Plan Management Advisory Workgroup

October 10, 2024

AGENDA

Time	Topic	Presenter
10:00 – 10:05	Welcome and Agenda Review	Rick Krum
10:05 – 10:25	MY 2023 Quality Rating System (QRS) Results	Mireya Furman
10:25 – 10:55	2026 – 2028 QHP Issuer Model Contract Public Comment Themes and Draft Preview	EQT Team
10:55 – 12:00	Open Forum	All

Quality Rating System Ratings for Plan Year 2025

Mireya Furman
Equity and Quality Specialist

PY2025 QRS RATING FORMULA: KEY COMPONENTS

- Plan quality star ratings and enrollee survey results were calculated by the Centers for Medicare & Medicaid Services (CMS) using Measurement Year 2023 data provided by health plans in Ratings Year 2024 for display in Plan Year 2025.

- Plan Year 2025 ratings mark the second year following the introduction of CMS's new methodology for calculating the Global Rating. The methodology employs the static cut point approach to convert scores into ratings, which are then assigned on a 5-star scale, with only whole stars (ranging from 1 to 5) being awarded. The fixed cut point threshold values aim to uphold consistent performance targets over the years.

QUALITY RATING SYSTEM OVERVIEW

The Quality Rating System (QRS) is comprised of the following elements:

- ❑ Four ratings are reported for the Ratings Year 2024: a global quality rating and three summary indicator ratings.
- ❑ The global quality rating is a roll-up of three summary indicators per the following differential weighting:

Summary Indicators	Weights
Getting the Right Care (HEDIS)	66.7%
Members' Care Experience (CAHPS)	16.7%
Plan Services for Members (HEDIS and CAHPS)	16.7%

- ❑ One to five-star performance classification for each rating based on the static cut points method.
- ❑ The Plan Year 2025 ratings (Measurement Year 2023) are displayed on CoveredCA.com starting in October 2024.

PLAN YEAR 2025 QRS GLOBAL RATINGS SUMMARY

Global Rating:

- ❑Two QHPs maintained Global Ratings at 4 or 5 stars (Sharp Health HMO and Kaiser HMO respectively).
- ❑Two QHPs had an increase in Global Rating from 3 to a 4 star (Blue Shield HMO and WHA HMO).
- ❑Eight QHPs maintained a Global Rating of 3 stars (Anthem HMO, Anthem EPO, Blue Shield PPO, Health Net HMO, Health Net PPO, LA Care HMO, Molina HMO and VHP HMO).
- ❑One QHP's Global Rating previously rated at 3 was reassigned to "No Quality Rating" due to insufficient data to calculate the global rating (CCHP HMO).

PLAN YEAR 2025 QRS SUMMARY INDICATOR RATINGS

Getting the Right Care:

- ❑Two QHPs maintained rating at 4 or 5 stars (Sharp Health HMO and Kaiser HMO respectively)
- ❑One QHP's rating increased to 3 Stars (Anthem EPO).
- ❑Eight QHPs remained unchanged at 3 stars (Anthem HMO, Blue Shield PPO, Blue Shield HMO, Health Net HMO, Health Net PPO, LA Care HMO, WHA HMO and VHP HMO).
- ❑One QHP remained unchanged at 2 stars (Molina HMO).
- ❑One QHP previously rated at 3 was reassigned to "No Quality Rating" due to insufficient data (CCHP HMO).

PLAN YEAR 2025 QRS SUMMARY INDICATOR RATINGS

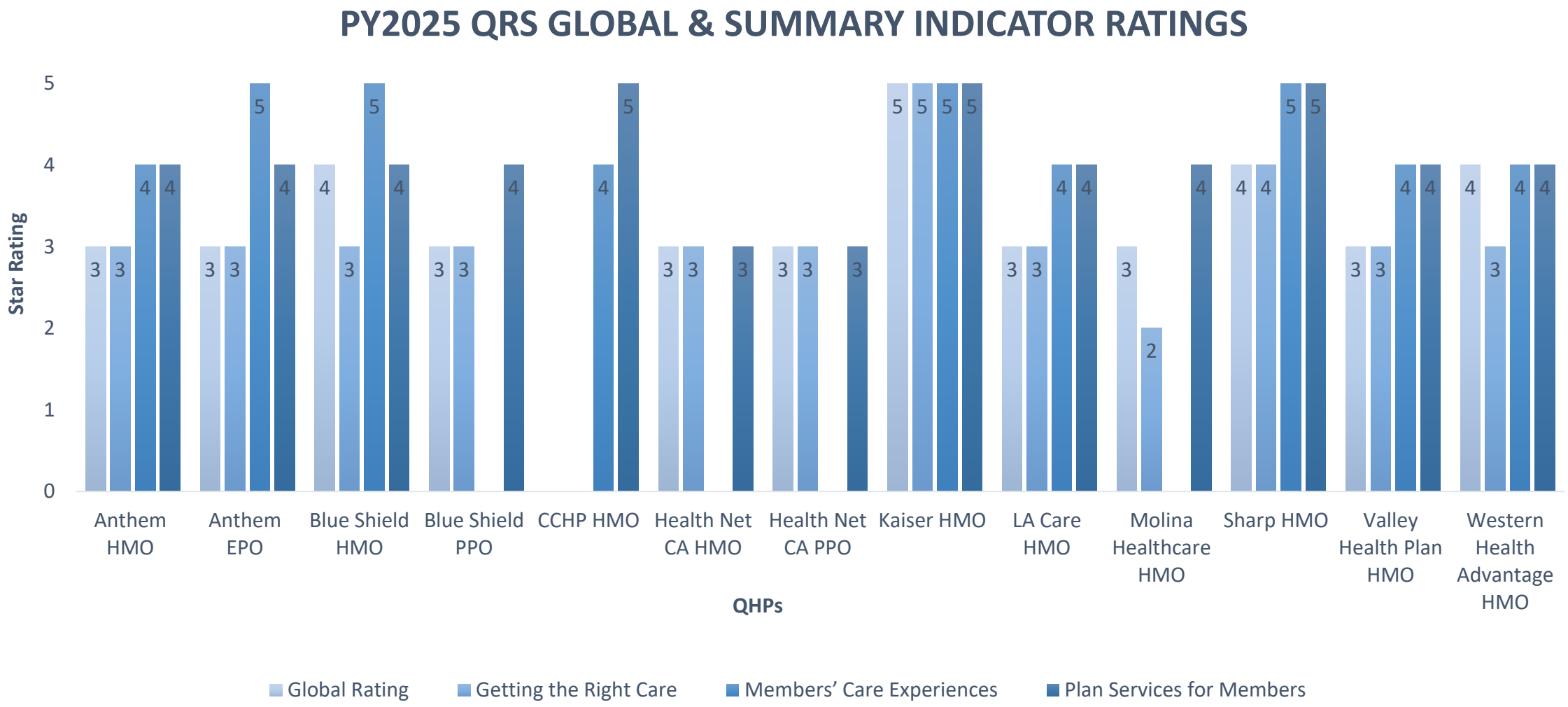
Members' Care Experience:

- ❑ Three QHPs, with a prior "No Quality Rating" due to insufficient survey responses, achieved scores of 4 or 5 stars (4 Stars: Anthem HMO, 5 Stars: Anthem EPO and Blue Shield HMO).
- ❑ Five QHP's ratings remained at 4 or 5 Stars (4 Stars: CCHP HMO, LA Care HMO, VHP HMO, 5 Stars: Kaiser HMO and Sharp HMO).
- ❑ One QHP's Members' Care Experiences Rating declined from 5 to 4 stars (WHA HMO).
- ❑ Two QHPs previously rated "No Quality Rating" due to insufficient data to calculate a score or rating maintained that status for PY2025 (Health Net HMO, Health Net PPO).
- ❑ Two QHPs previously rated 4 stars changed to having "No Quality Rating" due to insufficient data (Blue Shield PPO and Molina HMO).

Plan Services for Members:

- ❑ Five QHP's ratings remained unchanged (3 Stars: Health Net PPO, 4 Stars: Blue Shield PPO and WHA HMO, 5 Stars: Sharp HMO and Kaiser HMO).
- ❑ Eight QHPs achieved a 1 star increase in rating (3 Stars: Health Net HMO, 4 Stars: Anthem HMO, Anthem EPO, Blue Shield HMO, LA Care HMO, Molina HMO, VHP HMO, 5 Stars: CCHP HMO).

PY2025 QRS GLOBAL & SUMMARY INDICATOR RATINGS



QRS STAR RATINGS DISTRIBUTION OVER TIME

Distribution of Global Quality Ratings by Reportable Products for Individual & CCSB Markets

Plan Year* (# Products)	5 Stars ★★★★★	4 Stars ★★★★	3 Stars ★★★	2 Stars ★★	1 Star ★	No Global Rating**
2025 (13)	1	3	8	0	0	1
2024 (16)	1	1	12	0	0	2
2023 (16)	1	1	7	4	0	3
2022 (15)	2	0	4	7	0	2
2021 (15)	1	1	7	4	0	2

*Based on CMS or Covered CA-produced ratings.

**No global rating if a newer product and not eligible for reporting or insufficient sample sizes to report results for at least 2 of the 3 summary indicator categories.

PY2025 QRS GLOBAL & SUMMARY INDICATOR RATINGS

Issuer – Individual	Global Rating	Getting the Right Care	Members' Care Experiences	Plan Services for Members
Aetna[1]	Quality Rating in Future	Quality Rating in Future	Quality Rating in Future	Quality Rating in Future
Anthem HMO	★★★	★★★	★★★★	★★★★
Anthem EPO	★★★	★★★	★★★★★	★★★★
Blue Shield HMO	★★★★	★★★	★★★★★	★★★★
Blue Shield PPO	★★★	★★★	No Quality Rating	★★★★
CCHP HMO	No Quality Rating	No Quality Rating	★★★★	★★★★★
Health Net CA HMO	★★★	★★★	No Quality Rating	★★★
Health Net CA PPO	★★★	★★★	No Quality Rating	★★★
IEHP HMO [1]	Quality Rating in Future	Quality Rating in Future	Quality Rating in Future	Quality Rating in Future
Kaiser HMO	★★★★★	★★★★★	★★★★★	★★★★★
LA Care HMO	★★★	★★★	★★★★	★★★★
Molina Healthcare HMO	★★★	★★	No Quality Rating	★★★★
Sharp HMO	★★★★	★★★★	★★★★★	★★★★★
Valley Health Plan HMO	★★★	★★★	★★★★	★★★★
Western Health Advantage HMO	★★★★	★★★	★★★★	★★★★
Issuer - CCSB	**Global Rating**	**Getting the Right Care**	**Members' Care Experiences**	**Plan Services for Members**
Blue Shield HMO	★★★★	★★★	★★★★★	★★★★
Blue Shield PPO	★★★	★★★	No Quality Rating	★★★★
Kaiser HMO	★★★★★	★★★★★	★★★★★	★★★★★
Sharp HMO	★★★★	★★★★	★★★★★	★★★★★

[1] IEHP HMO first year of product offering in Plan Year 2024. Aetna second year of product offering in Plan Year 2024.

Green QHP gained 1 or more stars for Plan Year 2025 compared to Plan Year 2024.

Purple : QHP received No Quality Rating for PY2024 and a Star Rating for PY25

Red: QHP received a star rating for Plan Year 2024 and "No Quality Rating" for Plan Year 2025 or Star score decreased.

2026 – 2028 QHP Issuer Model Contract Public Comment Themes and Draft Preview

STAKEHOLDER ENGAGEMENT

Covered California engaged with and obtained stakeholder feedback on the Qualified Health Plan (QHP) Issuer Contracts for the Individual and Covered California for Small Business (CCSB) markets for a new contract duration of 2026-2028, and the 2024-2026 Qualified Dental Plan (QDP) Issuer Contract Amendment for the Individual and CCSB markets.

- The Plan Management Division (PMD) will provide a summary of comments for:
  - 2026-2028 QHP Individual Issuer Model Contract
  - 2026-2028 QHP CCSB Issuer Model Contract
  - 2024-2026 QDP Issuer Model Contract
- The Health Equity and Quality Transformation Division (EQT) will provide updates for the Model Contract sections 4.3.4 & Article 5, Attachment 1, 2, and 4.

STAKEHOLDER FEEDBACK – MODEL CONTRACTS

- Requests to define, clarify, and change existing requirements and timelines were received for the following sections:
  - Clarification requests for existing, updated, and new requirements:
    - Article 1 – General Provisions, Nondiscrimination and Fraud, Waste and Abuse; Ethical Conduct
    - Section 3.3 Agents in Covered California for the Individual Market
    - Section 4.3.2 Network Adequacy Standards
    - Section 6.1.1 Rates and Payments
  - Requests to change requirements for:
    - Section 3.2.1 Enrollment and Marketing Coordination and Cooperation, marketing spend expectation
    - Section 3.2.1.2 Contractors Activities to Promote Enrollment, link to Covered California website landing page
    - Section 4.2.7 Hearing Aid Coverage for Children Program
    - Section 4.3.2 Network Adequacy Standards (QDP)
  - Further define timelines for:
    - Section 2.1.1 Covered California Responsibilities, Covered California Weekly Carrier Call
    - Section 4.6.4 Customer Service Call Center, Special Operating Hours
- Appreciation of the addition of Section 4.2.7 Hearing Aid Coverage for Children Program

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

PROPOSED 2026-28 25/2/2 PROGRAM REQUIREMENTS

Model Contract Article 5 – Removal from the Exchange

- ❑ Annual assessment of QHP performance on QRS clinical measures
- ❑ Monitoring and remediation periods (two years each) for continued QHP clinical composite performance beneath the 25th percentile composite benchmark
- ❑ New static benchmark year established, likely Measurement Year (MY) 2025
- ❑ Removal of retired QRS measures from benchmark and composite score calculations
- ❑ Clinical measures added to QRS during contract cycle will be included and composite score calculations as benchmarks are published
- ❑ Minimum Performance Level (MPL) Action Plan required for each clinical measure falling beneath the 25th percentile for 2 consecutive years.

2026-28 25/2/2 PROGRAM PUBLIC COMMENT KEY THEMES

Issuer Model Contract- Removal from the Exchange

- Multiple stakeholders request the number of clinical measures be narrowed when considering the Minimum Performance Level (MPL) Action Plan requirement which would take effect for Measure Year 2026.
- One issuer requested the MPL Action Plan be removed from the 2026-2028 Model Contract as unnecessary.
- One issuer requested waiting for one year of reporting to be published by QRS before incorporating new measure results into the 25/2/2 composite scoring.

2026-28 25/2/2 PROGRAM

Issuer Model Contract- Removal from the Exchange

Notable changes to Issuer Model Contract 25/2/2	Rationale
MPL Action Plan to be required as directed by Covered California based on consistent or concerning underperformance.	Covered California will apply the MPL Action Plan requirement for consistent performance beneath the 25th percentile for clinically significant measures.

PROPOSED 2026-28 ACCESS REQUIREMENTS

Model Contract Article 4 – Access

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

2026-28 ACCESS PUBLIC COMMENT KEY THEMES

Model Contract Article 4 – Access

- Two Issuers and one stakeholder requested clarity on the secret shopper surveys, expressing concern for survey fatigue, survey criteria, and duplication with other public purchaser efforts

PROPOSED 2026-28 ACCESS CHANGES

Model Contract Article 4 – Access

Notable Changes to Draft	Rationale
No proposed changes	

PROPOSED 2026-28 ECP REQUIREMENTS

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

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

- ECP General Standard Sufficiency Requirements:
  - Issuers must demonstrate sufficient geographic distribution of a mix of essential community providers reasonably distributed throughout the geographic service area
  - Issuers must demonstrate providers agreements with at least 15% of 340B non-hospital providers in each rating region in which it offers QHPs
  - Issues must demonstrate agreements with at least one ECP hospital per county requirement or per rating area in counties with multiple rating regions

- Issuers in an integrated delivery system may request the ECP alternative standards and must demonstrate compliance by mapping low-income and HPSA member populations and network providers and facilities offering services in all ECP categories

2026-28 ECP PUBLIC COMMENT KEY THEMES

Model Contract Article 4 – Essential Community Providers Requirements

- Several Issuers requested an updated ECP List, more frequent updates to the ECP list, or inclusion of NPIs in the ECP list
- One Issuer requested clarification of evaluation approach for “Contractor’s ECP Contracting arrangements”
- One stakeholder requested additional clarification of proposed policies before finalizing the contract
- One Issuer requested removal from the denominator any ECPs who not agree to an offered QHP contract
- One Issuer requested clarity on Health Professional Shortage Area (HPSA) and Healthy Places Index (HPI) mapping integration into the evaluation of ECP requirements
- Several Issuers requested clarification and discussion of the expectations for contractors that qualify for alternate ECP standards
- One stakeholder requested greater clarity and definition of "sufficient number and sufficient geographic distribution" to ensure ECP networks provide timely and reasonable access to enrollees
- One stakeholder suggested including providers in HPI Quartiles 3 and 4 that serve Medi-Cal and vulnerable members in the ECP definition

PROPOSED 2026-28 ECP CHANGES

Model Contract Article 4 – Essential Community Providers Requirements

Notable Changes to Draft 4.3.4 Essential Community Providers	Rationale
No proposed changes at this time	

Attachment 1 Advancing Equity, Quality, and Value

PROPOSED 2026-28 ATTACHMENT 1 REQUIREMENTS

Article 1: Equity and Disparities Reduction

- Demographic Data Collection: Issuer must collect member self-identified race, ethnicity, and language data. Issuers must expand data collection to include member-level Sexual Orientation and Gender Identify (SOGI) data to establish baseline performance.
- Disparities Measurement: Patient Level Data (PLD) File: Issuer must submit the following Healthcare Effectiveness Data and Information Set (HEDIS) hybrid measure patient level data files for its enrollees:
  - Prenatal Depression Screen and Follow-up (PND-E)
  - Postpartum Depression Screen and Follow-up (PDS-E)
  - Quality Transformation Initiative (QTI) measures
  - Social Need Screening and Intervention (SNS-E)
- Disparities Measurement: Healthcare Evidence Initiative: Issuer and Covered California will review performance on specified disparities measures using HEI data.
- Disparities Reduction Intervention: Issuer must meet disparities reduction and health equity requirements throughout Attachment 1 and Attachment 4 Quality Transformation Initiative (QTI).
- NCQA Health Equity Accreditation: Issuer must achieve and maintain NCQA Health Equity Accreditation within the first year of contracting with Covered California

2026-28 ATTACHMENT 1 PUBLIC COMMENT KEY THEMES

Article 1: Equity and Disparities Reduction

- Several Issuers requested clarity on definitions
- Several Issuers requested specifics on Sexual Orientation and Gender Identity data submission timelines
- Several Issuers questioned the necessity of including expanded demographic data collection in the contract
- One Issuer suggested new entrant issuers should be held to demographic data completeness thresholds in the first year of operation
- One Issuer sought clarification on IDSS and Patient Level Data (PLD) file submissions, including layout and data volume, several issuers expressed concern with the number of measures included in the PLD file
- Multiple suggestions for performance measure adjustments related to PLD file required measures
- General support for the Disparities Reduction section changes
- One Issuer requested guidance on staff training for Culturally and Linguistically Appropriate Services (CLAS) standards
- One Issuer suggested submission of NCQA Health Equity Accreditation certificate rather than reporting related to specified standards

PROPOSED 2026-28 ARTICLE 1 CHANGES

Article 1: Equity and Disparities Reduction

Notable Changes to Draft Attachment 1	Rationale
No proposed changes	

PROPOSED 2026-28 ARTICLE 2 REQUIREMENTS

Article 2: Behavioral Health

- ❑ Issuer must submit specified NCQA Health Plan Accreditation Network Management reports, or a comparable report, and include timely provider network data if data used for accreditation was older than two years
- ❑ Issuer must promote access to behavioral health services and offer telehealth for behavioral health services, submitting screenshots of homepage and other relevant pages to demonstrate the promotion of behavioral health services across access points and languages
- ❑ Issuer must address disparities in behavioral health utilization by deploying disparities reduction strategies based on stratified utilization data and informed by engagement with impacted member populations
- ❑ Issuer must monitor behavioral health and virtual behavioral health care quality through monitoring of behavioral health utilization and submission of selection criteria for behavioral health care vendors
- ❑ Issuer must provide staff cultural humility training and deploy culturally tailored materials and strategies for historically marginalized groups
- ❑ Issuer must promote the appropriate use of opioids using a harm reduction framework and individualized approach to treatment planning aligned with Smart Care California guidelines; develop and maintain programming focused on Tobacco Cessation; and monitor Initiation, Engagement, Treatment (IET) and Follow-Up after Hospitalization (FUH) measure rates

PROPOSED 2026-28 ARTICLE 2 REQUIREMENTS

Article 2: Behavioral Health

- ❑ Issuer must report how it is promoting integration of behavioral health services with medical services
- ❑ Issuer 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.
- ❑ Issuer are required to submit annual reports on behavioral health spending by product in accordance with OHCA guidelines, work in partnership with other QHP Issuers and engage with the community on initiatives and are encouraged to suggest further activities that align with Covered California methodologies.

2026-28 ARTICLE 2 PUBLIC COMMENT KEY THEMES

Article 2: Behavioral Health

- ❑ Multiple Issuers requested clarity on culturally and linguistically appropriate services
- ❑ One Issuer raised concerns for specific follow-up measures
- ❑ One Issuer expressed concerns on low denominators impacting data reporting
- ❑ Consumer advocates urged Covered California to ensure educational materials are culturally and linguistically responsive
- ❑ Consumer advocates asked for clarifying language regarding the "Prevention" step of Smart Care California guidelines

PROPOSED 2026-28 ARTICLE 2 CHANGES

Article 2: Behavioral Health

Notable Changes to Draft Attachment 1	Rationale
2.01.4 Payment to Support Behavioral Health New section added outlining Issuer requirements to report behavioral health expenditure in alignment with OHCA benchmarks and Covered California methodology	Broadening behavioral health payment frameworks to ensure sufficient funding to support high quality, equitable behavioral health care

PROPOSED 2026-28 ARTICLE 3 REQUIREMENTS

Article 3: Population Health

Population Health Management

- ❑ Issuer must ensure the use of health promotion and prevention services, increase utilization of high value services, risk stratify Enrollees, and develop targeted interventions based on risk
- ❑ Issuer must identify opportunities, conduct outreach, and engage all Covered California Enrollees, not just Covered California Enrollees who obtain services from providers, in population health activities
- ❑ Issuer must submit specific elements of their NCQA Population Health Management plan or provide alternative reporting as outlined in 3.01.1

Health Prevention and Promotion

- ❑ Issuer must identify Enrollees who are eligible for certain high value preventive and wellness benefits, notify Enrollees about the availability of these services, ensure those eligible receive appropriate services and care coordination, and monitor the health status of these Enrollees
- ❑ Issuer must provide a CDC-recognized Diabetes Prevention Program available in different modalities to its eligible Covered California Enrollees

PROPOSED 2026-28 ARTICLE 3 REQUIREMENTS

Article 3: Population Health

Supporting At-Risk Enrollees Requiring Transition

- ❑ Issuer must submit an evaluation and formal transition plan for any service area reduction or any modification to its existing service area
- ❑ Issuer must outreach to all Covered California Enrollees alerting them of the service reduction and options to continue care with other QHP Issuers and conduct outreach to At-Risk Enrollees and get authorization to send health information to receiving QHP Issuers to minimize disruption of continuity of care
- ❑ Issuer receiving At-Risk Enrollees must establish processes to identify At-Risk Enrollees, ensure care transitions account for Enrollees' current health status and provide other vital information that aids in continuity of care

Social Health

- ❑ Issuer must report Enrollee social needs screening process for food, housing and transportation needs, including touch points, who performed the screening, and which methods and instruments were used to conduct screening
- ❑ Issuer must report screening efforts by provider networks, including coordination efforts with providers on screening and linkage to services to connect Covered California Enrollees
- ❑ Issuer must collect and report data for all components of the Social Needs Screening & Intervention (SNS-E) Measure and screen positive rate

PROPOSED 2026-28 ARTICLE 3 REQUIREMENTS

Article 3: Population Health Management

Use of Generative Artificial Intelligence in Qualified Health Plan Issuer Operations

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

2026-28 ARTICLE 3 PUBLIC COMMENT KEY THEMES

Article 3: Population Health

Health Promotion and Prevention

- ❑ No comments received

Supporting At-Risk Enrollees Requiring Transition

- ❑ One Issuer requested clarification on the use of “at-risk” vs “high-risk” in the enrollee transition requirements given the use of “high-risk” in current law
- ❑ Consumer advocates urged consideration of members undergoing medication assisted treatment for substance use disorders as high-risk enrollees.

Social Health

- ❑ No comments received

2026-28 ARTICLE 3 PUBLIC COMMENT KEY THEMES

Article 3: Population Health Management

Use of Generative Artificial Intelligence in Qualified Health Plan Issuer Operations

- One issuer requested flexibility in GenAI reporting requirements language to accommodate emerging information
- One issuer inquired about collaboration efforts with other plans and Covered CA
- Multiple issuers expressed concern with the addition of GenAI language in QHP operations
- One issuer expressed that there wasn't a need to alert patients on the uses of GenAI within their healthcare services due to the growing popularity of GenAI
- One stakeholder expressed concern proposed contract language may not align with Health & Safety Code § 1367.01(e) which states that "denying, delaying, or modifying services based on medical necessity and requires such determinations to be made only by a licensed physician or professional"

PROPOSED 2026-28 ARTICLE 3 CHANGES

Article 3: Population Health

Notable Changes to Draft Attachment 1	Rationale
No proposed changes to Health Promotion and Prevention	
Addition of members undergoing medication assisted treatment for substance use disorders in definition of At-Risk Enrollees	Covered California believes that including individuals with behavioral health conditions, especially those undergoing medication-assisted treatment for substance use disorders, in the high-risk enrollee category is crucial. This ensures they receive targeted care that improves outcomes and efficiency. It is also vital for maintaining continuity of care during transitions between healthcare plans, safeguarding against gaps in treatment.
No proposed changes to Social Health	
Adopting language to align with legal requirements within SB-1120 Health Coverage: Utilization Review	Covered California adheres to California's Health & Safety Code § 1367.01(e), which ensures that medical necessity decisions are made by licensed professionals, upholding patient care standards. Attachment 1 revisions ensure alignment of GenAI's use in health care with legal requirements, emphasizing the need for physician oversight and clear governance, balancing innovation with ethical and legal integrity.

PROPOSED 2026-28 ARTICLE 4 REQUIREMENTS

Article 4: Delivery System and Payment Strategies to Drive Quality

Advanced Primary Care

- ❑ Issuer must match enrollees with PCPs and report the number of enrollees who select a PCP or who were assigned a PCP
- ❑ Issuer must review and improve primary care selection and healthcare utilization using HEI submitted data
- ❑ Issuer must review and improve member continuity of care; measure results to be generated by Covered California using HEI-submitted data
- ❑ Issuer must report on total primary care spend in alignment with Office of Health Care Affordability (OHCA)
- ❑ Issuer must work with Covered California and other stakeholders to analyze the relationship between primary care spend as a percentage of total healthcare expenditures (TCHE) and network performance, including quality, equity, and cost

PROPOSED 2026-28 ARTICLE 4 REQUIREMENTS

Article 4: Delivery System and Payment Strategies to Drive Quality (Continued)

Networks Based on Value:

- ❑ Issuer must report how cost, quality, patient safety, patient experience, and equity are considered in network design and management
- ❑ Issuer must report on Alternative Payment Model (APM) adoption and Total Cost of Healthcare Expenditures in alignment with OHCA
- ❑ Issuers must participate in the IHA Align.Measure.Perform (AMP) program for physician groups and report AMP performance results to Covered California annually or allow IHA to submit results to Covered California

Hospital Quality, Value and Safety

- ❑ Issuer must demonstrate participation in collaborative engagement with Hospitals, Covered California, Issuers and Cal Healthcare Compare (CHC) to analyze performance variation and engage with poor performing hospitals
- ❑ Covered California requires contracted hospitals to comply with public price transparency rules by posting standard charges in a machine-readable format.
- ❑ Collaboration is intended to enhance patient safety in hospitals and address the opioid epidemic. Annual reporting will be utilized to evaluate improvements in hospital and facility cost, safety, and quality. Covered California will assess issuers based on their strategic planning and collaborative reporting efforts.

PROPOSED 2026-28 ARTICLE 4 REQUIREMENTS

Article 4: Delivery System and Payment Strategies to Drive Quality (Continued)

Comprehensive Maternity Care

- ❑ Issuer must work with Covered California to ensure maternity service providers in network hospitals utilize California Maternity Quality Care Collaborative (CMQCC) resources and enroll in the CMQCC Maternal Data Center.
- ❑ Issuer must report on engagement efforts with providers and maternity enrollees to promote individualized provider selection and high-value care delivery, aligned with Cal Healthcare Compare's Maternity Honor Roll Program, alongside facilitating access to necessary social support services.
- ❑ Issuer must develop and submit a strategy for expanding the network to include more doulas, nurse midwives, and licensed midwives, aimed at enhancing access to maternity care and ensuring care provider diversity that mirrors member demographics.
- ❑ Issuer must collect and analyze data on maternal health disparities, particularly focusing on outcomes stratified by race and ethnicity, and implement targeted interventions to improve care for specific subpopulations, drawing on insights from Cal Healthcare Compare and CMQCC guidelines.

PROPOSED 2026-28 ARTICLE 4 REQUIREMENTS

Article 4: Delivery System and Payment Strategies to Drive Quality (Continued)

Use of Virtual Care

- ❑ Issuers must report all virtual care solutions and vendors in place and disclose vendors' NCQA Virtual Care Accreditation status
- ❑ Issuers must collect quality monitoring measures from virtual care vendors and annually report summary findings to Covered California
- ❑ Issuers must provide member support for navigating virtual services, ensuring solutions are culturally and linguistically tailored, and share relevant tools and resources with Covered California
- ❑ Issuers must report on reimbursement policies for both network and third-party providers, ensuring payment parity for virtual services
- ❑ Issuers must collaborate with Covered California to review virtual care service utilization, address disparities using HEI, submit improvement plans for outliers, and participate in best practice collaboratives, including digital literacy support

Participation in Quality Collaboratives

- ❑ Contractors must report participation in quality collaboratives

2026-28 ARTICLE 4 PUBLIC COMMENT KEY THEMES

Article 4: Delivery System and Payment Strategies to Drive Quality

Advanced Primary Care

- Two QHP issuers and one association recommend further research into trends in Continuity of Care (CoC) with primary care providers (PCP) and the correlation with quality of care before setting benchmarks.
  - Concerns raised about differences in continuity between PPO/EPO and HMO products, with a request for a reporting-only period to establish baseline.
  - Concerns expressed that focusing on continuity of care with the same provider could result in unnecessary visits, increasing premiums and out-of-pocket costs for members.
- Consumer advocates and American Family Board of Medicine (ABFM) support the CoC metric due to its positive impact on patient outcomes and cost reduction.
- Several issuers and consumer advocates highlight the importance of monitoring timely access to new patient appointments with PCPs.
- Two QHP issuers and one association express concern over duplicative data reporting requirements, requesting alignment with state regulatory frameworks to streamline efforts.
- Two issuers support increased primary care spending but request adjustments to the reporting template for spend categorization and transparency in reporting, addressing data limitations.

2026-28 ARTICLE 4 PUBLIC COMMENT KEY THEMES

Article 4: Delivery System and Payment Strategies to Drive Quality

Networks Based on Value

- Several stakeholders express concern or opposition to making OHCA's APM goals mandatory in Covered California contracts, highlighting concerns about the timing, redundancy, and the administrative burden of overlapping APM requirements. Comments also warn of the potential for inadvertent increased provider consolidation, which may worsen access to care.
- One issuer proposes eliminating the provision that allows Covered California to request copies of the contractor's medical management policy.
- One issuer and one association request removing expectations for contractors to address "low value care," noting contractors do not practice medicine.

Hospital Value and Safety

- One Issuer suggests excluding "all lines of business" from reporting requirements.

Comprehensive Maternity Care

- Consumer advocates express support for prioritizing the equitable access to doula and midwife providers.
- One issuer seeks clarity on data tracking requirements and highlights difficulties with third-party network data management

2026-28 ARTICLE 4 PUBLIC COMMENT KEY THEMES

Article 4: Delivery System and Payment Strategies to Drive Quality

Use of Virtual Care

- One Issuer requested clarification of intended scope of virtual care services
- One Issuer suggested removing the requirement for virtual care improvement plan for outlier utilization findings
- One Issuer suggested the addition of URAC telehealth accreditation status as an option for inventory reporting

Participation in Quality Collaboratives

- No comments received

PROPOSED 2026-28 ARTICLE 4 CHANGES

Article 4: Delivery System and Payment Strategies to Drive Quality

Notable Changes to Draft Attachment 1	Rationale
No proposed changes to Advanced Primary Care	
No proposed changes to Networks Based on Value	
No proposed changes to Hospital Value and Safety, Comprehensive Maternity Care	
No proposed changes to Use of Virtual Care	
No proposed changes to Participation in Quality Collaboratives	

PROPOSED 2026-28 ARTICLE 5 REQUIREMENTS

Article 5: Measurement and Data Sharing

- ❑ Issuers must submit to Covered California its QRS data and participate in NCQA Quality Compass Reporting for its other lines of business
- ❑ Issuers must submit quality and cost data to HEI in accordance with data submission requirements and in alignment with the HIPAA Privacy Rule and California law, and acknowledge that Covered California will publish this data in accordance with AB-929
- ❑ Issuers must implement and maintain a secure Patient Access API, and report on its use
- ❑ Issuers must execute the Data Sharing Agreement (DSA) as required by Health and Safety Code section 130290 and participate in at least one QHIO
- ❑ Issuers must monitor its network hospital's compliance with ADT event Technical Requirements and report on their adherence
- ❑ Issuers must share information on enrollees with primary care providers for their assigned members

2026-28 ARTICLE 5 PUBLIC COMMENT KEY THEMES

Article 5: Measurement and Data Sharing

- ❑ Multiple Issuers requested clarity in data sharing protocols
- ❑ Multiple comments on tailoring reporting requirements

PROPOSED 2026-28 ARTICLE 5 CHANGES

Article 5: Measurement and Data Sharing

Notable Changes to Draft Attachment 1	Rationale
No proposed changes to draft language	

PROPOSED 2026-28 ARTICLE 6 REQUIREMENTS

Article 6: Certification, Accreditation, and Regulation

- Issuer must achieve and maintain current National Committee for Quality Assurance (NCQA) Health Plan Accreditation by year-end 2026. If Issuer is not currently accredited by NCQA, Issuer must be accredited by Utilization Review Accreditation Commission (URAC) or Accreditation Association for Ambulatory Healthcare (AAAHC) and submit plan to obtain NCQA health plan accreditation
- Issuer must notify Covered California of scheduled NCQA health plan accreditation review and its results. Issuer must submit a copy of the assessment report within 30 days of its receipt from NCQA
- Issuers that receive any status other than “Accredited”, lose an accreditation, or fail to maintain a current and up to date accreditation, must:
  - Notify Covered California within ten (10) days of the status change,
  - Implement strategies to achieve the level of “Accredited”
  - Submit a copy of the same Corrective Action Plan (CAP) issued by the NCQA within thirty (30) days, and provide details on all relevant updates
  - Submit a written report to Covered California quarterly regarding the status and progress of Accreditation reinstatement
- Issuers must submit a copy of any Corrective Action Plan (CAP) issued by the NCQA within thirty (30) days, and provide details on all relevant updates regardless of accreditation status

2026-28 ARTICLE 6 PUBLIC COMMENT KEY THEMES

Article 6: Certification, Accreditation, and Regulation

- ❑ No comments received

PROPOSED 2026-28 ARTICLE 6 CHANGES

Article 6: Certification, Accreditation, and Regulation

Notable Changes to Draft Attachment 1	Rationale
No changes proposed	

Attachment 2 Performance Standards with Penalties

PROPOSED 2026-2028 ATTACHMENT 2 REQUIREMENTS

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

2026-28 ATTACHMENT 2 PUBLIC COMMENT KEY THEMES

Performance Standard 1 Reducing Health Disparities: Demographic Data Collection – Enrollee Race and Ethnicity Self-Identification

Performance Standard 2 Reducing Health Disparities: Demographic Data Collection – Enrollee Spoken and Written Language

- ❑ One Issuer suggested consideration of “Decline to state” or “Asked but not answered” as acceptable values.
- ❑ One Issuer requested removal of alternate standard for newly contracted QHP Issuers in the first year of operation.

Performance Standard 3 Collaboration Across QHP Issuers and With Community

- ❑ Two Issuers requested clarification of definitions or evaluation approach to assess 80% participation

2026-28 ATTACHMENT 2 PUBLIC COMMENT KEY THEMES

Performance Standard 7 Utilization & Primary Care: Overall Engagement with Members

- One Issuer expressed concerns with potential increased member costs and premiums.
- One Issuer suggested reporting-only phase to establish baselines before introducing new performance standards.

Performance Standard 8 Utilization & Primary Care: Monitoring Continuity of Care

- One Issuer advocated for use of existing validated quality measures to reduce administrative burden.
- One Issuer suggested reporting-only phase to establish baselines before introducing new performance standards.
- One Issuer expressed concerns with setting improvement targets for Continuity of Care (CoC) without adequate research on its correlation with quality.
- Two Issuers requested clearer guidance on CoC calculations, reporting specifications, timelines, and data definitions.

PROPOSED 2026-28 ATTACHMENT 2 CHANGES

Notable Changes to Draft Attachment 2	Rationale
Performance Standard 1 - Reducing Health Disparities: Demographic Data Collection – Enrollee Race and Ethnicity Self-Identification No proposed changes	
Performance Standard 2 - Reducing Health Disparities: Demographic Data Collection – Enrollee Spoken and Written Language No proposed changes	
Performance Standard 3 - Collaboration Across QHP Issuers and With Community No proposed changes	

PROPOSED 2026-28 ATTACHMENT 2 CHANGES

Notable Changes to Draft Attachment 2	Rationale
Performance Standard 7 - Utilization & Primary Care: Overall Engagement with Members No proposed changes	
Performance Standard 8 - Utilization & Primary Care: Monitoring Continuity of Care No proposed changes	

Attachment 4 Quality Transformation Initiative

PROPOSED 2026-28 ATTACHMENT 4 REQUIREMENTS

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

2026-28 ATTACHMENT 4 PUBLIC COMMENT KEY THEMES

QTI Measure Set & Benchmarks

- Multiple Issuers voiced concerns about the DSF-E measure and that it contains two measures in one.
- Three Issuers requested a transition from CIS Combo 10 to Combo 7 due to nationwide challenges in administering flu vaccines.
- Two Issuers raised concerns about transitioning to BPC-E measure, which has not yet been approved by NCQA, and the impact of non-billable blood pressure screenings on data collection.
- Three Issuers expressed the need for at least one-year reporting-only phase for any new measures to establish benchmarks.
    - Concerns expressed about administrative burden and costs associated with implementing custom measures.
- Two Issuers and one association highlighted the potential delay in receiving QRS national percentiles, requesting that benchmarks be set using MY2024 instead of MY2025.
- Two Issuers raised concerns about the administrative burden of implementing Quality Improvement Plans at the subpopulation level.
- Two Issuers and one association suggested resetting the QTI percent at risk to 0.8% for the MY2026 contract year, citing concerns about how QTI payments will be applied for the Health Equity Methodology.
    - One Issuer also recommended setting the maximum total amount at risk at 3% over the 2026-2028 contract period.

PROPOSED 2026-28 ATTACHMENT 4 CHANGES

QTI Measure Set and Benchmarks

Notable Updates to Draft Attachment 4	Rationale
QTI Scored Measures: Language added to specify if DSF-E data not available to assess performance or establish a benchmark, Covered California may choose not to assess.	Covered California recognizes measure is still new and CMS benchmarks are pending.
Amount at Risk for Newly Contracted QHP Issuers: No proposed changes	
Amount at Risk for Currently Contracted QHP Issuers: No proposed changes	

PROPOSED 2026-28 ATTACHMENT 4 REQUIREMENTS

Health Equity Methodology

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

2026-28 ATTACHMENT 4 PUBLIC COMMENT KEY THEMES

Race and Ethnicity Stratification and Methodology

- One Issuer suggested excluding Middle Eastern/North African as a sub-population until officially recognized by OMB
- One Issuer recommended alignment with NCQA HEDIS race and ethnicity stratification rather than consolidation in an "all other members" category
- One Issuer expressed support for stratification of COL and CBP, but concern with potential stratification of CBP-E
- One Issuer and one association expressed concerns with potential reweighting of QTI payments based on persistent or worsening disparities and requested removal of re-weighting language
- Several Issuers requested clarification on application pf payments for subpopulation performance not reaching the 66th percentile
- Several Issuers expressed concerns about payment assessments at the sub-population level

PROPOSED 2026-28 ATTACHMENT 4 CHANGES

Health Equity Methodology

Notable Changes to Draft Attachment 4	Rationale
Race and Ethnicity Stratification Methodology No proposed changes	

2026-2028 MODEL CONTRACT DRAFTS & RESPONSE TO COMMENT

2026-2028 Model Contract Drafts and Response to Comment documents will be posted to HBEX Friday, October 18th:

https://www.hbex.ca.gov/stakeholders/plan-management/contract-listings/2026/

Any questions please email PMDContractsUnit@covered.ca.gov or EQT@covered.ca.gov

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