Plan Management Advisory Workgroup Meeting

November 10, 2021

AGENDA

Time	Topic	Presenter
10:30 – 10:35	Welcome and Agenda Review	Rob Spector
10:35 – 10:40	Plan Year 2023 Certification Update	Meiling Hunter
10:40 – 10:50	2023-2025 QHP Model Contract Overview	Hayley Figeroid
10:50 – 11:25	2023-2025 Attachment 1 (formerly Attachment 7) Overview	Margareta Brandt Taylor Priestley
11:25 – 11:50	2023-2025 Attachment 2 and Attachment 3 (formerly Attachment 14) Overview	Andrea Barandas
11:50 – 12:00	Open Forum & Announcements	All

PLAN YEAR 2023 CERTIFICATION UPDATE

Meiling Hunter, Lead Certification Program Specialist

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

- Please email QHPCertification@covered.ca.gov for any questions regarding the Plan Year 2023 Certification process or requirements.

2023 QUALIFIED HEALTH PLAN ISSUER MODEL CONTRACTS DISCUSSION

Hayley Figeroid, Assistant Deputy Director

2023 – 2025 MODEL CONTRACT: LEADING THE WAY

- Covered California's strategic pillars and cross-cutting initiatives drive year-over-year innovation and improvement in partnership with our issuers.
- The Covered California update of its Model Contract for QHP Issuers for the 2023 -2025 contract term has acknowledged the high bar set by the current contract, which keeps California at the forefront of the nation's ACA implementation:
  - **Patient-Centered Benefit Designs**, including requirement of off-exchange product and coordination of MOOP with pediatric dental
  - **Robust Networks** and ECP requirements
  - **Cobranded and Coordinated Marketing**, including ID cards, digital, and social
  - **Provider Directory Requirements**, including consideration of ethnic and language diversity of providers available to serve enrollees
  - **Quality Initiative**, including reducing health disparities, quality management and data submissions
- The 2023-25 Attachment 1 (formerly Attachment 7) refresh strengthens, enhances, and simplifies the quality and equity requirements, building on the foundation of Attachment 7 developed over the past seven years and the substantial revisions made in the 2022 Amendment.
- The 2023-25 Attachments 2 and 3 (formerly Attachment 14) reformat the attachment, further clarifying the changes made in 2022 by splitting performance standards into expectation only vs. with required financial contribution based on poor performance.

MAJOR NEW POTENTIAL REQUIREMENTS UNDER CONSIDERATION

- In addition to significant incremental changes to existing requirements, Covered California is considering two areas that aim to spur dramatic improvements in quality and equity:
  - **Additional Incentives/Required Financial Contribution Based on Poor Performance for Quality and Equity:** Increased contractual expectations for quality improvement, including introduction of the Quality Transformation Initiative, which incentivizes the delivery of higher quality and equitable care by assessing a required financial contribution based on poor quality performance on lower quality plans at an amount starting at 1% and increasing to 4% of premium.
  - **Formalizing Plan Selection/Exclusion Criteria**: The determination of how many plans should be offered in a given area, and what additional criteria should be used to evaluate the addition of new, and/or removal of existing health plans, based on the value they provide to consumers.
- In considering these options, Covered California is in the process of conducting a detailed market analysis, review of the literature, assessing legal and regulatory issues and engaging stakeholders as well experts to inform the approaches under consideration to develop proposals for the Board in January 2022.

COVERED CALIFORNIA QUESTIONS REGARDING FINANCIAL INCENTIVES FOR QUALITY

Quality Transformation Initiative: Instituting Potentially Major Incentives to Spur Quality Improvement

1. Overall: Is the proposed approach directionally sound and well-constructed?

2. Number of and selection of measures: Core to the initiative is selecting a set of measures that are (1) parsimonious in number (fewer than 10); (2) aligned with other purchasers and regulators; (3) clinically important and outcomes-based; and (4) relatively not “gameable.” Reactions in general and specifically to the measures under consideration?

3. Performance thresholds: In aiming for substantial improvement in quality, the proposal is to have maximal required financial contribution for performance below low/poor (e.g., 25th percentile national performance), but have some required financial contribution based on poor performance applied all the way to the 75th percentile national performance. Reactions?

4. Potential required financial contribution based on poor performance: The goal is for the potential required financial contribution based on poor performance to be financially meaningful, with a potential required financial contribution based on poor performance of 1% premium in the first year of implementation, rising by 1% each year over the next three years, for a maximum potential required financial contribution based on poor performance of up to 4% in year four and beyond. Reactions?

5. Anything else we should consider?

2023 – 2025 MODEL CONTRACT UPDATE

- The refreshed 2023-2025 Issuer Contracts are completing the first comment cycle:
  - Comments for QHP model contracts for Individual and Small Business markets, QDP Amendment for 2023, Attachment 7 (1) for Individual and Small Business markets, QTI, and Attachment 14 (2 and 3) for Individual and Small Business markets have been received, with responses publicly posted second week of November 2021.
  - All documents will be available for reference on the HBEX website: https://hbex.coveredca.com/stakeholders/plan-management/
- An Appendix "2022 Current vs 2023-25 Proposed Requirements" for the QHP model contract is attached for reference to this presentation.
  - Updates have been made to contract documents providing clarifications and definitions as needed and based on comments received.
  - All contract appendices have been renumbered and can be referenced on the slide "Model Contract Numbering Update" which follows.
- QDP is in another Amendment year in 2023.

MODEL CONTRACT NUMBERING UPDATE IN 2023

QHP Model Individual	Renumber	QHP Model CCSB	Renumber	QDP Model	Renumber
Section 12.17 Days	**Glossary**	Same	Same	Same	Same
Section 3.3.2c) Notice of Material Network Changes	**Section 3.3.3c)i.** Notification Changes Provider Network	Same	Same	N/A – any QHP Section 3	N/A
Section 3.3.3 Essential Community Providers	**Section 3.3.4**	N/A	N/A	**QDP Model Unique Section Items**	**Renumber**
Section 3.3.4 Special Rules Governing America Indians - Alaskan Natives	**Section 3.3.5**	N/A	N/A	12.18 Ambiguities Not Held Against Drafter	12.17
Section 3.3.5 Network Stability	**Section 3.3.3**	N/A	N/A	12.19 Clerical Error	12.18
Section 4.6 Quality Improvement Strategy	**Deleted as is an Attachment 7 (1) Item**	Same	Same	12.20 Admin. of Agreement	12.19
Section 4.7 Data Submission Req.	**Section 4.6**	N/A	N/A	12.21 Performance of Requirements	12.20

Attachments	Renumber
Attachment 3 Silver 70 Off-Exchange Plan, Non-Mirrored Silver Plan Design	**Attachment 4** - Silver 70 Off-Exchange Plan, Non-Mirrored Silver Plan Design
Attachment 7 Quality, Network Management, Delivery System Standards and Improvement Strategy	**Attachment 1 -** Quality, Equity, and Delivery System Transformation Requirements and Improvement Strategy
Attachment 14 Groups 2, 3, 4, and 5 **Attachment 14** Group 1	**Attachment 2 –** Performance Standards with Penalties **Attachment 3 –** Performance Standards and Expectations

2023 – 2025 QHP ISSUER CONTRACT UPDATE SUMMARY

- Presented here is a summary of the kinds of changes made in the refresh of the 2023 – 2025 QHP Model Contract(s). Reference the Appendix for more section specific detail about what contract changes were made.
- **Article 1: General Provisions**
  - General update throughout model contracts brought consistency of term to inclusive listings, updating all “including but not limited to” and “including without limitation” to “including.”
  - Notification requirements were added or updated in several contract sections for personnel and delegate changes for clarity or definition, and to enhance operational efficiencies.
- **Article 2: Eligibility and Enrollment**
  - New section language added in several contract sections with notification and update timelines with remedies if unmet.
  - New section language was added to enhance Agent and Sales operations with new reconciliation files and reporting.

2023 – 2025 QHP ISSUER CONTRACT UPDATE SUMMARY

- **Article 3:**

  - Notification requirements with timelines were added for system and operational changes in several contract sections to enhance operational efficiencies.
  - The defining notification requirement for a “material” change in networks was clarified to increase notification of network disruptions and establish a baseline for notifications to capture more disruption in rural areas.

2023 – 2025 QHP ISSUER CONTRACT UPDATE TIMELINE

Comment Cycle 1	September 2021
Response to Comment Public Posting	November 2021
Updated Contract Draft Documents Public Posting	November 2021
Comment Cycle 2	November 2021
Response to Comment Public Posting	December 2021
Final 2023 Contract Documents for January Board Approval	December 2021

2023-2025 ATTACHMENT 1 OVERVIEW

Taylor Priestley, Health Equity Officer
Margareta Brandt, Quality Improvement Unit Manager

OVERVIEW

- ❑ 2020 vision statements serve as north star for quality and equity work
- ❑ 2022 included substantive review and refresh of Attachment 7
- ❑ 2023 significant as the beginning of a new, three-year contract cycle
- ❑ In recognition that improvement is necessarily iterative and ongoing, initial provisions for 2023 will be followed by amendments in 2024, 2025
- ❑ Covered California's approach includes:
  - Building on seven years of experience and investment
  - Increased focus on data and outcomes over narrative reporting
  - Intentional alignment with other public purchasers
  - Implementation of Quality Transformation Initiative
- ❑ New attachment number: Attachment 7 will become **Attachment 1**

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

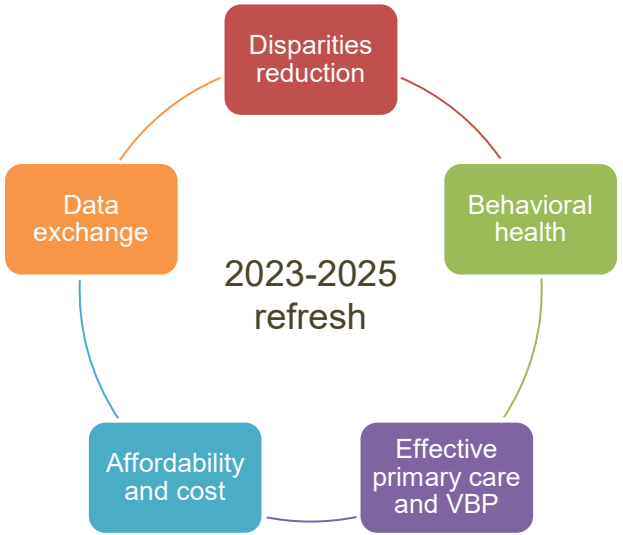
Make quality count

Amplify through alignment

Promote public good

Care about cost

STRATEGIC FOCUS AREAS



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

2023-25 EQT REFRESH WORKSTREAMS

Attachment 1 Implementation	Attachment 1 Process Reporting	Quality Playbook	Quality Transformation Initiative	Attachment 2
• Establish implementation or activity requirements	• Designate select areas for reporting with a focus on priority areas	• Simplify Attachment 1 by transitioning some requirements to the Quality Playbook as best practices and resources	• Select QTI measures and benchmarks • Determine QTI methodology and premium at risk • Determine how QTI funds will be invested	• Identify key areas for performance guarantees in addition to QTI

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. Avoidable Ambulatory Emergency Room (ER) Visits© per 1,000;
    4. Adult Preventive Visits© per 1,000;
    5. Breast Cancer Screening (BCS) (NQF #2372); and
    6. 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: Issuers will meet a multi-year disparities reduction target.

- ❑ 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.

2023-25 ATTACHMENT 1 PUBLIC COMMENT KEY THEMES

Article 1: Equity and Disparities Reduction

- ❑ Request for more substantive language for Article 1.01.1 Expanded Demographic Data Collection.
- ❑ Require plans to share best practices and plan of action for collection of demographic data; establish a disparities workgroup to determine how to best improve collection of demographic data.
- ❑ Request to make race, ethnicity, and language questions required elements in enrollment application with decline to state response option.
- ❑ Update language data requirement target (currently 80% by 2025) after baseline is established.
- ❑ Request bidirectional data updates between Contractor and Covered California for demographic data.
- ❑ PLD File: request only Covered California data be provided; request that stratification be pursued based on NCQA final timeline.
- ❑ HEI measures: consider additional stratified measures; align measures with NCQA Medi-Cal accreditation measures; establish process to reconcile difference in measure performance to produce accurate results.
- ❑ Clarify that current NCQA Multicultural Health Care Distinction (MHCD) meets requirement through its term before Health Equity Accreditation is required.

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 Covered California will proceed with stratification by income for disparities identification and monitoring.	Explicit statement of Covered California's intention to stratify HEI measures by income and expand disparities identification and improvement work.
1.01.2 Race, Ethnicity, and Language Data Collection Considering revision of the current threshold (80% of enrollees by 2025) for collection of spoken and written language.	Covered California will continue to research existing language data collection processes (including the default to English if a language preference is not provided) to identity the appropriate threshold and timeline for this requirement.
1.02.1 Disparities Measurement: Patient Level Data Removed requirement to include commercial and Medi-Cal lines of business in summary file submission and added the following measures: • Prenatal Depression Screen and Follow-up (PND-E) • Postnatal Depression Screen and Follow-up (PDS-E)	Covered California will work with purchasers to monitor disparities across enrolled populations; narrowed data submission requirement reduces administrative burden on issuers and focuses resources on preparation of actionable data. Disparities in maternal health disproportionately affect Black and Latino populations at higher rates than other racial or ethnic groups; Covered CA is proposing several requirements to assess and monitor disparities in maternal health for Covered California members.

PROPOSED 2023-25 ATTACHMENT 1 CHANGES

Article 1: Equity and Disparities Reduction

Notable Changes to Draft Attachment 1	Rationale
Clarifying Language **1.02 Identifying Disparities in Care** Language modified to ***determined*** *by Covered California and Contractor.* **1.03.1 Disparities Reduction Intervention** Language modified to *Contractor will* ***meet*** a *multi-year disparities reduction target.* **1.04.1 Health Equity Accreditation** Addition of ***at the expiration of the current MHCD period*** for the NCQA Health Equity Accreditation requirement.	Clarifies disparities identification and disparities improvement requirements. Clarifies intent of disparities reduction requirement. Clarifies that an unexpired Multicultural Health Care Distinction (MHCD) meets accreditation requirement throughout its term before Health Equity Accreditation is required.

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.

2023-25 ATTACHMENT 1 PUBLIC COMMENT KEY THEMES

Article 2: Behavioral Health

- ❑ Request to clarify if NCQA Network Management reports must be submitted every year or every three years in alignment with the NCQA three-year accreditation cycle.
- ❑ Suggestions to incorporate Comprehensive Medication Management into behavioral health requirements.
- ❑ Suggestion to add requirements for issuers report on payment parity for behavioral health and telehealth.
- ❑ Request to ensure issuers continue to meet network adequacy requirements for in-person behavioral health services in addition to offering behavioral health telehealth services.
- ❑ Suggestions 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.
- ❑ Request to define the Collaborative Care Model.
- ❑ Requests for telehealth services to be incorporated into quality measure requirements in alignment with NCQA HEDIS.

PROPOSED 2023-25 ATTACHMENT 1 CHANGES

Article 2: Behavioral Health

Notable Changes to Draft Attachment 1	Rationale
2.01.1 Behavioral Health Provider Network – Revised NCQA reporting requirements from annually to every three-years in accordance with the NCQA accreditation cycle (if no significant changes).	Revised based on issuer feedback and in accordance with the three-year NCQA accreditation cycle. If significant changes are made during the three-year cycle, issuers must resubmit the reports.
2.01.2 Offering Telehealth for Behavioral Health and **2.01.3 Promoting Access to Behavioral Health Services** – Re-organized sections and revised to clarify the requirements.	Revisions to clarify the requirements and ensure emphasis on access to in-person behavioral health services.
2.03.1 Guidelines for Appropriate Use of Opioids – 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.
2.03.2 Monitoring Access to Opioid Use Disorder Treatment – Re-organized sections and revised requirements including replacing *Use of Pharmacotherapy for Opioid Use Disorder* measure with *Pharmacotherapy for Opioid Use Disorder* measure and removing *Concurrent Use of Opioids and Benzodiazepines* and *Use of Opioids at High Dosage in Persons Without Cancer*.	Transitioned from the CMS measure *Use of Pharmacotherapy for Opioid Use Disorder* to the NCQA measure *Pharmacotherapy for Opioid Use Disorder* to align with other public purchasers. Removed measures other measures to emphasize Medication Assisted Treatment (MAT) and concerns about potential harm and lack of improved safety.
2.04 Integration of Behavioral Health Services with Medical Services – Added definition of Collaborative Care Model.	Issuers requested a definition of the Collaborative Care Model. Reference the definition from the AIMS Center at the University of Washington.

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 housing instability and food insecurity; report aggregated counts of members screened and positive screens for housing instability and food insecurity.
- 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.

2023-25 ATTACHMENT 1 PUBLIC COMMENT KEY THEMES

Article 3: Population Health

- ❑ Request for clarification on the term “financially responsible” in the introduction language.

Population Health Management

- ❑ Requests to receive automatic credit, if NCQA accredited, in substitution of submitting a copy of their NCQA Population Health Management plan.
- ❑ Request to clarify if the NCQA Population Health Management plan must be submitted every year or every three years in alignment with the NCQA three-year accreditation cycle.
- ❑ Concerns about potential algorithm bias within population health management stratification and segmentation methods.

Health Promotion & Prevention

- ❑ Requests to obtain trended performance analysis for tobacco cessation programs from HEI claims submissions.
- ❑ Concerns about tobacco cessation population being too low to provide appropriate or accurate results.
- ❑ Requests for clarification on the term “expected rates” in the diabetes prevention program requirements.

Social Health

- ❑ Concerns and questions regarding requirement to screen all enrollees for hunger and housing instability or homelessness; requests to return to 2022 screening requirement limited to enrollees in participating in plan programs.
- ❑ Suggestion to require standard screening questions or instruments.
- ❑ Request to require issuers to adequately fund screening efforts if required of contracted providers.

PROPOSED 2023-25 ATTACHMENT 1 CHANGES

Article 3: Population Health

Notable Changes to Draft Attachment 1	Rationale
3.01.1 Population Health Management Plan Submission – Added NCQA Population Health Management Plan: Standard 6 (PHM Impact) to PHM plan submission requirement Revised NCQA reporting requirements from annually to every three-years in accordance with the NCQA accreditation cycle (if no significant changes).	Adding the NCQA Population Health Management Plan: Standard 6 will assist Covered California in developing and strengthening our population health management requirement by assessing the impact of the population health management programs. Revised plan submission frequency to be in accordance with the three-year NCQA accreditation cycle. If significant changes are made during the three-year cycle, issuers must resubmit the reports.
3.02.1 Tobacco Cessation Program – Removed reporting requirements for utilization rates and replaced with new requirement for issuers to report analysis of trended performance over time for tobacco cessation program utilization. Added new requirement for issuers to report analysis of tobacco use prevention strategies and its impact on smoking prevalence rate.	Covered California is committed to reducing tobacco use as part of our health promotion and prevention mission. The collection of analysis of trended utilization performance over time and improvement strategies will help inform future tobacco cessation requirements.

PROPOSED 2023-25 ATTACHMENT 1 CHANGES

Article 3: Population Health

Notable Changes to Draft Attachment 1	Rationale
3.02.2 Diabetes Prevention Program – Added new requirement for issuers to report strategies to close the gap on diabetes prevention program utilization.	Covered California is committed to diabetes prevention as part of our health promotion and prevention mission. The collection of diabetes prevention strategies to close the gap on diabetes prevention program utilization rates will help inform future diabetes prevention requirements.
3.04.1 Screening for and Addressing Social Health - Considering focused requirement to screen and refer for hunger, with encouraged or required use of standard two question screening. Screening and referral requirements for housing instability and homelessness would be added in future years. Considering approaches to requirements that minimize fragmentation or duplication of screening and referral activities.	Health-related social needs impact all members, not only those involved in plan-based programs. The intention of screening all Enrollees is to identify and address these needs in a timely manner before unmet needs lead to adverse health outcomes. Food insecurity in California has dramatically increased across the state during the COVID-19 pandemic. 25% of Californian households are currently food insecure, a rate 2.5 times higher than pre COVID-19 levels.

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 Commercial HMO and ACO measure sets (as applicable), 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.

2023-25 ATTACHMENT 1 PUBLIC COMMENT KEY THEMES

Article 4: Delivery and Payment Strategies to Drive Quality

Effective Primary Care

- Suggestions to incorporate Comprehensive Medication Management into primary care requirements.

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

- Suggestion to incorporate the prevalence of advanced primary care practices in reporting on ACO characteristics.

Networks Based on Value

- General support for leveraging CMS Hospital Price Transparency rules in hospital network contracting.
- Concerns about the collection and reporting of the new proposed maternal health measures.

Telehealth

- General support for integration and coordination of care between telehealth vendors and primary care and encouraging telehealth provided through network providers. Request to ensure issuers continue to meet network adequacy requirements for in-person services in addition to offering telehealth services.
- Request to require issuers to report how interpreter services for telehealth are made available to enrollees.

Participation in Quality Collaboratives

- General support for issuers to participate in quality collaboratives. Request to add reporting on the financial support provided by issuers for quality improvement and technical assistance.
- Request to add the California Right Meds Collaborative to the list of collaboratives.

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 – Revised language to ensure enrollees are informed about the benefits of primary care upon enrollment and are given the opportunity to select a PCP.	Covered California wants to encourage enrollees to select a PCP to strengthen their connection to PCPs. Issuers should inform enrollees about the role and benefits of primary care upon enrollment.
4.01.3 Payment to Support Advanced Primary Care – Expanded requirement to report on primary care payment models by HCP LAN categories and subcategories.	Reporting by HCP LAN categories and subcategories will allow for more detailed analysis.
4.03.3 Provider Value – Added language to promote collaboration among issuers to improve provider group performance along with Covered California support.	Purchasers recommended Covered California promote collaboration among issuers to improve provider group performance.
4.03.4.4 Hospital Value – Added requirement for issuers to report number and percent of network hospitals in compliance with CMS Hospital Price Transparency Rule.	Covered California supports price transparency as an effective resource for enrollees to assist with their health care planning. There was broad support of the federal hospital price transparency rule from advocates and purchasers.

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 – Added requirement for issuers to submit patient level data files for maternal health HEDIS measures: • Prenatal Depression Screen and Follow-up (PND-E) • Postnatal Depression Screen and Follow-up (PDS-E) Additionally, issuers will report on their engagement activities with contracted providers to improve performance on these measures as well as how they identify and address maternal health disparities.	Issuers expressed concerns over the effectiveness of these maternal health measures. Covered California is committed to reducing maternal health disparities. The collection and stratification of these measures by race and ethnicity will help inform future maternal health requirements.
4.04.1 Telehealth Offerings – Added language to promote the use of network providers to provide telehealth, note that issuers must continue to comply with network adequacy standards to in-person services, and ensure issuers are educating enrollees about interpreter services for telehealth.	Revisions based on feedback from advocates and provider organizations to ensure emphasis on access to in-person medical services and ensure enrollees are aware of interpreter services for telehealth.
4.05 Participation in Quality Collaboratives – Added requirement for issuers to report on financial support provided to quality collaboratives and revised the list of collaboratives.	Added and removed collaboratives based on feedback from purchasers and collaboratives. Added reporting on financial support for collaboratives based on feedback from purchasers.

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.

2023-25 ATTACHMENT 1 PUBLIC COMMENT KEY THEMES

Article 5: Measurement and Data Sharing

- ❑ Request to expand beyond the federal rules for patient-facing Application Programming Interfaces (APIs) and support electronic prior authorization.
- ❑ Request to enhance requirements beyond Health Information Exchange (HIE) participation to require participation in the new state health information exchange network and eventual community information exchanges.
- ❑ Suggestions to revise the Healthcare Evidence Initiative section.
- ❑ Request for clarification on the Health Information Exchange (HIE) participation requirements.
- ❑ Suggestion to collaborate on feedback or input on measure and measure set development for QRS and NCQA, including NCQA ECDS measures.

PROPOSED 2023-25 ATTACHMENT 1 CHANGES

Article 5: Measurement and Data Sharing

Notable Changes to Draft Attachment 7	Rationale
Article 5 – Revised introduction to support collaboration between issuers and Covered California to provide feedback on measure development and measure sets.	Issuers suggested Covered California and issuers could work together to provide feedback to NCQA and QRS on measure sets.
5.02.3 Data Exchange – Revised to clarify that issuers must participate in an HIE that is a member of the California Trusted Exchange Network (CTEN).	Issuers requested clarification on this requirement.
5.02.3 Data Exchange – Added language to strengthen collaboration between Covered California and issuers on statewide HIE efforts.	Revisions based on feedback from advocates suggesting issuers should participate in the new state health information exchange network. We will continue to track this effort and collaborate with issuers and others as this effort progresses.

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

- ❑ There are no significant changes to Article 6.

DISCUSSION AND NEXT STEPS

- Covered California will be conducting additional research and following up on several areas based on public comments including:
  - Comprehensive Medication Management
  - Potential algorithm bias within population health management stratification and segmentation methods
  - Alignment or support of federal rules for patient-access APIs and CMS Hospital Price Transparency
  - Statewide Health Information Exchange
- The draft 2023-25 Attachment 1 will be presented to the Board on November 18, 2021 for discussion
- There will be a second public comment period from November 9 to December 6, 2021
- Please send questions and comments to Margareta Brandt at margareta.brandt@covered.ca.gov

PROPOSED 2023 - 2025 ATTACHMENT 2 AND 3 QHP PERFORMANCE STANDARDS

Andrea Barandas, Lead Contract Compliance Specialist

OVERVIEW

- ❑ Attachment 14 will be separated into two Attachments. New attachment numbers are:
  - Attachment 2 - Performance Standards with Penalties
  - Attachment 3 - Performance Standards and Expectations

- Attachment 2 - Performance Standards with Penalties
- ❑ Covered California is proposing penalties for key performance areas outside of QTI
  - Proposing to remove some 2022 performance standards, add several new standards, and re-distribute the percent at risk

- Attachment 3 - Performance Standards and Expectations
- ❑ Issuer performance will be posted publicly on Covered California's website
  - Customer Service, Operational (except HEI Data), Covered California Customer Service

2023-25 ATTACHMENT 2 PUBLIC COMMENT KEY THEMES AND PRELIMINARY RESPONSES

Reducing Health Disparities: Demographic Data Collection (standards 1 and 2)

- Recommendations to include mandatory race, ethnicity, and language questions in the enrollment application and add "Decline to State" response option
  - Covered California agrees the enrollment application is an important opportunity to collect this information but does not intend to pursue mandatory questions in the enrollment application. We will continue to explore best practices and opportunities to improve capture and sharing of member demographic data.
  - Covered California agrees the enrollment application is an important opportunity to collect this information but does not intend to pursue mandatory questions in the enrollment application.
  - The 80% threshold acknowledges that not all members choose to share this information.

National Committee for Quality Assurance (NCQA) Health Equity Accreditation (standard 4)

- Request to extend credit opportunities for early achievement of Health Equity Accreditation or reduce the at-risk amount.
  - For 2023 and beyond, there are no credit opportunities in Attachment 2, and we do not intend to change the at-risk amount.

2023-25 ATTACHMENT 2 PUBLIC COMMENT KEY THEMES AND PRELIMINARY RESPONSES

Primary Care Payment (standard 5)

- Requests for separate targets for plan type or plans operating with limited network options.
  - Covered California intends to use the same standards for HMOs and EPO/PPOs in 2023-2025. Our goal is for all plans to meet similar standards. We have adjusted the performance levels to account for this change.

Primary Care Spend and Payment to Support Networks Based on Value (standards 6 and 7)

- Questions and concerns about the reporting process and reporting methodology.
  - Covered California will collaborate with issuers to develop the data collection mechanism and methodology. We will aim to follow standardized methodology that minimizes reporting burden on issuers.

Quality Rating System (QRS) QHP Enrollee Experience Summary Indicator Rating (standard 8)

- Requests to remove this standard or adjust the penalty amounts.
  - Covered California intends to maintain the performance standard for QRS QHP Enrollee Experience. We will adjust the performance levels to 20% penalty for a 1-star rating and 10% penalty for a 2-star rating.

2023-25 ATTACHMENT 2 PUBLIC COMMENT KEY THEMES AND PRELIMINARY RESPONSES

Healthcare Evidence Initiative (HEI) Data Submission (standard 9)

- Overall concerns regarding performance standard expectations and the methodology for each component of the standard.
  - Covered California intends to maintain the performance standard expectations as drafted. After 2022 data is analyzed, Covered California will revisit the expectations.

General Comments

- Request for credits to offset penalties.
  - Covered California will not be implementing credits for 2023-2025 Attachment 2.
- Requests for the 0.2% of premium at risk for Attachment 2 be included in an overall 1% at risk for QTI and Attachment 2.
  - Covered California has adjusted the percent at risk for performance standards and QTI. We are proposing to adopt 0.2% of premium at risk for performance standards with penalties in Attachment 2 and 0.8% of premium at risk for QTI for 2023. We are proposing the total percent at risk will continue to increase by 1% each year to 4% and QTI will remain the majority of the percent at risk over time.

NEXT STEPS

- ❑ Documents were released for first Public Comment period from 10/15/21 – 11/5/21.
  - Comments will be tracked, and formal responses will be developed.
  - Updates may be made to the documents based on comments received.

- ❑ Second public comment period proposed November 17, 2021, to December 17, 2021. Documents will be posted to the website and emailed to stakeholders:
  - Formal response to comments
  - Updated versions of Attachment 2 - Performance Standards with Penalties and Attachment 3 - Performance Standards and Expectations

OPEN FORUM & ANNOUNCEMENTS

QUALITY TRANSFORMATION INITIATIVE UPDATE

- Covered California is working towards releasing an updated proposal for the Quality Transformation Initiative (QTI) in the next few weeks.
- We are aiming to release the following materials:
  - QTI concept paper (expands on the QTI materials released in September and incorporates public comment feedback)
  - QHP performance on candidate QTI QRS measures
  - Responses to public comments
- The revised QTI proposal will be presented to the Board on November 18, 2021 for discussion.
- We are exploring convening an advisory committee of methodological experts to support QTI development. We will be following up with more details.

2024-2026 QDP ISSUER MODEL CONTRACT REFRESH – QUALITY & EQUITY INITIATIVES

- Plan Management and Health Equity and Quality Transformation Divisions are excited to begin the important work of developing quality and equity initiatives for the 2024-2026 QDP Issuer Model Contract Refresh.
- Please send interest in participating to PlanManagementMeetings@covered.ca.gov

APPENDIX
2022 CURRENT VS 2023-25 PROPOSED REQUIREMENTS

2022 CURRENT VS 2023-25 PROPOSED REQUIREMENTS - APPENDIX

Article 1 – General Provisions

2022 Current Requirements	2023-25 Proposed Requirements	Comment	2023-25 Proposed Requirements Comment Based Update
Section 1.3 Relationship of the Parties Defines CovCA and Contractor's relationship as independent contractors. Contractor to require all subcontractors, assignees, or delegates to comply with applicable requirements of agreement, and to monitor for compliance.	**New notification requirement item c) addition:** New language ensuring Covered California is notified when a Carrier newly assigns or delegates services to a Vendor or changes to existing for: Enrollment and Eligibility, Customer Service Call Center, Managed Behavioral Health Organizations (MBHOs) or Behavioral Health Vendor, Third-Party Administrator for Dental Providers, Third-Party Administrator for Provider Contracts, or Third-Party Administrator for Claims Administration	Several Issuers voiced concerns over the volume of notifications this requirement would create and questioned its value. *"Various vendors are used to provide services under the agreement. It is not practicable for Contractor to provide prior notification in each instance."*	Covered California agrees to modify Section 1.3c) with the following list for notification requirements: 1. Enrollment and Eligibility 2. Customer Service Call Center 3. Managed Behavioral Health Organizations (MBHOs) or Behavioral Health Vendor 4. Third Party Administrator for Dental Providers 5. Third Party Administrator for Provider Contracts 6. Third Party Administrator for Claims Administration

2022 CURRENT VS 2023-25 PROPOSED REQUIREMENTS - APPENDIX

Article 1 – General Provisions

2022 Current Requirements	2023-25 Proposed Requirements	Comment	2023-25 Proposed Requirements Comment Based Update
Section 1.5 General Duties of the Contractor Subsection b) states a dedicated liaison is the primary contact for Covered California and is working with Covered California to implement the agreement. The dedicated liaison, along with other personnel, is available as needed to fulfill Contractor's duties under this Agreement.	**New notification requirement item i. addition:** New language ensuring timely notification by Issuers of changes in "Key Personnel" as listed in the Contractor's organizational chart provided during the annual Certification Application process along with contact information: Chief Executive Officer, Chief Finance Officer, Chief Operations Officer, Chief Medical Officer, Contracts, Plan and Benefit Design, Network and Quality, Enrollment and Eligibility, Legal, Marketing and Communications, Information Technology, Information Security, Policy and Dedicated Liaison.	Several Issuers requested a limit of the notice obligation to only certain "Key Personnel"; such as CEO, CFO, COO and Dedicated Liaison. An issuer requested changing the notification requirement from 10 days to 30 days.	Covered California agrees to limit the notice requirement of key personnel to: CEO, COO, CFO, CMO, and Dedicated Liaison only. The notification timeline will remain 10 days.

2022 CURRENT VS 2023-25 PROPOSED REQUIREMENTS - APPENDIX

Article 2 – Eligibility and Enrollment Responsibilities

2022 Current Requirements	2023-25 Proposed Requirements	Comment	2023-25 Proposed Requirements Comment Based Update
Section 2.1.2 Contractor Responsibilities Subsection c) requires Contractor to participate in the Reconciliation Process comparison of Covered California enrollment against the Contractor's membership enrollment and financial databases, and to implement identified changes within 10 business days.	**New text added to 2.1.2c) for Reconciliation Process:** New language requires Contractor to notify Covered California by the 10th business day if they can't implement changes within the given timeline, provide information explaining why can't be implemented by the due date, and to identify another date in which the changes will be implemented. The Contractor will be required to conduct root cause analysis, develop a corrective action plan to resolve the issues, and provide an implementation for resolution if Covered California identifies ongoing and persistent data issues with the Contractor through the Reconciliation Process.	Issuers request for timeline extension from ten (10) business days business days to fifteen (15) business days for implementation of Reconciliation Process changes.	Covered California agrees to modify Section 2.1.2c) to allow fifteen (15) business days for confirmation the enrollment and financial changes identified through the Reconciliation Process have been implemented.

2022 CURRENT VS 2023-25 PROPOSED REQUIREMENTS - APPENDIX

Article 2 – Eligibility and Enrollment Responsibilities

2022 Current Requirements	2023-25 Proposed Requirements	Comment	2023-25 Proposed Requirements - Comment Based Update
Section 2.2.6 Agents in Covered California for the Individual Market Subsection f) Agent of Record explains an Agent delegation might occur at initial enrollment and Covered California will send notice to the Contractor via the 834 enrollment file. The process requires Contractor's approval, with the exception of unlicensed or unappointed Agents, upon receipt of the 834 file and allows 5 days for system update. Language is included recognizing the different organizational structures delegated Agents may be working within. The requirement for what an Agent of Record Exception Report contains is defined and only required upon request.	**New text added to f) Agent of Record for Reconciliation Process:** Additional language identifying a possible weekly Reconciliation file to be sent to the Issuers, in addition to 834 Enrollment files for use in update of Agent delegations in Issuer systems. Addition of exceptions to the required Contractor approval process for a delegation that would conflict with Contractor's vesting provisions of its Agent agreements. Additional organizational structure language added as to who may be delegated Agents: "the Agency, or primary Agent at the Agency, instead of the specific Agent who enrolled a consumer. As such, an Agent delegation may consist of an Agent, Agency, or primary Agent with an Agency." The requirement for an Agent of Record Exception Report for updates requested but not made changed to the last day of the month.	Issuers request for timeline extension from five (5) business days to ten (10) business days for update of their system. Issuers request the Agent of Record Exception Report remain 'upon request', not a monthly requirement.	Covered California agrees to modify Section 2.2.6f) to allow ten (10) business days for update of Agent of Record to their system. Covered California will keep the contract language requiring the Agent of Record Exception Report on a monthly basis to improve consistency in Issuer system reconciliation of Agent of Record information.

2022 CURRENT VS 2023-25 PROPOSED REQUIREMENTS - APPENDIX

Article 2 – Eligibility and Enrollment Responsibilities

2022 Current Requirements	2023-25 Proposed Requirements	Comment	2023-25 Proposed Requirements Comment Based Update
Section 2.2.6 Agents in Covered California for the Individual Market	**New subsection i) Agent Communication and Sales Strategy inserted:** Annual requirement added and defined for Contractor to supply an "agent communication and sales strategy" for the individual market. Also allows Covered California to request updates if individual market conditions change due to legislative action or economic fluctuations.	Issuers questioning the intent and a request for removal.	Covered California has declined removal and explained the need to understand each Agent Marketing and Sales Strategy for alignment with changes made by Covered California, for example changes in the market for both on and off exchange markets in response to the State subsidy and American Rescue Plan.
Section 2.3 Enrollment and Marketing Coordination and Cooperation Subsection o) lists marketing plan submittals are due at least thirty (30) days prior to Open Enrollment, and within thirty (30) days after Open Enrollment begins for Retention and Renewal effort marketing plans.	**New text added:** All deadlines were made a consistent "at least" deadline, and a SEP reporting requirement was added: at least thirty (30) days prior to Open Enrollment and Special Enrollment Period, and at least thirty (30) days after Open Enrollment begins for Retention and Renewal efforts.	No comments received.	No contract update made.

2022 CURRENT VS 2023-25 PROPOSED REQUIREMENTS - APPENDIX

Article 2 – Eligibility and Enrollment Responsibilities

2022 Current Requirements	2023-25 Proposed Requirements	Comment	2023-25 Proposed Requirements Comment Based Update
Section 2.3 Enrollment and Marketing Coordination and Cooperation Subsection p) lists actualized spend amount submittals are due within thirty (30) days after OEP closes, thirty (30) days after calendar year end for SEP, and thirty (30) days after OEP begins for retention and renewal. OEP actualized spend submissions requirements of spend by media channel to include : • distribution by Designated Market Area (DMA) • brand versus direct response spend allocation • categorization of messaging and indication of co-branding efforts.	**New text added:** Request made for “annual” actualized spend amounts and deadlines made consistent “at least” requirements: at least thirty (30) days after OEP closes, at least thirty (30) days after calendar year end for SEP, and at least thirty (30) days after OE begins for retention and renewal. OEP actualized spend submissions requirements of spend by media channel revised : • Designated Market Area (DMA) • brand versus direct response • as well as note if messaging was co-branded with Covered California.	No comments received.	No contract update made.

2022 CURRENT VS 2023-25 PROPOSED REQUIREMENTS - APPENDIX

Article 2 – Eligibility and Enrollment Responsibilities

2022 Current Requirements	2023-25 Proposed Requirements	Comment	2023-25 Proposed Requirements Comment Based Update
Section 2.4.2 Marketing Materials that Must Be Submitted to Covered California Subsection b) defines marketing materials and related collateral to be submitted to Covered California as reasonably requested by Covered California.	**New deadline text added:** Subsection b) changes the submittal of marketing materials and related collateral to Covered California to at least 30 days prior to OEP, and at least thirty (30) days prior to SEP.	Issuer request for a March 1 deadline by which Covered California will update the document.	Covered California has agreed to the March 1 Contact Guideline update and the contract will be updated.

2022 CURRENT VS 2023-25 PROPOSED REQUIREMENTS - APPENDIX

Article 3 – QHP Issuer Program Requirements

2022 Current Requirements	2023-25 Proposed Requirements	Comment	2023-25 Proposed Requirements Comment Based Update
Section 3.1.3 Plan Naming Conventions Requires Contractor adhere to CovCA's Plan Naming Conventions on all State Regulators plan filings, marketing material, Enrollee material, and SERFF submissions.	**New text added:** Expands the plan naming requirement to off-Exchange mirrored products.	No comments received.	No contract update made.
Section 3.1.4 Operational Requirements and Liquidated Damages **Communication with Plan Manager and Covered California** Requires Contractor notify Covered California of changes with operational impacts to CovCA, Enrollees or CalHEERS. Example given, change to Contractor's vendor interfacing with CalHEERS. Contractors are to attempt to avoid making any operational changes impacting CalHEERS 30 days prior to and during each Renewal and Open Enrollment Period.	**New text added to d) Communication with Plan Manager and Covered California:** Adds a new notification requirement for any "system", as well as operational change, and adds 60-day advance notification timelines for planned system activities or modifications affecting electronic transmissions, any transition or migration to a different platform, or new vendors supporting electronic integration and interfacing with CalHEERS. Adds 30-day advance notification for unplanned activities or system changes and listed operational changes at call centers. Adds 'upon request' provision of technical documentation.	Issuers request for recognition of emergent problems that would make 60 and 30 day notifications untenable. Issuer requests for timeline adjustments.	Covered California agreement to add qualifying language to allow for notification "immediately upon Contractor's knowledge" in 60 day notifications, and in one requested 30 day notification. No timeline adjustments were agreed to.

2022 CURRENT VS 2023-25 PROPOSED REQUIREMENTS - APPENDIX

Article 3 – QHP Issuer Program Requirements

2022 Current Requirements	2023-25 Proposed Requirements	Comment	2023-25 Proposed Requirements Comment Based Update
Section 3.3.2 Network Adequacy Subsection c) Notice of material network changes, requires Contractor to notify Covered California of pending material change in its provider network , or its participating provider contracts, at least 60 days prior to any change or immediately upon Contractor's knowledge.	**Changes to Notice of material changes:** "Material" struck, section moved to fall within renumbered section 3.3.3 Network Stability, subsection c) Network Disruptions	Issuers request for reinsertion of "material" in many subsections of now numbered Section 3.3.3.	Covered California has declined all such updates based on Covered California's objective to be aware of upcoming network changes which might require time to prepare our Service Centers. The contract change will stand, to make contract compliance clearer for the carriers as there is no common definition for "material".
Section 3.3.3 Essential Community Providers	**Renumbered 3.3.4 Essential Community Providers, d) Notice of changes to ECP network:** Refers back to 3.3.3c) for same Network Disruption requirements, deletes the work "material."	Issuers concern over deletion of section is misunderstanding of redline effect when text is moved. Issuers request to remove 3.3.3c) and c)i. references to hospital disruptions, don't apply to ECP.	Covered California has agreed to delete the references to 3.3.3c) and c)i.
Section 3.3.4 Special Rules Governing American Indians and Alaskan Natives	**Renumbered 3.3.5**	Issuers concern over apparent deletion of section is misunderstanding of redline effect when text is moved.	No contract update made.

2022 CURRENT VS 2023-25 PROPOSED REQUIREMENTS - APPENDIX

Article 3 – QHP Issuer Program Requirements

2022 Current Requirements	2023-25 Proposed Requirements	Comment	2023-25 Proposed Requirements Comment Based Update
Section 3.3.5 Network Stability Subsection c) Network Disruptions, requires Contractor to provide prior notice to Covered California and State Regulators if there are disruptions making it necessary for Enrollees to change QHPs or Participating Providers.	**Renumbered 3.3.3 Network Stability and new text added:** Update clarifies what constitutes a network disruption and when Issuers are required to report. Establishes a notification baseline of 10% impacted enrollees residing within any county of an affected region, defines notification requirements to Covered California, and adds language to ensure access to care.	Issuer request to modify new threshold of 10% of impacted enrollees to providers. Issuers request to delete a notification requirement to State Regulators in 3.3.3c).	Covered California declines this update request as the intent of an impacted enrollee baseline is to establish a safety net for rural region populations. Covered California agreed to and made the update request to delete a State Regulator notification requirement in 3.3.3c)
Section 3.6.16 Required Reports Requirement to submit standard reports as mutually agreed upon and defined as: customer service reports, use of plan website, enrollment reports, and premiums collected.	**Change to reporting requirement:** Updates submittal requirement to “as specified by” Covered California for the existing list of reports for Enrollee customer service, Use of Plan website, Enrollment, and Premiums collected.	Issuer comment to restore by ‘mutual agreement’ to standard report submittal requirements.	Covered California always seeks to ensure required reports are both accurate representations of the situation and administratively feasible to produce, but cannot commit to always reaching mutual agreement on their design and declines this update request.

2022 CURRENT VS 2023-25 PROPOSED REQUIREMENTS - APPENDIX

General Contract Update

2022 Current Requirements	2023-25 Proposed Requirements	Comment	2023-25 Proposed Requirements Comment Based Update
General Contract Terms for Inclusive Listing Varied references used throughout contract: including, including but not limited to, including without limitation	General update throughout model contracts brought consistency of term to inclusive listings, updating all “including but not limited to”, and “including without limitation”, to “including.”	Issuer comments to restore “including but not limited to” in several specific instances.	Covered California’s clean-up of inconsistent language throughout the contract to the appropriate language of “including” will remain. "Including" is by definition not an exhaustive list.

APPENDIX
PROPOSED 2023 - 2025 ATTACHMENT 2 & 3 QHP AND CCSB PERFORMANCE STANDARDS

APPROACH TO PENALTIES

- With the implementation of the Quality Transformation Initiative (QTI) in 2023, Covered California is proposing to focus Attachment 2 - Performance Standards with Penalties on the following areas:
  - Health disparities
  - Payment reform
  - Enrollee experience (QRS)
  - HEI data
  - Oral health
- For 2023, Performance Standards with Penalties (formerly Attachment 14), the total amount at risk is decreasing from ten percent (10%) of the total participation fee paid by the issuer (0.325% of premium) to 0.2% of premium due to the implementation of QTI
- Covered California is proposing to include the 0.2% of premium for Performance Standards with Penalties within in overall percentage at risk for QTI
  - For 2023, 0.8% of premium would be at risk for QTI performance and 0.2% would be at risk for Performance Standards with Penalties

QHP PROPOSED CHANGES FOR 2023 PERFORMANCE STANDARDS AND EXPECTATIONS (NO PENALTY)

Performance Standards and Expectations	Covered California will create an Annual Report of Performance Standards and Expectations, displaying Contractor's final Plan Year 2022 performance in Performance Standards and Expectations, Standards 1.1 - 1.11, to be posted publicly on Covered California's website. Covered California will continue public reporting of its service level performance metrics.	Proposed Change
1.1 Abandonment Rate	Expectation: No more than 3% of incoming calls abandoned in a calendar month. Divide number of abandoned calls by the number of calls offered to a phone representative.	No change
1.2 Service Level	Expectation: 80% of calls answered in 30 seconds or less.	No change
1.3 Grievance Resolution	Expectation: 95% of Covered California enrollee grievances resolved within 30 days of initial receipt.	No change
1.4. Covered California member Email or Written Inquiries Answered and Completed	Expectation: 90% of Covered California member email or written inquiries not relating to Urgent Access to Care issues answered and completed within 15 business days of the inquiry.	No change
1.5 ID Card Processing Time	Expectation: 99% of ID cards issued within 10 business days of receiving complete and accurate enrollment information and binder payment for a specific consumer(s).	No change
1.6 Implementation of Appeals Decisions	Expectation: 90% of Administrative Law Judge decisions will be implemented within ten (10) days of Contractor's receipt of all necessary data elements from Covered California required to implement the appeals decision.	No change
1.7 834 Processing	Expectation: Covered California will receive a TA1 or 999 file, or both as appropriate within three business days of receipt of the 834 transaction 95% of the time.	No change
1.8 834 Generation – Effectuation and Cancellation Transactions	Expectation: Covered California will successfully receive and process effectuation, and cancellation 834 transactions within 60 days from either the coverage effective date or transaction timestamp, whichever is later 95% of the time.	No change

QHP PROPOSED CHANGES FOR 2023 PERFORMANCE STANDARDS AND EXPECTATIONS (NO PENALTY)

Performance Standards and Expectations	Covered California will create an Annual Report of Performance Standards and Expectations, displaying Contractor's final Plan Year 2022 performance in Performance Standards and Expectations, Standards 1.1 - 1.11, to be posted publicly on Covered California's website. Covered California will continue public reporting of its service level performance metrics.	Proposed Change
1.9 834 Generation – Termination Transactions	Expectation: Covered California will receive termination 834 transactions within ten days of the grace period expiration 95% of the time.	No change
1.10 Reconciliation Process	Expectation: Covered California shall receive a comparison reconciliation extract in accordance with the file validations and resolution timelines, as mutually agreed upon in the Reconciliation Process Guide (Extranet, Data Home, Contractor's folder) 90% of the time for accuracy and timeliness.	No change
1.11 Provider Directory Data Submission	Expectation: Full and regular submission of provider data according to the standards outlined in the Performance Standard contract specific to contract Section 3.4.4. Submissions occur every month pursuant to the submission schedule (Extranet, Plan Home, Resources, Provider Directory Resources, Covered California Provider Data Submission Schedule_Current Year).	No change
1.12 Essential Community Providers – Article 3, Section 3.3.3	Expectation: 1. Contractor to demonstrate provider agreements with at least 15% of 340B non-hospital providers in each applicable rating region. 2. Contractor to demonstrate provider agreements that reflect a mix of essential community providers (hospital and non-hospital) reasonably distributed to serve the low-income, vulnerable, or medically underserved populations. Or meet Alternate Standard Contractor requirements. Refer to Article 3, Section 3.3.3.	No change
~~1.13 Hospital Safety – Attachment 7, Article 10, Section 10.02~~	~~Contractor shall adopt a payment strategy that places hospital payments in Covered California networks either at risk or subject to a bonus payment for quality performance Contractor may structure this strategy according to its own priorities, with the exception that if the Contractor uses readmissions measure, it shall not be the only measure.~~ ~~Contractor shall report on its strategy and progress on adoption of the payment strategy annually.~~ ~~Expectation: At least 2% of payments to hospitals in Covered California network(s) are at-risk for quality performance by year end 2021.~~	Removed from Performance Standards and Expectations; remains in Attachment 7, will evaluate for AB 929 public reporting

SUMMARY OF 2023-2025 PERCENT AT RISK

Performance Area	Performance Standards with Penalties	Percent of At-Risk Amount 2023	Percent of At-Risk Amount 2024	Percent of At-Risk Amount 2025
Health Disparities	1. Reducing Health Disparities: Demographic Data Collection – Enrollee Race and Ethnicity Self-Identification	10%	5%	5%
	2. Reducing Health Disparities: Demographic Data Collection – Enrollee Spoken and Written Language	10% (for reporting)	5%	5%
	3. Reducing Health Disparities: Disparities Reduction Intervention	10%	10%	10%
	4. National Committee for Quality Assurance (NCQA) Health Equity Accreditation	0%	10%	10%
Payment	5. Primary Care Payment	10%	10%	10%
	6. Primary Care Spend	10% (for reporting)	5%	5%
	7. Payment to Support Networks Based on Value	10% (for reporting)	10%	10%
Enrollee Experience	8. Quality Rating System (QRS) QHP Enrollee Experience Summary Indicator Rating	20%	20%	20%
Data	9. Healthcare Evidence Initiative (HEI) Data Submission	20%	20%	20%
Oral Health	10. Dental Quality Alliance (DQA) Pediatric Measure Set	0%	5%	5%

QHP PROPOSED CHANGES FOR 2023 PERFORMANCE STANDARDS WITH PENALTIES (1 OF 2)

Performance Standards With Penalties	2022 % at Risk	Proposed 2023 % at Risk	Proposed Change and Rationale
1. Reducing Health Disparities – Demographic Data Collection – Race/Ethnicity	7.5%	10%	Continue 2022 approach of equal emphasis on demographic data collection and disparity reduction
2. Reducing Health Disparities: Demographic Data Collection – Spoken and Written Language	n/a	10% (for reporting)	New for 2024, 2025 to support prioritization of issuer complete and accurate member demographic data
3. Disparities Reduction Intervention	7.5%	10%	Continue 2022 approach of equal emphasis on demographic data collection and disparity reduction
4. National Committee for Quality Assurance (NCQA) Health Equity Accreditation	n/a	10%	Penalty goes into effect in 2024
5. Primary Care Payment	HMO – 10% PPO/EPO – 20%	10%	Continue overall standard and product-specific performance levels; proposing to adjust performance levels for 2023-2025
6. Primary Care Spend	n/a	10% (for reporting)	New reporting standard starting in 2023 to report primary care spend; start at pay for reporting in 2023 and move to thresholds of spend in 2024 and 2025

Where applicable, scores are provided per product, and penalties and credits are weighted based on the enrollment in each product.

QHP PROPOSED CHANGES FOR 2023 PERFORMANCE STANDARDS WITH PENALTIES (2 OF 2)

Performance Standards With Penalties	2022 % at Risk	Proposed 2023 % at Risk	Proposed Change and Rationale
7. Payment to Support Networks Based on Value	0%	10% (for reporting)	New proposed standard for HCP LAN reporting for a QHPs network payment models; start at pay for reporting in 2023 and move to thresholds of payment in 2024 and 2025
8. Quality Rating System – QHP Enrollee Survey Summary Rating	16.5%	20%	Retained due to breadth of measures and affirmation of federal standards; no change to performance level
9. HEI Data Submission	10%	20%	Increase in percent at risk signals importance of HEI data to monitoring quality and equity performance
10. Dental Quality Alliance (DQA) Pediatric Measure Set	0%	0%	2024 and 2025 performance levels to be established using 2023 baseline HEI data
Total	**100%**	**100%**	

Where applicable, scores are provided per product, and penalties and credits are weighted based on the enrollment in each product.

2022 PERFORMANCE STANDARDS WITH PENALTIES PROPOSED FOR REMOVAL IN 2023

Performance Standards With Penalties	2022 % at Risk	Proposed 2023 % at Risk	Proposed Change and Rationale
Quality Rating System – Clinical Effectiveness Rating	33.5%	n/a	Removed from Performance Standards with Penalties due to implementation of QTI
Health Equity Capacity Building (2% Credit)	0%	n/a	Credit for early achievement replaced with penalty for failure to achieve NCQA Health Equity Accreditation by year-end 2023
Accountable Care Organizations	HMO – 10% PPO/EPO – 0%	n/a	Removed from Performance Standards with Penalties; remains in Attachment 7 with enhanced reporting on ACO structure; will evaluate for AB 929 public reporting
Appropriate Use of C-Sections (maternity payment strategy)	5%	n/a	Removed from Performance Standards with Penalties; remains in Attachment 7 with enhanced requirement for issuers to submit intervention plan to improve low performing network hospitals; will evaluate for AB 929 public reporting

CCSB 2023 ATTACHMENT 14 PROPOSED APPROACH

- Attachment 14 will be separated into two Attachments. New attachment numbers are:
  - Attachment 2 - Performance Standards with Penalties
  - Attachment 3 - Performance Standards and Expectations

- For Attachment 2 - Performance Standards with Penalties:
  - the total amount at risk is decreasing from three percent (3%) of the total participation fee (5.2%) paid by the issuer (approximately 0.156% of premium) to 0.05% of premium due to align with the Individual QHP Contract language.
  - Covered California will not be implementing penalties for the CCSB Attachment 2 in 2023.
  - Covered California is proposing penalties for HEI Data Submission and Dental Quality Alliance (DQA) Pediatric Measure Set beginning in 2024 and beyond.

- For Attachment 3 - Performance Standards and Expectations:
  - Issuers will continue to report on Customer Service and Operational performance.

CCSB PROPOSED CHANGES FOR 2023 PERFORMANCE STANDARDS AND EXPECTATIONS (NO PENALTY)

Performance Standards and Expectations		Proposed Change
1.1 Abandonment Rate	Expectation: No more than 3% of incoming calls abandoned in a calendar month. Divide number of abandoned calls by the number of calls offered to a phone representative.	No change
1.2 Service Level	Expectation: 80% of calls answered in 30 seconds or less.	No change
1.3 Grievance Resolution	Expectation: 95% of Covered California enrollee grievances resolved within 30 days of initial receipt.	No change
1.4. Covered California member Email or Written Inquiries Answered and Completed	Expectation: 90% of Covered California member email or written inquiries answered and completed within 15 business days of the inquiry. Does not include appeals or grievances.	No change
1.5 ID Card Processing Time	Expectation: 99% of ID cards issued within 10 business days of receipt of complete and accurate enrollment information for a specific consumer(s).	No change
1.6 Provider Directory Data Submission	Expectation: Full and regular submission of provider data according to the standards outlined in the Performance Standard contract specific to contract Section 3.4.4. Submissions occur every month pursuant to the submission schedule (Extranet, Plan Home, Resources, Provider Directory Resources, Covered California Provider Data Submission Schedule_Current Year).	Waived for 2023.

CCSB PROPOSED CHANGES FOR 2023 PERFORMANCE STANDARDS WITH PENALTIES

Performance Standards With Penalties	2023% at Risk	Proposed 2024 % at Risk	Proposed 2025 % at Risk	Proposed Change and Rationale
1. HEI Data Submission	0%	80%	80%	Pilot Period January 1, 2023-December 31, 2023 Penalties will not be assessed in 2023. Increase in percent at risk signals importance of HEI data to monitoring quality and equity performance.
2. Dental Quality Alliance (DQA) Pediatric Measure Set	0%	20%	20%	Pilot Period January 1, 2023-December 31, 2023 Penalties will not be assessed in 2023. 2024 and 2025 performance levels to be established using 2023 baseline HEI data.
Quality, Equity, And Delivery System Transformation Standards				Covered California will continue monitor and assess CCSB performance. As CCSB membership grows, performance standards may be added and penalties may be assessed in future years.
Total	**0%**	**100%**	**100%**	