

Quality, Network Management, Delivery System Standards and Improvement Strategy

Preamble

PROMOTING HIGHER QUALITY AND BETTER 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.

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

1.01 Coordination and Cooperation

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

- 1) Covered California shall 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:
 - (a) Enrollees and other consumers;
 - (b) Providers in terms of burden, changes in payment and rewarding the triple aim of improving care, promoting better health and lowering costs; and
 - (c) Contractors in terms of the burden of reporting, participating in quality or delivery system efforts.
- 2) 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.

1.02 Assuring Networks are Based on Value

Central to its contractual requirements of its QHP Issuers, Covered California requirements include multiple elements related to assuring that Issuers' plans and networks provide quality care, including Network Design (Section 3.3.2), the inclusion of Essential Community Providers (Section 3.3.3) and a wide range of elements detailed in this Attachment. To complement these provisions and to promote accountability and transparency of Covered California's expectation that network design and provider selection considers quality and patient experience in addition to cost and efficiency, the Contractor shall:

- 1) Include quality, which may include clinical quality, patient safety and/or patient experience and cost in all provider and facility selection criteria when designing and composing networks for inclusion in Covered California products
- 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 or facility selection. Such information may be made publicly available by Covered California.
- 3) Covered California expects Contractor to only contract with providers and hospitals that demonstrate they provide quality care and promote the safety of 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 Covered California provider networks or to document each year in its Application for Certification the rationale for continued contracting with each provider that is identified as a poor performing outlier and efforts the provider is undertaking to improve performance. 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.

- 4) Contractor shall report each year, starting with its Application for Certification for 2018, 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 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.
- 5) While Covered California welcomes Issuers’ use of Centers of Excellence, that may include design incentives for consumers, the current standard benefit designs do not envision or allow for “tiered” in-network providers.

1.03 Demonstrating Focus on High Cost Providers

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

- 1) Contractor shall Report to Covered California in its Application for Recertification for 2018, and annually thereafter:
 - (a) The factors it considers in assessing the relative unit prices and total costs of care;
 - (b) The extent to which it adjusts or analyzes the reasons for cost factors based on elements such as area of service, population served, market dominance, services provided by the facility (e.g., trauma or tertiary care) or other factors;
 - (c) How such factors are used in the selection of providers or facilities in networks available to Covered California enrollees; and
 - (d) The identification of and distribution of providers and facilities by cost deciles (or describe other ways providers and facilities are grouped by costs); and the percentage of costs for the contractor that are expended in each cost decile.

- 2) In its Application for Recertification for 2018, and annually thereafter, Contractor shall report on its strategies to assure that contracted providers are not charging unduly high prices, and for what portions of its entire enrolled population it applies each strategy, which may include but are not limited to:
 - (a) Telemedicine;
 - (b) Use of Centers of Excellence; and
 - (c) Reference Pricing; and
 - (d) Efforts to make variation in provider or facility cost transparent to consumers.
- 3) For contract year 2019, Contractor will be expected to exclude hospitals and other facilities that demonstrate outlier high cost from provider networks serving Covered California or to document each year in its Application for Certification the rationale for continued contracting with each hospital that is identified as a high cost outlier and efforts that the hospital or facility is undertaking to lower its costs.

1.04 Demonstrating a Focus on High Cost Pharmaceuticals

Appropriate treatment with pharmaceuticals is often the best clinical strategy to treating conditions, as well as managing chronic and life threatening conditions. Covered California expects its Contractor to assure that its enrollees get timely access to appropriate prescription medications. At the same time, Covered California is concerned at the trend in rising prescription drug costs, especially those in Specialty Pharmacy, which reflect a growing driver of total cost of care.

Contractor shall report in its annual application for certification a description of its approach to achieving value in delivery of pharmacy services, which should include a strategy in each of the three areas that follow:

- 1) Contractor shall describe how it considers value in its selection of medications for use in its formulary, including the extent to which it applies value assessment methodology developed by independent groups and/or uses independent drug assessment reports on comparative effectiveness and value to design benefits, negotiate prices or determine coverage within Covered California standard benefit designs. The contractor shall report the specific way(s) they use a value assessment methodology and/or independent reports to improve value in pharmacy services and indicate which of the following sources it relies upon:
 - (a) Drug Effectiveness Review Project (DERP)
 - (b) NCCN Resource Stratification Framework (NCCN-RF)
 - (c) NCCN Evidence Blocks (NCCN-EB)
 - (d) ASCO Value of Cancer Treatment Options (ASCO- VF)
 - (e) ACC/AHA Cost/Value Methodology in Clinical Practice Guidelines
 - (f) Oregon State Health Evidence Review Commission Prioritization Methodology
 - (g) Premera Value-Based Drug Formulary (Premera VBF)
 - (h) DrugAbacus (MSKCC) (DAbacus)
 - (i) The ICER Value Assessment Framework (ICER-VF)
- 2) Efforts to impact state and national policy on pharmacy pricing, marketing, transparency or development; and

- 3) How it provides decision support for prescribers and consumers related to the clinical efficacy and cost impact of treatments and their alternatives.

1.05 Quality Improvement Strategy

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

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

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

- (a) The percentage, number and performance of total participating providers;
- (b) The number and percent of Covered California enrollees participating in the initiative;
- (c) The number and percent of all the Contractor's covered lives participating in the initiative; and
- (d) The results of Contractor's participation in this initiative, including clinical, patient experience and cost impacts.

1.06 Participation in Collaborative Quality Initiatives

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

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.
http://www.chhs.ca.gov/PRI/_CalSIM%20Maternity%20Initiative%20WriteUp%20April%202014.pdf (See Article 5, Section 5.03)
- (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. <http://www.iha.org/grants-projects-reducing-overuse-workgroup.html> (See Article 7, Section 7.05)

2) Covered California is interested in Contractors' participation in other collaborative initiatives. As part of the Application for Certification for 2017, and annually thereafter, Contractor shall report to Covered California its participation in any of the following collaboratives, or other similar activities not listed:

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

- i. Children's Hospital of Orange County,
- ii. LA Care,
- iii. National Rural Accountable Care Consortium,
- iv. California Quality Collaborative of PBGH, and
- v. VHA/UHC Alliance NewCo, Inc.

All five 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 4.02)

(b) Partnership for Patients: The CMS Innovation Center (CMMI) implemented this program focused on hospital patient safety between 2012 and 2014 resulting in 87,000 fewer deaths, mostly in 2013-14. (<http://www.ahrq.gov/professionals/quality-patient/safety/pfp/interimhacrate2014.html> See article 5, section 5.02)

Awardees for 2015-2016 are:

- i. Hospital Quality Initiative subsidiary of the California Hospital Association.
- ii. Dignity Hospitals,
- iii. VHA/UHC, and
- iv. Children's Hospitals' Solutions for Patient Safety

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

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

(e) California Immunization Registry (CAIR)

(f) Any IHA or CMMI sponsored payment reform program

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

(h) California Perinatal Quality Care Collaborative

(i) California Quality Collaborative

(j) Leapfrog

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.

1.07 Data Exchange with Providers

- 1) 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 providers who have been managing the patient on an ambulatory basis.
 - (b) Developing systems to collect clinical data as a supplement to the annual HEDIS process, such as HbA1c lab results and blood pressure readings which are important under Article 3 below.
 - (c) Racial and ethnic self-reported identity collected at every patient contact

- 2) Initiatives to make this exchange routine include various Health Information Exchanges including:
 - (a) Inland Empire Health Information Exchange (IEHIE)
 - (b) Los Angeles Network for Enhanced Services (LANES)
 - (c) Orange County Partnership Regional Health Information Organization (OCPRHIO)
 - (d) San Diego Health Connect
 - (e) Santa Cruz Health Information Exchange
 - (f) CallIndex.

1.08 Data Aggregation across Health Plans

Covered California and Contractor recognize the importance of aggregating data across purchasers and payers to more accurately understand the performance of providers that have contracts with multiple health plans. Such aggregated data reflecting a larger portion of a provider, group or facility's practice can potentially be used to support performance improvement, contracting and public reporting.

- 1) Contractor 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

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 for Contractor's HEDIS and CAHPS quality data submission shall be consistent with the timeline for submitting data to the NCQA Quality Compass and/or DHCS. Covered California reserves the right to use the Contractor-reported measures to construct Contractor summary quality ratings that Covered California may use for such purposes as supporting consumer choice and Covered California's 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 information currently captured in contractor's information systems related to its Covered California Enrollees to Contractor's Business Associate, Truven Health Analytics ("Truven").

1) Disclosures to Truven Health Analytics:

- (a) 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 and submit on a monthly basis at a time that is mutually agreed upon by Contractor and Truven.
- (b) If a current BAA does not exist, to enable 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, prior to by January 1, 2017. 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.

2) Disclosures to Covered California:

- (a) Truven must 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 not request any Personally Identifiable Health Information from Truven or attempt to use the de-identified or aggregated data it receives from Truven to re-identify any person.

3) Covered California as a Health Oversight Agency:

- (a) 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 2017, 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 2019.

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 evaluation regarding 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 that is provided by Contractor due to Contractor's inability to report on all Covered California-specific business. If applicable, Contractor shall report data separately for HMO/POS, PPO and EPO product lines.

Contractor shall provide Covered California information regarding their 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.

Article 3. Reducing Health Disparities and Assuring Health Equity

Covered California and the Contractor recognize 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.

1) Identification:

- (a) By the end of 2019, Contractor will achieve 80 percent self-reported racial/ethnic identity in all lines of business excluding Medicare. 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.
- (b) Contractor shall report the percent 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.
- (c) Covered California and Contractor will negotiate annual targets to be reported in subsequent Applications for Certification.
- (d) 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.

2) Measures for Improvement:

- (a) Measures selected for improvement beginning in plan year 2017 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.)
- (b) In future contract periods, Covered California shall consider adding 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, there is agreement that health care disparities can be narrowed through quality improvement activities tailored to specific populations and targeting select measures at the health plan level. Covered California and the Contractor agree that collection of data on clinical measures for the purpose of improvement requires development and adoption of systems for enhanced information exchange (see Section 1.07).

- 1) Contractor shall report baseline measurements from plan year 2015 on the measures listed in 3.01(2)(a) based either on self-reported identity or on proxy identification across all lines of business excluding Medicare in the Application for Certification for 2017. Covered California anticipates that this baseline data may be incomplete.
- 2) Targets for 2019 and for annual intermediate milestones in reduction of disparities will be established by Covered California based on national benchmarks, analysis of variation in California performance 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. Areas for consideration include, but are not limited to:

- 1) Income
- 2) Disability status
- 3) Sexual orientation
- 4) Gender identity
- 5) Limited English Proficiency (LEP)

3.04 NCQA Certification

Meeting the standards for Multicultural Health Care Distinction by NCQA is encouraged as a way to build a program to reduce documented disparities and to develop culturally and linguistically appropriate communication strategies. To the extent the Contractor has applied for or received this Certification, Contractor shall provide this information with its Application for Certification for 2017 and annually thereafter. Covered California may publicly recognize this achievement and consider it in the development of presentation of information to consumers.

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. Contractor is required to actively promote the development and use of care models that promote access, care coordination and early identification of at-risk enrollees and consideration of total costs of care. Contractor is required to design networks and payment models for providers serving Covered California Enrollees to reflect these priorities.

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

- 1) Effective primary care services, including 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 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 including reporting baseline from plan year 2015 in the 2017 Application for Certification.

4.02 Patient Centered Medical Home

A growing body of evidence documents that advanced models of primary care, often called Patient Centered Medical Homes (PCMH) 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 interested stakeholders including providers in the process of developing this standard definition in preparation for use in the Application for Certification for 2018. As part of this effort, Contractor agrees to work with Covered California to work to limit the reporting burden on providers.

- 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 (alternatives to face-to-face visits and care provided 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:
 - (a) Based 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.
 - (b) A baseline of the percent of PCPs whose contracts are based on the payment strategy defined in 4.02(2) for primary care services;
 - (c) The number and percent of Covered California enrollees who receive care in such practices;
 - (d) The number and percent of all enrollees in all lines of business excluding Medicare who receive care in such practices; and
 - (e) How its payment to PCMH practices differs from those payments made to practices that have not met the standards.

4.03 Integrated Healthcare Models (IHM)

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

- 1) The IHM is defined as:
 - (a) An integrated organization that coordinates care across the care continuum including multi-discipline 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 Contractor and providers, and among providers across specialties and institutional boundaries, holding the IHM accountable for nationally recognized evidence-based clinical, financial, and operational performance, as well as incentives for improvements in population outcomes. As providers accept more accountability under this provision, Contractors shall be aware of their obligations under Knox Keane to ensure that providers have the capacity to manage the risk.

- 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 4.03(1) and including the number and percent of members who are managed under IHMs in its Application for Certification for 2017 and annually thereafter for all lines of business and specific to Covered California enrollees.
- 3) Targets for 2017-2019 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.

4.05 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 the strategies Contractor has implemented and its progress in:

- 1) Making behavioral health services available to Covered California enrollees;
- 2) How it is integrating Behavioral Health Services with Medical Services; and
- 3) Reports shall include documenting the percent of services provided under an integrated behavioral health-medical model for Covered California enrollees and for the Contractor's overall covered lives. These reports should 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 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 for Covered California enrollees and for the Contractor's total covered lives, the number of unique patients and number of separate servicing provided for telemedicine and 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 include whether these models are implemented in association with PCMH and IHM models or are independently implemented.

Article 5. Hospital Quality

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

5.01 Hospital Payments to Promote Quality and Value

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

- 1) Adopt a hospital payment methodology that 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 (HCAPS). Contractor is required to select standard measures commonly in use in hospitals and that are endorsed by the National Quality Forum;

Contractor shall adopt balancing measures to track, address, and prevent unintended consequences from at-risk payments including exacerbation of health care disparities. Contractor shall report what strategies they are implementing to support hospitals serving at-risk populations in achieving target performance.

Implementation of this requirement may differ for integrated delivery systems and require alternative mechanisms for tying payment to performance.

- 2) Contractor shall report in its annual Application for Certification the:
 - (a) Amount, structure and metrics for hospital payment strategy;
 - (b) The percent of network hospitals operating under contracts reflecting this payment methodology;
 - (c) The total dollars and percent or best estimate of hospital payments that are tied to this strategy; and
 - (d) The dollars and percent or best estimate that is respectively paid or withheld to reflect value. The hospital payments to promote value shall be distinct from shared-risk and performance payments to hospitalization related to their participating in IHMs as described in Article 4.03.

5.02 Hospital Patient Safety

Contractor agrees to work with Covered California to support and enhance hospital's 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 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.
- 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.
- 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.

5.03 Appropriate Use of C-Sections

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

- 1) Work collaboratively with Covered California to promote and encourage all in-network hospitals that provide maternity services to enroll in the California Maternity Quality Care Collaborative (CMQCC) Maternal Data Center (MDC).
- 2) Report in its Application for Certification for 2017, and annually thereafter, the C-section rate for NTSV deliveries and the overall C-Section rate for each of its network hospitals for the hospital's entire census.
- 3) Adopt a payment methodology progressively to include all contracted physicians and hospitals such that by 2019 payment is structured to support only medically necessary care and there is no financial incentive to perform C-sections. Contractor shall report on its design and the percent of hospitals contracted under this model in its Application for Certification for 2017 and annually thereafter.
- 4) Covered California expects Contractor to only contract with hospitals that demonstrate they provide quality care and promote the safety of Covered California enrollees. Effective with the Application for Certification for 2019 Contractors will be expected to either exclude hospitals that are unable to achieve an NTSV C-section rate below 23.9 per cent from provider networks or to document each year in its Application for Certification the rationale for continued contracting with each hospital that has an NTSV C-Section rate above 23.9% and efforts the hospital is undertaking to improve its performance.

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

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

- 1) Necessary preventive services appropriate for each enrollee and shall report to Covered California the number and percent of members who take advantage of their 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 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) Tobacco cessation intervention, inclusive of evidenced-based counseling and appropriate pharmacotherapy, if applicable; and shall report to Covered California the number and percent of its members who take advantage of the tobacco cessation 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 in use of 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) Obesity management, if applicable shall report to Covered California the number and percent of its members who take advantage of their 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 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 communication 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 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 encouraged to support community health initiatives that have undergone or are being piloted through systematic review to determine effectiveness in promoting health and preventing disease, injury, or disability and have been recommended by the Community Preventive Services Task Force.

Contractor 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.

Such programs may include, but are not limited to,

- 1) Partnerships with local, state or federal public health departments such as Let's Get Healthy California
- 2) CMS Accountable Health Communities
- 3) Voluntary health organizations which operate preventive and other health programs such as CalFresh
- 4) Hospital activities undertaken under the Community Health Needs Assessment required every three years under the Affordable Care Act.

6.03 Determining Enrollee Health Status and Use of Health Assessments

Contractor shall demonstrate the capacity and systems to collect, maintain 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 to and Collaborating with Covered California Regarding Health Status

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

Contractor shall report to Covered California its process to monitor and track 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 6.05, 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 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:

- 1) Identification of in-network providers with appropriate clinical expertise or any alternative therapies including specific drugs when transitioning care;
- 2) 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;
- 3) Where possible, advance notification and understanding of out-of-network provider status for treating and prescribing physicians; and
- 4) A process to allow incoming Enrollees access to Contractor's formulary information prior to enrollment.

6.06 Identification and Services for At-Risk Enrollees

Contractor agrees to identify and proactively manage 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 include the following:

- 1) Methods to identify and target At-Risk Enrollees;
- 2) Description of Contractor's predictive analytic capabilities to assist in identifying At-Risk Plan Enrollees who would benefit from early, proactive intervention;
- 3) Communication plan for known At-Risk Enrollees to receive information prior to provider visit, including the provision of culturally and linguistically appropriate communication;
- 4) Process to update At-Risk Enrollee medical history in the Contractor maintained Plan Enrollee health profile;
- 5) 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.
- 6) 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;
- 7) 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;
- 8) 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 to care.

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

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

7.01 Enrollee Healthcare Services Price and Quality Transparency Plan

1) In the Application for Certification 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.

(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.
- (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 out-of-pocket.

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 2017. If Contractor enrollment is under 100,000, the information may be provided by alternative means such as a call center.

- 2) Contractor shall in its annual Application for Certification:
- (a) Report the number and percent 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.
 - (b) User experience with the tool (or equivalent service such as a call center) from a representative sample of users who respond to a survey which includes a user overall satisfaction with rating. Include separate results for Covered California users and all lines of business.
 - (c) Contractor will provide access and log in credentials for Covered California staff per mutually agreeable terms to safeguard Contractor proprietary information and services.

7.03 Enrollee Personalized Health Record Information

- 1) 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".
- 2) The content of such PHRs includes: medical records; billing and payment records; insurance information; clinical laboratory test results; medical images, such as X-rays; wellness and disease

management program files; and clinical case notes; and other information used to make decisions about individuals.

- 3) 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.
- 4) Contractor will provide access and log in credentials for Covered California staff per mutually agreeable terms to safeguard Contractor proprietary information and services.

7.04. 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.

- 1) 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.
- 2) 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.
- 3) 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:

- 1) C- Sections for low risk (NTSV) deliveries
- 2) Opioid overuse and misuse, and
- 3) 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 5.03)

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

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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 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 and should include the Contractor's entire book of business with the provider.

- 1) Among the strategies for which Covered California has established requirements for payment strategies to support delivery system reforms are:
 - (a) Advanced Primary Care or Patient-Centered Medical Homes (4.02)
 - (b) Integrated Healthcare Models (4.03)
 - (c) Appropriate use of C-sections (5.03)
 - (d) Hospital Patient Safety (5.02)
- 2) In addition to those required payment strategies above, 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:
 - (a) Direct participation or alignment with CMMI innovative payment models such as the Oncology or Joint Replacement model.
 - (b) Adoption of new Alternative Payment Models associated with the implementation of the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA)

8.03 Value-Pricing Programs

Contractor agrees to provide Covered California with the details of any value-pricing programs for procedures or in service areas that have the potential to improve care and generate savings for 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

- 1) 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.

- 2) The CPR National Scorecard will provide a view of progress on payment reform at the national level and then at the market level as the methodology and data collection mechanisms allow.
- 3) The CPR National Compendium will be an up-to-date resource regarding payment reforms being tested in the marketplace and their available results. The Compendium will be publicly available for use by all health care stakeholders working to increase value in the system.
- 4) Yearly report on the progress and impact of value-oriented payment initiatives imputed to the Purchaser's annual spend for the preceding calendar year, using both the format and calculation methodology in the Covered California eValue8 RFI and CPR's Payment Reform Evaluation Framework.

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Article 9. Accreditation

- 1) Contractor agrees to maintain a current accreditation throughout the term of the Agreement from one of the following accrediting bodies: (i) Utilization Review Accreditation Commission (URAC); (ii) National Committee on Quality Assurance (NCQA); (iii) Accreditation Association for Ambulatory Health Care (AAAHC). Contractor shall authorize the accrediting agency to provide information and data to Covered California relating to Contractor's accreditation, including, the most recent accreditation survey and other data and information maintained by accrediting agency as required under 45 C.F.R. § 156.275.
- 2) 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.
- 3) If Contractor receives a rating of less than "accredited" in any category, loses an accreditation or fails to maintain a current and up to date accreditation, Contractor shall notify Covered California within ten (10) business days of such rating(s) change and shall be required to provide Covered California with all 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.
- 4) Following the initial submission of the corrective action plans ("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). Contractor shall request a follow-up review by the accreditation entity at the end of twelve (12) months and submit a copy of the follow-up Assessment Report to Covered California within thirty (30) days of receipt, if applicable.
- 5) In the event Contractor's overall accreditation is suspended, revoked, or otherwise terminated, or in the event Contractor has undergone review prior to the expiration of its current accreditation and reaccreditation is suspended, revoked, or not granted at the time of expiration, Covered California reserves the right to terminate 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.
- 6) Upon request by Covered California, Contractor will identify all health plan certification or accreditation programs undertaken, including any failed accreditation or certifications, and will also provide the full written report of such certification or accreditation undertakings to Covered California.

Quality, Network Management and Delivery System Standards

Glossary of Key Terms

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

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

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

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

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

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

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

Primary Care Physician (or Personal 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 payer 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 payer 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.