Plan Management Advisory Workgroup

November 14, 2024

AGENDA

Time	Topic	Presenter
10:00 – 10:05	Welcome and Agenda Review	Rick Krum
10:05 – 10:35	Results on QHP Issuer Accountability Programs	Peg Carpenter Monica Soni
10:35 – 11:05	2026 – 2028 QHP Issuer Model Contract Updates	Steph Carlson Charles Raya Joy Dionisio Barbara Rubino
11:05 – 12:00	Open Forum	All

Results on QHP Issuer Accountability Programs

EQT Team

POLICY FOR REMOVAL FROM THE EXCHANGE (ALSO KNOWN AS 25-2-2)

MAKING QUALITY COUNT: CONTRACT PROVISIONS ON QUALITY

For existing carriers: “25/2/2” allows for selective contracting and removal from marketplace for consistent poor performance on quality measures.

Quality Transformation Initiative: assesses quality improvement payments up to 66th percentile national performance.

2023-2025 REMOVAL FROM THE EXCHANGE "25/2/2" POLICY AND METHODOLOGY

Assessment Structure	Composite measure score on QRS Clinical Quality Management Summary Indicator measures compared to MY 2018 25th percentile individualized composite benchmark for each product. • **Monitoring Period**: If an issuer has one or more products that falls below the 25th percentile individualized composite benchmark for its product-reportable subset of the QRS Clinical Quality Management Summary Indicator measures for **two consecutive** years. • **Remediation Period**: The product is required to meet or exceed the 25th percentile individualized composite benchmark within the **following two years**, or it will not be certified for the Plan Year following the performance assessment of the last year of the remediation period. • **Removal from Exchange**: If the product does not perform above the 25th percentile individualized composite benchmark for **four consecutive years**.
25th Percentile Benchmark	Covered California uses the 25th percentile score for each of the QRS Clinical Quality Management Summary Indicator measures from the QRS national percentile data. An unweighted average of these scores is computed to establish the 25th percentile composite benchmark excluding Non-Reportable (NR) scores and measures without a 2018 benchmark.
Annual Assessment	If the issuer product meets the CMS eligibility criteria to report QRS measures scores, it will be assessed for this 25/2/2 program as early as Measurement Year 2021. Product performance will be assessed annually.

MY 2023 INDIVIDUAL MEASURE & COMPOSITE RESULTS

MY 2023 25-2-2 Assessment

Identifier	Measure Acronym	QRS Clinical Quality Management Summary Indicator Measures	MY 2018 25th Percentile	Anthem HMO	Anthem EPO	Blue Shield HMO	Blue Shield PPO	Chinese Community HMO	Health Net HMO	Health Net PPO	Kaiser HMO	L.A. Care HMO	Molina HMO	Sharp HMO	Valley HMO	Western HMO
		MY 2018 Individualized Composite Benchmark	**0.534**	**0.537**	**0.534**	**0.537**	**0.537**	**0.561**	**0.537**	**0.537**	**0.537**	**0.534**	**0.537**	**0.537**	**0.550**	**0.528**
		MY 2023 Composite Score		**0.582**	**0.562**	**0.619**	**0.612**	**0.559**	**0.621**	**0.561**	**0.754**	**0.604**	**0.547**	**0.666**	**0.598**	**0.616**
S1M2	AMM	Antidepressant Medication Management	0.588	**0.555**	0.604	**0.580**	**0.580**	NR	0.588	0.594	0.735	0.615	0.603	0.714	**0.571**	0.659
S1M17	CCS	Cervical Cancer Screening	0.481	**0.477**	0.543	0.563	0.694	0.584	0.637	0.506	0.760	0.559	**0.472**	0.694	0.499	0.620
S1M18	COL	Colorectal Cancer Screening	0.467	0.501	0.504	0.612	0.576	0.547	0.598	**0.448**	0.703	0.477	**0.341**	0.605	**0.392**	0.617
S1M6	CBP	Controlling Blood Pressure	0.538	0.672	0.620	0.689	0.642	**0.524**	0.625	0.611	0.777	0.678	0.669	0.764	0.550	0.648
S1M7	PDC	Proportion of Days Covered (RAS Antagonists)	0.729	**0.667**	**0.656**	**0.685**	**0.716**	**0.675**	0.733	**0.694**	0.809	0.743	**0.687**	0.826	0.777	0.765
S1M8	PDC	Proportion of Days Covered (Statins)	0.681	**0.609**	**0.649**	**0.640**	**0.671**	**0.589**	**0.668**	**0.651**	0.855	0.690	**0.639**	0.798	0.748	0.737
S1M13	PDC	Proportion of Days Covered (Diabetes All Class)	0.678	0.693	0.690	0.699	**0.669**	0.724	0.762	0.699	0.781	0.738	0.721	0.816	0.792	0.736
S1M9	EED	Comprehensive Diabetes Care: Eye Exam (Retinal) Performed	0.406	0.455	**0.389**	0.550	0.421	**0.384**	0.470	**0.324**	0.732	0.513	0.433	0.687	0.416	0.479
S1M19	PPC	Prenatal and Postpartum Care: Postpartum Care	0.658	0.796	0.808	0.796	0.805	NR	0.834	0.867	0.913	0.842	0.796	0.804	0.725	0.806
S1M20	PPC	Prenatal and Postpartum Care: Timeliness of Prenatal Care	0.774	0.810	0.822	0.810	0.843	NR	0.924	0.884	0.947	0.908	**0.713**	0.867	0.784	0.806
S1M23	CHL	Chlamydia Screening in Women	0.402	0.517	0.472	0.523	0.489	NR	0.473	0.416	0.642	0.641	0.556	0.608	0.533	0.497
S1M25	MSC	Medical Assistance With Smoking and Tobacco Use Cessation	0.483	NR	**0.399**	NR	NR	**0.457**	NR	NR	NR	**0.385**	NR	NR	**0.471**	NR
S1M47	IMA	Immunizations for Adolescents Combination 2	0.174	0.316	0.200	0.351	0.251	NR	0.311	0.217	0.581	0.402	0.311	0.331	NR	0.190
S1M30	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	0.586	0.709	0.672	0.668	0.620	**0.547**	0.734	0.661	0.898	0.734	0.719	0.757	0.686	0.685
S1M31a	W30	Well-Child Visits in the First 30 Months of Life (First 15 Months)	0.661	**0.562**	**0.528**	0.672	0.774	NR	**0.451**	**0.367**	0.776	**0.304**	**0.324**	**0.530**	NR	NR
S1M15	PCR	Plan All-cause Readmissions (reverse scored)	0.234	0.397	0.434	0.445	0.426	NR	0.503	0.483	0.403	0.440	**0.226**	**0.186**	0.425	0.373

- Red shaded cells indicate a measure score result below the measure year 2018 25th percentile baseline.
- "NR" indicates this measure was not reportable to QRS for measure year 2023 or the denominator did not meet the minimum threshold for reporting.
  - NR results are omitted from composite scoring results.
- Products with composite score results below the 25th percentile benchmark target may currently be operating within the removal timeline (appendix).

TRENDED MEASURES BELOW THE 25TH PERCENTILE

12 of 13 QHPs remain in **good standing** based on composite performance

- ❑ 6 QHP issuer products have less measures below the 25th percentile baseline.
- ❑ Several Clinical Quality Measures remain below the 25th percentile for some QHP issuer products despite the total number of measures decreasing.
- ❑ There has been meaningful improvement from MY 2021 to MY 2023, although not across all issuer products.
- ❑ Chinese Community Health Plan has entered the monitoring period for Plan Year 2024 based on their 2023 composite performance results.

- Numerator represents the **total number of Clinical Quality Measures currently below the 25th percentile** for the QHP Issuer Product.
- Denominator represents the **total number of reportable scores** for the QHP issuer product.

QHP Products	MY 2021	MY 2022	MY 2023
ANTHEM BLUE CROSS HMO	4/18	5/19 ↑	5/15 =
ANTHEM BLUE CROSS EPO	8/20	8/20 =	5/16 ↓
BLUE SHIELD CALIFORNIA HMO	4/20	5/19 ↑	4/15 ↓
BLUE SHIELD CALIFORNIA PPO	4/19	3/19 ↓	4/16 ↑
CHINESE COMMUNITY HEALTH PLAN HMO	5/14	6/13 ↑	6/09 =
HEALTH NET HMO	2/19	1/19 ↓	2/15 ↑
HEALTH NET PPO	5/19	7/19 ↑	5/15 ↓
KAISER HMO	0/18	0/18 =	0/15 =
L.A. CARE HMO	3/20	3/20 =	2/16 ↓
MOLINA HEALTHCARE HMO	10/19	10/18 =	7/15 ↓
SHARP HEALTHCARE HMO	2/19	2/19 =	2/16 =
VALLEY HEALTH PLAN HMO	2/17	2/17 =	3/14 ↑
WESTERN HEALTH ADVANTAGE HMO	3/19	2/19 ↓	0/14 ↓

QUALITY TRANSFORMATION INITIATIVE

Measurement Year 2023 | Year 1 Results

THE PROBLEM

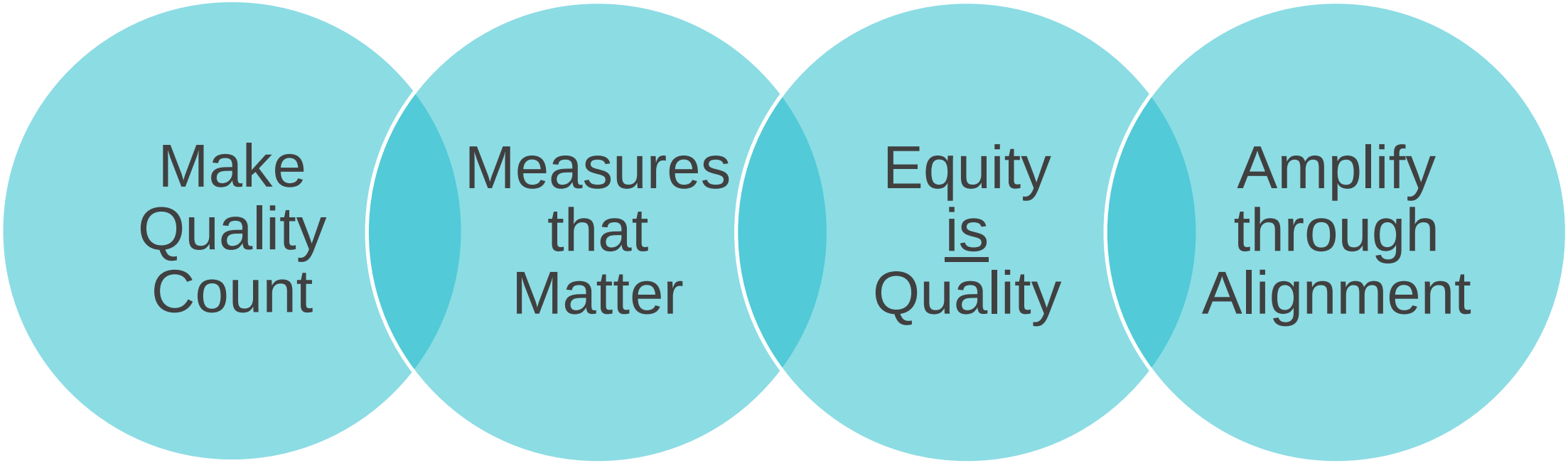
Proliferation of quality measures

Clinician administrative burden

Stagnant or worsening quality outcomes

Persistent health disparities

QUALITY TRANSFORMATION INITIATIVE



0.8% to 4% premium at risk for

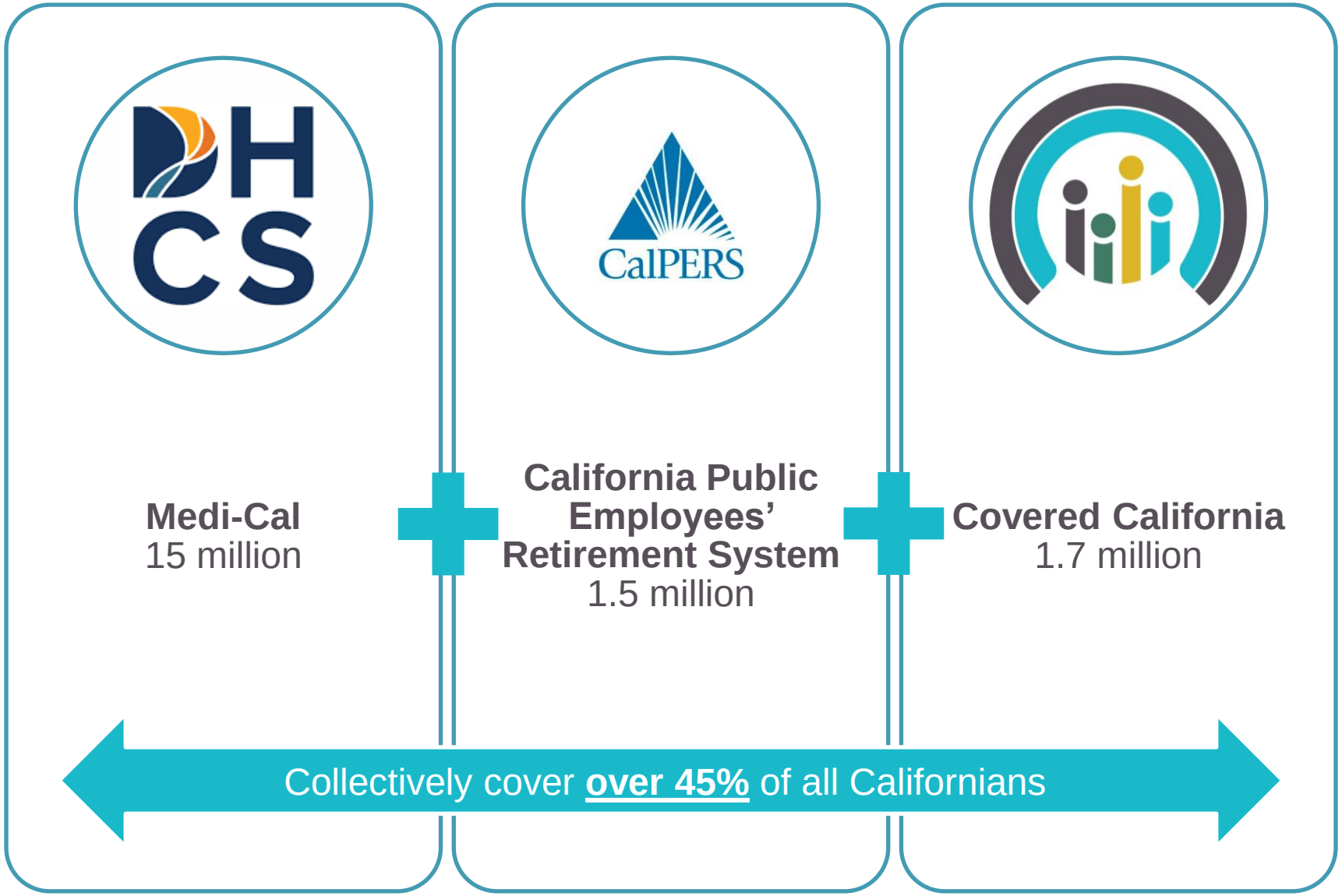
a small set of clinically important measures

stratified by race/ethnicity

selected in concert with other public purchasers*

*Public purchasers includes CalPERS and DHCS/Medi-Cal

AN ALIGNED STATE-WIDE APPROACH



EQUITY-CENTERED OUTCOMES MEASURES

Core Measures	Clinical Context
Blood Pressure	Key risk factor for cardiovascular disease (heart attacks and strokes) & the leading cause of death in the United States. BP control rates are ~10% lower for Asian, Black and Hispanic people than White counterparts. Black Americans have 4-5 times greater hypertension-related mortality than White counterparts
Diabetes (A1c control)	~50% Californians have prediabetes or diabetes, which is a leading cause of blindness and amputation and key risk factor for cardiovascular disease. It is 2x more prevalent among Black, AI/AN, and Hispanic people than Whites. Diabetes death was 3x higher among Black and NH/PI than White counterparts
Colorectal Cancer Screening	Cancer is the second leading cause of death after heart disease, and colorectal cancer is the second leading cause of cancer death after lung cancer. Black Americans are 20% more likely to get colorectal cancer and 40% more likely to die from it than others. Screening reduces the risk of developing and dying from CRC cancer by 60-70%
Childhood Immunizations	Childhood immunizations prevent 10.5m diseases annually. Black, Hispanic, AI/AN children have lower vaccine coverage than White children. For every $1 spent on immunizations, there is as much as $29 in savings

YEAR 1 (MY2023) QTI OVERVIEW

Contract Period:

- 2023-2025 Covered California QHP IND Issuer Contract

Measures Assessed:

- Controlling High Blood Pressure (NQF #0018)
- Comprehensive Diabetes Care: Hemoglobin A1c Control (<8.0%) NQF #0575)
- Colorectal Cancer Screening (NQF #0038)
- Childhood Immunization Status (Combo 10) (NQF #0038)

Issuers Assessed:

- 13 issuer products from 10 issuers

Percent Premium at Risk:

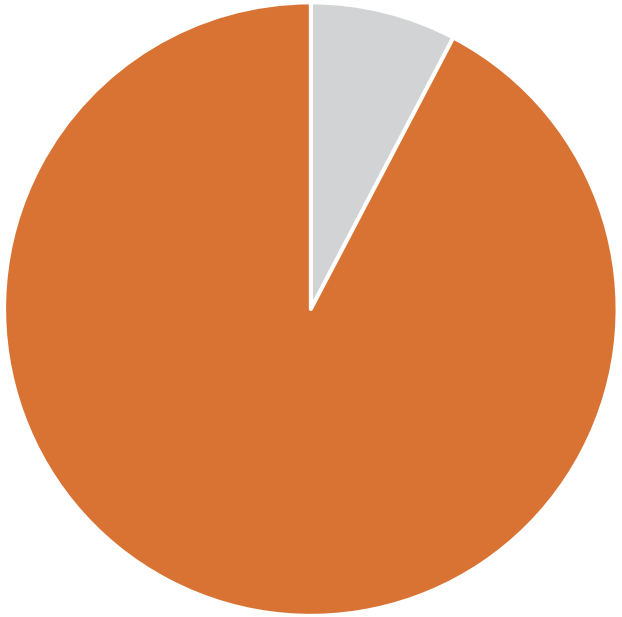
- 0.8% of total Gross Premium per product per measure

QHP Issuers Participating in QTI

PY2023	PY2024	PY2025	PY2026
Anthem	Anthem	Aetna	Aetna
Blue Shield	Blue Shield	Anthem	Anthem
CCHP	CCHP	Blue Shield	Blue Shield
Health Net	Health Net	CCHP	CCHP
Kaiser	Kaiser	Health Net	Health Net
LA Care	LA Care	Kaiser	IEHP
Molina	Molina	LA Care	Kaiser
Sharp	Sharp	Molina	LA Care
VHP	VHP	Sharp	Molina
WHA	WHA	VHP	Sharp
		WHA	VHP
			WHA

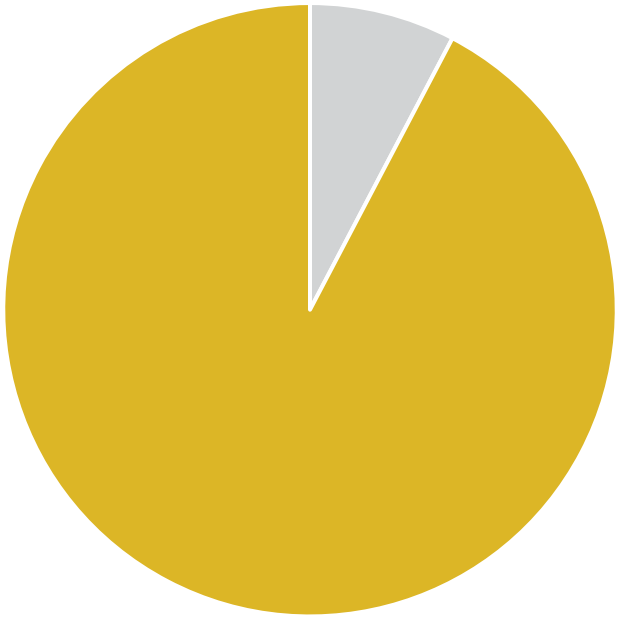
QTI LEADS TO IMPROVEMENTS IN CHRONIC DISEASE CONTROL AND CANCER SCREENING RATES

CBP



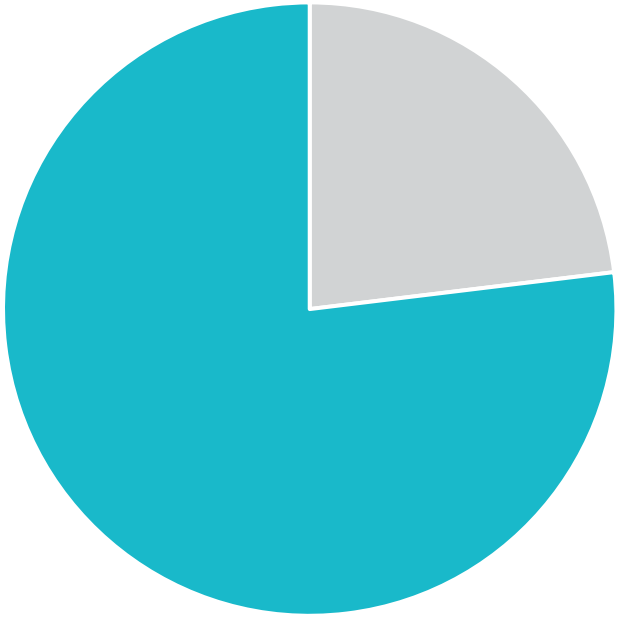
12 of **13** Issuer products had an **increase** in score for **controlling blood pressure**

HbA1c <8%



12 of **13** Issuer products had an increase in score for **diabetes management**

COL



10 of **13** Issuer products had an **increase** in score for **colorectal cancer screening**

THE INAUGURAL YEAR OF QTI A SUCCESS, WITH HEADWINDS FROM VACCINE HESITANCY

	% of issuer products with improvement	Performance Improved from MY22 to MY23	Overall CCA % Improvement MY22 to MY23
A1c <8%	92%	12/13	+6%
Colorectal Cancer Screening	77%	10/13	+5%
Controlling Blood Pressure	92%	12/13	+12%
CIS-10	30%*	3/10	-4%

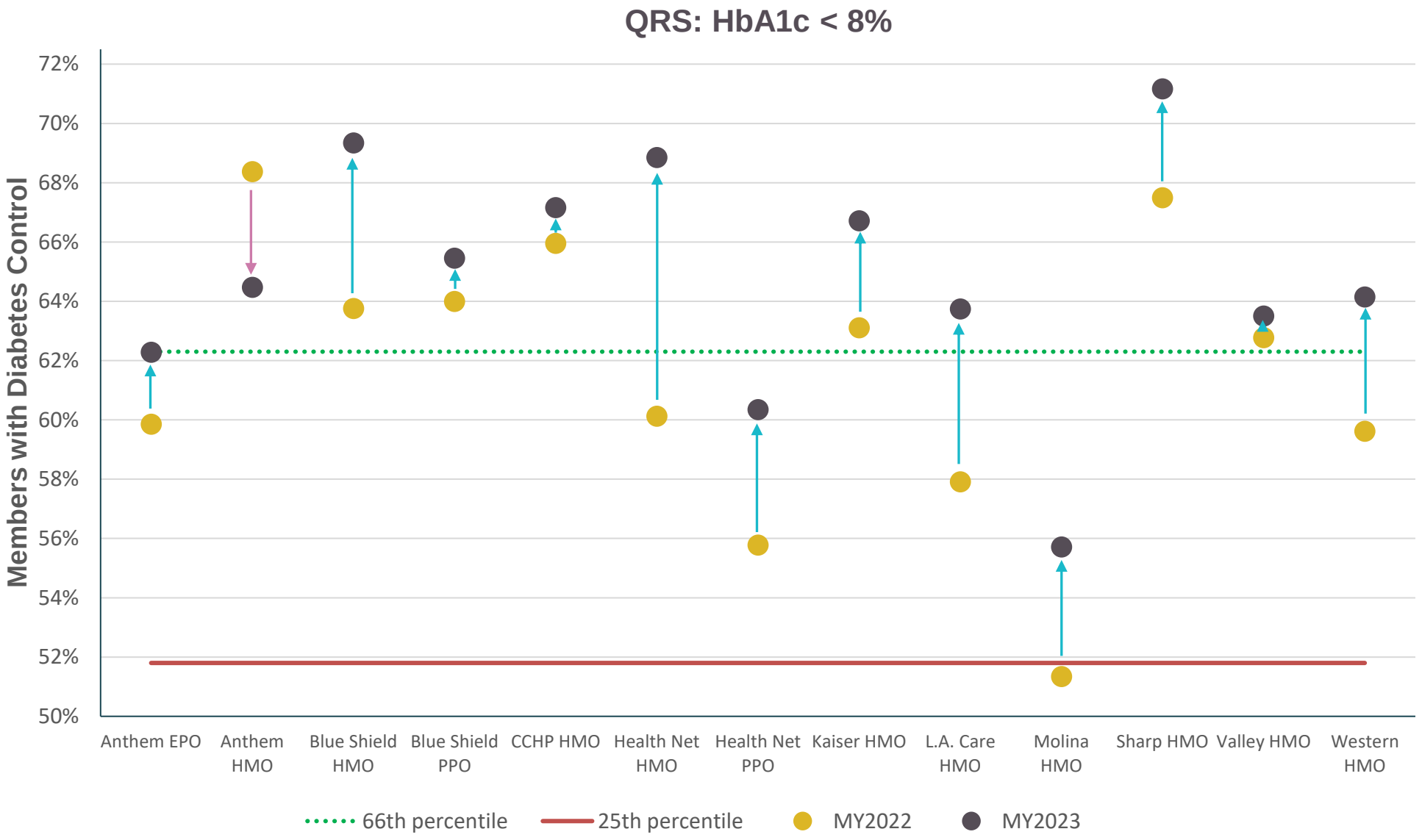
*Only 10 issuers with reportable results for the measure

MY2023: DIABETES CONTROL IMPROVES ACROSS 12 ISSUER PRODUCTS

Assessment Total for Measure

Projected Total: $2,182,771

Actual Total: $543,708

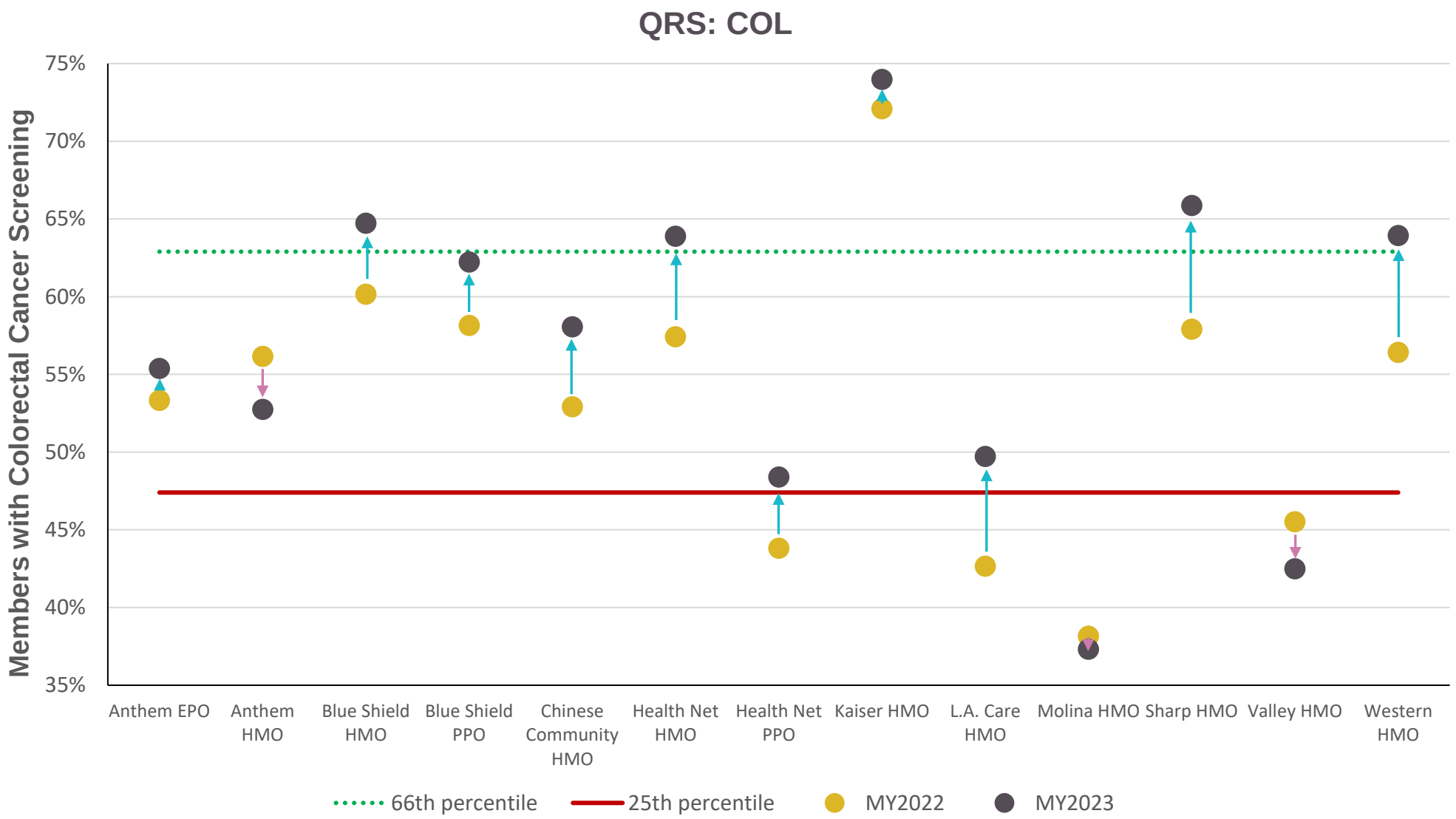


MY2023: COLON CANCER SCREENING IMPROVES ACROSS 10 ISSUER PRODUCTS

Assessment Total for Measure

Projected Total: $7,269,339

Actual Total: $4,619,868

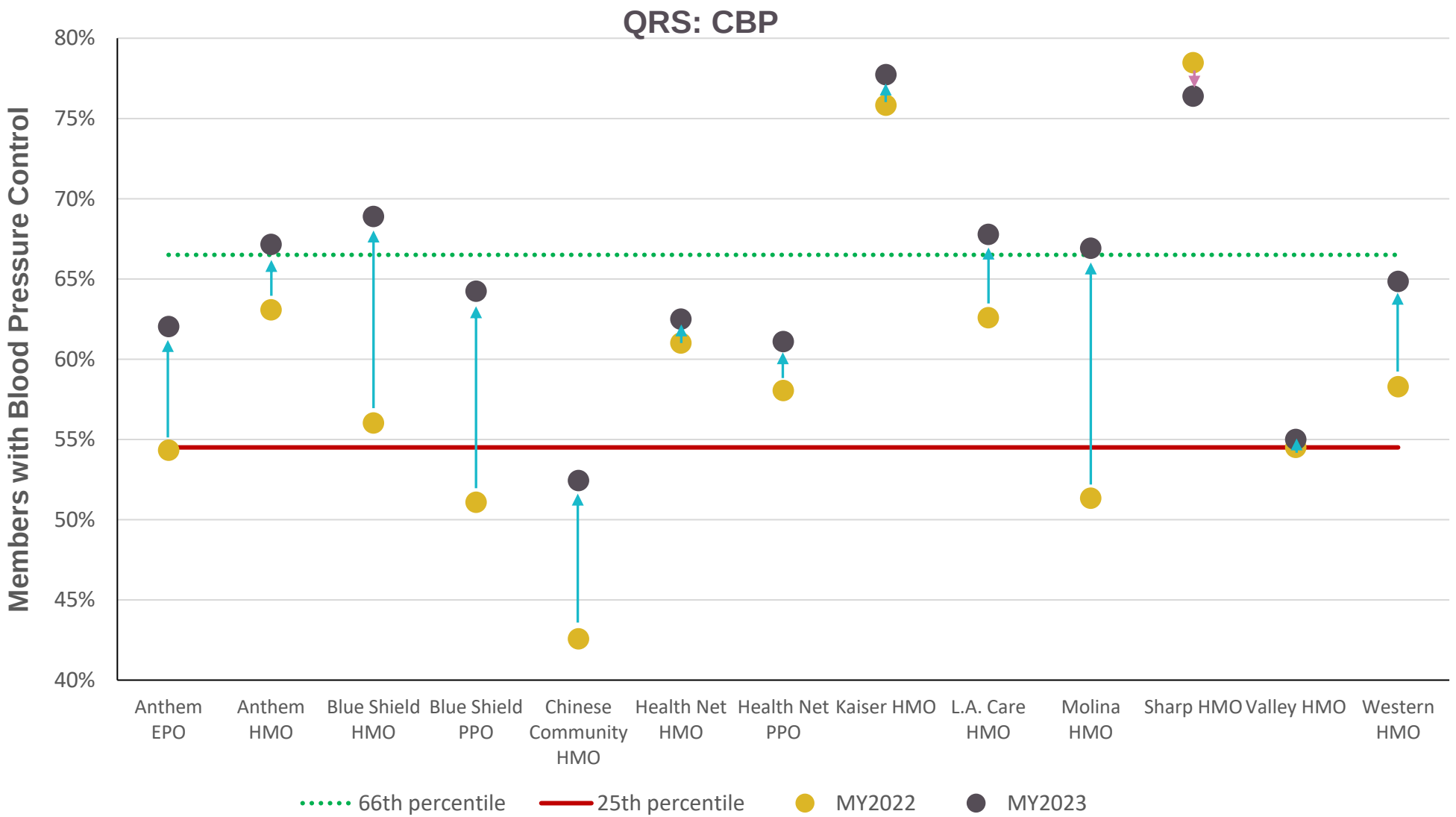


MY2023: BLOOD PRESSURE CONTROL IMPROVES ACROSS 12 ISSUER PRODUCTS

Assessment Total for Measure

Projected Total: $12,212,236

Actual Total: $2,681,774

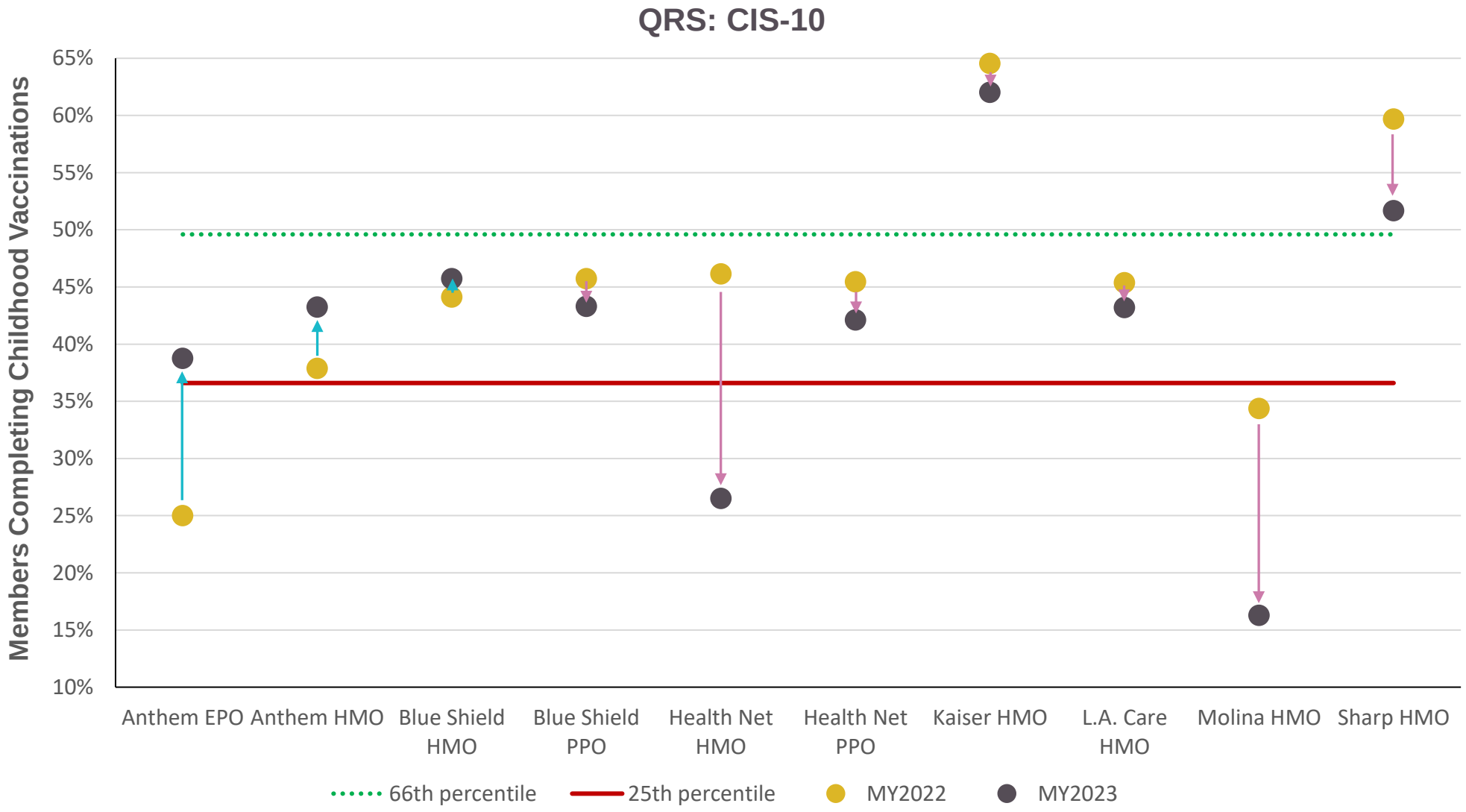


MY2023: CHILDHOOD VACCINATION RATES A CHALLENGE, CONSISTENT WITH NATIONAL TRENDS

Assessment Total for Measure

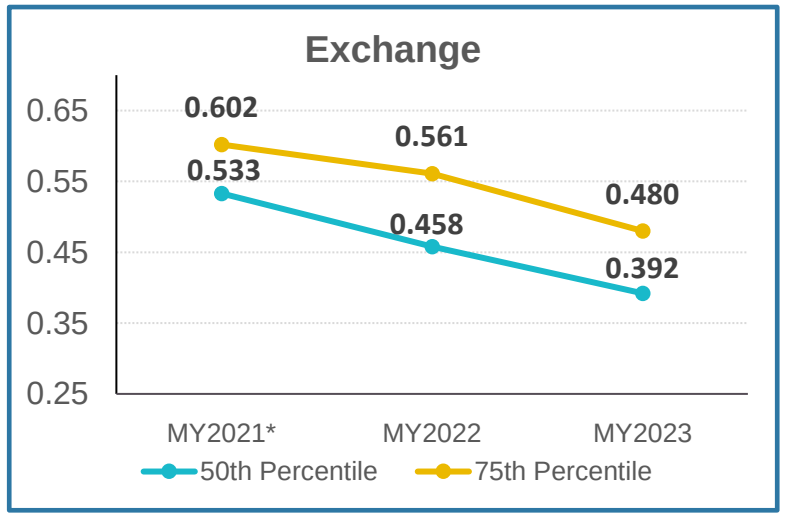
Projected Total: $6,989,631

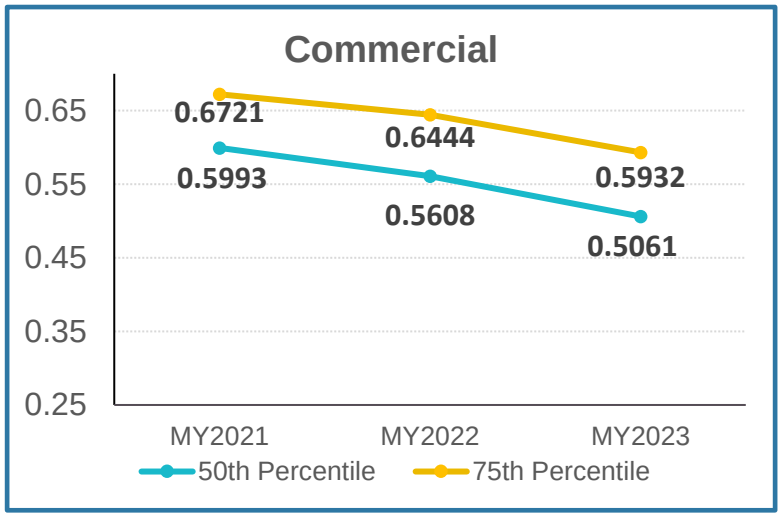
Actual Total: $8,882,252

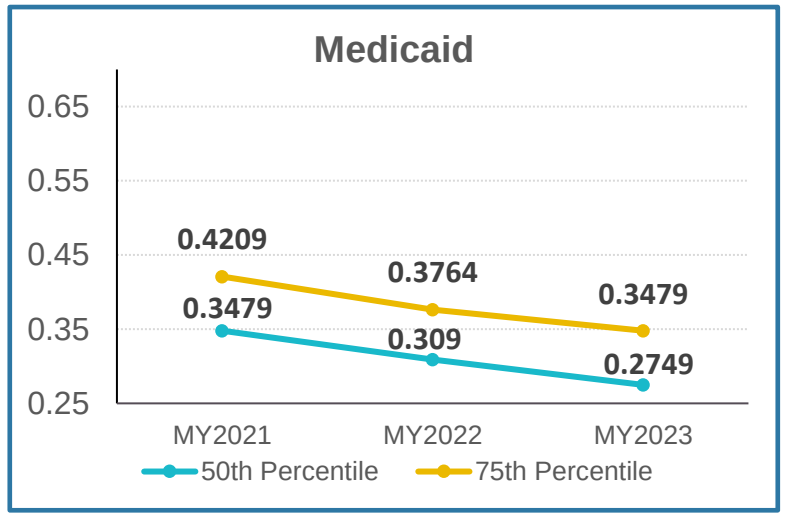


NATIONAL TRENDS IN CHILDHOOD VACCINATION

National CIS-10 Trends





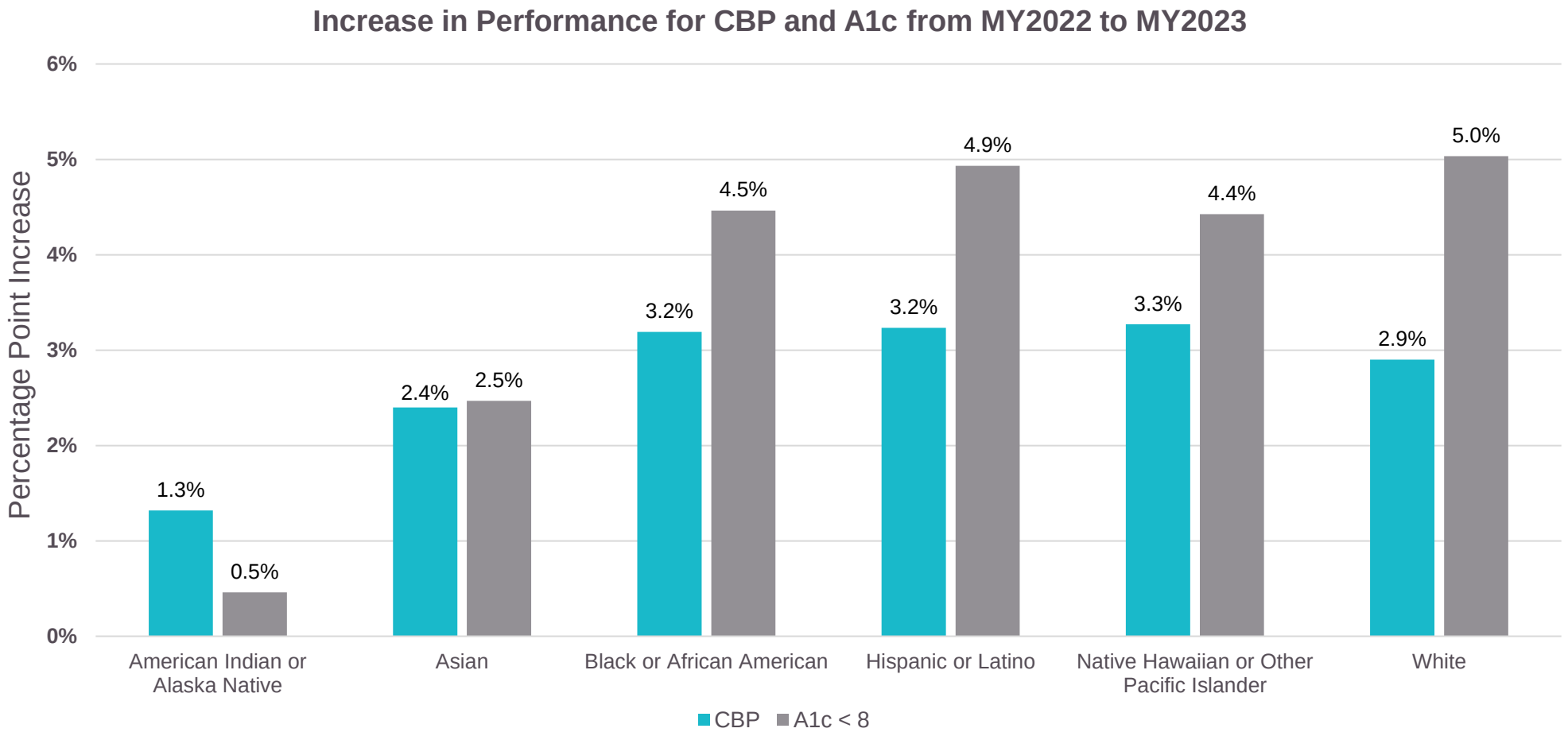


- ***Decline in Routine Vaccination Rates***
  - Share of kindergarten children up to date on their vaccinations has declined during the COVID-19 pandemic and has not returned to pre-pandemic levels
  - As of 2022-2023 school year, 93% of kindergarteners were vaccinated with all state-required vaccines, including MMR, DTaP, polio, and varicella, which is lower than pre-pandemic levels of 95%
- ***Increase in Vaccine Exemptions***
  - From 2019-2020 school year to 2022-2023 school year, the national exemption rate rose from 2.5% to 3.0%, the highest to date
  - Non-medical exemptions increased from 2.2% in 2020-2021 to 2.8% in 2022-2023

Source: https://www.kff.org/coronavirus-covid-19/issue-brief/headed-back-to-school-in-2024-an-update-on-childrens-routine-vaccination-trends/

*MY2021 Only reported, not scored

PERFORMANCE INCREASED ACROSS ALL SUBPOPULATIONS FOR BOTH DIABETES AND BLOOD PRESSURE CONTROL



YEAR 1: COVERED CALIFORNIA-WIDE IMPACT OF QTI

Diabetes Control (A1c <8)	Colorectal Cancer Screening (COL)	Controlling Blood Pressure (CBP)
10/13 Issuer Products performed at or above the MY2021 66th percentile, accounting for **86% of members** in the measured population	**5/13** Issuer Products performed at or above the MY2021 66th percentile, accounting for **51% of members** in the measured population	**6/13** Issuer Products performed at or above the MY2021 66th percentile, accounting for **63% of members** in the measured population

FORWARD PROGRESS ON OUR MISSION

	HbA1c Control MY2022	HbA1c Control MY2023	HbA1c Delta	COL MY2022	COL MY2023	COL Delta	CBP MY2022	CBP MY2023	CBP Delta
Number of issuer products at goal*	7/14	10/13	**+3**	1/14	5/13	**+4**	2/14	6/13	**+4**
Percentage of members in the measured population at goal	44%	86%	**+42%**	36%	51%	**+15%**	38%	63%	**+25%**

**QTI uses MY2021 national exchange 66th percentile as goal*

2026 – 2028 QHP Issuer Model Contract Updates

EQT Team

Essential Community Providers

Hannah Turner, Zach Sherman, Gary Cohen, and Andy Elkins
Health Management Associates

HMA

Covered California Essential Community Providers (ECP) Refresh:

Analytics Update

November 14, 2024

PRESENTED BY:
Hannah Turner, Zach Sherman, Gary Cohen, and Andy Elkins

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Covered California's Essential Community Provider (ECP) Refresh

ECP REFRESH PROJECT PURPOSE

Covered California is refreshing the Essential Community Provider (ECP) standards to:

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

Covered California has been evaluating and analyzing policies to achieve these goals through updates the definition of an ECP as well as the required QHP network sufficiency thresholds.

ECP REFRESH PROJECT STATUS

- Proposed contract language revising the ECP standards in the 2026-2028 QHP Issuer Model Contract was released for public comment in August 2024
- Since then, Covered California's internal ECP workgroup, with support from HMA, conducted an analytic evaluation on the potential impact of the proposed changes
- The results of this evaluation will be presented and discussed today
- In the coming months, the proposed ECP standards will be revised to incorporate findings from the analytics, including the potential for new sufficiency thresholds, as well as feedback and input received during the public comment period

See Appendix for recommended changes and additions to ECP categories.

OVERVIEW OF THE ANALYTICS PROCESS

- HMA and Covered California's analytics process encompassed two key phases – construction of a new proposed ECP list and analysis of current ECP utilization, and network and utilization analysis of the new ECP list
- Phase 1:
  - HMA and Covered California identified 12 criteria to update the current ECP list. At each step of the process, HMA documented:
    - The criteria used,
    - The impact to the ECP list (both additions and removals), and
    - The overlap with the current/updated ECP list (e.g., providers that were added to the ECP list through more than one category)
  - Next, Covered California requested data from Merative to understand how many QHP enrollees are using the current ECP list to help measure and identify:
    - The effectiveness of current standards,
    - QHP enrollee utilization in historically underserved areas or by historically underserved populations, and
    - ECPs that had been removed, such as HITECH PCPs, with high utilization that may warrant continued inclusion on ECP list
    - Note: Due to some data limitations, this analysis will be re-run.

OVERVIEW OF THE ANALYTICS PROCESS (CONTINUED)

- Phase 2:
  - Using data provided by Covered California, HMA compared the updated ECP list to the current QHP provider networks to analyze impact
    - HMA created a summary of QHP networks by updated ECP provider type
  - Next, the EQT Informatics Team conducted a utilization analysis of the new ECP list
    - EQT Informatics Team evaluated the set of ECP providers that are in-network across multiple utilization paths and the degree of utilization among those providers

PHASE 1 RESULTS

FINDINGS – HOSPITALS & CLINICS

Current ECP List

- Hospital ECPs – 250
- Non-Hospital ECPs – 3,005
- HITECH PCP ECPs – 9,312

Action	Source of Standard?	Impact
Add Social Security Act (SSA) §1927 Providers **Add Family Planning sites (included in 2016 Payment Notice)** – CMS data set also included overlap of current ECP categories which allowed us to identify additional providers to satisfy those categories	Federal Req	**+ 1,017 ECPs** +722 Behavioral Health +124 Rural Health Clinics +102 FQHCs +44 Family Planning (117 already current ECPs) + 2 Critical Access Hospitals (CAH)
Add Critical Access Hospitals (CAH)	CCA Policy Priority	**+ 4 ECPs** 89% already current ECPs
Add Small Rural Hospital Improvement Program (SHIP) Hospitals	CCA Policy Priority	**+ 5 ECPs** 87% already current ECPs
Add Rural Health Clinics (RHC) – Added each location to ensure full coverage, instead of only including one parent entity.	CCA Policy Priority	**+ 175 ECPs** 4% already current ECPs 32% added in steps 2/3
Add Certain Health Professional Shortage Area (HPSA) Providers – Includes FQHCs, Rural Health Clinics, and Indian Health Service	CCA Policy Priority	**+ 0 ECPs** 100% already current ECPs

FINDINGS – PRIMARY CARE

Current ECP List

- Hospital ECPs – 250
- Non-Hospital ECPs – 3,005
- HITECH PCP ECPs – 9,312

Action	Source of Standard?	Impact
Remove HITECH PCPs	CCA Policy Priority	**- 9,312 ECPs**
Add Primary Care Providers in Healthy Places Index (HPI) Quartiles 1 & 2 – Used Medi-Cal Managed Care Primary Care providers located in HPI quartiles 1 & 2 (and small population areas without an HPI score). – Filtered providers based on taxonomy codes – For providers with multiple locations, NPI may be included multiple times in updated ECP list (one entry per location zip code per rating region)	CCA Policy Priority	**+ 21,627 ECPs**
Add Medi-Cal Providers based on Utilization – Primary Care / Behavioral – Intent was to add providers with high volume Medi-Cal patients – Issue – No utilization data currently available.	CCA Policy Priority	**N/A**
Add HCAI Workforce Grant Recipients – Primary Care – Song-Brown Healthcare Primary Care Residency (PCR) – Intent was to add primary care providers – Issue – Unable to add JUST the primary care providers within the hospital systems that received the grant (e.g. “UCLA Family Medicine Residency Program”). Would have resulted in adding the entire hospital which was too broad and not the intended purpose.	CCA Policy Priority	**N/A**

FINDINGS – BEHAVIORAL HEALTH

Current ECP List

- Hospital ECPs – 250
- Non-Hospital ECPs – 3,005
- HITECH PCP ECPs – 9,312

Action	Source of Standard?	Impact
Add HCAI Workforce Grant Recipients – Behavioral Health – by location – Intent was to add behavioral health care providers – Added each location to ensure full coverage, instead of only including one parent entity that received the grant	CCA Policy Priority	**+ 1,313 ECPs**
Add Behavioral Health Providers in Health Places Index (HPI) Quartiles 1 & 2 – Used Medi-Cal Managed Care Behavioral Health providers located in HPI quartiles 1 & 2 (and small population areas without an HPI score). – Filtered providers based on taxonomy codes – For providers with multiple locations, NPI may be included multiple times in updated ECP list (one entry per location zip code per rating region)	CCA Policy Priority	**+ 12,967 ECPs**
Add Medi-Cal Providers based on Utilization – Primary Care / Behavioral – Intent was to add providers with high volume Medi-Cal patients – Issue – No utilization data available at this time.	CCA Policy Priority	**N/A**

FINDINGS – ORAL HEALTH

Current ECP List

- Hospital ECPs – 250
- Non-Hospital ECPs – 3,005
- HITECH PCP ECPs – 9,312

Action	Source of Standard?	Impact
Add Pediatric Oral Service Providers, Medi-Cal Managed Care & FFS only – Included providers who see pediatric patients only. – Medi-Cal Managed Care providers did not cover all Covered California rating regions. – Medi-Cal FFS providers did not include data to identify whether General Dentist providers see pediatric patients so only included Pediatric Dentists – For providers with multiple locations, NPI may be included multiple times in updated ECP list (one entry per location zip code per rating region)	CCA Policy Priority	**+ 2,004 ECPs**
Add Dental Hygienists in Alternative Practice, from Medi-Cal FFS – Included these providers who have specialized training to provide dental care in non-traditional settings. – Note: Category not included in original analytics plan but was identified during analysis process as fulfilling a CCA policy priority.	CCA Policy Priority	**+ 220 ECPs**

FINDINGS – SUMMARY

Type	Category	Current ECPs	Updated ECPs
Facility	Hospital	250	267
	Non-Hospital / Clinic	3,005	5,501
Provider	Primary Care	9,312	21,627
	Behavioral Health	--	12,967
	Oral Health	--	2,224
	TOTAL	**12,567**	**42,586**

Note: Non-Hospital / Clinics provide a wide range of services that often includes primary care, behavioral health, and sometimes oral health services. These providers only included in the Non-Hospital/Clinic category even though they may also include services that overlap with other ECP categories.

For providers included based on locations in HPI 1&2 quartiles, this also includes providers in location with No HPI score. For statistical reliability and validity of the HPI index, no HPI score is available for census tracts with less than 1,500 people or >50% of residents live in institutional settings (e.g. dorms, nursing homes, prisons).

For providers with multiple locations, Updated ECP list may include NPI multiple times (one entry per location zip code per rating region).

FINDINGS – SUMMARY

» Updated ECPs (by Region)

Category	TOTAL	1 Northern Counties	2 North Bay Area	3 Greater Sacramento	4 San Francisco County	5 Contra Costa County	6 Alameda County	7 Santa Clara County	8 San Mateo County	9 Santa Cruz, San Benito, Monterey Counties	10 Central Valley	11 Fresno, Kings, Madera Counties	12 Central Coast	13 Eastern Counties	14 Kern County	15 Los Angeles County East	16 Los Angeles County West	17 Inland Empire	18 Orange County	19 San Diego County	n/a Unknown
Hospital	**267**	38	10	13	9	2	11	6	1	7	18	10	12	6	8	27	34	28	16	11	0
Non-Hospital	**5,501**	444	189	237	195	66	329	201	34	127	435	330	294	35	120	462	912	371	235	485	0
Primary Care	**21,627**	1,860	310	1,111	177	183	512	412	105	345	1,491	2,107	242	136	914	2,550	3,283	3,176	1,136	1,577	0
Behavioral Health	**12,967**	561	240	1,704	145	612	315	52	13	16	2,152	458	57	33	200	1,535	1,255	2,305	209	1104	1
Oral Health	**2,224**	16	20	47	174	22	91	38	16	9	29	17	70	2	11	209	452	272	191	255	282

For providers with multiple locations, Updated ECP list may include NPI multiple times (one entry per location zip code per rating region).

Unknown region is for providers with location just outside of California in a neighboring state, or for certain providers where a specific location was not available (e.g. Dental Hygienists in Alternative Practice).

PHASE 2 RESULTS

PHASE 2 RESULTS – NETWORK ANALYSIS

- Comparison of Updated ECP List to Current QHP Provider Networks
  - Providers matched by NPI + Region
    - Matching methodology requires the ECP to be in-network in the same region as the provider is on the Updated ECP List. Aligns with sufficiency standards which are based on QHP regions.
    - While methodology used for some Update ECP list categories based on zip codes (e.g. HPI Quartile 1 & 2), requiring QHP network to have the exact same zip code as Updated ECP List resulted in a number of ECPs showing as out of network even though the provider was in QHP network in a neighboring zip code (or other nearby zip code within the same region).
    - Not requiring the exact zip code allows a broader comparison of providers still within the same geographic rating region, but not as localized as HPI Quartile 1 & 2 zip codes.
  - Additional Notes:
    - Hospital and Non-Hospital facility providers are likely under-represented in network comparison since facility participation not easily identified by NPI
    - For some issuers, Dental ECP provider participation is under-represented since their provider network data did not include any dental providers

PHASE 2 RESULTS – NETWORK ANALYSIS

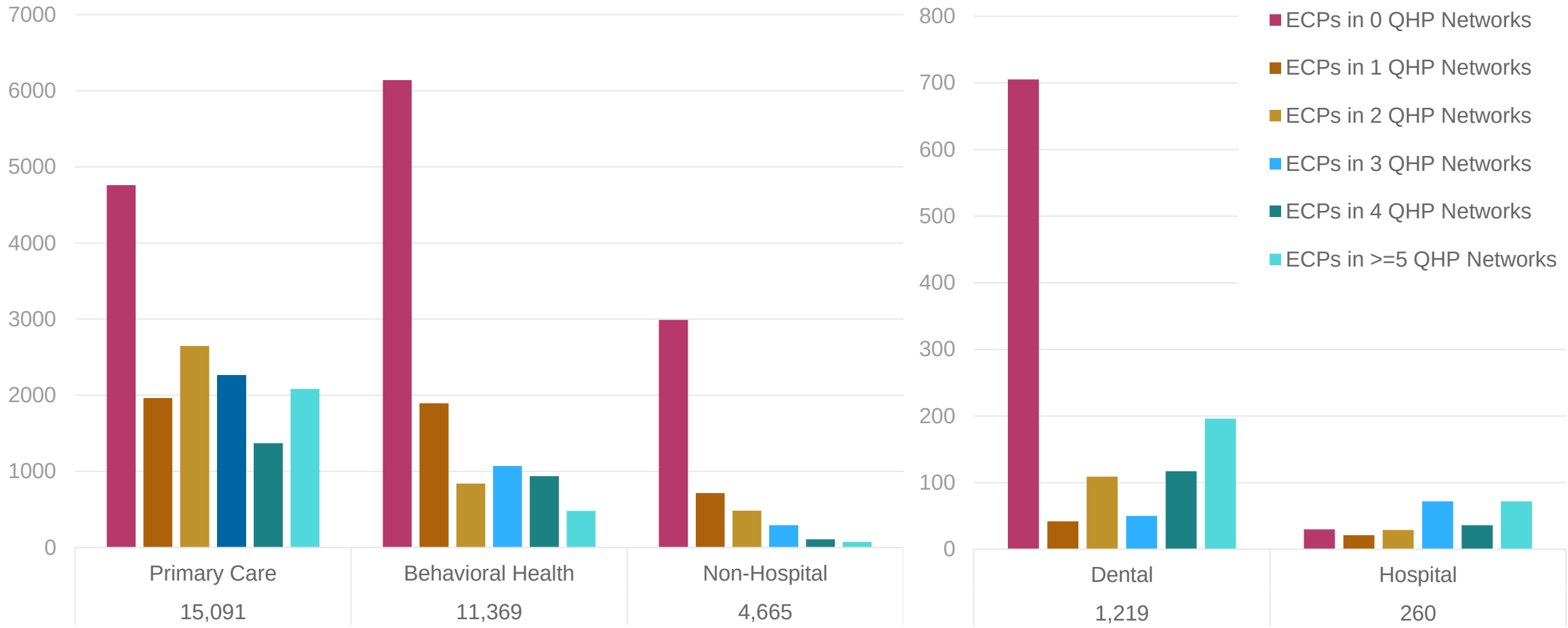
» Updated ECPs – Current QHP Network Participation **(NPI + Region)**

(NPI + Region)	Primary Care		Behavioral Health		Dental		Non-Hospital		Hospital	
Updated ECP List	15,091		11,369		1,219		4,665		260	
ECPs in 0 QHP Networks	4,759	31.5%	6,141	54.0%	705	57.8%	2,989	64.1%	30	11.5%
ECPs in 1 QHP Networks	1,964	13.0%	1,895	16.7%	42	3.4%	716	15.3%	21	8.1%
ECPs in 2 QHP Networks	2,649	17.6%	841	7.4%	109	8.9%	485	10.4%	29	11.2%
ECPs in 3 QHP Networks	2,264	15.0%	1,072	9.4%	50	4.1%	294	6.3%	72	27.7%
ECPs in 4 QHP Networks	1,371	9.1%	938	8.3%	117	9.6%	107	2.3%	36	13.8%
ECPs in >=5 QHP Networks	2,084	13.8%	482	4.2%	196	16.1%	74	1.6%	72	27.7%

Network participation based on matching by NPI and Region only. For providers with multiple locations, NPI may be included multiple times in updated ECP list (one entry per location per rating region). Participation for Non-Hospital and Hospital ECPs is under-represented since facility participation not fully represented by NPI. Some issuers provider network data did not include any dental providers (even though they have dental providers in network). Excludes issuer(s) subject to alternative ECP standards.

PHASE 2 RESULTS – NETWORK ANALYSIS

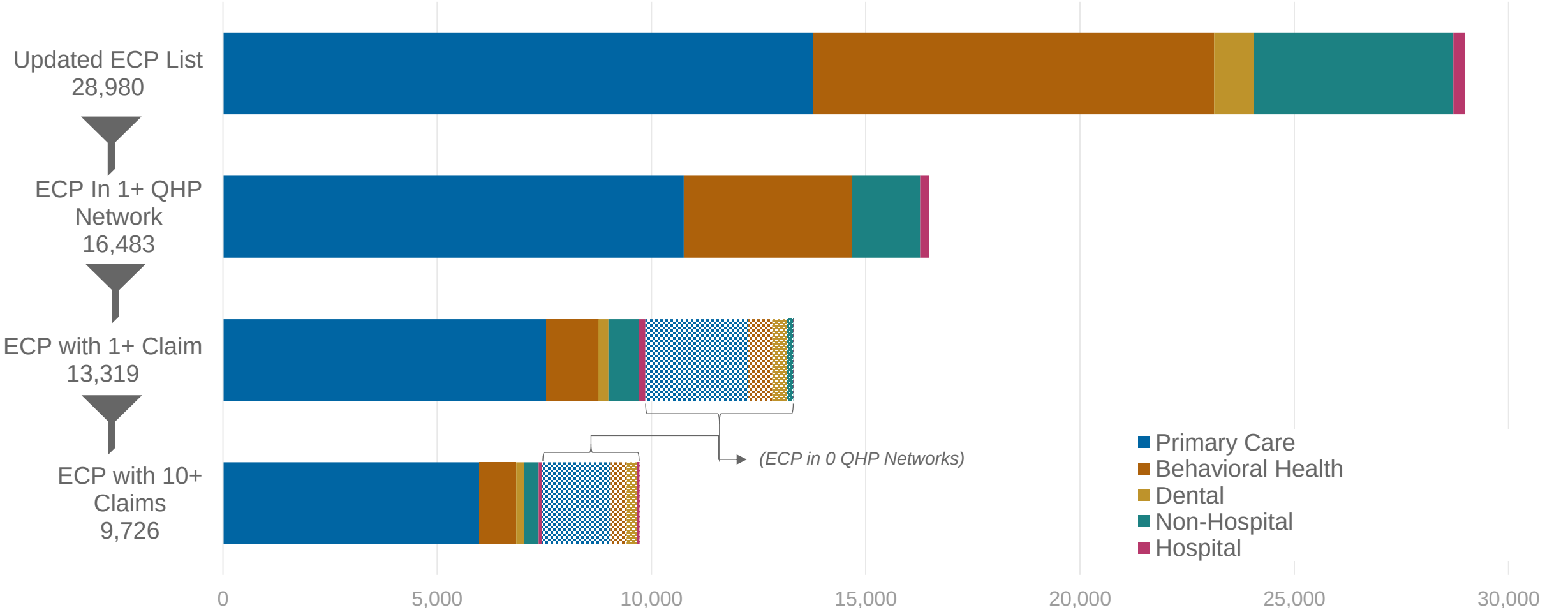
Updated ECPs – Current QHP Network Participation **(NPI + Region)**



Network participation based on matching by NPI and Region. For providers with multiple locations, NPI may be included multiple times in updated ECP list (one entry per location rating region). Participation for Non-Hospital and Hospital ECPs is under-represented since facility participation not fully represented by NPI. Some issuers provider network data did not include any dental providers (even though they have dental providers in network). Excludes issuer(s) subject to alternative ECP standards.

PHASE 2 RESULTS – CLAIMS UTILIZATION ANALYSIS

Updated ECP – Claims Utilization **(NPI only)**



Claims incurred in 2022 plan year. Network participation for claims is based on NPI only. Participation for Non-Hospital and Hospital ECPs is under-represented since facility participation not fully represented by NPI. Some issuers provider network data did not include any dental providers (even though they have dental providers in network). Claims for providers in 0 networks is based on 2022 claims and 2024 QHP networks.

PHASE 2 RESULTS – CLAIMS UTILIZATION REGIONAL ANALYSIS

Covered CA Rating Region	Number of Claim Processed	Utilization Percentage
Region 17: Inland Empire	2371	17.76%
Region 16: Los Angeles County South & West	2078	15.56%
Region 15: Los Angeles County North & East	1803	13.50%
Region 19: San Diego County	1228	9.20%
Region 10: San Joaquin Valley	938	7.03%
Region 1: Northern Counties	921	6.90%
Region 3: Sacramento Valley	845	6.33%
Region 18: Orange County	588	4.40%
Region 11: Central San Joaquin	457	3.42%
Region 14: Kern County	419	3.14%

Top 10 Claims Utilization by Region

- A total of 13,352 claims were processed for proposed Essential Community Providers (ECP) in 2022
- Inland Empire and Los Angeles Regions account for 46.82% of processed claims in 2022
- For 23% of proposed ECPs by new criteria, 2022 utilization was identified but these providers are not currently in network

The percent calculated is the number of updated ECP claims processed in one region (numerator) divided by the total 13,352 claims processed in 2022 (denominator)

SUFFICIENCY THRESHOLDS

REVISIONS TO SUFFICIENCY THRESHOLDS

- Covered California authority[1]:
  - QHP issuers "…shall maintain a network that includes a sufficient geographic distribution of care, including essential community providers ("ECP"), and other providers available to provide reasonable and timely access to Covered Services for low-income, vulnerable, or medically underserved populations…"
- Current Proposal - Revise the sufficiency standards to:
  - 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%

1 - From COVERED CALIFORNIA QUALIFIED HEALTH PLAN ISSUER CONTRACT FOR THE INDIVIDUAL MARKET

REVISIONS TO SUFFICIENCY THRESHOLDS

- Updated Proposal - Revise the sufficiency standards to:
  - 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)
  - Adopt category specific, or entity specific, thresholds:
    - Primary Care ECPs
    - Behavioral Health Care ECPs

REVISIONS TO SUFFICIENCY THRESHOLDS

Discussion questions:

- Feedback to the proposed removal of the 340B sufficiency threshold of 15%?
- Feedback to Covered California proposal that Primary Care and Behavioral Health Care ECPs have category specific sufficiency thresholds?
- What other category specific, or entity specific, thresholds are recommended?

TIMELINE AND NEXT STEPS

TIMELINE AND NEXT STEPS

Timeframe	Activity
November 2024	Present and solicit feedback on ECP analytics and their implications on the revised standards to the Plan Management Advisory Workgroup
December 2024	Updated draft ECP standards, including revised sufficiency thresholds, released
January 2025	Board discussion on draft 2026-2028 QHP Issuer Model Contract, inclusive of updated ECP contract language
February/March 2025	Board action on draft 2026-2028 QHP Issuer Model Contract

Attachment 2 Performance Standard 3

2026-28 PERFORMANCE STANDARD 3 COLLABORATION ACROSS ISSUERS AND WITH COMMUNITY

Overview

Attachment 2 to the 2026-2028 QHP Contract requires Contractor to attend and engage in at least 80% equity focused learning sessions, work groups, and community engagement activities – otherwise financial penalties apply. This document outlines proposed methodology Covered California will use to assess Contractor performance and penalties. Specific to Attachment 1, Articles 1.03, 2.01, 2.03, 3.05, and 4.02.

Performance Standard

Attachment 2 requires Contractor to meet the target of eighty percent (80%) of collaboration activities with community and partners. To effectively measure and assess the performance of Qualified Health Plan (QHP) Issuers against Performance Standard 3, which focuses on collaboration across QHP Issuers and with the community, a detailed assessment methodology or criteria checklist is required. The following outlines a structured approach to evaluate compliance and engagement:

2026-28 PERFORMANCE STANDARD 3: PROPOSED ASSESSMENT CRITERIA

Attachment 2 to the 2026-2028 Qualified Health Plan (QHP) Issuer Contract requires Contractor to attend and engage in at least 80% of equity focused learning sessions, working groups, and community engagement activities during the Plan Year. Covered California will host, invite, or notify Issuers of sessions throughout each Plan Year in the following focused areas, tied to Attachment 1 contractual requirements:

- ❑ Disparities reduction in care (Attachment 1, Article 1.03);
- ❑ Behavioral health services (Attachment 1, Article 2.01);
- ❑ Substance use disorders (Attachment 1, Article 2.03);
- ❑ Use of generative artificial intelligence (Attachment 1, Article 3.05);
- ❑ Advanced primary care (Attachment 1, Article 4.01); and
- ❑ Networks based on value (Attachment 1, Article 4.02).

Contractor-led collaborative QHP Issuer and community engagement activities tied to these focused areas that are submitted and approved by Covered California may also count toward this requirement.

2026-28 PERFORMANCE STANDARD 3: PROPOSED ASSESSMENT CRITERIA

Scoring Process

Covered California hosted or suggested sessions:

- ❑ Covered California will score compliance with Performance Standard 3 by using a denominator that contains the planned sessions that Covered California hosts or suggests. Covered California will measure compliance by scoring Contractor attendance at events, divided by the total hosted events during the Plan Year.
- ❑ The following required meetings do not fall into the denominator: SABRs, PMAG, or Carrier Calls.

Contractor-led sessions:

- ❑ QHP Issuers can submit a list of planned activities and learning collaboratives in each domain and Covered California will determine if said activities meets the contract requirement.
- ❑ Covered California will adjust both the numerator and the denominator of the Performance Standard score to account for any approved hosted or attended QHP issuer sessions.

Performance Levels and Penalties

- ❑ Contractor does not meet 80% target annual collaboration: 10% penalty
- ❑ Contractor meets 80% target for annual collaboration: no penalty

Attachment 2 Performance Standard: Continuity of Care

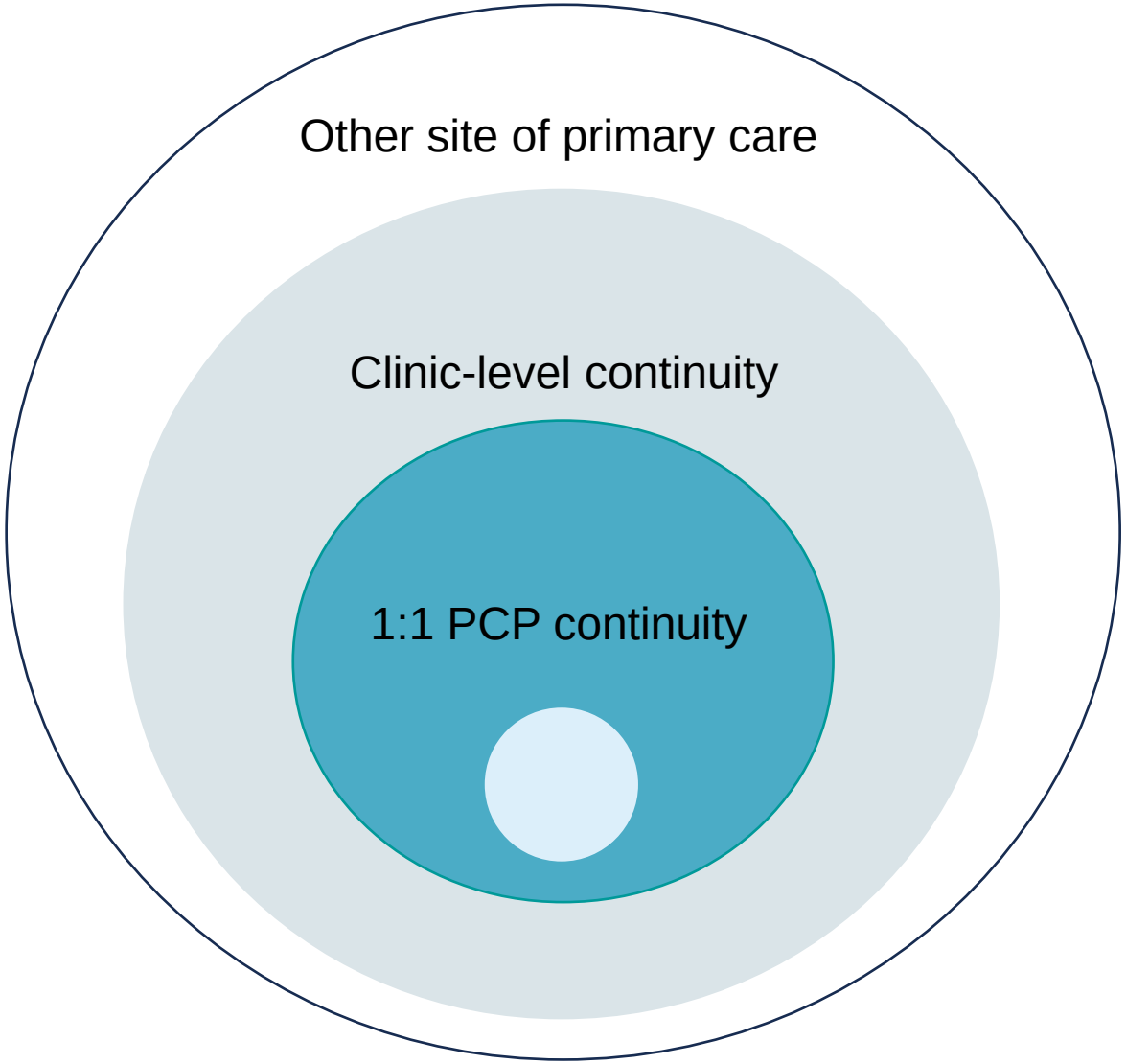
CONTINUITY OF CARE FEEDBACK AND DISCUSSION

Covered California's EQT team recently met with all QHP Issuers and discussion included the proposed Continuity of Care (CoC) measure requirements.

Issuer Feedback Summary

- There was a recommendation to leverage existing, validated quality measures to reduce administrative burden.
- A suggestion was made to implement a reporting-only phase to establish baseline data before introducing new performance standards.
- Concerns were raised about setting improvement targets for CoC without sufficient research on its correlation with quality.
- Requests were made for more detailed guidance on CoC calculations, along with clearer reporting specifications, timelines, and data definitions.

CONTINUITY OF CARE AT THE CLINIC LEVEL



Key Findings:

- The effect of physician-level continuity was associated with reduced ED visits and hospitalizations
  - Effect was strongest among complex and older patients, but had significant impact on ED use in young and healthy patients
- Clinic continuity had a similar, but *less dramatic effect* than physician-level continuity.

The Impact of Primary Care Clinic and Family Physician Continuity on Patient Health Outcomes: A Retrospective Analysis From Alberta, Canada

CONTINUITY OF CARE PROPOSED REVISED THRESHOLD

Proposed revised threshold: Establish a baseline for the CoC index and require improvement efforts if the index falls below 0.7 for at least 60% of enrollees

Rationale: The revision to 60% of enrollees (instead of 70%) aims to set a more achievable target. This adjustment addresses concerns about the challenges issuers may face in meeting the originally proposed threshold, while still encouraging progress in improving continuity of care.

2026-2028 MODEL CONTRACT DRAFTS & RESPONSE TO COMMENT

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

Appendix

REMINDER: RECOMMENDED CHANGES AND ADDITIONS TO ESSENTIAL COMMUNITY PROVIDER (ECP) CATEGORIES

The ECP categories should be modified as follows:

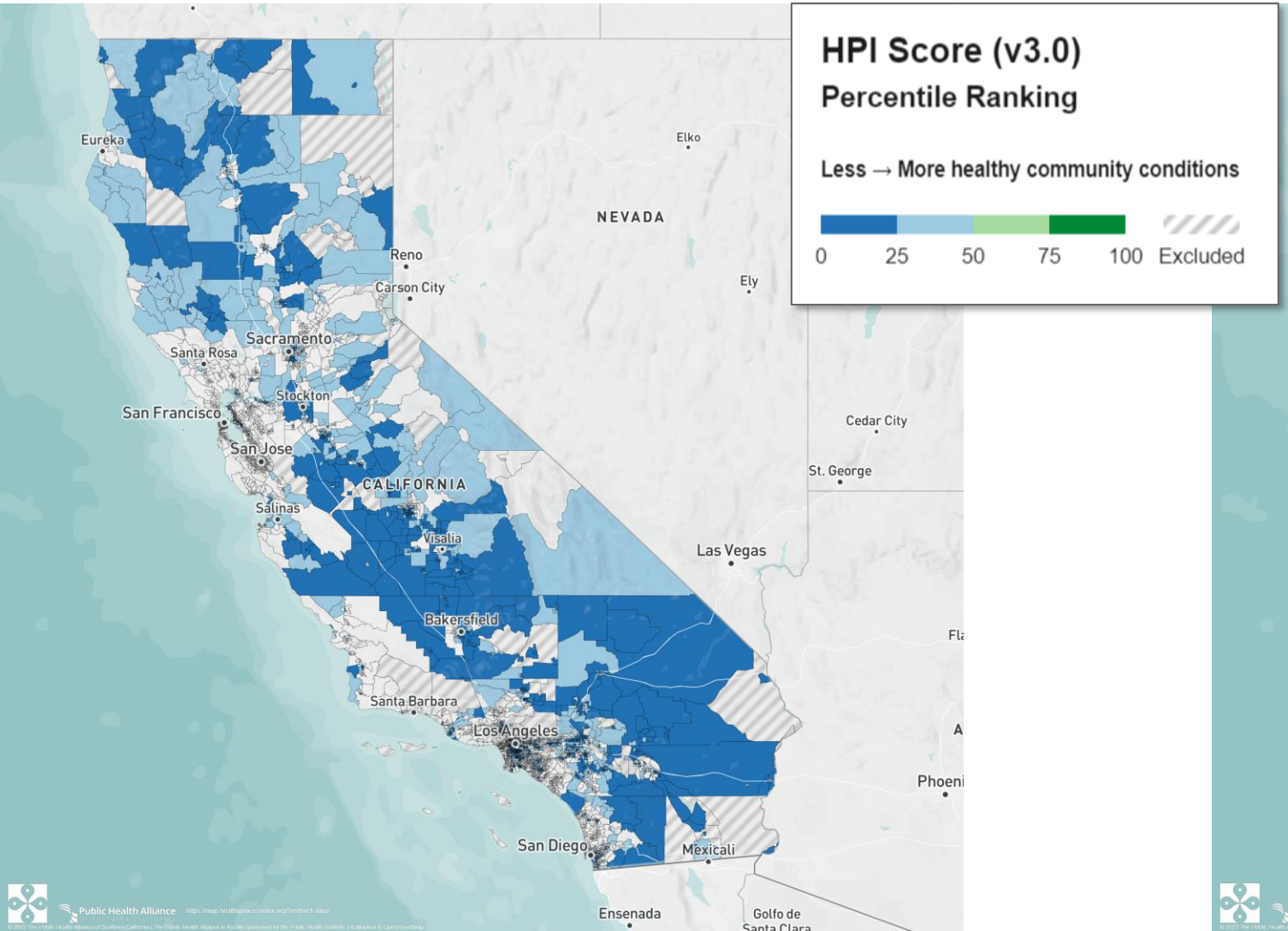
Federal ECP Categories	Current Covered California ECP Provider Categories	Future ECP Category Changes and Additions
• FQHCs • Ryan White Program Providers • Family Planning Providers • Indian Health Care Providers • Inpatient Hospitals • Mental Health Facilities • SUD Treatment Centers • Other Providers	• Hospitals (340B, DSH, Children's hospitals, county or publicly owned)	• Add missing Critical Access Hospitals and Small Rural Health Improvement Program Hospitals
	• Non-Hospitals (340B, FQHCs, Community Clinics, Free Clinics, Tribal and Urban Indian Clinics)	• Add pediatric oral service providers • Add "1927 providers and certain family planning sites included in the 2016 NBPP

	• HITECH PCPs	• Rename category and remove HITECH PCP list
		• Add HCAI workforce grant recipients (primary care and 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

- Provider entities described in Section 1927 of the Social Security Act that are required to be included in the definition of ECPs in the Affordable Care Act

CALIFORNIA HEALTHY PLACES INDEX (HPI)

HPI Q1 & Q2 (0-50th percentile)



HPI Q1 (0-25th percentile)