Plan Management Advisory Workgroup

December 12, 2024

AGENDA

Time	Topic	Presenter
10:00 – 10:05	Welcome and Agenda Review	Rick Krum
10:05 – 10:35	Essential Community Provider (ECP) Updates	Eryn Burnett
10:35 – 11:05	2026 – 2028 QHP Issuer Model Contract Public Comment Responses and Draft Updates	EQT Team
11:05 – 12:00	Open Forum	All

Essential Community Providers (ECP) Project Updates

Eryn Burnett, Equity and Quality Specialist
Taylor Priestley, Director, Equity and Quality Transformation

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.

COVERED CALIFORNIA'S ESSENTIAL COMMUNITY PROVIDER (ECP) REFRESH

Stage 1: Stakeholder Engagement and Policy Proposals

Stage 2: Analytics in Two Phases

- ❑ Phase 1: constructing the "new" list of proposed ECPs
- ❑ Phase 2: networks and utilization analyses

Stage 3: Finalize proposed ECP standards

- ❑ Plan Year 2026 QHP certification application language
- ❑ 2026-2028 QHP issuer contract language

OVERVIEW OF ECP STANDARDS RECOMMENDATIONS

The ECP Internal Workgroup recommended changes to the following ECP Standards:

- ❑ Definition
- ❑ Categories
- ❑ Sufficiency Standards
- ❑ General and Alternative Standards
- ❑ Approach to Evaluating the Impact of the Refreshed Standards
- ❑ How to Measure Success

ECP PROJECT CURRENT STATUS

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

ECP ANALYTICS PHASE 2 RESULTS

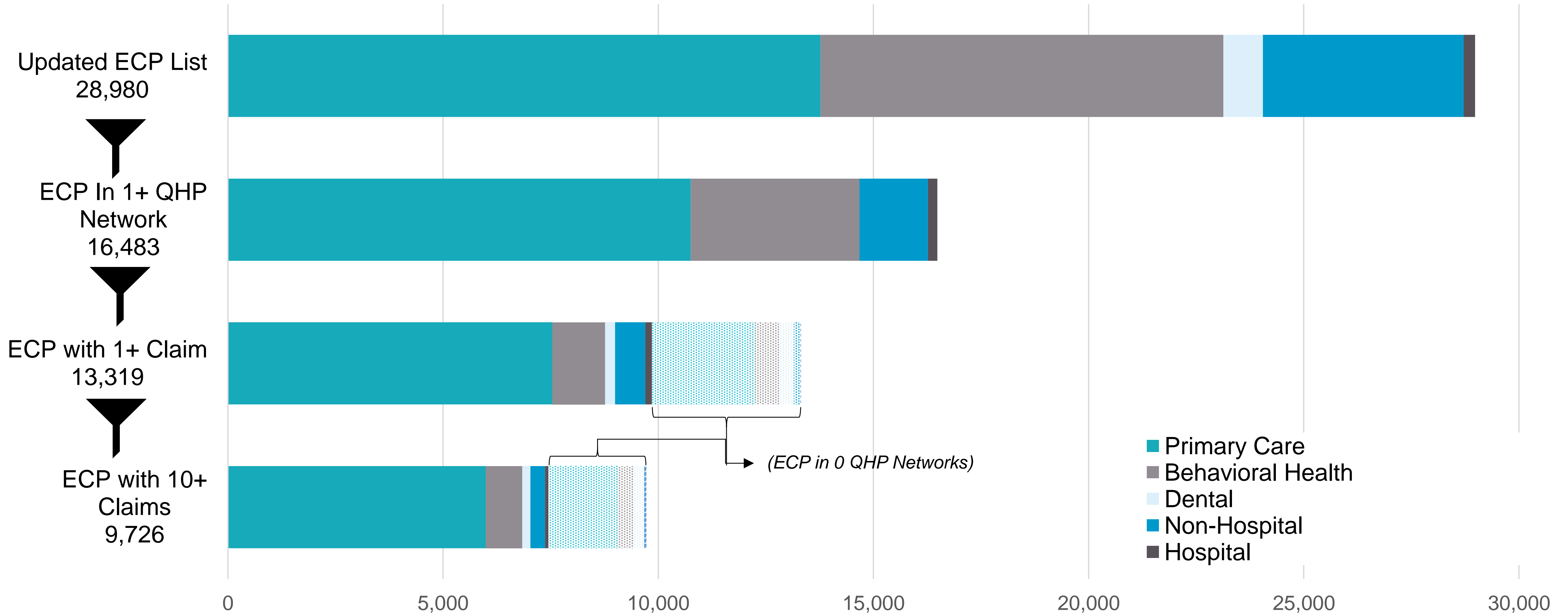
ANALYTICS PROCESS OVERVIEW

Phase 2:

1. 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

2. Next, the EQT Informatics Team conducted a utilization analysis of the new updated 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

OVERALL, 46% OF ECPS ON THE UPDATED LIST ARE ALREADY BEING UTILIZED



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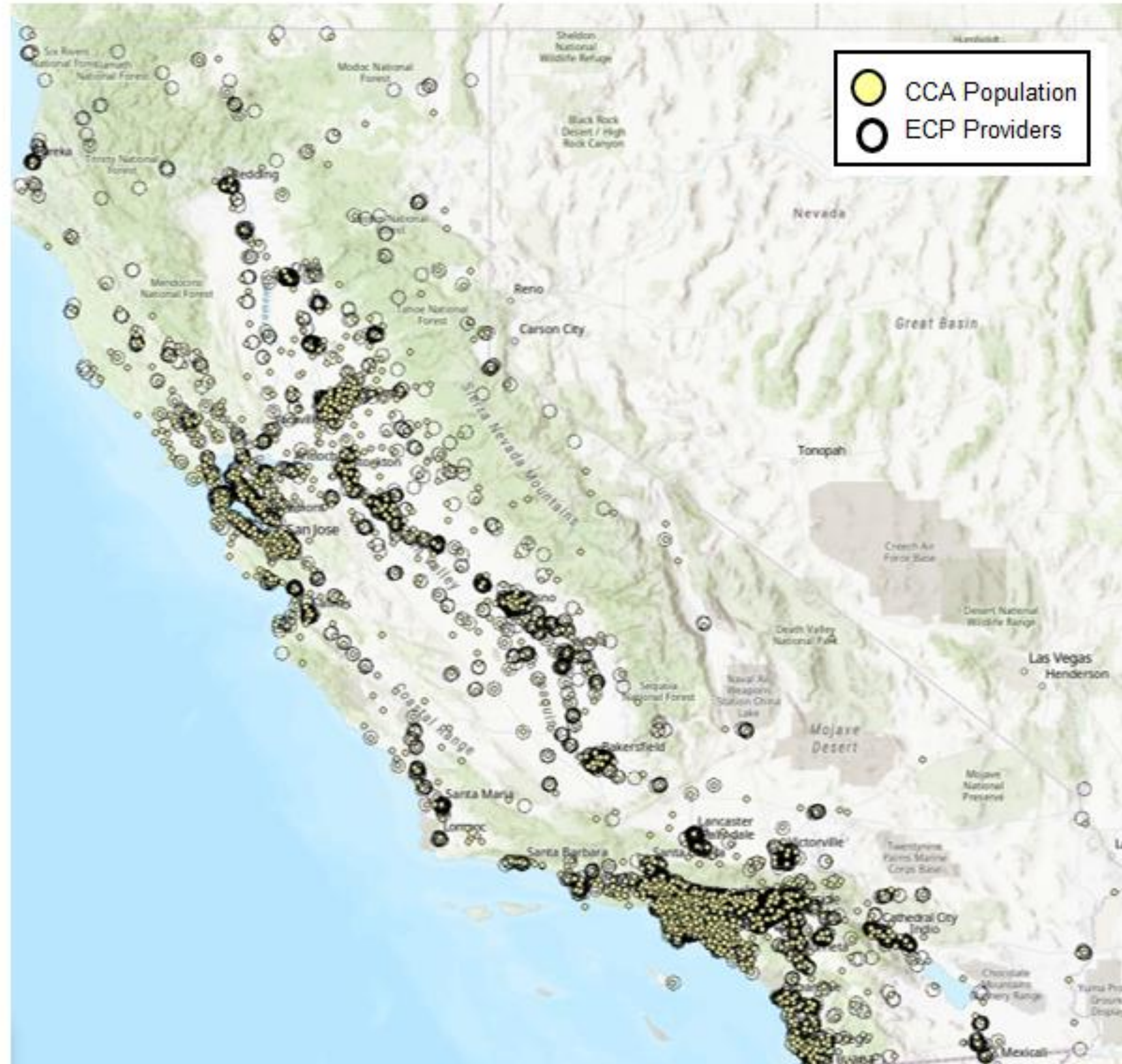
Claims incurred in 2022 plan year. Network participation for claims is based on NPI only. Participation for Non-Hospital and Hospital ECPs is under-represented since facility participation not fully represented by NPI. Some issuers provider network data did not include any dental providers (even though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

GEOGRAPHIC DISTRIBUTION OF PROPOSED ECPS

GEOGRAPHIC DISTRIBUTION OF PROPOSED ECP AND COVERED CA MEMBERSHIP DISTRIBUTION



FURTHER ANALYSIS TO UNDERSTAND UTILIZATION PATTERNS

28,980 total proposed ECPs using new criteria

16,483 proposed ECPs found to be in 1+ QHP Networks

13,319 proposed ECPs have any claims in 2022

9,762 proposed ECPs have 10+ claims

Further analysis conducted on this subset of ECPs that had active utilization via claims in 2022 to understand regional and demographic variation

Claims incurred in 2022 plan year. Network participation based on 2024 provider networks. 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).

THE MAJORITY OF PROPOSED ECPS WITH UTILIZATION ARE LOCATED IN URBAN SETTINGS

Essential Community Provider Distribution by Geographic Region		
Geographic Region	Number of Providers	Provider Distribution Percentage
Urban	29,543	82.41%
Rural	4,109	11.46%
Super Rural	2,195	6.12%

- 82% of proposed ECPs that were utilized in 2022 are located urban settings
- 18% of proposed ECPs utilized in 2022 are located in rural or super rural settings

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Note: Some providers may be counted more than once since the data was aggregated by issuer network

PROPOSED ECP UTILIZATION IS HIGHEST IN THE INLAND EMPIRE AND LOS ANGELES COUNTY

Covered CA Rating Region (Top 10 by ECP Utilization Rate)	Updated ECP Providers with one or more claims	Percentage of All Updated ECP Providers with one or more claims
Region 17: Inland Empire	2,371	17.76%
Region 16: Los Angeles County South & West	2,078	15.56%
Region 15: Los Angeles County North & East	1,803	13.50%
Region 19: San Diego County	1,228	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%

- ❑ 87% of the 13,352 proposed ECPs with claims are located in the 10 regions shown in this table
- ❑ 47% of 13,352 proposed ECPs with claims are located in Inland Empire and Los Angeles Regions (regions 15, 16, & 17)

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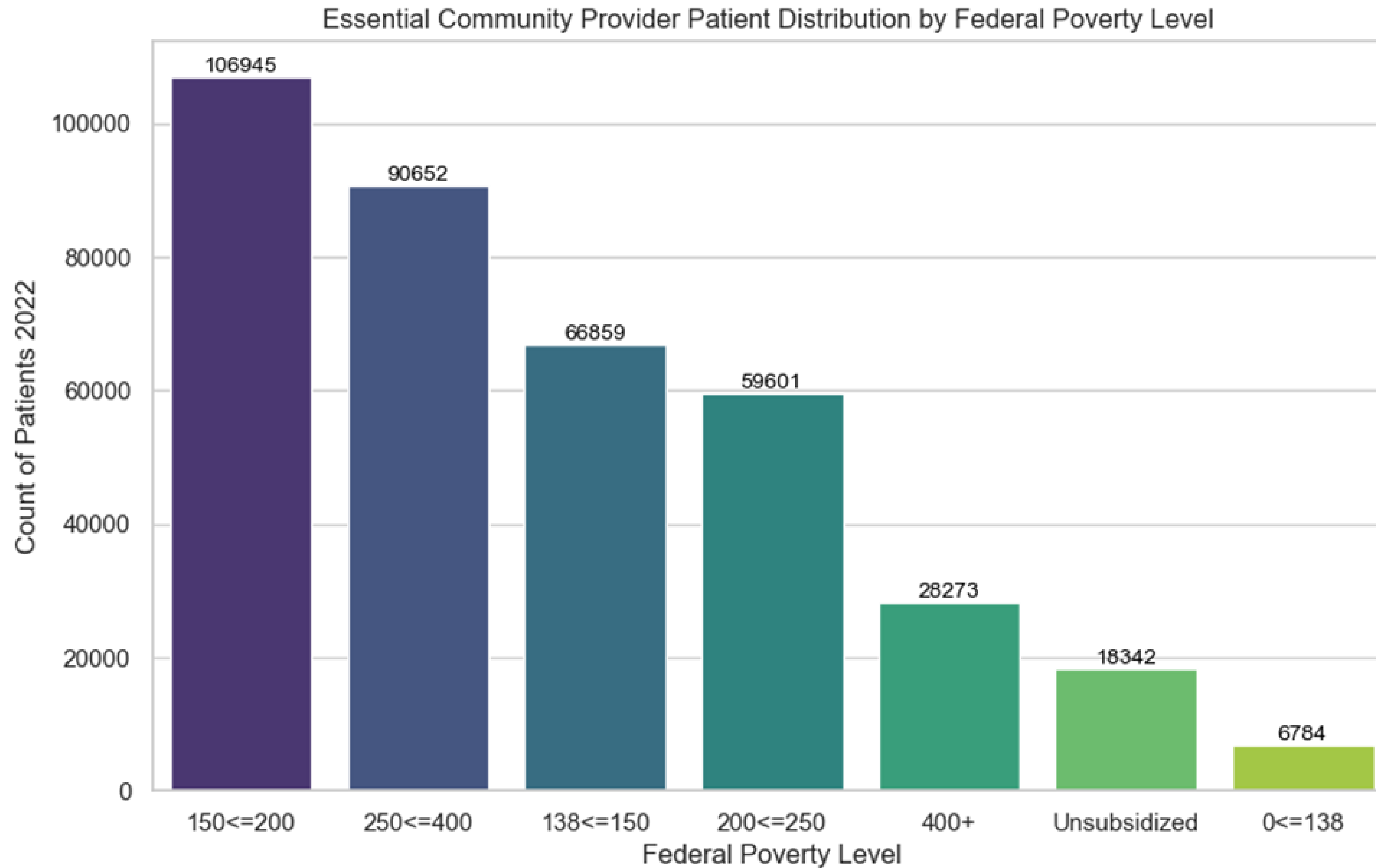
The utilization percent calculated is the number of proposed ECPs with any claims processed in 2022 in one region (numerator) divided by the total 13,352 proposed ECPs with any claims processed in 2022 (denominator)

PROPOSED ECP KEY FINDINGS AND UTILIZATION TRENDS

- Proposed ECPs are already being utilized
  - 46% of proposed ECPs have 1+ claims with patients in 2022
  - 34% of proposed ECPs have 10+ claims from 2022

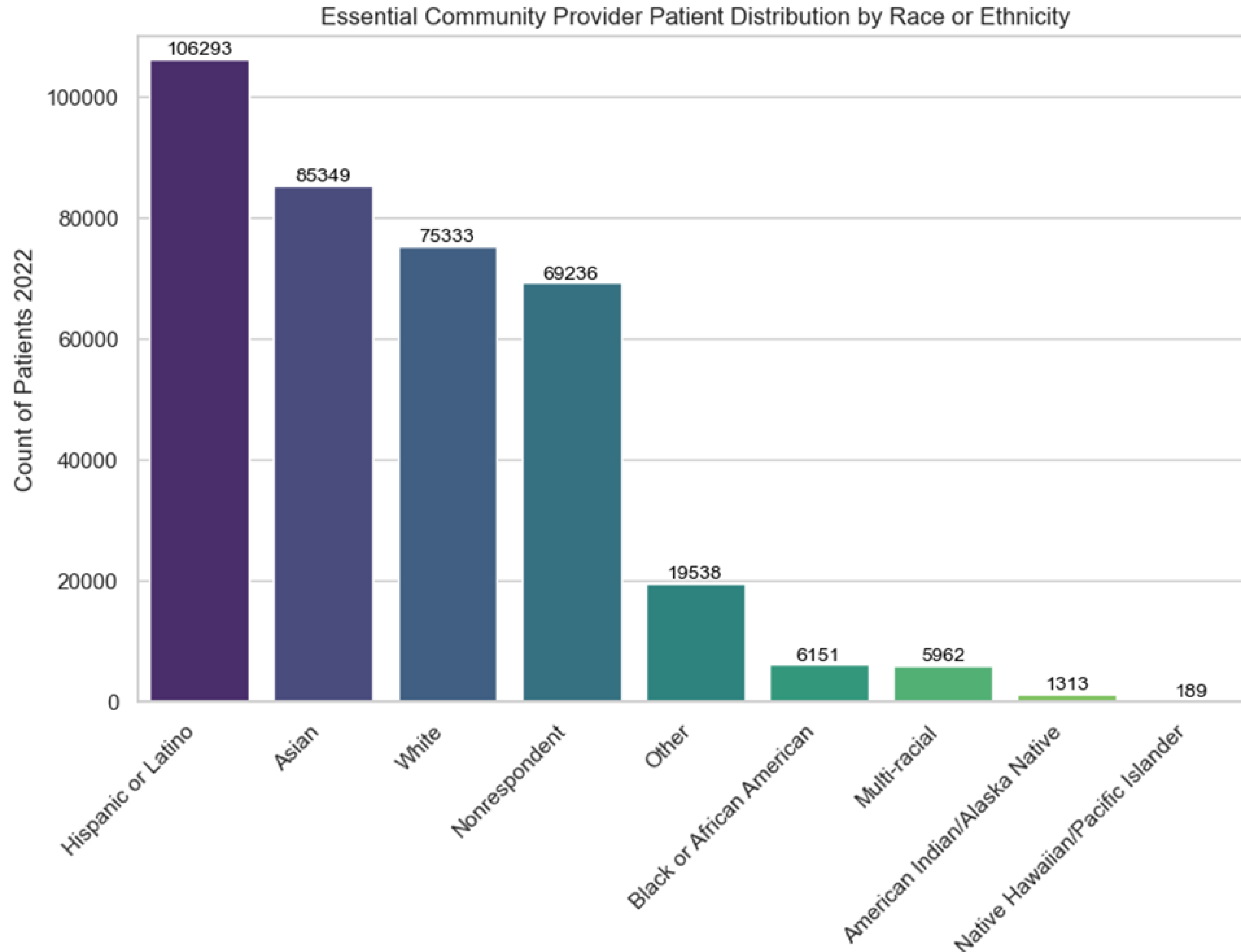
- Proposed ECPs are located in regions where we see the highest overall CCA utilization rates for ECP utilization
  - 47% of proposed ECPs with claims are located in Inland Empire and Los Angeles Regions (Regions 15, 16, & 17)
  - 49% of patients who utilize ECPs are located in these same three regions (Regions 15, 16, and 17)

PATIENT CHARACTERISTICS: 64% OF PATIENTS WHO USED PROPOSED ECPS HAVE INCOMES <=250% FPL



- **64%** (240,189/377,456) **of patients who used proposed ECPs in 2022 had incomes <=250%**
  - 18% have incomes 138-150% FPL
  - 28% have incomes 150-200% FPL
- **Only 7% of patients who used ECPs had income levels >400% FPL**

PATIENT CHARACTERISTICS: ECP UTILIZATION BY RACE ETHNICITY



- **29%** (106,293/369,364) of patients who received care from a proposed ECP in 2022 **identify as Hispanic or Latino**
- **23%** (85,349/369,364) of patients who received care from a proposed ECP **identify as Asian**

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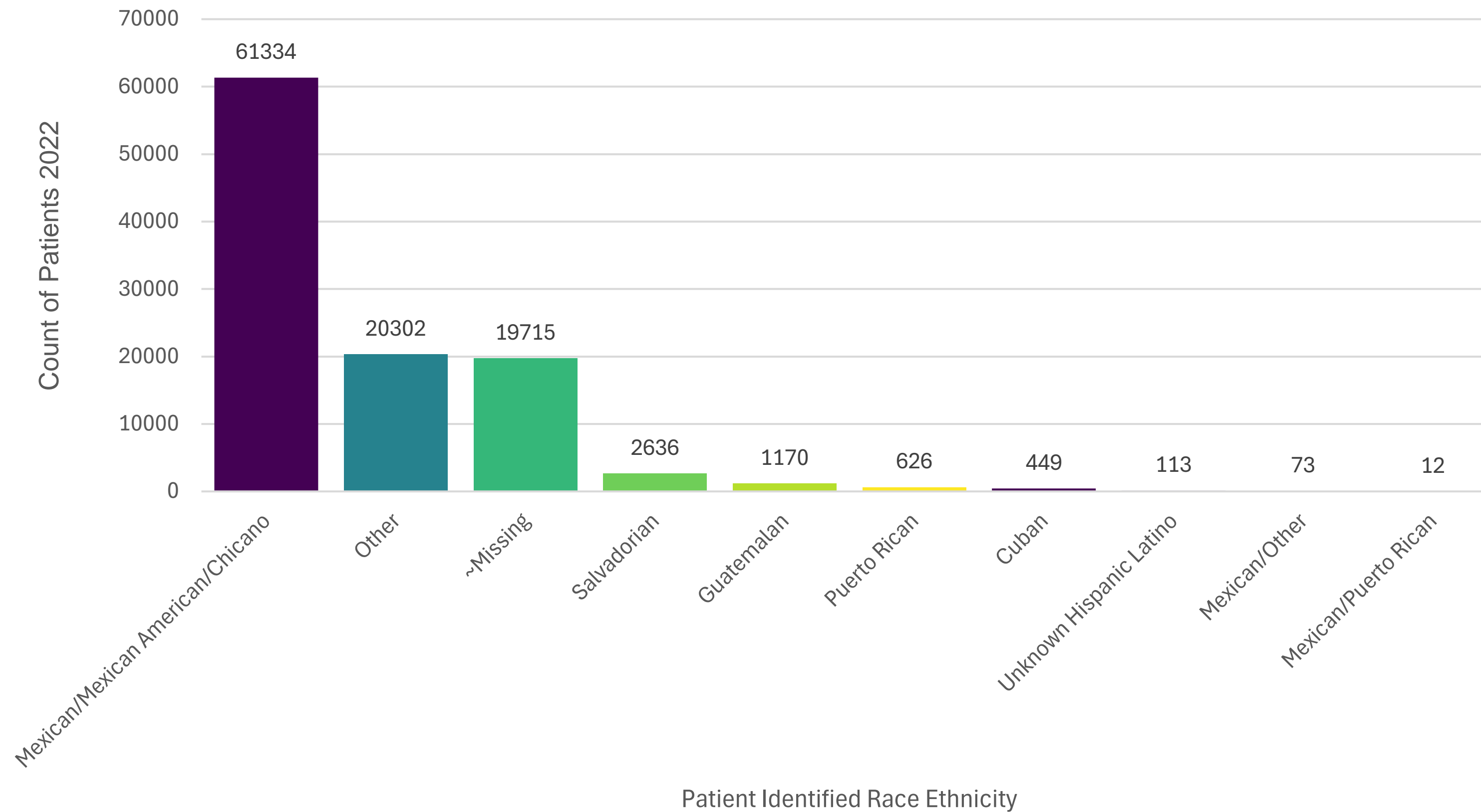
Note: 8,092 patients who received care from a proposed ECP in 2022 are missing race and ethnicity information and are not reflected in this analysis

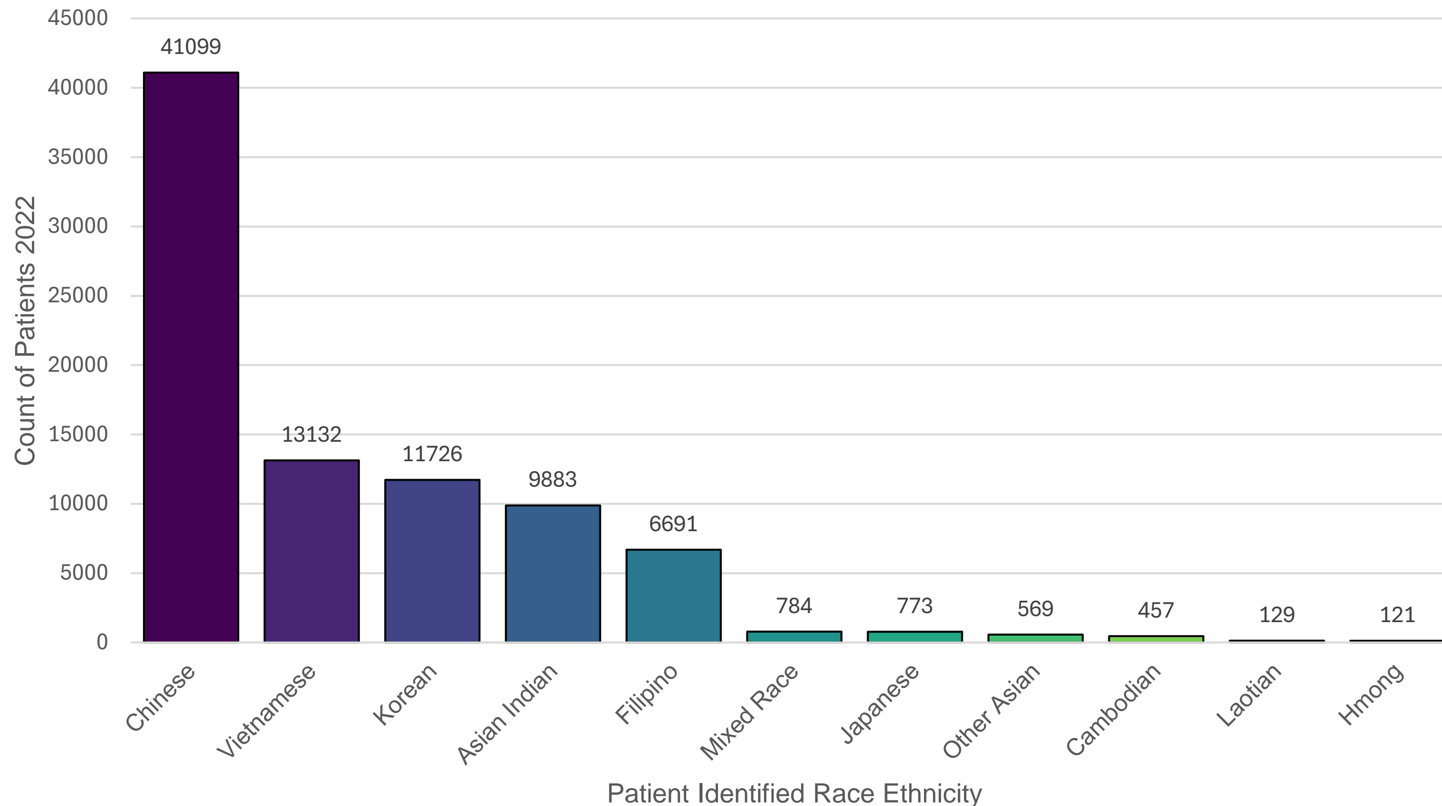
UTILIZATION BY RACE AND ETHNICITY: HISPANIC/LATINO SUBPOPULATION



- **58%** (61,334/106,462) of patients who identify as Hispanic or Latino who received care from a proposed ECP in 2022 **identify as Mexican/Mexican American/Chicano**
- **19%** (20,302/106,462) of patients who identify as Hispanic or Latino who received care from a proposed ECP **identify as Other Hispanic or Latino**

Graph excludes counts under 11 patients. Total self-identified as Hispanic or Latino population that obtained services from ECP provider 106,462±.

UTILIZATION BY RACE AND ETHNICITY: ASIAN SUBPOPULATION



- **48%** (41,099/85,364) of patients who received care from a proposed ECP in 2022 **identify as Chinese**
- **15%** (13,132/85,364) of patients who received care from a proposed ECP **identify as Vietnamese**
- **14%** (11,726/85,364) of patients who received care from a proposed ECP **identify as Korean**

Total self-identified as Asian population that obtained services from an ECP provider in 2022 is 85,364 ±.

PATIENT CHARACTERISTICS KEY FINDINGS

The demographics of patients who utilize ECPs differ from the overall Covered California population

- Patients who identify as Hispanic or Latino represent 29% of all patients using ECPs, which aligns with Covered California's overall membership
- However, only 20% of patients who use ECPs identify as White yet 33% of all Covered California enrollees identify as White.

ECP SUFFICIENCY THRESHOLDS

REVISIONS TO SUFFICIENCY THRESHOLDS

Following initial analytic work, revised sufficiency standards were proposed:

- 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)
- Remove 15% 340B entity specific threshold
- Adopt category specific, or entity specific, thresholds:
  - Primary Care ECPs (Medi-Cal primary care providers located in quartiles 1 and 2 of the California Healthy Places Index)
  - Behavioral Health Care ECPs (Medi-Cal behavioral health providers located in quartiles 1 and 2 of the California Healthy Places Index)

Sufficiency Threshold Modeling

Following the policy recommendation to adopt specific thresholds for primary care and behavioral health ECPs, HMA and Covered California modeled various thresholds.

SUFFICIENCY THRESHOLD MODELING AGGREGATED

Number of QHPs meeting specified Primary Care Sufficiency Thresholds (15%, 35%, 50%)

- Number of QHPs >= 15% ECPs in network (proposed)
- Number of QHPs >= 35% ECPs in network
- Number of QHPs >= 50% ECPs in network

Northern Counties	North Bay Area	Greater Sacramento	San Francisco County	Contra Costa County	Alameda County	Santa Clara County	San Mateo County	Santa Cruz, San Benito, Monterey Counties	Central Valley	Fresno, Kings, Madera Counties	Central Coast	Eastern Counties	Kern County	Los Angeles County East	Los Angeles County West	Inland Empire	Orange County	San Diego County
2 of 3	2 of 4	4 of 6	3 of 4	2 of 4	2 of 4	3 of 4	0 of 4	4 of 4	3 of 3	3 of 4	3 of 3	4 of 4	4 of 4	7 of 7	7 of 7	7 of 7	6 of 6	6 of 6

Total Number of Primary Care ECPs by Geographic Rating Region

1,085	301	796	176	173	431	389	105	220	1,021	678	228	89	611	2,098	2,391	2,256	871	1,172

The number of QHP networks in the chart above excludes two Issuers from the count (Kaiser and Sharp) who qualify for the alternate standard. Data used in this report assumes issuers offer plans in full region. In future analyses, issuers offering plans in partial region will likely have increased ECP network participation as it will be based on a subset of ECPs rather than all Primary Care and/or Behavioral Health ECPs in any given geographic rating region.

SUFFICIENCY THRESHOLD MODELING AGGREGATED

Number of QHPs meeting specified Behavioral Health Sufficiency Thresholds (5%, 10%, 15%)

- Number of QHPs >= 5% ECPs in network
- Number of QHPs >= 10% ECPs in network
- Number of QHPs >= 15% ECPs in network (proposed)

Geographic Rating Region	Chart label	Total Number of Primary Care ECPs by Geographic Rating Region
Northern Counties	3 of 3	394
North Bay Area	0 of 4	240
Greater Sacramento	2 of 6	1,587
San Francisco County	3 of 4	144
Contra Costa County	0 of 4	603
Alameda County	1 of 4	302
Santa Clara County	3 of 4	52
San Mateo County	2 of 4	13
Santa Cruz, San Benito, Monterey Counties	3 of 4	16
Central Valley	0 of 3	1,922
Fresno, Kings, Madera Counties	3 of 4	435
Central Coast	2 of 3	56
Eastern Counties	3 of 4	32
Kern County	3 of 4	188
Los Angeles County East	4 of 7	1,390
Los Angeles County West	5 of 7	983
Inland Empire	5 of 7	1,785
Orange County	4 of 6	204
San Diego County	4 of 6	1,022

The number of QHP networks in the chart above excludes two Issuers from the count (Kaiser and Sharp) who qualify for the alternate standard. Data used in this report assumes issuers offer plans in full region. In future analyses, issuers offering plans in partial region will likely have increased ECP network participation as it will be based on a subset of ECPs rather than all Primary Care and/or Behavioral Health ECPs in any given geographic rating region.

SUFFICIENCY THRESHOLD MODELING AGGREGATED NETWORK ANALYSIS RESULTS

Primary Care ECP Sufficiency Observations

- More variation among QHPs meeting proposed thresholds within a region

Behavioral Health ECP Sufficiency Observations

- Less variation among QHPs meeting proposed thresholds within regions and more variation across regions, indicating likelihood of different provider dynamics within counties

PROPOSED SUFFICIENCY THRESHOLDS

Proposed new sufficiency thresholds:

- ❑ 15% of Primary Care ECPs in each region of the QHP’s service area
- ❑ 15% of Behavioral Health ECPs in each region of the QHP’s service area

Full compliance required in Plan Year 2029

PRELIMINARY FEEDBACK ON PROPOSED SUFFICIENCY THRESHOLDS

Covered California continues to accept feedback on proposed ECP standards for 2026-2028.

Comments received so far:

- ❑ Two Issuers expressed support for proposed 15% primary care and behavioral health ECP thresholds
- ❑ One Issuer suggested a 10% threshold for primary care ECPs
- ❑ One stakeholder commented that 15% for primary care ECP threshold may be too low
- ❑ One stakeholder expressed concern with availability of behavioral health ECPs to contract with QHP issuers
- ❑ Several issuers posed clarifying questions regarding data and methods used

2026 – 2028 QHP ISSUER MODEL CONTRACT PUBLIC COMMENT RESPONSES AND DRAFT UPDATES

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 ECP REQUIREMENTS

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

- Issuers must meet ECP General Standard by maintaining a network which 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 provider contracts with at least 15% of Primary Care ECPs in each rating region in which it offers QHPs
  - Issuers must demonstrate provider agreements with at least 15% of Behavioral Health ECPs in each rating region in which it offers QHPs
  - Issuers must demonstrate agreements with at least one ECP hospital per county requirement or per rating area in counties with multiple rating regions

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Primary Care and Behavioral Health ECPs refer to Medi-Cal primary care and behavioral health providers located in quartiles 1 and 2 of the California Health Places Index

PROPOSED 2026-28 ECP REQUIREMENTS

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

- ECP General Standard Sufficiency Requirements (continued):
  - If Issuers are unable to meet the sufficiency requirements stated on the previous slide:
    - Issuers must demonstrate provider agreements with at least 15% of 340B non-hospital providers in each rating region in which it offers QHPs
    - Issuers must demonstrate documentation of good faith efforts to achieve the sufficiency requirements stated previously for the first plan year of the contract period
    - Issuers must demonstrate documentation of improvements in plan years 2027 and 2028 showing material increases in percentage of contracts with Primary Care and Behavioral Health ECPs
- 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

Primary Care and Behavioral Health ECPs refer to Medi-Cal primary care and behavioral health providers located in quartiles 1 and 2 of the California Health Places Index

2026-28 ECP PUBLIC COMMENT KEY THEMES

Model Contract Article 4 – Essential Community Providers

- One Issuer expressed concern about meeting the minimum number in their network due to contracting challenges with FQHCs, state-owned family planning sites, free clinics, and Community Health Centers
- One Issuer requested an ECP workshop to create an opportunity for questions, concerns, and further collaboration
- One stakeholder requested greater clarity and a definition of "sufficient number and sufficient geographic distribution" to ensure ECP networks provide timely and reasonable access to enrollees

PROPOSED 2026-28 ECP CHANGES

Model Contract Article 4 – Essential Community Providers Requirements

Notable Changes to Draft 4.3.4 Essential Community Providers	Rationale
Removal of 15% sufficiency threshold for 340B non-hospital providers	Adjusting approach to sufficiency thresholds to meet ECP guiding principles: improving access to primary and behavioral health care, improving continuity of care between Medi-Cal and Covered California and serving low-income and medically underserved populations.
Addition of 15% sufficiency threshold for Primary Care ECPs	
Addition of 15% sufficiency threshold for Behavioral Health ECPs	
An alternate sufficiency standard if above requirements cannot be met will be added: Issuers must demonstrate meeting the 15% sufficiency threshold for 340B non-hospital providers, documentation of good faith efforts in first plan year, and percentage increase of Primary Care and Behavioral Health ECPs with each subsequent plan year	Proposed changes to sufficiency standards will require contracting efforts by QHP issuers which may reasonably require multiple years to achieve.
Addition of annual publication of QHP ECP network performance	Increased transparency as part of expanded approach to ongoing evaluation of ECP standards

Primary Care and Behavioral Health ECPs refer to Medi-Cal primary care and behavioral health providers located in quartiles 1 and 2 of the California Health Places Index

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

Issuer Model Contract- Removal from the Exchange

- One issuer requested that we update the language to reflect: **upon request*, plans *may be* required to submit a Minimum Performance Level Action Plan to Covered California for measures repeatedly below the 25th percentile benchmark.

2026-28 25/2/2 PROGRAM

Issuer Model Contract- Removal from the Exchange

Notable changes to Issuer Model Contract 25/2/2	Rationale
Revised Minimum Performance Level Action Plan language: For each CMS QRS measure for which Contractor consistently scores below 25th percentile national benchmark, Covered California may require a Minimum Performance Level Action Plan (MPL).	Covered California will apply the MPL Action Plan requirement for consistent performance beneath the 25th percentile for clinically significant measures.

Attachment 1 Advancing Equity, Quality, and Value

2026-28 ATTACHMENT 1 PUBLIC COMMENT KEY THEMES

Article 1: Equity and Disparities Reduction

- In response to the Expanded Demographic Data Collection requirement to collect Sexual Orientation and Gender Identity (SOGI) data, one issuer requested a copy of the SOGI methodology document
- In response to the Monitoring Disparities: Patient Level Data File (PLD) requirement, in which Issuers are required to submit Covered California member-level Healthcare Effectiveness Data Information Set (HEDIS) measure results via PLD files, one issuer requested final decisions on the implementation of ECDS measures as early as possible

PROPOSED 2026-28 ARTICLE 1 CHANGES

Article 1: Equity and Disparities Reduction

Notable Changes to Draft Attachment 1	Rationale
Disparities Reduction Revised language describing requirement that QHP issuer conduct or attend activities conducted by other QHP issuers to meet QHP collaborative and community engagement requirements.	Language revisions clarify expectation that QHP issuer conduct activities to meet QHP collaborative and community engagement requirements.

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2026-28 ARTICLE 2 PUBLIC COMMENT KEY THEMES

Article 2: Behavioral Health

- ❑ One Issuer requested clarifying language about Behavioral Health Spend benchmarks
- ❑ One Issuer requested updating language for Tobacco Treatment to remove "in accordance with current QRS measure" and to remove "administrative claims and encounter data"

PROPOSED 2026-28 ARTICLE 2 CHANGES

Article 2: Behavioral Health

Notable Changes to Draft Attachment 1	Rationale
Language updated throughout changing “tobacco cessation” to “tobacco treatment”.	Updating language to align with current policy and clinical practice language.
Expanded data sources to meet tobacco treatment outcomes analysis requirement	The expanded data sources removes perceived limitations on data to be used for the outcomes analysis.
Revised language describing requirement that QHP issuer conduct or attend activities conducted by other QHP issuers to meet QHP collaborative and community engagement requirements.	Language revisions clarify expectation that QHP issuer conduct activities to meet QHP collaborative and community engagement requirements.

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 Management

Use of Generative Artificial Intelligence in Qualified Health Plan Issuer Operations

- ❑ One stakeholder acknowledged Covered California's efforts to align with Health and Safety Code 1317.01 (e), which states that Gen AI may not be used to deny or modify patient care
- ❑ One Issuer requested language changes to requirements for integrating best practices for Gen AI
- ❑ One Issuer requested clarification on disclosure requirements for Covered California enrollees pertaining to the use of Gen AI
- ❑ One Issuer requested the removal of language regarding notifying enrollees about written interactive health benefit communications
- ❑ One Issuer requested the exclusion of utilization review approvals from Gen AI disclosure requirements

PROPOSED 2026-28 ARTICLE 3 CHANGES

Article 3: Population Health

Notable Changes to Draft Attachment 1	Rationale
No proposed changes to Article 3	

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2026-28 ARTICLE 4 PUBLIC COMMENT KEY THEMES

Article 4: Delivery System and Payment Strategies to Drive Quality

Advanced Primary Care

- ❑ One issuer requested for clarification of "Member Value and Engagement in Care" and whether additional context will be added.
- ❑ A coalition expressed strong support for the inclusion of a Continuity of Care baseline threshold as a performance standard.
- ❑ One issuer reiterated a request to include cultural preference information in the 834 file to better address members' needs.
- ❑ One issuer suggested that care provided by different providers within the same office should count towards the requirement of two or more visits for the Continuity of Care requirement.

2026-28 ARTICLE 4 PUBLIC COMMENT KEY THEMES

Article 4: Delivery System and Payment Strategies to Drive Quality

Networks Based on Value

- ❑ One issuer requested a definition for "low value care”.

Hospital Value and Safety

- ❑ No comments received

Comprehensive Pregnancy and Postpartum Care

- ❑ One QHP Issuer requested revising "birthing patients" to "maternal" to ensure clarity and align with commonly understood clinical and policy language.

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 acceptance of URAC accreditation in lieu of NCQA accreditation when reporting third-party vendors who offer virtual care services

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
Advanced Primary Care Added definition of Member Value and Engagement in Care.	The draft language was inadvertently omitted from the October 2024 versions of the contract.
Networks Based on Value Added definition of Low-value care: refers to services or treatments that offer minimal clinical benefit, deviate from evidence-based guidelines, or have safer, more cost-effective alternatives.	Definition added to clarify intent.
Comprehensive Pregnancy and Postpartum Care Updated the term "birthing" patient to "Pregnant and Postpartum" patients and "birthing care" to "Pregnancy and Postpartum care" to provide greater clarity and precision while maintaining inclusivity. Added language specifying the inclusion of monitoring and reduction of maternal mental health disparities through Substance Use Disorder and Medication Assisted Treatment programs and coordinated care.	Updated language explicitly encompasses all phases of care, including pregnancy, childbirth, and postpartum while respecting the diverse identities of those accessing care. Expanded requirement addresses the full scope of prenatal and postpartum behavioral health disparities.
Use of Virtual Care Added URAC as accrediting body option to the third-party virtual care vendors reporting requirement.	URAC offers multiple digital and telehealth accreditation programs.

2026-28 ARTICLE 5 PUBLIC COMMENT KEY THEMES

Article 5: Measurement and Data Sharing

- ❑ One Issuer requested clarity on how Covered California analyzes Fraud/Waste/Abuse data
- ❑ One stakeholder suggested the addition of language around defining QHIO requirements

PROPOSED 2026-28 ARTICLE 5 CHANGES

Article 5: Measurement and Data Sharing

Notable Changes to Draft Attachment 1	Rationale
Data Exchange Expanded language related to participation in at least one QHIO to include a statement that QHIOs should share data to “support quality measurement and operations”	Language intended to articulate explicit purpose of QHIO data sharing and its benefits on quality measurement as well as operational and administrative burden reduction

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

- One issuer expressed concern with QHPs being held to contractual requirements for collecting race and ethnicity data if challenges in doing so arise from political factors and also recommended that race and ethnicity data be collected at time of enrollment and that the field be designated as required in the application

2026-28 ATTACHMENT 2 PUBLIC COMMENT KEY THEMES

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

- One issuer requested a more nuanced penalty approach, considering efforts to engage unresponsive members.
- One issuer requested removal of this proposed standard, citing potential increased costs and premiums.
- One plan requested guidance on increasing performance over the baseline rate and expressed concerns about the new proposed performance standard, preferring to focus on QTI measures.

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

- A coalition strongly supported keeping the Continuity of Care index threshold at 0.7 for 70% of enrollees, emphasizing the importance of maintaining a higher standard.
- One issuer requested removing this proposed performance standard due to resource constraints, and suggested moving the measure to reporting only with no penalty

PROPOSED 2026-28 ATTACHMENT 2 CHANGES

Notable Changes to Draft Attachment 2	Rationale
Performance Standard 3 - Collaboration Across QHP Issuers and With Community Revised language narrows scope of performance standard to specified QHP collaborative or community engagement sessions .	Simplifies and focuses performance standard on QHP issuer efforts to work in partnership with each other and the community to improve equity, access, and quality.
Performance Standard 6 - Pediatric Topical Fluoride for Children, Dental Services (TFL-CH-A) (NQF #3700 ~~2528~~) Measure specification change from NQF #2528 to #3700	The updated measure specification includes both dental and oral health services in the numerator, broadening the scope and ensuring permissible inclusion of clinically appropriate services provided in both dental and non-dental settings.
Added assessment timing language to all performance standards.	New language clarifies timing of performance standard assessment for each performance standard.

Attachment 4 Quality Transformation Initiative

2026-28 ATTACHMENT 4 PUBLIC COMMENT KEY THEMES

QTI Measure Set & Benchmarks

- One issuer requested clarification on the purpose and evaluation process for issuer-operated PopHI, whether issuers must contribute to existing PopHIs and whether the PopHI would serve a broader marketplace population beyond their own enrollees.
- One issuer requested to reconsider the QTI penalty timeline and maximum in light of OHCA cost-reduction requirements.
- One issuer recommended adding contract language to allow flexibility in adjusting QTI benchmark measurement years during the contract cycle.
- Two issuers emphasized the need for earlier establishment of QTI benchmarks for new ECDS measures, such as CBP-E, to reduce administrative burden and support improvement activities.
- One issuer suggested removing QTI payment assessment for the first year of ECDS measures due to the lack of benchmarks.
- One issuer proposed adjusting contract language to allow QTI payment obligations to extend into the next calendar year for smoother financial planning.
- One issuer requested for adequate time for public comment on substantial QTI measure changes to ensure transparency and stakeholder input.

PROPOSED 2026-28 ATTACHMENT 4 CHANGES

QTI Measure Set and Benchmarks

Notable Updates to Draft Attachment 4	Rationale
Revised language describing approach to updating benchmarks if established through use of QRS proof sheets or use of prior version of measure.	Revised language permits stability through maintaining established benchmarks.

2026-28 ATTACHMENT 4 PUBLIC COMMENT KEY THEMES

Race and Ethnicity Stratification and Methodology

- One issuer requested to know what specific benchmark year would be used to assess performance after transitioning to ECDS
- One issuer requested that future edits to QTI Methodology reconsider weights of smaller subpopulations, include cross-carrier interventions, and impacts of the Knox-Keene Act on carriers' ability to report enrollee demographics
- One issuer expressed concern for the financial accountability and fairness of application associated with meeting contractual requirements
- One issuer requested the removal or further clarification of section 1.04 Preventing Increases in Health Disparities/Requiring Maintained Efforts

PROPOSED 2026-28 ATTACHMENT 4 CHANGES

Health Equity Methodology

Notable Changes to Draft Attachment 4	Rationale
Race and Ethnicity Stratification Methodology No proposed changes	
Preventing Increases in Health Disparities/Requiring Maintained Efforts Revisions to more clearly define the conditions under which payment allocations may be re-weighted: lack of improvement or declining performance for a subpopulation.	Revised language addresses perceived ambiguity.

2026-2028 MODEL CONTRACT DRAFTS & RESPONSE TO COMMENT

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

Appendix:
Essential Community Provider (ECP)

ECP STAKEHOLDER ENGAGEMENT SUMMARY

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)

State-based Marketplaces

- 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

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

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The state-based marketplaces that were engaged include Washington, Connecticut, and Minnesota.

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	✓	✓			✓

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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

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CALIFORNIA HEALTHY PLACES INDEX (HPI)

HPI Q1 & Q2 (0-50th percentile)

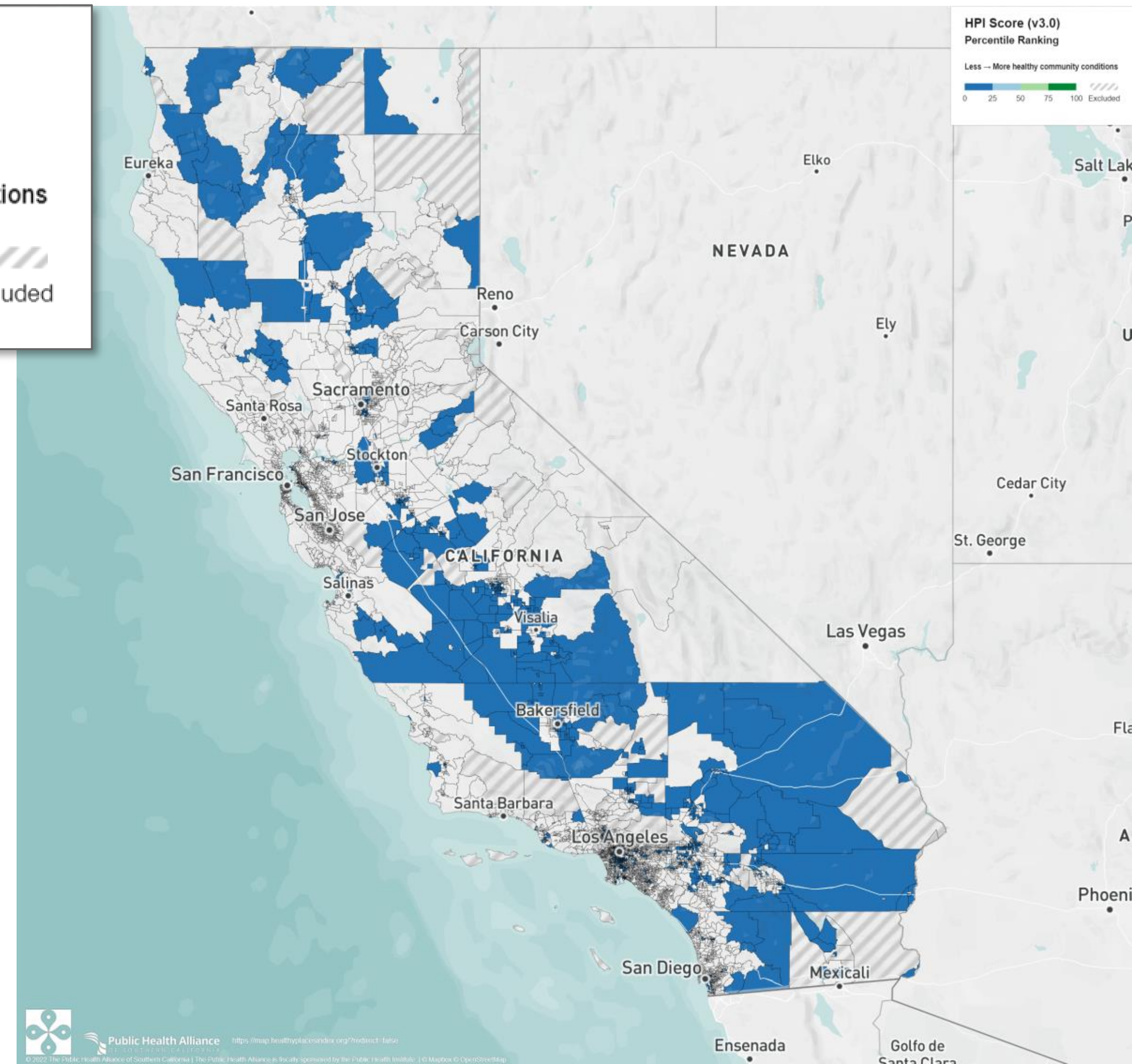
Eureka
Elko
NEVADA
Reno
Carson City
Ely
Sacramento
Santa Rosa
Stockton
San Francisco
Cedar City
San Jose
St. George
CALIFORNIA
Salinas
Visalia
Las Vegas
Bakersfield
Santa Barbara
Los Angeles
Phoeni
San Diego
Mexicali
Ensenada
Golfo de Santa Clara
Public Health Alliance

HPI Score (v3.0)
Percentile Ranking

Less → More healthy community conditions

0 25 50 75 100 Excluded

HPI Q1 (0-25th percentile)



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.

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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

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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**

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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**

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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**

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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).

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FINDINGS – SUMMARY

Updated ECPs (by Region)

Category	TOTAL	Northern Counties 1	North Bay Area 2	Greater Sacramento 3	San Francisco County 4	Contra Costa County 5	Alameda County 6	Santa Clara County 7	San Mateo County 8	Santa Cruz, San Benito, Monterey Counties 9	Central Valley 10	Fresno, Kings, Madera Counties 11	Central Coast 12	Eastern Counties 13	Kern County 14	Los Angeles County East 15	Los Angeles County West 16	Inland Empire 17	Orange County 18	San Diego County 19	Unknown n/a
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).

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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

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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.

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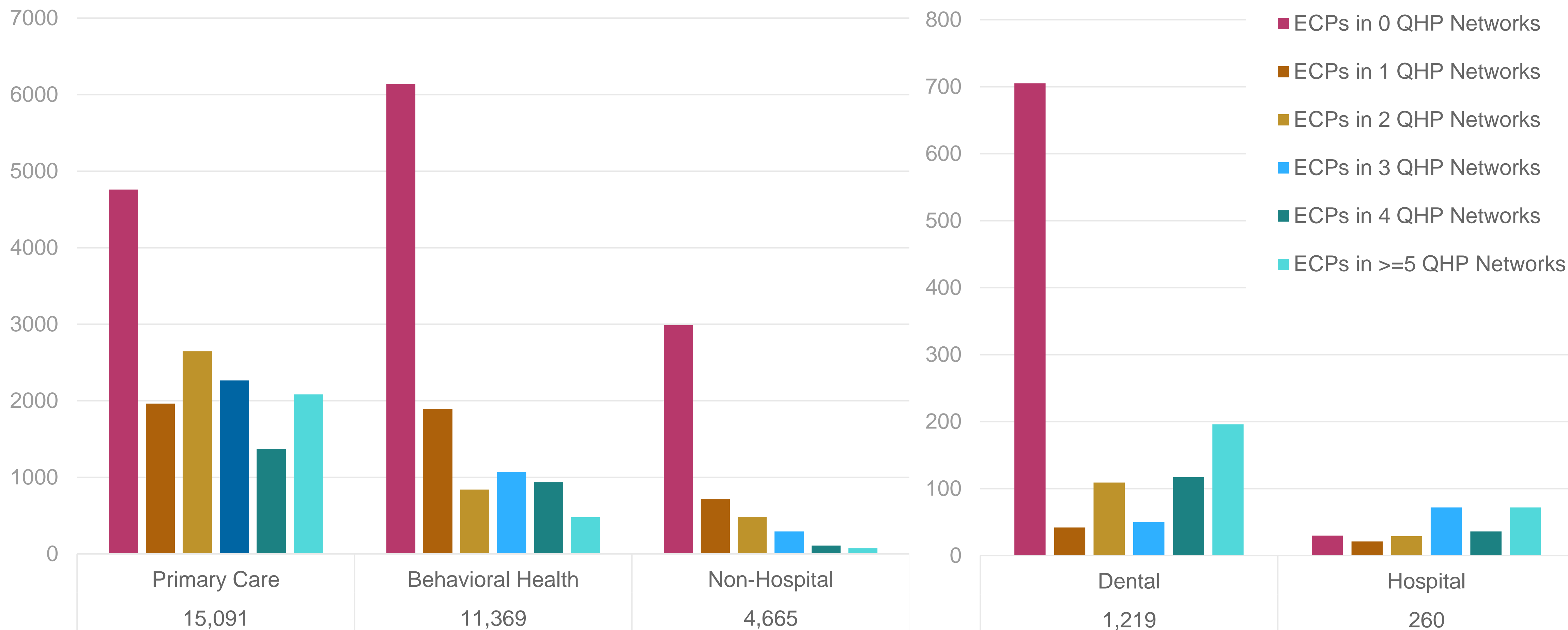
PHASE 2 RESULTS – NETWORK ANALYSIS

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.

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Appendix:
Draft 2026-2028 QHP Issuer Model Contract

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

- No comments received

PROPOSED 2026-28 ACCESS CHANGES

Model Contract Article 4 – Access

Notable Changes to Draft	Rationale
No proposed changes	

COVERED CALIFORNIA

PROPOSED 2026-28 25/2/2 PROGRAM REQUIREMENTS

Model Contract Article 5 – Removal from the Exchange Check if requirements need updating

- ❑ 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 as Measurement Year (MY) 2024
- ❑ Removal of retired QRS measures from benchmark and composite score calculations
- ❑ Should new clinical measures with benchmarks after 2024 be introduced, Covered California may revise the 2024 benchmark to include these measures.
- ❑ Minimum Performance Level (MPL) Action Plan required for each clinical measure falling beneath the 25th percentile for 2 consecutive years.

COVERED CALIFORNIA

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

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.

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

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

- No comments received

Social Health

- No comments received

PROPOSED 2026-28 ARTICLE 4 REQUIREMENTS

Article 4: Delivery System and Payment Strategies to Drive Quality Check if requirements need updating

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 Birthing 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 or **URAC** 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

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 by sharing data
- ❑ 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

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 for Health Plan Accreditation	

2026-28 ATTACHMENT 2 PUBLIC COMMENT KEY THEMES

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

No comments received

Performance Standard 3 Collaboration Across QHP Issuers and With Community

No comments received

Performance Standard 4 Data Submission specific to HEI in Attachment 1, Article 5.02.1

No comments received

Performance Standard 5 Pediatric Oral Evaluation Dental Services (OEV-CH-A) (NQF #2517)

No comments received

Performance Standard 6 Pediatric Topical Fluoride for Children, Dental Services (TFL-CH-A) (NQF #2528)

No comments received

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 4 - Healthcare Evidence Initiative (HEI) Data No proposed changes	
Performance Standard 5 - Pediatric Oral Evaluation, Dental Services (OEV-CH-A) (NQF #2517) 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	

PROPOSED 2026-28 ATTACHMENT 4 REQUIREMENTS

- Proposed QTI Measure Set:
- Blood Pressure Control for Patients with Hypertension (BPC-E) *if adopted by CMS QRS by MY2026, otherwise will continue with CBP*
  1. Glycemic Status Assessment for Patients with Diabetes (GSD) >9%
  2. Colorectal Cancer Screening (COL-E)
  3. Childhood Immunization Status (CIS-E)
  4. Depression Screening and Follow-Up for Adolescents and Adults (DSF-E) - *pending CMS QRS benchmarks*
  5. 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

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.