Plan Management Advisory Workgroup

February 13, 2025

AGENDA

Time	Topic	Presenter
10:00 – 10:05	Welcome and Agenda Review	Amy Frith
10:05 – 10:20	2026 – 2028 QHP Issuer Model Contract Requirements	EQT Team
10:20 – 10:40	Plan Performance Report Release Year 2024	EQT Team
10:40 – 10:50	Enhanced Benefit Designs	Melanie Droboniku
10:50 – 12:00	Open Forum	

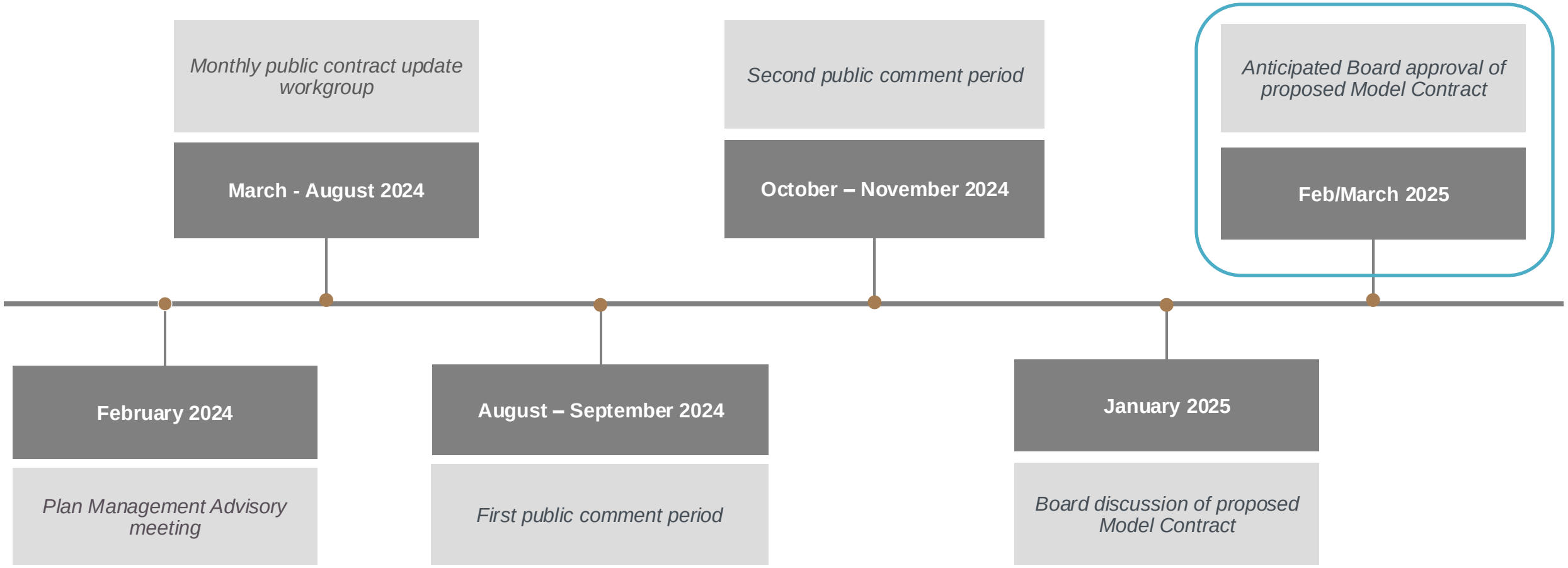
2026-2028 QHP ISSUER MODEL CONTRACT REQUIREMENTS

EQT Team

2026-2028 QHP INDIVIDUAL AND CCSB ISSUER CONTRACT

EQT Team

2026 QHP ISSUER CONTRACT UPDATE TIMELINE



2026-2028 CONTRACT DEVELOPMENT GUIDING PRINCIPLES

Principles	Framework
Equity is quality	Build on the strong foundation of 2023-2025 contract
Center the member	Prioritize alignment with DHCS, CalPERS, & OHCA
Make it easy to do right	Emphasize outcomes
Amplify through alignment	Pursue administrative simplification
Focused scope for high impact	

Model Contract	Attachment 1	Attachment 2	Attachment 4
• Essential Community Providers (ECPs) • Article 5	• Articles 1-6	• Performance standards	• Quality Transformation Initiative

ADVANCING EQUITY, QUALITY AND VALUE CONTRACT UPDATE

Model Contract *with PMD*	Attachment 1	Attachment 2 *with PMD*	Attachment 4
• Essential Community Providers (ECPs) • Article 5	• Articles 1-6	• Performance standards	• Quality Transformation Initiative

CCSB Contract Scope

BUILDING ON 2023-2025 WITH BOLD NEW ADDITIONS

Actionable Data

- Selective Contracting for Quality
- Expansion of Demographic Data Collection
- Data Exchange
- Behavioral Health Disparities Reduction
- Quality Transformation Initiative (QTI)

Healthy Workforce

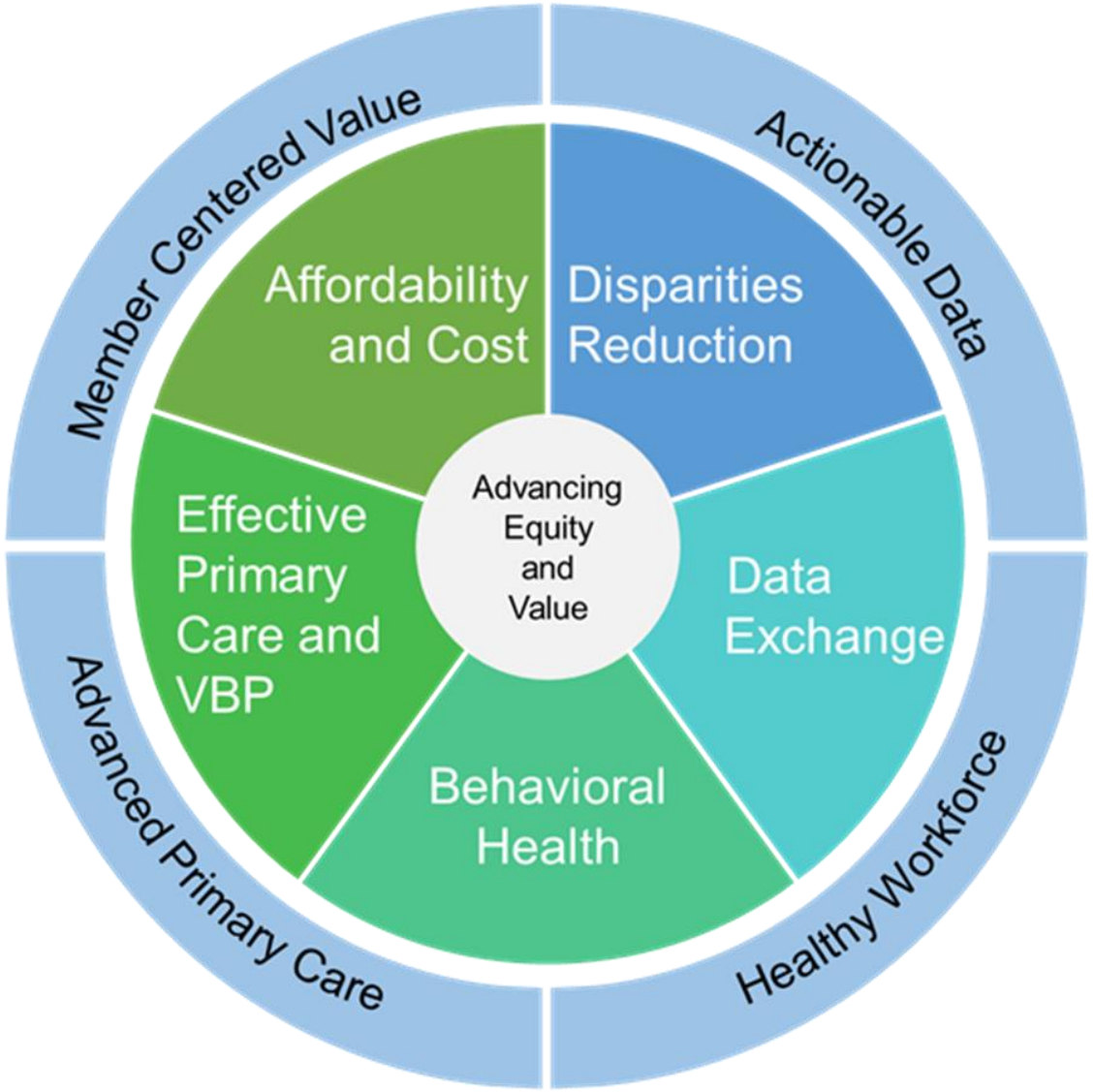
- Essential Community Providers
- Generative Artificial Intelligence
- Primary and Behavioral Health Care Spend Tracking
- Engagement in Collaboratives and with Community

Advanced Primary Care

- Continuity of Care
- Use and Quality of Digital Care
- Behavioral Health Promotion
- Substance Use Disorder Care
- Behavioral Health Vendor Oversight

Member-Centered Value

- Access to Care
- Comprehensive Maternal Healthcare
- Population Health Investments
- Targeted Engagement and Outreach



2026 – 2028 QHP ISSUER MODEL CONTRACT DRAFT UPDATES

QHP Issuer Model Contract
Article 4 QHP Issuer Program Requirements
Article 5 Advancing Equity Quality, and Value
Essential Community Providers, Access, and Removal From the Exchange (“25/2/2”)

COVERED CALIFORNIA

PROPOSED 2026-28 ECP REQUIREMENTS

Model Contract Article 4 – Essential Community Providers (ECP) Requirements

- Issuers must meet ECP General Standard by maintaining a network which includes a sufficient geographic distribution of care to provide reasonable and timely access to low-income populations, individuals living in Health Professional Shortage Areas (HPSAs) and medically underserved individuals

- ECP General Standard Sufficiency Requirements:
  - Issuers must demonstrate sufficient geographic distribution of a mix of essential community providers reasonably distributed throughout the geographic service area
  - Issuers must demonstrate provider contracts with at least 15% of Primary Care ECPs in each rating region in which it offers QHPs
  - Issuers must demonstrate provider agreements with at least 15% of Behavioral Health ECPs in each rating region in which it offers QHPs
  - Issuers must demonstrate agreements with at least one ECP hospital per county requirement or per rating area in counties with multiple rating regions

Primary Care and Behavioral Health ECPs refer to Medi-Cal primary care and behavioral health providers located in quartiles 1 and 2 of the California Health Places Index

PROPOSED 2026-28 ECP REQUIREMENTS

Model Contract Article 4 – Essential Community Providers (ECP) Requirements

- ECP General Standard Sufficiency Requirements (continued):
  - If Issuers are unable to meet the sufficiency requirements stated on the previous slide:
    - Issuers must demonstrate provider agreements with at least 15% of 340B non-hospital providers in each rating region in which it offers QHPs
    - Issuers must demonstrate documentation of good faith efforts to achieve the sufficiency requirements stated previously for the first plan year of the contract period
    - Issuers must demonstrate documentation of improvements in plan years 2027 and 2028 showing material increases in percentage of contracts with Primary Care and Behavioral Health ECPs
- Issuers in an integrated delivery system may request the ECP alternative standards and must demonstrate compliance by mapping low-income and HPSA member populations and network providers and facilities offering services in all ECP categories

Primary Care and Behavioral Health ECPs refer to Medi-Cal primary care and behavioral health providers located in quartiles 1 and 2 of the California Health Places Index

PROPOSED 2026-28 ACCESS REQUIREMENTS

Model Contract Article 4 – Access

- To assess and monitor Beneficiary Experience and Outcomes, Covered California will track and publicly report CMS QRS Enrollee Experience performance, although removed from Attachment 2 as a performance standard
- To assess and improve Provider Availability and Accessibility, Covered California will leverage Healthcare Evidence Initiative (HEI) for Network measures agreed upon by California public purchasers and/or regulators, with improvement plans required for underperforming Issuers
  - Provider-to-member ratio: The number of providers per beneficiary
  - Active providers : The percentage of providers serving beneficiaries in the past year
  - Provision of telehealth services: The percentage of providers providing telehealth services
- To assess and improve Service Utilization and Quality, Covered California may launch a secret shopper survey utilizing questions from DHCS and CalPERS surveys in PY2026 with improvement plans required for underperforming Issuers
  - A repeat survey may be implemented biennially (every other year) if pervasive underperformance

PROPOSED 2026-28 25/2/2 PROGRAM REQUIREMENTS

Model Contract Article 5 – Removal from the Exchange

- ❑ Annual assessment of QHP performance on QRS clinical measures
- ❑ Monitoring and remediation periods (two years each) for continued QHP clinical composite performance beneath the 25th percentile composite benchmark
- ❑ New static benchmark year established, Measurement Year (MY) 2024
- ❑ Removal of retired QRS measures from benchmark and composite score calculations
- ❑ Clinical measures added to QRS during contract cycle will be included and composite score calculations as benchmarks are published
- ❑ Minimum Performance Level (MPL) Action Plan requested for clinically significant measures falling beneath the 25th percentile for 2 consecutive years.

PROPOSED 2026-28 MODEL CONTRACT CHANGES

Model Contract

Notable Changes to January Draft Model Contract	Rationale
Article 4 – Essential Community Providers No changes proposed	
Article 4 – Access No changes proposed	
Article 5 – Removal From the Exchange (“25/2/2”) No changes proposed	

Attachment 1 Advancing Equity, Quality, and Value

2026 – 2028 PROPOSED ATTACHMENT 1 REQUIREMENTS

Attachment 1	Summary of Requirements
Article 1: Equity and Disparities Reduction	• Collect race, ethnicity, language, gender identity and sexual orientation demographic data • Submit quality measure data stratified by race and ethnicity and review results with Covered CA • Meet QTI health equity expectations • Achieve NCQA Health Equity Accreditation by year end 2023
Article 2: Behavioral Health	• Promote access to behavioral health services; offer telehealth for behavioral health • Monitor behavioral and virtual behavioral health quality and oversee delegated entities • Implement policies and programs to promote the appropriate use of opioids and tobacco treatment • Provide staff cultural humility training, deploy culturally specific materials for marginalized groups, and implement behavioral health utilization disparity reduction emphasizing community engagement • Annually report on behavioral health spending by product according to OHCA guidelines • Promote the integration of behavioral health services with primary care services
Article 3: Population Health	• Submit population health management plans • Conduct prevention efforts including diabetes prevention • Screen enrollees for food insecurity and support linkages to appropriate social services • Support transitioning enrollees in the event of a QHP withdrawal • Implement, monitor and report on best practices for use of Generative AI

PROPOSED 2026-28 ARTICLE 1 CHANGES

Article 1: Equity and Disparities Reduction

Notable Changes to January Draft Attachment 1	Rationale
Demographic Data Collection No changes proposed	
Identifying Disparities in Care No changes proposed	
Disparities Reduction No changes proposed	
Health Equity Capacity Building No changes proposed	
Culturally and Linguistically Appropriate Care No changes proposed	

PROPOSED 2026-28 ARTICLE 2 CHANGES

Article 2: Behavioral Health

Notable Changes to January Draft Attachment 1	Rationale
Access to Behavioral Health Services No changes proposed	
Quality of Behavioral Health Services No changes proposed	
Substance Use Disorders No changes proposed	
Integration of Behavioral Health Services No changes proposed	
Behavioral Health Network Provider Oversight No changes proposed	

PROPOSED 2026-28 ARTICLE 3 REQUIREMENTS

Article 3: Population Health Management

Use of Generative Artificial Intelligence in Qualified Health Plan Issuer Operations

- Align with federal requirements around Patient Care Decision Support Tools **45 C.F.R § 92.210** inclusive of but not limited to GenAI
- Incorporate evolving best practices for use of GenAI and healthcare into use cases
- Ensure transparency with members about the use of generative AI
- Implement processes to address and mitigate bias
- Participate in collaborative discussions and shared learnings across Issuers
- Report on:
  - Processes and approach to mitigate bias
  - GenAI Governance approach
  - GenAI use cases

ARTICLE 3 GEN AI COMMENTS KEY THEMES

- Multiple Issuers and a trade association expressed concern for the operational and cost implications of notifying enrollees when GenAI or algorithms are used at the time decisions are made available to enrollees
- One Issuer and a trade association expressed concerns that GenAI contract requirements may extend to medical providers or propriety UM used for care decisions
- One stakeholder group requested clarity on how to apply these requirements in situations such as those mandated by SB 855

PROPOSED 2026-28 ARTICLE 3 CHANGES

Article 3: Population Health

Notable Changes to January Draft Attachment 1	Rationale
Population Health Management No changes proposed	
Health Promotion and Prevention No changes proposed	
Supporting At-Risk Enrollees Requiring Transition No changes proposed	
Social Health No changes proposed	
Use of Generative AI: 3.05.4 – Enrollee Transparency *"Provide written notice to a Covered California Enrollee when Contractor knowingly uses artificial intelligence including GenAI, algorithm, or other software for the purpose of utilization review or utilization management functions, based in whole or in part on medical necessity under the benefits provided by the QHP, at the time Contractor communicates the decision to the Enrollee in writing, including electronically. Notice may include information regarding Contractor's use of bias mitigation strategies. This requirement shall not apply to Contractor's medical groups or other delegated entities."*	The revised language balances ensuring transparency with enrollees about the use of AI within their healthcare decisions and maintaining operational practicality for issuers. It clarifies that issuers can incorporate this requirement into their existing written communication processes and exempts medical groups and delegated entities.

2026 – 2028 PROPOSED ATTACHMENT 1 REQUIREMENTS

Attachment 1	Summary of Requirements
Article 4: Delivery System and Payment Strategies to Drive Quality	• Match all enrollees to a PCP • Increase value-based payment models for PCPs and report on total primary care spend in alignment with OHCA • Review and improve member continuity of care measure results generated by Covered CA using HEI-submitted data • Track provider organization and hospital quality and costs and report on improvement efforts • Participate in collaborative engagement with Hospitals, Covered California, Issuers and Cal Healthcare Compare to analyze performance variation and engage with poor performing hospitals • Report on Alternative Payment Model (APM) adoption and Total Cost of Healthcare Expenditures in alignment with OHCA • Monitor maternal health disparities and report on intervention efforts; implement strategy to increase access to doulas and midwives • Report all virtual care solutions and vendors in place, provide member support for navigating virtual services, review virtual care service utilization and address disparities using HEI data • Report participation in quality collaboratives
Article 5: Measurement and Data Sharing	• Participate in QRS and submit QRS measure results to Covered California • Submit data to Covered California for the Healthcare Evidence Initiative (HEI) • Execute Data Sharing Agreement (DSA) as required by Health and Safety Code section 130290 and participate in at least one QHIO • Implement and maintain a secure Patient Access API, and report on its use • Submit data to the Integrated Healthcare Association (IHA)
Article 6: Accreditation	• Achieve NCQA health plan accreditation by year end 2024

PROPOSED 2026-28 ARTICLE 4 CHANGES

Article 4: Delivery System and Payment Strategies to Drive Quality

Notable Changes to January Draft Attachment 1	Rationale
Advanced Primary Care No changes proposed	
Networks Based on Value No changes proposed	
Use of Virtual Care No changes proposed	
Participation in Quality Collaboratives No changes proposed	

PROPOSED 2026-28 ARTICLES 5 AND 6 CHANGES

Article 5: Measurement and Data Exchange

Article 6: Certification, Accreditation, and Regulation

Notable Changes to January Draft Attachment 1	Rationale
Article 5 – Measurement and Analytics No changes proposed	
Article 5 – Data Sharing and Exchange No changes proposed	
Article 6 – QHP Accreditation No changes proposed	

CCSB QHP 2026-2028 ATTACHMENT 1

Article 1 Equity and Disparities Reduction - no change to substantive requirements
- continue NCQA Health Equity Accreditation requirement (not small group-specific)

Article 2 Behavioral Health - no change to substantive requirements
- continue all 2023-2025 requirements

Article 3 Population Health - no change to substantive requirements
- continue simplified Diabetes Prevention Program requirement
- continue Transitions of Care requirement

Article 4 Delivery System and Payment Reform Strategies - no change to substantive requirements
- continue provider costs reporting
- continue telehealth reporting
- continue participation in quality collaboratives

Article 5 Measurement and Data Sharing - no change to substantive requirements
- Continue all 2023-2025 requirements: Quality Rating System and Healthcare Evidence Initiative reporting

Article 6 Certification, Accreditation, and Regulation - no change to substantive requirements
- Continue requirement to achieve and maintain NCQA Health Plan Accreditation

Attachment 2 Performance Standards with Penalties

PROPOSED 2026-2028 ATTACHMENT 2 REQUIREMENTS

Performance Area	Performance Standards with Penalties	Percent of At-Risk Amount 2026-2028
Health Disparities 20%	1. Reducing Health Disparities: Demographic Data Collection – Enrollee Race and Ethnicity Self-Identification	10%
	2. Reducing Health Disparities: Demographic Data Collection – Enrollee Spoken and Written Language	10%
Engagement in Collaboratives 10%	3. Engagement in Collaboratives and with Community	10%
Data 40%	4. Healthcare Evidence Initiative (HEI) Data Submission	40%
Oral Health 10%	5. Dental Quality Alliance (DQA) Pediatric Measure Set – Pediatric Oral Evaluation, Dental Services (NQF #2517)	5%
	6. Dental Quality Alliance (DQA) Pediatric Measure Set – Pediatric Topical Fluoride for Children, Dental Services (NQF #2528)	5%
Utilization & Primary Care 20%	7. Utilization & Primary Care: Overall Engagement with Members	10%
	8. Utilization & Primary Care: Monitoring Continuity of Care	10%

PROPOSED 2026-28 ATTACHMENT 2 CHANGES

Attachment 2

Notable Changes to January Draft Attachment 2	Rationale
No changes proposed	

Attachment 4 Quality Transformation Initiative

PROPOSED 2026-28 ATTACHMENT 4 REQUIREMENTS

- Proposed QTI Measure Set:
  1. Blood Pressure Control for Patients with Hypertension (BPC-E) *if adopted by CMS QRS by MY2026, otherwise will continue with CBP*
  2. Glycemic Status Assessment for Patients with Diabetes (GSD) >9%
  3. Colorectal Cancer Screening (COL-E)
  4. Childhood Immunization Status (CIS-E)
  5. Depression Screening and Follow-Up for Adolescents and Adults (DSF-E) - *pending CMS QRS benchmarks*
  6. Pharmacotherapy for Opioid Use Disorder (POD) (Reporting Only)
- Proposed Benchmark: 66th percentile using national Exchange benchmark for CMS QRS measure and held static over contract cycle.
- Proposed Amount at Risk for QTI:
  - Newly contracted QHP issuers to start at 1% of premium at risk in year 1 of QTI eligibility
  - Up to 2.8% of premium at risk for MY2026 for currently contracted QHP issuers
  - Up to 3.8% of premium at risk for MY2027 and MY2028 for currently contracted QHP issuers
  - No more than 1% increase annually

PROPOSED 2026-28 ATTACHMENT 4 REQUIREMENTS

Health Equity Methodology

- ❑ Stratified measure results replace “all-population” measure results for colorectal cancer screening and blood pressure measures
- ❑ Assessment of QTI payments for these measures will be based on performance of stratified eligible subpopulations
- ❑ “Eligible Subpopulation” means the following stratified subpopulations, as defined by the federal Office of Management and Budget (OMB) or Centers for Disease Control (CDC) Race and Ethnicity Code Set, with at least 100 self-reported members in the denominator: American Indian or Alaska Native, Asian, Black or African American, Hispanic or Latino, Native Hawaiian or Other Pacific Islander, and White. Eligible Subpopulation shall also include Multirace, used when an individual reports two or more CDC codes that cross higher OMB concepts
- ❑ “All Other Members” means pooled results from members of the following subpopulations, as defined by OMB or CDC: Other Race, or Unknown, used when an individual has not reported race or ethnicity or where data is missing or inaccurate. All Other Members shall also include pooled results from members of subpopulations that would be Eligible Subpopulations but have fewer than 100 identified enrollees in the denominator.

PROPOSED 2026-28 ATTACHMENT 4 CHANGES

Attachment 4

Notable Changes to January Draft Attachment 4	Rationale
QTI Scored and Reporting-Only Measure Sets No changes proposed	
Race and Ethnicity Stratification and Methodology No changes proposed	
Benchmarks and QTI Payments No changes proposed	
QTI Performance Report No changes proposed	

PLAN PERFORMANCE REPORT
RELEASE YEAR 2024

Dr. Barbara Rubino & Chelsea Hart-Connor

GUIDING PRINCIPLES FOR PLAN PERFORMANCE REPORT RELEASED IN 2024

CHANGES FOR PPR RELEASED IN 2024

What we continued to do:

- Publish QHP-level QRS measure performance
- Publish select QHP-level measures extracted from HEI, stratified by race and ethnicity
- Publish plan-reported data via template submissions & cert app on contract compliance

What changed:

- **Phased release** of results as data became available throughout the year
- Additional **measures** and **stratifications**
  - All population results
  - New measures on utilization, behavioral health, and telehealth
  - Stratified results by race or ethnicity subpopulation, income, language, and geography
- Application of **statistical testing** to highlight disparities with statistical significance
- User-centered **formatting** and readability
  - Summative visuals
  - Key findings slides
  - Accompanying executive summary documents

PLAN PERFORMANCE REPORT: HEI ENHANCEMENTS

Release Year 2023 Measures

- Adult Preventive Visits
- Ambulatory Emergency Room Visits
- Breast Cancer Screening
- Diabetes Hemoglobin A1c Testing
- Proportion of Days Covered

&

Additional Release Year 2024 Measures

- Pharmacotherapy for Opioid Use Disorder (POD)
- Concurrent Use of Opioids and Benzodiazepines (COB)
- Use of High Dose Opioids (HDO)
- Primary Care Visits / 1000
- Behavioral Health Visits / 1000
- PC Telehealth Visits / 1000
- BH Telehealth Visits / 1000
- Non-utilization of care

*Stratified by...

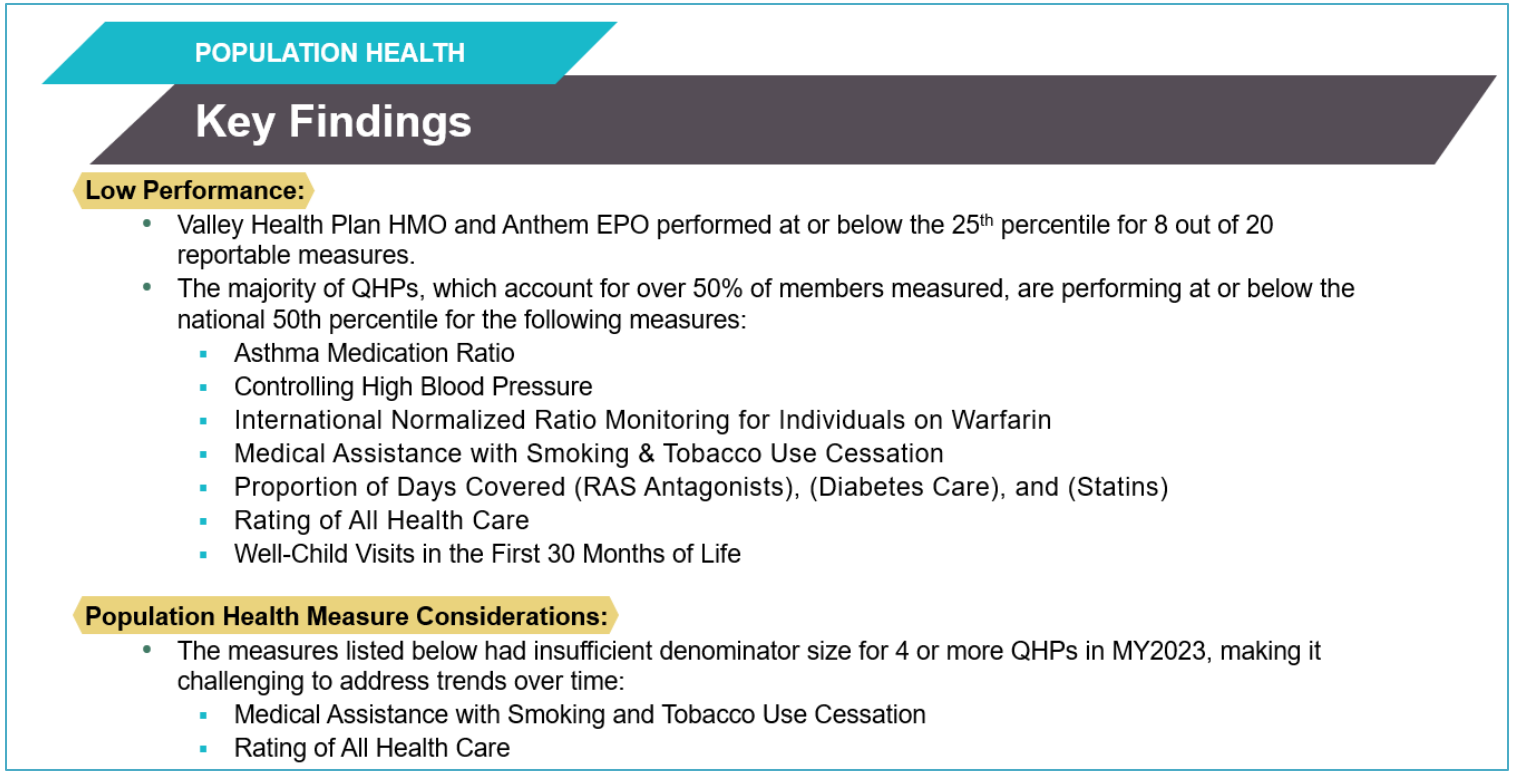
- Race and ethnicity
- Subpopulation for Asian American, Hispanic-Latino
- Preferred Language
- Income (FPL band)
- Geography

*Measures will be stratified if denominator for each category >=30 and numerator >=11 to ensure privacy of enrollees

PLAN PERFORMANCE REPORT: QRS ENHANCEMENTS

"Key Findings" slides:

- ❑ Available throughout each section of the QRS PPR reports
- ❑ Summarize data for a large set of slides to highlight high and low performance
- ❑ Call attention to major trends or YoY changes



POPULATION HEALTH

Key Findings

Low Performance:

- Valley Health Plan HMO and Anthem EPO performed at or below the 25th percentile for 8 out of 20 reportable measures.
- The majority of QHPs, which account for over 50% of members measured, are performing at or below the national 50th percentile for the following measures:
  - Asthma Medication Ratio
  - Controlling High Blood Pressure
  - International Normalized Ratio Monitoring for Individuals on Warfarin
  - Medical Assistance with Smoking & Tobacco Use Cessation
  - Proportion of Days Covered (RAS Antagonists), (Diabetes Care), and (Statins)
  - Rating of All Health Care
  - Well-Child Visits in the First 30 Months of Life

Population Health Measure Considerations:

- The measures listed below had insufficient denominator size for 4 or more QHPs in MY2023, making it challenging to address trends over time:
  - Medical Assistance with Smoking and Tobacco Use Cessation
  - Rating of All Health Care

PRIMARY CARE

CHILD AND ADOLESCENT WELL-CARE VISITS

HEI

ALL POPULATION PERFORMANCE

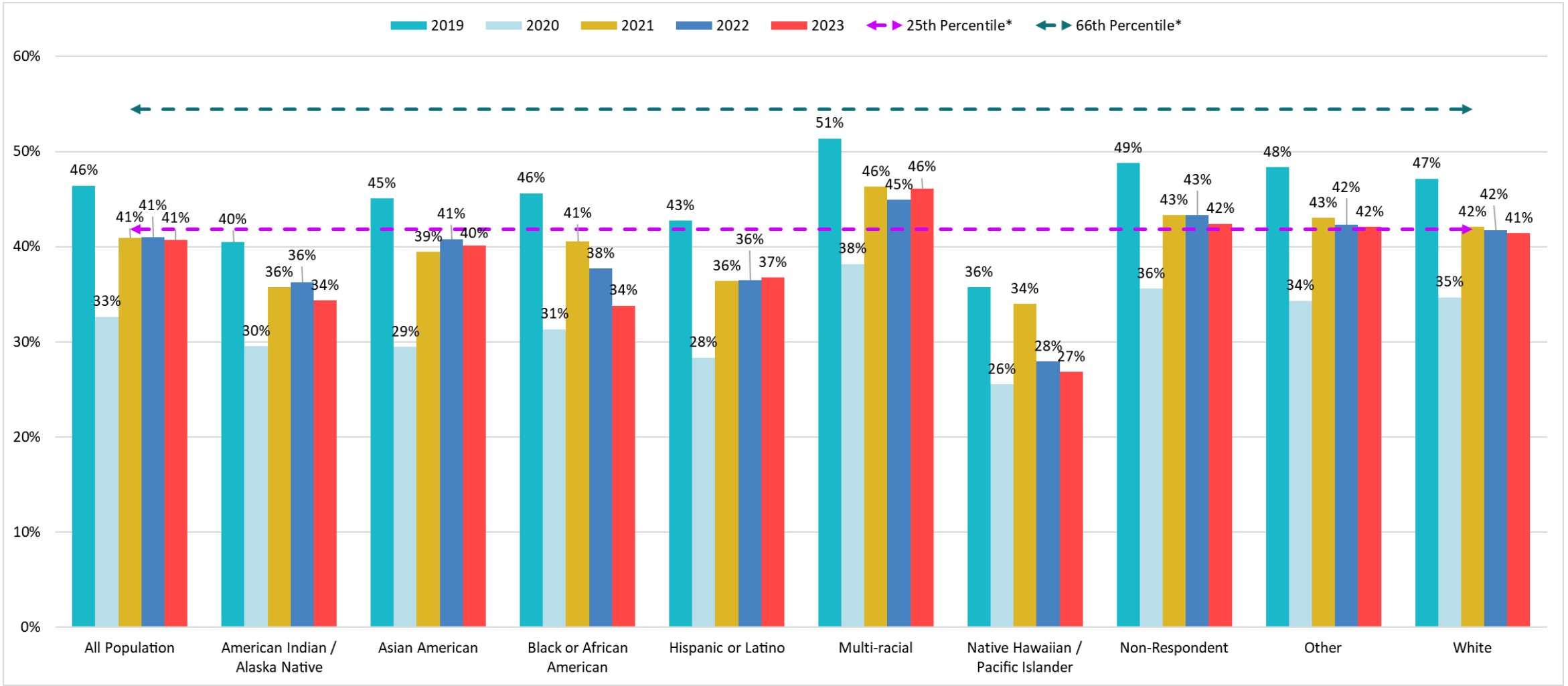
Child and Adolescent Well-Care Visits Summary

- **Definition**: The Child and Adolescent Well-Care Visit measure is the percentage of members, 3-21 years of age, who had at least one comprehensive well-care visit with a primary care or an OB/GYN practitioner during the year.
- **Key Findings**:
  - Overall rates of Child and Adolescent Well-Care Visits decreased between 2019 and 2020 likely due to the COVID-19 pandemic and in 2021-2023 remain steady and below pre-pandemic levels.
  - Stratification by rural versus urban geography revealed persistently lower rates of Well-Care Visits for members living in rural zip codes as compared with those living in urban zip codes in 2019-2023, with a notably significant 5% to 10% rate percentage point difference each year.
  - Stratification by race/ethnicity, income, and language preference did not result in persistent statistically significant differences in the rates of Well-Care Visits from 2019-2023, except in select years as noted below.
    - In 2021-2022, members identifying with Multiple Asian Races exhibited statistically significant higher rates of Well Care Visits compared to other Asian American subpopulations.
    - In 2020-2021, members identifying as Cuban showed statistically significant higher rates of Well Care Visits than those in other Hispanic/Latino subpopulations.

HEI

ALL POPULATION PERFORMANCE

Child and Adolescent Well-Care Visits Trend Over Time



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** QRS National percentile figures for MY2022 indicated as follows: 66th percentile at 0.54 and 25th percentile at 0.42.*

HEI

ALL POPULATION PERFORMANCE

Child and Adolescent Well-Care Visits with Other Stratifications

Language	2019	2020	2021	2022	2023
All Population	**46%**	**33%**	**41%**	**41%**	**41%**
Arabic	21%	28%	36%		34%
Armenian	44%	38%	29%	45%	33%
Cantonese	35%	24%	33%	32%	36%
English	47%	33%	42%	42%	41%
Farsi	52%	25%	38%	33%	
Korean	36%	29%	31%	31%	30%
Mandarin	41%	26%	38%	40%	39%
Russian	38%	19%	28%	30%	31%
Spanish	38%	25%	32%	32%	31%
Tagalog	38%		43%		
Vietnamese	43%	31%	36%	36%	29%

Income	2019	2020	2021	2022	2023
All Population	**46%**	**33%**	**41%**	**41%**	**41%**
0 to ≤138	40%	29%	35%	34%	34%
>138 to <150	26%	17%	31%	19%	17%
≥150 to <200	25%	16%	20%	20%	18%
≥200 to <250	28%	17%	22%	23%	21%
≥250 to <400	49%	35%	42%	42%	41%
≥400	43%	38%	46%	47%	47%
Unsubsidized	53%	39%	49%	46%	44%

Geography	2019	2020	2021	2022	2023
All Population	**46%**	**33%**	**41%**	**41%**	**41%**
Rural	37%	25%	33%	36%	34%
Urban	47%	33%	41%	41%	41%

Values marked as low rate outliers, based on z-scores or Interquartile Range, are identified with a red box. High rate outliers are identified with a blue circle.
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QHP PERFORMANCE

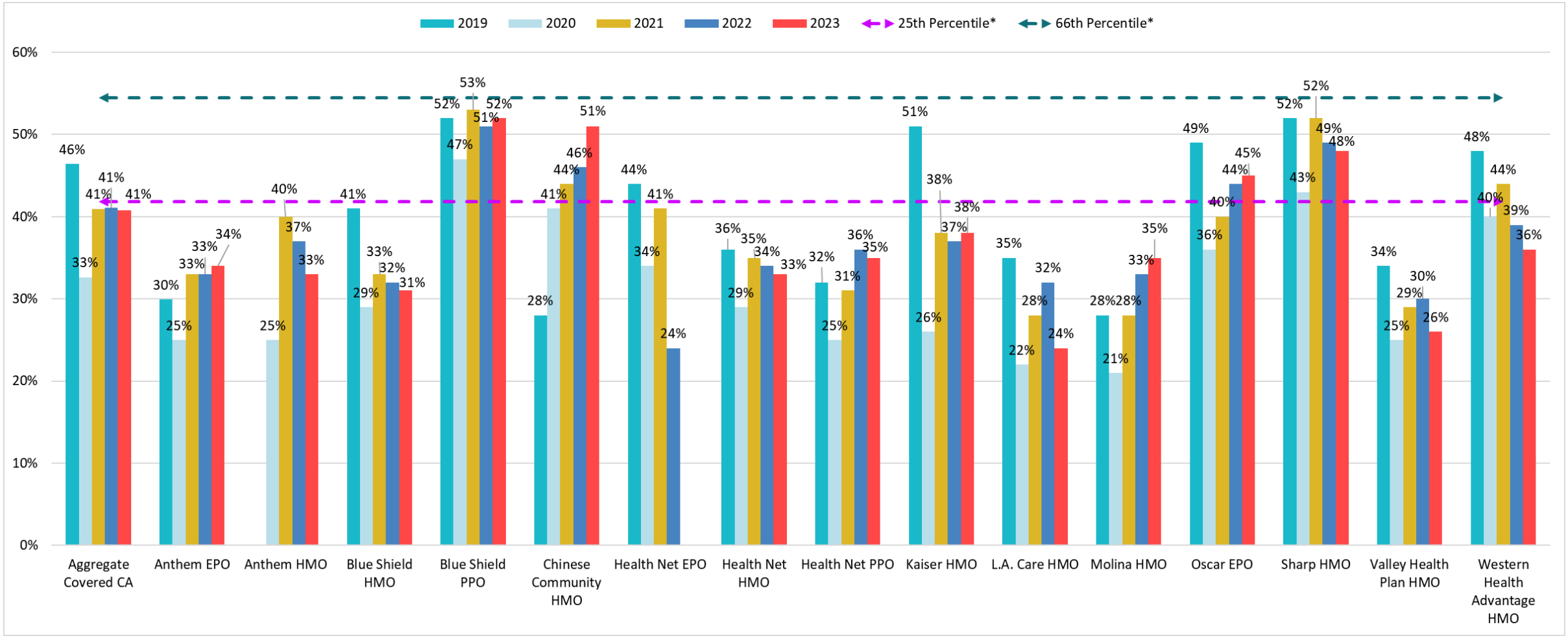
Child and Adolescent Well-Care Visits Summary

- **Definition**: The Child and Adolescent Well Care Visit measure is the percentage of members, aged 3-21 years, who had at least one comprehensive well-care visit with a primary care or an OB/GYN practitioner during the year.
- **Key Findings**:
  - While Blue Shield PPO and Sharp Health Plan HMO consistently have the highest All Population rates of Well Care Visits, and Health Net EPO and Valley Health Plan HMO has the lowest All Population rates, these differences in performance between QHPs are not statistically significant.
  - When stratifying by race/ethnicity, Blue Shield PPO (2022 and 2023) and Sharp HMO (2022) have multiple occurrences of statistically significantly higher Well Care Visit rates for multiple subpopulations as compared to other QHPs.

HEI

QHP PERFORMANCE

Child and Adolescent Well-Care Visits by QHP Over Time



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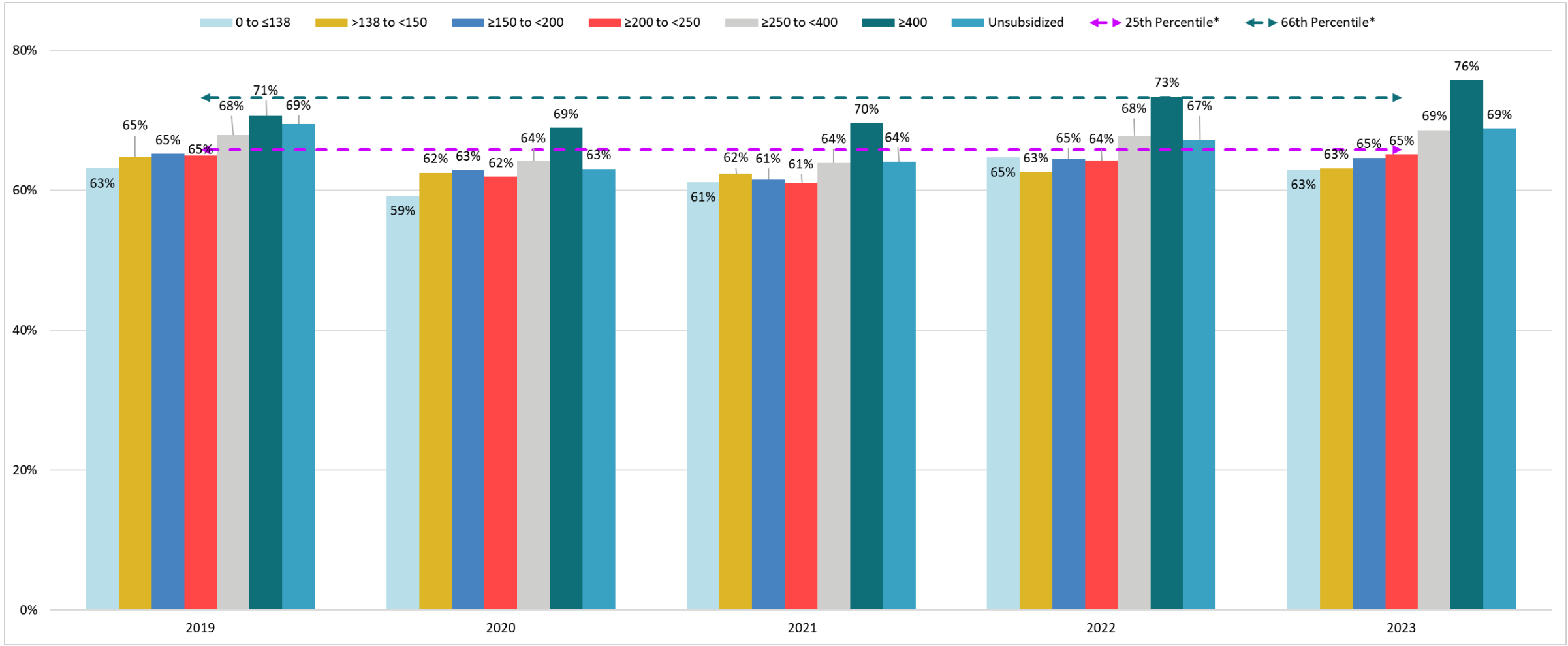
** QRS National percentile figures for MY2022 indicated as follows: 66th percentile at 0.54 and 25th percentile at 0.42.*

BREAST CANCER SCREENING

HEI

ALL POPULATION PERFORMANCE

Breast Cancer Screening by Federal Poverty Level Over Time



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** QRS National percentile figures for MY2022 indicated as follows: 66th percentile at 0.73 and 25th percentile at 0.66.*

HEI

ALL POPULATION PERFORMANCE

Breast Cancer Screening by Race/Ethnicity

Race/Ethnicity	2019	2020	2021	2022	2023
All Population	**66%**	**63%**	**63%**	**66%**	**67%**
American Indian / Alaska Native	65%	59%	59%	66%	66%
Asian American	63%	59%	59%	63%	63%
Black or African American	69%	67%	68%	70%	69%
Hispanic or Latino	69%	67%	65%	68%	68%
Multi-racial	66%	63%	62%	67%	66%
Native Hawaiian / Pacific Islander	68%	64%	61%	65%	67%
Non-Respondent	65%	62%	62%	65%	66%
Other	67%	64%	64%	68%	68%
White	67%	64%	64%	67%	69%

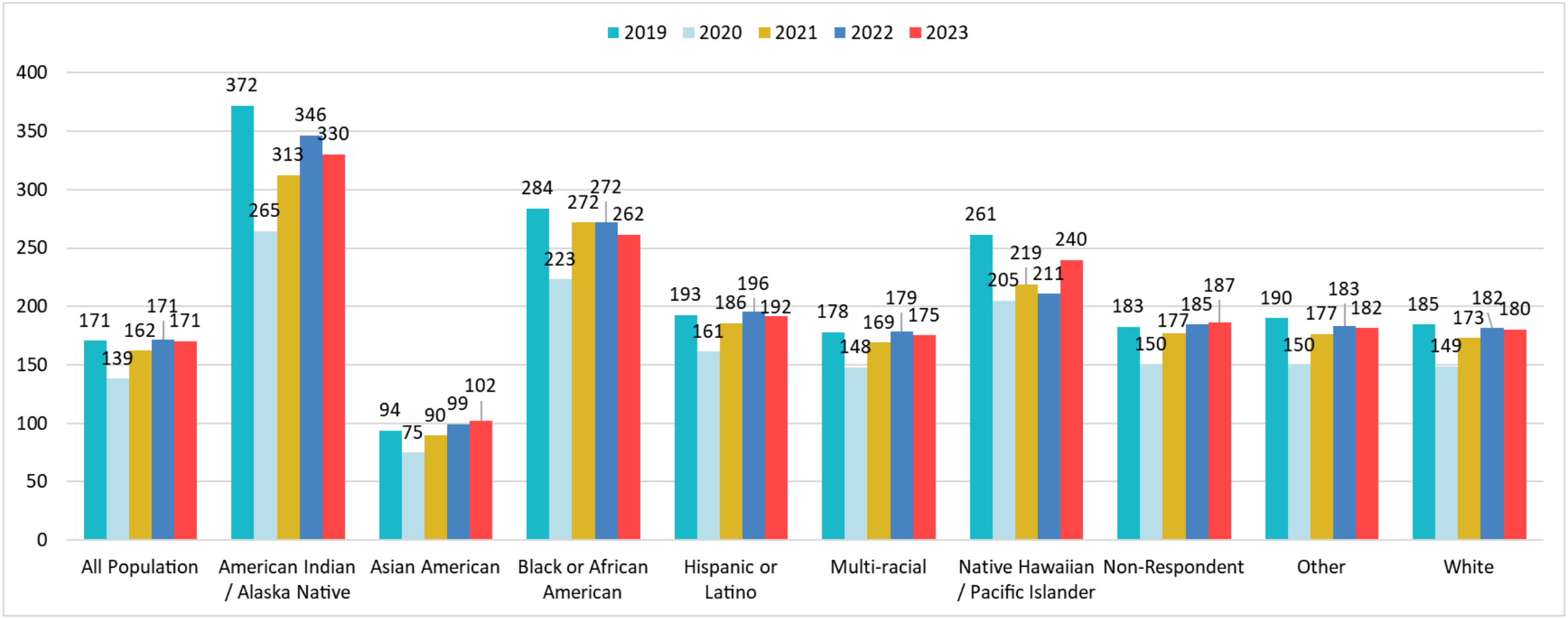
Values marked as low rate outliers, based on z-scores or Interquartile Range, are identified with a red box. High rate outliers are identified with a blue circle.
Blank cells are suppressed data due to counts too low to report.

EMERGENCY ROOM VISITS PER 1,000 MEMBERS

HEI

ALL POPULATION PERFORMANCE

Emergency Room Visits per 1,000 Members by Race/Ethnicity



HEI

ALL POPULATION PERFORMANCE

Emergency Room Visits per 1,000 Members by Race/Ethnicity

Race	2019	2020	2021	2022	2023
All Asian American Population	**94**	**75**	**90**	**99**	**102**
Asian Indian	168	144	172	179	182
Cambodian	107	79	95	101	90
Chinese	71	55	69	80	83
Filipino	133	106	118	126	125
Hmong	147	89	85	103	96
Japanese	75	57	69	74	79
Korean	71	52	62	67	69
Laotian	148	110	160	136	109
Mixed Race	90	73	78	79	80
Other Asian American	93	82	97	107	106
Vietnamese	79	64	70	80	82

Ethnicity	2019	2020	2021	2022	2023
All Hispanic/Latino Population	**193**	**161**	**186**	**196**	**192**
Guatemalan	200	169	195	197	190
Mexican/Mexican American/Chicano	183	156	179	191	190
Other	194	159	184	194	188
Puerto Rican	234	151	214	245	221
Salvadorian	195	170	182	183	182
Cuban	181	135	134	165	163

Values marked as high rate outliers (lower is better measure), based on z-scores or Interquartile Range, are identified with a red box. Lower rate outliers (lower is better) are identified with a blue circle.
Blank cells are suppressed data due to counts too low to report.

BEHAVIORAL HEALTH

BEHAVIORAL HEALTH

Initiation and Engagement of Substance Use Disorder Treatment

	MY 2018	MY 2019	MY 2020	MY 2021	MY 2022			
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	**US Benchmark**	**US Benchmark**	**US Benchmark**	**US Benchmark**	**US Benchmark**	**Percent of Enrollees**	**Number of Enrollees**	**Number of Plans**
Plans at 90th Percentile and Above	31 +	32 +	31 +	31 +	31 +	36%	606,930	1
Plans at 66th to 90th Percentile	25 to <31	26 to <32	26 to <31	25 to <31	28 to <31	36%	610,720	4
Plans at 50th to 66th Percentile	23 to <25	24 to <26	24 to <26	24 to <25	24 to <28	7%	114,750	1
Plans at 25th to 50th Percentile	19 to <23	19 to <24	20 to <24	20 to <24	20 to <24	17%	291,400	4
Plans Below 25th Percentile	Below 19	Below 19	Below 20	Below 20	Below 20	4%	65,780	4
Covered California Plan-Specific Performance	**MY 2018**	**MY 2019**	**MY 2020**	**MY 2021**	**MY 2022**			
Anthem HMO				27	29	5%	79,750	
Anthem EPO	22	18	18	19	20	5%	79,160	
Blue Shield HMO	26	25	25	22	29	8%	137,400	
Blue Shield PPO	26	26	26	25	30	21%	354,470	
CCHP HMO	22				18	<1%	3,540	
Health Net HMO	20	19	19	21	23	6%	97,350	
Health Net EPO						<1%	520	
Health Net PPO		24	24	29	31	2%	39,100	
Kaiser Permanente HMO	38	42	42	35	35	36%	606,930	
LA Care HMO	27	34	34	29	24	7%	114,750	
Molina Healthcare HMO	17	19	19	24	22	4%	64,840	
Oscar Health Plan EPO	45	20	20	18	22	3%	50,050	
Sharp Health Plan HMO	17	16	16	18	18	2%	32,110	
Valley Health Plan HMO	18	12	12	17	14	1%	20,570	
Western Health Advantage HMO	16	11	11	17	13	1%	9,560	

- **Measure Description:** The Initiation and Engagement of Substance Use Disorder Treatment measure, is the percentage of members,13 years of age and older, with a substance use disorder, who got behavioral health follow-up care at several points after being diagnosed.
- **Notable Trend:** From MY2021 to MY2022, the number of plans performing at or above the 66th percentile remained consistent at 5.
- **High Performance:** In MY2022, 5 out 14 plans products scored at or above the 66th percentile of national performance. These QHPs account for 72% of the measured population.
- **Low Performance:** In MY2022, 8 out of 14 plan products scored below the 50th percentile of national performance. These QHPs account for 21% of the measured population.

COVERED CALIFORNIA

Note: *Blank cells are suppressed data due to counts too low to report.*

ALL POPULATION PERFORMANCE

Behavioral Health Visits per 1,000 Members with Other Stratifications

Language	2019	2020	2021	2022	2023
All Population	**528**	**514**	**614**	**667**	**732**
Arabic	45	30	80	115	176
Armenian	137	78	87	87	154
Cambodian	53	47	17	57	65
Cantonese	47	50	63	65	54
English	650	628	742	800	877
Hindi					70
Farsi	298	352	374	496	439
Hmong					65
Korean	44	43	55	62	43
Mandarin	48	41	56	57	55
Punjabi			200	298	131
Russian	143	133	131	114	110
Spanish	88	88	102	106	108
Tagalog	31	38	48	85	90
Vietnamese	24	23	46	47	39

Income	2019	2020	2021	2022	2023
All Population	**528**	**514**	**614**	**667**	**732**
0 to ≤138	743	707	813	773	773
>138 to <150	688	643	739	777	871
≥150 to <200	525	532	635	698	730
≥200 to <250	403	409	481	539	589
≥250 to <400	410	401	484	550	628
≥400	4268	534	622	711	799
Unsubsidized	677	691	843	973	1053

Geography	2019	2020	2021	2022	2023
All Population	**528**	**514**	**614**	**667**	**732**
Rural	395	399	428	474	504
Urban	535	519	624	677	745

COVERED CALIFORNIA

Values marked as low rate outliers, based on z-scores or Interquartile Range, are identified with a red box. High rate outliers are identified with a blue circle.
Blank cells are suppressed data due to counts too low to report.
Some notably high values were not highlighted due to a low denominator, affecting their reliability.

HEI

ALL POPULATION PERFORMANCE

Behavioral Health Care Through Telehealth with Other Stratifications

Language	2019	2020	2021	2022	2023
All Population	**4%**	**62%**	**78%**	**76%**	**75%**
Arabic		75%	74%	70%	87%
Armenian		72%	92%	62%	86%
Cambodian		50%		57%	64%
Cantonese	5%	70%	78%	67%	72%
English	4%	62%	78%	76%	75%
Farsi	4%	62%	69%	63%	64%
Hindi					93%
Hmong					
Korean	3%	51%	73%	65%	84%
Mandarin	3%	66%	79%	70%	68%
Punjabi			84%	87%	92%
Russian		60%	81%	82%	80%
Spanish	4%	65%	80%	74%	71%
Tagalog		76%	89%	78%	88%
Vietnamese	5%	58%	82%	77%	75%

Income	2019	2020	2021	2022	2023
All Population	**4%**	**62%**	**78%**	**76%**	**75%**
0 to ≤138	4%	58%	80%	79%	77%
>138 to <150	3%	60%	78%	75%	74%
≥150 to <200	4%	63%	80%	78%	77%
≥200 to <250	5%	64%	79%	78%	76%
≥250 to <400	4%	65%	79%	77%	77%
≥400	5%	62%	77%	75%	74%
Unsubsidized	4%	57%	74%	70%	72%

Geography	2019	2020	2021	2022	2023
All Population	**4%**	**62%**	**78%**	**76%**	**75%**
Rural	5%	58%	69%	66%	65%
Urban	4%	62%	79%	77%	76%

COVERED CALIFORNIA

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POPULATION HEALTH

EQUITY & DISPARITIES REDUCTION

NCQA Health Equity Accreditation

	2020	2021	2022	2023
Anthem	✗	✗	✓	✓
Blue Shield	✗	✗	✓	✓
Chinese Community	✗	✗	✗	✗
Health Net	✓	✓	✓	✓
Kaiser Permanente – North	✗	✗	✗	✓
Kaiser Permanente – South	✓	✓	✓	✓
LA Care	✓	✓	✓	✓
Molina Healthcare	✓	✓	✓	✓
Oscar Health Plan	✗	✗	✓	✓
Sharp Health Plan	✗	✗	✗	✓
Valley Health Plan	✗	✗	✗	✓
Western Health Advantage	✗	✗	✓	✓

- NCQA transitioned the Multicultural Health Care Distinction to Health Equity Accreditation as of 2022
- This accreditation recognizes efforts around demographic data collection, culturally competent care and reducing health disparities
- This accreditation was not contractually required until 2023
- “Not Offered” indicates that the carrier did not offer that plan product to consumers during the plan year

No penalties were assessed for QHP Issuers for MY 2023

DATA SHARING

DATA SHARING & EXCHANGE

Participation in Health Information Exchanges (HIEs)

Health plans are required to actively participate in Health Information Exchanges (HIEs) within the California Trusted Exchange Network (CTEN), engage in bi-directional data exchanges with these HIEs, report on specific data exchange activities, collaborate on statewide data exchange strategies, and support hospitals in meeting CMS interoperability requirements.

Key reasons why it is important for health plans to adhere to these data exchange requirements include:

- **Improving Patient Care and Health Outcomes**: Efficient and effective data exchange enables better population health management, clinical care coordination, and personalized patient care, leading to improved health outcomes. Sharing data among all stakeholders in healthcare ensures that providers have access to the full picture of a patient's health, allowing for more informed decision-making and proactive management of health conditions.

- **Enhancing Healthcare Efficiency and Reducing Costs**: By streamlining the data sharing process and reducing reliance on paper-based systems, healthcare costs can be significantly lowered. This includes not only the direct costs associated with healthcare delivery but also the indirect costs such as those related to administrative overhead and time spent coordinating care across different providers. Efficient data exchange can reduce duplicate tests and procedures, saving both time and resources.

- **Promoting Equity and Access in Healthcare**: The contract highlights the importance of data exchange initiatives that specifically aim to enhance health equity and access. By capturing enhanced demographic and social risk factor data, health plans can better identify and address disparities in healthcare access and outcomes. This focus on equity ensures that all populations, particularly those historically underserved or at risk, receive the care and resources necessary to achieve optimal health.

PPR

DATA SHARING & EXCHANGE

Participation in Health Information Exchanges (HIEs)

	Aetna	Anthem	Blue Shield	CCHP	Health Net	Kaiser	LA Care	Molina	Sharp	Valley	WHA
Percent and Number of Network Hospitals Sending ADT Alerts	95% Hospitals	38% Hospitals	75% Hospitals	93% Hospitals	82% Hospitals	100% Hospitals	71% Hospitals	39% Hospitals	100% Hospitals	25% Hospitals	100% Hospitals
	Not Provided	97 Hospitals	285 Hospitals	13 Hospitals	147 Hospitals	37 Hospitals	52 Hospitals	47 Hospital	7 Hospitals	3 Hospitals	15 Hospitals
Issuer Participation in HIEs	*^Manifest MedEx	*^Manifest MedEx *^SacValley MedShare	*^Manifest MedEx	^Cozeva	*^Manifest MedEx *^Los Angeles Network for Enhanced Services *^San Diego Health Connect *^SacValley MedShare ^Cozeva Point Click Care	*^Manifest MedEx *^Orange County Partnership *^San Diego Health Connect *Santa Cruz Providence HIE	*^Los Angeles Network for Enhanced Services eConnect Point Click Care	*^Los Angeles Network for Enhanced Services *^San Diego Health Connect Point Click Care Riverside University Health System Loma Linda University Medical Center	*^San Diego Health Connect California Immunization Registry	None	None

COVERED CALIFORNIA

** indicates CTEN HIE*
^ indicates QHIO status

PY2026 CA ENHANCED COST SHARING PROGRAM AND ENHANCED BENEFIT DESIGNS

PY2026 BENEFIT DESIGNS AND CA ENHANCED COST-SHARING REDUCTION PROGRAM

- At the January Board Meeting, Covered California proposed ACA-Compliant Standard Benefit Designs for Plan Year 2026 and will request Board action on these designs at the February Board Meeting next week
- We will also introduce the Plan Year 2026 California Enhanced Cost- Sharing Reduction Program, including the Plan Year 2026 Enhanced Benefit Designs
  - Covered California proposes to maintain the parameters of the PY2025 program, including enhancing all silver enrollees without income eligibility restrictions
  - The enhanced designs will be held steady from the PY2025 program, including:
  - Eliminating all deductibles, prioritizing lowering generic drug costs, and lowering office copays and Maximum Out of Pocket amounts, among other enhancements
  - PMPM amounts will be updated in the Program Documents to reflect changes in the from 2025 to 2026 baseline benefit designs

2026 ENHANCED BENEFIT DESIGNS

Benefit	Individual-only Silver		Silver 73		CA Enhanced CSR Silver 73		Silver 87		CA Enhanced CSR Silver 87		Silver 94		CA Enhanced CSR Silver 94	
	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount
Deductible														
Medical Deductible		$5,200		$5,200		$0		$1,400		$0		$0		$0
Drug Deductible		$50		$50		$0		$50		$0		$0		$0
Coinsurance (Member)		30%		30%		30%		20%		20%		10%		10%
MOOP		$9,800		$8,100		$6,100		$3,350		$3,000		$1,400		$1,150
ED Facility Fee		$400		$400		$350		$200		$150		$50		$50
Inpatient Facility Fee	X	30%	X	30%		30%	X	20%		20%		10%		10%
Inpatient Physician Fee		30%		30%		30%		20%		20%		10%		10%
Primary Care Visit		$50		$50		$35		$15		$15		$5		$5
Specialist Visit		$90		$90		$85		$25		$25		$8		$8
MH/SU Outpatient Services		$50		$50		$35		$15		$15		$5		$5
Imaging (CT/PET Scans, MRIs)		$325		$325		$325		$100		$100		$50		$50
Speech Therapy		$50		$50		$35		$15		$15		$5		$5
Occupational and Physical Therapy		$50		$50		$35		$15		$15		$5		$5
Laboratory Services		$50		$50		$50		$30		$20		$10		$8
X-rays and Diagnostic Imaging		$95		$95		$95		$50		$40		$10		$8
Skilled Nursing Facility	X	30%	X	30%		30%	X	20%		20%		10%		10%
Outpatient Facility Fee		30%		30%		30%		20%		20%		10%		10%
Outpatient Physician Fee		30%		30%		30%		20%		20%		10%		10%
Tier 1 (Generics)		$19		$19		$15		$8		$5		$3		$3
Tier 2 (Preferred Brand)	X	$60	X	$55		$55	X	$25		$25		$10		$10
Tier 3 (Nonpreferred Brand)	X	$90	X	$85		$85	X	$45		$45		$15		$15
Tier 4 (Specialty)	X	20%	X	20%		20%	X	15%		15%		10%		10%
Tier 4 Maximum Coinsurance	$250		$250		$250		$150		$150		$150		$150	
Actuarial Value														
2026 AV (Final 2026 AVC)	**71.66**		**73.69**		**80.37**		**87.80**		**89.60**		**94.81**		**95.39**	

KEY		
	X	Subject to deductible
	*	Drug cap applies to all drug tiers
	†	Additive adjustment (included in AV)
		Increased member cost from 2025
		Decreased member cost from 2025
		Enhanced member cost from 2026
		Within .5 of upper de minimis
		Securely within AV

2026 PATIENT-CENTERED BENEFIT DESIGNS

Benefit	Individual-only Platinum Coinsurance		Individual-only Platinum Copay		Individual-only Gold Coinsurance		Individual-only Gold Copay		Individual-only Silver		Silver 73		CA Enhanced CSR Silver 73		Silver 87		CA Enhanced CSR Silver 87		Silver 94		CA Enhanced CSR Silver 94		Bronze		Bronze HDHP	
	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount
Deductible																										$7,200
Medical Deductible										$5,200		$5,200		$0		$1,400		$0		$0		$0		$5,800		
Drug Deductible										$50		$50		$0		$50		$0		$0		$0		$450		
Coinsurance (Member)		10%		10%		20%		20%		30%		30%		30%		20%		20%		10%		10%		40%		0%
MOOP		$5,000		$5,000		$9,200		$9,200		$9,800		$8,100		$6,100		$3,350		$3,000		$1,400		$1,150		$9,800		$7,200
ED Facility Fee		$175		$175		$350		$350		$400		$400		$350		$200		$150		$50		$50	X	40%	X	0%
Inpatient Facility Fee		10%		$225		30%		$375	X	30%	X	30%		30%	X	20%		20%		10%		10%	X	40%	X	0%
Inpatient Physician Fee		10%		---		30%		---		30%		30%		30%		20%		20%		10%		10%	X	40%	X	0%
Primary Care Visit		$15		$15		$40		$40		$50		$50		$35		$15		$15		$5		$5		$60	X	0%
Specialist Visit		$30		$30		$70		$70		$90		$90		$85		$25		$25		$8		$8	X	$95	X	0%
MH/SU Outpatient Services		$15		$15		$40		$40		$50		$50		$35		$15		$15		$5		$5		$60	X	0%
Imaging (CT/PET Scans, MRIs)		10%		$75		25%		$75		$325		$325		$325		$100		$100		$50		$50	X	40%	X	0%
Speech Therapy		$15		$15		$40		$40		$50		$50		$35		$15		$15		$5		$5		$60	X	0%
Occupational and Physical Therapy		$15		$15		$40		$40		$50		$50		$35		$15		$15		$5		$5		$60	X	0%
Laboratory Services		$15		$15		$40		$40		$50		$50		$50		$30		$20		$10		$8		$50	X	0%
X-rays and Diagnostic Imaging		$30		$30		$75		$75		$95		$95		$95		$50		$40		$10		$8	X	40%	X	0%
Skilled Nursing Facility		10%		$125		30%		$150	X	30%	X	30%		30%	X	20%		20%		10%		10%	X	40%	X	0%
Outpatient Facility Fee		10%		$75		30%		$130		30%		30%		30%		20%		20%		10%		10%	X	40%	X	0%
Outpatient Physician Fee		10%		$20		30%		$60		30%		30%		30%		20%		20%		10%		10%	X	40%	X	0%
Tier 1 (Generics)		$9		$9		$18		$18		$19		$19		$15		$8		$5		$3		$3		$20	X	0%
Tier 2 (Preferred Brand)		$16		$16		$60		$60	X	$60	X	$55		$55	X	$25		$25		$10		$10	X	40%	X	0%
Tier 3 (Nonpreferred Brand)		$25		$25		$85		$85	X	$90	X	$85		$85	X	$45		$45		$15		$15	X	40%	X	0%
Tier 4 (Specialty)		10%		10%		20%		20%	X	20%	X	20%		20%	X	15%		15%		10%		10%	X	40%	X	0%
Tier 4 Maximum Coinsurance		$250		$250		$250		$250		$250		$250		$250		$150		$150		$150		$150		$500*		
Maximum Days for charging IP copay				5																						
Begin Specialist deductible after # of copays																								3		
Actuarial Value																										
2026 AV (Final 2026 AVC)		**91.92**		**91.76**		**81.39**		**81.73**		**71.66**		**73.69**		**80.37**		**87.80**		**89.60**		**94.81**		**95.39**		**63.49**		**64.76**

KEY		
	X	Subject to deductible
	*	Drug cap applies to all drug tiers
	†	Additive adjustment (included in AV)
		Increased member cost from 2025
		Decreased member cost from 2025
		Enhanced member cost from 2026
		Within .5 of upper de minimis
		Securely within AV