



Plan Management Advisory Workgroup Meeting

October 8, 2020

AGENDA

Time	Topic	Presenter
10:00 – 10:05	Welcome and Agenda Review	Rob Spector
10:05 – 10:15	2022 Qualified Health Plan Certification Update	Meiling Hunter
10:15 – 10:30	QRS Update	Whitney Li
10:30 – 11:15	2022 Attachment 7 Amendment Proposal Presentation	Margareta Brandt
11:15 – 11:45	2022 Attachment 14 Proposal Presentation	James DeBenedetti
11:45 – 11:50	2023-2025 Attachment 7 Refresh Workgroup Update	Thai Lee
11:50 – 12:00	Open Forum	All

2022 QUALIFIED HEALTH PLAN CERTIFICATION

Meiling Hunter, Certification Team Lead

CERTIFICATION UPDATES

Contract Extension

Because the 2017 – 2021 QHP Contract period will be extended by one year, health and dental plan issuers contracted in 2017 will continue to be contracted through 2022, if certified.

Plan Year 2022 Certification Applications will be open to:

Individual Marketplace

- Existing or New Issuers offering QHPs or QDPs
- Medi-Cal Managed Care Plans

Covered California for Small Business

- Existing or New Issuers offering QHPs or QDPs

PROPOSED CERTIFICATION MILESTONES

Release Draft 2022 QHP & QDP Certification Applications	December 2020
Draft Application Comment Periods End	December 2020
Plan Management Advisory: Benefit Design & Certification Policy Recommendation	January 2021
January Board Meeting: Discussion of Benefit Design & Certification Policy Recommendation	January 2021
Letters of Intent Accepted	February 2021
Final AV Calculator Released*	February 2021
Applicant Trainings (electronic submission software, SERFF submission and templates*)	February 2021
March Board Meeting: Anticipated approval of 2022 Patient-Centered Benefit Plan Designs & Certification Policy	March 2021
QHP & QDP Applications Open	March 1, 2021
QHP & QDP Application Responses (Individual and CCSB) Due	April 30, 2021
Evaluation of QHP Responses & Negotiation Prep	May - June 2021
QHP Negotiations	June 2021
QHP Preliminary Rates Announcement	July 2021
Regulatory Rate Review Begins (QHP Individual Marketplace)	July 2021
Evaluation of QDP Responses & Negotiation Prep	June – July 2021
QDP Negotiations	July 2021
CCSB QHP Rates Due	July 2021
QDP Rates Announcement (no regulatory rate review)	August 2021
Public Posting of Proposed Rates	July 2021
Public Posting of Final Rates	September – October 2021



*Final AV Calculator and final SERFF Templates availability dependent on CMS release
 TBD = dependent on CCIIO rate filing timeline requirements

QUALITY RATING SYSTEM SCORES FOR PLAN YEAR 2021

Whitney Li, Senior Evaluation Specialist

BACKGROUND

- For each year prior to PY2021, the Quality Rating System Star Ratings were calculated based on that year's participating QHP results nationwide with no reference to scores from previous years.
- In April 2020, CMS announced suspension of the Quality Rating System and discontinuation of data submissions for PY2021.
 - No nationwide scoring or benchmarking work was done.
- The measurement tasks, which are done in the January-May period, overlapped with the initial COVID-19 infection wave and subsequent restrictions during spring 2020.
- Covered California consulted QHP Issuers and decided to maintain its work in the Quality Rating System by releasing a “QHP Best of” MY2019 or MY 2018 approach in the spring.
 - All eleven QHP Issuers submitted MY2019 HEDIS data.
 - Several QHP Issuers submitted MY2019 CAHPS data as Issuers had the option to forgo MY2019 CAHPS and use their MY2018 survey results.

QUALITY RATINGS REPORTING

The Covered California Quality Rating System (QRS) is comprised of the following elements:

- 1. Four ratings are reported: a global quality rating and three summary component ratings
- 2. The global quality rating is a roll-up of three summary components per the following differential weighting:

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

- 3. 1 to 5-star performance classification based on the distribution of results
- 4. The PY2021 scores are displayed on CoveredCA.com starting in October 2020

QRS RATING FORMULA: KEY COMPONENTS

- Selected the “QHP Best of” measure score for MY2019 and MY2018.
 - QHP Issuers supplied Covered California with their audited MY2019 HEDIS rates.
 - CMS supplied MY2018 scores a year ago.
- Compared the QHP’s measure scores to the QRS national 25th, 50th, 75th, and 90th percentile scores. An indirect standardization method was used to roll-up scores into composites, domains, and summary star ratings.
 - Each QHP was compared to benchmark results for the same measures.
 - The CMS measures weights, outlined in its March 2020 Call Letter, were applied in the roll-up method.
- Applied a meaningfully different test to assess if a QHP’s scores were meaningfully different than the national MY2018 QRS percentile cut points.
- Assigned star ratings based on QHP score differences from the percentile cut points, ultimately focusing on the closest fit benchmark percentile.

QRS STAR RATINGS DISTRIBUTION OVER TIME

Distribution of Global Quality Ratings by Reportable Products for Individual & CCSB Markets

	# Products with No Global Rating	1 Star ★	2 Star ★★	3 Star ★★★	4 Star ★★★★	5 Star ★★★★★
PY2021 QRS**	2*	0	4	7	1	1
PY2020 QRS**	4*	0	5	5	1	1
PY2019 QRS	3*	0	0	6	4	2

*No global rating if a newer product and not eligible for reporting or insufficient sample sizes to report results for at least 2 of the 3 summary indicator categories. **Based on Covered CA Alternative Methodology & CMS or CC Final Data

- Two QHPs had a Global Rating gain of 1-star (Health Net HMO and Oscar).

GLOBAL & SUMMARY INDICATOR RATINGS (PY 2021)

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

*Health Net PPO first year reportable ratings.

2022 ATTACHMENT 7 AMENDMENT PROPOSAL PRESENTATION

Margareta Brandt, Senior Quality Specialist

REVISED 2022 ATTACHMENT 7 AMENDMENT TIMELINE

2022 Plan Year



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

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

January 2020

2022 ASSURING QUALITY CARE (1 OF 3)

The following are recommended requirements for the 2022 Attachment 7 amendment:

Individualized Equitable Care

- Requirement remains for 80% capture of on-Exchange members race/ethnicity self-identification data; propose updating the demographic data collection reporting from issuer self-report to Healthcare Evidence Initiative (HEI) data submission
- For the disparities reduction requirements, Covered CA is proposing the following
 1. Contractor must submit the following HEDIS measure samples to Covered California:
 - Comprehensive Diabetes Care (CDC) HbA1c control <8.0% (NQF #0575)
 - Controlling High Blood Pressure CBP <140/90 mm Hg (NQF #0018)
 2. Based on the mutually agreed upon intervention proposal, Contractor must report progress for a measurable reduction in the selected disparity.
- Proposing a new requirement for issuers to participate in a collaborative effort to identify and align statewide disparity work
 - Identifying a statewide focus and aligning disparities reduction efforts across organizations will increase the impact of Covered CA and issuer's efforts to improve health equity in California
- Previously optional, proposed required achievement or maintenance of NCQA Multicultural Health Care Distinction by year-end 2022

Population Health Management

- 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

Health Promotion and Prevention

- Require issuers to continue reporting on tobacco use cessation program and weight management program utilization
- 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

2022 ASSURING QUALITY CARE (2 OF 3)

The following are recommended requirements for the 2022 Attachment 7 amendment:

Behavioral Health

- Submit NCQA Health Plan Accreditation Network Management reports for the elements related to the issuer's behavioral health provider network such as the network standard for access to behavioral healthcare
- 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 (audited by the issuer's HEDIS auditor); 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*
- Measure and report the number of active X waiver licensed prescribers in network and the number of total X waiver licensed prescribers in their network; an active X waiver licensed prescriber is defined as a provider who has written one or more MAT prescription in past 12 months
- Report how issuers are promoting the integration of behavioral health services with medical services with an emphasis on the Collaborative Care Model, report the percent of Enrollees cared for under integrated models, and whether the issuer reimburses for the Collaborative Care Model claims codes

2022 ASSURING QUALITY CARE (3 OF 3)

The following are recommended requirements for the 2022 Attachment 7 amendment:

Acute, Chronic and Other Conditions

- No new requirements

Complex Care

- 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 ADT events
- Continue requirements for at-risk enrollee engagement and Centers of Excellence

2022 EFFECTIVE CARE DELIVERY (1 OF 3)

The following are recommended requirements for the 2022 Attachment 7 amendment:

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); measure set will align with the IHA ACO measure set

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

- Participate in the Integrated Healthcare Association (IHA) and submit data for the IHA Commercial HMO and ACO measure sets (as applicable)
- Report the characteristics of the issuer's HMO, 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

2022 EFFECTIVE CARE DELIVERY (2 OF 3)

The following are recommended requirements for the 2022 Attachment 7 amendment:

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 hospitals with multiple signals of poor performance and engage these hospitals in efforts to improve performance
- Covered CA is proposing to remove the requirement for issuers to exclude outlier poor performing hospitals and providers due to challenges in developing a single, specific definition for outlier poor performers
 - Covered CA believes that additional research is needed to continue to require exclusion of hospitals
 - However, exclusion of hospitals with multiple signals of poor performance continues to be an important tool for health plans to address cost and quality concerns
 - Issuers will be required to report their rationale for continuing to contract with hospitals with multiple signals of poor performance
- Participate in the IHA Align Measure Perform (AMP) program and report contracted physician group performance results to Covered CA
- Work collaboratively with Covered CA and other issuers to define poor performing physician groups, notify physician groups with multiple indicators or poor performance, and engage these physician groups in efforts to improve performance

2022 EFFECTIVE CARE DELIVERY (3 OF 3)

The following are recommended requirements for the 2022 Attachment 7 amendment:

Sites & Expanded Approaches to Care Delivery

- ❑ Continue requirements for tracking and reducing hospital associated infections (HAI) and NTSV C-sections to improve hospital quality and safety
- ❑ Continue to require issuers to track and report on telehealth utilization and payment

Appropriate Interventions

- ❑ Continue requirements for issuers to ensure Enrollee have access to cost and quality information as well as shared decision making tools
- ❑ Continue requirements for issuers to report how it constructs pharmacy formularies based on total cost of care and how it manages specialty pharmacy and biologics

2022 KEY DRIVERS OF QUALITY CARE & EFFECTIVE DELIVERY

The following are recommended requirements for the 2022 Attachment 7 amendment:

Accreditation

- Achieve, or be in the process of achieving, NCQA Accreditation

Data Sharing and Analytics

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

Patient-Centered Social Needs

- 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.
- Maintain community resources listing by region served to support linkage to appropriate social services; submit documented process for referrals for housing instability and food insecurity

Measurement for Improvement, Choice and Accountability

- Development of a priority set of quality performance outcome measures, in alignment with key purchasers, to incentivize delivery of high-quality care
- Covered CA will use standard measure specifications from measure stewards including NCQA, CMS and PQA
 - If standard measure specifications are not available, Covered CA will develop measure specifications in collaboration with contracted issuers and the HEI vendor

Quality Improvement and Technical Assistance

- Adopt and implement Smart Care California guidelines for appropriate use of C-sections and opioids

PUBLIC COMMENT PERIOD

- Covered CA will distribute the draft 2022 Attachment 7 amendment for public comment on October 15
 - Public comment period: October 15 – November 12, 2020
- Covered CA is providing the following documents during the public comment period:
 - Draft 2022 Attachment 7 Amendment
 - Summary of Changes from 2021 to 2022 Attachment 7 Amendment
 - Crosswalk of Requirements from 2021 to 2022 Attachment 7 Amendment

The summary and crosswalk are companion documents to facilitate your review of the Attachment 7 amendment
- Please submit comments and feedback to PMDContractsUnit@covered.ca.gov by November 12
- Covered CA staff will review public comments and feedback and revise the draft Attachment 7 amendment throughout November
- Covered CA staff will summarize comments and present proposed changes to the draft Attachment 7 in the December Plan Advisory meeting

2022 ATTACHMENT 14 PROPOSAL PRESENTATION

James DeBenedetti, Plan Management Director

CONTEXT AND SUMMARY OF PROPOSED REVISIONS TO PERFORMANCE STANDARDS FOR 2022

The 2022 Amendment Attachment 14 Performance Standards proposals are intended to make small incremental steps toward a full review that would be part of 2023 contract revision to align with general direction of improving issuer accountability and redistribute % at risk with a focus on quality measures and performance standards:

- Emphasize Quality performance standards (90% of performance dollars at risk), with the greatest emphasis on QRS to signal importance of quality measures.
- Maintain performance requirements for submission of Healthcare Evidence Initiative (HEI) Data, as quality data collection is imperative to conduct enhanced monitoring of issuer quality and performance (10% of performance dollars at risk).
- For structural and process measures, move to report-only and no money at risk.

2023 and Beyond – Major Incentives/Penalties Anchored in Quality

- Plan Management Division is in the process of developing “Quality Transformation Fund” options for how to have substantial incentives related to health plans’ quality performance, with potential links to supporting quality improvement.

CURRENT APPROACH AND LIMITATIONS

Penalties and Credits to assess Performance Standards in four different performance categories:

- Group 1 – Customer Service
- Group 2 – Operational
- Group 3 – Quality, Network Management and Delivery System Standards
- Group 4 – Covered California Customer Service

Total amount at risk is 10% of Total Participation Fees, or 0.35% of Gross Premium.

- Amount at risk in 2018 was \$34.8 million.

Limitations of current methodology:

- The overall combination of credits allowed in Group 1, 3, and 4, the distribution of % at risk per performance standard, combined with the methodology that credits are allowed to offset penalties across all performance categories has resulted in the total amount collected from 2015-2018 of only \$101,000.
 - Group 4 credits related to Covered California's performance can also be applied to QHP issuer penalties. Each year, Covered California's performance has allowed credits to be applied.
 - Group 3 credits related to Quality metrics are unevenly distributed, allowing for a larger credit in areas that may be easy to meet or allow for leniency (alternate standards allowed). For example, the Essential Community Providers performance standards allows up to 10% credit, compared to the QRS scores that allow up to a 3.5% credit each.

ATTACHMENT 14 PERFORMANCE STANDARDS CURRENT STRUCTURE – GROUPS 1, 2, AND 4

Current Attachment 14 Structure - Penalties and Credits

Group 1 – Customer Service (15%) – Penalties and Credits can be earned for each standard based on performance.

- 1.1 Abandonment Rate - 3%
- 1.2 Service Level – 3%
- 1.3 Implementation of Appeals Decisions – Pilot/3%
- 1.4 Grievance Resolution – 3%
- 1.5 Covered CA Emails Completed – 3%

Group 2 – Operational (35%) – Penalties Only for poor performance (however, credits from other areas can offset penalties)

- 2.1 ID Card Processing Time – 5%
- 2.2 834 Processing – 5%
- 2.3 834 Generation – 5%
- 2.4 Reconciliation Process – 10%
- 2.5 Data Submissions: a) Provider Director – 5% and b) HEI Data – 5%

Group 4 – Covered California Customer Service - Penalties and Credits can be earned for each standard based on performance. A Covered California penalty is treated as a credit to issuers. (This has resulted in no payments or significantly reduced payments for issuers each year.)

- 4.1 Service Level – 3.75%
- 4.2 Abandonment Rate – 3.75%
- 4.3 Implementation of Appeals Decisions – Pilot/3.75%
- 4.4 Complaint Resolution – 3.75%

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 PERCENT AT RISK REDISTRIBUTION FOR PERFORMANCE STANDARDS - QUALITY (90%) AND HEI DATA (10%)

QHP – Group 3 - Quality, Network Management, Delivery System	Current % at Risk	Proposed % at Risk	Recommended Change
3.1 Quality Rating System – Clinical Effectiveness Rating	3.5%	25%	Increase % at-risk in alignment with emphasis on health plan accountability for health care quality.
3.2 Quality Rating System – QHP Enrollee Survey Summary Rating	3.5%	25%	Increase % at-risk in alignment with emphasis on health plan accountability for consumer experience of care.
3.3 Essential Community Providers	10%	0%	Continue annual assessment, remove performance guarantee; current assessment methodology has several limitations and does not adequately address the ECP alternate standard. Launch updated methodology for 2023.
3.4 Reducing Health Disparities a) Race/Ethnicity HEI Data Submission b) Disparity Reduction c)NEW: Proposed 2% Credit for early achievement of NCQA MHCD	2% 3%	15%	Changing from issuer self-reported race/ethnicity data performance to measurement in HEI data emphasizes importance of demographic data collection as foundation for future disparities measurement and reduction work; emphasis on disparities reduction with elimination of specific intervention requirement and measurement of reduction outcome rather than process.
3.5 Network Design Based on Quality	4%	0%	Remove performance guarantee as it relies heavily on qualitative information and is challenging to uniformly assess issuer performance.
3.6 Primary Care a) Physician Assignment b) Payment Strategy c) PCMH Recognition	2% 3% 3%	0% 8% 0%	Consolidation of primary care performance standards and % at-risk to payment strategy.
3.7 Accountable Care Organizations	5%	8%	Increase % at-risk and modify to include percentage of hospitals under issuer's total cost of care budget or ACO payment arrangement that includes shared risk or shared savings.
3.8 Appropriate Use of C-Sections	4.5%	4.5%	Maintain performance level.
3.9 Hospital Safety	4.5%	4.5%	Maintain performance level.
Group 3 Subtotal	48%	90%	
2.5 b) HEI Data	5%	10%	Increase % at-risk and increase performance level.
Total at Risk Quality (90%) and HEI data (10%) Standards		100%	



NEXT STEPS

Discussion and feedback on proposed structure of Attachment 14 for 2022:

- Methodology: Penalty Only
- Performance Standards for 2022:
 - Removal of Group 1, 2, and 4 Performance Standards
 - Keeping only Group 3 and HEI Data Performance Standards
 - Redistribution of percent at risk for the remaining performance standards as detailed in Slide 5
- Total \$ at Risk: 100% of total possible penalty (maximum 10% of Participation Fee)

Timeline for Board discussion and approval:

- January 2021 – Board discussion of the 2022 Attachment 14 proposal in open session
- March 2021 – Board approval of the 2022 Attachment 14 (along with the 2022 Model Contract and Attachment 7) in open session

Please submit comments and feedback to PMDContractsUnit@covered.ca.gov by October 30, 2020

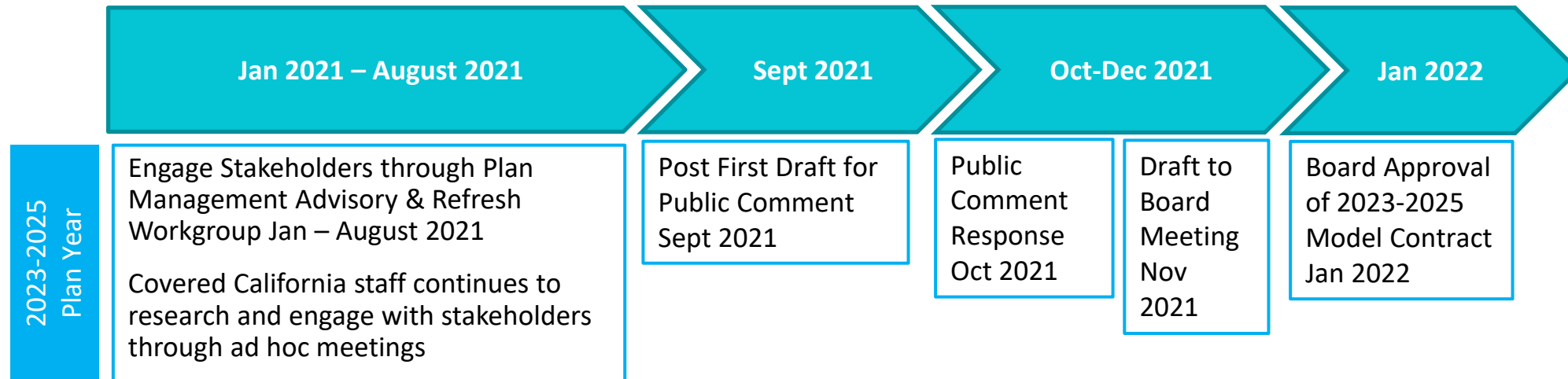
2023-2025 ATTACHMENT 7 REFRESH WORKGROUP UPDATE

Thai Lee, Senior Quality Specialist

2023-2025 ATTACHMENT 7 REFRESH WORKGROUP

- Attachment 7 Refresh Workgroup will resume monthly meetings starting in January 2021 to discuss areas related to Attachment 7 for 2023-2025
 - Stakeholders include: health plans, provider groups, consumer advocates, and subject matter experts
 - Areas of priority for discussion: Health Equity, Mental Health and Substance Use Disorder, Primary Care, among others
- Objective of the workgroup is to discuss and make recommendations on changes to the QHP Attachment 7 model contract for 2023-2025
- To join the workgroup or if you have questions, please contact Thai Lee at thai.lee@covered.ca.gov

2023-2025 ATTACHMENT 7 MODEL CONTRACT PROPOSED DEVELOPMENT TIMELINE



OPEN FORUM

THANK YOU