CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

March 8, 2019

Peter V. Lee
Covered California
Executive Director
Peter.Lee@covered.ca.gov

Subject: Covered California's Request for Input on Refreshing Expectations Designed to Promote Accountability and Delivery System Improvements

Dear Mr. Lee:

On behalf of our more than 400 hospitals and health systems, the California Hospital Association (CHA) appreciates the opportunity to provide comments to Covered California on its Request for Input (RFI) to Inform Refreshing Expectations Designed to Promote Accountability and Delivery System Improvements. In the RFI, Covered California invites stakeholder feedback as it proposes revisions to contractual terms outlined in *Attachment 7 to the 2017 Individual Market Qualified Health Plan (QHP) Issuer Contract: Quality, Network Management, Delivery System Standards and Improvement Strategy* that will take effect in plan year 2021. CHA shares Covered California's commitment to achieving the triple aim of improved patient care, including higher quality and satisfaction, improved population health, and more affordable health care for our patients.

Covered California, in collaboration with hospitals and health plans, leads the country in developing innovative payment models and continues to focus and draw attention in moving our health care system from paying for volume to paying for value. We are grateful for our collaboration and partnership with Covered California and look forward to continued dialogue. Our initial comments are noted below and reflect many previous conversations over the past several years. We look forward to additional dialogue in the coming weeks, as this process evolves and ideas further develop. As always, we look forward to your direct engagement with member hospitals and health systems to obtain their perspectives. If we can be helpful in convening those conversations, please let us know.

I. Covered California's Guiding Principles for Promoting Better Care and Delivery Reform and Current QHP Issuer Contract Terms: Quality, Network Management, Delivery System Standards and Improvement Strategy

CHA appreciates the opportunity to have worked with Covered California staff to develop and implement current quality improvement and delivery system reform standards and requirements. We agree that the proposed guiding principles continue to reflect Covered California's commitment to providing high-quality, affordable health care to millions of Californians, and we support these efforts. Our perspective on the policy underlying many of these guiding principles has been articulated in our previous comments, which are attached. We respectfully request that Covered California reconsider our

previous comments, as a number of our questions remain unaddressed. As we move into a new contract period, discussion of these questions is timely — and important.

II. **Contractual Expectations Domains and Strategies: Right Care/Accountability and Delivery System Improvement**

CHA encourages Covered California to not only prioritize the 13 proposed strategies, but also stage and sequence them in a phased implementation that seeks to drive improvements more strategically. For several years, public attention on hospital care has increased — and we welcome that heightened focus. However, an early and focused effort on consumer and patient engagement, coupled with work in advancing health literacy, would support all of Covered California's proposed strategies. We also believe several issues — including behavioral health — are at a tipping point. CHA will continue to prioritize aligning our work with state efforts to address behavioral health. We welcome additional dialogue about each of these strategies, so that we may provide additional insights going forward.

III. **Contractual Expectation Domains and Strategies**

CHA appreciates the opportunity to comment on the select strategies outlined below:

Hospital Care
The Hospital Quality Institute (HQI) and CHA have worked with hospitals and key stakeholders across the state, resulting in significantly improved maternity care and rates of hospital-acquired infections (HAIs). HQI and CHA's relationships — and leverage — with hospital leaders across the state have remained a key driver for hospital participation in statewide efforts aimed at improving health care. Our work to partner with both the California Maternal Quality Care Collaborative and the Health Services Advisory Group (HSAG) — in addition to the statewide, multi-stakeholder HAI Prevention workgroup — has resulted in significantly improved rates of HAI rates and nulliparous, term, singleton, vertex (NTSV) Cesarean (C-section) births, as Covered California noted in its report. We have provided hospitals an opportunity to use recent data to better inform their improvement activities through the Hospital Quality Intelligence Initiative (HQI^2) and encouraged stakeholder transparency through the Transparency Dashboard Initiative — both of which helped to drive improvement further and faster.

HQI and CHA support the strategy that encourages hospitals to participate in quality and patient safety collaboratives, such as Partnership for Patients and the California Maternal Quality Care Collaborative. Hospitals that have been engaged in these collaboratives, while partnered with HQI's and CHA's clinical improvement advisors and subject matter experts, have shown meaningful improvement in safety and reliability.

HQI and CHA also support reporting data related to NTSV C-section and HAI rates. While improvements have been made, rates still require a focus in these specific areas. Because of the need for that precise focus, HQI and CHA would not recommend removing those areas from the overall focus on quality and safety. Instead, we would support an obligation to demonstrate ongoing improvement work in other aspects of maternity care, such as a structural measurement and attestation by hospitals that evidence-based practices are in place to prevent harm from maternal emergencies, such as severe preeclampsia or post-partum hemorrhage. Additionally, CHA and HQI would support a structural measurement of and hospital attestation to ongoing efforts to prevent adverse drug events related to high alert medications — such as those related to anticoagulant, hypoglycemic and opioid medications — through the

Partnership for Patients program. However, we would not advise that Covered California require outcomes data related to this area of improvement, due to a lack of standardized measurement nationally.

HQI and CHA would support expanding focus areas to include aspects of quality and patient safety that do not require a data reporting burden for hospitals. For example, the Transparency Dashboard Initiative — supported by HQI and CHA and embraced by 96.2 percent of hospitals across California — provides an avenue for hospitals to report data on five key indicators on their public websites. These indicators include outcomes data for catheter-associated urinary tract infection (CAUTI), central line-associated bloodstream infections (CLABSI), venous thromboembolism (VTE), sepsis mortality and NTSV C-section rates. The dashboard also includes three structural measures that give hospitals an opportunity to document the safety measures in place for sepsis care, maternity care and respiratory monitoring. We believe that a focus on these measures, implemented through a commitment to posting the Quality Transparency Dashboard, would not create a data reporting burden for hospitals and would provide a clear picture of safety and quality to all stakeholders.

Networks Based on Value

CHA encourages Covered California to consider a more expansive view of the benefits of provider integration. Across the country, health care providers are reinventing themselves to meet patients' and communities' evolving needs by harnessing the power of technology and innovations in care delivery. For hospitals, this means coming together to extend specialty care in new ways and to ensure care is accessible in underserved communities. These changes are a direct response to the expectation people have for convenient, affordable, high-quality care. By joining, hospital systems are able to invest in technology and quality improvement that they would not otherwise. Seventy-five percent of California's hospital beds are part of hospital systems, and California ranks ninth lowest nationally in per capita hospital costs. Hospital integration has shown to reduce annual operating expenses by 2.5 percent.

Mental/Behavioral Health and Substance Use Disorder Treatment

CHA commends Covered California for including mental health and substance use disorder treatment as a distinct strategy in Attachment 7. California's behavioral health crisis has pushed our health care system to the breaking point. Simply stated, people are not getting the care they need; hospitals, emergency departments, and doctors are overwhelmed; and patients and families are frustrated. The most recent data show that, while hospital emergency department utilization overall increased by 14 percent over a six-year period, emergency department utilization increased by a whopping 47 percent for people with behavioral health conditions. There is no "easy fix," and this is a problem that deserves a thoughtful, purposeful approach that engages all stakeholders in building a solution. The momentum is strong to face this crisis head-on: Governor Newsom is committed to behavioral health, evidenced by his forthcoming appointment of a brain health czar; California's hospitals have joined with the National Alliance on Mental Illness, California on a statewide campaign to call attention to the issue and de-stigmatize behavioral health conditions; and there is a renewed political will among policymakers and stakeholders for effective, serious solutions.

Despite mental health parity laws, behavioral health is not treated the same as physical health when it comes to reimbursement — payments are lower and the number of treatments is often capped, thus disincentivizing providers to grow capacity. Administrative complexity imposed on providers by health plans also serves as a disincentive to enter into or stay in contracts with plans. CHA recommends that

Covered California hold plans accountable to mental health parity laws and support strategies that treat the whole person (i.e., physical health and behavioral health needs).

Pharmacy Management
The Governor's Executive Order to create a single-purchaser system of drugs in California is an important component of his larger vision to reform the health care delivery system, provide affordable coverage and access, and lower the total cost of health care. CHA recognizes the need to reduce prescription drug costs, which are the fastest rising costs in health care. This is among the most potent drivers forcing our country, our state, and our families to spend an ever-growing portion of income on health care. We are committed to helping find a solution, while continuing to protect patients who benefit from the federal 340B Drug Discount Program.

CHA appreciates Covered California's longtime planning and leadership to promote stability in the individual health insurance market — work that has directly benefited the 1.2 million people enrolled through Covered California. This work has also moderated premium increases for an additional 1 million Californians who purchase individual market coverage but earn too much to qualify for premium tax credits or cost-sharing subsides. Thank you for the opportunity to provide comments. If you have any questions, please contact me at (916) 552-7543.

Sincerely,

Amber Kemp
Vice President, Health Care Coverage

cc: Lance Lang, Chief Medical Officer, Covered California
James DeBenedetti, Director, Plan Management, Covered California

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

February 8, 2016

Peter V. Lee
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Subject: Draft Qualified Health Plan (QHP) Certification Application for Plan Year 2017

Dear Mr. Lee:

On behalf of our more than 400 member hospitals and health systems, the California Hospital Association (CHA) welcomes the opportunity to provide comments to Covered California on its draft Qualified Health Plan (QHP) Certification Application for Plan Year 2017 ("Draft") and Attachment 7, Quality, Network Management and Delivery System Standards ("Attachment 7") released on January 21, 2016. We appreciate the opportunity Covered California has provided to hospitals and other stakeholders to engage in this process.

Before providing specific comments, we would like to note our shared commitment to achieving the triple aim of improved patient care experience including quality and satisfaction, improved population health, and a reduction in per capita health care program costs. We recognize the impact Covered California has on improving the health of *all* Californians. CHA appreciates its partnership with Covered California and looks forward to continued collaboration with Covered California, its QHPs and other providers in developing policies that will achieve this shared goal. We also support the important role that the Hospital Quality Institute (HQI) has played – and will continue to play – in efforts to improve hospital safety. We fully support opportunities for Covered California and HQI to collaborate on the performance improvement initiatives outlined in Attachment 7, as well as data sharing and reporting requirements. We welcome further discussions about this collaboration, as well as on our comments below.

I. Draft Qualified Health Plan (QHP) Certification Application for Plan Year 2017

Section 3 of the Draft precludes tiered hospital and physician networks or preferred and non-preferred hospital and physician networks from being offered by QHPs. **CHA supports this policy as it is ineffective in an integrated health care delivery model and forces patients to base decisions on finances, rather than clinical quality and outcomes.**

Section 4.4.5 of the Draft requires plans to describe any contractual agreements with participating providers that preclude the plan from making contract terms transparent to plan sponsors and members, and to agree to make commercially reasonable efforts to exclude any contract provisions that would prohibit disclosure of such information to the Exchange. **As we have stated in our previous comments, provider contracts and payment terms are proprietary, confidential and competitive. There is no policy reason for Covered California to have this detailed information since it is negotiating with the health plan issuer on premium rates; detailed proprietary contract information from specific providers is not necessary for the purpose of negotiating premiums.** In addition, Covered California may obtain aggregated information from its contracted health plan issuers that sufficiently satisfies any legitimate policy purpose, without requiring access to individual proprietary provider contracts. We have

no confidence this sensitive information will remain confidential and will not be used by other parties inappropriately or for anti-competitive reasons.

Section 5 requires plans to demonstrate that its QHP proposals meet requirements for geographic sufficiency of its essential community provider (ECP) network and includes the ECP categories that will meet this requirement. CHA appreciates that Covered California is dedicated to inclusion of ECPs who serve the low-income and medically underserved communities in the provider networks offered by its QHPs. **CHA emphasizes the importance of cultivating meticulous lists and requests that Covered California commit to annually review the lists with CHA and other provider associations to ensure accuracy.**

II. Attachment 7. Quality, Network Management and Delivery System Standards

CHA appreciates Covered California's continued focus and attention in moving our health care system from paying for volume to paying for value. In doing so, CHA also believes that we must focus on a narrow set of consensus-based and nationally-endorsed quality measures that align the efforts of the public and private sectors, leading to accelerated improvement and demonstrated results. Further, we believe payment methodologies implemented by QHPs should focus on rewarding providers for achievement and improvement in performance. CHA does not support payment approaches that implement arbitrary payment reductions based on undefined or subjective metrics. Such approaches undermine a provider's ability to dedicate limited financial and personnel resources to quality improvement efforts that will lead us to our shared goals.

Attachment 7 presents a number of opportunities for alignment; we offer the following specific comments for consideration. In addition, we respectfully request additional clarity in a number of areas that we believe will promote shared understanding of the intended policies and requirements of health plans, hospitals and physicians.

1.02 Assuring Networks are Based on Value

b. This shall include a detailed description of how cost, clinical quality, patient reported experience or other factors are considered in network design and provider or facility selection. Such information may be made publicly available by Covered California. Contractor may provide this information with its Application for Certification for 2017**.** Covered California may, at its discretion, make such information available to Enrollees and interested individuals.

CHA respectfully requests that this information be made available to hospitals and physicians, at a minimum. In addition, hospitals and physicians should have embargoed data provided for review to identify errors that require corrections prior to public release. Understanding expectations of health plans in their quality goals for selection in network design and facility selection will ensure transparency in the process. Further, knowing the source and year of the data is also important.

e. Covered California expects Contractor to only contract with providers and hospitals that demonstrate they provide quality care and promote the safety of Covered California Enrollees. To meet this expectation, by contract year 2018, Covered California will work with its contracted plans to identify areas of "outlier poor performance" based on variation analysis. As part of this process, Covered California will engage experts in quality and cost variation and shall consult with California's hospitals. For contract year 2019, Contractors will be expected to either exclude those hospitals that are outlier poor performers on either cost or quality from provider networks or to document each year in its Application for Certification the rationale for continued contract with each hospital that is

identified as a poor performing outlier. Such reports will detail contractual requirements and their enforcement, monitoring and evaluation of performance, consequences of noncompliance and plans to transition patients from the care of providers with poor performance. Such information may be made publicly available by Covered California.

CHA appreciates the opportunity to engage in the development of a methodology on performance standards for hospitals, and looks forward to working with Covered California in its development. Several key principles should be considered as a framework for analysis. **We believe strongly that this process should begin as early as possible to allow sufficient time for thoughtful input, analysis, modeling and education of hospitals and health systems. We encourage a transparent process inclusive of hospital representatives, CHA and other interested stakeholders.**

1.03 Participation in Collaborative Quality Initiatives.

Effective in 2017, Contractor shall be required to participate in two such collaboratives:

a) CalSIM Maternity Initiative: Sponsored by Covered California, DHCS and CalPERS as well as other major purchasers with support from by CMQCC, which provides statewide analysis of variation and promotes the appropriate use of C-sections with associated reductions in maternal and newborn mortality and morbidity. www.chhs.ca.gov/PRI/_CalSIM%20Maternity%20Initiative%20WriteUp%20April%202014.pdf (See Article 5, Section 5.01)

b) Statewide Workgroup on Overuse: Sponsored by Covered California, DHCS and CalPERS, this multi-stakeholder work group facilitated by Integrated Healthcare Association (IHA), will leverage Choosing Wisely decision aids to support efforts to drive appropriate use of C-sections, prescription of opioids and low back imaging. www.iha.org/grants-projects-reducing-overuse-workgroup.html (See Article 7, ~~Section 7.04~~ Section 7.05~~)~~

In reviewing the section noted above, we have noted some confusion in the field about the requirements for hospital participation in various quality collaboratives. First, CHA understands the requirement above as applying to QHPs. CHA also understands Covered California's goal of 100 percent of California maternity hospitals submitting data to CMQCC, and supports this partnership. However, we are unclear if Covered California intends for hospitals to participate in the Statewide Workgroup on Overuse and request additional clarity regarding.

In section 7.05, Covered California states that improvement strategies and targets for 2019 must be established to address reduction in the overuse of opioids and imaging for low-back pain. These issues, while important for hospitals, will be most impactful if addressed at the ambulatory setting. We ask that Covered California further clarify the applicable entity for this requirement. Should Covered California intend to require hospital participation, CHA wishes to understand in greater detail requirements of participation and to be fully involved in developing improvement strategies and targets as discussed in section 7.05.

In addition, we understand the section after Section 1.03(b) which perhaps should be labeled separately as (c), reflects Covered California's interest in participation rates of providers, rather than a requirement that hospitals participate in all of the collaboratives listed on page 5.

We ask that Covered California revise its list of quality collaboratives on page 5 to ensure that any hospital engagement network (HEN), including those not listed, would be counted for participation. In

addition, we request the inclusion of the Children's Hospitals' Solutions for Patient Safety HEN in addition to the other HENs listed in Section 1.03. We request that Covered California also consider quality collaboratives associated with the state's 1115 Medicaid Waiver Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program to be considered for inclusion in Section 1.03.

In addition, CMS' recently proposed *CMS-9937-P Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017* rule further implements provisions of the Affordable Care Act that mandate certain patient safety and quality improvement requirements in order to contract with a QHP through health insurance exchanges. The comments below reference our comments to CMS on Subpart D §156.1110, establishment of the patient safety standards for QHP issuers. **Notably, we believe CMS' approach, though not yet finalized, to allow participation in both a quality collaborative and a federally qualified patient safety organization (PSO) outlined in the proposed rule is an important next step in meeting the ACA's requirement. We encourage Covered California to consider adopting as an interim step toward those final requirements by adding participation in a Federally-Qualified Patient Safety Organization (for example, CHPSO) to the list of quality collaboratives in Section 1.03.**

PSOs — like CHPSO — carry out a variety of patient safety activities with the goal of improving patient safety and the quality of health care delivery. PSOs are able to collect, aggregate and analyze patient safety events and information that is protected under privilege and confidentiality standards. The patient safety evaluation system provisions set forth in the ACA and implemented in regulation align with the triple aim and the goals laid out in the National Quality Strategy.

We believe it would be premature to add CMS' proposed rule language to this section of Attachment 7. However, the ACA requirement for PSO participation is an important step in achieving the goals that Covered California has set forth. CHA and CHPSO believe that the regulatory framework used to implement this section of law should strongly encourage hospital participation in federally-qualified PSOs, while retaining flexibility for continued and ongoing work in the important quality collaborative work outlined in this section.

Covered California goes a step further and proposes to collect information about provider participation, but notes that in the future it will seek additional information.

> Contractor will provide Covered California information regarding their participation in each collaboration. **Such information shall be in a form that shall be mutually agreed to by the Contractor and may include copies of reports used by the Contractor for other purposes.** Contractor understands that Covered California will seek increasingly detailed reports over time that will facilitate the assessment of the impacts of these programs which should include: (1) the percentage of total Participating Providers, as well as the percentage of Covered California specific Providers participating in the programs; (2) the number and percentage of potentially eligible Plan Enrollees who participate through the Contractor in the Quality Initiative; (3) the results of Contractors' participation in each program, including clinical, patient experience and cost impacts; and (4) such other information as Covered California and the Contractor identify as important to identify programs worth expanding.
>
> Covered California and Contractor will collaboratively identify and evaluate the most effective programs for improving care for enrollees and participation in specific collaboratives may be required in future years.

Annual attestation of participation in these programs should be sufficient to meet Covered California requirements, and CHA encourages health plans to consider a simple attestation process. Notably, many quality improvement initiatives are restricted to only a certain number of hospitals due to limited funding for participation. Throughout the year, and over the course of many years, hospitals will likely move from one initiative to another, or to PSO participation, as they seek to continually improve both performance and patient care. As new initiatives are developed, hospitals must have flexibility to prioritize the areas that are most critical for their quality improvement efforts. The list of collaboratives should not remain static, and should be added to or reduced as appropriate in consultation with stakeholders. Hospital attestation allows for flexibility and will limit the administrative burden on both QHPs and hospitals.

While we understand and appreciate the request for additional information by Covered California, we do not agree with collecting data without a clear objective and understanding of its intended use. Rather, a more prudent approach would be to understand participation in various collaboratives and together design a strategic approach to gathering information on hospital performance. CHA does not support requiring health plans to duplicate already ongoing data collection. We stand ready to work with stakeholders to achieve Covered California's goals in a way that limits administrative burden and costly and unnecessary data collection efforts that will only waste limited financial and personnel resources.

5.01 Appropriate Use of C-Sections

CHA fully supports Covered California's goal of appropriate use of C-sections. According to a report issued by the California Maternal Quality Care Collaborative (CMQCC), the rate of cesarean deliveries in the United States as a whole rose by 50 percent between 1998 and 2008. The increasing rate of cesarean deliveries in the United States is attributed to an increase in first-birth cesareans done in the course of labor as well as a decline in vaginal births after a prior cesarean. We feel that there are concrete quality improvement activities that can be performed to address the differences in cesarean delivery rates among hospitals and through collaborative efforts by HQI, CMQCC and CalSIM.

3) Adopt a payment methodology progressively to include all contracted hospitals **and physicians** such that by 2019 there is no financial incentive to perform C-sections. Contractor shall report on its design and the percent of hospitals **and physicians** contracted under this model in its Application for Certification for 2017 and annually thereafter.

First and foremost, we are concerned about creating a disincentive to provide medically appropriate care, and that this language, if not clarified, may create a disincentive for delivery by medically-necessary C-sections — and lead to inadequate payment for medically necessary C-sections. Hospitals are working hard to reduce the C-section rate in California. CHA urges Covered California to consider clarifying language outlining payment designs that promote medically-necessary care for mothers while incentivizing vaginal delivery when medically appropriate. More specifically, CHA understands Covered California does not wish to dictate the manner in which this payment is designed and we agree that providers and health plans should have the flexibility to negotiate a hospital specific rate that incentivizes vaginal delivery while not penalizing hospitals for medically necessary and appropriate C-Sections. One option is to consider a blended hospital-specific rate for C-sections and vaginal deliveries. Another option may be to establish one bundled rate that includes both the physician and hospital component. For the reasons noted below, we believe it is premature for QHPs to consider a bundled or episode approach to the payment of maternity care, rather we encourage and support methodologies that will reward achievement and

improvements in the lowering of the low-risk C-section rates, while maintaining adequate payment for medically necessary C-sections.

In addition, we believe strongly that a similar payment provision for contracted OB/GYN physicians is critical in making this policy truly effective and propose the above changes to item 3. While hospitals play a critical role in lowering C-section rates, hospitals do not make those medical decisions — this is a decision made by the physician and the patient. California, unlike other states, cannot employ physicians and thus alignment can be more challenging. A payment policy that ignores the necessary alignment between hospitals and physicians — the majority of whom are not employed by hospitals in California — is short-sighted and must be reconsidered.

4) Covered California expects Contractor to only contract hospitals **and physicians** that demonstrate they provide quality care and promote the safety of Covered California enrollees. Effective with the Application for Certification for 2019, contractor shall either exclude hospitals **and physicians** from provider networks for purposes of maternity services or to document each year in its Application for Certification the rationale for continued contract with each hospital that demonstrates a C-section rate for NTSV deliveries that is substantially above 23.9 percent.

Adoption of a physician-level metric, similar to that for hospitals, must be a top priority for Covered California and the QHPs. CHA strongly believes that any proposal to exclude hospitals from networks or other actions (discussed below) should apply to not only a hospital but also to physicians.

Finally CHA wishes to express concerns about the above language citing "substantially above" 23.9 percent. All hospitals with labor and delivery must understand the target goal. However, "substantially above" is vague and subjective. It is problematic for hospitals to face a possible scenario of coming to the end of a measurement performance year and then be told they would be excluded from a network because of a QHP's subjective interpretation of what constitutes "substantially above." Further, we believe that the baseline, performance year, volume thresholds for exclusions, and other important factors are clear and transparent in setting the target. Finally, we do not believe hospitals should be automatically excluded; we believe the language below is more appropriate.

> *For contract year 2019, Contractors will be expected to either **exclude hospitals and physicians** that are unable to achieve the target C-section rate from provider networks or to document each year in its Application for Certification the rationale for continued contracting with each hospital and physician that is identified as a poor performing outlier on safety and efforts the hospital is undertaking to improve its performance.*

5.02 Hospital Patient Safety

1) Contractor shall report in its Application for Certification for 2017 baseline rates of specified Hospital Acquired Conditions (HACs) for each of its network hospitals. In order to obtain the most reliable measurement, minimize the burden on hospitals and in the interest of promoting common measurement, Contractor shall employ best efforts to base this report on clinical data such as is reported by hospitals to the California Department of Public Health and to CMS under the Partnership for Patients initiative.

CHA applauds Covered California for recognizing that QHPs should not develop new measures or data collection efforts to meet this section's intended goals. **However, we urge you to remove the language "employ best efforts" to ensure that: a) all QHPs use the HAC measures already required by CMS**

and CDPH; and b) that QHPs do *not* create an alternative data collection mechanism, but rather employ current data collection efforts (i.e. National Healthcare Safety Network) to streamline reporting for hospitals and ensure that a robust data validation effort is part of this process. We urge Covered California to establish a work group to advise on measure selection for use in public reporting and performance-based programs such as those described in 5.02 and 5.03 and 7.01(b).

2) Prior to its Application for Certification for 2018, target rates for 2019 and for annual intermediate milestones for each HAC measured at each hospital will be established by Covered California based on national benchmarks, analysis of variation in California performance and best existing science of quality improvement and effective engagement of stakeholders.

3) The HACs that are the subject of these initiatives are:

    a. Catheter Associated Urinary Tract Infection (CAUTI);

    b. Central Line Associated Blood Stream Infection (CLABSI);

    c. Surgical Site Infection (SSI) with focus on colon;

    ~~d. Adverse Drug Events (ADE) with focus on hypoglycemia, inappropriate use of blood thinners, and opioid overuse; and~~

    e. Clostridium difficile colitis (C. Diff) infection.

4) The subject HACs may be revised in future years; Covered California expects to include Sepsis Mortality at such time as the standardized CMS definition and measurement strategy has been tested and validated.

CHA appreciates Covered California's selection of existing measures that are reported at the state and federal level through the Centers for Disease Control and Prevention's National Healthcare Safety Network. However, we believe it is premature to include the proposed adverse drug event measure, which should instead be considered in future years. This data collection is only just beginning through the voluntary Partnership for Patients initiative, which is focused on data collection for the purposes of quality improvement. This data is not currently used in CMS national pay–for-reporting programs, and, as such, CHA is concerned that the level of hospital resources dedicated to data collection for this measure is significantly lower than the resources devoted to the rigorous data collection for HACs that are currently required in national pay-for-performance and public reporting programs. In addition, opioid overuse is being addressed through a statewide workgroup. As a matter of principle, CHA urges Covered California to adopt measures only after they have been publicly reported for at least one year. The data on Hospital Compare, while imperfect, undergoes a fairly rigorous validation process, which is critically important when measures move from pay-for-reporting to pay-for-performance.

Additionally, there should be separate consideration in this provision for hospitals that serve primarily or exclusively pediatric populations, since national pediatric benchmarks may not exist and adult benchmarks may be inappropriate. For example, surgical site infection *with a focus on colon* is not relevant for pediatric patients; C. Difficile infections in children are less common than adults and there is limited high-quality evidence to guide the management of pediatric C. Difficile infection. Therefore, we request clarity as to how the requirements of this section would apply to hospitals that serve primarily

pediatric patients. In addition, we request clarity on how this provision would apply to inpatient psychiatric facilities, free standing inpatient rehab facilities and long-term acute care hospitals.

5) Covered California expects Contractor to only contract with hospitals that demonstrate they provide quality care and promote the safety of Covered California enrollees. **To meet this expectation, by contract year 2018, Covered California will work with its contracted plans and with California's hospitals to identify area of "outlier poor performance" based on variation analysis of HAC rates.** For contract year 2019, Contractors will be expected to either exclude hospitals that demonstrate outlier poor performance on safety from provider networks or to document each year in its Application for Certification the rationale for continued contracting with each hospital that is identified as a poor performing outlier on safety and efforts the hospital is undertaking to improve its performance.

CHA appreciates Covered California's willingness to work with California's hospitals and CHA in defining outlier or poor performance. We do not believe that currently available methods to identify "outlier poor performance" are able to adjust adequately for factors such as socioeconomic status, geography, complexity of illness, comprehensiveness of services, wages, post-hospitalization costs, etc. Nor is there evidence that "exclusion" of poor performers is a rational approach to improving care. CHA is concerned that this policy may have the effect of reducing access. Therefore, this process should be open and transparent, and dedicated analytic resources should be made available to understand the impacts of various metrics on providers.

Lastly, CHA urges Covered California to seek public comment on the identification of additional measures going forward in this process. In addition, similar to section 5.03, Covered California should only adopt measures that are endorsed by the National Quality Forum (NQF) — we urge you to reconsider the language in this section to reflect this important measure characteristic.

5.03 Hospital Payments to Promote Quality and Value

Covered California expects its Contractors to pay differentially to promote and reward better quality care rather than pay for volume. Contractor shall:

1) Adopt a hospital payment methodology that by 2019 places at least 6 percent of reimbursement to hospitals at-risk for quality performance. Each contractor may structure this strategy according to their own priorities such as:

    a. The extent to which the payments "at risk" take the form of bonuses, withholds or other penalties; and

    b. The metrics that are the basis of such value-payments, such as HACs, readmissions, or satisfaction measured through the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). Contractor is required to select standard measures commonly in use in hospitals and that are endorsed by the National Quality Forum.

CHA supports Covered California's move toward contracts that focus on quality performance that incentivize both hospitals and physicians to work together to improve quality. While the current six percent of payments proposed to be at risk in this section is somewhat similar to the amount of Medicare hospital fee-for-service inpatient payments currently at risk, an important difference is that the Medicare payments were phased in over a three-year period. Further, the payments proposed in this section encompass three very different programs.

CHA understands this to mean six percent of all payments to the hospital for Covered California patients, rather than six percent of payments for a total health plan population, but we seek additional clarity on this definition. In addition, CHA urges a phased approach to the implementation of this requirement to allow sufficient ramp up time for providers and QHPs. This is essential for California's critical access hospitals that are currently not subject to the Medicare fee-for-service risk-based programs like hospital value-based purchasing, readmissions and the HAC reduction program. Critical access hospitals and other small or low volume providers should be considered for exclusion from certain proposed measures as there will be insufficient volume for valid and reliable measurement and risk-adjustment. Further, it is our understanding that this provision would only apply to general short-term acute care hospitals and would exclude children's hospitals, inpatient psychiatric facilities, inpatient rehabilitation facilities and long-term acute care hospitals that are contracted with QHPs — we ask Covered California to clarify.

CHA understands the desire for plans and hospitals to work together to design mutually agreeable risk contracts. However, we believe a number of principles — including, but not limited to, the following — should be adhered to as part of the QHP contracting process.

- **Use a Common and Parsimonious Set of Measures.** All measures used by QHPs should be identical (numerator, denominator, risk adjustment, data collection methods, data source etc.), regardless of the program in which they are used. The proliferation of measures, data sources, and risk adjustment methodologies for the sake of differentiation wastes limited financial and personal resources. In the April 2015 Institute of Medicine report, *Vital Signs: Core Metrics for Health and Health Care Progress*, researchers concluded that the vast — and constantly growing — number of quality measures that providers are required to track "limits their overall effectiveness." Therefore, the Institute proposed a more streamlined approach for assessing performance. We should not miss this opportunity to lead the nation in demonstrating that a parsimonious set of high-impact measures — instead of a proliferation of measures that dilute performance — can drive performance at an accelerated rate. We understand that this provision would limit QHPs to measures under consideration for pay-for-performance, HAC measures listed in 5.02 (except adverse drug events), Medicare readmissions measures (discussed below) and HCAHPS measures, but do not believe additional measures should be added to this list without additional input from the provider community. We urge Covered California to establish a work group to discuss selection of measures as discussed above.

- **Use NQF-Endorsed Measures.** All measures should, at a minimum, be endorsed by the NQF, a consensus-based entity that evaluates quality measures based on their importance, scientific acceptability, feasibility to collect and usability. Measures endorsed by the NQF are typically suitable for public reporting. Each of the measures noted above are currently NQF-endorsed. However, not all measures are suitable for pay-for-performance programs; we urge Covered California to work with stakeholders to ensure that only the most robust, reliable and valid measures are adopted into those programs.

- **Promote "Carrot, Not Stick" Payment Methodologies.** CHA believes that hospitals should be rewarded for both achievement and improvements, and that QHPs should focus on that type of approach to accelerate improvement. **CHA does not support penalty programs — particularly a methodology like the Medicare HAC program that will always, by design, penalize 25 percent of hospitals regardless of their improvements over the performance period**.

- **Evaluate Additional Risk Adjustment.** CHA has continued to express our disappointment that, despite overwhelming evidence, CMS has failed to adjust the Medicare readmissions measures

for sociodemographic factors that influence a readmissions rate. It is our understanding in reading Attachment 7 that Covered California intends to use nationally-recognized measures such as Medicare readmissions measures. In doing so, we hope that Covered California will work with providers to evaluate appropriate sociodemographic status (SDS) adjusters and to encourage CMS to make these changes at the national level. **Should Covered California intend to proceed with using Medicare readmissions measures based on QHP claims data, we would welcome additional discussion on the significant limitations of these measures that would make them inappropriate for application to the QHP population.**

- **Considerations for Small and Rural Hospitals.** As noted above, critical access hospitals are not currently subject to risk-based programs under Medicare, and were excluded because they often have insufficient volume or patient mix for valid and reliable measurement. There must be appropriate exclusions for small and/or rural hospitals that are essential to provider networks, but may not be appropriate hospitals for inclusion in a value-based purchasing program, similar to Medicare. We ask that Covered California consider that these hospitals may need an additional year to identify appropriate methodologies to meet the goals of the program without unintended consequences.

7.01 Enrollee Health Care Services Price and Quality Transparency Plan

In the Application for Certification for 2017, Contractor will report its planned approach to providing healthcare shopping cost and quality information available to all members enrolled in Contractor's Covered California population. Covered California recognizes that timeline and expectations will differ, based on variables such as Contractor membership size and current tool offerings. Regardless of how the requirement is fulfilled, the common elements at the end point of each Contractor plan submission will include:

a) Cost information:

iii. Enable consumers to view their cost share for common elective specialty, and hospital services and prescription drugs specific to their plan product. Also provide real time information on member accumulation toward deductible(s), when applicable, and out of pocket maximums. Health Savings Account (HSA) users' information shall include account deposit and withdrawal/payment amounts.

iv. Allowed charges for all network providers, including the facility and physician cost, for common elective specialty, and hospital services, or comparable clear statement of patient's specific share at each provider. Commonly used service information should be organized in ways that are meaningful for consumers to understand.

v. Provider-specific costs for care delivered in the inpatient, outpatient, and ambulatory surgery/facility settings; such information shall include the facility name, address, and contact information.

CHA appreciates the important role that cost and quality information play in engaging consumers in their health care, and we believe price transparency will require the commitment and active participation of all stakeholders. CHA was part of a national taskforce convened by Healthcare Financial Management Association that addressed the price transparency issue, and put forth recommendations for consideration. One of the important contributions the taskforce makes in its report, titled *Price Transparency in Health Care*, is providing a clear set of definitions for terms such as charge, cost and price. As a first step, we ask Covered California to more clearly define its definitions of the allowed charges and provider-specific

costs described above. We urge Covered California to consider this nationally-recognized set of common definitions so that all parties agree to what is being asked and can comment specifically on this proposal. Absent a set of common definitions, we offer our comments based on our understanding and welcome additional dialogue.

First, CHA appreciates the recognition that it is incumbent on health plans to provide consumers with understandable information related to their out of pocket costs, because providers do not have timely access to this information. CHA fully supports section iii.

In California, unlike other states, a hospital's chargemaster is public and reported to the California Office of Statewide Health Planning and Development. As such, we believe requesting this information would be duplicative. Providing consumers allowable charge information, alongside out of pocket costs, may cause confusion. While there has been an historical relationship between charges and prices for health care services, that relationship has become less relevant as new payment models have emerged. Moreover, there must be additional consumer education on the differences in hospital charges that are a result of the unique services provided. For example, some hospitals have higher cost structures due to their commitment to teaching or to providing high-cost services like trauma or burn care. We do not believe charges are an appropriate proxy for price, nor do we support the release of confidentially-negotiated rates between providers and hospitals. CHA stands ready to work with Covered California and the QHPs on developing a strategy to provide important and useable data and to do so in a way that is consistent across all plans.

b) Quality information:

iii. Covered California expects Contractor with over 100,000 enrollees to provide consumers with internally developed quality ratings specific to physician and facility by the end of 2019,

iv. Nationally endorsed quality information, in accordance with the principles of the Patient Charter for Physician Performance Measurement, will be accepted as an interim step for plans with enrollments over 100,000 until provider-specific quality information specific to Covered California experience can be provided and may be a longer term solution for smaller plans. Sources for national or state quality information for tool inclusion are:

i. The California Office of the Patient Advocate (www.opa.ca.gov/)

ii. The Department of Insurance Healthcare Compare (www.consumerreports.org/cro/health/california-health-cost-and-quality---consumer-reports/index.htm)

iii. CMS Hospital Compare Program (https://www.medicare.gov/hospitalcompare/search.html)

iv. CMS Physician Quality Reporting System (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html?redirect=/pqri/)

v. In addition, Contractor shall recognize California hospitals that have achieved target rates for NTSV C-Section utilization and Hospital Acquired Conditions (HACs) as defined in Article 5, Sections 5.01 and 5.02.

CHA is concerned about the approach outlined in section b) that encourages each individual QHP to develop its own internal quality rating system for providers and facilities. While we agree that providing quality information is important, and are pleased to see Covered California list nationally-recognized and publicly available data for use in this process, we disagree with the approach. **CHA urges Covered California adopt one approach all QHPs may use in providing quality information to consumers.**

Covered California consumers are shopping for their health insurance through the exchange; many may change plans from year to year. We believe one methodology for both providers and consumers would consistently result in accurate information. CHA is committed to working with our partners in developing **a single approach** that makes sense for consumers and providers, which would reduce unnecessary costs and administrative burden for both health plans and providers.

Finally, CHA appreciates the above language in Section 7.01 iii which clearly states that Covered California will recognize in a positive way hospitals that achieve their targets. We understand this approach to be one that promotes positive recognition for important work throughout the year. CHA fully supports this approach and believes consumers will appreciate this simple designation.

We believe some may argue that rather than promoting achievement, an alternative approach would be to perhaps grade hospitals on their performance (average, below average, poor, etc.). As previously stated, we would not support multiple methodologies for the array of quality performance data for QHPs. Any alternative approach should be considered through a stakeholder engagement and public comment process.

CHA appreciates the opportunity to provide comments to Covered California on the Draft and Attachment 7. We appreciate your consideration of the above recommendations, and look forward to our continued partnership. If you have any questions, please contact me at (916) 552-7543.

Sincerely,

Amber Kemp
Vice President, Health Care Coverage

cc: Lance Lang, Chief Medical Officer, Covered California
Anne Price, Director, Plan Management, Covered California

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

February 16, 2016

Peter V. Lee
Covered California
Executive Director
Peter.Lee@covered.ca.gov

Subject: Second Draft Qualified Health Plan (QHP) Certification Application for Plan Year 2017

Dear Mr. Lee:

On behalf of our more than 400 member hospitals and health systems, the California Hospital Association (CHA) welcomes the opportunity to provide comments to Covered California on its second draft Qualified Health Plan (QHP) Certification Application for Plan Year 2017 Attachment 7, Quality, Network Management and Delivery System Standards ("second draft") released on February 11, 2016.

As our February 8 comments reflect, we have a shared commitment to achieving the triple aim of improved patient care including quality and satisfaction, improved population health, and a reduction in per capita health care program costs. CHA appreciates Covered California's continued focus and attention in moving our health care system from paying for volume to paying for value. CHA appreciates its partnership with Covered California and looks forward to continued collaboration with Covered California, its QHPs and other providers in developing policies that will achieve this shared goal.

With that said, CHA wishes to express our deep concern regarding some of the most recent changes proposed to Attachment 7 and the limited time allowed for stakeholder input and discussion. Moreover, there are a number of questions that remain unanswered and the lack of clarity regarding QHP and provider requirements is of great concern as we move forward.

While we appreciate the vision and leadership that Covered California aspires to achieve, we do not believe the current process supports the needs of Covered California or other stakeholders in being able to fully vet and consider both the opportunities and challenges of the proposed policies outlined in Attachment 7. CHA is particularly concerned with the most recent additions outlined in section 1.03 related to high cost providers. The issues of quality and cost measurement are important but they are also very complex and deserve greater scrutiny. A 5-day comment period is woefully inadequate for evaluation of such polices and we urge Covered California to reconsider its approach.

In reviewing comments of other stakeholders including our own, it is clear there is confusion regarding these complex and often overlapping provisions. We have identified areas that if not addressed will lead to overly burdensome and costly data collection, multiple competing health plan priorities and a downstream effect that will divert precious health care dollars away from direct patient care. This is contrary to the goals and vision that Covered California has outlined.

We urge Covered California to revisit the process for input so that these policies can be more fully vetted and issues can be addressed in a way that accelerates improvement, reduces costs and improves the health of all Californians. We believe the current path we are on will result in a number of false starts that will frustrate providers and health plans, leading to costly reworks and potentially unintended consequences

that with an improved and strategic approach may be avoided. One way to accomplish this is to consider a more phased approach and realistic implementation timeline to allow for a more robust discussion, planning, testing and implementation. Starting small and building on our success over time will engender cooperation and collaboration at all levels – a key success factor in achieving our shared goals.

We stand ready to work with Covered California in addressing a number of outstanding issues that have yet to be resolved and are detailed in our comments noted below.

I. Draft Qualified Health Plan (QHP) Certification Application for Plan Year 2017

While the second draft of the QHP Certification Application for Plan Year 2017 does not appear to have been released for additional public comment, Covered California indicated at its February 11 Plan Management Advisory and Delivery System Reform Advisory Group meeting that it does not intend to change the proposed Section 4.4.5 requirement that plans describe any contractual agreements with participating providers that preclude the plan from making contract terms transparent to plan sponsors and members. The proposal also requires that plans agree to make commercially reasonable efforts to exclude any contract provisions that would prohibit disclosure of such information to Covered California. **CHA is disappointed that Covered California refused to acknowledge that provider contracts and payment terms are proprietary, confidential and competitive. CHA does not support this provision as it raises anti-trust concerns.**

There is no policy reason for Covered California to have this detailed information since it is negotiating with the QHPs on premium rates; detailed proprietary contract information from specific providers is not necessary for the purpose of negotiating premiums. In addition, Covered California may obtain aggregated information from its QHPs that sufficiently satisfies any legitimate policy purpose, without requiring access to individual proprietary provider contracts. We have no confidence this sensitive information will remain confidential and will not be used by other parties inappropriately or for anti-competitive reasons.

II. Attachment 7. Quality, Network Management and Delivery System Standards

1.02 Assuring Networks are Based on Value

CHA is very concerned about the addition of section 1.03 and its relationship to sections 1.02 and the related nature of section 1.07. As we discuss in our comments, Covered California uses the terms cost, charge and price interchangeably throughout the document. There are areas throughout the attachment where cost and quality information are linked. The expectation that plans include both cost and quality factors in all provider and facility selection does not take into account region variation of physician distribution and facility resources. We suggest that prior to the required reporting with the 2018 Application for Certification, Covered California engage with stakeholders, including CHA, to develop a more specific, evidence-based model, which objectively measures both quality of care and the promotion of safety, if it expects QHPs to only contract with providers and hospitals which demonstrate both. CHA is concerned that without additional dialogue, we will find ourselves in a place where lower cost equals lower quality, or vice versa, despite evidence to the contrary. In addition, the language in each of the three sections (1.02, 1.03 and 7.01) is confusing and must be clarified to ensure shared understanding and consistent approaches that achieve their intended purpose. More specifically:

2) Contractor shall disclose to Covered California, with its Application for Certification for 2017, how it meets this requirement and the basis for the selection of providers or facilities in networks available to Covered California enrollees. This shall include a detailed description of how cost, clinical quality, patient reported experience or other factors are considered in network design and provider facility selection. Such information may be made publicly available by Covered California.

In order to facilitate understanding of the methodologies used by QHPs in developing networks, CHA respectfully requests that this information be made available to hospitals and physicians. In addition, hospitals and physicians should have embargoed data provided for review to identify errors that require corrections prior to public release to any entity. If the QHP methodology excludes a provider from the network, both the methodology and the data should be transparent to the provider. Understanding expectations of QHPs in their quality goals for network design and facility selection will bring greater transparency to the process. Further, knowing the source and year of the data is also important.

3) Covered California expects Contractor to only contract with providers and hospitals that demonstrate they provide quality care and promote the safety of Covered California Enrollees at a reasonable price. To meet this expectation, by contract year 2018, Covered California will work with its contracted plans to identify areas of "outlier poor performance" based on variation analysis. As part of this process, Covered California will engage experts in quality and cost variation and shall consult with California's providers. For contract year 2019, Contractors will be expected to either exclude those providers that are outlier poor performers on either cost or quality from provider networks or to document each year in its Application for Certification the rationale for continued contract with each provider that is identified as a poor performing outlier and efforts the provider is undertaking to improve performance. Such reports will detail contractual requirements and their enforcement, monitoring and evaluation of performance, consequences of noncompliance and plans to transition patients from the care of providers with poor performance. Such information may be made publicly available by Covered California.

As we have previously shared, CHA appreciates the opportunity to engage in the development of a methodology on performance standards for providers, and looks forward to working with Covered California in its development. **However, CHA remains concerns that the process to date for stakeholder input has not been sufficient to support the tremendous work that lies ahead and we urge Covered California to begin this work in earnest as soon as possible. Several key principles should be considered as a framework for analysis and there must be sufficient time for thoughtful input, analysis, modeling and education of hospitals and health systems. We encourage a transparent process inclusive of providers, CHA and other interested stakeholders.**

In addition, Section 1.02 is the first of several sections where Covered California proposes to exclude providers from contracting with QHPs if metrics are not achieved and the methodologies for arriving at those metrics are not yet known. CHA believes these provisions, noted in 1.02, as well as other places in Attachment 7 are worthy of additional dialogue. More specifically, should Covered California proceed, we believe they are also obligated to measure the impact to consumers on their access to care and their out-of-pocket costs. More specifically, Covered California may wish to consider an independent evaluation that is both qualitative and quantitative to measure the impact of access to care for patients and on plan networks as a whole. We are particularly concerned about our low volume providers (small, rural or critical access hospitals) that are essential in meeting the needs of patients in their communities, but due to low volume, the metrics may exclude them meeting a threshold for inclusion in a network, creating access issues in many parts of the state. While well intentioned, we believe these policies need additional refinement and discussion.

1.03 Demonstrating Focus on High Cost Providers

Section 1.03 asserts that the "wide variation in unit price and total costs of care charged by providers, with some providers charging far higher for care irrespective of quality, is one of the biggest contributors to high costs of medical services." The section requires plans to report the factors it considers in assessing the relative unit prices and total costs of care, the distribution of providers and facilities by cost deciles, and strategies to assure that contracted providers are not charging unduly high prices. However, as noted in more detail in our comments in Section 1.07, Covered California fails to clearly define costs, charges and prices. These definitions can vary widely and may refer to the charges billed to the QHP, the amount payable to the provider from the QHP, or the expense incurred by the hospital to deliver the health care services to the patient. The charges billed by the hospital are often much higher than the amount paid by the QHP, and the expense incurred by the hospital to deliver the health care services can be higher or lower than the amount paid by the QHP, depending on the services provided and the contractually negotiated rates that are negotiated between the hospital and the QHP. **Due to these significant discrepancies, CHA urges Covered California to reconsider its approach. Prior to proceeding, Covered California must engage in further discussions with stakeholders, including CHA, to ensure there are clear definitions and a consistent approach in collecting data related to cost, charges and price in order to ensure uniform reporting. Much of this information is already publicly available. CHA supports Covered California's efforts to increase transparency, but in order to provide meaningful information to consumers and comparative analytics, it is vital that the data are standardized and consistent.**

This section also states that the Contractor will be expected to exclude hospitals and other facilities that demonstrate outlier high cost from provider networks serving Covered California or to document the rationale for continued contracting with each hospital and efforts the hospital is undertaking to lower its costs. Pricing is often inconsistent across the hospital industry, because hospitals operate under different circumstances based on the unique range of services they offer, continuing emergence of new medical technology, workforce shortages, government underfunding and patient demographics. It can also vary regionally based on legislative mandates and market demand for labor, supplies (e.g. pharmacy costs), real estate and other costs. Unfunded mandates such as seismic requirements, for example, result in much higher costs. In addition, we are very concerned about variation in the approach for defining a high cost provider. This is a problematic provision that was added with little time for stakeholder input. **For these reasons, CHA does not support requiring QHPs to exclude hospitals that are perceived to be high cost outliers from provider networks. We ask that Covered California remove this provision in its entirety until additional input can be gathered and considered.**

1.06 Participation in Collaborative Quality Initiatives

In our February 8 comments, we requested that Covered California revise its list of quality collaboratives listed in Section 1.03 (Section 1.06 in the second draft) to ensure that any hospital engagement network (HEN), including those not listed, would be counted for participation, including the Children's Hospitals' Solutions for Patient Safety HEN and quality collaboratives associated with the state's 1115 Medicaid Waiver Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program. **CHA appreciates that Covered California has added Children's Hospitals' Solutions for Patient Safety HEN and quality collaboratives associated with the state's 1115 Medicaid Waiver PRIME program to the list of quality collaboratives. Since Covered California did not incorporate our previous recommendation that it revise the list of quality collaboratives to ensure that any HEN, including those not listed, be counted for participation, we more specifically request that Covered California add Premiere, Inc. to the list of HENs that would count toward a hospital's participation in a quality collaborative.**

As we noted in our February 8 comments, CMS' recently proposed *CMS-9937-P Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017* rule further implements provisions of the Affordable Care Act (ACA) that mandate certain patient safety and quality improvement requirements in order to contract with a QHP through health insurance exchanges. **We believe CMS' approach, though not yet finalized, to allow participation in both a quality collaborative and a federally qualified patient safety organization (PSO) outlined in the proposed rule is an important next step in meeting the ACA's requirement. We strongly urge Covered California to add participation in a federally-qualified Patient Safety Organization (for example, CHPSO) to the list of quality collaboratives in Section 1.06, as an interim step toward the anticipated final requirements.**

PSOs — like CHPSO — carry out a variety of patient safety activities with the goal of improving patient safety and the quality of health care delivery. PSOs are able to collect, aggregate and analyze patient safety events and information that are protected under privilege and confidentiality standards. The patient safety evaluation system provisions set forth in the ACA and implemented in regulation align with the triple aim and the goals laid out in the National Quality Strategy.

We believe it would be premature to add CMS' proposed rule language to this section of Attachment 7. However, the ACA requirement for PSO participation is an important step in achieving the goals that Covered California has set forth. CHA and CHPSO believe that the regulatory framework used to implement this section of law should strongly encourage hospital participation in federally-qualified PSOs, while retaining flexibility for continued and ongoing work in the important quality collaborative work outlined in this section.

Covered California goes a step further and proposes to collect information about provider participation, but notes that in the future it will seek additional information.

> Contractor will provide Covered California information regarding their participation in each collaboration. **Such information shall be in a form that shall be mutually agreed to by the Contractor and may include copies of reports used by the Contractor for other purposes.** Contractor understands that Covered California will seek increasingly detailed reports over time that will facilitate the assessment of the impacts of these programs which should include: (1) the percentage of total Participating Providers, as well as the percentage of Covered California specific Providers participating in the programs; (2) the number and percentage of potentially eligible Plan Enrollees who participate through the Contractor in the Quality Initiative; (3) the results of Contractors' participation in each program, including clinical, patient experience and cost impacts; and (4) such other information as Covered California and the Contractor identify as important to identify programs worth expanding.
>
> Covered California and Contractor will collaboratively identify and evaluate the most effective programs for improving care for enrollees and participation in specific collaboratives may be required in future years.

Annual attestation of participation in these programs should be sufficient to meet Covered California requirements, and CHA encourages health plans to consider a simple attestation process when fulfilling these requirements. Notably, many quality improvement initiatives are restricted to only a certain number of hospitals due to limited funding for participation. Throughout the year, and over the course of many years, hospitals will likely move from one initiative to another, or to PSO participation, as they seek to continually improve both performance and patient care. As new initiatives are developed, hospitals must have flexibility to prioritize the areas that are most critical for their quality improvement

efforts. The list of collaboratives should not remain static, and should be added to or reduced, as appropriate, in consultation with stakeholders. Hospital attestation allows for flexibility and will limit the administrative burden on both QHPs and hospitals.

As we have previously shared, while we understand and appreciate the request for additional information by Covered California in future years, we do not agree with collecting data without a clear objective and understanding of its intended use. Rather, a more prudent approach would be to understand participation in various collaboratives and together design a strategic approach to gathering information on hospital performance. CHA does not support requiring QHPs to duplicate already ongoing data collection. We stand ready to work with stakeholders to achieve Covered California's goals in a way that limits administrative burden and costly and unnecessary data collection efforts that will only waste limited financial and personnel resources.

1.07 Data Exchange with Providers

Covered California and Contractor recognize the critical role of sharing data across specialties and institutional boundaries as well as between health plans and contracted providers in improving quality of care and successfully managing total costs of care. Contractor shall report in its annual Application for Certification the initiatives Contractor has undertaken to improve routine exchange of timely information with providers to support their delivery of high quality care. Examples that could impact the Contractor's success under this contract may include:

a) Notifying PCPs when one of their empaneled patients is admitted to a hospital, a critical event that often occurs without knowledge of either the primary care or specialty care providers who have been managing the patient on an ambulatory basis.

b) Developing systems to collect clinical data as a supplement to the annual HEDIS process, such as HbA1c lab results and blood pressure readings which are important under Article 3 below.

c) Racial and ethnic self-reported identity collected at every patient encounter.

CHA supports the exchange of patient data to between QHPs and providers to ensure better care coordination. California hospitals remain committed to EHR implementation and using technology to achieve the best patient outcomes. CHA appreciates Covered California's focus on this area but we believe additional refinements to this section are needed to better align efforts already underway in the state.

More specifically, the *Office of the National Coordinator for Health Information Technology Data Brief of April 2015* identified that 68 percent of non-federal acute care hospitals in California responding to the ONC/American Hospital Association annual survey had electronically exchanged health information with outside ambulatory providers or hospitals in 2014. This is statistically lower than the national average of 76 percent. While we are making headway, and we agree more work needs to be done, this work must be aligned with currently specified goals.

CHA does not support QHPs developing new approaches to health information exchange that will divert precious and scarce resources from current efforts. Any new QHP effort will require hospital and provider resources to achieve. A more strategic approach would be for Covered California, in collaboration with QHPs and other stakeholders to assess the current initiatives

underway in the state and to identify within that list of ongoing work a few key priority areas for accelerated development that both providers and health plans would work on together. Creating strategic alignment with ongoing work will only accelerate change. CHA supports the goals that Covered California is promoting, but encourages Covered California to adopt processes that do not place unrealistic requirements on providers or demand the use of technology that is not supported currently.

1.08 Data Aggregation across Health Plans

Covered California and Contractor recognize the importance of aggregating data across purchasers and payers to be more accurately understand the performance of providers that have contracts with multiple health plans. Such aggregated data reflecting a larger portion of a provider, group or facility's practice can potentially be used to support performance improvement, contracting and public reporting.

Contractor shall report in its annual Application for Certification its participation in initiatives to support the aggregation of claims and clinical data. Contractor should include its assessment of additional opportunities to improve measurement and reduce the burden of data collection on providers through such proposals as a statewide All Payer Claims Database.

Examples to date have included:

(a) The Integrated Health Association (IHA) for Medical Groups
(b) The California Healthcare Performance Information System (CHPI)
(c) The CMS Physician Quality Reporting System
(d) CMS Hospital Compare or
(e) CalHospital Compare
(f) Hospital Quality Institute (HQI)

Critical to the work of Attachment 7 is having reliable and valid data aggregators, for both administrative claims data as well as the data needed to construct accurate and reliable quality measures. CHA respectfully requests that Covered California add (f) Hospital Quality Institute (HQI) to the list of examples for inclusion under Section 1.08. HQI is a demonstrated leader in quality improvement in the state, and a trusted source of quality information for hospitals.

Established in April 2013 to realize statewide impact of improving patient safety and quality care for all Californians, HQI has worked tirelessly to accelerate the rate of improvement, and to advance California as a national leader in quality performance. HQI consists of several programs focusing on quality improvement and patient safety including but not limited to CHPSO, the federally qualified patient safety organization, the state's HEN and Patient Safety First. Each program works separately as well as integrated with each other so that reporting redundancy is eliminated, multiple contacts are minimized, and hospital staff focus on improvement goals with the entire support network of HQI.

5.01 Hospital Payments to Promote Quality and Value

Covered California expects its Contractors to pay differently to promote and reward better quality care rather than pay for volume. Contractor shall:

1) Adopt a hospital payment methodology that by 2019 places at least 6 percent of reimbursement for Contractor's entire book of business with each hospital at-risk for quality performance. Each contractor may structure this strategy according to their own priorities such as:

    a. The extent to which the payments "at risk" take the form of bonuses, withholds or other penalties;

    b. The metrics that are the basis of such value-payments, such as HACs, readmissions, or satisfaction measured through the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). Contractor is required to select standard measures commonly in use in hospitals and that are endorsed by the National Quality Forum.

CHA appreciates the additional clarification Covered California has provided about the application of this provision to the Contractor's entire book of business, as this was not clear in the first draft. As we have previously noted, we urge a phased approach to the implementation of this requirement to allow sufficient ramp up time for providers and QHPs. This is essential for California's critical access hospitals that are currently not subject to the Medicare fee-for-service risk-based programs. Critical access hospitals and other small or low volume providers should be considered for exclusion from certain proposed measures and payment requirements as there will be insufficient volume for valid and reliable measurement and risk-adjustment. In our previous comments we noted that our understanding is that this provision would only apply to general short-term acute care hospitals and would exclude children's hospitals, inpatient psychiatric facilities, inpatient rehabilitation facilities and long-term acute care hospitals that are contracted with QHPs, asking Covered California to clarify. As this has not been clarified in the second draft, we request that the final draft include this level of specificity.

In addition, CHA supports Covered California's move toward contracts that focus on quality performance that incentivize both hospitals and physicians to work together to improve quality. However, before proceeding, it is imperative that we have an agreed upon set of parsimonious quality measures from which providers and health plans would choose from that that would be the basis for the programs to proceed. Unfortunately, this section does not refer to a draft *Appendix 2 to Attachment 7: Measurement Specifications (Appendix 2)* which we believe is the beginning of such a list of measures for consideration for these programs. CHA urges Covered California to incorporate a forthcoming Appendix 2 following additional stakeholder input.

CHA understands the desire for QHPs and hospitals to work together to design mutually agreeable risk contracts and believes that a number of principles — including, but not limited to, the following — should be adhered to as part of the QHP contracting process.

- **Use a Common and Parsimonious Set of Measures.** All measures used by QHPs should be identical (numerator, denominator, risk adjustment, data collection methods, data source etc.), regardless of the program in which they are used. The proliferation of measures, data sources, and risk adjustment methodologies for the sake of differentiation wastes limited financial and personal resources. In the April 2015 Institute of Medicine report, titled *Vital Signs: Core Metrics for Health and Health Care Progress*, researchers concluded that the vast — and constantly growing — number of quality measures that providers are required to track "limits their overall effectiveness." Therefore, the Institute proposed a more streamlined approach for assessing performance. We should not miss this opportunity to lead the nation in demonstrating that a

parsimonious set of high-impact measures — instead of a proliferation of measures that dilute performance — can drive performance at an accelerated rate. We urge Covered California to establish a workgroup to discuss selection of measures for inclusion in these programs and believe Appendix 2 is the appropriate starting place for the discussion but that additional dialogue is needed.

- **Use NQF-Endorsed Measures.** All measures should, at a minimum, be endorsed by the NQF, a consensus-based entity that evaluates quality measures based on their importance, scientific acceptability, feasibility to collect and usability. Measures endorsed by the NQF are typically suitable for public reporting. Each of the measures noted above is currently NQF-endorsed. However, not all measures are suitable for pay-for-performance programs; we urge Covered California to work with stakeholders to ensure that only the most robust, reliable and valid measures are adopted into those programs.

- **Promote "Carrot, Not Stick" Payment Methodologies.** CHA believes that hospitals should be rewarded for both achievement and improvements, and that QHPs should focus on that type of approach to accelerate improvement. CHA does not support penalty programs — particularly a methodology such as the Medicare HAC program that will always, by design, penalize 25 percent of hospitals regardless of their improvements over the performance period.

- **Evaluate Additional Risk Adjustment.** CHA continually expressed disappointment that, despite overwhelming evidence, CMS has failed to adjust the Medicare readmissions measures for sociodemographic factors that influence a readmissions rate. It is our understanding in reading Attachment 7 that Covered California intends to use nationally-recognized measures such as Medicare readmissions measures, however there are no readmission measures currently specified in Appendix 2 and therefore we would like to have additional dialogue regarding such measures for consideration under these programs. We urge Covered California to work with providers to evaluate appropriate sociodemographic status (SDS) adjusters for readmission measures that may be under consideration. Should Covered California intend to proceed with using Medicare readmissions measures based on QHP claims data, we welcome additional discussion on the significant limitations of these measures that would make them inappropriate for application to the QHP population.

- **Considerations for Small and Rural Hospitals (Low Volume).** As noted above, critical access hospitals are not currently subject to risk-based programs under Medicare and were excluded because they often have insufficient volume or patient mix for valid and reliable measurement. There must be appropriate exclusions for low-volume, small and/or rural hospitals that are essential to provider networks but that may not be appropriate hospitals for inclusion in a value-based purchasing program, similar to Medicare. We ask Covered California to consider that these hospitals may need an additional year to identify appropriate methodologies to meet the goals of the program without unintended consequences.

5.02 Hospital Patient Safety

1) Contractor shall report in its Application for Certification for 2017 baseline rates of specified Hospital Acquired Conditions (HACs) for each of its network hospitals. In order to obtain the most reliable measurement, minimize the burden on hospitals and in the interest of promoting common measurement, Contractor shall employ best efforts to base this report on clinical data

such as is reported by hospitals to the National Healthcare Safety Network (NHSN), California Department of Public Health (CDPH) and to CMS under the Partnership for Patients initiative.

As we noted in our February 8 comments, CHA applauds Covered California for recognizing that QHPs should not develop new measures or data collection efforts to meet this section's intended goals. **However, we are disappointed that Covered California did not remove the language "employ best efforts" from the above to ensure that: a) all QHPs use the HAC measures already required by CMS and CDPH; and b) that QHPs do *not* create an alternative data collection mechanism, but rather employ current data collection efforts to streamline reporting for hospitals and ensure that a robust data validation effort is part of this process. We urge Covered California to establish a workgroup to advise on measure selection for use in public reporting and performance-based programs such as those described in 5.02 and 5.03 and 7.01(b). We believe coming to stakeholder consensus on a list of measures for consideration is the first step in this important discussion.**

1) Prior to its Application for Certification for 2018, target rates for 2019 and for annual intermediate milestones for each HAC measured at each hospital will be established by Covered California based on national benchmarks, analysis of variation in California performance and best existing science of quality improvement and effective engagement of stakeholders.

2) The HACs that are the subject of these initiatives are:

    a. Catheter Associated Urinary Tract Infection (CAUTI);

    b. Central Line Associated Blood Stream Infection (CLABSI);

    c. Surgical Site Infection (SSI) with focus on colon;

    d. Adverse Drug Events (ADE) with focus on hypoglycemia, inappropriate use of blood thinners, and opioid overuse; and

    e. Clostridium difficile colitis (C. Diff) infection.

3) The subject HACs may be revised in future years; Covered California expects to include sepsis mortality at such time as the standardized CMS definition and measurement strategy has been tested and validated.

As we've previously shared, while we appreciate Covered California's selection of existing measures that are reported at the state and federal level through the Centers for Disease Control and Prevention's NHSN, we firmly believe it is premature to include the proposed adverse drug event measure, which should instead be considered in future years. This data collection is only just beginning through the voluntary Partnership for Patients initiative, which is focused on data collection for the purposes of quality improvement. This data is not currently used in CMS national pay-for-reporting programs and, therefore, CHA is concerned that the level of hospital resources dedicated to data collection for this measure is significantly lower than the resources devoted to the rigorous data collection for HACs that are currently required in national pay-for-performance and public reporting programs. In addition, opioid overuse is being addressed through a statewide workgroup. **CHA urges Covered California to adopt measures only after they have been publicly reported for at least one year.** The data on Hospital Compare, while imperfect, undergo a fairly rigorous validation process, which is critically important when measures move from pay-for-reporting to pay-for-performance.

CHA is disappointed that Covered California has not included consideration in this provision for hospitals that serve primarily or exclusively pediatric populations, since national pediatric benchmarks may not exist and adult benchmarks may be inappropriate. For example, surgical site infection *with a focus on colon* is not relevant for pediatric patients; C. Difficile infections in children are less common than adults and there is limited high-quality evidence to guide the management of pediatric C. Difficile infection. **We request that Covered California provide clarity on this in its final draft, as well as provide clarity on how this provision would apply to inpatient psychiatric facilities, free standing inpatient rehab facilities and long-term acute care hospitals.**

5) Covered California expects Contractor to only contract with hospitals that demonstrate they provide quality care and promote the safety of Covered California enrollees. **To meet this expectation, by contract year 2018, Covered California will work with its contracted plans and with California's hospitals to identify area of "outlier poor performance" based on variation analysis of HAC rates.** For contract year 2019, Contractors will be expected to either exclude hospitals that demonstrate outlier poor performance on safety from provider networks serving Covered California or to document each year in its Application for Certification the rationale for continued contracting with each hospital that is identified as a poor performing outlier on safety and efforts the hospital is undertaking to improve its performance.

CHA appreciates Covered California's willingness to work with California's hospitals and CHA in defining outlier or poor performance. As we have previously shared, we do not believe that currently available methods to identify "outlier poor performance" are able to adjust adequately for factors such as socioeconomic status, geography, complexity of illness, comprehensiveness of services, wages, post-hospitalization costs, etc. Additionally, there is no evidence that "exclusion" of poor performers is a rational approach to improving care. CHA is concerned that this policy may have the effect of reducing access. Therefore, this process should be open and transparent, and dedicated analytic resources should be made available to understand the impacts of various metrics on providers.

Lastly, CHA urges Covered California to seek public comment on the identification of additional measures going forward in this process. In addition, similar to section 5.01, Covered California should only adopt measures that are endorsed by the National Quality Forum (NQF) — we urge you to reconsider the language in this section to reflect this important measure characteristic.

5.03 Appropriate Use of C-Sections

As we have previously noted, CHA fully supports Covered California's goal of appropriate use of C-sections and strongly believes that a similar payment provision for contracted OB/GYN physicians is critical in making this policy truly effective. While hospitals play a critical role in lowering C-section rates, hospitals do not make those medical decisions — this is a decision made by the physician and the patient. California, unlike other states, cannot employ physicians and thus alignment can be more challenging. A payment policy that ignores the necessary alignment between hospitals and physicians — the majority of whom are not employed by hospitals in California — is short-sighted and must be reconsidered. **We appreciate that Covered California has acknowledged this in the second draft by applying its proposed payment strategy to physicians. CHA strongly believes that any proposal to exclude hospitals from networks or other actions should apply to not only a hospital but also to physicians.** CHA is disappointed that Covered California did not include this recommendation in its second draft. Adoption of a physician-level metric, similar to that for hospitals, must be a top priority for Covered California and the QHPs.

4) Covered California expects Contractor to only contract hospitals **and physicians** that demonstrate they provide quality care and promote the safety of Covered California enrollees. Effective with the Application for Certification for 2019, contractor shall either exclude hospitals **and physicians** from provider networks for purposes of maternity services or to document each year in its Application for Certification the rationale for continued contract with each hospital that demonstrates a C-section rate for NTSV deliveries that is substantially above 23.9 percent.

CHA does not believe that hospitals should be automatically excluded from provider networks if they are unable to achieve an NTSV C-section rate below 23.9 percent. We request that the standard for consideration for exclusion including a statistically significant difference from the 23.9 percent target, rather than falling 'below 23.9 percent'; realizing that C-section volume will impact the validity of this measurement. We appreciate that Covered California is permitting plans to document in their Application for Certification the rationale for continued contracting with each hospital that has an NTSV C-section rate above 23.9 percent and efforts the hospital is undertaking to improve its performance, as this may be important for patients to access appropriate care in their local communities.

Lastly, we see that in addition to NTSV C-Sections, Covered California is also requiring an overall C-Section rate to be reported. We are concerned that two C-Section rates may be confusing to consumers and we respectfully request additional dialogue on this issue as this was a last minute addition to Attachment 7 that we believe should be considered more fully before it is implemented.

7.01 Enrollee Health Care Services Price and Quality Transparency Plan

In the Application for Certification for 2017, Contractor will report its planned approach to providing healthcare shopping cost and quality information available to all members enrolled in Contractor's Covered California population. Covered California recognizes that timeline and expectations will differ, based on variables such as Contractor membership size and current tool offerings. Regardless of how the requirement is fulfilled, the common elements at the end point of each Contractor plan submission will include:

a) Cost information:

i. Enable consumers to view their cost share for common elective specialty, and hospital services and prescription drugs specific to their plan product. Also provide real time information on member accumulation toward deductible(s), when applicable, and out of pocket maximums. Health Savings Account (HSA) users' information shall include account deposit and withdrawal/payment amounts.

ii. Allowed charges for all network providers, including the facility and physician cost, for common elective specialty, and hospital services, or comparable clear statement of patient's specific share at each provider. Commonly used service information should be organized in ways that are meaningful for consumers to understand.

iii. Provider-specific costs for care delivered in the inpatient, outpatient, and ambulatory surgery/facility settings; such information shall include the facility name, address, and contact information.

CHA appreciates the important role that cost and quality information play in engaging consumers in their health care, and we believe price transparency will require the commitment and active participation of all stakeholders. CHA was part of a national taskforce convened by Healthcare Financial Management Association that addressed the price transparency issue, and put forth recommendations for consideration. One of the important contributions the taskforce makes in its report, titled *Price Transparency in Health Care*, is providing a clear set of definitions for terms such as charge, cost and price. As previously stated, we ask Covered California to more clearly define its definitions of the allowed charges and provider-specific costs described above. We urge Covered California to consider this nationally-recognized set of common definitions so that all parties agree to what is being asked and can comment specifically on this proposal. Absent a set of common definitions, we offer our comments based on our understanding and welcome additional dialogue.

First, CHA appreciates the recognition that it is incumbent on health plans to provide consumers with understandable information related to their out of pocket costs, because providers do not have timely access to this information. CHA fully supports section iii.

In California, unlike other states, a hospital's chargemaster is public and reported to the California Office of Statewide Health Planning and Development. As such, we believe requesting this information would be duplicative. Providing consumers allowable charge information, alongside out of pocket costs, may cause confusion. While there has been an historical relationship between charges and prices for health care services, that relationship has become less relevant as new payment models have emerged. Moreover, there must be additional consumer education on the differences in hospital charges that are a result of the unique services provided. For example, some hospitals have higher cost structures due to their commitment to teaching or to providing high-cost services such as trauma or burn care. We do not believe charges are an appropriate proxy for price, nor do we support the release of confidentially-negotiated rates between providers and hospitals. CHA stands ready to work with Covered California and the QHPs on developing a strategy to provide important and useable data and to do so in a way that is consistent across all plans.

b) Quality information:

i. Enable consumers to compare providers based on quality performance in selecting a personal care physician or for common elective specialty and hospital services.

ii. Covered California expects Contractor to base quality measurement on nationally endorsed quality information, in accordance with the principles of the Patient Charter for Physician Performance Measurement.

iii. As an interim step prior to integrating quality measurement into provider chooser tools, quality information can be provided by linking to:

a. The California Office of the Patient Advocate (www.opa.ca.gov/)

b. The Department of Insurance Healthcare Compare (www.consumerreports.org/cro/health/california-health-cost-and-quality---consumer-reports/index.htm)

c. CMS Hospital Compare Program (https://www.medicare.gov/hospitalcompare/search.html)

d. CMS Physician Quality Reporting System (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html?redirect=/pqri/)

iv. In addition, Contractor shall recognize California hospitals that have achieved target rates for Hospital Acquired Conditions (HACs) and NTSV C-section utilization as defined in Article 5, Sections 5.02 and 5.03.

CHA is pleased that Covered California has eliminated its initially proposed requirement that QHPs provide consumers with *internally* developed quality ratings specific to physician and facility by the end of 2019. As we have previously stated, we are concerned with an approach that encourages each individual QHP to develop its own internal quality rating system for providers and facilities. In future years, CHA urges Covered California to adopt one approach that all QHPs may use in providing quality information to consumers.

Covered California consumers are shopping for their health insurance through the exchange; many may change plans from year to year. We believe one methodology for both providers and consumers would consistently result in accurate information. CHA is committed to working with our partners in developing **a single approach** that makes sense for consumers and providers, which would reduce unnecessary costs and administrative burden for both health plans and providers.

CHA appreciates the opportunity to provide comments to Covered California on the second draft. We prepared comments quickly to meet Covered California's compressed timeframe to review and provide comment. Should we identify other areas of concern, we will submit our comments to Covered California in an expeditious manner. If you have any questions, please contact me at (916) 552-7543.

Sincerely,

Amber Kemp
Vice President, Health Care Coverage

cc: Lance Lang, Chief Medical Officer, Covered California
Anne Price, Director, Plan Management, Covered California

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

March 16, 2016

Peter V. Lee
Covered California
Executive Director
Peter.Lee@covered.ca.gov

Subject: Covered California's March 4, 2016 Draft Appendix 2 to Attachment 7: Measurement Specifications

Dear Mr. Lee:

On behalf of our more than 400 member hospitals and health systems, the California Hospital Association (CHA) is providing the attached comments to Covered California on its draft 2017-19 Qualified Health Plan (QHP) Certification Application, Appendix 2 to Attachment 7: Measurement Specifications ("Appendix 2"), released on March 4, 2016. We appreciate that Covered California provided CHA an opportunity to meet and discuss Appendix 2 on March 11. The ongoing dialogue is an important step in bringing to light a number of issues still not well understood by the hospital field. While our comments are limited to Appendix 2, they are largely reflective of many unanswered questions in Attachment 7, Quality, Network Management and Delivery System Standards ("Attachment 7"). CHA continues to appreciate Covered California's engagement in meaningful dialogue to bring clarity to both Attachment 7 and Appendix 2 going forward.

As we have previously shared, CHA supports Covered California's goal of moving from paying for volume to paying for value and stands ready to work with interested stakeholders to achieve this goal. To do so responsibly, there must be a deep and shared understanding between providers, QHPs and Covered California of the operational and technical issues that, if not addressed, will limit our progress toward these shared goals.

As a first step in achieving success, CHA believes that Covered California must focus on a narrow set of consensus-based and nationally endorsed quality measures that align the efforts of the public and private sectors, leading to accelerated improvement and demonstrated results. Starting with a narrow set of clearly defined measures allows providers and QHPs to build infrastructure in which additional measures can be considered in the future. Starting with an unreasonable set of measures will dilute our ability to achieve improvements and undermine our long-term goals. Hospital Compare started with 10 measures because the Centers for Medicare & Medicaid Services (CMS) and stakeholders agreed that starting small and building a reliable infrastructure was key in building momentum.

CHA believes strongly that Appendix 2 should be viewed as a menu of measures from which QHPs and providers choose as they design their approach to meeting the requirements of Covered California, as outlined in Articles 5.01 and 5.02 of Attachment 7. CHA agrees that Covered California should not dictate how QHPs and hospitals contract for value, but we do believe Covered California plays a critical role in mandating the use of an agreed upon measure set (numerator, denominator and a clearly defined population) from which QHPs and hospitals can choose. Such a list promotes alignment and accelerates improvement. **CHA does not support the proliferation of**

variations on quality measures and urges Covered California to promote alignment in a way that will not mandate a value-based purchasing (VBP)-type approach.

Without a common understanding and agreed upon detailed definitions, baseline and performance period time frames, further delineated patient populations, appropriate risk adjustment methodologies and transparent criteria for the exclusion of certain providers — among other things — we are concerned we may miss an opportunity to promote alignment.

At the same time, we urge Covered California to have further discussions regarding what is currently on the list in light of this request. **More specifically, CHA believes that for Article 5.01 QHPs should rely only on the standardized infection ratio (SIR) calculations for the hospital-acquired condition (HAC) measures, rather than multiple competing measures.** These are nationally endorsed and risk adjusted measures that, with the exception of C. Difficile infection, are appropriate for public reporting and performance programs.

We support the efforts currently being taken by organizations to address adverse drug events (ADEs) and the pilot projects underway to collect meaningful data that will lead to further improvement. **However, CHA does not believe the ADE measure is currently ready for inclusion at this time. We are open to further dialogue for other opportunities to advance this topic.**

It is our understanding that Covered California will convene stakeholders on March 22 to further discuss Appendix 2, and that Covered California will additionally discuss Appendix 2 with its Plan Management and Delivery System Reform Advisory Group on March 29, in advance of finalizing Appendix 2 by April 7. **CHA looks forward to participating in the scheduled discussions and urges Covered California to revise its April 7 deadline to finalize Appendix 2 if it appears additional discussions with stakeholders are warranted.**

In addition, **CHA requests that Covered California exclude inpatient psychiatric facilities (IPFs), free standing inpatient rehab facilities (IRFs) and long-term acute care hospitals (LTCHs) and children's hospitals from Attachment 7 Section 5.01 Hospital Payments to Promote Quality and Value, and requests that Covered California provide this additional clarification regarding the applicability in Attachment 7 Section 5.02 Hospital Patient Safety.** General acute care hospitals are better positioned to take on more performance based contracts because the measures for these hospitals have been in use for many years. This is not the case for other providers. Most national quality reporting programs began only a few short years ago. Notably, all county run IPFs that are not certified by Medicare are not currently reporting measures – excluding a huge portion of IPFs from even having readily available data for consideration in VBP like programs. More importantly, IRFs and LTCHs are just beginning data collection on several new measures as a result of the implementation of the IMPACT Act. We are hopeful that these measures will provide reliable and valid data that reflect the patient population and quality of care provided in these settings, but these measures remain untested and are very early in adoption.

In addition, surgical site infection with a focus on colon is not relevant to pediatric patients; C. Difficile infections in children are less common than in adults, and there is limited high-quality evidence to guide the management of pediatric C. Difficile infection. This document does not currently identify any pediatric-sensitive measures, nor does it address the important differences in the applicability of measures in unique settings including inpatient psychiatric facilities, freestanding inpatient rehabilitation facilities and long-term acute care hospitals. Therefore we believe these facilities should be excluded at this time.

CHA believes it would be premature to require this provision to be applicable to other providers until we have more measures that reliably reflect the quality of care provided in that setting.

We have previously shared with Covered California a number of principles that should be adhered to as part of the QHP contracting process and in developing Appendix 2. These principles include, but are not limited to, the following:

- **Use a Common and Parsimonious Set of Measures.** All measures used by QHPs should be identical (numerator, denominator, risk adjustment, data collection methods, data source etc.), regardless of the program in which they are used. The proliferation of measures, data sources and risk adjustment methodologies for the sake of differentiation wastes limited financial and personnel resources. In the April 2015 Institute of Medicine report titled *Vital Signs: Core Metrics for Health and Health Care Progress*, researchers concluded that the vast — and constantly growing — number of quality measures that providers are required to track "limits their overall effectiveness." Therefore, the Institute proposed a more streamlined approach for assessing performance. We should not miss this opportunity to lead the nation in demonstrating that a parsimonious set of high-impact measures — instead of a proliferation of measures that dilute performance — can drive performance at an accelerated rate.

- **Use NQF-Endorsed Measures.** All measures should, at a minimum, be endorsed by the NQF, a consensus-based entity that evaluates quality measures based on their importance, scientific acceptability, feasibility to collect and usability. Measures endorsed by the NQF are typically suitable for public reporting. CHA reminds Covered California that not all measures are suitable for pay-for-performance programs; we urge Covered California to work with stakeholders to ensure that only the most robust, reliable and valid measures are adopted into these programs. CHA appreciates that Covered California has used NQF-endorsed measures in Section 5.01; however, Covered California does not use NQF-endorsed measures in Section 5.02. CHA requests that Covered California only use NQF-endorsed measures.

- **Evaluate Additional Risk Adjustment.** CHA has continually expressed disappointment that, despite overwhelming evidence, CMS has failed to adjust the Medicare readmissions measures for sociodemographic factors that influence a readmissions rate. **It is our understanding in reading Attachment 7 that Covered California intends to use nationally-recognized measures such as Medicare readmissions measures; however, Appendix 2 does not list readmissions measures under consideration. If Covered California wishes to use readmission measures, they should be clearly defined and include appropriate sociodemographic status adjusters.**

  As noted in Appendix 2, Covered California is very interested in robust data collection on race and ethnicity. CHA supports these efforts but seeks further dialogue to ensure this data is reported, on both claim level and encounter data, consistently with National Uniform Billing Committee processes. Though we believe Covered California's proposal is in alignment, we request additional clarity. This data is an important component in the development of measures' risk stratification and may be used where appropriate for risk adjustment — along with income, education and other factors evidence suggests are predictors of health outcomes. However, we do not wish to create competing data collection efforts that will be administratively burdensome to providers and health plans.

CHA looks forward to continued discussions with Covered California as it finalizes a set of agreed upon measures and guidance. We appreciate Covered California's consideration of our recommendations and look forward to our continued partnership. If you have any questions, please contact me at (916) 552-7543.

Sincerely,

Amber Kemp
Vice President, Health Care Coverage

cc: Lance Lang, Chief Medical Officer, Covered California
Anne Price, Director, Plan Management, Covered California

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

May 18, 2016

Peter V. Lee
Covered California
Executive Director
Peter.Lee@covered.ca.gov

Subject: Covered California's May 3, 2016 Draft Appendix 2 to Attachment 7: Measurement Specifications

Dear Mr. Lee:

On behalf of our more than 400 member hospitals and health systems, the California Hospital Association (CHA) welcomes the opportunity to provide comments to Covered California on its near-final draft 2017-19 Qualified Health Plan (QHP) Certification Application, Appendix 2 to Attachment 7: Measurement Specifications ("Appendix 2"), released on May 3, 2016. We appreciate that Covered California has delayed finalization of Appendix 2 to June 1 to allow for much needed stakeholder discussion on measurement specifications for the reporting requirements included in Attachment 7.

As we have previously shared, CHA supports Covered California's goal of moving from paying for volume to paying for value, and stands ready to work with interested stakeholders to achieve this goal. To do so responsibly, providers, QHPs and Covered California must share an understanding of the operational and technical issues that will enhance our progress toward these goals.

I. Hospital Patient Safety

CHA believes that, for Article 5.02, QHPs should rely only on the standardized infection ratio (SIR) calculations for the hospital-acquired condition (HAC) measures — rather than multiple competing measures, such as the proposed ratio measures. SIR calculations are nationally endorsed and risk-adjusted measures that, with the exception of C. Difficile infection, are appropriate for public reporting and performance programs. CHA appreciates that Covered California has omitted the Catheter-Associated Urinary Tract Infections (CAUTI), Central Line-Associated Bloodstream Infection (CLABSI), C.Difficile, and Colorectal Surgical Site Infections (SSIs) ratio measures from Appendix 2. As Appendix 2 still reflects the use of the Urinary Catheter Utilization and Central Line Utilization ratio measures, we request that these be omitted as well.

CHA supports the efforts organizations are currently taking to address adverse drug events (ADEs) and the pilot projects underway to collect meaningful data that will lead to further improvement. As we've previously shared, CHA does not believe the ADE-opioid measure — though important — is ready for inclusion at this time, because it is not yet NQF-endorsed and is not based on a national data repository. **As the current form of this measure is too premature for use, we are pleased that Covered California has allowed more time for it to be fully developed by replacing it with Methicillin-resistant Staphylococcus aureus bloodstream infection (MRSA BSI), for which hospitals are already reporting data. We look forward to future discussion with Covered California on how best how to track, trend and improve performance on ADEs given the barriers noted by the workgroup.**

II. Hospital Payments to Promote Quality and Value

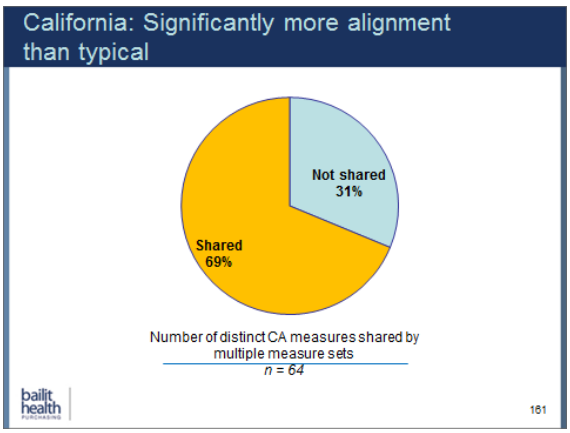
As we have previously shared, CHA believes that Covered California must focus on a narrow set of consensus-based and nationally endorsed quality measures that align the efforts of the public and private sectors, leading to accelerated improvement and demonstrated results. Starting with a narrow set of clearly defined measures allows providers and QHPs to build infrastructure in which additional measures can be considered in the future. Allowing all QHPs to develop and implement their own sets of measures for inclusion in value-based purchasing (VBP) programs as part of Article 5.01 will only lead to duplicative and redundant measurement efforts that dilute our ability to achieve improvements and undermine our long-term goals.

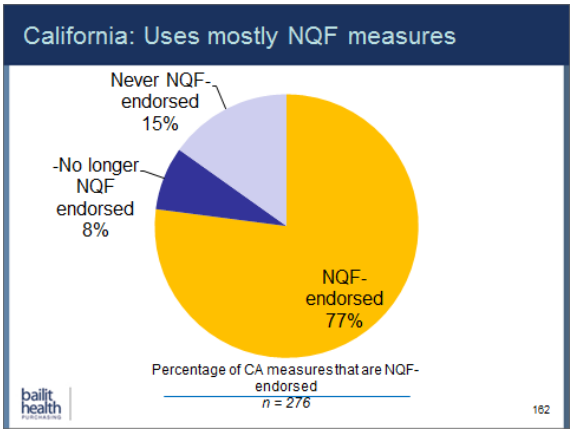
In September, 2013 Buying Value[i] commissioned a study of state and regional measure sets that was released. While the study found a preference for standardized measures among state agencies and regional initiatives, it also found shockingly poor alignment among the measures in use.

Highlights of the research include:

- Only 20 percent of the measures appeared in more than one of the 48 measure sets analyzed.
- Approximately 25 percent of even the shared measures were modified in some way, compounding the lack of comparability.
- Further aggravating the problem, states/regions frequently used non-standardized, "homegrown" measures, which made up 39 percent of the 509 distinct measures in the 48 measure sets.

Looking to the past informs our work today. For example, Hospital Compare started with 10 core measures because the Centers for Medicare & Medicaid Services and stakeholders agreed that starting small and building a reliable infrastructure was key in building momentum and sustainability. Notably, the Medicaid program, the Qualified Entity Program and other federal programs begin with a set of measures that may or may not be expanded once a set of core measures is adopted. California outpaces the nation in alignment of measures and is ranked better than other states in its use of NQF-endorsed measures. CHA urges Covered California to build on previous alignment efforts and continue to build momentum.





CHA believes strongly that Appendix 2 should be viewed as a menu of measures (i.e., the universe of measures) from which QHPs and providers may choose as they design their approaches to meeting Covered California's requirements. CHA agrees that Covered California should not dictate

how QHPs and hospitals contract for value, but we do believe it plays a critical role in mandating the use of an agreed upon measure set (numerator, denominator and a clearly defined population) from which QHPs and hospitals can choose. Such a list promotes alignment and accelerates improvement. **CHA does not support the proliferation of variations on quality measures and urges Covered California to promote alignment in a way that will not mandate a VBP-type approach.**

Without a common understanding and agreed upon detailed definitions, baseline and performance period time frames, further delineated patient populations, appropriate risk adjustment methodologies and transparent criteria for the exclusion of certain providers — among other things — we are concerned we may miss an opportunity to promote alignment.

While CHA appreciates the progress made on Appendix 2, we request that as a next step, Covered California convene QHPs and CHA to create a forum to discuss any outstanding issues around definitions, appropriate data collection and consistency. As an example, we have previously requested that Covered California include a common set of definitions for the various types of payment arrangements for C-Section (e.g. fee-for-service linked to quality, blended rate, capitated rate) to ensure appropriate data collection and consistency. **We believe it is incumbent upon Covered California to provide this level of shared understanding among providers, and would like such discussions to commence immediately.**

CHA appreciates that Covered California has incorporated the changes noted above related to Article 5.02 into Appendix 2 and urges it to incorporate our feedback related to Article 5.01. We look forward to our continued partnership with Covered California, QHPs and other stakeholders to achieve progress toward the "Triple Aim" of improved population health, enhanced patient care experience and lowered health care costs. If you have any questions, please contact me at (916) 552-7543.

Sincerely,

Amber Kemp
Vice President, Health Care Coverage

cc: Lance Lang, Chief Medical Officer, Covered California
Anne Price, Director, Plan Management, Covered California

[i] http://www.buyingvalue.org/about/about-buying-value/