

ATTACHMENT 1 TO COVERED CALIFORNIA 2023-2025 INDIVIDUAL MARKET QHP ISSUER CONTRACT: ADVANCING EQUITY, QUALITY, AND VALUE

The mission of Covered California is to increase the number of insured Californians, improve healthcare quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value.

Health Insurance Issuers contracting with Covered California to offer Qualified Health Plans (QHPs) are integral to Covered California's ability to achieve its mission of improving the quality, equity, and value of healthcare services available to Enrollees. QHP Issuers have the responsibility to work with Covered California to support models of care that promote the vision of the Affordable Care Act and meet Enrollee needs and expectations.

Given the unique role of Covered California and QHP Issuers in the State's healthcare ecosystem, Contractor is expected to contribute to broadscale efforts to improve the delivery system and health outcomes in California. For there to be a meaningful impact on overall healthcare cost, equity, and quality, solutions and successes need to be sustainable, scalable, and must expand beyond local markets or specific groups of individuals. This will require both Covered California and Contractor to coordinate with and promote alignment with other purchasers and payers, and strategically partner with organizations dedicated to delivering better quality, more equitable care, at higher value. In addition, QHP Issuers shall collaborate with and support their contracted providers in continuous quality and value improvement, which will benefit both Covered California Enrollees and the QHP Issuer's entire California membership.

Covered California is committed to balancing the need for QHP Issuer accountability with reducing the administrative burden of Attachment 1 by intentionally aligning requirements with other major purchasers, accreditation organizations, and regulatory agencies. In the same spirit, Covered California expects all QHP Issuers to streamline requirements and reduce administrative burden on providers as much as possible.

This Attachment 1 is focused on key areas that Covered California believes require systematic focus and investment in order to ensure its Enrollees and all Californians receive high-quality, equitable care.

By entering into this Agreement, Contractor affirms its commitment to be an active and engaged partner with Covered California, and agrees to work collaboratively with Covered California to develop and implement policies and programs that will promote quality and health equity, and lower costs for Contractor's entire California membership.

The Contractor shall comply with the requirements in this Attachment 1 by January 1, 2023, unless otherwise specified.

Contractor must complete and submit information, including reports, plans, and data, as described in this Attachment 1 annually at a time and in a manner determined by Covered California unless otherwise specified. Information will be used to assess compliance with requirements, evaluate performance, and for negotiation and evaluation purposes regarding any extension of this Agreement. When submitting its information to Covered California, Contractor shall clearly identify any information it deems confidential, a trade secret, or proprietary. Contractor agrees to engage and work with Covered California to review its performance and discuss health equity initiatives, quality improvement, and delivery system strategies for all requirements, required reports, or data submissions.

Covered California will use Healthcare Evidence Initiative (HEI) data and measures to monitor Contractor performance and evaluate HEI measures' effectiveness in assessing Contractor performance. Contractor agrees to engage and work with Covered California to review its performance on all HEI measures, not only those measures specifically described in this Attachment 1. Contractor agrees to meet with Covered California at least twice a year to review its performance on HEI analysis. Based on these reviews, Covered California may revise the HEI measures during the contract period or in future contract years.

Contractor shall submit all required information as defined in Attachment 1 and listed in the annual "Contract Reporting Requirements" table found on Covered California's Extranet site (Hub page, PMD Resources library, Contract Reporting Compliance folder).

Covered California will use information on cost, quality, and health disparities provided by Contractor to evaluate and publicly report both QHP Issuer performance and its impact on the healthcare delivery system and health coverage in California.

ARTICLE 1 - EQUITY AND DISPARITIES REDUCTION

The Institute of Medicine defines health equity as “providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.” Healthy People 2020 defines disparities as “a particular type of health difference that is closely linked with social, economic and/or environmental disadvantage.” Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.

Addressing health equity and disparities in healthcare is integral to the mission of Covered California. In order to have impactful and meaningful change, Covered California and Contractor recognize that addressing health disparities requires alignment, commitment, focus, and accountability.

1.01 Demographic Data Collection

Collection of accurate and complete member demographic data is critical to effective measurement and reduction of health disparities.

1.01.1 Expanded Demographic Data Collection

Contractor shall work with Covered California to expand the disparity identification and improvement requirements in this article. Covered California intends to proceed with measures stratification by income for disparities identification and monitoring purposes. Other areas for consideration include:

- 1) Disability status
- 2) Sexual orientation
- 3) Gender identity

1.01.2 Race, Ethnicity, and Language Data Collection

1) Race and Ethnicity Data Collection

- a) If Contractor was contracted with Covered California in Plan Year 2023, Contractor must collect self-identified race and ethnicity data for at least eighty percent (80%) of its Covered California Enrollees. Contractor must demonstrate compliance by including a valid Covered California Enrollee self-identified race and ethnicity attribute for at least 80% of its Covered California Enrollees in its Healthcare Evidence Initiative (HEI) data submissions.
- b) If Contractor was first contracted with Covered California in 2024, Contractor must collect self-identified race and ethnicity data for at least eighty percent (80%) of its Covered California Enrollees by Plan Year 2025 and in accordance with the schedule below. Contractor must demonstrate compliance by including a valid Covered California Enrollee self-identified race and ethnicity attribute for its Covered California Enrollees in its HEI data submissions.

Contractor must meet the following schedule:

- i. For Plan Year 2024, Contractor must submit valid Covered California Enrollee self-identified race and ethnicity attributes in its HEI data submissions.
- ii. For Plan Year 2025, Contractor must submit valid Covered California Enrollee self-identified race and ethnicity attributes in its HEI data submissions for at least eighty percent (80%) of its Covered California Enrollees.
- c) If Contractor is first contracted with Covered California in 2025, Contractor must collect self-identified race and ethnicity data for its Covered California Enrollees. Contractor must demonstrate compliance by including a valid Covered California Enrollee self-identified race and ethnicity attribute for its Covered California Enrollees in its HEI data submissions.

2) Preferred Spoken and Written Language Data Collection

Contractor must collect data on Covered California Enrollees' preferred spoken and written languages and submit that data in its HEI submissions to ensure effective communication with providers and timely access to healthcare services.

If Contractor was contracted with Covered California as of Plan Year 2023, Contractor must collect written or spoken language preferences for a minimum of eighty percent (80%) of its Covered California Enrollees by year end 2025. Covered California will negotiate an interim performance target for 2024 based on 2023 baseline performance.

If Contractor was first contracted with Covered California in Plan Year 2024, Contractor will meet a negotiated interim performance target for 2025 based on 2024 baseline performance.

If Contractor was first contracted with Covered California in Plan Year 2025, Contractor must collect data on Covered California Enrollees' preferred spoken and written languages and submit that data in its HEI submissions. Covered California will use Plan Year 2025 performance will be used to establish baseline performance and inform a negotiated interim performance target effective in Plan Year 2026.

1.02 Identifying Disparities in Care

Covered California recognizes that the underlying causes of health disparities are multifactorial and include social and economic factors that impact health. While the healthcare system cannot single handedly eliminate health disparities, there is evidence to show that when disparities are identified and addressed in the context of healthcare, they can be reduced over time through activities tailored to specific populations and targeting select measures. Therefore, Covered California is requiring Contractor to regularly collect data and report on its Covered California Enrollees as specified in this article to identify disparities, measure disparities over time, and develop disparity reduction efforts and targets to be determined by Covered California and Contractor. As Covered California transitions to expanded use of the HEI data to assess improvements in healthcare quality and equity, Covered California expects that certain measures previously submitted by Contractor for disparities monitoring will be generated using HEI data and stratified by demographic factors.

1.02.1 Monitoring Disparities: Patient Level Data File

Contractor must submit the following Healthcare Effectiveness Data and Information Set (HEDIS) measure patient level data files for its Covered California Enrollees:

- 1) Controlling High Blood Pressure (NQF #0018)
- 2) Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%) (NQF #0575)
- 3) Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (NQF #0059)
- 4) Colorectal Cancer Screening (NQF #0034)
- 5) Childhood Immunization Status (Combo 10) (NQF #0038)
- 6) Depression Screening & Follow-Up for Adolescents & Adults (DSF)
- 7) Pharmacotherapy for Opioid Use Disorder (POD)
- 8) Prenatal Depression Screening and Follow-up (PND-E)
- 9) Postnatal Depression Screening and Follow-up (PDS-E)
- 10) Prenatal and Postpartum Care (PPC) (NQF #1517)
- 11) Social Need Screening and Intervention (SNS-E)

Contractor must submit a patient level data file that includes a unique person identifier as specified by Covered California and valid race and ethnicity attributes for each person in the denominator. Contractor must also submit numerator and denominator totals and rates at the summary level.

Covered California will modify the measures set over time, with stakeholder input, to track disparities in care and health outcomes in additional areas, including behavioral health. Covered California will work with public purchaser partners to assess and monitor disparities across enrolled populations.

1.02.2 Monitoring Disparities: Healthcare Evidence Initiative

Contractor agrees to engage and work with Covered California to review its performance on the disparities measures using HEI data, submitted in accordance with Article 5.02.1, including the measures listed in this section.

- 1) Ambulatory Emergency Room (ER) Visits[©] per 1,000
- 2) Breast Cancer Screening (BCS) (NQF #2372)
- 3) Child and Adolescent Well-Care Visits (WCV)
- 4) Proportion of Days Covered: Three Rates by Therapeutic Category (NQF #0541)
 - a) Diabetes All Class (PDC-DR) (NQF #0541)
 - b) RAS Antagonists (PDC-RASA) (NQF #0541)
 - c) Statins (PDC-STA) (NQF #0541)

1.03 Disparities Reduction

Achieving disparities reduction in care is critical for delivery of individualized, equitable care and promotion of health equity.

1.03.1 Disparities Reduction Intervention

- 1) If Contractor was contracted with Covered California in Plan Years 2020, 2021, and 2022, Contractor must meet a multi-year disparity reduction target beginning Plan Year 2023. Contractor must report progress toward this target by submitting specified progress reports. Covered California will assess Contractor's performance based on the submitted HEDIS measures file per Article 1.02, specified progress reports, and its disparity reduction intervention results.
- 2) If Contractor was contracted with Covered California in Plan Year 2022 but not 2021 or 2020, Contractor must meet the following schedule:
 - a) For Plan Year 2023, Contractor must submit a disparity reduction intervention proposal, as specified by the Covered California template and approved by Covered California, that includes the following intervention components:

- i. Baseline measurement for disparity identification;
 - ii. Root Cause Analysis (RCA);
 - iii. Intervention design levels, strategies, and modes;
 - iv. Implementation timeline and evaluation; and
 - v. Baseline for performance measurement and proposed improvement target.
- b) For Plan Year 2024, Contractor must meet a quality improvement target for the disparity intervention population based on the disparity reduction intervention proposal approved by Covered California. Contractor must report progress through submission of specified progress reports. Covered California will assess Contractor's performance based on the submitted HEDIS measures file per Article 1.02, specified progress reports, and intervention results.
- c) For Plan Year 2025, Contractor must meet a multi-year disparity reduction target. Contractor must report progress toward this target by submitting specified progress reports. Covered California will assess Contractor's performance based on the submitted HEDIS measures file per Article 1.02, specified progress reports, and its disparities reduction intervention results.
- 3) Contractors that were first contracted with Covered California in Plan Year 2023 must meet the following schedule:
- a) For Plan Year 2023, Contractor must demonstrate through participation in learning activities and meetings, as specified by Covered California, understanding of and readiness (including dedicated resources and infrastructure) to meet contractual obligations in Plan Years 2024 and 2025.
 - b) For Plan Year 2024, Contractor must submit a disparity reduction intervention proposal, as specified by the Covered California template, and approved by Covered California, that includes the following intervention components:
 - i. Baseline measurement for disparity identification;
 - ii. Root Cause Analysis (RCA);
 - iii. Intervention design levels, strategies, and modes;

- iv. Implementation timeline and evaluation; and
 - v. Baseline for performance measurement and proposed improvement target.
- c) For Plan Year 2025, Contractor must meet a quality improvement target for the disparity intervention population based on the disparity reduction intervention proposal approved by Covered California. Contractor must report progress through submission of specified progress reports. Covered California will assess Contractor's performance based on the submitted HEDIS measures file per Article 1.02, specified progress reports, and intervention results.
- 4) Contractors that were first contracted with Covered California in Plan Year 2024 must meet the following schedule:
- a) For Plan Year 2024, Contractor must demonstrate through participation in learning activities and meetings, as specified by Covered California, understanding of and readiness (including dedicated resources and infrastructure) to meet contractual obligations in Plan Year 2025, and
 - b) Contractor must submit a disparity reduction intervention proposal, as specified by the Covered California template, and approved by Covered California, that includes the following intervention components:
 - i. Baseline measurement for disparity identification;
 - ii. Root Cause Analysis (RCA);
 - iii. Intervention design levels, strategies, and modes;
 - iv. Implementation timeline and evaluation; and
 - v. Baseline for performance measurement and proposed improvement target.
 - c) For Plan Year 2025, Contractor must meet a quality improvement target for the disparity intervention population based on the disparity reduction intervention proposal approved by Covered California. Contractor must report progress through submission of specified progress reports. Covered California will assess Contractor's performance based on the submitted HEDIS measures file per Article 1.02, specified progress reports, and intervention results.

- 5) Contractors that were first contracted with Covered California in Plan Year 2025 must meet the following schedule:
 - a) For Plan Year 2025, Contractor must demonstrate through participation in learning activities and meetings, as specified by Covered California, understanding of and readiness (including dedicated resources and infrastructure) to meet contractual obligations in Plan Years 2026 and beyond.

1.04 Health Equity Capacity Building

Attaining health equity requires organizational investment in building a culture of health equity. Meeting the standards for the Health Equity Accreditation by the National Committee for Quality Assurance (NCQA) (previously Multicultural Health Care Distinction (MHCD)) provides the necessary structure to build a program to reduce documented disparities and to develop culturally and linguistically appropriate communication strategies.

1.04.1 Health Equity Accreditation

Contractor must achieve or maintain NCQA Health Equity Accreditation. If Contractor has previously achieved NCQA Multicultural Health Care Distinction (MHCD), Contractor must provide its transition plan to attain the NCQA Health Equity Accreditation at the expiration of the MHCD period.

Contractor must demonstrate compliance according to the following schedule:

- 1) If Contractor was contracted with Covered California as of Plan Year 2022, Contractor must submit:
 - a) Evidence of NCQA Health Equity Accreditation or MHCD by January 31, 2023, or adhere to the following schedule:
 - i. January 31, 2023: Submit first Progress Report
 - ii. August 31, 2023: Submit second Progress Report
 - iii. December 29, 2023: Submit evidence of NCQA Health Equity Accreditation achievement or transition plan to achieve Health Equity Accreditation at the expiration of the current MHCD period.
 - b) If Contractor has not achieved NCQA Health Equity Accreditation by year-end 2023, Contractor must adhere to the following schedule:

- i. January 31, 2024: Submit workplan to achieve Health Equity Accreditation by year-end 2024.
 - ii. May 31, 2024: Submit first Progress Report
 - iii. August 30, 2024: Submit second Progress Report
 - iv. December 31, 2024: Submit evidence of NCQA Health Equity Accreditation.
- 2) If Contractor was first contracted with Covered California in Plan Year 2023, Contractor must submit:
 - a) Evidence of NCQA Health Equity Accreditation or MHCD by January 31, 2024, or adhere to the following schedule:
 - i. January 31, 2024: Submit first Progress Report
 - ii. August 30, 2024: Submit second Progress Report
 - iii. December 31, 2024: Submit evidence of NCQA Health Equity Accreditation achievement or transition plan to achieve Health Equity Accreditation at the expiration of the current MHCD period.
 - b) If Contractor has not achieved NCQA Health Equity Accreditation by year-end 2024, Contractor must adhere to the following schedule:
 - i. January 31, 2025: Submit workplan to achieve Health Equity Accreditation by year-end 2025.
 - ii. May 30, 2025: Submit first Progress Report
 - iii. August 29, 2025: Submit second Progress Report
 - iv. December 31, 2025: Submit evidence of NCQA Health Equity Accreditation.
- 3) If Contractor was first contracted with Covered California in Plan Year 2024, Contractor must submit:
 - a) Evidence of NCQA Health Equity Accreditation or MHCD by January 31, 2025, or adhere to the following schedule:
 - i. January 31, 2025: Submit first Progress Report
 - ii. August 29, 2025: Submit second Progress Report

- iii. December 31, 2025: Submit evidence of NCQA Health Equity Accreditation achievement or transition plan to achieve Health Equity Accreditation at the expiration of the current MHCD period.
- b) If Contractor has not achieved NCQA Health Equity Accreditation by year-end 2025, Contractor must adhere to the following schedule:
- i. January 30, 2026: Submit workplan to achieve Health Equity Accreditation by year-end 2026.
 - ii. May 29, 2026: Submit first Progress Report
 - iii. August 31, 2026: Submit second Progress Report
 - iv. December 31, 2026: Submit evidence of NCQA Health Equity Accreditation.
- 4) If Contractor was first contracted with Covered California in Plan Year 2025, Contractor must submit:
- a) Evidence of NCQA Health Equity Accreditation or MHCD by January 30, 2026, or adhere to the following schedule:
- i. January 30, 2026: Submit first Progress Report
 - ii. August 31, 2026: Submit second Progress Report
 - iii. December 31, 2026: Submit evidence of NCQA Health Equity Accreditation achievement or transition plan to achieve Health Equity Accreditation at the expiration of the current MHCD period.
- b) If Contractor has not achieved NCQA Health Equity Accreditation by year-end 2026, Contractor must adhere to the following schedule:
- i. January 29, 2027: Submit workplan to achieve Health Equity Accreditation by year-end 2027.
 - ii. May 31, 2027: Submit first Progress Report
 - iii. August 31, 2027: Submit second Progress Report
 - iv. December 31, 2027: Submit evidence of NCQA Health Equity Accreditation.

Culturally and Linguistically Appropriate Care

1.04.2 Evidence of Culturally and Linguistically Appropriate Services

- 1) For Covered California to evaluate how Contractor ensures provision of culturally and linguistically appropriate services to Enrollees, Contractor must submit the following National Committee for Quality Assurance (NCQA) Health Equity Accreditation Standards reports:
 - a) Health Equity Standard 3: Access and Availability of Language Services
 - b) Health Equity Standard 4: Practitioner Network Cultural Responsiveness
 - c) Health Equity Standard 5: Culturally and Linguistically Appropriate Services Programs

Contractor must submit evidence once every three years in accordance with the three-year NCQA Health Equity Accreditation cycle. Covered California will not require annual submission of the specified NCQA Health Equity Accreditation Standards unless changes are made during the three-year cycle at which point Contractor must resubmit the revised reports to Covered California.

- 2) If Contractor's NCQA Multicultural Healthcare (MHC) Distinction remains current, Contractor must confirm current Distinction status and submit the following MHC standards reports:
 - a) MHC 2: Access and Availability of Language Services
 - b) MHC 3: Practitioner Network Cultural Responsiveness
 - c) MHC 4: Culturally and Linguistically Appropriate Services Programs
- 3) Alternatively, if Contractor has not yet attained the NCQA Health Equity Accreditation or is unable to provide components of the NCQA Health Equity Accreditation Standards per Article 1.05.1.1, Contractor must complete and submit a report to Covered California that addresses each of the following components:
 - a) Access and Availability of Language Services
 - i. Vital information provided to Enrollees in threshold languages, including assessment of the use of competent translators based on proficiency in the source and target language, and whether translation is provided in a timely manner. For guidance on translation competency and timely

access, see NCQA Health Equity Accreditation Standard 3.

- ii. Use of competent interpreter or bilingual services to communicate with individuals who need to communicate in a language other than English. For definition of competent interpreter, see NCQA Health Equity Accreditation Standard 3.
- iii. Support for practitioners in providing competent language services.
- iv. Annual distribution of a written notice communicating in English and up to 15 threshold languages the availability of free language assistance and how individuals can obtain language assistance in English and in threshold languages.

a) Practitioner Network Cultural Responsiveness

- i. How Contractor maintains a practitioner network that can serve its diverse membership and is responsive to member language needs and preferences.
- ii. If and how Contractor:
 - (1) Collects languages in which a practitioner is fluent when communicating about medical care.
 - (2) Collects language services available through the practice.
 - (3) Collects practitioner race/ethnicity data.
 - (4) Publishes practitioner languages in the physician directory.
 - (5) Publishes language services available through practices in the physician directory.
 - (6) Provides practitioner race/ethnicity on request.
 - (7) At least every three years, analyzes the capacity of its network to meet the language needs of members.
 - (8) At least every three years, analyzes the capacity of its network to meet the needs of members for culturally appropriate care.
 - (9) Develops a plan to address gaps identified as a result of analysis, if applicable.
 - (10) Acts to address gaps based on its plan, if applicable.

b) Culturally and Linguistically Appropriate Services Programs

- i. Program description for improving culturally and linguistically appropriate services (CLAS) that includes the following elements:
 - (1) A written statement describing the Contractor's overall objective for serving a culturally and linguistically diverse population.
 - (2) A process to involve members of the culturally diverse community in identifying and prioritizing opportunities for improvement.
 - (3) A list of measurable goals for the improvement of CLAS and reduction of health care disparities.
 - (4) An annual work plan.
 - (5) A plan for monitoring against the goals.
 - (6) Annual approval by the governing body.
- ii. If and how Contractor conducts an annual written evaluation of the CLAS program.

ARTICLE 2 - BEHAVIORAL HEALTH

Mental health and substance use disorder services – collectively referred to as behavioral health services – includes identification, engagement, and treatment of those with mental health conditions and substance use disorders. Consistent with evidence and best practices, Covered California expects Contractor to ensure Enrollees receive timely and effective behavioral healthcare that is integrated with medical care, and in particular primary care. Covered California and Contractor recognize the critical importance of behavioral health services, as part of the broader set of healthcare services provided to Enrollees, in improving health outcomes and reducing costs.

2.01 Access to Behavioral Health Services

Monitoring and improving access to behavioral health services is necessary to ensure Enrollees are receiving appropriate and timely behavioral health services.

2.01.1 Behavioral Health Provider Network

For Covered California to evaluate how Contractor tracks access to behavioral health services and the strategies Contractor implements to improve access to behavioral health services for Enrollees, Contractor must submit the following National Committee for Quality Assurance (NCQA) Health Plan Accreditation Network Management reports:

- 1) Network Standard 1, Element A: Cultural Needs and Preferences (including behavioral health providers);
- 2) Network Standard 1, Element D: Practitioners Providing Behavioral Healthcare;
- 3) Network Standard 2, Element B: Access to Behavioral Healthcare; and
- 4) Network Standard 3, Element C: Opportunities to Improve Access to Behavioral Healthcare Services.

Contractor must submit the Network Management reports once every three years in accordance with the three-year NCQA accreditation cycle. Covered California will not require annual submission of the Network Management reports unless changes are made to the Network Management reports during the three-year cycle at which point Contractor must resubmit the revised reports to Covered California.

Alternatively, if Contractor is not yet NCQA accredited or is unable to provide components of its NCQA Network Management reports, Contractor must submit a separate report once every three years for its Covered California population that addresses each of the NCQA Network Management standards for behavioral health listed above. These reports can be from Contractor's accrediting body, either URAC or the Accreditation Association for Ambulatory Health Care (AAAHC), or supplemental reports that include a description of Contractor's behavioral health provider network, how cultural, ethnic, racial and linguistic needs of Enrollees are met, access standards, the methodology for monitoring access to behavioral health appointments, and at least one intervention to improve access to behavioral health services and the effectiveness of this intervention.

2.01.2 Offering Telehealth for Behavioral Health

Telehealth has the potential to address some of the access barriers to behavioral health services such as cost, transportation, and the shortage of providers, particularly for linguistically and culturally diverse Enrollees and for rural areas.

Telehealth is not a replacement for Contractor developing a network of in-person behavioral health providers. However, given persistent and extensive workforce challenges, to strengthen access to behavioral health services, Contractor must offer telehealth for behavioral health services when clinically appropriate based on a Covered California Enrollee's needs and at a cost share equal to or less than the cost share for in-person behavioral health services. Covered California encourages Contractor to use network providers to provide telehealth for behavioral health services whenever possible. Contractor must continue to comply with applicable network adequacy standards for in-person services for behavioral health.

2.01.3 Promoting Access to Behavioral Health Services

To ensure Covered California Enrollees are aware of the availability of behavioral health services, including services available through telehealth, Contractor must:

- 1) Clearly and prominently display the types of behavioral health services that are covered on key Covered California Enrollee pages, such as the home page in its member portal and the provider directory page;
- 2) Explain the scope and availability of behavioral health services, including telehealth;

- 3) Educate Covered California Enrollees how to access behavioral health services, including through telehealth;
- 4) Inform primary care clinicians of the referral process for Covered California Enrollees for behavioral health services and available behavioral health resources for Covered California Enrollees;
- 5) Ensure that its provider directory displays which providers offer behavioral health services, including through telehealth (e.g., Jane Doe, Ph.D. Psychologist, telehealth video/phone), or other member portal navigation features; and
- 6) Promote integration and coordination of care between third party telehealth vendor services and primary care and other network providers.

2.01.4 Monitoring Behavioral Health Service Utilization

Contractor agrees to engage and work with Covered California to review its depression treatment penetration rate and its behavioral health service utilization rate, which will be calculated by Covered California using HEI data submitted in accordance with Article 5.02.1, to further understand Enrollees' access to behavioral health services within the Contractor's network. Penetration rate is determined by dividing the number of members who receive a behavioral health service by the expected prevalence rate of behavioral health needs within a state or region, multiplied by 100 to report as a percent; this data will be analyzed separately for in-person and telehealth services.

2.02 Quality of Behavioral Health Services

Measuring and monitoring quality is necessary to ensure Enrollees receive appropriate, evidence-based treatment and to inform quality improvement efforts.

2.02.1 Screening for Depression

Contractor must work with its contracted providers, including primary care clinicians, to collect Depression Screening and Follow-Up for Adolescents and Adults (DSF) measure results, stratified by race and ethnicity, for its Covered California Enrollees and submit patient level data files in accordance with Article 1.02.1.

Covered California strongly encourages Contractor to use the Patient Health Questionnaire-2 and 9 (PHQ-2, PHQ-9) as standardized depression screening and measurement tools when implementing this measure. If a different tool is used, Contractor must specify the tool when it reports the measure results.

2.02.2 Monitoring Quality Rating System Behavioral Health Measures

To monitor the quality of Contractor's behavioral health services, Contractor agrees to engage and work with Covered California to review its performance on the behavioral health measures reported by Contractor to CMS for the Quality Rating System (QRS) submitted in accordance with Article 5.01.1.

2.03 Appropriate Use of Opioids

Appropriate use of opioids and evidence-based treatment of opioid use disorder, including Medication Assisted Treatment (MAT), can improve outcomes, reduce inappropriate healthcare utilization, and lower opioid overdose deaths.

2.03.1 Guidelines for Appropriate Use of Opioids

Contractor shall implement policies and programs that align with the guidelines from Smart Care California to promote the appropriate use of opioids by its contracted providers. Contractor's policies and programs shall use a harm reduction framework and an individualized approach to treatment planning and should consider Smart Care California guidelines when making formulary decisions (<https://www.iha.org/wp-content/uploads/2021/02/Curbing-Opioid-Epidemic-Checklist-Health-Plans-Purchasers.pdf>). Contractor's policies and programs must include the following priority areas:

- 1) Prevent: use opioids sparingly by decreasing the number of new starts, with lower doses and shorter durations when medically appropriate; support non-pharmacological approaches to pain management such as removing prior authorizations for physical therapy;
- 2) Manage: identify patients on risky drug regimens such as high-dose opioids or opioids and sedatives; ensure providers co-prescribe naloxone with chronic opioid prescriptions; ensure providers develop individualized treatment plans; ensure providers are using appropriate medical standards of care to determine the need for and proper dosage of opioids for pain management while avoiding mandatory tapers;
- 3) Treat: streamline access to evidence-based treatment for opioid use disorder, including Medication Assisted Treatment (MAT) medications such as buprenorphine, methadone, and naltrexone, and behavioral therapy, by addressing cost and logistical barriers at all points in the healthcare system; and
- 4) Stop deaths: promote data-driven harm reduction strategies, such as naloxone access and syringe exchange.

2.03.2 Monitoring Opioid Use Disorder Treatment

To monitor access to opioid use disorder treatment, Contractor agrees to engage and work with Covered California to review its Medication Assisted Treatment (MAT) prescriptions, and to review its concurrent prescribing of opioids and naloxone rate using HEI data submitted in accordance with Article 5.02.1.

Contractor must collect Pharmacotherapy for Opioid Use Disorder (POD) measure results for its Covered California Enrollees and report those results, stratified by race and ethnicity, in accordance with Article 1.02.1.

2.04 Integration of Behavioral Health Services with Medical Services

Integrated behavioral health services with medical services, particularly primary care services, increases access to behavioral health services and improves treatment outcomes. Evidence suggests the Collaborative Care Model, as defined by the AIMS Center at the University of Washington, is a best practice among integrated behavioral health models (<https://aims.uw.edu/collaborative-care>).

Contractor shall pay its contracted providers through population-based payment and other alternative payment models, in accordance with Article 4.01.3, to support behavioral health integration with primary care.

2.04.1 Promotion of Integrated Behavioral Health

To monitor the adoption of integrated behavioral health, Contractor must report:

- 1) How it is promoting the integration of behavioral health services with primary care, including data exchange between Contractor, its contracted primary care clinicians, and its behavioral health providers;
- 2) The percent of its Covered California Enrollees and the percent of enrollees outside of Covered California cared for under an integrated behavioral and primary care model, such as the Primary Care Behavioral Health or the Collaborative Care Model; and
- 3) Whether it reimburses for the Collaborative Care Model claims codes and if so, in what settings and to which entities. If Contractor does not reimburse for the Collaborative Care Model claims codes, Contractor must describe the barriers to reimbursing for these codes.

2.04.2 Monitoring Collaborative Care Model Utilization

Contractor agrees to engage and work with Covered California to develop analysis to track utilization of the Collaborative Care Model services or track providers who are using the Collaborative Care Model using HEI data submitted in accordance with Article 5.02.1.

2.05 Behavioral Health Subcontractor, Downstream Entity, and Behavioral Health Network Provider Oversight

To ensure high-quality, equitable care is provided to Enrollees, Contractor shall be accountable for its behavioral health Subcontractors, Downstream Entities, and behavioral health network providers' delegated functions related to compliance with applicable provisions in Article 2 of Attachment 1. Contractor must hold behavioral health Subcontractors, Downstream Entities, and behavioral health network providers accountable for meeting the health equity, quality, access, and delivery system reform requirements within Article 2 of Attachment 1. Contractor must demonstrate compliance with the requirements specified in Article 2.05 by December 31, 2025. However, if Contractor is first contracted with Covered California in Plan Year 2025 and is unable to demonstrate compliance by December 31, 2025, Contractor and Covered California will mutually agree upon a reasonable alternative deadline to come into compliance with Article 2.05.

2.05.1 Contractor Accountability, Duties, and Obligations

Contractor shall demonstrate robust compliance, monitoring, and oversight programs for all delegated entities to ensure Covered California Enrollees receive quality behavioral health care and have access to behavioral health services. Contractor must disclose delegation arrangements and include justification for the use of delegated entities.

- 1) Contractor remains fully responsible for the performance of all duties, obligations, and services undertaken by a behavioral health network provider, Subcontractor, or Downstream Entity.
- 2) Contractor must evaluate each prospective behavioral health network provider's, Subcontractor's, or Downstream Entity's ability to perform the contracted services or functions.
- 3) Contractor must maintain policies and procedures to ensure that behavioral health network providers, Subcontractors, or Downstream Entities fully comply with the terms and conditions of Article 2 of Attachment 1.

- 4) To ensure behavioral health Subcontractor's and Downstream Entity's compliance, Contractor must:
 - a) Include all duties and obligations in Article 2 of Attachment 1, relating to the delegated duties, in all behavioral health Subcontractor agreements;
 - b) Ensure the behavioral health Subcontractor includes all obligations under Article 2 of Attachment 1, relating to the delegated duties, in all behavioral health Downstream Entity agreements;
 - c) Review behavioral health Subcontractors' policies and procedures applicable to the delegated functions;
 - d) Monitor and oversee all delegated functions, including those that may flow down to behavioral health Downstream Entities;
 - e) Ensure behavioral health network providers comply with all applicable requirements under Article 2 of Attachment 1 and all requirements set forth in their provider network agreements; and
 - f) Disclose all delegated relationships and submit a delegation report as specified in Article 2.05.3.

2.05.2 Quality and Health Equity Oversight

Contractor shall monitor and evaluate the quality of behavioral health care delivered by all its behavioral health network providers, Subcontractors, and Downstream Entities and implement necessary improvements in any setting. Contractor must also monitor health disparities in behavioral health care using at minimum the measures described in Article 1.02. Contractor is responsible for the quality and health equity of all behavioral health services whether those services have been delegated to a behavioral health Subcontractor, Downstream Entity, or network provider.

- 1) Contractor must deliver quality behavioral health care that enables Covered California Enrollees to maintain, improve, or manage their behavioral health. This includes ensuring quality behavioral health care in each of the following areas:
 - a) Clinical quality of behavioral health care;
 - b) Access to behavioral health care providers and services;
 - c) Continuity and care coordination across physical health care and behavioral health care settings, including in-person and telehealth, as well

as coordination between levels of care and transitions in care to establish stable provider-patient relationships; and

- d) Overall Covered California Enrollee experience with behavioral health services.
- 2) Contractor shall be accountable for all access, quality improvement, and health equity functions for behavioral health services, including responsibilities that are delegated to behavioral health Subcontractors and any Downstream Entities. Contractor shall specify the following requirements in its behavioral health Subcontractor agreements and Downstream Entity agreements, as applicable:
- a) Access, quality improvement, and health equity responsibilities for behavioral health services and specific subcontracted functions and activities of behavioral health Subcontractor and Downstream Entity;
 - b) Schedule for Contractor's ongoing oversight, monitoring, and evaluation of behavioral health Subcontractor and Downstream Entity; and
 - c) Actions and remedies if behavioral health Subcontractor's and Downstream Entity's obligations are not satisfactorily performed.
- 3) Contractor shall maintain oversight procedures for behavioral health services to ensure behavioral health Subcontractor's and Downstream Entity's compliance with all access, quality improvement, and health equity delegated activities that:
- a) Evaluate behavioral health Subcontractor's and Downstream Entity's ability to provide behavioral health services, including an initial determination that the behavioral health Subcontractor and Downstream Entity have the administrative capacity, experience, and budgetary resources to fulfill their contractual obligations;
 - b) Ensure behavioral health Subcontractor and Downstream Entity meet access, quality improvement, and health equity standards; and
 - c) Include continuous monitoring, evaluation, and approval of its delegated functions to the behavioral health Subcontractor and Downstream Entity.

2.05.3 Delegation Reporting

- 1) Contractor must provide a delegation report that describes:
 - a) All contractual relationships with behavioral health Subcontractors and Downstream Entities including:
 - i. Name of behavioral health Subcontractor and Downstream Entity;
 - ii. Type of behavioral health Subcontractor;
 - iii. Description of all delegated and sub-delegated functions; and
 - iv. Purpose and justification for delegation.
 - b) Contractor's oversight responsibilities for all delegated obligations.
 - c) How Contractor oversees or intends to oversee access, parity, quality improvement, and health equity functions that are delegated to behavioral health Subcontractors and any Downstream Entities.
 - d) How Contractor oversees or intends to oversee all delegated activities, including details regarding key personnel who will be overseeing such delegated functions.
- 2) Contractor must submit a delegation report according to the following schedule:
 - a) If Contractor was Contracted with Covered California in Plan Year 2024, Contractor must submit a delegation report by December 31, 2024.
 - b) If Contractor was first Contracted with Covered California in 2025, Contractor must submit a delegation report by December 31, 2025.

Covered California will not require annual submission of a delegation report unless changes are made at which point Contractor must resubmit an updated report to Covered California annually. To reduce administrative burden, Contractor may provide Covered California with delegation reports that are submitted by Contractor to the California Department of Health Care Services (DHCS) or the California Public Employees' Retirement System (CalPERS) if Contractor uses the same delegation arrangements for the products offered under these programs.

ARTICLE 3 - POPULATION HEALTH

Covered California and Contractor recognize the importance of population health, including ensuring the use of health promotion and prevention services, increasing utilization of high value services, risk stratifying Enrollees, and developing targeted interventions based on risk. To improve the health of Covered California Enrollees, Contractor shall identify opportunities, conduct outreach, and engage all Covered California Enrollees, not just Covered California Enrollees who obtain services from providers, in population health activities.

3.01 Population Health Management

Covered California and Contractor recognize that Population Health Management ensures accountability for delivering quality care. Population Health Management provides focus and a framework for improving health outcomes through registries, care coordination, and targeted patient engagement.

3.01.1 Population Health Management Plan

Submission of a Population Health Management plan is a requirement for health plan accreditation by the National Committee for Quality Assurance (NCQA). The Population Health Management plan provides a vehicle for establishing a formal strategy to optimize population health outcomes, including a defined approach for population identification and stratification, with attention to care management for complex Enrollees. The Population Health Management plan is a critical part of achieving improvement in Enrollee health outcomes and is interrelated with all other quality care domains.

Contractor must submit the following components of its NCQA Population Health Management plan:

- 1) Population Health Management Standard 1: Population Health Management Strategy;
- 2) Population Health Management Standard 2: Population Identification; and
- 3) Population Health Management Standard 6: Population Health Management Impact.

Contractor must submit the Population Health Management plan once every three years in accordance with the three-year NCQA accreditation cycle. Covered California will not require annual submission of the Population Health Management plan unless changes are made to the Population Health Management plan during the three-year cycle at which point Contractor must resubmit the revised plan to Covered California.

Alternatively, if Contractor is not yet NCQA accredited or is unable to provide components of its NCQA Population Health Management plan, Contractor must submit a separate Population Health Management plan for its Covered California population that addresses each of the following components:

- a) A Population Health Management Strategy for meeting the care needs of its Enrollees that includes the following:
 - i. Goals, focus populations, opportunities, programs, and services available for keeping Enrollees healthy, managing Enrollees with emerging risk, patient safety or outcomes across settings, and managing multiple chronic illnesses.
 - ii. Mechanism for informing Enrollees eligible for interactive programs with details of how to become eligible for participation, how to use program services, and how to opt in or out of a program.
 - iii. Activities performed by Contractor targeted at populations or communities as a part of the Population Health Management strategy that are not direct Enrollee interventions.
 - iv. Coordination of Enrollee programs across settings, providers, external management programs, and levels of care to minimize confusion and maximize reach and impact.
- b) Evidence of systematic collection, integration, and assessment of Enrollee data to assess the needs of the population and determine actionable categories for appropriate intervention, including the following:
 - i. How Contractor integrates multiple sources of data for use in Population Health Management functions that includes: medical and behavioral claims or encounters, pharmacy claims, laboratory results, health appraisal results, a copy of individual risk assessment questions, electronic health records, health programs delivered by the Contractor, and other advanced data sources.

- ii. Contractor's process for at least annually assessing the following:
 - (1) Characteristics and needs, including health related social needs of its Enrollees;
 - (2) Needs of specific Enrollee subpopulations; and
 - (3) Needs of children and adolescents, Enrollees with disabilities, and members with serious and persistent mental illness.
 - iii. How Contractor uses the population assessment at least annually to review and update its Population Health Management activities and resources to address Enrollee needs. Also, how Contractor reviews community resources for integration into program offerings to address Enrollee needs.
 - iv. Its process, including data sources and population health categories, to stratify its Covered California population into subsets for targeted intervention at least annually.
- c) A systemic process of measuring the effectiveness of its Population Health Management strategy to determine if Population Health Management goals are met and to gain insights into areas needing improvement, including the following:
- i. How Contractor conducts its annual comprehensive analysis of the impact of its Population Health Management strategy that includes the following:
 - (1) Quantitative results of relevant clinical, cost and utilization, and experience measures;
 - (2) Comparison of results with a benchmark or goal; and
 - (3) Interpretation of results.
 - ii. Its process to identify and address opportunities for improvement, using the results from the Population Health Management impact analysis at least annually.

3.02 Health Promotion and Prevention

Health promotion and prevention are key components of high value healthcare. Research shows that treating those who are sick is often far costlier and less effective than preventing disease from occurring and keeping populations healthy. Covered California's health promotion and prevention requirements are centered on identifying Enrollees who are eligible for certain high value preventive and wellness benefits, notifying Enrollees about the availability of these services, making sure those eligible receive appropriate services and care coordination, and monitoring the health status of these Enrollees.

3.02.1 Tobacco Cessation Program

Tobacco use is preventable and contributes to high morbidity and mortality. Reducing tobacco use will have greater impact on health outcomes in marginalized communities which have disproportionately higher rates of use. To analyze Contractor's tobacco cessation programs, Contractor must report:

- 1) Analysis of outcomes and results for Covered California Enrollees who use tobacco and enroll in tobacco cessation programs trended over time, inclusive of evidenced-based counseling and appropriate pharmacotherapy.
- 2) Analysis of whether its strategies to improve tobacco use prevention and reduce tobacco use were successful and if the smoking prevalence of Covered California Enrollees has decreased over time.
- 3) Its strategies to improve its rates on the Medical Assistance with Smoking and Tobacco Use Cessation measure (NQF #0027), which may include evidence-based interventions or participation in quality collaboratives.

3.02.2 Diabetes Prevention Programs

Diabetes contributes to high rates of morbidity and mortality. Access to diabetes prevention programs is critical in the prevention of diabetes related complications. Contractor must:

- 1) Provide a Centers for Disease Control and Prevention (CDC)-recognized Diabetes Prevention Lifestyle Change Program, also known as a Diabetes Prevention Program (DPP) to its eligible Covered California Enrollees. The DPP must be available both in-person and online to ensure Covered California Enrollees have equitable access to these services in the event of service area challenges such as rural locations or limited program availability and to allow Covered California Enrollees a choice of modality (in-person, online, distance learning, or a combination of modes). The DPP must be accessible to eligible Covered California Enrollees with limited English proficiency (LEP) and eligible Covered California Enrollees with disabilities. The DPP is covered as a diabetes education benefit with zero cost sharing pursuant to the Patient-Centered Benefit Plan Designs. Contractor's DPP must have pending or full recognition by the CDC as a DPP. A list of recognized programs in California can be found at: https://nccd.cdc.gov/DDT_DPRP/Registry.aspx.
- 2) Report the following:
 - a) Analysis of utilization rates of eligible Covered California Enrollees who enroll in the Diabetes Prevention Program in relation to expected rates trended over time. Expected rates include total eligible Covered California Enrollees identified as high risk for diabetes and total eligible Covered California Enrollees who should have been identified as high risk for diabetes, which can be projected using the CDC Diabetes Prevention Impact Toolkit (<https://nccd.cdc.gov/Toolkit/DiabetesImpact/>); and
 - b) Its strategies to close the gap between the Diabetes Prevention Program utilization rates by eligible Covered California Enrollees in relation to expected rates.
- 3) Establish and meet a multi-year improvement target to close the gap if there is a gap between utilization rates and expected rates. Contractor must report progress toward this target by submitting specified progress reports, including baseline measurement, intervention design, implementation timeline, and performance meeting improvement target.

3.03 Supporting At-Risk Enrollees Requiring Transition

An Enrollee transition plan allows for a clear process to transfer critical health information for At-Risk Enrollees during transitions between healthcare coverage. Covered California is particularly concerned about At-Risk Enrollees who are transitioning from one QHP Issuer to another, which includes Enrollees who are: (1) in the middle of acute treatment, third trimester pregnancy, or those who would otherwise qualify for Continuity of Care under California law, (2) in case management programs, (3) in disease management programs, or (4) on maintenance prescription drugs for a chronic condition.

3.03.1 Submission of Transition Plan

In the event of a service area reduction such that Contractor withdraws its existing, approved network from any geographic region or modifies any portion of its service area, Contractor must submit an evaluation and formal transition plan in accordance with the requirements outlined in the Qualified Health Plan Issuer Contract for 2023-2025 for the Individual Market, Articles 4.3.1 and 8.3.2, to facilitate transitions of care with minimal disruption for At-Risk Covered California Enrollees who are transitioning from one QHP Issuer to another QHP Issuer or to an off-Exchange product offered by the QHP Issuer. In such events, Covered California may automatically transition Contractor's Covered California Enrollees into a different QHP Issuer to avoid gaps in coverage. If Contractor receives Covered California Enrollees from another QHP Issuer pursuant to a service area reduction, Contractor must implement policies and programs to facilitate transitions of care.

- 1) If Contractor is terminating Covered California Enrollees, Contractor must:
 - a) Conduct outreach to alert all Covered California Enrollees impacted by the service area reduction that their QHP will be ending. Outreach must include instructions, timing, and options for enrolling with a new QHP Issuer.
 - b) Conduct outreach to At-Risk Covered California Enrollees, giving them the option to authorize Contractor to send their personal health information to the Covered California Enrollee's new QHP Issuer with the goal of improving the transition of care.
 - c) Send Covered California Enrollee health information relevant to creating transitions of care with minimal disruption to the Covered California Enrollee's new QHP Issuer for those Covered California Enrollees who have provided authorization to do so, as follows:

- i. For all terminating Covered California Enrollees impacted by the service area reduction, send primary care clinician information on record.
 - ii. For At-Risk Covered California Enrollees, send relevant personal health information.
 - d) Conduct outreach to providers in impacted service areas to facilitate Covered California Enrollee transitions with minimal disruption.
- 2) If Contractor receives terminating Covered California Enrollees from another QHP Issuer pursuant to a service area reduction, Contractor must:
- a) Identify At-Risk Covered California Enrollees, either through existing Contractor practices, or through receipt of both health information from the prior QHP Issuer and the data file with transitioning enrollment information from Covered California (which would occur after these Covered California Enrollees have effectuated coverage).
 - b) Ensure At-Risk Covered California Enrollees care transitions account for their medical situation, including participation in case or disease management programs, locating in-network providers with appropriate clinical expertise, and any alternative therapies, including specific drugs.
 - c) Establish internal processes to ensure all parties involved in the transition of care for At-Risk Covered California Enrollees are aware of their responsibilities. This includes anyone within or outside of Contractor's organization who are needed to ensure the transition of prescriptions or provision of care.
 - d) Provide information on continuity of care programs, including alternatives for transitioning to an in-network provider.
 - e) Ensure the new At-Risk Covered California Enrollees have access to Contractor's formulary information prior to enrollment.

3.04 Social Health

Given the strong evidence of the role of social factors on health outcomes, addressing health-related social needs is an important step in advancing Covered California's goal to ensure everyone receives the best possible care.

Covered California acknowledges the importance of understanding patient health-related social needs – an individual’s socioeconomic barriers to health – to move closer to equitable care and seeks to encourage the use of social needs informed and targeted care. As social needs are disproportionately borne by disadvantaged populations, identifying and addressing these barriers at the individual patient level is a critical first step in improving health outcomes, reducing health disparities, and reducing healthcare costs.

Identification and information sharing of available community resources is critical to meeting identified member social needs.

3.04.1 Screening for and Addressing Social Needs

Contractor must screen all Covered California Enrollees at least annually for unmet food, housing, and transportation needs. Contractor must use one or more screening instruments specified in the Social Need Screening and Intervention (SNS-E) measure specifications. Screening for additional health-related social needs and screening in coordination with contracted providers is highly encouraged.

Contractor must address Covered California Enrollees’ identified health-related social needs and support linkages to appropriate social services throughout all regions covered. This requirement may be met through contracting with a vendor that maintains a resource directory or community resource platform applicable to Contractor’s geographic licensed service area.

To demonstrate Contractor is screening for and addressing health-related social needs, Contractor must report:

- 1) Its process for screening Covered California Enrollees for social needs and collecting data for the Social Need Screening and Intervention (SNS-E) measure, including which Covered California Enrollee touch points include social need screening, whether the screening is performed by Contractor’s staff, vendor, or network providers, and which screening instrument(s) are used to screen for health-related social needs.
- 2) The social needs screening efforts by its provider network and the actions Contractor takes to coordinate screening and linkage to services with its provider network, including what support Contractor provides to contracted providers to connect Covered California Enrollees.
- 3) Its process for linking Covered California Enrollees with food insecurity or other health-related social needs to resources and how Contractor tracks if or when the social need has been addressed.

- 4) Measurement Year 2024 and 2025 performance on the Social Need Screening and Intervention (SNS-E) measure, stratified by race and ethnicity, and submitted via patient level data file in accordance with Article 1.02.1. Submission of performance on the intervention rate component of the SNS-E measure is optional.
- 5) Enrollee screen positive rate for each of the three subcomponents of the Social Need Screening and Intervention (SNS-E) measure.

Covered California will not publicly release Contractor's SNS-E measure performance until measure results are publicly reported by NCQA and appropriate benchmarks are available.

DRAFT

ARTICLE 4 - DELIVERY SYSTEM AND PAYMENT STRATEGIES TO DRIVE QUALITY

Contractor is expected to contribute to broadscale efforts to improve the healthcare delivery system in California. To meet goals of the Triple Aim and the goal of a safe, timely, effective, efficient, equitable and patient-centered (STEEEP) healthcare system as set forth by the Institute of Medicine, Contractor shall work with Covered California to promote effective primary care, increase integration and coordination within the healthcare system, and manage and design networks based on value. These delivery system reform efforts must be supported with value-based payment models.

4.01 Advanced Primary Care

Covered California and Contractor recognize that providing high-quality, equitable, and affordable care requires a foundation of advanced primary care. Advanced primary care is patient-centered, accessible, team-based, data driven, supports the integration of behavioral health services, and provides care management for patients with complex conditions. Advanced primary care is supported by alternative payment models such as population-based payments and shared savings arrangements. Contractor shall actively promote the development and use of advanced primary care models that promote access, care coordination, and quality while managing the total cost of care.

Contractor shall work with Covered California to provide comparison reporting for the requirements specified below for all lines of business to compare performance and inform future Covered California requirements.

4.01.1 Encouraging Use of Primary Care

Ensuring Enrollees have a primary care clinician is foundational for promoting access to and encouraging the use of primary care. To encourage the use of primary care, Contractor must:

- 1) Ensure that upon enrollment, Covered California Enrollees are informed about the role and benefits of primary care and are given the opportunity to select a primary care clinician. Within sixty (60) Days of effectuation into the plan, if a Covered California Enrollee does not select a primary care clinician, Contractor must provisionally assign the Covered California Enrollee to a primary care clinician, inform the Covered California Enrollee of the assignment, and provide the Covered California Enrollee with an opportunity to select a different primary care clinician. When assigning a primary care clinician, Contractor shall use commercially reasonable efforts

consistent with the Covered California Enrollee's stated gender, language, ethnic and cultural preferences, geographic area, existing family member assignment, and any prior primary care clinician.

- 2) Engage and work with Covered California to review the number and percent of Covered California Enrollees who select a clinician and the number and percent of Covered California Enrollees who are assigned to a primary care clinician using HEI data submitted in accordance with Article 5.02.1.

Covered California will evaluate the effectiveness of this policy in collaboration with Contractor and other stakeholders. Contractor agrees to provide Covered California with data and other information to perform this evaluation.

4.01.2 Measuring Advanced Primary Care

Advanced primary care is patient-centered, accessible, team-based, data driven, supports the integration of behavioral health services, and provides care management for patients with complex conditions. To support advanced primary care, primary care clinicians should have access to data related to the care their patients receive throughout the delivery system to promote integrated and coordinated care.

Measuring the performance of primary care practices within Contractor's network is important to ensure Enrollees receive high-quality care, to inform quality improvement and technical assistance efforts, and to support the adoption of alternative payment models. To measure the performance of primary care practices, Contractor must:

- 1) Implement a measure set that includes quality and cost-driving utilization measures for advanced primary care to assess the prevalence of high-quality, advanced primary care practices within Contractor's network. Contractor will collaborate with Covered California, the Integrated Healthcare Association (IHA), California Quality Collaborative (CQC), and other stakeholders to implement the measure set.
- 2) Submit data to IHA to implement the measure set. Contractor must report its performance on the measure set to Covered California or allow IHA to submit results to Covered California on Contractor's behalf.

4.01.3 Payment to Support Advanced Primary Care

Covered California and Contractor recognize the importance of adopting and expanding primary care payment models that provide the necessary revenue to

fund accessible, data-driven, team-based care with accountability for providing high-quality, equitable care, and managing the total cost of care. To expand the adoption of primary care payment models to support advanced primary care, Contractor must:

- 1) Report on its primary care payment models using the Health Care Payment Learning and Action Network Alternative Payment Model (HCP LAN APM) categories and associated subcategories of fee for service with no link to quality and value (Category 1), fee for service with a link to quality and value (Category 2), alternative payment models built on a fee for service structure such as shared savings (Category 3), and population-based payment (Category 4), including:
 - a) The number and percent of its contracted primary care clinicians paid using each HCP LAN APM category and associated subcategories;
 - b) Total primary care spend, as defined by IHA, and the percent of spend within each HCP LAN APM category and associated subcategory; and
 - c) A description of the Contractor's payment model for its 5 largest physician groups, as defined by the number of providers, and how their primary care clinicians are paid.

A combination of payment models across HCP LAN APM categories may be the most effective to support advanced primary care.

- 2) Adopt and progressively expand the percent of primary care clinicians paid through the HCP LAN APM categories of population-based payment (Category 4) and alternative payment models built on a fee for service structure such as shared savings (Category 3).
- 3) Work with Covered California and other stakeholders to analyze the relationship between the percent of spend for primary care services with performance of the overall delivery system. If the evidence shows that rebalancing to increase primary care spend improves quality or drives lower total cost of care, Covered California may set a target or floor for primary care spend in future Covered California requirements.

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

Evidence suggests the adoption and expansion of integrated, coordinated, and accountable systems of care such as IDSs or ACOs can lead to improved quality and reduced costs. An IDS is defined as an organized healthcare delivery system

in which payers, hospitals, and providers coordinate to provide patient care, integrate care across settings, and share responsibility for patient outcomes and resource use. IDS partners are generally managed by the same organization. An ACO is defined as a system of population-based care coordinated across the continuum including multidisciplinary physicians and physician groups, hospitals, and ancillary providers with combined risk sharing arrangements and shared incentives between providers or between payers and providers. Ideally ACO partners are held accountable for nationally recognized clinical, financial, and operational performance. As providers accept more accountability under this provision, Contractor shall ensure that providers have the capacity to manage the risk. There are many variations of ACO implementation with evidence suggesting that there are key characteristics of an ACO model that influence its success.

Contractor shall work with Covered California to provide comparison reporting for the requirements specified below for all lines of business to compare performance of its IDSs and ACOs and inform future Covered California requirements.

4.02.1 Enrollment in IDSs and ACOs

Contractor shall work with Covered California to increase enrollment in integrated, coordinated, and accountable systems of care with the goal of improved quality and decreased cost. Achieving these goals requires not only increased enrollment, but also continued improvement within IDSs and evolving ACOs. To monitor the adoption of IDSs and ACOs, Contractor must report:

- 1) The characteristics of its IDS and ACO systems, such as the payment model including risk sharing structure, leadership structure, quality incentive programs, data exchange processes, and the number and type of partner organizations. Contractor will work collaboratively with Covered California and other stakeholders to define a registry of characteristics to support this reporting.
- 2) The number and percent of Covered California Enrollees who are cared for within an ACO or IDS.
- 3) The percent of spend under ACO and IDS contracts compared to its overall spend on healthcare services.

4.02.2 Measuring IDS and ACO Performance

Measuring the performance of IDSs and ACOs is important to ensure Enrollees receive high-quality, equitable, and affordable care, to inform improvement efforts, and to establish best practices. To measure the performance of IDSs

and ACOs, Contractor must:

- 1) Submit data to IHA and participate in the IHA Align. Measure. Perform. (AMP) Program, as applicable for its delivery system model. Contractor must report its performance on the IHA AMP measure set for all applicable lines of business to Covered California or allow IHA to submit results to Covered California on Contractor's behalf.
- 2) Engage and work with Covered California to evaluate its performance using the results of the IHA AMP Program and the characteristics of different IDS and ACO systems to establish best practices to inform future requirements.

4.03 Networks Based on Value

Contractor shall curate and manage its networks to address variation in quality and cost performance across network hospitals and providers, with a focus on improving the performance of hospitals and providers. Contractor is accountable for measuring, analyzing, and reducing variation to achieve consistent high performance for all network hospitals and providers. Affordability is core to Covered California's mission to expand the availability of insurance coverage. The wide variation in unit price and total costs of care, with some providers and facilities charging far more for care irrespective of quality, is a key contributor to the high cost of medical services. Contractor shall hold its contracted hospitals and providers accountable for improving quality and managing or reducing cost and provide support to its contracted hospitals and providers to improve performance.

4.03.1 Designing and Managing Networks Based on Value

Contractor shall design and manage its networks based on cost, quality, safety, patient experience, and equity to ensure that Enrollees receive high-quality, affordable, and equitable care. To demonstrate Contractor is designing and managing networks based on value, Contractor must:

- 1) Include quality – which should include clinical quality, equity, patient safety, patient experience – and cost in the evaluation and selection criteria for all providers, including physicians and physician groups, and all facilities, including hospitals, when designing and managing networks for its QHPs.
- 2) Report how it meets this requirement and the basis for the selection and review of providers and facilities in networks for QHPs and if applicable, the rationale for excluding a provider or facility. Reports must include a detailed description of how cost, quality, patient safety, patient experience,

or other factors are considered in network design and provider and facility selection and review. Information submitted may be made publicly available by Covered California.

- 3) Engage and work with Covered California to develop analysis of total cost of care or other indicators of network value and performance using HEI data submitted in accordance with Article 5.02.1.

4.03.2 Payment to Support Networks Based on Value

To continue to build and strengthen networks based on value, Contractor must support its providers through value-based payment models that promote high-quality, affordable, and equitable care.

Contractor must report on its network payment models using the Health Care Payment Learning and Action Network Alternative Payment Model (HCP LAN APM) categories and associated subcategories of fee for service with no link to quality and value (Category 1), fee for service with a link to quality and value (Category 2), alternative payment models built on a fee for service structure such as shared savings (Category 3), and population-based payment (Category 4). Contractor must report the percent of spend within each HCP LAN APM category and associated subcategory compared to its overall budget.

4.03.3 Provider Value

Contractor shall contract with providers, including physicians and physician groups, that demonstrate they provide quality care and promote the safety of Enrollees at a reasonable price. Contractor shall improve quality and cost performance across its contracted providers.

- 1) Covered California will work with the Integrated Healthcare Association (IHA), California providers, and QHP Issuers to profile and analyze variation in performance on provider quality measures. This profile and analysis will be based on national and state benchmarks, variation in provider performance, best existing science of quality improvement, and informed by effective engagement of stakeholders. To meet this expectation, Contractor must:
 - a) Submit data to IHA and participate in the IHA Align. Measure. Perform (AMP) program for physician groups and report AMP performance results for each contracted physician group that participates in its QHPs to Covered California or allow IHA to submit results to Covered California on Contractor's behalf. Contractor shall

use AMP performance results to profile and analyze variation in performance on quality measures and total cost of care.

- b) Submit an intervention plan to address low quality and high-cost providers if Contractor contracts with physicians and physician groups performing in the lowest decile on state or national benchmarks for quality and highest decile on cost. The intervention plan may include quarterly provider performance reviews, providing technical assistance for specific quality and cost domains, tying provider payment to quality and cost, or excluding the provider from the QHP network. The intervention plan is subject to review and approval by Covered California. Contractor must continue to comply with applicable network adequacy standards, with attention to access for rural and traditionally underserved populations. If Contractor is required to exclude a provider from the QHP network pursuant to the intervention plan, Contractor must immediately notify Covered California and the appropriate state regulator and licensing entity. Exclusion of a provider may be subject to prior regulatory review and could result in required reductions in Contractor's licensed service area.
- 2) Covered California encourages collaboration among QHP Issuers in order to achieve maximum quality and safety performance in provider networks. To this end, Covered California will provide technical assistance to foster this collaborative effort through the Clinical Leaders Forum, Plan Management Advisory group, and other venues as helpful.
 - 3) To demonstrate Contractor is managing provider costs, Contractor must report:
 - a) The factors Contractor considers in assessing relative unit prices and total cost of care;
 - b) Contractor's analysis of variation in unit prices including capitation rates;
 - c) The extent to which Contractor adjusts for 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), or other factors;
 - d) How unit prices, capitation rates, and total cost of care are used in the selection of providers in networks for QHPs; and

- e) The distribution of providers by region and by cost decile, or describe other ways providers and facilities are grouped by costs, such as comparison of costs as a percentage of Medicare costs and the percentage of costs for Contractor that are expended in each cost decile.

4.03.4 Hospital Value

Contractor shall contract with hospitals that demonstrate they provide high-quality, affordable, and equitable care and promote the safety of Enrollees. Contractor shall improve quality and cost performance across its contracted hospitals.

- 1) Covered California will work with Cal Hospital Compare, California hospitals, and QHP Issuers to profile and analyze variation in performance on hospital quality measures. Analysis will be based on best available national and state benchmarks, variation in hospital performance considering hospital case mix and services provided, best existing science of quality improvement including the challenges of composite measures, and informed by effective engagement of stakeholders. Assessment of hospital quality and safety shall not be based on a single measure alone. To meet this expectation, Contractor must:
 - a) Submit an intervention plan to address low quality hospitals if Contractor contracts with hospitals performing in the lowest decile on state or national benchmarks for quality and safety. The intervention plan may include quarterly hospital performance reviews, providing technical assistance for specific quality and safety domains, implementation of corrective action plans, tying hospital payment to quality and safety, or excluding the hospital from the QHP network. The intervention plan is subject to review and approval by Covered California. Contractor must continue to comply with applicable network adequacy standards, with attention to geographical access needs and specific specialty service needs. If Contractor is required to exclude a hospital from the QHP network pursuant to the intervention plan, Contractor must immediately notify Covered California and the appropriate state regulator and licensing entity. Exclusion of a hospital may be subject to prior regulatory review and could result in required reductions in Contractor's licensed service area.

- 2) Covered California encourages collaboration among QHP Issuers in order to achieve maximum quality and safety performance in hospital networks. To this end, Covered California will provide technical assistance to foster this collaborative effort through the Clinical Leaders Forum, Plan Management Advisory group, and other venues as helpful.
- 3) To demonstrate Contractor is managing hospital and facility costs, Contractor must report:
 - a) The factors Contractor considers in assessing relative unit prices and total cost of care;
 - b) The extent to which Contractor adjusts for 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), or other factors;
 - c) How unit prices, total cost of care, and data obtained from the CMS Hospital Price Transparency Rule are used in the selection of facilities in networks for QHPs; and
 - d) The distribution of facilities by region and by cost decile, or describe other ways facilities are grouped by costs such as comparison of costs as a percentage of Medicare costs and the percentage of costs for Contractor that are expended in each cost decile.
- 4) Covered California supports price transparency as a resource for Enrollees to make better informed decisions about their healthcare services. In alignment with the CMS Hospital Price Transparency rule, Contractor shall report:
 - a) A list of network hospitals by region that do not provide a machine-readable file that includes payer-specific negotiated amounts for all the services that could be provided by the hospital on an inpatient or outpatient basis; and
 - b) The number and percent of network hospitals by region that provide information on the 70 CMS-specified shoppable services as a comprehensive machine-readable file with all items and services and in a display of shoppable services in a consumer-friendly format.

4.03.5 Hospital Payments to Promote Quality and Value

Hospitals play a pivotal role in providing critical care to those in the highest need and should be supported with coordinated efforts across health plans and purchasers. Value based payments can be a driver to promote and reward better quality care rather than payment based on service volume.

- 1) Contractor shall adopt a hospital payment methodology for each general acute care hospital in its QHP networks that ties payment to quality performance.

CMS Critical Access Hospitals, as defined by the Centers for Medicare and Medicaid, and long term care hospitals, inpatient psychiatric hospitals, rehabilitation hospitals, and children's hospitals are not subject to this requirement. Contractor is accountable for the quality of care and safety of Covered California Enrollees receiving care in these hospitals.

- 2) In developing payment methodology, Contractor shall consider data from Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), Leapfrog hospital safety scores, and Cal Hospital Compare Patient Safety Honor Roll.
- 3) Implementation of this requirement may differ for integrated delivery systems and accountable care organizations and require alternative mechanisms for linking payment to performance. Those hospitals participating in an IDS or ACO that have shared risk or other accountability for total cost of care shall be considered to have met this performance-based payment requirement as outlined in Article 4.03.5.
- 4) To demonstrate Contractor is adopting value-based payment models for hospitals, Contractor must report:
 - a) The amount and structure for its hospital performance-based payment strategy, including the shared-risk and performance payment structure to hospitals participating in ACOs, if applicable.
 - b) The metrics that are applied for performance-based payments such as: mortality, Hospital Associated Infections (HAIs), adherence to sepsis management guidelines, readmissions, or satisfaction as measured through HCAHPS. Such metrics should be commonly in use in hospitals and endorsed by the National Quality Forum to limit hospital measurement burden or in current use by the CMS Value Purchasing programs for Inpatient, Outpatient, and Ambulatory Surgery.

- c) The percent of network hospitals operating under contracts reflecting this payment methodology.
 - d) The dollars and percent, or best estimate, that are respectively paid or withheld to reflect value, including the extent to which the "at-risk" payments take the form of bonuses, withholds, or other performance-based payment mechanisms.
 - e) The dollars and percent, or best estimate, of hospital payments that are tied to hospital "improvement" versus "attainment" of a performance threshold.
- 5) Contractor shall work with Covered California to provide comparison reporting for the requirements in Article 4.03.5 for all lines of business to compare performance and inform future Covered California requirements in this area.

4.03.6 Hospital Patient Safety

Covered California has focused on aligned and collaborative efforts to promote hospital safety based on the recognition that improving hospital performance in this area requires a comprehensive and cross-payer approach. Monitoring and improving hospital safety measures will improve clinical outcomes and reduce wasteful healthcare spending.

- 1) Contractor shall work with Covered California to support and enhance acute general hospitals' efforts to promote safety for their patients.

CMS Critical Access Hospitals, as defined by the Centers for Medicare and Medicaid, and long term care hospitals, inpatient psychiatric hospitals, rehabilitation hospitals, and children's hospitals are excluded from this requirement.

- 2) Covered California has identified a set of patient safety measures for quality improvement focus consisting of five hospital associated infections (HAIs) measures and one sepsis management (SEP-1) measure. Substituting patient safety measures in future years will be done so in a transparent manner and in collaboration with stakeholders. The required patient safety measures are:
- a) Catheter-associated Urinary Tract Infection (CAUTI) (NQF #0138);
 - b) Central Line Associated Blood Stream Infection (CLABSI) (NQF #0139);
 - c) Surgical Site Infection (SSI) with focus on colon (NQF #0753);

- d) Methicillin-resistant Staphylococcus aureus (MRSA) (NQF #1716);
 - e) Clostridioides difficile colitis (C. Diff) infection (NQF #1717); and
 - f) Sepsis Management (SEP-1).
- 3) Contractor shall work with its contracted hospitals to pursue a Standardized Infection Ratio (SIR) of 1.0 or lower for each of the specified HAIs. Contractor shall also work with its contracted hospitals to improve adherence to the Sepsis Management (SEP-1) guidelines. Contractor must report its quality improvement strategies to improve safety in network hospitals. The quality improvement strategies will be informed by review of specified patient safety measures in Article 4.03.6.2 for all network hospitals.
- 4) Covered California is committed to addressing the opioid epidemic and continues to pursue improvement in the appropriate use of opioids in both the outpatient and hospital settings. Article 2.03.1 addresses opioid use in the outpatient setting. To support the appropriate use of opioids in the hospital setting, Contractor must:
- a) Report its strategies to improve the appropriate use of opioids in its network hospitals.
 - b) Encourage all network hospitals to utilize the Opioid Management Hospital Self-Assessment, which outlines key milestones to achieving opioid safety, and to participate in the Opioid Care Honor Roll program from Cal Hospital Compare. The self-assessment can be accessed from: https://calhospitalcompare.org/wp-content/uploads/2022/08/Opioid-Mgmt-Hospital-Self-Assessment_2023-1.pdf.

4.03.7 Maternity Care

According to the World Health Organization, maternal health refers an individual's health during pregnancy, childbirth, and the postpartum period. Covered California is committed to addressing all three phases to provide a comprehensive approach to maternal health.

- 1) Cesarean sections (C-sections) can be lifesaving, but significant numbers of low-risk, first-time pregnancies are undergoing this invasive surgery when it is not medically necessary. Reducing the rate of unnecessary C-sections improves health outcomes and patient safety. To avoid unnecessary C-sections, Contractor must:

- a) Work collaboratively with Covered California to promote and encourage all network hospitals that provide maternity services to use the resources provided by California Maternity Quality Care Collaborative (CMQCC) and enroll in the CMQCC Maternal Data Center (MDC).
- b) Review information on C-section rate for Nulliparous, Term, Singleton, Vertex (NTSV) deliveries and use it to inform a hospital engagement strategy to reduce NTSV C-sections, such as quarterly hospital and provider performance reviews, providing technical assistance for specific quality and safety domains, and other similar activities.
- c) Adopt value-based payment strategies structured to support only medically necessary care with no financial incentive to perform C-sections for all contracted physicians and hospitals by year end 2023. These value-based payment strategies include:
 - i. Blended case rate payment for both physicians and hospitals;
 - ii. Including a NTSV C-section metric in existing hospital and physician quality incentive programs; and
 - iii. Population-based payment models, such as maternity episode payment models.
- d) Contractor must report:
 - i. How it is engaging with providers and maternity Enrollees to promote the appropriate use of C-sections; and
 - ii. Its payment strategy for maternity care, including how this strategy promotes the appropriate use of C-sections, and the number and percent of network maternity hospitals under each strategy.
- e) Covered California expects Contractor to encourage providers with high rates of NTSV C-section delivery to pursue CMQCC coaching. Covered California expects Contractor to consider NTSV C-section rate, improvement trajectory, and willingness to engage in coaching as part of its maternity hospital contracting decisions and terms by year end 2023 and annually thereafter. Covered California does not expect Contractor to base potential network removal decisions on one measure alone.

2) Maternal health disparities exist across the full spectrum of maternal health, from preconception, to pregnancy, and the postpartum period. Disparities in maternal health disproportionately affect Black and Latino populations at higher rates than other racial groups. Reducing and eliminating gaps in maternal health requires a multifaceted approach. To accomplish this, Contractor must:

a) Collect measure results, stratified by race and ethnicity, for its Covered California Enrollees and submit patient level data files for the following HEDIS measures in accordance with Article 1.02.1 for:

- i. Prenatal Depression Screening and Follow-up (PND-E)
- ii. Postnatal Depression Screening and Follow-up (PDS-E)
- iii. Prenatal and Postpartum Care (PPC) (NQF #1517)

b) Report:

- i. How it engages with its contracted providers to improve performance on the maternal health measures in Article 4.03.7.2, which may include performance reviews, evidence-based interventions, and participation in quality collaboratives.
- ii. How it identifies maternal health disparities among its maternity Enrollees.
- iii. How it engages with hospitals and providers to address maternal health disparities. Engagement may include quarterly performance reviews, data analysis on race and ethnicity of its maternity Enrollees and outcomes, and implementation of corrective action plans.
- iv. How it ensures that its network perinatal providers, staff, and facilities are complying with the California Dignity in Pregnancy and Childbirth Act, which mandates implicit bias training in order to reduce the effects of implicit bias in pregnancy, childbirth, and postnatal care.
- v. How it supports its maternity Enrollees, such as access to culturally and linguistically appropriate maternity care, referrals to group prenatal care or community-centered care models for patients, in home lactation and nutrition consultants, doula support for prenatal, labor, delivery, and postpartum care, and related services.

- vi. How it ensures that its maternity Enrollees are aware of the supportive services available to them, including the services described in (v) above, and that Enrollees know how to access these services.
- c) Engage and work with Covered California to review its performance, stratified by race and ethnicity, on the Prenatal and Postpartum Care (PPC) (NQF #1517) measure reported in accordance with Article 1.02.1.
- d) Work collaboratively with Covered California to promote and encourage all in-network hospitals that provide maternity services to use the resources provided by California Maternity Quality Care Collaborative (CMQCC) and the California Department of Public Health's Maternal, Child and Adolescent Health (MCAH) Division to address maternal health disparities.

4.04 Telehealth

Telehealth includes synchronous and asynchronous patient-provider communication, remote patient monitoring, e-consults, hospital at home, and other virtual health services. Telehealth has the potential to improve access to and cost of care when used for the right conditions under the right payment models. Potential benefits include addressing barriers to care such as transportation, childcare, limited English proficiency (LEP), and time off work which may exist for Enrollees.

4.04.1 Telehealth Offerings

Contractor shall report the extent to which Contractor is supporting the use of telehealth, remote patient monitoring, and other technologies when clinically appropriate to assist in providing high quality, accessible, patient-centered care. Covered California encourages Contractor to use network providers to provide telehealth whenever possible. Contractor must continue to comply with applicable network adequacy standards for in-person services.

To monitor Contractor's telehealth services, Contractor must report:

- 1) The types and modalities of telehealth and virtual health services that Contractor offers to Covered California Enrollees, as well as the goal or desired outcome from the service (e.g., decreased ED visits, better access to specialty care, improved diabetes management, etc.), including:
 - a) Interactive dialogue over the phone (voice only encounter)
 - b) Interactive face to face (video and audio encounter)

- c) Asynchronous via email, text, instant messaging or other
 - d) Remote patient monitoring (e.g., blood pressure, glucose control, etc.)
 - e) e-Consult
 - f) Hospital at Home
 - g) Other modalities
- 2) How Contractor is communicating with and educating Covered California Enrollees about telehealth services including:
- a) Explaining service availability on key Covered California Enrollee website pages, such as the home page and provider directory page;
 - b) Explaining service cost-share on key Covered California Enrollee website pages like the summary of benefits and coverage page and medical cost estimator page; and
 - c) Explaining the availability of interpreter services for telehealth on key Covered California Enrollee website pages, such as the home page and provider directory page.
- 3) How Contractor facilitates the integration and coordination of care between third party telehealth vendor services and primary care and other network providers, particularly if the telehealth service is for urgent care, chronic disease management, or behavioral health.
- 4) How Contractor screens for Covered California Enrollee access barriers to telehealth services such as broadband affordability, digital literacy, smartphone ownership, and the geographic availability of high-speed internet services.
- 5) A description of Contractor's telehealth reimbursement policies for network providers and for third party telehealth vendors, including payment parity between:
- a) Telehealth modalities, including voice only when appropriate, and comparable in-person services.
 - b) Telehealth vendor and contracted provider rendered telehealth services.

- 6) The impact telehealth has on cost and quality of care provided to Covered California Enrollees, including the extent to which telehealth replaces or adds to utilization of specialty care, Emergency Department, or urgent care services.

4.04.2 Monitoring Telehealth Utilization

Contractor agrees to engage and work with Covered California to review its utilization of telehealth services using HEI data submitted in accordance with Article 5.02.1.

4.05 Participation in Quality Collaboratives

Improving healthcare quality and reducing overuse and costs can only be done over the long-term through collaboration, data sharing, and effective engagement of hospitals, providers, and other providers of care. There are several established statewide and national collaborative initiatives that are aligned with Covered California's requirements and expectations for quality improvement, addressing health disparities, and improving data sharing.

Covered California and Contractor will collaboratively identify and evaluate the most effective programs for improving care for Enrollees. Covered California may require participation in specific quality improvement collaboratives and data sharing initiatives in future years. To inform this process, Contractor must report its participation in any of the following collaboratives or initiatives, including the amount of financial support (if any) Contractor provides:

- 1) American Joint Replacement Registry (AJRR) for California
- 2) Cal Hospital Compare
- 3) California Maternal Quality Care Collaborative (CMQCC)
- 4) California Quality Collaborative (CQC)
- 5) Collaborative Healthcare Patient Safety Organization (CHPSO)
- 6) California Improvement Network (CIN)
- 7) California Right Meds Collaborative
- 8) Leapfrog
- 9) Integrated Healthcare Association (IHA)
- 10) Symphony Provider Directory

11) Health Care Payments Data (HPD) System

12) Other similar collaboratives or initiatives

DRAFT

ARTICLE 5 - MEASUREMENT AND DATA SHARING

Measurement is foundational to assessing the quality, equity, and value of care provided by Contractor to Enrollees. Because of this, Covered California uses a variety of HEDIS and CAHPS measures in its assessment of QHP performance, and is developing a robust Healthcare Evidence Initiative to assess further dimensions of quality, equity, and value. Contractor agrees to work with Covered California to exchange and prioritize feedback on measure development and measure sets. This includes measurement refinements related to the National Committee for Quality Assurance (NCQA) Electronic Clinical Data System, the Quality Rating System, and Healthcare Evidence Initiative measures.

With the healthcare industry increasingly using electronic health records, data sharing between patients, providers, hospitals, and payers is a critical driver of quality of care. Covered California is committed to making patient data available and accessible to support population health management, clinical care, and coordination. Efficient data sharing decreases healthcare costs, reduces paperwork, improves outcomes, and gives patients more control over their healthcare.

5.01 Measurement and Analytics

5.01.1 Covered California Quality Rating System Reporting

Contractor and Covered California recognize that the Quality Rating System is an important mechanism to monitor QHP Issuers for quality performance, a standardized source of consumer information for Enrollees and the public, and can inform measure alignment with other purchasers and measure sets.

- 1) Contractor shall collect and report to Covered California, for each QHP product type, its numerators, denominators, and rates for the measures included in the CMS Quality Rating System measure set. This includes data for select HEDIS and CAHPS measures and may also include data for other types of measures included in the Quality Rating System. Contractor must provide all collected data to Covered California each year regardless of CMS submission and reporting requirements.
- 2) Contractor shall work with Covered California, including participating in quality assurance activities, in order for Covered California to produce the Quality Rating System ratings each year.

- 3) Covered California reserves the right to use Contractor-reported data to construct Contractor summary quality ratings that Covered California may use for purposes such as supporting consumer choice, quality improvement efforts, establishing performance standards, and other activities related to Covered California's role as a Health Oversight Agency. Covered California will publicly report the Quality Rating System scores and ratings each year.

5.01.2 National Committee for Quality Assurance (NCQA) Quality Compass Reporting

Contractor and Covered California recognize that performance measure comparison for the Covered California population to national benchmarks for commercial and Medicaid lines of business promotes health equity, informs efforts to address health disparities, and ensures consistent quality of care across all populations. To enable performance measure comparisons to national benchmarks, Contractor shall:

- 1) Collect and report HEDIS and CAHPS scores to the National Committee for Quality Assurance (NCQA) Quality Compass for its commercial (which includes Covered California Enrollees) and Medi-Cal lines of business. This submission to NCQA Quality Compass shall include the numerator, denominator, and rate for the NCQA Quality Compass required measures.
- 2) Submit to Covered California HEDIS and CAHPS scores including the measure numerator, denominator, and rate for the required measures that are reported to the NCQA Quality Compass and DHCS, for each product type for which it collects data in California, if requested. For Contractors that have commercial lines of business that do not permit public reporting of their results to NCQA Quality Compass, HEDIS and CAHPS scores for the NCQA Quality Compass measures set must still be submitted to Covered California.
- 3) Report such information to Covered California in a form that is mutually agreed upon by the Contractor and Covered California and participate in quality assurance activities to validate measure numerator, denominator, and rate data.

5.02 Data Sharing and Exchange

5.02.1 Data Submission (Healthcare Evidence Initiative)

Contractor must comply with the following data submission requirements:

- 1) General Data Submission Requirements

- a) California law requires Contractor to provide Covered California with information on cost, quality, and disparities to evaluate the impact of Covered California on the healthcare delivery system and health coverage in California.
 - b) California law requires Contractor to provide Covered California with data needed to conduct audits, investigations, inspections, evaluations, analyses, and other activities needed to oversee the operation of Covered California, which may include financial and other data pertaining to Covered California's oversight obligations. California law further specifies that any such data shall be provided in a form, manner, and frequency specified by Covered California.
 - c) Contractor is required to provide Healthcare Evidence Initiative Data ("HEI Data") that may include data and other information pertaining to quality measures affecting Enrollee health and improvements in healthcare quality and patient safety. This data may likewise include Enrollee claims and encounter data needed to monitor compliance with applicable provisions of this Agreement pertaining to improvements in health equity and disparity reductions, performance improvement strategies, alternative payment methods, as well as Enrollee specific financial data needed to evaluate Enrollee costs and utilization experiences. Covered California shall only use HEI Data for those purposes authorized by law.
 - d) The Parties mutually agree and acknowledge that financial and other data needed to evaluate Enrollee costs and utilization experiences includes information pertaining to contracted provider reimbursement rates and historical data as required by applicable California law.
 - e) Covered California may, in its sole discretion, require that certain HEI Data submissions be transmitted to Covered California through a vendor (herein, "HEI Vendor") which will have any and all legal authority to receive and collect such data on Covered California's behalf.
- 2) Healthcare Evidence Initiative Vendor
- a) Contractor shall work with any HEI vendor which Covered California contracts with to assist with its statutory obligations.
 - b) The parties acknowledge that any such HEI Vendor shall be retained by Covered California and that Covered California shall be responsible for HEI Vendor's protection, use and disclosure of any such HEI Data.

- c) Notwithstanding the foregoing, Covered California acknowledges and agrees that disclosures of HEI Data to HEI Vendor or to Covered California shall at all times be subject to conditions or requirements imposed under applicable federal or California State law.
- 3) HEI Vendor Designation
- a) Should Covered California terminate its contract with its then-current HEI Vendor, Covered California shall provide Contractor with at least thirty (30) Days' written notice in advance of the effective date of such termination.
 - b) Upon receipt of the aforementioned written notice from Covered California, Contractor shall terminate any applicable data-sharing agreement it may have with Covered California's then-current HEI Vendor and shall discontinue the provision of HEI Data to Covered California's then-current HEI Vendor.
- 4) Covered California shall notify Contractor of the selection of an alternative HEI Vendor as soon as reasonably practicable and the parties shall at all times cooperate in good faith to ensure the timely transition to the new HEI Vendor.
- 5) HIPAA Privacy Rule
- a) PHI Disclosures Required by California law:
 - i. California law requires Contractor to provide HEI Data in a form, manner, and frequency determined by Covered California. Covered California has retained and designated an HEI Vendor to collect and receive certain HEI Data on its behalf.
 - ii. Accordingly, the parties mutually agree and acknowledge that the disclosure of any HEI Data to Covered California or to HEI Vendor which represents PHI is permissible and consistent with applicable provisions of the HIPAA Privacy Rule which permit Contractor to disclose PHI when such disclosures are required by law (45 CFR §164.512(a)(1)).

b) PHI Disclosures for Health Oversight Activities:

- i. The parties mutually agree and acknowledge that applicable California law (CA Gov Code §100503.8) requires Contractor to provide Covered California with HEI Data for the purpose of engaging in health oversight activities and declares Covered California to be a health oversight agency for purposes of the HIPAA Privacy Rule (CA Gov Code §100503.8).
- ii. The HIPAA Privacy Rule defines a “health oversight agency” to consist of a person or entity acting under a legal grant of authority from a health oversight agency (45 CFR §164.501) and HEI Vendor has been granted legal authority to collect and receive HEI Data from Contractor on Covered California’s behalf.
- iii. Accordingly, the parties mutually acknowledge and agree that the provision of any HEI Data by Contractor to Covered California or HEI Vendor which represents PHI is permissible under applicable provisions of the HIPAA Privacy Rule which permit the disclosure of PHI for health oversight purposes (45 CFR §164.512(d)).

c) Publication of Data and Public Records Act Disclosures

- i. Contractor acknowledges that Covered California intends to publish certain HEI Data provided by Contractor pertaining to its cost reduction efforts, quality improvements, and disparity reductions.
- ii. Notwithstanding the foregoing, the parties mutually acknowledge and agree that data shall at all times be disclosed in a manner which protects the Personal Information (as that term is defined by the California Information Privacy Act) of Contractor’s Enrollees or prospective Enrollees.
- iii. The parties further acknowledge and agree that records which reveal contracted rates paid by Contractor to healthcare providers, as well as any Enrollee cost share, claims or encounter data, cost detail, or information pertaining to Enrollee payment methods, which can be used to determine contracted rates paid by Contractor to healthcare providers shall not at any time be subject to public disclosure and shall at all times be deemed to be exempt from compulsory disclosure under the Public Records Act. Accordingly, Covered California shall take all reasonable steps necessary to ensure such records are not publicly disclosed.

- 6) Merative is the current HEI Vendor. Merative is the measure developer for select measures used by Covered California. The measure definitions are derived from the Merative Health Insights® solution for these select measures.

5.02.2 Interoperability and Patient Access

Covered California and Contractor recognize that interoperability is critical to improved data exchange which in turn is foundational to providing less fragmented, more coordinated care. Data interoperability, as well as Enrollee and provider access to health records, will also give Enrollees greater control of their health information to support self-management. To support data interoperability, Contractor must:

- 1) Implement and maintain a secure, standards-based Patient Access API consistent with the existing Centers for Medicare & Medicaid (CMS) Interoperability & Patient Access final rule (CMS-9115-F) and any technical updates associated with the new CMS Reducing Provider & Patient Burden by Improving Prior Authorization Processes, and Promoting Patients' Electronic Access to Health Information final rule (CMS-9123-P) for Federally Facilitated Marketplaces. Contractor must report:
 - a) The number and percent of patients accessing their Patient Access Application Programming Interface (API).
- 2) Enhance QHP Issuer information services for Covered California Enrollees consistent with the existing CMS Interoperability and Patient Access final rule (CMS-9115-F) and any technical updates consistent with the new CMS Reducing Provider and Patient Burden by Improving Prior Authorization Processes, and Promoting Patients' Electronic Access to Health Information final rule (CMS-9123-P) that requires QHP Issuer participation in payer-to-payer data exchange and consumer education for Federally Facilitated Marketplaces. Contractor must:
 - a) Participate in payer-to-payer data exchange at enrollment; and
 - b) Educate Covered California Enrollees about opting in to authorize data transfers from their prior health plan to their new health plan.

5.02.3 Data Exchange

Covered California and Contractor recognize that data sharing between patients, providers, hospitals, and payers is a critical quality of care driver. Contractor agrees to engage and work with Covered California to make patient data available and accessible to support population health management, clinical care, and coordination. Efficient data sharing decreases healthcare costs, reduces paperwork, improves outcomes, and gives patients more control over their healthcare. To support data sharing and data exchange, Contractor must:

- 1) Participate in a Health Information Exchange (HIE) that is a member of the California Trusted Exchange Network (CTEN).
- 2) Bi-directionally exchange information with HIE(s) as characterized by:
 - a) Receipt of information from an HIE(s); and
 - b) Dissemination of information to an HIE(s).
- 3) Report on the following activities to support data exchange with providers and hospitals:
 - a) Bi-directional exchange of information with one or more HIE(s) that participates in CTEN.
 - b) Data exchange initiatives that enhance health equity and access, specifically steps taken to support enhanced demographic and social risk factor data capture.
- 4) Work with Covered California and other stakeholders regarding a transition to a statewide approach to streamline Health Information Exchange participation and other efforts that could improve the exchange of data. This includes participation in the development of the “California Health and Human Services Data Exchange Framework” and plan of action associated with Health and Safety Code § 130290 (A.B. 133 (2021)), adoption of the 2015 Office of the National Coordinator for Health Information Technology Electronic Health Records standards, and discussions to develop future requirements beyond the existing federal standards.

- 5) Support and monitor its hospitals, consistent with the existing CMS Interoperability and Patient Access final rule (CMS-9115-F), in the application of the Medicare Condition of Participation to have electronic information exchange to notify primary care clinicians of Admission, Discharge, Transfer (ADT) events for Covered California Enrollees. Contractor must report the following:
 - a) Description of Contractor's actions to ensure hospitals, including psychiatric hospitals and critical access hospitals, are complying with the ADT notification requirements specified above;
 - b) Number and percent of hospitals, including psychiatric hospitals and critical access hospitals, that have implemented ADT notification for Covered California Enrollees; and
 - c) Description of the mechanisms Contractor has implemented to assist those hospitals not yet exchanging ADT data with primary care clinicians for Covered California Enrollees.

5.02.4 Data Aggregation

Covered California and Contractor recognize that aggregating data across purchasers and payers to more accurately understand the performance of providers that have contracts with multiple QHPs can improve performance, contracting, and public reporting. To support data aggregation, Contractor must:

- 1) Submit data to IHA and participate in the IHA Align. Measure. Perform (AMP) program and the IHA California Regional Healthcare Cost & Quality Atlas. Contractor must report performance results to Covered California or allow IHA to submit Contractor's performance results to Covered California on Contractor's behalf.
- 2) Submit data to IHA for use in the Advanced Primary Care measure set as specified in Article 4. Contractor must report performance results to Covered California or allow IHA to submit Contractor's performance results to Covered California on Contractor's behalf.

ARTICLE 6 - CERTIFICATION, ACCREDITATION, AND REGULATION

Covered California seeks to align with the standard measures and annual benchmarks for equity and quality in healthcare delivery established by the Department of Managed Health Care as required by Health and Safety Code § 1399.871 (A.B.133 (2021)). This furthers Covered California's goal to establish a common standard of core health plan functions across all QHP Issuers. Using a common standard will allow Covered California to phase in higher standards aimed at improving Enrollee outcomes that are aligned with a single health plan accreditation process and enhance coordinated improvement actions.

6.01 QHP Accreditation

6.01.1 NCQA Health Plan Accreditation

Contractor must maintain current health plan accreditation for its Covered California membership throughout the term of the Agreement. Contractor shall authorize the accrediting agency to provide information and data to Covered California relating to Contractor's accreditation, including the NCQA submissions and audit results, and other data and information maintained by its accrediting agency as required by 45 C.F.R. § 156.275.

Covered California required all Contractors to achieve NCQA health plan accreditation by year end 2024. If Contractor is not currently accredited by NCQA health plan accreditation, Contractor shall:

- 1) Submit a plan to Covered California regarding the status and progress of the pre-NCQA accreditation process to achieve NCQA health plan accreditation. The plan shall include a timeline specifying Contractor's expected NCQA approval date.
- 2) Be currently accredited by URAC or AAAHC health plan accreditation until NCQA health plan accreditation is achieved.

If Contractor first contracted with Covered California in Plan Year 2024 or later, and is not currently accredited by NCQA, Contractor is required to achieve accreditation within 12 months of submitting its initial application for QHP Certification or no later than 90 days before the second Open Enrollment Period that its QHPs are offered.

6.01.2 Accreditation Review

Contractor shall notify Covered California of the date of any accreditation review scheduled during the term of this Agreement and the results of such review.

Upon completion of any health plan accreditation review conducted during the term of this Agreement, Contractor shall submit to Covered California a copy of the assessment report within thirty (30) Days of receiving the report.

6.01.3 Changes in Accreditation Status

If Contractor receives a rating of less than accredited in any category, loses an accreditation, or fails to maintain a current and up to date accreditation, Contractor shall:

- 1) Notify Covered California within ten (10) business days of such rating(s) change. Contractor must implement strategies to raise Contractor's rating to a level of at least accredited or to reinstate accreditation. Contractor will submit a written corrective action plan (CAP) to Covered California within thirty (30) Days of receiving its initial notification of the change in rating or loss of accreditation.
- 2) Following the initial submission of the CAP, submit a written report to Covered California, when requested, but no less than quarterly, regarding the status and progress of the accreditation reinstatement. Contractor shall request a follow-up review by the accreditation entity no later than twelve (12) months after loss of accreditation and submit a copy of the follow-up assessment report to Covered California within thirty (30) Days of receipt, if applicable.
- 3) Proceed with any pre-NCQA Accreditation application submission steps to become newly accredited or re-accredited by NCQA.
- 4) Coordinate improvement efforts and the CAP, as applicable, with any improvement efforts and corrective action plan(s) required by Health and Safety Code, § 1399.872 (A.B.133 (2021)).

6.01.4 Disciplinary and Enforcement Actions

- 1) In the event Contractor's overall accreditation is suspended, revoked, or otherwise terminated, or in the event Contractor has undergone review prior to the expiration of its current accreditation and reaccreditation is suspended, revoked, or not granted at the time of expiration, Covered California reserves the right to terminate this Agreement, decertify Contractor's QHPs, or suspend enrollment in Contractor's QHPs, to ensure Covered California is in compliance with the federal requirement that all participating issuers maintain

a current approved accreditation pursuant to 45 C.F.R. § 156.275(a).

- 2) Upon request by Covered California, Contractor will identify all health plan certification or accreditation programs undertaken, including any failed accreditation or certifications, and will also provide the full written report of such certification or accreditation undertakings to Covered California.

DRAFT