Covered California's Core Building Blocks for Improving Quality and Lowering Costs

Strengthen value-based, patient-centered benefit design to improve access to primary care.

Require providers to meet quality standards without exception to provide safe care for all, including racial and ethnic groups.

Adopt payment strategies that support quality performance.

Be sure consumers get the right care at the right time — adopt proven models of primary care and integrated care delivery models.

Provide tools to consumers so they can make informed choices when selecting providers.

Covered California: Promoting the Triple Aim*

DIAGNOSIS

1. Many consumers fail to receive effective care, with nearly half of adults failing to receive recommended care.
2. Health care costs are far higher in the United States than in any other developed country, and costs have historically risen at twice the rate of GDP — resulting in higher costs to taxpayers, employers and consumers.
3. Market forces have not been effective in getting consumers the best value — multiple third-party payers have not worked together to reward value, and consumers have not had the tools or incentives to make better choices.

COVERED CALIFORNIA'S SOLUTION

1. Promote robust changes in measurement, payment and consumer tools that will not only benefit Covered California enrollees, but also help foster changes in how care is delivered.
2. Align payments and other efforts with those of CMS, CalPERS and other major private and public purchasers — promoting improvement with coordinated market signals.
3. Put the consumer at the center of all solutions — considering how they will benefit.

* See Covered California Individual Contract: Quality, Network Management, Delivery System Standards and Improvement Strategy – 2016 (http://bit.ly/1MSHEfQ)

Covered California: Ensuring the Right Care at the Right Time

DIAGNOSIS

1. Many consumers — especially the newly insured — do not have an entry point for care, such as a primary care clinician.
2. Patient care is often fragmented and uncoordinated, resulting in care that delivers inconsistent outcomes and high costs.
3. Payment has been based on “more is better” (the fee-for-service model), not on rewarding outcomes and effective coordination.

COVERED CALIFORNIA’S SOLUTION

1. Require all plans, regardless of model, to assign a primary care clinician to Covered California enrollees within 30 days of their health plan coverage date.
2. Require plans to change payments to incentivize enrollment and pay to reward advanced models of primary care, including patient-centered medical homes and integrated health care models, such as accountable care organizations.
3. Implement patient-centered benefit designs that improve access to care when it is needed.

Covered California: Promoting and Rewarding Quality Care at the Best Value

DIAGNOSIS

1. Payments for volume provide no rewards to hospitals and other providers to improve care and make it safer for their patients.
2. Many patients receive unnecessary care or actually suffer from avoidable harm — with an estimated 400,000 patients dying annually as a result of preventable harm.[1]
3. Studies show wide variations in both cost and quality and *no* correlation between higher costs and better care.

COVERED CALIFORNIA'S SOLUTION

1. Require plans to disclose information about providers' clinical quality, patient safety and patient experience.
2. Work with stakeholders to develop tools to address cost and quality of outlier hospitals. As of 2019, plans will either exclude outliers or provide a justification for inclusion in the network.
3. Require plans to implement payment reform to reward outcomes and results in hospitals, rather than just volume, with increasing percentages of payments being tied to hospital performance starting in 2019.

[1] James, John T. "A New, Evidence-Based Estimate of Patient Harms Associated with Hospital Care." Journal of Patient Safety. 2013.

Covered California: Reducing Health Disparities and Promoting Health Equity

DIAGNOSIS

1. While there are significant health disparities, the specific quality gaps vary dramatically by income level and ethnic group:
   - Latinos and African-Americans are more than twice as likely to be admitted to hospitals for uncontrolled diabetes than are whites or Asians/Pacific Islanders.
   - African-Americans are less likely to receive treatment for major depressive disorder.
2. Not all health plans or health systems are effectively measuring health outcomes for California's most vulnerable populations, or targeting groups for improvement.

COVERED CALIFORNIA'S SOLUTION

1. Require health plans to improve the collection of self-identified racial/ethnic information.
2. Require health plans to track, trend and improve over time care related to diabetes, asthma, hypertension and depression across **all payers** to achieve target goals within reasonable timelines.

Covered California: Giving Consumers Tools to Make the Best Choices

DIAGNOSIS

1. The wide variation in costs — even for covered services — is often unknown to consumers who do not have the right tools available to pick a provider based on cost and quality. For example, in San Francisco, the consumer's cost of treatment for appendicitis can vary between $1,276 and $6,250.[1]
2. It's hard for consumers to calculate their out-of-pocket costs. Two out of three individuals say it is difficult to know how much specific doctors or hospitals charge for medical treatments or procedures.[2]

COVERED CALIFORNIA'S SOLUTION

1. Require plans to develop tools (online/mobile) that enable consumers to compare costs and quality when choosing a provider.
2. Require plans to promote consumers' access and use of a "personal health record."
3. Require plans to promote patient engagement and "shared decision-making" between patients and their providers.

[1] Insurance Company Payment is taken from California Healthcare Compare: http://www.consumerreports.org/cro/health/california-health-cost-and-quality---consumer-reports/index.htm.

[2] Kaiser Family Foundation. Health Tracking Poll. April 2015.