

Attachment 7 to Covered California 2017 Individual Market QHP Issuer Contract: Quality, Network Management, Delivery System Standards and Improvement Strategy

Preamble

PROMOTING HIGHER QUALITY AND BETTER VALUE

Covered California's "Triple Aim" framework seeks to lower costs, improve quality, and improve health outcomes, while ensuring a good choice of plans for consumers. 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 payors to support delivery system reform. Qualified Health Plan (QHP) Issuers 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 this Agreement with Covered California, Contractor agrees 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 Contractor's entire California membership. All 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 all QHP Issuers to balance the need for accountability and transparency at the Provider-level with the need to reduce administrative burdens on Providers as much as possible. 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 Issuers.

This Quality, Network Management, Delivery System Standards and Improvement Strategy outlines the ways that Covered California and the Contractor will focus on the promotion of better care and higher value for Enrollees and for other California health care consumers. This focus will require both Covered California and 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, 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 Contractor recognize that driving the significant improvements needed to ensure better quality care is delivered at lower cost will require tactics and strategies that extend beyond the term

of this agreement. 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. This Attachment 7 contains numerous reports that will be required as part of the annual certification and contracting process with QHP Issuers. This information will be used for negotiation and evaluation purposes regarding any extension of this Agreement and the recertification process for subsequent years.

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 Covered California and Contractor, but also with Providers, consumers and other important stakeholders.

- 1) Covered California shall facilitate ongoing discussions with 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 and participating in quality or delivery system efforts.
- 2) Contractor agrees to participate in Covered California advisory and planning processes, including participating in the Plan Management and Delivery System Reform Advisory Group.

1.02 Ensuring Networks are Based on Value

Central to its contractual requirements of its QHP Issuers, Covered California requirements include multiple elements related to ensuring that QHP 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 patient experience and cost in all Provider and facility selection criteria when designing and composing networks for inclusion in Covered California products
- 2) Contractor will be required to report to Covered California as part of its annual application for certification for purposes of negotiations, how it meets this requirement and the basis for the selection of Providers or facilities in networks available to Enrollees. This will 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. Information submitted for the application for certification in 2019 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 Enrollees at a reasonable price. To meet this expectation, by contract year 2018, Covered California will work with its QHP Issuers 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 Providers throughout California. For contract year 2019, QHP Issuers 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. Rationales for continued inclusion of Providers may include the impact on consumers in terms of geographical access and their out-of-pocket costs, or other justification provided by the QHP Issuer. QHP Issuer’s rationale for inclusion of outliers on cost or quality will be released to the public by Covered California. Selection of specific measures of cost and quality, as well as criteria for defining “outlier poor performance” in a way that can be implemented consistently across Contractors will be established by Covered California based on national benchmarks, analysis of variation in California performance which shall include consideration of hospital case mix and services provided, best existing science of quality improvement, and effective engagement of stakeholders. Contractor agrees to participate in these collaborative processes to establish definitions. Reports from Contractor must detail implementation of such criteria through contractual requirements and enforcement, monitoring and evaluation of performance, consequences of noncompliance, corrective action and improvement plans if appropriate, 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 will be required to report each year as part of the annual negotiation and certification process, starting with its application for certification for 2017, how Enrollees with conditions that require highly specialized management (e.g. transplant patients and burn patients) are managed by Providers with documented special experience and proficiency based on volume and outcome data, such as Centers of Excellence. In addition, to the extent that the Contractor uses Centers of Excellence more broadly, it will be required to include in its application for certification for 2017 and annually thereafter, the basis for inclusion of such Centers of Excellence, the method used to promote consumers’ usage of these Centers, and the utilization of these Centers by Enrollees.
- 5) While Covered California welcomes QHP Issuers’ use of Centers of Excellence, which may include design incentives for consumers, the current standard benefit designs do not envision or allow for “tiered” in-network Providers.

1.03 Demonstrating Action 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 more for care irrespective of quality, is one of the biggest contributors to high costs of medical services.

- 1) Contractor will be required to report to Covered California as part of its application for certification for 2017, and annually thereafter, which will be used for negotiation purposes:
 - (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 Enrollees; and
 - (d) The identification of specific hospitals and their distribution by cost deciles or describe other ways Providers and facilities are grouped by costs such as comparison of costs as a percentage of Medicare costs; and the percentage of costs for Contractor that are expended in each cost decile. Contractor understands that it is the desire and intention of Covered California to expand this identification process to include other Providers and facilities in future years.

- 2) In its application for certification for 2017, and annually thereafter, which will be used for negotiation purposes, Contractor will be required to report on its strategies to ensure 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:
 - (a) Telemedicine;
 - (b) Use of Centers of Excellence; and
 - (c) Design of Networks (see Article 1.02)
 - (d) Reference Pricing; and
 - (e) Efforts to make variation in Provider or facility cost transparent to consumers and the use of such tools by 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 Action 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 ensure that its Enrollees get timely access to appropriate prescription medications. At the same time, Covered California is concerned with the trend in rising prescription drug costs, including those in Specialty Pharmacy, and compounding increases in costs of generic drugs, which reflect a growing driver of total cost of care.

Contractor will be required to report in its annual application for certification for negotiation purposes, a description of its approach to achieving value in delivery of pharmacy services, which should include a strategy in each of the following areas:

- 1) Contractor must 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 or uses independent drug assessment reports on comparative effectiveness and value to design benefits, negotiate prices, develop pricing for consumers, and determine formulary placement and tiering within Covered California standard benefit designs. Contractor shall report the specific ways they use a value assessment methodology 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)
 - (j) Real Endpoints
 - (k) Blue Cross/Blue Shield Technology Evaluation Center
 - (l) International Assessment Processes (e.g., United Kingdom’s National Institute for Health and Care Excellence – “NICE”)
 - (m) Other (please identify)

- 2) Contractor shall describe how its construction of formularies is based on total cost of care rather than on drug cost alone
- 3) Contractor shall describe how it monitors off-label use of pharmaceuticals and what efforts are undertaken to assure any off-label prescriptions are evidence-based;
- 4) Contractor must describe 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 application for certification for 2017, 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, which will be used for negotiation purposes during the application process. 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 of 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 will include:

- (a) The percentage, number and performance of total participating Providers;
- (b) The number and percent of 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 ¶

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 that are aligned with priorities established by Covered California with requirements specified below.

- 1) Effective January 1, 2017, Contractor must 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 the California Maternal Quality Care Collaborative (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 the 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.ihc.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, for negotiation purposes, Contractor will be required to 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 of these collaboratives are 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, which between 2012 and 2014 resulted 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 working with California hospitals 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
- v. Premiere, Inc.

- (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
 - (l) Leapfrog
 - (m) A Federally Qualified Patient Safety Organization such as CHPSO
 - (n) The IHA Encounter Standardization Project
- 3) When reporting this information to Covered California, such information shall be in a form that is mutually agreed upon by the Contractor and may include copies of reports used by 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 will 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.
- 4) Covered California and Contractor will collaboratively identify and evaluate the most effective programs for improving care for Enrollees and Covered California may require participation in specific collaboratives in future years.

1.07 Data Exchange with Providers

Covered California and Contractor recognize the critical role of sharing data across specialties and institutional boundaries as well as between health plans and contracted Providers in improving quality of care and successfully managing total costs of care.

- 1) Contractor will be required to report in its annual application for certification for negotiation purposes, 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 Primary Care clinicians when one of their empaneled patients is admitted to a hospital, a critical event that often occurs without the

knowledge of either the primary care or specialty Providers who have been managing the patient on an ambulatory basis.

- (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) Contractor will be required to describe its participation in statewide or regional initiatives that seek to make data exchange routine, including, but not limited to the following Health Information Exchanges:
- (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 payors 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 will be required to report in its annual application for certification for negotiation purposes, its participation in initiatives to support the aggregation of claims and clinical data. Contractor must 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 Payor Claims Database.

Examples include but are not limited to:

- (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 must provide such data to Covered California each year regardless of the 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 DHCS, for each Product Type for which it collects data in California. The timeline for Contractor's HEDIS and CAHPS quality data must be submitted at the same time as Contractor submits this to the NCQA Quality Compass and 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 oversight of Contractor's QHPs.

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 QHP 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 participation in the Exchange EAS Vendor in a manner consistent to that which Contractor currently provides to its major purchasers.

- 1) Disclosures to Enterprise Analytics Vendor:
 - (a) Covered California has entered into a contract with an Enterprise Analytics Vendor ("EAS Vendor") to support its oversight and management of health exchange. EAS Vendor 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 EAS Vendor with the data identified in the EAS Dataset on a monthly basis, which is attached as Appendix 1 to this Attachment 7. The parties may modify the data fields in Appendix 1 to Attachment 7 upon mutual agreement of the parties, and without formal amendment to this Agreement.
 - (b) To enable the submission of the EAS Dataset to EAS Vendor, Contractor has executed a Business Associate Agreement ("BAA"), and any other agreements that Contractor determines are required for the submission of the EAS Dataset to EAS Vendor. Contractor's obligation to provide any data to EAS Vendor is contingent on a BAA being in force at the time information is to be provided to EAS Vendor. Covered California may, upon request to Contractor, review such BAA and any other agreements between Contractor and EAS Vendor related to the submission of the EAS Dataset.

- 2) Disclosures to Covered California:
 - (a) EAS Vendor must protect the EAS Dataset submitted to it by Contractor pursuant to the BAA and any other agreements entered into with Contractor, applicable federal and state laws, rules and regulations, including the HIPAA Privacy and Security 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 data. Covered California shall not request any Personally Identifiable Health Information from EAS Vendor or attempt to use the de-identified data it receives from EAS Vendor to re-identify any person.

- 3) EAS Vendor Designation:
 - (a) Truven Health Analytics (“Truven”) is Covered California’s current EAS Vendor. In the event that Covered California terminates its contract with Truven during the term of this Agreement, Covered California shall provide notice to Contractor pursuant to section 12.3 of the Agreement. Any such termination of the agreement with Truven shall excuse any performance of Contractor under this section 2.02 effective on the date of termination of the agreement with Truven until a replacement EAS Vendor is designated.

- 4) Covered California is a Health Oversight Agency:
 - (a) Covered California continues to maintain that it operates as 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. At such time that Covered California receives technical assistance from the Office for Civil Rights, or otherwise receives guidance from the federal government, that reasonably confirms 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 as permitted by state and federal laws, in order for Covered California to perform its mandated oversight activities.

2.03 eValue8 Submission

For measurement year 2017, Contractor will be required to 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 in connection with the evaluation regarding any extension of this Agreement and the recertification process for subsequent years. The timing, nature and extent of such responses 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 Covered California-based business and any information that reflects California-based business when data on Covered California-specific business is not available. If applicable, Contractor must report data separately for HMO/POS, PPO and EPO product lines.

Contractor will be required to provide Covered California information regarding their quality improvement and delivery system reform efforts through annual reporting in the Covered California eValue8 Health Plan RFI in the annual application for certification. Such information in connection with the evaluation regarding any extension of this Agreement and the recertification process for subsequent years and may include copies of reports used by the Contractor for other purposes.

2.04 Data Measurement Specifications

The measurement specifications for data reporting requirements in this attachment are included in Appendix 2 to this attachment.

**ARTICLE 3
REDUCING HEALTH DISPARITIES AND ENSURING HEALTH EQUITY**

Mitigation of health disparities is central to the mission of Covered California, and the California Language Assistance Act adopted as SB 853 in 2003. In alignment with these principles, Covered California and Contractor recognize that promoting better health requires a focus on addressing health disparities and health equity. Covered California will require Contractor to track, trend and reduce health disparities with the phased approach outlined below.

3.01 Measuring Care to Address Health Equity

Contractor must track and trend quality measures by racial or ethnic group, or both, and by gender for the Contractor's full book of business, excluding Medicare.

- 1) Identification:
 - (a) By the end of 2019, Contractor must achieve 80 percent self-identification of racial/ethnic identity for Covered California enrollees.
 - (b) In the application for certification for 2017, Contractor will be required to report the percent of self-reported racial or ethnic identity for Covered California enrollees.
 - (c) Covered California and Contractor will negotiate annual targets to be reported in the applications for certification for 2018 and beyond.
 - (d) To the extent Contractor does not have self-reported information on racial or ethnic identity, or both, it shall use a standardized tool for proxy identification through the use of zip code and surname to fill any gaps in information.
- 2) Measures for Improvement:
 - (a) Disparities in care by racial and ethnic identity and by gender will be reported by QHP Issuers in the annual application for certification based on its Enrollees. The tool for proxy identification shall be used to supplement self-reported racial or ethnic identity. Contractor agrees to work with Covered California to provide comparison reporting for its other lines of business where comparative data can offer meaningful reference points.
 - (b) Measures selected for improvement beginning in plan year 2017 include Diabetes, Hypertension, Asthma (control plus hospital admission and ER visit rates) and Depression (HEDIS appropriate use of medications and all-cause ER utilization).
 - (c) Covered California will consider adding additional measures for plan year 2020 and beyond.

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 population health improvement requires development and adoption of systems for enhanced information exchange (see Section 1.07).

- 1) In the application for certification for 2017, Contractor reported baseline measurements from plan year 2015 on the measures listed in 3.01(2)(a) of this Attachment, based either on self-reported identity or on proxy identification on its Enrollees. 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, 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:

- 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 Contractor has applied for or received NCQA Certification, Contractor must provide this information with its annual application for certification. Covered California may publicly recognize this achievement and include it in information provided to consumers.

ARTICLE 4 PROMOTING DEVELOPMENT AND USE OF EFFECTIVE CARE MODELS

Covered California and Contractor agree that promoting the triple aim 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 agrees 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 agrees to design networks and payment models for Providers serving 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 ensuring that all enrollees have a Primary Care clinician.
- 2) Promotion of Patient-Centered Medical Homes (PCMH), which use a patient-centered, accessible, team-based approach to care delivery, 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

Contractor must ensure that all Enrollees either select or be provisionally assigned to a Primary Care clinician by January 1, 2017 or within 60 days of effectuation into the plan, whichever is sooner. If an Enrollee does not select a Primary Care clinician, Contractor must provisionally assign the Enrollee to a Primary Care clinician, inform the Enrollee of the assignment and provide the enrollee with an opportunity to select a different Primary Care clinician. When assigning a Primary Care clinician, Contractor shall use commercially reasonable efforts to assign a Primary Care clinician consistent with an Enrollee's stated gender, language, ethnic and cultural preferences, geographic accessibility, existing family member assignment, and any prior Primary Care clinician. Contractor will be required to report on this requirement annually in the application for certification for negotiation and evaluation purposes regarding any extension of this Agreement and the recertification process for subsequent years.

4.02 Patient-Centered Medical Homes

A growing body of evidence shows that advanced models of primary care, often called Patient-Centered Medical Homes (PCMH), greatly improve the care delivered to patients and support triple aim goals.

- 1) Contractor agrees to cooperate with Covered California 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 QHP Issuers 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 and other purchasers, such as CalPERS, the Department of Health Care Services (DHCS) and private employers, 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 limit the reporting burden on Providers.

- 2) Contractor will be required to describe in its application for certification for 2017, a payment strategy for adoption and progressive expansion among Providers caring for Enrollees, that creates a business case for Primary Care Providers to adopt accessible, data-driven, team-based care (alternatives to face-to-face visits and care provided by non-MDs) with accountability for meeting the goals of the triple aim, including total cost of care.
- 3) Contractor will be required to report in the application for certification for 2018:
 - (a) The number and percent of Covered California enrollees who obtain their primary care in a PCMH.
 - (b) Based on the data provided in the 2018 Application, Covered California will establish targets for 2019 for the percent of Covered California enrollees obtaining primary care in a PCMH based on national benchmarks, analysis of variation in California performance and best existing science of quality improvement and effective engagement of stakeholders.
 - (c) A baseline of the percent of Primary Care clinicians whose contracts for Covered California Enrollees are based on the payment strategy defined in 4.02(2) for primary care services.
 - (d) Methods for enrolling or attributing members to a PCMH including whether the plan engages in formal enrollment and or outreach to members based on a risk algorithm.
 - (e) How Contractor's payment to PCMH practices differs from those payments made to practices that have not met PCMH standards.
- 4) Contractor agrees to work with Covered California to provide comparison reporting for its other lines of business to compare performance and inform future Covered California requirements where comparative data can offer meaningful reference points. The non-Covered California lines of business data is to support contract negotiations in setting targets and requirements for Covered California-only business and any required data will be submitted as part of Contractor's annual application for certification, which will be used for negotiation and evaluation purposes regarding any extension of this Agreement and the recertification process for subsequent years.

4.03 Integrated Healthcare Models (IHM) or Accountable Care Organizations (ACO)

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) A system of population-based care coordinated across the continuum including multi-discipline physician practices, hospitals and ancillary Providers.
 - (b) Having 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) Having 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 in the Health and Safety Code and Insurance Code to ensure that Providers have the capacity to manage the risk.
- 2) Contractor must 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), including the number and percent of Enrollees who are managed under IHMs in its response to the annual application for certification, which will be used for negotiation and evaluation purposes regarding any extension of this Agreement and the recertification process for subsequent years..
- 3) Targets for 2017-2019 for the percentage of Enrollees who select or are attributed to IHMs will be established by Covered California based on national benchmarks, analysis of variation in California performance, best existing science of quality improvement, and effective engagement of stakeholders.

- 4) Contractor agrees to work with Covered California to provide comparison reporting for its other lines of business to compare performance and inform future Covered California requirements where comparative data can offer meaningful reference points. The non-Covered California lines of business data is to support contract negotiations in setting targets and requirements for Covered California-only business and any required data will be required as part of Contractor's annual application for certification.

4.04 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.

Contractor will be required to report in its annual application for certification on the strategies Contractor has implemented and its progress in:

- 1) Making behavioral health services available to Enrollees;
- 2) How it is integrating Behavioral Health Services with Medical Services; and
- 3) Reports must include documenting the percent of services provided under an integrated behavioral health-medical model for Enrollees and the reports should include the percent for Contractor's overall covered lives, where such information is useful for comparison purposes and informing future Covered California requirements. These reports should also include whether these models are implemented in association with PCMH and IHM models or are independently implemented and will be used for negotiation and evaluation purposes regarding any extension of this Agreement and the recertification process for subsequent years.

4.05 Telemedicine and Remote Monitoring

In the annual application for certification, Contractor will be required to report the extent to which the Contractor is supporting and using technology to assist in higher quality, accessible, patient-centered care, and the utilization for Enrollees on the number of unique patients and number of separate servicing provided for telemedicine and remote home monitoring. Contractor agrees to work with Covered California to provide comparison reporting for its other lines of business to compare performance and inform future requirements for the exchange where comparative data can offer meaningful reference points. Such information will be used for negotiation and evaluation purposes regarding any extension of this Agreement and the recertification process for subsequent years.

Reporting requirements will be met through eValue8 in the annual application for certification, but contractor may supplement such reports with data on the efficacy and impact of such utilization. These reports must 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 incrementally places at least six percent of reimbursement to hospitals for Contractor's Covered California business with each general acute care hospital at-risk or subject to a bonus payment for quality performance. At minimum, this methodology shall include two percent of reimbursement by January 1, 2019 with a plan for satisfying future increases in reimbursement, four percent of reimbursement by January 1, 2021 and six percent by January 1, 2023. Contractor may structure this strategy according to its own priorities such as:
 - (a) The extent to which the payments "at risk" take the form of bonuses, withholds or other penalties; or
 - (b) The selection of specific metrics upon which performance based payments are made may include, but are not limited to, Hospital Acquired Conditions (HACs), readmissions, or satisfaction measured through the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAPS), but Contractor must use standard measures commonly in use in hospitals and that are endorsed by the National Quality Forum – with the goal of limiting measurement burden on hospitals.
 - (c) Contract arrangements with hospitals that participate in Integrated Healthcare Models or Accountable Care Organizations, whether sponsored by the QHP Issuer or by Provider organizations, which include accountability or shared risk for total cost of care shall be considered to have met this requirement.
- 2) Because there is some evidence that readmissions may be influenced by social determinants beyond the control of the health care system or social supports that a hospital can provide at discharge, if Contractor includes readmissions as a measure under this provision, it shall not be the only measure. Additionally, Contractor must 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 it is implementing to support hospitals serving at-risk populations in achieving target performance. In alignment with CMS rules on payments to hospitals for inpatient hospital services, Critical Access Hospitals as defined by the Centers for Medicare and Medicaid, are excluded from this requirement. In addition, the following types of hospitals are excluded from this requirement:
 - a) Long Term Care hospitals
 - b) Inpatient Psychiatric hospitals

- c) Rehabilitation hospitals
- d) Children's hospitals

Contractor shall still be accountable for the quality of care and safety of Covered California members receiving care in the aforementioned hospitals. Implementation of this requirement may differ for integrated delivery systems and require alternative mechanisms for tying payment to performance.

- 3) Report in its annual application for certification for negotiation purposes, for Enrollees, the:
 - (a) Amount, structure and metrics for its 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 must be distinct from shared-risk and performance payments to hospitalization related to participation in IHMs as described in Article 4.03.

Additionally, Contractor agrees to work with Covered California to provide comparison reporting for Contractor's entire book of business where comparative data can offer meaningful reference points. Such information will be used for negotiation and evaluation purposes regarding any extension of this Agreement and the recertification process for subsequent years.

5.02 Hospital Patient Safety

- 1) Contractor agrees to work with Covered California to support and enhance acute general hospitals' efforts to promote safety for their patients. Exclusions for this requirement include CMS Critical Access Hospitals as defined by the Centers for Medicare and Medicaid. In addition, the following types of hospitals are excluded:
 - (a) Long Term Care hospitals
 - (b) Inpatient Psychiatric hospitals
 - (c) Rehabilitation hospitals
 - (d) Children's hospitals
- 2) Contractor will be required to report in its annual application for certification, baseline rates of specified 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 must 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. Such information will be used for negotiation and evaluation purposes regarding any extension of this Agreement and the recertification process for subsequent years.

- 3) Prior to the 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.
- 4) Covered California has identified an initial set of HACs for focus in 2017. Certain HACs may be substituted for others in the event that a common data source cannot be found. The decision to substitute HACs would be made transparently and collaboratively through the advisory process. The HACs that are currently the subject of the 2017 hospital safety initiatives are listed below:
 - (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 first-year focus on opioid overuse; and
 - (e) Clostridium difficile colitis (C. Diff) infection.
- 5) The subject HACs may be revised in future years. Covered California expects to include additional ADEs including hypoglycemia and inappropriate use of blood thinners as well as Sepsis Mortality at such time as the standardized CMS definition and measurement strategy has been tested and validated.
- 6) Covered California expects Contractor to only contract with hospitals that demonstrate they provide quality care and promote the safety of Enrollees. To meet this expectation, by year end 2017, Covered California will work with QHP Issuers and with California's hospitals to identify areas of "outlier poor performance" based on variation analysis of HAC rates. For contract year 2019, as detailed in Article 1.02(3), Contractors must 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 percent 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) Annually report in its application for certification 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. Such information will be used for negotiation and evaluation purposes regarding any extension of this Agreement and the recertification process for subsequent years.
- 3) Adopt a payment methodology progressively to include all contracted physicians and hospitals serving Enrollees, such that by 2019, payment is structured to support only medically necessary care and there is no financial incentive to perform C-sections. Contractor must report on its design and the percent of hospitals contracted under this model in its annual application for certification.
- 4) Covered California expects Contractor to only contract with hospitals that demonstrate they provide quality care and promote the safety of Enrollees. Beginning with the application for certification for 2019, As detailed in Article 1.02(3), Contractors must either exclude hospitals from networks serving Enrollees that are unable to achieve an NTSV C-section rate below 23.9 percent 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 percent 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 work collaboratively to achieve these objectives.

6.01 Health and Wellness Services ¶

Contractor shall ensure Enrollees have access to preventive health and wellness services. For the services described below, Contractor must identify Enrollees who are eligible, notify Enrollees of their availability, and report utilization.

- 1) Necessary preventive services appropriate for each Enrollee. Contractor must report utilization to Covered California on the number and percent of Enrollees who take advantage of their wellness benefit.
- 2) Tobacco cessation intervention, inclusive of evidenced-based counseling and appropriate pharmacotherapy, if applicable. Contractor must report to Covered California the number and percent of Enrollees who take advantage of the tobacco cessation benefit.
- 3) Obesity management, if applicable. Contractor must report to Covered California the number and percent of its Enrollees who take advantage of the obesity benefit.
- 4) To ensure the Enrollee health and wellness process is supported, Contractor must report on its:
 - (a) Health and wellness communication processes delivered to its Enrollees and applicable Participating Providers, that take into account cultural and linguistic diversity; and
 - (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.

Contractor will be required to report on each of these four service categories in its annual application for certification. Additionally, Contractor agrees to work with Covered California to provide comparison reporting for its other lines of business to compare performance and inform future requirements for the exchange where comparative data can offer meaningful reference points. The non-exchange line of business data is to support contract negotiations in setting targets and requirements for exchange-only business and any required data will be submitted as part of Contractor's annual application for certification.

For each of the four service categories described above, Covered California will establish targets for 2018 and annual milestones thereafter for the percent of the population that uses annual preventive visits based on national benchmarks, analysis of variation in California performance, best existing science of quality improvement, and effective engagement of stakeholders

6.02 Community Health and Wellness Promotion ¶

Covered California and Contractor recognize that promoting better health for 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. 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 will be required to report annually in its application for certification the initiatives, programs and projects that it supports that promote wellness and better community health for Enrollees, and is encouraged to report on such initiatives for Contractor's overall population. Such reports must include available results of evaluations of these community programs for Enrollees, including clinical or other health impacts and efficacy and will be used for negotiation and evaluation purposes regarding any extension of this Agreement and the recertification process for subsequent years.

Such programs may include:

- 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; and
- 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, use, and protect from disclosure individual information about 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 in all threshold languages to all Enrollees over the age of 18, including those Enrollees that have previously completed such an assessment. If a Health Assessment tool is used, Contractor should select a tool that adequately evaluates Enrollees current health status and provides a mechanism to conduct ongoing monitoring for future intervention(s). In addition, Health Assessments should advise policyholders at the outset on how the information collected may be used, and explain that the member is opting in to receive information from the plan, and that participating in the assessment is optional.

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 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 Enrollees' health status, which may include its process for identifying individuals who show a decline in health status, and referral of such 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 Enrollees who are identified through their selected mechanism and the results of their referral to receive additional services.

6.05 Supporting At-Risk Enrollees Requiring Transition ¶

Contractor shall have an evaluation and transition plan in place for the Enrollees transitioning into or from employer-sponsored insurance, 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 must 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 processes 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 Enrollees with existing and newly diagnosed chronic conditions, including, diabetes, asthma, heart disease, or hypertension, 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 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 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 Contractor's maintained Enrollee health profile;
- 5) Process for sharing registries of Enrollees with their identified risk, as permitted by state and federal law, with appropriate accountable Providers, especially the enrollee's PCP.
- 6) Mechanisms to evaluate access within the 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 Enrollee intervention and care management. Contractor agrees to provide Covered California with a documented plan and include "tools" and strategies to supplement or expand care management and Provider network capabilities, including an expansion or reconfiguration of specialties or health care professionals to meet clinical needs of At-Risk Enrollees;
- 8) Data on number of Enrollees 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's mission and naturally promotes the Triple Aim by supporting decisions consistent with the Enrollee's values and preferences and fostering consumer 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 have reported for negotiation and certification purposes, its planned approach to providing healthcare shopping cost and quality information available to all Enrollees. Covered California does not require using a specific form or format and recognizes that the timeline and expectations will differ, based on variables such as Contractor's membership size and current tool offerings. Regardless of how the requirement is fulfilled, the common elements at the end point of each Contractor planned approach must include:
 - (a) Cost information:
 - i. That enables Enrollees to understand their exposure to out-of-pocket costs based on their benefit design, including real time information on member accumulation toward deductibles, when applicable, and out of pocket maximums. Health Savings Account (HSA) user information shall include account deposit and withdrawal/payment amounts.
 - ii. That enables Enrollees to understand Provider-specific consumer cost shares for prescription drugs and for care delivered in the inpatient, outpatient, and ambulatory surgery/facility settings. Such information must include the facility name, address, and other contact information and be based on the contracting rates to give the Enrollee estimates of out of pocket costs that are as accurate as possible.
 - iii. Commonly used service information should be organized in ways that are useful and meaningful for consumers to understand.
 - (b) Quality information:
 - i. That enables Enrollees to compare Providers based on quality performance in selecting a Primary Care clinician or common elective specialty and hospital Providers.
 - ii. That is based on quality measurement consistent with nationally-endorsed quality information in accordance with the principles of the

Patient Charter for Physician Performance Measurement.

- iii. That, as an interim step prior to integrating quality measurement into Provider chooser tools, 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 must recognize California hospitals that have achieved target rates for 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 includes accumulations of expenses applicable to deductible and out-of-pocket maximums.
 - (d) Contractor agrees to monitor care provided out of network to ensure that consumers understand that their cost share will be higher and are choosing care out of network intentionally.
 - (e) If Contractor enrollment exceeds 100,000 for Covered California business, the cost and quality information shall be provided through an online tool easily accessible across a variety of platforms and made available by 2018. If Contractor enrollment is under 100,000 for Covered California business, the information may be provided by alternative means such as a call center.
- 2) Contractor will be required in its annual application for certification to:
- (a) Report the number and percent of unique Enrollees for each of the consumer tools offered for the reporting period of the plan year.
 - (b) Report 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.

- (c) Provide access and log-in credentials for Covered California staff per mutually agreeable terms to safeguard Contractor proprietary information and services.

Contractor agrees to work with Covered California to provide comparison reporting for its other lines of business to compare performance and inform future requirements for the exchange where comparative data can offer meaningful reference points. The non-exchange line of business data is to support contract negotiations in setting targets and requirements for exchange-only business and any required data will be submitted as part of Contractor's annual application for certification

7.02 Enrollee Personalized Health Record Information ¶

- 1) In its Application for Certification for 2017, Contractor will have reported for negotiation and certification purposes, the extent to which Enrollees can easily access personal health information or have reported 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, clinical case notes, and other information used to make decisions about individuals.
- 3) Covered California will establish targets for 2019 and annual milestones thereafter for Enrollee use of personal health information based on national benchmarks, analysis of variation in California performance, 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.

7.03. 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 Enrollees 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 will be required to report in its annual application for certification specific information regarding the number of Enrollees who have accessed consumer information 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 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 will be required to report in its annual application for certification 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 will be required to report in its annual application for certification participation in these programs and their results, including clinical, patient experience and costs impacts.
- 4) These reports will be used for negotiation and evaluation purposes regarding any extension of this Agreement and the recertification process for subsequent years.

7.04 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.

**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 Enrollees with identified chronic conditions. To the extent Contractor implements such a program 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 annually.

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 must include those payments to hospitals and physicians that are linked to quality metrics, performance, costs and value measures and must 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 the required payment strategies above, Contractor will be required to report in its annual application for certification an inventory and evaluation of the impact of other value-based payment models it is implementing including, but not limited to:
 - (a) Direct participation or alignment with CMMI innovative payment models such as the Oncology or Joint Replacement model; and
 - (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 Enrollees. Contractor agrees to share with Covered California, the results of programs that may focus on high cost regions or those with the greatest cost variation(s). These programs may include payment bundling pilots for specific procedures where wide cost variations exist.

8.04 Payment Reform and Data Submission

- 1) Contractor agrees to provide information to Covered California pursuant to 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) Contractor must annually 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.

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 the accrediting agency as required under 45 C.F.R. § 156.275.
- 2) Contractor shall be currently accredited and maintain its NCQA, URAC or AAAHC 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 change and must provide Covered California with all corrective action(s). Contractor will implement strategies to raise 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 CAPs, Contractor shall provide a written report to Covered California on at least a quarterly basis regarding the status and progress of the submitted CAP. 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 this Agreement, suspend enrollment in Contractor's QHPs or avail itself of any other remedies in this Agreement, 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 payor 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 - 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 clinician. Covered California does not require that Primary Care clinicians serve as a “gatekeeper” or the source of referral and access to specialty care. Covered California recognizes Internal Medicine, Pediatrics and Family Medicine as primary care specialties.

Population Health Management - A management process that strives to address health needs at all points along the continuum of health and wellbeing, through participation of, engagement with and targeted interventions for the population. The goal of a Population Health Management program is to maintain and/or improve the physical and psychosocial wellbeing of individuals through cost-effective and tailored health solutions.

Preventive Health and Wellness Services - The provision of specified preventive and wellness services and chronic disease management services, including preventive care, screening and immunizations, set forth under Section 1302 of the Affordable Care Act (42 U.S.C. Section 18022) under the Section 2713 of the Affordable Care Act (42 U.S.C. Section 300gg-13), to the extent that such services are required under the California Affordable Care Act.

Reference Pricing - A payor contracting, network management and enrollee information process that identifies and differentially promotes delivery system options for care based on transparent display of comparative costs for identical services or procedures, typically after each Provider has passed a quality assessment screen. In some cases, value pricing will identify the individual enrollee’s out-of-pocket costs accounting for plan design and deductible status. While quality is incorporated in the process, typically there is no differentiation based on comparative quality once a threshold performance level is achieved.

Remote Patient Monitoring - A technology or set of technologies to enable monitoring of patients outside of conventional clinical settings (e.g. in the home), which may increase access to care and decrease healthcare delivery costs.

Reward Based Consumer Incentive Program - (aka: Value-Based Insurance Design) individualizes the benefits and claims adjudication to the specific clinical conditions of each high risk member and to reward participation in appropriate disease management & wellness programs. Positive Consumer Incentive

programs help align employee incentives with the use of high-value services and medications, offering an opportunity for quality improvement, cost savings and reduction in unnecessary and ineffective care.

Shared Decision Making - The process of making decisions regarding health care diagnosis and treatment that are shared by doctors and patients, informed by the best evidence available and weighted according to the specific characteristics and values of the patient. Shared decision making combines the measurement of patient preferences with evidence-based practice.

Team Care - A plan for patient care that is based on philosophy in which groups of professional and non-professional personnel work together and share the work to identify, plan, implement and evaluate comprehensive client-centered care. The key concept is a group that works together toward a common goal, providing qualitative comprehensive care. The team care concept has its roots in team nursing concepts developed in the 1950's.

Telemedicine - Professional services given to a patient through an interactive telecommunications system by a practitioner at a distant site. Telemedicine seeks to improve a patient's health by permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site. This electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment.

Value Pricing - A payor contracting, network management and enrollee information process that identifies and differentially promotes delivery system options for care that provide better value through the identification and transparent display of comparative total cost, out-of-pocket cost for enrollees and standardized quality performance to allow for informed consumer choice and Provider referrals for individual services and bundles of services.

Value-Based Reimbursement - Payment models that rewards physicians and Providers for taking a broader, more active role in the management of patient health, and provides for a reimbursement rate that reflects results and quality instead of solely for specific visits or procedures.