2026-2028 Contract Update:
Generative AI, Virtual Care, Access and Attachment 2

July 2, 2024

AGENDA

Time	Topic	Presenter(s)
9:00-9:10	Welcome and Introductions	Charles Raya
9:10-9:20	Generative Artificial Intelligence	Barbara Rubino
9:20-9:35	Virtual Care	Barbara Rubino
9:35-9:50	Access	Monica Soni
9:50-10:20	Attachment 2	Taylor Priestley Barbara Rubino
10:20-10:30	Wrap Up & Next Steps	Charles Raya

Generative AI

Barbara Rubino, MD
Associate Chief Medical Officer
Health Equity & Quality Transformation Division (EQT)
Covered California

WHAT IS GENERATIVE ARTIFICIAL INTELLIGENCE?

Automation	Traditional AI	Generative AI
❑Rule-based systems that follow predetermined instructions to provide an output over and over again	❑Systems that learn from data given to them and make decisions based on that data, can ingest new data when data is added	❑Systems that learn from data and inputs and create something **new** from the information given to them

GENERATIVE AI IN HEALTHCARE: TRANSFORMATIVE OR TEMPORARY?

Potential Benefits of GenAI

- ❑ Proliferation of available tools and use cases
- ❑ Can increase team efficiency for manual tasks when used to **inform** its users
- ❑ Can make large amounts of information more easily accessible[2]
- ❑ Increasingly being applied in the care delivery system[1]

Potential Risks of GenAI

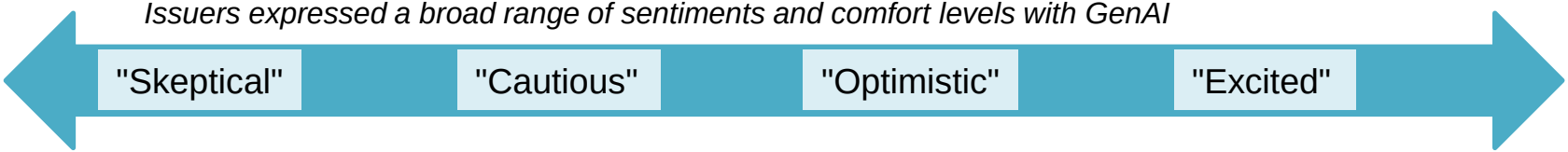
- ❑ Can hallucinate or produce erroneous responses[1]
- ❑ Known to introduce and amplify bias
- ❑ May pose significant privacy and security risks[3]
- ❑ Lack of evidence of its impact and efficacy to support decision making in healthcare

1. https://www.nature.com/articles/s41746-023-00988-4
2. https://www.hhs.gov/sites/default/files/public-benefits-and-ai.pdf?utm_medium=email&_hsenc=p2ANqtz--73e6xKUbx_gP2SEOb-Mulw4wl8Onfts4HhbWi0JcfmIdR21vn7uIEl_mdp3f6apbLmg17j-9XFfS22g4IbmFFwF0TliI127clDA37HtA7RoCbTrQ&_hsmi=307222479&utm_content=307222479&utm_source=hs_email
3. *JAMA.* 2023;330(4):313-314. doi:10.1001/jama.2023.9630

CURRENT PERSPECTIVES ACROSS ISSUERS

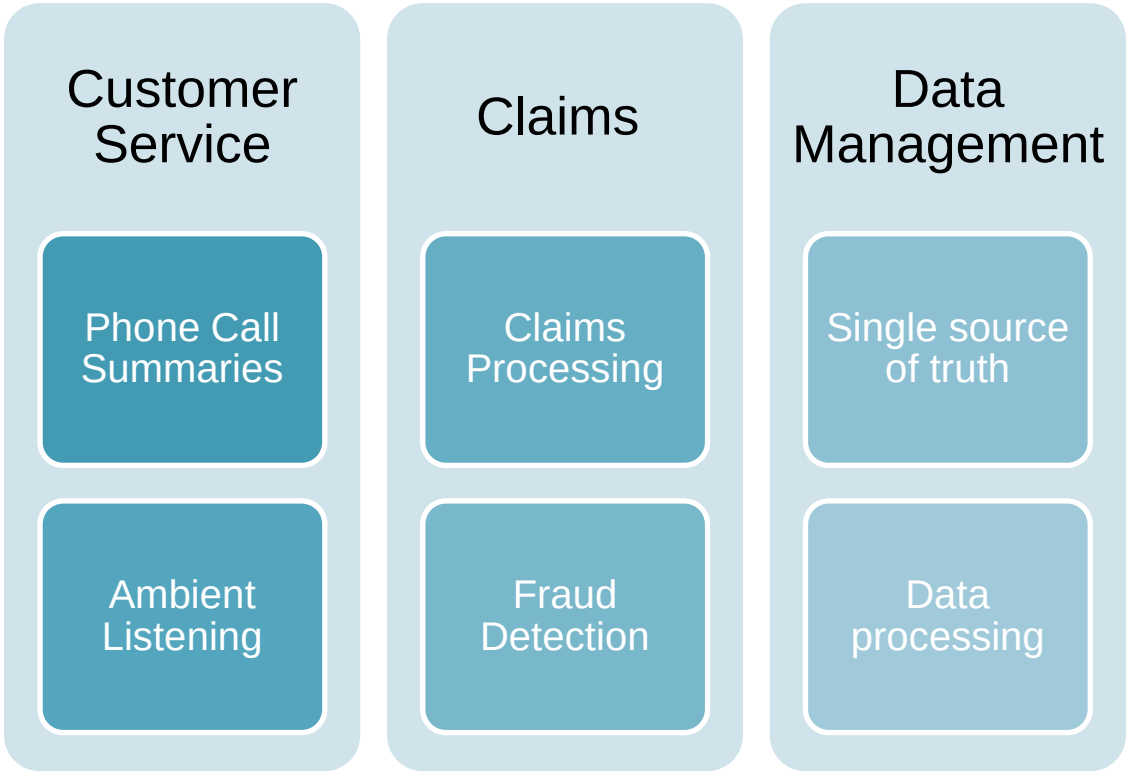
Covered California met with each QHP Issuer in Q1 2024 to explore current practices

Issuers expressed a broad range of sentiments and comfort levels with GenAI



- Policy and Security Concerns
- Data Management and Data Quality Concerns
- Concerns about Bias and Reliability
- Desire for Guidance and Best Practices
- Interest in Collaboration and Sharing

ISSUERS' CURRENT STATE USE CASES



PROPOSED 2026-2028 MODEL CONTRACT

New Section on Use of Generative AI	Rationale

Use of Generative Artificial Intelligence in Qualified Health Plan Issuer Operations: Best Practice and Bias Mitigation
❑ Incorporate best practices for GenAI in healthcare as they evolve across the state and national landscape
❑ Ensure transparency with members
  ❑ All materials generated by AI are referenced as such
  ❑ Members are alerted when AI is used as part of processes or determinations that affect their coverage or services they receive
❑ Implement processes to address and mitigate bias in GenAI algorithms or products
❑ Participate in collaborative discussions and shared learning sessions with Issuers and CCA
	❑ Support alignment and shared learning/best practices
	❑ Respond to Issuers' desire to experiment yet be clear about guardrails
	❑ Be proactive about identifying and mitigating bias

PROPOSED 2026-2028 MODEL CONTRACT

New Section on Use of Generative AI	Rationale

Use of Generative Artificial Intelligence in Qualified Health Plan Issuer Operations: Reporting Requirements
❑ Report on:
  ❑ All clinical use cases where GenAI is used
  ❑ Processes and approach to mitigate bias
  ❑ GenAI Governance approach
	❑ Facilitates CCA support and dissemination of best practices
	❑ Ensures accountability and provides for regular updates in a rapidly-evolving field

Virtual Care

Barbara Rubino, MD
Associate Chief Medical Officer

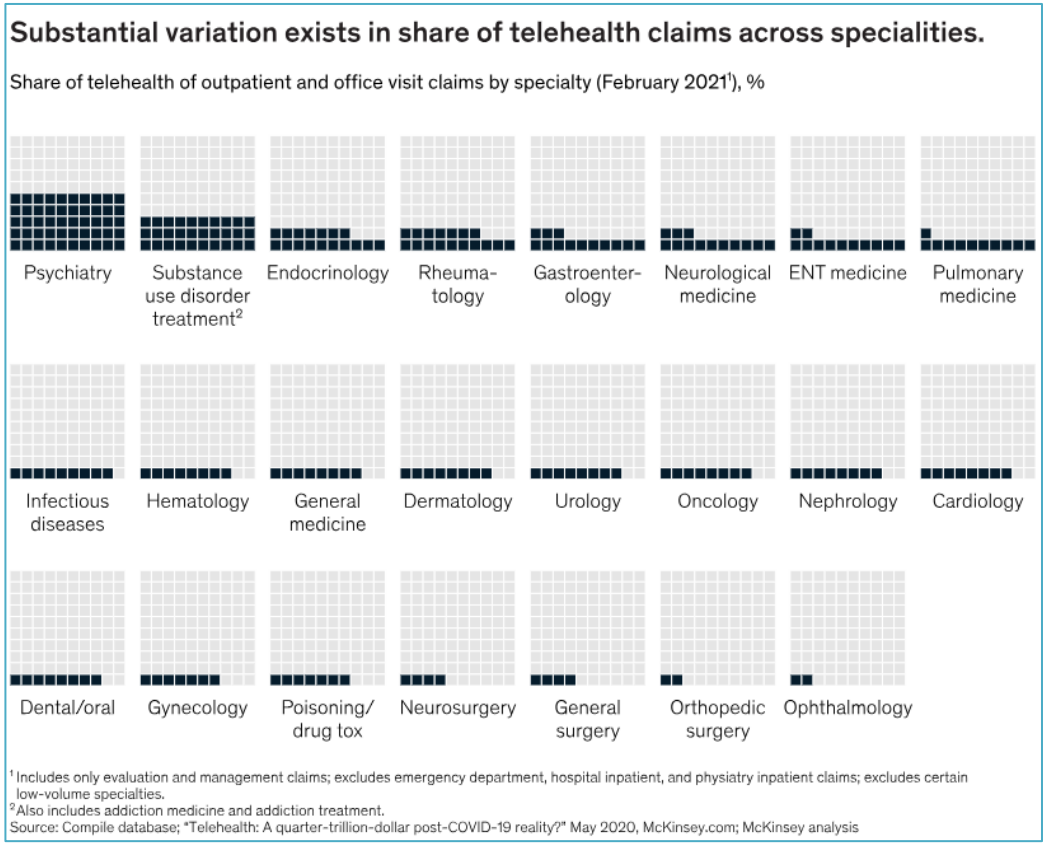
DEFINITIONS

- **Telehealth**: **mode of delivering health care services via information and communication technologies** to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care. **includes synchronous interactions and asynchronous** store and forward transfers. (Telehealth includes telemedicine) (Business and Professions Code section 2290.5(a)(6))

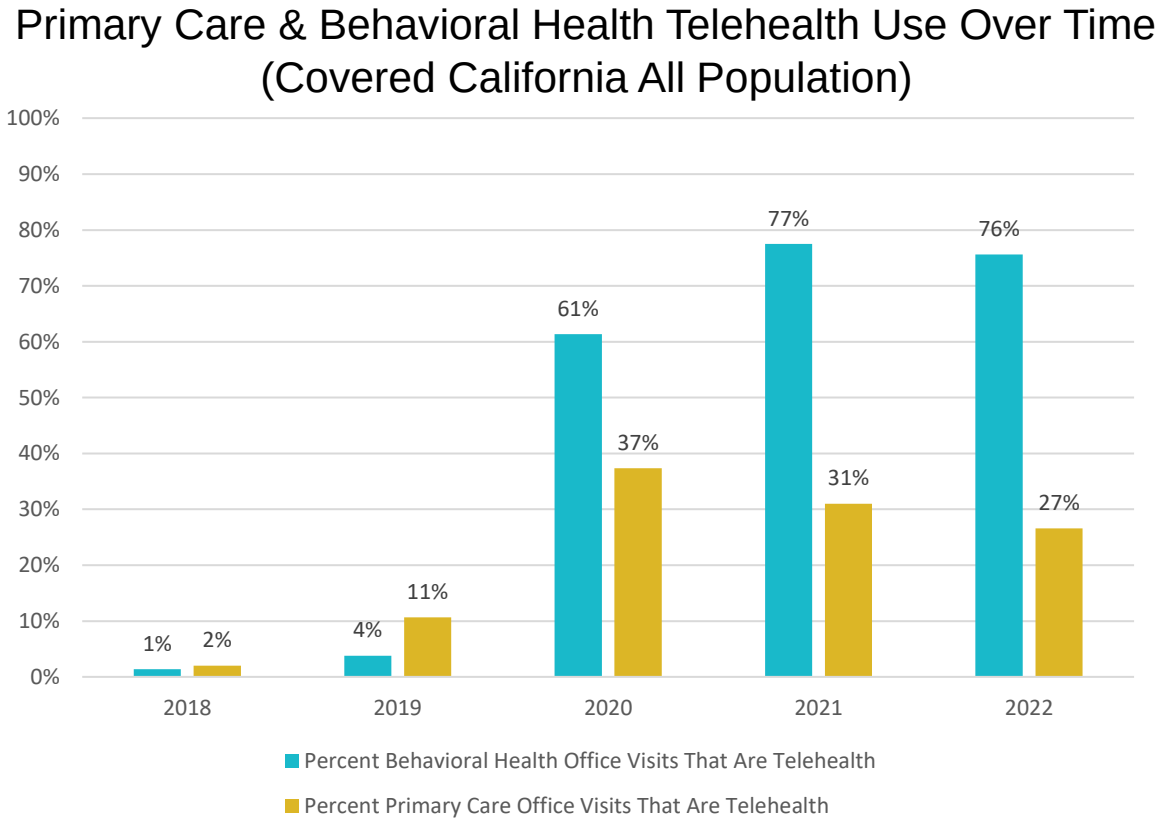
- **Virtual Care:** more broad term that encompasses **all means to digitally interact with patients**, including those done via telehealth and also inclusive of digital technologies such as remote patient monitoring, app-based interventions.

LANDSCAPE OF TELEHEALTH & VIRTUAL CARE

- Rapid adoption of virtual modalities resulting from COVID
  - April 2023 HHS Brief showed that 22% of adults in US reported telehealth use in the last 4 weeks
- Use varies widely by specialty
- Proliferation of virtual care point solutions and use cases without strong evidence to support quality



COVERED CALIFORNIA TELEHEALTH USE TRENDS



WHAT DO WE MEAN WHEN WE SAY VIRTUAL CARE?

Virtual Care Point Solutions

- ❑ Delivered via technology tools (video, chat, text)
- ❑ Prioritizes accessibility & flexibility
- ❑ May be offered direct to consumer, via employer, etc.

Virtual Modalities Used by Traditional Healthcare Teams

- ❑ Synchronous and asynchronous audio, video, e-visit, remote patient monitoring or e-consult
- ❑ Additional tool in the toolkit of visit types and ways to connect with patients
- ❑ Adjunct or complement to in-person option

LIMITED AND MIXED EVIDENCE EXISTS DEPENDING ON MODALITY, SPECIALTY

- ❑ Deliver timely access to care
- ❑ Specific use cases have evidence of quality
  - ❑ Tele dermatology (i.e., store and forward) is a reliable diagnostic method
  - ❑ Virtual behavioral health, smoking cessation interventions
  - ❑ Treatment of acute conditions (i.e., UTI)
- ❑ Serves some patients not otherwise engaging with healthcare system (e.g., rural, transportation limited)

- ❑ Do not deliver care equitably
  - ❑ Virtual Care services are inequitably distributed and utilized
  - ❑ May preferentially decrease barriers for those with high rate of engagement at baseline
- ❑ May increase healthcare costs and ER visits
  - ❑ Virtual Visit with non-familiar PCP increases 7d ER rate
- ❑ Increasing instability in the retail and tech-enabled clinical models disrupt relationships

PROPOSED 2026-2028 ATT 1 CHANGES

Att 1 - Virtual Care	Rationale

Use of Virtual Care - Vendors & Point Solutions:
❑ Report to Covered California all virtual care point solutions / vendors used
  ❑ Encourage and report on NCQA Virtual Care Accreditation (PC and UC) status for all vendors
❑ Require all vendors offering digital interventions and/or virtual care to have quality monitoring measures in place and submit list of measures annually to Covered California
❑ Offer navigation and support to members seeking virtual services
  ❑ Deploy framework to guide members to virtual solutions that best suit their needs
  ❑ Share navigation tools, processes, and member-facing resources with Covered California
❑ Share strategies in place to reduce fragmentation and duplication of services
	❑ Wide array of virtual care point solutions available on the market, with mixed and limited evidence of their impact on health outcomes
	  ❑ NCQA has recognized this and has already piloted its proposed standards
	❑ Spectrum of virtual point solutions offered by Issuers, Covered California wants to ensure equitable access through navigation and extra support

PROPOSED 2026-2028 ATT 1 CHANGES

Att 1 - Virtual Care	Rationale

Use of Virtual Care – Virtual Modalities used by Healthcare Teams:
❑ Engage with Covered California to evaluate virtual care utilization patterns in HEI and disparities found
  ❑ Contract will submit improvement plan for outlier findings
  ❑ Contractor will engage in cross-industry collaboratives on best practice, including digital literacy efforts
❑ Offer navigation and support to members interested in connecting with providers who offer both virtual and in-person modalities
  ❑ Encourage provider directory to display or highlight providers with multi-modal capabilities
	❑ Predominant or very prevalent modality, depending on type of care delivered (BH, PC)
	❑ Evidence supports benefits of accessing and using virtual care when used as one tool to maintain engagement and continuity with patients
	  ❑ Covered California wants to support members in engaging with care in whichever ways work best for them
	  ❑ Members in rural locations or with barriers to transportation may benefit from clinical teams who have telehealth capabilities

Access

S. Monica Soni, MD
Chief Medical Officer
Chief Deputy Executive Director, EQT

ACCESS IS BAD AND INEQUITABLY SO

- **48% of Californians** report waiting longer than they thought reasonable to get an **appointment for physical health** care
  - **Low-income** Californians report **waiting longer** than those with higher incomes
  - **Black and Latino/x** Californians more likely to report **waiting longer** than White Californians
- **55% of Californians** who tried to make an **appointment for mental health** care report waiting longer than they thought was reasonable
  - **Black Californians are nearly 3x** as likely to report waiting than White Californians
- In a secret shopper study in California, among **Spanish-speaking callers** who reached a live scheduler, **22% reached someone who did not engage** (eg, were hung up on) and, as a result, could not obtain appointment information for depression medication.

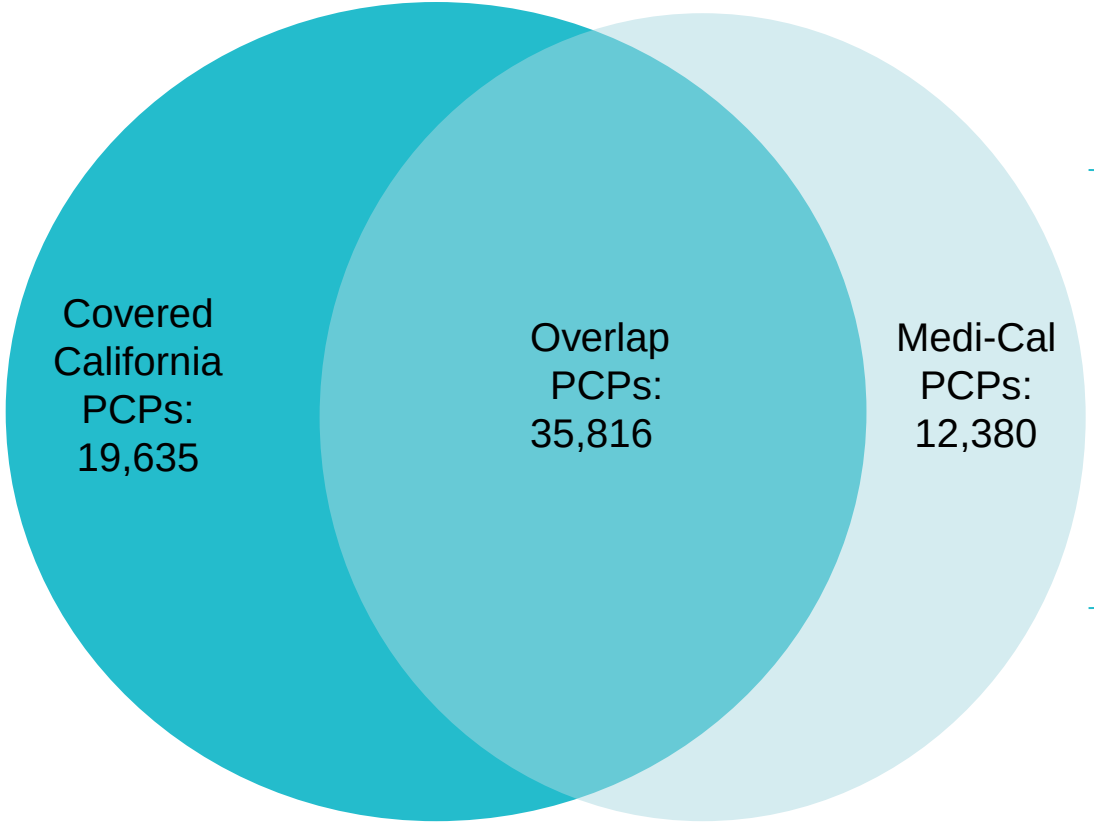
https://www.chcf.org/wp-content/uploads/2024/01/2024CHCFCAHealthPolicySurvey.pdf
https://academic.oup.com/healthaffairsscholar/article/1/3/qxad033/7242276

DHCS' ACCESS MONITORING STRATEGY

- California Department of Health Care Services (DHCS) is developing a centralized and standardized access-monitoring strategy across Medi-Cal's four managed care delivery systems: Medi-Cal Managed Care (MCMC), Dental Managed Care (Dental MC), Specialty Mental Health Services (SMHS), and Drug Medi-Cal Organized Delivery System (DMC-ODS).
- Proposed domains include beneficiary characteristics, provider availability and accessibility, service use, beneficiary experience & beneficiary outcomes,
- Tools include:
  - ✓ Annual secret shopper surveys
  - ✓ Annual enrollee experience surveys
  - ✓ A comprehensive set of access measures
  - ✓ HEDIS quality measures focused on access and follow-up

https://www.cms.gov/newsroom/fact-sheets/medicaid-and-childrens-health-insurance-program-managed-care-access-finance-and-quality-final-rule

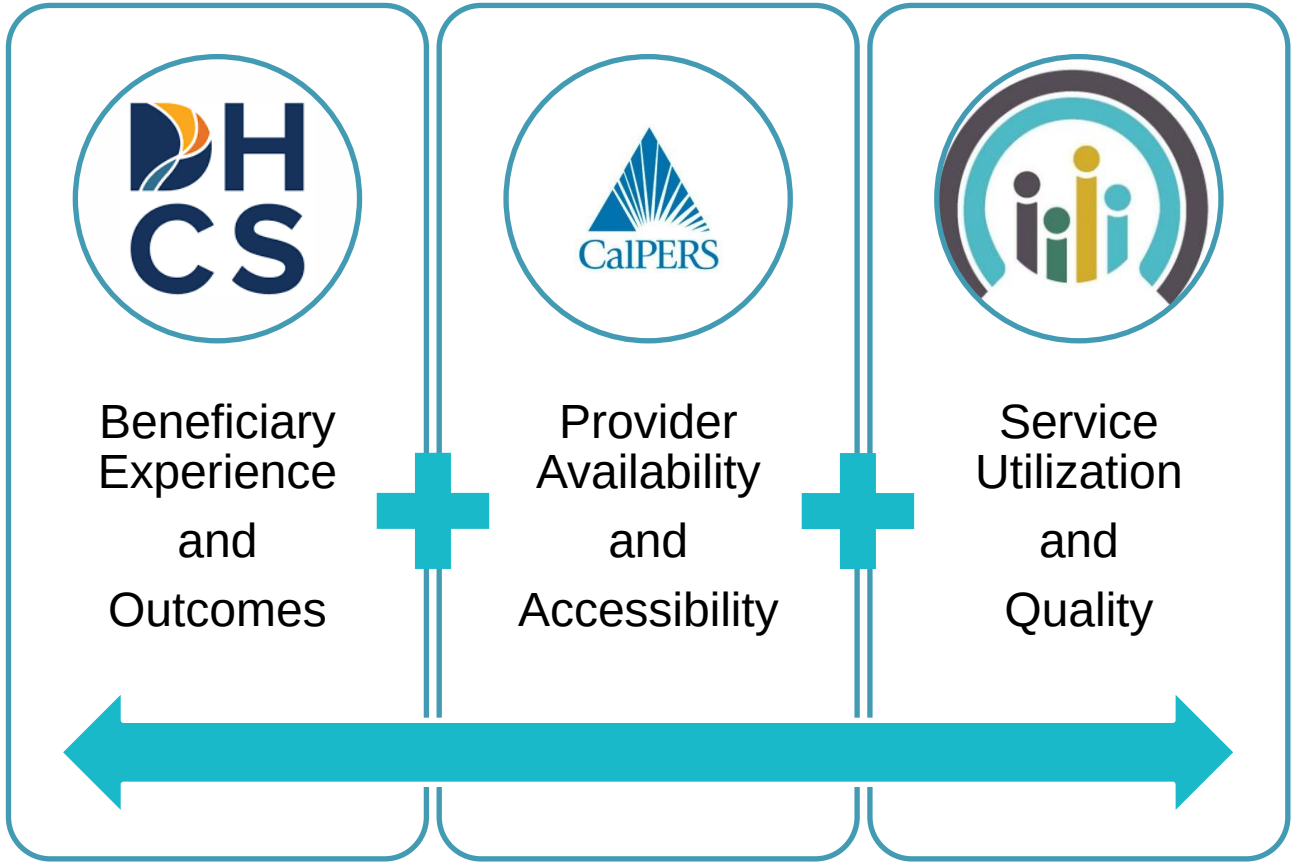
PRIMARY CARE PROVIDER NETWORK OVERLAP



74% of all Medi-Cal primary care providers are in-network for Covered California enrollees

Analysis used Primary Care Provider NPI from October 2023 Provider Files

AN ALIGNED STATE-WIDE APPROACH TO ACCESS MONITORING



PROPOSED 2026-2028 ATT 1 CHANGES

Att 1 - Access	Rationale

Access Monitoring:
❑ Beneficiary Experience and Outcomes:
  ❑ CMS QRS Enrollee Experience performance will be continued to tracked and reported publicly, although removed from Attachment 2
  ❑ QRS measures on access are part of 25/2/2
❑ Provider Availability and Accessibility
  ❑ Covered California leverage HEI for new network measures
  ❑ Improvement plans will be required for underperforming issuers
❑ Service Utilization and Quality
  ❑ Covered California will launch a secret shopper survey utilizing questions from DHCS and CalPERS surveys in PY2026
  ❑ Improvement plans will be required for underperforming issuers
  ❑ Repeat survey may be implemented biennially if pervasive underperformance
	❑ Multifaceted approach to monitoring access
	❑ Leverages work occurring within DHCS and CalPERS
	❑ High degree of overlap with Medi-Cal and Covered California primary care network
	❑ Administrative burden of implementation shouldered by Covered California
	  ❑ Only underperforming plans will submit improvement plans

PROPOSED PROVIDER AVAILABILITY AND ACCESSIBILITY MEASURES

Measure	Description	Numerator Denominator	Data Source
Provider-to-member ratio (with subset analysis for PCP, Specialty, behavioral health, pediatric dental providers, etc.)	Number of providers per beneficiary	**Numerator:** Number of providers contracting with plan **Denominator:** Number of beneficiaries enrolled in plan	Enrollment file Provider directory
Active providers (with subset analysis for PCP, Specialty, behavioral health, pediatric dental providers, etc.)	Percentage of providers serving beneficiaries in the past year	**Numerator:** Number of providers serving none,1 to 49, or over 50 of the plan's beneficiaries **Denominator:** Number of providers contracting with plan	HEI/Claims Provider directory
Provision of telehealth services (with subset analysis for PCP, Specialty, behavioral health, etc.)	Percentage of providers providing telehealth services	**Numerator:** Number of providers that billed at least one telehealth service in the MY **Denominator:** Number of providers contracting with plan	HEI/Claims Provider directory

Attachment 2

Taylor Priestley
Director, EQT
Health Equity Officer

SUMMARY OF 2023-2025 ATT 2 & PERCENT AT RISK

Performance Area	Performance Standards with Penalties	Percent of At-Risk Amount 2023	Percent of At-Risk Amount 2024	Percent of At-Risk Amount 2025
Health Disparities 30%	1. Reducing Health Disparities: Demographic Data Collection – Enrollee Race and Ethnicity Self-Identification	10%	5%	5%
	2. Reducing Health Disparities: Demographic Data Collection – Enrollee Spoken and Written Language	10% (for reporting)	5%	5%
	3. Reducing Health Disparities: Disparities Reduction Intervention	10%	10%	10%
	4. National Committee for Quality Assurance (NCQA) Health Equity Accreditation	0%	10%	10%
Payment 25%	5. Primary Care Payment	10%	10%	10%
	6. Primary Care Spend	10% (for reporting)	5%	5%
	7. Payment to Support Networks Based on Value	10% (for reporting)	10%	10%
Enrollee Experience 20%	8. Quality Rating System (QRS) QHP Enrollee Experience Summary Indicator Rating	20%	20%	20%
Data 20%	9. Healthcare Evidence Initiative (HEI) Data Submission	20%	20%	20%
Oral Health 5%	10. Dental Quality Alliance (DQA) Pediatric Measure Set	0%	5%	5%

PROPOSED 2026-2028 ATTACHMENT 2 CHANGES

Notable Changes to Draft IND Attachment 2	Rationale
Performance Standard 1 Reducing Health Disparities: Demographic Data Collection – Enrollee Race and Ethnicity Self-Identification No changes proposed	Critical to our health equity work and our ability to stratify performance, identify disparities, and hold Issuers accountable to equity
Performance Standard 2 Reducing Health Disparities: Demographic Data Collection – Enrollee Spoken and Written Language No changes proposed	Critical to our health equity work and our ability to stratify performance, identify disparities, and hold Issuers accountable to equity

PROPOSED 2026-2028 ATTACHMENT 2 CHANGES

Notable Changes to Draft IND Attachment 2	Rationale
Performance Standard 3 Reducing Health Disparities: Disparities Reduction Intervention Recommendation: Retire as performance standard	The Quality Transformation Initiative (QTI) and its Health Equity Methodology is the mechanism by which Covered California will hold health plans financially accountable for equitable outcomes.
Performance Standard 4 NCQA Health Equity Accreditation Recommendation: Retire as performance standard	NCQA Health Equity Accreditation will remain as a contract requirement but will no longer be an area of financial accountability.

PROPOSED 2026-2028 ATTACHMENT 2 CHANGES

Notable Changes to Draft IND Attachment 2	Rationale
Performance Standard 5 Primary Care Payment Recommendation: Retire as performance standard	As discussed in May Workgroup, OHCA is implementing primary care payment and spend targets. We will retain contract language to require reporting in Article 4 and align with OHCA's methodology.
Performance Standard 6 Primary Care Spend Recommendation: Retire as performance standard	As discussed in May Workgroup, OHCA is implementing APM targets. We will retain contract language to require reporting in Article 4 and align with OHCA's methodology.
Performance Standard 7 Payment to Support Networks Based on Value Recommendation: Retire as performance standard	As discussed in May Workgroup, OHCA is implementing APM targets. We will retain contract language to require reporting in Article 4 and align with OHCA's methodology.
Performance Standard 8 Quality Rating System (QRS) QHP Enrollee Experience Summary Indicator Recommendation: Retire as performance standard	As discussed in March Workgroup, propose to continue to collect enrollee experience data and explore other survey mechanisms but remove performance standard

PROPOSED 2026-2028 ATTACHMENT 2 CHANGES

Proposed Changes to Draft IND Attachment 2	Rationale

Performance Standard 9 HEI Data Submission
Recommendation:
❑ Consolidate all components of current PS 9 into one performance standard
❑ Assess performance using a unified and comprehensive methodology document that outlines all timely and complete data expectations
  ❑ Incorporates expectations around submission of enrollment, claims, capitation, and embedded dental data across product types
❑ Incorporate use of Corrective Action Plan (CAP) to address gaps in HEI data submissions when assessed against methodology
❑ Only if Issuer fails to address data quality issues by timeframe and through plan specified in CAP will financial penalty be assessed
	❑ HEI data should be submitted to support high priority use cases
	  ❑ Use cases align with QHP Issuer contract, Strategic Plan, and CCA's mission
	❑ For every Issuer, potential data gaps are different and distinct
	  ❑ Unified methodology to define complete, usable, timely data submissions allows for understanding of each Issuer's unique issues and a tailored plan to address gaps in partnership with CCA

PROPOSED 2026-2028 ATTACHMENT 2 CHANGES

Reevaluating the Approach to PS 9 HEI Data Submission

HEI Data Submission Performance Standard – Proposed Pathway for Feedback

- Proposal for robust dialogue and regular engagement to identify and address HEI data issues through:
  1. Regular, standing meetings
  2. Monthly reports which highlight gaps in accordance with assessment criteria
  3. Technical assistance for individual Issuer to identify plan and specific timeline for remediation (which may include data replacement)
  4. Reassess data
     - If issue has been resolved, no further action
     - If issue persists, plan receives a warning regarding progression to potential Corrective Action Plan (CAP)
  5. Issuer re-attempts fix and provides updated timeline
  6. Reassess data
     - If issue has been resolved, no further action
     - If Issue persists, plan receives CAP
  7. CAP is implemented and goes into effect, including data gaps to be addressed with timeline
  8. Per stipulations of CAP, if the issue is not addressed in accordance with formal CAP and timeline, penalty will be assessed

PROPOSED 2026-2028 ATTACHMENT 2 CHANGES

New Performance Standard to Draft IND Attachment 2	Rationale
Engagement in Collaboratives and with Community ❑ Issuer will engage in learning collaboratives and other activities as set forth by Covered California (i.e., CalHealthcare Compare, IHA) ❑ Issuer will engage in improvement activities co-created by community, community-based organizations, members or patients ❑ Issuer will share best practices and learnings with other CCA Issuers	▪ We have identified variation in level of engagement of participation in healthcare quality collaboratives across Issuers ▪ Cross-Issuer collaboration on quality and equity initiatives is more likely to be effective and accelerates progress ▪ We believe that quality and equity interventions should be co-created with members and community-based organizations (https://www.chcf.org/publication/equitable-co-design-in-health-care/, https://dmc.mn/wp-content/uploads/2022/01/Community_CoDesign_Booklet.pdf)

PROPOSED 2026-2028 ATTACHMENT 2 CHANGES

Notable Changes to Draft IND Attachment 2	Rationale
Performance Standard 10 Pediatric Oral Evaluation, Dental Services (NQF #2517) Recommendation: No changes proposed	Pediatric oral health and dental disparities are core to our work to improve health outcomes and hold Issuers accountable
Performance Standard 11 Pediatric Topical Fluoride for Children, Dental Services (NQF #2528) Recommendation: No changes proposed	Pediatric oral health and dental disparities are core to our work to improve health outcomes and hold Issuers accountable

PROPOSED 2026-2028 ATTACHMENT 2 CHANGES

New Performance Standard to Draft IND Attachment 2	Rationale
Primary Care and Utilization: **Overall Member Engagement** ❑ Issuer must track and report non-utilization of healthcare services for members meeting a continuous enrollment threshold. ❑ Issuer shall submit the required Covered California Evidence Initiative (HEI) Data for each measurement year to generate its non-utilization rates. ❑ Covered California may set baseline rates and improvement targets, if appropriate.	▪ Literature and evidence-based impact shows that primary care exhibits a clear dose-response relationship, improving health outcomes while reducing ER visits, hospitalizations, and mortality rates. ▪ Increased access to primary care also correlates with significant cost savings across the healthcare system ▪ Fosters accountability and supports quality improvement activities. ▪ Emphasizing primary care metrics encourages patient-centered practices. This approach builds trust, improves care coordination, and leverages technology

PROPOSED 2026-2028 ATTACHMENT 2 CHANGES

New Performance Standard to Draft IND Attachment 2	Rationale
Primary Care Utilization: **Measuring Continuity of Care** ❑ Issuer must track and report continuity of care assessment and other analytics to measure advanced primary care. ❑ Issuer shall submit the required Covered California Healthcare Evidence Initiative (HEI) Data for each measurement year. ❑ Covered California may set baseline rates and improvement targets, if appropriate.	▪ In addition to the rationale listed in Overall Member Engagement, continuity of care fosters better care coordination among providers. Continuity ensures that patients receive consistent and integrated health services ▪ Promotes regular monitoring of patients' health status and adherence to preventive care guidelines ▪ Enhances patient satisfaction and builds trust between patients and providers

SUMMARY OF PROPOSED 2026-2028 ATT 2

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

Wrap-up and Next Steps

Please submit feedback on today's topics, questions, and suggestions for future meetings to EQT@covered.ca.gov

Thank you!