

Cover Page

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

The following is the draft 2022 Attachment 7 amendment for the first public comment period. The first public comment period is from October 15 through November 12, 2020. Please submit comments to PMDCONTRACTSUNIT@COVERED.CA.GOV by November 12, 2020.

Covered California is providing the following documents during the public comment period as companion documents to facilitate your review of the draft 2022 Attachment 7:

1. Summary of Changes from 2021 to 2022 Attachment 7 Amendment; and
2. Crosswalk of Requirements from 2021 to 2022 Attachment 7 Amendment.

All documents will be posted to the Plan Management HBEX webpage:
<https://hbex.coveredca.com/stakeholders/plan-management/>.

The draft indicates which Attachment 7 requirements are subject to performance standards within Attachment 14 with yellow highlight. Covered California will be releasing a draft Attachment 14 for public comment in November 2020.

The draft also indicates placeholders for appendices as supplemental resources to Attachment 7. These appendices will be shared in January 2021 with the release of Attachment 7 for the second public comment period.

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

PROMOTING HIGHER QUALITY AND BETTER VALUE

Covered California's framework for holding Health Insurance Issuers accountable for quality care and delivery system reform seeks to lower costs, improve quality and health outcomes, and promote health equity, while ensuring a good choice of health plans for consumers. Covered California and the Contractor recognize that promoting better quality and value is contingent upon supporting providers and strategic, collaborative efforts to align with other major purchasers and payers to support delivery system reform. Health Insurance Issuers contracting with Covered California to offer Qualified Health Plans (QHPs) are integral to Covered California achieving its mission:

The mission of Covered California 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, the Contractor agrees to work with Covered California to develop and implement policies and practices that will promote quality and health equity, and lower costs for the Contractor's entire California membership. This Quality, Network Management, Delivery System Standards and Improvement Strategy is designed to hold QHP Issuers accountable for ensuring that Enrollees receive high-quality, equitable care, while QHP Issuers work to improve the healthcare delivery system and reduce costs.

All QHP Issuers have the opportunity to take a leading role in helping Covered California support models of care that promote the vision of the Affordable Care Act and meet consumer needs and expectations. The Contractor and Covered California can promote improvements in the entire healthcare delivery system. This focus will require both Covered California and Contractor to coordinate with and promote alignment with other purchasers, organizations, and groups that seek to deliver better care and higher value. By entering into this Agreement, 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, equity, and value.

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 burden 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 the QHP Issuer's entire California membership.

This Attachment 7 contains numerous reports that will be required as part of the annual certification and contracting process with QHP Issuers. The Contractor shall submit all required reports as defined in Attachment 7 and listed in the annual "Contract Reporting Requirements" table found on Covered California's Extranet site (Plan Home, in the Resources folder, Contract Reporting Compliance subfolder). This information will be used for negotiation and evaluation purposes regarding any extension of this Agreement and will be reported as required in the annual application for certification.

ARTICLE 1

INDIVIDUALIZED, EQUITABLE CARE

Covered California is committed to ensuring that care is individualized and equitable for not only those Enrollees currently needing or receiving treatment, but for those who are working to stay healthy. The concept of individualized, equitable care means regardless of one's circumstances, race, gender, where one lives or other socioeconomic factors, every individual deserves the best possible, personalized, cost-effective care delivered in the right setting at the right time.

Addressing health equity and disparities in healthcare is integral to the mission of Covered California. In order to have impactful and meaningful change, Covered California and Contractor recognize that addressing health disparities requires alignment, commitment, focus, and accountability. To this end, Article 1 requirements support the continued commitment, focus, and accountability to ensure that everyone receives individualized, equitable care.

1.01 Demographic Data Collection

1.01.1 Collection of accurate and complete member demographic data is critical to effective measurement and reduction of health disparities.

The Contractor shall work with Covered California 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)
- 6) Spoken language

1.01.2 For Measurement Year 2022, the Contractor must achieve eighty percent (80%) self-identification of race and ethnicity data for Covered California Enrollees. The Contractor must demonstrate compliance by including a valid race and ethnicity attribute for at least 80% of Covered California Enrollees in its Healthcare Evidence Initiative (HEI) data submissions.

The Contractor must engage with Covered California to review its race and ethnicity data for off-Exchange members for Measurement Year 2022.

1.02 Identifying Disparities in Care

1.02.1 Covered California recognizes that the underlying causes of health disparities are multifactorial and include social and economic factors that impact health. While the healthcare system cannot single handedly eliminate health disparities, there is evidence to show that when disparities are identified and addressed in the context of health care, they can be reduced over time through activities tailored to specific populations and targeting select measures. Therefore, Covered California is requiring the Contractor to regularly collect data on its Covered California Enrollees to identify disparities, measure over time, and determine disparity reduction efforts and targets to be mutually agreed upon by Covered California and the Contractor.

1.02.2 For Measurement Year 2022, the Contractor must submit the following Healthcare Effectiveness Data and Information Set (HEDIS) measure hybrid sample files to Covered California for the Contractor's full book of business, excluding Medicare:

- 1) Comprehensive Diabetes Care (CDC) HbA1c Control <8.0% (NQF #0575)
- 2) Controlling High Blood Pressure (CBP) (NQF #0018)

For the Covered California line of business, the Contractor must submit a patient-level measure file that includes a unique person identifier for each person in the denominator. The Contractor must also either (a) compile at summary level or (b) submit controls to Covered California so Covered California can compile at the summary level. The Contractor must also submit HEDIS hybrid sample numerators and denominators by Race/Ethnicity category summary measure files for all commercial product types for which it reports these HEDIS measures to the National Committee for Quality Assurance (NCQA) Quality Compass and for each Medi-Cal Managed Care product for which it reports these HEDIS measures to the Department of Health Care Services (DHCS).

Covered California will consider adding additional measures to track disparities in care for plan year 2023 and beyond.

1.03 Disparities Reduction Intervention

1.03.1 Achieving disparities reduction in care is critical for delivery of individualized, equitable care and promotion of health equity.

1.03.2 The Contractor will reduce an identified disparity based on the mutually agreed-upon health disparities reduction intervention proposal. The Contractor must report progress through submission of the disparities intervention reporting template. Covered California will assess the Contractor's reduction in their intervention disparity based on the submitted HEDIS measures sample per Article 1, Section 1.02.

If the Contractor does not select either HbA1c Control <8.0% or Controlling High Blood Pressure for its intervention, the Contractor must additionally submit the patient-level HEDIS measure file to Covered California for their approved intervention HEDIS measure.

1.04 Statewide Focus Health Equity Collaborative Efforts

1.04.1 Identifying a statewide focus and aligning disparities reduction efforts across organizations will increase the impact of Covered California and Contractor's efforts to improve health equity in California.

1.04.2 The Contractor must participate in a collaborative effort to identify and align statewide disparity work. Participation is defined as regular attendance by the Contractor staff at a leadership level of the organization with appropriate content knowledge and background on disparities work.

1.05 Culture of Health Equity Capacity Building

1.05.1 Attaining health equity requires organizational investment in building a culture of health equity. Meeting the standards for the Multicultural Health Care Distinction (MHCD) by the National Committee for Quality Assurance (NCQA) is required to build a program to reduce documented disparities and to develop culturally and linguistically appropriate communication strategies.

1.05.2 For Measurement Year 2022, the Contractor must achieve or maintain NCQA Multicultural Health Care Distinction (MHCD). The Contractor must demonstrate compliance by submitting the following to Covered California:

- 1) By January 31, 2022, evidence of NCQA MHCD or workplan to achieve the Distinction.
- 2) For Contractors unable to demonstrate NCQA MHCD by January 31, 2022, the following schedule to achieve Distinction by year-end 2022 must be met:
 - a) January 31, 2022: Submit workplan to achieve NCQA MHCD by December 30, 2022
 - b) May 31, 2022: 1st Progress Report
 - c) September 30, 2022: 2nd Progress Report
 - d) December 20, 2022: Evidence of NCQA MHCD achievement

DRAFT

ARTICLE 2

POPULATION HEALTH MANAGEMENT

Covered California and the Contractor recognize that Population Health Management ensures accountability for delivering quality care. Population Health Management shifts the focus from a disease-centered approach to the needs of enrollees and provides focus for improving health outcomes through care coordination and patient engagement.

2.01 Population Health Management Plan Submission

2.01.1 The Population Health Management (PHM) plan provides a vehicle for establishing a formal strategy and organization for population identification and stratification. These are critical components to success and are interrelated with all other quality care domains. Submission of a PHM plan is a requirement for health plan accreditation by the National Committee for Quality Assurance (NCQA).

2.01.2 Contractor must annually submit NCQA Population Health Management (PHM) plan component one (1), the Population Health Management Strategy, and component two (2), Population Stratification and Resource Integration, in their entirety to Covered California.

If the Contractor is not yet accredited by NCQA, the Contractor must submit a Population Health Management plan that addresses each of the following components:

- 1) A Population Health Management Strategy for meeting the care needs of its Enrollees that includes the following:
 - a) Goals, focus populations, opportunities, programs and services available for keeping members healthy, managing members with emerging risk, patient safety or outcomes across settings, and managing multiple chronic illnesses.
 - b) Mechanism for informing Enrollees eligible for interactive programs with details of how to become eligible for participation, how to use program services, and how to opt in or out of a program.
 - c) Activities performed by the Contractor targeted at populations or communities as a part of the Population Health Management strategy that are not direct member interventions.
 - d) Coordination of member programs across settings, providers, external management programs, and levels of care to minimize confusion and maximize reach and impact.
- 2) Evidence of systematic collection, integration, and assessment of member data to assess the needs of the population and determine actionable categories for appropriate intervention. The Contractor must describe the following:
 - a) How the Contractor integrates multiple sources of data for use in Population Health Management functions that includes: medical and behavioral claims or encounters, pharmacy claims, laboratory results, health appraisal results, electronic health records, health programs delivered by the Contractor, and other advanced data sources.
 - b) The Contractor's process for at least annually assessing the following:
 - i) Characteristics and needs, including social determinants of health of its members;
 - ii) Needs of specific member subpopulations; and

- iii) Needs of children and adolescents, members with disabilities, and members with serious and persistent mental illness.
- c) How the Contractor uses the population assessment at least annually to review and update its Population Health Management activities and resources to address member needs. Also, how the Contractor reviews community resources for integration into program offerings to address member needs.
- d) Its process for stratifying at least annually its entire population into subsets for targeted intervention.

DRAFT

ARTICLE 3

HEALTH PROMOTION AND PREVENTION

Health promotion and prevention are key components of high-value health care. Research shows that treating those who are sick is often far costlier and less effective than preventing disease from occurring and keeping populations healthy. Covered California's health promotion and prevention requirements are centered on identifying Enrollees who are eligible for certain preventive and wellness benefits, notifying Enrollees about the availability of these services, making sure those eligible receive appropriate services and care coordination, and monitoring the health status of these Enrollees.

3.01 Health and Wellness Services Communication

3.01.1 Effective communication of health and wellness services to Enrollees ensures equitable access to these services.

3.01.2 To ensure the Enrollee health and wellness process is supported, the Contractor must report in the annual application for certification:

- 1) How it identifies Enrollees who are eligible for health and wellness services.
- 2) The number and percent of Enrollees who enroll in a health and wellness program.
- 3) The number and percent of Enrollees who complete a health and wellness program.
- 4) How it communicates its annual member benefits and education on no-cost preventive health benefits.
- 5) How it provides education and self-management tools on its portal. Example components of this reporting may include:
 - a) Disseminating annual member "preventive coverage" communication;
 - b) Member portal "prevention coverage section;" and
 - c) Whether it gives prominence to health and wellness topics such as counseling for unhealthy weight or nutrition and smoking or tobacco use.

3.02 Tobacco Cessation Program

3.02.1 Tobacco use is preventable and contributes to high morbidity and mortality. Reducing tobacco use will have greater impact on health outcomes in marginalized communities which have disproportionately higher rates of use.

3.02.2 The Contractor must report to Covered California in the annual application for certification:

- 1) How it identifies Enrollees eligible for tobacco cessation programs;
- 2) The number and percent of Enrollees who enroll in tobacco cessation programs, inclusive of evidenced-based counseling and appropriate pharmacotherapy; and
- 3) Its strategies to improve its rates on the Medical Assistance with Smoking and Tobacco Use Cessation measure (NQF #0027), which may include evidence-based interventions or participation in quality collaboratives.

3.03 Weight Management Program

3.03.1 Unhealthy weight and obesity contribute to high morbidity and mortality. Effective weight management programs will have greater impact on health outcomes in marginalized communities that have disproportionately higher rates of unhealthy weight and obesity.

3.03.2 The Contractor must report to Covered California in the annual application for certification:

- 1) How it identifies Enrollees eligible for unhealthy weight management programs;
- 2) The number and percent of Enrollees who enroll in weight management programs, inclusive of evidenced-based counseling, physical activity benefits such as gym memberships, and appropriate pharmacotherapy; and
- 3) Its strategies to improve its rates on the Weight Assessment and Counseling for Nutrition & Physical Activity for Children and Adolescents measure (NQF #0024), which may include evidence-based interventions or participation in quality collaboratives.

3.04 Diabetes Prevention Programs

3.04.1 Diabetes contributes to high rates of morbidity and mortality. Access to diabetes prevention programs is critical in the prevention of diabetes related complications.

3.04.2 The Contractor must provide a Centers for Disease Control and Prevention (CDC)-recognized Diabetes Prevention Lifestyle Change Program, also known as a Diabetes Prevention Program (DPP) to its eligible Enrollees. The DPP must be accessible both in-person and online. The DPP shall be available to all Enrollees in the geographic service area and covered under the \$0 preventive services benefit or diabetes education benefit in the Patient-Centered Benefit Design Plans. Contractor's DPP must have pending or full recognition by the CDC as a DPP. A list of recognized programs in California can be found at:
https://nccd.cdc.gov/DDT_DPRP/Programs.aspx.
https://nccd.cdc.gov/DDT_DPRP/Programs.aspx.

3.04.3 Contractor must report to Covered California in the annual application for certification:

- 1) How it identifies eligible Enrollees for the Diabetes Prevention Program;
- 2) How it informs its Enrollees about the Diabetes Prevention Program;
- 3) The number and percent of its eligible Enrollees who enroll in the Diabetes Prevention Program;
- 4) The number and percent of its eligible Enrollees who complete the Diabetes Prevention Program; and
- 5) How it monitors and evaluates the effectiveness of the Diabetes Prevention Program.

ARTICLE 4

MENTAL HEALTH AND SUBSTANCE USE DISORDER TREATMENT

Mental health and substance use disorder treatment, collectively behavioral health services, includes activities to identify, engage, and provide treatment to those with mental health conditions and substance use disorders, and ensure they are provided with timely and effective care that is integrated with primary care. Covered California and the Contractor recognize the critical importance of behavioral health services, as part of the broader set of medical services provided to Enrollees, in improving health outcomes and reducing costs.

4.01 Access to Behavioral Health Services

4.01.1 Monitoring and improving access to behavioral health services is necessary to ensure Enrollees are receiving appropriate and timely behavioral health services.

4.01.2 For Covered California to monitor how the Contractor tracks access to behavioral health services and the strategies the Contractor implements to improve access to behavioral health services for Enrollees, the Contractor must submit annually its National Committee for Quality Assurance (NCQA) Health Plan Accreditation Network Management reports for the elements related to its behavioral health provider network. Specifically, the Contractor must provide reports for:

- 1) Network Standard 1, Element A: Cultural Needs and Preferences
- 2) Network Standard 1, Element D: Practitioners Providing Behavioral Healthcare;
- 3) Network Standard 2, Element B: Access to Behavioral Healthcare; and
- 4) Network Standard 3, Element C: Opportunities to Improve Access to Behavioral Healthcare Services.

If the Contractor is not accredited by NCQA, the Contractor must submit a report that addresses each of the NCQA Network Management standards for behavioral health. These reports can be from the Contractor's accrediting body, either URAC or the Accreditation Association for Ambulatory Health Care (AAAHC), or supplemental reports that include a description of the Contractor's behavioral health provider network, how cultural, ethnic, racial and linguistic needs of Enrollees are met, access standards, the methodology for monitoring access to behavioral health appointments, and at least one intervention to improve access to behavioral health services and the effectiveness of this intervention.

4.01.3 The Contractor must engage with Covered California to review its depression treatment penetration rate and its behavioral health service utilization rate using Health Evidence Initiative (HEI) data to further understand Enrollees' access to behavioral health services within the Contractor's network. Penetration rate is determined by dividing the number of members who receive a behavioral health service by the expected prevalence rate of behavioral health needs within a state or region, multiplied by 100 to reach a percent.

4.02 Offering Telehealth for Behavioral Health Services

4.02.1 Telehealth has the potential to address some of the access barriers to behavioral health services, particularly in rural areas, such as cost, transportation, and the shortage of providers.

4.02.2 To strengthen access to behavioral health services, the Contractor must offer telehealth for behavioral health services. Additionally, the Contractor must:

- 1) When behavioral health telehealth services are offered via a third-party behavioral health provider:
 - a) Explain behavioral health telehealth services on its provider directory page or another primary page in its member portal; and
 - b) Ensure that Enrollees can easily find behavioral health telehealth services through a telehealth provider search attribute, inclusion of telehealth service in provider profile (e.g. Jane Doe, Ph.D. Psychologist telehealth video/phone), or other member portal navigation feature.
- 2) Educate Enrollees about how to access telehealth services, including behavioral health telehealth services, and report to Covered California how this education is provided.
- 3) Display coverage of behavioral health services and behavioral health telehealth services clearly and prominently.

The Contractor will demonstrate compliance with the requirements through reporting in the annual application for certification.

4.02.3 The Contractor must engage with Covered California to review its utilization of behavioral health telehealth services using HEI data.

4.03 Quality of Behavioral Health Services

4.03.1 Measuring and monitoring quality is necessary to ensure Enrollees receive appropriate, evidence-based treatment and inform quality improvement efforts.

4.03.2 The Contractor must collect Depression Screening and Follow-Up Plan (NQF #0418) measure results for its Enrollees and annually report results in the annual application for certification. The measure data must be audited by the Contractor's HEDIS auditor. The Contractor must engage with Covered California to review its performance.

4.03.3 The Contractor must engage with Covered California to review its performance on the following behavioral health measures reported by the Contractor to CMS for the Quality Rating System (QRS):

- 1) Antidepressant Medication Management (NQF #0105);
- 2) Follow-Up After Hospitalization for Mental Illness (7-Day Follow-Up) (NQF #0576); and
- 3) Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (NQF #0004).

4.04 Appropriate Use of Opioids

4.04.1 Appropriate use of opioids and evidence-based treatment of opioid use disorder, including Medication Assisted Treatment (MAT), can improve outcomes, reduce inappropriate healthcare utilization, and lower opioid overdose deaths.

4.04.2 The Contractor shall implement policies and programs that align with the guidelines from Smart Care California to promote the appropriate use of opioids and lower opioid overdose deaths (<https://www.iha.org/ourwork/insights/smart-care-california/focus-area-opioids>). The Contractor's policies and programs must include the following priority areas:

- 1) Prevent: decrease the number of new starts: fewer prescriptions, lower doses, shorter durations;

- 2) Manage: identify patients on risky regimens (high-dose, or opioids and sedatives) and develop individualized treatment plans, avoiding mandatory tapers;
- 3) Treat: streamline access to evidence-based treatment for substance use disorder at all points in the healthcare system; and
- 4) Stop deaths: promote data-driven harm reduction strategies, such as naloxone access and syringe exchange.

The Contractor must report in the annual application for certification how it is implementing such policies and programs in accordance with the Smart Care California guidelines.

4.04.3 To monitor access to opioid use disorder treatment, the Contractor must measure and report in the annual application for certification the number of active X waiver licensed prescribers in its network and the number of total X waiver licensed prescribers in its network. An active X waiver licensed prescriber is defined as a provider who has written one or more MAT prescriptions in the past 12 months.

4.04.4 The Contractor must engage with Covered California to review its performance on the following opioid use disorder measures using HEI data:

- 1) Use of Pharmacotherapy for Opioid Use Disorder (NQF #3400);
- 2) Concurrent Use of Opioids and Benzodiazepines (NQF #3389);
- 3) Use of Opioids at High Dosage in Persons Without Cancer (NQF #2940); and
- 4) Concurrent Use of Opioids and Naloxone.

4.05 Integration of Behavioral Health Services with Medical Services

4.05.1 Integrated behavioral health services with primary care increases access to behavioral health services and improves treatment outcomes. Evidence suggests the Collaborative Care Model is a best practice among integrated behavioral health models.

4.05.2 Contractor must report in the annual application for certification:

- 1) How it is promoting the integration of behavioral health services with primary care;
- 2) The percent of its Covered California Enrollees and the percent of its enrollees outside of Covered California cared for under an integrated behavioral and primary care model such as co-located care, Primary Care Behavioral Health, and the Collaborative Care Model; and
- 3) Whether it reimburses for the Collaborative Care Model claims codes and, if so, in what settings and to which entities. If the Contractor does not reimburse for the Collaborative Care Model claims codes, the Contractor must describe the barriers to reimbursing for these codes.

4.05.3 The Contractor must engage with Covered California to review its utilization of the Collaborative Care Model using HEI data.

ARTICLE 5

ACUTE, CHRONIC AND OTHER CONDITIONS

Covered California and the Contractor recognize the importance of developing robust programs for acute and chronic conditions to serve enrollees along the continuum of health. Interventions to provide curative services to life-threatening emergencies, exacerbation of illnesses, and routine health problems should be integrated to strengthen healthcare delivery systems. In addition, appropriate medical management, systematic monitoring, and building capacity for effective patient engagement is critical for successful chronic disease management.

5.01 Measures Reported to the Marketplace Quality Rating System

5.01.1 Public reporting of quality performance measures to the Centers for Medicaid and Medicare Services' Marketplace Quality Rating System (QRS) is a critical mechanism for oversight and accountability. Embedded in this reporting are measures designed to drive quality in acute and chronic conditions.

5.01.2 The Contractor must engage with Covered California to review its performance on the following measures related to acute and chronic conditions reported by the Contractor for QRS:

- 1) Appropriate Testing for Children with Pharyngitis (NQF #0002)
- 2) Appropriate Treatment for Children with Upper Respiratory Infection (NQF #0069)
- 3) Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (NQF #0058)
- 4) Comprehensive Diabetes Care: Eye Exam (Retinal) Performed (NQF #0055)
- 5) Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%) (NQF #0575)
- 6) Comprehensive Diabetes Care: Medical Attention for Nephropathy (NQF #0062)
- 7) Controlling High Blood Pressure (NQF #0018)
- 8) International Normalized Ratio Monitoring for Individuals on Warfarin (NQF #0555)
- 9) Asthma Medication Ratio (NQF #1800)
- 10) Plan All-Cause Readmissions (NQF #1768)
- 11) Prenatal and Postpartum Care (Timeliness of Prenatal Care) (NQF #1517)
- 12) Prenatal and Postpartum Care (Postpartum Care) (NQF #1517)
- 13) Use of Imaging Studies for Low Back Pain (NQF #0052)
- 14) Access to Care (CAHPS)
- 15) Care Coordination (CAHPS)

5.02 Supporting At-Risk Enrollees Requiring Transition

5.02.1 An Enrollee transition plan allows for a clear process to transfer critical health information for at-risk members during movement between health care coverage. Covered California is particularly concerned about QHP Issuer transitions of enrollment for At-Risk Enrollees, which includes Enrollees who are: (1) in the middle of acute treatment, third trimester pregnancy, or those who would otherwise qualify for Continuity of Care under California law, (2) in case management programs, (3) in disease management programs, or (4) on maintenance prescription drugs for a chronic condition.

5.02.2 In the event of a service area reduction, the Contractor must submit an evaluation and formal transition plan to facilitate transitions of care with minimal disruption for At-Risk Enrollees who are switching from one QHP Issuer to another or into or out of Covered California. If this occurs, Covered California may automatically transition the Contractor's Enrollees into a different QHP Issuer to avoid gaps in coverage.

The Contractor must demonstrate compliance by submission of a plan to Covered California that meets the following requirements:

- 1) The Contractor terminating Enrollees must:
 - a) Conduct outreach to alert all impacted Enrollees that their QHP will be ending. Outreach will include instructions, timing, and options for enrolling with a new QHP Issuer.
 - b) Conduct outreach to At-Risk Enrollees with a sensitive diagnosis, giving them the option to authorize Contractor to send their personal health information to the Enrollee's new QHP Issuer with the goal of improving the transition of care.
 - c) Send Enrollee health information relevant to creating transitions of care with minimal disruption to the Enrollee's new QHP Issuer for those Enrollees who have provided authorization to do so, as follows:
 - i) For all terminating Enrollees, send Primary Care Provider information on record.
 - ii) For At-Risk Enrollees, send relevant personal health information.
 - d) Conduct outreach to providers in impacted service areas to create Enrollee transitions with minimal disruption.
- 2) If the Contractor receives terminating Enrollees from another QHP Issuer pursuant to a service area withdrawal, the Contractor must do the following:
 - a) Identify At-Risk Enrollees, either through existing Contractor practices, or through receipt of both health information from the prior QHP Issuer and the data file with transitioning enrollment information from Covered California (which would occur after these Enrollees have effectuated coverage).
 - b) Ensure At-Risk Enrollee care transitions account for the Enrollee's medical situation, including participation in case or disease management programs, locating in-network Providers with appropriate clinical expertise, and any alternative therapies, including specific drugs.
 - c) Establish internal processes to ensure all parties involved in the transition of care for At-Risk Enrollees are aware of their responsibilities. This includes anyone within or outside of the Contractor's organization who are needed to ensure the transition of prescriptions or provision of care.
 - d) Provide information on continuity of care programs, including alternatives for transitioning to an in-network provider.
 - e) Ensure the new Enrollees have access to the Contractor's formulary information prior to enrollment.

ARTICLE 6

COMPLEX CARE

Covered California and the Contractor recognize the importance of effectively managing complex conditions for individuals that require multiple high-cost specialty treatments or end of life care.

6.01 At-Risk Enrollee Engagement

6.01.1 Enrollees with existing and newly diagnosed complex conditions are the most likely to benefit from effective, proactive management for successful delivery of care.

6.01.2 Building on the National Committee for Quality Assurance (NCQA) Population Health Management plan submission requirement (Article 2, Section 2.01), the Contractor must demonstrate compliance by reporting the following details specific to care management of At-Risk Enrollees in the annual application for certification:

- 1) Description of an outreach plan including:
 - a) Modalities used (e.g. mail, email, telephone, text, patient portal);
 - b) If more than one modality is used, an explanation of the multimodal approach or use of modalities in succession; and
 - c) Number of outreach attempts per Enrollee.
- 2) Number and percent of At-Risk Enrollees successfully contacted; and
- 3) Number and percent of At-Risk Enrollees engaged in appropriate care management (e.g. enrolled in Care Management Program, receiving care from specialty provider).

6.02 Centers of Excellence

6.02.1 Centers of Excellence allow for complex care patients to be seen in very specialized settings that are optimal for their care. Covered California welcomes the Contractor's use of Centers of Excellence, which may include design incentives for consumers.

6.02.2 The Contractor must report details on access to providers with documented special experience and proficiency, based on volume and outcome data, that treat conditions which require highly specialized management (e.g. transplant patients and burn patients). Such report must be submitted in the annual application for certification and must include:

- 1) A description of how Enrollees gain access to specialized providers;
- 2) A list of Centers of Excellence affiliated with the Contractor, including the condition treated by each institution;
- 3) For the three (3) top conditions based on volume and cost for Covered California (total joint, spine, and bariatric treatments), a description of the basis of inclusion for these Centers of Excellence and the method used to promote consumers' usage of these Centers; and
- 4) For each condition identified with Centers of Excellence in 2) as well as the top conditions for Covered California noted in 3):
 - a) The number and percent of Enrollees with each diagnosis; and
 - b) The number and percent of Enrollees who received care at each of these Centers.

6.02.3 The Contractor must engage with Covered California to review its utilization of Centers of Excellence using HEI data to better understand where care is delivered to complex Enrollees and create a foundation for analysis of related outcomes.

6.03 Care Coordination

6.03.1 Provision of well-coordinated care requires timely communication between members of a care team. It is a critical component to improve experience of care, health outcomes, and reduce costs.

6.03.2 Contractor must support and monitor their hospitals in application of the Medicare Condition of Participation to have electronic information exchange to notify primary care providers of Admission, Discharge, Transfer (ADT) events for Covered California Enrollees. Contractor must report the following in its annual application for certification:

- 1) Description of actions taken to ensure implementation of ADT notification from hospitals for Enrollees;
- 2) Number and percent of hospitals that have implemented ADT notification for Covered California Enrollees; and
- 3) Mechanisms in place to remedy non-adherence with this requirement.

ARTICLE 7

EFFECTIVE PRIMARY CARE

Covered California and the Contractor recognize that providing high-quality, equitable and affordable care requires a foundation of effective and patient-centered primary care. Effective primary care is data driven, team-based and supported by alternative payment models such as population-based payment and shared savings. The Contractor shall actively promote the development and use of advanced primary care models that promote access, care coordination, and quality while managing the total cost of care.

The Contractor shall work with Covered California to provide comparison reporting for all lines of business to compare performance and inform future Covered California requirements.

7.01 Encouraging Use of Primary Care

7.01.1 Ensuring all Enrollees have a primary care clinician is foundational for promoting access to and encouraging the use of primary care.

7.01.2 The Contractor must ensure that all Enrollees either select or are provisionally assigned to a primary care clinician within sixty (60) days of effectuation into the plan. If an Enrollee does not select a primary care clinician, the 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, the 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 must report in the annual application for certification the number and percent of Enrollees who select a clinician and the number and percent of Enrollees who are assigned to a primary care clinician.

7.01.3 Covered California will evaluate the effectiveness of this policy based on criteria mutually agreed-upon between Covered California and the Contractor. The Contractor shall provide Covered California with data and other information to perform this evaluation.

7.02 Promotion of Advanced Primary Care

7.02.1 Advanced primary care is patient-centered, accessible, team-based, data driven, supports the integration of behavioral health services, and provides care management for patients with complex conditions. Primary care clinicians should have access to data related to the care their patients receive throughout the delivery system to enable primary care clinicians to provide integrated care. Many barriers prevent a large share of primary care practices from fulfilling their role as the foundation of a highly functioning delivery system.

7.02.2 The Contractor shall work with Covered California to promote and support advanced primary care models. Covered California strongly encourages the Contractor to support or provide quality improvement and technical assistance to primary care practices to implement or strengthen advanced primary care models such as providing practice coaches or investing in information technology. Additionally, Covered California strongly encourages the Contractor to participate in primary care improvement collaboratives.

The Contractor must report in the annual application for certification the quality improvement support and technical assistance being provided by the Contractor or other organization to implement or strengthen advanced primary care models. The Contractor must also report in the annual application for certification the extent and nature of its participation in primary care

improvement collaboratives such as the California Quality Collaborative (CQC) or the California Improvement Network (CIN).

7.03 Measuring Advanced Primary Care

7.03.1 Measuring the performance of primary care practices within the Contractor's network is important to ensure Enrollees receive high-quality care, to inform quality improvement and technical assistance efforts, and to support the adoption of alternative payment models.

7.03.2 The Contractor must pilot a measure set that includes quality and cost-driving utilization measures for advanced primary care to assess the prevalence of high-quality, advanced primary care practices within the Contractor's network. Contractor will collaborate with Covered California, the Integrated Healthcare Association (IHA), CQC, and other stakeholders to develop and implement the measure set.

The Contractor must submit data to IHA to pilot the measure set. The Contractor must annually report its performance on the measure set to Covered California.

7.03.3 The Contractor must engage with Covered California to evaluate the performance of its contracted primary care practices using the measure set.

7.04 Payment to Support Advanced Primary Care

7.04.1 Covered California and the Contractor recognize the importance of adopting and expanding primary care payment models that provide the necessary revenue to fund accessible, data-driven, team-based care with accountability for providing high-quality, equitable care and managing the total cost of care.

7.04.2 The Contractor must report on its primary care payment models using the Health Care Payment Learning and Action Network Alternative Payment Model (HCP LAN) categories of fee for service with no link to quality and value (Category 1), fee for service with a link to quality and value (Category 2), alternative payment models built on a fee for service structure such as shared savings (Category 3), and population-based payment (Category 4). The Contractor must report in the annual application for certification:

- 1) The number and percent of its contracted primary care clinicians paid using the HCP LAN categories;
- 2) The number and percent of its Enrollees who are cared for by primary care clinicians paid using each HCP LAN category;
- 3) The percent of spend within each HCP LAN category compared to its overall primary care spend; and
- 4) If the Contractor participates in the annual HCP LAN survey, the Contractor shall share its survey responses and reports with Covered California. Covered California encourages the Contractor to participate in the annual HCP LAN APM Measurement Effort.

7.04.3 **The Contractor must adopt and progressively expand the number and percent of primary care clinicians paid through the HCP LAN categories of population-based payment (Category 4) and alternative payment models built on a fee for service structure such as shared savings (Category 3) each year.**

7.04.4 The Contractor shall work with Covered California and other stakeholders to analyze the relationship between the percent of spend for primary care services with performance of the overall delivery system. If the evidence shows that rebalancing to increase primary care spend

improves quality and drives lower total cost of care, Covered California may set a target for primary care spend in future Covered California requirements.

DRAFT

ARTICLE 8

PROMOTION OF INTEGRATED DELIVERY SYSTEMS (IDS) AND ACCOUNTABLE CARE ORGANIZATIONS (ACO)

Evidence suggests the adoption and expansion of integrated, coordinated, and accountable systems of care can lead to improved quality and reduced costs. As detailed in two Covered California reports ¹, Integrated Delivery Systems (IDSs) have significantly outperformed network model, shared delivery systems on quality measures. Accountable Care Organizations (ACOs) are being developed and implemented within health plan networks with a shared delivery system in hope of emulating the success of Integrated Delivery Systems.

An ACO is defined as a system of population-based care coordinated across the continuum including multidisciplinary physicians and physician groups, hospitals, and ancillary providers with combined risk sharing arrangements and incentives between the Contractor and providers. ACO partners are held accountable for nationally recognized evidence-based clinical, financial, and operational performance. As providers accept more accountability under this provision, the Contractor shall ensure that providers have the capacity to manage the risk. There are many variations of ACO implementation with evidence suggesting that the characteristics of an ACO model influence its success. For example, ACOs with risk-based contracts that are physician-led are associated with greater savings and improved quality results.²

The Contractor shall work with Covered California to provide comparison reporting for all lines of business to compare performance and inform future Covered California requirements.

8.01 Enrollment in IDSs and ACOs

8.01.1 The Contractor shall work with Covered California to improve the healthcare delivery system and reduce provider and facility variation in performance on quality and cost. This requires continued improvement within IDSs, adopting, enhancing and evolving ACOs, as well as increasing enrollment in these coordinated systems of care.

8.01.2 **The Contractor must demonstrate an increasing number of Enrollees cared for within an ACO or IDS model each year.** The Contractor must report in the annual application for certification:

- 1) The characteristics of their IDS and ACO systems such as the payment model, leadership structure, quality incentive programs, and data exchange processes. Contractor will work collaboratively with Covered California and other stakeholders to define a registry of characteristics to support this reporting.
- 2) The number and percent of Enrollees who are cared for within an ACO or IDS.
- 3) The percent of spend under ACO and IDS contracts compared to its overall spend on health care services.

¹ Covered California. (2019). Covered California's First Five Years: Improving Access, Affordability and Accountability. https://hbex.coveredca.com/data-research/library/CoveredCA_First_Five_Years_Dec2019.pdf

Covered California. (2019). Covered California Holding Health Plans Accountable for Quality and Delivery System Reform. https://hbex.coveredca.com/data-research/library/CoveredCA_Holding_Plans_Accountable_Dec2019.pdf

² Covered California. (2019). Current Best Evidence and Performance Measures for Improving Quality of Care and Delivery System Reform. https://hbex.coveredca.com/stakeholders/plan-management/library/coveredca_current_best_evidence_and_performance_measures_07-19.pdf

8.02 Measuring IDS and ACO Performance

8.02.1 Measuring the performance of IDSs and ACOs is important to ensure Enrollees receive high-quality care, to inform improvement efforts, and to establish best practices.

8.02.2 The Contractor must participate in the Integrated Healthcare Association (IHA) and submit data to IHA for use in the IHA Commercial ACO Measure Set and Commercial HMO Measure Set, as applicable for its delivery system model. Contractor must annually report its performance on the IHA Commercial ACO and HMO Measure Set for all lines of business to Covered California.

8.02.3 The Contractor must engage with Covered California to evaluate its performance using the results of the IHA Commercial ACO and HMO reports and the characteristics of different systems to establish best practices to inform future requirements.

DRAFT

ARTICLE 9

NETWORKS BASED ON VALUE

Covered California contracted QHP Issuers shall curate and manage their networks and address variation in quality and cost performance across network hospitals and providers, with a focus on improving the performance of hospitals and providers. The Contractor is accountable for measuring, analyzing, and reducing variation to achieve consistent high performance for all network hospitals and providers.

Affordability is core to Covered California's mission to expand the availability of insurance coverage and ensure Enrollees receive high-quality, affordable, and equitable care. The wide variation in unit price and total costs of care, with some providers and facilities charging far more for care irrespective of quality, is one of the biggest contributors to high costs of medical services. The Contractor shall hold its contracted hospitals and providers accountable for improving quality and managing or reducing cost and provide the support needed to improve performance across its network.

Covered California will support the Contractor in analyzing data to understand variation in performance and holds the Contractor accountable for acting on such data to improve network performance. Covered California recognizes the limits of quality and cost performance data for hospitals and providers as such data can be imprecise and incomplete. Covered California also recognizes that the resources available to hospitals and providers, such as their payor mix, case mix, organizational structure, and the social determinants of health of populations served can influence the performance of hospitals and providers. Despite these challenges, the Contractor must curate and manage its networks and improve quality and cost performance across network hospitals and providers.

In accordance with Covered California's framework for assuring quality care and promoting delivery system reform, Article 10, Sites and Expanded Approaches to Care Delivery, covers hospital quality improvement requirements, while Article 9 describes the expectation of the Contractor to curate and manage their provider and hospital networks based on cost and quality.

9.01 Designing and Managing Networks Based on Value

9.01.1 The Contractor's networks must be designed and managed based on cost, quality, safety, patient experience, and equity to ensure that all Enrollees receive high-quality, affordable, and equitable care.

9.01.2 The Contractor must include quality, which may include clinical quality, patient safety, patient experience, and cost in the evaluation and selection criteria for all providers, including physicians and physician groups, and all facilities, including hospitals, when designing and managing networks for Covered California QHPs.

The Contractor must report in the annual application for certification how it meets this requirement and the basis for the selection and review of providers and facilities in networks for Covered California QHPs and if applicable, the rationale for excluding a provider or facility. Reports must include a detailed description of how cost, clinical quality, patient safety, patient experience, or other factors are considered in network design and provider and facility selection and review. Information submitted may be made publicly available by Covered California.

9.01.3 The Contractor must engage with Covered California to review its unit price range and trends and quality indicators of network performance using HEI data.

9.02 Hospital Networks Based on Value

9.02.1 The Contractor shall contract with hospitals that demonstrate they provide quality care and promote the safety of Enrollees at a reasonable price. Covered California expects Contractor to improve quality and cost performance across its contracted hospitals.

9.02.2 To meet this expectation, Covered California will work with Cal Hospital Compare, California hospitals, and its contracted QHP Issuers to profile and analyze variation in performance on hospital quality measures. For details on the hospital quality measures of focus, see Article 10, Section 10.03 Hospital Patient Safety and Section 10.04 Appropriate Use of C-sections. Analysis will be based on best available national and state benchmarks, variation in hospital performance considering hospital case mix and services provided, best existing science of quality improvement including the challenges of composite measures, and effective engagement of stakeholders. Assessment of hospital quality and safety shall not be based on a single measure alone. The Contractor must report in the annual application for certification:

- 1) How the Contractor is engaging with their network hospitals (particularly those with multiple signals of poor performance on safety and quality) and holding hospitals accountable to improve their performance. Components of this engagement and accountability may include quarterly performance reviews, tying hospital payment to quality and patient safety, supporting patient safety technical assistance programs, implementation of corrective action plans, assessment of hospital resources, or excluding hospitals with multiple signals of poor performance and no improvement from its networks.
- 2) Its rationale for continued contracting with each hospital performing in the lowest decile on state or national benchmarks for quality and safety as well as the strategies the hospital is undertaking to improve its performance and the progress resulting from these improvement activities. Rationales for continued inclusion of hospitals may include geographical access needs, specific specialty service needs, or other justification provided by the Contractor.

Rationale and criteria for inclusion of hospitals with multiple signals of poor performance on cost, safety, and quality may be released to the public by Covered California.

9.02.3 To demonstrate the Contractor is managing hospital and facility costs, the Contractor must report in the annual application for certification:

- 1) The factors it considers in assessing relative unit prices and total cost of care;
- 2) The extent to which it adjusts for 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;
- 3) How such factors are used in the selection of facilities in networks for Covered California QHPs; and
- 4) The identification of specific facilities by region and their distribution by cost deciles or describe other ways facilities are grouped by costs such as comparison of costs as a percentage of Medicare costs and the percentage of costs for the Contractor that are expended in each cost decile.

9.03 Physician Networks Based on Value

9.03.1 The Contractor shall contract with providers, including physicians and physician groups, that demonstrate they provide quality care and promote the safety of Enrollees at a reasonable price.

Covered California expects the Contractor to improve quality and cost performance across its contracted providers.

9.03.2 To meet this expectation, Covered California will work with the Integrated Healthcare Association (IHA), California providers, and its contracted QHP Issuers to profile and analyze variation in performance on provider quality measures. Analysis will be based on national and state benchmarks, variation in provider performance, best existing science of quality improvement, and effective engagement of stakeholders. The Contractor must:

- 1) Participate in the IHA Align.Measure.Perform (AMP) program for physician groups and report AMP performance results for each contracted physician group that participates in Covered California QHPs to Covered California annually.
- 2) Report in the annual application for certification how the Contractor is engaging with its network physician groups (particularly physician groups with multiple indicators of poor quality and high cost performance) and holding physician groups accountable to improve their performance. Components of this engagement and accountability may include implementing alternative payment models such as shared savings and population-based payment, quarterly performance reviews, assessment of physician group resources, provision of technical assistance or support for infrastructure, implementation of corrective action plans, or excluding physician groups with multiple indicators of poor-quality performance and no improvement from its provider networks.
- 3) Report in the annual application for certification how the Contractor is analyzing variation in performance of independent, direct contracted physicians, engaging with its physicians (particularly physicians with multiple indicators of poor-quality performance and high cost performance), and holding physicians accountable to improve their performance. Components of this engagement may include implementing alternative payment models such as shared savings and population-based payment that cascade to the point of care, quarterly performance reviews, assessment of physician resources, provision of technical assistance or support for infrastructure, implementation of corrective action plans, or excluding poor performing physicians from its provider networks.
- 4) Report in the annual application for certification how the Contractor is providing or supporting quality improvement or technical assistance to physicians in their network with multiple indicators of poor quality to improve their performance. Quality improvement support or technical assistance may be provided by the Contractor, the contracted physician group, or other organization.
- 5) Report in the annual application for certification its rationale for continued contracting with physicians and physician groups performing in the lowest decile on state or national benchmarks for quality and cost as well as the strategies the physicians and physician groups are undertaking to improve its performance and the progress resulting from these improvement activities. Rationales for continued inclusion of physicians and physician groups may include geographical access needs, specific specialty service needs, or other justification provided by the Contractor.

Rationale and criteria for inclusion of the lowest decile of physicians and physician groups on cost, safety, and quality may be released to the public by Covered California.

9.03.3 To demonstrate the Contractor is managing provider costs, the Contractor must report in the annual application for certification:

- 1) The factors it considers in assessing relative unit prices and total cost of care;
- 2) The Contractor's analysis of variation in unit prices including capitation rates and whether including high cost providers results in underfunding of other providers;
- 3) The extent to which it adjusts for 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;
- 4) How such factors are used in the selection of providers in networks for Covered California QHPs; and
- 5) The identification of specific providers by region 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.

DRAFT

ARTICLE 10

SITES AND EXPANDED APPROACHES TO CARE DELIVERY

Covered California is committed to improving how and where Enrollees receive health care. Improving hospital safety and reducing unnecessary medical procedures can improve health outcomes and reduce costs.

For Article 10, “Sites” refers to the traditional medical care settings of hospitals and physician offices. Because there is some overlap in requirements, care in primary care physician offices is covered in Article 7, Effective Primary Care. “Expanded approaches to care delivery” refers to care that goes beyond the traditional in-office service provided by a clinician, such as telehealth, and includes who provides care in addition to physicians including clinically appropriate providers such as registered nurses, pharmacists, midwives, nurse practitioners, physician assistants or non-licensed providers like community health workers.

Covered California has not yet developed contract requirements related to many of the existing and evolving sites of care or approaches to care delivery such as urgent care facilities, retail clinics, or home care. Ongoing discussions and engagement with stakeholders will inform future contract requirements in this article.

Covered California recognizes the importance of hospital quality metrics and reimbursement structure in a Contractor’s negotiation and contracting process with providers and hospitals. In accordance with Covered California’s framework for assuring quality care and promoting delivery system reform, Article 10 covers hospital quality improvement requirements, while Article 9, Networks Based on Value, covers the expectation of Contractors to curate and manage their provider and hospital networks based on cost and quality.

10.01 Telehealth

10.01.1 Telehealth offers greater access to health care for Enrollees. Telehealth can be used to provide timely access to medical care, increase access to services like behavioral health in which there are particular access barriers, and improve self-care management through remote patient monitoring. Telehealth and other virtual health services offer additional access points to medical care that may reduce disparities in the healthcare system.

10.01.2 In the annual application for certification, the Contractor shall report the extent to which the Contractor is supporting the use of telehealth, remote patient monitoring, and other technologies to assist in providing high quality, accessible, patient-centered care. The Contractor must report:

- 1) The types and modalities of telehealth and virtual health services that Contractor offers to Enrollees.
- 2) How Contractor is communicating with and educating Enrollees about telehealth services including:
 - a) Service availability explained on key Enrollee website pages like the home page and provider directory page; and
 - b) Service cost-share explained on key Enrollee website pages like the summary of benefits and coverage page and medical cost estimator page.
- 3) The frequency of all-member communications to inform Enrollees of telehealth services.
- 4) How the Contractor facilitates the integration and coordination of care between third party telehealth vendor services and primary care or other contracted providers.

- 5) How the Contractor facilitates Enrollee access to telehealth services such as screening for and reporting on broadband affordability and lower-cost alternative modalities, digital literacy, availability of smartphones or other devices for internet connectivity, and the geographic availability of high-speed internet services.
- 6) Description of the Contractor's telehealth reimbursement policies for network providers and for third party telehealth vendors to include payment parity between:
 - a) Telehealth including voice only when appropriate and comparable in-person or other non-telehealth services; and
 - b) Telehealth vendor and contract provider rendered telehealth services.
- 7) How the Contractor evaluates the impact telehealth has on the cost and quality of care provided to Enrollees such as the extent to which telehealth replaces or adds to utilization of Emergency Department services.

10.01.3 The Contractor must engage with Covered California to review its utilization of telehealth services using HEI data.

10.02 Hospital Payments to Promote Quality and Value

10.02.1 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. Payment can be a driver to promote and reward better quality care rather than pay for volume.

10.02.2 The Contractor shall adopt a hospital payment methodology for the Contractor's Covered California business with each general acute care hospital that places the hospital at-risk or subject to a bonus payment for quality performance. At minimum, this methodology shall include five percent (5%) of reimbursement by year end 2022 with a plan for satisfying future increases in reimbursement.

The Contractor must adopt balancing measures such as Hospital Consumer Assessment of Healthcare Providers and Systems (HCAPS) to track, address, and prevent unintended consequences from at-risk payments including exacerbation of health care disparities.

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:

- 1) Long Term Care hospitals;
- 2) Inpatient Psychiatric hospitals;
- 3) Rehabilitation hospitals; and
- 4) Children's hospitals.

The Contractor is accountable for the quality of care and safety of Covered California Enrollees receiving care in the hospitals described above.

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

Those hospitals participating in an Accountable Care Organization, available in a Contractor's QHP network, that have shared risk or other accountability for total cost of care shall be considered to have met this performance-based payment requirement.

10.02.3 The Contractor must report in the annual application for certification:

- 1) The amount and structure for its hospital performance-based payment strategy, including the shared-risk and performance payment structure to hospitals participating in ACOs, if applicable.
- 2) The metrics that are applied for performance-based payments such as: mortality, Hospital Associated Infections (HAIs), adherence to sepsis management guidelines, readmissions, or satisfaction as measured through HCAPS. Such metrics should be commonly in use in hospitals and endorsed by the National Quality Forum to limit hospital measurement burden.
- 3) The percent of network hospitals operating under contracts reflecting this payment methodology.
- 4) The dollars and percent, or best estimate, that is respectively paid or withheld to reflect value, including the extent to which the "at risk" payments take the form of bonuses, withholds, or other performance-based payment mechanisms.
- 5) The dollars and percent or best estimate of hospital payments that are tied to hospital "improvement" versus "attainment" of a performance threshold.

Contractor shall work with Covered California to provide comparison reporting for all lines of business to compare performance and inform future Covered California requirements.

10.03 Hospital Patient Safety

10.03.1 Covered California has focused on aligned and collaborative efforts to promote hospital safety based on the recognition that improving hospital performance in this area requires a comprehensive and cross-payer approach. Monitoring and improving hospital safety measures will improve clinical outcome and reduce wasteful health care spending.

10.03.2 The Contractor shall 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: Long Term Care hospitals, Inpatient Psychiatric hospitals, Rehabilitation hospitals, and Children's hospitals.

- 1) The Contractor must report its strategies to improve safety in network hospitals in the annual application for certification. The quality improvement strategies will be informed by review of specified patient safety measures in all network hospitals. Patient safety measure rates will be provided by Covered California from established sources of clinical data such as rates reported by hospitals to the National Healthcare Safety Network (NHSN) or the California Department of Public Health (CDPH).
- 2) Covered California has identified an initial set of patient safety measures for focus consisting of five hospital associated infections (HAIs) and sepsis management (SEP-1). Certain patient safety measures may be substituted for others if a common data source cannot be found. The decision to substitute patient safety measures will be made transparently and collaboratively with stakeholders. The patient safety measures that are currently the subject of the hospital safety initiatives are:
 - a) Catheter Associated Urinary Tract Infection (CAUTI) (NQF #0138);
 - b) Central Line Associated Blood Stream Infection (CLABSI) (NQF #0139);
 - c) Surgical Site Infection (SSI) with focus on colon (NQF #0753);

- d) Methicillin-resistant Staphylococcus aureus (MRSA) (NQF #1716);
 - e) Clostridioides difficile colitis (C. Diff) infection (NQF #1717); and
 - f) Sepsis Management (SEP-1).
- 3) The Contractor shall work with its contracted hospitals to continuously pursue a Standardized Infection Ratio (SIR) of 1.0 or lower for each of the specified hospital associated infections prioritizing hospitals that care for a high-volume of the Contractor's Enrollees. The Contractor also shall work with its contracted hospitals to improve adherence to the Sepsis Management (SEP-1) guidelines.

10.04 Appropriate Use of C-sections

10.04.1 Cesarean sections (C-sections) can be life-saving, but significant numbers of healthy first-time mothers are undergoing this major surgery when it is not medically necessary. Reducing the rate of unnecessary C-sections improves health outcomes and patient safety.

10.04.2 The Contractor must:

- 1) Adopt and actively implement guidelines set by Smart Care California to promote the appropriate use of C-sections. Smart Care California is not currently active, but its guidelines remain endorsed by Covered California, DHCS, and CalPERS as well as major employers of Pacific Business Group on Health. Smart Care California has adopted the goal of reducing Nulliparous, Term Singleton, Vertex (NTSV) C-section rates to meet or exceed the national Healthy People 2020 target of twenty-three-point nine percent (23.9%) for each hospital in the state.
- 2) Work collaboratively with Covered California to promote and encourage all in-network hospitals that provide maternity services to use the resources provided by California Maternity Quality Care Collaborative (CMQCC) and enroll in the CMQCC Maternal Data Center (MDC).
- 3) Review information on C-section rate for NTSV deliveries and use it to inform hospital engagement strategy to reduce NTSV C-sections.
- 4) **Adopt a payment methodology structured to support only medically necessary care with no financial incentive to perform C-sections for all contracted physicians and hospitals serving Enrollees by year end 2022.** Smart Care California has outlined three payment strategies to align payment with medically necessary use of C-sections:
 - a) Adopt a blended case rate payment for both physicians and hospitals;
 - b) Include a NTSV C-section metric in existing hospital and physician quality incentive programs; and
 - c) Adopt population-based payment models, such as maternity episode payment models.

10.04.3 The Contractor must annually report in the application for certification:

- 1) How it has adopted and implemented Smart Care California guidelines to promote the appropriate use of C-sections.
- 2) Its payment methodology for maternity care, how this methodology aligns with the Smart Care California payment strategies, and the number and percent of network maternity hospitals under each strategy.

10.04.4 Covered California expects the Contractor to contract with hospitals that demonstrate they provide quality care and promote the safety of Enrollees. Though Covered California does not expect the Contractor to base poor performance, and potential network removal decisions, on one measure alone, it is expected that Contractor will encourage providers with high rates of NTSV C-section delivery to pursue CMQCC coaching. Covered California expects the Contractor to consider NTSV C-section rate, improvement trajectory, and willingness to engage in coaching as part of its maternity hospital contracting decisions and terms by year end 2022 and annually thereafter.

DRAFT

ARTICLE 11

APPROPRIATE INTERVENTIONS

Appropriate Interventions include examining clinical interventions, such as prescription and nonprescription pharmaceutical treatments, procedures (like surgery), diagnostic tests (lab tests, X-rays, MRIs, etc.) and devices (like implants and pacemakers), to ensure they are rooted in the National Academy of Medicine's six aims for ensuring every individual's care is safe, timely, effective, efficient, equitable, and patient-centered. Equally important is effective consumer and patient engagement that (1) supports consumers in making decisions about health care services, treatments, and providers that are consistent with their values and preferences and (2) fosters access to care.

Over the next few years, a wide range of innovations in care delivery will have dramatically impact how care is provided, and the quality and cost of that care. Decision support to providers and patients at the point of care is particularly promising and bringing this information to where decisions are made appears to be critical to successful adoption. Covered California is continuously assessing the extent to which its contractual requirements can assist in prioritizing and standardizing implementation of best practices to benefit all Californians.

11.01 Demonstrating Action on High Cost Pharmaceuticals

11.01.1 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 the Contractor to ensure that its Enrollees receive timely access to appropriate prescription medications. Covered California is also 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. Access to affordable and effective prescription medications ensures equitable health outcomes for all Enrollees.

11.01.2 The Contractor must report in the annual application for certification a description of its approach to achieving value in delivery of pharmacy services, which must include a strategy in each of the following areas:

- 1) 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. The Contractor shall report the specific ways it uses a value assessment methodology or independent reports to improve value in pharmacy services and indicate which of the following sources it relies on:
 - a) Drug Effectiveness Review Project (DERP)
 - b) NCCN Resource Stratification Framework (NCCN-RF)
 - c) ASCO Value of Cancer Treatment Options (ASCO-VF)
 - d) ACC/AHA Cost/Value Methodology in Clinical Practice Guidelines
 - e) Premera Value-Based Drug Formulary (Premera VBF)
 - f) DrugAbacus (MSKCC) (DAbacus)
 - g) The ICER Value Assessment Framework (ICER-VF)

- h) Or other value assessment methodology
- 2) How its construction of formularies is based on total cost of care rather than on drug cost alone;
- 3) Its process for managing specialty pharmacy and biologics management; and
- 4) How it provides decision support for prescribers and consumers related to the clinical efficacy and cost impact of treatments and their alternatives.

11.02 Enrollee Healthcare Services Price and Quality Transparency Plan

11.02.1 Enrollee access to cost and quality information is essential for an Enrollee to make informed decisions about their health care. This information also allows transparency and accountability in ensuring there is equitable health care being delivered to Enrollees.

11.02.2 The Contractor must report in the annual application for certification its 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 the Contractor's membership size and current tool offerings. Regardless of how the requirement is fulfilled, the Contractor's planned approach must include:

- 1) Cost information:
 - a) 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 or payment amounts.
 - b) That enables Enrollees to understand provider-specific consumer cost shares for prescription drugs and for care delivered in the inpatient, outpatient, and ambulatory surgery or 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.
 - c) Commonly used service information should be organized in ways that are useful and meaningful for consumers to understand.
- 2) Quality information:
 - a) That enables Enrollees to compare providers based on quality performance in selecting a primary care clinician or common elective specialty and hospital providers.
 - b) That is based on quality measurement consistent with nationally-endorsed quality information.
 - c) That, as an interim step prior to integrating quality measurement into provider directory tools, can be provided by linking to:
 - i) The California Office of the Patient Advocate (www.opa.ca.gov/)
 - ii) Cal Hospital Compare (www.calhospitalcompare.org)
 - iii) CMS Hospital Compare Program (<https://www.medicare.gov/care-compare/>)
 - iv) CMS Physician Compare Program (<https://www.medicare.gov/care-compare/>)

- 3) The Contractor shall monitor care provided out of network to ensure that Enrollees understand that their cost share will be higher and are choosing out of network care intentionally.
- 4) If the 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. If Contractor enrollment is under 100,000 for Covered California business, the information may be provided by alternative means such as a call center.

11.02.3 The Contractor must report in the annual application for certification:

- 1) The number and percent of Enrollees in Covered California and all lines of business that have accessed each of the consumer tools offered.
- 2) How Enrollees in Covered California and all lines of business are using the cost and quality information to aid in their health care decisions and how the Contractor assesses the effectiveness of its consumer tools.

11.03 Enrollee Shared Decision-Making

11.03.1 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. Covered California encourages the incorporation of Choosing Wisely decision aids to promote decisions about appropriate and necessary treatment (<https://www.choosingwisely.org/>).

11.03.2 The Contractor shall promote and encourage patient engagement in shared decision-making with contracted providers. The Contractor must report in the annual application for certification for Enrollees in Covered California and all lines of business:

- 1) Specific information regarding the number and percent of eligible 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, the 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) 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) Participation in these programs and their results, including clinical, patient experience, and costs impacts.
- 4) How Choosing Wisely guidelines are being implemented by contracted providers to aid in conversations with Enrollees on appropriate and necessary care.

11.04 Enrollee Personalized Health Record Information

11.04.1 Accessibility to Enrollee personal health management information equips the Enrollee to be active and engaged in decisions about their coverage, care, and health. This transparency and personal authority contribute to achieving equitable health care.

11.04.2 To ensure accessibility of Enrollee health record information:

- 1) The Contractor must report in the annual application for certification, the services the Contractor provides for Enrollees in all lines of business, through its Enrollee portal, to easily access personalized information about their coverage and care. The Contractor shall explain services it makes available to Enrollees including:
 - a) Personal Health Record information and functions including provider appointment scheduling, test results look-up, prescription drug refill ordering, preventive screenings and vaccination history, visit summaries, wellness care and program enrollment; and
 - b) Coverage and cost information and functions including premium payment transactions, coverage and cost-share schedule, benefits cost accumulation year-to-date, explanation of benefits look-up, price and service comparisons for shopping.
- 2) The Contractor will provide access and log-in credentials for Covered California staff per mutually agreed-upon terms to safeguard Contractor proprietary information and services.

DRAFT

ARTICLE 12

KEY DRIVERS OF QUALITY CARE AND EFFECTIVE DELIVERY

Covered California's expectations of the Contractor are driven by its desire to improve health, improve quality of care delivered, reduce the cost of care, and reduce health disparities for all Enrollees. Covered California recognizes that achieving these goals within a delivery system shared among many purchasers and payors will require extensive alignment and coordination. To shape and organize this ongoing work, Covered California focuses its efforts on a number of key drivers, or leverage points, that have been shown to drive quality care and effective delivery. These key drivers have been selected after consulting industry leaders like the National Quality Strategy as well as consulting with key stakeholders.

Many of these key drivers are specifically articulated as expectations of Contractors throughout Attachment 7 as ways to ensure quality care, foster improvements in care delivery, and promote health equity (the appendix describes where each of the requirements tied to key drivers can be found throughout Attachment 7). While all of the key drivers are defined below, many of these drivers are also the subject of their own article (see Articles 13-17).

Finally, Attachment 7 necessarily focuses on the work of Covered California and its Contractors, but there are "community health drivers" that also play a large role in the health of all Enrollees. These community health drivers may be out of the scope of an individual Contractor's responsibility or Attachment 7, but it is important to recognize these drivers are a part of the context within which health care is delivered. Examples of community drivers are detailed after the roster of key drivers specific to Contractor's work.

12.01 Definitions of Key Drivers

Covered California's Key Drivers of Quality Care and Effective Delivery are chosen because: (1) changes to policies around each of these parts of the healthcare delivery system have been shown to change how care is delivered, both negatively and positively, and (2) they are within the scope of activities performed or overseen by Covered California and its Contractors.

The key drivers that make the foundation of this contract are:

- 1) **Benefit Design:** Standardized, patient-centered benefit designs help consumers make informed decisions because they are easier to compare across QHPs. They can also incentivize access to the right care at the right time. Benefit designs may include incentives that encourage patients to use particular providers or sites of care and formulary design and other designs that encourage providers to use particular interventions as appropriate for the benefit of each patient and the cost of care generally. Standard benefit designs along with guaranteed issue and risk adjustment create a level playing field among QHP Issuers ensuring that competition is based on the quality of care and service, network design, and efficiency as translated into premium price.
- 2) **Measurement for Improvement, Choice, and Accountability:** Effectively analyzing, tracking and trending the best data available to monitor patient care, outcomes and experiences allows Covered California to provide meaningful and actionable performance feedback to providers, plans, and the public to inform improvement efforts, delivery system reforms, consumer choice and accountability (see Article 13 for requirements). For a list of the measurement-related requirements that are found throughout Attachment 7, refer to Appendix A.
- 3) **Payment:** Payment reforms reward and incentivize delivery of high-quality patient-centered care that promotes better health, quality improvement and value while also fostering innovation, improving efficiency and adopting evidence-based practices. Evidence shows that payment models focused on

enhancing value are a consistent critical ingredient in successful system transformation. For a list of the payment-related requirements that are found throughout Attachment 7, refer to Appendix B.

- 4) **Patient-Centered Social Needs:** An individual's social and economic barriers to health can play a significant role in shaping outcomes. Many people face barriers that prevent them from receiving the right care at the right time, such as lack of transportation or food insecurity. A healthcare system that identifies and appropriately addresses health related social needs can impact health, transform lives, and reduce costs to the system overall. These are also commonly referred to as health-related social needs (see Article 14 for requirements).
- 5) **Patient and Consumer Engagement:** An individual's engagement in managing one's health and making health care decisions is a critical component of achieving optimal health outcomes, appropriate resource use and a responsive and effective healthcare delivery system. Support and system navigation assistance for all consumers can increase the use of appropriate health care services and improve patient outcomes. Effective patient engagement can also include shared decision-making and consumer-directed care and services. For a list of the patient and consumer engagement-related requirements that are found throughout Attachment 7, refer to Appendix C.
- 6) **Data Sharing:** Effective data sharing means making patient data available and accessible to support clinical care and coordination, limit health care costs, reduce administrative complexity, improve outcomes and give patients more control over their health care. Advances in data interoperability across providers and patients, new data capture, and measurement systems are critical to support appropriate care, population health management, successful ACO performance, successful integrated care delivery, advanced primary care, and disparities reduction. Timely data exchange among providers and between providers and plans is central to supporting transitions in care, effective care delivery and coordination, and accountability. Incorporation of data on behavioral, physical, and social health, including health related social needs such as housing or food insecurity, enables providers and plans to provide holistic, patient-centered care (see Article 15 for requirements).
- 7) **Data Analytics:** Data analytics requires inspecting, transforming and modeling data to discover timely and reliable information that will aide in a patient or provider's decision-making processes. Access to timely, reliable and accurate data and analytics is critical to positive ACO performance and effective primary care. This includes the analytical capacity of health plans to support providers with performance measurement, financial benchmarking and patient attribution as well as provider capacity to assess quality of care, coordinate care, identify at-risk patients and develop appropriate interventions. Practices need patient-level data to coordinate and manage care for their assigned populations; and practice-level data to track performance and course correct as needed on key cost, quality, and utilization metrics (see Article 15 for requirements).
- 8) **Administrative Simplification:** Implementing system changes to maximize the time providers spend with patients and minimize unnecessary administrative burden creates a more effective health care system for all while also protecting against provider burnout. Covered California is committed to driving change that does not increase provider and system burden.
- 9) **Quality Improvement and Technical Assistance:** Systems are transformed when all stakeholders are aligned around initiatives that lead to better patient outcomes and improved care delivery approaches. Strategies include strengthening the evidence base to inform decision-making and fostering learning environments that offer training, resources, tools and guidance to help organizations achieve quality improvement goals. In many areas, the evidence remains incomplete, at times inconsistent, and is constantly changing. Covered California looks to support and drive

efforts to increase the evidence available to all as well as promote established initiatives that have been shown to be effective (see Article 16 for requirements). For a list of the quality improvement and technical assistance-related requirements that are found throughout Attachment 7, refer to Appendix D.

- 10) Certification, Accreditation and Regulation: Covered California and Contractor are expected to follow existing mandatory regulatory and accreditation processes as well as use appropriate accrediting standards when they are available and that have been shown to drive quality and healthcare delivery improvement. Covered California may use accrediting standards to ensure the Contractor meets foundational requirements for safety and quality (see Article 17 for requirements).

12.02 Definitions of Community Drivers

Along with the key drivers of healthcare delivery reform, Covered California recognizes that many factors beyond specific instances of healthcare influence the individual health of its enrollees. Below are three drivers of community health. Covered California has chosen these drivers because they have been shown to be a powerful way of identifying and analyzing the many social and structural barriers individuals face when attempting to make healthy choices or access appropriate healthcare. However, these drivers are not included above as key drivers and they are not linked to contract requirements because they represent policy choices that are largely outside of the scope of activities performed or overseen by Covered California and Contractors.

While these community drivers are outside of the scope of enforcement for this contract, Covered California seeks to better understand them, explore how they lead to health inequities, and build partnerships for collective action around them whenever possible.

The community drivers that Covered California is highlighting are:

- 1) **Workforce:** Investing in people to develop a diverse, intergenerational and effective healthcare workforce, including supporting life-long learning for those working in the health field. A diverse workforce calls for a diversity of roles (including nonclinical health workers such as promotores and peer providers) and a diversity of backgrounds that are reflective of patient communities to be served.
- 2) **Community-wide Social Determinants:** Conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life-risks and outcomes.³
- 3) **Population and Public Health:** Good health on a community basis is often driven by broad interventions such as immunizations, smoking prevention programs, promoting healthy eating, etc.

³ Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved 10/7/2020, from <https://health.gov/healthypeople/objectives-and-data/social-determinants-health>.

ARTICLE 13

MEASUREMENT FOR IMPROVEMENT, CHOICE, AND ACCOUNTABILITY

Effectively analyzing, tracking and trending the best data available to monitor patient care, outcomes and experiences allows Covered California to provide meaningful and actionable performance feedback to providers, QHP Issuers, and the public to inform improvement efforts, delivery system reforms, consumer choice, and accountability. Covered California has described specific measurement requirements throughout the Attachment 7 contract as they relate to domains of care or care delivery strategies. Article 13 focuses on the submission and use of Quality Rating System measure data and subsequent comparison of Covered California performance to national benchmarks that cross multiple articles throughout Attachment 7. These two overarching requirements recognize that consistent measurement of QHP Issuers performance and benchmarks anchored in Quality Rating System and Quality Compass reporting requirements provide stakeholders with the opportunity to track and trend improvements over time. Furthermore, the Covered California measurement approach described herein will inform Healthcare Evidence Initiative (HEI) efforts, provider-level, and other QHP Issuer-level reporting described in other articles.

For a list of the measurement-related requirements that are found throughout Attachment 7, refer to Appendix A.

13.01 Covered California Quality Rating System Reporting

- 13.01.1 The Contractor and Covered California recognize that the Quality Rating System is an important component for overall performance accountability, an effective communication tool for Enrollees and the public, and can inform measure alignment with other purchasers and measure sets.
- 13.01.2 The 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). The 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.
- 13.01.3 The Contractor shall work with Covered California, including participating in quality assurance activities, to produce the Quality Rating System summary quality ratings each year.
- 13.01.4 Covered California reserves the right to use the Contractor-reported data to construct Contractor summary quality ratings that Covered California may use for purposes such as supporting consumer choice, quality improvement efforts, performance standards, and other activities related to Covered California's role as a Health Oversight Agency of Contractor's QHPs.

13.02 National Committee for Quality Assurance (NCQA) Quality Compass Reporting

- 13.02.1 The Contractor and Covered California recognize that performance measure comparison for the Covered California population to national benchmarks for commercial and Medicaid lines of business promotes health equity, informs efforts to address health disparities, and ensures consistent quality of care among all populations.
- 13.02.2 The Contractor shall annually collect and report HEDIS and CAHPS scores for its commercial (inclusive of the Covered California population) and Medi-Cal lines of business to the National Committee for Quality Assurance (NCQA) Quality Compass. This submission to NCQA Quality Compass shall include the numerator, denominator, and rate for the NCQA Quality Compass-required measures set.

13.02.3 The 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 the NCQA Quality Compass and DHCS, for each product type for which it collects data in California. The Contractor shall report HEDIS and CAHPS quality data to Covered California through the annual application for certification. For Contractors that have commercial lines of business that do not permit public reporting of their results to NCQA Quality Compass, HEDIS and CAHPS scores for the NCQA Quality Compass measures set should still be submitted to Covered California.

The Contractor shall report such information to Covered California in a form that is mutually agreed upon by the Contractor and Covered California in addition to participating in quality assurance activities to validate measure numerator, denominator, and rate data throughout the year.

DRAFT

ARTICLE 14

PATIENT-CENTERED SOCIAL NEEDS

Given the strong evidence of the role of social determinants on health outcomes, addressing patient-centered social needs is an important step in advancing Covered California's goal to ensure everyone receives the best possible care. Covered California has identified key requirements to better understand the effectiveness of current approaches to addressing patient-centered social needs and to help develop evidence for effective patient-centered social needs interventions.

14.01 Social Needs Screening for Food Insecurity and Housing Instability or Homelessness

14.01.1 Covered California acknowledges the importance of understanding patient health-related social needs – an individual's social and economic barriers to health – to move closer to equitable care and seeks to encourage the use of social needs informed care and targeted care. As social needs are disproportionately borne by disadvantaged populations, identifying and addressing these barriers at the individual patient level is a critical first step in improving health outcomes, reducing health disparities, and reducing health care costs.

14.01.2 The Contractor must screen for a minimum of two standard social needs: food insecurity and housing instability or homelessness. At minimum, all Enrollees engaged in plan-based programs such as complex care management, case management, and health education or promotion programs must be screened.

The Contractor must annually report to Covered California:

- 1) Its process for screening Enrollees for social needs, including which Enrollee touch points include social need screening, whether the screening is performed by Contractor's staff, vendor or network provider, and who performs the screening (clinician, Community Health Worker (CHW), or other non-clinical provider) and which social needs are routinely screened for.
- 2) The social needs screening efforts by its provider network and the actions the Contractor takes to coordinate screening and linkage to services with its provider network.
- 3) The total number of Enrollees screened for food insecurity and housing instability or homelessness, the number and percent who screened positive for each, and the number and percent who screened positive that were successfully linked to resources to meet the social need.

14.02 Community Resources Directory

14.02.1 Identification and information sharing of available community resources is critical to meeting identified member social needs.

14.02.2 The Contractor must develop and maintain a list of community resources by region covered to support linkages to appropriate social services. This requirement may be met through contracting with a vendor that maintains a resource directory or community resource platform applicable to Contractor's geographic licensed service area.

The Contractor must submit documentation of (1) the process for linking members with food insecurity or housing instability or homelessness to resources, and (2) how the Contractor tracks if or when the social need has been addressed.

ARTICLE 15

DATA SHARING AND ANALYTICS

Covered California is committed to making patient data available and accessible to support clinical care and coordination, decrease health care costs, reduce paperwork, improve outcomes and give patients more control over their health care. To allow for the discovery of timely and reliable information that will aid in a patient or provider's decision-making processes, Covered California will engage QHP Issuers in actively inspecting, transforming and modeling patient data.

15.01 Data Submission

15.01.1 Covered California and the Contractor recognize the importance of submitting timely and appropriate data for use in improving quality of care.

15.01.2 Contractor must comply with the following data submission requirements:

- 1) General Data Submission Requirements
 - a) California law requires the Contractor to provide Covered California with information on cost, quality, and disparities to evaluate the impact of Covered California on the healthcare delivery system and health coverage in California.
 - b) California law requires the Contractor to provide Covered California with data needed to conduct audits, investigations, inspections, evaluations, analyses, and other activities needed to oversee the operation of Covered California, which may include financial and other data pertaining to Covered California's oversight obligations. California law further specifies that any such data shall be provided in a form, manner, and frequency specified by Covered California.
 - c) The Contractor is required to provide Healthcare Evidence Initiative Data ("HEI Data") that may include, but need not be limited to, data and other information pertaining to quality measures affecting enrollee health and improvements in healthcare care coordination and patient safety. This data may likewise include enrollee claims and encounter data needed to monitor compliance with applicable provisions of this Agreement pertaining to improvements in health equity and disparity reductions, performance improvement strategies, individual payment methods, as well as enrollee-specific financial data needed to evaluate enrollee costs and utilization experiences. Covered California agrees to use HEI Data for only those purposes authorized by applicable law.
 - d) The Parties mutually agree and acknowledge that financial and other data needed to evaluate Enrollee costs and utilization experiences shall include, but need not be limited to, information pertaining to contracted provider reimbursement rates and historical data as required by applicable California law.
 - e) Covered California may, in its sole discretion, require that certain HEI Data submissions be transmitted to Covered California through a vendor (herein, "HEI Vendor") which will have any and all legal authority to receive and collect such data on Covered California's behalf. Notwithstanding the foregoing, the parties mutually agree and acknowledge that the form, manner, and frequency wherein Covered California may require the submission of HEI Data may, in Covered California's discretion, require the use of alternative methods for the submission of any such data. Such alternative methods may include but need not be limited to data provided indirectly through an alternative vendor or directly to

Covered California either via the terms of this Agreement or the certification process for Covered California participation. Covered California will provide Contractor with sufficient notice of any such alternative method.

- f) The parties further mutually agree that the aforementioned HEI Data may include information which represents Protected Health Information (PHI) for purposes of the HIPAA Privacy Rule (45 CFR §160.103), and that such data may no longer be subject to the HIPAA Privacy Rule once disclosed by Contractor to HEI Vendor or Covered California.

2) Healthcare Evidence Initiative Vendor (HEI Vendor)

- a) Covered California represents and warrants that any HEI Vendor which, in its sole discretion, Covered California should contract with to assist with its health oversight functions and activities shall have any and all legal authority to provide any such assistance, including but not limited to the authority to collect, store, and process HEI Data subject to this Agreement.
- b) The parties acknowledge that any such HEI Vendor shall be retained by and work solely with Covered California and that Covered California shall be responsible for HEI Vendor's protection, use and disclosure of any such HEI Data.
- c) Disclosures of HEI Data to HEI Vendor or to Covered California shall at all times be subject to conditions or requirements imposed under applicable federal or California state law.

3) HIPAA Privacy Rule

- a) PHI Disclosures Required by California law:
 - i) California law requires Contractor to provide HEI Data in a form, manner, and frequency determined by Covered California. Covered California has retained and designated HEI Vendor to collect and receive certain HEI Data information on its behalf.
 - ii) Accordingly, the parties mutually agree and acknowledge that the disclosure of any HEI Data to Covered California or to HEI Vendor which represents PHI is permissible and consistent with applicable provisions of the HIPAA Privacy Rule which permit Contractor to disclose PHI when such disclosures are required by law (45 CFR §164.512(a)(1)).
- b) PHI Disclosures for Health Oversight Activities:
 - i) The parties mutually agree and acknowledge that applicable California law (CA Gov Code §100503.8) requires Contractor to provide Covered California with HEI Data for the purpose of engaging in health oversight activities and declares Covered California to be a health oversight agency for purposes of the HIPAA Privacy Rule (CA Gov Code §100503.8).
 - ii) The HIPAA Privacy Rule defines a "health oversight agency" to consist of a person or entity acting under a legal grant of authority from a health oversight agency (45 CFR §164.501) and HEI Vendor has been granted legal authority to collect and receive HEI Data from Contractor on Covered California's behalf.

- iii) Accordingly, the parties mutually acknowledge and agree that the provision of any HEI Data by Contractor to Covered California or HEI Vendor which represents PHI is permissible under applicable provisions of the HIPAA Privacy Rule which permit the disclosure of PHI for health oversight purposes (45 CFR §164.512(d).
- c) Publication of Data and Public Records Act Disclosures
 - i) The parties mutually acknowledge and agree that California law requires Covered California to publish certain HEI Data provided by Contractor pertaining to its cost reduction efforts, quality improvements, and disparity reductions.
 - ii) Notwithstanding the foregoing, the parties mutually acknowledge and agree that data shall at all times be disclosed in a manner which protects the Personally Identifiable Information of Contractor's Enrollees.
 - iii) The parties further acknowledge and agree that records which reveal contracted rates paid by Contractor to health care providers, as well as any enrollee cost share, claims or encounter data, cost detail, or information pertaining to enrollee payment methods, which can be used to determine contracted rates paid by the Contractor to health care providers shall not at any time be subject to public disclosure and shall at all times be deemed to be exempt from compulsory disclosure under the Public Records Act.

15.02 Data Exchange with Providers

15.02.1 Covered California and the 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.

15.02.2 The Contractor must report on the following activities to support data exchange with providers in the annual application for certification:

- 1) The initiatives undertaken to improve routine exchange of timely information with providers to support their delivery of high-quality care. This requirement is supplemental to the mandatory implementation of electronic information exchange of admission, discharge, and transfer events outlined in Article 6, Section 6.03.
- 2) Describe participation in statewide or regional initiatives that seek to make data exchange routine, including the following Health Information Exchanges:
 - i) Manifest MedEx (formerly CallIndex)
 - ii) Los Angeles Network for Enhanced Services (LANES)
 - iii) Orange County Partnership Regional Health Information Organization (OCPRHIO)
 - iv) San Diego Health Connect
 - v) Santa Cruz Health Information Exchange
- 3) Report number and percent of the following that participate in Health Information Exchanges:
 - i) Professional providers
 - ii) Hospitals

The Contractor agrees to engage with Covered California in discussions regarding a transition to a statewide approach to streamline Health Information Exchange participation.

15.02.3 The Contractor must use standard processes for encounter data exchange with its contracted providers, which include:

- 1) The use of the 837-P and 837-I industry standard transaction sets for encounter data intake. These standard transaction sets must include appropriate cost sharing and member out of pocket information.
- 2) The use of the 277 CA transaction set and industry standard code sets to communicate encounter data that was successfully processed, as well as any encounter data that was rejected and requires resubmission. If the Contractor uses a clearing house to process encounter data and the 277 CA is not utilized, the Contractor must provide a daily detailed file to the clearing house of all rejected records and corresponding reasons for rejections. The Contractor must ensure its contracted providers receive visibility to the specific reasons the encounter data was rejected to allow for both successful resubmissions and any process improvement needed to minimize future rejections.

The Contractor shall participate in industry collaborative initiatives for improving encounter data exchange processes in California.

15.03 Data Aggregation Across Health Plans

15.03.1 Covered California and the Contractor recognize that aggregating data across purchasers and payors to more accurately understand the performance of providers that have contracts with multiple health plans can potentially be used to support performance improvement, contracting and public reporting.

15.03.2 The Contractor shall report in the annual application for certification its participation in initiatives to support the aggregation of claims and clinical data across health plans. The Contractor must include its assessment of additional opportunities to improve measurement and reduce the burden of data collection on health plans and providers through such proposals as a statewide All Payor Claims Database.

15.04 Patient Access Application Programming Interface

15.04.1 Covered California and the Contractor recognize that transparency in health information such as costs and outcomes will promote a value-based health care system. To this intent, Patient Access Application Programming Interface (API) software provides the ability to give patients greater control of their health information and care management.

15.04.2 The Contractor must implement and maintain a secure, standards-based Patient Access API. Specifically, the Contractor must:

- 1) Implement and maintain a secure, standards-based Patient Access API consistent with the CMS Patient Access final rule for Federally Facilitated Marketplaces.
 - a) Make the data available to 3rd-party application developers.
 - b) Using the Fast Healthcare Interoperability Resource (FHIR) standard, make the following types of information available:
 - i) Claims and encounters including encounters with capitated providers, provider remittance and enrollee cost-sharing data.
 - (1) Must contain all covered services including subcontracted, capitated or delegated services.

- (2) Must contain claims data for payment decision that may be appealed, were appealed or are in the process of appeal.
 - ii) Clinical data based on the United States Core Data for Interoperability (USCDI) data elements and classes, if maintained by Contractor.
 - c) Make the information available no later than one (1) business day after it is received by the Contractor.
 - d) Make API documentation publicly accessible.
 - e) Must conduct routine testing and monitoring and update as appropriate to ensure API functions properly.
 - f) Must provide educational materials about privacy and security considerations when selecting a 3rd-party application.
- 2) Report number and percent of patients accessing their Patient Access API in the annual application for certification.

DRAFT

ARTICLE 16

QUALITY IMPROVEMENT AND TECHNICAL ASSISTANCE

Covered California believes systems are transformed when all stakeholders are aligned around initiatives that lead to better patient outcomes and improved care delivery approaches. Strategies include strengthening the evidence base to inform decision-making and fostering learning environments that offer training, resources, tools, and guidance to help organizations achieve quality improvement goals. Covered California is also committed to supporting quality care collaboratives and data sharing initiatives that may lead to reductions in health disparities.

Covered California recognizes 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. Providers also play a critical role in ensuring quality care and should be supported with resources and tools to improve the delivery of care.

Quality improvement and technical assistance requirements are described throughout the Attachment 7 contract as they relate to specific domains of care or care delivery strategies. Article 16 focuses on the overarching quality improvement strategies that cross multiple articles. These overarching requirements recognize that improving health care quality, reducing overuse, and reducing cost can be achieved when multiple stakeholders join collaboratively in quality improvement efforts.

For a list of the Quality Improvement and Technical Assistance requirements that are found in Attachment 7, refer to Appendix D.

16.01 Quality Improvement Strategy

16.01.1 The 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 and reimbursement with delivery system and quality targets.

16.01.2 The Contractor shall align its Quality Improvement Strategy with the contractual requirements and initiatives of Covered California and to report on its multi-year strategy for implementing each initiative through the annual application for certification submitted to Covered California. The Contractor shall report such information in a form that is mutually agreed upon by the Contractor and Covered California and may include copies of reports used by the Contractor for other purposes. The Contractor understands that Covered California will seek increasingly detailed reports over time that will facilitate the assessment of the impacts of these strategies.

The annual application for certification 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 strategy.

16.02 Participation in Quality Improvement Collaboratives and Data Sharing Initiatives

16.02.1 Covered California believes that improving health care quality, reducing overuse and reducing costs can only be done over the long-term through collaborative efforts that effectively engage and support hospitals, clinicians and other providers of care and promotes data sharing among health systems. There are several established statewide and national collaborative initiatives for quality improvement and data sharing that are aligned with priorities established by Covered California.

16.02.2 The Contractor must report its participation in any of the following collaboratives or initiatives or other similar activities in the annual application for certification:

- 1) American Joint Replacement Registry (AJRR) for California
- 2) The CalHIVE Network
- 3) Cal Hospital Compare
- 4) California Maternal Quality Care Collaborative (CMQCC)
- 5) California Quality Collaborative (CQC)
- 6) Collaborative Healthcare Patient Safety Organization (CHPSO)
- 7) Integrated Healthcare Association (IHA)
- 8) Leapfrog
- 9) Symphony Provider Directory

16.02.3 Covered California and the Contractor will collaboratively identify and evaluate the most effective programs for improving care for Enrollees. Covered California may require participation in specific quality improvement collaboratives and data sharing initiatives in future years.

16.03 Adoption and Implementation of Smart Care California Guidelines

16.03.1 Smart Care California is a multi-stakeholder purchaser-led work group that leveraged Choosing Wisely decision aids to develop guidelines to support and drive quality improvement in hospital and patient safety.⁴ Smart Care California is not presently active, but its guidelines for management of opioids and a menu of payment options for maternity care remain endorsed by Covered California, DHCS, and CalPERS as well as the employers of Pacific Business Group on Health (PBGH). They can be found at <https://www.iha.org/our-work/insights/smart-care-california>.

16.03.2 The Contractor shall adopt and actively implement the Smart Care California guidelines supporting the appropriate use of C-sections for Nulliparous, Term, Singleton, Vertex (NTSV) deliveries (see Article 10, Section 10.04) and opioids (see Article 4, Section 4.03). The Contractor will report how it implements the guidelines from Smart Care California in the annual application for certification.

16.03.3 The Contractor will collaboratively work with Covered California to ensure that Smart Care guidelines are being implemented, to evaluate the effectiveness of the guidelines, and to update them as needed. Covered California will regularly monitor clinical outcomes and improvement strategies and engage with the Contractor to review its performance.

⁴ Smart Care California is currently on a suspended state due to the 2020 COVID-19 pandemic and the state's budget crisis. Covered California will continue to endorse the Smart Care California quality improvement guidelines for the 2022 Attachment 7 contract.

ARTICLE 17

CERTIFICATION, ACCREDITATION AND REGULATION

Covered California seeks to align with external-validated, industry standards in quality and set a base standard of core health plan functions across all plans. Assurance of a base standard will allow Covered California to phase in higher standards and standardize complementary elements of Population Health Management.

17.01 QHP Accreditation

17.01.1 The Contractor must maintain current health plan accreditation for its Covered California membership throughout the term of the Agreement. The Contractor shall authorize the accrediting agency to provide information and data to Covered California relating to the Contractor's accreditation, including the NCQA submissions and audit results, and other data and information maintained by accrediting agency as required under 45 C.F.R. § 156.275.

17.01.2 If the Contractor is not currently accredited by NCQA health plan accreditation:

- 1) The Contractor shall provide a written workplan to Covered California at least annually regarding the status and progress of the submitted workplan to achieve NCQA health plan accreditation by year end 2024.
- 2) If the Contractor is not currently accredited by NCQA health plan accreditation, the Contractor shall be currently accredited by URAC or AAHC health plan accreditation until NCQA health plan accreditation is achieved by year end 2024.

17.01.3 The 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, the Contractor shall provide Covered California with a copy of the Assessment Report within thirty (30) days of report receipt.

17.01.4 If the 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:

- 1) The Contractor shall notify Covered California within ten (10) business days of such rating(s) change. The Contractor will implement strategies to raise the Contractor's rating to a level of at least accredited or to reinstate accreditation. The Contractor will submit a written corrective action plan (CAP) to Covered California within thirty (30) days of receiving its initial notification of the change in category ratings.
- 2) Following the initial submission of the corrective action plan (CAP), the Contractor shall provide a written report to Covered California, when requested and at least quarterly, regarding the status and progress of the accreditation reinstatement. The Contractor shall request a follow-up review by the accreditation entity no later than twelve (12) months after loss of accreditation and submit a copy of the follow-up Assessment Report to Covered California within thirty (30) days of receipt, if applicable.

17.01.5 In the event the Contractor's overall accreditation is suspended, revoked, or otherwise terminated, or in the event the Contractor has undergone review prior to the expiration of its current accreditation and reaccreditation is suspended, revoked, or not granted at the time of expiration, Covered California reserves the right to terminate any agreement by and between the Contractor and Covered California or suspend enrollment in the Contractor's QHPs, to ensure

Covered California is in compliance with the federal requirement that all participating issuers maintain a current approved accreditation pursuant to 45 C.F.R. § 156.275(a).

17.01.6 Upon request by Covered California, the 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.

DRAFT

QUALITY, NETWORK MANAGEMENT AND DELIVERY SYSTEM STANDARDS

GLOSSARY OF KEY TERMS

Accountable Care Organization (ACO) - An ACO is defined as a system of population-based care coordinated across the continuum including multidisciplinary physicians and physician groups, hospitals, and ancillary providers with combined risk sharing arrangements and incentives between the Contractor and providers. ACO partners are held accountable for nationally recognized evidence-based clinical, financial, and operational performance. As providers accept more accountability under this provision, the health plans shall ensure that providers have the capacity to manage the risk.

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.

Contractor - The Health Insurance Issuer contracting with Covered California under this Agreement to offer a QHP and perform in accordance with the terms set forth in this Agreement.

Covered California – The California Health Benefit Exchange, doing business as Covered California and an independent entity within the Government of the State.

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 – Enrollee means each and every individual enrolled for the purpose of receiving health benefits.

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.” 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.”

Health Insurance Issuer - Health Insurance Issuer has the same meaning as that term is defined in 42 U.S.C. § 300gg-91 and 45 C.F.R. § 144.103.

Integrated Delivery Systems – An integrated delivery system (IDS) is a network of physicians and healthcare facilities that provide a continuum of healthcare services managed under one organization or one parent company. Similar to an ACO, an IDS includes population-based care coordinated across the continuum including multi-discipline physician practices, hospitals, and ancillary Providers with combined risk sharing arrangements and incentives between health plans and Providers, and among Providers across specialties and institutional boundaries. The IDS is held accountable for nationally recognized evidence based- clinical, financial, and operational performance, as well as incentives for improvements in population outcomes.

Measurement Year - The calendar year that the activity being assessed is performed.

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 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.

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 (NAM, 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, OBGYN, Pediatrics, General Practice, and Family Medicine as primary care specialties.

Qualified Health Plan or QHP– A health care service plan contract or policy of insurance offered by a QHP Issuer and certified by Covered California.

Qualified Health Plan Issuer or QHP Issuer - means a licensed health care service plan or insurer that has been selected and certified by Covered California to offer QHPs through Covered California.

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.

Reporting Year - The calendar year that performance data is reported to Covered California.

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-based 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.

Telehealth – A mode of delivering professional health care and public health services to a patient through information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site.

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.