Advancing Equity, Quality and Value
2026-2028 QHP Issuer Model Contract Update

June 6, 2024

AGENDA

Time	Topic	Presenter
9:00-9:10	Welcome and Introductions	Charles Raya
9:10-10:00	Behavioral Health	Steph Carlson Charles Raya
10:00-10:25	Essential Community Providers (ECPs)	Lizzeth Romero Taylor Priestley
10:25-10:30	Wrap Up & Next Steps	Charles Raya

Attachment 1 Article 2 Behavioral Health

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2023-25 ATTACHMENT 1 REQUIREMENTS

Article 2: Behavioral Health

- Issuers must submit NCQA Health Plan Accreditation Network Management reports, or a comparable report, for the elements related to the issuer's behavioral health provider network.
- Issuers must promote access to behavioral health services and offer telehealth for behavioral health services.
- Issuers must annually report Depression Screening and Follow Up (NQF #0418) measure results for Covered California enrollees; Covered California will engage with issuers to review their performance.
- Issuers must promote the appropriate use of opioids using a harm reduction framework and individualized approach to treatment planning aligned with Smart Care California guidelines.
- Covered California will monitor the Pharmacotherapy for Opioid Use Disorder measure and Medication Assisted Treatment (MAT) prescriptions through HEI and engage with issuers to review their performance.

2023-25 ATTACHMENT 1 REQUIREMENTS

Article 2: Behavioral Health

- Issuers must promote the integration of behavioral health services with medical services, report the percent of enrollees cared for under integrated models, and whether the issuer reimburses for the Collaborative Care Model claims codes.
- Issuers must oversee delegated entities to ensure enrollees' access to quality behavioral health care, including monitoring and evaluating behavioral health quality. Issuers must submit a delegation report describing entities, types, purpose and description.

WHAT DO WE KNOW ABOUT THE STATE OF BEHAVIORAL HEALTH?

WHAT WE KNOW ABOUT BEHAVIORAL HEALTH

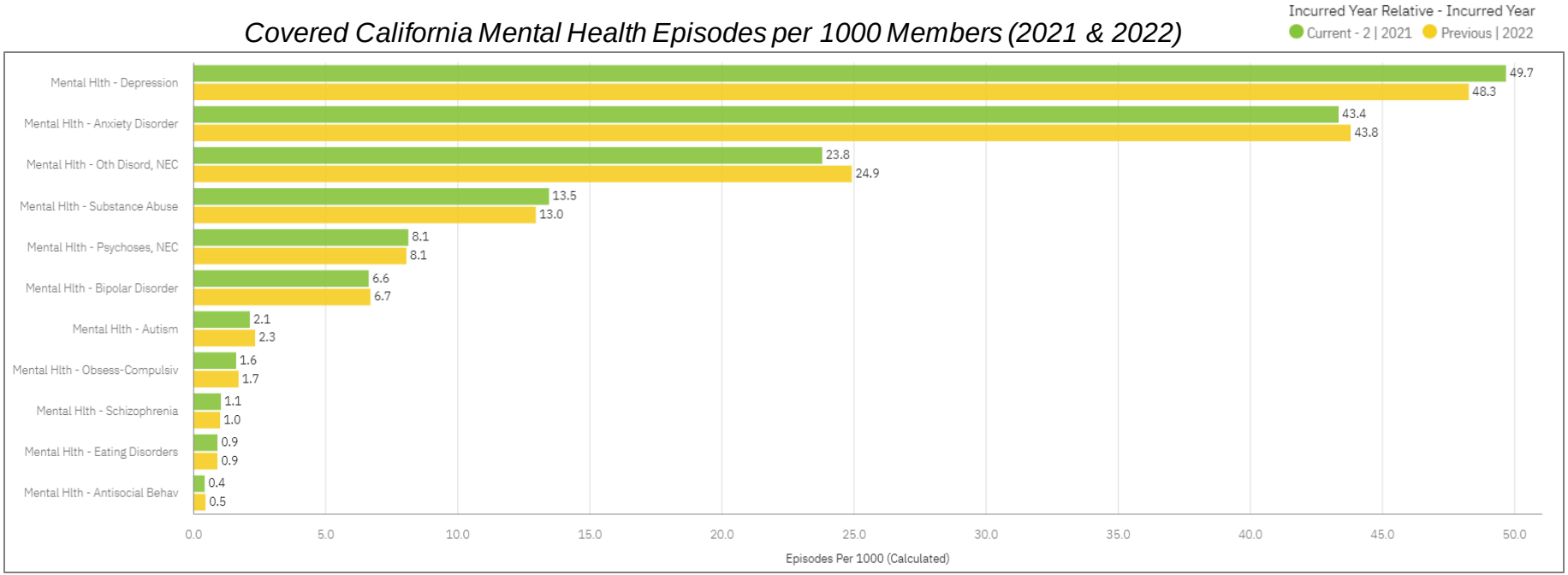
In the US -

- 1 in 5 adults experience a mental health issue each year in the U.S.
  - Depression is one of the most common mental disorders in the U.S.
- Suicide is the second leading cause of death AI/AN youth (15 to 24) in the US.
- Substance Use Disorders are common
  - Alcohol misuse in 2022: 137.4 million people
  - Cannabis misuse in 2022: 42.3 million people
  - Opioid misuse in 2022: 7.9 million people

MOST COMMON DIAGNOSES ACROSS COVERED CALIFORNIA

1. Depression
2. Anxiety
3. “Other” Mental Health Disorders
4. Substance Use Disorders
5. Psychotic Disorders

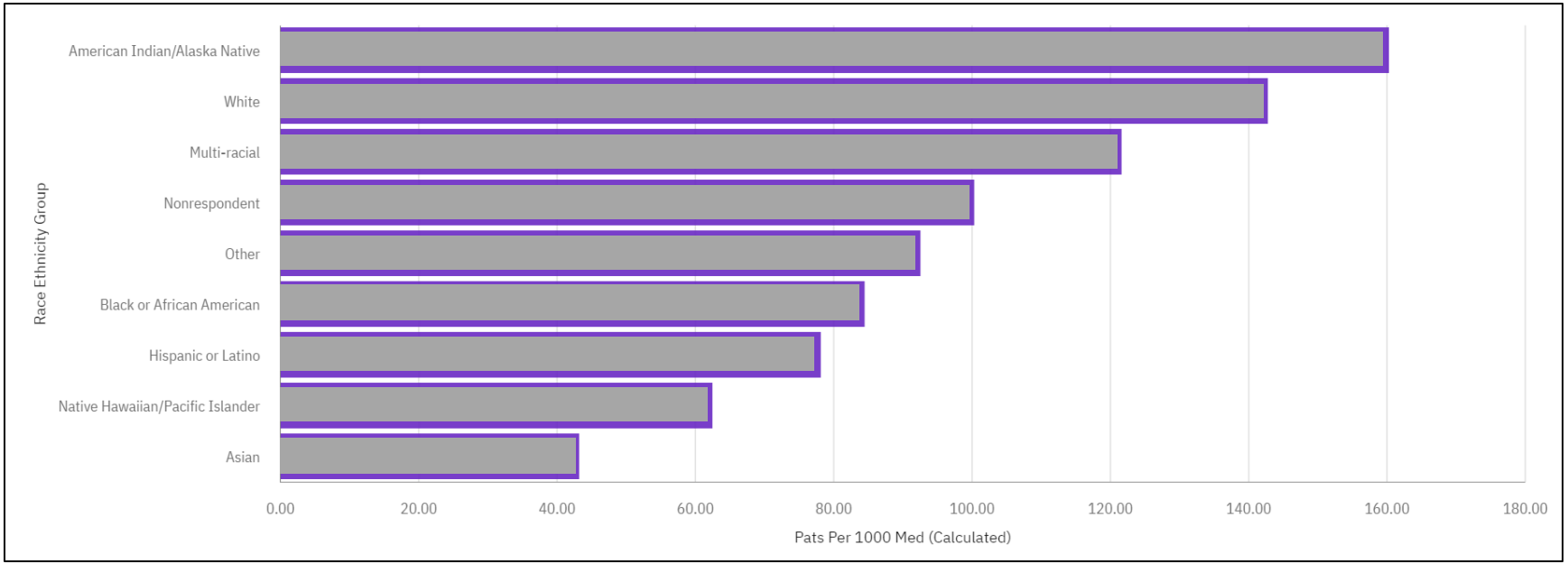
Covered California Mental Health Episodes per 1000 Members (2021 & 2022)



PREVALENCE VARIES BY RACE/ETHNICITY

Consistent with national data, prevalence varies by race/ethnicity with disparities in burden of disease and severity

Covered California Mental Health Condition Rates by Race/Ethnicity (2022)



BEHAVIORAL HEALTH UTILIZATION

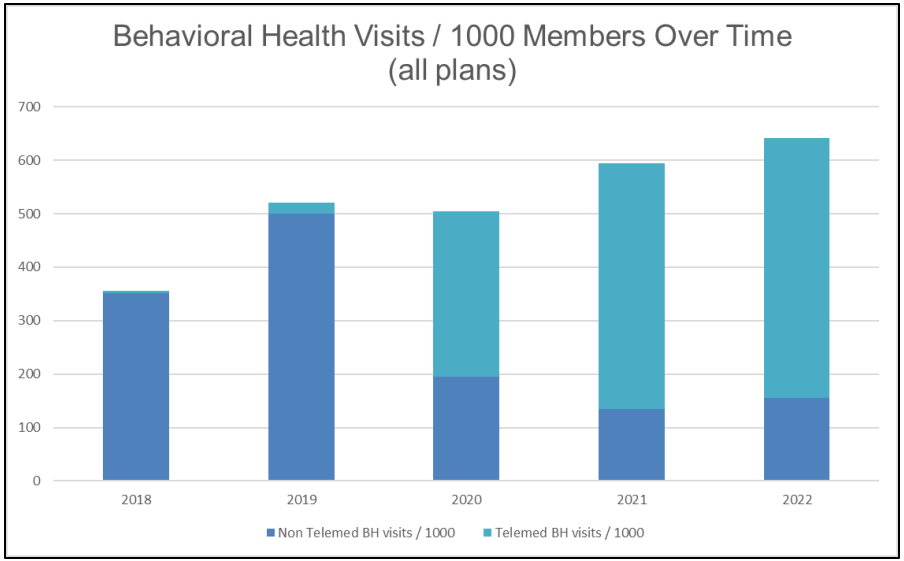
Behavioral Health Utilization by Race (2022)

Race/Ethnicity Group	Prevalence of MH Conditions/1000 Members	Behavioral Health Visits/1000 (median)
American Indian/Alaska Native	160	431
Asian	44	202
Black or African American	84	644
Hispanic or Latino	78	409
Multi-racial	121	923
Native Hawaiian/Pacific Islander	62	402
Other	92	553
White	142	867

MEETING MEMBER NEEDS

- Behavioral Health utilization continues to rise year over year
- The telehealth modality is dominant in Behavioral Health
- This contrasts with what is observed in Primary Care
  - ✓ 27% of Primary Care visits were categorized as telehealth, versus 76% for Behavioral Health in 2022

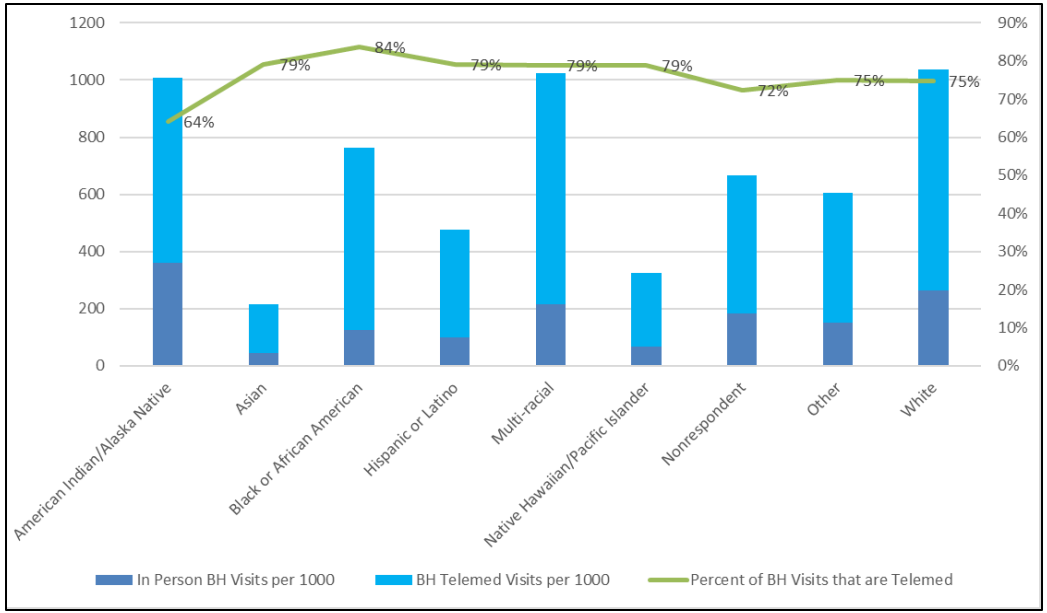
Behavioral Health Visits Amongst Covered California Enrollees (2022)

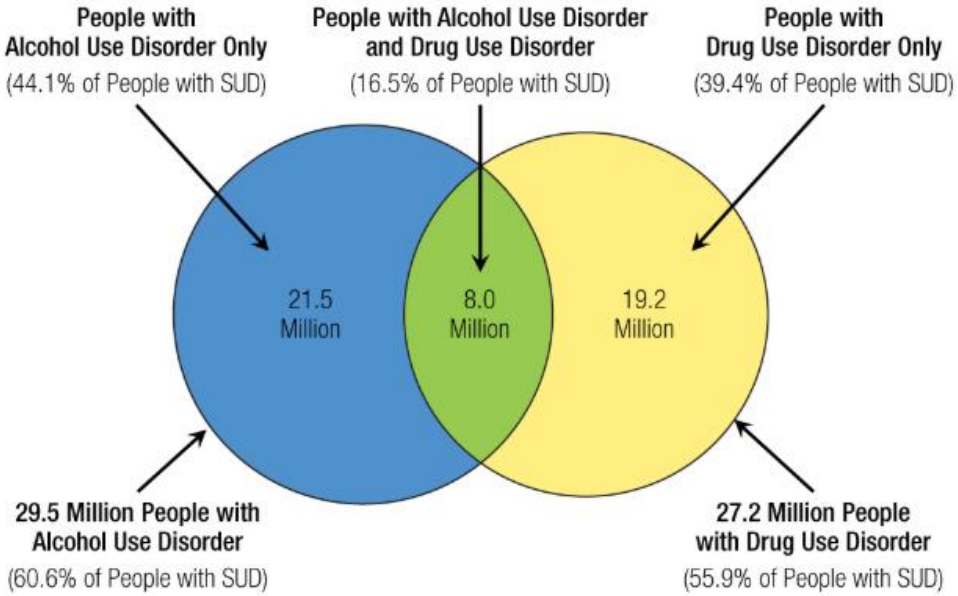


MAJORITY OF BEHAVIORAL HEALTH VISITS ACROSS RACE/ETHNICITY ARE TELEHEALTH

- Despite the variation in overall Behavioral Health utilization across race/ethnicity groups, the percentage of telehealth utilization is overall consistent

Behavioral Health Visit Modality by Race/Ethnicity (2022)



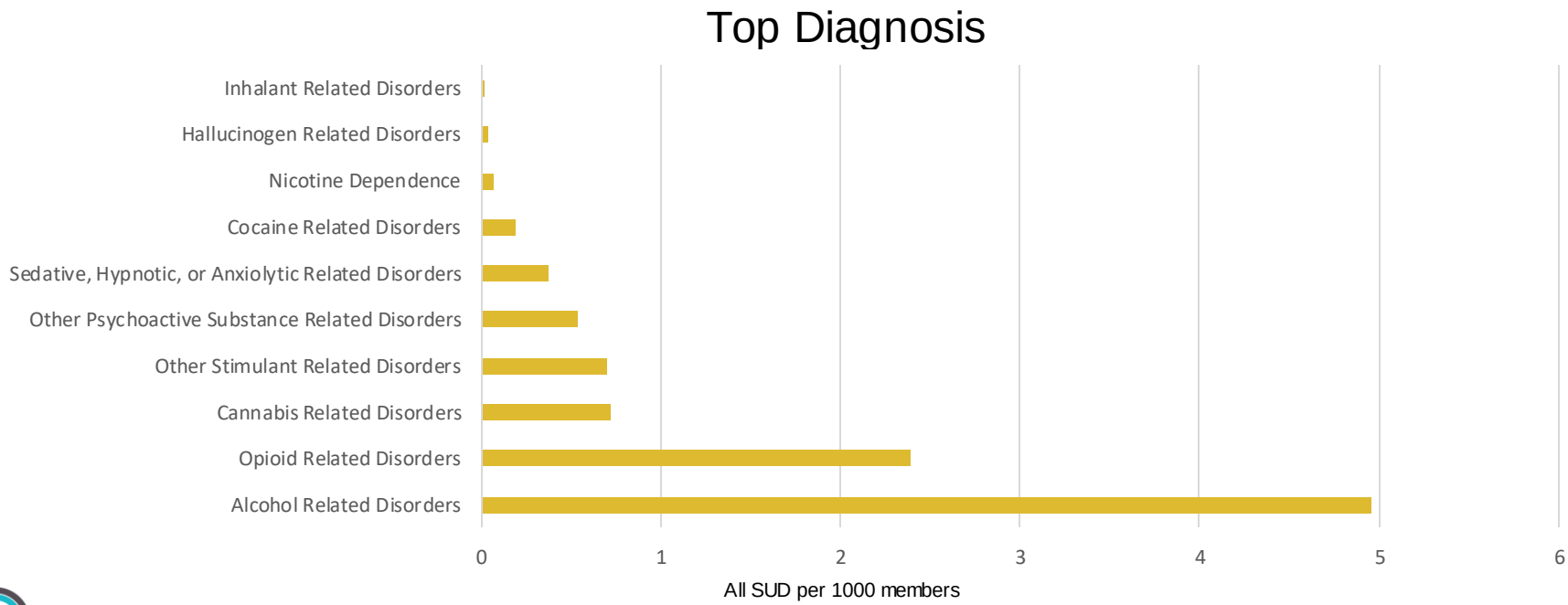


Note: Drug Use Disorder includes data from all past year users of marijuana, cocaine, heroin, hallucinogens, inhalants, methamphetamine, and prescription psychotherapeutic drugs (i.e., pain relievers, tranquilizers, stimulants, or sedatives).

SAMHSA
Substance Abuse and Mental Health Services Administration

COVERED CALIFORNIA SUD PREVALENCE

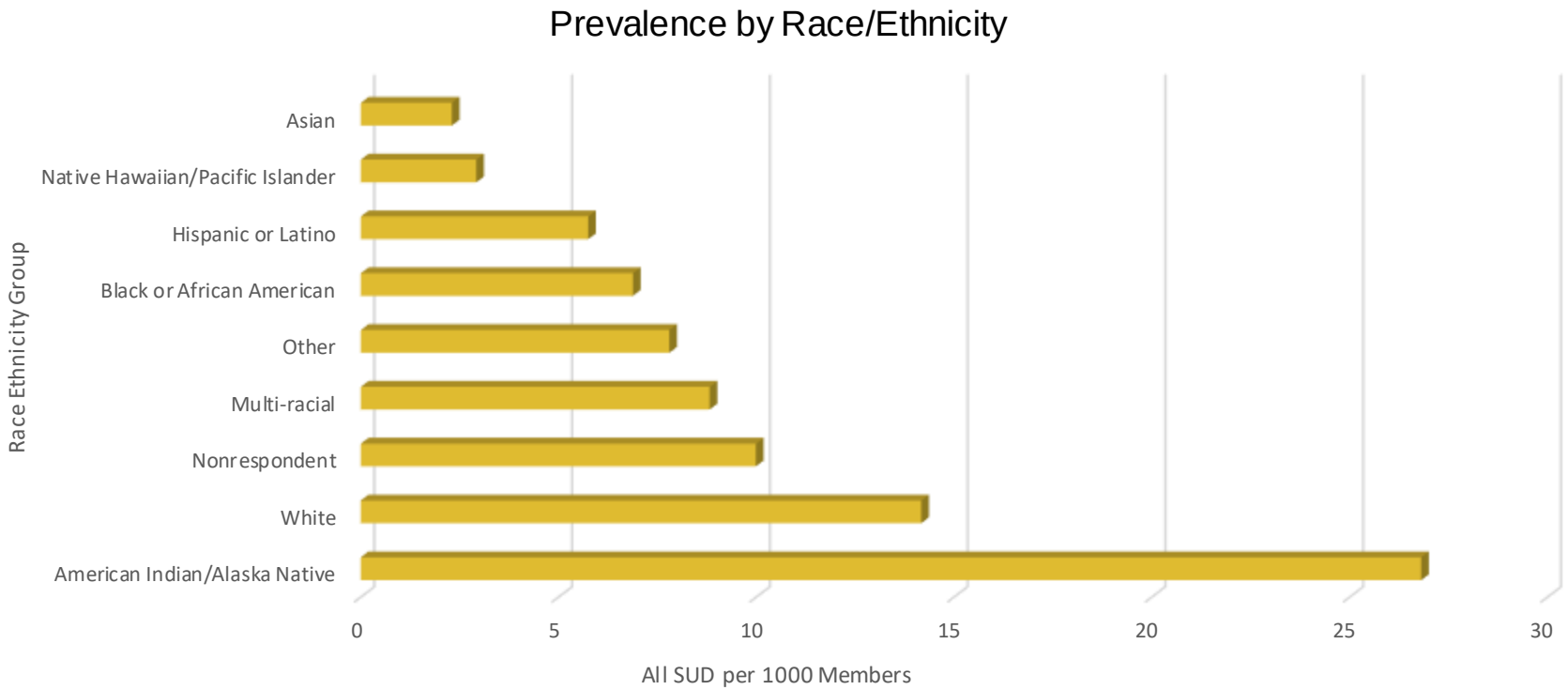
- 120.9/1000 of Covered CA enrollees are diagnosed with a behavioral health or mental health condition
- 8.5/1000 members are diagnosed with a substance use disorder
  - Out of all SUD, half are EtOH



Data source: Merative
Incurred year: 2022

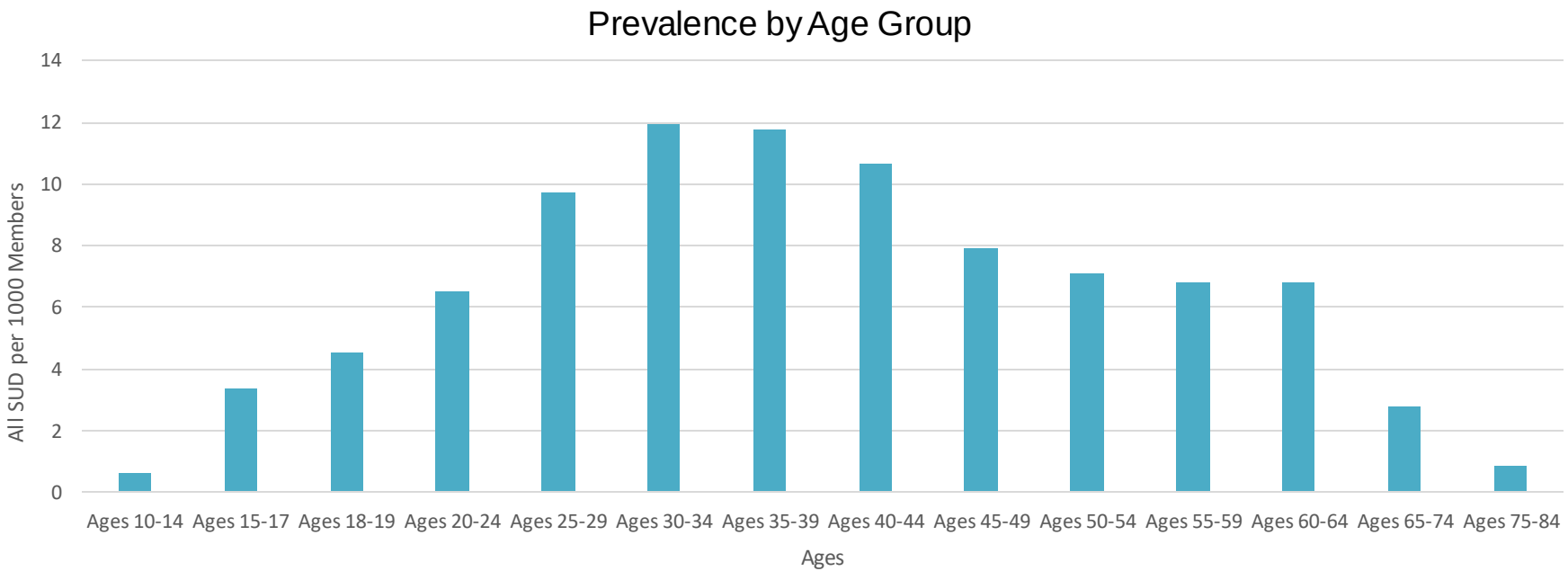
COVERED CALIFORNIA SUD STRATIFIED RATES

- Prevalence rates differ dramatically across racial and ethnic subpopulations



COVERED CALIFORNIA SUD RATES BY AGE

- Covered California members' SUD prevalence distribution by age peaks at older age range compared to annual SAMHSA national survey



Data source: Merative
Incurred year: 2022

BEHAVIORAL HEALTH: BACK TO BASICS

BEHAVIORAL HEALTH: BACK TO BASICS

1. Increase access to Behavioral Health care
2. Address disparities in utilization
3. Monitor Behavioral Health and virtual Behavioral Health quality
4. Reduce stigma
5. Expand Substance Use Disorder focus
6. Align contract with realities of implementing integrated models

#1: INCREASE ACCESS TO BEHAVIORAL HEALTH

Current State

- Across different racial and ethnic groups, while there are variations in the overall use of behavioral health services, the proportion of services accessed through telehealth remains relatively stable
- Evidence telehealth is working for many members
- 1/3 of new Covered California report having a BH condition

Challenges

- Shortage of providers, particularly providers reflecting California's diverse population

Proposed Approach

- Continue provider network reports submission and telehealth requirements
- July workgroup: broader access discussion including potential network analytics

BEHAVIORAL HEALTH ACCESS REQUIREMENTS

2023-2025 ATTACHMENT 1	SUMMARY OF PROPOSED CHANGES
2.01.2 Offering Telehealth for BH ▪ Contractor must offer telehealth for behavioral health services.	▪ No changes proposed
2.01.1 BH Provider Network Reports ▪ Submission of NCQA Health Plan Accreditation Network Management Reports addressing cultural needs, preferences, access to BH care and efforts to improve access. ▪ Issuers submit based on accreditation cycle.	▪ Require submission of more recent provider network data if data used for accreditation was older than 2 years

BEHAVIORAL HEALTH ACCESS REQUIREMENTS

2023-2025 ATTACHMENT 1	SUMMARY OF PROPOSED CHANGES
2.01.3 Promoting Access ▪ Issuers must conduct activities to ensure enrollees are aware of availability and methods to access BH services including the referral process, updated provider directory and integration with telehealth vendors.	▪ Add requirements for Issuers to submit screen shots and sample communications demonstrating the promotion of BH services across access points and languages.

#2: ADDRESS DISPARITIES IN UTILIZATION

Current State

- Absence of care that is both culturally sensitive and linguistically aligned has been identified as a likely key contributor to low utilization rates among Asian American members
- Enrollees with lower income levels are often less likely to utilize care

Challenges

- How to reach underutilizing groups
- Gaps in care by location and income

Strategies to Reduce Health Disparities

- Identify member subpopulations with low utilization rates
- Conduct root cause analysis to identify and understand obstacles
- Work together with Covered California and others identify solutions
- Develop specialized strategies and culturally tailored interventions informed by members of focus populations
- Reduce stigma associated with accessing services

ADDRESS DISPARITIES IN UTILIZATION

Proposed Approach

- Expand current utilization monitoring requirements to add explicit equity focus
- Expand Healthcare Evidence Initiatives Monitoring Disparities measures list
- Covered California to assess behavioral health utilization data for disparities by race, ethnicity, language, income, plan type with requirement for Issuers to engage with Covered California to review results
- Add requirements for Issuers to conduct root cause analysis, design and deploy interventions to address identified disparities in behavioral health care utilization
- Specify requirements for Issuers to engage with impacted member populations through community engagement, establishment of member advisory groups, or other activities

BEHAVIORAL HEALTH DISPARITIES REQUIREMENTS

2023-2025 ATTACHMENT 1	SUMMARY OF PROPOSED CHANGES
2.01.4 Monitoring Behavioral Health Utilization ▪ Issuer must engage with Covered California to evaluate enrollee BH services utilization and depression treatment penetration rate using HEI data. **2.02.1 Screening for Depression** ▪ Using standard screening tools, collect Depression Screening and Follow-up for Adolescents and Adults measure results stratified by race and ethnicity.	▪ Add requirements to design and deploy disparities reduction strategies to address disparities identified in collaboration with Covered California, adhering to best practices and the Advancing Health Equity *Road Map to Advance Health Equity*[1] . ▪ Ensure implementation of culturally tailored depression screening tools and practices.

1. https://advancinghealthequity.org/roadmap-to-ahe/#:~:text=A%20multi%2Dstep%20framework%20to,care%20and%20foster%20health%20equity.&text=The%20roadmap%20was%20created%20with,overall%20health%20of%20the%20nation.

BEHAVIORAL HEALTH DISPARITIES REQUIREMENTS

2023-2025 ATTACHMENT 1	SUMMARY OF PROPOSED CHANGES
2.02.2 Monitoring QRS BH Measures ▪ 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.	▪ Add the following measures to Healthcare Evidence Initiatives Monitoring Disparities measures list in Article 1.02.2 to support ongoing assessment and identification of behavioral health disparities: ▪ Initiation and Engagement of Substance Use Disorder (IET) ▪ Follow-Up After Hospitalization for Mental Illness (7 Day and 30-Day Follow)

#3: MONITOR BEHAVIORAL HEALTH QUALITY

Current State

- Existing behavioral health quality measures do not capture necessary breadth and depth of mental health and substance use disorder assessment and care needs, regardless of site of care
- Significant numbers of members are seeking and utilizing behavioral health care via virtual care

Challenges

- Utilization of virtual care ranges across modalities and includes diverse mobile platforms dedicated to particular conditions or populations, making them challenging to measure
- Assessment of virtual behavioral health care quality yet to be implemented or tested by any organization

CMS Quality Ratings System Measures

- Antidepressant Medication Management
- Follow-Up After Hospitalization for Mental Illness (7-Day Follow-Up and 30-Day Follow-Up)
- Initiation and Engagement of Substance Use Disorder Treatment
- Annual Monitoring for Persons on Long-term Opioid Therapy

MONITOR BEHAVIORAL HEALTH QUALITY

Proposed Approach

- Expand utilization monitoring requirements to review indicators of best practice (e.g., # visits per member for psychotherapy, rates of members with multiple visits with consistent provider)
- Add requirement for Issuers to submit descriptions of selection criteria for behavioral health care vendors including virtual platforms

BEHAVIORAL HEALTH QUALITY REQUIREMENTS

2023-2025 ATTACHMENT 1	SUMMARY OF PROPOSED CHANGES
2.01.4 Monitoring Behavioral Health Utilization ▪ Issuer must engage with Covered California to evaluate enrollee BH services utilization and depression treatment penetration rate using HEI data.	▪ Expand utilization measures ▪ Remove requirement for calculating and tracking depression treatment penetration rate
2.02.2 Monitoring QRS BH Measures ▪ 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)	▪ No changes proposed

BEHAVIORAL HEALTH QUALITY REQUIREMENTS

2023-2025 ATTACHMENT 1	SUMMARY OF PROPOSED CHANGES
2.05 Contractor Accountability, Duties and Obligations ▪ Contractor must oversee delegated entities to ensure enrollees' access to quality behavioral health care and justify delegations ▪ Contractor shall monitor and evaluate behavioral health quality ▪ Contractor shall provide a delegation report describing entities, types, purpose and description.	▪ No changes proposed

#4: REDUCE BEHAVIORAL HEALTH STIGMA

Challenges

- Lack of member awareness and understanding of available comprehensive behavioral health care services
- Cultural and social norms related to behavioral health and help-seeking behavior
- Language barriers
- Insufficient health plan staff and delivery system staff proficiency in cultural humility
- Access to care
- Privacy concerns

Stigma Reduction Activities

- Enhanced educational programs
- Cultural humility training
- Promotion of positive language
- Increased accessibility to services
- Policy advocacy
- Peer support programs
- Privacy protections
- Community engagement and outreach

REDUCE BEHAVIORAL HEALTH STIGMA

Proposed Approach

- Deploy culturally tailored educational and engagement materials to member populations
- Plans actively pursue stigma reduction through the implementation of staff training focused on cultural humility and effective collaboration with interpreters

BEHAVIORAL EDUCATION REQUIREMENTS

2023-2025 ATTACHMENT 1	SUMMARY OF PROPOSED CHANGES

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
 	
2.01.3 Promoting Access to Behavioral Health Services
▪ Contractor must educate Covered California Enrollees how to access behavioral health services, including through telehealth
	▪ In alignment with DHCS and CalPERS requirements, implement staff training focused on cultural humility and effective collaboration with interpreters, such as:
	  ▪ Annual training on diversity and cultural humility
	  ▪ Use of National Standards for Culturally and Linguistically Appropriate Services (CLAS)
	▪ Implement at least 1 intervention to enhance member experience for historically marginalized group, such as:
	  ▪ Create culturally appropriate materials for any population that exceeds a specified volume threshold
	  ▪ Adjust website language to reflect threshold groups
	  ▪ Develop a member/community advisory board
	  ▪ Partner with a community-based organization

#5: EXPAND SUBSTANCE USE DISORDER (SUD) FOCUS

Current State

- 1 in 5 Californians say they or someone they know has needed treatment for substance use[2]
- Low percentages across the board for follow-up, initiation, and engagement in treatment
- American Indian/Alaskan Natives (AI/AN) enrollees are almost twice as likely to have a SUD compared to enrollees who identify as White

Challenges

- Fewer than half of those who initiate treatment stay engaged in treatment
- Connecting with high prevalence groups
- Pronounced and persistent disparities in prevalence, assessment and treatment rates

Current CMS QRS Measure(s)

- Initiation and Engagement of Substance Use Disorder Treatment (IET)
- Annual Monitoring for Persons on Long-term Opioid Therapy

2. 2024 CHCF Survey https://www.chcf.org/press-release/new-2024-chcf-ca-health-policy-survey/

EXPAND SUBSTANCE USE DISORDER (SUD) FOCUS

Proposed Approach

- Continue requirement to submit results for the Pharmacotherapy for Opioid Use Disorder (POD) measure among Covered California Enrollees and report these findings, categorized by race and ethnicity, as specified in Article 1.02.1
- Continue requirements to engage with Covered California to assess Issuer's Medication Assisted Treatment (MAT) prescriptions and concurrent prescribing rates of opioids and naloxone using HEI data outlined in Article 5.02.1
- Explore addition of HEDIS measure Diagnosed Substance Use Disorder (DSU) – Reporting Only (the percentage of members 13 years and older who are diagnosed with substance use disorder: alcohol disorder, opioid disorder, other unspecified drugs, any substance use disorder) to establish baseline Covered California population SUD prevalence rate

BEHAVIORAL HEALTH: (SUD) REQUIREMENTS

2023-2025 ATTACHMENT 1	SUMMARY OF PROPOSED CHANGES

2.03.1 Appropriate Use of Opioids
▪ Issuers are required to implement policies and programs aligned with Smart Care California guidelines to ensure the appropriate use of opioids by contracted providers. Must prioritize the following areas:
  ▪ Prevent: minimizing opioid initiation with lower doses and shorter durations
  ▪ Manage: identifying patients on risky drug regimens, ensuring naloxone co-prescription, promoting individualized treatment plans
  ▪ Treat: improving access to evidence-based opioid use disorder treatment
  ▪ Stop Deaths: promoting data-driven harm reduction strategies
	▪ No proposed change to selected guidelines
	
	Rationale for Smart Care California
	▪ Member focused
	▪ Attainable range of themes
	▪ Framework applicable to health plan functions and provider network

BEHAVIORAL HEALTH: (SUD) REQUIREMENTS

2023-2025 ATTACHMENT 1	SUMMARY OF PROPOSED CHANGES

2.03.2 Monitoring OUD Treatment
▪ Contractor commits to collaborating with Covered California to assess its Medication Assisted Treatment (MAT) prescriptions and concurrent prescribing rates of opioids and naloxone using HEI data outlined in Article 5.02.1
▪ Contractor is required to gather results for the Pharmacotherapy for Opioid Use Disorder (POD) measure among Covered California Enrollees and report these findings, categorized by race and ethnicity, as specified in Article 1.02.1
	▪ Revise to reflect expanded focus on substance use disorders
	▪ Add language specifying monitoring of IET measure results using HEI data
	  ▪ The percentage of members 13 years and older who are diagnosed with substance use disorder:
	  ▪ Alcohol disorder, opioid disorder, other unspecified drugs, any substance use disorder
	  ▪ This data can help establish both a Covered California population baseline SUD rate and support individual plan efforts to meet member needs

#6: ALIGN INTEGRATION REQUIREMENTS

Current State

- Truly integrated behavioral health services difficult to implement and therefore not widespread

Challenges

- Dearth of Collaborative Care Model codes in HEI data

Proposed Approach

- Reduce contractual requirements related to implementing and expanding integrated behavioral health services to permit focus on priority access, equity, and quality activities
- Retain annual reporting requirement

BEHAVIORAL HEALTH: INTEGRATION REQUIREMENTS

2023-2025 ATTACHMENT 1	SUMMARY OF PROPOSED CHANGES

2.04 Integration of BH with Medical Services
 	
▪ Issuers must report:
  ▪ Activities conducted to promote integration
  ▪ Percent of Covered CA enrollees and those outside Covered CA cared for under integrated model
  ▪ Reimbursement of Collaborative Care Model codes and if yes, what settings and entities
 	
▪ Issuers must engage with Covered CA 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
	▪ Remove all requirements except annual report of activities conducted to encourage implementation and expansion of integrated care

FEEDBACK REQUESTS

- Feedback on developing strategies and culturally tailored interventions informed by members of focus populations
- Feedback on Issuers submitting selection criteria for BH vendors, including virtual
- Feedback on expanding focus of SUD and the addition of HEDIS measure Diagnosed Substance Use Disorder (DSU)

Essential Community Providers (ECP) Project

Lizzeth Romero, Equity & Quality Specialist
Taylor Priestley, Director Equity & Quality Transformation

WHY ARE THE ECP STANDARDS BEING REFRESHED?

Essential Community Providers are critical to providing access to high quality care for low-income and medically underserved populations

The ECP refresh is a core objective of the Strategic Plan goal of increased access to "…high quality, diverse providers who practice with cultural humility."

As part of this effort, Covered California seeks to:

- Ensure the current ECP standards are consistent with updated federal regulations; and
- Improve outcomes for priority populations through better access, continuity of care, and provider capacity

ELEMENTS OF FEDERAL ECP REQUIREMENTS

Element	Applicability
1. Definition of an ECP *(Est. 2012, amended in 2015)*	Individual and Small Group QHPs/QDPs on SBEs and FFE
2. General ECP standard *(Est. 2012, amended in 2015)*	Individual and Small Group QHPs/QDPs on SBEs and FFE
3. Alternate ECP standard *(Est. 2012, amended in 2015)*	Individual and Small Group *Integrated* QHPs on SBEs and FFE (excludes QDPs)
4. Approach to evaluating sufficiency a. Overall participation threshold b. Contract offering/service category requirement c. Category-specific thresholds d. Unmet ECP standards *(Est. 2015, amended in 2023)*	Individual and Small Group QHPs/QDPs on the FFE
5. Requirements for payments to Federally Qualified Health Centers (FQHCs) *(Est. 2012, amended in 2015)*	Individual and Small Group QHPs/QDPs on SBEs and FFEs

HOW DO WE MEASURE SUCCESS?

Once the phased ECP refresh approach has been implemented, Covered California's ECP priorities will be met if the refreshed standards result in

1. Improved access to primary care and behavioral health services in low-income communities and HPSAs
2. Improved continuity of care across Medi-Cal and Covered California
3. Improved ECP capacity to serve low-income and medically underserved populations
4. Improved choice of providers serving the diverse needs of members

RECOMMENDED ECP IMPACT EVALUATION APPROACH

The impact of ECPs on advancing Covered California's quality and health equity goals is unknown and should be evaluated

- Covered California should analyze ECP specific claims to identify
  - Who is using ECPs
  - Where ECPs are accessed (HPSAs, HPI quartiles, etc.)
  - What percentage of all services are accessed in ECPs (by entity type and/or ECP category)
  - What percentage of Covered California primary care and behavioral health ECPs also accept Medi-Cal members

- Covered California should regularly analyze the ECP lists to identify key ECPs access in underserved geographic regions (e.g., HPSAs or HPI quartiles 1 and 2) to identify critical providers without contracts

- Covered California should require issuers to report on their ECP contracting arrangements
  - This could enable Covered California to assess adherence to fair compensation requirements

- Covered California should conduct an annual public comment period soliciting feedback on the ECP standards and resulting provider lists

GUIDING PRINCIPLES AND PRIORITIES

Equity is quality

- An updated ECP definition should enable ECPs meeting the needs of priority populations, and the goal of improving equitable access to care for Covered California members

Center the Member

- Strengthened ECP standards should improve the member experience for populations living in Health Professional Shortage Areas (HPSAs), increase the ability for Medi-Cal members moving to Covered California to continue seeing their preferred providers, and enhance continuity of care and lead to improved outcomes

Make it easy to do right

- An updated ECP definition will better capture the ECPs who can best meet members' care needs

Focused scope for high impact

- The refreshed ECP standards should result in greater transparency and insight into the impact of ECPs, and an ECP definition in compliance with applicable regulatory requirements but focused on the providers most capable of serving the target populations

Amplify through alignment

- Updating the standards can increase alignment with statewide health equity and workforce development efforts tailored to meet members' needs

RECOMMENDED PHASED APPROACH TO ECP REFRESH

Phase 1

- Make modest adjustments to strengthen and clarify current standards and to align with federal regulations
- Incorporate updates into QHP Issuer model contracts and QHP certification application
- Design and adopt framework for making future changes to improve access, continuity of care, and provider capacity

Complete by September 2024

Phase 2

- Analyze and assess impact of current standards to inform future changes and quantifiable success measures
- Make data- and stakeholder-informed revisions to ECP definition, sufficiency standards, and enforcement approach

Timeline to be determined

STAKEHOLDER ENGAGEMENT SUMMARY

State-based Marketplaces (Washington, Connecticut, & Minnesota)

- The states who differ from the federal ECP standards generally set higher sufficiency requirements, align their standards to require overlap with Medicaid providers, and include additional provider types as ECPs
- Connecticut produces their own ECP list because the federal list is outdated and incomplete, and Minnesota has a state designation process

Issuers

- Suggested the original goals of the ECP standards had been achieved by ensuring ECPs would not experience funding shortfalls due to a decrease in the uninsured
- Were generally resistant to new standards or requirements and noted that some ECPs are hesitant to contract in the commercial market

Consumer Advocates

- Emphasized that the federal ECP standards as a starting point and stressed the importance of maintaining a California specific approach
- Noted the importance of overlap and alignment between Medi-Cal and Covered California (e.g., provider types, geographic region)

STAKEHOLDER ENGAGEMENT SUMMARY

Tribal and Urban Indian Health Care Providers

- Members are typically covered by Medi-Cal. However, they noted similar trends from other stakeholders including provider issues such as maintaining adequate capacity and reimbursement issues with providers from out of state

Safety Net Providers

- Echoed provider capacity issues and discussed the lengthy contracting process their providers experience with issuers

INTERNAL ECP WORKING GROUP RECOMMENDATIONS APPROACH

The internal working group, supported by HMA, met regularly over the past two months to review and discuss ideas and considerations for refreshed ECP standards which have been informed by:

- Other state approaches to ECP requirements, identified through interviews with state representatives and research
- Key California stakeholders, including consumer advocates, issuers, and representatives from Safety Net and Urban and Tribal Indian Health providers

An analytic evaluation of the current ECP standards has not been conducted to date but is part of the internal workgroup's recommendations

This learning and stakeholder engagement period resulted in the internal working group's guiding principles and priorities as well as initial recommendations for changes to Covered California's ECP standards

These recommendations are policy proposals and to date **have not** been vetted for administrative feasibility or to determine if the data needed, if applicable, is available and accessible

RECOMMENDED CHANGES AND ADDITIONS TO ECP CATEGORIES

The ECP categories should be modified as follows:

Federal ECP Categories	Current Covered California ECP Provider Categories	Future ECP Category Changes and Additions
▪ FQHCs ▪ Ryan White Program Providers ▪ Family Planning Providers ▪ Indian Health Care Providers ▪ Inpatient Hospitals ▪ Mental Health Facilities ▪ SUD Treatment Centers ▪ Other Providers	▪ Hospitals (340B, DSH, Children's hospitals, county or publicly owned)	▪ No change
	▪ Non-Hospitals (340B, FQHCs, Community Clinics, Free Clinics, Tribal and Urban Indian Clinics)*	▪ Add pediatric oral service providers

	▪ HITECH PCPs	▪ Rename category and remove HITECH PCP list
		▪ Add HCAI workforce grant recipients (focus on behavioral health providers)
		▪ Add geographic and Medi-Cal specific providers including:
		  ▪ Certain providers in HPSAs
		  ▪ Providers with a minimum percentage of Medi-Cal members
		  ▪ Providers in HPI quartiles 1 and 2

*Currently assessing overlap with Mental Health Facilities and SUD Treatment Centers

RECOMMENDED CHANGES TO SUFFICIENCY STANDARDS

The sufficiency standards should:

- Maintain the applicable geographic region as rating area (and not service area)
- Maintain the one ECP hospital per county requirement, except in counties with multiple rating areas
- Newly require issuers to contract with one ECP hospital per rating area in counties with multiple rating areas (i.e., LA County)
- Maintain the 340B sufficiency threshold of 15% (for now)

To inform future sufficiency standards changes, Covered California should engage stakeholders and assess the impact of:

- Increasing the hospital requirement in high density population areas
- Increasing the threshold above 15% and expanding the applicability to non-340B entities
- Adopting category specific, or entity specific, thresholds
- Limiting some, or all, categories to providers with a minimum percentage of Medi-Cal members

RECOMMENDED CHANGES TO THE ECP GENERAL STANDARDS TO CLARIFY TARGET POPULATIONS

The ECP general standards should be updated to:

- Comply with federal requirements applicable to all exchange types by adding individuals living in Health Professional Shortage Areas (HPSAs) as a priority population, in addition to low-income populations

RECOMMENDED CHANGES TO THE ECP ALTERNATIVE STANDARDS TO CLARIFY TARGET POPULATIONS AND ADD SPECIFICITY

The ECP alternative standards should be updated to:

- Comply with federal requirements applicable to all exchange types by adding individuals living in HPSAs as a priority population, in addition to low-income populations

- Maintain and refine existing mapping requirements to align with federal priority populations defined as HPSAs and zip codes with at least 30% of the population under 200% FPL

- Add specific requirements to clarify how an integrated delivery system's compliance will be assessed and validated by requiring that they provide services in each of the ECP categories in each county within their service area, either through their system or by offering a contract to at least one outside ECP per category

FEEDBACK REQUESTS

- Feedback on suggested new provider types for ECP definition:
  - HCAI workforce grant recipients (focus on behavioral health providers)
  - Geographic and Medi-Cal specific providers including:
    - Certain providers in HPSAs
    - Providers with a minimum percentage of Medi-Cal members
    - Providers in HPI quartiles 1 and 2
- Feedback on phased approach to updating ECP standards
- Feedback on evaluation approach and measures of success

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!

Appendix
Essential Community Providers (ECP) Project

COVERED CALIFORNIA'S ECP REFRESH: GUIDING PRINCIPLES AND PRIORITIES

Equity is quality:

- Increased and improved access to providers with experience caring for demographically diverse and low-income populations will improve the quality of the care they receive

- Improved ECP standards will further Covered California's strategic priority to "Increase access to high quality, diverse providers who practice with cultural humility"

- An updated ECP definition should enable
  - ECPs meeting the needs of priority populations, and
  - The goal of improving equitable access to care for Covered California members

COVERED CALIFORNIA'S ECP REFRESH: GUIDING PRINCIPLES AND PRIORITIES

Center the member:

- ECPs are more likely to
  - Be in communities serving low-income and medically underserved populations, including Medi-Cal members, and
  - Have employees with the cultural humility and cultural and linguistic concordance necessary to ensure the members' needs and perspectives are understood, considered, and met

- Strengthened ECP standards should
  - Improve the member experience for populations living in Health Professional Shortage Areas (HPSAs),
  - Increase the ability for Medi-Cal members moving to Covered California to continue seeing their preferred providers, and
  - Enhance continuity of care and lead to improved outcomes

COVERED CALIFORNIA'S ECP REFRESH: GUIDING PRINCIPLES AND PRIORITIES

Make it easy to do right:

- An updated ECP definition will better capture the ECPs who can best meet members' care needs

- Aligning the requirements set forth in regulation, the QHP certification application, and the Model Contract should
  - Make it easier for issuers to know what is required of them and to achieve the intent and purpose of the ECP standards; and
  - Ensure the administrative burden on issuers is streamlined and minimal

COVERED CALIFORNIA'S ECP REFRESH: GUIDING PRINCIPLES AND PRIORITIES

Focused scope for high impact:

- Adequate prevalence and access to ECPs is critical to providing essential sources of health care services, including primary care and behavioral health care, to low-income and medically underserved Californians

- The refreshed ECP standards should result in
  - Greater transparency and insight into the impact of ECPs, and
  - An ECP definition in compliance with applicable regulatory requirements but focused on the providers most capable of serving the target populations

COVERED CALIFORNIA'S ECP REFRESH: GUIDING PRINCIPLES AND PRIORITIES

Amplify through alignment:

- Updating the standards to align with state and federal regulations will make clear the importance of compliance with the ECP standards

- This initiative should lead to
  - ECP standards that are clear, measurable, and impactful, and
  - Increased alignment with statewide health equity and workforce development efforts tailored to meet members' needs

ALIGNMENT OF RECOMMENDATIONS WITH THE GUIDING PRINCIPLES

Guiding Principles	Definition and Category Changes	Sufficiency Changes	General Standard Changes	Alternative Standards Changes	ECP Impact Assessment
Equity is quality	✓	✓	✓	✓	
Center the member	✓	✓			
Make it easy to do right			✓	✓	✓
Amplify through alignment	✓		✓	✓	
Focused scope for high impact	✓	✓			✓

GLOSSARY – ECP CATEGORIES IN FFES

HHS Identifies eight major ECP categories and associated provider types for FFE QHP certification purposes:

Major ECP Category	ECP Provider Type
Federally Qualified Health Centers (FQHC)	FQHC and FQHC "Look-Alike" Clinics
Ryan White Providers	Ryan White HIV/AIDS Providers
Family Planning Providers	State-owned family planning service sites, governmental family planning service sites, including Title X Family Planning Clinics and Title X "Look-Alike" Family Planning Clinics, Not-for-profit family planning service sites that do not receive Federal funding under special programs, including under Title X of the PHS Act or other 240B-qualifying funding
Indian Health Care Providers	Tribes, Tribal Organization and Urban Indian Organization Providers, Indian Health Service Facilities.
Impatient Hospitals	Disproportionate Share Hospital (DSH), Children's Hospitals, Rural Referral Centers, Sole Community Hospitals, Free-standing Cancer Centers, Critical Access Hospitals.
Substance Use Disorder Treatment Centers	Substance Use Disorder Treatment Providers
Mental Health Facilities	Community Mental Health Centers, Other Mental Health Providers
Other ECP Providers	Black Lung Clinics, Hemophilia Treatment Centers, Rural Health Clinics, STD Clinics, TB Clinics, Rural Emergency Hospitals.

GLOSSARY – EXPANDED ECP DEFINITION FOR COVERED CA

2012 Covered California ECP standards expanded the ECP definition to include:

ECP Provider Type	Definition
California Disproportionate Share Hospitals (DSH)	Medi-Cal supplemental payment program created to reimburse hospitals for a portion of the uncompensated care costs incurred from providing inpatient hospital services to Medi-Cal beneficiaries and uninsured individuals
Federally designated 638 Tribal Health Programs	Operated by Tribes or Tribal organizations and Urban Indian Health Centers and serve as outpatient health care programs and facilities that specialize in caring for American Indians and Alaska natives
Title V Urban Indian Health Programs	Provide public health services and support to the US urban American Indian and Alaska Native population through Title V of the Indian Health Care Improvement Act
Licensed Community Clinics	Non-profit, tax-exempt clinics that provide comprehensive primary health care, dental care, mental health, school-based health programs and other community-based health services to anyone in need regardless of their insurance status or ability to pay
HI-TECH Medi-Cal Electronic Health Record Incentive Program Providers	Providers that have adopted and become meaningful users of electronic health records (EHRs) via funding under the American Reinvestment and Recovery Act (ARRA)

Appendix

2026 Contract Development Guiding Principles

Equity is quality

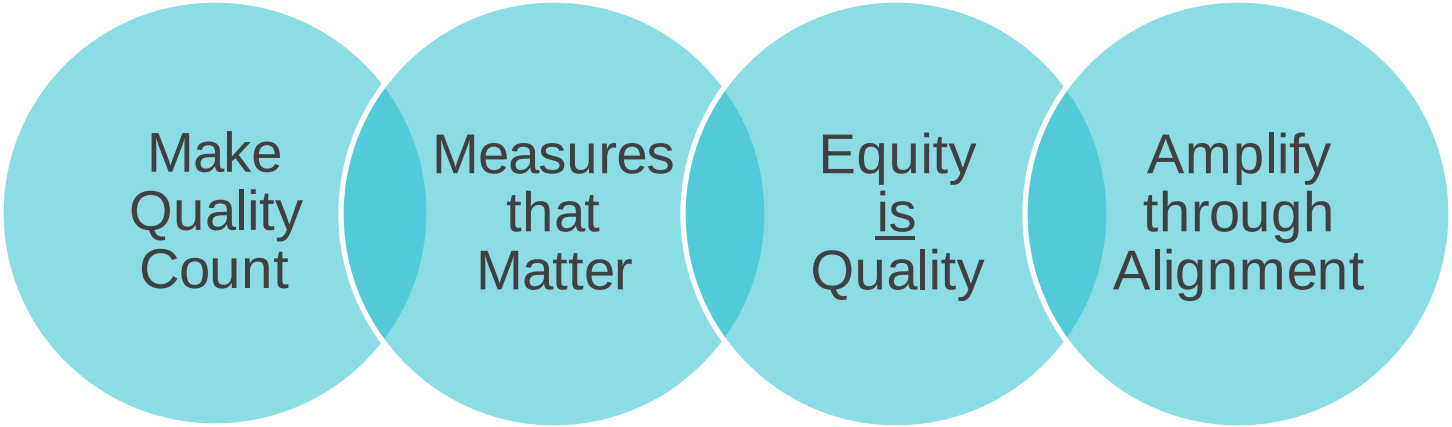
Center the member

Make it easy to do right

Amplify through alignment

Focused scope for high impact

THERE IS NO QUALITY WITHOUT EQUITY



Delivering on Covered California's vision to improve the health of all Californians, this proposed methodology aligns with efforts occurring at DMHC, DHCS/Medi-Cal, and CalPERS

OUR COMMITMENT

Covered California appreciates that success necessitates:

- Accuracy and completeness of race and ethnicity data
- Evidence-based approach to minimum population threshold
- Early visibility into QHP performance at subpopulation level
- Iterative, bi-directional learning
- Collaboration in a safe environment

WHAT SUCCESS LOOKS LIKE

★★★ Receipt of high-quality care for all members regardless of subpopulation size

Embrace of an equity-centered approach to meet diverse needs with tailored interventions

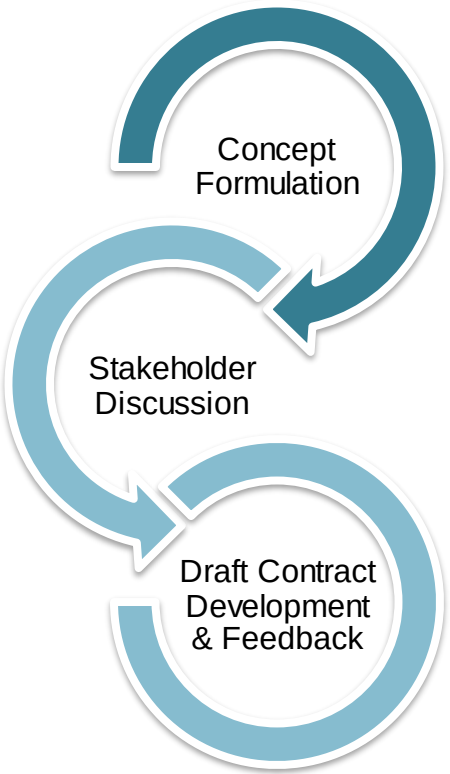
Greatest financial accountability for subpopulations least served by current quality improvement approaches

Deep engagement and monitoring by Covered California to ensure disparities do not increase

2026-2028 Advancing Equity, Quality & Value Contract Update Workstreams

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

Proposed Approach for Contract Update Workgroup

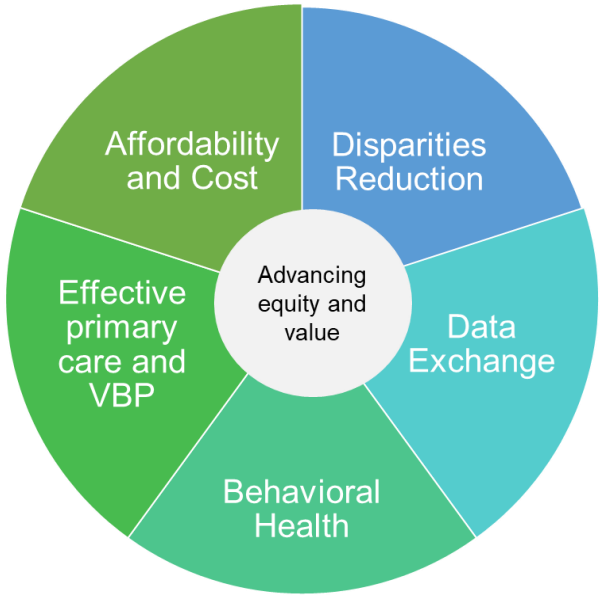


- Covered California leadership and staff engage in strategic planning sessions to develop concept proposal for the refresh framework, principles, and priority areas for focus
- Contract Update workgroup
  - Scheduled monthly meetings
  - Forum for large group discussion on proposed changes to Attachments 1, 2 and 4
  - Learning space to share ideas and best practices among stakeholders
  - Participants will review and give feedback on contract proposals and draft contract language
  - Additional focus group meetings on specific priority areas can be scheduled as necessary to help facilitate contract development

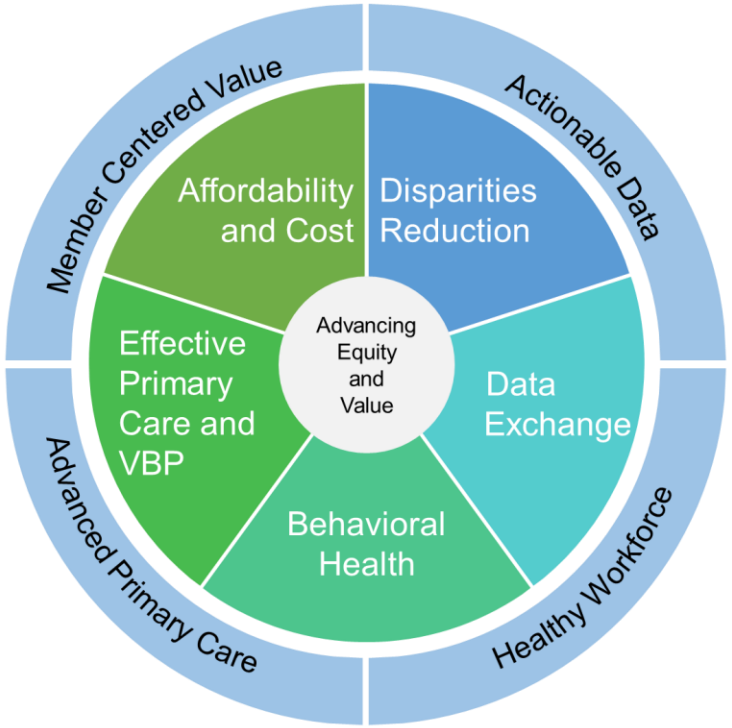
2026 QHP ISSUER MODEL CONTRACT UPDATE TIMELINE

- **February 2024** Plan Management Advisory meeting – preview timeline
- **March 2024** – kick off external contract update workgroup
- **Late summer 2024** – first public comment period
- **Sept/October 2024** – second public comment period
- **January 2025** – Board discussion of proposed model contract
- **March 2025** – anticipated Board approval of proposed model contract

2026-2028 Strategy Builds Upon 2023-2025 Focus Areas



2023-2025



2026-2028