

## **Covered California: Request for Input to Inform Refreshing Expectations Designed to Promote Accountability and Delivery System Improvements**

As part of our contracts with Qualified Health Plan (QHP) Issuers, Covered California has set forth specific requirements related to improving quality, lowering costs, promoting better health and reducing health care disparities, both for our enrolled population and more broadly in the health care system. Covered California has focused on prices, benefits, networks, quality, and other factors that assure those with coverage through Covered California get the right care at the right time and that promote delivery system reforms to improve health care for all Californians. Central to Covered California's strategy has been to align its expectations with actions of other payers and purchasers and to anchor its policies in the best evidence available.

Covered California set forth our standards and strategy for quality improvement and delivery system reform in our QHP Issuer Model Contract, specifically within the "Quality, Network Management, Delivery System Standards and Improvement Strategy" section, also known as "Attachment 7" (<https://hbex.coveredca.com/insurance-companies/PDFs/QHP-Model-Contract-2017-2019-Amended-for-2017-and-2018.pdf>).

Covered California is in the process of revising its quality improvement and delivery system reform standards and requirements. To inform Covered California's efforts, we are conducting independent research and surveying the efforts of other purchasers. In addition, we are seeking input from health plans, providers, advocates, experts and other stakeholders as we propose revisions to contractual terms that take effect in plan year 2021. For additional background on Covered California's Attachment 7 refresh process, please see: *Covered California – Refreshing Contractual Expectations Designed to Promote Accountability and Delivery System Improvements* (<https://board.coveredca.com/meetings/2019/01-17%20Meeting/Refreshing-Contractual-Expectations.pdf>).

Covered California welcomes written feedback on its current efforts and how it might improve them in the coming years. Please provide comments in any form, but if possible please respond to the questions and topic areas detailed on the pages that follow. **Please insert your responses to the questions directly in this document, adding more space under each question as needed. Save the file with your organization's name and return to [QHP@covered.ca.gov](mailto:QHP@covered.ca.gov) by February 15, 2019.**

This questionnaire solicits comments, observations and suggestions in the following areas:

- Covered California's *Guiding Principles for Promoting Better Care and Delivery Reform*
- *Current QHP Issuer Contract Terms: Quality, Network Management, Delivery System Standards and Improvement Strategy*
- *Contractual Expectations Domains and Strategies: Right Care/Accountability and Delivery System Improvement*
- *Enabling Factors that Promote Delivery Reform*

We will not share individual responses, though we may share aggregated themes.

**Name:** Conrad Amenta, Director, Health Policy  
**Organization:** California Academy of Family Physicians  
**Contact E-Mail:** [camenta@familydocs.org](mailto:camenta@familydocs.org)  
**Phone:** 415-345-8668

## **Covered California's Guiding Principles for Promoting Better Care and Delivery Reform**

The following are proposed guiding principles for Covered California's efforts to assure its contracted QHP Issuers are held accountable for providing the right care and are promoting needed improvements in the delivery system.

1. Driven by the desire to meet two complementary and overlapping objectives:
  - a. **Right Care/Accountability:** Ensure our members receive the right care, at the right time, in the right setting, at the right price.
  - b. **Delivery System Improvement:** Promoting value-enhancing strategies that have the potential to reform the delivery system in the near and long term.
2. Seek to improve the health of the population, improve the experience of care, reduce the cost of care, reduce administrative burden, and reduce health care disparities.
3. Success will be assessed by outcomes, measured at the most appropriate level, in preference to adoption of specific strategies.
4. We will promote alignment with other purchasers as much as possible.
5. Consumers will have access to networks offered through the contracted QHP Issuers that are based on readily available access to high quality and efficient providers.
6. Enrollees have the tools needed to be active consumers including both provider selection and shared clinical decision making.
7. Payment will increasingly be aligned with value and proven delivery models.
8. Variation in the delivery of quality care will be minimized by assuring that each provider meets minimum standards.

**Please note your agreement or disagreement with the guiding principles and provide any questions, concerns, or suggested additions you may have.**

CAFP's Health Care System Policy, which outlines principles of reform ([http://www.familydocs.org/f/2017-07/17.ADV\\_HealthSystemReformPolicy.7.31.17.pdf](http://www.familydocs.org/f/2017-07/17.ADV_HealthSystemReformPolicy.7.31.17.pdf)) stipulates that the Academy will assess proposed reforms in terms of their contributions to universality, comprehensiveness, timeliness, quality, and sustainability. These principles are broadly in line with those articulated above.

However, we have received troubling input from our members regarding limited networks and access challenges faced by patients. This can take the form of restrictions placed by hospitals and health plans on family physicians. CAFPP encourages Covered California to take a more aggressive approach to ensuring access to care for patients by holding health plans more accountable for creating and maintaining robust networks of health care providers empowered to practice at the top of their license.

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### **Current QHP Issuer Contract Terms: Quality, Network Management, Delivery System Standards and Improvement Strategy (Attachment 7 – 2017-2020)**

In the current Attachment 7 of the QHP Issuer Contract, Covered California aims to promote care that reduces excessive costs, minimizes unpredictable quality and reduces inefficiencies of the current system (<https://hbex.coveredca.com/insurance-companies/PDFs/QHP-Model-Contract-2017-2019-Amended-for-2017-and-2018.pdf>). Covered California also expects all contracted issuers to balance the need for provider accountability and transparency with the need to reduce administrative burden on providers. The requirements within Attachment 7 consist of the following focus areas:

- Article 1: Improving Care, Promoting Better Health and Lowering Costs: Ensuring networks are based on value, addressing high cost providers and high cost pharmaceuticals
- Article 2: Provision and Use of Data and Information for Quality of Care: Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers & Systems (CAHPS), Quality Rating System (QRS) reporting and IBM Watson data submissions
- Article 3: Reducing Health Disparities and Ensuring Health Equity: Increasing self-identification of race or ethnicity and measuring and narrowing disparities
- Article 4: Promoting Development and Use of Effective Care Models: Primary care provider (PCP) matching, promotion of patient-centered medical homes (PCMH) and integrated healthcare models (IHMs), supporting primary care through value-based payment, increasing mental and behavioral health integration with medical care, and using telehealth
- Article 5: Hospital Quality and Safety: Payment models to increase value, reducing hospital acquired conditions (HACs) and unnecessary C-Sections
- Article 6: Population Health: Preventive Health, Wellness and At-Risk Enrollee Support: Wellness services, community health, supporting at-risk enrollees, and diabetes prevention
- Article 7: Patient-Centered Information and Support: Price and quality transparency for enrollees, shared decision making, reducing overuse, and using the statewide provider directory
- Article 8: Payment Incentives to Promote Higher Value Care: Increasing value-based reimbursement
- Article 9: Accreditation

**Please provide any overarching or specific feedback on the current Attachment 7 that we should consider as we approach the revision.**

CAFP believes the Patient-Centered Medical Home (PCMH) model of care represents a vital opportunity to further team-based primary and preventative care. We also strongly believe implementing appropriate, risk-adjusted prospective payment will incentivize providers to implement strategies to achieve many of the Articles described above, including pursuing PCMH accreditation. Some contracted issuers have not reviewed or updated their primary care payment rates in several years or meaningfully piloted prospective payment that effectively adjusts for patient population. Resources to support and maintain PCMH transformation have not emerged, and primary care

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physicians who have opened PCMH-accredited practices are in danger of losing the progress they have made to improve patient care.

We urge Covered California to require contracted issuers to:

- 1) meaningfully explore implementation of risk-adjusted prospective payment in order to create the underlying conditions necessary to achieve the Articles described above.
- 2) contract with a minimum proportion of PCMH-accredited practices.

We urge Covered California to educate contracted issuers on the benefits of the PCMH. CAFPP would be pleased to contribute to such discussions. In 2010, CAFPP joined the self-insured Fresno Unified School District/Joint Health Management Board in supporting the creation of a local PCMH. The 2014 final report, including infographics about cost savings and quality gains, is available here:

<http://www.familydocs.org/f/FresnoPCMHPilotReport2014.pdf>

A video about the project was also produced, which you can find here:

<https://cafponcloud.egnyte.com/dl/Xr7lqufDbR>

The American Academy of Family Physicians (AAFP) has produced an Advanced Alternative Payment Model (AAPM) (<https://www.aafp.org/dam/AAFP/documents/advocacy/payment/apms/PR-PTAC-APC-APM-41417.pdf>), currently piloted by the Centers of Medicare and Medicaid Services (CMS). The AAPM is designed to emphasize value over volume. We urge Covered California to assess this payment model for its appropriateness in a California context and explore the possibility of piloting it with contracted issuers.

AAFP has also produced a comprehensive 'Principles of Administrative Simplification,' (<https://www.aafp.org/about/policies/all/principles-adminsimplification.html>) which identifies opportunities to reduce administrative burden on physicians and other providers while maintaining accountability, transparency, and quality of care. CAFPP strongly recommends that all contracted issuers review all existing administrative requirements, especially the use of prior authorization and lack of standardization in quality metrics, before instituting new administrative tasks designed to achieve the Articles outlined above. Covered California could play a critical role in bringing health plans, pharmacies and providers together to reduce the overwhelming administrative obstacles in health care that play no role in improving patient care.

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## Contractual Expectation Domains and Strategies

Covered California is considering reorganizing the initiatives and strategies addressed in Attachment 7 into two broad domains with a total of 13 distinct individual strategies:

*Right Care/Accountability:* We are looking for more transparency into issuer oversight of care delivery, what kinds of problems are being found and how are they being addressed.

1. Chronic Care, General Health Care, and Access
2. Hospital Care
3. Major/Complex Care – Identification of High-Risk or High-Cost Individuals and Getting them the Right Care
4. Mental/Behavioral Health and Substance Use Disorder Treatment
5. Health Equity: Disparities in Healthcare
6. Preventive Services
7. Pharmacy Management

*Delivery System Improvements:* With these longer term efforts, we seek to redesign care delivery to be more effective in meeting the triple aim, reducing administrative burden, and reducing disparities.

8. Networks Based on Value (narrow or limited physician, hospital, and ancillary provider networks, Centers of Excellence)
9. Promotion of Effective Primary Care (PCP matching or assignment, patient-centered medical home or other models)
10. Promotion of Integrated Healthcare Models (IHMs) and Accountable Care Organizations (ACOs)
11. Alternate Sites of Care Delivery (e.g., telehealth, alternatives to emergency room use, retail clinics)
12. Consumer and Patient Engagement (e.g., quality and cost tools, personal health record, patient shared decision-making)
13. Population-based and Community Health Promotion Beyond Enrolled Population

***NOTE: High level questions for input follow – for a detailed outline of questions and some specific issues regarding particular strategies see the Addendum: Detailed Questions – Contractual Expectation Domains and Strategies at the end of this survey.***

### **A. Please comment on these domains as a way to reorganize Attachment 7.**

While the areas of focus are positive and reflect the needs of patients in California, the degree to which ‘Chronic Care,’ ‘Major/Complex Care’ and ‘Preventative Services’ are distinct from one another may be unclear. We urge Covered California to be cautious in pursuing each of these initiatives and strategies in a way that may contribute to fragmented care or variability in support for improvements. Instead, we urge Covered California to focus on those Delivery System Improvements that contribute to the underlying conditions that make possible ‘Right Care/Accountability.’ As mentioned in our comments for the previous section of this document, movement to prospective payment and support for PCMH-accredited practices, which can be included under #8: ‘Networks Based on Value,’ will contribute to the necessary conditions from each improvement will flow.

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Additionally, it is unclear the degree to which Mental/Behavioral Health and Substance Use Disorder Treatment should be combined.

### B. Have we missed any strategies that should be considered or included in our domains?

As mentioned above, Mental/Behavioral Health and Substance Use Disorder Treatment may be better treated as distinct strategies / initiatives given the distinct payment models, degree of integration, professionals involved and collaborative care models employed in addressing each, as well as the distinctness of severity across patient populations.

Additionally, Covered California should consider the degree to which contracted issuers should be required to publicly report the proportion of their revenue dedicated to primary care. Legislative precedent for these measures exists in other states, primarily Oregon and Rhode Island. The California legislature recently allocated funds to establish an 'all-payer claims database,' to be housed in the Office of Statewide Health Planning and Development. This database will be instrumental in enabling contracted issuers to track, aggregate and report their primary care spending. Research performed in other states, primarily Rhode Island, has indicated that information about a contracted issuer's primary care spending can be collected on a voluntary basis and just the act of comparing and reporting a contracted issuer's primary care spend has the potential to increase over time the proportion of revenue dedicated to primary care. (<https://www.milbank.org/publications/standardizing-measurement-commercial-health-plan-primary-care-spending/>)

### C. Please provide any comments, observations or recommendations with regard to the 13 strategies articulated. Where relevant, please refer to and/or attach any relevant supporting or reference material.

### D. Recognizing these strategies are all "priority" elements, we request your ranking of the 13 strategies from high to low priority for Covered California, looking ahead 2-5 years. If applicable, please include any other strategies identified in the previous question.

Strategy	Your Ranking for Covered California's Prioritization 2021-2023 Contract
	Rank from Highest to Lowest (1 to 13)
Chronic Care, General Health Care, and Access	4
Hospital Care	12
Major/Complex Care	13
Mental/Behavioral Health and Substance Use Disorder Treatment	10
Health Equity: Disparities in Healthcare	6
Preventive Services	3
Pharmacy Management	11
Networks Based on Value	2
Promotion of Effective Primary Care	1
Promotion of Integrated Healthcare Models and Accountable Care Organizations	5

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Alternate Sites of Care Delivery	9
Consumer and Patient Engagement	8
Population-based and Community Health Promotion Beyond Enrolled Population	7
Other:	
Other:	
Other:	

**E. Are there particularly important challenges you foresee with respect to Covered California promoting improvements in the domains and strategies identified and what could Covered California do to address them?**

As mentioned above, the risk in addressing each of these strategies and initiatives as distinct projects is that it may contribute to fragmentation of care and variability in support. Covered California may be better served by focusing on the fundamental aspects of prospective payment, establishing minimum thresholds of PCMH-accredited practices, and requiring contracted issuers to report the proportion of their revenue dedicated to primary care, as these contribute to the conditions from each the sought improvements will be derived.

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### Enabling Factors that Promote Delivery Reform

Covered California's contractual expectations have included requiring or encouraging contracted QHP Issuers to engage in a range of "enabling factors" that may support the success of particular strategies. Covered California welcomes comments on its potential emphasis/focus on the enabling factors and their potential continued or changed inclusion as a contract requirement.

1. Payment Models (e.g., higher or lower payment, risk-based payments, bonuses or withholds; which may include payment that directly supports greater integration and coordination including budgets to support team-based care and payments that reflect include accountability across specialist and institutional boundaries)
2. Channeling of Members or Patients (e.g. exclusive networks or preferential)
3. Measurement and Data to Inform Impact
4. Data Exchange to Support Improved Clinical Care and Care Coordination
5. Provider-level Coaching or Quality Improvement Efforts to Support the Strategy
6. Alignment Across Payors or Purchasers to Provide Better "Signal Strength" to Provider
7. Benefit Design or Other Consumer-Facing Incentives
8. Public Reporting, Consumer Tools or other Consumer/Patient-Engagement Strategies

#### **A. Please provide any comments on which of these enabling strategies you believe to be most important for Covered California to reflect as a contractual expectation of its QHP Issuers and why?**

CAFP strongly believes aggressively piloting and promoting the PCMH and prospective payment that supports practices achieving PCMH accreditation is key to improving coordination and access to care. For that reason, Payment Models vastly outweigh the other options in terms of potential to transform care delivery.

As stated above, we urge Covered California to require contracted issuer to:

- 1) meaningfully explore implementation of risk-adjusted prospective payment in order to create the underlying conditions necessary to achieve the Articles described above.
- 2) contract with a minimum proportion of PCMH-accredited practices.

We urge Covered California to educate contracted issuers on the benefits of the PCMH. CAFPP would be pleased to contribute to such discussions. In 2010, CAFPP joined the self-insured Fresno Unified School District/Joint Health Management Board in supporting a local PCMH. The 2014 final report, including infographics about cost savings and quality gains, available here:

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The American Academy of Family Physicians (AAFP) has produced an Advanced Alternative Payment Model (AAPM) (<https://www.aafp.org/dam/AAFP/documents/advocacy/payment/apms/PR-PTAC-APC-APM-41417.pdf>), which is currently being piloted by the Centers of Medicare and Medicaid Services (CMS). The AAPM is designed to emphasize value over volume. We urge Covered California to assess this payment model for its appropriateness in a California context and explore the possibility of piloting it with able contracted issuers.

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- B. Given the importance of Covered California aligning with other purchasers, are there particular enabling factors you believe are more important to be promoted as common goals and standards across purchasers?**

Harmonization of quality indicators for providers across purchasers and across contracted issuers will be an important contributor to reduction of administrative burden.

- C. Have we missed any enabling factors that should be considered?**

CAFP has heard from a number of our family physician members who have indicated that they have been prevented from practicing obstetric, pediatric and other services as a result of hospital by-laws and health plan policies that reduce or restrict privileges without regard to quality of care. Because California is experiencing an acute shortage of providers in the primary care workforce, it is essential that we enable the workforce that we have to practice in a way that reflects their education and training. CAFP would be pleased to share with Covered California information about how family physicians have been constrained from practicing full-spectrum family medicine and to connect you with members to describe the circumstances under which their practices have been constrained. We urge Covered California to review with contracted issuers the terms of hospital by-laws and plan policies that can and have resulted in constraints on the practice of medicine by qualified family physicians.

- D. Please provide any comments, observations or recommendations with regard to the enabling factors articulated. Where relevant, please refer to and/or attach any relevant supporting or reference material.**

## **Addendum: Detailed Questions -- Contractual Expectation Domains and Strategies**

In this section, please provide any comments or suggestions for us to consider in thinking about each strategy. If you have no comments or considerations for a strategy, please feel free to leave blank. Where relevant, please refer to and/or attach any relevant supporting or reference material.

### **1. Chronic Care, General Health Care, and Access**

- a. General comments/observations on this strategy for Covered California as an area of focus:

### **2. Hospital Care**

- a. General comments/observations on this strategy for Covered California as an area of focus:
- b. We believe improvements have been made in maternity care and hospital safety. Given these improvements, should Covered California continue and broaden this effort to focus on additional hospital quality issues? If so, please specify your suggested areas of focus.
- c. Should Covered California change its focus to address other hospital issues (e.g., total cost of care)?

### **3. Major/Complex Care – Identification of High-Risk or High-Cost Individuals and Getting them the Right Care**

- a. General comments/observations on this strategy for Covered California as an area of focus:

### **4. Mental/Behavioral Health and Substance Use Disorder Treatment**

- a. General comments/observations on this strategy for Covered California as an area of focus:
- b. What should Covered California focus on to:
  - i. Improve mental health and substance use access and treatment?
  - ii. Monitor access, treatment effectiveness, or outcomes for members needing behavioral health or substance use disorder services?

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### **5. Health Equity: Disparities in Healthcare**

- a. General comments/observations on this strategy for Covered California as an area of focus:
- b. To what extent should Covered California and contracted issuers move or shift emphasis toward addressing “upstream” determinants of health? What areas do you think are relevant to specific attention on the part of issuers and providers?
- c. Does aligning population health efforts for issuers working in similar geographic areas or within provider or other systems warrant additional focus? Are there important steps or milestones for common work for diverse issuers throughout the state of California or should efforts be focused within/by each issuer?

### **6. Preventive Services**

- a. General comments/observations on this strategy for Covered California as an area of focus:

### **7. Pharmacy Management**

- a. General comments/observations on this strategy for Covered California as an area of focus:
- b. Should Covered California, perhaps working with other state purchasers and issuers, explore adopting coordinated procurement strategies?

### **8. Networks Based on Value**

- a. General comments/observations on this strategy for Covered California as an area of focus:
- b. Should Covered California consider addressing provider concentration and expensive providers? If so, what strategies should be considered?

### **9. Promotion of Effective Primary Care**

- a. General comments/observations on this strategy for Covered California as an area of focus:

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**10. Promotion of Integrated Healthcare Models and Accountable Care Organizations**

- a. General comments/observations on this strategy for Covered California as an area of focus:

**11. Alternate Sites of Care Delivery**

- a. General comments/observations on this strategy for Covered California as an area of focus:

**12. Consumer and Patient Engagement**

- a. General comments/observations on this strategy for Covered California as an area of focus:
  
- b. Should Covered California explore requirements and/or standards for consumer engagement?

**13. Population-based and Community Health Promotion Beyond Enrolled Population**

- a. General comments/observations on this strategy for Covered California as an area of focus:
  
- b. Should Covered California, perhaps working with other state purchasers and issuers, explore adopting coordinated population-based or community health interventions?
  
- c. Should Covered California explore requirements and/or standards for community health promotion?