PLAN MANAGEMENT ADVISORY GROUP

February 11, 2016

WELCOME AND AGENDA REVIEW

BRENT BARNHART, CHAIR
PLAN MANAGEMENT ADVISORY GROUP

AGENDA

AGENDA
Plan Management and Delivery System Reform Advisory Group
Meeting and Webinar
Thursday, February 11, 2016, 10:00 a.m. to 12:00 p.m.

Webinar link: https://attendee.gotowebinar.com/rt/6132192224704601089

	February Agenda Items	Suggested Time
I.	Welcome and Agenda Review	10:00 - 10:05 (5 min.)
II.	Review of Draft 2017 Applications for Certification	10:05 – 10:45 (40 min.)
III.	Review of Draft 2017 Benefit Designs	10:45 – 11:05 (20 min.)
IV.	Review of Draft 2017 Contract	11:05 – 11:55 (50 min.)
V.	Wrap-Up and Next Steps	11:55 – 12:00 (5 min.)

REVIEW OF DRAFT 2017 APPLICATIONS FOR CERTIFICATION

ANNE PRICE, DIRECTOR
PLAN MANAGEMENT DIVISION

2017 CERTIFICATION UPDATE

- There were no significant comments received on the 2017 certification approach recommendation made to the board in January.

- The exchange participation fee percentage is still being evaluated in relation to Covered California's Fiscal Year 16/17 budget and strategy work that is currently occurring in coordination with PwC.
  - The percentage fee for all lined of business (individual, dental and small business) will be recommended to the board in April with final approval sought May
  - Approval at a later date will require carriers to incorporate the fee recommended in April in their rates submitted on May 2.
  - Any changes to the recommended fee can be incorporated into the rates after the first rate negotiation prior to the rates being announced in July.

2017 INDIVIDUAL PLAN CERTIFICATION RECOMMENDATION

- For 2017, recommend one QHP Certification application that is open to all licensed health insurers. Covered California will review applications, negotiate with carriers and announce Qualified Health Plans in July 2016.

- The 2017 application is for a multi-year contract term (2017 – 2019) with annual plan re-certification that includes review and Covered California approval of the following:

    - Contract compliance and performance review
    - Rates
    - Benefits
    - Networks
    - New products
    - Updates to performance targets and requirements if needed

- May allow new entrants in 2018 and 2019 if the carrier is newly licensed or a Medi-Cal managed care plan and the addition brings value to what is already being offered in the region(s).

- Exchange participation fee will be set at a percent of gross premium for 2017 and reviewed annually for 2018 and 2019 with the goal of reducing the percentage when possible.

2017 DENTAL PLAN CERTIFICATION RECOMMENDATION (INDIVIDUAL AND CCSB)

- For 2017, recommend one QDP Certification application that is open to all licensed dental plans.
- The 2017 application is for a multi-year contract term (2017 – 2019) with annual plan certification that includes review and Covered California approval of the following:
    - Contract compliance and performance review
    - Rates
    - Benefits
    - Networks
    - New products
    - Updates to Performance Requirements
- May allow new dental issuer entrants in 2018 and 2019 if the issuer is newly licensed or the addition brings value to what is already being offered in the region(s).
- Exchange participation fee will be set at a percent of gross premium for 2017 and reviewed annually for 2018 and 2019 with the goal of reducing the percentage when possible.

2017 SMALL GROUP CERTIFICATION RECOMMENDATION

- Covered California for Small Business QHP certification application will be open to all licensed health insurers and not limited to carriers who offer QHPs for Individual.
- Multi-year contract term (2017 – 2019) with annual carrier certification that includes review of premium competitiveness and stability, performance, and compliance with QHP contract requirements.
- Allowance of new carrier entrant off annual certification cycle.
- Allowance for quarterly change in rates, addition of new plans and networks (subject to Covered California approval).
- Exchange participation fee will be set at a percent of gross premium for 2017 and reviewed annually for 2018 and 2019 with the goal of reducing the percentage when possible.

2017 CERTIFICATION TIMELINE

Plan Management Advisory • Benefit Design & Certification Policy recommendation	January 14, 2016
Release draft 2017 QHP & QDP Certification Applications	January 19 – February 9, 2016
January Board Meeting: discussion of benefit design & certification policy recommendation	January 21, 2016
Draft application comment periods end	February 16, 2016
Letters of Intent Accepted	February 1 – February 19
Final AV Calculator Released	February
February Board Meeting: anticipated approval of 2017 Standard Benefit Plan Designs & Certification Policy	February 18
Applicant Trainings (electronic submission software, SERFF submission and templates)	February 22 -26
QHP & QDP Applications Open	March 1, 2016
QHP Application Responses Due	May 2, 2016
Evaluation of QHP Responses & Negotiation Prep	May 3 – June 5
QHP Negotiations	June 6 – June 17
Covered California for Small Business (CCSB) QHP Application Submissions Due	June 17, 2016
QHP Preliminary Rates Announcement	Week of July 4
Regulatory Rate Review Begins (QHP)	Week of July 4
QDP Application Responses Due	June 1
Evaluation of QDP Responses & Negotiation Prep	June 2 – July 10
QDP Negotiations	July 11 – July 17
CCSB QHP Rates Due	July 29, 2016
QDP Rates Announcement (no regulatory rate review)	August 1
Public posting of proposed rates, if exception requested by Covered California (proposed date per CCIIO)	August 31
Public posting of final rates, if exception requested by Covered California (proposed date per CCIIO)	November 1

Changes above in red

2017 DRAFT APPLICATION – PUBLIC COMMENT SUMMARY

Issue #	Section	Issue Area	Consolidated Comment	Covered California Response
1	Global	Clarifications	Clarifications requested regarding dates, instructions, appendices and attachments.	Covered CA will update all dates that have shifted since release of the draft application, as well as clarify instructions throughout the application. Each appendix and attachment is referenced in the specific question or requirements that refers to it. Plan proposal instructions will clearly explain the detailed requirements, including new language describing AI/AN plan variations.
2	Global	Document Structure	Does the QHP Certification Application for Individual Marketplace apply to Covered California for Small Business? Are currently contracted QHP Issuers expected to complete the entire application?	The 2017 certification applications will be separated for the separate marketplaces. All Applicants must complete the certification application for 2017 regardless of their status with the Exchange in 2016.
3	3	Benefits	Does requesting benefit deviations refer to allowing alternate benefit designs in the Individual Marketplace? Comments received that Covered CA should not allow for deviations from the standard benefit designs.	Alternate benefit designs are not permitted in the Individual Marketplace. Some issuers must adjust benefits to comply with regulatory requirements (e.g federal mental health parity compliance) or as a result of the issuer's delivery system. Covered CA requires a standardized mechanism for monitoring these requests and approving them as appropriate.
4	3	Benefits	Pediatric dental policy clarification.	While the Exchange encourages the inclusion of pediatric dental EHB in QHPs proposed for the Individual Marketplace as a result of Board-adopted policy, Applicants are not required to embed the pediatric dental benefit.
5	3	Benefits	Covered CA should work closely with regulators to ensure EOC documents are in compliance with applicable laws and regulations.	Covered CA reviews member documents including SBCs and EOCs carefully and defers to the applicable state regulator for approval of these documents.

2017 DRAFT APPLICATION – PUBLIC COMMENT SUMMARY

Issue #	Section	Issue Area	Consolidated Comment	Covered California Response
6	Global	State and Federal law	Covered CA should state Applicants are required to comply with specific state laws in applicable questions and requirements.	Covered CA does not intend to re-state requirements dictated by federal or state laws.
7	3	Networks	"Preferred and non-preferred networks" could be construed to mean PPO network design.	Covered CA will remove "preferred and non-preferred networks" from language prohibiting tiered networks.
8	4.4.1	Networks	Covered CA should require demonstration of Applicant capacity to comply with SB 137 requirements related to provider directory updates. Covered CA should require the submission of additional information in Applicant provider data submissions.	Determination of the provider data elements currently requested resulted from extensive collaborative discussion to identify elements that can be consistently and accurately captured across a range of issuers. Covered CA will continue to defer to the applicable regulator for compliance with provider data regulations.
9	4.4.5	Networks	Covered CA should not require disclosure of provider contract details.	Covered CA does not intend to change the requirement of issuers to disclose contract provisions that prevent transparency.
10	5	Essential Community Providers	Importance of maintaining a complete and accurate ECP, and reviewing annually.	Covered CA is committed to regular review and maintenance of the ECP list in accordance with policy adopted by the Exchange Board. The ECP list remains publicly available for review and comment.
11	6.3.5	Customer Service	Applicants should be required to provide customer assistance in all threshold languages.	Final application requirements will include all threshold languages.
12	8	eValue8	Suggestions to revise information requested in the eValue8 tool, including reading level and language services.	All Applicants will complete the same eValue8 tool. The eValue8 tool can be modified for application to Exchange QHPs, including removal of references to tiered networks, but the questions embedded in the tool are standardized for use across all health plans.

REVIEW OF DRAFT 2017 BENEFIT DESIGNS

JAMES DEBENEDETTI, DEPUTY DIRECTOR
PLAN MANAGEMENT DIVISION

2017 STANDARD BENEFIT DESIGN UPDATE

- The final Actuarial Value (AV) calculator was released in January with no significant updates that required further changes to the benefit designs discussed at the January 21st board meeting.

- Stakeholder and carrier feedback requested clean-up in language as a result of removing cost sharing related to the emergency room physician fee. Covered California is making the following changes:

    - the emergency room benefit display was changed back to the 2016 format (separate line item for facility and physician fee)
    - **the ER physician fee will have "No Charge" listed as the member cost share for every plan**
    - have added clear language regarding waiving emergency room cost sharing if admitted to the hospital

- Due to HDHP requirements, we must require that the deductible is applied to the "ER physician fee" in the Silver and Bronze HDHPs. Once the deductible is satisfied, there is no charge to the member for ER physician fees.

- Corrected that the medical deductible does apply for emergency medical transportation for every plan that has a medical deductible consistent with 2016 benefits.

- Revised language for Endnote #18:
"The inpatient physician cost share may apply for any physician who bills separately from the facility (e.g. surgeon). A member's primary care physician or specialist may apply the office visit cost share when conducting a visit to the member in a hospital or skilled nursing facility."

The proposed 2017 Standard Benefit Plan Design is undergoing formal certification. AV confirmation is expected by the time of the Board meeting

2017 PROPOSED DENTAL STANDARD BENEFIT DESIGN

- **Copay Plan Design (Pediatric & Adult)**
  - Standardize copays for all procedure codes.

- **Coinsurance Design**
  - Include Periodontal Maintenance benefits in Basic Services.
  - Reduce out-of-network levels of coverage. Proposed plan coinsurance:
    - Diagnostic & Preventive: Plan pays 90%
    - Basic Services: Plan pays 70%
    - Major Services: Plan pays 50%
  - ***Adult benefits only***: Standardize the following exclusions: Tooth Whitening, Adult Orthodontia, and Implants.

- **Employer-Sponsored Adult Coinsurance Plan Design**
  - No waiting period for any service category.
  - Periodontal Services included in Basic Services.
  - Adult Endodontic Services included in Basic Services

REVIEW OF DRAFT 2017 CONTRACT

ELISE DICKENSON, CONTRACTS MANAGER
PLAN MANAGEMENT DIVISION

2017 – 2019 QHP ISSUER CONTRACT

Covered California solicited and received comments from QHP Issuers, Consumer Advocate Groups, and CAHP. We are in the process of reviewing all comments. Highlights of the revisions made include the following:

- 2.1.2 (b) Updated the appeals language to ensure both the QHP Issuer and Covered California are working together to implement appeals decisions in a timely manner.
- 2.2.6 (b) and (c) Updated language on Agent Commissions to ensure all products are being offered to consumers consistently throughout the market.
- 7.2.4 Remedies in case of QHP Issuer Default or Breach expanded. Additional remedies were added to help Covered California work with the QHP issuers in making improvements and in some instances protect consumers while improvements are in process.
- Attachment 14 – 5% penalty increased to 10% penalty for QHP Issuer failure to submit timely reconciliation reports.

REVIEW OF DRAFT 2017 ATTACHMENT 7

DR. LANCE LANG, CHIEF MEDICAL OFFICER
PLAN MANAGEMENT DIVISION

2017 ATTACHMENT 7 UPDATE

- Covered California received many comments on the Draft 2017 Attachment 7. The following slides summarize key themes and Covered California responses.

- In addition to responses to comments received, we are proposing additional Attachment 7 updates, some of which involve new requirements:

  - Article 1- Improving Care, Promoting Better Health and Lowering Costs (restructured with section updates/additions)
    - Assuring Networks are Based on Value (1.02)
    - Demonstrating a Focus on High Cost Providers (1.03)
    - Demonstrating a Focus on High Cost Pharmaceuticals (1.04, new)
    - Quality Improvement Strategy (1.05, moved from Article 2)
    - Participation in Collaborative Quality Initiatives (1.06)
    - Data Exchange with Providers (1.08)
    - Data Aggregation Across Health Plans (1.09)
  - Article 3 –Reducing Health Disparities and Assuring Health Equity.
    - Self identification and disparity measures clarified to refer to all lines of business (3.01 &3.02)
    - Limited English Proficiency added to list for expanded measurement in 2018-2019 (3.03)
  - Article 5 - Hospital Quality
    - Hospital payment methodology by 2019 refers to all lines of business (5.01)
  - Article 7 – Patient Centered Information and Support
    - Quality measurement added to consumer tools will be based on nationally endorsed quality information in accordance with the principles of the Patient Charter for Physician Performance Measurement (7.01)
    - Enable comparison of providers based on quality information (7.01)
  - Article 8 – Payment Incentives to Promote Higher Value Care
    - Reporting for value-based reimbursement inventory clarified to be for all lines of business with the provider (8.02)

1.03 DEMONSTRATING FOCUS ON HIGH COST PROVIDERS

Affordability is core to Covered California's mission. The wide variation in unit price and total costs of care charged by providers, with some providers charging far higher for care irrespective of quality, is one of the biggest contributors to high costs of medical services.

1) Contractor shall Report in its Application for Recertification for 2018, and annually thereafter:

- The factors it considers in assessing the relative unit prices and total costs of care;
- The extent to which it adjusts or analyzes the reasons for cost factors based on elements such as area of service, population served, market dominance, services provided by the facility (e.g., trauma or tertiary care)
- How such factors are used in the selection of providers or facilities in networks available to Covered California enrollees; and
- The distribution of providers and facilities by cost deciles.

2) In its Application for Recertification for 2018, and annually thereafter, Contractor shall report on its strategy to assure that contracted providers are not charging unduly high prices, which may include but are not limited to:

- Telemedicine;
- Use of Centers of Excellence; and
- Efforts to make variation in provider or facility cost transparent to consumers;

3) For contract year 2019, Contractor will be expected to exclude hospitals and other facilities that demonstrate outlier high cost from provider networks serving Covered California or to document each year in its Application for Certification the rationale for continued contracting with each hospital that is identified as a high cost outlier and efforts that the hospital or facility is undertaking to lower its costs.

1.04 DEMONSTRATING FOCUS ON HIGH COST PHARMACEUTICALS

Appropriate treatment with pharmaceuticals is often the best clinical strategy to treating conditions, as well as managing chronic and life threatening conditions. Covered California is concerned at the trend in rising prescription drug costs, especially those in Specialty Pharmacy, which reflect a growing driver of total costs of care.

Contractor shall report in its annual application for certification a description of its approach to achieving value in delivery of pharmacy services, which may include strategies to:

1. Provide newer therapies based on independent assessments of the relative value of such therapies within the Covered California standard benefit design. To the extent contractor conducts or relies upon relative value assessment it shall report which, if any, of the following it relies upon:

    - Drug Effectiveness Review Project (DERP)
    - NCCN Resource Stratification Framework (NCCN-RF)
    - NCCN Evidence Blocks (NCCN-EB)
    - ASCO Value of Cancer Treatment Options (ASCO- VF)
    - ACC/AHA Cost/Value Methodology in Clinical Practice Guidelines
    - Oregon State Health Evidence Review Commission Prioritization Methodology
    - Premera Value-Based Drug Formulary (Premera VBF)
    - DrugAbacus (MSKCC) (DAbacus)
    - The ICER Value Assessment Framework (ICER-VF)

2. Efforts to impact state and national policy on pharmacy pricing, marketing, transparency or development; and

3. How it provides decision support for prescribers and consumers related to the clinical efficacy and cost impact of treatments and their alternatives.

1.07 DATA EXCHANGE WITH PROVIDERS

1) Covered California and Contractor recognize the critical role of sharing data across specialties and institutional boundaries as well as between health plans and contracted providers in improving quality of care and successfully managing total costs of care. Contractor shall report in its annual Application for Certification the initiatives Contractor has undertaken to improve routine exchange of timely information with providers to support their delivery of high quality care. Examples that could impact the Contractor's success under this contract may include:

a) Notifying PCPs when one of their empaneled patients is admitted to a hospital, a critical event that often occurs without knowledge of either the primary care or specialty providers who have been managing the patient on an ambulatory basis.
b) Developing systems to collect clinical data as a supplement to the annual HEDIS process, such as HbA1c lab results or blood pressure readings which are important under Article 3 below.

2) Initiatives to make this exchange routine include various Health Information Exchanges including:

a) Inland Empire Health Information Exchange (IEHIE)
b) Los Angeles Network for Enhanced Services (LANES)
c) Orange County Partnership Regional Health Information Organization (OCPRHIO)
d) San Diego Health Connect
e) Santa Cruz Health Information Exchange
f) CalIndex.

1.08 DATA AGGREGATION ACROSS HEALTH PLANS

Covered California and Contractor recognize the importance of aggregating data across purchasers and payers to more accurately understand the performance of providers that have contracts with multiple health plans. Such aggregated data reflecting a larger portion of a provider, group or facility's practice can potentially be used to support performance improvement, contracting and public reporting.

Examples to date have included:

a) The Integrated Health Association (IHA) for Medical Groups
b) The California Healthcare Performance Information System (CHPI)
c) The CMS Physician Quality Reporting System
d) CMS Hospital Compare or
e) CalHospital Compare

Contractor shall report in its annual Application for Certification its participation in such initiatives to support the aggregation of claims and clinical data. Contractor should include its assessment of additional opportunities to improve measurement and reduce the burden of data collection on providers through such proposals as a statewide All Payer Claims Database.

2017 DRAFT ATTACHMENT 7– PUBLIC COMMENT SUMMARY

Issue #	Article	Issue Area	Consolidated Comment	Covered California Response
1	Article 1	Quality in Payments	Adding quality elements to contracts requires time and collaboration, especially if re-opening contracts is involved.	Adding quality to contracting for payments and networks is part of a phased approach through 2019. All efforts that connect to payment reform or criteria for network participation have funded opportunities for providers to get coaching support through collaboratives.
2	Article 1	Quality in Networks	Some providers are impacted by variables, such as environment or population served, that could hamper ability to meet quality targets, which could lead to access issues.	QHPs can retain providers not meeting targets if rationale is provided.
3	Article 1	Quality in Networks	Make QHP rationale for network inclusion or exclusion available to consumers.	Both current QHP network participation criteria and rationale for inclusion of providers that don't achieve performance goals may be made publicly available by Covered CA.
4	Article 2	Federal QIS	Federal QIS requires only that strategies fit within targeted buckets and include a focus on disparities and market based incentives.	State-based exchanges may establish their own requirements and reporting structure as long as they meet the two guardrails.
5	Articles 3, 4, 5	Disparities	Consider requiring NQF Risk Adjustment for Socioeconomic Status	Covered CA is tracking the NQF trial of Risk Adjustment for Socioeconomic Status and will work with other stakeholders to consider application to appropriate metrics if successful.
6	Article 3	Disparities	Some quality initiatives have potential to increase health disparities if not implemented carefully.	Covered CA will be alert for unintended consequences through the use of balancing measures.
7	Article 3	Disparities	The 2019 goal of 85% for self-reported racial/ethnic identity is too high.	The target is reduced to 80%. However, two plans have attained 85%. Success will require increased data exchange with providers to take advantage of each contact to collect self-reported identity and for clinical data collection.

2017 DRAFT ATTACHMENT 7– PUBLIC COMMENT SUMMARY

Issue #	Article	Issue Area	Consolidated Comment	Covered California Response
8	Article 3	Disparities	Definitions for “Health Disparities”, “Healthcare Disparities” and “Health Equity” proposed.	Covered CA will add these definitions to the Attachment 7 Glossary.
9	Article 4	Care Models	Concern over the proposal for “combined risk sharing arrangements between hospitals and physicians”.	As providers accept more accountability under this provision, QHPs shall be aware of their obligations under Knox Keane to ensure that providers have the capacity to manage the risk.
10	Article 4	Care Models	Can Integrated Healthcare Model (IHM) definition accommodate physician led IHMs that contract and manage hospital risk?	IHM definition was modified to focus on function rather than structure.
11	Article 4	Care Models	Concern for the future of the PPO.	Covered CA supports models that increase coordination & reduce fragmentation. QHPs can support mechanisms to improve quality of care through greater integration and coordination without requiring providers to leave independent practice.
12	Article 4	Care Models	Please clarify why “Personal Care Physician is used instead of “Primary Care Physician”.	QHPs may adopt their own language. Covered CA is emphasizing that in requiring that enrollees have a Personal Care Physician, there is no requirement to implement a gatekeeper model.
13	Article 4	Care Models	The process for connecting patients to Patient Centered Medical Homes (PCMHs), once defined, is complex and it will take time for QHPs to establish participation. it requires a concerted effort and active support from all key stakeholders.	We will work together to define PCMH, and are asking for a growing percent after determining baseline. Covered CA will help facilitate participation.
14	Article 4	Mental Health	Clarity needed on what is meant by integrating behavioral health with medical care.	Covered CA is asking through the 2017 application what plans are currently doing, and how integration is interpreted in order to chart a path forward.

2017 DRAFT ATTACHMENT 7– PUBLIC COMMENT SUMMARY

Issue #	Article and Section	Issue Area	Consolidated Comment	Covered California Response
15	Article 5	QHPs setting quality targets	Is the role of QHPs to assure quality performance such as the target C-section rate.	Covered CA does expect QHPs to serve as our agents in developing provider networks based on both cost and quality performance.
16	Article 5	Target setting and data availability	Concern regarding setting targets for safety measures and the availability of data.	Covered CA will work with QHPs to find clinical data from some combination of CDPH, OSHPD, HQI, other Partnership for Patients participants, and hospitals. We will work from baseline measurement to set targets.
17	Article 5	Hospital Associated Conditions (HACs)	Can Covered CA list of five HACs be adjusted?	After much consultation, HACs are set for 2017. Goal was to choose set with most impact and relevance. Additional HACs will be added in 2018, one of which will be Sepsis Mortality.
18	Article 5	Payment strategy for C-section	Can Covered CA add to C-Section payment strategy, so it applies to hospitals & physicians?	Covered CA agrees and will adjust.
19	Article 6	Population Health	What is meant by "culturally" and "linguistically" appropriate communication?	Covered CA recommends using NCQA Multi-Cultural Health Recognition program.
20	Article 7	Cost and Quality Tools	Comment range includes: desire to provide as much specific cost/quality information as possible to both potential and current members; and hesitation on disclosure of confidentially negotiated rates and development of internal plan quality rating system.	Covered CA does require that enrollees have decision support including both cost and quality performance in choosing where to seek care. We do not currently require that plans make tools available to prospective enrollees and look forward to further dialogue on this issue.
21	Global	Data reporting & information sharing workload	Challenging for physicians to provide the data QHPs require to assess or improve performance.	Challenges go both ways. Physicians need more data such as notification of hospital and ER admissions to fulfill their responsibilities. Quality improvement requires both to engage in increased data exchange to benefit enrollees.

2017 DRAFT ATTACHMENT 7– PUBLIC COMMENT SUMMARY

Issue #	Article and Section	Issue Area	Consolidated Comment	Covered California Response
22	Global	Covered CA enrollees versus whole book	Concern that some quality initiative requirements apply to all lines of business instead of just Covered CA enrollees.	ACA and Covered CA expect that requirements established for Medicare, Medicaid and the Exchanges will drive delivery system reform for all.
23	Global	Deadlines	Some required data will not be available in time for Application for Certification.	For reporting depending on HEDIS, the reporting deadline will be delayed to Q3 each year. For reporting on HACs, the first year deadline will depend on identification of timely data sources.
24	Global	Metric Specifications	Specifications were just published last week without enough time for feedback.	The Board will adopt the contract but not metric specifications. Plenty of time will be allowed to thoroughly review and improve the draft metric specifications.
25	Articles 4,5 and 8	Payment Reform	Strategies may not be fully defined in time for Application for Certification for 2017.	For some payment reform strategies, submission may be allowed to be delayed until Q3 2017 if needed.
26	Article 3	Disparities	Pace of data submission and requirements for improvement are not strong enough. Pace of data submission and requirements for improvement don't account for the challenges of data availability and collecting the data for a new purpose.	Covered CA recognizes that both views are legitimate and will work with all stakeholders to set a high bar but recognize operational challenges in implementation.
27	eValue8 and PGs	Transition from 2015 & 2016 to 2017 Contract	Confusion on when eValue8 scores will no longer be part of Performance Guarantees.	QHPs will submit updated eValue8 in compliance with 2015 and 2016 contracts for scoring. eValue8 will still be part of the Application for Certification for 2018 but will not be scored for the 2017 Performance Guarantees. Due dates should align with submission to PBGH.

WRAP UP AND NEXT STEPS

BRENT BARNHART, CHAIR
PLAN MANAGEMENT ADVISORY GROUP