COVERED CALIFORNIA POLICY AND ACTION ITEMS

January 21, 2016

COVERED CALIFORNIA'S VISION AND MISSION

Covered California Vision

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

Covered California Mission Statement

The mission of Covered California is to increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value.

RECOMMENDED 2017 CERTIFICATION

Anne Price, Director of Plan Management Division

COVERED CALIFORNIA

2017 CERTIFICATION TIMELINE

Activity	Proposed Date
January Board Meeting: discussion of 2017 certification, benefit design & quality draft recommendation	January 21
Final AV Calculator Released	Mid to late February
Stakeholder and Carrier Feedback on Draft Proposals Due	February 4
Plan Management Advisory Meeting	February 11
February Board Meeting: anticipated approval of 2017 certification, benefit design & quality requirements	February 18
QHP & QDP Applications for Individual Marketplace & Covered California for Small Business Open	March 1
QHP Application for Individual Marketplace Responses Due	May 2
Evaluation of QHP Responses & Negotiation Preparation	May 3 – June 5
QHP Negotiations	June 6 – June 17
QHP Preliminary Rates Announcement	July 5 – July 8
QHP Regulatory Rate Review Begins	July 5 – July 8
QDP Application for Individual Marketplace & Covered California for Small Business Responses Due	June 1
Evaluation of QDP Responses & Negotiation Preparation	June 2 – July 10
QDP Negotiations	July 11 – July 17
QDP Rates Announcement	August 1
Public posting of proposed rates **(if exception requested to CCIO by Covered California is accepted)*	August 31

2017-2019 INDIVIDUAL CERTIFICATION GUIDING PRINCIPLES

Provide stability for consumers by having a portfolio of carriers, products, and networks that offer distinct choice and quality healthcare at a cost with annual changes that are at or below trend.

- Promote continued growth and implementation of integrated models of care such as Accountable Care Organizations (ACO), Medical Homes, and models that reimburse and support primary care.
- Implement provider payment models that reward higher value and the delivery to consumers of the right care, at the right time by the right provider.
- Revision of contract requirements to require continued improvement in the quality of care provided to consumers and align with the federal requirements of Quality Improvement Strategy requirements (QIS) that focus on the unique economic, demographic and regional variations that exist within our membership.
- Allow for annual changes to benefit designs that promote preventive care, increase management of chronic conditions and increase access to needed care.

RECOMMENDED APPROACH FOR 2017 INDIVIDUAL PLAN CERTIFICATION

- Maintain policy of requiring Qualified Health Plans (QHPs) to offer standard benefit designs while giving consumers broad choices on price, provider networks, formularies and health plans' quality and philosophy.
- Recommend one QHP Certification application that is open to all licensed health insurers. Covered California will review applications, negotiate with carriers and select QHPs in July 2016.
- The 2017 application is for a multi-year contract term (2017 – 2019) with annual plan. recertification that includes review and Covered California approval of contract compliance, plan performance, proposed rates, benefits, and networks.
- May allow new entrants in 2018 and 2019 if the carrier is newly licensed or a Medi-Cal managed care plan and the addition brings value to what is already being offered in the region(s).
- Exchange participation fee will be set at percent of gross premium for 2017 instead of a flat PMPM value and reviewed annually for 2018 and 2019 with the goal of reducing the percentage when possible.
    - Currently evaluating setting the percent at 3.5% of gross premium
    - Recommendation will be made at February board meeting with board approval requested in March

2017-2019 DENTAL CERTIFICATION GUIDING PRINCIPLES (INDIVIDUAL AND CCSB)

With family dental being a new option for 2016 in the Individual market, the guiding principles for 2017 certification will be focused on stability in products offered and stability in future premium changes as we look to increase enrollment and assure that those who have enrolled in this benefit are getting good value.

- Focus on strategies to retain members and increase new enrollment.
- Provide stability for consumers by having a portfolio of carriers, products, and networks that offer unique choice and quality at a cost with annual changes that are at or below trend.
- Allow for annual changes to benefit designs that promote preventive care and value.
- Assure the quality of care delivered and require continued improvement in the quality of care provided to consumers.

RECOMMENDED APPROACH FOR 2017 DENTAL PLAN CERTIFICATION (INDIVIDUAL AND CCSB)

- For 2017, recommend one QDP Certification application that is open to all licensed dental plans.
- The application is for a multi-year contract term (2017 – 2019) with annual plan recertification that includes review and Covered California approval of contract compliance, plan performance, proposed rates, benefits, and networks.
- May allow new dental issuer entrants in 2018 and 2019 if the issuer is newly licensed and the addition brings value to what is already being offered in the region(s).
- Because of the significant variance in dental HMO and PPO premiums, the exchange participation fee will be set at percent of gross premium for 2017 instead of a flat PMPM value and reviewed annually for 2018 and 2019 with the goal of reducing the percentage when possible.
    - Currently evaluating setting the percent at 3.5% of premium
    - Recommendation will be made at February board meeting with board approval requested in March

2017-2019 COVERED CALIFORNIA FOR SMALL BUSINESS (CCSB) CERTIFICATION GUIDING PRINCIPLES

- Provide a competitive portfolio of products that will offer employees of small groups the choice to enroll with a carrier that is focused on providing quality care at premiums that are at or lower than other options available in the small group market.
- Flexibility to adjust products, networks and premiums consistent with small group market and regulatory requirements.
- Certification and contract requirements that include expectations for quality improvement and delivery system improvement.
- Benefit designs that promote preventive care, increase management of chronic conditions and increase access to needed care.

RECOMMENDED APPROACH FOR 2017 CCSB CERTIFICATION

- Covered California for Small Business QHP certification application, will be open to all licensed health insurers and not limited to carriers who are QHPs for the Individual product.
- Multi-year contract term (2017 – 2019) with annual carrier recertification that includes review of premium competitiveness and stability, performance, and compliance with QHP contract requirements.
- Consideration of new carrier entrant off annual certification with Covered California approval.
- Allowance for quarterly change in rates, addition of new plans and networks (subject to Covered California and regulatory approval)
- Exchange participation fee will be set at percent of gross premium for 2017 instead of a flat PMPM value and reviewed annually for 2018 and 2019 with the goal of reducing the percentage when possible.
    - Currently evaluating setting the percent at ~4.7% of premium which is equivalent in total to what is collected today
    - Recommendation will be made at the February board meeting with board approval requested in March

RECOMMENDED 2017 BENEFIT DESIGNS FOR INDIVIDUAL, SMALL BUSINESS AND FAMILY DENTAL

Anne Price, Director Plan Management Division

2017 BENEFITS AND NETWORKS SUBCOMMITTEE

Covered California would like to acknowledge the participants of this subcommittee and express our appreciation for their thoughtful input and productive discussion over the last four months.

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Anthem

Brent Barnhart
Formerly Department of Managed Health Care

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Consumers Union

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United Healthcare

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BAART Programs

Cary Sanders
California Pan-Ethnic Health Network

KEY CONSIDERATIONS IN DESIGNS OFFERED

The plan designs on the following pages represent consideration of the review of national best practices, workgroup, plan, and committee input. Primary considerations to the recommendations are:

- Design meets Target Actuarial Value (AV) as computed with the 2017 Proposed AV Calculator.
  - Ideally, allow margin in the 2017 AV for each metal tier to allow for future year flexibility
- Address benefit design priority areas that will reduce financial barriers and improve consumers' access to needed care.
- Identify benefit design areas that should be improved for consumer understanding of coverage and ease of plan comparison.
- Foster aligned incentives between members, provider, and plans on quality and cost for benefits that generally have a wide variation in cost for the service.
- Are operationally feasible for both Covered California and contracted health plans to implement.
- As medical treatments, services, and cost/quality tools evolve over the coming years, we have the ability to further refine benefit offerings.

SUMMARY OF RECOMMENDED CHANGES TO 2017 BENEFIT DESIGNS

- Areas of proposed decreases to cost sharing in 2017:
  - ***To promote access to care,*** reduce primary care / mental health / rehab copays by $5-10 in every metal tier except Bronze
  - ***To promote access to urgent care when needed,*** urgent care copays were reduced to the same cost sharing as primary care in every metal level
  - ***To improve consumer understanding of benefits,*** the deductible and physician copay were removed from Emergency Department services
  - ***To meet new regulatory requirements,*** apply drug cap after deductible in the HDHP plans (per AB 339)

- Areas of increased cost sharing in 2017:
  - Increase deductible by $100-300 for Silver and Bronze
  - Increase MOOP by $550 (Silver and Gold), $300 (Bronze), $100-250 (Enhanced Silver)
  - Increase x-rays / diagnostics by $5-15
  - Increase imaging by $25-50
  - Increase ED facility copay by $75-100 in Silver and Gold Plans

RECOMMENDED 2017 ACTUARIAL VALUES

	Bronze		Silver				Gold		Platinum	
	HDHP	Standard	Silver	Silver 73	Silver 87	Silver 94	Coin Plan	Copay Plan	Coin Plan	Copay Plan
AV Target	60	60	70	73	87	94	80	80	80	80
Deviation Allowance	+/-2.0%	+/-2.0%	+/-2.0%	+/-1.0%	+/-1.0%	+/-1.0%	+/-2.0%	+/-2.0%	+/-2.0%	+/-2.0%
2015 AV	60.6	59.4	70.3 / 69.9	73.5 / 74.0	88.0	94.9 / 94.8	78.8	78.6	88.1	88.0
2016 AV	61.1	61.9	70.4	72.8	86.8	93.8	80.2	81.0	88.5	89.5
2017 AV	**61.1**	**61.9**	**71.5**	**73.7**	**87.5**	**94.1**	**80.9**	**81.6**	**89.7**	**90.5**

	CCSB Silver		
	Copay	Coins	HDHP
AV Target	70	70	70
Deviation Allowance	+/-2.0%	+/-2.0%	+/-2.0%
2015 AV	71.0	71.5	71.6
2016 AV	71.3	71.6	70.5
2017 AV	**71.3**	**71.6**	**71.2**

KEY	
	Does not meet AV
	Within 0.5 de minimus
	Securely within AV

RECOMMENDED 2017 PORTFOLIO: BRONZE/SILVER/CSRS

Benefit	BRONZE		BRONZE HDHP		SILVER		SILVER 73		SILVER 87		SILVER 94	
	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount
Deductible				$4,500								
Medical Deductible		$6,300				$2,500		$2,200		$650		$75
Drug Deductible		$500				$250		$250		$50		$0
Coinsurance (Member)		100%		40%		20%		20%		15%		10%
MOOP		$6,800		$6,650		$6,800		$5,700		$2,350		$2,350
ED Facility Fee	X	100%	X	40%		$350		$350		$100		$50
ED Physician Fee		---		---		---		---		---		---
Urgent Care‡	X	$75	X	40%		$35		$30		$10		$5
Inpatient Facility Fee	X	100%	X	40%	X	20%	X	20%	X	15%	X	10%
Inpatient Physician Fee	X	100%	X	40%	X	20%	X	20%	X	15%	X	10%
Primary Care Visit	X	$75	X	40%		$35		$30		$10		$5
Specialist Visit	X	$105	X	40%		$70		$55		$25		$8
MH/SU Outpatient Services	X	$75	X	40%		$35		$30		$10		$5
Imaging (CT/PET Scans, MRIs)	X	100%	X	40%		$300		$300		$100		$50
Rehabilitative Speech Therapy		$75	X	40%		$35		$30		$10		$5
Rehabilitative Occupational/PT		$75	X	40%		$35		$30		$10		$5
Laboratory Services		$40	X	40%		$35		$35		$15		$8
X-rays and Diagnostic Imaging	X	100%	X	40%		$70		$65		$25		$8
Skilled Nursing Facility	X	100%	X	40%	X	20%	X	20%	X	15%	X	10%
Outpatient Facility Fee	X	100%	X	40%		20%		20%		15%		10%
Outpatient Physician Fee	X	100%	X	40%		20%		20%		15%		10%
Tier 1 (Generics)	X	100%*	X	40%*		$15		$15		$5		$3
Tier 2 (Preferred Brand)	X	100%* †	X	40%* †	X	$55	X	$50	X	$20		$10
Tier 3 (Nonpreferred Brand)	X	100%* †	X	40%* †	X	$80	X	$75	X	$35		$15
Tier 4 (Specialty)	X	100%*	X	40%*	X	20%	X	20%	X	15%		10%
Tier 4 Maximum Coinsurance	$500		$500		$250		$250		$150		$150	
Maximum Days for charging IP copay												
Begin PCP deductible after # of copays	3 visits											
Actuarial Value	**61.89**		**61.13**		**71.53**		**73.67**		**87.48**		**94.12**	
AV Δ FROM 2016	**+ 0.02**		**+ 0.07**		**+ 1.08**		**+ 0.84**		**+ 0.64**		**+ 0.28**	

KEY		
		Increase member cost from 2016
		Decrease member cost from 2016
		Does not meet AV
		Within 0.5 de minimus
		Securely within AV
	*	Drug cap applies to drug tier
	†	Need Milliman to calculate custom input in new AVC
	‡	Benefit not included in AV Calculator

RECOMMENDED 2017 PORTFOLIO: ALL STANDARD PLANS

Benefit	GOLD COPAY		GOLD COINS		PLATINUM COP		PLATINUM COINS	
	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount
Deductible								
Medical Deductible								
Drug Deductible								
Coinsurance (Member)		20%		20%		10%		10%
MOOP		$6,750		$6,750		$4,000		$4,000
ED Facility Fee		$325		$325		$150		$150
ED Physician Fee		---		---		---		---
Urgent Care‡		$30		$30		$15		$15
Inpatient Facility Fee		$600/day		20%		$250		10%
Inpatient Physician Fee		$55 †		20%		$40 †		10%
Primary Care Visit		$30		$30		$15		$15
Specialist Visit		$55		$55		$40		$40
MH/SU Outpatient Services		$30		$30		$15		$15
Imaging (CT/PET Scans, MRIs)		$275		20%		$150		10%
Rehabilitative Speech Therapy		$30		$30		$15		$15
Rehabilitative Occupational/PT		$30		$30		$15		$15
Laboratory Services		$35		$35		$20		$20
X-rays and Diagnostic Imaging		$55		$55		$40		$40
Skilled Nursing Facility		$300/day		20%		$150/day		10%
Outpatient Facility Fee		$600 †		20%		$250 †		10%
Outpatient Physician Fee		$55 †		20%		$40 †		10%
Tier 1 (Generics)		$15		$15		$5		$5
Tier 2 (Preferred Brand)		$55		$55		$15		$15
Tier 3 (Nonpreferred Brand)		$75		$75		$25		$25
Tier 4 (Specialty)		20%		20%		10%		10%
Tier 4 Maximum Coinsurance		$250		$250		$250		$250
Maximum Days for charging IP copay		5				5		
Begin PCP deductible after # of copays								
Actuarial Value		**81.59**		**80.86**		**90.46**		**89.72**
AV Δ FROM 2016		**+ 0.56**		**+ 0.62**		**+ 0.99**		**+ 1.22**

KEY		
		Increase member cost from 2016
		Decrease member cost from 2016
		Does not meet AV
		Within 0.5 de minimus
		Securely within AV
	*	Drug cap applies to drug tier
	†	Need Milliman to calculate custom input in new AVC
	‡	Benefit not included in AV Calculator

COVERED CALIFORNIA

RECOMMENDED 2017 PORTFOLIO: SMALL BUSINESS

Benefit	CCSB SILVER COPAY		CCSB SILVER COINS		CCSB SILVER HDHP	
	Ded	Amount	Ded	Amount	Ded	Amount
Deductible						$2,000
Medical Deductible		$2,000		$2,000		
Drug Deductible		$250		$250		
Coinsurance (Member)		20%		20%		20%
MOOP		$6,800		$6,800		$6,650
ED Facility Fee		$350		$350	X	20%
ED Physician Fee		---		---		---
Urgent Care‡		$45		$45	X	20%
Inpatient Facility Fee	X	20%	X	20%	X	20%
Inpatient Physician Fee	X	20%	X	20%	X	20%
Primary Care Visit		$45		$45	X	20%
Specialist Visit		$75		$75	X	20%
MH/SU Outpatient Services		$45		$45	X	20%
Imaging (CT/PET Scans, MRIs)		$300		20%	X	20%
Rehabilitative Speech Therapy		$45		$45	X	20%
Rehabilitative Occupational/PT		$45		$45	X	20%
Laboratory Services		$40		$40	X	20%
X-rays and Diagnostic Imaging		$70		$70	X	20%
Skilled Nursing Facility	X	20%	X	20%	X	20%
Outpatient Facility Fee		20%		20%	X	20%
Outpatient Physician Fee		20%		20%	X	20%
Tier 1 (Generics)		$15		$15	X	20%*
Tier 2 (Preferred Brand)	X	$55	X	$55	X	20%* †
Tier 3 (Nonpreferred Brand)	X	$85	X	$85	X	20%* †
Tier 4 (Specialty)	X	20%	X	20%	X	20%*
Tier 4 Maximum Coinsurance		$250		$250		$250
Maximum Days for charging IP copay						
Begin PCP deductible after # of copays						
Actuarial Value		**71.25**		**71.56**		**71.16**
AV Δ FROM 2016		**- 0.01**		**- 0.01**		**+ 0.66**

KEY		
		Increase member cost from 2016
		Decrease member cost from 2016
		Does not meet AV
		Within 0.5 de minimus
		Securely within AV
	*	Drug cap applies to drug tier
	†	Need Milliman to calculate custom input in new AVC
	‡	Benefit not included in AV Calculator

COVERED CALIFORNIA

RECOMMENDED UPDATES TO 2017 BENEFIT DESIGNS FOR CONSUMER CLARITY

Endnotes:

- Added clarifying language on endnotes for mental health outpatient items, “other practitioner” category, cost-sharing for services subject to MHPAEA.
- New endnote clarifying benefit category for inpatient and Skilled Nursing Facility (SNF) physician fees.
- New endnote specifying the mental health outpatient services benefit category for autism/pervasive developmental disorder.
- New endnote for diabetes self-management to specify a $0 cost share for members.
- Deleted endnote on tiered networks to disallow tiered provider networks in the plan designs.

RECOMMENDED 2017 DENTAL STANDARD BENEFIT DESIGN

Copay Plan Design (Pediatric & Adult)

- Standardize copays for all procedure codes.

Adult Coinsurance Design

- Include Periodontal Maintenance benefits in Basic Services.
- Reduce out-of-network levels of coverage. Proposed plan coinsurance:
  - Diagnostic & Preventive: Plan pays 90%
  - Basic Services: Plan pays 70%
  - Major Services: Plan pays 50%
- Standardize the following exclusions:
  - Tooth Whitening
  - Adult Orthodontia
  - Implants.

Employer-Sponsored Adult Coinsurance Plan Design

- No waiting period for any service category.
- Periodontal Services included in Basic Services.
- Considering annual benefit limit increase to $2,000 **or** inclusion of Endodontic Services in Basic Services

OTHER KEY 2017 RECOMMENDED CONTRACT REQUIREMENTS

To ensure retention, increased enrollment, and good risk mix of the exchange pool, we are proposing the addition of the following requirements:

- Qualified Health Plans (QHPs) must apply best efforts to enroll all subsidy eligible members through the exchange and will work collaboratively with the exchange to educate and reduce the number of consumers who may be forgoing subsidy by direct enrollment with the carrier.
- Brokers and agents play a key role in the enrollment of consumers in California and are required by the exchange to market all carriers and plans. Because of this requirement, all QHPs will be required to pay commission to brokers and agents for both Open and Special Enrollment that will continue to be reviewed by the exchange during certification.

For non-compliance of contract terms, the exchange will add interim action steps that can be taken to enforce requirements without de-certifying a plan if necessary.

- Options for non-compliance include not allowing new plan enrollment during the special enrollment period or open enrollment.
- Any action imposed by the Exchange for non-compliance would be taken considering the consumers' best interest for non-disruption of services and severity of the QHP's non-compliance action.

COVERED CALIFORNIA QUALITY AND DELIVERY SYSTEM REFORM

Dr. Lance Lang, Chief Medical Officer

RECOMMENDATIONS ANCHORED IN COLLABORATION

Covered California would like to acknowledge and thank many stakeholders for their collaboration in our 2017 quality planning and strategy. Our meetings, starting in July 2015, included:

- Individual 3 hour meetings with each of the 12 contracted health plans
- Deep dive 3 hour meetings with all health plans together with other state purchasers, stakeholders and content experts,
  - Payment Reform
  - Hospital Safety (two meetings)
  - Appropriate use of C-Section for low risk deliveries
  - Advanced Primary Care
- Public input from advocates, regulators, health plans, and other health policy experts
  - Plan Management Advisory Group
  - Quality Subcommittee Work Group plus a separate session with consumer advocates

COVERED CALIFORNIA AND A QUALITY DELIVERY SYSTEM

Covered California is focused on achieving the triple aim on behalf of all Californians and our contract requirements for 2017 – 2019 will continue to move us towards achieving that goal

Guiding principals for raising the bar on quality requirements include the following:

- We will promote alignment with other purchasers including CMS, DHCS, CalPERS and employers as much as possible which will allow us to have similar focus and requirements across the delivery system
- Certain requirements apply to a contracted health plan's entire book of business
- Requirements will focus on tracking, trending and reducing healthcare disparities in care of chronic disease by race and ethnicity as well as gender
- Consumers will have access to networks offered through the Contracted Health Plans that are based on high quality and efficient providers
- Enrollees have the tools needed to be active consumers including both provider selection and shared clinical decision making
- Payment will increasingly be aligned with value and proven delivery models
- Variation in the delivery of quality care will be minimized by assuring that each provider meets minimum standards

ALIGNMENT BETWEEN CMS AND COVERED CALIFORNIA'S STRATEGY

Covered California is evolving its work with Contracted Health Plans from "tell us what your doing" to a required set of initiatives resulting in demonstrated improvement over time.

Aligned with CMS Quality Improvement strategy starting in plan year 2017

- Improved Health outcomes
- Prevent hospital readmissions
- Improve patient safety and reduce errors
- Reduce Disparities
- Promote health and wellness

With emphasis on aligning financial incentives with improvement strategy.

Covered California and Contracted Health Plans recognize that driving significant improvements needed to assure better quality care is delivered at lower cost will need tactics and strategies that will extend over the coming contract period and beyond. Success will depend on establishing targets based on current performance, national benchmarks and the best improvement science conducting rigorous evaluation of progress and adjusting goals annually based on experience.

BUILDING ON ATTACHMENT 7 – WITH A MULTI-YEAR STRATEGY

2014-2016	2017
1. Improving Care, Promoting Better Health and Lowering Costs	1. Improving Care, Promoting Better Health and Lowering Costs
2. Accreditation: NCQA, URAC or AAAHC	2. Provision & Use of Data and Information for Quality of Care
3. Provision and Use of Data and Information for Quality of Care	3. Reducing Health Disparities and Assuring Health Equity
4. Preventive Health and Wellness	4. Promoting Development and Use of Care Models
5. Access, Coordination, and At-Risk Enrollee Support	5. Hospital Quality
6. Patient-Centered Information and Communication	6. Population Health: Preventive Health, Wellness and At-Risk Enrollee Support
7. Promoting Higher Value Care	7. Patient-Centered Information and Communication
8. Drug Formulary Changes	8. Promoting Higher Value Care
	9. Accreditation: NCQA, URAC or AAAHC

ARTICLE 1: IMPROVING CARE, PROMOTING BETTER HEALTH & LOWERING COSTS

Covered California supports provider networks that are designed based on quality, satisfaction and cost efficiency standards to insure that enrollees have access to quality care.

Requirements of the Contracted Health Plan will include:

1. Provider network composition includes measurement that is based on quality in addition to other plan factors and report the methodology for doing so in its Application for Certification for 2018.
2. Contracted plans are expected to only contract with providers and hospitals that demonstrate they provide quality care and promote the safety of Covered California enrollees. Providers with outlier poor performance in metrics targeted under Attachment 7 will not be included in the network by 2019 or contracted plans will report rationale for continuing participation.
3. Report how enrollees with conditions that require highly specialized management such as transplant or burn patients are directed to providers with documented experience and proficiency based on volume and outcome data.
4. Promote participation in collaborations, with two identified as required and reporting on others' in which QHPs participate.

ARTICLE 2: PROVISION AND USE OF DATA FOR IMPROVEMENTS IN QUALITY OF CARE DELIVERY

Covered California will coordinate annual reporting of all quality and delivery system reform requirements and targets using the following mechanisms:

Requirements of the Contracted Health Plan will include:

1. Provide contracted claims and clinical data for exchange enrollees as specified in Attachment 7 to use in the Exchange's Enterprise Analytics Solution (EAS).
2. Report HEDIS, CAHPS, and other performance data for each product type as required for use in Covered California's Quality Rating System (QRS).
3. Report work plan and annual progress of the federally-required Quality Improvement Strategy (QIS) through the annual certification application.
4. Report on broader quality improvement and delivery system reform efforts through annual reporting in the Covered California eValue8 Request for Information included in the annual certification application.

ARTICLE 3: REDUCE HEALTH DISPARITIES AND ASSURE HEALTH EQUITY

Covered California recognizes that promoting better health requires a focus on addressing health disparities and health equity while recognizing that some disparity results from determinants outside the control of the health care delivery system.

Requirements of the Contracted Health Plan will include:

1. Increase self reported identity annually 2017 and 2018, achieving 85% by year end 2019.
2. Track, trend and improve quality measures by ethnic/racial group and by gender.
   - For ethnic/racial group identification, Plans shall use self-reported data supplemented by proxy measures based on zip code and surname
   - Initial focus: Diabetes, Hypertension, Asthma and Depression
3. Report baseline data in 2017 application for certification.
   - Baseline per cent of self-reported racial/ethnic identity
   - Baseline quality measures based on HEDIS from MY 2015
4. Achieve Covered California targets for annual reduction in disparities.

**All California Health Plans have been required to collect race, ethnicity, and language data on their enrollees under SB 853 since 2003.*

ARTICLE 4: PROMOTING DEVELOPMENT AND USE OF CARE MODELS PRIMARY CARE AND PCMH

Primary care is the foundation of an effective healthcare delivery system. Adults who have a primary or personal care physician have 33 percent lower health care costs and 19 percent lower odds of dying than those who see only a specialist (Starfield, Milbank Quarterly, 2005). Primary Care redesigned as “Patent Centered Medical Home” (PCMH) is supported by a growing body of evidence that primary care can exceed the track record documented by Starfield including improved management of total costs of care. (https://www.pcpcc.org/results-evidence)

Covered California has structured standard benefits to minimize enrollee cost share for primary care visits.

Requirements of the Contracted Health Plan will include:

1. For 2017, assure that all enrollees either select or are provisionally assigned to a Personal Care Physician. This requirement is not to be interpreted as requiring that the PCP serve as a gatekeeper.
2. Cooperate in evaluating various PCMH accreditation and certification programs as well as other frameworks for defining a consistent standard for determining the percent of primary care provided by PCMHs for Exchange enrollees and for the Plan’s book of business.
3. Apply this standard to determine a baseline that will be included in the Application for Certification in 2018. Covered California will establish a target for 2019 with annual intermediate milestones.
4. Adopt and progressively expand a contracting and payment strategy that creates a business case for PCPs to adopt accessible, data-driven, team-based care (alternatives to face to face visits and care by non-MDs) with accountability for improving triple aim metrics including total cost of care

ARTICLE 4: PROMOTING DEVELOPMENT AND USE OF CARE MODELS – INTEGRATED HEALTHCARE MODELS (IHM)

“Despite the social need and the feasibility of measurement, actual pursuit of the Triple Aim remains the exception…success requires…existence of an “integrator” able to focus and coordinate services to help the population on all three dimensions at once.” (Berwick, The Triple Aim, Health Affairs, 2008). Covered California places great importance on promoting integrated/coordinated care and is adopting a modified version of the description of an Integrated HealthCare Model (IHM) from CalPERS.

Requirements of the Contracted Health Plan will include:

1. Describe how the requirements of an integrated healthcare model are met
2. Report the percent of Covered California and book of business enrollees receive care from the ACO or integrated model of care in the Application for Certification for 2017.
3. Report how these models ensure accountability for triple aim metrics including both quality and total cost of care across specialties and institutional boundaries.
4. After establishing baseline enrollment, Covered California shall establish targets for a progressively greater share of enrollees for whom care is provided under these models.

ARTICLE 5: HOSPITAL QUALITY

Covered California and Contractor recognize that hospitals have contracts with multiple health plans and are engaged in an array of quality improvement and efficiency initiatives. Hospitals play a pivotal role in providing critical care to those in the highest need and should be supported with coordinated efforts across health plans and purchasers.

Requirements of the Contracted Health Plan will include:

1. Report the quality performance of contracted network hospitals including at minimum an agreed set of hospital acquired conditions (HACs) and the C-section rates for low risk pregnancies.
2. Covered California will set annual targets for increasing the number of hospitals that meet the goals for reducing HACs and that achieve the national Healthy People 2020 goal for C-sections of 23.9 percent for low risk first pregnancies .
3. Adopt a payment strategy for hospitals such as that employed by Centers for Medicare and Medicaid Services (CMS), which by 2019 putting at least 6 percent of reimbursement at risk based on quality performance. Each contractor will structure this according to their own priorities including HACs, readmissions, or Hospital satisfaction scores.
4. Additionally, adopt a payment strategy for physicians and hospitals designed such that there is no financial incentive for surgical delivery.
5. Only contract with providers and hospitals that demonstrate they provide quality care and promote the safety of Covered California enrollees. Providers with outlier poor performance on hospital safety or that do not achieve a C-section rate of 23.9 for low risk pregnancies will not be included in the network by 2019 or contracted plans will report rationale for continuing participation.

ARTICLE 6: POPULATION HEALTH- PREVENTIVE HEALTH, WELLNESS AND AT-RISK ENROLLEE SUPPORT

Covered California and Contracted Health Plans recognize that access to care, timely preventive care, coordination of care and early identification of high risk enrollees are central to improving each part of the triple aim.

Requirements of the Contracted Health Plan will include:

1. Report the number and percent of members who have utilized preventive care, tobacco cessation, and obesity management services in the annual Application for Certification.
2. Report on any participation in evidence based community health and wellness initiative, such as those recommended by the Community Preventive Services Task Force in 2017, CMS Healthy Communities Initiative or other similar pilots.
3. Report the results of ongoing health assessments and incorporate into monitoring and management through the annual Application for Certification.
4. Report programs to proactively identify and manage at-risk enrollees.
5. Provide support to at-risk enrollees transitioning to or from coverage under Covered California.
6. Assure mental and behavioral health is effectively integrated and delivered.

ARTICLE 7: PATIENT-CENTERED INFORMATION AND COMMUNICATION AND COST TRANSPARENCY DECISION SUPPORT TOOLS

Contracted Health Plans negotiate agreements which often result in varied reimbursement levels and difference in quality performance for identical services and or procedures. Improving the transparency of the consumer's share of cost and quality of providers offers significant benefit to Covered California enrollees.

Requirements of the Contracted Health Plan will include:

1. Report a plan to provide by 2018 either online tools or phone alternatives that allow enrollees to understand their share of cost for medical services in the Application for Certification for 2017.
2. Report on tools provided with the percent of enrollees who utilize tools in the Annual Application for Certification.
3. Report on strategy to inform enrollees by 2019 of the quality performance of providers with emphasis on target metrics for hospital quality defined in Attachment 7.

ARTICLE 7: PROMOTING HIGHER VALUE CARE AND REDUCING OVERUSE THROUGH CHOOSING WISELY

- Covered California requires deployment of tools to support enrollees in understanding their medical diagnosis and treatment options to aid in discussion with their provider. Shared decision-making is a powerful evidence-based approach to reducing overuse or misuse of clinical interventions.
- One such set of decision aids is Choosing Wisely. National organizations representing medical specialists asked their providers to “choose wisely” by identifying tests or procedures commonly used in their field whose necessity should be questioned and discussed. The resulting lists of ”Things Providers and Patients Should Question” (http://www.choosingwisely.org/clinician-lists/) will spark discussion about the need—or lack thereof—for many frequently ordered tests or treatments.
- Requirements of the Contracted Health Plan will include:
- Join Covered California in partnership with DHCS and CalPERS in a statewide multi-stakeholder workgroup to support reduction of overuse through Choosing Wiseley. Targeted conditions include:
  - C-sections,
  - Opioid Prescription and
  - Imaging for Low Back Pain

ARTICLE 8: PROMOTING HIGHER VALUE CARE

Covered California requires that quality and delivery system improvement strategies include payment models that align.

Covered California has established requirements for the following initiatives:

- Advanced Primary Care or Patient-Centered Medical Homes (Article 4)
- Integrated Healthcare Models (Article 4)
- Appropriate use of C-sections (Article 5)
- Hospital Quality (Article 5)

Requirements of the Contracted Health Plan will include reporting in the annual Application for Certification on experience with other innovations in payment or market-based incentives. These will include

1. Participation or alignment with CMMI innovative payment models such as the Oncology or Joint Replacement model and
2. Adoption of new Alternative Payment Models associated with the implementation of the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA).

ARTICLE 9: ACCREDITATION

All contracted health plans are required to be accredited by NCQA, URAC or AAAHC.