Plan Management Advisory Workgroup Meeting

March 11, 2021

AGENDA

Time	Topic	Presenter
10:00 – 10:10	Welcome and Agenda Review	Rob Spector
10:10 - 10:20	2021 Plan Management Advisory Group Membership	James DeBenedetti
10:20 – 10:50	2022 Health Benefit Plan Design Update	Jan Falzarano
10:50 – 11:50	2022 Attachment 7 Amendment Overview 2022 Attachment 14 Amendment Overview	Taylor Priestley Margareta Brandt
11:50 – 12:00	Open Forum & Announcements	All

2021 PLAN MANAGEMENT ADVISORY GROUP MEMBERSHIP

James DeBenedetti

PLAN MANAGEMENT ADVISORY GROUP MEMBERS

David Brabender
Independent Health Insurance Agent
California Association of Health Underwriters

Douglas Brosnan
Emergency Room Physician
California Medical Association Representative

Anthony Chen
M.D., F.A.A.F.P.; Primary Care Physician
Torrance Memorial Physician Network

Diana Douglas
Policy and Legislative Advocate
Health Access California

Amy Frith
Manager, Strategic Client, Account Management
Health Net of California

Héctor Hernández-Delgado
Staff Attorney
National Health Law Program

Emma Hoo
Director, Pay for Value
Purchaser Business Group on Health

Rick Krum
Growth Director, CA Individual Commercial
Anthem Blue Cross

April Martin
Division Director, Payer Strategy & Relationships
CommonSpirit Health

John Newman
Executive Director, California Exchange Operations
Kaiser Permanente

Cary Sanders
Senior Director, Policy
California Pan-Ethnic Health Network

Robert Spector (Chair)
Senior Director, State Public Programs
Blue Shield of California

HEALTH BENEFIT PLAN DESIGN UPDATE

Jan Falzarano

BENEIT DESIGN CHANGES SINCE JANUARY BOARD MEETING

- Proposed 2022 Standard Benefit Plan Designs (SBPDs) were presented for discussion at the January Board meeting
- Additional benefit modeling was performed on Silver 70 and 73 (Individual and Family Plans only)
- Dental plan benefit designs have not changed
- CCSB benefit plan designs have not changed

2022 PROPOSED BENEFIT PLAN DESIGN CHANGES

Proposed benefit cost share changes to Silver tier plans with cost share reductions (CSR). Changes since January in red:

- Silver 94: 100% - 150% Federal Poverty Level (FPL)
  - reduced MOOP from $1,000 to $800
- Silver 87: 150% - 200% FPL
  - reduced the medical deductible from $1,400 to $800
  - eliminated the Rx deductible
- Silver 73: 200% - 250% FPL
  - reduced the Rx deductible from $275 to ~~$50~~ $10
  - reduced Tier 1 Rx copay from $16 to $15
  - reduced specialist visits from $75 to $70
  - reduced MOOP from $6,500 to $6,300

2022 PROPOSED BENEFIT PLAN DESIGN CHANGES, con't

Proposed benefit cost share changes to Silver 70 (MOOP remains at $8,200). Changes since January in red:

- reduced Rx deductible from $300 to ~~$50~~ $10
- copays for: primary care, behavioral health, and speech/occupational/physical therapy visits reduced from $40 to $35
- reduced Tier 1 Rx copay from $16 to $15
- reduced medical deductible from $4,000 to $3,700
- reduced specialist visits from $80 to $70
- reduced tier 2 Rx from $60 to $55
- reduced Tier 3 Rx from $90 to $85

2022 ATTACHMENT 7 AMENDMENT OVERVIEW

Taylor Priestley
Margareta Brandt

2022 ATTACHMENT 7 AMENDMENT TIMELINE

COVERED CALIFORNIA'S FRAMEWORK FOR HOLDING PLANS ACCOUNTABLE FOR QUALITY CARE AND DELIVERY REFORM

Assuring Quality Care

INDIVIDUALIZED, EQUITABLE CARE

- Population Health Management: Assessment and Segmentation
- Health Promotion and Prevention
- Mental Health and Substance Use Disorder Treatment
- Acute, Chronic and Other Conditions
- Complex Care

Effective Care Delivery Strategies

ORGANIZING STRATEGIES

- Effective Primary Care
- Promotion of Integrated Delivery Systems and ACOs
- Networks Based on Value

Sites and Expanded Approaches to Care Delivery

Appropriate Interventions

Key Drivers of Quality Care and Effective Delivery

Covered California recognizes that promoting change in the delivery system requires aligning with other purchasers and working with all relevant payers to reform health care delivery in a way that reduces burdens on providers.

- Benefit Design
- Measurement for Improvement Choice and Accountability
- Payment
- Patient-Centered Social Needs
- Patient and Consumer Engagement
- Data Sharing and Analytics
- Administrative Simplification
- Quality Improvement and Technical Assistance
- Certification, Accreditation and Regulation

Community Drivers: Community-Wide Social Determinants, Population and Public Health, and Workforce

January 2020

APPROACH TO 2022 AMENDMENT

- **2022 is a transitional year to focus on a narrowed set of QHP issuer requirements to lay the foundation for more transformational requirements in 2023**
- 2022 Attachment 7 Amendment was developed using the criteria of reducing burden, focusing on priorities, considering feasibility, and implementing foundational elements in preparation for 2023 and beyond
  - These criteria guided the addition of requirements, enhancing current requirements, and removing other requirements
- Covered CA staff engaged issuers and stakeholders in the development of the 2022 Attachment 7 amendment through the Plan Management Advisory group
- Covered CA staff also considered public comments on the proposed changes and edited the 2022 Attachment 7 amendment where appropriate
- The following slides summarize how the 2022 Attachment 7 requirements differ from the 2021 requirements and what changes were made based on the public comments received in response to the draft Attachment 7 shared in January 2021

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 1: Individualized Equitable Care

- Issuers will continue to meet 80% capture of member race/ethnicity self-identification, assessed in Healthcare Evidence Initiative (HEI) data submission
- Issuers will submit patient level data files for required disparities measures instead of reporting disparities measures rates aggregated across lines of business
- Issuers will participate in collaborative effort to identify opportunities for aligned statewide disparity work
- Issuers must achieve and maintain NCQA Multicultural Health Care Distinction (MHCD) by year-end 2023. For an early distinction credit per Attachment 14, issuers must show evidence of MHCD by December 30, 2022.

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 1: Individualized Equitable Care

Notable Changes to Draft Attachment 7	Rationale
1.02 Identifying Disparities in Care Added language describing Covered California intention to use HEI data to produce disparities measures previously reported by QHP Issuers.	New language clarifies intent to continue monitoring a broad set of diabetes, hypertension, asthma, and depression measures for racial and ethnic disparities purposes.
1.03 Disparities Reduction Intervention Revised requirement: issuer must demonstrate meaningful improvement for the intervention population for the identified disparity measure with analysis of results including potential to replicate or scale, rather than demonstrating reduction in disparity in 2022.	Due to COVID-19 impacts in 2020, disparity intervention efforts were delayed and, in most cases, significantly modified, reducing the time period to reasonably expect interventions to result in measurable disparity reduction.
1.04 Statewide Focus on Health Equity Collaborative Efforts Language added to clarify participation requirements and goals of statewide disparity focus.	Clarifying language added to address public comments indicating the requirement objective and participation requirements lacked clarity.
1.05 Culture of Health Equity Capacity Building Deadline to achieve NCQA Multicultural Health Care Distinction extended to year-end 2023. Deadline to achieve a NCQA MHCD early achievement credit (per Attachment 14) extended to December 30, 2022.	This extension acknowledges the impacts of current and new disparities reduction requirements and other new requirements across Attachment 7.

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 2: Population Health Management

- Issuers will continue to submit copy of NCQA Population Health Management Plan: Standard 1 (Population Health Management Strategy) and Standard 2 (Population Stratification and Resource Integration) to demonstrate population assessment and segmentation approach or submit a comparable plan

Notable Changes to Draft Attachment 7	Rationale
Added language for requirement to submit NCQA Population Health Management Plan: Standard 1 and Standard 2 or a comparable alternative plan. "When submitting its plan to Covered California, Contractor shall clearly designate any information it deems confidential, trade secret, or proprietary information as such."	Issuers expressed concerns about submitting NCQA accreditation reports to Covered California, which contain information on products that are not subject to Covered California oversight. Covered California has amended draft Attachment 7 to allow Issuers to designate any information provided as confidential, trade secret, or proprietary information.

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 3: Health Promotion and Prevention

- Issuers will continue to report on tobacco cessation program and weight management program utilization
- Issuers will report strategies to improve rates of Medical Assistance with Smoking and Tobacco Use Cessation and Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents measures
- Issuers will continue to offer Diabetes Prevention Programs (DPP) as both online and in-person formats
- Issuers will be expected to address gaps in care due to the COVID-19 pandemic with the goal of meeting performance targets of (1) great than or equal to Measurement Year 2019 pre-COVID-10 performance by Jan 1st, 2022 and (2) perform greater than or equal to the national 50th percentile year-end 2022 on the following measures:
  - Childhood Immunization Status (Combination 3) (NQF #0038) *(Anticipated change to Combination 10 for MY 2022 in alignment with NCQA and QRS)*;
  - Immunizations for Adolescents (Combination 2) (NQF #1407); and
  - Colorectal Cancer Screening (NQF #0034)
- Covered California will also work with QHP issuers to assess COVID-19 vaccination rates and ensure appropriate outreach to eligible enrollees

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 3: Health Promotion and Prevention

Notable Changes to Draft Attachment 7	Rationale
Amended language for requirement for issuers to offer Diabetes Prevention Programs (DPP) as BOTH online and in-person formats "The DPP must be available both in-person and online by year end 2022 to allow Enrollees a choice of modality (in-person, online, distance learning, or a combination of modes)."	Issuers requested that the requirement for *both* online and in-person DPP be changed to online *or* in-person, citing a limited number of in-person programs and low attendance. Covered California has amended draft Attachment 7 to clarify the requirement intent and designated an implementation deadline. We are committed to ensuring that all Enrollees have access to preventative diabetes care and education. Providing both in-person and online DPP services ensures Enrollees have equitable access to these services and allows Enrollees to choose their preferred choice of modality.
New expectation for issuers to address gaps in care due to the COVID-19 pandemic with the goal of meeting the following performance targets: (1) greater than or equal to Measurement Year 2019 pre-COVID-19 pandemic performance level by January 1, 2022 (Measurement Year 2021); and (2) greater than or equal to the national 50th percentile threshold by year-end 2022 (Measurement Year 2022) on the following measures reported by the Contractor to CMS for the Quality Rating System (QRS): ▪ Childhood Immunization Status (Combination 3) (NQF #0038) *(Anticipated change to Combination 10 for MY 2022 in alignment with NCQA and QRS)* ▪ Immunizations for Adolescents (Combination 2) (NQF #1407) ▪ Colorectal Cancer Screening (NQF #0034) Covered California will work with QHPs to assess COVID-19 vaccination rates and ensure appropriate outreach to eligible enrollees.	The COVID-19 pandemic has created gaps in quality due to deferred care and highlighted disparities in our health care delivery system. Childhood vaccines protect children from a number of serious and potentially life-threatening diseases at a time in their lives when they are the most vulnerable. 15% fewer children under age 3 have received the first dose MMR. 28% fewer adolescents ages 11-13 have received the Tdap booster. Treatment for colorectal cancer in its earliest stage can lead to a 90 percent survival rate after five years. National colorectal cancer screening rates dropped 86% initially and has remained 36% lower than previous years. MY 2019 performance multiple QHPs below the national 50th percentile threshold on all three measures.

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 4: Behavioral Health

- Submit NCQA Health Plan Accreditation Network Management reports (or a comparable report) for the elements related to the issuer's behavioral health provider network
- Offer telehealth for behavioral health services and provide Enrollee education about how to access telehealth services; Covered CA will monitor utilization of telehealth services through HEI
- Annually report *Depression Screening and Follow Up (NQF #0418)* measure results for Covered CA enrollees; Covered CA will engage with issuers to review their performance
- Covered CA will monitor the following measures through HEI and engage with issuers to review their performance:
  - *Antidepressant Medication Management (NQF #0105)*
  - *Follow-Up After Hospitalization for Mental Illness (7-Day Follow-Up) (NQF #0576)*
  - *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (NQF #0004)*
  - *Use of Pharmacotherapy for Opioid Use Disorder (NQF #3400)*
  - *Concurrent Use of Opioids and Benzodiazepines (NQF #3389)*
  - *Use of Opioids at High Dosage in Persons Without Cancer (NQF #2940)*
  - *Concurrent Use of Opioids and Naloxone*
  - Medication Assisted Treatment (MAT) prescriptions by clinician and by region
- Report how issuers are promoting the integration of behavioral health services with medical services, report the percent of Enrollees cared for under integrated models, and whether the issuer reimburses for the Collaborative Care Model claims codes

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 4: Behavioral Health

Notable Changes to Draft Attachment 7	Rationale
Replaced the requirement to track active X waiver licensed prescribers with a requirement to Issuers to engage with Covered California to review its Medication Assisted Treatment (MAT) prescriptions by clinician and by region using HEI data	Issuers commented that it would be challenging to track active X waiver license prescribers since this data is not currently tracked. The US Department of Health and Human Services recently shared a press release announcing plans to publish guidance eliminating certain X-waiver requirements while SAMHSA released a statement that this announcement was made prematurely. Based on the conflicting statements and unclear future of the X waiver license requirements, Covered California has replaced the requirement to track X waiver licensed prescribers with a requirement to track MAT using HEI data.

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 5: Acute, Chronic and Other Conditions

- Issuers will continue to engage with Covered California to review QRS measure performance related to acute and chronic conditions
- Issuers will continue to support transition of enrollment for at-risk enrollees

Notable Changes to Draft Attachment 7	Rationale
There are no new significant changes to the draft Attachment 7.	

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 6: Complex Care

- Issuers will continue to describe methods to ensure, support, and monitor contracted hospitals' compliance with Medicare Condition of Participation rules to have electronic information exchange to notify primary care providers of Admission, Discharge, Transfer (ADT) events
- Issuers will continue requirements for at-risk enrollee engagement and Centers of Excellence

Notable Changes to Draft Attachment 7	Rationale
There are no new significant changes to the draft Attachment 7.	

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 7: Effective Primary Care

- Continue to match enrollees with PCPs and report the number of enrollees who select a PCP vs. those who are assigned a PCP
- Report the quality improvement and technical assistance being provided to physician groups to implement or support advanced primary care models
- Continue to require primary care payment reporting and increase the number of PCPs paid through shared savings and population-based payment models
- Pilot a quality measure set for advanced primary care to assess the prevalence of high-quality, advanced primary care practices within the issuer's network in collaboration with the California Quality Collaborative (CQC) and the Integrated Healthcare Association (IHA)

Notable Changes to Draft Attachment 7	Rationale
There are no new significant changes to the draft Attachment 7.	

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 8: Promotion of Integrated Delivery Systems (IDS) and Accountable Care Organizations (ACOs)

- Participate in the Integrated Healthcare Association (IHA), submit data for the IHA Commercial HMO and ACO measure sets (as applicable), and report performance on the measure sets to Covered California annually
- Report the characteristics of the issuer's IDS and ACO systems such as payment model, leadership structure, quality incentive programs, data exchange processes, etc.
- Continue to require reporting the number of enrollees in IDS and ACO systems and increase the number of enrollees cared for under IDS and ACO systems

Notable Changes to Draft Attachment 7	Rationale
There are no new significant changes to the draft Attachment 7.	

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 9: Networks Based on Value

- Continue to require issuers to include quality and cost in all provider and facility selection criteria
- Continue to require issuers to notify poor performing hospitals and engage these hospitals in improvement efforts to reduce variation in performance across contracted hospitals and report the rationale for continuing to contract with poor performing hospitals
  - Covered California has defined poor performance as hospitals performing in the lowest decile on state or national benchmarks for quality and safety
- Participate in the IHA Align Measure Perform (AMP) program and report contracted physician group performance results to Covered California
- Work collaboratively with Covered California and other issuers to define poor performing physicians and physician groups, notify poor performers, and engage physician groups in improvement efforts to reduce variation in performance across contracted physician groups
  - Covered California will use the IHA AMP program to profile and analyze variation in physician groups performance on quality measures and total cost of care

Notable Changes to Draft Attachment 7	Rationale
There are no new significant changes to the draft Attachment 7.	

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 10: Sites and Expanded Approaches to Care Delivery

- Issuers will continue to track and report strategies to reduce hospital associated infections (HAI) and NTSV C-sections to improve hospital quality and patient safety
- Issuers will continue to track and report on telehealth utilization and payment

Notable Changes to Draft Attachment 7	Rationale
There are no new significant changes to the draft Attachment 7.	

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 11: Appropriate Interventions

- Issuers will continue to report how it considers value in its medications formulary
- Issuers will continue to ensure Enrollees have access to accurate cost and quality information
- Issuers will report how they are encouraging providers to implement *Choosing Wisely* guidelines or other evidence based shared decision making tools

Notable Changes to Draft Attachment 7	Rationale
Removed requirements for issuers to report detailed utilization information on shared decision making between provider and Enrollee.	Shared decision making occurs at the point of care between a provider and Enrollee. Issuers report that data collection is challenging as they do not have reliable insight into this process. Requirements were removed to reduce reporting burden and data inconsistency. Covered California will continue to investigate the best practices for collecting information on shared decision making to inform future contract requirements.

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 12: Key Drivers of Quality Care and Effective Delivery

- Article 12 defines and summarizes the Key Drivers
- Key Drivers with their own article:
  - Article 13: Measurement for Improvement, Choice, and Accountability
  - Article 14: Patient-Centered Social Needs
  - Article 15: Data Sharing and Analytics
  - Article 16: Quality Improvement and Technical Assistance
  - Article 17: Certification, Accreditation, and Regulation
- Key Drivers as an appendix:
  - Appendix A: Measurement for Improvement, Choice, and Accountability
  - Appendix B: Payment
  - Appendix C: Patient and Consumer Engagement
  - Appendix D: Quality Improvement and Technical Assistance

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 13: Measurement for Improvement, Choice, and Accountability

- Continue requirements related to data submission for the Quality Rating System and NCQA Quality Compass
- Consolidated and re-arranged the current measurement requirements in the draft 2022 Attachment 7

Notable Changes to Draft Attachment 7	Rationale
There are no new significant changes to the draft Attachment 7.	

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 14: Patient-Centered Social Needs

- Issuers must screen all enrollees receiving plan-based services (such as complex care management or case management) for at least housing instability and food insecurity; report aggregated counts of members screened and positive screens for housing instability and food insecurity
- Issuers must maintain community resources inventory by region served to support linkage to appropriate social services; submit documented process for referrals for housing instability and food insecurity

Notable Changes to Draft Attachment 7	Rationale
There are no new significant changes to the draft Attachment 7.	

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 15: Data Sharing and Analytics

- Issuers will continue to implement and maintain a secure, standards-based Patient Access Application Programming Interfaces (API) consistent with the Federally Facilitated Marketplace (FFM) rule
- Issuers will continue requirements to support data exchange with providers and data aggregation across plans

Notable Changes to Draft Attachment 7	Rationale
No changes will be made to the requirement for data exchange with providers to include additional Health Information Exchange (HIE) options	Issuers requested to include additional HIEs to the HIE list included in the contract. Covered California understands this list is not an exhaustive list. Issuers are to clarify their participation in other qualified HIEs with the "Other Health Information Exchange" option. No changes will be made to draft Attachment 7.

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 16: Quality Improvement and Technical Assistance

- Issuers will continue to report on participation in any quality improvement collaborative and data sharing initiatives in the annual application for certification
- Issuers will continue to adopt and implement Smart Care California guidelines supporting the appropriate use of C-sections and Opioids

Notable Changes to Draft Attachment 7	Rationale
There are no new significant changes to the draft Attachment 7.	

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 17: Certification, Accreditation and Regulation

- Issuers will be required to be accredited by NCQA by year end 2024
  - Previously Covered California allowed issuers to be accredited by one out of three accrediting bodies (NCQA, AAAHC, or URAC)
- Covered California will align with the CMS accreditation timeline and 30-day written notification of changes or actions affecting an issuer's accreditation status

Notable Changes to Draft Attachment 7	Rationale
There are no new significant changes to the draft Attachment 7.	

DISCUSSION AND NEXT STEPS

- The final 2022 Attachment 7 Amendment will be presented to the Board on March 18, 2021 for approval.
- Please send questions and comments to Margareta Brandt at margareta.brandt@covered.ca.gov.

2022 ATTACHMENT 14 AMENDMENT OVERVIEW

PROPOSED CHANGES FOR 2022 PERFORMANCE STANDARDS – GROUPS 1, 2, 3, AND 4

- Retain monthly reporting to maintain accountability, and remove penalties and credits associated with:
  - Group 1 – Customer Service
  - Group 2 – Operational (except HEI Data)
  - Portions of Group 3 – Quality, Network Management and Delivery System Standards
  - Group 4 – Covered California Customer Service

- Retain monthly reporting and penalties. Redistribute % at risk among the remaining performance standards:
  - Group 2 – HEI Data
  - Group 3 – Quality, Network Management and Delivery System Standards

PROPOSED CHANGES FOR 2022 PERFORMANCE STANDARDS – SUMMARY

New Attachment 14 Structure

- Removed all credits with the exception of 3.3c) early NCQA MHCD attainment (2%)

- Performance Standards and Expectations *(renumbered 1.1, 1.2, etc.)*
  - Customer Service Performance Standards
  - Operational Performance Standards (with the exception of HEI Data Submission)
  - Essential Community Providers and Hospital Safety Performance Standards
  - Removal of Covered CA Customer Service Performance Standards from contract language

- Performance Standards With Penalties
  - Updated HEI Data Submission Performance Standard *(renumbered 2.1)*
  - Updated Quality Performance Standards *(renumbered 3.1, 3.2, etc.)*
  - Dental Quality Alliance Pediatric Measure Set – still in Pilot for 2022 *(renumbered 4.1, 4.2, etc.)*

PROPOSED ATTACHMENT 14 PERFORMANCE STANDARDS WITH PENALTIES

Performance Standards with Penalties	Current % at Risk	Proposed % at Risk	
		HMO	PPO/EPO
2.1 HEI Data	5%	10%	10%
3.1 Quality Rating System – Clinical Quality Management Summary Rating	3.5%	33.5%	33.5%
3.2 Quality Rating System – QHP Enrollee Experience Summary Rating	3.5%	16.5%	16.5%
3.3 Reducing Health Disparities a) Race/Ethnicity Self-Identification Capture 80% in HEI Data b) Disparity Reduction c) NEW: Proposed 2% Credit for early achievement of NCQA MHCD	 2% 3%	 7.5% 7.5%	 7.5% 7.5%
3.4 Primary Care Payment Strategy	3%	10%	20%
3.5 Accountable Care Organizations	5%	10%	0%
3.6 Appropriate Use of C-Sections	4.5%	5%	5%
Total at Risk - Quality (90%) and HEI data (10%) Standards		100%	100%

PROPOSED 2022 ATTACHMENT 14 CHANGES BASED ON PUBLIC COMMENT

Notable Changes to Draft Attachment 14	Rationale
3.3b) Health Disparities Interventions – Adjusting the performance level from disparity reduction to intervention population improvement and analysis of results including potential to replicate or scale intervention.	Due to COVID-19 impacts in 2020, disparity intervention efforts were delayed and, in most cases, significantly modified, reducing the time period to reasonably expect interventions to result in measurable disparity reduction.
3.4 Primary Care Payment – Different percent at risk and performance levels by HMO and PPO/EPO products HMO – 10% PPO/EPO – 20% **3.5 ACO Enrollment** – Different percent at risk and performance levels by HMO and PPO/EPO products HMO – 10% PPO/EPO – 0%	Covered California recognizes that many PPO/EPO plans cannot meet the current definition of an ACO with combined risk sharing across physicians and hospitals. Many PPO/EPO plans are focusing on implementing primary care and physician group payment reforms therefore Covered California is proposing to redistribute risk from 3.5 ACO Enrollment to 3.4 Primary Care Payment for PPO/EPO plans. This structure maintains 50% at risk for quality, 15% at risk for disparities reduction, and 25% at risk for payment reform for all products.

OPEN FORUM & ANNOUNCEMENTS