Plan Management Advisory Workgroup Meeting

January 13, 2022

AGENDA

Time	Topic	Presenter
10:00 – 10:05	Welcome and Agenda Review	Rob Spector
10:05 – 10:35	New Proposals for the 2023 Contract and Certification Process	James DeBenedetti
10:35 – 11:05	2023 Standard Benefit Design Update	Jan Falzarano
11:05 – 11:15	Plan Year 2023 Certification Application Overview	Meiling Hunter EQT Staff
11:15 – 11:35	2023-2025 Attachment 1 Overview	EQT Staff
11:35 – 11:55	Quality Transformation Initiative Update	Alice Chen Margareta Brandt
11:55 – 12:00	Open Forum	All

NEW PROPOSALS FOR THE 2023 CONTRACT AND CERTIFICATION PROCESS

James DeBenedetti
Director, Plan Management Division

UPDATE ON HEALTH PLAN CONTRACTING 2023-2025

The material in this PowerPoint updates a December 21, 2021 outline of policies being considered for Covered California's contracting with carriers and for the potential removal of carriers or allowing of entry to new carriers. Covered California will release details on the final staff recommendations for the January 20th board meeting. Additional comments will be considered for the development of those recommendations and are encouraged to be submitted to QHPCertification@Covered.CA.gov.

It is important to note that the elements of the contract described in this PowerPoint complement a range of other contracting and certification requirements. Some of these policies have been in place for many years, while others have been subject to extensive engagement or are relatively new and are organized in the restructured contract. These include:

Ongoing contract requirements:

- Standard patient-centered benefit designs to reduce consumer confusion and ensure quality of coverage
- Requirements related to scope of marketing, including coordination, targeting and co-branding, and expectations to provide adequate support to certified agents
- Adequate provider networks, including inclusion of Essential Community Providers
- Initiatives to improve healthcare quality, address health equity and disparities, and promote delivery system and payment reform

Revised Attachment 1 (formerly Attachment 7) and Attachment 2 (formerly Attachment 14) of the contract including significant additions to existing contractual requirements in the areas of:

- Disparities reduction
- Behavioral health
- Value based delivery systems (advanced primary care, integrated delivery systems, payment reform)
- Affordability and cost (provider networks and consumer affordability)
- Data exchange requirements

Newly considered requirements:

- Requiring all carriers to work with Covered California to support continuity of coverage between all of the carrier's lines of business – both Medi-Cal and Employer-sponsored – to maximize consumers' awareness of and enrollment in Covered California when they lose those coverages through consumer outreach and auto-enrollment efforts.

Across the board, Covered California's contracting is designed to be aligned with and complement efforts of other major purchasers, including CMS, Medi-Cal, CalPERS (the state employee purchasing program), and others.

QUALITY STANDARDS FOR EXCLUSION OF EXISTING PLANS

- The following policies will take effect in plan year 2023
  - Health plan products that fall below established quality benchmarks for two consecutive years would be put on notice that they would be required to improve within two years or be decertified in the subsequent plan year.
  - The quality benchmark is the equivalent of 25th percentile of performance using the QRS “Getting Right Care” standard measures.
  - The exclusion policy would not be applied to health plans in a region with fewer than a minimum threshold of health plans.
  - Carriers would be required to submit a plan detailing the action they will take to improve quality and equity.
  - Covered California would monitor and work with carriers to assure improvement efforts do not have negative impacts on consumers.
  - If the health plan product does not meet the quality benchmark within the two-year period, that health plan product will be decertified and removed from Covered California’s Marketplace and consumers will be assisted in selecting a new health plan.
  - Carriers will be eligible to reapply to offer that health plan product that was removed once their quality scores have improved and are above the performance threshold.

QUALITY STANDARDS FOR NEW ENTRANTS

- New entrants must demonstrate that the likely quality of care provided through its contracted networks and delivery support systems will be above a quality threshold equivalent to the 25th percentile of performance using the QRS “Getting Right Care” standard measures.

- Demonstration of likely performance will be assessed by proxy measures, such as:
  - HEDIS performance from substantively similar provider networks in the carrier’s other lines of business in California.
  - Modeling of quality indicators from providers contracted for the proposed network.

NEW CONTRACTUAL TERMS REGARDING ENROLLMENT

Taking effect in plan year 2023, the contract will more clearly articulate the agreement between Covered California and the Carriers that we are jointly responsible for and committed to work together to maximize enrollment of individuals eligible for subsidies in Covered California and in individual coverage generally. That agreement will be reflected in requirements for carriers to:

- Support smooth member transitions and facilitate continuous coverage for enrollees to and from Covered California and other health coverage programs, including Medi-Cal and other governmental health care programs and for consumers leaving coverage provided by Employers, including enrollees eligible for COBRA or Cal-COBRA but may have better coverage options through Covered California.
- Continue sharing plans and budgets for marketing and coordinating marketing efforts with Covered California. The contract will also continue the expectation that Carriers commit resources to marketing and outreach efforts, though we will maintain the existing terms that do not establish minimum marketing spend. Covered California will reduce the current expectation for certification that 0.6% of premium be spent on marketing to 0.4%, with the expectation that this amount be spent on direct response advertising, outreach and community-based efforts, and non-open enrollment "brand" marketing, that includes co-branding of Covered California. Brand marketing that does not reference Covered California would not be reflected in determining the "creditable marketing."
- Support and adequately compensate Certified Agents for enrollments in its QHPs.

Covered California would consider Carriers engagement, partnership and how these requirements are met as a critical component when deciding whether to re-contract with Carriers for future contract periods or whether to make the requirement tied to specific liquidated damage or enforcement criteria in future years.

ALLOWING NEW ENTRANTS TO JOIN DURING ANY YEAR

- When Covered California was first established, new entrant applications from most carriers were only allowed during the first year of a multi-year contract period. This policy sought to promote a robust and healthy marketplace during the period of uncertainty in launching a new program. Certain carriers (e.g., Medi-Cal local initiatives and newly licensed plans) were exempt from this requirement. As Covered California approaches the completion of its eighth successful Open Enrollment period, Covered California continues to promote stability and certainty for consumers, but intends to update this policy.

- Effective Plan Year 2023, Covered California will now consider any potential new entrant for certification during all years covered by the contract – not just the first year. New Entrants will be held to all standards applicable to existing carriers.

2023 STANDARD BENEFIT DESIGN UPDATE

Jan Falzarano
Deputy Director, Plan Management Division

2023 STANDARD BENEFITS DESIGN WORKGROUP

- The Draft 2023 Notice of Benefit and Payment Parameters was released on Tuesday, December 28, 2021.
  - Draft NBPP included proposed narrowing of the Actuarial Value de minimus range

- Draft Actuarial Value (AV) Calculator was released on Thursday, December 30, 2021

- SBD Workgroup updates:
  - Review modeling
  - SBD timeline
    - January Board – high level update on SBD workgroup discussion
    - February Board for 1st review of SBD and informational agenda item
    - March Board for final review and Board action item

2023 NOTICE OF BENEFIT AND PAYMENT PARAMETERS

- The Draft 2023 Notice of Benefit and Payment Parameters proposed to narrow the Actuarial Value de minimus range related to levels of coverage:
  - De minimus range for Standard Bronze, Gold, and Platinum Tiers will be +2/-2 (from +2/-4)
  - Expanded Bronze and Bronze HDHP has AV range of +5/-2 (from +5/-4)
  - The proposed rules narrow de minimus range for Silver to +2/0 (from +2/-4)
  - Enhanced Silver variants have de minimus range of +1/0 (from +1/-1)
  - Silver 73 – no changes to increase AV beyond the +1/0, but would be required to be at least 2 percentage points above the standard Silver plan's AV

- California law sets the AV de minimus range at +2/-2 for all metal products since PY 2017
- Bronze HDHP expanded to +4/-2 through Chapter 38, Statutes of 2019 (SB 78) for PY 2020
- Bronze and Bronze HDHP expanded to +5/-2 for PY 2021
- HHS also issued a guidance letter on the annual limitation on cost sharing for 2023 and has set the consumer maximum out of pocket at $9,100

2023 ANNUAL LIMITATION ON COST SHARING

	2019	2020	2021	2022	2023
Maximum annual limitation on cost-sharing (federal)	$7,900 / $15,800	$8,150 / $16,300	$8,550 / $17,100	$8,700 / $17,400	$9,100 / $18,200
Less CA MOOP ($350) for dental	$7,550 / $15,100	$7,800 / $15,600	$8,200 / $16,400	$8,350 / $16,700	$8,750 / $17,500
CSR 73 Maximum annual limitation	$6,300 / $12,600	$6,500 / $13,000	$6,800 / $13,600	$6,950 / $13,900	$7,250 / $14,500
CSR 87 Maximum annual limitation	$2,600 / $5,200	$2,700 / $5,400	$2,850 / $5,700	$2,900 / $5,800	$3,000 / $6,000
CSR 94 Maximum annual limitation	$2,600 / $5,200	$2,700 / $5,400	$2,850 / $5,700	$2,900 / $5,800	$3,000 / $6,000

2023 ACTUARIAL VALUE CALCULATOR TREND

- The AV Calculator utilizes the Health Intelligence Company, LLC (HIC) database and includes detailed enrollment and claims information from 2018 and projected forward to 2023.

- The claims cost in the draft 2023 AV Calculator are projected forward
  - From 2018 to 2021 at an annual rate of 5.4 percent for medical spending and 8.7 percent for drug spending
  - From 2021-2022, it was revised to be 3.2 percent for medical spending and 4.55 percent for drug spending (note: this was previously at 0.0 percent trending)
  - From 2022-2023, 5.8 percent for medical spending and 8.7 percent for drug spending

AV INCREASES FROM 2022 TO 2023

	Bronze		Silver				Gold		Platinum	
	HDHP	Standard	Silver	Silver 73	Silver 87	Silver 94	Copay	Coins	Copay	Coins
AV Target	60	60	70	73	87	94	80	80	90	90
Deviation Allowance	+5/-2%	+5/-2%	+2/0%	+1/0%	+1/0%	+1/0%	+/-2.0%	+/-2.0%	+/-2.0%	+/-2.0%
2022 AV	64.60	64.90	71.5	73.85	87.88	94.66	78.01	81.90	89.25	91.59
2022 Additive Adjustments		-0.12	-0.43	-0.43	-0.13	0.00				
2022 Final AV	64.60	64.78	71.07	73.42	87.75	94.66	78.01	81.90	89.25	91.59
2023 AV*	**64.17**	**64.73**	**73.88**	**76.24**	**88.44**	**95.19**	**79.20**	**82.64**	**89.75**	**91.76**

*Draft AV does not include 2023 copay accumulation additive adjustment – will update with final screenshots

Red text: AV is outside de minimis range

Blue text: AV is within de minimis range

For illustrative purpose only.

Proposed Plan Designs Side-by-Side View for IFP

Benefit	Individual-only Platinum Coinsurance		Individual-only Platinum Copay		Individual-only Gold Coinsurance		Individual-only Gold Copay		Individual-only Silver		Silver 73		Silver 87		Silver 94		Bronze		Bronze HDHP	
	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount
Deductible																				$7,000
Medical Deductible										$3,700		$3,700		$800		$75		$6,300		
Drug Deductible										$10		$10		$0		$0		$500		
Coinsurance (Member)		10%		10%		20%		20%		20%		20%		15%		10%		40%		0%
MOOP		$4,500		$4,500		$8,200		$8,200		$8,200		$6,300		$2,850		$800		$8,200		$7,000
ED Facility Fee		$150		$150		$350		$350		$400		$400		$150		$50	X	40%	X	0%
Inpatient Facility Fee		10%		$250		20%		$600	X	20%	X	20%	X	15%	X	10%	X	40%	X	0%
Inpatient Physician Fee		10%		---		20%		---		20%		20%		15%		10%	X	40%	X	0%
Primary Care Visit		$15		$15		$35		$35		$35		$35		$15		$5	X	$65	X	0%
Specialist Visit		$30		$30		$65		$65		$70		$70		$25		$8	X	$95	X	0%
MH/SU Outpatient Services		$15		$15		$35		$35		$35		$35		$15		$5	X	$65	X	0%
Imaging (CT/PET Scans, MRIs)		10%		$75		20%		$150		$325		$325		$100		$50	X	40%	X	0%
Speech Therapy		$15		$15		$35		$35		$35		$35		$15		$5		$65	X	0%
Occupational and Physical Therapy		$15		$15		$35		$35		$35		$35		$15		$5		$65	X	0%
Laboratory Services		$15		$15		$40		$40		$40		$40		$20		$8		$40	X	0%
X-rays and Diagnostic Imaging		$30		$30		$75		$75		$85		$85		$40		$8	X	40%	X	0%
Skilled Nursing Facility		10%		$150		20%		$300	X	20%	X	20%	X	15%	X	10%	X	40%	X	0%
Outpatient Facility Fee		10%		$100		20%		$300		20%		20%		15%		10%	X	40%	X	0%
Outpatient Physician Fee		10%		$25		20%		$40		20%		20%		15%		10%	X	40%	X	0%
Tier 1 (Generics)		$5		$5		$15		$15	X	$15	X	$15		$5		$3	X	$18	X	0%
Tier 2 (Preferred Brand)		$15		$15		$55		$55	X	$55	X	$55		$25		$10	X	40%	X	0%
Tier 3 (Nonpreferred Brand)		$25		$25		$80		$80	X	$85	X	$85		$45		$15	X	40%	X	0%
Tier 4 (Specialty)		10%		10%		20%		20%	X	20%	X	20%		15%		10%	X	40%	X	0%
Tier 4 Maximum Coinsurance		$250		$250		$250		$250		$250		$250		$150		$150		$500*		
Maximum Days for charging IP copay				5				5												
Begin PCP deductible after # of copays																		3 visits		
Actuarial Value																				
2023 AV (Draft 2023 AVC)		**91.76**		**89.75**		**82.64**		**79.20**		**73.88**		**76.24**		**88.44**		**95.19**		**64.73**		**64.17**
2022 Additive Adjustment										**-0.43**		**-0.43**		**-0.13**				**-0.12**		
2022 AV (Final 2022 AVC)†		**91.59**		**89.25**		**81.90**		**78.01**		**71.07†**		**73.42†**		**87.75†**		**94.66**		**64.78†**		**64.60**
Enrollment as of June 2021		61,090				151,430				227,540		124,900		328,850		205,510		352,860		108,220
Percent of Total enrollment		4%				10%				15%		8%		21%		13%		23%		7%

KEY:		
	X	Subject to deductible
	*	Drug cap applies to all drug tiers
	†	Additive adjustment (included in AV)
		Increased member cost from 2022
		Decreased member cost from 2022
		Does not meet AV
		Within .5 of upper de minimis
		Securely within AV

For illustrative purpose only.

Proposed 2023 AV Model – Silver Plan

Benefit	Silver		Silver A		Silver B		Silver C		Silver D		Silver E		Silver F	
	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount
Deductible														
Medical Deductible		$3,700		$3,700		$3,700		$5,000		$4,000		$4,000		$5,000
Drug Deductible		$10		$10		$10		$325		$60		$60		$60
Coinsurance (Member)		20%		20%		20%		20%		20%		20%		20%
MOOP		$8,200		$8,700		$8,700		$8,750		$8,700		$8,750		$8,750
ED Facility Fee		$400		$400		$400		$400		$400		$400		$400
Inpatient Facility Fee	X	20%	X	30%	X	30%	X	20%	X	30%	X	30%	X	30%
Inpatient Physician Fee		20%		30%		30%		20%		30%		30%		30%
Primary Care Visit		$35		$45		$50		$40		$40		$40		$40
Specialist Visit		$70		$70		$70		$80		$70		$80		$80
MH/SU Outpatient Services		$35		$45		$50		$40		$40		$40		$40
Imaging (CT/PET Scans, MRIs)		$325		$325		$325		$325		$325		$325		$325
Speech Therapy		$35		$45		$50		$40		$40		$40		$40
Occupational and Physical Therapy		$35		$45		$50		$40		$40		$40		$40
Laboratory Services		$40		$40		$40		$40		$40		$60		$50
X-rays and Diagnostic Imaging		$85		$85		$85		$85		$85		$105		$95
Skilled Nursing Facility	X	20%	X	30%	X	30%	X	20%	X	30%	X	30%	X	30%
Outpatient Facility Fee		20%		20%		20%		20%		20%		20%		20%
Outpatient Physician Fee		20%		20%		20%		20%		20%		20%		20%
Tier 1 (Generics)	X	$15	X	$15	X	$17	X	$17	X	$17	X	$17	X	$17
Tier 2 (Preferred Brand)	X	$55	X	$55	X	$55	X	$60	X	$60	X	$60	X	$60
Tier 3 (Nonpreferred Brand)	X	$85	X	$85	X	$85	X	$90	X	$85	X	$90	X	$90
Tier 4 (Specialty)	X	20%	X	20%	X	20%	X	20%	X	20%	X	20%	X	20%
Tier 4 Maximum Coinsurance		$250		$250		$250		$250		$250		$250		$250
Maximum Days for charging IP copay														
Begin PCP deductible after # of copays														
Actuarial Value														
2023 AV (Draft 2023 AVC)		**73.88**		**72.72**		**71.97**		**71.96**		**72.67**		**71.89**		**71.89**
2022 Additive Adjustment		**-0.43**		**-0.43**		**-0.43**		**-0.43**		**-0.43**		**-0.43**		**-0.43**
2022 AV (Final 2022 AVC)		**71.07†**												

For illustrative purpose only.

Proposed 2023 AV Model – Silver CSR 73 Plan

Benefit	Silver 73		Silver 73 A		Silver 73 B		Silver 73 C		Silver 73 D		Silver 73 E	
	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount
Deductible												
Medical Deductible		$3,700		$3,700		$4,850		$5,000		$4,500		$5,000
Drug Deductible		$10		$10		$275		$275		$55		$55
Coinsurance (Member)		20%		20%		20%		20%		20%		20%
MOOP		$6,300		$6,800		$7,250		$7,250		$7,250		$7,250
ED Facility Fee		$400		$400		$400		$400		$400		$450
Inpatient Facility Fee	X	20%	X	30%	X	20%	X	20%	X	30%	X	30%
Inpatient Physician Fee		20%		30%		20%		20%		30%		30%
Primary Care Visit		$35		$35		$40		$40		$40		$40
Specialist Visit		$70		$70		$80		$80		$75		$70
MH/SU Outpatient Services		$35		$35		$40		$40		$40		$40
Imaging (CT/PET Scans, MRIs)		$325		$325		$325		$325		$325		$325
Speech Therapy		$35		$35		$40		$40		$40		$40
Occupational and Physical Therapy		$35		$35		$40		$40		$40		$40
Laboratory Services		$40		$40		$40		$40		$60		$55
X-rays and Diagnostic Imaging		$85		$85		$85		$85		$105		$95
Skilled Nursing Facility	X	20%	X	30%	X	20%	X	20%	X	30%	X	30%
Outpatient Facility Fee		20%		20%		20%		20%		20%		20%
Outpatient Physician Fee		20%		20%		20%		20%		20%		20%
Tier 1 (Generics)	X	$15	X	$15	X	$16	X	$16	X	$16	X	$16
Tier 2 (Preferred Brand)	X	$55	X	$55	X	$55	X	$55	X	$55	X	$55
Tier 3 (Nonpreferred Brand)	X	$85	X	$85	X	$85	X	$85	X	$85	X	$85
Tier 4 (Specialty)	X	20%	X	20%	X	20%	X	20%	X	20%	X	20%
Tier 4 Maximum Coinsurance		$250		$250		$250		$250		$250		$250
Maximum Days for charging IP copay												
Begin PCP deductible after # of copays												
Actuarial Value												
2023 AV (Draft 2023 AVC)		**76.24**		**75.50**		**74.00**		**73.98**		**73.86**		**73.93**
2022 Additive Adjustment		**-0.43**		**-0.43**		**-0.43**		**-0.43**		**-0.43**		**-0.43**
2022 AV (Final 2022 AVC)		**73.42†**										

For illustrative purpose only.

Proposed 2023 AV Model – Silver CSR 87 Plan

Benefit	Silver 87		Silver 87 A		Silver 87 B		Silver 87 C		Silver 87 D		Silver 87 E	
	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount
Deductible												
Medical Deductible		$800		$800		$800		$800		$800		$800
Drug Deductible		$0		$0		$100		$50		$0		$25
Coinsurance (Member)		15%		15%		15%		15%		15%		15%
MOOP		$2,850		$3,000		$3,000		$3,000		$3,000		$3,000
ED Facility Fee		$150		$150		$150		$150		$150		$150
Inpatient Facility Fee	X	15%	X	20%	X	20%	X	20%	X	20%	X	25%
Inpatient Physician Fee		15%		20%		20%		20%		20%		25%
Primary Care Visit		$15		$15		$15		$15		$20		$15
Specialist Visit		$25		$25		$25		$25		$25		$25
MH/SU Outpatient Services		$15		$15		$15		$15		$20		$15
Imaging (CT/PET Scans, MRIs)		$100		$100		$100		$100		$100		$100
Speech Therapy		$15		$15		$15		$15		$20		$15
Occupational and Physical Therapy		$15		$15		$15		$15		$20		$15
Laboratory Services		$20		$20		$20		$20		$20		$20
X-rays and Diagnostic Imaging		$40		$40		$40		$40		$40		$40
Skilled Nursing Facility	X	15%	X	20%	X	20%	X	20%	X	20%	X	25%
Outpatient Facility Fee		15%		15%		15%		15%		15%		15%
Outpatient Physician Fee		15%		15%		15%		15%		15%		15%
Tier 1 (Generics)		$5		$5	X	$5	X	$6		$6	X	$5
Tier 2 (Preferred Brand)		$25		$25	X	$25	X	$25		$25	X	$25
Tier 3 (Nonpreferred Brand)		$45		$45	X	$45	X	$45		$45	X	$45
Tier 4 (Specialty)		15%		15%	X	15%	X	15%		15%	X	15%
Tier 4 Maximum Coinsurance		$150		$150		$150		$150		$150		$150
Maximum Days for charging IP copay												
Begin PCP deductible after # of copays												
Actuarial Value												
2023 AV (Draft 2023 AVC)		**88.44**		**88.16**		**87.43**		**87.60**		**87.88**		**87.88**
2022 Additive Adjustment		**-0.13**		**-0.13**		**-0.13**		**-0.13**		**-0.13**		**-0.13**
2022 AV (Final 2022 AVC)		**87.75†**										

For illustrative purpose only.

Proposed 2023 AV Model – Silver CSR 94 Plan

Benefit	Silver 94		Silver 94 A		Silver 94 B		Silver 94 C		Silver 94 D		Silver 94 E	
	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount
Deductible												
Medical Deductible		$75		$75		$75		$75		$75		$75
Drug Deductible		$0		$0		$0		$10		$10		$0
Coinsurance (Member)		10%		10%		10%		10%		10%		10%
MOOP		$800		$1,000		$900		$900		$900		$900
ED Facility Fee		$50		$50		$50		$50		$50		$50
Inpatient Facility Fee	X	10%	X	10%	X	10%	X	10%	X	10%	X	10%
Inpatient Physician Fee		10%		10%		10%		10%		10%		10%
Primary Care Visit		$5		$5		$5		$5		$5		$5
Specialist Visit		$8		$8		$8		$8		$8		$8
MH/SU Outpatient Services		$5		$5		$5		$5		$5		$5
Imaging (CT/PET Scans, MRIs)		$50		$50		$50		$50		$50		$50
Speech Therapy		$5		$5		$5		$5		$5		$5
Occupational and Physical Therapy		$5		$5		$5		$5		$5		$5
Laboratory Services		$8		$8		$8		$8		$8		$8
X-rays and Diagnostic Imaging		$8		$8		$8		$8		$8		$8
Skilled Nursing Facility	X	10%	X	10%	X	10%	X	10%	X	10%	X	10%
Outpatient Facility Fee		10%		10%		10%		10%		10%		10%
Outpatient Physician Fee		10%		10%		10%		10%		10%		10%
Tier 1 (Generics)		$3		$3		$3	X	$3	X	$5		$5
Tier 2 (Preferred Brand)		$10		$10		$10	X	$10	X	$10		$10
Tier 3 (Nonpreferred Brand)		$15		$15		$15	X	$15	X	$15		$15
Tier 4 (Specialty)		10%		10%		10%	X	10%	X	10%		10%
Tier 4 Maximum Coinsurance		$150		$150		$150		$150		$150		$150
Maximum Days for charging IP copay												
Begin PCP deductible after # of copays												
Actuarial Value												
2023 AV (Draft 2023 AVC)		**95.19**		**94.59**		**94.88**		**94.81**		**94.69**		**94.78**
2022 Additive Adjustment		**0.00**		**0.00**		**0.00**		**0.00**		**0.00**		**0.00**
2022 AV (Final 2022 AVC)		**94.66**										

For illustrative purpose only.

TIMELINE AND NEXT STEPS

- January 19, 2022: Standard Benefit Design Workgroup
- January 20, 2022: Board meeting: Brief update on SBD process, including major services areas impacted by AVC

- Please submit comments and questions to Wandy Mah at Wandy.Mah@covered.ca.gov

BRINGING COVERAGE WITHIN REACH REPORT

- Covered California is pleased to share with you the report entitled "**Bringing Coverage within Reach: Promoting California Marketplace Affordability and Improving Access to Care in 2023 and Beyond**."
- This report provides specific options for how California – or other states- could use federal funds that are anticipated in concept in the proposed Build Back Better Act to expand cost-sharing support.
- Accompanying the report is an **Executive Summary** and a companion detailed analysis produced by our actuaries at **Milliman**

PLAN YEAR 2023 CERTIFICATION APPLICATION UPDATE

Meiling Hunter, Lead Certification Program Specialist

PUBLIC COMMENT

- Plan Management Division received 22 public comments across the four Applications. The comments were technical in nature technical or for clarification.

- The requirements for Patient-Centered Medical Homes have been removed so the Confidentiality and Non-Disclosure Agreement is no longer required and will not be posted with the Letter of Intent.

- Please see the accompanied attachment “Public Comment Summary” which represents comments concerning or resulting in Application content changes.

PLAN YEAR 2023 CERTIFICATION MILESTONES

Release Draft 2023 QHP & QDP Certification Applications	December 2021
Draft Application Comment Periods End	December 2021
Plan Management Advisory: Benefit Design & Certification Policy Recommendation	January 2022
January Board Meeting: Discussion of Benefit Design & Certification Policy Recommendation	January 2022
Letters of Intent Accepted	February 2022
Final AV Calculator Released*	February 2022
Applicant Trainings (electronic submission software, SERFF submission and templates*)	February 2022
March Board Meeting: Anticipated approval of 2023 Patient-Centered Benefit Plan Designs & Certification Policy	March 2022
QHP & QDP Applications Open	March 1, 2022
QHP & QDP Application Responses (Individual and CCSB) Due	April 29, 2022
Evaluation of QHP Responses & Negotiation Prep	May - June 2021
QHP Negotiations	June 2022
QHP Preliminary Rates Announcement	July 2022
Regulatory Rate Review Begins (QHP Individual Marketplace)	July 2022
Evaluation of QDP Responses & Negotiation Prep	June – July 2022
QDP Negotiations	July 2022
CCSB QHP Rates Due	July 2022
QDP Rates Announcement (no regulatory rate review)	August 2022
Public Posting of Proposed Rates	July 2022
Public Posting of Final Rates	September – October 2022

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

PLAN YEAR 2023 CERTIFICATION APPLICATION OVERVIEW

EQT Staff

2023 QHP CERTIFICATION APPLICATION PUBLIC COMMENT KEY THEMES AND PROPOSED CHANGES

Question 16.2 Health Equity and Disparities Reduction

- ❑ One issuer expressed concern with inclusion of “declined to state” in the race/ethnicity response rate denominator.

Notable Changes to Draft QHP Certification Application	Rationale
16.2.1 Organizational Commitment to Cultivating a Culture of Health Equity – Added option to allow submission of the NCQA Health Equity Accreditation documentation, if available, in lieu of responses to this section.	Covered California conducted an internal review to identify opportunities to reduce reporting burden and minimize redundancy.
16.2.2 Race/Ethnicity Data collection – no change to be made	Calculation will remain consistent with prior performance standard methodology.

2023 QHP CERTIFICATION APPLICATION PUBLIC COMMENT KEY THEMES

Question 16.4 Health Promotion and Prevention

- Issuers requested standardized requirements on how Applicants can identify tobacco-dependent enrollees in their claims data, HRA, etc.
- Issuers expressed concern about the requirement to offer both in-person ***and*** online Diabetes Prevention Programs (DPP), citing limited availability of in-person programs.
- Issuers requested clarification on how Applicants are to complete the new DPP outcomes of interest, which aligns with one of CDC's National DPP outcomes of interest.

PROPOSED 2023 QHP CERTIFICATION APPLICATION CHANGES

Question 16.4 Health Promotion and Prevention

Notable Changes to Draft QHP Certification Application	Rationale
16.4.5 Diabetes Prevention Program – No change for requirement for issuers to offer Diabetes Prevention Programs (DPPs) as BOTH in-person and online formats. Included additional language regarding concerns about potential service area challenges such as rural location or limited program availability.	Issuers requested that the requirement for both in-person and online DPPs be changed to in-person and/or online, citing a limited availability of in-person programs. Covered California will not amend the recommendation at this time but included additional language to align with Attachment 1 and to address concerns about potential service area challenges. We are committed to ensuring all Enrollees have access to preventive diabetes care and education; providing both in-person and online DPP services ensures Enrollees have equitable access to these services in the event of service area challenges and allows Enrollees to choose their preferred modality.
16.4.5 Diabetes Prevention Program – No change for requirement regarding the outcomes of interest such as the number of enrollees who reached a modest reduction in hemoglobin A1c (HbA1c) of 0.2% using an in-person or online DPP.	Covered California recognizes that this is an ***optional*** CDC National DPP outcomes of interest. At this time, we will not amend the recommendation because this outcome of interest is consistent with our clinical priorities (QTI, QRS, etc.).

2023 QHP CERTIFICATION APPLICATION PUBLIC COMMENT KEY THEMES

No public comments were received, and no significant changes were made to the following sections:

- ❑ Question 16.1 Accreditation
- ❑ Question 16.3 Behavioral Health
- ❑ Question 16.5 Population Health Management
- ❑ Question 16.6 Complex Care
- ❑ Question 16.7 Affordability and Cost
- ❑ Question 16.8 Participation in Quality Improvement Collaboratives
- ❑ Question 16.9 Data Sharing and Exchange
- ❑ Questions 18.4, 19.4, 20.4, 21.4 Delivery System and Payment Strategies to Drive Quality

2023-2025 ATTACHMENT 1 OVERVIEW

EQT Staff

COVERED CALIFORNIA'S FRAMEWORK FOR HOLDING PLANS ACCOUNTABLE FOR QUALITY, EQUITY AND DELIVERY SYSTEM TRANSFORMATION

Domains for Equitable, High-Quality Care

PHYSICAL | BEHAVIORAL | ORAL | SOCIAL

- Population health management
- Health promotion and prevention
- Acute care
- Chronic care
- Complex care

Care Delivery Strategies

- Effective primary care
- Appropriate, accessible specialty care
- Integrated delivery systems and ACOs
- Networks based on value
- Leveraging technology
- Cultural and linguistic competence

Goals

- Improvement in health status
- Elimination of disparities
- Evidence-based care
- Patient-centered care
- Affordability for consumers and society

Key Levers

Covered California recognizes that promoting change in the delivery system requires **aligning** with other purchasers and working with all relevant payers in a way that improves value for consumers and society while minimizing administrative burden on plans and providers.

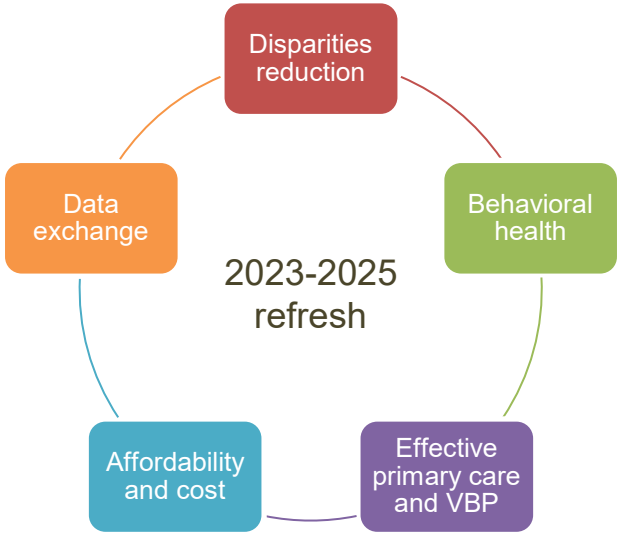
- Benefit design
- Measurement for improvement and accountability
- Data sharing and analytics
- Payment reform
- Consumer empowerment
- Quality improvement collaboratives
- Technical assistance
- Certification and accreditation

Community Drivers: Social Influences on Health, Economic and Racial Justice

PRINCIPLES AND STRATEGIC FOCUS AREAS

- Quality is central
- Equity is quality
- Measures that matter
- Make quality count
- Amplify through alignment
- Promote public good
- Care about cost

STRATEGIC FOCUS AREAS



Alignment with DHCS/CalPERS
Quality Transformation Initiative
Data analytics/Healthcare Evidence Initiative

PROPOSED GLOBAL REVISIONS TO ATTACHMENT 1

- The 2023-2025 Attachment 1 will no longer specify that reporting for contract performance assessment purposes will occur through the annual application for certification
  - Separating contractually-required reporting from the QHP certification process permits more flexibility to set manageable reporting processes and timelines, and reflects the ongoing engagement model between Covered California and contracted QHP issuers
  - Covered California will continue to consider contract compliance and performance in QHP recertification and issuer participation decisions
- Covered California has revised the language to specify that reporting will occur annually at a time determined by Covered California
  - Some reporting may continue to occur through the application for certification, other reporting will occur through separate mechanisms as Covered California seeks to minimize administrative burden
- Covered California will determine the reporting mechanism for contract performance assessment purposes in collaboration with QHP Issuers and stakeholders as we move closer to the 2023 plan year

2023-25 ATTACHMENT 1 PUBLIC COMMENT KEY THEMES

Article 1: Equity and Disparities Reduction

- ❑ Issuers would like to partner with Covered California to improve capture of member self-identified race, ethnicity, and language data and request that Covered California make the race, ethnicity, and language questions mandatory in the enrollment application.
- ❑ Issuers would like to see the standardized categories for collection of expanded demographic data, including disability status, sexual orientation, and gender identity.
- ❑ Issuers would like to partner with Covered California to identify opportunities for bidirectional data sharing.
- ❑ Issuers would like to see the performance scoring methodology for the member preferred language data collection requirement and whether there will be bidirectional sharing of language data.
- ❑ Consumer advocates expressed concern on the automatic assignment to English language for members who leave the field for “written and spoken language” blank.
- ❑ Consumer advocates would like to see a performance guarantee applied to reducing health disparities by language.
- ❑ Issuer request to remove the “decline to state” members from the numerator and denominator when calculating the 80% race/ethnicity response rate.
- ❑ Issuer request to remove Avoidable Ambulatory Emergency Room (ER) Visits per 1,000 and Comprehensive Diabetes Care: HbA1c Testing from the HEI measures list.

PROPOSED 2023-25 ATTACHMENT 1 CHANGES

Article 1: Equity and Disparities Reduction

Notable Changes to Draft Attachment 1	Rationale
1.01.1 Expanded Demographic Data Collection – No changes made to this section.	
1.01.2 Race, Ethnicity, and Language Data Collection Added language to distinguish between new and returning Contractors, clarify requirement timeline for new Contractors and move accountability for 80% race/ethnicity threshold to PY2024 for new entrant Contractors.	New Contractors will meet 80% self-identified race/ethnicity by PY 2024 rather than PY2025 given the high voluntary response rate in providing this information on the enrollment application and NCQA's adoption of the 80% threshold for measure stratification.
1.02.1 Disparities Measurement: Patient Level Data – added candidate QTI measures	Updated as anticipated following QTI development.
1.02.1 Disparities Measurement: Healthcare Evidence Initiative (HEI) – Removed the following measure from the HEI measure set: Avoidable Ambulatory Emergency Room (ER) Visits© per 1,000.	Covered California will pursue identification of a similar valid and reliable measure for avoidable ambulatory emergency room visits and will keep the HbA1c Testing measure as it continues to be appropriate for diabetes care health disparities assessment.
1.03.1 Disparities Reduction Intervention – Added language to distinguish between new and returning Contractors and to clarify requirement timeline for new Contractors.	New Contractors will meet specified phased requirements based on QHP data availability, including engaging with Covered CA in PY 2023 to demonstrate readiness to meet PY 2024 and 2025 contractual obligations. Returning Contractors will meet a multi-year disparities reduction target beginning PY 2023.

2023-25 ATTACHMENT 1 PUBLIC COMMENT KEY THEMES

Article 2: Behavioral Health

- ❑ Suggestion to add requirements for issuers to educate providers on how to refer to behavioral health services and help ensure enrollees have access to behavioral health services.
- ❑ Request to standardize cost shares for behavioral health telehealth services such that cost shares are equal for in-person and telehealth services.
- ❑ Request to revise requirements for implementing depression screening to specify working with primary care providers.
- ❑ Suggestion to revise the appropriate use of opioid requirements to emphasize non-pharmacological pain management treatments and address the potential improper tapering of opioid prescriptions that can be harmful to patients.

PROPOSED 2023-25 ATTACHMENT 1 CHANGES

Article 2: Behavioral Health

Notable Changes to Draft Attachment 1	Rationale
2.01.2 Offering Telehealth for Behavioral Health – No changes made to this section in response to request to standardize cost shares for behavioral health telehealth services such that cost shares are equal for in-person and telehealth services.	Covered California is continuing to explore options for standardizing cost shares for telehealth services. We coordinated with DMHC on the proposed telehealth requirements and the cost shares for telehealth services to ensure these requirements follow DMHC guidance.
2.01.3 Promoting Access to Behavioral Health Services – Added a requirement for QHP issuers to inform primary care providers about the enrollee referral process for behavioral health services.	Revised based on suggestion to add requirements for issuers to educate providers on how to refer to behavioral health services and help ensure enrollees have access to behavioral health services.
2.02.1 Screening for Depression – Revised language to include working with primary care providers to implement the depression screening measure.	Issuers requested the requirements for implementing depression screening to specify working with primary care providers.
2.03.1 Guidelines for Appropriate Use of Opioids – Further revised language to emphasize using a harm reduction framework and individualized approach to treatment planning.	Revisions based on feedback to emphasize the harm reduction framework, individualized approach to treatment planning, and access to non-pharmacological approaches to pain management.

2023-25 ATTACHMENT 1 PUBLIC COMMENT KEY THEMES

Article 3: Population Health

- ❑ Request for clarification in the introduction language to better reflect the responsibility of a QHP to address the health of all Enrollees, not just Enrollees who utilize services.

Population Health Management

- ❑ Concerns about potential algorithm bias within population health management stratification and segmentation methods.

Health Promotion & Prevention

- ❑ Requests for clarification on consumer incentive programs.
- ❑ Requests to stratify Diabetes Prevention Program (DPP) data by patient demographic variables (race, ethnicity, and language).
- ❑ Concerns about developing a corrective action plan for DPP utilization.

Social Health

- ❑ Suggestion to include caregiving in future standard screening requirements.

PROPOSED 2023-25 ATTACHMENT 1 CHANGES (1 OF 2)

Article 3: Population Health

Notable Changes to Draft Attachment 1	Rationale
3.01 Population Health – Clarified the introduction language to better reflect the responsibility of a QHP.	Issuers requested clarification in the introduction language regarding the responsibility of QHPs to address the health of all Enrollees, not just Enrollees who utilize services.
3.02.2 Diabetes Prevention Program – Included additional language to address concerns about potential service area challenges such as rural location or limited program availability.	Covered California included additional language to align with QHP Certification Application and to address concerns about potential service area challenges. We are committed to ensuring all Enrollees have access to preventive diabetes care and education; providing both in-person and online DPP services ensures Enrollees have equitable access to these services in the event of service area challenges and allows Enrollees to choose their preferred modality.
3.02.2 Diabetes Prevention Program – Clarified language regarding the corrective action plan to better reflect our intent.	Covered California is committed to diabetes prevention as part of our health promotion and prevention mission. Our intent is to hold issuers accountable and gain a better understanding of the processes in place to address a potential gap in DPP utilization.

PROPOSED 2023-25 ATTACHMENT 1 CHANGES (2 OF 2)

Article 3: Population Health

Notable Changes to Draft Attachment 1	Rationale
3.04.1 Screening for and Addressing Social Health – removed housing instability from minimum required screening requirements, added requirement to use Accountable Health Community Health-Related Social Needs Screening Tool food insecurity questions, and added PY 2024 requirement to stratify reporting measures by enrollee race and ethnicity	Covered California is committed to use of evidence-based screening questions and measurement for health-related social needs. These proposed revisions reflect increased requirements related to food insecurity screening, referral, and reporting based on strength of evidence and in alignment with December 2021 CMS Measures Under Consideration.

2023-25 ATTACHMENT 1 PUBLIC COMMENT KEY THEMES

Article 4: Delivery and Payment Strategies to Drive Quality

Effective Primary Care

- Request to align the PCP matching requirement with Medi-Cal initial health assessment requirements

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

- No public comments were received for this section

Networks Based on Value

- Comments received expressing concern about possible violations of state regulatory network adequacy standards if health plans are allowed to remove poor performing providers and hospitals from their networks
- Comments received requesting Covered California amend its contract language to be more explicit about providers complying with the California Dignity in Pregnancy and Childbirth Act, which mandates implicit bias training for perinatal providers, staff, and facilities
- General comments supporting Covered California's initiatives to reduce maternal health disparities

Telehealth

- General comments supporting the integration of third-party telehealth providers and primary care

Participation in Quality Collaboratives

- No public comments were received for this section

PROPOSED 2023-25 ATTACHMENT 1 CHANGES

Article 4: Delivery and Payment Strategies to Drive Quality

Notable Changes to Draft Attachment 1	Rationale
4.01.1 Encouraging Use of Primary Care – No changes were made to this section in response to the request to align the PCP matching requirement with Medi-Cal initial health assessment requirements.	Covered California reviewed the Medi-Cal requirements for an initial health assessment. Covered California is requiring enrollees to be provisionally assigned to a primary care clinician within 60 days of effectuation. We are not requiring primary care clinicians to conduct initial health assessments currently.
4.03.3 Provider Value – Contract language updated to ensure that health plans notify Covered California and the appropriate state regulator and licensing entity if they decide to remove a provider or hospital from its network. Additionally, any exclusion of a provider group or hospital may be subject to prior regulatory review and could result in required reductions in the Contractor's licensed service area.	The language was updated in conjunction with DMHC to ensure that health plans comply with network adequacy standards.
4.03.4.4 Hospital Value – Contract language updated to ensure that health plans notify Covered California and the appropriate state regulator and licensing entity if they decide to remove a provider or hospital from its network. Additionally, any exclusion of a provider group or hospital may be subject to prior regulatory review and could result in required reductions in the Contractor's licensed service area.	The language was updated in conjunction with DMHC to ensure that health plans comply with network adequacy standards.

PROPOSED 2023-25 ATTACHMENT 1 CHANGES

Article 4: Delivery and Payment Strategies to Drive Quality

Notable Changes to Draft Attachment 1	Rationale
4.03.7.2 Maternity Care – Contract language updated to be explicit about implicit bias training for perinatal providers, staff, and facilities in accordance with the California Dignity in Pregnancy and Childbirth Act	Covered California is committed to reducing maternal health disparities and will align its requirements with current laws where appropriate.
4.04.1 Telehealth Offerings – There are no new significant changes to this section.	
4.05 Participation in Quality Collaboratives – There are no new significant changes to this section.	

2023-25 ATTACHMENT 1 PUBLIC COMMENT KEY THEMES AND PROPOSED 2023-25 ATTACHMENT 1 CHANGES

Article 5: Measurement and Data Sharing Public Comment Themes

- ❑ Issuers requested technical clarification and offered suggestions on the Healthcare Evidence Initiative section.

Article 5: Measurement and Data Sharing Proposed Attachment 1 Changes

- ❑ There are no significant changes to Article 5.

PROPOSED 2023-25 ATTACHMENT 1 REQUIREMENTS, PUBLIC COMMENT KEY THEMES AND CHANGES

Article 6: Certification, Accreditation, and Regulation Requirements

- ❑ All issuers will be required to be NCQA accredited by year end 2024.

Article 6: Certification, Accreditation, and Regulation Public Comment Themes and Changes

- ❑ No public comments were received and there are no significant changes to Article 6.

DISCUSSION AND NEXT STEPS

- ❑ The 2023-25 Attachment 1 reflecting the second round of public comments will be presented to the Board on January 20, 2022
- ❑ Please send questions and comments to Margareta Brandt at margareta.brandt@covered.ca.gov

QUALITY TRANSFORMATION INITIATIVE UPDATE

Alice Chen, MD, MPH, Chief Medical Officer
Margareta Brandt, Quality Improvement Unit Manager

Overarching Quality Transformation Initiative Strategy

- The Quality Transformation Initiative (QTI) is one component of Covered California's tripartite measurement strategy which also includes annual tracking, monitoring and reporting of about 40 HEDIS and CAHPS measures that are part of the national Quality Rating System (QRS) as well as ongoing assessment of care through Healthcare Evidence Initiative (HEI) measures as outlined in Attachment 1 and 2 of the proposed 2023-2025 contract.

- Disparities reduction measures and financial assessments are integral to the Quality Transformation Initiative. The methodology for such assessments will be developed in conjunction with DHCS, CalPERS, DMHC; potential to add for inclusion in assessment either via contract amendment for PY 2025 or as part of next contract cycle.

- "Reporting only" measures related to behavioral health are measures for which there are not currently established national benchmarks and are included to signal intent to potentially incorporate into QTI during the next contract cycle.

- Metrics and targets will be regularly reassessed. Those that are topped out may be dropped, with new measures and targets added only as part of formal contract amendment process or during the next contract cycle.

- The carriers would be required to submit an action plan detailing the actions they plan to take to improve quality and equity for any measure for which they score below the 25th percentile. Covered California would monitor and work with carriers to assure improvement efforts do not have negative impacts on consumers.

QTI Measures: Number, Approach to Selection

Measure Criteria

- ✓ Established/vetted
- ✓ Available/low burden
- ✓ Clinical outcomes focused
- ✓ Epidemiologically important
- ✓ Opportunities to address disparities
- ✓ Impacted by healthcare
- ✓ National benchmarks through QRS measures set (if $)

- Widespread agreement with parsimony (fewer than 10 with many encouraging fewer than 5).

  "If you measure everything, you measure nothing."

- Some concerns that focusing on selected conditions would be to the detriment of others.

- Widespread support for alignment with DHCS/CalPERS.

  *"**Alignment of measures is more important than using the best measures."***

- Suggestions for additional measures included maternal care, total cost of care, avoidable ED visits, and readmissions.

QTI Measures: Recommended Initial Core Set of 4 Metrics

Measure Proposed 11/10	Feedback	Potential Revisions 12/20
Blood pressure control*	Strong consensus	Keep
Diabetes control*	Strong consensus	Keep
Colorectal cancer screening*	General support	Keep
Childhood immunizations*	General support, strong interest DHCS	Keep
Adolescent immunizations	General support	Remove to not “overweight” immunizations measures
Cervical cancer screening	General support, but not in DHCS VBP set	Remove due to high attainment and to align with DHCS
CAHPS (care experience)	Patient experience important but CAHPS inadequate	Keep in contract section A2 with performance guarantees, work towards better measures
Depression screening	BH important but challenging	Reporting only given not QRS
Pharmacotherapy opiates	No specific comments	Reporting only given not QRS

* Race/ethnicity stratification for reporting only in initial years, with assessments in 2025 or 2026

QTI Measures: Core Set MY 2019 Performance

Kaiser's HMO is the only plan product that has no measure below 50th percentile national performance.

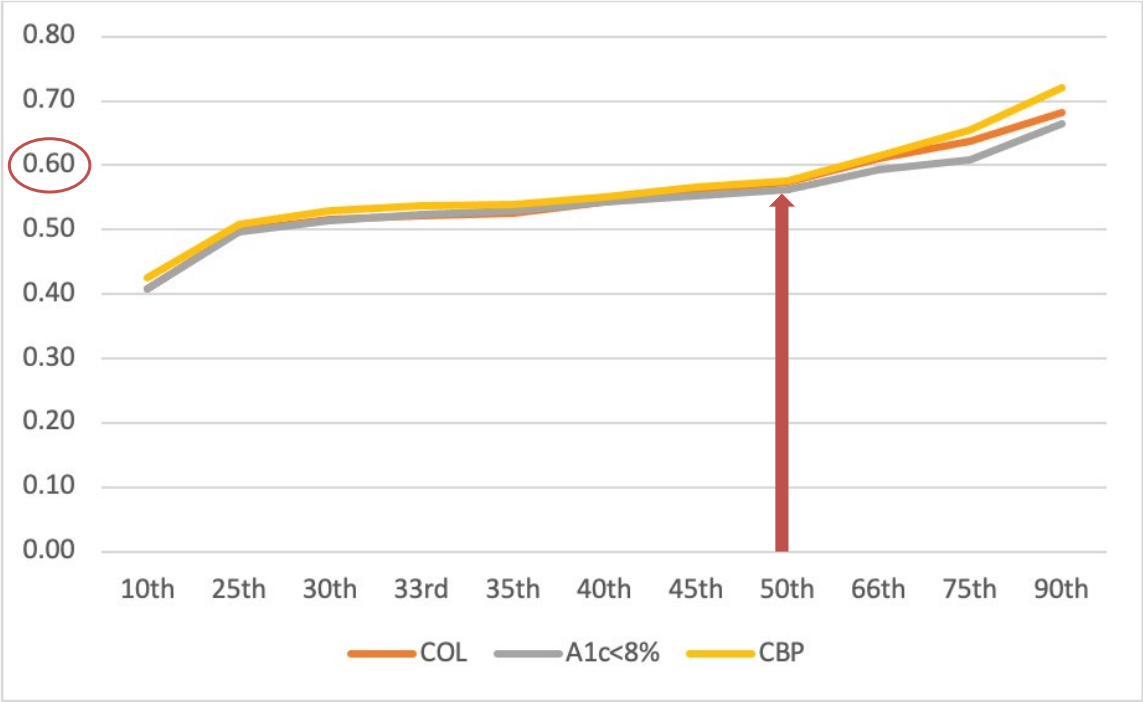
2 plan products (Anthem EPO and Oscar EPO) have all four measures below 50th percentile national performance.

3 plan products (Blue Shield PPO, HealthNet PPO, Molina HMO) have three measures below 50th percentile national performance.

								Benchmark:	≥90th Percentile		50th - 90th Percentile		25th - 50th Percentile		< 25th Percentile	
Measure Title	Year	Anthem HMO	Anthem PPO	Anthem EPO	BSC HMO	BSC PPO	CCHP HMO	Health Net HMO	Health Net EPO	Health Net PPO	Kaiser HMO	LA Care HMO	Molina HMO	Oscar EPO	Sharp HMO	VHP HMO	WHA HMO
Colorectal Cancer Screening	2019			45	59	51	60	62	53	40	76	54	31	36	66	54	52
	2020																
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)	2019			57	64	64	57	61	63	61	70	62	58	50	76	69	53
	2020																
Controlling High Blood Pressure	2019			45	66	56	68	63	59	55	81	68	65	46	79	64	65
	2020																
Childhood Immunization Status (Combination 3)	2019			51	64	63		69		55	84	82	74	34	77		
	2020																

QTI Measures: MY2019 National Distribution

At the 50th percentile of national performance for blood pressure control, diabetes control and colorectal cancer screening measures means that fewer than 60% of enrollees receive recommended care.



QTI Performance Thresholds: Options Under Consideration

The exact amount of financial contribution will be determined by both performance and payment rate at each level of performance.

Percentiles would be based on NATIONAL percentiles and measurement year 2021 performance to allow for improvement over time against static frame of reference.

Covered California is currently considering two options:

Option A. Potential payments up to the 66th percentile performance.

- Full payment below 25th percentile performance.
- Payment between 25th and 66th percentile at declining rate to no payment at 66th percentile.

Option B. Potential payments up to the 75th percentile performance.

- Full payment below 25th percentile performance.
- Payment between 25th and 75th percentile at declining rate to no payment at 75th percentile.

OPEN FORUM & ANNOUNCEMENTS

APPENDIX

PROPOSED 2023-25 ATTACHMENT 1 REQUIREMENTS

Article 1: Equity and Disparities Reduction

- ❑ Demographic Data Collection: Issuers must collect member self-identified race, ethnicity, and language data. Covered California intends to proceed with measures stratification by income for disparities identification and monitoring purposes.

- ❑ Disparities Measurement: Patient Level Data File: Issuers must submit the following Healthcare Effectiveness Data and Information Set (HEDIS) hybrid measure patient level data files for its enrollees: Prenatal Depression Screen and Follow-up (PND-E) Postnatal Depression Screen and Follow-up (PDS-E), and Quality Transformation Initiative (QTI) measures.

- ❑ Disparities Measurement: Healthcare Evidence Initiative: Issuer and Covered California will review performance on specified disparities measures using HEI data.
    1. Comprehensive Diabetes Care (CDC): Hemoglobin A1c (HbA1c) Testing (NQF #0057);
    2. Ambulatory Emergency Room (ER) Visits© per 1,000;
    3. Adult Preventive Visits© per 1,000;
    4. Breast Cancer Screening (BCS) (NQF #2372); and
    5. Proportion of Days Covered: Three Rates by Therapeutic Category (NQF #0541)
        a) Diabetes All Class (PDC-DR)
        b) RAS Antagonists (PDC-RASA)
        c) Statins (PDC-STA)

- ❑ Disparities Reduction Intervention: Returning Contractors will meet a multi-year disparities reduction target. New Contractors will meet phased requirements under an alternative timeline.

- ❑ NCQA Health Equity Accreditation: Issuers must achieve or maintain NCQA Health Equity Accreditation by year-end 2023 or submit plan to achieve Health Equity accreditation at the expiration of the MHCD period, if their MHCD has not yet expired.

PROPOSED 2023-25 ATTACHMENT 1 REQUIREMENTS

Article 2: Behavioral Health

- ❑ Issuers will submit NCQA Health Plan Accreditation Network Management reports, or a comparable report, for the elements related to the issuer's behavioral health provider network.
- ❑ Issuers will promote access to behavioral health services and offer telehealth for behavioral health services.
- ❑ Issuers will annually report Depression Screening and Follow Up (NQF #0418) measure results for Covered California enrollees; Covered California will engage with issuers to review their performance.
- ❑ Issuers will promote the appropriate use of opioids using a harm reduction framework and individualized approach to treatment planning aligned with Smart Care California guidelines.
- ❑ Covered California will monitor the Pharmacotherapy for Opioid Use Disorder measure and Medication Assisted Treatment (MAT) prescriptions through HEI and engage with issuers to review their performance.
- ❑ Issuers will promote 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 2023-25 ATTACHMENT 1 REQUIREMENTS

Article 3: Population Health

Population Health Management

- ☐ Issuers will continue to submit a copy of NCQA Population Health Management Plan: Standard 1 (Population Health Management Strategy) and Standard 2 (Population Stratification and Resource Integration) and will newly submit Standard 6 (Population Health Management Impact), or a comparable Population Health Management plan.

Health Promotion and Prevention

- ☐ Issuers will report its analysis of trended performance over time for its tobacco cessation program and diabetes prevention program utilization rates and its improvement strategies.
- ☐ Issuers will report strategies to improve its rates on the Medical Assistance with Smoking and Tobacco Use Cessation measure (NQF #0027).
- ☐ Issuers will continue to offer diabetes prevention programs as both online and in-person formats.

Acute, Chronic, and Other Conditions

- ☐ Issuers will continue to support transition of enrollment for at-risk enrollees.

Social Health

- ☐ Issuers must screen all enrollees for at least food insecurity using Accountable Health Communities standard screening questions; report aggregated counts of members screened, positive screens for food insecurity and other social needs, and members who screened positive referred for services.
- ☐ 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.

PROPOSED 2023-25 ATTACHMENT 1 REQUIREMENTS

Article 4: Delivery and Payment Strategies to Drive Quality

Effective Primary Care

- Issuers will continue to match enrollees with PCPs and report the number of enrollees who select a PCP vs. those who are assigned a PCP.
- Issuers will implement a quality measure set for advanced primary care in collaboration with the California Quality Collaborative (CQC) and the Integrated Healthcare Association (IHA). Issuers will submit data to IHA to implement the measure set.
- Issuers will continue to report on primary care payment models using the Health Care Payment Learning and Action Network Alternative Payment Model (HCP LAN APM) categories and increase the number of PCPs paid through shared savings and population-based payment models.
- Issuers will newly report total primary care spend compared to overall spend by HCP LAN category and a description of the payment models for their 5 largest physician groups.

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

- Issuers will continue to report the number of enrollees in IDS and ACO systems and increase the number of enrollees cared for under IDS and ACO systems.
- Issuers will continue to report the characteristics of the issuer's IDS and ACO systems such as payment model, leadership structure, quality incentive programs, data exchange processes, etc. and newly report the percent of spend under ACO and IDS contracts compared to overall spend.
- Participate in the Integrated Healthcare Association (IHA), submit data for the IHA AMP measure sets, and report performance on the measure sets to Covered California annually.

PROPOSED 2023-25 ATTACHMENT 1 REQUIREMENTS

Article 4: Delivery and Payment Strategies to Drive Quality

Networks Based on Value

- Issuers will continue to report how cost, quality, patient safety, patient experience, or other factors are considered in network design and provider and facility selection and review.
- Issuers will report on their network payment models by HCP LAN categories and associated subcategories.
- Issuers must participate in the IHA Align.Measure.Perform (AMP) program for physician groups and report AMP performance results to Covered California annually or allow IHA to submit results to Covered California.
- Issuers will continue to adopt a hospital payment methodology for each general acute care hospital in its QHP networks that ties payment to quality performance.
- Issuers must report its strategies to improve the appropriate use of opioids in its network hospitals.
- Issuers will continue to adopt value-based payment strategies structured to support only medically necessary care with no financial incentive to perform C-sections.

Telehealth

- Issuers will continue to report how they facilitate the integration and coordination of care between third party telehealth vendor services and primary care and other network providers.
- Issuers will report how they screen for enrollee access barriers to telehealth services such as broadband affordability, digital literacy, smartphone ownership, and the geographic availability of high-speed internet services.
- Issuers will continue to report its telehealth reimbursement policies for network providers and for third party telehealth vendor.

Participation in Quality Collaboratives

- Issuers will continue to report participation in any collaborative initiatives that are aligned with Covered California's requirements and expectations for quality improvement, addressing health disparities, and improving data sharing.

PROPOSED 2023-25 ATTACHMENT 1 REQUIREMENTS

Article 5: Measurement and Data Sharing

- ❑ Issuers will continue to submit data for the Quality Rating System, NCQA Quality Compass and Covered California's Healthcare Evidence Initiative.
- ❑ Issuers will implement and maintain a secure, standards-based Patient Access Application Programming Interfaces (API) consistent with the Federally Facilitated Marketplace (FFM) rule.
- ❑ Issuers will participate in a Health Information Exchange (HIE) that is a member of the California Trusted Exchange Network (CTEN) and bi-directionally exchange data.
- ❑ Issuers will continue to support data aggregation across plans including participation in IHA.