Data on language proficiency specifically, is vital to eliminating racial and ethnic disparities as racially and ethnically diverse patients with Limited English proficiency (LEP) are more likely than their English speaking White counterparts to suffer from adverse events, and these adverse events tend to have greater clinical consequences.[1] We also urge Covered California to ensure demographic data is disaggregated for smaller, racial/ethnic and LEP populations in order to target disparities reduction efforts in those communities.

Thank you for your time. We strongly urge you to take action now to ensure the 2017 QHP contract requirements including Appendix 2 of Attachment 7 provide an important and meaningful step towards reducing rather than holding constant or even worsening persistent health disparities. Please contact myself or Cary Sanders, Director of Policy Analysis, if you have any further questions at (510) 832-1160.

Sincerely,

Sarah de Guia, JD
Executive Director/CPEHN

Cc: Members, Covered California Board

[1] Divi C, Koss RG, Schmaltz SP, et al., Language proficiency and adverse events in US hospitals: a pilot study, *Int J Qual Health Care,* 2007; 19(2):60-7. Available at: http://www.ncbi.nlm.nih.gov/pubmed/17277013

CPEHN
California Pan-Ethnic Health Network

February 16, 2016

Anne Price, Director
Plan Management

Dr. Lance Lang, M.D.
Chief Medical Officer
Covered California
1501 Exposition Way
Sacramento, CA 95815
Via electronic submission

Re: 2017 QHP Issuer Contract Attachment 7: Final Draft Redline Revisions

Dear Ms. Price and Dr. Lang,

The California Pan-Ethnic Health Network (CPEHN), a multicultural statewide health advocacy organization that works to improve the health of communities of color and an active participant in the Covered California Plan Management committee and its quality workgroup provides the following comments on the revised 2017 QHP Issuer Contract Attachment 7.

CPEHN appreciates the revisions Covered California has made to Attachment 7 including the following key changes:

- Agreement through a new section 1.07 on the importance of the development and adoption of systems for enhanced information exchange as a means, for example, of improving the quality of care and reducing racial and ethnic health disparities (see Section 1.07: Data Exchange with Providers).
- Clarification that the baseline measurement data Covered California seeks on tracking and trending racial and ethnic health disparities by self-reported or proxy data is across all lines of business. However we seek clarification as to why Medicare is excluded. (Section 3.01: Measuring Care to Address Health Equity).
- Extending the disparities identification and improvement program to include Limited English Proficiency (LEP) in future years. However we would urge Covered California to include geographic region in future years as well. (Section 3.03: Expanded Measurement)
- Acknowledgement of the need to track, address, and prevent unintended consequences including the exacerbation of health care disparities as part of Covered California sanctioned hospital payment incentives (Section 5.01: Hospital Payments to Promote Quality and Value)
- Inclusion of a definition of health disparities and health equity in the Glossary of Key Terms (Glossary of Key Terms). Covered California may wish to include a definition of cultural and linguistic access in future contracts as well to clarify expectations with regards to communications and other outreach strategies.

The adoption of these revisions will help to ensure a more successful and targeted approach to the reduction of health disparities in Covered California.

We also applaud Covered California for requiring health plans to meet concrete, enforceable year-over-year disparities reduction goals in specific target areas and publicly reporting on the results of those efforts (Attachment 7, Article 3), however we reiterate our concern at the exceedingly slow pace of these efforts. We urge Covered California to use 2015 as the baseline measurement year for disparities reduction efforts and to begin its assessment of payment incentives and penalties in 2017 (Attachment 7). Waiting until 2018 or 2019 to incentivize disparities reduction is too long (Attachment 14).

CPEHN reiterates our request outlined in our 2/04/16 letter, that Covered California ensure health equity is an integral component of key quality improvement initiatives included in Attachments 7 and 14. For too long quality improvement and disparities reduction have been treated as separate objectives. This approach is not feasible in a state like California where a majority of Covered California enrollees, and the majority of the state's residents, are racially and ethnically diverse. Disparities in access to care are pervasive which is why the Centers for Medicare and Medicaid Services (CMS) is now recommending that agencies evaluate disparities impacts and integrate equity solutions across all CMS programs.[1] There is a clear rationale for prioritizing and integrating health equity in quality improvement initiatives. Most quality improvement strategies will not automatically benefit all segments of the population equally. For example, an intervention that improves quality at the same rate for all racial and ethnic groups leaves existing disparities constant. Additionally, without an explicit focus on disparities reduction, other quality interventions such as pay-for-performance programs may have the unintended consequence of worsening health care disparities by creating pressure for providers to avoid caring for people who are perceived to be high-risk patients.[2]

General Recommendations:
CPEHN provides the following key recommendations below to the revised version of Attachment 7. For detailed section-by-section comments please see our previous letter to Covered California dated 2/04/16.

- **Make Impact on Equity an Integral Component of all Covered California Quality Improvement Efforts.** Covered California's focus on reducing health disparities through payment incentives as outlined in Attachments 7 and 14 is a good first step. However there are other contract areas where tracking and trending disparities could assist Covered California and health plans at achieving overall quality improvement goals. For example, identifying and addressing disparities in Primary Care Physician Selection (4.01) or access to Health and Wellness Services (6.01) such as tobacco cessation and obesity prevention are complementary objectives to Covered California's efforts to reduce health disparities in Article 3 as primary care selection is paramount to diagnosis of such conditions and tobacco use and obesity are often co-morbid with diabetes, hypertension and asthma. We urge this type of tracking and trending of disparities as part of other quality initiatives as well including: 1.03 Participation in Collaborative Quality Initiatives, 4.02 Patient Centered Medical Home, 4.03 Integrated Healthcare Models (IHM), 4.04 Mental and Behavioral Health, 4.05 Telemedicine and

[1] "The CMS Equity Plan for Improving Quality in Medicare," September 2015. https://www.cms.gov/About-CMS/Agency-Information/OMH/OMH_Dwnld-CMS_EquityPlanforMedicare_090615.pdf
[2] "Quality improvement efforts under health reform: How to ensure that they help reduce disparities – not increase them," RM Weinick, R Hasnain-Wynia – Health Affairs, 2011. http://www.ncbi.nlm.nih.gov/pubmed/21976324

Remote Monitoring, as information on disparities in accessing these types of services could point to targeted solutions for improving access overall.

- **Conduct a Disparities Impact Assessment in order to Ensure Quality Initiatives will not Unintentionally Harm Vulnerable Populations or Leave Disparities in Place.** We urge Covered California to conduct a disparities impact assessment in all Covered California quality improvement initiatives, particularly pay-for-performance initiatives that may unintentionally incentivize plans to cherry-pick easy patients in an attempt to demonstrate immediate quality improvement. Covered California's added requirement that health plans "adopt balancing measures to track, address, and prevent unintended consequences from at-risk payments including exacerbation of health care disparities" as part of hospital payment incentive programs (Section 5.01) is an example of the careful assessment we seek. However we were dismayed to learn that Covered California will still allow plans to structure hospital payment incentives according to its own priorities, thus potentially allowing plans to apply the entire 6% penalty to readmissions rates despite ample literature on the adverse impacts on providers serving low-income communities of color. We urge Covered California to adopt the National Quality Forum recommendations for risk adjustment. We also urge Covered California to pursue this type of health disparities assessment as part of other key quality initiatives including as an example, efforts to reduce the use of C-Sections (5.03). If there are racial and ethnic disparities in the use of C-sections, once the data has been risk-stratified, that would raise very serious questions in our mind about whether care is appropriate or not: we know of no clinical reason why the use of C-section should vary by race and ethnicity.

Conclusion:
Making equity a central component of Covered California quality improvement initiatives will help to ensure those initiatives are actually meeting agreed upon benchmarks for quality improvement. California has the opportunity to lead the nation by ensuring that health equity is not only important but central to *all of your* quality improvement strategies and to the exchange's ability to achieve its mission of reducing health disparities in our state. We seek concrete, enforceable contract conditions to require QHPs in Covered California to reduce the health disparities of its members by meeting concrete disparities reduction goals in specific target areas starting in 2017 and publicly reporting on the results of those efforts.

We strongly urge you to take action now to ensure the 2017 QHP contract requirements provide an important and meaningful step towards reducing rather than holding constant or even worsening persistent health disparities. Please contact myself or Cary Sanders, Director of Policy Analysis, if you have any further questions at (510) 832-1160.

Sincerely,

Sarah de Guia, JD
Executive Director/CPEHN

Cc: Members, Covered California Board

The Voice of Accountable Physician Groups

February 9, 2016

Peter Lee, Executive Director
Covered California
1601 Exposition Blvd.
Sacramento, CA 95815

Re: QHP Model Contract – Revised Attachment 7 dated Jan. 25, 2016

Dear Peter:

Thank for the opportunity to comment on the Revised Attachment 7 dated January 25, 2016. We noted your comments at the January Board meeting that "words matter" and that "making sure the language is right and clear."[1] We also acknowledge the work that has been done to incorporate some of the concepts presented from the CAPG letter submitted on January 20th. We have a few additional observations and suggestions concerning Attachment 7.

In our conversations with Dr. Lang on the revised version of Attachment 7 we've come to understand that the Exchange has concluded that it doesn't have the data in hand to determine specific standardized performance benchmarks between all contracting plans. For example, the Exchange does not know the current percentage of integrated-coordinated provider delivery systems in each plan's overall network. This information will not be available for review and analysis until each potential contracting plan submits their respective applications. As Dr. Lang has explained it the Exchange will then determine common benchmarks for the three-year term of the agreement.

[1] January 21, 2016 Board Mtg. Recording. Accessed on 2/5/2016 at: https://www.youtube.com/watch?v=QEGVm_X729o&feature=youtu.be. At 1:56:30.

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With that understanding in mind, our further comments have been narrowed to just a few points that are summarized as follows:

- Use the existing "Hedis by Geography" tracking system operated by the Integrated Healthcare Association to better understand the relative performance and value of various types of health plan provider networks

- The language of Article 4 that defines the "Integrated Health Model" requires the inclusion of hospitals in the "structure" of the IHM. It also requires "risk sharing" arrangements between hospitals and physicians, but is silent as to any risk-based payment between the plan and the two types of providers. Obviously, there cannot be risk-sharing between providers if there is no underlying risk-based payment by the plan (as in the example of a hospital risk pool). The original CalPERS definition does not include either of these requirements to qualify as an IHM and we believe that they are not necessary or intended. We will propose clarifying language.

Tracking variation in cost and quality in provider networks. As you know, the Integrated Healthcare Association has done substantial work in building a tracking system for provider cost and quality through its Hedis by Geography project.[2] The project tracks provider performance across all major payer lines – commercial HMO and PPO, Medi-Cal managed care and Medicare and the major types of provider networks used by plans, including both fragmented and integrated provider network delivery models. As such the HEDIS by Geography tracking system provides a tool for the comparison of provider cost and quality outcomes across the full range of environments where Covered California operates. IHA also uses Truven Analytics.

It is also valuable to compare provider total cost of care and quality performance across various systems such as Covered California, CalPERS, Commercial fully-insured group HMO and PPO coverage and Medicare Advantage. As IHA gathers performance data from other sources outside of Covered California, it can provide the Exchange with a larger picture of provider performance both inside and outside QHP networks.

For example, the ability of IHA to gather and report data on Medi-Cal Managed Care ("MMC") is valuable to the Exchange as it continues to formulate policy and strategy to better accommodate the needs of the "churn population" (individuals that migrate back and forth across the 138 percent of federal poverty eligibility) relative to continuity of

[2] Integrated Healthcare Association, HEDIS by Geography. Accessed at: https://hbg.iha.org/. See also Attachment 1.

care provisions that affect enrollees transitioning from MMC to the Exchange and back again over the course of a year.

We recognize that purchasers like CalPERS and Covered California have additional and/or differing performance measures over and above the six used by IHA in the initial pilot of the tracking system. It is less difficult to incorporate the varying measures from each purchaser into HEDIS by Geography rather than to build separate, duplicative silos within Covered California, Medi-Cal, the OPA and CalPERS. Contributing to a single system will ultimately build a more comprehensive picture of the entire market, affording Covered California and other purchasers superior information for decision analysis.

Article 4 description of IHM characteristics and requirements. Article 4 establishes three priority delivery system reform models for plans to incorporate into their overall provider networks. The three models include:

1. Assignment of a personal primary care physician to coordinate care
2. Promotion of Patient Centered Medical Homes (PCMH)
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.

We appreciate the inclusion and adoption by reference of the Berkeley Forum delivery model characteristics. We believe that by doing so, Covered California is demonstrating alignment with national delivery system reform priorities established by Secretary Burwell in early 2015.

However, in having borrowed the CalPERS IHM model and adapted it for Covered California, we observe two instances involving the specific use of language in the IHM description that raise technical concerns, namely:

- To be classified as an IHM the entity's organizational structure must include a hospital, rather than to merely demonstrate a functional integration with a hospital:

    1) The IHM structures will include the following:

    (a) An integrated organizational structure consisting of multi-discipline physician practices, hospitals and ancillary providers that address and coordinate patient care across the care continuum.

- The IHM must include risk-sharing arrangements between a hospital and physicians, which is ambiguous and restrictive, without reference to any requirement for the plan to first establish a risk-based payment arrangement with both providers:

> *(c) Combined risk sharing arrangements and incentives between the hospitals and physicians, holding them accountable for nationally recognized evidence-based clinical, financial, and operational performance, as well as incentives for improvements in population outcomes.*

Both of these cited provisions in Section 4.03 operate to exclude a significant number of potential IHM candidates that are currently used within the CalPERS delivery system.

Professor Jaime Robinson recently authored a report citing the relative value-based performance of provider delivery systems based on hospital ownership and physician ownership of their business structure.[3] He concluded that:

> *From the perspective of the insurers and patients, between 2009 and 2012, hospital-owned physician organizations in California incurred higher expenditures for commercial HMO enrollees for professional, hospital, laboratory, pharmaceutical, and ancillary services than physician-owned organizations. Although organizational consolidation may increase some forms of care coordination, it may be associated with higher total expenditures.*[4]

Should Covered California require that the only eligible IHM's include hospital ownership, approximately 118 physician organizations tracked in the Robinson study would be excluded from participation in Covered California provider networks as IHMs – including several of the Integrated Healthcare Association's top performers under their total cost of care performance measurement system.

We suggest alternative language that would remove the ambiguity:

> *1) The IHM ~~structures~~ will include the following functional characteristics:*
>
> *(a) ~~An integrated organizational structure consisting of multi-discipline physician practices, hospitals and ancillary providers that address and coordinate patient care across the care continuum.~~ The IHM addresses and coordinates patient care across the care continuum of multi-discipline physician practices, hospitals and ancillary providers.*

[3] **Robinson JC,** Miller K. Total Expenditures per Patient in Hospital-Owned and Physician-Owned Medical Groups in California. *JAMA* 2014; 312(16):1663-1669.
[4] Id, Abstract of article. See Attachment 2.

The second issue concerns the requirement that an IHM incorporate a risk-sharing arrangement between hospitals and physicians. It is uncertain what a "risk-sharing arrangement" means, but the common understanding involves an underlying risk-based payment mechanism between a plan and the two types of providers, like a hospital risk pool. But section 4.03 and the definition of "value based payment" elsewhere in Attachment 7 do not reference any requirement for risk-based payment mechanisms by plans for IHMs. If there is no underlying risk-based payment model required, it is impossible to create risk-shifting between two types of providers within the plan's network. We understand the goal of requiring collaboration between providers in an ACO model and the adherence to national standards and best practices. Deletion of the phrase "risk-sharing arrangement" would remove the ambiguity and preserve the underlying intent of the subsection:

> *(c) ~~Combined risk sharing arrangements and incentives between the hospitals and physicians,~~ Holding the~~m~~ IHM accountable for nationally recognized evidence-based clinical, financial, and operational performance improvements in population outcomes by physicians, hospitals and ancillary providers. ~~as well as incentives for improvements in population outcomes.~~*

Conclusion

In addition to the foregoing suggested inclusions and changes our counsel, Carol Lucas, has prepared a further redlined edit of the Attachment 7 document with an eye toward clarity and enforcement of the specific concepts that Covered California has worked hard to incorporate into the master agreement. Please see Attachment 3.

We look forward to further engagement with you on these important topics.

Sincerely,

_____

Donald H. Crane
President and CEO, CAPG

Attachments

1: IHA. HEDIS by Geography. Report and Executive Summary.
2: James Robinson. Total Expenditures per Patient in Hospital-Owned and Physician-Owned Medical Groups in California. *JAMA* 2014. Abstract.
3: Redlined suggested changes to Attachment 7

CC: Covered California Board

Attachment 1

Healthcare Hot Spotting:
Variation in Quality and Resource Use in California

Integrated Healthcare Association

Identifying where to target performance improvement efforts is a critical step toward achieving the triple aim of better care, better health and lower costs. A new on line tool—**HEDIS by Geography**—from the Integrated Healthcare Association (IHA) allows users to view health plan HEDIS (Healthcare Effectiveness Data and Infor mation Set) results by geographic area to gain a clearer picture of population health across California. The tool allows users to examine performance on six clinical quality measures and three resource use measures, by health plan product line for about 19 million Califor nians, including commercial health maintenance orga nizations (HMOs) and preferred provider organizations (PPOs), Medicare Advantage and managed Medi-Cal. A new analysis of HEDIS by Geography data indicates that health care quality and resource use vary widely throughout the state, and that health plan products that rely primarily on integrated care delivery networks, such as HMOs and Medicare Advantage, generally have high er quality scores without using more resources. Overall, the sizeable performance differences observed signal an opportunity for major improvements in care for large segments of California's population.

WHAT IS HEDIS BY GEOGRAPHY?

Current health care performance measurement and public reporting efforts—often anchored by HEDIS—typically focus on health plans and physician organizations. While useful to inform provider quality improvement efforts and consumer decision-making, current HEDIS results do not provide a clear picture of population health across geographic areas. **HEDIS by Geography**, an online tool created by IHA with support from the California HealthCare Foundation, fills this information gap in California by collecting 2013 HEDIS results from 11 health plans by geographic regions—down to ZIP codes. The tool, accessible at https://hbg.iha.org, also allows the information to be reviewed by product lines, allowing consumers, providers, health plans, purchasers and other stakeholders to identify where the greatest potential for improvement exists. **HEDIS by Geography** tracks clinical measurements for the core priority health conditions of cancer, diabetes and asthma, and resource use based on utilization measures, such as inpatient bed days.

HEDIS BY GEOGRAPHY MEASURES

Quality Measures. Breast cancer screening; colorectal cancer screening; blood sugar control for people with diabetes; blood sugar screening for people with diabetes; kidney disease monitoring for people with diabetes; and medication management for people with asthma.

Resource Use Measures. *All-Cause Readmissions:* Percentage of acute inpatients ages 18 and older discharged and readmitted for any diagnosis within 30 days. *Emergency Department (ED) Visits:* Overall rate of ED visits per thousand member years (PTMY). *Inpatient Bed Days:* Overall rate of bed days associated with acute inpatient care discharges on a PTMY basis.

HEDIS BY GEOGRAPHY KEY FINDINGS

- **Health care quality and resource use vary widely across California.**

  There are large geographic variations in both quality performance and resource use across the state. For example, there is more than a 40-percentage-point gap in the colorectal cancer screening rate between the highest performing county (Solano, 76.4%) and the lowest performing county (Modoc, 33.5%). Similar gaps exist for other quality measures.

  The tool also highlights geographic variation in the three resource use measures—readmissions, ED visits and inpatient bed days. For example, the readmission rate at the 5th percentile ZIP code is about 5 percent compared to 10 percent at the 50th percentile and 14 percent at the 95th percentile. The range is even larger for ED visits—111 visits PTMY at the 5th percentile ZIP code, 194 visits at the 50th percentile and 385 visits at the 95th percentile—and inpatient bed days—76 days PTMY at the 5th percentile, 195 days at the 50th percentile and 413 days at the 95th percentile.

- **Insurance products using integrated care delivery networks generally had higher quality without using more resources.**

  Commercial HMOs outperformed commercial PPOs on five

of the six HEDIS by Geography clinical quality measures. For example, of the population included in HEDIS by Geography, about 85 percent of the Commercial HMO women ages 50-74 met clinical guidelines for breast cancer screening and received a mammogram, compared to about 70 percent of similar Commercial PPO patients. If PPOs had performed at the same level as HMOs, an estimated 55,356 more California women would have received mammograms in 2013. A large gap also exists in colorectal cancer screening rates between commercial HMOs and PPOs (71% of those meeting clinical guidelines were screened in HMOs, compared to 48% in PPOs); an estimated 197,385 PPO enrollees would have received colorectal cancer screening in 2013 if the PPO rate had matched the HMO rate.

Likewise, Medicare Advantage, the HMO product available to Medicare beneficiaries as an alternative to traditional fee-for-service (FFS) care, had the highest average quality scores compared with other product lines for every reported clinical quality measure.

- **Resource use patterns differ by product line.**

  Unlike commercial HMOs and PPOs, which generally had similar utilization rates, the difference between managed and unmanaged Medicare utilization rates was striking. Although the results came from different sources, the substantial difference—with Medicare Advantage utilization rates only 55-65 percent of Medicare FFS rates—indicates that there is likely a true performance difference. Selection bias may also contribute to the difference—that is, older people with more complex health conditions opting to stay in traditional Medicare FFS—but lower Medicare Advantage utilization could also reflect more effective population health management.

- **Medi-Cal performance mixed.**

  Managed Medi-Cal clinical quality scores were lower than commercial HMOs and Medicare Advantage across the board. However, managed Medi-Cal rates were higher than commercial PPOs for diabetes care—for both blood sugar control and kidney disease monitoring measures. Patients covered by Medi-Cal are lower income and are more likely to have complex conditions compared to commercial PPO enrollees, so Medi-Cal's better performance on these two quality measures is somewhat surprising. While inpatient bed days and readmission rates were similar for managed Medi-Cal and commercial populations, emergency department use was substantially higher in Medi-Cal compared to commercial HMO and PPO.

ABOUT THE RESULTS

Data in the HEDIS by Geography tool represent care delivered during 2013, before full implementation of the Affordable Care Act—including the expansion of Medi-Cal and launch of Covered California, the state's health benefit exchange. As previously uninsured patients enroll in Medi-Cal and Covered California products, future updates to the data may reveal different results. The results presented here are descriptive; adjustments were not made for the characteristics of the patient population or availability of medical services in a geographic area. Further details about the tool and findings are available in IHA's Healthcare Hot Spotting Issue Brief and at https://hbg.iha.org.

ABOUT IHA

The Integrated Healthcare Association (IHA) is a nonprofit multi-stakeholder leadership group that promotes healthcare quality improvement, accountability and affordability for the benefit of all Californians. IHA has over a decade of experience leading regional and statewide performance measurement and incentive programs and serving as an incubator for pilot programs and demonstration projects.

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Integrated Healthcare ASSOCIATION

Healthcare Hot Spotting: Variation in Quality and Resource Use in California

Kelly Miller, Project Manager
Jill Yegian, Ph.D., Senior Vice President, Programs and Policy
Dolores Yanagihara, M.P.H., Vice President, Performance Measurement

A new online tool, HEDIS by Geography, tracks the quality of care and health care resource use in California—and displays them by ZIP code and product line. The results graphically pinpoint areas to target for improvement.

Extensive information is available on the quality performance of health plans and physician organizations in California. The Office of the Patient Advocate (OPA) has report cards for HMO and PPO health plans and medical groups serving HMO patients. In 2015, OPA will add Medicare Advantage to its medical group report card. In addition, California's Department of Health Care Services maintains a Medi-Cal Managed Care Performance Dashboard tracking the quality, resource use and satisfaction levels with the state's health plans. While essential for informing providers in quality improvement efforts and consumers in decision-making, this information does not paint a clear picture of population health by geographic region.

This Issue Brief presents analyses of data available through the HEDIS by Geography tool, accessible at https://hbg.iha.org. The tool allows users to display and compare measures of both quality of care and use of health care resources throughout California. Rates can be displayed by product line and geographic area—from as granular as a ZIP code to as extensive as statewide averages.

Two main themes are highlighted in this brief:

Health plan products that rely primarily on integrated care delivery networks, such as HMOs and Medicare Advantage, generally have higher quality scores without using more resources. Analysis reveals higher quality scores in Commercial HMOs compared to Commercial PPOs, and data suggest lower resource use rates in Medicare Advantage compared to Medicare fee-for-service (FFS).

Resource use and health care quality vary widely throughout the state. The data collected and displayed highlight substantial variation within single measures across geographic areas in California.

Data on the website cover about 19 million Californians, nearly half of the state's total population. Eleven health plans participated in this project, contributing data across all of their product lines. Exhibit 1 shows enrollment for each product line

ABOUT THIS ISSUE BRIEF

In May 2015, the Integrated Healthcare Association (IHA) launched an interactive online tool that displays Healthcare Effectiveness Data and Information Set (HEDIS) data by various geographic units. The tool, available at https://hbg.iha.org, tracks clinical measurements for the priority health conditions of cancer, diabetes and asthma. It also displays data summarizing quality of care and resource use as filtered by product line.

This Issue Brief presents highlights of data available through the HEDIS by Geography tool—with particular concentration on what products offered the highest quality, as well as variation in quality measures tracked by geographic area.

Integrated Healthcare Association

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Exhibit 1: Product Lines and Enrollment, HEDIS by Geography (2013 data)

Product Line	HEDIS by Geography Enrollment	% of Total Enrollment in CA
Commercial HMO	8,512,070	≈ 80%
Commercial PPO	4,653,804	≈ 50%
Medicare Advantage	1,650,563	≈ 85%
Managed Medi-Cal	4,107,006	≈ 70%
Total	18,923,443	

Sources: Total Enrollment in CA data gathered from the California HealthCare Foundation (http://www.chcf.org/), the Kaiser Family Foundation (http://kff.org/), the California Department of Health Care Services (http://www.dhcs.ca.gov) and the California Department of Managed Health Care (https://www.dmhc.ca.gov/). Percentages are approximate.

available on the HEDIS by Geography tool, as well as the approximate proportion of statewide enrollment represented by the data; data on fee-for-service Medi-Cal and Medicare are not included, nor is the uninsured population. Appendix A lists the plans that contributed data, and provides details on the methodology. Appendix B provides information about the six clinical quality and three resource use measures analyzed in this brief, as well as a comprehensive user's guide to the tool.

A note on limitations of the analysis: the results presented here are descriptive. Adjustments were not made for the characteristics of the patient population or availability of medical services in a geographic area. While such adjustments may be appropriate and useful in some cases, particularly for resource use measures, the objective of this Issue Brief was simply to present observed rates of clinical quality and resource use for key measures. Data presented here represent care delivered during 2013, before full implementation of the Affordable Care Act—including the expansion of Medi-Cal and launch of Covered California, the state's health benefit exchange. As previously uninsured patients enroll in Medi-Cal and Covered California products, future updates to the data may reveal different results.

CLINICAL QUALITY BY PRODUCT LINE

Commercial HMOs outperform Commercial PPOs

Commercial HMOs outperformed Commercial PPOs on five of the six clinical quality measures that HEDIS by Geography tracks. The results reflect the number of patients who received appropriate care; a higher percentage indicates more people receiving care in line with optimal clinical guidelines. For example, of the population included in HEDIS by Geography, 84.5% of the Commercial HMO women ages 50-74 met clinical guidelines for breast cancer screening and received a mammogram. In comparison, only 69.7 percent of similar Commercial PPO patients were screened for breast cancer. If the 4.6 million PPO enrollees represented by these data had been appropriately screened for breast cancer at the same rate as those in HMOs, 55,356 more California women would have received mammograms in 2013.

"If the PPO enrollees had been appropriately screened for breast cancer at the same rate as those in HMOs, 55,356 more California women would have received mammograms in 2013."

PPO average quality scores trailed those of HMOs by 11 to 46 percentage points, with the sole exception of the measure of Medication Management for People with Asthma, for which the Commercial PPO rate was a few points higher than the HMO rate.

In some cases, there is a dramatic spread. However, the largest gap, in Blood Sugar Control for People with Diabetes, may be at least partially due to data availability, as it requires that lab results data be received by the plan and matched with the correct patient; the other measures are taken directly from claims and encounter data—the equivalent of a bill sent from the physician to the plan after services are rendered.

The difference in Colorectal Cancer Screening rates is also large: 24 percentage points. By way of illustration, 197,385 more PPO enrollees represented by these data would have to receive a colorectal cancer screening to make the two rates equal.

Exhibit 2 shows the average result for each of the six clinical quality measures tracked in HEDIS by Geography, by product line.

Strong performance in Medicare HMO

Medicare Advantage, the HMO product line available to Medicare enrollees as an alternative to obtaining care in the market on a fee-for-service basis, had the highest average quality scores compared with the other product lines. Statewide averages were highest for every reported clinical quality measure.

For example, the average rates for Breast Cancer Screening by population were:

Exhibit 2: Clinical Quality Measures by Product Line

	California Statewide Average				
Measure Name	Commercial HMO (%)	Commercial PPO (%)	Medicare Advantage (%)	Managed Medi-Cal (%)	All Products (%)
Breast Cancer Screening	84.5	69.7	86.8	57.4	80.7
Colorectal Cancer Screening	71.1	47.5	79.4	N/A	67.1
Blood Sugar Control for People with Diabetes	70.3	24.5	77.9	42.9	62.4
Blood Sugar Screening for People with Diabetes	91.6	80.7	95.0	78.3	89.3
Kidney Disease Monitoring for People with Diabetes	90.1	70.7	95.8	79.8	87.5
Medication Management for People with Asthma	40.1	44.1	N/A	35.4	39.7

- 86.8 percent in Medicare Advantage
- 84.5 percent in Commercial HMO
- 69.7 percent in Commercial PPO, and
- 57.4 percent in Managed Medi-Cal.

Medi-Cal quality scores low

Managed Medi-Cal clinical quality scores were lower than the managed Commercial and managed Medicare rates for all clinical quality measures included here. (Colorectal Cancer Screening is not measured in the Medi-Cal population, as it is only recommended for patients over 50.)

However, managed Medi-Cal rates were higher than Commercial PPO for diabetes care—for both Blood Sugar Control and Kidney Disease Monitoring measures. In general, the patient population covered by Medi-Cal is considered more complex, and is lower income, than Commercial PPO enrollees. Accordingly, it is somewhat surprising that the Medi-Cal managed care plans show stronger results than the Commercial PPO plans on several quality measures.

Data presented here represent care delivered during 2013, before the Medi-Cal expansion in California.

RESOURCE USE BY PRODUCT LINE

The HEDIS by Geography tool also tracks resource use across ZIP codes in California by product line. For the Emergency Department (ED) Visits and Inpatient Bed Days measures, results are presented per thousand member years (PTMY). The Readmissions measure reports the percent of hospital admissions resulting in a readmission within 30 days. Resource Use results are presented by product line in Exhibit 3. Unlike quality measures, where a higher score indicates more patients receiving clinically appropriate care, there is no ideal level of resource use. However, trends in health care indicate substantial overuse of services, and lower rates can indicate that care is coordinated more efficiently.

Managed Medi-Cal utilization high

The Medi-Cal population had some of the highest utilization rates, driven largely by the high need SPD population (Seniors and Persons with Disabilities). The SPD average rate of Readmissions was 16.4 percent, while the non-SPD average was 8.7 percent, similar to the Commercial HMO and PPO rate of 8.1 percent. The same pattern was seen for Inpatient Bed Days, where the non-SPD rate was similar to the Commercial rates, but the SPD rate was significantly higher.

For ED Visits, however, both the SPD average of 392.4 and non-SPD average of 421.5 were much higher than Commercial HMO and PPO product lines (159.3 and 116.3, respectively), and even topped the Medicare Advantage ED visit average (372.3). Higher use of emergency department services among the Medi-Cal population is not surprising, but the extent of the difference raises questions about what is driving the utilization and how it might be more effectively managed.

Commercial HMO and PPO resource utilization similar

The average Commercial HMO and PPO utilization rates statewide were almost identical for Readmissions and Inpatient Bed Days. Commercial HMO members had higher

Exhibit 3: Resource Use Measures by Product Line

Measure Name	California Statewide Average						
	Commercial HMO	Commercial PPO	Medicare FFS	Medicare Advantage	Managed Medi-Cal Non-SPD	Managed Medi-Cal SPD	All Products
Readmissions (% of admissions)	8.1	8.1	18.4	11.2	8.7	16.4	10.2
ED Visits (PTMY)	159.3	116.3	567	372.3	421.5	392.4	228.3
Inpatient Bed Days (PTMY)	133.5	133.3	1,363	758.3	121.5	534.5	209.9

Abbreviations: PTMY = Per Thousand Member Years; SPD = Seniors and Persons with Disabilities, a subset of the Medi-Cal population
Sources: Medicare FFS data come from Medicare Geographic Variation Public Use Files, State/County Table—All Beneficiaries, 2013 at www.cms.gov; source for all other data is HEDIS by Geography.

GETTING A BOOST FROM THE STARS?

To encourage Medicare Advantage plans to provide quality care, the Affordable Care Act authorized Medicare to pay plans bonuses based on the program's 5-star quality rating system.

The Centers for Medicare and Medicaid Services (CMS) launched a three-year demonstration implemented in 2012, rewarding high scoring plans with bonus payments and the ability to market to beneficiaries. In addition, CMS reserves the right to terminate contracts with those plans that earn a rating below three stars for three consecutive years.

CMS uses quality measures focusing on areas such as managing long-term conditions, preventative care, member experiences with drug plans and plans' customer service. Like HEDIS by Geography, the CMS Medicare Stars program tracks breast and colorectal cancer screenings, diabetes blood sugar screening and control, and diabetes kidney disease monitoring, although it does not measure asthma medication management.

Early analysis shows the performance incentives are working. The ratings CMS released for 2015 showed stable or improved performance in nearly 70 percent of the 46 Medicare Parts C and D Star measures—seven of which improved by more than ½ Star from 2014 to 2015, and 13 of which earned ratings above 4 Stars in 2015. These results are consistent with the HEDIS by Geography project findings that Medicare Advantage plans provide high quality care.

While there is much room for improvement, the Stars data not only act as an incentive for plans to achieve bonuses—but importantly, will provide a way to monitor whether quality ratings and bonus payments foster better care and improved health outcomes for patients in the future.

ED use than Commercial PPO members however; they visited the ED an average of 43 more times per thousand member years. The small difference between utilization rates in the Commercial HMO and PPO product lines is unexpected, given the perception that utilization in HMO products is managed more tightly than in PPO.

Medicare Advantage utilization rates were significantly higher than the Commercial product lines, which is expected given the greater complexity of the health care needs of the senior population.

Medicare Advantage utilization lower than FFS

Unlike Commercial HMO and PPO, the difference between managed and unmanaged Medicare utilization rates was striking. Although the results came from different sources, the substantial difference in utilization rates—with Medicare Advantage rates only 55-65% of the Medicare FFS rates—indicates that there is likely a true difference in performance. Selection bias may be contributing to the difference—that is, older people with more complex health conditions opting out of Medicare Advantage—but lower utilization could also reflect effective population health management by the Medicare Advantage health plans and their contracted providers.

CALIFORNIA IN A NATIONAL CONTEXT

California outperforms the nation as a whole on both clinical quality and resource use, based on comparison of HEDIS by Geography data to national averages reported by the National Committee for Quality Assurance (NCQA). At the national level, HEDIS measures follow the same patterns as those observed in HEDIS by Geography for California: Commercial HMO rates are higher than Commercial PPO rates

Exhibit 4: Comparison of National and California Clinical Quality Measures

Measure Name	National Average		California Average	
	Commercial HMO (%)	Commercial PPO (%)	Commercial HMO (%)	Commercial PPO (%)
Breast Cancer Screening	73.7	69.5	84.5	69.7
Colorectal Cancer Screening	62.9	56.5	71.1	47.5
Blood Sugar Control for People with Diabetes	69.3	62.4	70.3	24.5
Blood Sugar Screening for People with Diabetes	89.6	87.3	91.6	80.7
Kidney Disease Monitoring for People with Diabetes	83.8	78.8	90.1	70.7
Medication Management for People with Asthma	46.8	49.6	40.1	44.1

Source for national data is NCQA Quality Compass, 2014 (reflects performance in 2013); source for California data is HEDIS by Geography.

for every clinical quality measure except Medication Management for People with Asthma (see Exhibit 4).

But the quality differential between product lines in California is larger than the national differential. Commercial HMO rates in California outperformed national rates for every measure except for Medication Management for People with Asthma, while California Commercial PPO rates were lower than national PPO rates for five of the six measures and about the same for the Breast Cancer Screening measure. One would expect California's rates to be somewhat lower than national rates, simply because the national measurement rates use a process called "chart review" that allows data collectors to go back to a patient's chart and find the information they need for the clinical quality measure, usually resulting in a higher score; by contrast, the California HEDIS by Geography rates rely purely on billing data. Therefore, the lower California PPO rates compared to national rates are not particularly surprising, while the higher HMO rates indicate performance strong enough to overcome the disadvantage conferred by administrative-only data.

Exhibit 5 shows national averages for Commercial HMO and PPO product lines for two of the resource use measures tracked in HEDIS by Geography. Both Commercial product lines in California have lower utilization of ED Visits and Inpatient Bed Days than the national average.

GEOGRAPHIC VARIATION ACROSS CALIFORNIA

The HEDIS by Geography tool highlights the variation in each of the three resource use measures—Readmissions, Emergency Department (ED) Visits and Inpatient Bed Days—presenting a graphic picture of the variations in both resource use and quality of care throughout the state.

Exhibit 5: Comparison of National and California Resource Use Measures

Measure Name	National Average		California Average	
	Commercial HMO	Commercial PPO	Commercial HMO	Commercial PPO (%)
ED Visits (PTMY)	191.5	178.7	159.3	116.3
Inpatient Bed Days (PTMY)	180.1	170.2	133.5	133.3

Abbreviation: PTMY = Per Thousand Member Years

Notes: Source for national data is NCQA Quality Compass, 2014 (reflects performance in 2013); source for California data is HEDIS by Geography. Readmissions are not included in the table because national data that is comparable to the HEDIS by Geography data is not available.

Exhibit 6: Resource Use Across Zip Codes

Percentiles Across ZIP Codes			
	5th	50th	95th
Readmissions (% of admissions)	4.9	9.9	14.1
ED Visits (PTMY)	111.3	193.9	385.4
Inpatient Bed Days (PTMY)	75.7	195.4	412.9

Abbreviation: PTMY = Per Thousand Member Years

Large variation in resource use measures by ZIP code

The 5th percentile of Readmissions is 4.9 percent: about 5 percent of ZIP codes had a lower Readmission rate, and 95 percent of ZIP codes had a higher Readmission rate. Readmissions are almost three times as high in the 95th percentile ZIP code compared to the 5th percentile ZIP code.

The range is even larger for ED Visits and Inpatient Bed Days. The 95th percentile of ED Visits is about 3.5 three times larger than the rate for the 5th percentile. For Inpatient Bed Days, the 95th percentile ZIP code rate was more than five times as large as the rate for the 5th percentile ZIP code.

Exhibit 6 shows the 5th, 50th and 95th percentiles of the resource use measures across ZIP codes in California.

Exhibit 7 shows the 10 counties in the state with the highest and lowest rates for ED Visits, which vary significantly. Residents in Kings, the county with the highest ED use, visit the ED more than three times as frequently as residents in Santa Cruz.

Exhibit 7: ED Visit Rates: Lowest and Highest, by County

Emergency Department Visits (PTMY)					
10 Counties with Lowest Rates			10 Counties with Highest Rates		
County	Rank	Rate	County	Rank	Rate
Santa Cruz	1	108.0	Kings	58	353.5
Sutter	2	121.6	Tulare	57	348.0
Butte	3	128.5	Stanislaus	56	347.3
Monterey	4	134.2	San Bernardino	55	325.9
Glenn	5	136.0	Madera	54	302.6
Shasta	6	147.7	Imperial	53	301.2
Santa Barbara	7	147.9	Sacramento	52	290.1
Colusa	8	149.5	Riverside	51	265.8
Ventura	9	154.3	Fresno	50	265.3
Santa Clara	10	156.1	Los Angeles	49	244.5

Abbreviation: PTMY = Per Thousand Member Years

Exhibit 8: ED Visits, Counties with Highest and Lowest Rates

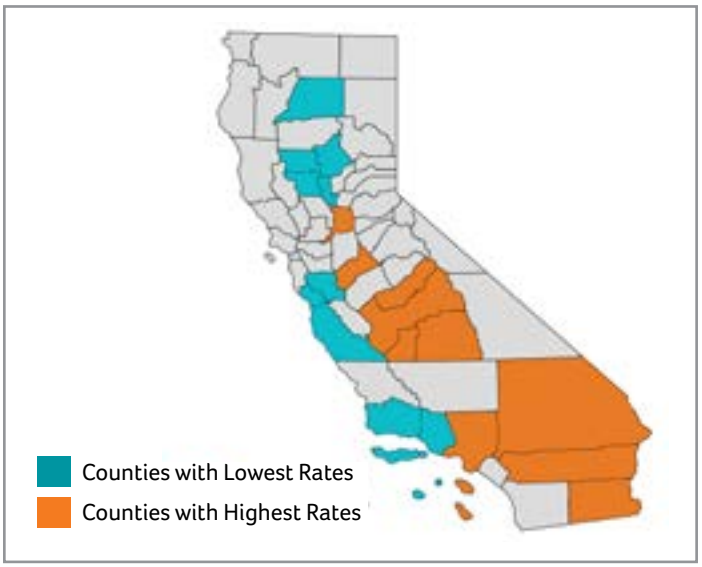


Exhibit 8 is a graphic depiction of the use of health care resources throughout the state. Blue counties indicate counties with the lowest rates of ED Visits, while orange counties are those with the highest use.

Large variation in clinical quality measures by ZIP code

Exhibit 9 shows the minimum and maximum rates, as well as the 25th, 50th, and 75th percentiles of the rates of clinical quality measures across ZIP codes in California. In general, the lowest quartiles have the largest ranges—indicating there is more variation, and more room for improvement, among lower performing ZIP codes.

Exhibit 10 shows the 10 highest and lowest performing counties in the state for Colorectal Cancer Screening. The rates vary significantly across counties. For example, the rate of screening in Modoc county trails that of Solano by a substantial 43 percentage points. Since Medi-Cal data are not available for colorectal cancer screening, the figures below represent the statewide averages across commercial HMO, commercial PPO, and Medicare Advantage product lines for participating health plans; see Table B-1 in Appendix B for a full listing of measures by product line.

Exhibit 11 helps illustrate the quality of health care by county. Blue counties have the highest rates of Colorectal Cancer Screening; orange counties are those with the lowest

Exhibit 9: Variation in Clinical Quality Ratings by ZIP Code

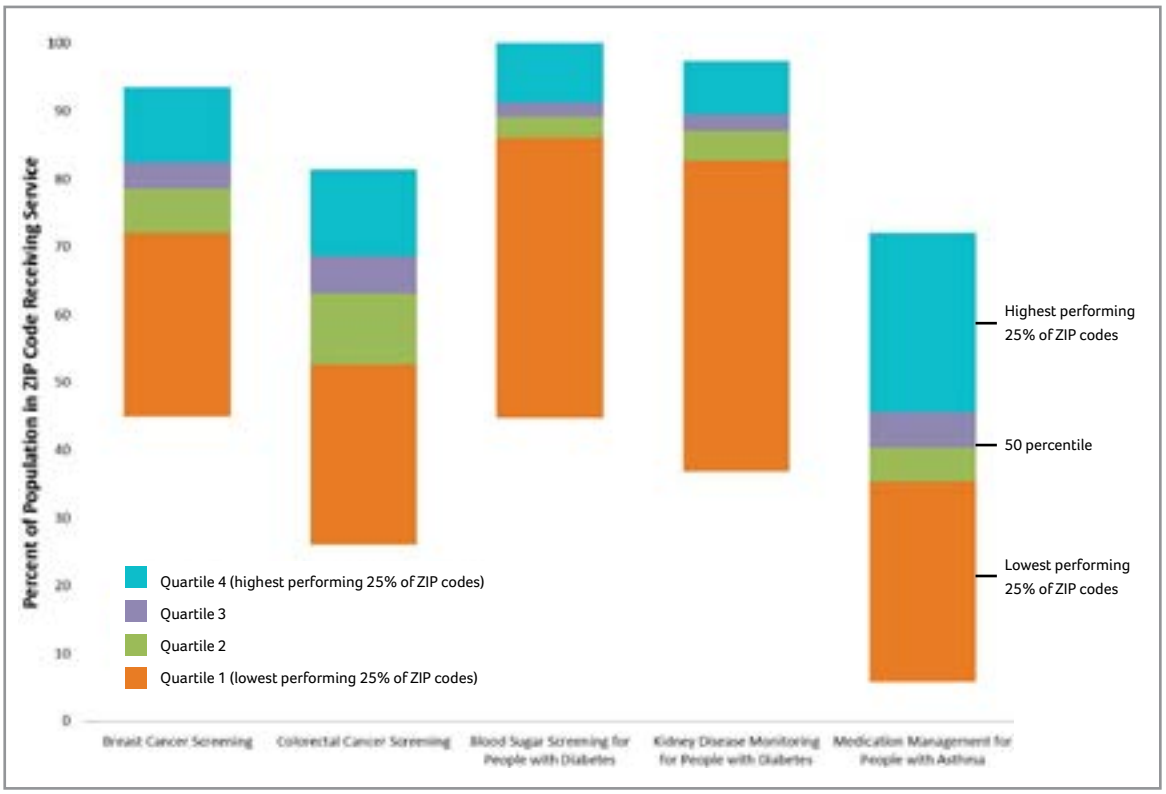
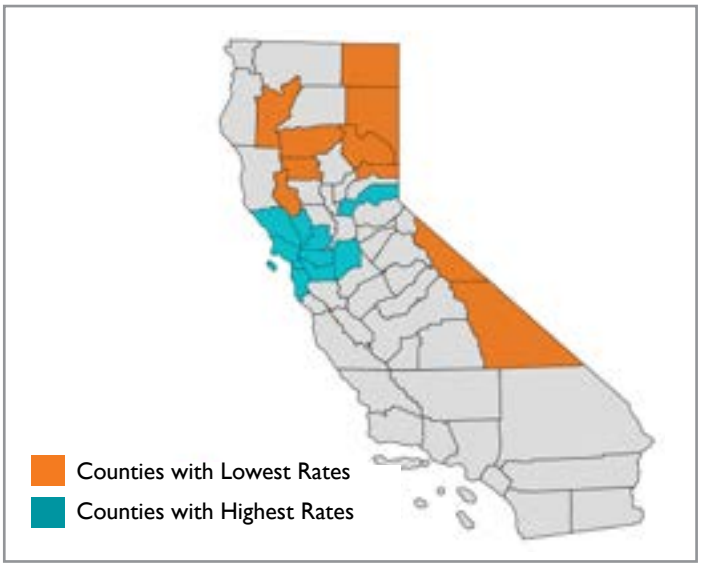


Exhibit 10: Colorectal Cancer Screening Rates, Highest to Lowest, by County

Colorectal Cancer Screening					
10 Highest Performing Counties			10 Lowest Performing Counties		
County	Rank	Rate (%)	County	Rank	Rate (%)
Solano	1	76.4	Modoc	58	33.5
Contra Costa	2	74.3	Mono	57	39.6
Alameda	3	74.2	Plumas	56	39.9
Marin	4	73.9	Trinity	55	43.0
Sonoma	5	72.4	Glenn	54	43.1
Napa	6	72.1	Tehama	53	43.6
San Joaquin	7	71.6	Lassen	52	44.2
San Mateo	8	71.6	Sierra	51	45.0
San Francisco	9	71.4	Inyo	50	45.6
Placer	10	71.1	Lake	49	45.9

rates. The highest performing counties are centered in the greater Bay Area, while the lowest performers are in rural areas of North and Central California.

Exhibit 11: Colorectal Cancer Screening: Counties with Highest and Lowest Rates



INSIGHTS GAINED

Aggregating and analyzing data on several clinical quality and resource use measures representing 19 million Californians generated new insights based on product line and geography.

Viewing the data at the ZIP code level by product line reveals that commercial HMOs outperform commercial PPOs on clinical quality, with similar resource use; national data reinforce the finding, showing similar results. Likewise, the significantly lower resource use rates for Medicare Advantage's HMO products compared to Medicare FFS suggest a potential for savings based on reducing use of inpatient services; data on Medicare FFS quality ratings were not available.

Medi-Cal managed care shows lower quality and higher resource use for several measures in comparison with Commercial products. In some cases, utilization is dramatically higher, especially for the SPD members. While not entirely surprising given that the Medi-Cal population is low-income and tends to be more complex, the results nevertheless point to the potential for significant quality improvement and savings in Medi-Cal. Moreover, the data pre-dates the expansion of Medi-Cal eligibility in California. Since Medi-Cal now covers nearly one-third of California's population, the findings are even more salient—and urgent.

Analyzing quality and resource use measures through a geographic lens reveals wide variation across the state, with vast differences in clinical quality and resource use between the counties with the highest and lowest rates. Such large differences signify an opportunity for major improvements in the care provided to large segments of California's population.

Additional analyses, going beyond the results presented in this Issue Brief, will doubtless yield new insights. For example, geographic units representing hospital referral regions, hospital service areas and Covered California regions within California are all available for viewing on the interactive map at https://hbg.iha.org, and for analysis through the downloadable data.

Acknowledgments

This project was generously supported by a grant from the California HealthCare Foundation (CHCF). IHA's HEDIS by Geography project team included Cayman Nava, who created the online mapping tool, https://hbg.iha.org, and Brian Goodness and Ann Hardesty, who contributed to data collection and analysis. Barbara Kate Repa provided invaluable editing services. The project could not have been completed without the participation of the health plan partners, who contributed both data and time to this effort. The participating plans, the Department of Health Care Services, and Maribeth Shannon at CHCF reviewed a draft of the brief and provided valuable feedback.

APPENDIX A

Methodology for HEDIS by Geography

In 2014, the Integrated Healthcare Association (IHA) recruited 11 health plans to participate in the project.

Exhibit A1: Participating Health Plans, by Product Line

	Commercial HMO	Commercial PPO	Medicare Advantage	Managed Medi-Cal
Anthem Blue Cross	X	X	X	X
Blue Shield of California	X	X	X	
CalOptima			X	X
Health Net	X	X	X	X
Inland Empire Health Plan			X	X
Kaiser Permanente	X		X	X
L.A. Care Health Plan			X	X
San Francisco Health Plan				X
SCAN Health Plan			X	
UnitedHealthcare	X	X	X	
Western Health Advantage	X			

Through a series of workgroup meetings with representatives from each plan, participants agreed on nine measures to report. Measures were chosen on the basis of clinical importance and applicability across product lines.

Only two of the measures, Asthma Medication Management and Colorectal Cancer Screening, are not reported for all product lines. The Table in Appendix B below shows a complete list of measures by product line.

The managed Medi-Cal plans reported additional breakdowns for the three resource use measures, allowing for comparison of the utilization of Seniors and Persons with Disabilities (SPD population) to all other Medi-Cal members.

Each health plan contributed numerator and denominator data by ZIP code reflecting 2013 results for the nine selected HEDIS measures for their Medi-Cal, Commercial HMO and PPO, and Medicare Advantage members in California. The Medi-Cal data is more localized, because Medi-Cal managed care plans operate only in certain counties. Only members in those counties—and neighboring ones, if members cross county lines to seek care—are included in the Medi-Cal rates.

Data provided was administrative-only for the entire member population; it was not a sample and there was no medical record review. Plans attributed members to a ZIP code based on their home address. One plan with statewide enrollment supplied data for the Medication Management for People with Asthma measure only in Southern California, due to data availability issues.

IHA aggregated the data across plans at the ZIP code level, and rolled the ZIP codes up to Hospital Service Area, Hospital Referral Region, County, Covered California Region (one of 19 regions established by the state for California's public exchange) and statewide averages.

Rates displayed on the map and included in the export feature are suppressed if contributed by only one plan, or if the denominator of the aggregated rate is fewer than 30.

The demographic data displayed was downloaded at the ZIP code level from the Census Bureau website. It was collected in the 2012 American Community Survey.

APPENDIX B

User's Guide to HEDIS by Geography

In May 2015, the Integrated Healthcare Association (IHA) launched an interactive online map tool that allows users to access Healthcare Effectiveness Data and Information Set (HEDIS) data by various geographic units and by product line offered.

Ways to Access the Information

Accessible at https://hbg.iha.org, HEDIS by Geography allows users to display and compare both quality of care and use of health care resources throughout the state of California. Information can also be viewed on the demographics of the populations living there.

Geographical Views Included

Users can filter and view HEDIS data by specific geographical areas, including:

- Statewide
- County, and
- ZIP code.

They can also see the data according to provider service area, including:

- Covered California Region
- Hospital Referral Region, and
- Hospital Service Area.

For each of these geographical views, users can also drill down to sort and view the data by specific product line, including:

- All Plans
- Commercial PPOs
- Commercial HMOs
- Medicare Advantage, and
- Managed Medi-Cal.

Measurements Included

HEDIS by Geography illustrates the quality and use of the state's health care resources by clinical and resource use measures. Some demographic indicators, such as race, education level and primary language spoken, can also be displayed.

Display by Clinical Measures

The site includes clinical measurements involving cancer, diabetes and asthma—commonly considered core priority health conditions, and all with strong performance measures in place.

The measurements included are:

- **Breast Cancer Screening:** Percentage of women ages 50 to 74 years old who had one or more mammogram(s) to screen for breast cancer
- **Colorectal Cancer Screening:** Percentage of adults ages 50 to 75 years old who had one or more screening(s) for colorectal cancer—including fecal occult blood tests, flexible sigmoidoscopies and colonoscopies
- **Blood Sugar Control for People with Diabetes:** Percentage of adults 18 to 75 years old with either Type 1 or Type 2 diabetes whose most recent HbA1c level is above 9% or who have not been tested during the measurement year (This result is inverted so that a higher rate is better.)
- **Blood Sugar Screening for People with Diabetes:** Percentage of adults 18 to 75 years old with either Type 1 or Type 2 diabetes who have had an HbA1c test performed
- **Kidney Disease Monitoring for People with Diabetes:** Percentage of adults 18 to 75 years old with either Type 1 or Type 2 diabetes who had nephropathy screening or evidence of nephropathy
- **Medication Management for People with Asthma:** Percentage of people with persistent asthma who remained on an asthma controller medication for at least 75% of their treatment period

All performance measures are for the year the care was delivered.

Display by Resource Use

Hospital Readmissions, Emergency Department (ED) Visits and Inpatient Bed Days, important indicators of resources used, as defined below, were also tracked in HEDIS by Geography.

All-Cause Readmissions: Percentage of acute inpatients ages 18 and older discharged and readmitted for any diagnosis within 30 days. An additional breakdown is available for Seniors and Persons with Disabilities who have Managed Medi-Cal coverage; their utilization is usually much

higher than the rest of the Medi-Cal-eligible population.

Emergency Department Visits: Overall rate of visits per thousand member years (PTMY). An additional breakdown is available for Seniors and Persons with Disabilities who have Managed Medi-Cal coverage.

Inpatient Bed Days: Overall rate of all bed days associated with acute inpatient care discharges, on a per thousand member year (PTMY) basis. For Medicare Advantage and Medi-Cal, members 18 and older are included. For Commercial HMOs and PPOs, members 18-64 are included.

Display by Demographics

Users can view the HEDIS data according to the percentage of the population that is:

- Black or African American
- Asian
- Hispanic, and
- White.

And they can also sort it by the percentage of the population who speaks:

- Asian or Pacific Island languages, and
- Spanish or Spanish Creole languages.

The populations can also be viewed according to:

- Median income, and
- Educational attainment, defined as those with a high school degree or above.

Exhibit B1: HEDIS by Geography: Measurements at a Glance

	Measure Name	Commercial HMO	Commercial PPO	Medicare Advantage	Managed Medi-Cal	Total Population
Clinical Quality	Breast Cancer Screening	X	X	X	X	
	Colorectal Cancer Screening	X	X	X		
	Blood Sugar Control for People with Diabetes	X	X	X	X	
	Blood Sugar Screening for People with Diabetes	X	X	X	X	
	Kidney Disease Monitoring for People with Diabetes	X	X	X	X	
	Medication Management for People with Asthma	X	X		X	
Resource Use	All Cause Readmissions	X	X	X	X	
	Emergency Department Visits	X	X	X	X	
	Inpatient Bed Days	X	X	X	X	
Demographic	African American Population					X
	Asian Languages					X
	Asian Population					X
	Educational Attainment					X
	Hispanic Population					X
	Median Income					X
	Spanish Language					X
	White Population					X

Note: All clinical quality and resource use rates are calculated from numerators and denominators reported by the participating health plans.
Demographic data is from the U.S. Census Bureau, American Community Survey, 2012: http://factfinder.census.gov/faces/nav/jsf/pages/download_center.xhtml

Attachment 2

Original Investigation | October 22/29, 2014

Total Expenditures per Patient in Hospital-Owned and Physician-Owned Physician Organizations in California FREE

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JAMA. 2014;312(16):1663-1669. doi:10.1001/jama.2014.14072.

ABSTRACT

Importance Hospitals are rapidly acquiring medical groups and physician practices. This consolidation may foster cooperation and thereby reduce expenditures, but also may lead to higher expenditures through greater use of hospital-based ambulatory services and through greater hospital pricing leverage against health insurers.

Objective To determine whether total expenditures per patient were higher in physician organizations (integrated medical groups and independent practice associations) owned by local hospitals or multihospital systems compared with groups owned by participating physicians.

Design and Setting Data were obtained on total expenditures for the care provided to 4.5 million patients treated by integrated medical groups and independent practice associations in California between 2009 and 2012. The patients were covered by commercial health maintenance organization (HMO) insurance and the data did not include patients covered by commercial preferred provider organization (PPO) insurance, Medicare, or Medicaid.

Main Outcomes and Measures Total expenditures per patient annually, measured in terms of what insurers paid to the physician organizations for professional services, to hospitals for inpatient and outpatient procedures, to clinical laboratories for diagnostic tests, and to pharmaceutical manufacturers for drugs and biologics.

Exposures Annual expenditures per patient were compared after adjusting for patient illness burden, geographic input costs, and organizational characteristics.

Results Of the 158 organizations, 118 physician organizations (75%) were physician-owned and provided care for 3 065 551 patients, 19 organizations (12%) were owned by local hospitals and provided care for 728 608 patients, and 21 organizations (13%) were owned by multihospital systems and provided care for 693 254 patients. In 2012, physician-owned physician organizations had mean expenditures of $3066 per patient (95% CI, $2892 to $3240), hospital-owned physician organizations had mean expenditures of $4312 per patient (95% CI, $3768 to $4857), and physician organizations owned by multihospital systems had mean expenditures of $4776 (95% CI, $4349 to $5202) per patient. After adjusting for patient severity and other factors over the period, local hospital–owned physician organizations incurred expenditures per patient 10.3% (95% CI, 1.7% to 19.7%) higher than did physician-owned organizations (adjusted difference, $435 [95% CI, $105 to $766], $P = .02$). Organizations owned by multihospital systems incurred expenditures 19.8% (95% CI, 13.9% to 26.0%) higher (adjusted difference, $704 [95% CI,$512 to $895], $P < .001$) than physician-owned organizations. The largest physician organizations incurred expenditures per patient 9.2% (95% CI, 3.8% to 15.0%, $P = .001$) higher than the smallest organizations (adjusted difference, $130 [95% CI, $−32 to $292]).

Conclusions and Relevance From the perspective of the insurers and patients, between 2009 and 2012, hospital-owned physician organizations in California incurred higher expenditures for commercial HMO enrollees for professional, hospital, laboratory, pharmaceutical, and ancillary services than physician-owned organizations. Although organizational consolidation may increase some forms of care coordination, it may be associated with higher total expenditures.

Hospitals and multihospital systems are acquiring medical groups and physician practices as part of a strategy to build integrated delivery systems capable of providing the full range of professional, facility, laboratory, and pharmaceutical services to affiliated patients.[1] This consolidation may lead to greater coordination of care, less duplication of tests and treatments, a substitution of low-cost for high-cost settings where appropriate, and, as a result, lower total expenditures for care.[2] However, this consolidation could lead to higher patient care expenditures due to preferential use of high-priced hospitals for inpatient admissions, substitution of hospital-affiliated outpatient departments for ambulatory surgery and imaging facilities, and increased prices to insurers for laboratory tests, drugs, and other ancillary services.[3-6] The policy debate about consolidation has gained new policy attention due to the financial incentives provided by the Affordable Care Act for physicians to join hospital-affiliated accountable care organizations (ACOs).[7]

It has been difficult to ascertain the influence of hospital ownership on the expenditures for care delivered by physician organizations. Available measures of expenditures often do not cover the full range of services used by patients, because insurers often are reluctant to release claims data, hospitals often refuse to release price data, drugs often are reimbursed by independent pharmacy benefit management firms, and laboratory tests are conducted by a mix of physician practices, hospital facilities, and national laboratory firms. However, public policy makers and private purchasers increasingly are focusing on their total expenditures, rather than expenditures for particular components of care, as the basis for emerging methods of compensation such as pay-for-performance[8] and shared savings for ACOs.[9] The objective of this study was to determine whether total expenditures per patient were higher in physician organizations owned by local hospitals or multihospital systems compared with physician organizations owned by participating physicians.

METHODS

This study was approved by the Western Institutional Review Board, on behalf of the Integrated Healthcare Association (IHA). A waiver was received for informed consent, as no patient identifiers were included in the data. Data on physician organizations were obtained from the IHA, an association of insurers, hospitals, and physician organizations in California.[10] Since 2001, the IHA has coordinated the state's pay-for-performance program in collaboration with the participating health insurance plans and physician organizations. The program focuses on patients enrolled in health maintenance organizations (HMOs), the dominant form of commercial insurance in California. These patients are nonelderly and nonindigent, are not eligible for either Medicare or Medicaid, and thus are broadly representative of the working population in California. They account for 24% of persons with employment-based insurance in California in 2012. All physician organizations are paid by the health plans on a monthly per-member basis for professional and ancillary services, sometimes supplemented with partial capitation for hospital services. The organizations are eligible for financial bonuses if they perform well on measures of clinical process and outcome, patient experience and satisfaction with care, and the meaningful use of clinical information technology. The California pay-for-performance program has been described elsewhere.[11]

For this study, physician organizations were categorized as integrated medical groups, with employed physician members, or independent practice associations (IPAs), with contracting physician practices. Ownership data on each medical group and IPA were obtained from the consulting firm of Cattaneo & Stroud.[12] Cattaneo & Stroud maintain an annually updated database on all physician organizations in California that contract with HMOs, including information of ownership and size. For purposes of this study, organizations were categorized in terms of whether they were owned by their member physicians, a local hospital, or a multihospital system. Physician-owned organizations typically are structured as a partnership or professional corporation. Organizations owned by individual hospitals and local hospital chains, which do not extend across geographic regions (and typically include fewer facilities than regional hospital chains), are categorized for this study as owned by a local hospital (rather than owned by a regional multihospital

system).

Four regional multihospital systems own physician organizations in multiple geographic markets in California. Integrated medical groups and IPAs owned by any of these 4 systems are categorized for this study as owned by a regional multihospital system, as distinct from an individual hospital. The organizations included in this study do not provide services to Kaiser Foundation Health Plan, the largest HMO in California, which obtains professional services exclusively from its affiliated Permanente medical groups.

The size of each organization was measured in terms of the number of patients for which the organization received capitation payment from commercial and Medicare Advantage HMO plans. This measure does not capture the scale of the organization's services provided to patients enrolled in commercial preferred provider organizations (PPOs) and the Medicare fee-for-service program. It is not a direct measure of the number of physicians affiliated with the organization. In particular, IPAs tend to have larger numbers of affiliated physicians than integrated medical groups.

The IHA provided 2009-2012 data on the total annual expenditures for the care of patients affiliated with every organization participating in the California pay-for-performance program. The expenditure data were obtained by the IHA from multiple sources, depending on the site and type of care, and represent expenditures from the point of view of insurers and the perspective of employers and individuals who pay insurance premiums. For example, expenditures for hospital services are measured in terms of the negotiated rates paid by insurers and the out-of-pocket co-payments made by patients, not the expenditures incurred by the hospitals for wages, supplies, capital equipment, and other inputs.

For physician services, expenditures for care were measured as the monthly capitation payments from the insurers to the organization to cover primary care and specialist physician services, plus the expenditures for laboratory tests. Expenditures by the insurers on hospital services, ambulatory surgery, subacute care, diagnostic imaging, pharmaceuticals, and other nonphysician services were obtained from insurance claims paid to the facilities and pharmaceutical distributors. The data were not audited independently by the IHA but are compiled for each physician organization from the individual claims data for every individual patient by Truven Health Analytics on behalf of the insurers and the IHA. These expenditure data are subject to close scrutiny by insurers and physician organizations for accuracy, because they must reflect the negotiated payment rates and the actual levels of utilization of each type of service by the patients affiliated with each organization. They are not estimates of expenditures, but are the actual expenditures made for covered services. Payments for mental health services were not included, as these services are provided by managed behavioral health organizations on behalf of the health plans and are not delegated to participating organizations.

Expenditures were measured in terms of the actual amount paid by the insurer, not billed charges. Annual per-patient expenditures were truncated at $100 000 to exclude the effect of small numbers of very sick patients on average expenditures per patient. Patient co-payments required at the time of receiving care were included in the measure of expenditures.

Professional, hospital, ancillary, pharmaceutical, and consumer cost sharing expenditures during the course of each year were aggregated for each patient by the health insurance plans and Truven Health Analytics, the data intermediary for the pay-for-performance program, to create a measure of the total annual expenditures per patient. The patient data then were aggregated by Truven to measure the average expenditure per patient for each organization in each year. We obtained the expenditure data from Truven for this study already aggregated to the level of the medical group for each year.

The data represent all the expenditures incurred on behalf of the patients, not merely the services directly provided by each organization. The hospital-owned organizations directly provide outpatient and inpatient facility services in addition to physician services. Physician-owned organizations provide only professional services, and refer outpatient and inpatient services to independent facilities. In our measure, expenditures incurred by independent facilities are ascribed to the medical group or IPA with which the patient is affiliated. The measure thus is comparable across organizations regardless of the mix of internally and externally delivered services.[13]

The expenditures incurred by each medical group were adjusted according to the disease burden of its affiliated patient population and the salaries and other inputs that vary across geographic regions. Expenditures were adjusted for differences in disease burden using patient-level relative risk scores based on the Diagnostic Cost Groups (DxCG) relative risk model.[14] The relative risk score accounts for patient age, sex, and health status using diagnosis data obtained from insurance claims. It indicates how much the medical group would be expected to spend on the care of each patient, given the patient's demographic and health status, and is used to adjust the data on actual spending per patient. Risk scores were calculated for all the patients affiliated with each physician organization. The geographic adjustment factor, published by the Centers for Medicare & Medicaid Services and based on its hospital wage index, was used to adjust for input prices in the local market for each physician organization.[15] It measures the ratio of average wages in the local market area of each medical group divided by the national average wage level. The measures of relative risk and geographic input prices were used as covariates in the statistical analyses.

We calculated the annual trend between 2009 and 2012 in expenditures per patient for all physician organizations according to ownership, structure, and size. We measured expenditures for physician-owned, local hospital–owned, and multihospital system–owned organizations separately. We divided the organizations into 4 size quartiles based on the number of HMO patients affiliated with each, and measured expenditures per patient for each quartile of organizations to obtain the association between expenditures and this measure of size. We also calculated expenditures separately for different structures: integrated medical groups (organizations with employed physicians) and IPAs (organizations with contracted physicians).

The multivariable association between organizational characteristics and expenditures was calculated using linear regression analysis in Stata (StataCorp), version 12.1. Dollars were converted into logarithmic units so that the coefficients in the regression analyses can be interpreted as percentage differences associated with each covariate. Coefficients from the logarithmic regressions were converted to percentage effects using the transformation $P = 100 [(\exp \times B) - 1]$, where P is the percentage change, exp is the exponential function, and B is the parameter from the regression equation.

We also conducted multivariable regression analyses using expenditures in dollar units rather than in logarithmic units. These dollar regression analyses were used to calculate the dollar differences in expenditures per patient associated with organizational ownership, as a complement to the calculation of percentage differences in expenditures per patient. The coefficients for the ownership covariates in the multivariable regressions directly measure the dollar difference in total expenditures per patient associated with different ownership forms for physician organizations. Covariates included organizational ownership (physician, local hospital, or multihospital system), size (quartile in distribution of number of HMO patients), structure, the geographic expenditure adjustor, the patient disease burden adjustor, and indicator variables for each of the 4 study years. The error terms in the linear regression analyses were clustered by organization across years to account for heteroscedasticity.[16] Differences were considered statistically significant when *P* values were .05 or less in a 2-tailed *t* test.

RESULTS

Table 1 presents 2012 descriptive statistics on all physician organizations participating in the California pay-for-performance program. The number of patients affiliated with these organizations, including both commercial HMO and Medicare Advantage, declined from 4.8 million in 2009 to 4.5 million in 2012. The number of patients affiliated through commercial HMOs declined from 4.4 million to 3.9 million. This accounted for 21% of the total number of persons with private health insurance in California in 2012. During this period, the market share of these HMOs declined in favor of PPO health plans and as an increasing share of total HMO enrollment shifted to Kaiser Permanente, which is not included in this study. The number of physician organizations declined from 162 to 158 due to mergers and acquisitions. In 2009, independent hospitals owned 10 physician organizations, accounting for 7.7% of the HMO patients. By 2012, this had increased to 19 independent hospital–owned organizations and 16.2% of patients. In 2009, the 4 multihospital health systems owned 21 physician organizations, accounting for 15.7% of the patients. The number of multihospital systems remained constant at 15.4%.

Table 1. Characteristics of Physician Organizations Participating in the California Pay-for-Performance Program in

2012

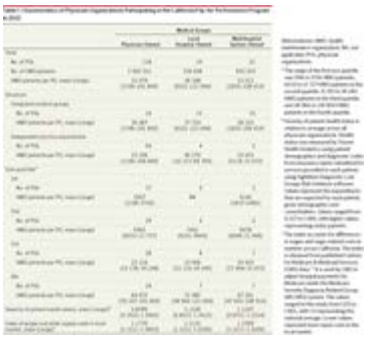

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Table 2 presents trends in total expenditures per patient between 2009 and 2012. The mean expenditure per patient across all physician organizations increased during these 4 years by 16.5%, from $2954 (95% CI, $2803-$3105) to $3443 (95% CI, $3528-$3627), *P* = .001. By 2012, expenditures per patient had increased to an average of $3066 (95% CI, $2892-$3240) in physician-owned organizations, $4312 (95% CI, $3768-$4857) in local hospital–owned organizations, and $4776 (95% CI, $4349-$5202) in multihospital system–owned organizations. These represent a 40.6% relative difference in expenditures per patient associated with hospital ownership (*P* = .001) and 55.8% relative difference associated with ownership by a multihospital system (*P* = .001) compared with ownership by member physicians.

Table 2. Total Annual Cost of Care per Patient in Physician Organizations in California, 2009-2012

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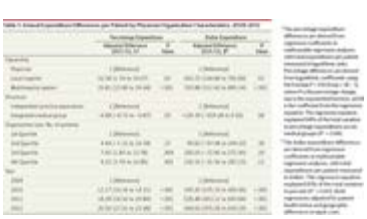
Table 3 presents the association between total expenditures for care and ownership by a local hospital or a multihospital system, after adjusting for organizational size, structure, patient illness severity, geographic differences in input costs, and year effects. Local hospital–owned physician organizations incurred total annual expenditures per patient 10.3% (95% CI, 1.7% to 19.7%) higher than did physician-owned organizations, after adjusting for other relevant factors (*P* = .02). Expenditures per patient were 19.8% (95% CI, 13.9% to 26.0%) higher in organizations owned by multihospital systems than in organizations owned by member physicians (*P* = .001). Local hospital–owned organizations incurred total annual expenditures per patient $435 (95% CI, $105 to $766) higher than did physician-owned organizations, after adjusting for other relevant factors (*P* = .010). Expenditures per patient were $704 (95% CI, $512 to $895) higher in organizations owned by multihospital systems than in organizations owned by member physicians (*P* = .000). The expenditure per patient was higher in organizations with a larger compared with smaller number of patients; after adjusting for other factors, organizations in the largest size quartile incurred expenditures 9.2% (95% CI, 3.8% to 15.0%) greater than those in the smallest size quartile (*P* = .001), adjusted difference, $130 (95% CI, $−32 to $292). The IPAs with contracted physicians incurred expenditures 4.9% (95% CI, 0.9% to 8.7%) higher than did integrated medical groups with employed physicians, after controlling for other factors (*P* = .02).

Table 3. Annual Expenditure Differences per Patient by Physician Organization Characteristics, 2009-2012



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DISCUSSION

Local hospitals and multihospital health systems are acquiring physician organizations and employing individual physicians as part of a strategy to build integrated delivery systems that can provide the full range of professional and institutional services. Hospitals have been encouraged in this population-based focus by the Affordable Care Act, which creates incentive for the development of ACOs. The ACOs need not be owned by a hospital. As a practical matter, however, hospitals often have more financial capital and managerial expertise to create these complex organizations than physician-owned organizations.

Numerous studies have examined the relationship of mergers between hospitals with the prices charged for hospital services and 1 recent study has examined the association between hospital acquisition of physician practices and prices.[18,19] The present study is the first of which we are aware to measure the association between hospital ownership and the total expenditures on care, including professional, institutional, laboratory, imaging, and pharmaceutical services. The findings are not encouraging for proponents of integration. Organizations owned by local hospitals and multihospital systems may better coordinate care than organizations owned by their participating physicians. For the hospital-owned organizations represented in this study, however, any resulting improvements in coordination were not associated with lower expenditures per patient. Organizations in California that are owned by local hospitals or multihospital systems incur significantly higher expenditures per patient than integrated medical groups and IPAs owned by participating physicians. Between 2009 and 2012 the total expenditures for care per patient were 10% higher in physician organizations that were owned by a local hospital and 20% higher in organizations owned by a multihospital system than in organizations owned by participating physicians, after adjusting for patient disease severity and other factors.

These findings are in contrast to the hope and expectation that organizational consolidation of physicians with hospitals would result in greater coordination, and hence lower expenditures. Policymakers must strive to ensure that hospital acquisition of medical groups and physician practices does not lead to higher expenditures. Antitrust law and policy need to find the appropriate balance between permitting hospital acquisitions that improve efficiency, on the one hand, and preventing acquisitions that increase expenditures, on the other.[20] Reform of payment methods by Medicare and private insurers should focus on the total expenditures made on behalf of patients by the physicians and facilities involved in their care to promote coordination but also to create incentives for efficiency and price reductions.

The results from the study should be interpreted within the limitations of the data. First, our measure of expenditures includes physician, hospital, laboratory, imaging, and pharmaceutical services, but excludes payment for mental health care. We were not able to distinguish whether total expenditures reflect differences in unit prices vs differences in the volume of services provided (eg, price per ambulatory surgery procedure vs number of procedures). Second, our measure reflects the point of view of insurers and consumers, for whom expenditures are measured in terms of what is paid to providers and manufacturers. It does not reflect the production costs incurred by the physician organizations, hospitals, pharmaceutical firms, and other providers. Third, we were not able to measure the quality of the services provided across the range of services embodied in our expenditure measure. Thus, policy efforts to decrease expenditures may have uncertain effects on the quality of medical services provided by physician groups. Fourth, our data are derived from physician organizations in California, a state with a long tradition of group practice, capitation payment, and managed care. These findings may not be generalizable directly to other states. However, physicians outside California increasingly are joining integrated medical groups and IPAs, many of which are being acquired by hospitals. The organization of physician practice nationally is coming to resemble forms traditionally associated with California. Public policy makers and private purchasers also are endeavoring to shift payment methods from fee-for-service to population-based payments that resemble those prevalent in the California managed care market. Fifth, the study focuses solely on the expenditures for patients enrolled in commercial HMOs, to the exclusion of patients covered by commercial PPOs, Medicare, and Medicaid. We do not have expenditure data on these patients.

CONCLUSIONS

From the perspective of the insurers and patients, between 2009 and 2012, hospital-owned physician organizations in California incurred higher expenditures for commercial HMO enrollees for professional, hospital, laboratory, pharmaceutical, and ancillary services than did physician-owned organizations. Although organizational consolidation

may increase some forms of care coordination, it may be associated with higher total expenditures per patient.

ARTICLE INFORMATION

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Author Contributions: Dr Robinson had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

Study concept and design: Robinson.

Acquisition, analysis, or interpretation of data: Robinson, Miller.

Drafting of the manuscript: Robinson.

Critical revision of the manuscript for important intellectual content: Robinson, Miller.

Statistical analysis: Robinson, Miller.

Obtained funding: Robinson.

Administrative, technical, or material support: Robinson, Miller.

Study supervision: Robinson.

Conflict of Interest Disclosures: All authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest and none were reported.

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Attachment 3

Quality, Network Management, Delivery System Standards and Improvement Strategy

Preamble

PROMOTING HIGHER QUALITY AND BETTER VALUE

The mission of Covered California is to increase the number of insured Californians, improve health care quality and access to care, promote better health, lower costs, and reduce health disparities through an innovative and competitive marketplace that empowers consumers to choose the health plan and providers that offer the best value. Covered California's "Triple Aim" framework seeks to improve the patient care experience including quality and satisfaction, improve the health of the population, and reduce the per capita cost of Covered Services. 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 payers to support delivery system reform. Qualified Health Plans Issuers ("QHP Issuer" or "Contractor") 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 an agreement with Covered California ("Agreement"), QHP Issuers agree 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 the Contractor's entire California membership. 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 its Contractors to balance the need for accountability and transparency at the provider-level with the need to reduce as much as possible administrative burdens on providers. 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 Issuer.

These Quality, Network Management, Delivery System Standards and Improvement Strategy outline the ways that Covered California and the Contractor will focus on the promotion of better care and higher value for the Plan Enrollees and for other California health care consumers. This focus will require both Covered California and the 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, the 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 QHP Issuers recognize that driving the significant improvements needed to assure better quality care is delivered at lower cost will need tactics and strategies that will extend beyond the coming contract period. 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.

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~~ improv~~ing~~e care and reduc~~ing~~e administrative burdens will require active partnership between both Covered California and the Contractor~~, but also with Providers, consumers and other important stakeholders~~.

1) Covered California ~~shall~~ will facilitate ongoing discussions with the 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:

   i. Enrollees and other consumers;

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

   iii. Contractors in terms of the burden of reporting, participating in quality or delivery system efforts.

(b) The Contractor agrees to participate in Covered California advisory and planning processes, including but not limited to participating in the Plan Management and Delivery System Reform Advisory Group. Contractor will delegate a representative of Contractor to participate in Covered California's Plan Management and Delivery System Reform Advisory Group.

1.02 Assuring Networks are Based on Value.

~~Central to its contractual requirements of its QHP Issuers,~~ Covered California requirements for QHP Issuers include multiple elements related to assuring that Issuers' plans and networks provide quality care, including Network Design (Section 3.05), the inclusion of Essential Community Providers (Section 3.06) and a wide range of additional elements detailed in this Attachment. T~~ of Covered California's expectation that network design and provider selection considers quality and patient experience in addition to cost and efficiency~~he Contractor shall:

a) Include both quality and cost factors in all provider and facility selection criteria when designing and composing networks for inclusion in Covered California products

b) Contractor shall ~~disclose~~ report to Covered California, with its Application for Certification for ~~2018~~2017, how it meets this requirement and the basis for the selection of providers or facilities in networks available to Covered California enrollees. This report shall 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. Such information ~~may~~ will be made publicly available by Covered California, unless application is made, on good cause shown, to treat any

such information confidentially. ~~Contractor may provide this information with its Application for Certification for 2017. Covered California may, at its discretion, make such information available to Enrollees and interested individuals.~~

c) Contractor ~~shall~~ will report each year, starting with its Application for Certification for 2017, 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 shall include in its Application for Certification for ~~2018~~ 2017 and annually thereafter, 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 Covered California Enrollees. ~~Contractor may provide this information in its Application for Certification for 2017.~~

d) While Covered California welcomes Issuers' use of Centers of Excellence~~, that may include standard benefit design incentives for consumers,~~ the current benefit designs do not envision or allow for "tiered" networks.

e) Covered California will require~~expects~~ Contractor to ~~only~~ contract only with providers and hospitals that provide high quality care and promote the safety of Covered California Enrollees. To meet this expectation, by contract year 2018, Covered California will ~~work with its contracted plans to~~ identify areas of "outlier poor performance" based on variation analysis and work with its contracted plans to address them. As part of this process, Covered California will engage experts in quality and cost variation and shall consult with California's hospitals. For contract year 2019, Contractors will be ~~expected~~ required to either to exclude those hospitals that are outlier poor performers on either cost or quality from provider networks or to document each year in its Application for Certification ~~the~~ a compelling rationale for continued contract with each hospital that is identified as a poor performing outlier. Such reports will detail contractual requirements and their enforcement, monitoring and evaluation of performance, consequences of noncompliance and plans to transition patients from the care of providers with continued poor performance. Such information ~~may~~ will be made publicly available by Covered California.

1.03 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~~ requires 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 aligned with priorities established by Covered California with requirements specified in articles below~~.

Effective in 2017, Contractor shall be required to participate in the following two ~~such~~ collaborative initiatives:

a) CalSIM Maternity Initiative: ~~Sponsored by Covered California, DHCS and CalPERS as well as other major purchasers with support from by 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. http://www.chhs.ca.gov/PRI/_CalSIM%20Maternity%20Initiative%20WriteUp%20April%202014.pdf (See Article 5, Section 5.01)

b) Statewide workgroup on Overuse~~: Sponsored by Covered California, DHCS and CalPERS, this multi-stakeholder work group facilitated by Integrated Healthcare Association (IHA), will~~ leverages Choosing Wisely decision aids to support efforts to drive appropriate use of C-sections, prescription of opioids and low back imaging. http://www.iha.org/grants-projects-reducing-overuse-workgroup.html (See Article 7, Section 7.04)

Covered California will require ~~is interested in~~ Contractors' participation in additional ~~other~~ collaborative initiatives beginning in 2017. As part of the Application for Certification for 2017, and annually thereafter, Contractor shall report to Covered California its participation in other ~~collaboratives~~quality initiatives, which shall include but not be limited to the following:

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)

~~All five will be 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 4.01)~~

b) Partnership for Patients: Inplemented by t~~T~~he CMS ~~Innovation~~ Center for Medicare and Medicaid Innovation (CMMI), it ~~implemented this program~~ focused on hospital patient safety between 2012 and 2014, resulting in 87,000 fewer deaths, mostly in 2013-14. ~~Awardees for 2015-16 are~~

~~Hospital Quality Initiative subsidiary of the California Hospital Association.~~

~~Dignity Hospitals, and~~

~~VHA/UHC. http://www.ahrq.gov/professionals/quality-patient safety/pfp/interimhacrate2014.html (See article 5, section 5.02)~~

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

d) California Immunization Registry (CAIR)

e) ~~Any~~ IHA and~~or~~ CMMI ~~-~~ sponsored payment reform programs

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

g) California Perinatal Quality Care Collaborative

h) California Quality Collaborative

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i) Leapfrog

Contractor will provide Covered California specific information regarding ~~their~~ its participation in each quality initiative~~collaboration~~. Such information shall be in a form determined by ~~that shall be mutually agreed to by~~ the Contractor and approved by Covered California and may include copies of reports used by the Contractor for other purposes. Contractor ~~understands~~ acknowledges and agrees that Covered California will seek increasingly detailed reports over time ~~that will~~in order to ~~facilitate the~~ assess ~~ment of~~ the impacts of these programs. Such reports ~~which should~~ will include: (1) the percentage of Contractor's 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 particular ~~Quality~~ quality ~~Initiative~~initiative; (3) the results of Contractors' participation in each program, including clinical, patient experience and cost ~~impacts~~effects; and (4) such other information as Covered California and the Contractor identify as important to identify programs that successfully address the goals of Covered California~~worth expanding~~.

~~Covered California and Contractor will collaboratively identify and evaluate the most effective programs for improving care for enrollees and participation in specific collaboratives may be required in future years.~~

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 shall provide such data to Covered California each year regardless of 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 NCQA Quality Compass and/or DHCS, per each Product Type for which it collects data in California. The ~~timeline~~ deadline for Contractor's HEDIS and CAHPS quality data submission shall be ~~consistent with the timeline~~the same as for submitting data to the NCQA Quality Compass and/or DHCS. Covered California reserves the right to use the Contractor-reported measures scores to construct Contractor summary quality ratings that Covered California may use for such purposes as supporting consumer choice and Covered California's plan oversight management.

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 issuers, and to the Covered California population as a whole. In order to conduct this assessment, Contractor shall provide ~~certain~~ the following information ~~currently captured in contractor's information systems~~ related to its Covered California Enrollees to Contractor's Business Associate, Truven Health Analytics ("Truven").

a) Disclosures to Truven Health Analytics.

Covered California has entered into a contract with Truven to support its oversight and management of health data for Covered California. Truven 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 Truven with the data identified in the EAS Dataset, which is attached as Appendix 1 to this Attachment 7, no later than February 27, 2016, and shall continue to submit this data to Truven on a monthly basis by the 20th day of each month. ~~at a time that is mutually agreed upon by Contractor and Truven.~~

~~To enable~~In connection with the submission of the EAS Dataset to Truven, Contractor agrees to execute a Business Associate Agreement ("BAA"), and any other documents required for the submission of the EAS Dataset to Truven, by January 1, 2016. ~~Covered California may, upon request to Contractor, review such BAA and any other agreements between Contractor and Truven related to the submission of the EAS Dataset.~~

b) Disclosures to Covered California.

Truven ~~must~~ shall protect the EAS Dataset submitted to it by Contractor pursuant to applicable laws, rules and regulations, including the Privacy 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 or

aggregated data. Covered California ~~shall~~ agrees that it will not request any ~~Personally~~ Individually Identifiable Health Information from Truven or attempt to use the de-identified or aggregated data it receives from Truven to re-identify any person.

c) Covered California as a Health Oversight Agency

Covered California is 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. ~~Insofar as contractor seeks further assurances that Covered California is a Health Oversight Agency entitled to receive protected health information from Contractor, Covered California shall communicate promptly to the Contractor technical assistance from the Office for Civil Rights, or other guidance from the federal government, that relates to 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, in order for Covered California to perform its mandated oversight activities.~~

2.03 eValue8 Submission.

For measurement year 2016, Contractor shall respond to those eValue8 questions identified and required by Covered California in the Covered California eValue8 Health Plan Request for Information as part of the Application for Certification for 2017.

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/or in connection with ~~the~~ its evaluation ~~regarding~~ of any extension of the Agreement and/or the recertification process. The timing, nature and extent of such disclosures will be established by Covered California based on its evaluation of various quality-related factors. Contractor's response shall include information relating to all of Contractor's then-current California-based business and Contractor shall disclose any information that reflects California-based information generally if ~~that is provided by~~ Contractor is unable ~~due to Contractor's inability~~ to report on all Covered California-specific business; provided, however, that Contractor will report the reason for any such inability and will commit to report Covered California-specific business as soon as possible. ~~If applicable,~~ Contractor shall report data separately for HMO/POS, PPO and EPO product lines.

Contractor will provide Covered California information regarding ~~their~~ its broad quality improvement and delivery system reform efforts through annual reporting in the Covered California eValue8 Health Plan RFI. Such information may include copies of reports used by the Contractor for other purposes.

2.04 Quality Improvement Strategy.

Starting with the 2017 Certification Application, Contractor, as~~is~~ required under the Affordable Care Act and regulations from CMS, ~~to~~ shall implement a Quality Improvement Strategy (QIS). ~~The core CMS requirement for QIS strategies 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. ~~Contractor understands that the application~~ serves as ~~the~~ a primary reporting mechanism and measurement tool for assessing Contractor

QIS work plans and progress in achieving i~~I~~mprovement targets with respect to each Covered California quality and delivery system reform initiative~~s~~.

Contractor ~~understands~~ acknowledges and agrees that Covered California will seek increasingly detailed reports over time that will facilitate the assessment of the impacts of each initiative which ~~should~~ shall include:

a) The percentage, number and performance of total participating providers;
b) The number and percentage of Covered California enrollees participating in the initiative;
c) The number and percentage 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~~effects.

Article 3. Reducing Health Disparities and Assuring Health Equity.

Covered California and the Contractor ~~recognize~~ agree that promoting better health requires a focus on addressing health disparities and health equity, which are central to Covered California's mission.

3.01 Measuring Care to Address Health Equity.

Contractor shall be required to track and trend quality measures by ethnic/racial group and by gender for ~~the~~ Contractor's entire population.

(a) Identification

i. By the end of ~~2019~~ 2018, Contractor will achieve 85 percent self-reported racial/ethnic identity. ~~This target has already been achieved by two Covered California-contracted health plans, which represent very different models, through collaboration with providers to collect information at every patient encounter.~~

ii. Contractor shall report the percentage of self-reported ethnic racial identity in the Application for Certification for 2017 and annually thereafter, along with current enrollment across all lines of businesses based on self-reported or proxy.

~~iii. Covered California and Contractor will negotiate annual targets to be reported in subsequent Applications for Certification.~~

~~iv.~~iii. To the extent Contractor does not have self-reported information on ethnic racial identity, it shall use a standardized tool for proxy identification through use of zip code and surname to fill the gap.

(b) Measures for Improvement

i. Measures for plan year 2016 include Diabetes, Hypertension and Asthma (control plus hospital and ER admission rates) and Depression (HEDIS appropriate use of medications) (See Appendix for detailed specifications; to the extent the full specifications are not completed at the time of contract execution, Contractor and Covered California agree to work together in good faith, with other stakeholders to finalize such specifications.)

ii. In future contract periods, Covered California ~~shall consider adding~~will add additional measures.

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, they~~ agree that health care disparities can be narrowed through quality improvement activities tailored to specific populations and targeting select measures at the health plan level. In connection with that goal:

a. Contractor shall report baseline measurements from Measurement Year 2015 on the measures listed in 1.03(b)(i), based either on self-reported identity or on proxy identification in the Application for Certification for 2017. ~~Covered California anticipates that this baseline data may be incomplete.~~

b. Targets for ~~2019~~ 2018 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 and 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. Other a~~A~~reas of disparity ~~for consideration~~ include, but are not limited to:

(a) Income

(b) Disability status

(c) Sexual orientation

(d) Gender identity

3.04 NCQA Certification.

By 2019, Contractor shall ~~Meeting~~ meet the standards for Multicultural Health Care Distinction by NCQA. ~~is encouraged as a way to build a program to reduce documented disparities.~~ To the extent the Contractor has applied for or received this Certification, Contractor shall provide this information with its Application for Certification for 2017 and annually thereafter.

Article 4 Promoting Development and Use of Effective Care Models.

Covered California and the Contractor agree ~~that promoting the triple aim to improve the patient care experience including quality and satisfaction, improve the health of the population, and reduce the per capita cost of Covered Services 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 is essential to achieve the triple aim of Covered California. Contractor ~~is required to~~shall 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 ~~is required to~~shall design networks and payment models for providers serving Covered California Enrollees to reflect these priorities.

In particular, ~~the~~ Contractor shall design networks and payment models that promote~~Covered California's priority models which align with CMS requirements under the QIS, are~~:

1) Effective primary care services, including assuring that all enrollees have a Personal Care Physician,

2) Promotion of Patient Centered Medical Homes (PCMH) which use a patient-centered, accessible, team-based approach to care delivery and 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 Physician Selection.

~~Covered California requires~~ Contractor shall~~to~~ ensure that all Enrollees either select or be provisionally assigned to a Personal Care Physician by January 1, 2017 and thereafter within 30 days of enrollment into the plan. In the event the Enrollee does not select a Personal Care Physician, Contractor may provisionally assign the enrollee to a Personal Care Physician and the assignment shall be communicated to the Enrollee, providing the enrollee with an opportunity to accept or select an alternative. In the event of an assignment, Contractor shall use commercially reasonable efforts to make assignment to a participating provider consistent with an Enrollee's stated gender, language, ethnic and cultural preferences, and will consider geographic accessibility and existing family member assignment or prior provider assignment. Contractor will confirm adherence to this requirement annually in its Application for Certification.

4.02 Patient Centered Medical Home

Contractor acknowledges that Covered California values~~A growing body of evidence documents that~~ advanced models of primary care, often called Patient Centered Medical Homes (PCMH), that greatly improve the care delivered to patients and foster meeting the triple aim goals.

1) Contractor shall cooperate with Covered California and other contracted health plans in evaluating various PCMH accreditation and certification programs promulgated by national entities as well as other frameworks for determining clinical practice transformation with the goal of adopting a consistent standard definition across covered California's Contracted Health Plans ~~for determining which providers or practices meet the standards for redesigned primary care in Covered California networks~~. Covered California and Contractor agree to engage with interested stakeholders, including providers, in the process of developing this standard definition in preparation for use in the Application for Certification in 2018. As part of this effort, Contractor ~~agrees to work with~~and Covered California ~~to work to~~shall endeavor to limit the reporting burden on providers to the extent practicable.

2) Contractor shall describe in its Application for Certification for 2018 a payment strategy ~~for~~

~~adoption and progressive expansion~~ that creates a business case for PCPs to adopt accessible, data-driven, team-based care (including alternatives to face-to-face visits and care by non-MDs) with accountability for improving triple aim metrics including total cost of care.

3) Contractor shall report in the Application for Certification for 2018:
~~Based~~ building on the data provided in the 2018 Application, targets for 2019 based on national benchmarks, analysis of variation in California performance and best existing science of quality improvement and effective engagement of stakeholders.

   i. A baseline of the percentage of PCPs whose contracts are based on the payment strategy defined in 4.02(2) for primary care services;
   ii. The number and percentage of Covered California enrollees who receive care in such practices;
   iii. The number and percentage of all of the ~~contractors~~ Contractor's enrolleesenrolling ~~and~~ who receive care in such practices; and
   iv. How ~~its~~ Contractor's payment to PCMH practices differs from ~~those~~ payments made to practices that have not met the standards.

4.03 Integrated Healthcare Models (IHM).

Contractor acknowledges that 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 ~~structures~~ will include the following functional characteristics:

   (a) ~~An integrated organizational structure consisting of multi-disciplinarye physician practices, hospitals and ancillary providers that address and coordinate patient care across the care continuum~~. The IHM addresses and coordinates patient care across the care continuum of multi-disciplinary physician practices, hospitals and ancillary providers.

   (b) 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) ~~Combined risk sharing arrangements and incentives between the hospitals and physicians, h~~Holding the~~m~~ IHA accountable for nationally recognized evidence-based clinical, financial, and operational performance improvements in population outcomes by physicians, hospitals and ancillary providers~~, as well as incentives for improvements in population outcomes~~.

2) Contractor shall provide Covered California with details on its existing or planned integrated systems of care describing how the systems meet the criteria in ~~Article~~ Section 4.03(1) and including the number and percentage of members who are managed under IHMs in its Application for Certification for 2017 and annually thereafter both for all lines of business and for ~~specific to~~ Covered California enrollees specifically.

3) Targets for 2019 and intermediate milestones for 2018 for the percentage of members who select or are attributed to IHMs 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.

4.04 Data Integration

Covered California and Contractor ~~recognize the critical role of~~agree that sharing data across specialties and institutional boundaries is critical to improving quality of care and successfully managing total costs of care whether between a PCP and other parts of the delivery system or a PCMHs and IHMs. Hospital admission is one 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.

Contractor shall report in its annual Application for Certification the initiatives Contractor has undertaken to ensure responsible ambulatory providers are notified of admissions in a timely manner. The reports shall include the number and percentage of hospitalized patients for whom such notification has taken place both for Covered California enrollees and for ~~the~~ Contractor's full book of business.

4.05 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 of Covered California.

Contractor shall report in its annual Application for Certification on its strategies and ~~success~~progress ~~in~~:

1) Making behavioral health services available to Covered California enrollees; and

2) ~~How it is i~~Integrating Behavioral Health Services with Medical Services.~~; and~~

These reports shall include documenting the percentage of services provided under an integrated behavioral health-medical model both for Covered California enrollees and for the Contractor's overall covered lives. These reports ~~should~~ shall include whether these models are implemented in association with PCMH and IHM models or are independently implemented.

4.06 Telemedicine and Remote Monitoring

~~Covered California requires the~~ Contractor ~~to~~ shall report the extent to which the Contractor is supporting and using technology to assist in higher quality, accessible, patient-centered care. Contractor shall report, in its Application for Certification for 2017 and annually thereafter, the utilization both for Covered California enrollees and for the Contractor's total covered lives, the number of unique patients and number of separate servicing provided for:

a. Telemedicine

b. Remote home monitoring.

Reporting requirements shall be met through eValue8, but contractor may supplement such reports with data on the efficacy and impact of such utilization. These reports should also specify ~~include~~ whether these models are implemented in association with PCMH and IHM models or are independently implemented.

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Article 5 Hospital Quality

Covered California and Contractor ~~recognize~~ agree 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 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 ~~per cent~~% for each hospital in the state by 2019. In addition to actively participating in this ~~collaborative~~effort, 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) Report in its Application for Certification for 2017, and annually thereafter, the C-section rate for NTSV deliveries for each of its network hospitals for the hospital's entire census and the C-section rate for all of the Contractors delivering at each hospital.

3) Adopt a payment methodology ~~progressively~~ to include all contracted hospitals such that by 2019 there is no financial incentive to perform C-sections. Contractor shall report on its ~~design~~ methodology and the percentage of hospitals contracted under this model in its Application for Certification for 2017 and annually thereafter.

4) Covered California ~~expects~~ requires Contractor, ~~to only contract hospitals that demonstrate they provide quality care and promote the safety of Covered California enrollees. E~~effective with the Application for Certification for 2019, ~~contractor shall~~to either exclude hospitals from provider networks for purposes of maternity services or to document each year in its Application for Certification the rationale for continued contract with each hospital that demonstrates a C-section rate for NTSV deliveries that is ~~substantially~~ above 23.9 percent.

5.02 Hospital Patient Safety

Contractor agrees to ~~work with Covered California to~~ support ~~and enhance hospital's~~hospitals' efforts to promote safety for their patients.

1) Contractor shall report in its Application for Certification for 2017 baseline rates of specified Hospital Acquired Conditions (HACs) for each of its network hospitals~~. In order to obtain the most reliable measurement, minimize the burden on hospitals and in the interest of promoting common measurement, Contractor shall employ best efforts to~~ Contractor may base this report on clinical data such as is reported by hospitals to the California Department of Public Health and to CMS under the Partnership for Patients initiative.

2) ~~Prior to its Application for Certification for 2018, t~~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.

3) The HACs that are the subject of these initiatives are:

   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. Adverse Drug Events (ADE) with focus on hypoglycemia, inappropriate use of blood thinners, and opioid overuse; and

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

4) The ~~subject~~ HACs addressed by these initiatives are expected to ~~may~~ be revised from time to time~~in future years~~; Covered California expects to include Sepsis Mortality at such time as the standardized CMS definition and measurement strategy has been tested and validated.

5) Covered California ~~expects~~ requires Contractor only to ~~only~~ contract with hospitals that demonstrate they provide quality care and promote the safety of Covered California enrollees. To meet this expectation, by contract year 2018, Covered California will work with its contracted plans and with California's hospitals to identify area of "outlier poor performance" based on variation analysis of HAC rates. For contract year 2019, Contractors will be ~~expected~~ required ~~to~~ either to exclude hospitals that demonstrate outlier poor performance on safety from provider networks 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.

5.03 Hospital Payments to Promote Quality and Value

Covered California ~~expects~~ requires its Contractors to ~~pay differentially to~~ promote and reward better quality care rather than pay for volume through payment mechanisms designed to that end. Contractor shall:

1) Adopt a hospital payment methodology that by 2019 places at least 6 percent of reimbursement to hospitals at-risk for quality performance. ~~Each contractor~~Contractor may ~~structure~~ implement this directive ~~strategy~~ using various elements~~according to their own priorities such as~~:

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

   b. The metrics that are the basis of such value-payments, such as HACs, readmissions, or satisfaction measured through the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAPS). Contractor is required to ~~select~~ utilize standard ~~measures~~ metrics commonly ~~in use in~~used by hospitals and that are endorsed by the

National Quality Forum.

2) Contractor shall report in its annual Application for Certification the:

   a. Amount, structure and metrics for hospital payment strategy;

   b. The percentage of network hospitals operating under contracts reflecting this payment methodology;

   c. The total dollars and percentage of hospital payments that are ~~about~~ related to this strategy; and

   d. The dollars and percentage that is respectively paid or withheld to reflect value. The hospital payments to promote value shall be distinct from shared-risk and performance payments to hospitalization related to their participating in IHMs as described in Article 4.03.

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

Covered California and Contractor ~~recognize~~ agree 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 agree to work collaboratively to achieve these objectives.

6.01 Health and Wellness Services. Contractor shall ensure Plan Enrollees have access to preventive health and wellness services. For the following services, Contractor shall identify Enrollees who are eligible, notify Enrollees of their availability, and report utilization no less frequently than annually:

1) ~~Necessary preventive services appropriate for each enrollee and~~Contractor shall report to Covered California the number and percentage of members who take advantage of ~~their~~ its wellness benefit for Covered California enrollees and for contractor's entire book of business;

   a) In the Application for Certification for 2017, and annually thereafter, Contractor will report utilization

   b) Targets for 2018 and annually thereafter ~~milestones in percent of the population that uses annual preventive visits~~ 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.

2) In connection with t~~T~~obacco cessation intervention, inclusive of evidenced-based counseling and appropriate pharmacotherapy, if applicable, Contractor~~; and~~ shall report to Covered California the number and percentage of its members who use tobacco and who take advantage of the tobacco cessation benefit for Covered California enrollees and the number and percentage for Contractor's entire book of business;

   a) In the Application for Certification for 2017 and annually thereafter, Contractor will report utilization

b) Targets for 2018 and annually thereafter ~~milestones in use of~~ for Tobacco cessation interventions 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.

3) In connection with o~~O~~besity management, if applicable, Contractor shall report to Covered California the number and percentage of its members who take advantage of ~~their~~ the wellness benefit for Covered California enrollees and the number and percent for contractor's entire book of business;

a) In the Application for Certification for 2017 and annually thereafter, Contractor will report utilization

b) Targets for 2018 and annually thereafter ~~milestones for use of~~ for Obesity management services 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) To ensure the Enrollee health and wellness process is supported, Contractor will report on the following:

a) Health and wellness communications ~~processes~~ delivered to: all Enrollees (across all lines of business), Covered California-specific enrollees, and applicable Participating Providers, that take into account cultural and linguistic diversity,

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.

6.02 Community Health and Wellness Promotion.

Covered California and Contractor ~~recognize~~ agree that promoting better health for Plan 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. ~~The~~ Contractor ~~is~~ shall~~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. Such programs may include, but are not limited to,

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

b) CMS Accountable Health Communities

c) Voluntary health organizations which operate preventive and other health programs

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

Contractor shall report annually in its Application for Certification the initiatives, programs and/or projects that it supports that promote wellness and better community health for Covered California enrollees, and Contractor's overall population as well as those that specifically reach beyond the Contractor's Enrollees. Such reports shall include available results of evaluations of these community programs including clinical or other impact and efficacy.

6.03 Determining Enrollee Health Status and Use of Health Assessments.

Contractor shall demonstrate the capacity and systems to collect, maintain and use individual information about Covered California Plan 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 to all Plan Enrollees over the age of 18, including those Plan Enrollees that have previously completed such an assessment. If a Health Assessment tool is used, Contractor should select a tool that adequately evaluates Plan Enrollees current health status and provides a mechanism to conduct ongoing monitoring for future intervention(s).

6.04 Reporting Health Status.

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

Contractor shall report to Covered California in its Application for Certification its process to monitor and track Plan Enrollees' health status, which may include its process for identifying individuals who show a decline in health status, and referral of such Plan Enrollees to Contractor care management and chronic condition program(s) as defined in Section 5.04, for the necessary intervention. Contractor shall annually report to Covered California the number of Plan 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 of Covered California ~~enrollees~~ into or from employer-sponsored insurance, through 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 will include the following:

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

(b) Clear process(es) to communicate Enrollee's continued treatment using a specific therapy, specific drug or a specific provider when no equivalent is available in-network;

(c) Where possible, advance notification and understanding of out-of-network provider status for treating and prescribing physicians; and

(d) 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 the Plan Enrollees with existing and newly diagnosed chronic conditions ~~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 will target at-risk enrollees, typically with one or more conditions, including, but not limited to, diabetes, asthma, heart disease or hypertension. Contractor shall provide Covered California with a documented process, care management plan and strategy for targeting and managing At-Risk Enrollees. Such documentation ~~may~~ shall include the following:

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

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

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

d) Process to update At-Risk Enrollee medical history in the Contractor- maintained Plan Enrollee health profile;

(e) Process for sharing registries of enrollees with their identified risk (within limits for sharing PHI under HIPAA or other relevant statutes) with appropriate accountable providers, especially the enrollee's PCP.

(f) Mechanisms to evaluate access within 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;

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

(h) Data on number of individuals identified and types of services provided.

Article 7. Patient-Centered Information and Support

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

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~~ agrees to 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

In the Application for Certification for 2017, Contractor will report its planned approach to providing healthcare cost and quality information available to all members enrolled in Contractor's Covered California population, including:

a) Cost information:

i. Enable consumers to view their cost share for common elective specialty, and hospital services and prescription drugs specific to their plan product. Also provide real time information on member accumulation toward deductible(s), when applicable, and out of pocket maximums. Health Savings Account (HSA) users' information shall include account deposit and withdrawal/payment amounts.

ii. Allowed charges for all network providers, including the facility and physician cost, for common elective specialty, and hospital services, or comparable clear statement of patient's specific share at each provider. Commonly used service information should be organized in ways that are meaningful for consumers to understand.

iii. Provider-specific costs for care delivered in the inpatient, outpatient, and ambulatory surgery/facility settings; such information shall include the facility name, address, and contact information.

b) Quality information:

i. ~~Covered California expects~~For each Contractor with over 100,000 enrollees, to provide consumers with internally developed quality ratings specific to physician and facility by the end of 2019,

ii. Nationally endorsed quality information, in accordance with the principles of the Patient Charter for Physician Performance Measurement, will be accepted as an interim step for plans with enrollments over 100,000 until provider-specific quality information specific to Covered California experience can be provided and may be a longer term solution for smaller plans. Sources for national or state quality information for tool inclusion are:

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

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

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

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

iii. In addition, Contractor shall recognize California hospitals that have achieved target rates for NTSV C-Section utilization and Hospital Acquired Conditions (HACs) as defined in Article 5, Sections 5.01 and 5.02.

c) Health Insurance Benefit Information. Contractor shall make available personalized benefit-specific information to all enrollees that shall include accumulations of expenses applicable to deductible and ~~maximizing~~ minimizing out-of-pocket costs.

If Contractor enrollment exceeds 100,000, the cost and quality information shall be provided through an online tool easily accessible across a variety of platforms, which shall be available by 2019. If Contractor enrollment is under 100,000, the information may be provided by alternative means such as a call center.

Contractor shall in its annual Application for Certification:

i. Report the number and percentage of unique Covered California member healthcare shopper users, and total users for each of the consumer tools offered across all lines of business, for the reporting period.

ii. Report u~~U~~ser 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. Include separate results for Covered California users and all lines of business.

Contractor will provide access and log in credentials for Covered California staff, subject to the protection of ~~per mutually agreeable terms to safeguard~~ Contractor proprietary information. ~~and services.~~

7.03 Enrollee Personalized Health Record Information.

a) In its Application for Certification for 2017, Contractor shall report the extent to which enrollees can easily access personal health information or shall submit its plan to provide such access through such tools as a Personal Health Record (PHR) or other ”patient portal”.

b) 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; and clinical case notes; and other information used to make decisions about individuals.

c) Targets for 2019 and for annual intermediate milestones for Enrollee use of personal

health information 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.

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

7.04. 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 members 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.

a) Contractor shall report in its annual Application for Certification specific information to Covered California regarding the number of Plan Enrollees who have accessed consumer information and/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 but not limited to 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.

b) Contractor shall report 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.

c) Contractor shall report in its annual Application for Certification participation in these programs and their results, including clinical, patient experience and costs impacts and to the extent collected provide the results to Covered California.

7.05 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:

a. C- Sections for low risk (NTSV) deliveries
b. Opioid overuse and misuse, and
c. Imaging for low back pain.

~~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 5.01)~~

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.

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 Plan Enrollees with identified chronic conditions. To the extent Contractor implements such a program for Plan Enrollees ~~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.

8.02 Value-Based Reimbursement ~~Inventory and Performance~~. Contractor agrees to implement and expand value-based reimbursement methodologies to providers within networks contracted to serve Covered California. Value-based reimbursement methodologies will include those payments to hospitals and physicians that are linked to quality metrics, performance, costs and/or value measures.

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

(a) Capitation-based payment models

~~(a)~~(b) Advanced Primary Care or Patient-Centered Medical Homes (4.01)

~~(b)~~(c) Integrated Healthcare Models (4.02)

~~(c)~~(d) Appropriate use of C-sections (5.01)

~~(d)~~(e) Hospital Quality (5.03)

The Contractor shall report in its annual Application for Certification an inventory and evaluation of the impact of other value-based payment models it is implementing including:

1) The percentage of total valued-based reimbursement to providers, by provider and provider type.

2) The total number of Contractor Plan Enrollees accessing participating providers reimbursed under value-based payment methodologies.

3) The percentage of total Contractor Network Providers participating in value-based provider payment programs.

4) Direct participation or alignment with CMMI innovative payment models such as the Oncology or Joint Replacement model.

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

6) An evaluation of the overall performance of Contractor network providers, by geographic region, participating in value-based provider payment programs.

Contractor and Covered California shall reach an annual agreement on the targeted percentage of providers to be reimbursed under value-based provider reimbursement methodologies.

When considering the implementation of value-based reimbursement programs, Contractor shall demonstrate and design approaches to payment that reduce waste and inappropriate care, while not diminishing quality, including by delegation of care to Integrated Healthcare Models .

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 Covered California enrollees. Contractor agrees to share the results with Covered California of programs that ~~may~~ focus on high cost regions or those with the greatest cost variation(s). These programs may include but are not limited to payment bundling pilots for specific procedures where wide cost variations exist.

8.04 Payment Reform and Data Submission.

(a) Contractor will provide information to Covered California noted in all areas of 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.

(b) 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.

(c) 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.

Article 9. Accreditation

a) Contractor agrees to maintain a current accreditation throughout the term of the Agreement from at least 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.

b) Contractor shall be currently accredited and maintain its NCQA, URAC or AAAHC health plan 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.

c) 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(s) change and shall ~~be required to~~ provide Covered California with ~~all~~ any corrective action(s). Contractor will implement strategies to raise the 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.

d) Following the initial submission of the corrective action plans ~~("CAPs"),~~CAPS Contractor shall provide a written report to Covered California on at least a quarterly basis regarding the status and progress of the submitted ~~corrective action plan(s~~CAPs~~)~~. Contractor shall request a follow-up review by the accreditation ~~entity~~ agency 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~~.

e) 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~~shall have the option, in its sole discretion, to terminate any agreement by and between Contractor and Covered California or suspend enrollment in Contractor's QHPs~~, to ensure Covered California is in compliance with the federal requirement that all participating issuers maintain a current approved accreditation~~.

f) ~~Upon request by Covered California~~In its Application for Certification, 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 payer 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.

Primary Care Physician - 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 Physicians. Covered California does not require that Primary Care Physicians serve as a "gatekeeper" or the source of referral and access to specialty care.

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.

Telemedicine - Professional services given to a patient through an interactive telecommunications system by a practitioner at a distant site. Telemedicine 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. Value-Based Reimbursement includes capitation.

ConsumersUnion®
POLICY & ACTION FROM CONSUMER REPORTS

February 4, 2016

Anne Price, Director
Plan Management

Lance Lang, MD
Chief Medical Officer
Covered California
1601 Exposition Blvd
Sacramento, CA 95815

RE: Attachment 7 to the 2017 QHP Contract

Dear Ms. Price and Dr. Lang:

On behalf of Consumers Union, the policy and advocacy division of nonprofit Consumer Reports, we offer the following comments on the draft Attachment 7 to Covered California's Qualified Health Plan Contract for 2017 on "Quality, Network Management and Delivery System Standards and Improvement Strategy." We offer these comments as an organization committed to improving the health status of Californians, as well as the quality of care provided, and which has participated in the Plan Management and Delivery System Reform Advisory Committee and work groups on quality over the past few years at Covered California.

This comprehensive draft proposal holds the potential for California to lead the nation in promoting health improvement, health care value, and consumer safety and satisfaction. Moreover, by prioritizing steps to reduce disparities and assure health equity, some of which are suggested in greater detail by California Pan-Ethnic Health Network (CPEHN), Covered California has the opportunity to make significant headway via concrete contract provisions that will benefit the majority of your enrollees.

1.02 Assuring Networks Based on Value

Having sufficient numbers of high quality of providers, readily accessible, in plan networks is of the greatest importance to consumers. We support your proposals to require QHPs to disclose their criteria for network selection, not allow tiering within networks, and require specific steps to ensure optimal quality and safety of healthcare. On the latter point, we support compelling plans to identify "outliers" with poor performance.

While we support this avenue to improving the quality of care and patient safety for Covered California enrollees, we urge the Exchange to take steps to ensure that networks designed around quality metrics—and the exclusion of providers from

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networks based on low quality metrics—do not further exacerbate disparities by inappropriately penalizing hospitals and providers that care for a racially and ethnically diverse population. To that end, we recommend that Covered California draw guidance from the National Quality Forum's (NQF) current trial measures well as recommendations for tailored risk adjustment by socioeconomic status or other sociodemographic factors.[1] NQF is currently collecting the needed data to evaluate how risk adjustment affects a measure, as well as assessing unintended consequences, such as a weakening of the network of providers serving disadvantaged populations.

In addition, we suggest two amendments:

1. Moving up the dates by one year so that outliers are identified in 2017 and excluded for 2018, unless a reasonable justification is provided.
2. Stating that the information on the criteria for network selection submitted by QHPs to Covered California shall be made publicly available, rather than having such disclosure simply as an option to the Exchange. Inclusion of hospitals in a network implies that they are of good quality and the public would benefit from knowing if, in fact, providers of poor performance, especially on safety measures, are being included and the justification. On the flipside, consumers would also benefit from understanding why certain facilities are excluded from networks.

1.03 Participation in Collaborative Quality Initiatives

We support requiring participation in the two listed collaborative efforts and encouraging participation in the others. The CalSIM maternity initiative, and CMQCC in particular, have garnered national notoriety as groundbreaking efforts to improve maternal and infant outcomes. Consumers Union is a partner in the Choosing Wisely initiative, and also participates in the statewide Work group on Overuse.

One minor point of clarification: while the draft states that contractor "will leverage Choosing Wisely decision aids to support efforts to drive appropriate use of C-sections, prescription opioids and low back imaging," there is no specific set of Choosing Wisely decision aids currently around C-sections since the American College of Obstetricians and Gynecologists has not issued its recommendations. Consumer Reports expects, however, in conjunction with other stakeholders, to create aids to help the Workgroup with this topic. (This also pertains to section 7.05). You may want to adjust your language to reflect this.

2.01 HEDIS and CAHPS Reporting

[1] National Quality Forum, *Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors,* August 2014. Available at http://www.qualityforum.org/Publications/2014/08/Risk_Adjustment_for_Socioeconomic_Status_or_Other_Sociodemographic_Factors.aspx.

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We support requiring QHPs to collect and report HEDIS and CAHPS data to Covered California. We also urge that the contract specify collection of race, ethnicity, gender, primary language spoke, and sexual orientation/gender identity.

2.02 Data Submission Requirements

Consumers Union understands that data tracking is key to establishing a baseline health status of enrollees and for measuring trends. We support the disclosure requirements in (a)-(c), but also want to ensure that consumer privacy is protected. To that end, we make the following recommendations.

Sub-section (b) states that such data disclosed to Covered California shall be "de-identified or aggregated…." (emphasis added). Although aggregation may imply de-identification and could shield personally identifiable information if enough data sets are included, it is no guarantee of privacy. Given the high level of importance consumers give to health privacy, we urge Covered California to ensure that all health data is de-identified by removing "or aggregated" from this sub-section. By eliminating the option of aggregating rather than de-identifying, the data can still be aggregated as well, but aggregated data will never include consumers' individually identifiable private health information.

This section does not specify standards for de-identification. Consumers Union recommends adoption of the *Safe Harbor* method of de-identification, HIPAA §164.514(b)(2), as a baseline. We also encourage Covered California and Truven to explore whether there are additional identifiers that can be removed without impacting the quality of data, beyond those detailed under *Safe Harbor*. If you do so, we urge Covered California to direct Truven to adopt the most rigorous de-identification practices possible, that still maintain usability of the data for your intended health care quality purposes.

It is our understanding that Covered California intended to allow consumers the opportunity to opt out of having their data shared by the plan. Perhaps it is embodied in another part of the contract, but Subsection 2.02 lacks a requirement for consumer choice on whether their data is included in this initiative. We urge Covered California to amend this draft to allow consumers to opt out. While there is a lot of potential benefit to be gained from measuring trends via data tracking, there may be some consumers that prefer to be removed from the process. Requiring QHPs to afford an opt-out provision respects consumer preferences without slowing the process.

2.03 eValue8 Submission

The data set Covered California will collect from the *Covered California eValue8 Health Plan Request for Information* is substantial. Consumers Union recommends that—when Covered California uses the information to evaluate Contractors' performance—particular attention should be directed towards the parts that address reducing racial and ethnic disparities. We also recommend that Covered California evaluate responses

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to the survey related to price transparency. We encourage the exchange to publically report the results of those surveys.

3.01 Measuring Care to Address Health Equity

Lack of baseline demographic data severely impacts the ability to identify disparities and track improvement. We, therefore, support the requirement that plans achieve 85% self-reported racial/ethnic identity by 2019, and urge you to add a data element for primary language spoken (which OSHPD currently collects from hospitals). Although the preference is for 100% accuracy in racial/ethnic identity data, we recognize the use of proxy data as an interim source of information, especially for the smallest health plans.

We note the increased prevalence of patients with Limited English Proficiency (LEP) experiencing physical harm from adverse events compared to those whose primary language is English. In fact, of those adverse events resulting in physical harm, LEP patients were nearly twice as likely to experience levels of harm ranging from moderate harm to death as primarily English speaking patients.[2] Thus, having this data broken out would support Covered California's safety monitoring and improvement goals.

Consumers Union also supports the specific conditions targeted for improvement, arrived at through thoughtful discussion with the Quality Working Group, and the allowance for additional measures in future years. In that time, we encourage Covered California to also explore additional data points, including sexual orientation and gender identity.

Finally, we urge Covered California to target disparities reduction efforts for smaller, racial/ethnic and LEP populations communities by disaggregating their demographic data. Guidance on helping providers achieve demographic data collection goals is available from the Institute of Medicine (IOM)/National Quality Forum (NQF) and Hospital Research & Education Trust (HRET). Additionally, because demographic data may be collected through the adoption of Stage 2 Meaningful Use requirements, we recommend that the Exchange and the health plans incentivize providers to adopt software and technical support to providers to improve the collection and reporting of Electronic Health Record data.

3.02 Narrowing Disparities

Consumers Union appreciates the recognition that some disparities are affected by socio-economic factors outside the healthcare system; we also agree that in some cases, healthcare disparities can be narrowed at the health plan level through quality

[2] Divi C, Koss RG, Schmaltz SP, et al., Language proficiency and adverse events in US hospitals: a pilot study, *Int J Qual Health Care,* 2007; 19(2):60-7. Of those adverse events resulting in physical harm, 46.8% of the limited English proficient patient adverse events had a level of harm ranging from moderate temporary harm to death, compared with 24.4% of English speaking patient adverse events. Available at: http://www.ncbi.nlm.nih.gov/pubmed/17277013

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improvement activities specifically tailored to impacted populations. We strongly encourage initiatives to reduce and eventually eliminate disparities and agree that setting a baseline is the first step towards improvement. We question, however, the timeline proposed here. In delaying milestones in reduction of disparities until 2019, several productive years may be lost. Rather, we urge Covered California to compel health plans to identify and target disparities reduction activities starting in 2017. While we recognize that not all initiatives can be launched within a short time frame, we believe narrowing disparities is a long road and there is no reason to delay in starting the journey.

3.03 Expanded Measurement

Consumers Union supports the leeway to expand the categories for disparities identification for the future, and encourages the Exchange to actually do so, including for the four suggested examples. We suggest adding language to this draft to set a timeline not only to assess, but also to actually identify feasible identifiers and to put them into use.

3.04 NCQA certification

We support encouraging groups to meet the standards for Multicultural Health Care Distinction by NCQA as this may support achieving the health disparities reduction goals detailed earlier. Health plans that earn this distinction should be required to report their results to Covered California.

4.01 Primary Care Physician Selection

Consumers Union believes that health care coverage can best be utilized and managed when the enrollee has a primary care physician (PCP). Thus, the plan designs for which we have advocated at Covered California support usage of primary care providers as the hub of the care model. In our comments here, we assume that a “Personal Care Physician,” the term used in this section, is comparable to a PCP. If it is not, we urge Covered California to clearly demarcate the two.

We support the suggested criteria for default assignments, when assignment is needed, as these criteria have the best chance of ensuring a good fit with the enrollee’s demographic characteristics and continuity with a prior PCP and other family members’ providers. A simple process, with adequate notice, of the right and process for changing a default assignment should also be a requirement. Further, it should be clarified that consumers may request reassignment at any time, should they consider their assigned PCP a “bad fit.” Regarding some operational aspects of this subsection:

- We question whether 30 days is enough time for consumers to select their own PCP before being assigned one by the plan. Given the turnaround time required for plans to process new enrollees, to dispatch member identification cards and product information to consumers, and for consumers to get

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acclimated with their new insurance and then to respond for requests for information, it seems unlikely that a 30 day timeframe will be enough. Instead, we suggest gathering data from QHPs about their experience with turn around times for mailings and first PCP visits after enrollment; it may be that a period of a few months is more appropriate.

- We suggest establishing some requirements for consumer education about the benefit of having a designated PCP, especially for products that do not traditionally require or assign one. Additionally, Covered California should work with the plans to develop materials that assist consumers in making an informed decision when selecting their PCPs.
- We recommend a requirement that QHPs afford multiple modes of communication for consumers to transmit their PCP preference (i.e. hardcopy form or electronic, telephonic).
- We recommend specifying that, depending on the care model, there should be no adverse financial or access consequences for consumers seeking care from a provider not designated as their PCP. This is of particular relevance for policyholders of plans that do not traditionally include PCP designations.

5.01 Appropriate Use of C-sections

Consumers Union supports the various requirements of this section to promote the medically appropriate use of C-sections. The skyrocketing rates of C-sections and dramatic variations across the state among hospitals and physicians signal the need for focused efforts at improvement, for the health of mothers and infants. To that end, we suggest clarifying the language in the introductory section to clearly indicate that 23.9% is a maximum. For example, by changing from the current language ("the goal of reducing NTSV…C-section rates to meet or exceed the Healthy People 2020 target of 23.9 per cent for each hospital") to "reducing NTSV…C-section rates to no more than the Healthy People 2020 target of 23.9 per cent for each hospital in the state by 2019."

In particular, we strongly support requiring QHP collaboration with ongoing efforts, including CMQCC, and non-certification of hospitals that exceed the target maximum absent sufficient explanation. Additionally, we note that risk-stratifying the data may reveal racial and ethnic disparities in the use of C-sections. We are not aware of any clinical evidence for why C-section rates should vary by race and ethnicity. Therefore, any such disparities that are exposed should be evaluated and addressed.

5.02 Hospital safety

Consumers Union strongly supports the effort to leverage Covered California's market power to improve the safety of care delivered to Californians. Consumers Union has prioritized reporting of facility-acquired infections and adverse events for many years. To avoid definitional confusion, because of the specific meaning of "Hospital Acquired Conditions" in the federal non-payment program and federal hospital-acquired

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conditions reduction program, we suggest using a different term here and adding a definition to the glossary in Article 9, such as “California Hospital Safety Measures.”

Also, we recommend inclusion of some additional facility-acquired measures since the California Department of Public Health (CDPH) collects more than is reported to the federal government. Specifically, California stands out nationally by requiring hospital reporting of additional antibiotic-resistant infections. Thus, Consumers Union suggests adding incidence of MRSA and VRE infections.

Moreover, as to the surgical site infection (SSI) measure, we encourage Covered California to go beyond SSIs focused on the colon; CDPH has collected comprehensive SSI data for several years on 29 surgical procedures. We note that the most recent CDPH report on infections shows three surgical infections for which the statewide rates are not lower than or comparable to the national baseline: appendectomy, vaginal hysterectomy, and rectal surgery. We suggest adding reference to them and to other common procedures such as hip and knee replacements. We do note, and support, the leeway afforded to revise these measures in future years and agree that the sepsis mortality measure will be an important one to include.

Also, CDHP’s most recently published hospital-acquired infections report (for 2013 data) notes the importance of data validation by hospitals to ensure capturing all the relevant categories of hospital-acquired infections and identification of patient care units that need attention for preventing infections. Yet, nearly 23% of hospitals did not engage in validation (see itemization in CDPH report Appendix A). And a few hospitals had incomplete reporting, for example due to failure to give CDPH the necessary permissions to access NHSN data. We recommend including in the “outlier” designation a factor for failure to validate infection data and for incomplete reports.

5.03 Hospital Payments to Promote Quality and Value (and 8.01-.04)

We support the judicious use of hospital payments to incentivize safer, better quality care, and understand that some flexibility for QHPs is warranted. Covered California should take precautions, though, to ensure that hospitals that are more at risk of underperforming on quality measures such as hospital readmission rates—for example because they are caring for a sicker, poorer population lacking social supports needed for recuperation—are not inappropriately or disproportionately penalized. Implementing a policy based on poor performance on certain measures alone could lead to unintended consequences, such as hospital closures in areas that are medically underserved today; this could potentially worsen health disparities rather than alleviate them among Covered California enrollees living in low-income areas. As noted above regarding section 1.02, we recommend that Covered California draw guidance from the National Quality Forum’s (NQF) current trial measures well as recommendations for

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tailored risk adjustment by socioeconomic status or other sociodemographic factors[3] on targeted risk adjustment when assessing hospital quality performance.

We also note that risk adjustment is not appropriate in all circumstances. For example, because the incidence of hospital acquired infections should not vary based on race/ethnicity, gender, or income, related hospital-acquired infection incidence should not be risk adjusted.

Finally, because each hospital may have its own, unique "formula" for reaching the 6% reimbursement at risk, we urge that the formula used by each hospital be made public. Since the Applications for Certification are likely not public, we urge adding a sub-section (3) that specifies that Covered California will make the structure and metrics for the hospital payment strategy public.

6.01-6.06 Population Health

Consumers Union applauds your inclusion of this Article aimed at improving access to preventive care and at enhancing wellness and support for at-risk enrollees. Proactive outreach to enrollees, in particular those who appear eligible for preventive health and wellness services (6.01), is welcome and needed. Utilization of preventive services recommended by the USPS Task Force at no-cost to enrollees is a great benefit under the Affordable Care Act, but one that is under-utilized. Take-up of preventive health services is contingent upon patient awareness of insurance benefits under the ACA; many newly insured individuals and populations will not know the full array of health services available to them. Other patients may be misinformed on the effectiveness of screenings, immunizations, and other forms of preventive medicine. Addressing these knowledge gaps is paramount for early screening and for eliminating disparities in preventive health services utilization.

Community-wide initiatives, such as those listed by example (6.02), can fill those gaps and effectively promote better health. Evidence supports community health workers and peer counselors as effective community educators about the importance and availability of preventive services. We encourage Contractors supporting community health initiatives that utilize peer counselors, and other in-community educators.

Health assessments, offered as an option, may prove useful for QHPs in tracking and improving enrollees' health status (6.03). We also want to ensure that this information is protected. Thus, to the first sentence we suggest adding to the list of duties ("…collect, maintain, and use individual information") an additional duty: "protect from disclosure." Moreover, health assessments should be available in the threshold languages to realize the intent of the requirement that, if used, they are offered to all enrollees over age 18.

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[3] National Quality Forum, *Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors,* August 2014. Available at http://www.qualityforum.org/Publications/2014/08/Risk_Adjustment_for_Socioeconomic_Status_or_Other_Sociodemographic_Factors.aspx.

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Finally, we recommend that plans be required to advise policyholders at the outset of any Health Assessment of how the information collected may be used, that the member is opting in to receiving information from the plan, and that participating in the assessment is optional. Without adequate education upfront, there is a risk of generating confusion or mistrust among policyholders and losing the opportunity to improve enrollee's health.

We appreciate the intent of section 6.05 to ensure continuity of services and information during the inevitable transitions amongst different forms of coverage between Covered California on the one hand and Medi-Cal, Medicare and employer coverage on the other. Regarding open access to formularies—a crucial requirement for incoming at-risk populations—we support requiring QHPs to allow open access prior to enrollment. (6.05(d)).

7.01 Enrollee Healthcare Services Price and Quality Transparency Plan

It is our understanding that this provision is intended to assist policyholders in shopping for their providers and/or care once they are already insured. Consumers Union firmly supports having comparable data on cost and quality available for consumers both at the time they are selecting their insurance product as well as further down the line, when they are researching healthcare options. For purposes of this provision, we agree that cost information and physician-specific quality data, data from sections 5.01 and 5.02 (C-section rates and safety), and a personalized calculator to track deductible and out-of-pocket maximums all offer useful information for consumers in decision-making.

Charges should be shown for all network providers, including the facility and physician cost, and should display in one place all likely aspects of a single episode of care. In addition, we recommend that Covered California require plans to follow a standardized display of the content and format of information displayed on plan websites. Among these guidelines would be methods to provide information in a consumer-friendly, culturally, and linguistically appropriate manner. User experience should be evaluated based on a representative sample of racially and ethnically diverse users, as well as a such sample for users with cognitive, sensory or physical disabilities.

While we welcome information that assists consumers in making informed health care decisions, we also believe that cost and quality information is useful for consumers when selecting a plan, not only when seeking care. This is particularly relevant when a provider is included in the network of one plan but not another. We, therefore, suggest plans be required to include messaging on their websites directing non-policyholder visitors to the Covered California website that offers side-by-side comparisons.

7.05 Reducing Overuse Through "Choosing Wisely"

Consumers Union, as a key partner with the American Board of Internal Medicine on the Choosing Wisely initiative and member of the Overuse workgroup, supports the

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required participation of QHPs in the Overuse workgroup and its use of Choosing Wisely materials to leverage reductions in overuse. See also comment to 1.03, above.

8.01 Reward-based Consumer Incentive Programs

Consumers Union supports initiatives that engage consumers in their health care. However, we caution that improperly executed reward-based consumer incentive programs threaten worsening disparities and, when promoted by a health plan, may function as de facto underwriting based on health status. We, therefore, urge Covered California to require QHPs to conduct a health disparities assessment prior to the implementation of any such program; this assessment would be designed to identify and resolve issues such as access and cultural and linguistic appropriateness.

Thank you for your consideration.

Sincerely,

Elizabeth Imholz
Consumers Union

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HEALTH ACCESS
CALIFORNIA

February 3, 2016

Anne Price
Plan Management
Covered California
1601 Exposition Blvd.
Sacramento, CA

Re: Proposed 2017 Quality Initiatives

Dear Ms. Price,

Health Access California, the statewide health care consumer advocacy coalition committed to quality, affordable care for all Californians offers comment on the quality initiatives proposed for the 2017 QHP contract. We are generally supportive of the quality initiatives proposed for the 2017 contract. Covered California staff has explored a variety of options: those that are recommended will move Covered California forward from collecting information to requiring contracting health plans to improve quality and reduce health disparities.

Moving forward on the quadruple aim of lower costs, better care, better health and reduced disparities will require ongoing efforts over a number of years: we support those initiatives that require actual improvements in quality and disparities reduction. We support the proposal of the California Pan-Ethnic Health Network to incorporate evaluation of the impact of quality initiatives on disparities so that the quality initiatives proposed by Covered California do not inadvertently worsen disparities.

We strongly support the underlying principle which governs most, though not all of the quality initiatives, that is for all contracting plans to make progress on the same set of quality initiatives, rather than allowing plans to cherry pick quality initiatives in the same way they used to cherry pick enrollees. The Affordable Care Act is about system transformation to support the quadruple aim as well as extending coverage to millions.

Networks: Quality, Satisfaction, Cost Efficiency

Covered California is taking the first steps toward requiring provider networks based on quality as well as cost. As it does so, we urge that the quality measures take into account the demographics of those served so that this effort does not inadvertently worsen disparities.

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Participation of the Covered California plans in the existing California maternity initiative as well as the efforts on drug overuse will extend and strengthen these collaborative efforts.

Quality Data

Our organizations support further data collection, including claims and clinical data as well as regional survey data for the quality rating system. Los Angeles County alone, with ten million people, has more people than 43 states. We know that there is considerable regional variation within California which is masked by the current practice of surveying at the state level. We look forward to working with Covered California staff on further quadruple aim efforts that reflect the actual enrollment of Covered California.

Health Disparities

From the beginning, Covered California has had a stated commitment to reducing health disparities. By extending coverage to over two million Californians, most of them people of color, over the last two years, it has taken the first step toward reducing disparities in access to care. For the 2017 contract year, we support a requirement to reduce disparities in health outcomes by requiring plans to report baseline data on race/ethnicity and gender, and to be able to show in the 2018 contract application, year over year improvement during the 2017 contract year. Since 2003, California law has required health plans to collect data on race, ethnicity and language of their enrollees. It is a rather modest step to require all contracting plans to report that data to Covered California as part of health disparities reduction efforts.

We appreciate the focus on reducing disparities for diabetes, hypertension, asthma and depression that will be reflected in the 2017 and 2018 contract requirements: these are the high prevalence, high impact conditions that affect communities of color, particularly adults. Making progress in steps toward control of these conditions a priority is essential to improving the health of communities of color, the majority of Californians and exchange enrollees.

Again, we also support CPEHN's proposal to evaluate other quality initiatives in terms of disparities impacts to assure that no quality initiative inadvertently worsens disparities, or even fails to reduce already problematic disparities.

Primary Care, Accountable Care Organizations

As consumer advocates, we have supported standardized benefit designs that minimize enrollee cost sharing for primary care while providing appropriate access for specialty care and emergency room services. We support requiring all Covered California enrollees having a primary care physician so long as the proposal recognizes that many Covered California enrollees, and more in the future, will have had prior coverage and

should have a primary care physician already. We support applying this requirement to PPOs and EPOs as well as HMOs.

While there is no standard definition of a patient-centered medical home, our preference is for a definition that starts from the consumer perspective rather than the convenience of the physician or physician reimbursement.

With respect to Accountable Care Organizations, we support better integration of care and a focus on the quadruple aim. Payment reform which fails to take into account existing health disparities and the social determinants of health risks worsening disparities in pursuit of lower costs or better outcomes for those consumers for whom social determinants of health work in their favor rather than against them. For instance, an over-reliance on readmissions penalties without taking into account well-established disparities affecting lower income communities of color would not well serve moderate income consumers or Covered California's goals.

We are troubled by the proposal for "combined risk sharing arrangements between hospitals and physicians". We are well aware that physician groups, even those licensed as risk bearing organizations, rarely carry significant reserves. The current regulatory requirement in California for RBOs is that the RBO be one dollar net positive, not two dollars, not a month's operating reserve, not tangible net equity, not risk based capital. Risk without reserves is a recipe for financial insolvency: in California, we have gone through this time and again.

Hospital Quality and Safety

As consumer advocates, some of us have fought for decades to require better reporting of Hospital Avoidable Complications and adverse events. We strongly support requiring reporting of hospital avoidable complications, including the six conditions listed. As we understand the literature, these complications should not be adjusted for disparities: sepsis, adverse drug events, and hospital acquired infections should not vary based on race/ethnicity, gender or income. Going to the hospital should make people better, not sicker.

With respect to appropriate use of C-sections, we support Covered California's participation in the effort to reduce inappropriate C-sections. We commend the joint efforts of the Department of Health Care Services, the California Department of Public Health, CalPERS, Covered California and the California Health and Human Services Agency to encourage hospital participation in this collaborative: taken together, these public entities pay for a majority of the births in California as well as licensing California hospitals. It is our understanding that C-section rates vary by race, ethnicity and income: evaluating the impact of the C-section initiatives on disparities would be an important step if we are correct in our understanding

Population Health

Tobacco cessation, obesity management, and preventive care as well as identification of at-risk enrollees at the point of transition are important elements of population health. In addressing each of these, disparities should be taken into account. While California does better than the nation on many of these measures, that is not true of all Californians, and particularly not true of moderate income Californians from communities of color which are the overwhelming majority of Covered California enrollment.

With respect to community health, we note that the programs identified are partial at best. For example, the Community Health Needs Assessment required under the ACA applies only to non-profit hospitals and not to district hospitals, public hospitals or for-profit hospitals. Similarly CMS Accountable Health Communities do not include all of California. The listed community health and wellness promotion initiatives apply only to a part of the community that is California.

With respect to "at-risk" enrollees, we concur that those enrollees with major chronic conditions such as diabetes, asthma, heart disease and hypertension should be identified and managed. So should those enrollees in the midst of the course of treatment for a significant condition such as pregnancy, cancer, organ transplant or other time-limited but critical course of care.

Cost and Quality Transparency, Choosing Wisely

As consumer advocates, we support transparency of enrollee costs and quality data. We acknowledge how much Covered California has already done to support transparency for enrollees, from standard benefit designs to Shop and Compare to condition-specific fact sheets. We also acknowledge that from Day One, consumers shopping for a plan through Covered California were given plan Quality Ratings alongside premiums. While there is certainly more to do on transparency of cost and quality, consumers in the individual market are no longer shopping blind for an expensive but necessary product that provides both coverage and care.

We also support use of the Choosing Wisely decision aids. More care is not necessarily better care or even appropriate care. Sometimes the simplest care is the best: rest and liquids for the common cold, mild exercise for a sore back, and nursing care during labor and delivery rather than a surgical intervention. Choosing Wisely is intended to help consumers converse with their providers and become active players finding the appropriate care for their individual situation.

Summary

Staff explored a number of initiatives with consumer advocates as well as plans and providers. Some possible initiatives were not a good fit for the Covered California population or lacked sufficient grounding or had operational barriers to implementation. The quality initiatives that remain will make Covered California a leader in system transformation with a focus on the quadruple aim of lower costs, better care, better

health and reduced disparities. We have noted in our comments a number of initiatives that would be strengthened by including a focus on disparities as well as cost and quality. We are generally supportive of Covered California's proposed quality initiatives.

Sincerely,

Anthony Wright
Executive Director
Health Access California

February 4, 2016

Anne Price
Director of Plan Management Division
Covered California
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Sacramento, CA 95815
Via email to:
qhp@hbex.ca.com and anne.price@covered.ca.gov

Re: Proposed 2017 Benefit Design

The National Health Law Program (NHeLP) appreciates the opportunity to provide written comments in response to the recommended 2017 Benefit Designs presented at the January 21, 2016 Covered California Board meeting. NHeLP advocates, litigates, and educates at the federal and state levels to protect and advance the health rights of low-income and underserved individuals.

We participated in the Benefits and Networks Subcommittee of the Covered CA Plan Management Advisory Group where benefit designs were discussed at length over a four month period. We greatly appreciate the opportunity to have been involved in that process, and support the subcommittee goals of addressing benefit design priority areas that will reduce financial barriers and improve consumers' access to needed care, while also identifying benefit design areas that should be improved for consumer understanding of coverage and ease of plan comparison. Below are our comments on the benefit design recommendations made by Covered CA staff to the Board.

1. Primary Care, Mental Health and Rehabilitative Services Copays Reduced

We fully support the recommendation to reduce primary care, mental health and rehabilitative services copays by $5-10 in every metal tier (except bronze due to actuarial value limitations.) Making primary care visits affordable is an important step to better manage overall health and can lead to improved health outcomes. In addition, oftentimes, primary care serves as the portal for accessing other services. Copays can deter individuals from receiving the care that they need. Lowering the primary care

copay reduces this financial barrier and is a step in the right direction for improving access to care.

Equally important, is a reduction in mental health and rehabilitative services copays. In compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA), the copays for mental health and substance use outpatient services have been reduced since there is a proposed reduction to primary care copays. There has also been a reduction of copays for rehabilitative speech, occupational, and physical therapy. For individuals that need to access rehabilitative services, their treatment plan may require numerous visits, and having a reduced copay will help ensure they can afford this care, which may be critical for a full recovery.

We also appreciate that these copays were reduced without increasing specialty care copays, as originally proposed. Individuals with chronic conditions may need to access all, or most, of their care through a specialist, and an increased copay would serve as a barrier to accessing needed care.

2. Urgent Care Copays Reduced

We support the recommendation to reduce urgent care copays to the same cost-sharing as primary care in every metal level. Urgent care is an important health care option. Enrollees may need immediate care, but cannot get an appointment with their physician or their work schedule may only allow them to access after-hours care. Reducing the urgent care copay to the same amount as the primary care copay ensures that enrollees who need to access urgent care are not being penalized with higher copays for what oftentimes are circumstances out of their control, and it may also deter unnecessary Emergency Department use.

3. Emergency Department Services

We support the restructured Emergency Department (ED) fees, which include the elimination of the deductible for ED visits, and merging the ED physician copay into the ED facility copay in order to avoid separate copays for the same visit. These changes will significantly improve consumers' understanding of the cost involved with an ED visit, and for those who need to access this service, it will make it more affordable by not having the deductible apply.

4. Increased Cost-Sharing (Deductibles, Out-of-Pocket Maximums, and Copays)

Increased cost-sharing reduces access to care, particularly among low-income populations. In order to meet the Target Actuarial Value (AV), the Covered CA staff proposal includes: 1) increases to the deductible by $100-300 for silver and bronze, 2) increases in the out-of-pocket maximum by $550 for silver and gold, $300 for bronze, and $100-250 for enhanced silver, and 3) increases in copays for x-rays and diagnostic imaging. These increases may serve as a barrier to care.

We understand that there are constraints placed by the AV requirements, yet we know it is important to make accessing care affordable. Since the proposed computations were done using the 2017 *proposed* AV calculator, we request that once the *final* AV calculator is released (later this month), that Covered CA staff re-evaluate whether these cost-sharing increases are necessary, and that every effort is made to keep cost-sharing as low as possible.

5. Diabetes Education and Self-Management

We appreciate the clarification made in endnotes 25 and 26 of the 2017 Standard Benefit Plan Designs where Covered CA staff has indicated that cost-sharing may not be applied to diabetes education and self-management, and has defined what is covered under each of those services. This will help ensure that all health plans and issuers have a clear understanding of what they are expected to cover, and that enrollees are able to access this critical care at no cost to them.

6. Value-Based Insurance Design

We support the recommendation not to proceed with a value-based insurance design (VBID) at this time. In the Benefits and Networks Subcommittee meetings there was extensive discussion about a diabetes management VBID. With the number of individuals with diabetes on the rise, we know that diabetes treatment and management is important, but many questions remain unanswered in terms of the effectiveness of a diabetes management VBID, and whether it would lead to improved health outcomes and reduced costs. For this reason, we agree with Covered CA staff that further research and data is needed in order to determine if this is a good option for the Marketplace.

7. Tiered Networks

We support the recommendation to disallow tiered networks in 2017. Tiered designs can be incredibly confusing to consumers and often result in consumers paying additional cost-sharing for which they should not be liable. Therefore removing network tiering will improve consumer understanding of coverage and ease of plan comparison.

Thank you again for the opportunity to submit these comments. We look forward to our continued work together. If you have any questions regarding these comments, please contact Michelle Lilienfeld at (310) 736-1648 or lilienfeld@healthlaw.org.

Sincerely,

Kimberly Lewis
Managing Attorney

Michelle Lilienfeld
Senior Attorney

NHeLP
NATIONAL HEALTH LAW PROGRAM

February 8, 2016

Mr. Peter Lee
Executive Director
Covered California
1601 Exposition Blvd.
Sacramento, CA 95815

SUBJECT: Proposed Qualified Health Plan Certification Application for Plan Year 2017

Dear Mr. Lee:

On behalf of Private Essential Access Community Hospitals (PEACH), thank you for the opportunity to submit comments on the proposed Qualified Health Plan (QHP) Certification Application for Plan Year 2017 and draft Attachment 7 *Quality, Network Management, Delivery System Standards and Improvement Strategy.*

On average, California's community safety net hospitals provide 88 percent of their care to Medi-Cal enrollees, low-income seniors and the uninsured. As essential community providers, community safety net hospitals serve a disproportionate number of low-income communities throughout California, and play a critical role in providing access to high-quality medical care in Medi-Cal managed care and Covered California networks.

PEACH is supportive of Covered California's focus on advancing the Triple Aim of the Affordable Care Act and generally supports Covered California's proposals to require that its QHPs participate in collaborative quality initiatives, promote the use of patient-centered medical homes and integrate care management for patients with complex conditions. We are also supportive of the proposed requirements that Covered California's QHPs gather and report data on health disparities and improve quality measures by ethnic/racial group by gender.

A. Comments on the *Draft Qualified Health Plan (QHP) Certification Application for Plan Year 2017*

<u>*Section 4.4.5*</u> would require plans to describe any contractual agreements with participating providers that preclude the plan from making contract terms transparent to plan sponsors and members, and to agree to make commercially reasonable efforts to exclude any contract provisions that would prohibit disclosure of such information to the Exchange.

PEACH asks that provider contracts be excluded from disclosure requirements, since provider contracts and payment terms are proprietary, confidential and competitive. There is no policy reason for Covered California to have this detailed information since it is negotiating with the health plan issuer on premium rates. Detailed proprietary contract information from specific providers is not necessary for the purpose of negotiating premiums.

<u>*Section 5*</u> would require plans to demonstrate that its QHP proposals meet requirements for geographic sufficiency of its Essential Community Provider (ECP) network and includes the ECP categories that meet this requirement. PEACH greatly appreciates Covered California's commitment to include ECPs that serve the low-income and underserved communities in its QHP provider networks. **PEACH asks that Covered California annually review the lists with the California Hospital Association (CHA) and other provider associations to ensure the accuracy of these lists.**

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B. PEACH offers the following comments and recommendations regarding the January 20, 2016 draft Attachment 7, which we believe will help create a fair and more uniform pathway by which all of Covered California's hospital providers can succeed in improving care quality, health outcomes, and value.

1) Appropriate Use of C-Sections – Attachment 7, Article 5.01

PEACH supports the goal of the joint effort by Covered California, DHCS and CalPERS to reduce NTSV C-Section rates and to meet or exceed the Healthy People 2020 target of 23.9 percent for all hospitals by 2019. PEACH also supports the proposal to implement a progressive payment methodology that would appropriately eliminate financial incentives to perform C-Sections by 2019.

Recommendations:

- PEACH understands that Covered California intends to give providers and plans flexibility in determining the progressive payment methodology and to negotiate a hospital-specific rate that incentivizes vaginal delivery while not penalizing hospitals for medically necessary and appropriate C-Sections. At this time, as California's community safety net hospitals work diligently toward reducing NTSV C-Section rates, PEACH supports a blended hospital-specific rate for C-sections and vaginal deliveries – not a bundled rate for maternity care. It is premature for QHPs to consider a bundled or episode approach to the payment of maternity care. We urge Covered California to support methodologies that will reward improvements in reducing low-risk C-Section rates, while maintaining adequate payment for medically necessary C-Sections.

- Additionally, we believe that a similar payment provision (i.e., blended rate) for contracted OB/GYN physicians is essential to make this policy effective. PEACH supports the suggested language changes to items 3 and 4 in this section, as noted below. Since private hospitals in California cannot employ physicians, adding a physician payment policy that facilitates alignment between hospitals and physicians is critical to reducing NTSV C-Section rates.

  3) Adopt a payment methodology progressively to include all contracted hospitals **and physicians** such that by 2019 there is no financial incentive to perform C-sections. Contractor shall report on its design and the percent of hospitals **and physicians** contracted under this model in its Application for Certification for 2017 and annually thereafter.

  4) Covered California expects Contractor to only contract hospitals **and physicians** that demonstrate they provide quality care and promote the safety of Covered California enrollees. Effective with the Application for Certification for 2019, contractor shall either exclude hospitals **and physicians** from provider networks for purposes of maternity services or to document each year in its Application for Certification the rationale for continued contract with each hospital that demonstrates a C-section rate for NTSV deliveries that is substantially above 23.9 percent.

We look forward to working with Covered California and the CHA to ensure that this payment methodology is developed in a way that maximizes the success of hospitals in reaching this important goal.

2) Hospital Patient Safety: Attachment 7, Article 5.02

PEACH supports Covered California's goal that its QHPs support and enhance hospitals' efforts to improve quality of care and patient safety. Reducing HACs and increasing patient safety is of great concern to community safety net hospitals. In order to ensure that all hospitals can effectively reduce hospital HACs, PEACH has the following concerns and recommendations to the Covered California proposed QHP requirements below:

5.02 (1)

Contractor shall report in its Application for Certification for 2017 baseline rates of specified Hospital Acquired Conditions (HACs) for each of its network hospitals. In order to obtain the most reliable measurement, minimize the burden on hospitals and in the interest of promoting common measurement, Contractor shall employ best efforts to base this report on clinical data such as is reported by hospitals to the California Department of Public Health and to CMS under the Partnership for Patients initiative.

Recommendations:

- PEACH appreciates Covered California's recognition of the importance of promoting common hospital measurement reporting using the most reliable measurements. To best achieve this objective, we urge to Covered California to delete the proposed language above stating that the contractor shall "employ best efforts to" and, instead, require that QHPs use the same HAC measures that are currently required by CMS and the California Department of Public Health, thus preventing QHPs from creating alternative data collection mechanisms and promoting common measurement.

- PEACH also supports CHA's recommendation that Covered California establish a workgroup to advise it on measure selection for use in public reporting and performance-based programs.

5.02 (5)

Covered California expects Contractor to only contract with hospitals that demonstrate they provide quality care and promote the safety of Covered California enrollees. To meet this expectation, by contract year 2018, Covered California will work with its contracted plans and with California's hospitals to identify area of "outlier poor performance" based on variation analysis of HAC rates. For contract year 2019, Contractors will be expected to either exclude hospitals that demonstrate outlier poor performance on safety from provider networks 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.

While we appreciate Covered California's commitment to work with California's hospitals in defining outlier or poor performance, we do not believe that currently available methods to identify "outlier poor performance" can adjust adequately for factors such as socioeconomic status, geography, complexity of illness, comprehensiveness of services, wages, post-hospitalization costs, etc. As a result, PEACH is concerned that excluding poor performing outlier hospitals without giving them an opportunity to implement a plan of correction may result in reduced access to care.

Recommendations:

- PEACH recommends that hospitals that are identified as having "outlier poor performance" for HAC rates be required to submit a plan of correction and be given reasonable time to effectuate that plan before being considered for QHP network exclusion. The compressed timeframe of identifying the outlier poor performing hospitals in 2018 and potential exclusion for contract year 2019 does not appear to give hospitals sufficient time to implement measurable improvements.

- PEACH recommends the creation of a Covered California-sponsored hospital learning collaborative in which best practices in patient safety, readmission and HAC rate reduction would be shared among all hospitals, with required participation for hospitals designated as outlier poor performers.

- PEACH also urges Covered California to seek input and public comment in future efforts to identify additional HAC measures and that it only adopt measures that are endorsed by the National Quality Forum (NQF).

We look forward to the opportunity to work with CHA and Covered California in a transparent process to refine the definition and the process by which it will identify HAC outlier poor performance to understand the impact of various metrics on providers – especially safety-net hospital providers that serve a disproportionate share of low-income communities.

3) Hospital Payments to Promote Quality and Value: Attachment 7, Article 5.03

PEACH strongly agrees with Covered California's statement in Article 5 that "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" (page 15). This is especially true of Covered California's ECP hospitals that serve predominately low-income, ethnically diverse communities with a higher prevalence of complex chronic conditions and social support needs.

5.03 (1)

1) Adopt a hospital payment methodology that by 2019 places at least 6 percent of reimbursement to hospitals at-risk for quality performance. Each contractor may structure this strategy according to their own priorities such as:

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

b. The metrics that are the basis of such value-payments, such as HACs, readmissions, or satisfaction measured through the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). Contractor is required to select standard measures commonly in use in hospitals and that are endorsed by the National Quality Forum.

PEACH, along with CHA, understands this to be 6 percent of all payments to the hospital for Covered California patients, rather than 6 percent of payments for a total health plan population. We ask that Covered California clarify the definition of the 6 percent.

Recommendations and Further Points of Clarification:

- PEACH concurs with the CHA analysis that the current 6 percent of hospital payments proposed to be at risk is similar to the amount of Medicare hospital fee-for-service inpatient payments currently at risk. However, the 6 percent of Medicare payments was phased in over a three-year period and encompasses three very different programs. Therefore, PEACH supports a phased approach to the implementation of the 6 percent to allow sufficient ramp-up time for providers and QHPs.

- PEACH also seeks clarification that this provision only be applicable to general short-term acute care hospitals and exclude children's hospitals, freestanding inpatient psychiatric facilities, freestanding inpatient rehabilitation facilities, and long-term acute care hospitals that are contracted with QHPs.

5.03 (2)
PEACH is greatly concerned that the Covered California recommendations on quality improvement in this section leave it to the QHPs' discretion to determine the "Amount, structure and metrics for hospital strategy." Consistent with our recommendations regarding section 5.02 (1), PEACH urges Covered California to establish uniform value-based payment metrics in consultation with CHA and the QHPs, to achieve continuity in quality of care standards across all of Covered California's plan networks.

Additionally, PEACH urges Covered California to adopt the following CHA-proposed principles to help guide Covered California's QHPs and hospitals as they design mutually agreeable risk contracts:

- **Common and Parsimonious Set of Measures**: All the measures used by QHPs should be identical measures (numerator, denominator, risk adjustment, data collection methods, etc.) regardless of the program in which they are used. We urge Covered California to establish a work group to discuss selection of these measures.

- **Use NQF-Endorsed Measures:** All measures should at a minimum be NQF-endorsed. We urge Covered California to work with stakeholders to ensure that only the most robust, reliable and valid measures are adopted into pay-for-performance programs.

- **Promote Carrot, Not Stick Payment Methodologies:** Hospitals should be rewarded for both achievement and improvements and that QHPs should focus on these types of approaches to accelerate improvement. We do not support penalty programs – such as a methodology like the Medicare HAC program that will always, by design, penalize 25 percent of hospitals regardless of their improvements over the performance period.

- **Evaluate Additional Risk Adjustment:** Despite overwhelming evidence, CMS has failed to adjust the Medicare readmissions measures for sociodemographic factors that influence a readmissions rate. It is our understanding in reading Attachment 7 that Covered California intends to use nationally-recognized measures such as Medicare readmissions measures. We urge Covered California to work with providers to evaluate appropriate sociodemographic status (SDS) adjusters and to encourage CMS to make these changes at the national level. **Should Covered California intend to proceed with using Medicare readmissions measures based on QHP claims data, we would welcome additional discussion on the significant limitations of these measures that would make them inappropriate for application to the QHP population.**

    - **Considerations for Small and Rural Hospitals:** There must be appropriate exclusions for small and/or rural hospitals that are essential in provider networks, but may not be appropriate hospitals for inclusion in a value-based purchasing program, similar to Medicare. We ask that Covered California consider that these hospitals may need an additional year to identify the appropriate methodologies to meet the goals of the program without unintended consequences.

4) Enrollee Healthcare Services Price and Quality Transparency Plan: Attachment 7, Article 7.01

b) Quality information:

i. Covered California expects Contractor with over 100,000 enrollees to provide consumers with internally developed quality ratings specific to physician and facility by the end of 2019,

ii. Nationally endorsed quality information, in accordance with the principles of the Patient Charter for Physician Performance Measurement, will be accepted as an interim step for plans with enrollments over 100,000 until provider-specific quality information specific to Covered California experience can be provided and may be a longer term solution for smaller plans. Sources for national or state quality information for tool inclusion are:

i. The California Office of the Patient Advocate (www.opa.ca.gov/)
ii. The Department of Insurance Healthcare Compare (www.consumerreports.org/cro/health/california-health-cost-and-quality--consumer-reports/index.htm)
iii. CMS Hospital Compare Program (https://www.medicare.gov/hospitalcompare/search.html)
iv. CMS Physician Quality Reporting System (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-AssessmentInstruments/PQRS/index.html?redirect=/pqri/)

Recommendation:
PEACH agrees that providing quality information to consumers is important. However, PEACH is concerned that the proposed language above encourages each QHP to develop its own internal quality rating system for providers and facilities. We urge Covered California to adopt one approach for all QHPs to use in providing quality information to consumers to ensure consumers have access to reliably comparable data.

Thank you for your consideration of our comments and recommendations. PEACH looks forward to working with Covered California to continue to improve health care quality and access to care, promote better health, lower costs, and reduce health disparities. Please feel free to contact me at (916) 446-6000 should you have any questions.

Sincerely,

Catherine K. Douglas
President and CEO

CC: Diana Dooley, Chair, California Health Benefit Exchange Board
Paul Fearer, California Health Benefit Exchange Board
Genoveva Islas, California Health Benefit Exchange Board
Marty Morgenstern, California Health Benefit Exchange Board
Art Torres, California Health Benefit Exchange Board
Dr. Lance Lang, Chief Medical Officer, Covered California
Anne Price, Director, Plan Management, Covered California

February 16, 2016

Diana Dooley, Chair
Covered California Board

Peter Lee, Executive Director
Covered California
1601 Exposition Boulevard
Sacramento, CA 95815

RE: QHP Model Contract, Attachment 7

Dear Director Lee:

On behalf of the California State Council of the Service Employees International Union (SEIU California), I write to comment on the proposed Covered California Quality, Network Management, Delivery System Standards and Improvement Strategy for qualified health plans (QHPs) as outlined in Attachment 7 of the QHP Model Contract. SEIU California has an interest in promoting the delivery of high quality health care on behalf of our 700,000 members statewide, among whom we represent: individuals who may have coverage for themselves or their family members through Covered California; Covered California Service Center employees; County Medi-Cal eligibility workers; and individuals who work and receive care in California's health care delivery system. Taken together, our interests in Covered California are expansive, but aligned with Covered California's mission 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."

First, we want to commend Covered California for explicitly including the reduction in health disparities as part of your core mission, and for reflecting advancement of that goal throughout Attachment 7.
For too long, health policy leaders have understandably misconstrued the broad aim toward improving health care quality to be inclusive of the elimination or reduction of health care disparities. We know, however, that systems can improve overall health and health care quality, while not making progress on the reduction of health care disparities[1]. It is therefore imperative that purchasers such as Covered California make the goal of reducing health care disparities explicit, as you have done.

Throughout the country, not just in California, one of the biggest barriers to making meaningful progress on health equity is the lack of self-reported race, ethnicity, and language data (REL) and other demographic data at the plan or provider level. Covered California's adoption of a proposal put forward by advocates[2] to set a

[1] 2013 National Healthcare Quality Report and 2014 National Healthcare Quality and Disparities Report

[2] EHN, Health Access, SEIU, Asian Americans Advancing Justice – LA, Community Health Councils, Consumers Union, National Health Law Program, Vision y Compromiso November 17, 2015 letter to Diana Dooley and Peter Lee.

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target that each QHP will achieve 80% collection of self-reported race and ethnicity data by 2019 and to set targets for improvement by 2017 is an important step toward the identification and reduction of disparities through Covered California's role as an active purchaser. We look forward to working with Covered California and stakeholders on analyzing the race and ethnicity reported data, and on proposing areas and strategies for improvement over time. We also applaud Covered California for setting forth the goal of expanded measurement to include: income, disability status, sexual orientation, gender identity, and Limited English Proficiency.

We urge Covered California to also require reporting throughout the QHP Attachment 7 requirements to be stratified by race, ethnicity, and gender initially, and later by the additional factors of income, disability status, sexual orientation and gender identity, and Limited English Proficiency. For example, Health and Wellness Services interventions reported under Section 6.01 should be broken out to assess whether disparities exist, and improvements can be made to target and enhance prevention and wellness strategies.

These efforts will also support the added requirement in section 5.01 *Hospital Payments to Promote Quality and Value*, for QHPs to assess the impact of any proposed value-based payments on health care disparities. However, we caution Covered California that much of the discourse around the unintended consequences of measurement and payment reform on the safety net may have a downstream, cumulative impact, rather than an immediate, direct impact on health disparities, and as such, the impact assessed should be with an eye toward both health care disparities as well as an analysis of the sociodemographic factors of the population served by each hospital to discern whether there may be other factors at play influencing how value-based payments are being disbursed. For example, a study[3] published in Health Affairs of the impacts of the Medicare value-based purchasing policies on California safety-net providers found that they were more likely to be penalized under the value-based purchasing program, readmissions penalties, and the electronic health record meaningful-use program even though they performed better on thirty-day risk-adjusted mortality outcomes for patients with acute myocardial infarction, heart failure, or pneumonia and their cost was virtually identical when compared with non-safety-net hospitals. As laid out in Section 5.01, Covered California's value-based purchasing strategy could result in the full 6% being applied as a readmissions penalty, despite evidence that it is strongly correlated with patient population demographics.

Given the broadly documented potential for these sorts of payment reforms to have detrimental impacts on the health care safety net, we urge Covered California to require reporting on the sociodemographic factors of each of the hospitals subject to Section 5.01. Furthermore, we would urge Covered California to continuously analyze and examine what sorts of impacts, if any, its overall quality improvement strategies are having on the availability of culturally and linguistically appropriate, high quality health care in safety net communities. While it is true that Covered California is available to Californians of all income levels, it is also true that a substantial number of Covered California enrollees are subsidy eligible and there is significant churn between the low-income communities served by our Medi-Cal program and Covered California. As such, Covered California is correct in viewing the state's health care safety net as an important segment of the providers contracted through QHPs. We support the recommendation to look at safety net systems' important role in serving underserved communities, and ensuring that payment reform does not have any unintended consequences for these providers and the communities they serve.

[3] Gilman M, Adams EK, Hockenberry JM, Wilson IB, Milstein AS, Becker ER. California Safety-Net Hospitals Likely To Be Penalized By ACA Value, Readmission, And Meaningful-Use Programs. Health Affairs. August 2014. 33:81314-1322.

Finally, we thank Covered California for adding definitions of "health equity," and "health disparities," to your Glossary of Key Terms.

Through Covered California's focus on taking meaningful steps to identify and reduce disparities throughout its QHP Model Contract, Covered California will again lead the nation and set groundbreaking policy as an active purchaser that drives system-wide change through its marketplace. We commend Covered California for your progress toward this goal, to date, and respectfully request your consideration of our comments.

Sincerely,

Michelle Doty Cabrera
Healthcare & Research Director