**Appendix H 2017 Covered California Initiatives – Contract Requirements**

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| **9.2.1 Provider Networks** **Based on Quality** |
| *Federal QIS Topic Area: Activities to improve patient safety and reduce medical errors* |
| 2017 QHP Issuer Contract, Section 1.02 |
| **Requirements:**   * Applicant shall include both quality and cost factors in all provider and facility selection criteria when designing and composing networks for inclusion in Covered California products * Applicant shall disclose to Covered California, with its Application for Certification for 2018, 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. * Applicant shall 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 Applicant 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. Applicant may provide this information in its Application for Certification for 2017. * Covered California expects Applicant 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, Applicants 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 rational 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. |

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| **9.2.2 Reducing Health Disparities and Assuring Health Equity** |
| *Federal QIS Topic Area: Activities to reduce health and health care disparities* |
| 2017 QHP Issuer Contract, Section 3.01 and 3.02 |
| **Requirements:**   * By the end of 2019, Applicant will achieve 85 percent self-reported racial/ethnic identity. * Applicant shall report baseline percent of self-reported racial/ethnic 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. * Covered California and Applicant will negotiate annual targets to be reported in subsequent Applications for Certification. * To the extent Applicant 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. * Measures for plan year 2016 include Diabetes, Hypertension and Asthma (control plus hospital and ER admission rates) and Depression (HEDIS appropriate use of medications) * In future contract periods, Covered California shall consider adding additional measures. Applicant 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. * 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. |

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| **9.2.3 Promoting Development and Use of Care Models – Primary Care** |
| *Federal QIS Topic Area: Activities for improving health outcomes* |
| 2017 QHP Issuer Contract, Section 4.01 and 4.02 |
| **Requirements:**   * Covered California requires Applicant 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, Applicant 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, Applicant 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. Applicant will confirm adherence to this requirement annually in its Application for Certification. * Applicant 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 Applicant agree to engage 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, Applicant agrees to work with Covered California to work to limit the reporting burden on providers. * Applicant 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 by non-MDs) with accountability for improving triple aim metrics including total cost of care. * Applicant shall report in the Application for Certification for 2018: 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.   (a) A baseline of the percent of PCPs whose contracts are based on the payment strategy defined in 4.02(2) for primary care services;  (b) The number and percent of Covered California enrollees who receive care in such practices;  (c) The number and percent of all of the Applicants enrolling and who receive care in such practices; and  (d) How its payment to PCMH practices differs from those payments made to practices that have not met the standards. |

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| **9.2.4 Promoting Development and Use of Care Models – Integrated Healthcare Models (IHM)** |
| *Federal QIS Topic Area: Activities for improving health outcomes* |
| 2017 QHP Issuer Contract, Section 4.03 |
| **Requirements:**   * The Exchange places great importance on the adoption and expansion integrated, coordinated and accountable systems of care and is adopting the CalPERS definition Integrated HealthCare Models also known as Accountable Care Organizations (ACOs). The IHM structures will include the following:  1. An integrated organizational structure consisting of multi-discipline physician practices, hospitals and ancillary providers that address and coordinate patient care across the care continuum. 2. 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 Applicant:   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.  Hospital inpatient level of integration will include, at minimum, lab, radiology, pharmacy, CDR, clinical decision support, and prescription documentation.  There must be Stage two (2) (Advanced Clinical Processes) of Meaningful Use of the certified EHR within the IHM:   * 1. Health Information and Data,   2. Results Management,   3. Order Entry/Management,   4. Clinical Decision Support,   5. Electronic Communications and Connectivity, and   6. Patient Support.  1. 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.  * Applicant shall provide the Exchange 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.   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. |

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| **9.2.5 Appropriate use of C-Sections** |
| *Federal QIS Topic Area: Activities for improving health outcomes* |
| 2017 QHP Issuer Contract, Section 5.01 |
| **Requirements:**   * Applicant shall work collaboratively with the Exchange to promote and encourage all in-network hospitals that provide maternity services to enroll in the California Maternity Quality Care Collaborative’s (CMQCC) Maternal Data Center (MDC). * 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 Applicants delivering at each hospital. * Adopt a payment methodology progressively to include all contracted hospitals such that by 2019 there is no financial incentive to perform C-sections. Applicant shall report on its design and the percent of hospitals contracted under this model in its Application for Certification for 2017 and annually thereafter. * Covered California expects Applicant to only contract hospitals that demonstrate they provide quality care and promote the safety of Covered California enrollees. Effective with the Application for Certification for 2019, Applicant shall 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. |

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| **9.2.6 Hospital Patient Safety** |
| *Federal QIS Topic Area: Activities to improve patient safety and reduce medical errors* |
| 2017 QHP Issuer Contract, Section 5.02 and 5.03 |
| **Requirements:**   * Applicant 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, Applicant 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. * 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. * Priority HACs to be focused on through this initiative have been selected in consultation with stakeholders and experts in hospital safety. These HACs are:  1. Catheter Associated Urinary Tract Infection (CAUTI); 2. Central Line Associated Blood Stream Infection (CLABSI); 3. 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.   * 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. * Covered California expects Applicant 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, Applicants 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 rational 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. * Adopt a hospital payment methodology that by 2019 places at least 6 percent of reimbursement to hospitals at-risk for quality performance. Each Applicant may structure this strategy according to their own priorities such as:  1. The extent to which the payments “at risk” take the form of bonuses, withholds or other penalties; and 2. 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). Applicant is required to select standard measures commonly in use in hospitals and that are endorsed by the National Quality Forum.  * The Exchange expects Applicant to exclude hospitals with outlier poor performance from provider networks by 2019 or to document each year in its Application for Certification the rational for continued contract. * Applicant shall report in its annual Application for Certification the:  1. Amount, structure and metrics for hospital payment strategy; 2. The percent of network hospitals operating under contracts reflecting this payment methodology; 3. The total dollars and percent of hospital payments that are about this strategy; and 4. The dollars and percent 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. |
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| **9.2.7 Patient-Centered Information and Support** |
| *Federal QIS Topic Area: Activities for improving health outcomes* |
| 2017 QHP Issuer Contract, Sections 7.01 |
| **Requirements:**   * In the Application for Certification for 2017, Applicant will report its planned approach to providing healthcare shopping cost and quality information available to all members enrolled in Applicant’s Covered California population. Covered California recognizes that timeline and expectations will differ, based on variables such as Applicant membership size and current tool offerings. Regardless of how the requirement is fulfilled, the common elements at the end point of each Applicant 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 and should be organized in ways that are meaningful for consumers to understand.   1. 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. 2. Quality information:    * 1. Covered California expects Applicant with over 100,000 enrollees to provide consumers with internally developed quality ratings specific to physician and facility by the end of 2019,      2. 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:   (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/>)  iii. In addition, Applicant 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. |