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Submitted electronically via qisupport@ahrq.hhs.gov

1. Current Initiatives: Describe any ongoing initiatives related to diagnostic excellence, diagnostic safety, or diagnostic quality within your organization.

Covered California is the state's health insurance marketplace under the Affordable Care Act with a mission to reduce the number of uninsured Californians, improve health care quality, lower costs and reduce health disparities through an innovative, competitive marketplace. Covered California is an active purchaser, ensuring access to equitable, high-quality care for over 1.9 million Californians, facilitating enrollment in 15 Qualified Health Plans (QHP) including HMO, PPO, and EPO products across 12 issuers.

Covered California holds QHP issuers responsible for delivering high quality, equitable care through the 2023-2025 Qualified Health Plan (QHP) Issuer Contract, which includes financial accountability programs that focus on quality and health equity. For example, through the "25/2/2" program, we may remove health plans from the exchange for persistent, low performance on a focused set of Quality Rating System (QRS) measures. Our Quality Transformation Initiative (QTI) holds health plans accountable to a national performance benchmark. Health plans who don't meet benchmarks for a set of clinically important measures aligned with other California public purchasers are fined if improvements are not made. In its inaugural year, the QTI program led to substantial improvement in health plan performance in diabetes and blood pressure care, as well as colorectal cancer screening rates. Additionally, we hold health plans accountable using public reporting through our annually published Plan Performance Reports, which detail a health plan's performance based on cost, quality, and disparities reduction.

2. Measures Used for Diagnostic: Provide details on the measures you are currently using to assess diagnostic excellence and how they are utilized.

In addition to the measures included in our 2023-2025 QHP Issuer Contract, we are proposing to include the Continuity of Care Index in our 2026-2028 QHP Issuer Contract. The index is a measure related to diagnostic excellence for its capacity to support trust, develop longitudinal efforts to decipher symptoms, and develop longitudinal knowledge of patients' health, social, family, and life risk factors. Furthermore, there is a robust set of national and international evidence through peer-

reviewed publications that continuity of care with a primary care provider (PCP) reduces acute care utilization, reduces mortality, and reduces overall healthcare costs, while improving patients' overall experience. This index is calculated for each patient based on their visits to PCPs, with scores ranging from 0 (completely disjointed care) to 1 (complete continuity with the same PCP). The data sources include electronic health records (EHRs) and administrative claims data. We map data to standardized concepts using the Observational Medical Outcomes Partnership (OMOP) Common Data Model.

For organizations not currently measuring diagnostic excellence, the Continuity of Care Index could be beneficial. This measure provides insights into the continuity of care provided by PCPs and its impact on patient outcomes. Our organization is a public purchaser, and we believe that similar measures could be useful for other healthcare systems, state/local health departments, and professional societies.

4. Standardized Measures: Indicate your likelihood of using standardized measures with national benchmarks if made available by AHRQ.

Given our position as a public purchaser, it is critical that we adopt standardized, validated, and evidence-based measures. For our health plan accountability programs, we look to national benchmarks to set the standard for high quality.

5. Comments on AHRQ's Diagnostic Excellence-Related Measures: Offer feedback on the diagnostic excellence-related measures proposed by AHRQ.

While we appreciate the inclusion of measures that focus on clinical excellence at the point of care, the implementation of these measures may be challenging or ineffective given system and EHR limitations. For example, for Measure 1A/B "Missed red flag SaferDx e-measures" 1 and 2, 30-60 days may be too short of a window to capture the appropriate downstream actions. Additionally, in the setting of trainee-based clinics that provide a large portion of care in certain safety net systems, the workflows and pathways for referral may suffer from increasing variability. Many referrals may happen outside of the EHR or in alternative documentation pathways (for example, a free-text addendum to a note).

In the case of Measure 5, "Rate of Timely Follow-up on Abnormal Stool-based tests for CRC," the satisfying diagnostic evaluation for this measure should be restricted to high-quality colonoscopy because flexible sigmoidoscopy does not provide access to the entire colon, and CT colonography is only useful for visualizing abnormalities of the large intestinal lumen and not for tissue diagnosis. More generally, this measure itself may suffer from similar pitfalls related to documentation of positive test results as noted above. In several large systems, eConsultation is used for specialty referral for procedures and sits outside of the EHR.

Other measures, such as measure 2A/B “Emergency Presentation SaferDx” and 3A/B “Late-stage diagnosis SaferDx” suffer from significant challenges around measurement and data capture as described above. These measures, and others on the list, rely on a regular provider and access to affordable, timely care. Multiple studies have shown that there are substantial delays in care related to patient cost-sharing and unaffordability.¹ Without continuous, high quality, accessible and affordable primary care, these measures will continue to be out of reach.

6. Additional Comments: Share any other relevant insights or suggestions.

We appreciate AHRQ's efforts to develop measures for diagnostic excellence. We believe that the Continuity of Care measure aligns well with AHRQ's goals and criteria. This measure has been shown to improve patient outcomes, reduce healthcare costs, decrease hospitalizations and improve population mortality. We advocate for the inclusion of this measure because it meets a standard of rigorous evidence-based validity and has direct impacts on patient experience, outcomes, mortality, and cost of care.

In general, we caution against the creation of numerous new measures, especially novel measures with limited basis of evidence. The increased burden of data collection and documentation has been well-documented as a source of burnout and cost strain on our healthcare system.² Instead, we encourage the AHRQ and the healthcare ecosystem to focus on the validated, evidence-based measures that save lives and deploy programs that improve performance on these measures.³ We know that performance across quality measures has been declining nationally, and there is work to be done to learn how to shift entire populations to better performance and eliminate disparities. Additionally, foundational work to reduce administrative burden by optimizing data exchange should be considered a precursor to the addition of new measures into standardized measure sets.

Sincerely,



Jessica Altman
Executive Director

¹ Agarwal, Rajender, Olena Mazurenko, and Nir Menachemi. "High-Deductible Health Plans Reduce Health Care Cost And Utilization, Including Use Of Needed Preventive Services." *Health Affairs* 36, no. 10 (October 2017). <https://doi.org/10.1377/hlthaff.2017.0>.

² Saraswathula, A., Merck, S.J., Bai, G., et al. "The Volume and Cost of Quality Metric Reporting." *JAMA* 329, no. 21 (2023): 1840–1847. <https://doi.org/10.1001/jama.2023.7271>.

³ Peter Amico et al., "The Business Case for Quality: Estimating Lives Saved and Harms Avoided in a Value-Based Purchasing Model," *Health Affairs Scholar* 2, no. 5 (May 2024): qxae052, <https://doi.org/10.1093/haschl/qxae052>.