COVERED CALIFORNIA

Covered California Holding Health Plans Accountable for Quality and Delivery System Reform

December 2019

Cover Image
This report provides data and analysis on Covered California's efforts to improve the performance of California's health care system and to ensure that its members receive affordable, high-quality care. The people featured on the cover are individuals who have benefited from these efforts. Their stories — and those of others told here: https://www.coveredca.com/real-stories/ — go beyond the data to provide personal perspectives on what Covered California has achieved over the past five years.

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Foreword

The Affordable Care Act opened the door to quality care for millions of Americans who had previously been shut out of our health care system. A companion to this report, "Covered California's First Five Years: Improving Access, Affordability and Accountability", provides an overview of how California — the state government, Covered California, and other stakeholders — are working together to use the tools provided by the Affordable Care Act to lower costs for consumers and provide meaningful choice and coverage that truly meets consumers' needs. The state is now building on and going beyond the Affordable Care Act on the path toward universal coverage.

This report details how for more than five years, Covered California has held itself accountable as a public entity charged with assuring consumers get the right care at the right time, while we hold the 11 health insurance companies we have chosen to contract with accountable for making sure that consumers receive high-quality care and that both insurers and providers are implementing the delivery system reforms needed to improve care for all Californians.

For Covered California, accountability means making sure health plans are meeting consumers' needs today and seeing that they are taking concerted and deliberate action to improve how health care is paid for, organized and delivered in California. The goal of this accountability is to have a health care system that truly addresses the triple aim of improving health, delivering better-quality care and lowering costs.

This report focuses on how contracted health insurers are held accountable for assuring quality care *and* for promoting delivery system reform. Chapter 1 describes the framework that now guides this work. Chapters 2 through 6 describe how Covered California holds insurers accountable for assuring quality care, including not only the specific measures used to track performance, but also the progress that has been made overall and by individual insurers on these measures. Chapters 8 through 11 then summarize the approaches to holding each health insurer accountable for advancing health care delivery reform.

We share this report not because we believe our work is done, but rather because it is just beginning. Improving health care quality and lowering underlying health costs is long-term pursuit. That pursuit is central to Covered California's mission, and this report identifies progress made and areas of needed attention as we move forward.

Peter V. Lee
Executive Director

Covered California Holding Health Plans Accountable for Quality and Delivery System Reform

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Chapter 1: Covered California's Framework for Assuring Quality Care and Promoting Delivery System Reform

Covered California's current contract requirements with qualified health plan (QHP) issuers (also referred to as "health insurance companies", "insurers" or "health plans" in this report)[1] are laid out in Attachment 7: Quality, Network Management, Delivery System Standards and Improvement Strategy of the QHP issuer contract. The contract is designed to hold insurers accountable for ensuring that people get the right care at the right time and that care is individualized for their specific needs, while seeking to improve how care is delivered and promoting care that is increasingly high-quality, equitable and cost-effective.[2]

The current Attachment 7 is composed of nine articles; each article has a distinct focus, including ensuring networks are based on value and reducing health disparities. In addition, multiple articles have elements related to quality improvement, network management and delivery system reform requirements. Attachment 7 includes a number of initiatives that require concerted, multi-year efforts of health insurance companies across the California delivery system. Insurers report annually and as part of quarterly review meetings with Covered California on their Attachment 7 performance. Covered California staff review and assess the information submitted for both contract compliance purposes and to assess the success of the Attachment 7 initiatives in achieving the priority outcomes of quality care and effectively delivering that care.

Covered California is working to update its health insurance company contract terms for the 2022-2024 plan years and is seeking to refresh its requirements for the future that continue to address the "Triple Aim" of lowering costs, improving quality and improving health outcomes, with a focus on reducing health disparities. This update will include a revised framework for Attachment 7 that is organized and composed of two main strategies: Assuring Quality Care and Effective Care Delivery. This report describes the progress Covered California contracted health insurance companies have made between 2014 and 2019[3] in implementing the requirements within the current Attachment 7 organized by the revised framework described in *Figure 1. Covered California's Framework for Holding Plans Accountable for Quality Care and Delivery Reform Framework*.

Assuring Quality Care

Covered California is committed to ensuring that care is individualized and equitable for not only those people currently needing or receiving treatment, but for those who are working to stay healthy. The

[1] The term "health insurance companies" or "insurers" refers to the organizations providing health coverage and "health plan" refers to the health coverage products they provide, such as an HMO plan vs. a PPO plan.

[2] Beginning with the inaugural 2014 plan year and updated in 2017, Covered California set forth standards and strategies for quality improvement and delivery system reform in its QHP issuer contract, specifically in the section of the contract titled "Attachment 7: Quality, Network Management, Delivery System Standards and Improvement Strategy". See more: https://hbex.coveredca.com/insurance-companies/PDFs/Attachment-7_2020_Clean_Final-Model.pdf.

[3] This report does not include data for plan year or measurement year 2014; rather it describes the progress Covered California contracted health insurance companies have made since 2014 on Attachment 7 requirements with the first year of data representing plan year or measurement year 2015 for most requirements.

Figure 1. Covered California's Framework for Holding Plans Accountable for Quality Care and Delivery Reform Framework

concept of individualized, equitable care[4] means regardless of one's circumstances, race, gender, where one lives or other socioeconomic factors — and for some decisions where more than one evidence-based treatment is available, based on one's values and preferences — every individual deserves the best possible care that is personalized for them and delivered in the right setting at the right time, does not cause harm and is the most cost-effective possible. These goals are consistent with the six domains of health care quality identified by the Institute of Medicine:[5] safe, timely, effective, efficient, equitable and patient-centered (STEEEP). In addition to assuring quality care for those insured through the marketplace, Covered California will continue its efforts to identify and reduce racial and ethnic health disparities for the entire population.

What follows are the organizing domains for assuring quality care beyond the cross-cutting concept that all care should be individualized and equitable:

- **Health promotion and prevention:** Everyone is encouraged to receive preventive care services and health screenings and use support tools that promote a healthy lifestyle. This includes everything from regular checkups to smoking cessation and dietary programs.
- **Mental health and substance use disorder treatment:** Identifying, engaging and supporting through treatment people with mental health conditions and substance use disorders and ensuring that they are provided with timely and effective care that is integrated with their other health care needs.

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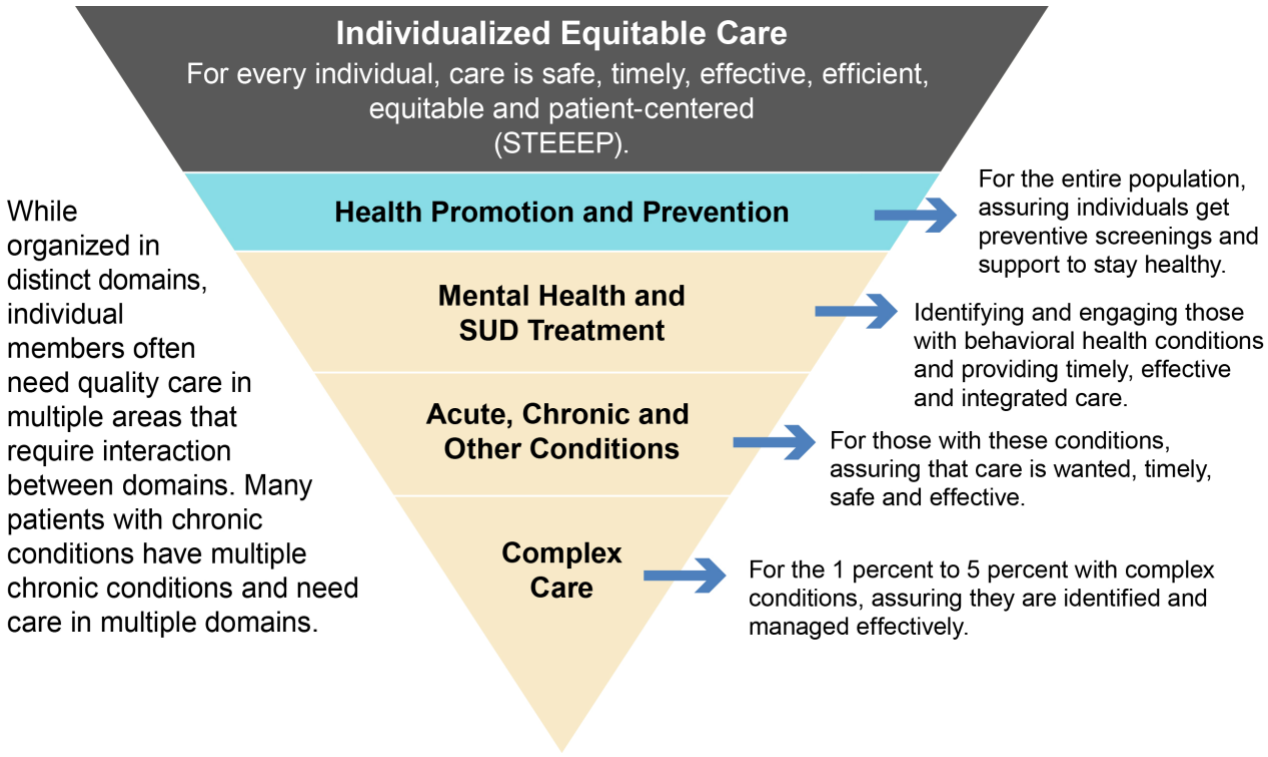
[4] In the current contract, Covered California focused health equity efforts on reduction of health disparities. While inclusive of health disparities reduction, the revised framework of Individualized, Equitable Care is intended to capture the broad goal of care that is individualized to address an individual's health needs.

[5] Committee on Quality Health Care in America, Institute of Medicine. (2001). Crossing the quality chasm: a new health system for the 21st century. Washington, D.C.: National Academy Press.

- **Acute, chronic and other conditions:** Actively managing care for people with acute conditions, which are defined as illnesses or diseases that are short term and last typically a few days to weeks, such as an infection or an injury; chronic conditions, which typically develop slowly over time and last months to years, such as diabetes, most cancers, cardiovascular disease, and infectious diseases like Human Immunodeficiency Virus (HIV); and other conditions that are temporary, such as pregnancy or gestational diabetes.
- **Complex care:** Effectively managing very complex conditions for individuals that require a multitude of specialty, high-cost treatments — such as cancer or transplants — or require end of life care. These are individuals who need to be managed effectively or seen in very specialized settings by providers who know how to manage their condition well and can provide coordinated interventions.

The concept of individualized, equitable care as it applies to the specific care domains is illustrated in *Figure 2. Covered California's Domains for Assuring Contracted Health Plans Deliver Quality Care*, recognizing that some members with mental health, substance use disorders or multiple chronic conditions need care in multiple domains.

Figure 2. Covered California's Domains for Assuring Contracted Health Plans Deliver Quality Care



Effective Care Delivery

In addition to addressing various populations and the care they receive, Covered California also focuses on effective care delivery strategies and its contractual requirements promote improving the way care is delivered for our enrollees and all Californians, whether it is provided by a primary care physician, hospital, clinic or other provider. What follows are the organizing strategies for effective care delivery:

- **Effective primary care:** The foundation of providing appropriate and equitable care is built on team-based, data-driven primary care that is well integrated, coordinated and continuous. While many consumers benefit from an ongoing continuous relationship with a single physician, there is strong evidence that primary care through well-integrated sites of care or delivery systems are more effective.
- **Promotion of integrated delivery systems and accountable care organizations:** Effectively caring for and managing a person's health requires an integrated care system that can coordinate across providers, sites and time for a variety of conditions while delivering good outcomes and quality at an affordable cost.
- **Networks based on value:** All clinicians, providers, hospitals and sites of care are selected and regularly assessed based on how those individuals or institutions provide care that is safe, timely, effective, efficient, equitable, and patient-centered. Ideally, every network is composed of integrated systems, effective primary care and designed considering the value it provides.

Regardless of the organizing strategies — whether focused on primary care, an integrated delivery system or the overall network — Covered California aims to ensure the interventions that patients receive are both appropriate and delivered through sites and services that meet their needs:

- **Appropriate interventions:** The use of clinical interventions, such as prescriptions, procedures, diagnostic tests and devices that are rooted in the STEEEP domains and based on strong evidence and shared decision-making.
- **Sites and expanded approaches to care delivery:** Covered California supports patients in getting health interventions and treatments in the most appropriate setting. That means assuring quality care is delivered not only in hospitals, whether on an in-patient or outpatient basis, but in ambulatory settings such as a doctor's office, urgent care facilities, retail facilities such as drop-in clinics, at home, or through telehealth. Expanded approaches to care delivery also include who provides care in addition to physicians, such as registered nurses, pharmacists, midwives or other non-licensed providers like community health workers.

Key Drivers of Quality Care and Effective Delivery

Covered California recognizes that moving health reform forward in an impactful way within a delivery system shared among many purchasers and health insurance companies will require aligning with other purchasers and working with all relevant payers in a way that reduces the burden on providers. When considering the key drivers of quality care and effective delivery, Covered California has looked to the National Quality Strategy[6] and mirrored many of the same levers initially noted in 2011.

Many of these levers or drivers are specifically articulated as expectations of health insurers in Attachment 7 as ways to assure individuals get the right care. Insurers are working to improve the delivery system over time. However, some of the "community drivers" that are identified may be outside of the scope of an individual insurer's responsibility or Covered California's contract. Nevertheless, it is important to recognize these drivers are a part of the context within which health care is delivered and the quality of health that consumers experience. Examples of community drivers are detailed after the roster of drivers specific to health insurer's work. Key drivers include:

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[6] Agency for Healthcare Research and Quality. (2011) 2011 Report to Congress: National Strategy for Quality Improvement in Health Care. Retrieved from https://www.ahrq.gov/workingforquality/reports/2011-annual-report.html

1. **Benefit design:** Helping consumers make informed decisions by standardizing benefit designs, so they are easier to understand and compare, and incentivize access to the right care at the right time. Benefit design may include incentives to encourage patients to use particular providers or particular sites of care or formulary and other designs to encourage providers to select particular interventions as appropriate.
2. **Measurement for improvement, choice and accountability:** Providing meaningful and actionable performance feedback to providers, insurers and the public to improve care and compare treatment results, cost and patient experiences for consumers.
3. **Payment:** Rewarding and incentivizing 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.
4. **Patient-centered social needs:** Identifying, and, as needed, addressing patient-centered support for non-medical services, recognizing that many people may face barriers that prevent them from staying healthy and receiving the right care at the right time, such as food insecurity, housing insecurity and lack of transportation to their doctor.
5. **Patient and consumer engagement:** Increasing support for and the level of participation by patients and consumers in managing their health and making their personal health care decisions.
6. **Data sharing:** 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.
7. **Data analytics:** Inspecting, transforming and modeling data to discover timely and reliable information that will aid in a patient or provider's decision-making processes.
8. **Administrative simplification and provider burden reduction:** Implementing system changes to maximize the time providers spend with patients and minimize unnecessary administrative burden.
9. **Certification, accreditation and regulation:** Employing existing regulatory and accreditation processes and work with other agencies and departments to ensure approaches meet safety and quality standards. For example, California's Departments of Insurance and Managed Health Care enforce the regulatory standards that Covered California relies on for network adequacy. The National Committee for Quality Assurance (NCQA), among others, conducts health plan accreditation.
10. **Quality improvement and technical assistance:** Promoting initiatives that will lead to better patient outcomes and better care delivery approaches, strengthening the evidence base to inform better decision-making and fostering learning environments that offer training, resources, tools and guidance to help organizations achieve quality improvement goals.

Beyond the drivers of more effective care and healthier populations that relate to what an individual insurer can do or be held accountable for, Covered California recognizes and seeks to better understand the impact of broader social and structural issues on health status, care and care delivery. Community health drivers include:

- **Workforce:** Investing in people to prepare the next generation of health care professionals and support lifelong learning for providers.
- **Community-wide social determinants:** Addressing structural social and economic influences that impact individual and group differences in health.
- **Population and public health:** Increasing the health of a community through broad interventions that address public health, homelessness or food insecurity.

ASSURING QUALITY CARE

Chapter 2: Individualized, Equitable Care — Best Possible Care for All

Covered California's overarching goal is to ensure that everyone receives the best possible health care. This goal entails striving to ensure that care is personalized, does not cause harm, is delivered in the right setting at the right time, and is as cost effective as possible. For decisions where more than one evidence-based treatment is available, the goal is to support individuals in choosing treatment based on their values and preferences. In the framework proposed by the Institute of Medicine 20 years ago, everyone should receive care that is safe, timely, effective, efficient, equitable, and patient-centered (often captured by the acronym "STEEEP").[7] Unfortunately, the quality of care delivered in the United States varies dramatically.

Of the elements related to the Institute of Medicine's framework, the domain that has too often not been given central focus is the charge to ensure that care is equitable. Addressing health equity and disparities in health care has been integral to Covered California's mission. Given that focus, after reviewing some important overall indicators of how health plans are generally meeting consumers' needs, much of this chapter specifically addresses Covered California's focus on the issue of equity. The other domains of the STEEEP framework are addressed throughout the report and are integral to Covered California's approach. The Quality Rating System (QRS), which includes performance measures based both on clinical measures and on patients' reported experience of getting care, provides a global picture of how Covered California's health plans are doing at providing the best possible care. In this chapter, the Global and Summary Components of the

Highlights

- Covered California enrollees are generally very satisfied with their experience with their health plans and their health care, with the vast majority enrolled in plans that score above the 50th percentile for enrollee satisfaction with their health care and plan.
- Global Quality Ratings have improved since their launch in 2016, but a dip in 2019 has generated further scrutiny.
- Covered California has launched a long-term initiative to reduce health disparities. In response to contractual requirements, 93 percent of enrollees are in plans that were at or above the 80 percent requirement for enrollee self-identification of race/ethnicity.
- All 11 insurers are analyzing disparities in care for patients with diabetes, hypertension, asthma and depression for all of their lines of business, not just Covered California, and planning targeted interventions.
- Gaps in quality by race/ethnicity were found for all insurers — but were not consistent (e.g., for some insurers African Americans warranted targeted interventions for diabetes, and Latinos in others).
- Racial and ethnic disparities are generally smaller than the differences in quality across plans: enrollment in Sharp Health Plan or Kaiser Permanente is a better predictor of receiving good care than race or ethnicity is.
- Nevertheless, all insurers have identified a disparity where a targeted intervention can improve help reduce disparities and improve health.

[7] Committee on Quality Health Care in America, Institute of Medicine. (2001). Crossing the quality chasm: a new health system for the 21st century. Washington, D.C.: National Academy Press.

health plan quality ratings are presented, along with two measures that relate to enrollee satisfaction with their health plan and their care.

Social, economic and geographic disparities in health and health care pose a particularly serious challenge to the goal of ensuring the best possible care for all. Because social and environmental factors are powerful determinants not only of the care individuals receive but also of their underlying health, reducing disparities requires efforts within the health care delivery system and in the broader community. Covered California recognizes that meaningful progress will require multi-pronged and multi-year efforts.

Covered California is working to reduce disparities and promote health equity. To this end, Covered California has hired a new health equity officer who plans, implements and integrates Covered California's health equity agenda with Covered California's quality improvement and delivery system reform efforts. The health equity officer leads the work of the new Population Care Unit within the Plan Management Division, which is composed of staff positions dedicated to quality improvement, health equity and social determinants of health.

Covered California is working with health plans to reduce health disparities and promote health equity by: (1) identifying the race/ethnicity of all enrollees; (2) collecting data on diabetes, hypertension, asthma and depression to measure how quality varies by race/ethnicity; (3) conducting population health-improvement activities and interventions to narrow observed disparities in care; and (4) promoting community health initiatives that foster better health, healthier environments, and promote healthy behaviors. This chapter describes how Covered California has moved forward in each of these areas.

This chapter on individualized, equitable care is organized as follows:

Section 1. Qualified Health Plan Experience

Section 2. Health Plan-Reported Measures for Health Disparities

Section 3. Implications for the Future

Section 1. Qualified Health Plan Experience

Health Plan Measures Reported to the Quality Rating System

This section presents performance data reported by health insurance companies for contract requirements and includes assessments and observations by Covered California. One key mechanism used by Covered California for health plan oversight and accountability is public reporting of global and individual health plan quality-performance measures to the Centers for Medicare and Medicaid Services' Marketplace Quality Rating System (QRS). In the current contract requirements, health plans are required to:

1. Annually collect and report to Covered California for each product type the measure numerator, denominator and rates for its QRS data, including Healthcare Effectiveness Data and Information Set (HEDIS) measures, Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data and other performance data.
2. Submit HEDIS and CAHPS scores to include the measure numerator, denominator and rate for the required measures set reported to NCQA Quality Compass and the Department of Health Care Services (DHCS), for each product type for which it has data in California.

Global and Summary Component Health Plan Quality Ratings

The Marketplace QRS global quality ratings show how health plans compare on helping members get the right medical care and on member-reported experiences of care and service. Covered California displays each health plan's QRS rating to enrollees through the plan shopping experience and on coveredca.com.

Plans are rated on a scale of one to five stars. To assign the star rating, each health plan's results are compared to about 200 marketplace health plans nationwide. A five-star plan means that health plan scored among the top plans nationwide; a one-star rating means the plan's score was among the lowest.

QRS is composed of a global quality ratings and summary component ratings for three major aspects of health plan performance.[8] Each health plan's product (HMO, PPO, EPO) receives a separate QRS rating.

Global quality rating: The global quality rating is a roll-up of three summary components per the following weighting:

Summary Components	Weights
Getting Right Care (HEDIS)	66%
Members' Care Experience (CAHPS)	17%
Plan Services (HEDIS and CAHPS)	17%

A global quality rating is constructed for each health plan that has at least two of the three component scores, and one of the scores must be for the "Getting the right care" component:

- **Getting the right care:** Each year, a sample of members from each health plan is selected, and their records are checked to compare their medical care with national standards for care and evidence-based treatments. More than 30 HEDIS measures are tracked using medical charts and billing records sent by providers and hospitals. These quality measures include how well the health plan and its providers care for enrollees, such as controlling high blood pressure, lowering cholesterol and getting the right medications.
- **Members' care experience:** Members' experiences with their doctor and care are based on the CAHPS survey that asks about members' recent experiences when visiting the doctor and getting medical care. About one of every five people who receive a survey in the mail or by phone provides a response, with about 250 members from each plan completing surveys. CAHPS surveys are currently only available in English or Spanish, but insurers are encouraged to translate the surveys into other languages that reflect their patient population. Translation guidelines are readily available from CMS.
- **Plan services for members:** A sample of plan members' records is checked to see if patients got unnecessary care — services that could be harmful and wasteful. The CAHPS member survey is also used to report on members' experiences in getting help and information from the insurer's customer service staff.

[8] See the Appendix 2 for the complete list of measures used to determine each summary component rating of QRS.

The QRS ratings of Covered California health plans have generally improved over time, but there was a downward trend in 2019.[9] For the 2019 reporting year, which represents the 2018 measurement year, the overall trend is lower star ratings compared to 2018: for the global rating, only one plan has a 5-star rating and one plan has a 4-star rating while most have 2 and 3-star ratings (see *Table 1. Global Quality Ratings by Reportable Products for Individual and CCSB Markets, 2016-2019*).

Table 1. Global Quality Ratings by Reportable Products for Individual and Covered California for Small Business (CCSB) Markets, 2016-2019

Overall Quality Ratings by Reportable Products for Individual and CCSB Markets						
	# Products with No Global Rating	1 Star ★	2 Star ★★	3 Star ★★★	4 Star ★★★★	5 Star ★★★★★
2019 QRS	**3***	**0**	**5**	**5**	**1**	**1**
2018 QRS	**3***	**0**	**0**	**6**	**4**	**2**
2017 QRS	**4***	**0**	**3**	**6**	**1**	**1**
2016 QRS	**5***	**1**	**7**	**2**	**1**	**1**

*No global rating if a newer product and not eligible for reporting or insufficient sample sizes to report results for at least 2 of the 3 summary component categories.

Source: Covered California Health Plan QRS Reporting

Table 2 lists the global rating and the three summary component ratings for each Covered California health plan for 2019. Covered California health plans generally performed well on the Plan Services for Members component rating, with all plans receiving a 3-star rating or above on this component.

[9] The 2018 reporting year, which represented the 2017 measurement year, was impacted by a federal statistical methodology that appears to have inflated star ratings for that year. Covered California is working with CMS to achieve a more stable methodology that will allow better year-to-year comparisons of star ratings based on changes in performance. This affected only the star rating, not the underlying measure scores reported below.

Table 2. Covered California Health Plan QRS Global and Summary Component Ratings, 2019

Health Plan	Product Type	Global Rating	Getting the Right Care	Members' Care Experiences	Plan Services for Members
Anthem	EPO	★★	★★	★★	★★★
Blue Shield	PPO	★★★	★★	★★★	★★★
Blue Shield	HMO	★★★	★★	★★★	★★★
CCHP	HMO	★★★	★★★	★★	★★★★★
Health Net	HMO	★★	★★★	★	★★★
Health Net	EPO	One Quality Rating Available	★★	Not Reportable**	Not Reportable**
Health Net	PPO	Quality Rating in Future*	Quality Rating in Future*	Quality Rating in Future*	Quality Rating in Future*
Kaiser	HMO	★★★★★	★★★★★	★★★★	★★★★★
LA Care	HMO	★★★	★★★	★★	★★★
Molina	HMO	★★	★★	★★	★★★
Oscar	EPO	★★	★★	★★★	★★★★★
Sharp	HMO	★★★★	★★★★	★★★	★★★★
Valley	HMO	★★★	★★★★	★	★★★
WHA	HMO	★★	★★	★★★	★★★★
Blue Shield	HMO/CCSB	★★★	★★	★★★	★★★
Health Net	PPO/CCSB	Quality Rating in Future*	Quality Rating in Future*	Quality Rating in Future*	Quality Rating in Future*

*Quality ratings are reported for a health plan product after its first two years with Covered California.

**Not enough data to calculate a score according to the quality rating methodology.

Source: Covered California Health Plan QRS Reporting

Enrollee Satisfaction With Their Health Care and Health Plan

Assuring that care is patient-centered requires assessment of a range of elements, including the extent to which patients receive the right care, at the right time, and in the most appropriate setting. As discussed in Chapter 10: Appropriate Interventions, it also means that care provided is informed and based on the patient's preferences and their understanding of the implications of their choices. At a high level, however, a starting point of making sure care is patient-centered is considering patient voices in assessing health plans' performance.

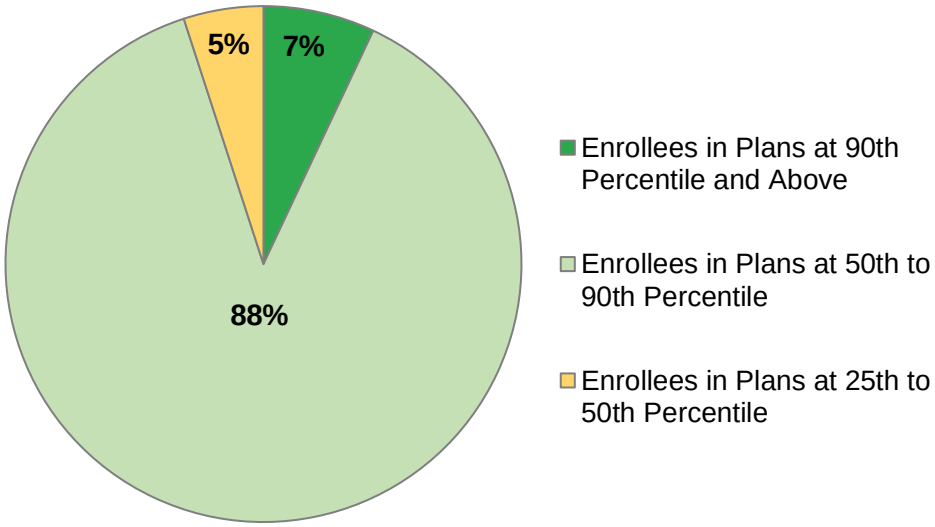
Among the health plan measures reported to the Marketplace Quality Rating System are Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures that reflect consumers' perspectives and their reported experience with care received. These Marketplace Quality Rating System (QRS) standard performance measures are a key mechanism used by Covered California for health plan oversight and accountability. To more sharply focus health plan accountability efforts, Covered California examined over 40 measures used by QRS and is proposing to prioritize a subset of 13 measures that were selected based on the following criteria: (1) health impact; (2) extent of health plan variation; (3) performance improvement opportunity; (4) alignment with other California accountability programs; and (5) balance across domains of care, such as prevention, chronic illness care and behavioral health. Three of the 13 measures overlap with the measures currently collected by race/ethnicity for health disparities reduction interventions as discussed in Section 2 of this chapter.

The following tables display the priority measures for individualized, equitable care in the QRS measure set and include the Covered California weighted average, the highest- and lowest-performing plans, plan-specific performance and national percentiles for all marketplace plans:

1. Rating of Health Plan (Table 3).
2. Rating of All Health Care (Table 4).

These two CAHPS questions the reflect consumers' overall satisfaction with their health plan and the care they received. As evident from each of these measures, there is generally high satisfaction among Covered California enrollees with their health plans (with 95 percent of enrollees reporting satisfaction that is above the 50th percentile nationally) and with their care (75 percent of enrollees reporting satisfaction that is above the 50th percentile nationally). (See *Figure 3. Covered California Enrollment in Health Plans by Consumer Rating of Health Plan — 95 Percent of Enrollees in Plans Scoring Above the 50th Percentile Nationally, and All Enrollees in Plans Above the 25th Percentile, 2019.*)

Figure 3: Covered California Enrollment in Health Plans by Consumer Rating of Health Plan — 95 Percent of Enrollees in Plans Scoring Above the 50th Percentile Nationally, and All Enrollees in Plans Above the 25th Percentile, 2019



Rating of Health Plan

The Rating of Health Plan measure indicates enrollee experience related to the rating of health plan QHP Enrollee Survey question.

Table 3: Covered California Enrollees Rating of Health Plan (CAHPS)

	2016	2017	2018	2019			
	US Benchmark	US Benchmark	US Benchmark	US Benchmark	Percent of Enrollees	Number of Enrollees	Number of Plans
Plans at 90th Percentile and Above	78 +	78 +	79 +	75 +	7%	93,322	1
Plans at 50th to 90th Percentile	72 to 78	72 to 78	73 to 79	69 to 75	88%	1,187,877	10
Plans at 25th to 50th Percentile	67 to 72	68 to 72	69 to 73	64 to 69	5%	64,031	1
Plans Below 25th Percentile	Below 67	Below 68	Below 69	Below 64	0%	-	0
Covered California High/Average/Low Performers							
Covered CA Highest Performer	79	80	82	76			
Covered CA Weighted Average	73	76	78	73			
Covered CA Lowest Performer	66	69	65	69			
Covered California Plan-Specific Performance							
Anthem HMO	71	74					
Anthem PPO	67	70					
Anthem EPO			67	69	5%	64,031	
Blue Shield HMO	70	75		76	7%	93,322	
Blue Shield PPO	75	75	78	71	25%	335,176	
CCHP HMO	74	76	78	73	1%	10,013	
Health Net HMO	70	75	73	70	11%	145,183	
Health Net EPO		69	65				
Health Net PPO							
Kaiser Permanente HMO	79	80	82	74	36%	477,683	
LA Care HMO	68	77	73	73	6%	84,750	
Molina Healthcare HMO	66	72	69	71	4%	56,023	
Oscar Health Plan EPO			80	71	3%	35,962	
Sharp Health Plan HMO	77	80	78	75	1%	17,335	
Valley Health Plan HMO	70	76	78	75	1%	16,366	
Western Health Advantage HMO	77	77	78	72	1%	9,386	

Rating of All Health Care

The "Rating of all health care" measure is an overall indicator of enrollees' satisfaction (0-10 scale) with their health care based on the QHP Enrollee Survey.

Table 4: Covered California Enrollees' Rating of All Health Care (CAHPS)

	2016	2017	2018	2019			
	US Benchmark	US Benchmark	US Benchmark	US Benchmark	Percent of Enrollees	Number of Enrollees	Number of Plans
Plans at 90th Percentile and Above	85 +	86 +	86 +	82 +	0%	-	0
Plans at 50th to 90th Percentile	82 to 85	83 to 86	83 to 86	78 to 82	75%	1,008,266	5
Plans at 25th to 50th Percentile	80 to 82	81 to 83	81 to 83	75 to 78	25%	336,964	7
Plans Below 25th Percentile	Below 80	Below 81	Below 81	Below 75	0%	-	0
Covered California High/Average/Low Performers							
Covered CA Highest Performer	84	88	86	80			
Covered CA Weighted Average	80	81	83	78			
Covered CA Lowest Performer	69	75	74	75			
Covered California Plan-Specific Performance							
Anthem HMO	78	79					
Anthem PPO	76	82					
Anthem EPO				76	5%	64,031	
Blue Shield HMO				80	7%	93,322	
Blue Shield PPO	83	82	85	78	25%	335,176	
CCHP HMO	80	80	81	77	1%	10,013	
Health Net HMO	74	78	78	75	11%	145,183	
Health Net EPO		81					
Health Net PPO							
Kaiser Permanente HMO	84	84	86	80	36%	477,683	
LA Care HMO	80	83	76	78	6%	84,750	
Molina Healthcare HMO	69	75	74	76	4%	56,023	
Oscar Health Plan EPO			82	76	3%	35,962	
Sharp Health Plan HMO	83	88	85	80	1%	17,335	
Valley Health Plan HMO	76	80	81	77	1%	16,366	
Western Health Advantage HMO	83	85	84	76	1%	9,386	

Covered California's Attention to Equity and Health Disparities

Covered California has prioritized initiatives to narrow health care and coverage disparities and ensure health equity for all. Reducing health disparities is part of Covered California's vision and mission statement and has the potential to benefit all Californians (with over 4 million consumers served to date through Covered California[10]) and because the populations measured and targeted for improvement by health insurance companies include all of their enrollees under age 65 across all lines of business.

While disparities are influenced by social and economic factors beyond the control of the health care delivery system, there is agreement and evidence that health care disparities can be narrowed through quality improvement activities tailored to the needs of specific populations and targeting select measures at the health plan level. To this end, Covered California has laid out a health disparities and health equity agenda centered on four requirements:

Covered California's Mission and Vision

Covered California's vision is to improve the health of all Californians by assuring their access to affordable, high quality care.

Covered California's mission 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.

1. Promoting community health initiatives that foster better health, healthier environments and healthy behaviors.
2. Identifying the race or ethnicity of all enrollees through self-identification or imputed methodology.
3. Collecting data by race/ethnicity for disease control and management measures for asthma, depression, diabetes and hypertension — conditions with especially high levels of morbidity and mortality experienced by disadvantaged populations.
4. Conducting population-health improvement activities and interventions to narrow observed disparities in care.

See Section 2 for information on health plan progress in conducting interventions to narrow observed disparities in care and collecting data by race/ethnicity for disease control and management measures for asthma, depression, diabetes and hypertension.

Promoting Community Health Initiatives That Foster Better Health, Healthier Environments, and Promotion of Healthy Behaviors

Under contract requirements, Covered California included requirements for engagement and promotion of community-wide initiatives that foster better health, healthier environments, and the promotion of healthy behaviors across the community. Covered California specifically encouraged community health initiatives that have undergone or are being piloted through systematic review to determine

[10] This figure only includes on-exchange enrollment since 2014. The figure is higher if off-exchange mirrored plan enrollment is included.

effectiveness in promoting health and preventing disease, injury or disability and have been recommended by the Community Preventive Services Task Force. Such programs may include:

1. Partnerships with local, state, or federal public health departments such as Let's Get Healthy California.
2. CMS Accountable Health Communities.
3. Organizations that operate preventive and other health programs, such as Cal Fresh.
4. Hospital activities undertaken under the Community Health Needs Assessment required every three years under the Affordable Care Act.

Table 5. Covered California Insurer Activities to Improve Community Health, 2018 shows health insurer reported initiatives, programs and projects that improve community health apart from the health delivery system. Health insurance company involvement in external-facing activities is used by Covered California to identify potential disparity-reduction opportunities.

Identifying the Race or Ethnicity of All Enrollees

Understanding disparities in care requires data collection on demographics and other social determinants of health. Health insurance companies vary in the degree to which demographic data is collected and integrated into member records. While state law requires health insurance companies to collect race, ethnicity, and language data, insurers use different methods to obtain this information and have different rates for the percentage of membership self-identifying race/ethnicity (i.e. race/ethnicity self-identification rates).[11] Before the initiatives described below, no purchaser or state agency in California monitored the success of collecting self-identification rates and there had been no broad attempt to use the data to evaluate disparities in care.

To achieve high self-identification rates across all health insurance companies, Covered California set a goal for all insurers to achieve identification of at least 80 percent of all Covered California membership by year-end 2019 and encouraged use of various data collection methods beyond the membership enrollment application to identify race/ethnicity. Starting with the 2018 plan year, insurers were assessed on a contract performance standard for the self-identification rate and received financial penalties or credits based on whether they achieved the target. Insurers proposed intermediate milestones for the performance standard for the 2018 plan year and will be assessed on whether they achieved a target of 80 percent in 2019.

Based on analysis of data gathered for this performance standard, eight insurers have achieved the 80 percent target as of 2018 and some have exceeded 95 percent. Insurers have attributed the increased identification rates to improved data collection and incorporation of best practices for asking enrollees for race/ethnicity information.

[11] Senate Bill 853, Chapter 717, Statutes of 2009.

Table 5. Covered California Insurer Activities to Improve Community Health, 2018

	Number of Health Plans
Internal facing, member related efforts	
Health education portal	3
Quality collaboratives	1
Member outreach	2
Lifestyle or disease-specific workshops and classes	8
Educational materials	5
Incentive programs	2
Connections to outside orgs and programs	2
Internal facing, member related efforts non-health-related	
Philanthropy	1
Non-health classes	1
Health insurance education	6
Financial counseling/decision-making support	2
Interpreting services availability education	1
External or community facing activities, health-related	
Health fairs (starred if funded)	7
Screening events (starred if funded)	2
Enrollment fairs	1
Public health conferences	1
Statewide or community collaboratives and taskforces	5
Community workshops/classes or peer to peer support	3
Health promotors program	2
Financial support of community health programs	4
Educational materials	2
External facing, non-health-related	
Employee volunteers	1
Ads and newsletters	2
Community events	3
Financial support of community non-health programs	2
Education support	2
Non-health coalitions (e.g. homelessness)	2
Health plan option education	1
Engaged with health systems for community risk assessments identifying high priority needs	
Through providers	3
Health plan activities	5
Community health effort	
School programs	1
In-home assessments	1
Educational campaign	2
Health plan-funded community health programs based on needs assessments or other activity	
Grant programs	4
Health fairs	2
Health resource center(s)	2
Community clinics	2
Screening events	2
Participated in geographic disaster relief efforts	
Safety policies	1
Member services in affected areas	1
Disaster relief as part of government	1
Disaster preparedness programs	2
Community partner support around disaster relief	2

Table 6. Number of Insurers Meeting the 80 Percent Target for Identification of Race/Ethnicity

	2015	2016	2017	2018
Number of Insurers	5	4	5	8

Source: Covered California Staff Analysis of Qualified Health Plan Submitted Data

Challenges in Data Collection

Health insurance companies can collect self-identification data from several sources. The race/ethnicity question in the Covered California enrollment application is voluntary and is included in the enrollment file sent to insurers. Beyond enrollment data, insurers have reported receiving data from providers, customer service, health risk assessments and website registration. Methods for data collection vary by insurer, resulting in considerable variation during 2015-18 in how well each insurer met Covered California's goals for ensuring race/ethnicity identification for quality improvement purposes.[12]

While all insurers have demonstrated improvement towards the 2019 target, it is important to note that these rates represent Covered California membership only. As discussed in Section 2. Health Plan-Reported Measures for Health Disparities, an objective of the health equity agenda is to track and trend a select set disparities measures that include a health insurance company's full book of business excluding Medicare. Larger numbers are necessary to be able to accurately measure performance, especially for relatively small minority populations. Identification of member race/ethnicity when reporting health disparities measures is similarly challenging. For this reason, Covered California has encouraged insurers to supplement self-reported identification with a proxy methodology based on surname and census track. Covered California will continue to work with insurers to improve and validate self-identification of race and ethnicity.

Section 2. Health Plan Reported Measures and Efforts to Narrow Health Disparities

Many of Covered California's contracted health insurance companies have been actively engaged in efforts to understand and address health care disparities for many years. These efforts are reflected in a range of activities. Four of Covered California's health insurance companies, Health Net, Kaiser Foundation Health Plan of Southern California, L.A. Care and Molina Healthcare, representing 36 percent (503,220 out of 1,384,030) of enrollment in 2018 earned the National Committee for Quality Assurance's (NCQA) Distinction in Multicultural Health Care (MHC), a program that recognizes organizations that provide culturally and linguistically sensitive services and work to reduce disparities in health and health care.[13]

In 2017, Covered California began an initiative to measure and seek improvement in health equity across all contracted insurers. In collaboration with health insurance companies and consumer

[12] In 2018, Covered California examined current self-identification rates in the Covered California enrollment file to compare to insurer reported rates. Covered California's self-identification rate in 2017 was 75.5 percent across all insurers. In theory, insurer reported rates should be equal to or higher than the rate provided in the enrollment file, assuming all data is transferred to the insurer and the insurer's other avenues of data collection supplement the race/ethnicity field in its membership file. In practice, some insurers have reported considerably lower rates and are currently evaluating internal data collection to understand the discrepancies. Covered California is also aware of some errors in the 834 data transmission related to race/ethnicity categorization and is actively working on a system change request to appropriately identify membership answering this question in the enrollment application.

[13] See more: https://www.ncqa.org/programs/health-plans/multicultural-health-care-mhc/.

stakeholders, Covered California targeted four conditions that affect large numbers of consumers, have serious potentially avoidable complications, and for which there is strong evidence of racial or ethnic disparities:

- **Asthma:** Although asthma affects all populations, the burden of this disease falls disproportionately on minority populations: the prevalence of childhood asthma is 12.7 percent among non-Hispanic blacks compared to 8 percent among non-Hispanic whites and 6.4 percent among Hispanics. Even more striking, the asthma mortality rate among non-Hispanic black children is nearly eight times that of non-Hispanic whites.[14]
- **Depression:** National surveys indicate that nearly one in six Americans has experienced a major depressive episode, with many experiencing multiple episodes. Depression is a leading cause of disability and death, largely related to the nearly tenfold higher risk of suicide among those with depression.[15] Depression is undertreated in all populations, but more so among minorities. Although 40 percent of non-Latino whites with depression failed to receive treatment, 64 percent of Latinos, 69 percent of Asians, and 59 percent of African Americans failed to receive any treatment.[16]
- **Diabetes:** While diabetes affects almost 10 percent of the U.S. population overall, the prevalence in Hispanics (11.9 percent) and African Americans (13.4 percent) is much higher than it is in non-Hispanic Whites. Diabetes is the seventh leading cause of death and contributes to an increased risk of heart attacks, stroke, amputation and kidney disease.[17]
- **Hypertension:** Almost one third of adults have hypertension (high blood pressure), a major risk factor for heart attacks (the leading cause of death in the U.S.) and strokes (the seventh leading cause of death). The prevalence of hypertension among non-Hispanic blacks (41 percent) is substantially higher than among whites (29 percent) or Hispanics (28 percent). Among those with hypertension, the proportion who were well controlled differed dramatically: whites at 53 percent, non-Hispanic blacks at 43 percent and Hispanics at 30 percent.[18]

Because of the public health importance of these conditions and the serious disparities in health and health care that have been documented and the potential for targeted interventions to reduce morbidity and mortality, Covered California selected 14 measures related to these conditions to track, of which five are National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) measures and nine are based on Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators (PQI). Importantly, these measures are now being reported by insurers annually not only for Covered California's enrollees, but also for all non-Medicare commercial

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[14] Forno, E., and Celedón, J. C. (2012). Health disparities in asthma. *American journal of respiratory and critical care medicine*, *185*(10), 1033–1035. doi:10.1164/rccm.201202-0350ED

[15] McLaughlin K. A. (2011). The public health impact of major depression: a call for interdisciplinary prevention efforts. *Prevention science: the official journal of the Society for Prevention Research*, *12*(4), 361–371. doi:10.1007/s11121-011-0231-8

[16] Alegría, M., Chatterji, P., Wells, K., Cao, Z., Chen, C. N., Takeuchi, D., … Meng, X. L. (2008). Disparity in depression treatment among racial and ethnic minority populations in the United States. *Psychiatric services (Washington, D.C.)*, *59*(11), 1264–1272. doi:10.1176/appi.ps.59.11.1264

[17] Centers for Disease Control and Prevention. National Diabetes Statistics Report, 2017. Atlanta, GA: Centers for Disease Control and Prevention, U.S. Dept of Health and Human Services; 2017. Retrieved from: https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf.

[18] Centers for Disease Control and Prevention. Prevalence of Hypertension and Controlled Hypertension — United States, 2007–2010. Atlanta, GA: Centers for Disease Control and Prevention, U.S. Dept of Health and Human Services; 2013. Retrieved from: https://www.cdc.gov/mmwr/preview/mmwrhtml/su6203a24.htm.

and Medi-Cal lives, with rates supplied by race/ethnicity (see *Table 7. Covered California Insurer "All-Plan" Reported Measures for Health Disparities*).

Data for the full non-Medicare population was required for the following principal reasons: (1) narrowing disparities requires quality improvement interventions regardless of coverage type; (2) the larger population size makes measurement of disparities more accurate; and (3) high turnover in the individual market results in consumers transitioning to other sources of coverage, such as employer-based coverage or Medi-Cal. These markets are served by the same health insurance companies that participate in Covered California.

During the first year of reporting for plan year 2015, insurers reported on 10 measures, and an additional four measures were phased in for plan year 2016. Insurers will continue reporting the data for all 14 measures through plan year 2020 as Covered California continues to evaluate insurer's data and the progress of planned interventions.

Table 7. Covered California Insurer "All-Plan" Reported Measures for Health Disparities

Measure	Measure Steward	Years Reported	Condition
AMR - Asthma Medication Ratio Ages 5-85	NCQA	MY 2015, 2016, 2017	Asthma
Admissions for Asthma among Older Adults with Asthma	AHRQ PQI	MY 2015, 2016, 2017	Asthma
Admissions for Bacterial Pneumonia among Members with Asthma	AHRQ PQI	MY 2016, 2017	Asthma
Admissions for Asthma among Children and Younger Adults with Asthma	AHRQ PQI	MY 2015, 2016, 2017	Asthma
Antidepressant Medication Management (Effective Acute Phase Treatment)	NCQA	MY 2015, 2016, 2017	Depression
Antidepressant Medication Management (Effective Continuation Phase Treatment)	NCQA	MY 2015, 2016, 2017	Depression
Diabetes Care: HbA1c Control < 8.0% (NQF 0575)	NCQA	MY 2015, 2016, 2017	Diabetes
Admissions for Diabetes Short-term Complications among Members with Diabetes	AHRQ PQI	MY 2015, 2016, 2017	Diabetes
Admissions for Diabetes Long-Term Complications among Members with Diabetes	AHRQ PQI	MY 2015, 2016, 2017	Diabetes
Admissions for Uncontrolled Diabetes among Members with Diabetes	AHRQ PQI	MY 2016, 2017	Diabetes
Admissions for Lower-Extremity Amputation among Members with Diabetes	AHRQ PQI	MY 2016, 2017	Diabetes
Controlling High Blood Pressure (NQF 0018)	NCQA	MY 2015, 2016, 2017	Hypertension
Admissions for Hypertension among Members with Hypertension	AHRQ PQI	MY 2015, 2016, 2017	Hypertension
Admissions for Heart Failure among Members with Hypertension	AHRQ PQI	MY 2016, 2017	Hypertension

Opportunities for Intervention

The dataset used to evaluate insurer populations for disparities is unique in that it aggregates data for enrollees under 65 across all lines of business. In addition to serving different geographies with known variations among them, each insurer has a very different mix of population served ranging from

predominantly employer-based commercial enrollees to predominantly Medi-Cal enrollees. Insurers also have varying quality of data, most aggregating 400-person HEDIS samples for each line of business but some having access to robust clinical data from electronic health records. For these reasons and more as detailed in *Appendix 1: Limitations and Major Caveats about Health Disparities Data,* Covered California has determined that the results cannot be used to compare performance across plans.

However, Covered California and each insurer found actionable differences in measures across race/ethnicity groups that justify interventions. In addition, one of the key observations was that the apparent disparities based on race/ethnicity were in almost all cases far smaller than the differences in care or treatment across health plans — with enrollment in Kaiser Permanente or Sharp Health Plan being a far better predictor of receiving good care than race/ethnicity. This observation was consistent with Covered California's findings regarding the generally superior care provided by integrated delivery systems (see Chapter 3 and Chapter 4).

The following sections present high-level summaries of key trends based on preliminary analysis of insurer-reported data and examples of disparity reduction proposals.

Conducting Population Health Improvement Activities and Interventions to Narrow Observed Disparities in Care

After collection and submission of three years of baseline data for the indicators of potential gaps in care related to the four conditions, Covered California has worked with each insurer to select a quality improvement project aimed at narrowing a health care disparity found in the baseline data related to the four target conditions. Covered California has met with each insurer to discuss opportunities for conducting quality improvement activities and interventions to narrow each health insurer's specific observed health care disparities. In 2020, each Covered California insurer will implement a quality improvement project aimed at narrowing a health care disparity and will periodically report their progress. Covered California will hold insurers accountable for narrowing the selected disparity while maintaining or improving outcomes for targeted enrollees, which in most cases encompasses more than just Covered California members — sometimes including all commercial enrollees and other enrollees in the individual market or all Medi-Cal enrollees.

In addition to data reporting and analysis, insurers are reporting progress on infrastructure and staffing enhancements needed to develop their health care disparity reduction project, as well as related and aligned activities to support this Covered California initiative. These activities range in scope and scale: some represent the next phase of multi-year efforts while others are starting by proposing time-limited or smaller scale projects. The following are examples of activities reported by insurers:

- Enhanced member education, messaging, incentives and self-management tools.
- Enhanced provider education and clinical guidance reminders.
- Streamlined data collection processes to increase reporting and monitoring quality.
- Focused partnerships with community stakeholders.
- Disease registry development and sharing between providers and insurers.
- Outreach events and mobile care in at-risk communities.
- Enhanced care team support for affected populations.

These important efforts are building the foundation for increasingly effective interventions to improve care for all while reducing disparities in both health and health care.

The tables below document four representative examples of the target populations, measurement gaps and interventions proposed to be undertaken by health insurance companies.

Table 8. Health Net's Proposed Interventions for Improved Diabetes and Hypertension Management

Rationale and Target Population(s) for Intervention	Summary of Select Interventions
Health Net proposes to target African American and Latino members for improved diabetes and hypertension management across Medi-Cal and individual market (Covered California and off-exchange) lines of business. Rationale and Target Population(s) for Intervention • Rates for HbA1c control for African American members are 14 percent lower than white members with diabetes. • Rates for blood pressure control for African American members are 32 percent lower than white members with hypertension. • Rates for blood pressure control for Latino members are 28 percent lower than white members with hypertension.	Community, Member and Provider Interventions • Focus on the social determinants of health (SDOH), social marketing, and community coalition and advisory group. • Collection of member-level SDOH data, one-stop clinics, medication adherence bundle protocols; nutrition and food insecurity pilot. • Partnership with select clinic and hospital; modified workflow; motivational interviewing training.

Source: Covered California Staff Analysis of Qualified Health Plan Submitted Data

Table 9. LA Care's Proposed Interventions for Improved Diabetes Management

Rationale and Target Population(s) for Intervention	Summary of Select Interventions
L.A. Care proposes to target African American and American Indian/Alaskan Native members for improved diabetes management for the Covered California line of business. Rationale and Target Population(s) for Intervention • The prevalence of diabetes among African Americans is 40 percent higher compared to the overall Los Angeles County population. • The prevalence of diabetes among American Indian/Alaskan Natives is more than 50 percent higher compared to the overall Los Angeles County population. • Rates of HbA1c control for African American members are 8 percent lower than the total diabetes population. • Rates of HbA1c control for American Indian/Alaskan Native members are 12 percent lower than the total diabetes population.	Member, Provider and Administrative Interventions • Online member portal diabetes education course. • Provider feedback, education and reminders of guideline therapies for members with diabetes control below target. • Systematic data collection process improvements to improve the accuracy and timeliness of HbA1c laboratory data.

Source: Covered California Staff Analysis of Qualified Health Plan Submitted Data

Table 10. Kaiser Permanente's Proposed Interventions for Improved Diabetes and Hypertension Management

Rationale and Target Population(s) for Intervention	Summary of Select Interventions
Kaiser Permanente proposes to target African American and Latino members for improved diabetes and hypertension management across Commercial lines of business (employer-based and individual market, for both Covered California and off-exchange enrollment). Rationale and Target Population(s) for Intervention • Mortality due to diabetes is 50 percent higher in Hispanic/Latino than in White members. • Mortality due to hypertension is 4-5 times higher in African Americans than in white members. • Rates of HbA1c control among Hispanic/Latino members are 12 percent lower than the overall Commercial diabetes population. • Rates of blood pressure control for Black/African American members are 7 percent lower than for the overall Commercial hypertensive population.	Member, Provider, and Administrative Interventions • Forums across sites for sharing best practices • Ongoing review of patient-facing materials for culturally responsive messaging • Language concordant care for Latino diabetics • Innovative approaches to community outreach (e.g. Mobile Health Vehicle to churches, blood pressure checks in barber shops) • Specialty blood pressure clinic for Black/African American members

Source: Covered California Staff Analysis of Qualified Health Plan Submitted Data

Table 11. Anthem's Proposed Interventions for Improved Depression Medication Management

Rationale and Target Population(s) for Intervention	Summary of Select Interventions
Anthem proposes to target Hispanic/Latino members for improved depression medication management for the Covered California line of business. Rationale and Target Population(s) for Intervention • Rates for the Antidepressant Medication Management (Effective Acute Phase Treatment) for Hispanic/Latino members are 40 percent lower than White Covered California members. • Rates for the Antidepressant Medication Management (Effective Continuation Phase Treatment) for Hispanic/Latino members are 32 percent lower than White Covered California members.	Member, Provider, and Policy Interventions • Member outreach and coaching through mail and telephone; telehealth initiatives for psychology and psychiatry services; pilot for prescribing providers and members • Review of provider education materials communications and implement changes, as appropriate, with aim to reduce care gaps • Updated evaluation of HEDIS specifications for potential advocacy

Source: Covered California Staff Analysis of Qualified Health Plan Submitted Data

Section 3: Implications for the Future

Satisfaction surveys (CAHPS) demonstrate that Covered California enrollees rate their health plans highly on two comprehensive measures. The Covered California initiative to promote health equity through individualized, equitable care for all is just beginning. As described in this chapter, finding appropriate data to use as a baseline for building strategies has been and will continue to be a challenge until all insurers have more complete clinical data. Despite these challenges, insurers have found actionable disparities and early initiatives are underway. As with other efforts to improve the performance of the health care system, addressing disparities in health and health care can best be accomplished by using data and evidence to understand the underlying causes of poor performance and by working with all involved to develop, test and spread successful interventions.

Even accounting for differences in measurement and populations, the findings regarding disparities in care suggest that on some measures, the more integrated health insurance companies report better quality scores for all groups – to levels that are among the best in the country. While some of these insurers have long invested in and hired staff to support culturally competent care, these findings suggest that integrated and coordinated approaches to care delivery may reduce racial or ethnic disparities on some measures of quality.

Covered California is evaluating progress and identifying opportunities for expansion of its health equity program in the future, including potentially analyzing health outcomes based on other demographic categories such as: (1) income; (2) disability status; (3) sexual orientation; (4) gender identity; and (5) limited English proficiency (LEP). Since the data is collected across all lines of business, Covered California will seek collaboration with other purchasers, especially the Department of Health Care Services (DHCS), which oversees California's Medi-Cal program that serves over approximately one third of the entire California population. Covered California is also considering encouraging all insurers to acquire the National Committee for Quality Assurance's (NCQA) Distinction in Multicultural Health Care (MHC) as this program recognizes organizations that provide culturally and linguistically sensitive services and that work to reduce disparities in health and health care.

In the current contract, Covered California requires its insurers to engage in and report on efforts to impact the health of populations beyond their enrollees. Both the data provided by the insurers and research conducted by Health Management Associates (HMA) did not find evidence of the efficacy of such interventions.[19] There is, however, evidence of the impact of health insurance companies focusing on specific social determinants of health for enrolled populations — such as providing transportation or food assistance for insured individuals with particular needs. Given these findings, Covered California is reassessing the contractual expectations of its insurers for addressing social determinants of health.

Covered California has a potentially critical role to play in promoting broad engagement among public and private purchasers to address health equity. In work commissioned by Covered California, PricewaterhouseCoopers found that while focusing on health equity and disparities was a priority for public purchasers, very few private purchasers consider this issue a priority.[20]

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[19] The most current best evidence is documented in Chapter 1, Health Equity: Reducing Disparities, of a companion Covered California report, Current Best Evidence and Performance Measures for Improving Quality of Care and Delivery System Reform.

[20] "Health Purchaser Strategies for Improving Quality of Care and Delivery System Reform." Review conducted for Covered California by PricewaterhouseCoopers. Available at: https://hbex.coveredca.com/stakeholders/plan-management/library/coveredca_health_purchaser_strategies_07-19.pdf.

Chapter 3: Health Promotion and Prevention

Health Promotion and Prevention relates to health insurance company activities to encourage all enrollees to receive preventive care services and health screenings and use tools that promote a healthy lifestyle. This includes everything from regular checkups to smoking cessation and dietary programs.

This chapter on Health Promotion and Prevention is organized as follows:

Section 1. Qualified Health Plan Experience

Section 2. Health Plan Measures Reported to the Marketplace Quality Rating System

Section 3. Implications for the Future

Section 1. Qualified Health Plan Experience

Qualified Health Plan Experience presents performance data reported by health insurance companies for contract requirements and includes assessments and observations by Covered California. Prevention and wellness 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. Prevention occurs at three levels, each of which is important in promoting enrollee health and wellness and each of which is represented in Covered California's prevention reporting and requirements.

- **Primary Prevention:** Primary prevention focuses on intervening before a health event occurs. Promotion of healthy behaviors and vaccinations are forms of primary prevention that insurers play a role in promoting. Intervening on risk factors for disease, like obesity or smoking status, is also a form of primary prevention.
- **Secondary Prevention:** Secondary prevention includes screening for diseases to identify diseases at an early stage. The positive impact of timely screening for

Highlights

- Kaiser Permanente frequently performed at or above the 90th percentile nationally on preventive screening measures while most other plans performed in the 25th to 90th percentile.
- For the three HEDIS preventive care measures Covered California identified as priority measures — breast, cervical, and colorectal cancer screening — not only was there wide variation observed among plans over the past four years, but from two to six health plans reported performance below the 25th percentile nationally — highlighting both the need and opportunity for improvement.
- Across insurers, there exist robust health communication processes to inform enrollees about health and wellness benefits. Insurers offered information about free preventive services, offered a 24/7 telephonic nurse line, inbound and outbound telephonic coaching, as well as member reminders.
- Contract requirements call for reporting on tobacco cessation and obesity management programs, but this data was incomplete due to the lack of access to clinical data for most insurers. Covered California is looking at the feasibility of (1) better collection of clinical data to improve enrollee identification or requiring insurers to do so and (2) better tracking of program availability and participation rates.
- Covered California is assessing what factors contribute to better performance among some providers in non-Kaiser Permanente insurers and how Kaiser Permanente's performance can be replicated across California.

cancer, for example, is well documented. This screening helps providers identify and treat cancers early, before symptoms appear.

- **Tertiary Prevention:** Tertiary prevention focuses on managing diseases after a diagnosis to help slow or stop disease progression and prevent debilitating or other negative impacts of disease.

Covered California's prevention and wellness requirements are centered on identifying enrollees who are eligible for certain preventive and wellness benefits, notifying enrollees about the availability of these services, and making sure those eligible receive appropriate services. Proactively identifying and notifying enrollees eligible for prevention and wellness benefits, monitoring health status and making appropriate referrals, and ensuring at-risk enrollees receive proactive coordinated care all center around making sure people get the right preventive care when they need it at all three levels of prevention, instead of waiting until more serious and costly manifestations of disease prompt care. Covered California has identified several priority disease areas for reporting, including those with significant evidence around the importance of prevention. Under contract requirements, insurers are required to report the following:

1. Utilization of tobacco cessation intervention services;
2. Utilization of obesity management services;
3. Processes for communicating health and wellness benefits to enrollees and providers and the way they incorporate and use of enrollee-specific health and wellness information; and
4. Utilization of necessary preventive services through the following select HEDIS measures: breast cancer screening, cervical cancer screening, colorectal cancer screening, and chlamydia screening for women.

Tobacco Cessation

Covered California health insurance companies reported significant data challenges in reporting both the number of tobacco dependent enrollees and participation rates in smoking cessation programs. Integrated delivery systems, such as Kaiser Permanente and Sharp Health Plan, reported the most consistent data year-over-year, likely due to having access to clinical data that confirms a diagnosis of tobacco dependency. Other insurers were hampered by data challenges that include a lack of access to clinical data, inability to track physician referrals to tobacco cessation programs or educational classes offered by medical groups that are not documented or billed on a claim, reliance on enrollee provided data in health risk assessments that are not universally administered, and inability to track by lines of business, such as Covered California membership. Given this set of challenges, the available data reported for both Covered California enrollees and members in all lines of business (inclusive of Covered California) ranged between less than 1 percent to as high as 70 percent.[21] Covered California cautions these figures are likely incomplete. Future requirements in this area will need to consider the feasibility of (1) collecting clinical data to improve identification of tobacco dependent members and (2) better tracking of program availability and participation rates.

[21] Health plans reporting participation rates on the high end of the range generally had a far smaller number of enrollees identified as tobacco dependent. Covered California did not calculate a weighted average participation rate due to incomplete reporting and data collection challenges.

Obesity Management

Covered California health insurance companies experienced a similar set of challenges for tracking obese members; the most important of which is the lack of access to clinical data that documents a diagnosis of obesity. Some insurers also reported they do not track specific lines of business, such as Covered California membership, for participation in weight management programs. Some insurers relied on data through health risk assessments, wellness portals, and self-referrals by enrollees. Given this set of challenges, the available 2018 data reported for Covered California enrollees ranged between less than 1 percent to roughly 40 percent. For members in all lines of business (inclusive of Covered California),[22] the 2018 data ranged between roughly 1 percent to nearly 20 percent. Again, Covered California cautions these figures are likely incomplete. Future requirements in this area will need to consider the feasibility of (1) collecting clinical data to improve identification of obese members and (2) better tracking of program availability and participation rates.

Processes for Communicating Health and Wellness Benefits

Through annual reporting, health insurance companies reported the methods used to communicate health and wellness benefits to enrollees using pre-defined categories, such as customized printed materials about free preventive services or 24/7 telephonic nurse lines. *Table 12. Processes for Communicating Health and Wellness Benefits for Commercial and Covered California Enrollees, 2016* summarizes this data which reflects insurers' activities in 2016 as this information was not required in later reporting.

Health communication processes offered to enrollees are relatively consistent across health insurance companies. Most or all insurers offered information, both template and customized, about free preventive services, offered a 24/7 telephonic nurse line, inbound and outbound telephonic coaching, as well as member care service reminders. While not universally used, most health insurance companies reported using nurse lines for specific populations (i.e., complex conditions or oncology patients) as well as interactive voice response (IVR) member care/service reminders (offered by 7 out of 12 insurers).

[22] Health plans reporting participation rates on the high end of the range generally had a far smaller number of enrollees identified as tobacco dependent. Covered California did not calculate a weighted average participation rate due to incomplete reporting and data collection challenges.

Table 12. Processes for Communicating Health and Wellness Benefits for Commercial and Covered California Enrollees, 2016[23]

Processes for Communicating Health and Wellness Benefits	Number of Health Plans
Template newsletter articles/printed materials about free preventive services	12
Customized printed materials about free preventive services	11
24/7 Telephonic Nurse Line	11
24/7 Nurse Navigator for complex conditions	4
24/7 Nurse Navigator for oncology management	3
Inbound telephonic health coaching	12
Outbound telephone health coaching	10
Member care/service reminders (IVR)	7
Member care/service reminders (Paper)	11

Source: Covered California Staff Analysis of Qualified Health Plan Submitted Data

Section 2. Health Plan Measures Reported to the Marketplace Quality Rating System

Health Plan Measures Reported to the Marketplace Quality Rating System details health plan performance on Healthcare Effectiveness Data Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures reported to the Centers for Medicaid and Medicare Services' Quality Rating System (QRS). These standard performance measures are a key mechanism used by Covered California for health plan oversight and accountability. To more sharply focus health plan accountability efforts, Covered California examined over 40 measures used by QRS and is proposing to prioritize a subset of 13 measures that were selected based on the following criteria: (1) health impact; (2) extent of health plan variation; (3) performance improvement opportunity; (4) alignment with other California accountability programs; and (5) balance across domains of care, such as prevention, chronic illness care and behavioral health. Three of the 13 measures also overlap with the measures currently collected by race/ethnicity for health disparities reduction interventions as discussed in Chapter 2.

The following tables display the three measures for Health Promotion and Prevention in the QRS measure set that Covered California has identified as priority measures (with eight additional measures detailed in *Appendix 2: Additional Health Plan Measures Reported to the Quality Rating System*).

[23] The 11 health insurance companies in Covered California are: Anthem Blue Cross, Blue Shield of California, Chinese Community Health Plan, Health Net, Kaiser Permanente, L.A. Care, Molina Healthcare, Oscar Health, Sharp Health Plan, Valley Health Plan, and Western Health Advantage. In this table, Health Net is counted twice because its reports data separately for Health Net Life (PPO/EPO products) and Health Net of California (HMO/HSP products).

The tables include the Covered California weighted average, highest and lowest performing plans, plan-specific performance, as well as national percentiles for all Marketplace plans. The priority measures are:

1. Breast Cancer Screening (Table 13)
2. Cervical Cancer Screening (Table 14
3. Colorectal Cancer Screening (Table 15)

See *Appendix 2: Additional Health Plan Measures Reported to the Quality Rating System*, for eight additional QRS measures that pertain to Health Promotion and Prevention:

4. Chlamydia Screening in Women (Table A1)
5. Adult BMI Assessment (Table A2)
6. Childhood Immunizations (Combination 3) (Table A3)
7. Immunizations for Adolescents (Combination 2) (Table A4)
8. Flu Vaccinations for Adults Ages 18-64 (Table A5)
9. Medical Assistance with Smoking and Tobacco Use Cessation (Table A6)
10. Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (Table A7)
11. Annual Dental Visit (Table A8)

Appendix 2 also describes how to interpret the display of the measures.

Performance on other measures included in the QRS measure set are presented in relevant subject chapters, but most are covered in Chapter 5: Acute, Chronic and Other Conditions.

For the Health Promotion and Prevention measures, some of the overall observations include:

- Kaiser Permanente frequently performed at or above the 90th percentile nationally on preventive screening measures while most other plans performed in the 25th to 90th percentile.
- For the three HEDIS preventive care measures Covered California identified as priority measures — breast, cervical, and colorectal cancer screening — not only was there wide variation observed among plans over the past four years, but from two to six health plans reported performance below the 25th percentile nationally — highlighting both the need and opportunity for improvement.
- The variation in performance, with some health plans performing below the 25th percentile nationally is reflected in the eight measures reported in Appendix 2.

Breast Cancer Screening

The Breast Cancer Screening measure is the percentage of women 50-74 years of age who have received a mammogram to screen for breast cancer.

Table 13. Breast Cancer Screening for Covered California Enrollees

	2016	2017	2018	2019			
	US Benchmark	US Benchmark	US Benchmark	US Benchmark	Percent of Enrollees	Number of Enrollees	Number of Plans
Plans at 90th Percentile and Above	MN-S	79 +	79 +	79 +	35%	477,683	1
Plans at 50th to 90th Percentile	MN-S	70 to 79	70 to 79	70 to 79	9%	118,451	3
Plans at 25th to 50th Percentile	MN-S	65 to 70	65 to 70	65 to 70	43%	573,681	3
Plans Below 25th Percentile	MN-S	Below 65	Below 65	Below 65	13%	176,811	6
Covered California High/Average/Low Performers							
Covered CA Highest Performer	89	86	84	84			
Covered CA Weighted Average	74	70	72	72			
Covered CA Lowest Performer	67	52	58	47			
Covered California Plan-Specific Performance							
Anthem HMO	70	67					
Anthem PPO	68	61					
Anthem EPO			58	57	5%	64,031	
Blue Shield HMO		63	65	69	7%	93,322	
Blue Shield PPO	67	61	65	65	25%	335,176	
CCHP HMO	87	65	68	64	1%	10,013	
Health Net HMO	71	66	69	69	11%	145,183	
Health Net EPO			62	58	0%	1,396	
Health Net PPO							
Kaiser Permanente HMO	89	86	84	84	35%	477,683	
LA Care HMO		52	65	73	6%	84,750	
Molina Healthcare HMO		59	61	47	4%	56,023	
Oscar Health Plan EPO				51	3%	35,962	
Sharp Health Plan HMO	82	76	74	72	1%	17,335	
Valley Health Plan HMO		69	67	71	1%	16,366	
Western Health Advantage HMO	75	69	65	64	1%	9,386	

*M-NS: This measure was not used in determining the overall QRS rating in 2016.

Cervical Cancer Screening

The Cervical Cancer Screening measure is the percentage of women 21-64 years of age who were screened for cervical cancer.

Table 14. Cervical Cancer Screening for Covered California Enrollees

	2016	2017	2018	2019			
	US Benchmark	US Benchmark	US Benchmark	US Benchmark	Percent of Enrollees	Number of Enrollees	Number of Plans
Plans at 90th Percentile and Above	72 +	71 +	74 +	73 +	35%	477,683	1
Plans at 50th to 90th Percentile	55 to 72	56 to 71	56 to 74	56 to 73	38%	507,707	4
Plans at 25th to 50th Percentile	46 to 55	47 to 56	48 to 56	48 to 56	20%	269,251	6
Plans Below 25th Percentile	Below 46	Below 47	Below 48	Below 48	7%	91,985	2
Covered California High/Average/Low Performers							
Covered CA Highest Performer	81	82	80	79			
Covered CA Weighted Average	59	62	65	64			
Covered CA Lowest Performer	35	33	41	42			
Covered California Plan-Specific Performance							
Anthem HMO	59	62					
Anthem PPO	55	53					
Anthem EPO			55	53	5%	64,031	
Blue Shield HMO	41	45	49	48	7%	93,322	
Blue Shield PPO	52	59	63	60	25%	335,176	
CCHP HMO	50	53	56	57	1%	10,013	
Health Net HMO	50	55	60	56	11%	145,183	
Health Net EPO		53	59	53	0%	1,396	
Health Net PPO							
Kaiser Permanente HMO	81	82	80	79	35%	477,683	
LA Care HMO	35	54	51	54	6%	84,750	
Molina Healthcare HMO	40	33	41	42	4%	56,023	
Oscar Health Plan EPO			50	45	3%	35,962	
Sharp Health Plan HMO	56	61	62	64	1%	17,335	
Valley Health Plan HMO	38	46	43	50	1%	16,366	
Western Health Advantage HMO	59	55	62	54	1%	9,386	

Colorectal Cancer Screening

The Colorectal Cancer Screening measure is the percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.

Table 15. Colorectal Cancer Screening for Covered California Enrollees

	2016	2017	2018	2019			
	US Benchmark	US Benchmark	US Benchmark	US Benchmark	Percent of Enrollees	Number of Enrollees	Number of Plans
Plans at 90th Percentile and Above	MN-S	67 +	68 +	69 +	35%	477,683	1
Plans at 50th to 90th Percentile	MN-S	52 to 67	54 to 68	55 to 69	1%	17,335	1
Plans at 25th to 50th Percentile	MN-S	44 to 52	45 to 54	47 to 55	52%	695,592	8
Plans Below 25th Percentile	MN-S	Below 44	Below 45	Below 47	12%	156,016	3
Covered California High/Average/Low Performers							
Covered CA Highest Performer	82	80	78	76			
Covered CA Weighted Average	51	55	58	58			
Covered CA Lowest Performer	28	35	34	27			
Covered California Plan-Specific Performance							
Anthem HMO	46	53					
Anthem PPO	44	47					
Anthem EPO			42	40	5%	64,031	
Blue Shield HMO	38	36	39	51	7%	93,322	
Blue Shield PPO	41	42	51	49	25%	335,176	
CCHP HMO	46	49	53	53	1%	10,013	
Health Net HMO	41	47	51	51	11%	145,183	
Health Net EPO		48	54	49	0%	1,396	
Health Net PPO							
Kaiser Permanente HMO	82	80	78	76	35%	477,683	
LA Care HMO	29	38	49	54	6%	84,750	
Molina Healthcare HMO	28	35	34	27	4%	56,023	
Oscar Health Plan EPO			37	36	3%	35,962	
Sharp Health Plan HMO	62	55	66	57	1%	17,335	
Valley Health Plan HMO	54	52	50	54	1%	16,366	
Western Health Advantage HMO	62	53	57	52	1%	9,386	

*M-NS: This measure was not used in determining the overall QRS rating in 2016.

Section 3. Implications for the Future

Covered California included reporting requirements related to smoking cessation and obesity management programs because substantial evidence shows that effective interventions can improve health outcomes and reduce health care costs.[24] Based on the inability of insurers to provide information on program participation in a consistent manner, Covered California is considering other ways to promote these services including exploring the feasibility of (1) collecting clinical data to improve enrollee identification or (2) better tracking of program availability and participation rates and perhaps using large databases that predict public health risks by census track. Covered California is working with insurers to ensure these health promotion and prevention programs are offered in the languages spoken by their enrollees and further promote the availability of translation services.

In the major areas related to health plan measures of screening, the main observation from the reporting over the past four years is that there is wide variation among the plans. Kaiser Permanente and Sharp Health Plan frequently report screening rate scores that are in the top 90th percentile in the nation; while other most of the other plans have lower scores – ranging from the 25th to just above the 50th percentile. The fact that several health plans performed below the 25th percentile nationally on cancer screenings and on other preventive care measures detailed in Appendix 2 — in particular, six health plans had a breast cancer screening rate score below the 25th percentile — is concerning and warrants concerted efforts from both Covered California and the health plans to address. Low screening rates could be partially attributed to poor data collection techniques and lack of patient education and engagement. Covered California is engaging with its contracted health plans to develop strategies to improve their screening rates.

The ability of integrated systems, such as Kaiser Permanente and Sharp Health Plan, to achieve such positive results is a clear indicator of what is possible with well-coordinated and integrated care. In future years, Covered California should assess what factors can contribute to better performance among non-integrated plans and how the performance of integrated systems can be replicated across California. Covered California will seek to foster national benchmark performance across all plans.

[24] The most current best evidence is documented in Chapter 2, Health Promotion and Prevention, of a companion Covered California report, Current Best Evidence and Performance Measures for Improving Quality of Care and Delivery System Reform.

Chapter 4: Mental Health and Substance Use Disorder Treatment

Mental Health and Substance Use Disorder Treatment includes health insurance company activities to identify, engage and provide treatment to those with mental health conditions and substance use disorders, and ensure that they are provided with timely and effective care that is integrated with their general health care needs.

This chapter on Mental Health and Substance Use Disorder Treatment is organized as follows:

Section 1. Qualified Health Plan Experience

Section 2. Health Plan Measures Reported to the Marketplace Quality Rating System

Section 3. Implications for the Future

Section 1. Qualified Health Plan Experience

Qualified Health Plan Experience presents performance data reported by insurers for contract requirements and includes assessments and observations by Covered California. Covered California recognizes the critical importance of mental health and substance use disorder treatment, collectively "behavioral health services," in improving health outcomes and reducing costs. Consistent with the ACA's expansion of mental health and substance use disorder services and promotion of integrating these services into mainstream health care, Covered California requires insurers to report progress on:

1. Making behavioral health services available to enrollees;
2. Integrating behavioral health services with medical services; and
3. Reporting the percent of enrollees cared for in an integrated behavioral health model.

In the absence of an established best practice for integrating medical and behavioral health services in 2016, the current contract requirements largely focus on gathering qualitative information about health insurance company strategies. Covered California has summarized strategies reported by insurers but

Highlights

- For the adult behavioral health measures, there is wide variation in performance among the plans over the past four years with most health plans performing poorly. For two of three priority measures in 2019, six or more plans performed below the 25th percentile. For each of the three measures, only one plan performed at or above the 90th percentile nationally. Covered California is actively engaging with insurers on how to improve in these areas.
- To promote access to and availability of behavioral health services, insurers report a range of activities, including increasing provider capacity, implementing telehealth services, and adopting new CPT codes that support care collaboration.
- Insurers are pursuing a broad spectrum of behavioral health integration efforts, including co-location of services, increased coordination with carve-out vendors, and embedded behavioral health staff in primary care clinics.
- The percent of enrollees cared for under an integrated behavioral health model appears to have increased between 2015 and 2018. Requirements for future reporting are being revised to better support tracking and trending of behavioral health integration.
- Covered California is exploring how best to use patient-reported outcome measures to track improvement in behavioral health care. Monitoring outcomes for behavioral health is a major gap in assessing performance of insurers and the delivery system.

notes that these qualitative descriptions will benefit from standardized definitions to better quantify adoption in future reporting.

Promoting Availability of Behavioral Health Services, 2015, 2017 and 2018[25]

The following are strategies one or more health insurance companies adopted to promote the availability of behavioral health services during 2015, 2017 and 2018:

- Added a full-time Behavioral Health Medical Director to the physician leadership team; added mental health providers, psychiatrists (including with bilingual skills), and medical social workers to the provider network;
- Increased access in the following ways:
    - Offered more appointments through expanded hours and expanded and improved facilities where mental health and wellness care is provided;
    - Allow enrollees to self-refer to behavioral health providers instead of requiring prior authorization;
    - Provided open access to free-standing network for professional and facility behavioral health providers;
    - Offered a telehealth program, with some offering a 24/7 program for behavioral health services, including programs to improve psychiatry access;
    - Annually monitored access through provider-to-member ratios, provider surveys, member experience surveys, grievances and appeals and HEDIS results;
    - Required underperforming providers to implement a corrective action plan;
    - Offered classes on behavioral health; and
    - Provided online patient portals.
- Adopted Psychiatric Care Collaborative Current Procedural Terminology (CPT) codes to Physician Fee schedules and removed prior authorization requirements for behavioral health outpatient services;
- Expanded opioid treatment and implemented a disease management program for depression;
- Carve-out or subcontracted vendors educated primary care physicians about behavioral health services via hotlines, online toolkits, and provided access to Behavioral Health Integration specialists and Community Transition coordinators some of whom were also on the medical staff of physician organizations; and
- Deployed an electronic care management program that provides virtual psychiatric support and financial incentives to improve care for patients with behavioral health issues, including screenings and online consultations.

[25] Data only available for plan year 2015 and plan years 2017-18. Covered California waived data collection for plan year 2016.

Integrating Behavioral Health Services with Primary Care, 2015, 2017 and 2018[26]

The following are strategies one or more health insurance companies engaged in to integrate behavioral health services with primary care during 2015, 2017 and 2018:

- Developed a universal consent form to allow data sharing between primary care and behavioral health providers;
- Primary care physicians and behavioral health providers coordinated care through the same medical record or through an e-management model that facilitated communication and electronic data sharing. Leveraged an integrated data warehouse (medical, behavioral health, pharmacy, etc.) to identify gaps in care and at-risk members for interventions by case managers;
- Primary care physicians referred directly to behavioral health case management programs for assistance with complex care patients; case management departments at the plan level helped facilitate referrals to medical groups or providers; outpatient behavioral health departments that were in the same physical location as primary care, pharmacy, and specialty services helped facilitated primary care physician referrals and team-based care;
- Implemented a "Feedback-Informed Care" model which involves soliciting an enrollee's feedback about the therapy process and allowing them to direct their care;
- Implemented a pay-for-performance program that connected primary care physicians with behavioral health providers to coordinate on referrals and care coordination;
- Integrated behavioral health with providers participating in Accountable Care Organization (ACO) models;
- Worked with a health system to integrate psychiatrists within primary care clinics;
- Provided care management following discharge from an inpatient setting;
- Implemented a co-management strategy that involves integrated clinical rounds between medical and behavioral health teams; and
- Managed behavioral health needs through carve-out vendors or delegated providers as follows:
    - Enhanced coordination of behavioral and physical health care through housing carve-out vendors onsite, monthly joint clinical rounds or weekly integration meetings with co-located providers.
    - Carve-out vendors monitored outcomes, such as case management volume and engagement, utilization management trends, and quality of care issues.
    - Shared data with carve-out vendors to monitor drug interactions and compliance.
    - Held periodic meetings with delegated behavioral health providers to focus on a variety of topics, including data, best practices, communication and collaboration, referral processes, HEDIS measures performance, and CAHPS Experience of Care and Health Outcomes (ECHO) survey results.

[26] Data only available for plan year 2015 and plan years 2017-18. Covered California waived data collection for plan year 2016.

Enrollees Cared for in an Integrated Behavioral Health Model, 2015 and 2018[27]

Health insurance companies reported the percent of enrollees cared for in an integrated behavioral health model (IBHM) based on their respective definitions as current contract requirements do not include standard reporting on best practices implemented (e.g., use of unified care plans or patient registries). It is important to note that this measure also does not capture the range of health insurance company activities for behavioral health integration. As the percent of enrollees cared for in an IBHM is a quantitative measure, the following numbers should be viewed with caution since (1) there has not been a standard definition for an IBHM and (2) insurers reported incomplete data and Covered California observed year-to-year inconsistencies.

In 2015, 2 percent of Covered California enrollees were cared for in an IBHM; with individual insurers ranging from 0 to 6 percent.[28] Based on incomplete numbers for 2018, enrollees cared for in an IBHM model appears to have increased to 11 percent, with reporting insurers ranging from 0 to 34 percent. Given the challenges observed to date, requirements for future reporting will be based on standardized best practices to support tracking and trending adoption of behavioral health integration.

Section 2. Health Plan Measures Reported to the Marketplace Quality Rating System

Health Plan Measures Reported to the Marketplace Quality Rating System detail health plan performance on Healthcare Effectiveness Data Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures reported to the Centers for Medicaid and Medicare Services' Quality Rating System (QRS). These standard performance measures are a key mechanism used by Covered California for health plan oversight and accountability. To more sharply focus health plan accountability efforts, Covered California examined over 40 measures used by QRS and is proposing to prioritize a subset of 13 measures.

The following tables display the priority measures for Mental Health and Substance Use Disorder Treatment in the QRS measure set (with one additional measure detailed in *Appendix 2: Additional Health Plan Measures Reported to the Quality Rating System*) and include the Covered California weighted average, highest and lowest performing plans, plan-specific performance, as well as national percentiles for all Marketplace plans:

1. Antidepressant Medication Management (Table 16)
2. Follow Up After Hospitalization for Mental Illness (Table 17)
3. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (Table 18)

See *Appendix 2: Additional Health Plan Measures Reported to the Quality Rating System*, for one additional QRS measure that pertains to Mental Health and Substance Use Disorder Treatment: Follow Up Care for Children Prescribed ADHD Medication (ADD) (Table A9). Covered California is evaluating

[27] Data only available for plan year 2015 and plan years 2017-18. Covered California waived data collection for plan year 2016.

[28] Data only available for plan years 2015 and 2018. Covered California waived data collection for plan year 2016 and 2017.

available behavioral health measures for children as part of its work in finding the right measures for subpopulations.

Appendix 2 also describes how to interpret the display of the measures.

For the priority adult behavioral health measures, there is wide variation in performance among the health plans over the past four years with most plans performing poorly. For two of three priority measures in 2019 (Antidepressant Medication Management and Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment), six or more plans performed below the 25th percentile. For each of the three measures, only one plan performed at or above the 90th percentile nationally.

Covered California recognizes that there are additional behavioral health measures, such as Utilization of the Patient Health Questionnaire-9 to Monitor Depression Symptoms for Adolescents and Adults, that use clinical data to monitor patients at the time of diagnosis and outcomes over time and therefore better represent the quality of care for depression. However, slow progress has been made in California in collecting clinical or patient reported outcome measures through 2018. Until most health insurance companies are collecting clinical data-based measures, Covered California must rely on the existing behavioral health measures.

Antidepressant Medication Management

The Antidepressant Medication Management measure is the percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment.

1. Effective Acute Phase Treatment: The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).
2. Effective Continuation Phase Treatment: The percentage of members who remained on an antidepressant medication for at least 180 days (6 months).

Table 16. Antidepressant Medication Management for Covered California Enrollees

	2016	2017	2018	2019			
	US Benchmark	US Benchmark	US Benchmark	US Benchmark	Percent of Enrollees	Number of Enrollees	Number of Plans
Plans at 90th Percentile and Above	MN-S	72 +	73 +	73 +	1%	16,366	1
Plans at 50th to 90th Percentile	MN-S	63 to 72	63 to 73	64 to 73	37%	495,018	2
Plans at 25th to 50th Percentile	MN-S	58 to 63	57 to 63	59 to 64	10%	138,670	3
Plans Below 25th Percentile	MN-S	Below 58	Below 57	Below 59	52%	695,176	6
Covered California High/Average/Low Performers							
Covered CA Highest Performer		68	78	84			
Covered CA Weighted Average		57	60	61			
Covered CA Lowest Performer		43	36	43			
Covered California Plan-Specific Performance							
Anthem HMO		50					
Anthem PPO		52					
Anthem EPO			53	52	5%	64,031	
Blue Shield HMO			66	60	7%	93,322	
Blue Shield PPO		53	53	56	25%	335,176	
CCHP HMO		56	36	43	1%	10,013	
Health Net HMO		51	55	53	11%	145,183	
Health Net EPO			65				
Health Net PPO							
Kaiser Permanente HMO		68	69	69	36%	477,683	
LA Care HMO		61	54	56	6%	84,750	
Molina Healthcare HMO		43	45	51	4%	56,023	
Oscar Health Plan EPO			78	62	3%	35,962	
Sharp Health Plan HMO		67	77	67	1%	17,335	
Valley Health Plan HMO				84	1%	16,366	
Western Health Advantage HMO		57	46	61	1%	9,386	

*M-NS: This measure was not used in determining the overall QRS rating in 2016.

Follow Up After Hospitalization for Mental Illness

The Follow Up After Hospitalization for Mental Illness measure is the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness and who had a follow-up visit with a mental health practitioner within 7 days after discharge.

Table 17. Follow Up After Hospitalization for Mental Illness for Covered California Enrollees

	2016	2017	2018	2019			
	US Benchmark	US Benchmark	US Benchmark	US Benchmark	Percent of Enrollees	Number of Enrollees	Number of Plans
Plans at 90th Percentile and Above	67 +	67 +	64 +	59 +	39%	477,683	1
Plans at 50th to 90th Percentile	48 to 67	48 to 67	41 to 64	38 to 59	39%	480,359	2
Plans at 25th to 50th Percentile	38 to 48	38 to 48	31 to 41	29 to 38	9%	110,657	2
Plans Below 25th Percentile	Below 38	Below 38	Below 31	Below 29	12%	148,781	2
Covered California High/Average/Low Performers							
Covered CA Highest Performer	75	79	73	72			
Covered CA Weighted Average	56	60	53	50			
Covered CA Lowest Performer	38	30	28	26			
Covered California Plan-Specific Performance							
Anthem HMO	51	48					
Anthem PPO	43	44					
Anthem EPO			39	27	5%	64,031	
Blue Shield HMO				30	8%	93,322	
Blue Shield PPO	56	55	42	38	28%	335,176	
CCHP HMO							
Health Net HMO	38	30	35	40	12%	145,183	
Health Net EPO							
Health Net PPO							
Kaiser Permanente HMO	75	79	73	72	39%	477,683	
LA Care HMO				26	7%	84,750	
Molina Healthcare HMO			28				
Oscar Health Plan EPO							
Sharp Health Plan HMO	70	65	57	35	1%	17,335	
Valley Health Plan HMO							
Western Health Advantage HMO							

Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

The Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) measure is the percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following:

1. Initiation of AOD Treatment: The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication treatment within 14 days of the diagnosis.
2. Engagement of AOD Treatment: The percentage of members who initiated treatment and who had two or more additional AOD services or medication treatment within 34 days of the initiation visit.

Table 18. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment for Covered California Enrollees

	2016	2017	2018	2019			
	US Benchmark	US Benchmark	US Benchmark	US Benchmark	Percent of Enrollees	Number of Enrollees	Number of Plans
Plans at 90th Percentile and Above	28 +	30 +	31 +	32 +	36%	477,683	1
Plans at 50th to 90th Percentile	21 to 28	21 to 30	23 to 31	24 to 32	0%	-	0
Plans at 25th to 50th Percentile	18 to 21	18 to 21	19 to 23	19 to 24	36%	490,372	3
Plans Below 25th Percentile	Below 18	Below 18	Below 19	Below 19	28%	377,175	8
Covered California High/Average/Low Performers							
Covered CA Highest Performer	33	33	33	34			
Covered CA Weighted Average	21	23	26	25			
Covered CA Lowest Performer	12	6	12	16			
Covered California Plan-Specific Performance							
Anthem HMO	17	18					
Anthem PPO	19	20					
Anthem EPO			20	18	5%	64,031	
Blue Shield HMO			21	18	7%	93,322	
Blue Shield PPO	19	19	29	23	25%	335,176	
CCHP HMO	14	21	17	22	1%	10,013	
Health Net HMO	12	14	14	20	11%	145,183	
Health Net EPO		12	23				
Health Net PPO							
Kaiser Permanente HMO	33	33	33	34	36%	477,683	
LA Care HMO	20	24	12	19	6%	84,750	
Molina Healthcare HMO	13	24	21	17	4%	56,023	
Oscar Health Plan EPO			18	18	3%	35,962	
Sharp Health Plan HMO	12	17	18	17	1%	17,335	
Valley Health Plan HMO			19	18	1%	16,366	
Western Health Advantage HMO	14	6	15	16	1%	9,386	

Section 3. Implications for the Future

Covered California included reporting requirements related to mental health and substance use disorder treatment services because of the significant unmet needs of enrollees and the increasing evidence that integrating primary care and behavioral health services improves health outcomes and delivers a return on investment by reducing downstream health care costs. Several models including collaborative care, co-location and telehealth have demonstrated success.[29]

While insurers report a wide array of approaches to promoting the availability of behavioral health services and the integration of behavioral health services with primary care, it is difficult to measure if these efforts are translating to better behavioral health care or outcomes for consumers. Covered California is determining how to promote better measurement and accountability in this area which may involve standardized definitions and use of best practices to support tracking and trending of available services and adoption of behavioral health integration.

For measures of behavioral health quality, the main observation from the reporting over the past four years is that there is wide variation among the plans and while some scores reflect high percentile ranking, for many measures there are multiple health plans that are performing poorly compared to national benchmark data. For the priority adult behavioral health measures, there is wide variation in performance among the health plans over the past four years with most plans performing poorly. For two of three priority measures in 2019 (Antidepressant Medication Management and Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment), six or more plans performed below the 25th percentile. For each of the three measures, only one plan performed at or above the 90th percentile nationally. This is concerning and warrants further concerted efforts from both Covered California and its contracted health plans to address. Covered California is engaging with health plans on adopting best practices for behavioral health care and developing strategies to improve their performance on these behavioral health measures.

Covered California is also seeking to improve behavioral health measurement. The current HEDIS behavioral health measures in the QRS measure set should be replaced or updated. None assess behavioral health status or outcomes making performance assessment of health insurance companies and the delivery system difficult. Covered California is exploring how best to use patient-reported outcome measures for behavioral health. One promising measure is the use of the Patient Health Questionnaire-9 (PHQ-9) because it can be used to both identify patients with depression symptoms and monitor their outcomes over time. However, slow progress has been made in California because this measure relies on collecting clinical data.

There is significant opportunity for collaboration on spreading integrated behavioral health models and collecting clinical data through statewide collaboratives including the Integrated Healthcare Association and California Quality Collaborative.

[29] The most current best evidence is documented in Chapter 3, Mental Health and Substance Use Disorder Treatment, of a companion Covered California report, Current Best Evidence and Performance Measures for Improving Quality of Care and Delivery System Reform.

Chapter 5: Acute, Chronic and Other Conditions

Acute, Chronic and Other Conditions entails health insurance companies actively managing care for enrollees with acute conditions, which is defined as an illness or disease that is short-term and lasts typically a few days to weeks (such as an infection, an injury or the misuse of medications), chronic conditions, which typically develop slowly over time and last months to years (such as diabetes, most cancers, cardiovascular disease, and infectious diseases like Human Immunodeficiency Virus) and other conditions that are temporary, such as pregnancy or gestational diabetes.

In addition, this chapter, Acute, Chronic and Other Conditions, encompasses subpopulations covered in subject chapters of this report: Chapter 4: Mental Health and Substance Use Disorder Treatment; Chapter 6: Complex Care; Chapter 7: Promotion of Effective Primary Care; and Chapter 10: Appropriate Interventions.

This chapter on Acute, Chronic, and Other Conditions is organized as follows:

Section 1. Health Plan Measures Reported to the Marketplace Quality Rating System

Section 2. Implications for the Future

Highlights

- For the measures related to care for chronic conditions, there is wide variation among plans, with Kaiser Permanente and Sharp Health Plan being among the 90th percentile nationally, while other plans have a range of scores. The ability of these integrated delivery systems to achieve such positive results is a clear indicator of what is possible with well-coordinated and integrated care. Covered California is assessing what factors contribute to better performance among non-integrated systems and how this performance can be replicated across California.
- Enrollee satisfaction with their health plan and care is comparable to nationwide results for most Covered California plans. However, compared to the nation, enrollees report less favorably about their access to care and how well their care is coordinated. For these two priority CAHPS Measures, Access to Care and Care Coordination, most plans' scores cluster around the national 50th percentile or below the 25th percentile. CAHPS results for marketplace plans nationwide are highly compressed with only a few points difference among percentile and all results are relatively high compared to other measures.

Section 1. Health Plan Measures Reported to the Marketplace Quality Rating System

As described in previous chapters, one key mechanism used by Covered California for health insurance company oversight and accountability is public reporting of global and individual health plan quality performance measures to the Centers for Medicaid and Medicare Services' Marketplace Quality Rating System (QRS). To more sharply focus health plan accountability efforts, Covered California examined over 40 measures used by QRS and is proposing to prioritize a subset of 13 measures.

The following tables display the priority measures for Acute, Chronic and Other Condition measures in the QRS measure set (with 11 additional measures detailed in *Appendix 2: Additional Health Plan Measures Reported to the Quality Rating System*) and include the Covered California weighted average, highest and lowest performing plans, plan-specific performance, as well as national percentiles for all Marketplace plans:

1. Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%) (Table 19)

2. Controlling High Blood Pressure (Table 20)
3. Plan All-Cause Readmissions (Table 21)
4. Access to Care (Table 22)
5. Care Coordination (Table 23)

See *Appendix 2: Additional Health Plan Measures Reported to the Quality Rating System*, for the 11 additional QRS measures that pertain to Acute, Chronic and Other Conditions:

6. Proportion of Days Covered (RAS Antagonists) (Table A10)
7. Proportion of Days Covered (Statins) (Table A11)
8. Proportion of Day Covered (Diabetes All Class) (Table A12)
9. Comprehensive Diabetes Care: Eye Exam (Retinal) Performed (Table A13)
10. Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing (Table A14)
11. Comprehensive Diabetes Care: Medical Attention for Nephropathy (Table A15)
12. Medication Management for People with Asthma (75% of Treatment Period) (Table A16)
13. Prenatal and Postpartum Care (Postpartum Care) (Table A17)
14. Prenatal and Postpartum Care (Timeliness of Prenatal Care) (Table A18)
15. Well-Child Visits in the First 15 Months of Life (6 or More Visits) (Table A19)
16. Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (Table A20)

Appendix 2 also describes how to interpret the display of the measures.

For the measures related to care for chronic conditions, there is wide variation among plans, with Kaiser Permanente and Sharp Health Plan being among the 90th percentile nationally, while other plans have a range of scores. The ability of these integrated delivery systems to achieve such positive results is a clear indicator of what is possible with well-coordinated and integrated care. Covered California is assessing what factors contribute to better performance among non-integrated systems and how this performance can be replicated across California.

The wide variation in performance is particularly meaningful for measures related to managing diabetes and hypertension that target the opportunities to improve the morbidity and mortality attributable to these conditions. Better performance on these indicators means there would be fewer adverse events and more lives saved. A 1 percent reduction in HbA1c reduces diabetes-related deaths by 21 percent and myocardial infarctions (heart attacks) by 14 percent.[30] For every 10 percent reduction in HbA1c (e.g., 10 to 9 or 9 to 8) the risk of progression to blindness fell 44 percent, progression to kidney failure fell 25 percent, and loss of sensation in the feet by 30 percent.[31] Another study estimated the effect of having all health plans nationally achieve the 90th percentile on measures focused on diabetes and cardiovascular disease found it would result in 2.3 million fewer heart attacks (a reduction of 22 percent), 800,000 fewer strokes (a reduction of 12 percent) as well as reduced incidence of several

[30] Stratton, I. M., Adler, A. I., Neil, H. A., Matthews, D. R., Manley, S. E., Cull, C. A., … Holman, R. R. (2000). Association of glycaemia with macrovascular and microvascular complications of type 2 diabetes (UKPDS 35): prospective observational study. BMJ (Clinical research ed.), 321(7258), 405–412. doi:10.1136/bmj.321.7258.405

[31] Nathan, D. M., Bayless, M., Cleary, P., Genuth, S., Gubitosi-Klug, R., Lachin, J. M., … DCCT/EDIC Research Group (2013). Diabetes control and complications trial/epidemiology of diabetes interventions and complications study at 30 years: advances and contributions. Diabetes, 62(12), 3976–3986. doi:10.2337/db13-1093

other less common complications over a ten year period.[32] The researchers estimated approximately 4.9 million years of life would have been saved during this same period.

Covered California health insurers generally have worse scores than the rest of the nation on the Access to Care and Care Coordination measures, with the majority of insurers below the 25th percentile and none above the 50th. It is important to note that the CAHPS results for marketplace plans nationwide are highly compressed with only a few points difference among each percentile and all results are relatively high compared to other measures. Also, California's demographic diversity includes greater numbers of people in race/ethnicity groups who tend to give plans lower scores. This suggests insurers may not meet the needs of all groups equally. Covered California sees these enrollee-experience scores as reason for both concern and future research. Covered California is working with its health insurance companies to assure improvement in these areas and is seeking to expand the number and sources of measures that can best assess consumers' experience in access to care, care coordination and other important quality domains.

[32] Note these estimates are from a 2008 study based on the Archimedes simulation model. At the time, impacts were modeled for the U.S. population of 210 million adults ages 18-85 over a ten-year period, 1995-2005: Eddy, D. M., Pawlson, L. G., Schaaf, D.

Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)

The Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control measure is the percentage of members 18–75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level was less than 8 percent.

Table 19. Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%) for Covered California Enrollees

	2016	2017	2018	2019			
	US Benchmark	US Benchmark	US Benchmark	US Benchmark	Percent of Enrollees	Number of Enrollees	Number of Plans
Plans at 90th Percentile and Above	67 +	67 +	69 +	68 +	37%	495,018	2
Plans at 50th to 90th Percentile	56 to 67	58 to 67	59 to 69	58 to 68	43%	582,871	5
Plans at 25th to 50th Percentile	46 to 56	48 to 58	50 to 59	52 to 58	17%	223,389	4
Plans Below 25th Percentile	Below 46	Below 48	Below 50	Below 52	3%	45,348	2
Covered California High/Average/Low Performers							
Covered CA Highest Performer	75	70	73	72			
Covered CA Weighted Average	58	60	63	64			
Covered CA Lowest Performer	38	47	52	49			
Covered California Plan-Specific Performance							
Anthem HMO	61	60					
Anthem PPO	56	61					
Anthem EPO			62	57	5%	64,031	
Blue Shield HMO	47	48	59	56	7%	93,322	
Blue Shield PPO	53	55	56	64	25%	335,176	
CCHP HMO	65	60	73	57	1%	10,013	
Health Net HMO	63	58	65	58	11%	145,183	
Health Net EPO		62	68	63	0%	1,396	
Health Net PPO							
Kaiser Permanente HMO	68	70	71	70	35%	477,683	
LA Care HMO	39	54	62	62	6%	84,750	
Molina Healthcare HMO	38	47	52	58	4%	56,023	
Oscar Health Plan EPO			57	50	3%	35,962	
Sharp Health Plan HMO	75	70	71	72	1%	17,335	
Valley Health Plan HMO	60	58	59	60	1%	16,366	
Western Health Advantage HMO	69	61	64	49	1%	9,386	

Controlling High Blood Pressure

The Controlling High Blood Pressure measure is the percentage of members 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled.

Table 20. Controlling High Blood Pressure for Covered California Enrollees

	2016	2017	2018	2019			
	US Benchmark	US Benchmark	US Benchmark	US Benchmark	Percent of Enrollees	Number of Enrollees	Number of Plans
Plans at 90th Percentile and Above	76 +	76 +	77 +	75 +	35%	477,683	1
Plans at 50th to 90th Percentile	58 to 76	59 to 76	61 to 77	62 to 75	20%	273,647	5
Plans at 25th to 50th Percentile	49 to 58	47 to 59	49 to 61	54 to 62	37%	495,303	5
Plans Below 25th Percentile	Below 49	Below 47	Below 49	Below 54	7%	99,993	2
Covered California High/Average/Low Performers							
Covered CA Highest Performer	85	86	82	81			
Covered CA Weighted Average	63	63	66	66			
Covered CA Lowest Performer	49	43	43	44			
Covered California Plan-Specific Performance							
Anthem HMO	51	56					
Anthem PPO	55	61					
Anthem EPO			62	45	5%	64,031	
Blue Shield HMO				61	7%	93,322	
Blue Shield PPO	57	43	52	56	25%	335,176	
CCHP HMO	72	73	62	68	1%	10,013	
Health Net HMO	57	61	63	63	11%	145,183	
Health Net EPO		49	54	59	0%	1,396	
Health Net PPO							
Kaiser Permanente HMO	85	86	82	81	35%	477,683	
LA Care HMO	50	59	56	68	6%	84,750	
Molina Healthcare HMO	49	51	43	58	4%	56,023	
Oscar Health Plan EPO			54	44	3%	35,962	
Sharp Health Plan HMO	75	72	81	74	1%	17,335	
Valley Health Plan HMO	59	64	68	64	1%	16,366	
Western Health Advantage HMO	61	64	66	58	1%	9,386	

Plan All-Cause Readmissions

The Plan All-Cause Readmissions measure is a ratio that compares the number of acute inpatient stays for members 18–64 years of age that were followed by an unplanned acute readmission for any diagnosis within 30 days to the predicted number of acute readmissions.[33] This measure compares the actual readmission rate of a health plan to the expected admission rate. If the actual readmission rate is lower than the expected readmission rate, the plan is performing better at reducing readmissions than expected and the plan would have a measure value less than 100. A plan can have a measure value above 100 if their observed rate was greater than their expected rate meaning their performance was worse than expected. A lower rate indicates better performance.

Table 21. Plan All-Cause Readmissions for Covered California Enrollees

	2016	2017	2018	2019			
	US Benchmark	US Benchmark	US Benchmark	US Benchmark	Percent of Enrollees	Number of Enrollees	Number of Plans
Plans at 90th Percentile and Above	M-NS	<= 58	<= 53	<= 52	1%	17,335	1
Plans at 50th to 90th Percentile	M-NS	78 to 58	76 to 53	71 to 52	54%	693,735	5
Plans at 25th to 50th Percentile	M-NS	88 to 78	86 to 76	77 to 71	37%	477,683	1
Plans Below 25th Percentile	M-NS	Above 88	Above 86	Above 77	7%	94,136	2
Covered California High/Average/Low Performers							
Covered CA Highest Performer	59	17	66	52			
Covered CA Weighted Average	86	80	74	71			
Covered CA Lowest Performer	163	119	86	95			
Covered California Plan-Specific Performance							
Anthem HMO	95	91					
Anthem PPO	82	80					
Anthem EPO			74	71	5%	64,031	
Blue Shield HMO				68	7%	93,322	
Blue Shield PPO	94	76	86	70	26%	335,176	
CCHP HMO	163	17					
Health Net HMO	74	77	71	71	11%	145,183	
Health Net EPO							
Health Net PPO							
Kaiser Permanente HMO	88	84	68	73	37%	477,683	
LA Care HMO	59	119	72	80	7%	84,750	
Molina Healthcare HMO	65	82	66	55	4%	56,023	
Oscar Health Plan EPO							
Sharp Health Plan HMO	75	56	67	52	1%	17,335	
Valley Health Plan HMO		115					
Western Health Advantage HMO	103	76		95	1%	9,386	

[33] The observed to expected readmission rates are multiplied by 100 to convert to whole numbers.

*M-NS: This measure was not used in determining the overall QRS rating in 2016.

Access to Care

The Access to Care measure is based on four 2019 QHP Enrollee Survey questions about enrollee's experience of receiving care:

1. In the last 6 months, when you needed care right away, in an emergency room, doctor's office, or clinic, how often did you get care as soon as you needed?
2. In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?
3. In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?
4. In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?

Table 22. Access to Care for Covered California Enrollees

	2016	2017	2018	2019			
	US Benchmark	US Benchmark	US Benchmark	US Benchmark	Percent of Enrollees	Number of Enrollees	Number of Plans
Plans at 90th Percentile and Above	81 +	82 +	84 +	80 +	0%	-	0
Plans at 50th to 90th Percentile	76 to 81	77 to 82	80 to 84	75 to 80	0%	-	0
Plans at 25th to 50th Percentile	72 to 76	74 to 77	77 to 80	72 to 75	62%	839,580	4
Plans Below 25th Percentile	Below 72	Below 74	Below 77	Below 72	38%	505,650	8
Covered California High/Average/Low Performers							
Covered CA Highest Performer	78	79	81	75			
Covered CA Weighted Average	70	71	77	72			
Covered CA Lowest Performer	56	60	67	57			
Covered California Plan-Specific Performance							
Anthem HMO	62	61					
Anthem PPO	66	72					
Anthem EPO			77	69	5%	64,031	
Blue Shield HMO				71	7%	93,322	
Blue Shield PPO	70	71	79	73	25%	335,176	
CCHP HMO	62	65	67	67	1%	10,013	
Health Net HMO	65	65	69	66	11%	145,183	
Health Net EPO		74					
Health Net PPO							
Kaiser Permanente HMO	78	77	81	75	36%	477,683	
LA Care HMO	73	72	67	67	6%	84,750	
Molina Healthcare HMO	59	60	69	68	4%	56,023	
Oscar Health Plan EPO			77	71	3%	35,962	
Sharp Health Plan HMO	76	79	74	73	1%	17,335	
Valley Health Plan HMO	56	65	70	57	1%	16,366	
Western Health Advantage HMO	74	79	79	73	1%	9,386	

Care Coordination

The Care Coordination measure is based on six 2019 QHP Enrollee Survey questions about enrollee's experience of receiving care:

1. When you visited your personal doctor for a scheduled appointment in the last 6 months, how often did he or she have your medical records or other information about your care?
2. In the last 6 months, when your personal doctor ordered a blood test, x-ray, or other test for you, how often did someone from your personal doctor's office follow up to give you those results?
3. In the last 6 months, when your personal doctor ordered a blood test, x-ray, or other test for you, how often did you get those results as soon as you needed them?
4. In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?
5. In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking?
6. In the last 6 months, did you get the help that you needed from your personal doctor's office to manage your care among these different providers and services?

Table 23. Care Coordination for Covered California Enrollees

	2016	2017	2018	2019			
	US Benchmark	US Benchmark	US Benchmark	US Benchmark	Percent of Enrollees	Number of Enrollees	Number of Plans
Plans at 90th Percentile and Above	88 +	89 +	88 +	87 +	0%	-	0
Plans at 50th to 90th Percentile	84 to 88	85 to 89	85 to 88	83 to 87	0%	-	0
Plans at 25th to 50th Percentile	82 to 84	82 to 85	83 to 85	81 to 83	3%	35,962	1
Plans Below 25th Percentile	Below 82	Below 82	Below 83	Below 81	97%	1,309,268	11
Covered California High/Average/Low Performers							
Covered CA Highest Performer	85	88	86	83			
Covered CA Weighted Average	81	81	83	79			
Covered CA Lowest Performer	74	76	74	73			
Covered California Plan-Specific Performance							
Anthem HMO		76					
Anthem PPO	81	81					
Anthem EPO				79	5%	64,031	
Blue Shield HMO				81	7%	93,322	
Blue Shield PPO	81	82	84	81	25%	335,176	
CCHP HMO	76	77	77	80	1%	10,013	
Health Net HMO	76	78	79	76	11%	145,183	
Health Net EPO		84					
Health Net PPO							
Kaiser Permanente HMO	85	83	85	80	36%	477,683	
LA Care HMO	81	83	78	77	6%	84,750	
Molina Healthcare HMO	74	77	74	78	4%	56,023	
Oscar Health Plan EPO			80	83	3%	35,962	
Sharp Health Plan HMO	84	88	85	79	1%	17,335	
Valley Health Plan HMO	79	79	79	73	1%	16,366	
Western Health Advantage HMO	84	81	86	81	1%	9,386	

Section 2. Implications for the Future

For these health plan measures for addressing chronic illnesses, the main observation from the reporting over the past four years is that there is wide variation among the plans. Kaiser Permanente and Sharp Health Plan frequently report providing services or getting results that are in the top 90th percentile in the nation, while other plans have lower scores – ranging from the 25th to just above the 50th percentile. The wide variation in performance is particularly meaningful for measures related to managing diabetes and hypertension that do a remarkable job of targeting the opportunities to improve the morbidity and mortality attributable to those conditions. Improvement in performance across all California plans would be potentially life-saving and clinically meaningful for hundreds of thousands of Californians.

The ability of integrated delivery systems to achieve such positive results is a clear indicator of what is possible with well-coordinated and integrated care. Covered California is assessing what factors contribute to better performance among non-integrated systems and how this performance can be replicated across California.

Covered California identified four priority CAHPS measures. For two of these measures — overall satisfaction with care and with their health plan — most Covered California health plans perform above the 50th percentile compared to national marketplace plans (see Chapter 2: Individualized, Equitable Care). It is concerning that 8 health plans score below the 25th percentile on members' Access to Care and that 11 health plans score below the 25th percentile for Care Coordination. It is important to note that the CAHPS results for marketplace plans nationwide are highly compressed with only a few points difference among each percentile and all results are relatively high compared to other measures. Covered California sees these enrollee-experience scores as reason for both concern and future research and is working with its health insurance companies to assure improvement in these areas. Covered California is also seeking to expand the number and sources of measures that can best assess consumers' experience in access to care, care coordination and other important quality domains.

Chapter 6: Complex Care

Complex Care involves effectively managing very complex conditions for individuals that require a multitude of specialty, high-cost treatments – such as rare cancers or transplants – or require end of life care. These individuals need to be managed effectively, provided well-coordinated care, or be seen in very specialized settings.

This chapter on Complex Care presents performance data reported by health insurance companies for contract requirements and includes assessments and observations by Covered California. This chapter is organized as follows:

Section 1. Qualified Health Plan Experience

Section 2. Implications for the Future

Section 1: Qualified Health Plan Experience

Qualified Health Plan Experience presents performance data reported by health insurance companies for contract requirements and includes assessments and observations by Covered California. The current contract requirements for Complex Care largely focus on health plan processes for effectively managing at-risk enrollees with complex conditions, defined as: "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."[34]

It has been shown that when high-risk enrollees are identified early, they are most likely to benefit from

Highlights

- All insurers leverage medical and pharmacy claims as well as demographic information to identify high-cost or high-risk patients for various care and case management support, but there is no consistent measurement of the efficacy of their efforts, primarily due to the lack of standard population identification or quality measures for complex care.
- All insurers contracted with Centers of Excellence (COE), with the most common treatments being cancer care and bariatric surgery. Identification and performance measurement for COEs is not standardized.
- Only one insurer had a formal steerage program for transplants while most insurers promote their COEs by relying on member interactions with the service center or care management team.
- Most health plans offered Health Risk Assessments (HRAs) to determine enrollee health status on a voluntary basis, but completion rates are very low.
- A large-scale effort to support at-risk enrollees in effective coverage transitions coordinated by Covered California and insurers occurred when Anthem exited multiple rating regions in 2018, affecting nearly 137,000 consumers.

[34] See Glossary of Key Terms for Attachment 7 to Covered California 2017 Qualified Health Plan Contract: Quality, Network Management, and Delivery System Standards, and Improvement Strategy: https://hbex.coveredca.com/insurance-companies/PDFs/Attachment-7-Amended-for-2019.pdf.

well-coordinated care. As such, Covered California has the following requirements for health plans to address complex care:

1. Coordinating treatment for enrollees with conditions that required high specialized management, such as transplant patients, and the use of Centers of Excellence (COEs) for these enrollees;
2. Collecting information to monitor enrollee health status;
3. Tracking changes in health status and the use of health risk assessments;
4. Supporting at-risk enrollees requiring transition; and
5. Identification and services for at-risk enrollees.

Centers of Excellence

Health insurance companies are required to report on how enrollees with conditions that require highly specialized management, like transplant patients and burn patients, are managed by providers with documented special experience and proficiency based on volume and outcome data, such as Centers of Excellence (COEs). Centers of Excellence allow for complex care patients to be seen in very specialized settings, such as National Cancer Institute designated cancer centers.

Although there are no standards for identifying COEs, described below are common themes discussed by insurers about the process for use and promotion of COEs to enrollees with specialized conditions, as well as the strategy for including COEs in each insurer's network (see *Table 24. Covered California Insurer Processes and Strategies for Use of Centers of Excellence, 2015, 2017 and 2018*). All insurers contract with COEs but only one insurer has a formal steerage program to direct enrollees to COEs for transplants. Most health insurance companies promote COEs through enrollee interactions with their service centers or care management teams. Other insurers simply note that COEs are available in their Evidence of Coverage documents.

Table 24. Covered California Insurer Processes and Strategies for Use of Centers of Excellence, 2015, 2017 and 2018[35]

Process: Promotion of Centers of Excellence
• Steered all members to transplant COEs and encouraged use of COEs for other conditions • Member services or concierge teams assisted members in locating designated facilities and managing benefit requirements and limitations • Care managers and medical directors drove appropriate use of these facilities • Did not actively promote or steer members; identified COEs in coverage documents
Strategy: Basis for Inclusion in Network
• Must meet or exceed a specific level of volume and outcomes while demonstrating adherence to industry standards; inclusion in network reviewed yearly • Only contracted with COEs when a specific highly-specialized method of care was not available in-network; established single case referrals with COEs for specific procedures • Stringent selection criteria for choosing COEs; only included in provider directory if contracted for long-term versus one-time arrangements • Used COEs for transplants approved by the Department of Health Care Services (DHCS) • No formal COEs, but network included specific hospitals for tertiary and transplant cases

Source: Covered California Staff Analysis of Qualified Health Plan Submitted Data

[35] Data only available for plan year 2015 and plan years 2017-18. Covered California waived data collection for plan year 2016.

All 11 health insurance companies provided enrollees' access to at least two types of Centers of Excellence in 2018. Nine insurers provided access to at least one type of COE specializing in transplants, eight health plans offered a COE for cancer care, seven health plans offered a COE for bariatric surgery, and six plans offered a COE for burn care (see *Table 25. Covered California Enrollees' Access to Centers of Excellence for Specialized Conditions, 2015, 2017 and 2018*). A lower number of health plans offered COEs for cardiac care and orthopedics (such as hip and knee surgery).

Table 25. Covered California Enrollees' Access to Centers of Excellence for Specialized Conditions, 2015, 2017 and 2018[36]

	Number of Health Plans		
	2015	**2017**	**2018**
Cancer	9	9	8
Transplants	11	11	9
Cardiac Care	3	3	4
Bariatric Surgery	3	3	7
Orthopedics	2	2	5
Burn Care	7	7	6

Note: Covered California did not specifically ask if health plans contract with COEs for cardiac care or orthopedics. Additional health plans may contract with COEs for these conditions.

Source: Covered California Staff Analysis of Qualified Health Plan Submitted Data

Collecting Information to Monitor Enrollee Health Status

Health insurance companies are required to describe how they collect and report, at both the individual and aggregate levels, changes in enrollee health status. For example, reporting by insurers may include a comparative analysis of health status improvements across geographic regions and demographic groups. Health insurance companies are required to describe their process to monitor and track health status, which may include identifying individuals who show a decline in health status, and referral of such enrollees to care management programs.

In 2018, eight insurers described a system for collecting data on enrollee health status (either a clinical system for determining health status or the use of a survey). All insurers leveraged medical and pharmacy claims as well as demographic information to identify high-cost or high-risk patients for various care and case management support. Integrated delivery systems, such as Kaiser Permanente and Sharp Health Plan, leveraged access to more clinical data, such as lab results.

Health risk assessments (HRAs) can be used in concert with clinical data for predictive modeling for early intervention. HRAs are an important tool that can accurately stratify individuals with the highest risk because they capture both physical and behavioral health needs as well as social needs.

[36] Data only available for plan year 2015 and plan years 2017-18. Covered California waived data collection for plan year 2016.

Determining Enrollee Health Status and Use of Health Risk Assessments

Health insurance companies are required to describe their capabilities in collecting information about enrollees' health status and behaviors for health promotion and improved care management. If the insurer used health risk assessments to determine health status, the following requirements apply:

1. The assessment must be offered in all threshold languages to enrollees over the age of 18, including those that have previously completed such an assessment;
2. The assessment tool must adequately evaluate an enrollee's current health status and provide a mechanism to conduct ongoing monitoring for future intervention(s); and
3. Enrollees should be made aware at the beginning of the assessment about how information collected may be used, that they may opt in to receive information from the insurer, and that participation in the assessment is optional.

Most insurers offered HRAs on a voluntary basis, but completion rates reported by insurers for 2018 were very low. HRA completion rates ranged from 0 to 38 percent with 8 of the 11 insurers reporting under 6 percent completion.

While HRA completion rates were low for the overall population, insurers had several activities and capabilities that supported HRAs and best evidence supports targeted HRA collection for at-risk individuals (see *Table 26. Covered California Insurer Activities and Capabilities Supporting Health Risk Assessments, 2018*).[37] Most health insurance companies took multiple steps to address at-risk behaviors reported in an HRA. Eleven insurers generated a personalized report after completion which provided members specific actions they can take to lower their risk and directed them to a targeted intervention module. Three insurers auto-enrolled members into a disease management program and two allowed members the option to send assessment results to their physician. Given the lack of data, health insurance companies reported limited ability to proactively link enrollees with smoking cessation or weight management programs that they all offer.

Table 26. Covered California Insurer Activities and Capabilities Supporting Health Risk Assessments, 2018

	Number of Health Plans
Addressing At-Risk Behaviors	
Personalized HRA report is generated after HRA completion that provides member-specific risk modification actions based on responses	11
Members are directed to targeted interactive intervention module for behavior change upon HRA completion	10
At point of HRA response, risk-factor education is provided to member based on member-specific risk	6
Case manager or health coach outreach call triggered via HRA results	8
Member can update responses and track against previous responses	7
Ongoing push messaging for self-care based on member's HRA results	6
Member is automatically enrolled into a disease management or at-risk program based on responses	3
Member can elect to have HRA results sent electronically to physician	2

[37] The capabilities reported by health insurance companies only apply to the small number of enrollees they reported as successfully completing the Health Risk Assessment.

Tracking Health Status	
HRA responses tracked over time to observe changes in health status	8
HRA responses incorporated into member health record	5
HRA responses used for analysis of health status across demographics	5
HRA responses used for analysis of health status across regions	2

Source: Covered California Staff Analysis of Qualified Health Plan Submitted Data

Supporting At-Risk Enrollees Requiring Transition

Health insurance companies must demonstrate that they are able to facilitate transitions of care with minimal disruption for enrollees that (1) switched from one insurer into another or (2) into or out of coverage through Covered California. This requirement for supporting at-risk enrollees is broader than the continuity of care requirements in state law. Covered California's contracts with the majority of health insurance companies in California which places it in the unique position to better facilitate transitions of care for this population that will result in enrollees receiving the right care at the right time. Covered California is particularly concerned about transitions for the following "at-risk" enrollees:

1. Individuals in the middle of acute treatment, third trimester pregnancy, or those who would otherwise qualify for continuity of care under California law;
2. Individuals in case management programs;
3. Individuals in disease management programs; and
4. Individuals on maintenance prescription drugs for a chronic condition.

If enrollees experience a service area disruption, Covered California may automatically transition the enrollee into a different health insurance company to avoid gaps in coverage and facilitate care transitions. If this occurs, the insurer terminating the enrollee has several requirements, including conducting outreach to the affected enrollee, obtaining authorization to send personal health information to the receiving health insurance company, and collaborating with impacted providers.

Identification and Services for At-Risk Enrollees

Health insurance companies are required to identify and proactively manage enrollees with existing and newly diagnosed chronic conditions, including "at-risk enrollees" with diabetes, asthma, heart disease, or hypertension, who are most likely to benefit from well-coordinated care. Insurers must agree to support disease management activities at the insurer or provider level that meet standards of accrediting programs such as NCQA. Health insurance companies provide Covered California with a documented process, care management plan and strategy for targeting and managing at-risk enrollees. Such documentation may include (but is not limited to) methods to identify and target at-risk enrollees, description of predictive analytic capabilities, member communication plans, care and network strategies, and data on the number of enrollees identified as well as the types of services provided.

Most health insurance companies reported identifying at-risk enrollees with algorithms and other proprietary technology based on claims and utilization data.[38] Some insurers described using demographic data, HRA data, hospital discharge data, clinical data, and nurse advice line and provider referral data.

[38] No data was summarized in a table for 2018 due to specific proprietary technologies mentioned and because four out of 11 insurers explained what data they collected but did not explain how they analyzed the data for at-risk enrollee identification.

Supporting At-Risk Enrollees Transitioning between Covered California Insurers: Experience Assuring Care Transitions for over 135,000 Californians in 2018

In much of the nation, there has been substantial instability in insurers serving different states' individual market. One of the risks of insurers exiting markets is the potential for disruption of care for those with complex health care needs. California has been marked by stability among its insurers. The only significant disruption from an insurer changing its service areas occurred when Anthem exited multiple rating regions in 2018, affecting nearly 137,000 consumers — about 10 percent of Covered California enrollees — while remaining in large portions of the state. Covered California worked closely with Anthem and all other health insurers receiving transitioning enrollees to assure effective transitions. Carrying out an effective transition of Anthem enrollees required partnership and collaboration among Covered California staff, the health insurance companies receiving transitioning enrollees, and Anthem. Covered California and receiving insurers began working with Anthem staff months before the transitions in coverage to ensure appropriate and seamless continuity and transitions of care to protect the most vulnerable populations. The goal was to identify enrollees with specific care needs and to transfer information about enrollee's care needs to the receiving insurer.

This collaboration required Anthem and receiving insurers to agree to identifying an appropriate level of data required for transitioning enrollees, parameters on data sharing and use and processes to receive and act upon consumer information. At-risk enrollees included those undergoing case or disease management services as well as those with pregnancy/maternity and specialty medication needs. The data sharing resulted in receiving insurers having sufficient information to do timely consumer outreach. This outreach was of utmost benefit to consumers who would have otherwise navigated the health care system alone.

The type of services offered to at-risk enrollees varies substantially across insurers (see *Table 27. Types of Interventions for Covered California At-Risk Enrollees Eligible for Case Management, 2018*). All health insurance companies offered some level of live outbound telephonic coaching to members. Most offered member-specific reminders for health maintenance services (10 of 11) or face-to-face visits (six of 11). Online interactive self-management support was less common, with four of 11 plans offering it to high-risk or all enrollees.

Table 27. Types of Interventions for Covered California At-Risk Enrollees Eligible for Case Management, 2018

	Number of Health Plans		
Type of Intervention	**Not Offered**	**Offered in High-Risk Program**	**Available for All Enrollees**
Member specific reminders for health maintenance services	1	7*	3
Member specific reminders for medication events	5**	5	1
Interactive voice response with outbound messaging only	7	2*	2
Live outbound telephonic coaching program	0	7	4
Self-initiated text/email messaging	9	1	1
Online interactive self-management support	7	1	3
Face-to-face visits	5	5	1

*Includes contradictory responses from one health plan.

**Includes contradictory responses from two health plans.

Source: Covered California Staff Analysis of Qualified Health Plan Submitted Data

Section 2: Implications for the Future

Measurement of performance in caring for enrollees requiring complex care requires further development. Covered California found no standard quality measures for Complex Care to include in this chapter. The current Marketplace Quality Rating System measure set has one measure for behavioral health subpopulations, Follow Up After Hospitalization for Mental Illness (FUH) (HEDIS), which is presented in Chapter 4. The Plan All-Cause Readmissions measure, which is presented in Chapter 5, may include complex care patients but does not specifically measure care management processes or outcomes.

In a Covered California sponsored report released in July 2019, Current Best Evidence and Performance Measures for Improving Quality Care and Delivery System Reform, Health Management Associates (HMA) recommended a hybrid method of population stratification starting with automated data to identify high cost enrollees combined with survey data such as HRAs, behavioral health screening, screening for social needs or measuring patient activation to determine enrollees who are likely to continue to be high-risk and high-cost. In the same report, PricewaterhouseCoopers (PwC) recommended that Covered California use its claims data warehouse to track rates of inpatient and Emergency Department use and Emergency Department follow-up among complex care patients. PwC also recommended that Covered California consider the Transition of Care HEDIS measure which would require collection of discharge information that includes test results.

Covered California is working with health insurance companies and other stakeholders to establish best practices for population identification and management including a standardized approach to defining and measuring performance of Centers of Excellence.

EFFECTIVE CARE DELIVERY

Chapter 7: Promotion of Effective Primary Care

Effective Primary Care that is accessible, well-integrated, coordinated, continuous, team-based, and data driven is a core foundation of providing appropriate and equitable care. While many consumers benefit from an ongoing continuous relationship with a single physician, others may be able to receive effective primary care through sites of care or delivery systems that are well-integrated.

This chapter on Promotion of Effective Primary Care presents performance data for current contract requirements reported by health insurance companies for the 2015-18 plan years and includes assessments and observations by Covered California. This chapter is organized as follows:

Section 1. Qualified Health Plan Experience

Section 2: Health Plan Measures Reported to the Marketplace Quality Rating System

Section 3. Implications for the Future

Section 1: Qualified Health Plan Experience

Covered California believes promoting the Triple Aim and promoting health equity requires a foundation of effectively delivered primary care, which the Institute of Medicine defines as follows: "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."[39] To this end, Covered California promotes effective primary care with the following requirements:

Highlights

- Starting in 2017, virtually all Covered California's enrollees either selected or were matched with a primary care provider — including all enrollees in PPO model plans. Covered California is assessing the impact of this novel effort.
- While virtually all primary care provided in Kaiser Permanente is delivered by patient-centered medical home-recognized practices, outside of this system, enrollment served by PCMHs increased from 3 percent to 11 percent between 2016 and 2018.
- Several insurers are supporting primary care providers in clinical transformation to advanced primary care, though not meeting PCMH standards. Measurement of primary care performance will likely need to go beyond PCMH recognition process measures to include outcomes.
- Based on the Health Care Payment Learning and Action Network Alternative Payment Model Framework, 10 insurers now have *Positive Incentives* or *Strong Incentives* for transitioning from volume-based to value-based primary care payment.
- Significant increases were observed for shared savings and capitation-based payments between 2015-18. However, further assessment is needed to determine the extent to which capitation to medical groups or physician organizations cascades to individual providers.
- For insurers to continue to adopt value-based primary care payment or to increase investment, measurement of primary care performance will likely need to include outcomes.

[39] Institute of Medicine. 1994. *Defining Primary Care: An Interim Report.* Washington, DC: The National Academies Press. https://doi.org/10.17226/9153.

1. Ensure that all enrollees either select or be matched with a primary care physician (PCP) within 60 days of enrollment;
2. Insurers are required to have an increasing percentage of their enrollees cared for in patient-centered medical home models and annually report the number and percent of enrollees who obtain their care in a patient-centered medical home (PCMH); and
3. Describe how the insurer's payment strategy supports primary care physicians in adopting accessible, data-driven, team-based care with accountability for meeting the Triple Aim goals of enhanced quality, improved outcomes and lower costs.

Primary Care Physician Matching

In January 2017, Covered California required that all enrollees in preferred provider organizations (PPO), health maintenance organizations (HMO), and exclusive provider organizations (EPO), be matched to a primary care physician (PCP) or other primary care clinician, such as a nurse practitioner, upon enrollment. The purpose of the requirement was to bring the PCP match concept to the PPO and EPO environment and give enrollees a single point of contact who can help them navigate the health care system. A primary care physician can provide continuity and address most health care needs, helps consumers select the proper specialist, coordinates their care with other providers and ensures they understand their treatment options. While having a PCP can help select and coordinate care across specialty providers, enrollees in PPO and EPO plans can still choose to navigate the health care system on their own without permission from their PCP to seek treatment or a referral to see a specialist.

Since 2017, virtually all Covered California's enrollees, over 99 percent, either selected or were matched with a PCP upon enrollment which was nearly a 30-percentage point increase from the 2016 baseline rate of 70 percent.

Covered California believes this PCP match will ultimately help people get better access to care in a timelier manner. However, many enrollees may need more explanation of why working with their PCP is beneficial. Covered California is currently working with its plans to examine the data to understand the patient experience and clinical and financial effects of this program. Covered California will look to examine outcomes of clinical measures that may improve with a strong foundation in primary care.

Promoting Enrollment in Patient-Centered Medical Homes

A growing body of evidence shows that advanced models of primary care, which include patient-centered medical homes (PCMHs), greatly improve the care delivered to patients and support Triple Aim goals. Advanced primary care models utilize a patient-centered, accessible, team-based approach to care delivery, enrollee engagement and data-driven improvement, as well as integration of care management, behavioral health and community resources for patients with complex conditions. Under the existing contract requirement, insurers are required to have an increasing portion of enrollees who

obtain their care in a PCMH model and plans must use formal recognition programs to assess which providers are PCMHs.[40]

While there have been significant increases in the percentage of enrollees seen in PCMH settings, health insurance companies report that many in their primary care networks believe the current requirement tied to PCMH recognition is too limited and burdensome. As of 2018, about 40 percent of Covered California enrollees received primary care through providers that met PCMH standards. The great majority of that enrollment, however, was through Kaiser Permanente, which represented 82 percent of total PCMH enrollment in 2018. The percentage of enrollees cared for by PCMH-recognized practices, outside of the Kaiser Permanente system, increased threefold from 3 percent to 11 percent between 2016 and 2018, an 8-point increase (see *Table 28. Percentage of Covered California Enrollees Cared for in Patient Centered Medical Homes, 2016-18*). When looking at all insurers during the three years, the percent of Covered California enrollees who were cared for in PCMHs increased from 25 percent in 2015 to 40 percent in 2018. One of Sharp Health Plan's integrated medical groups achieved PCMH recognition in 2018 to comply with the Covered California requirement and this change accounts for most of the overall increase outside Kaiser Permanente. The percent of Sharp Health Plan enrollees cared for in a PCMH increased from 15 percent in 2017 to 66 percent in 2018.

Table 28. Percentage of Covered California Enrollees Cared for in Patient-Centered Medical Homes, 2016-18

	2016	2017	2018
All Enrollment	**25%**	**32%**	**40%**
Kaiser Permanente	*100%*	*100%*	*100%*
Non-Kaiser Permanente	*3%*	*6%*	*11%*

Source: Covered California Staff Analysis of Qualified Health Plan Submitted Data

Covered California has found that formal PCMH recognition programs have limitations and have been challenged as other measures of advanced primary care have evolved. The formal PCMH recognition programs largely document process improvement without measuring outcomes. Many advanced primary care practices have not sought formal recognition and many that have been recognized have implemented process improvements, but these may not have led to improvement in clinical quality or reduced cost. Additionally, several health insurance companies are focusing on primary care practice transformation programs that include practice coaching to support primary care providers in improving quality and efficiency rather than requiring or promoting PCMH recognition. Based on this feedback from health insurance companies and providers, Covered California is examining alternative approaches to promote improvements in primary care and assuring more enrollees benefit from these programs.

Payment Strategies that Promote Effective Primary Care

The Affordable Care Act included several demonstration projects and grants to test payment reforms that would shift volume-driven Fee-for-Service (FFS) payments to methods that link provider payment

[40] The current contract requirements list the following recognition programs: a) National Committee for Quality Assurance PCMH recognition; b) The Joint Commission Primary Care Medical Home certification; c) Accreditation Association for Ambulatory Health Care, Inc. Medical Home accreditation; and d) URAC PCMH Certification.

with performance on cost and quality. To measure health insurance company progress in payment strategies that promote accountability for Triple Aim goals, Covered California leveraged the four categories in the Health Care Payment Learning and Action Network (HCP LAN) Alternative Payment Model (APM) Framework[41] (see *Table 29. Covered California Assessment of Primary Care Payment Strategies Based on the HCP LAN Alternative Payment Model Framework, 2015, 2017 and 2018*).

While PCMHs are delivery models, not payment models, the Alternative Payment Model Framework notes that PCMHs and advanced primary care need the support of value-based payment models. Shifting payments from FFS to payments that increasingly hold primary care providers financially at-risk for high-quality care creates incentives for managing cost and quality. In assessing payment strategies, Covered California requires its contracted health plans to pay increasingly based on "Category 3: Shared Savings" and "Category 4: Population-based Payment," which Covered California reports below as having *Positive Incentives* and *Strong Incentives*, respectively.

As of 2018, Covered California assessment found that 10 health insurance companies were paying providers with either *Positive Incentives* or *Strong Incentives* for value – an increase of two insurers from 2015. More insurers are now assessed to have *Positive Incentives* or *Strong Incentives*.

Table 29. Covered California Assessment of Primary Care Payment Strategies Based on the HCP LAN Alternative Payment Model Framework, 2015, 2017 and 2018[42]

		Number of Health Plans		
Covered California Assessment	**APM Framework**	**2015**	**2017**	**2018**
Strong Incentives	**Category 4 – Population-based Payment** • Condition-specific population-based payment including per member per month payments • Comprehensive population-based payment such as global budgets or percent of premium payments • Integrated finance and delivery system such as global budgets in integrated systems	**2**	**2**	**2**
Positive Incentives	**Category 3 – APMs built on an FFS architecture:** • APMs with shared savings (upside risk only) • APMs with share savings and downside risk	**6**	**7**	**8**
Weak Incentives	**Category 2 – FFS– Link to quality and value** • Foundational payments for infrastructure and operations • Pay for reporting • Pay for performance • Rewards and penalties for performance	**3**	**2**	**1**
	Category 1 – Fee-for-Service (FFS)– No link to quality and value	**1**	**1**	**1**

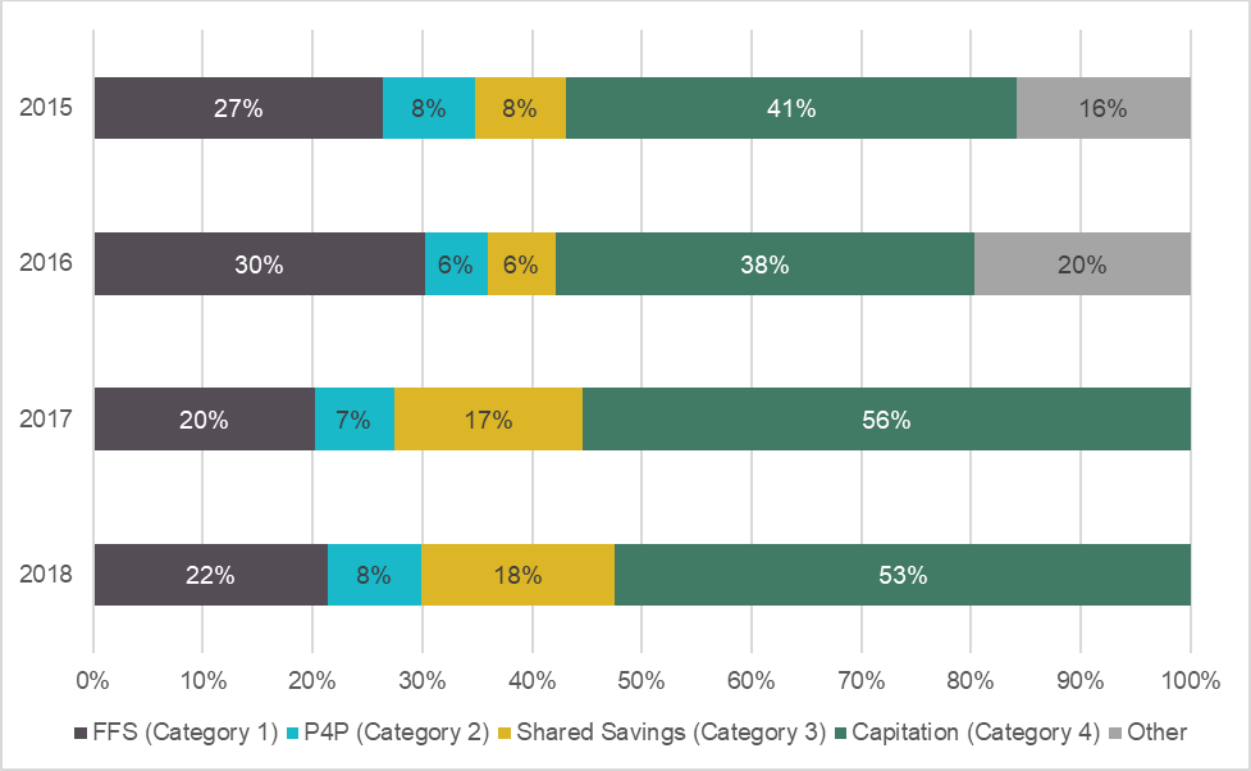
[41] Health Care Payment Learning and Action Network. (2017). Alternative Model Payment Framework. Retrieved from http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf.

[42] Data only available for plan year 2015 and plan years 2017-18. Covered California waived data collection for plan year 2016.

Source: Covered California Staff Analysis of Qualified Health Plan Submitted Data

As expected, payment strategies to PCPs vary widely (see *Figure 4. Covered California Insurer Payment Strategies for Primary Care Providers, 2015 – 2018*), but from 2015 to 2018 there has been a significant increase in payment to providers being based on capitation (increasing from 41 percent to 53 percent) and shared savings (increasing from 8 percent to 18 percent). The decline in payments to primary care providers based on fee-for-service and the fact that Covered California plans now pay 71 percent of primary care providers using capitation or shared savings is important progress. At the same time, based on discussions with insurers and provider groups, there is reason to be concerned that capitation payments made to medical groups or physician organizations may not cascade to individual providers, many of whom continue to be largely paid on a fee-for-service basis.

Figure 4. Covered California Insurer Payment Strategies for Primary Care Providers, 2015 – 2018



Note: "Other" refers to payments types that insurers could not breakdown into the four HCP LAN categories. These percentages are enrollment weighted and may not equal 100 due to rounding.

Source: California Staff Analysis of Qualified Health Plan Submitted Data

According to the HCP LAN, in calendar year 2018, about 56 percent of national commercial market total health care payments were FFS (Category 1), 14 percent of payments were FFS with a link to quality (Category 2), 28 percent of payments were shared savings (Category 3) and only 2 percent of payments were population-based payments or capitation.[43] This data is collected through surveys of

[43] Health Care Payment Learning and Action Network. Measuring Progress: Adoption of Alternative Payment Models in Commercial, Medicaid, Medicare Advantage, and Traditional Medicare Programs. October 24, 2019. Retrieved from: http://hcp-lan.org/workproducts/apm-methodology-2019.pdf.

health insurance companies and represents about 133.5 million covered lives which is 61 percent of the national commercial market. Although this data represents all commercial health care payments, it suggests that Covered California insurers have made significant progress in moving towards capitation or population-based payment and away from FFS payments for primary care providers compared to the rest of the nation. In 2018, only 22 percent of Covered California insurer's primary care payments were FFS compared to the national rate of 56 percent FFS for all health care payments for the commercial market.

Interaction of Payment Strategies, Patient-Centered Medical Homes, and Promotion of Advanced Primary Care

At this time, there is not enough information to establish a link between payment strategies and the percent of members cared for in a PCMH. There appears to be a clearer relationship between increased enrollment in a PCMH model and whether the plan is part of an integrated delivery system. Some health insurance companies assessed by Covered California to have *Strong Incentives* for their payment strategies also had a higher percent of enrollees cared for in PCMHs (e.g., Kaiser Permanente pays 100 percent of its primary care physicians a population-based payment, which is considered a Category 4 APM, and 100 percent of its providers are PCMH recognized). Kaiser Permanente and Sharp Health Plan, both fully integrated delivery systems, are high outliers for enrollment in a PCMH model. However, the other nine health insurance companies of which some are considered to have *Weak Incentives* because they paid their providers FFS, had similar percentages of enrollees cared for in a PCMH as those with *Strong Incentives* or *Positive Incentives*. In some instances, it was also difficult to attribute a relationship between specific payment strategies and enrollees cared for in a PCMH because some providers simultaneously received enhanced reimbursements for PCMH recognition from other payers, such as Medi-Cal.

Strategies to Enroll or Attribute Enrollees to Patient-Centered Medical Homes

Although not definitive, there may be a relationship between promoting PCMH-recognized providers to enrollees and the percent of enrollees cared for in a PCMH. Between 2015 and 2018, most health insurance companies did not actively promote PCMH providers to enrollees or actively assign or match enrollees to PMCHs. The few insurers that listed PCMH recognition in provider directories were observed to have higher rates of enrollees cared for in a PCMH.

Section 2: Health Plan Measures Reported to the Marketplace Quality Rating System

Health Plan Measures Reported to the Marketplace Quality Rating System details health plan performance on Healthcare Effectiveness Data Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures reported to the Centers for Medicaid and Medicare Services' Quality Rating System (QRS). These standard performance measures are a key mechanism used by Covered California for health plan oversight and accountability.

See *Appendix 2: Additional Health Plan Measures Reported to the Quality Rating System*, for Quality Rating System measures that pertain to Promotion of Effective Primary Care:

1. Rating of Personal Doctor (CAHPS) (Table A21)
2. Rating of Specialist (CAHPS) (Table A22)

The patient experience reporting of enrollees Rating of Personal Doctor showed wide variation but was marked by the fact that 9 of 11 health plans — representing 89 percent of enrollees — had ratings

below the 25th percentile nationally. However, the range of scores is exceedingly narrow; for Rating of Personal Doctor, a raw score below 86 is below the 25th percentile, while a raw score of 90 is the 90th percentile.

Section 3: Implications for the Future

Ensuring all enrollees have a PCP, regardless of their health plan product, provides a single point of contact to help them navigate the health care system. Covered California is evaluating the impact of PCP matching in EPO and PPO plans based on outcomes including utilization, continuity of care, cost and quality that may improve with a strong foundation in primary care. Covered California continues to work with insurers to help all enrollees understand the value of primary care.

Further assessment is needed to determine the extent to which capitation to medical groups or physician organizations cascades to individual providers. Covered California will continue to require health insurance companies to increasingly implement value-based payments for primary care providers like shared savings and population-based payment or capitation. One of the biggest barriers to full adoption of advanced primary care, despite the changes to payment structure described above, appears to be inadequate revenue or resources to support well-rounded care teams, underscoring the importance of continued efforts at primary care payment reform.

For health insurance companies to make these investments, measurement of performance will likely need to go beyond the PCMH recognition process measures to include outcome measures that reflect the impact advanced primary care can have improving quality, enhancing the patient experience, and reducing total cost of care and documenting a return on investment for insurers that increase primary care payment such that it accounts for a larger share of the overall health care budget.

Chapter 8: Promotion of Integrated Delivery Systems and Accountable Care Organizations

Promotion of integrated delivery systems and accountable care organizations is premised on the increasing evidence that effectively caring for and managing a person's health requires an integrated care system that can coordinate across providers, sites and times for a variety of conditions while delivering good outcomes and quality at an affordable cost.[44, 45]

This chapter on Promotion of Integrated Delivery Systems and Accountable Care Organizations presents performance data reported by health insurance companies for contract requirements and includes assessments and observations by Covered California. This chapter is organized as follows:

Section 1. Qualified Health Plan Experience

Section 2. Implications for the Future

Section 1: Qualified Health Plan Experience

Covered California has the following requirements for integrated delivery systems (IDSs) or accountable care organizations (ACOs):

1. Increase enrollment over time and report the number and percent of enrollees who are managed under an IDS or ACO as well as provide comparison reporting for other lines of business;

Highlights

- In 2018, 60 percent of Covered California enrollees were cared for in an Integrated Delivery System (IDS) or an Accountable Care Organization (ACO), which represents a 12-point increase from 2015. After excluding the fully-integrated delivery systems, Kaiser Permanente and Sharp Health Plan, 25 percent of Covered California enrollees were cared for in an ACO, which represents a 4-point increase from 2015 and far exceeds state and national benchmarks.
- Nine insurers reported offering technical support, data sharing support, or promoting participation in health information exchanges for providers in 2018, an increase from four insurers in 2015. Covered California has also seen a steady increase in the number of insurers using other common components of integrated coordinated care such as population health management support and holding providers accountable using standard quality measure sets.
- Insurers are required to report 2018 performance based on the IHA Commercial ACO measures by year-end 2019, which will allow better understanding of performance variation of different ACO models and inform future contract requirements.

[44] Covered California's recently completed evidence review affirmed the value and positive impact on quality and cost of effective care integration and some models of Accountable Care Organization (see Current Best Evidence and Performance Measures for Improving Quality Care and Delivery System Reform). In addition, recent data from the Integrated Health Care Association (IHA) Cost and Quality Atlas, shows clinical quality was higher for ACO and HMO members compared to PPO members for commercial plans (see https://atlas.iha.org/story/aco).

[45] 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. Accountable care organizations (ACOs) are groups of physicians and healthcare facilities that share financial and medical responsibility for providing coordinated care, with financial incentives to provide high-quality care and to limit avoidable, unnecessary spending.

2. Provide details on the key design characteristics of existing or planned integrated systems of care and how these systems of care compare to the definition in the Covered California contract; and
3. Report performance of different ACO models for all lines of business using the IHA Commercial ACO Measure Set once data becomes available for plan year 2018.

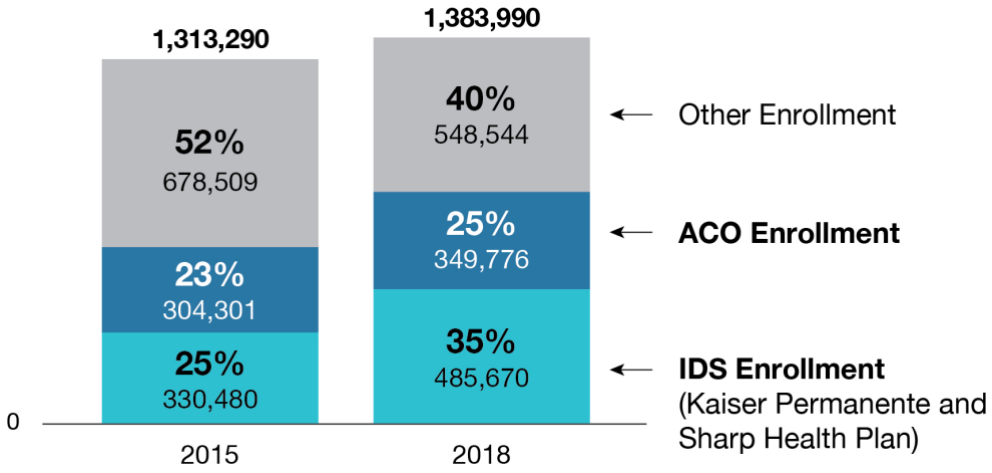
Percent of Enrollees in an Integrated Delivery System or Accountable Care Organization

Covered California requires health insurance companies to report the number and percent of enrollees who are managed under an IDS or ACO as well as provide comparison reporting for their other lines of business. Insurers are also are required to demonstrate an increase in the percent of enrollees who obtain their care in an IDS or ACO model between 2017 and 2019.

Nationally, the Centers for Medicare and Medicaid Services (CMS) is leading a drive to implement value-based payment models including integrated and coordinated delivery models such as ACOs. Leavitt Partners tracks the growth and spread of ACOs including the new models supported by CMS and their commercial and Medicaid analogs.[46] As of 2018, 10 percent of the U.S. population or 32.7 million Americans were cared for in ACOs in the commercial, Medicaid and Medicare markets. This includes every state, with penetration ranging from 2 percent to over 20 percent. Leavitt Partners reports that between 10 to 15 percent of Californians are cared for in such models.

In 2018, 60 percent of Covered California enrollees were cared for in an IDS or ACO, which represents a 12-point increase from 2015 (see *Figure 5. Covered California Enrollment in Integrated Delivery Systems or Accountable Care Organizations, 2015 and 2018*).[47]

Figure 5. Covered California Enrollment in Integrated Delivery Systems or Accountable Care Organizations, 2015 and 2018



[46] Muhlestein et al. (2018). Recent Progress in The Value Journey: Growth of ACOs and Value-Based Payment Models in 2018. Health Affairs blog. Retrieved from https://www.healthaffairs.org/do/10.1377/hblog20180810.481968/full/

[47] Data only available for plan year 2015 and plan year 2017-18. Covered California did not ask this question in the Certification Application for plan year 2016.

Source: Covered California Staff Analysis of Qualified Health Plan Data Submitted for 2015 and 2018
Note: Enrollment figures reflect only on-Exchange enrollment.

Two insurers, Kaiser Permanente and Sharp Health Plan, are fully integrated delivery systems and account for about 60 percent of the overall number.[48] As of 2018, after excluding enrollment in Kaiser Permanente and Sharp Health Plan, 25 percent of Covered California enrollees among the other insurers were cared for in an ACO, which represents a 2-percentage point increase from 2015. It is this latter statistic that is most comparable to the national data from Leavitt Partners; based on this report, California has greater penetration of these new models than the U.S. and Covered California penetration exceeds the rest of California even excluding those enrolled with Kaiser Permanente or Sharp Health Plan.

Health Plan Components of Integrated Delivery Systems or Accountable Care Organizations

Covered California places great importance on the adoption and expansion of integrated, coordinated and accountable systems of care. As such, health insurance companies are required to provide details on existing or planned integrated systems of care and how these systems of care compare to the following definition:

1. A system of population-based care coordinated across the continuum including multi-discipline physician practices, hospitals and ancillary providers; and
2. Having combined risk sharing arrangements and incentives between the health insurance company and providers, and among providers across specialties and institutional boundaries, holding the ACO accountable for nationally recognized evidence-based clinical, financial, and operational performance, as well as incentives for improvements in population outcomes.

Based on the descriptions of their IDS or ACO models provided by insurers, Covered California has identified several components many insurers are using in their respective models. In 2018, most insurers (nine out of 12) reported offering technical support, data sharing support, or promoting participation in health information exchanges for providers, an increase from four insurers in 2015 (see *Table 30. Components of Covered California Insurer's Support for Integrated Delivery Systems or Accountable Care Organizations, 2015, 2017 and 2018*). Covered California has also seen a steady increase in the number of health insurance companies using other common components like population health management support and holding providers accountable using standard quality measure sets.

[48] In Covered California, Kaiser Permanente and Sharp Health are fully integrated delivery systems while other health plans base their ACO model on existing provider organizations, such as integrated medical group and hospitals.

Table 30. Components of Covered California Insurer's Support for Integrated Delivery Systems or Accountable Care Organizations, 2015, 2017 and 2018[49,50]

Component	Number of Health Plans		
	2015	2017	2018
Data Sharing, Data Exchange and Health Information Technology Offers providers technical support, data sharing support, or promotes participation in health information exchanges	4	6	9
Provider Support and Feedback Offers providers opportunities to share best practices, participate in learning collaboratives, or offers practice coaching	5	5	6
Quality Measurement and Improvement Providers are held accountable for improvement using a standardized measure set	4	5	6
Population Health and Case Management Supports providers in case management or population health management such as providing registries or care gap reports	4	5	6
Financial Incentives Uses population-based capitation, shared savings or shared risk, may also use incentives for quality	5	5	6

Note: Not all insurers are listed for each component. Some insurers may only be using one of these components, while others are using several.

Source: Covered California Staff Analysis of Qualified Health Plan Data Submitted for 2015 and 2017-18.

Comparing Performance of Different ACO Models using the Integrated Healthcare Association Commercial ACO Measure Set

The Integrated Healthcare Association (IHA) has developed a Commercial ACO Measure Set[51] derived from their long-standing physician organization performance measures which has been widely adopted in California. While it is early to assess ACO performance in California as there is enormous variation in the structure of ACO contracts and many have only a few years of performance, IHA has begun to report on results from using the Commercial ACO Measure Set for 85 ACO contracts in California based on 2017 performance.

In the charts below, IHA reports performance for three mutually exclusive groups: members cared for by ACOs representing a mix of models built on both HMO and PPO platforms, members cared for by provider organizations under capitated, delegated HMO contracts (excluding Kaiser Permanente medical groups), and members cared for by physicians under PPO contracts aggregated across the 19 Covered California pricing regions (see *Figure 6. California Commercial ACO Performance Compared to HMOs and PPOs, 2017*). Based on IHA analysis, ACOs provide care that is the same quality at a somewhat lower cost than either HMOs or PPOs.

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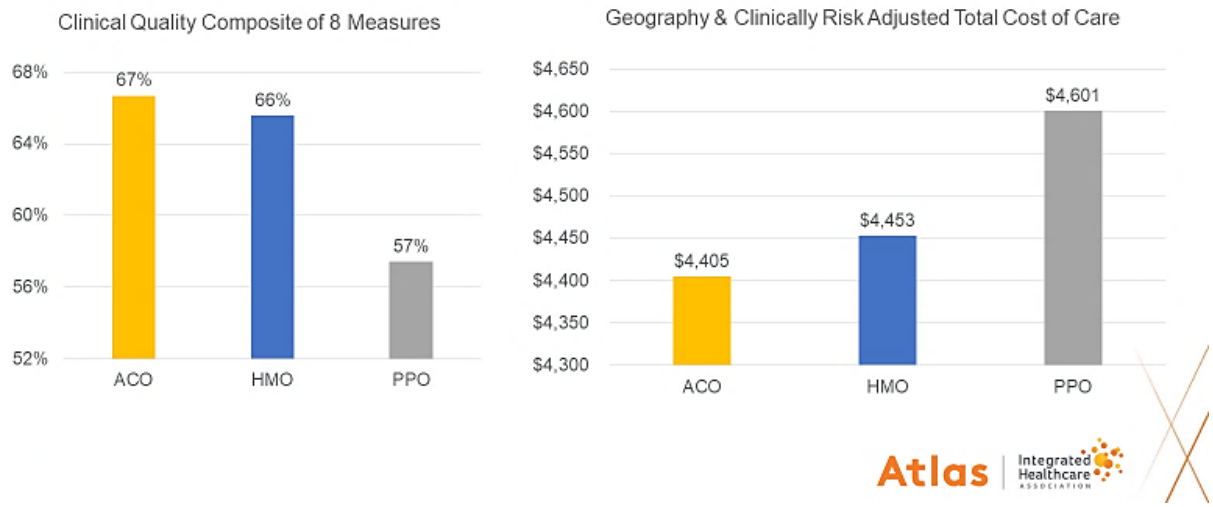
[49] Data only available for plan year 2015 and plan years 2017-18. Covered California waived data collection for plan year 2016.

[50] The 11 health insurance companies in Covered California are: Anthem Blue Cross, Blue Shield of California, Chinese Community Health Plan, Health Net, Kaiser Permanente, L.A. Care, Molina Healthcare, Oscar Health, Sharp Health Plan, Valley Health Plan, and Western Health Advantage. In the tables below, Health Net is counted twice because its reports data separately for Health Net Life (PPO/EPO products) and Health Net of California (HMO/HSP products).

[51] See more: https://www.iha.org/our-work/accountability/commercial-aco.

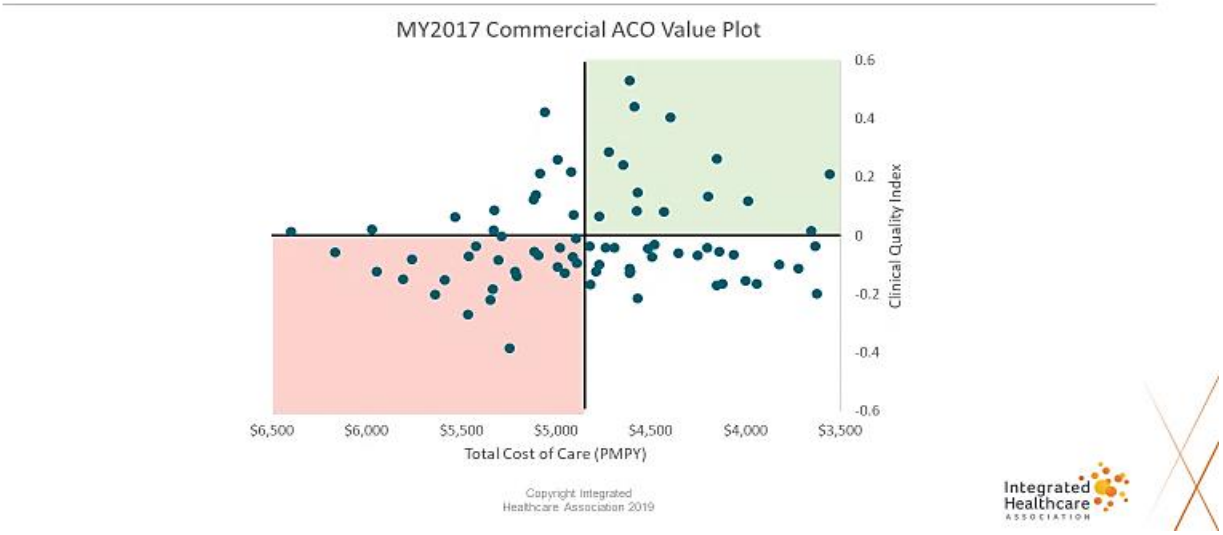
Figure 6: California Commercial ACO Performance Compared to HMOs and PPOs, 2017



Source: Integrated Healthcare Association, 2019

The aggregate ACO performance is encouraging but represents an average with wide variation among the ACOs measured (see *Figure 7. Variation in Quality and Cost in California Commercial ACO Performance, 2017*).

Figure 7: Variation in Quality and Cost in California Commercial ACO Performance, 2017



Source: Integrated Healthcare Association, 2019

The 14 “high value” ACOs in the upper right-hand quadrant — representing both lower cost and better quality — rival and sometimes exceed the performance of the best medical groups contracting with insurance companies within HMO models and one third of these high value ACOs are operating under PPO contracts (see *Figure 8: Characteristics of 14 “High Value” ACOs in California, 2017*).

Figure 8: Characteristics of 14 "High Value" ACO in California, 2017

Source: Integrated Healthcare Association, 2019

This first report from IHA comparing ACOs to other models demonstrates the potential value of integration and coordination through ACOs and that they can be implemented through all health plan products including PPOs.

The IHA Commercial ACO Measure Set reports for performance based on 2018 were recently released and health insurance companies are required to report these results to Covered California. The variation in performance among ACO contracts will be examined in cooperation with IHA, insurance companies and provider organizations and compared to the design elements MedPAC and others[52] have cited as predictors of success including two-sided risk, physician leadership (as compared to hospital leadership) and greater emphasis on advanced primary care.[53]

Section 2: Implications for the Future

Outside of the integrated delivery systems, Covered California's contracted health insurance companies that share overlapping networks are implementing a variety of ACO models or components of ACO models within their networks. Covered California enrollment in ACOs, excluding integrated delivery systems, exceeds comparisons in California and the nation. Performance variation among ACO models may be attributed to design elements such as the structure of financial incentives including downside risk, the role of physicians in sponsorship and leadership structure, the percent of budget spent in primary care and the sophistication of population health and case management

[52] The most current best evidence is documented in Chapter 8, Promotion of Integrated Delivery Systems and Accountable Care Organizations, of a companion Covered California report, Current Best Evidence and Performance Measures for Improving Quality of Care and Delivery System Reform.

[53] Primary Care Collaborative. (August 2018). Advanced Primary Care: A Key Contributor to Successful ACOs. Retrieved from: https://www.pcpcc.org/sites/default/files/resources/PCPCC%202018%20Evidence%20Report.pdf.

strategies. IHA is building a registry based on such elements for all ACOs they measure. As discussed above, Covered California is working with insurers to use the performance data from the IHA Commercial ACO measure set to establish correlations with the design elements in the registry of ACO characteristics to determine best practices and inform future contract requirements. This report cites several ways in which integrated delivery systems are outperforming network model health plans. The success of ACOs in replicating the performance of integrated delivery systems may depend on alignment in adopting common best practice design elements.

Chapter 9: Networks Based on Value

As a major strategy for effective care delivery, Covered California requires health insurance companies to select and regularly assess all clinicians, providers, hospitals and sites of care to ensure that care is safe, timely, effective, efficient, equitable, and patient-centered. Ideally, every network is designed to integrate and coordinate care, provides effective primary care and maximizes its value to enrollees.

For many consumers, whether the provider they want to see is in their network or not is the first sign of value. Assuring consumers have access to the full range of providers and treatments and that networks are composed of a range of quality providers is a central part of Covered California's review and selection process of its contracted insurers (see "Covered California Network Composition Review"). Covered California works to ensure health plan networks are designed and maintained with a deliberate strategy to promote better quality, lower cost, improved health and health equity.

This chapter on Networks Based on Value presents performance data and processes reported by health plans for contract requirements and includes assessments and observations by Covered California. This chapter is organized as follows:

Section 1. Qualified Health Plan Experience

Section 2. Implications for the Future

Highlights

- Between 2015 and 2018, more health insurance companies were assessed as having *Considered Comprehensive Factors* (cost, quality, and patient experience) or *Considered Cost Only* as criteria for selecting or contracting with providers and hospitals.
- For selecting providers, most insurers noted using provider credentialing, member satisfaction results, grievances and appeals information, and quality based on HEDIS measures. Fewer insurers reported using referral patterns to hospitals, value or cost reduction, or IHA Align Measure Perform (AMP) program results for selecting providers.
- All insurers indicated that a hospital's designation as a Center of Excellence was a selection factor and most reviewed and tracked publicly reported quality data from the Leapfrog Group, CMS Hospital Compare, and other quality-based organizations to determine whether to contract with a hospital. Fewer insurers reported evaluations of cost or participation in quality collaboratives as a factor in hospital selection.
- Hospital acquired infection rates are now reviewed routinely by health plans with their contracted hospitals. Cal Hospital Compare has provided health plans four partially overlapping lists of hospitals with consistently low performance. Covered California is tracking and learning how insurers use these lists to determine next steps.

Section 1: Qualified Health Plan Experience

Covered California's requirements for "Networks Based on Value" include multiple elements related to ensuring that network design and selection of providers considers quality and patient experience in addition to cost and efficiency.

Under current contract requirements, insurers report progress to Covered California for the following:

1. The factors used to select providers and hospitals in the health plan network, including cost, clinical quality, patient reported experience, or other factors.

2. Adopt policies and procedures to only contract with providers and hospitals that demonstrate quality and promote safety at a reasonable price. Based on a definition provided by Covered California, develop plans to exclude "outlier poor performers" on either cost or quality or document the rationale for continued contracting with poor performers, including any improvement efforts the provider or hospital has undertaken by year-end 2020.
3. Demonstrate action on high cost providers[54] by annually reporting the following:
    a. The factors a health plan considers in assessing the relative unit prices and total costs of care;
    b. The extent to which the reasons for cost factors are adjusted or analyzed by elements such as area of service, population served, market dominance, services provided by the facility (e.g., trauma or tertiary), or other factors;
    c. How such factors are used in the selection of providers and hospitals; and
    d. Identification of specific hospitals and their distribution by cost deciles or other ways providers and hospitals are grouped by costs, e.g., as a percentage of Medicare costs.

There are few best practices broadly adopted for managing networks based on value. Integrated delivery systems such as Kaiser Permanente and Sharp Health Plan have largely exclusive networks of hospitals and medical groups. This chapter includes an assessment of these integrated delivery systems but largely focuses on the various strategies adopted by health insurance companies that do not have fully integrated delivery systems and often have overlapping hospital and provider networks. Covered California adopted a common strategy in assessing hospital quality based on publicly reported data described in the "Sites and Expanded Approaches to Care Delivery" chapter. The hospital quality and safety requirements serve as a foundation on which insurers can build networks based on value.

In addition to requiring insurers to design their networks based on value, Covered California conducts annual reviews of each health plan's network (see *Covered California Network Composition Review*).

Covered California Network Composition Review

As part of its annual contracting cycles, Covered California assesses network composition including the number and types of physicians, medical groups and hospitals that are unique to particular health plans or available through multiple plans. Covered California also assesses the geographical distribution of health plan networks through drive times to hospitals and other indicators of how a health plan's distribution of providers assures consumers have timely access to care. Covered California coordinates with the California Department of Managed Health Care and the California Department of Insurance to ensure each health plan's network meets network adequacy standards and time and distance standards.

Covered California also requires its contracted insurers to include Essential Community Providers (ECPs) who serve low-income and medically underserved communities in their provider networks. Covered California provides insurers a list of ECPs each year that includes federally designated 340B providers, California disproportionate share hospitals, federally qualified health centers and Indian health and Tribal health organizations, among others. Each year, Covered California assesses the degree to which health plans have included a variety of ECPs in their networks.

[54] Covered California also requires health plans to report on the use of cost transparency tools as one of the strategies to ensure providers are not charging unduly high prices. See Chapter 10, Appropriate Interventions for health plan reporting on this topic.

Factors Used by Insurers to Select Medical Groups and Individual Providers

As described below (*Table 31. Assessment of Factors Used by Covered California Insurers to Select Physician Organizations and Individual Providers, 2015, 2017 and 2018*), Covered California assessed the number of health insurance companies using cost, quality and patient experience as criteria for selecting or contracting with a provider.[55] Between 2015 and 2018, Covered California assessment of provider selection factors found that the number of insurers that *Considered Comprehensive Factors* or *Considered Cost Only* increased from seven to 10.

Table 31. Assessment of Factors Used by Covered California Insurers to Select Physician Organizations and Individual Providers, 2015, 2017 and 2018[56]

	Number of Health Plans		
Assessment	**2015**	**2017**	**2018**
Considered Comprehensive Factors Includes cost, quality, and patient experience in selecting providers	5	7	6
Considered Cost Includes cost in provider selection	2	1	4
Considered Minimal Factors Does not include cost, quality, or patient experience in selecting providers	5	4	2

Source: Covered California Staff Analysis of Qualified Health Plan Submitted Data

For plan years 2017 and 2018, health insurance companies were asked generally about factors used to select providers.[57] For both years, most insurers reported using provider credentialing, member satisfaction results and grievances and appeals information, and quality or HEDIS measures for selecting providers. While six Covered California insurers formally participate in IHA's Align Measure Perform (AMP) program, few insurers described using AMP program results for selecting providers during 2017-18.[58] Three insurers reported reviewing referral patterns of providers or provider groups to determine whether they refer to in-network hospitals or have established referral patterns to in-network hospitals. Only two insurers cited cost savings or cost reduction as a factor for selecting providers.

Factors Used by Insurers to Select Hospitals

Covered California assessed and categorized the number of health insurance companies using cost, quality and patient experience as criteria for selecting or contracting with hospitals (see *Table 32. Assessment of Factors Used by Covered California Insurers to Select Hospitals, 2015, 2017 and*

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[55] The 11 health insurance companies in Covered California are: Anthem Blue Cross, Blue Shield of California, Chinese Community Health Plan, Health Net, Kaiser Permanente, L.A. Care, Molina Healthcare, Oscar Health, Sharp Health Plan, Valley Health Plan, and Western Health Advantage. In the tables below, Health Net is counted twice because its reports data separately for Health Net Life (PPO/EPO products) and Health Net of California (HMO/HSP products).

[56] Data only available for plan year 2015 and plan year 2017-18. Covered California did not ask this question in the Certification Application for plan year 2016.

[57] Information described here is based on insurers' narrative responses to questions in the Certification Application. Covered California asked generally about factors considered and did not specifically prompt insurers about each of them. As such, insurers could be using a factor to select providers but may not have described it.

[58] For the IHA AMP program, one insurer does not formally participate but reviews the program results as a provider selection factor and another insurer is planning to participate but does not formally participate currently.

2018).[59] Covered California's assessment of hospital selection factors found that as of 2018 four insurers *Considered Comprehensive Factors,* while others considered cost. While many insurers do not currently use comprehensive factors in hospital selection, most insurers have been actively engaged in work to promote improvement in hospital quality performance as described in Chapter 11: Sites and Expanded Approaches to Care.

Table 32. Assessment of Factors Used by Covered California Insurers to Select Hospitals, 2015, 2017 and 2018[60]

	Number of Health Plans		
Assessment	**2015**	**2017**	**2018**
Considered Comprehensive Factors Include cost, quality, and patient experience in selecting hospitals	3	4	4
Considered Cost Includes cost in hospital selection	4	5	7
Considered Minimal Factors Does not include cost, quality, or patient experience in selecting hospitals	5	3	1

Source: Covered California Staff Analysis of Qualified Health Plan Submitted Data

For 2017 and 2018, health insurance companies were asked generally about factors used to select hospitals.[61] For both years, all Covered California insurers indicated that they had processes to designate a hospital as a Center of Excellence which was a factor for determining inclusion of a hospital in-network. Several health plans also reviewed and tracked publicly reported quality data from the Leapfrog Group, CMS Hospital Compare, and other quality-based organizations to determine whether to contract with a hospital.

Health insurance companies considered the cost or prices charged by a hospital when determining whether to contract with them. For example, some insurers evaluated costs as a percentage of Medicare rates and used Diagnosis-Related Group (DRG) case-mix adjusted cost per discharge to identify and group hospitals by cost deciles. Similarly, other insurers developed cost indices for hospitals and used a combination of cost and quality measures to determine whether to remove the hospital from their network.

One insurer reported hospital participation in collaboratives, such as the California Maternal Quality Care Collaborative, as a factor for contracting with hospitals during 2017-18.

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[59] The 11 health insurance companies in Covered California are: Anthem Blue Cross, Blue Shield of California, Chinese Community Health Plan, Health Net, Kaiser Permanente, L.A. Care, Molina Healthcare, Oscar Health, Sharp Health Plan, Valley Health Plan, and Western Health Advantage. In the tables below, Health Net is counted twice because its reports data separately for Health Net Life (PPO/EPO products) and Health Net of California (HMO/HSP products).

[60] Data only available for plan year 2015 and plan year 2017-18. Covered California did not ask this question in the Certification Application for plan year 2016.

[61] Information described here is based on insurers' narrative responses to questions in the Certification Application. Covered California asked generally about factors considered and did not specifically prompt insurer about each of them. As such, insurer could be using a factor to select hospitals but may not have described it.

Covered California Targeting Outlier Poor Performance for Potential Exclusion from Networks

Covered California requires health insurance companies to exclude a hospital from their network if the hospital is an outlier poor performer and not working to improve safety and maternity care. To support insurers in meeting the requirement to exclude hospital outlier poor performers, Covered California has worked with Cal Hospital Compare to determine if there is a valid way to define outlier poor performance for hospitals in a way that can be implemented consistently across all insurers. This definition is based on specific measures of cost and quality, national benchmarks, analysis of variation in California performance, best evidence for quality improvement, and effective stakeholder engagement. Based on their review, Cal Hospital Compare found no single composite measure meeting these criteria was available so they provided insurers with four distinct lists of hospitals with consistently low performance based on:

1. The Hospital Acquired Condition Reduction Program (HACRP) through CMS that uses six publicly available measures in to publicly report and financially penalize hospitals that perform in the bottom 25 percent of all hospitals nationally;
2. An honor roll of top hospital performers developed by Cal Hospital Compare using the CMS HACRP metrics;
3. The Leapfrog Group's Hospital Safety Score; and
4. A report from the California Department of Public Health focused only on Hospital Associated Infections.

These tools do not meet the requirement for a single composite system, and none include key safety concerns where there is no standard publicly reported measure, like Adverse Drug Events. However, these four lists provide "signals of concern" and the measures on these lists include the five Hospital Associated Infections (HAIs) that Covered California has focused on. The greater the number of "low performance" lists a hospital appears on, the greater the concern. These lists are not yet publicly reported but have been provided to insurers for use in hospital negotiations. Insurers are responsible to notify Covered California which if any of these hospitals will be excluded from their networks or reasons for continued inclusion by year-end 2020.

Covered California's requirements for hospital quality and safety serve as a foundation for which health insurance companies can build networks based on value. As such, the requirement for excluding "outlier poor performers" and describing the factors they use to select hospitals is related to the requirement for insurers to work with hospitals to improve quality and safety, described in Chapter 11: Sites and Expanded Approaches to Care.

Assessing Relative Unit Prices and Total Costs of Care

Covered California supports strategies that promote a competitive market with restraint on prices and provides access to high quality care. Health insurance companies consider a range of processes and factors when assessing the relative unit prices and total costs of care at the hospital, medical group, or provider level. Insurer reported data shows that most insurers compared the cost of providers and hospitals to other similar providers in the market or region when assessing the costs of providers (see *Table 33. Covered California Insurer's Process and Factors for Assessing Costs of Providers and Hospitals, 2015, 2017 and 2018*). Most insurers also used specific fee schedules or fee schedules based on a percent of Medicare reimbursement in their contracts with providers. Three health insurance companies annually adjusted capitation payments to providers and hospitals or paid as a

percent of premium. One insurer used Office of Statewide Health Planning and Development (OSHPD) data to understand the cost-to-charge ratios of specific hospitals.

Table 33. Covered California Insurer's Process and Factors for Assessing Costs of Providers and Hospitals, 2015, 2017 and 2018[62]

	Number of Health Plans		
Process and Factors Used	**2015**	**2017**	**2018**
Compare the cost of providers and hospitals to other similar providers in the market or region	9	9	9
Use specific case rates, fee schedules or fee schedules based on a percent of Medicare reimbursement when contracting with providers	7	8	8
Annually adjust payments to providers and hospitals or pay as a percent of premium	3	3	3
Use Office of Statewide Health Planning and Development data to understand the cost-to-charge ratios of specific hospitals	1	1	1

Source: Covered California Staff Analysis of Qualified Health Plan Submitted Data

Section 2: Implications for the Future

Covered California holds health insurance companies accountable to manage variation across their networks in addition to reporting overall quality measures which reflect averages. In managing variation, enrollees should be assured that any provider they go to for care will meet high standards for quality and cost management. Variation in hospital performance was a first target since performance is publicly reported for several key safety measures. Insurers joined Covered California in focusing on a common set of measures in hospital performance evaluation and contracting. As reported in Chapter 11, this effort has led to improvements in hospital quality and safety. Covered California plans to continue to work with insurers, other purchasers, hospitals and other stakeholders to assess what can be done to establish common summary quality and cost hospital performance indicators that would appropriately be used for purposes of either targeting hospitals for improvement or exclusion from Covered California networks.

Covered California is also partnering with the Integrated Healthcare Association's (IHA) California Regional Health Care Cost and Quality Atlas to profile insurer's physicians and physician organization networks based on the wide variation in clinical quality, satisfaction, and total cost of care across the 19 Covered California regions by insurance type. Covered California encourages insurers to use the IHA Atlas data to profile their networks by displaying the cost and quality of physician organizations and physicians that serve HMO, EPO and PPO enrollees. Covered California is working with other purchasers, insurers, physician organizations and other stakeholders to define or create a standard for low-quality and high-cost physician organizations that could be the basis for targeted improvement or removing such physician organizations from their networks. As with variation in hospital networks, the first priority will be to seek ways to align efforts to improve care.

[62] Data only available for plan year 2015 and plan year 2017-18. Covered California did not ask this question in the Certification Application for plan year 2016.

Chapter 10: 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 Institute of Medicine's six aims for ensuring every individual's care is safe, timely, effective, efficient, equitable, and patient-centered.[63] 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.

Appropriate Interventions is an expansive topic, but this chapter, focuses on the following: (1) pharmacy utilization management; (2) consumer and patient engagement, which includes the use of cost transparency tools and shared decision-making; (3) addressing overuse of care through Smart Care California; and (4) appropriate use of services, as measured through standard measures in the Marketplace Quality Rating System.

This chapter on Appropriate Interventions is organized as follows:

Section 1. Qualified Health Plan Experience

Section 2. Health Plan Measures Reported to the Marketplace Quality Rating System

Section 3. Implications for the Future

Highlights

- In 2018, ten insurers considered value in pharmacy formulary management and ten insurers used at least one third-party value assessment methodology (e.g. ICER Value Assessment Framework).
- All health insurance companies use a systematic, evidence-based process for monitoring off-label use of pharmaceuticals.
- Virtually all of Covered California enrollees have access to cost transparency tools to assist consumer decision making about treatments or procedures (ten of 11 insurers covering 99 percent of enrollees).
- Insurers are approaching completion of implementation of many of the recommended Smart Care California improvements to reduce opioid overuse including limiting the quantity of tablets in first prescriptions, removing barriers to medication-assisted treatment and drugs used to reverse overdoses. This collaborative work with other California state purchasers has contributed to reduced opioid prescribing and increased prescribing for buprenorphine, the leading medication to treat opioid disorders.
- Covered California is continuing to expand the scope and nature of its efforts to reduce waste and assure patients are only getting medically necessary care.

Section 1. Qualified Health Plan Experience

Qualified Health Plan Experience presents performance data reported by health insurance companies for contract requirements and includes assessments and observations by Covered California.

[63] Committee on Quality Health Care in America, Institute of Medicine. (2001). Crossing the quality chasm: a new health system for the 21st century. Washington, D.C.: National Academy Press.

Pharmacy Utilization Management

One component of appropriate interventions is the appropriate use of prescriptions and how health insurance companies consider cost and quality in determining their drug lists or formularies. Drug costs continue to increase at a higher rate than other health care costs for generics, name brands and specialty drugs across all insurance markets. Health insurance companies can put downward pressure on drug spending through a variety of mechanisms. Covered California requires insurers to describe ways they are working to achieve value in drug spending, ranging from formulary decision making to decision support tools. Covered California collects information on health insurance company activities to inform its analysis of the relative efficacy of different strategies. As part of contract requirements on achieving value in prescription drug spend, insurers annually report the following:

1. How they currently consider value in formulary selection;
2. If independent value assessment methodologies are used, which ones are used;
3. If and how construction of formularies is based on total cost of care;
4. If and how off-label use is monitored; and
5. The extent of decision support provided to prescribers and members.

Because insurers reported information in a narrative format, further data would be needed to assess the effectiveness and impact of their activities, which may be facilitated by the addition of cost data to the information currently submitted by insurers to Covered California.

Ten of 11 health insurance companies considered value in pharmacy formulary management in 2018 (see *Table 34. Covered California Insurer's Consideration of Value in Formulary and Value Assessment Methods, 2017 and 2018*). Nine insurers described the use of a value assessment methodology as part of their Pharmacy and Therapeutics (PandT) Committee, which all insurers are required to use.

Health insurance companies also report on the use of the following third-party value assessment methodologies:

- Drug Effectiveness Review Project (DERP)
- NCCN Resource Stratification Framework (NCCN-RF)
- NCCN Evidence Blocks (NCCN-EB)
- ASCO Value of Cancer Treatment Options (ASCO- VF)
- ACC/AHA Cost/Value Methodology in Clinical Practice Guidelines
- Oregon State Health Evidence Review Commission Prioritization Methodology
- Premera Value-Based Drug Formulary (Premera VBF)
- DrugAbacus (MSKCC) (DAbacus)
- The Institute for Clinical and Economic Review (ICER) Value Assessment Framework (ICER-VF)
- Real Endpoints
- Blue Cross/Blue Shield Technology Evaluation Center
- International Assessment Processes (e.g., United Kingdom's National Institute for Health and Care Excellence (NICE))

Eight of 11 insurers used at least one third-party value assessment methodology as part of its PandT Committee process in 2018. Seven insurers consider value assessment in formulary tier placement.

Health insurance companies use one of several different independent value assessment methodologies listed, but the Institute for Clinical and Economic Review (ICER) assessment is the most commonly used. ICER is considered to have a strong methodology compared to others and emphasizes

transparency, conflict-free funding, and actionable activities for plans that consider the total cost of care. ICER also includes a framework for evaluating short and long-term budget impacts, and includes a "value-based price benchmark," reflecting how each drug should be priced to appropriately reflect long-term improved patient outcomes.

Table 34. Covered California Insurer's Consideration of Value in Formulary and Value Assessment Methods, 2017 and 2018

	Number of Health Plans	
Consideration of Value	**2017**	**2018**
Consider value in pharmacy management	9	10
Use value assessment methodology as part of Pharmacy and Therapeutics (PandT) process	6	9
Use at least one third-party value assessment methodology (e.g. ICER Value Assessment Framework)	10	8
Consider value assessment in formulary tier placement	7	7

Source: Covered California Staff Analysis of Qualified Health Plan Submitted Data

For constructing formularies based on the total cost of care, seven of 11 insurers used a process for analyzing drug efficacy in context of total cost of care and outcomes (see *Table 35. Covered California Insurer's Consideration of Total Cost of Care in Formulary, Off-Label Use Monitoring and Decision Support for Providers and Consumers, 2017 and 2018*).

All 11 health insurance companies engaged in systematic, evidence-based process for monitoring off-label use of pharmaceuticals, which reflects state law requirements for using nationally recognized sources for evidence-based off label monitoring.

In 2018, nine of 11 insurers provided member-specific decision support for both prescribers and consumers, of which seven provided this support at the point-of-care. Several new software products have recently become available and are now being used by Covered California's insurers to allow physicians to see pricing information on drugs they are prescribing and the availability of cheaper, equally effective alternatives. Examples of these software tools include Gemini Health's Drug-Cost Transparency Service, Sure Scripts Real-Time Prescription Benefit, and OptumRx's PreCheck MyScript.

Table 35. Covered California Insurer's Consideration of Total Cost of Care in Formulary, Off-Label Use Monitoring and Decision Support for Providers and Consumers, 2017 and 2018

	Number of Health Plans	
Consideration of Total Cost of Care	**2017**	**2018**
Analyze drug efficacy in context of total cost of care and outcomes	7	7
Use a systematic, evidence-based process for monitoring off-label use of pharmaceuticals	11	11
Offer member-specific decision support initiatives for both the prescriber and consumer, including point-of-care support software	5	7
Offer member-specific decision support initiatives for both prescriber and consumer, but not at the point of care	1	2

Source: Covered California Staff Analysis of Qualified Health Plan Submitted Data

Consumer and Patient Engagement

Cost Transparency Tools

Covered California supports strategies that promote a competitive market with restraint on prices and provide access to high quality care. As part of its requirements for demonstrating action on high cost providers, Covered California required insurers to report on their efforts to make variation in provider or hospital cost transparent to consumers and the use of cost transparency tools by consumers.[64] Cost transparency tools have the potential to reduce costs by enabling patients to switch to lower priced providers and publicly acknowledging high-priced providers which could lead to these providers reducing their prices.[65]

Covered California required health insurance companies with more than 100,000 enrollees to deploy online tools and 10 of the 11 insurers now do so, representing 99 percent of Covered California enrollees. *Table 36. Covered California Insurer's Use of Cost Transparency Tools, 2015, 2017 and 2018* describes the number of insurers that use cost transparency tools, what services are provided, and the percentage of enrollees with access to each type of tool. As of 2018, the tools offered to the most enrollees were Online Procedure and Treatment Cost Estimators, which were available through three different health plans to about 70 percent of enrollees. Other tools include Provider-Specific Cost Information which three health plans provide to about 21 percent of enrollees.

Table 36. Covered California Insurer's Use of Cost Transparency Tools, 2015, 2017 and 2018[66]

	Number of Insurers			Number of Enrollees with Access to Tool	Percent of Total Enrollment (1,384,030)
	2015	2017	2018	2018	
Insurers Offering Cost Transparency Tools	**6**	**9**	**10**	**1,371,720**	**99%**
Services Offered					
Online Cost and Quality Tool	1	1	1	67,070	5%
Provider-Specific Cost Information	2	2	3	289,460	21%
Online Procedure and Treatment Cost Estimator	3	3	3	974,780	70%
Online Drug Cost Lookup Tool	1	5	5	706,140	51%
Online Real-time Tracking of Out-of-Pocket Costs	3	6	7	1,218,270	88%
Planning to add Cost Information Online	3	2	0	N/A	N/A

Source: Covered California Staff Analysis of Qualified Health Plan Submitted Data

The consumer utilization of available tools varied widely among Covered California's contracted health insurance companies. The tools available to the largest number of enrollees were used by 3 percent to

[64] Network design and reference pricing are also strategies in this requirement. Network design is discussed in Chapter 9: Networks Based on Value in the sections on provider and facility selection criteria. No insurers reported using reference pricing, which would require Covered California making changes to its standard benefit design.

[65] Mehrotra, Ateev. "Defining the Goals of Health Care Price Transparency: Not Just Shopping Around." *NEJM Catalyst, June* 26 (2018).

[66] Data only available for plan year 2015 and plan year 2017-18. Covered California did not ask this question in the Certification Application for plan year 2016.

7.5 percent of consumers. There are not standard national benchmarks to assess the volume and type of consumer utilization of cost transparency tools, so Covered California is in the process of determining how best to assess what volume and type of utilization best meets consumers' needs.

While there is growing research on how best to effectively engage consumers in their care, discussions about value should both educate consumers and help them work with their providers to make better choices to align their preferences and likely outcomes.[67] However, there are currently no standard benchmarks related to use of consumers tools and definitions of the types of users. Similarly, there are multiple definitions for consumer engagement, with all assuming that consumers have the knowledge and skills to understand and participate in the engagement process.[68] Covered California is reviewing these issues and the available evidence to inform future contract expectations.

Shared Decision-Making

There is clear evidence that for many "preference-sensitive" conditions, clinicians do not regularly elicit patients' preferences or provide information to support informed patient decision-making. Too often variation in care tracks with provider preferences rather than those of patients. Shared decision-making engages patients in bringing their values and preferences to bear often with the help of decision aids that present the basic science of the condition being treated, the various options for treatment and the tradeoffs such as quality or length of life. Shared decision-making is designed for preference-sensitive conditions, such as breast cancer, prostate cancer, and knee and hip replacements where more than one evidence-based treatment is available or where the evidence is incomplete or uncertain. Variation in treatment of these conditions based on patient preferences is important and the Covered California contract requirements included reporting how insurers support shared decision-making including the proportion of patients with preference sensitive conditions who have used a decision aid.

The requirement for health insurance companies to report on shared decision-making was put on hold to enable health insurance companies to focus on cost and quality tools and implement the Smart Care initiatives described below. Based on Covered California's ongoing discussions with insurers, several have contracts with vendors that publish decision aids and are using them in case management.

Evidence documents that when patients use decision aids to support shared decision-making with their clinician at the time and place decisions are made, their knowledge of their options improves, and they feel better about what matters to them.[69] There are a variety of vendors for decision aids which vary in quality and evidence supporting their effectiveness. Each insurance company and many medical groups have made their own vendor selections and therefore offer different tools. None has achieved implementation at scale and it's unlikely they will with this diversity. Covered California has an opportunity over the next several years to work with stakeholders across the delivery system to consider selecting a single vendor and to support broad adoption of shared decision-making at the point of care.

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[67] S, Delbanco, T. Delbanco, Technology and Transparency: Empowering Patients and Clinicians to Improve Health Care Value, *Ann Intern Med.* 2018;168(8):585-586.

[68] Hibbard JH. (September 2017). Refining Consumer Engagement Definitions and Strategies. Journal of Ambulatory Care Management.

[69] The most current best evidence is documented in Chapter 9: Appropriate Interventions of a companion Covered California report, Current Best Evidence and Performance Measures for Improving Quality of Care and Delivery System Reform.

Addressing Overuse of Care through Smart Care California

In 2015, Covered California joined the other state purchasers, the Department of Health Care Services (DHCS) and the California Public Employees' Retirement System (CalPERS), to form a multi-stakeholder workgroup called Smart Care California to address overuse of services that result when evidence-based practices are not being followed. This multi-stakeholder work group is facilitated by the Integrated Healthcare Association (IHA), with funding and thought leadership from the California Health Care Foundation (CHCF). Smart Care California selected three areas of focus from the list of Choosing Wisely guidelines published by the American Board of Internal Medicine Foundation in cooperation with other specialty societies: (1) low-risk (nulliparous term, singleton, vertex (NTSV)) deliveries performed without medical indication; (2) opioid overuse and misuse; and (3) imaging for low back pain.[70]

Health insurance companies are invited to participate in the development of improvement strategies and are required to adopt the guidelines developed by Smart Care California. All insurers are participating either as regular attendees or by implementing guidelines published by Smart Care California. Work is underway for adopting best practices for payment for maternity services as well as for combatting the opioid crisis. At this time, Smart Care has focused on these two areas, while overuse of imaging for low back pain, which would entail a large-scale effort to change the care patterns of thousands of physicians across California, has been on hold while resource and other implementation challenges are considered. The measure for imaging for low back pain will still be collected in Marketplace QRS and other quality measurement programs.

Health insurance companies' efforts to reduce low-risk C-section deliveries are impacting the entire maternity population served at each plan's network hospitals, not just Covered California's enrolled population. In addition, Covered California, DHCS, and CalPERS are collaboratively engaged in efforts to reduce low-risk C-sections, so the same initiatives are positively impacting their hospitals and care regardless of the source of the consumer's coverage. Further discussion of efforts to reduce low-risk C-sections is included in Chapter 11: Sites and Expanded Approaches to Care Delivery.

Smart Care California Efforts to Reduce Opioid Overuse

The Smart Care California work group has surveyed health insurance companies on their efforts to reduce opioid overuse in four categories: (1) preventing new starts; (2) managing pain safely; (3) treating addiction; and (4) stopping death. Comparison of performance in these areas are based on aggregated survey data from Covered California, CalPERS and DHCS is provided in *Figure 9. Smart Care California Purchaser Level Performance on Opioid Overuse Reduction, 2018*. Covered California insurers are approaching completion of implementation for many of the recommended improvements including limiting the quantity of tablets in first prescriptions, removing barriers to medication-assisted treatment and for drugs used to reverse overdoses. The table below reflects remarkable improvement as none of these recommendations were practices before Smart Care California published their guidelines. This survey will continue to be conducted annually.

According to the Smart Care survey, all 11 Covered California insurers now implement quantity limits for new starts of opioids and nine Covered California insurers have removed prior authorization for physical therapy for back pain, improving timely patient access to care and preventing new starts of opioid medications. The survey also indicates that more than half of insurers have increased access to

[70] See more: https://www.iha.org/our-work/insights/smart-care-california.

behavioral health services for patients with chronic pain, while two insurers are in the planning stages to increase access. These improvements have the potential to greatly aide in curbing the opioid epidemic in the state.

Figure 9. Smart Care California Purchaser Level Performance on Opioid Overuse Reduction, 2018

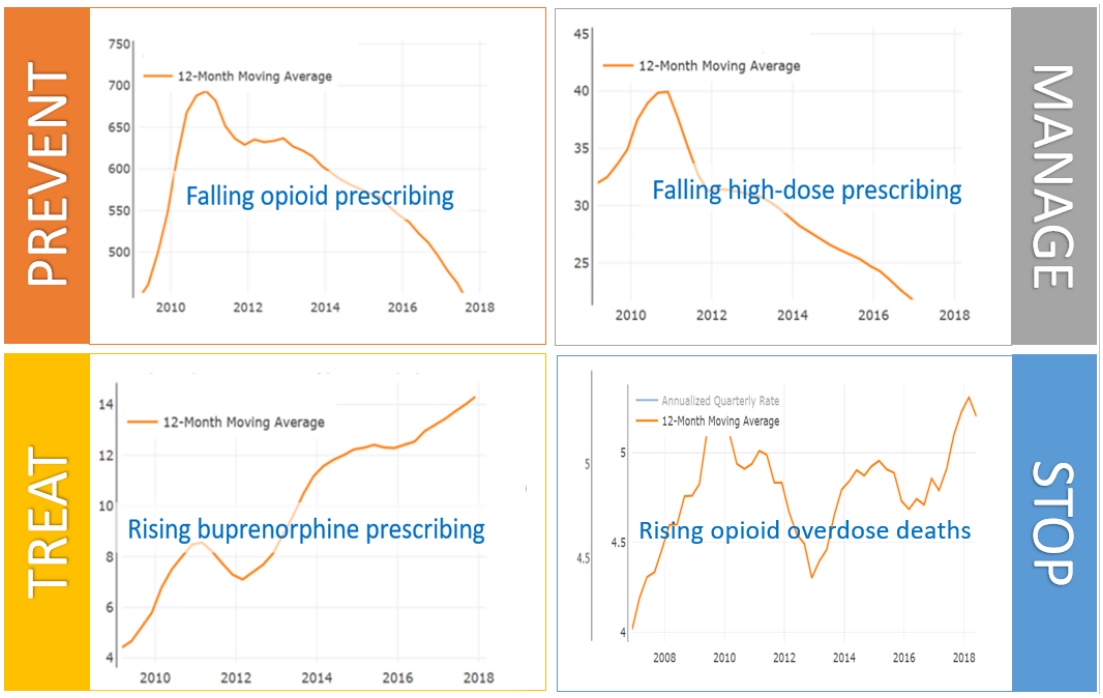
Priority	Approach	Status	Purchaser: CalPERS	Purchaser: Covered CA	Purchaser: Medi-Cal
PREVENT new starts	Implement quantity limits for new starts	In Place	100.0%	100.0%	94.1%
		In Planning	0.0%	0.0%	5.9%
		No Plans	0.0%	0.0%	0.0%
	Remove prior authorization requirement for first course of physical therapy for back pain, and ensure timely access to care	In Place	85.7%	81.8%	70.6%
		In Planning	0.0%	9.1%	17.6%
		No Plans	14.3%	9.1%	11.8%
MANAGE pain safely	Offer or support specific programs that help providers safely manage patients on high opioid doses or combinations (opioids and benzodiazepines), avoiding mandatory tapers to arbitrary dose targets	In Place	85.7%	63.6%	83.3%
		In Planning	14.3%	9.1%	16.7%
		No Plans	0.0%	27.3%	0.0%
	Set up policies to decrease new starts for concurrent opioid and benzodiazepine use	In Place	83.3%	81.8%	88.2%
		In Planning	16.7%	9.1%	11.8%
		No Plans	0.0%	9.1%	0.0%
TREAT addiction	Evaluate network adequacy for primary care addiction treatment (buprenorphine and naltrexone) and develop action plan to meet demand	In Place	42.9%	27.3%	38.9%
		In Planning	57.1%	45.5%	44.4%
		No Plans	0.0%	27.3%	16.7%
	Evaluate network adequacy for specialty addiction treatment and develop action plan to meet demand	In Place	42.9%	27.3%	27.8%
		In Planning	57.1%	63.6%	44.4%
		No Plans	0.0%	9.1%	27.8%
	Increase access to behavioral health services for patients with chronic pain	In Place	85.7%	63.6%	58.8%
		In Planning	14.3%	18.2%	35.3%
		No Plans	0.0%	18.2%	5.9%
	Remove authorization requirements for initiating and maintaining buprenorphine for addiction, including eliminating requirements for detox in lieu of maintenance	In Place	100.0%	100.0%	Not applicable for Medi-Cal plans due to a carve out
		In Planning	0.0%	0.0%	
		No Plans	0.0%	0.0%	
	Work with hospitalists to start buprenorphine or methadone treatment with patients hospitalized with addiction-related diagnoses (e.g., endocarditis or osteomyelitis)	In Place	16.7%	10.0%	23.5%
		In Planning	50.0%	40.0%	41.2%
		No Plans	33.3%	50.0%	35.3%
STOP deaths	Remove authorization requirements and copays for naloxone	In Place	50.0%	54.5%	Not applicable for Medi-Cal plans due to a carve out
		In Planning	0.0%	9.1%	
		No Plans	50.0%	36.4%	

Source: Smart Care California, 2019

As seen below in *Figure 10. California 2010-2018 Progress on Opioid Overuse Reduction*, prescribing for opioids is falling and prescribing for buprenorphine, the leading medication to treat opioid disorders, is rising. But overdose deaths remain high. The reason overdoses are still such a threat appears to be

that street drugs are replacing prescription drugs as the cause of death.[71] This data implies that neither California or the nation has found the right balance for treating opioid addiction. Opioid prescriptions appear to have fallen faster than capacity for treatment has expanded.

Figure 10: California 2010-2018 Progress on Opioid Overuse Reduction



Source: California Health Care Foundation analysis of data from the California Department of Public Health
www.cdph.ca.gov/opioiddashboard

Much more needs to be done to support providers in reducing opioid prescriptions safely including expanding access to medication assisted treatment. While efforts to address the opioid epidemic have benefited from many sectors focusing needed attention on this problem, Covered California believes the Smart Care initiative is an example of how improvement can be encouraged when major purchasers — in this case Medi-Cal, CalPERS and Covered California — align to work with insurers and providers to meet a common clinical need. Additionally, Covered California is more closely tracking opioid use and medication assisted treatment use through its Healthcare Evidence Initiative database.

Section 2: Health Plan Measures Reported to the Marketplace Quality Rating System

Health Plan Measures Reported to the Marketplace Quality Rating System details health plan performance on Healthcare Effectiveness Data Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures reported to the Centers for Medicaid and Medicare Services' Quality Rating System (QRS). These standard performance measures are a key mechanism used by Covered California for health plan oversight and accountability.

[71] The New York Times, "Short Answers to Hard Questions About the Opioid Crisis", Josh Katz, August 10, 2017 https://www.nytimes.com/interactive/2017/08/03/upshot/opioid-drug-overdose-epidemic.html.

See *Appendix 2: Additional Health Plan Measures Reported to the Quality Rating System*, for six Quality Rating System measures that pertain to Appropriate Interventions:

1. Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (Table A23)
2. Appropriate Testing for Children with Pharyngitis (Table A24)
3. Appropriate Treatment for Children with Upper Respiratory Infection (Table A25)
4. Use of Imaging Studies for Low Back Pain (Table A26)
5. Annual Monitoring for Patients on Persistent Medications (Table A27)
6. Access to Information (Table A28)

These measures address the both the overuse of low value services and the appropriate use of services. The first three measures above reflect efforts to reduce overuse of antibiotics which is resulting in wide spread resistance to potentially lifesaving treatment.

Imaging for low back pain, especially CT and MRI scans, should only be used when considering surgery for intractable pain or neurologic complications related to low back pain.

Many patients with conditions like rheumatoid arthritis are on complex medications with potential side-effects. Standard routine monitoring, as measured by Annual Monitoring for Patients on Persistent Medications, may be overlooked if not tracked and implemented systematically.

As detailed under the section on shared decision-making, supporting patients with the right information to partner with their providers to decide on appropriate interventions for their care is critical not only for preference sensitive care but to increase adherence to evidence-based care.

Section 3: Implications for the Future

There is good evidence that a very high proportion of care delivered is unwarranted or delivered poorly; some diagnostic tests are overused, and there is limited information available to assess relative efficacy and value of many drugs, devices and even some surgical interventions. Genetic testing is starting to show value in guiding clinical decisions and “personalized” approaches to cancer care are being developed and tested. All these innovations come with extraordinary costs and only preliminary understanding of which patients will benefit the most.

Shared decision making requires that there is active and transparent information sharing between consumers and their providers. Cost and quality tools provide consumers with the knowledge to better engage with their own health decision making, but even among the tools that are available today there is little success engaging patients or providers in their adoption. Future improvements in technology and data sharing will lead to better consumer engagement. Covered California is continuing to monitor insurers to ensure that consumers are being provided the most reliable tools and information so that they can receive the best care at the right time. Covered California has an opportunity over the next several years to work with stakeholders across the delivery system to consider selecting a single vendor and to support broad adoption of shared decision-making at the point of care.

Over the next few years, a wide range of innovations in care delivery will have dramatic impacts on how care is provided, and the quality and cost of that care. Covered California has shown how purchasers, payers and providers can work together in adopting best practices to reduce variation in hospital performance and address overuse of opioids. Decision support to providers and patients at the point of care is particularly promising, whether through consumer cost tools integrated with the medical record, shared decision-making decision aids or point of care software integrated with electronic health record order entry to support adherence to formularies, bringing this information to where decisions are made

appears to be critical to successful adoption. Covered California is assessing the extent to which its contractual requirements can assist in prioritizing and standardizing implementation of best practices to benefit all Californians.

Chapter 11: Sites and Expanded Approaches to Care Delivery

Covered California is better understanding and promoting evidence-based health interventions and treatments beyond the traditional physician office and hospital-based care, whether on an inpatient or outpatient basis: urgent care facility, retail facilities such as drop-in clinics, at home, or through a variety of emerging telehealth strategies. Expanded approaches to care delivery also 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.

This chapter on Sites and Expanded Approaches to Care Delivery has a different organization. "Sites" refer to the traditional medical care settings of hospitals and physician offices. Care in physician offices is covered in Chapter 7: Promotion of Effective Primary Care, while Chapter 10: Appropriate Interventions, examines various clinical interventions largely delivered in or ordered by physician offices, to ensure they are rooted in the Institute of Medicine's six aims for safe, timely, effective, efficient, equitable and patient-centered care.[72]

Hospital care is a broad topic and can include a range of system level reforms. This chapter focuses on publicly reported performance data that health insurance companies are using to establish contract requirements for hospital quality and safety, which are (1) within an insurer's oversight authority; (2) help foster alignment across contracted insurers and their contracted hospitals; and (3) benefit from the availability of publicly reported hospital performance data reflecting the experience of the hospital's entire patient population. Covered California has worked with hospitals and the California Hospital Association to select measures for which coaching programs,

Highlights

- The California Department of Public Health reports that as of 2018 there has been a statistically significant reduction in major types of hospital associated infection rates in California hospitals (CLABSI, SSI, MRSA, and C. difficile bacterial). Covered California's contract requirements — aligned with those of CMS and other purchasers — insurer engagement, and work with improvement collaboratives have contributed to 3,392 infections avoided, 251 lives saved and over $62M in one-year cost savings.
- Covered California's support for appropriate C-Sections helped 56% of California hospitals achieve the national goal of NTSV C-section rates of 23.9% or lower in 2018, representing a 12-point improvement from 2015, avoiding 7,200 C-sections over 3 years.
- The number of insurers that participated in the Smart Care California collaborative, increased from six to all 11 by 2017 with full participation continuing since then. Similarly, the number of insurers that participated in Partnership for Patients collaborative increased from two to ten insurers between 2016 and 2018.
- For insurer engagement of network hospitals, 10 insurers were assessed as having *Full Engagement* or *Engaged* for hospital safety in 2018. For maternity care, all 11 insurers were assessed as *Full Engagement* or *Engaged* for maternity care in 2018.

[72] Committee on Quality Health Care in America, Institute of Medicine. (2001). Crossing the quality chasm: a new health system for the 21st century. Washington, D.C.: National Academy Press.

quality collaboratives and change packages are available and aligned with priorities established by national consensus including CMS and Healthy People 2020.

For expanded approaches to care delivery, current requirements pertaining to (1) telehealth and (2) Centers of Excellence are discussed, while Covered California has not developed reporting or contract requirements related to many of the existing and evolving sites of care or approaches.

Qualified Health Plan Experience

For **hospital quality and safety**, Covered California has the following requirements of contracted health plans:[73]

1. Encouraging hospital participation in quality improvement collaboratives and coaching programs
2. Reducing the avoidable hospital associated infections (HAIs) starting with the metrics included in the CMS Hospital Acquired Condition Reduction Program (HACRP)
    a. Catheter associated urinary tract infection (CAUTI)
    b. Central line associated blood stream infections (CLABSI)
    c. Methicillin-resistant Staphylococcus aureus (MRSA)
    d. Clostridioides difficile (formerly Clostridium difficile bacterial infection) (CDI)
    e. Surgical site infection of the colon (SSI Colon)
3. Reducing low-risk, nulliparous term singleton vertex (NTSV) C-section rates to 23.9 percent or lower (a national Healthy People 2020 goal);[74]
4. Expanding value-based payments for hospital quality and maternity care including:
    a. Tying two percent of hospital payments to value by the end of 2019
    b. Eliminating financial incentives for hospitals or physicians to perform C-Sections; and
5. Excluding a hospital from their network initially by year-end 2020 if the hospital is an outlier poor performer and not working to improve safety and maternity care.

For **expanded approaches to care delivery**, Covered California requires health plans to use technology, including telehealth and remote home monitoring,[75] to assist in higher quality, accessible, patient-centered care.

Hospital Quality and Safety

Encouraging Hospital Participation in Coaching Programs and Collaboratives

Health insurance companies are required to encourage hospitals to participate in the Partnership for Patients coaching program, which is funded by the federal Department of Health and Human Services (HHS) to support designated Hospital Improvement Innovation Networks (HIINs).[76] In California, there are 5 HIINs which engage individual hospitals and systems to participate in trainings to reduce hospital associated infections, adverse drug events, falls, pressure ulcers, and other negative health events that occur in hospital settings.[77] This encouragement can be accomplished through hospital administrator

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[73] Currently, hospital quality and safety performance are tracked at general acute care (GAC) hospitals, because specialized hospitals (such as long-term care) have different performance benchmarks and variables to consider.

[74] First pregnancy (nulliparous), full term, no twins or beyond (singleton), and head down (vertex) or NTSV pregnancies are generally thought of as low risk. See more: https://www.healthypeople.gov/2020/topics-objectives/topic/maternal-infant-and-child-health

[75] Telehealth services can include remote monitoring when used for disease management in between visits.

[76] See more: https://partnershipforpatients.cms.gov/about-the-partnership/aboutthepartnershipforpatients.html.

[77] In California, the five HIINs are: (1) Health Services Advisory Group, which is managed by the Hospital Quality Institute, (2) Dignity, (3) Vizient (created by the VHA/UHC merger), (4) Children's Hospitals' Solutions for Patient Safety, and (5) Premiere Inc.

engagement, letter campaigns to providers, contracting discussions, and other creative means that communicate the importance and urgency of reducing the incidence of avoidable negative health events in hospitals.

Covered California also requires insurers to engage with their network hospitals to promote awareness of (1) NTSV C-section rates, (2) availability of provider and consumer education, and (3) promote participation in data sharing and coaching offered by the California Maternal Quality Care Collaborative (CMQCC), with the goal of reducing NTSV C-sections to the national Healthy People 2020 target of 23.9 percent of deliveries or lower. The CMQCC is a multi-stakeholder organization that provides real time data sharing, quality improvement toolkits, and coaching collaboratives to improve maternal and neonatal health in several measure areas, including NTSV C-sections. Additionally, Smart Care California built consensus around a menu of payment structures to promote the goal of ending financial incentives for providing NTSV C-Sections: (1) blended case rates; (2) low risk C-section reduction as a metric for payment incentive programs; or (3) population-based payment models.[78]

As shown in *Table 37. Covered California Insurer Participation in Improvement Collaboratives*, the number of insurers that participated in Smart Care California increased from six to 11 between 2016 and 2017 and this trend of full participation continued through 2018. Similarly, the number of insurers that participated in Partnership for Patients increased from two to ten health plans between 2016 and 2018.

Table 37. Covered California Insurer Participation in Improvement Collaboratives[79]

Collaborative	2016	2017	2018
Smart Care California Focuses on outreach to reduce NTSV C-Sections through collaboration with California Maternal Quality Care Collaborative	6	11	11
Partnership for Patients U.S. Department of Health and Human Services program that focuses on reducing infections in hospitals	2	10	10

Source: Covered California Staff Analysis of Qualified Health Plan Submitted Data

Health insurance companies have engaged network hospitals on the importance of reducing hospital associated infections and NTSV C-sections and are spreading awareness of ways that performance can be improved, such as coaching programs through Partnership for Patients funded HIINs and CMQCC. Insurer activities range from sending tailored mail to hospitals, physicians and administrative staff, tracking measures and discussing performance in regular hospital quality meetings or contract renewal meetings, including participation in coaching programs as a metric in hospital incentive programs, hosting webinars, adjusting website content for members and providers, and visiting hospitals to distribute materials.

As summarized below (*Table 38. Covered California Insurer Engagement with Network Hospitals*), Covered California assessment of insurer engagement activities with hospitals on improving quality

[78] Smart Care California. October 2017. Aligning Birth Payment to Reduce Unnecessary C-Section. http://www.iha.org/sites/default/files/files/page/c-section_menu_of_payment_and_contracting_options.pdf

[79] Covered California did not ask the specific collaborative participation question in 2019 QHP Certification Application (reported in 2018). The year in these tables refers to the year the information was submitted by the insurer to Covered California, so it may refer to activities in the previous year or in the first quarter of that year. For example, a summary for 2017 likely includes activities from 2016 and the first quarter of 2017.

found the number of insurers with *Full Engagement* for hospital safety tripled from three to nine between 2016 and 2017. As of 2018, 10 insurers had *Full Engagement* or were *Engaged* for Hospital Safety. For maternity care, most insurers have consistently had *Full Engagement* from 2016 to 2018, with all plans having *Full Engagement* or *Engaged* as of 2018.

Table 38. Covered California Insurer Engagement with Network Hospitals

	Hospital Safety			Maternity Care		
Assessment	**2016**	**2017**	**2018**	**2016**	**2017**	**2018**
Full Engagement Active engagement with hospitals in quality improvement includes best practices to be potentially shared among health plans.	3	9	8	9	9	8
Engaged Has initiated engagement with hospitals either through internal planning or external action.	5	1	2	1	1	3
Minimal Engagement Has not acted either internally or externally to engage with hospitals.	3	1	1	1	1	-

Source: Covered California Staff Analysis of Qualified Health Plan Submitted Data

Partly as a result of insurers' encouragement and other factors, including growing hospital awareness of Covered California's focus on outlier poor performance, there is now nearly universal participation in improvement collaboratives among California's hospitals. Publicly reported data on hospital participation in quality improvement programs shows a positive trend over the past four years, with 148 hospitals participating in 2014 to 251 hospitals in 2018 (see *Figure A2. California Hospitals Involved in Hospital Quality Institute Hospital Improvement Innovation Networks, 2014-18* in *Appendix 4: Additional Publicly Reported Hospital Quality and Safety Data*). Participation in the five HIIN improvement programs is near universal, with fewer than ten acute care hospitals in California not participating, according to the Hospital Quality Institute.

Collectively Reducing Avoidable Hospital Associated Infections

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.

Every day, about one in 25 hospital patients nationally contracts at least one hospital associated infection (HAI).[80] These infections can significantly delay recovery, increase the expense of a hospital stay, and even result in death. Of the approximately two million American patients who acquire a HAI annually, an estimated 90,000 will die.[81] Before implementation of the Partnership for Patients program,

[80] Centers for Disease Control and Prevention. Healthcare-associated Infections. Retrieved from: https://www.cdc.gov/hai/index.html.

[81] Stone, P. W. (2009). Economic burden of healthcare-associated infections: an American perspective. Expert review of pharmacoeconomics and outcomes research, 9(5), 417-422.

it was estimated that HAIs and other avoidable hospital complications were associated with more than 400,000 deaths per year.[82,83]

Not only are HAIs harmful, they are also a burden on the healthcare system. The cost of a single case can range from just under $1,000 to nearly $50,000, with costs borne by insurers, employers, and patients through out-of-pocket expenses.[84] Depending upon the type of infection, the direct cost of HAIs to hospitals ranges from $28 billion to $45 billion.[85]

Measures to track HAIs are readily available through CMS Hospital Compare, California Department of Public Health (CDPH), and Cal Hospital Compare. Covered California determined the five HAIs to focus on through consultation with stakeholders and subject matter experts including CDPH, Cal Hospital Compare, Hospital Quality Institute (a quality improvement center within the California Hospital Association), Centers for Medicare and Medicaid Services (CMS), insurers, and consumer advocates. The criteria for selecting these measures were:

- Clinical importance;
- Robust, publicly available performance data;
- Alignment with other purchasers including CMS;
- Wide variation in performance among California hospitals; and
- Availability of coaching collaboratives with change packages to support improvement for free or minimal cost to hospitals.

Understanding Hospital Performance Variation to Target Quality Improvement Efforts

Covered California assists insurers in understanding hospital performance variation to enable better targeting of hospitals for engagement and quality improvement. Covered California displays hospital performance through graphic distributions where every California hospital's measure score is represented by a dot, and dots are color coded to denote in- or out-of-network status. The goal of these graphs is to bring attention to the variation in hospital performance on each HAI and to help insurers know which hospitals to focus on in their engagement and quality improvement efforts. For example, below *Figure 11. Sample of One Covered California Insurer's Hospital Associated Infection Incidence for Catheter-associated Urinary Tract Infection (CAUTI) — In-Network and Out-of-Network Hospitals, 2018* shows the performance of an insurer's 2018 network for CAUTI standardized infection ratios. The hospitals identified by blue dots on the right-hand side of the chart represent in-network hospitals for this insurer that have infection rates above the risk adjusted expected rate. Covered California's identification and display of hospital infection rates provides additional information for insurers to use in their design of networks and in their engagement with hospitals to encourage participation in quality improvement initiatives.

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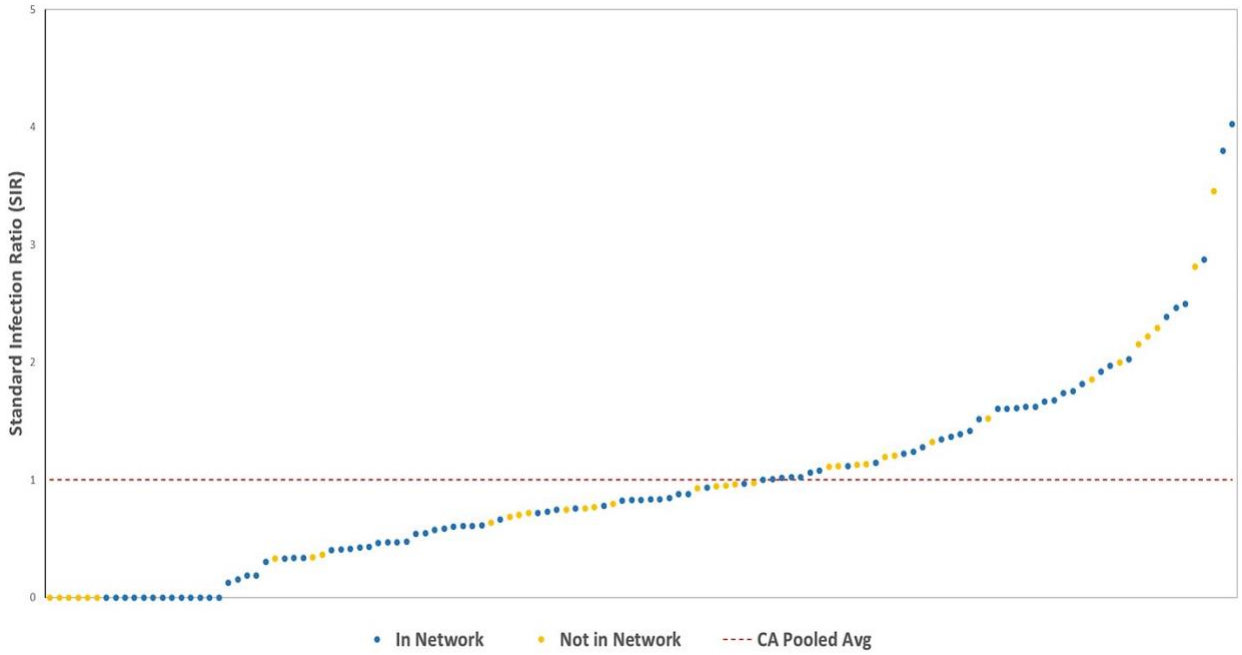
[82] James, J. T. (2013). A new, evidence-based estimate of patient harms associated with hospital care. Journal of patient safety, 9(3), 122-128.

[83] Potentially avoidable errors were grouped into the following categories: 1) errors of commission; 2) errors of omission; 3) errors of communication; 4) errors of context; and 5) diagnostic errors.

[84] Castlight and The Leapfrog Group. (2018). Healthcare-Associated Infections. Retrieved from: https://www.leapfroggroup.org.

[85] Ibid.

Figure 11. Sample of One Covered California Insurer's Hospital Associated Infection Incidence for Catheter-associated Urinary Tract Infection (CAUTI) — In-Network and Out-of-Network Hospitals, 2018



Source: 2018 Data from Cal Hospital Compare and California Department of Public Health (CDPH).

To develop tailored approaches for targeting network hospitals for improvement, insurers can also leverage the 2018 HAI reports from CDPH,[86] which list hospitals with better or worse HAI incidence than the national baseline by county (see *Appendix 4: Additional Publicly Reported Hospital Quality and Safety Data*).

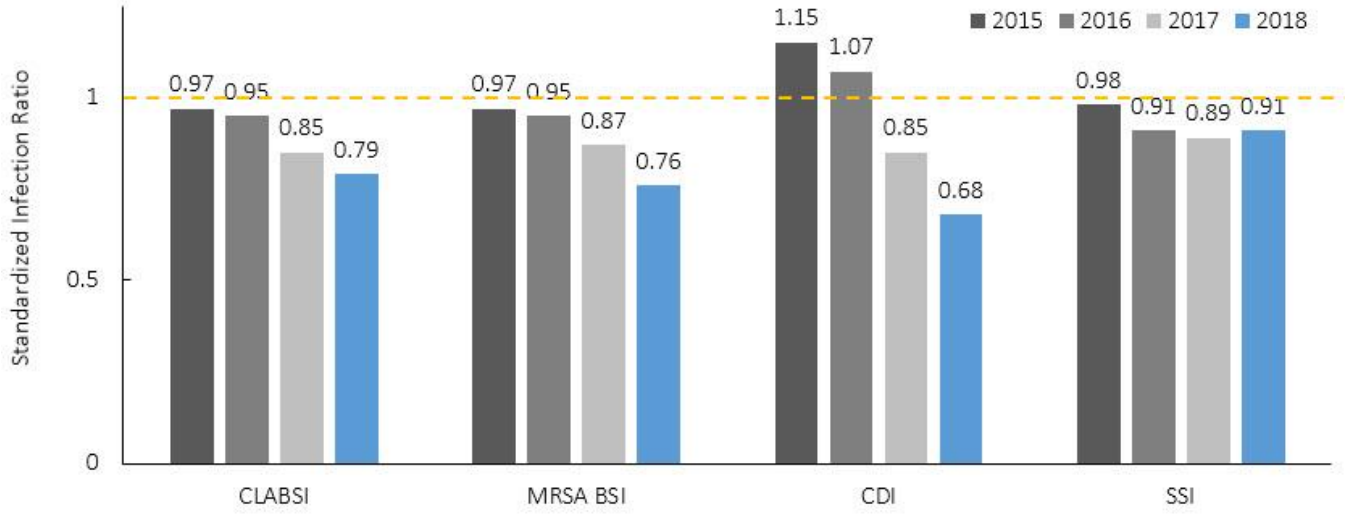
Publicly reported data on HAIs are reported at the hospital level, not the insurer level, through CDPH data on infection rate trends. According to the CDPH, there has been a statistically significant reduction in CLABSI, SSI, MRSA, and C. difficile bacterial infection rates between 2015 and 2018 (see *Figure 12. Hospital Associated Infection Incidence in California Hospitals, 2015-18*).[87]

For these four HAI measures, the above chart shows a steady drop over three years, of which C. Difficile infections were the last to show progress, but as of 2018 has dropped 41 percent since 2015. The rates are expressed as a ratio of observed over a risk adjusted expected rate based on national standards. For all infection rates to be falling and for all rates to be below the national expected ratio of 1.0 reflects concerted effort among many stakeholders in California and represents remarkable progress. CDPH does not include hospital CAUTI information in its analysis.

[86] See more: https://www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/AnnualHAIReports.aspx.

[87] For additional data, see C. Diff Incidence Rates in California Counties in Appendix 4.

Figure 12. Hospital Acquired Infection Incidence in California Hospitals, 2015-18



Note: Hospital associated infections are reported as a standardized infection ratio (SIR), a risk-adjusted measure managed nationally that compares observed versus expected number of complications per year. The dashed line represents an SIR of 1.0. A score of 1.0 means a hospital has an expected rate while below 1.0 is better and above is worse.

Source: California Department of Public Health. November 2019.

It is challenging to calculate the impact of hospital infections that have been prevented. However, Cal Hospital Compare, with support from IBM Watson, calculated the mortality rates of hospital associated infections and the usual costs of caring for those infections based on evidence from the literature. They have evidence to support this calculation for four of the targeted infections: CLABSI, CAUTI, SSI Colon, and C. Diff. The result, for the twelve months between October 1, 2017 and September 30, 2018, compared to April 1, 2016 to March 31, 2017, shows that 3,392 infections were avoided resulting in 251 Californian lives saved and $62 million dollars saved.

It is important to note that Covered California insurer engagement and payment strategy efforts did not create this improvement alone, but the contract requirements were likely helpful contributors to the success.[88] Covered California has partnered with existing stakeholder groups and organizations, to implement hospital quality and safety requirements that include a standard set of metrics and several common approaches to quality improvement with aligned expectations across 11 health insurance companies. Prior to 2016, health insurance companies did not find most hospitals receptive to discussion of quality performance in contract discussions and insurer medical management and network management teams were traditionally siloed internally. Importantly, under the leadership of the Hospital Quality Institute, the California Hospital Association has taken a lead in increasing the focus on quality. Health insurance companies also reported that the alignment of 11 insurers with consistent message of insurer accountability for variation and a prioritized set of measures has changed the environment and supported measurable improvement.

[88] Of note, these requirements became effective in 2017 but stakeholder discussions on the importance of quality improvement began in summer of 2015. Some plans began engaging hospitals earlier than 2017 and some as early as summer 2015.

Collectively Reducing Unnecessary C-Sections: Reduce Low-Risk NTSV C-Section Rates to 23.9 Percent or Lower

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. Unnecessary C-sections are dangerous for the mother and baby, increasing the risk of complications such as hemorrhage, infection, transfusions, blood clots, respiratory complications, and neonatal intensive care unit (NICU) admission.[89] Roughly 90 percent of women with a prior C-Section currently deliver by C-section for future births, leading to higher risks of additional complications, including placenta previa or accreta and uterine rupture (which can cause hemorrhage, hysterectomy, or death).[90] Compared to vaginal delivery, babies born by repeat C-section have higher rates of respiratory morbidity and NICU admission rates resulting in longer hospital stays and higher medical costs.[91]

Covered California holds health insurance companies responsible to manage variation in provider performance across their contracted networks rather than manage to average performance. To that end, insurers are required to engage with their network hospitals to promote awareness of (1) low risk C-section rates, (2) availability of provider and consumer education, and (3) promote participation in data sharing and coaching offered by the California Maternal Quality Care Collaborative (CMQCC), with the goal of reducing NTSV C-sections to 23.9 percent of deliveries or lower (as set in the national Healthy People 2020 goals).

CMQCC gained national attention for contributing to California's decreasing maternal mortality rates and now works to reduce NTSV C-sections. Hospital participation in the CMQCC data collection and improvement collaborative is now nearly universal partly due to insurer encouragement and inclusion in contracting discussions with hospitals. As of July 2018, nearly 95 percent of California hospital births occur at hospitals participating in data reporting or collaboratives managed by the Maternal Data Center (MDC) within the CMQCC (see *Figure A3: Percentage of California Hospital Births at CMQCC Participating Hospitals* in *Appendix 4: Additional Publicly Reported Hospital Quality and Safety Data*).[92]

Progress to reduce NTSV C-sections has been substantial between 2015 and 2018. In 2015, the variation in C-section rates for NTSV deliveries among maternity hospitals in California was enormous, ranging from 10 to 75.8 percent. *Figure 13. Distribution of NTSV C-section Rates for Hospitals that Reported to the California Maternal Quality Care Collaborative, 2018* shows the range of NTSV C-section rates for hospitals reporting to CMQCC in 2018. The range was 6.2 to 41.1 percent with an aggregated rate of 23.3 percent and a median of 23.2 percent, which are both below the Healthy People 2020 target of 23.9 percent. The absence of the highest outliers signifies substantial change in maternity practice in the state of California.

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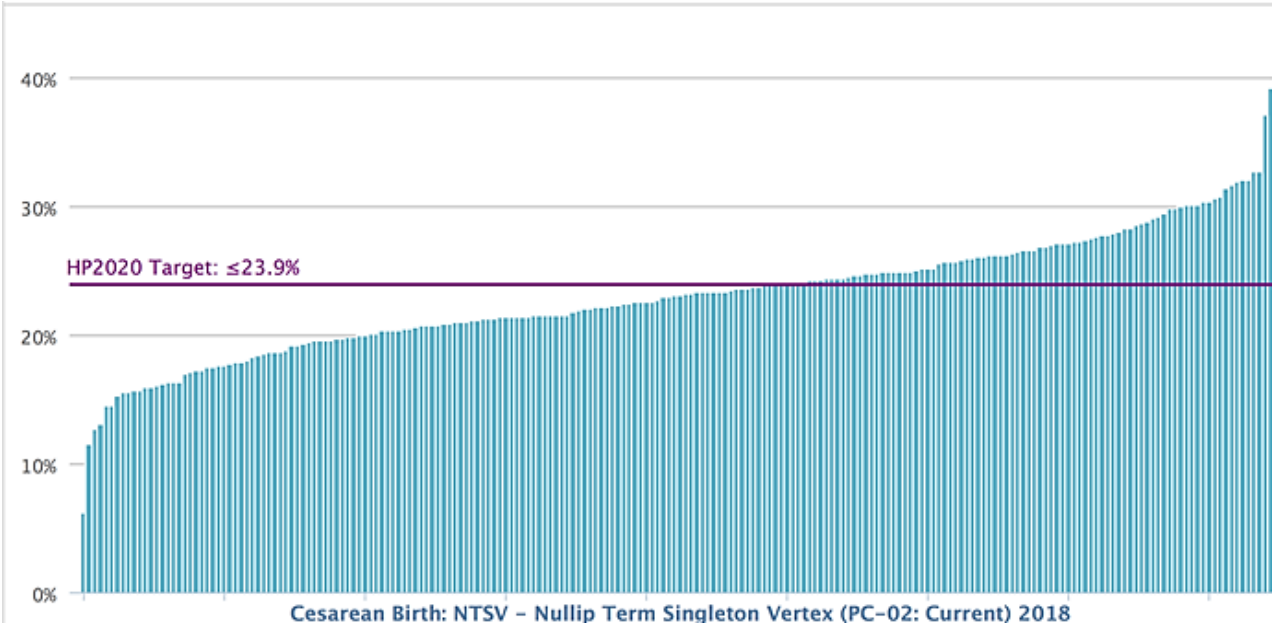
89 J. P. Souza et al., "Caesarean Section Without Medical Indications Is Associated with an Increased Risk of Adverse Short-Term Maternal Outcomes: The 2004-2008 WHO Global Survey on Maternal and Perinatal Health," BMC Medicine 8 (November 10, 2010): 71, doi:10.1186/1741-7015-8-71.

90 Smart Care California. (2017). Aligning Birth Payment to Reduce Unnecessary C-Section: A Menu of Options. Retrieved from http://www.iha.org/sites/default/files/files/page/c-section_menu_of_payment_and_contracting_options.pdf

91 Kamath, B. et al. "Neonatal Outcomes After Elective Cesarean Delivery". Obstetrics and Gynecology. 113(6):1231-1238, JUN 2009.

92 As of July 2018, 221 of 240 maternity hospitals representing nearly 95 percent of California hospital births occur at hospitals participating in data reporting or collaboratives managed by the Maternal Data Center (MDC) within the CMQCC.

Figure 13. Distribution of NTSV C-section Rates for Hospitals that Reported to the California Maternal Quality Care Collaborative, 2018



Note: Each of the blue bars represents each of the hospitals for which there is data available. HP 2020 refers to the Healthy People 2020 target of reducing NTSV C-Sections to 23.9 percent or less of deliveries.

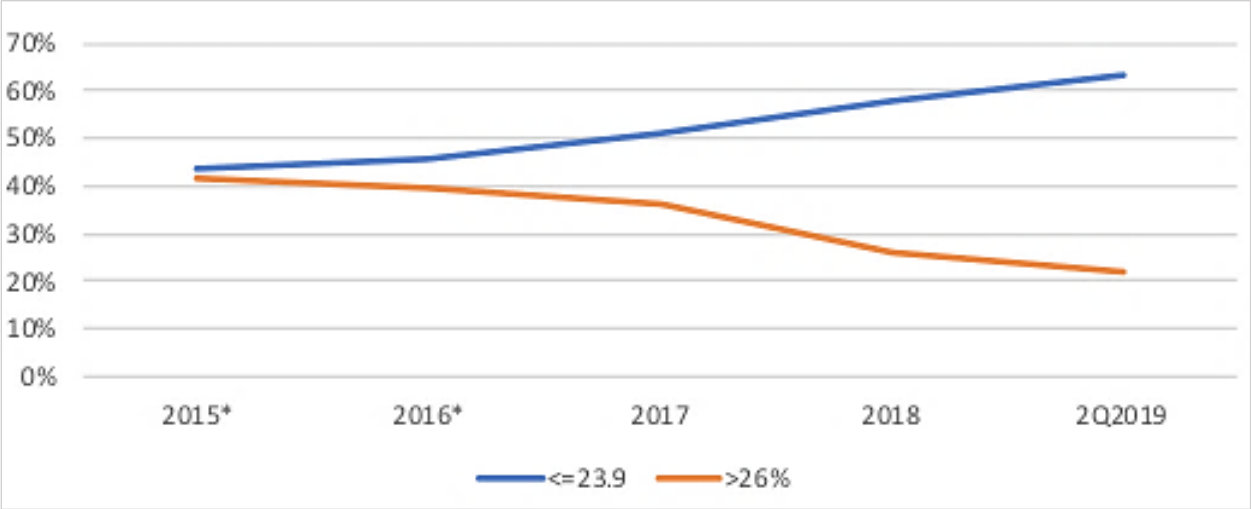
Source: CMQCC Maternal Data Center

After concerted effort by almost every maternity hospital in the state with contractual and other support from the three large state purchasers — Medi-Cal, CalPERS and Covered California — and the Pacific Business Group on Health, representing both public and private purchasers, 56 percent of California maternity hospitals that report to CMQCC (122 of 221) have achieved the national goal of NTSV C-section rates of 23.9 percent or lower.[93] On an aggregate level, CMQCC reported that 7,200 C-sections were avoided statewide from 2015 to 2018.

As of the first half of 2019, the number hospitals that participate in CMQCC and meet the NTSV C-section target was 63 percent (compared to 44 percent in 2015) and there has been a 22 percent decrease in the percent of hospitals with a rate above 26 percent (42 percent in 2015) (see *Figure 14. Hospitals with C-Sections Rates Below 23.9 Percent or Above 26 Percent Reported to the California Maternal Quality Care Collaborative, 2018*).

[93] Smart Care California. (2018). 2018 Hospital C-Section Honor Roll. Retrieved from https://www.iha.org/sites/default/files/2018_hospital_award_winners_final.pdf.

Figure 14. Hospitals with C-Sections Rates Below 23.9 Percent or Above 26 Percent Reported to the California Maternal Quality Care Collaborative, 2018



Source: CMQCC Maternal Data Center, 2019

Expand Value-based Payments for Hospitals and Maternity Care

Just as Covered California promotes changes in how physicians are paid to foster payments that encourage coordination and advanced primary care (see Chapter 7: Promotion of Effective Primary Care), it requires insurers to change payments to improve hospital quality and maternity care. Health plans are required to adopt payment methods that (1) tie at least two percent of hospital payments to value, and (2) eliminate financial incentives for hospital facilities or physicians to perform C-Sections.

Hospital Payments: Health insurance companies are required to adjust payments to hospitals so that at least two percent of overall hospital payments are tied to value for each product by the end of 2019 and increasing over the following years to at least 6 percent by year-end 2023. This can be accomplished by either withholding payment pending documentation of quality performance, bonuses, or a combination of both depending on the circumstances at each hospital. Health insurance companies are required to include the five specific HAI measures and the NTSV C-section measure, but insurers are given flexibility to include appropriate additional metrics based on their judgment and priorities such as patient satisfaction, additional clinical quality measures, safety, or readmissions. However, the entire two percent cannot be attributed to readmissions due to concern that hospitals serving a disproportionate share of disadvantaged populations may be inadvertently harmed.

Maternity Care Payments: Health insurance companies are encouraged to adjust labor and delivery payments to physicians and hospitals so that by year-end 2019 payment does not incentivize performing C-sections. To provide guidance to hospitals and insurers, Smart Care California, a public-private multi-stakeholder workgroup led by California state purchasers, built consensus around the following payment structures: (1) blended case rates; (2) low risk C-section reduction as a metric for

payment incentive programs; or (3) population-based payment models.[94] While Smart Care California emphasizes blended case rates, any of the payment structures would fulfill the requirement for payment to not incentivize performing C-sections.

As described in *Table 40. Covered California Insurer Engagement in Changing Payments to Hospitals, 2016-18*, most insurers have been *Re-contracting* with value-based payments for hospitals. As of 2018, 10 insurers were *Actively Re-contracting* or *Re-contracting.* The percent of network hospitals with value-based payments from the insurer is an indicator for the extent to which the insurer is scaling the program. Data reported for 2018 indicates wide variation in the extent to which an insurer's network hospitals have value-based payments, after excluding insurers with integrated delivery systems (Kaiser Permanente and Sharp Health Plan). Four insurers reported between 20 to 100 percent of hospitals have value-based payment contracts, two insurers reported less than 10 percent of hospitals have value-based payment contracts, and four insurers reported that 0 percent of network hospitals have value-based payment contracts.

For value-based payments for NTSV C-Sections, health plans made significant progress, from six health plans assessed as *Actively Re-contracting* or *Re-contracting* in 2016 to 10 health plans in 2018.

Table 40. Covered California Insurer Engagement in Changing Payments to Hospitals, 2016-18

	Hospital Payments			NTSV C-Sections		
Assessment	**2016**	**2017**	**2018**	**2016**	**2017**	**2018**
Actively Re-contracting Active re-contracting of network to adjust payment.	2	3	4	4	6	7
Re-contracting Describes efforts to start re-contracting payments (e.g. internal planning) and has initiated the process.	7	7	6	2	3	3
Minimal Re-contracting Has not yet started re-contracting toward value-based payment to hospitals.	2	1	1	5	2	1

Source: Covered California Staff Analysis of Qualified Health Plan Data Submitted for 2016-2018.

Covered California has worked with some insurers to amend their contract on this requirement, either because they function as a capitated integrated delivery system that has a payment structure aligned with quality performance or their population is too small to be the basis for leverage in contract negotiations to change the business model. The common elements in amendments involve continuing to track measures, engaging hospitals to improve and continually making efforts to change payment if not already aligned.

In summary, Covered California has worked with the California Hospital Association, Cal Hospital Compare, CMQCC and Smart Care California, all multi-stakeholder forums that include insurers, to adopt a focused list of maternity and safety metrics for hospitals. By working together and aligning 11 insurers on a common set of metrics and payment structure, quality performance is now part of hospital contract discussions in ways it was not in prior years. The state is seeing reductions in NTSV C-sections and avoidable hospital associated infections.

[94] Smart Care California. October 2017. Aligning Birth Payment to Reduce Unnecessary C-Section. Retrieved from: http://www.iha.org/sites/default/files/files/page/c-section_menu_of_payment_and_contracting_options.pdf.

Covered California's requirements link hospital payment reform with hospital improvement efforts. Hospital performance is improving faster than implementation of hospital payment reforms. Sustaining these improvements in hospital quality and safety will be reinforced as payment is gradually more aligned with quality and safety goals.

Expanded Approaches to Care Delivery

Telehealth

Health insurance companies are required to report the extent to which they support and use technology to assist in higher quality, accessible, patient-centered care and the utilization for enrollees on the number of unique patients and number of separate services provided for telehealth. Health insurance companies must describe whether these models are implemented in association with patient-centered medical homes, integrated delivery systems or accountable care organization models of care or are independently implemented.

All Covered California insurers offered a telehealth or web-based service in 2018, but they vary in their capabilities. Most insurers that offered a telehealth service in 2018 used a vendor with two insurers offering telehealth visits only through contracted medical groups and not as a free-standing program (see *Table 41. Covered California Insurer Telehealth Capabilities, 2015, 2017 and 2018*).

The percent of enrollees with a telehealth visit for Covered California insurers ranged from 0 percent to 59 percent in 2018. The high outlier, Kaiser Permanente, an integrated delivery system that uses telehealth as part of their model, reported that 59 percent of enrollees used telehealth or had a web visit in 2018. Oscar Health Plan reported that 17 percent of enrollees used telehealth or a web visit in 2018. Oscar Health Plan consistently and actively promotes the use of telehealth to its enrollees. Most other insurers reported that fewer than 10 percent of enrollees had engaged with care through telehealth.

Table 41. Covered California Insurer Telehealth Capabilities, 2015, 2017 and 2018

	Number of Health Plans		
	2015	2017	2018
Telehealth			
Telehealth with video through vendor	2	6	5
Telehealth through medical groups only	1	1	2
Telehealth with phone	2	2	4
Telehealth for mental health visits only	1	0	0
Web Visit using instant messaging	1	2	1

Note: 10 health plans offered a telehealth service in 2017 while all 11 health plans offered a telehealth service in 2018.

Table 42. Covered California Insurer Telehealth Cost Shares and Promotion to Enrollees, 2017-18

	Number of Health Plans	
	2017	2018
Cost-Share		
No cost-share*	4	4
Same cost as primary care or specialist visit	5	6
A $5 copay with vendor, but other services are the same an in-person visit	1	1
Promotion to Enrollees		
Promoted via email, print, online resources	5	5
Added telehealth visit cost-share next to ED cost-share on member ID card	1	1
Used as Follow up to Lab Visits	0	1
Promoted through Open Enrollment marketing	1	1
Promote on website, member portal, or mobile app	3	3
Promotes through medical groups	2	2
Did not promote telehealth services	3	1

*Note Bronze High Deductible enrollees or those with a Health Savings Account are subject to the deductible.

Source: Covered California Staff Analysis of Qualified Health Plan Submitted Data

Implications for the Future

Improving hospital quality and safety through reducing HAIs and NTSV C-section rates will continue to be areas of focus for Covered California. Additional measures will be incorporated as they are publicly reported. As acute care appropriately moves from the hospital to hospital outpatient centers and to ambulatory surgery centers, Covered California will support efforts to obtain and publicly report on the quality of care delivered in these sites. Covered California is exploring opportunities to measure volume, both in the number of patients served and the number of services delivered, as a proxy for safety at all sites of care. In addition, Covered California recognizes the need to look at additional measures or indications of health care quality or safety, including what other measures or indicators of appropriate care should be used.

The adoption of telehealth services, retail or convenience clinics and Centers of Excellence are examples of using alternative sites of care or expanded approaches to care delivery beyond the traditional hospital and physician office. Others include care at home and expanded use of technology such as eConsult and Project ECHO to facilitate integration and coordination across specialties and adoption of team-based care. Covered California is working with insurers to ensure telehealth or other technology programs are offered in the languages spoken by their enrollees and further promote the availability of translation services. Covered California is assessing how best to evaluate the extent to which these programs foster care that improves quality and patient experience while lowering costs.

Although this report heavily focuses on the hospital and physician office experience, Covered California recognizes that health care is being delivered to consumers outside of these traditional venues. Moving forward, Covered California will be evaluating quality outcomes from sites such as outpatient surgery centers, birthing centers, retail clinics and home care services. More and more consumers are turning to these non-traditional care sites and Covered California has an obligation to ensure that these sites meet its high-quality standards while keeping health care costs affordable.

Chapter 12: Summary and Implications for the Future

This report presents the initial findings of insurer progress towards meeting Covered California's contractual requirements to assure quality care and promote delivery system reform.

The most consistent finding across all domains was the remarkable variation in performance with the consistent high performance for Kaiser Permanente and Sharp Health Plan. This was true not only for measures included in the Quality Rating System, but also for disadvantaged populations when profiled for disparities. Hospitals in these integrated systems show much less variation in safety scores and both insurers have adopted best practices in primary care. Their focus on integrated, coordinated care likely explains their performance and reinforces Covered California's intent to promote ACOs to better organize care in the delivery systems of other insurers. While the integrated plans excelled, it was reassuring that, with few exceptions, most performance was between the 25th and 90th percentile nationwide for other plans across a wide range of measures. There are some measures, especially for behavioral health and preventive care, where several plans perform below the 25th percentile. However, Covered California has no outlier poor performing health plans.

Covered California worked with insurers to collect baseline data on race and ethnicity for all enrollees under 65 across all lines of business. Despite significant challenges with data quality, each insurer is moving ahead to address health disparities based on actionable differences found across a wide variety of population characteristics. This program is a priority to enhance and expand.

All Covered California enrollees now have a primary care physician and a growing number are cared for within Integrated Delivery Systems or ACOs. Significant work remains to support the implementation of advanced primary care models and to establish best practices for ACOs as they attempt to replicate the success of integrated systems.

Covered California holds health insurance companies accountable to manage variation in performance in addition to reporting overall average measurement through the Quality Rating System. Hospital performance was an initial focus using publicly reported data and supported by collaborative programs improving safety and maternity care. There has been important progress made demonstrating the value of alignment across multiple purchasers and payers as well as significant leadership from providers. Hospital care in California is safer as a result.

Covered California has established a framework and approach to systematic improvement that has started to show important results: slower cost growth, modest improvement in quality measures, adoption of more effective primary care models, progress toward implementation of integrated delivery systems and ACOs and, through collaboration with others, substantial gains in patient safety. Moreover, by requiring all insurers to stratify performance measures by race and ethnicity, Covered California has set the stage for achieving progress in reducing disparities.

Much remains to be done, especially in the arena of consistent and effective measurement that supports quality improvement strategies for better health outcomes. Covered California acknowledges that efforts to meet the long-term goals of consistent measurement would potentially increase administrative burden initially for providers and hospitals but if done effectively and carefully, would establish consistent data measurement across insurers and purchasers that targets improvement opportunities for the delivery system in quality, cost, effectiveness and equity. In the end, this would be expected to reduce administrative burden and complexity. Covered California is committed to working collaboratively and transparently to ensure that we contribute to a state where "Health Care for All" means that all Californians receive the best possible care.

APPENDICES

Appendix 1: Limitations and Major Caveats about Health Disparities Data

The data collected for the health disparities measures described in Chapter 2 is unique because it includes data for enrollees under age 65 across all lines of business for 11 insurers. Covered California cautions that it has several limitations and major caveats:

- **These are baseline results not reported for accountability:** Insurers have been required to collect ethnic and racial identity by law in California since 2003. The results were used only to determine which language translation services were needed. This is the first time ethnic and racial identity information has been used to stratify clinical outcomes data for the purpose of defining and addressing disparities. It has taken three years to establish a baseline for which strategies are being developed to reduce disparities.
- **Varying populations by insurer:** Health insurance companies collected data for their entire populations under 65 regardless of line of business. Because each insurer has different proportions of commercial and Medi-Cal populations, the results cannot be compared between insurers.
- **No formal audit process:** While insurers were encouraged to follow the measures specifications for HEDIS and PQI, the data reported by insurers has not been verified through a third-party audit as it would be for reporting to the National Committee for Quality Assurance's Quality Compass. Third-party auditors examine information practices and control procedure, sampling methods and procedures, data integrity, compliance with HEDIS specifications, analytic file production, and reporting and documentation.
- **Variation in data quality and collection:** Data quality varies by insurer, with some missing key data elements such as identification of certain groups (e.g., Native Hawaiian) and ability to identify claims using the measure specifications for admissions. Most insurers aggregated their 400-person HEDIS samples across all lines of business and a few had access to robust clinical data from electronic health records. HEDIS samples are drawn to represent the entire population but may not represent the ethnic and racial diversity of the plan's population.
- **Small denominators:** Because the health disparities measures are based on a subset of individuals with a diagnosed chronic condition and reported by six race/ethnicity categories, this results in small denominators among some groups for certain measures and make it difficult to identify actual differences in care and outcomes. Some admissions measures and American Indian/Alaskan Native populations are especially impacted by small denominators. As a result, no insurer proposed an admission measure as a focus of disparity reduction efforts. However, admissions are important enough that further work is needed to determine if interventions might be appropriate despite the small numbers.
- **Interpretation of data and identifying health Care disparities:** Health insurance companies report the numerators, denominators, and rates by race/ethnicity for each measure, and early discussions between Covered California and insurers have centered on observed rate differences in admissions, disease control, and medication management between race/ethnicity groups. An observed rate difference may require further analysis to consider confounding factors and statistical significance.

Appendix 2: Additional Health Plan Measures Reported to Quality Rating System

The following tables display the Covered California weighted average, highest and lowest performing plans, plan-specific performance, as well as national percentiles for all Marketplace plans for the remaining measures in the Marketplace Quality Rating System (QRS) measure set. A priority set of 13 measures were presented in the subject chapters of this report.

How to Interpret Quality Performance Data

Within the QRS measure set, HEDIS measures rely on claims or encounter data while CAHPS measures are collected as part of the Qualified Health Plan Enrollee Survey. Since insurers can offer multiple products that vary by network type (HMO, PPO, or EPO), the data below shows 16 total plans.

The data is listed by year the health plans reported the QRS measure set data such that the 2019 reporting year data represents health plan performance during the 2018 calendar year or measurement year and so on.

Only data for products meeting CMS participation criteria for QRS score eligibility are displayed in the tables. Blank cells indicate the following: (1) CMS participation criteria were not met for scoring because the health plan did not offer a product for two consecutive years through Covered California; (2) CMS participation criteria were met but denominator size for a given measure was below the minimum threshold for scoring; or (3) the health plan chose not to report the measure (Not Reported/NR).

The percentile values provide benchmark information for measure rates, allowing a health plan to compare its results to all other health plans and products nationally. CMS reports benchmark values that include the standardized 25th, 50th, 75th, and 90th percentile values for the numerical rates across all health plans and products. To create these benchmark values, CMS uses only measure rates that have met the minimum denominator size criteria for scoring.[95]

[95] Centers for Medicaid and Medicare Services. (2018). Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2019. Retrieved from https://www.cms.gov.

Additional Measures Related to Health Promotion and Prevention

In Chapter 3: Health Promotion and Prevention, three QRS measures are presented as potential "Priority Measures." These measures and the eight additional QRS measures pertaining to Health Promotion and Prevention are:

Potential Priority Measures

1. Breast Cancer Screening (Table 13)
2. Cervical Cancer Screening (Table 14)
3. Colorectal Cancer Screening (Table 15)

Additional Measures

4. Chlamydia Screening in Women (Table A1)
5. Adult BMI Assessment (Table A2)
6. Childhood Immunizations (Combination 3) (Table A3)
7. Immunizations for Adolescents (Combination 2) (Table A4)
8. Flu Vaccinations for Adults (Table A5)
9. Medical Assistance with Smoking and Tobacco Use Cessation (Table A6)
10. Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (Table A7)
11. Annual Dental Visit (Table A8)

Chlamydia Screening in Women

The Chlamydia Screening measure is the percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

Table A1. Chlamydia Screening in Women for Covered California Enrollees (HEDIS)

	2016	2017	2018	2019			
	US Benchmark	US Benchmark	US Benchmark	US Benchmark	Percent of Enrollees	Number of Enrollees	Number of Plans
Plans at 90th Percentile and Above	61 +	64 +	65 +	67 +	36%	477,683	1
Plans at 50th to 90th Percentile	44 to 61	45 to 64	48 to 65	47 to 67	46%	622,371	8
Plans at 25th to 50th Percentile	37 to 44	38 to 45	39 to 48	40 to 47	18%	245,176	3
Plans Below 25th Percentile	Below 37	Below 38	Below 39	Below 40	0%	-	0
Covered California High/Average/Low Performers							
Covered CA Highest Performer	69	73	75	73			
Covered CA Weighted Average	52	59	60	58			
Covered CA Lowest Performer	45	44	46	44			
Covered California Plan-Specific Performance							
Anthem HMO	52	52					
Anthem PPO	45	47					
Anthem EPO			48	44	5%	64,031	
Blue Shield HMO		53	51	49	7%	93,322	
Blue Shield PPO	45	48	50	49	25%	335,176	
CCHP HMO	55	55	58	59	1%	10,013	
Health Net HMO	47	50	51	47	11%	145,183	
Health Net EPO		44	58				
Health Net PPO							
Kaiser Permanente HMO	69	73	75	73	36%	477,683	
LA Care HMO	47	57	59	59	6%	84,750	
Molina Healthcare HMO	55	64	59	52	4%	56,023	
Oscar Health Plan EPO			55	46	3%	35,962	
Sharp Health Plan HMO	58	62	58	60	1%	17,335	
Valley Health Plan HMO			65	55	1%	16,366	
Western Health Advantage HMO	57	54	46	56	1%	9,386	

Adult Body Mass Index Assessment

The Adult BMI measure is the percentage of members 18–74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.

Table A2. Adult Body Mass Index Assessment for Covered California Enrollees (HEDIS)

	2016	2017	2018	2019			
	US Benchmark	US Benchmark	US Benchmark	US Benchmark	Percent of Enrollees	Number of Enrollees	Number of Plans
Plans at 90th Percentile and Above	MN-S	95 +	94 +	96 +	35%	477,683	1
Plans at 50th to 90th Percentile	MN-S	84 to 95	85 to 94	86 to 96	24%	329,670	6
Plans at 25th to 50th Percentile	MN-S	73 to 84	75 to 85	79 to 86	12%	157,353	2
Plans Below 25th Percentile	MN-S	Below 73	Below 75	Below 79	28%	381,920	4
Covered California High/Average/Low Performers							
Covered CA Highest Performer	97	96	97	97			
Covered CA Weighted Average	79	83	82	85			
Covered CA Lowest Performer	37	37	35	67			
Covered California Plan-Specific Performance							
Anthem HMO	82	86					
Anthem PPO	76	81					
Anthem EPO			81	83	5%	64,031	
Blue Shield HMO	37	37	35	79	7%	93,322	
Blue Shield PPO	67	71	68	67	25%	335,176	
CCHP HMO	92	71	88	94	1%	10,013	
Health Net HMO	75	80	85	89	11%	145,183	
Health Net EPO		71	71	75	0%	1,396	
Health Net PPO							
Kaiser Permanente HMO	97	96	97	97	35%	477,683	
LA Care HMO	79	82	93	95	6%	84,750	
Molina Healthcare HMO	77	84	81	86	4%	56,023	
Oscar Health Plan EPO			70	70	3%	35,962	
Sharp Health Plan HMO	92	94	96	95	1%	17,335	
Valley Health Plan HMO	90	95	95	91	1%	16,366	
Western Health Advantage HMO	81	83	88	74	1%	9,386	

*M-NS: This measure was not used in determining the overall QRS rating in 2016.

Childhood Immunizations Status (Combination 3)

The Childhood Immunization Status measure is the percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); and four pneumococcal conjugate (PCV) vaccines by their second birthday. The measure calculates a rate for each vaccine and one combination rate.

Table A3. Childhood Immunization Status (Combination 3) for Covered California Enrollees (HEDIS)

	2016	2017	2018	2019			
	US Benchmark	US Benchmark	US Benchmark	US Benchmark	Percent of Enrollees	Number of Enrollees	Number of Plans
Plans at 90th Percentile and Above	MN-S	85 +	86 +	86 +	0%	-	0
Plans at 50th to 90th Percentile	MN-S	76 to 85	75 to 86	77 to 86	46%	562,433	2
Plans at 25th to 50th Percentile	MN-S	69 to 76	65 to 75	65 to 77	1%	17,335	1
Plans Below 25th Percentile	MN-S	Below 69	Below 65	Below 65	52%	637,712	4
Covered California High/Average/Low Performers							
Covered CA Highest Performer	83	90	87	84			
Covered CA Weighted Average	70	74	73	72			
Covered CA Lowest Performer	62	60	56	50			
Covered California Plan-Specific Performance							
Anthem HMO							
Anthem PPO	62	66					
Anthem EPO			64	50	5%	64,031	
Blue Shield HMO				64	8%	93,322	
Blue Shield PPO	63	60	56	63	28%	335,176	
CCHP HMO							
Health Net HMO	78	80	73	58	12%	145,183	
Health Net EPO							
Health Net PPO							
Kaiser Permanente HMO	83	85	87	84	39%	477,683	
LA Care HMO				82	7%	84,750	
Molina Healthcare HMO							
Oscar Health Plan EPO							
Sharp Health Plan HMO	67	90	80	69	1%	17,335	
Valley Health Plan HMO							
Western Health Advantage HMO							

*M-NS: This measure was not used in determining the overall QRS rating in 2016.

Immunizations for Adolescents (Combination 2)

The Immunizations for Adolescents (Combination 2) measure is the percentage of adolescents 13 years old who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates.

Table A4. Immunizations for Adolescents (Combination 2) for Covered California Enrollees (HEDIS)

	2016	2017	2018	2019			
	US Benchmark	US Benchmark	US Benchmark	US Benchmark	Percent of Enrollees	Number of Enrollees	Number of Plans
Plans at 90th Percentile and Above	MN-S	MN-S	31 +	36 +	44%	562,433	2
Plans at 50th to 90th Percentile	MN-S	MN-S	19 to 31	23 to 36	24%	311,863	4
Plans at 25th to 50th Percentile	MN-S	MN-S	15 to 19	17 to 23	27%	344,562	2
Plans Below 25th Percentile	MN-S	MN-S	Below 15	Below 17	5%	64,031	1
Covered California High/Average/Low Performers							
Covered CA Highest Performer	83	33	51	54			
Covered CA Weighted Average	63	22	34	35			
Covered CA Lowest Performer	54	11	16	16			
Covered California Plan-Specific Performance							
Anthem HMO							
Anthem PPO	54	11					
Anthem EPO			16	16	5%	64,031	
Blue Shield HMO				24	7%	93,322	
Blue Shield PPO	57	14	22	23	26%	335,176	
CCHP HMO							
Health Net HMO	58	20	24	24	11%	145,183	
Health Net EPO							
Health Net PPO							
Kaiser Permanente HMO	83	33	51	54	37%	477,683	
LA Care HMO				39	7%	84,750	
Molina Healthcare HMO			29	26	4%	56,023	
Oscar Health Plan EPO							
Sharp Health Plan HMO		23	19	23	1%	17,335	
Valley Health Plan HMO							
Western Health Advantage HMO			18	22	1%	9,386	

Note: National percentiles not scored for Reporting Years 2016 and 2017. Between Reporting Years 2016 and 2019, this measure was renamed to "Immunizations for Adolescents (Combination 2)" and expanded to include the HPV vaccine alongside the Tdap and meningococcal vaccines.

*M-NS: This measure was not used in determining the overall QRS rating in 2016 or 2017.

Flu Vaccinations for Adults

The Flu Vaccination for Adults measure is the percentage of members 18-64 years of age who received a flu vaccination between July 1 of the measurement year and the date when the QHP Enrollee Survey was completed. This is the only immunization measure that includes adults, who make up the majority of Covered California plan enrollment.

Table A5. Flu Vaccinations for Covered California Enrollees Ages 18-64 (CAHPS)

	2016	2017	2018	2019			
	US Benchmark	US Benchmark	US Benchmark	US Benchmark	Percent of Enrollees	Number of Enrollees	Number of Plans
Plans at 90th Percentile and Above	50 +	50 +	54 +	58 +	0%	-	0
Plans at 50th to 90th Percentile	40 to 50	40 to 50	43 to 54	47 to 58	62%	829,225	3
Plans at 25th to 50th Percentile	35 to 40	37 to 40	38 to 43	43 to 47	18%	238,505	2
Plans Below 25th Percentile	Below 35	Below 37	Below 38	Below 43	21%	277,500	7
Covered California High/Average/Low Performers							
Covered CA Highest Performer	57	48	51	56			
Covered CA Weighted Average	36	40	45	48			
Covered CA Lowest Performer	25	30	30	29			
Covered California Plan-Specific Performance							
Anthem HMO	25	36					
Anthem PPO	32	30					
Anthem EPO			30	41	5%	64,031	
Blue Shield HMO	27	32		45	7%	93,322	
Blue Shield PPO	34	39	48	47	25%	335,176	
CCHP HMO	32	34	37	39	1%	10,013	
Health Net HMO	31	36	36	46	11%	145,183	
Health Net EPO		44	44				
Health Net PPO							
Kaiser Permanente HMO	48	47	51	56	36%	477,683	
LA Care HMO	30	33	38	40	6%	84,750	
Molina Healthcare HMO	29	35	30	29	4%	56,023	
Oscar Health Plan EPO			35	32	3%	35,962	
Sharp Health Plan HMO	45	36	35	42	1%	17,335	
Valley Health Plan HMO	57	48	42	47	1%	16,366	
Western Health Advantage HMO	41	31	42	41	1%	9,386	

Medical Assistance with Smoking and Tobacco Use Cessation

The Medical Assistance with Smoking and Tobacco Use Cessation measure is comprised of the following components:

1. Advising Smokers and Tobacco Users to Quit: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who received advice to quit during the measurement year.
2. Discussing Cessation Medications: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year.
3. Discussing Cessation Strategies: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were provided cessation methods or strategies during the measurement year.

Table A6. Medical Assistance with Smoking and Tobacco Use Cessation for Covered California Enrollees (CAHPS)

	2016	2017	2018	2019			
	US Benchmark	US Benchmark	US Benchmark	US Benchmark	Percent of Enrollees	Number of Enrollees	Number of Plans
Plans at 90th Percentile and Above	MN-S	59 +	60 +	63 +		-	0
Plans at 50th to 90th Percentile	MN-S	50 to 59	50 to 60	54 to 63		-	0
Plans at 25th to 50th Percentile	MN-S	45 to 50	45 to 50	48 to 54		-	0
Plans Below 25th Percentile	MN-S	Below 45	Below 45	Below 48		-	0
Covered California High/Average/Low Performers							
Covered CA Highest Performer			55				
Covered CA Weighted Average			39				
Covered CA Lowest Performer			37				
Covered California Plan-Specific Performance							
Anthem HMO							
Anthem PPO							
Anthem EPO							
Blue Shield HMO							
Blue Shield PPO							
CCHP HMO			51				
Health Net HMO			37				
Health Net EPO							
Health Net PPO							
Kaiser Permanente HMO							
LA Care HMO							
Molina Healthcare HMO							
Oscar Health Plan EPO							
Sharp Health Plan HMO							
Valley Health Plan HMO							
Western Health Advantage HMO			55				

*QRS did not collect this measure in 2016.

**M-NS: This measure was not used in determining the overall QRS rating in 2016.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents

The Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents measure is the percentage of members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year:

- BMI percentile documentation. Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value;
- Counseling for nutrition; and
- Counseling for physical activity.

Table A7. Weight Assessment and Counseling for Nutrition and Physical Activity for Covered California Children and Adolescents Enrollees (HEDIS)

	2016	2017	2018	2019			
	US Benchmark	US Benchmark	US Benchmark	US Benchmark	Percent of Enrollees	Number of Enrollees	Number of Plans
Plans at 90th Percentile and Above	82 +	83 +	84 +	87 +	35%	477,683	1
Plans at 50th to 90th Percentile	56 to 82	63 to 83	66 to 84	69 to 87	10%	128,464	4
Plans at 25th to 50th Percentile	46 to 56	51 to 63	53 to 66	59 to 69	25%	331,886	5
Plans Below 25th Percentile	Below 46	Below 51	Below 53	Below 59	30%	408,593	3
Covered California High/Average/Low Performers							
Covered CA Highest Performer	95	94	95	94			
Covered CA Weighted Average	61	68	68	73			
Covered CA Lowest Performer	4	4	7	33			
Covered California Plan-Specific Performance							
Anthem HMO	52	68					
Anthem PPO	52	56					
Anthem EPO			64	56	5%	64,031	
Blue Shield HMO	4	4	7	60	7%	93,322	
Blue Shield PPO	48	50	53	58	25%	335,176	
CCHP HMO	68	21	81	71	1%	10,013	
Health Net HMO	54	58	62	61	11%	145,183	
Health Net EPO		65	66	63	0%	1,396	
Health Net PPO							
Kaiser Permanente HMO	95	94	95	94	35%	477,683	
LA Care HMO	48	54	74	80	6%	84,750	
Molina Healthcare HMO	52	68	52	69	4%	56,023	
Oscar Health Plan EPO			10	60	3%	35,962	
Sharp Health Plan HMO	65	74	77	80	1%	17,335	
Valley Health Plan HMO		77	84	78	1%	16,366	
Western Health Advantage HMO	73	67	74	33	1%	9,386	

Annual Dental Visit

The Annual Dental Visit measure is the percentage of members 2–20 years of age who had at least one dental visit during the measurement year.

Table A8. Annual Dental Visit for Covered California Enrollees (HEDIS)

	2016	2017	2018	2019			
	US Benchmark	US Benchmark	US Benchmark	US Benchmark	Percent of Enrollees	Number of Enrollees	Number of Plans
Plans at 90th Percentile and Above	55 +	57 +	55 +	55 +	0%	-	0
Plans at 50th to 90th Percentile	27 to 55	27 to 57	32 to 55	31 to 55	0%	1,396	1
Plans at 25th to 50th Percentile	9 to 27	8 to 27	13 to 32	16 to 31	94%	758,424	6
Plans Below 25th Percentile	Below 9	Below 8	Below 13	Below 16	5%	43,087	3
Covered California High/Average/Low Performers							
Covered CA Highest Performer	24	38	41	43			
Covered CA Weighted Average	17	14	20	22			
Covered CA Lowest Performer	2	7	2	3			
Covered California Plan-Specific Performance							
Anthem HMO	13	18					
Anthem PPO	24	32					
Anthem EPO			35	28	8%	64,031	
Blue Shield HMO		7	13	18	12%	93,322	
Blue Shield PPO		12	21	25	42%	335,176	
CCHP HMO							
Health Net HMO	10	12	17	20	18%	145,183	
Health Net EPO		38	41	43	0%	1,396	
Health Net PPO							
Kaiser Permanente HMO							
LA Care HMO		13	18	18	11%	84,750	
Molina Healthcare HMO	2						
Oscar Health Plan EPO			28	21	4%	35,962	
Sharp Health Plan HMO	9	11	9	12	2%	17,335	
Valley Health Plan HMO		22	20	9	2%	16,366	
Western Health Advantage HMO	3	7	2	3	1%	9,386	

Additional Measures Related to Mental Health and Substance Use Disorder Treatment

In Chapter 4: Mental Health and Substance Use Disorder, three QRS measures are presented as potential "Priority Measures." These measures and one additional QRS measure pertaining to Mental Health and Substance Use Disorder are:

Potential Priority Measures

1. Antidepressant Medication Management (Table 16)
2. Follow Up After Hospitalization for Mental Illness (Table 17)
3. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (Table 18)

Additional Measures

4. Follow Up Care for Children Prescribed ADHD Medication (ADD) measure (Table A9)

Covered California is evaluating available behavioral health measures for children as part of its work in finding the right measures for subpopulations.

Follow Up Care for Children Prescribed ADHD Medication (HEDIS)

The Follow Up Care for Children Prescribed ADHD Medication (ADD) measure is the percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported:

1. **Initiation Phase:** The percentage of members 6–12 years of age as of the Index Prescription Start Data (IPSD) with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.
2. **Continuation and Maintenance (CandM) Phase:** The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

Table A9. Follow Up Care for Covered California Children Enrollees Prescribed ADHD Medication (HEDIS)

	2016	2017	2018	2019			
	US Benchmark	US Benchmark	US Benchmark	US Benchmark	Percent of Enrollees	Number of Enrollees	Number of Plans
Plans at 90th Percentile and Above	MN-S	53 +	63 +	51 +	59%	477,683	1
Plans at 50th to 90th Percentile	MN-S	36 to 53	41 to 63	45 to 51	41%	335,176	1
Plans at 25th to 50th Percentile	MN-S	29 to 36	35 to 41	39 to 45	0%	-	0
Plans Below 25th Percentile	MN-S	Below 29	Below 35	Below 39	0%	-	0
Covered California High/Average/Low Performers							
Covered CA Highest Performer		60	63	57			
Covered CA Weighted Average		47	60	53			
Covered CA Lowest Performer		32	58	46			
Covered California Plan-Specific Performance							
Anthem HMO							
Anthem PPO		51					
Anthem EPO							
Blue Shield HMO							
Blue Shield PPO		32	63	46	41%	335,176	
CCHP HMO							
Health Net HMO							
Health Net EPO							
Health Net PPO							
Kaiser Permanente HMO		60	58	57	59%	477,683	
LA Care HMO							
Molina Healthcare HMO							
Oscar Health Plan EPO							
Sharp Health Plan HMO							
Valley Health Plan HMO							
Western Health Advantage HMO							

*M-NS: This measure was not used in determining the overall QRS rating in 2016.

Additional Measures Related to Acute, Chronic and Other Conditions

In Chapter 5: Acute, Chronic and Other Conditions, five QRS measures are presented as potential "Priority Measures." These measures and the 11 additional QRS measures pertaining to Acute, Chronic and Other Conditions are:

Potential Priority Measures

1. Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%) (Table 19)
2. Controlling High Blood Pressure (Table 20)
3. Plan All-Cause Readmissions (Table 21)
4. Access to Care (Table 22)
5. Care Coordination (Table 23)

Additional Measures

6. Proportion of Days Covered (RAS Antagonists) (Table A10)
7. Proportion of Days Covered (Statins) (Table A11)
8. Proportion of Day Covered (Diabetes All Class) (Table A12)
9. Comprehensive Diabetes Care: Eye Exam (Retinal) Performed (Table A13)
10. Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing (Table A14)
11. Comprehensive Diabetes Care: Medical Attention for Nephropathy (Table A15)
12. Medication Management for People with Asthma (75% of Treatment Period) (Table A16)
13. Prenatal and Postpartum Care (Postpartum Care) (Table A17)
14. Prenatal and Postpartum Care (Timeliness of Prenatal Care) (Table A18)
15. Well-Child Visits in the First 15 Months of Life (6 or More Visits) (Table A19)
16. Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (Table A20)

The following proportion of days covered measures track the percentage of patients adhering to their medications for their condition. Once started, adherence to medications long term is important for chronic disease management and to prevent complications. Ideally, adherence or percent of days covered should approach 100 percent, but the measure is met if it was above the 80 percent threshold. Barriers to adherence to medications may include limited knowledge or awareness of long-term treatment goals, adverse side effects, financial barriers, or forgetfulness.

Proportion of Days Covered (RAS Antagonists) (Pharmacy Quality Alliance)

Diabetes is the most common cause of renal failure. Renin Angiotensin System (RAS) Antagonists protect patients against diabetic kidney disease. This drug also treats high blood pressure which is a common co-morbidity for diabetic patients. Patients typically receive a screening test to determine whether or not they need to be prescribed these medications if not already using them for hypertension.

The Pharmacy Quality Alliance (PQA) Proportion of Days Covered RAS Antagonists measure is the percentage of patients 18 years and older who met the proportion of days covered threshold of 80 percent for RAS Antagonists during the measurement period. A higher rate indicates better performance.

Table A10. Proportion of Days Covered (RAS Antagonists) for Covered California Enrollees (PQA)

	2016	2017	2018	2019			
	US Benchmark	US Benchmark	US Benchmark	US Benchmark	Percent of Enrollees	Number of Enrollees	Number of Plans
Plans at 90th Percentile and Above	82 +	83 +	83 +	85 +	1%	16,366	1
Plans at 50th to 90th Percentile	73 to 82	75 to 83	76 to 83	78 to 85	38%	505,031	3
Plans at 25th to 50th Percentile	67 to 73	70 to 75	72 to 76	73 to 78	3%	46,744	3
Plans Below 25th Percentile	Below 67	Below 70	Below 72	Below 73	58%	778,485	6
Covered California High/Average/Low Performers							
Covered CA Highest Performer	81	84	88	87			
Covered CA Weighted Average	67	71	75	74			
Covered CA Lowest Performer	59	59	66	63			
Covered California Plan-Specific Performance							
Anthem HMO	59	62					
Anthem PPO	59	61					
Anthem EPO			67	63	5%	64,031	
Blue Shield HMO	66	76	71	68	7%	93,322	
Blue Shield PPO	65	66	70	70	25%	335,176	
CCHP HMO	79	75	72	79	1%	10,013	
Health Net HMO	59	69	66	72	11%	145,183	
Health Net EPO		65	72	75	0%	1,396	
Health Net PPO							
Kaiser Permanente HMO	81	82	81	81	35%	477,683	
LA Care HMO	68	79	76	73	6%	84,750	
Molina Healthcare HMO	62	59	82	65	4%	56,023	
Oscar Health Plan EPO			79	76	3%	35,962	
Sharp Health Plan HMO	78	79	88	82	1%	17,335	
Valley Health Plan HMO	72	84	79	87	1%	16,366	
Western Health Advantage HMO	68	68	66	74	1%	9,386	

Proportion of Days Covered (Statins)

The PQA Proportion of Days Covered Statins (PDC-STA) measure is the percentage of patients 18 years and older who met the proportion of days covered threshold of 80 percent for statins during the measurement period. Statins are a class of drugs that lower blood cholesterol to prevent cardiovascular disease in patients with diabetes. Almost every diabetic can be on a statin. A higher rate indicates better performance.

Table A11. Proportion of Days Covered (Statins) for Covered California Enrollees (PQA)

	2016	2017	2018	2019			
	US Benchmark	US Benchmark	US Benchmark	US Benchmark	Percent of Enrollees	Number of Enrollees	Number of Plans
Plans at 90th Percentile and Above	77 +	78 +	80 +	82 +	0%	-	0
Plans at 50th to 90th Percentile	67 to 77	69 to 78	71 to 80	72 to 82	41%	557,359	5
Plans at 25th to 50th Percentile	63 to 67	64 to 69	66 to 71	68 to 72	1%	9,386	1
Plans Below 25th Percentile	Below 63	Below 64	Below 66	Below 68	58%	779,881	7
Covered California High/Average/Low Performers							
Covered CA Highest Performer	76	75	85	81			
Covered CA Weighted Average	59	63	68	68			
Covered CA Lowest Performer	48	47	57	51			
Covered California Plan-Specific Performance							
Anthem HMO	49	52					
Anthem PPO	53	55					
Anthem EPO			64	57	5%	64,031	
Blue Shield HMO	48	62	62	60	7%	93,322	
Blue Shield PPO	57	58	63	64	25%	335,176	
CCHP HMO	69	63	61	74	1%	10,013	
Health Net HMO	52	60	57	63	11%	145,183	
Health Net EPO		63	66	66	0%	1,396	
Health Net PPO							
Kaiser Permanente HMO	73	75	75	76	35%	477,683	
LA Care HMO	60	68	67	63	6%	84,750	
Molina Healthcare HMO	52	47	74	51	4%	56,023	
Oscar Health Plan EPO			72	73	3%	35,962	
Sharp Health Plan HMO	76	75	85	79	1%	17,335	
Valley Health Plan HMO	70	75	71	81	1%	16,366	
Western Health Advantage HMO	60	62	61	69	1%	9,386	

Proportion of Days Covered (Diabetes All Class)

The PQA Proportion of Days Covered Diabetes All Class (PDC-DR) measure is the percentage of patients 18 years and older who met the proportion of days covered threshold of 80 percent for diabetes medications during the measurement period. These medications control blood sugar. Nearly every diabetic patient will be prescribed a medication in this group. A higher rate indicates better performance.

Table A12. Proportion of Days Covered (Diabetes All Class) for Covered California Enrollees (PQA)

	2016	2017	2018	2019			
	US Benchmark	US Benchmark	US Benchmark	US Benchmark	Percent of Enrollees	Number of Enrollees	Number of Plans
Plans at 90th Percentile and Above	79 +	79 +	80 +	82 +	2%	26,379	2
Plans at 50th to 90th Percentile	68 to 79	69 to 79	71 to 80	72 to 82	37%	495,018	2
Plans at 25th to 50th Percentile	61 to 68	64 to 69	66 to 71	68 to 72	20%	275,281	4
Plans Below 25th Percentile	Below 61	Below 64	Below 66	Below 68	41%	549,948	5
Covered California High/Average/Low Performers							
Covered CA Highest Performer	77	80	87	86			
Covered CA Weighted Average	63	68	72	71			
Covered CA Lowest Performer	55	50	61	57			
Covered California Plan-Specific Performance							
Anthem HMO	55	60					
Anthem PPO	56	57					
Anthem EPO			63	58	5%	64,031	
Blue Shield HMO	60	59	65	65	7%	93,322	
Blue Shield PPO	60	61	66	66	25%	335,176	
CCHP HMO	77	77	69	86	1%	10,013	
Health Net HMO	57	66	67	71	11%	145,183	
Health Net EPO		50	67	66	0%	1,396	
Health Net PPO							
Kaiser Permanente HMO	77	80	79	78	35%	477,683	
LA Care HMO	66	78	75	71	6%	84,750	
Molina Healthcare HMO	64	56	81	57	4%	56,023	
Oscar Health Plan EPO			76	70	3%	35,962	
Sharp Health Plan HMO	73	74	87	80	1%	17,335	
Valley Health Plan HMO	75	76	76	85	1%	16,366	
Western Health Advantage HMO	64	64	61	71	1%	9,386	

Comprehensive Diabetes Care: Eye Exam (Retinal) Performed

The Comprehensive Diabetes Care: Eye Exam (Retinal) Performed measure is the percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed that screened or monitored for diabetic retinal disease.

Table A13. Comprehensive Diabetes Care: Eye Exam (Retinal) Performed for Covered California Enrollees (HEDIS)

	2016	2017	2018	2019			
	US Benchmark	US Benchmark	US Benchmark	US Benchmark	Percent of Enrollees	Number of Enrollees	Number of Plans
Plans at 90th Percentile and Above	64 +	65 +	65 +	66 +	35%	477,683	1
Plans at 50th to 90th Percentile	43 to 64	45 to 65	48 to 65	49 to 66	22%	302,322	4
Plans at 25th to 50th Percentile	35 to 43	37 to 45	38 to 48	41 to 49	35%	465,232	5
Plans Below 25th Percentile	Below 35	Below 37	Below 38	Below 41	8%	101,389	3
Covered California High/Average/Low Performers							
Covered CA Highest Performer	74	74	74	77			
Covered CA Weighted Average	47	50	53	57			
Covered CA Lowest Performer	34	28	33	29			
Covered California Plan-Specific Performance							
Anthem HMO	38	43					
Anthem PPO	34	37					
Anthem EPO			38	36	5%	64,031	
Blue Shield HMO	37	33	33	46	7%	93,322	
Blue Shield PPO	35	28	37	41	25%	335,176	
CCHP HMO	46	38	44	46	1%	10,013	
Health Net HMO	51	51	52	49	11%	145,183	
Health Net EPO		39	52	29	0%	1,396	
Health Net PPO							
Kaiser Permanente HMO	74	74	74	77	35%	477,683	
LA Care HMO	39	43	48	60	6%	84,750	
Molina Healthcare HMO	41	46	50	51	4%	56,023	
Oscar Health Plan EPO			33	30	3%	35,962	
Sharp Health Plan HMO	51	48	50	48	1%	17,335	
Valley Health Plan HMO	71	67	67	60	1%	16,366	
Western Health Advantage HMO	54	47	52	48	1%	9,386	

Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing

The Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing measure is the percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had a hemoglobin A1c (HbA1c) test.

Table A14. Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing for Covered California Enrollees (HEDIS)

	2016	2017	2018	2019			
	US Benchmark	US Benchmark	US Benchmark	US Benchmark	Percent of Enrollees	Number of Enrollees	Number of Plans
Plans at 90th Percentile and Above	96 +	95 +	95 +			-	0
Plans at 50th to 90th Percentile	92 to 96	92 to 95	92 to 95			-	0
Plans at 25th to 50th Percentile	89 to 92	90 to 92	91 to 92			-	0
Plans Below 25th Percentile	Below 89	Below 90	Below 91			-	0
Covered California High/Average/Low Performers							
Covered CA Highest Performer	96	96	96				
Covered CA Weighted Average	90	91	91				
Covered CA Lowest Performer	87	83	85				
Covered California Plan-Specific Performance							
Anthem HMO	88	91					
Anthem PPO	87	86					
Anthem EPO			86			64,031	
Blue Shield HMO	96	83	92			93,322	
Blue Shield PPO	87	87	85			335,176	
CCHP HMO	89	87	91			10,013	
Health Net HMO	91	90	92			145,183	
Health Net EPO		94	91			1,396	
Health Net PPO							
Kaiser Permanente HMO	96	96	96			477,683	
LA Care HMO	87	91	91			84,750	
Molina Healthcare HMO	90	93	91			56,023	
Oscar Health Plan EPO			93			35,962	
Sharp Health Plan HMO	93	94	95			17,335	
Valley Health Plan HMO	93	88	91			16,366	
Western Health Advantage HMO	96	92	93			9,386	

*This measure was not used in determining the overall QRS rating in 2019.

Comprehensive Diabetes Care: Medical Attention for Nephropathy

The Comprehensive Diabetes Care: Medical Attention for Nephropathy measure is the percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had medical attention for nephropathy through a screening or monitoring test or treatment for nephropathy.

Table A15. Comprehensive Diabetes Care: Medical Attention for Nephropathy for Covered California Enrollees (HEDIS)

	2016	2017	2018	2019			
	US Benchmark	US Benchmark	US Benchmark	US Benchmark	Percent of Enrollees	Number of Enrollees	Number of Plans
Plans at 90th Percentile and Above	94 +	94 +	94 +	95 +	8%	102,085	2
Plans at 50th to 90th Percentile	91 to 94	91 to 94	91 to 94	91 to 95	53%	717,584	4
Plans at 25th to 50th Percentile	89 to 91	88 to 91	89 to 91	89 to 91	14%	182,395	5
Plans Below 25th Percentile	Below 89	Below 88	Below 89	Below 89	26%	344,562	2
Covered California High/Average/Low Performers							
Covered CA Highest Performer	96	95	96	95			
Covered CA Weighted Average	90	92	92	91			
Covered CA Lowest Performer	86	83	86	88			
Covered California Plan-Specific Performance							
Anthem HMO	90	92					
Anthem PPO	87	88					
Anthem EPO			89	89	5%	64,031	
Blue Shield HMO	92	83	89	94	7%	93,322	
Blue Shield PPO	86	89	87	88	25%	335,176	
CCHP HMO	90	90	91	89	1%	10,013	
Health Net HMO	92	93	95	94	11%	145,183	
Health Net EPO		92	86	91	0%	1,396	
Health Net PPO							
Kaiser Permanente HMO	94	94	94	93	35%	477,683	
LA Care HMO	90	94	94	95	6%	84,750	
Molina Healthcare HMO	93	93	93	90	4%	56,023	
Oscar Health Plan EPO			94	90	3%	35,962	
Sharp Health Plan HMO	96	95	96	95	1%	17,335	
Valley Health Plan HMO	89	89	89	90	1%	16,366	
Western Health Advantage HMO	92	92	91	88	1%	9,386	

Medication Management for People with Asthma (75% of Treatment Period)

The Medication Management for People with Asthma (75% of Treatment Period) measure is percentage of members 5–64 years of age during the measurement year who were identified as having persistent asthma and who remained on an asthma controller medication for at least 75% of their treatment period.

Table A16. Medication Management for Covered California Enrollees with Asthma (75% of Treatment Period) (HEDIS)

	2016	2017	2018	2019			
	US Benchmark	US Benchmark	US Benchmark	US Benchmark	Percent of Enrollees	Number of Enrollees	Number of Plans
Plans at 90th Percentile and Above	MN-S	63 +	67 +	68 +	0%	-	0
Plans at 50th to 90th Percentile	MN-S	53 to 63	56 to 67	57 to 68	2%	26,721	2
Plans at 25th to 50th Percentile	MN-S	48 to 53	49 to 56	51 to 57	18%	229,933	2
Plans Below 25th Percentile	MN-S	Below 48	Below 49	Below 51	80%	1,026,235	5
Covered California High/Average/Low Performers							
Covered CA Highest Performer	65	64	78	62			
Covered CA Weighted Average	49	49	51	50			
Covered CA Lowest Performer	44	44	47	38			
Covered California Plan-Specific Performance							
Anthem HMO	44	44					
Anthem PPO	51	44					
Anthem EPO			50	45	5%	64,031	
Blue Shield HMO				49	7%	93,322	
Blue Shield PPO	45	46	50	50	26%	335,176	
CCHP HMO							
Health Net HMO	65	57	47	52	11%	145,183	
Health Net EPO							
Health Net PPO							
Kaiser Permanente HMO	46	48	49	50	37%	477,683	
LA Care HMO			78	53	7%	84,750	
Molina Healthcare HMO			49	38	4%	56,023	
Oscar Health Plan EPO							
Sharp Health Plan HMO	54	64	68	62	1%	17,335	
Valley Health Plan HMO							
Western Health Advantage HMO			49	58	1%	9,386	

Prenatal and Postpartum Care: Postpartum Care

The Prenatal and Postpartum Care: Postpartum Care measure is the percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.

Table A17. Prenatal and Postpartum Care: Postpartum Care for Covered California Enrollees (HEDIS)

	2016	2017	2018	2019			
	US Benchmark	US Benchmark	US Benchmark	US Benchmark	Percent of Enrollees	Number of Enrollees	Number of Plans
Plans at 90th Percentile and Above	86 +	87 +	87 +	88 +	36%	477,683	1
Plans at 50th to 90th Percentile	70 to 86	74 to 87	75 to 87	74 to 88	1%	17,335	1
Plans at 25th to 50th Percentile	60 to 70	65 to 74	65 to 75	66 to 74	23%	303,350	4
Plans Below 25th Percentile	Below 60	Below 65	Below 65	Below 66	39%	520,483	4
Covered California High/Average/Low Performers							
Covered CA Highest Performer	88	87	87	88			
Covered CA Weighted Average	73	72	73	73			
Covered CA Lowest Performer	38	59	43	59			
Covered California Plan-Specific Performance							
Anthem HMO	61	66					
Anthem PPO	71	75					
Anthem EPO			76	70	5%	64,031	
Blue Shield HMO			43	62	7%	93,322	
Blue Shield PPO	71	63	68	63	25%	335,176	
CCHP HMO	65						
Health Net HMO	64	59	70	66	11%	145,183	
Health Net EPO							
Health Net PPO							
Kaiser Permanente HMO	88	87	87	88	36%	477,683	
LA Care HMO	38		63	69	6%	84,750	
Molina Healthcare HMO	60	67	61	59	4%	56,023	
Oscar Health Plan EPO			71	65	3%	35,962	
Sharp Health Plan HMO	78	80	78	83	1%	17,335	
Valley Health Plan HMO							
Western Health Advantage HMO		79	72	67	1%	9,386	

Prenatal and Postpartum Care: Timeliness of Prenatal Care

The Prenatal and Postpartum Care: Timeliness of Prenatal Care measure is the percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester, on the enrollment start date or within 42 days of enrollment in the organization.

Table A18. Prenatal and Postpartum Care: Timeliness of Prenatal Care for Covered California Enrollees (HEDIS)

	2016	2017	2018	2019			
	US Benchmark	US Benchmark	US Benchmark	US Benchmark	Percent of Enrollees	Number of Enrollees	Number of Plans
Plans at 90th Percentile and Above	93 +	96 +	95 +	95 +	36%	477,683	1
Plans at 50th to 90th Percentile	81 to 93	85 to 96	84 to 95	85 to 95	24%	311,299	4
Plans at 25th to 50th Percentile	71 to 81	76 to 85	76 to 84	77 to 85	33%	437,884	3
Plans Below 25th Percentile	Below 71	Below 76	Below 76	Below 77	7%	91,985	2
Covered California High/Average/Low Performers							
Covered CA Highest Performer	96	96	96	96			
Covered CA Weighted Average	85	85	86	88			
Covered CA Lowest Performer	47	74	52	73			
Covered California Plan-Specific Performance							
Anthem HMO	77	87					
Anthem PPO	85	90					
Anthem EPO			88	86	5%	64,031	
Blue Shield HMO			52	78	7%	93,322	
Blue Shield PPO	83	76	83	84	25%	335,176	
CCHP HMO	87						
Health Net HMO	79	87	85	88	11%	145,183	
Health Net EPO							
Health Net PPO							
Kaiser Permanente HMO	96	96	96	96	36%	477,683	
LA Care HMO	47		80	88	6%	84,750	
Molina Healthcare HMO	60	74	71	73	4%	56,023	
Oscar Health Plan EPO			84	74	3%	35,962	
Sharp Health Plan HMO	93	92	94	92	1%	17,335	
Valley Health Plan HMO							
Western Health Advantage HMO		81	83	78	1%	9,386	

Well-Child Visits in the First 15 Months of Life (6 or More Visits)

The Well-Child Visits in the First 15 Months of Life (6 or More Visits) measure is the percentage of members who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life.

Table A19. Well-Child Visits in the First 15 Months of Life (6 or More Visits) for Covered California Enrollees (HEDIS)

	2016	2017	2018	2019			
	US Benchmark	US Benchmark	US Benchmark	US Benchmark	Percent of Enrollees	Number of Enrollees	Number of Plans
Plans at 90th Percentile and Above	MN-S	88 +	87 +	89 +	0%	-	0
Plans at 50th to 90th Percentile	MN-S	78 to 88	77 to 87	75 to 89	42%	477,683	1
Plans at 25th to 50th Percentile	MN-S	68 to 78	67 to 77	66 to 75	30%	335,176	1
Plans Below 25th Percentile	MN-S	Below 68	Below 67	Below 66	28%	319,871	4
Covered California High/Average/Low Performers							
Covered CA Highest Performer	92	89	87	87			
Covered CA Weighted Average	57	69	70	72			
Covered CA Lowest Performer	20	33	28	36			
Covered California Plan-Specific Performance							
Anthem HMO							
Anthem PPO	51	67					
Anthem EPO			65	62	6%	64,031	
Blue Shield HMO				64	8%	93,322	
Blue Shield PPO	50	64	68	72	30%	335,176	
CCHP HMO							
Health Net HMO	20	33	28	36	13%	145,183	
Health Net EPO							
Health Net PPO							
Kaiser Permanente HMO	92	89	87	87	42%	477,683	
LA Care HMO							
Molina Healthcare HMO							
Oscar Health Plan EPO							
Sharp Health Plan HMO	33	59	53	66	2%	17,335	
Valley Health Plan HMO							
Western Health Advantage HMO							

*M-NS: This measure was not used in determining the overall QRS rating in 2016.

Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

The Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life measure is the percentage of members 3–6 years of age who had one or more well-child visits with a PCP during the measurement year.

Table A20. Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life for Covered California Enrollees (HEDIS)

	2016	2017	2018	2019			
	US Benchmark	US Benchmark	US Benchmark	US Benchmark	Percent of Enrollees	Number of Enrollees	Number of Plans
Plans at 90th Percentile and Above	86 +	88 +	89 +	88 +	0%	-	0
Plans at 50th to 90th Percentile	75 to 86	76 to 88	75 to 89	76 to 88	36%	477,683	1
Plans at 25th to 50th Percentile	65 to 75	66 to 76	68 to 75	68 to 76	35%	473,223	4
Plans Below 25th Percentile	Below 65	Below 66	Below 68	Below 68	29%	384,311	6
Covered California High/Average/Low Performers							
Covered CA Highest Performer	79	85	81	79			
Covered CA Weighted Average	69	71	74	73			
Covered CA Lowest Performer	46	57	61	50			
Covered California Plan-Specific Performance							
Anthem HMO	64	66					
Anthem PPO	68	68					
Anthem EPO			69	63	5%	64,031	
Blue Shield HMO	59	64	61	65	7%	93,322	
Blue Shield PPO	68	70	73	74	25%	335,176	
CCHP HMO							
Health Net HMO	59	67	72	66	11%	145,183	
Health Net EPO		85	74				
Health Net PPO							
Kaiser Permanente HMO	79	79	81	79	36%	477,683	
LA Care HMO	46	57	66	75	6%	84,750	
Molina Healthcare HMO		66	66	58	4%	56,023	
Oscar Health Plan EPO			69	74	3%	35,962	
Sharp Health Plan HMO	71	68	69	75	1%	17,335	
Valley Health Plan HMO				50	1%	16,366	
Western Health Advantage HMO	72	57	65	66	1%	9,386	

Additional Measures Related to Promotion of Effective Primary Care

In Chapter 7: Promotion of Effective Primary Care, Covered California does not indicate any potential "Priority Measures." The two additional QRS measures pertaining to the Promotion of Effective Primary Care are:

Additional Measures

1. Rating of Personal Doctor (Table A21)
2. Rating of Specialist (Table A22)

Rating of Personal Doctor

The Rating of Person Doctor measure indicates enrollee experience related to the rating of personal doctor QHP Enrollee Survey question.

Table A21: Covered California Enrollees Rating of Personal Doctor (CAHPS)

	2016	2017	2018	2019			
	US Benchmark	US Benchmark	US Benchmark	US Benchmark	Percent of Enrollees	Number of Enrollees	Number of Plans
Plans at 90th Percentile and Above	91 +	92 +	91 +	90 +	0%	-	0
Plans at 50th to 90th Percentile	89 to 91	89 to 92	89 to 91	87 to 90	8%	110,657	2
Plans at 25th to 50th Percentile	88 to 89	88 to 89	88 to 89	86 to 87	3%	35,962	1
Plans Below 25th Percentile	Below 88	Below 88	Below 88	Below 86	89%	1,198,611	9
Covered California High/Average/Low Performers							
Covered CA Highest Performer	91	93	92	88			
Covered CA Weighted Average	88	87	90	85			
Covered CA Lowest Performer	79	85	81	83			
Covered California Plan-Specific Performance							
Anthem HMO		85					
Anthem PPO	87	90					
Anthem EPO				84	5%	64,031	
Blue Shield HMO				88	7%	93,322	
Blue Shield PPO	90	89	92	85	25%	335,176	
CCHP HMO	82	85	87	84	1%	10,013	
Health Net HMO	81	85	85	83	11%	145,183	
Health Net EPO		89					
Health Net PPO							
Kaiser Permanente HMO	91	87	92	86	36%	477,683	
LA Care HMO	88	89	87	83	6%	84,750	
Molina Healthcare HMO	79	85	81	83	4%	56,023	
Oscar Health Plan EPO			87	87	3%	35,962	
Sharp Health Plan HMO	91	93	88	87	1%	17,335	
Valley Health Plan HMO	84	87	85	84	1%	16,366	
Western Health Advantage HMO	90	89	89	85	1%	9,386	

The Rating of Specialist measure indicates enrollee experience related to the rating of specialist seen most often QHP Enrollee Survey question.

Table A22: Covered California Enrollees Rating of Specialist (CAHPS)

	2016	2017	2018	2019			
	US Benchmark	US Benchmark	US Benchmark	US Benchmark	Percent of Enrollees	Number of Enrollees	Number of Plans
Plans at 90th Percentile and Above	89 +	90 +	90 +	87 +	0%	-	0
Plans at 50th to 90th Percentile	87 to 89	88 to 90	87 to 90	85 to 87	2%	9,386	1
Plans at 25th to 50th Percentile	86 to 87	87 to 88	85 to 87	84 to 85	3%	17,335	1
Plans Below 25th Percentile	Below 86	Below 87	Below 85	Below 84	95%	562,433	2
Covered California High/Average/Low Performers							
Covered CA Highest Performer	88	90	83	86			
Covered CA Weighted Average	85	87	82	81			
Covered CA Lowest Performer	82	81	82	81			
Covered California Plan-Specific Performance							
Anthem HMO							
Anthem PPO							
Anthem EPO							
Blue Shield HMO							
Blue Shield PPO							
CCHP							
Health Net HMO	82	81	82				
Health Net EPO		90					
Health Net PPO							
Kaiser	86	90		81	81%	477,683	
LA Care				83	14%	84,750	
Molina							
Oscar			83				
Sharp	88			85	3%	17,335	
Valley							
Western Health Advantage	87			86	2%	9,386	

Additional Measures Related to Appropriate Interventions

In Chapter 10: Appropriate Interventions, Covered California does not indicate any potential "Priority Measures." The six additional QRS measures pertaining to Appropriate Interventions are:

Additional Measures

1. Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (Table A23)
2. Appropriate Testing for Children with Pharyngitis (CWP) (Table A24)
3. Appropriate Treatment for Children with Upper Respiratory Infection (URI) (Table A25)
4. Use of Imaging Studies for Low Back Pain (Table A26)
5. Annual Monitoring for Patients on Persistent Medications (Table A270
6. Access to Information (A28)

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis

The HEDIS Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis measure assesses adults 18–64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription. A higher rate represents better performance.

Table A23. Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis for Covered California Enrollees (HEDIS)

	2016	2017	2018	2019			
	US Benchmark	US Benchmark	US Benchmark	US Benchmark	Percent of Enrollees	Number of Enrollees	Number of Plans
Plans at 90th Percentile and Above	MN-S	44 +	47 +	48 +	38%	505,031	3
Plans at 50th to 90th Percentile	MN-S	26 to 44	28 to 47	30 to 48	8%	101,371	3
Plans at 25th to 50th Percentile	MN-S	21 to 26	24 to 28	24 to 30	47%	637,712	4
Plans Below 25th Percentile	MN-S	Below 21	Below 24	Below 24	8%	101,116	2
Covered California High/Average/Low Performers							
Covered CA Highest Performer	49	52	59	59			
Covered CA Weighted Average	31	35	37	38			
Covered CA Lowest Performer	23	24	25	21			
Covered California Plan-Specific Performance							
Anthem HMO	29	26					
Anthem PPO	23	28					
Anthem EPO			32	27	5%	64,031	
Blue Shield HMO			35	29	7%	93,322	
Blue Shield PPO	27	27	28	29	25%	335,176	
CCHP HMO	36	39	52	59	1%	10,013	
Health Net HMO	28	24	25	29	11%	145,183	
Health Net EPO							
Health Net PPO							
Kaiser Permanente HMO	47	44	49	53	36%	477,683	
LA Care HMO	33	27	35	24	6%	84,750	
Molina Healthcare HMO		42	31	34	4%	56,023	
Oscar Health Plan EPO				31	3%	35,962	
Sharp Health Plan HMO	49	52	59	53	1%	17,335	
Valley Health Plan HMO				21	1%	16,366	
Western Health Advantage HMO		44	43	40	1%	9,386	

*M-NS: This measure was not used in determining the overall QRS rating in 2016.

Appropriate Testing for Children with Pharyngitis

The HEDIS Appropriate Testing for Children with Pharyngitis measure assesses children 2–18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus test for the episode. A higher rate represents better performance.

Table A24. Appropriate Testing for Children with Pharyngitis for Covered California Enrollees (HEDIS)

	2016	2017	2018	2019			
	US Benchmark	US Benchmark	US Benchmark	US Benchmark	Percent of Enrollees	Number of Enrollees	Number of Plans
Plans at 90th Percentile and Above	93 +	94 +	94 +	95 +	0%	-	0
Plans at 50th to 90th Percentile	81 to 93	84 to 94	88 to 94	87 to 95	42%	495,018	2
Plans at 25th to 50th Percentile	72 to 81	76 to 84	79 to 88	80 to 87	0%	-	0
Plans Below 25th Percentile	Below 72	Below 76	Below 79	Below 80	58%	693,735	5
Covered California High/Average/Low Performers							
Covered CA Highest Performer	95	94	94	93			
Covered CA Weighted Average	71	79	83	79			
Covered CA Lowest Performer	37	55	69	42			
Covered California Plan-Specific Performance							
Anthem HMO							
Anthem PPO	65	72					
Anthem EPO			71	70	5%	64,031	
Blue Shield HMO				70	8%	93,322	
Blue Shield PPO	72	73	78	78	28%	335,176	
CCHP HMO							
Health Net HMO	37	55	69	55	12%	145,183	
Health Net EPO							
Health Net PPO							
Kaiser Permanente HMO	95	94	94	93	40%	477,683	
LA Care HMO							
Molina Healthcare HMO				42	5%	56,023	
Oscar Health Plan EPO							
Sharp Health Plan HMO			92	92	1%	17,335	
Valley Health Plan HMO							
Western Health Advantage HMO							

Appropriate Treatment for Children with Upper Respiratory Infection

The HEDIS Appropriate Treatment for Children with Upper Respiratory Infection measure assesses children 3 months–18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription. A higher rate indicates appropriate treatment of children with URI.

Table A25. Appropriate Treatment for Children with Upper Respiratory Infection for Covered California Enrollees (HEDIS)

	2016	2017	2018	2019			
	US Benchmark	US Benchmark	US Benchmark	US Benchmark	Percent of Enrollees	Number of Enrollees	Number of Plans
Plans at 90th Percentile and Above	96 +	96 +	97 +	97 +	39%	513,645	2
Plans at 50th to 90th Percentile	89 to 96	89 to 96	90 to 97	92 to 97	6%	81,366	2
Plans at 25th to 50th Percentile	82 to 89	84 to 89	84 to 90	86 to 92	55%	714,454	5
Plans Below 25th Percentile	Below 82	Below 84	Below 84	Below 86	0%	-	0
Covered California High/Average/Low Performers							
Covered CA Highest Performer	98	99	98	100			
Covered CA Weighted Average	92	93	93	94			
Covered CA Lowest Performer	88	89	83	87			
Covered California Plan-Specific Performance							
Anthem HMO							
Anthem PPO	89	89					
Anthem EPO			93	94	5%	64,031	
Blue Shield HMO			86	91	7%	93,322	
Blue Shield PPO	91	90	91	91	26%	335,176	
CCHP HMO							
Health Net HMO	88	89	88	87	11%	145,183	
Health Net EPO							
Health Net PPO							
Kaiser Permanente HMO	98	99	98	99	36%	477,683	
LA Care HMO			87	90	6%	84,750	
Molina Healthcare HMO			83	88	4%	56,023	
Oscar Health Plan EPO				100	3%	35,962	
Sharp Health Plan HMO	98	92	97	96	1%	17,335	
Valley Health Plan HMO							
Western Health Advantage HMO			94				

Use of Imaging Studies for Low Back Pain

The HEDIS Use of Imaging Studies for Low Back Pain measure assesses adults 18–50 years of age with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI or CT scan) within 28 days of the diagnosis. A higher rate represents better performance.

Table A26: Use of Imaging Studies for Low Back Pain for Covered California Enrollees (HEDIS)

	2016	2017	2018	2019			
	US Benchmark	US Benchmark	US Benchmark	US Benchmark	Percent of Enrollees	Number of Enrollees	Number of Plans
Plans at 90th Percentile and Above	84 +	84 +	86 +	86 +	1%	19,399	2
Plans at 50th to 90th Percentile	75 to 84	74 to 84	76 to 86	77 to 86	80%	1,074,401	6
Plans at 25th to 50th Percentile	70 to 75	69 to 74	72 to 76	72 to 77	8%	110,657	2
Plans Below 25th Percentile	Below 70	Below 69	Below 72	Below 72	10%	140,773	2
Covered California High/Average/Low Performers							
Covered CA Highest Performer	88	88	84	91			
Covered CA Weighted Average	80	79	79	80			
Covered CA Lowest Performer	69	69	67	71			
Covered California Plan-Specific Performance							
Anthem HMO	74	69					
Anthem PPO	76	73					
Anthem EPO			77	78	5%	64,031	
Blue Shield HMO			76	77	7%	93,322	
Blue Shield PPO	78	83	82	81	25%	335,176	
CCHP HMO	69	82	67	91	1%	10,013	
Health Net HMO	78	69	73	77	11%	145,183	
Health Net EPO							
Health Net PPO							
Kaiser Permanente HMO	88	83	82	85	36%	477,683	
LA Care HMO	73	74	76	71	6%	84,750	
Molina Healthcare HMO	86	76	74	72	4%	56,023	
Oscar Health Plan EPO			84	80	3%	35,962	
Sharp Health Plan HMO	74	72	72	73	1%	17,335	
Valley Health Plan HMO			72	78	1%	16,366	
Western Health Advantage HMO		88	77	87	1%	9,386	

Annual Monitoring for Patients on Persistent Medications

The Annual Monitoring for Patients on Persistent Medications measure is the percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year.

Table A27. Annual Monitoring for Patients on Persistent Medications for Covered California Enrollees (HEDIS)

	2016	2017	2018	2019			
	US Benchmark	US Benchmark	US Benchmark	US Benchmark	Percent of Enrollees	Number of Enrollees	Number of Plans
Plans at 90th Percentile and Above	89 +	89 +	89 +	89 +	1%	16,366	1
Plans at 50th to 90th Percentile	84 to 89	84 to 89	84 to 89	84 to 89	57%	763,639	4
Plans at 25th to 50th Percentile	81 to 84	81 to 84	81 to 84	82 to 84	33%	445,833	3
Plans Below 25th Percentile	Below 81	Below 81	Below 81	Below 82	9%	120,788	5
Covered California High/Average/Low Performers							
Covered CA Highest Performer	88	89	90	89			
Covered CA Weighted Average	84	85	85	85			
Covered CA Lowest Performer	77	75	77	76			
Covered California Plan-Specific Performance							
Anthem HMO	84	85					
Anthem PPO	80	80					
Anthem EPO			80	81	5%	64,031	
Blue Shield HMO	84	89	85	83	7%	93,322	
Blue Shield PPO	82	82	82	83	25%	335,176	
CCHP HMO	86	84	85	82	1%	10,013	
Health Net HMO	87	86	87	87	11%	145,183	
Health Net EPO		77	77	76	0%	1,396	
Health Net PPO							
Kaiser Permanente HMO	88	87	88	88	35%	477,683	
LA Care HMO	77	86	86	89	6%	84,750	
Molina Healthcare HMO	83	89	86	84	4%	56,023	
Oscar Health Plan EPO			83	77	3%	35,962	
Sharp Health Plan HMO	88	89	88	82	1%	17,335	
Valley Health Plan HMO	82	85	90	89	1%	16,366	
Western Health Advantage HMO	83	75	80	79	1%	9,386	

Access to Information

The Access to Information measure describes enrollee experience related to the following:

- Written materials or Internet provided information needed about how plan works;
- Found out from health plan about cost for health care service or equipment; and
- Found out from health plan about cost for specific prescriptions.

Table A28: for Covered California Enrollees' Access to Information (CAHPS)

	2016	2017	2018	2019			
	US Benchmark	US Benchmark	US Benchmark	US Benchmark	Percent of Enrollees	Number of Enrollees	Number of Plans
Plans at 90th Percentile and Above	62 +	64 +	63 +	54 +	0%	-	0
Plans at 50th to 90th Percentile	55 to 62	57 to 64	58 to 63	48 to 54	74%	992,719	10
Plans at 25th to 50th Percentile	52 to 55	54 to 57	54 to 58	44 to 48	26%	352,511	2
Plans Below 25th Percentile	Below 52	Below 54	Below 54	Below 44	0%	-	0
Covered California High/Average/Low Performers							
Covered CA Highest Performer	59	61	61	53			
Covered CA Weighted Average	51	59	60	50			
Covered CA Lowest Performer	46	46	60	46			
Covered California Plan-Specific Performance							
Anthem HMO							
Anthem PPO		55					
Anthem EPO				50	5%	64,031	
Blue Shield HMO				50	7%	93,322	
Blue Shield PPO	46			46	25%	335,176	
CCHP HMO				50	1%	10,013	
Health Net HMO	52	61		51	11%	145,183	
Health Net EPO		51					
Health Net PPO							
Kaiser Permanente HMO	56	59	60	53	36%	477,683	
LA Care HMO	54			50	6%	84,750	
Molina Healthcare HMO				49	4%	56,023	
Oscar Health Plan EPO			61	53	3%	35,962	
Sharp Health Plan HMO	55			46	1%	17,335	
Valley Health Plan HMO		46		51	1%	16,366	
Western Health Advantage HMO	59	52		48	1%	9,386	

Additional Measures

Plan Administration

The Plan Administration measure (Table A 29) describes enrollee experience related to the following:

- Customer service gave necessary information/help;
- Customer service staff courteous and respectful;
- Wait-time to talk to customer service took longer than expected;
- Forms were easy to fill out; and
- Health plan explained purpose of forms.

Table A29: Plan Administration for Covered California Enrollees (CAHPS)

	2016	2017	2018	2019			
	US Benchmark	US Benchmark	US Benchmark	US Benchmark	Percent of Enrollees	Number of Enrollees	Number of Plans
Plans at 90th Percentile and Above	77 +	79 +	79 +	76 +	4%	35,962	1
Plans at 50th to 90th Percentile	70 to 77	73 to 79	74 to 79	70 to 76	49%	495,018	2
Plans at 25th to 50th Percentile	66 to 70	68 to 73	71 to 74	67 to 70	25%	252,116	4
Plans Below 25th Percentile	Below 66	Below 68	Below 71	Below 67	22%	226,958	4
Covered California High/Average/Low Performers							
Covered CA Highest Performer	79	81	80	78			
Covered CA Weighted Average	74	71	74	70			
Covered CA Lowest Performer	65	67	65	64			
Covered California Plan-Specific Performance							
Anthem HMO		68					
Anthem PPO							
Anthem EPO				69	6%	64,031	
Blue Shield HMO				69	9%	93,322	
Blue Shield PPO							
CCHP HMO	68	76	75	69	1%	10,013	
Health Net HMO	69	72	65	64	14%	145,183	
Health Net EPO		67					
Health Net PPO							
Kaiser Permanente HMO	76	70	77	73	47%	477,683	
LA Care HMO	70	75	73	70	8%	84,750	
Molina Healthcare HMO	75	71		66	6%	56,023	
Oscar Health Plan EPO			80	78	4%	35,962	
Sharp Health Plan HMO	77	81		71	2%	17,335	
Valley Health Plan HMO	65	67		67	2%	16,366	
Western Health Advantage HMO	79	79		67	1%	9,386	

Appendix 3: 2019 Marketplace Quality Rating System Measure Set

2019 Quality Rating System Measure Set

The global quality rating is a roll-up of three summary components per the following weighting:

Summary Components	Weights
Getting Right Care (HEDIS)	66%
Members' Care Experience (CAHPS)	17%
Plan Services (HEDIS and CAHPS)	17%

The QRS measure set is listed below indicating which measures are included in the three summary components, the measure type and the measure source.

QRS Summary Component	Measure Title	QRS Measure Type	Measurement Source
Getting the Right Care	Adult BMI Assessment	Clinical	HEDIS
	Annual Dental Visit	Clinical	HEDIS
	Annual Monitoring for Patients on Persistent Medications	Clinical	HEDIS
	Antidepressant Medication Management	Clinical	HEDIS
	Breast Cancer Screening	Clinical	HEDIS
	Cervical Cancer Screening	Clinical	HEDIS
	Childhood Immunization Status (Combination 3)	Clinical	HEDIS
	Chlamydia Screening in Women	Clinical	HEDIS
	Colorectal Cancer Screening	Clinical	HEDIS
	Comprehensive Diabetes Care: Eye Exam (Retinal) Performed	Clinical	HEDIS
	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)	Clinical	HEDIS
	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing	Clinical	HEDIS
	Comprehensive Diabetes Care: Medical Attention for Nephropathy	Clinical	HEDIS
	Controlling High Blood Pressure	Clinical	HEDIS
	Flu Vaccinations for Adults Ages 18-64	Survey	QHP Enrollee Survey[96]
	Follow-Up After Hospitalization for Mental Illness (7-Day Follow-Up)	Clinical	HEDIS
	Follow-Up Care for Children Prescribed ADHD Medication	Clinical	HEDIS
	Immunizations for Adolescents (Combination 2)	Clinical	HEDIS
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Clinical	HEDIS
	Medication Management for People with Asthma (75% of Treatment Period)	Clinical	HEDIS

[96] The QHP Enrollee Survey draws heavily from the CAHPS® Health Plan Surveys, which are used widely to assess Medicare, Medicaid, and other commercial health plan performance.

QRS Summary Component	Measure Title	QRS Measure Type	Measurement Source
	Medical Assistance with Smoking and Tobacco Use Cessation	Survey	QHP Enrollee Survey
	Plan All-Cause Readmissions	Clinical	HEDIS
	Prenatal and Postpartum Care (Postpartum Care)	Clinical	HEDIS
	Prenatal and Postpartum Care (Timeliness of Prenatal Care)	Clinical	HEDIS
	Proportion of Days Covered (RAS Antagonists)	Clinical	Pharmacy Quality Alliance (PQA)
	Proportion of Days Covered (Statins)	Clinical	PQA
	Proportion of Days Covered (Diabetes All Class)	Clinical	PQA
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Clinical	HEDIS
	Well-Child Visits in the First 15 Months of Life (6 or More Visits)	Clinical	HEDIS
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Clinical	HEDIS
Member Experience with Their Doctors and Care	Access to Care	Survey	QHP Enrollee Survey
	Care Coordination	Survey	QHP Enrollee Survey
	Rating of All Health Care	Survey	QHP Enrollee Survey
	Rating of Personal Doctor	Survey	QHP Enrollee Survey
	Rating of Specialist	Survey	QHP Enrollee Survey
Plan management of care and customer service	Appropriate Testing for Children with Pharyngitis	Clinical	HEDIS
	Appropriate Treatment for Children with Upper Respiratory Infection	Clinical	HEDIS
	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Clinical	HEDIS
	Use of Imaging Studies for Low Back Pain	Clinical	HEDIS
	Access to Information	Survey	QHP Enrollee Survey
	Plan Administration	Survey	QHP Enrollee Survey
	Rating of Health Plan	Survey	QHP Enrollee Survey

Source: Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2019

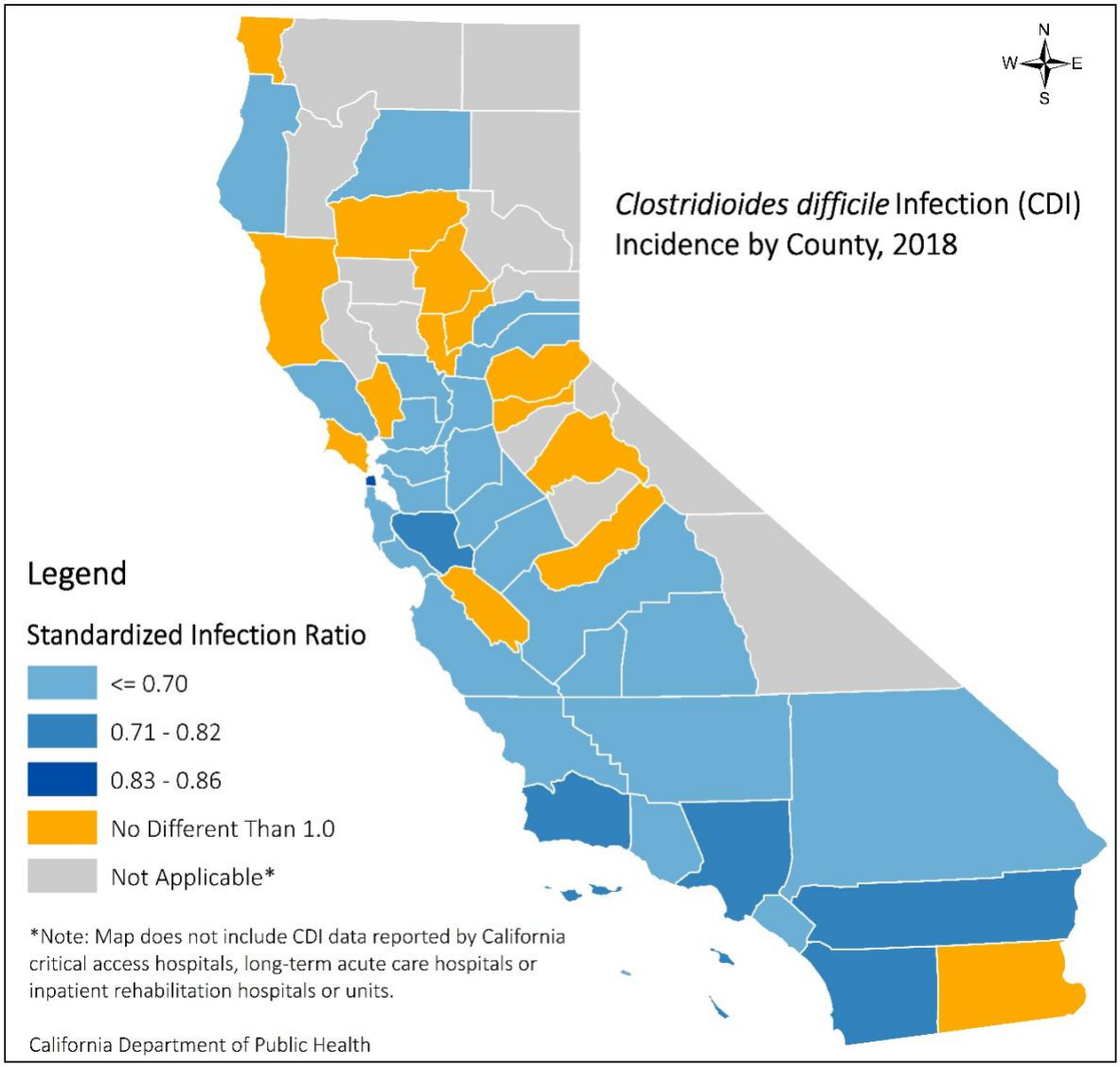
Appendix 4: Additional Publicly Reported Hospital Quality and Safety Data

CDI Incidence Rates in California Counties

Clostridioides difficile (CDI) is a bacterium that causes diarrhea and inflammation of the colon. It can be spread by healthcare workers and patients when they come in contact with contaminated surfaces. Because CDI can spread quickly among hospitals, clinics and nursing facilities, it is important to understand the infection rates by counties to inform prevention efforts.

The graphic below shows California counties' CDI incidence rates for 2018 presented as significantly lower, higher, or no different compared with the national baseline standardized infection ratio of 1.0.

Figure A1: CDI Incidence Rates in California, 2018



Source: California Department of Public Health (CDPH), November 2019

California Hospitals with Hospital Associated Infection Incidence Better (★) or Worse (x) than National Baseline, 2018

Hospitals by County	CDI	CLABSI	MRSA BSI	VRE BSI
Alameda				
Alameda Hospital		✖		
Alta Bates Summit Medical Center	★			
Alta Bates Summit Medical Center, Alta Bates Campus	★			
Eden Medical Center	★			
Highland Hospital	★			
Kaiser Foundation Hospital, Oakland/Richmond	★			★
Kaiser Foundation Hospital, San Leandro	★			
St Rose Hospital	★			
Butte				
Enloe Medical Center, Esplanade		★		
Contra Costa				
Contra Costa Regional Medical Center	★			
John Muir Medical Center, Concord Campus	★			
John Muir Medical Center, Walnut Creek Campus	★			
Kaiser Foundation Hospital, Antioch	★			
Kaiser Foundation Hospital, Walnut Creek		★		
Sutter Delta Medical Center	★			
El Dorado				
Barton Memorial Hospital	✖			
Marshall Medical Center		★		
Fresno				
Clovis Community Medical Center	★			
Community Regional Medical Center	★			
Saint Agnes Medical Center	★			
Humboldt				
St. Joseph Hospital, Eureka	★			
Kern				
Adventist Health Bakersfield	★			
Kern Medical Center	★			
Mercy Southwest Hospital	★			
Kings				
Adventist Health Hanford	★	★		
Los Angeles				
Adventist Health Glendale	★			
Adventist Health White Memorial	★			
Alhambra Hospital Medical Center	★			
Antelope Valley Hospital	★			

Hospitals by County	CDI	CLABSI	MRSA BSI	VRE BSI
California Hospital Medical Center, Los Angeles	★			
Cedars-Sinai Medical Center	★	★		
Centinela Hospital Medical Center	★	★	✖	
Children's Hospital Los Angeles	✖	★	★	
City of Hope Helford Clinical Research Hospital	✖			✖
College Medical Center	★			
Emanate Health Foothill Presbyterian Hospital		★	✖	
Emanate Health Inter-Community Hospital		★		
Emanate Health Queen of the Valley Hospital	★	★		
Encino Hospital Medical Center	★			
Garfield Medical Center	★	✖		✖
Glendale Memorial Hospital and Health Center	★			
Glendora Community Hospital	★			
Henry Mayo Newhall Hospital	★			
Hollywood Presbyterian Medical Center	★	✖		
Huntington Memorial Hospital		★		
Kaiser Foundation Hospital, Downey			★	
Kaiser Foundation Hospital, Los Angeles	★	✖		
Kaiser Foundation Hospital, Panorama City	★			
Kaiser Foundation Hospital, South Bay	★	★		
Kaiser Foundation Hospital, West LA		✖		
Keck Hospital of USC			★	
LAC/Harbor UCLA Medical Center	★			
LAC/Olive View UCLA Medical Center	★			
LAC+USC Medical Center	★	✖		
Martin Luther King Jr. Community Hospital	★			
Methodist Hospital of Southern California			★	
Mission Community Hospital	★			
Monterey Park Hospital			✖	
Northridge Hospital Medical Center	★			
Olympia Medical Center	★	✖	✖	
Pacifica Hospital of the Valley		✖		
PIH Health Hospital, Whittier	★			
Pomona Valley Hospital Medical Center	★			
Providence Holy Cross Medical Center	★			
Providence Little Company of Mary Medical Center Torrance	★	★	★	
Providence Saint John's Health Center		★		
Providence Saint Joseph Medical Center	★			

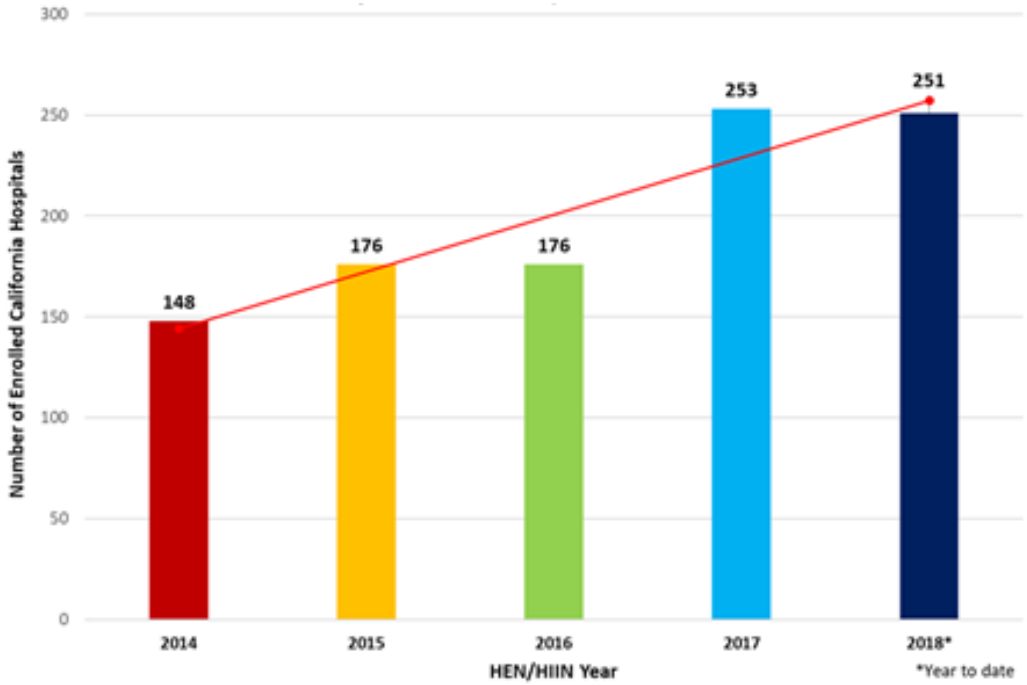
Hospitals by County	CDI	CLABSI	MRSA BSI	VRE BSI
Providence Tarzana Medical Center	★			
Ronald Reagan UCLA Medical Center				✖
Saint Francis Medical Center		★		
Saint Vincent Medical Center	✖	✖		✖
San Gabriel Valley Medical Center	★			
Sherman Oaks Hospital	★			
Southern California Hospital at Culver City	✖	✖		
Southern California Hospital at Hollywood	★			
Torrance Memorial Medical Center	★		✖	
Valley Presbyterian Hospital	★			✖
West Hills Hospital & Medical Center	✖	✖		
Whittier Hospital Medical Center	★			
Madera				
Valley Children's Hospital		★		
Merced				
Mercy Medical Center	★			
Monterey				
Natividad Medical Center	★			
Salinas Valley Memorial Hospital		★		
Napa				
Adventist Health St. Helena			✖	
Queen of the Valley Medical Center		✖		
Nevada				
Sierra Nevada Memorial Hospital	★			
Orange				
Anaheim Global Medical Center	★			
College Hospital Costa Mesa	★			
Hoag Memorial Hospital Presbyterian	★			
Huntington Beach Hospital	✖			
Kaiser Foundation Hospital, Orange County, Anaheim		★		
Los Alamitos Medical Center	★			
MemorialCare Orange Coast Medical Center	★	★		
Mission Hospital Regional Medical Center	★			
Orange County Global Medical Center	★			
Placentia Linda Hospital	★			
St. Joseph Hospital, Orange		★		
St. Jude Medical Center	★	★	★	
University of California Irvine Medical Center	★	★		

Hospitals by County	CDI	CLABSI	MRSA BSI	VRE BSI
Sharp Memorial Hospital	★		★	★
UC San Diego Health Hillcrest	★			✖
UC San Diego Health La Jolla	✖			
San Francisco				
California Pacific Medical Center, California West Campus Hospital	★			
California Pacific Medical Center, Davies Campus Hospital		★		
California Pacific Medical Center, Pacific Campus Hospital				✖
Kaiser Foundation Hospital, San Francisco	★			
Saint Francis Memorial Hospital	★			
UCSF Medical Center	✖			
UCSF Medical Center at Mission Bay				★
Zuckerberg San Francisco General Hospital and Trauma Center	★			★
San Joaquin				
Adventist Health Lodi Memorial	★			
San Joaquin General Hospital	★			
St. Joseph's Medical Center Of Stockton	★	★		
Sutter Tracy Community Hospital	★			
San Luis Obispo				
Twin Cities Community Hospital	★			
San Mateo				
Kaiser Foundation Hospital, Redwood City	★			
Kaiser Foundation Hospital, South San Francisco	★			
Santa Barbara				
Marian Regional Medical Center	★			
Santa Barbara Cottage Hospital				★
Santa Clara				
El Camino Hospital	★	★		
Good Samaritan Hospital, San Jose	★			
Kaiser Foundation Hospital, Santa Clara		★		
Lucile Packard Children's Hospital Stanford		★		
Regional Medical Center of San Jose	★			
St. Louise Regional Hospital	★			
Stanford Health Care		★	★	✖
Santa Cruz				
Dominican Hospital	★	★		
Shasta				

Hospitals by County	CDI	CLABSI	MRSA BSI	VRE BSI
Mercy Medical Center Redding	★	★		
Shasta Regional Medical Center	★			
Solano				
Kaiser Foundation Hospital and Rehab Center, Vallejo	★			
Northbay Medical Center	★			
Northbay Vacavalley Hospital	★			
Sonoma				
Kaiser Foundation Hospital, Santa Rosa	★	★		
Petaluma Valley Hospital	★			
Stanislaus				
Doctors Medical Center	★	★		
Emanuel Medical Center	★			
Kaiser Foundation Hospital, Modesto	★			
Memorial Medical Center	★			
Tulare				
Kaweah Delta Medical Center	★	✖	✖	
Sierra View Medical Center	★			
Ventura				
Adventist Health Simi Valley	★			
Community Memorial Hospital, San Buenaventura	★			
Los Robles Hospital & Medical Center	★			
Ventura County Medical Center		✖		

Source: California Department of Public Health (CDPH) 2018 HAI Annual Report.

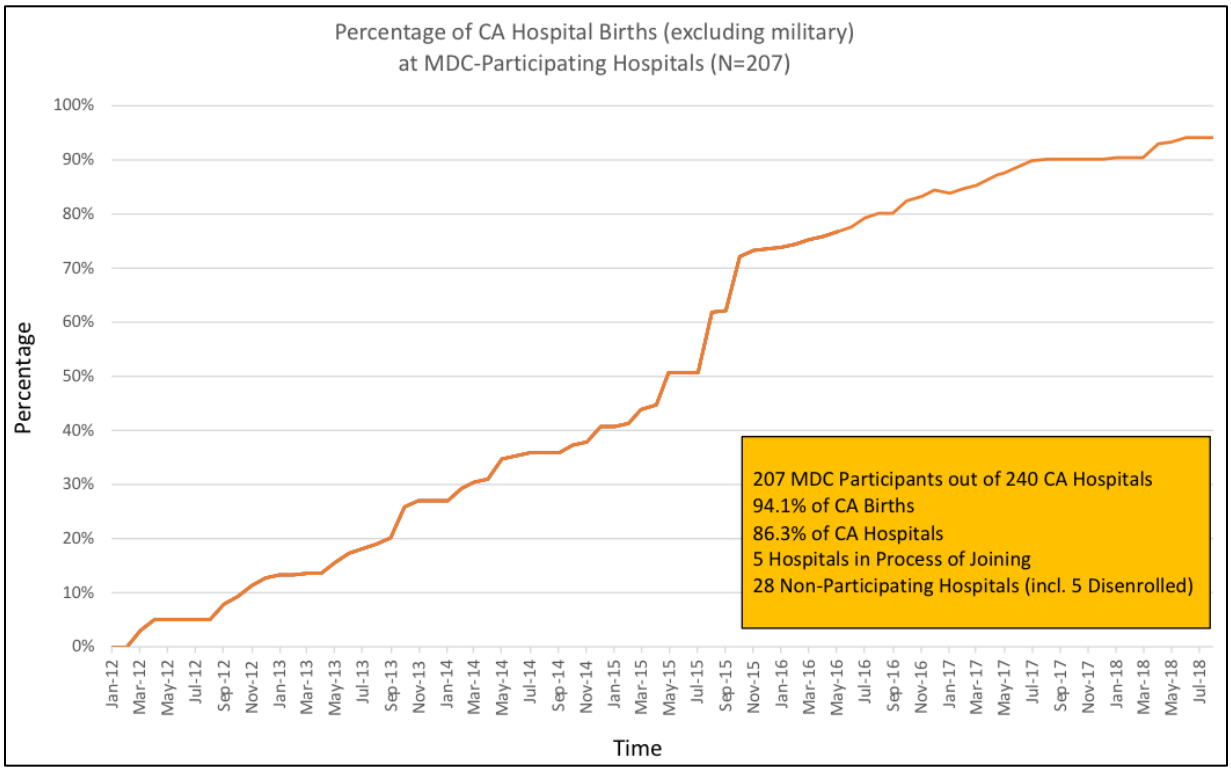
Figure A2. California Hospitals Involved in Hospital Quality Institute Hospital Improvement Innovation Networks, 2014-18[97]



Source: Hospital Quality Institute, 2018

[97] Note: The two fewer hospitals participating in the HIIN in 2018 compared to 2017 represent hospital closures. The acronym changed in 2016 from Hospital Engagement Networks (HEN) to Hospital Improvement Innovation Networks (HIINs).

Figure A3: Percentage of California Hospital Births at California Maternal Quality Care Collaborative Participating Hospitals



Source: California Maternal Quality Care Collaborative, 2018

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