Plan Management Advisory Workgroup

August 8, 2024

AGENDA

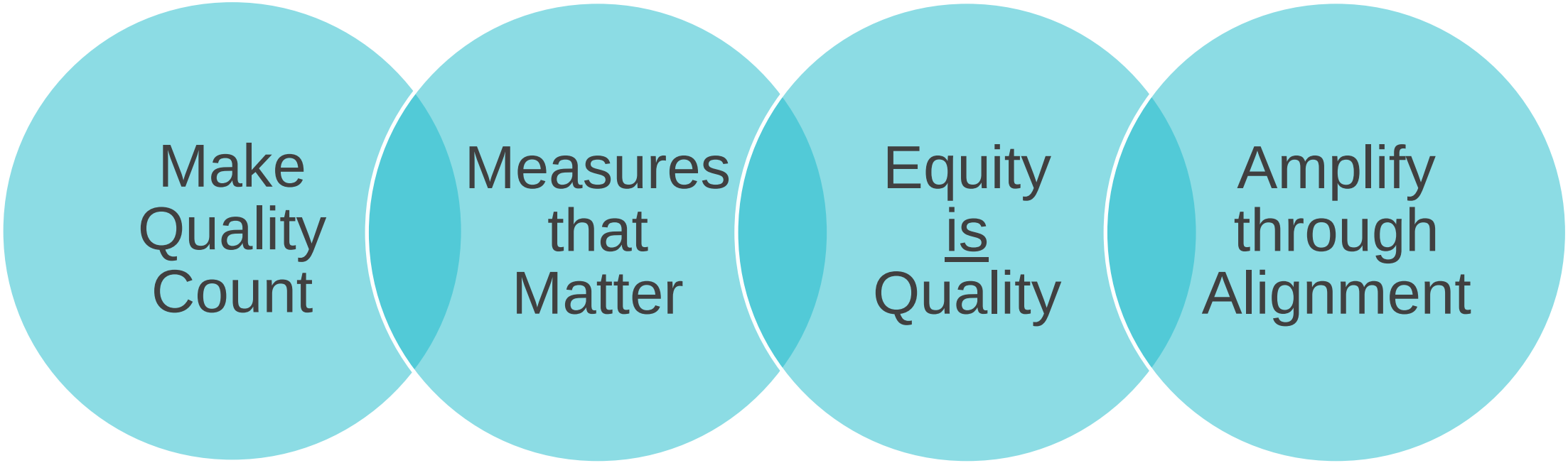
Time	Topic	Presenter
10:00 – 10:05	Welcome and Agenda Review	Rick Krum
10:05 – 10:30	QTI Population Health Investments (PopHI) Updates:	Joy Dionisio/ Monica Soni
10:30 – 11:20	2026 Contract Redlines	Taylor Priestley
11:20 – 11:30	2026-2028 Contract Updates	Tara Di Ponti
11:30 – 12:00	Open Forum	All

Quality Transformation Initiative: Update on Population Health Investments (PopHI)

S. Monica Soni, MD
Chief Medical Officer

Joy Dionisio, MPH
Senior Equity and Quality Specialist

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

GUIDING PRINCIPLES: USE OF FUNDS

Centered on goal to improve health outcomes for Covered California enrollees

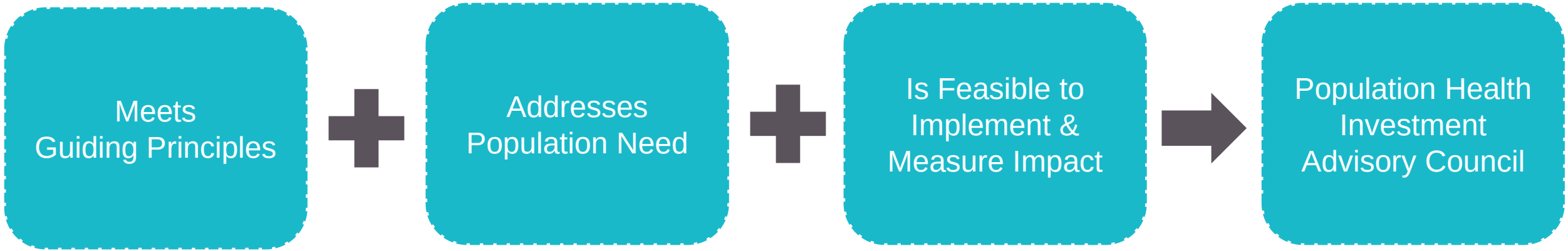
Equity First: funds should preferentially focus on geographic regions or communities with the largest identified gaps in health and quality among California subpopulations

Direct: use of funds should lead to measurable improvements in quality and outcomes for enrollees that are related to QTI Core Measure performance

Evidence-based: use of funds should be grounded in approaches that have established evidence of success in driving improvements in quality or outcomes

Additive: funds should be used to advance quality in a currently underfunded arena.

POPULATION HEALTH INVESTMENTS: SELECTION CRITERIA



A prioritized list of Population Health Investments (PopHI) was assembled after **14 months of stakeholder engagement** and **input from constituents**, including Covered California current enrollees, QHP issuers, consumer advocates, clinicians who serve Covered California enrollees, professional associations and public purchasers. **9 public meetings** were held, and **6 weeks of written comments** were solicited through the PopHI Advisory Council and Plan Management Advisory Group.

POPULATION HEALTH INVESTMENT ADVISORY COUNCIL

Membership:

The Advisory Council consists of 10 to 12 members plus Ex Officio, including the following:

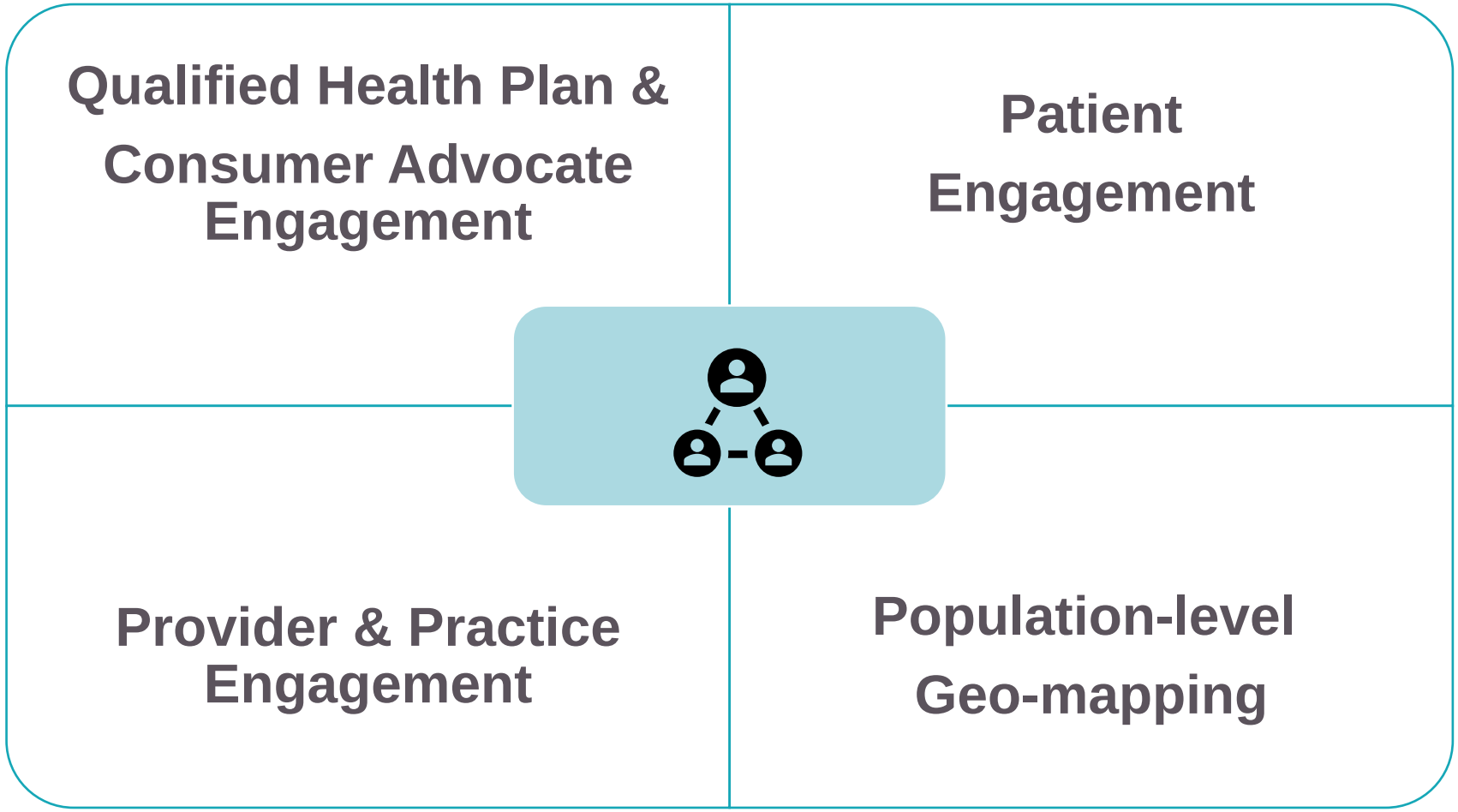
- Qualified Health Plan Issuers (2-3)
- California-based Government Officials (2)
- Consumer, Consumer Advocates, Thought Leaders, and Experienced Professionals (4-6)
- California-based Providers (2-3)
- Ex Officio (2)
    - California Department of Health Care Services
    - California Public Employees' Retirement System

Participants:

- **Tomás Aragón, MD, DrPH -** Director and State Public Health Officer, California Department of Public Health
- **Palav Babaria, MD, MPH -** Deputy Director & Chief Quality and Medical Officer, QPHM, Department of Health Care Services
- **Corrin Buchanan, MPP -** Deputy Secretary for Policy and Strategic Planning, CalHHS
- **Tracy M. Imley, MD -** Regional Assistant Medical Director, Quality and Clinical Analysis, Southern California Permanente Medical Group
- **Amanda Johnson -** Deputy Director, State and Population Health Group, CMS Innovation Center
- **Edward Juhn, MD, MBA, MPH -** Chief Quality Officer, Inland Empire Health Plan
- **Julia Logan, MD -** Chief Clinical Director, Clinical Policy & Programs Division, CalPERS
- **Peter Long, PhD -** Executive Vice President, Strategy and Health Solutions, Blue Shield of California
- **Bianca Mahmood** - Covered California Consumer
- **Sarita Mohanty, MD -** President and Chief Executive Officer, The SCAN Foundation
- **Cary Sanders, MPP -** Senior Policy Director, California Pan-Ethnic Health Network
- **Kristof Stremikis, MPP, MPH -** Director, Market Analysis and Insight, California Health Care Foundation
- **Sadena Thevarajah, JD -** Managing Director, Health Begins
- **Raymond Tsai, MD, MS -** Vice President, Advanced Primary Care, Purchaser Business Group on Health

POPULATION NEEDS ASSESSMENT

Themes and indicators of where investment is needed emerged



CONSUMER ADVOCATE ENGAGEMENT

Goal: To receive feedback from Consumer Advocates on what barriers they perceive to most strongly impact achievement of quality care for members and how to advance health and wellness

Method: 1:1 meeting series, plan management advisory group, written comment opportunities

Themes and Learning

- Recommend **working across siloes** to bridge programs available in DHCS/Medi-Cal and other state departments given fluidity of enrollment and mixed family status
- Need to continue to **hold QHP issuers accountable** for full spectrum of responsibilities, which includes access, quality, and equity
- Address **underlying financial barriers**, not limited to just cost of coverage, but also related financial burden of access and other immediate health related social needs
- Ensure place-based and regional investments are not a proxy for addressing **racial and ethnic inequities**
- **Increase transparency** of quality and equity reporting at issuer level and across purchaser programs

Next Steps: Continued meetings in fall for next phase of implementation

QHP ISSUER ENGAGEMENT

Goal: To inventory current interventions deployed and remaining challenges plans face while striving for the 66th percentile for QTI measures

Method: 1:1 meeting series, carrier calls, plan management advisory group, written comments

Themes and Learning

- Significant **new investments made in quality** (new departments, staff, vendors), although some work did not ramp up until 2023 therefore impact not yet seen
- **New senior and executive leadership commitment** given financial impact
- Several **new vendors** launched, some with good success, but others without desired impact
- **Increased incentive dollars** utilized at member level targeting eligible members
- Impacted or limited provider availability and **workforce shortages**
- **Increased in-home services** (in-home lab testing and colorectal cancer screening mailers)
- **Provider contracts** with additional dollars or increased weighting of measures
- New infrastructure for **direct to member outreach** as well as enhanced **data exchange**
- Concern that plans are being held accountable for **"non-compliant" members or families** and that **plans should be held harmless**

Next Steps: Additional 1:1 issuer meetings scheduled August-September for next phase of implementation

PROVIDER ENGAGEMENT

Goal: To gain insights into the challenges and barriers practices face in delivering quality care for Covered California members for consideration in Population Health Investment selection

Method: 1:1 listening sessions with practices with large volumes of attributed Covered California members

Themes and Learning

- **Payor-agnostic practice patterns** and workflow
- **Challenges with access** for patients in primary care, pediatrics, and ancillary services for preventive screenings
- Struggles with **workforce turnover**: provider, nursing staff, and ancillary staff such as technicians and front and back office
- **Sub-optimal data exchange**, lack of interoperability & inconsistent electronic medical record use, especially in small, independent practices
- Desire to **engage with community-based organization** to address health-related social needs, but varying levels of capacity and maturity

Next Steps: Meetings with clinical leaders of large volume practices and attend provider dinners hosted by issuers and medical associations

PATIENT ENGAGEMENT

Goal: To gain insights into the challenges and barriers members face in managing their health conditions that will inform selection of Population Health Investments

Method: Outbound calls made to members with a diagnosis of diabetes and/or hypertension to gather qualitative feedback on successes and challenges with chronic disease management

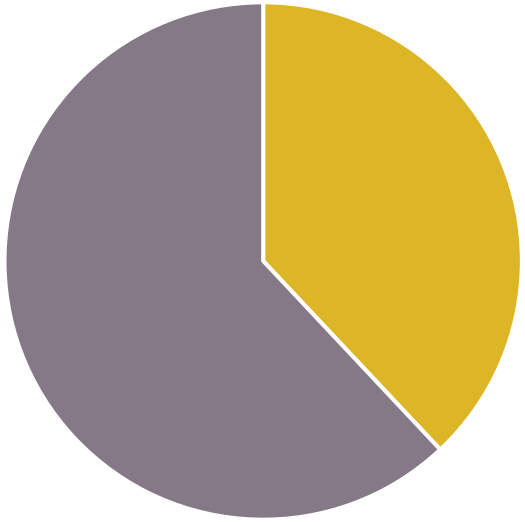
Themes and Learning

- Attempts to adopt healthier habits, although **barriers** like **affordability** or **time** often hinder their efforts
- **Rising** out of pocket and premium **costs** pose significant financial challenges for some members
- Difficulties finding **culturally sensitive care** or desired providers
- Challenges with **access** including rushed consultations and **long wait time** for appointments
- **Personal barriers** experienced that prevent some members from obtaining food, such as changes in the economy and current job situations
- Attempts to try to **save money** or **ration food** on a weekly basis
- Barriers related to **transportation**, such as not having enough **money for gas** or needing to take a bus distances to go grocery shopping
- Additional **financial concerns** and advocacy for **funds** to help **support utility bills** and/or **rent**
- Members concluded that **additional monetary support** in the range of **$100-$200 / month** would be most beneficial

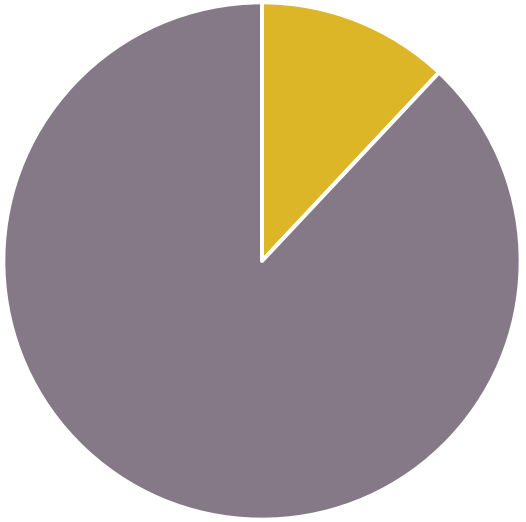
Next Steps: Final analysis of survey and continued patient calls

SNAPSHOT OF OUR ENROLLEES

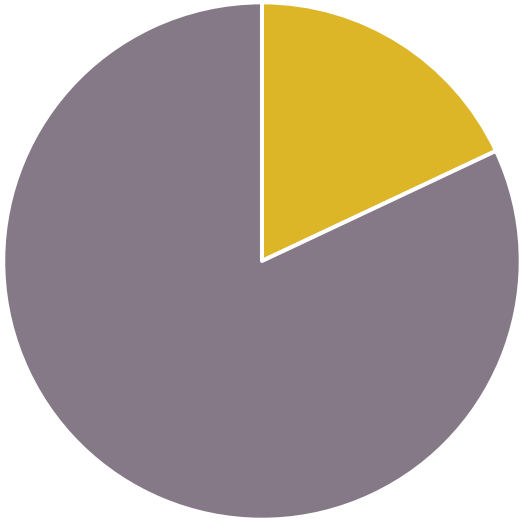
Covered California enrollees have a high prevalence of medical, mental health, and social health needs.



38% of all enrollees have a chronic condition



12% of all enrollees have a mental health diagnosis



18% of all enrollees live in Healthy Places Index lowest Quartile

COVERED CALIFORNIA

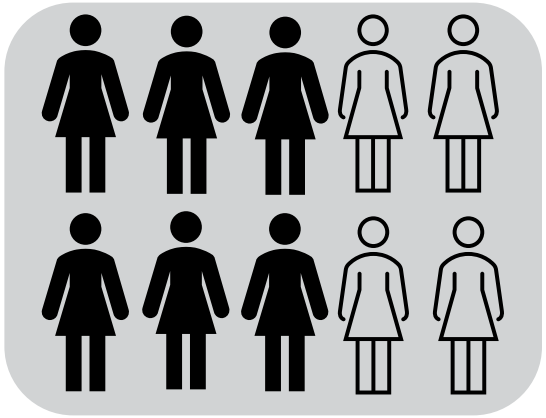
2022 on-exchange member data from Health Evidence Initiative all plan claims database

SNAPSHOT OF OUR ENROLLEES

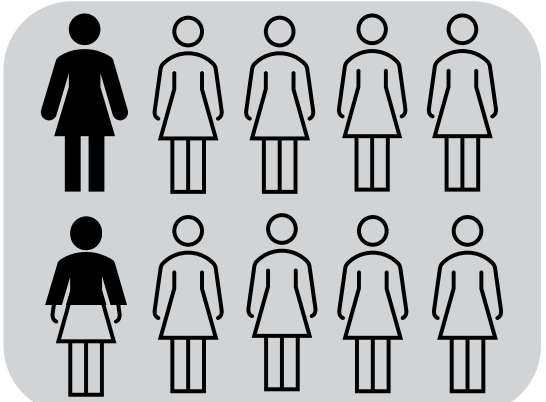
- **60%** of Covered California enrollees (880,770 total individuals) at **FPL 250% or less**
- **47%** of new members report feeling like they **do not have enough money to make ends meet** in the last 12 months

Of enrollees at FPL <200%

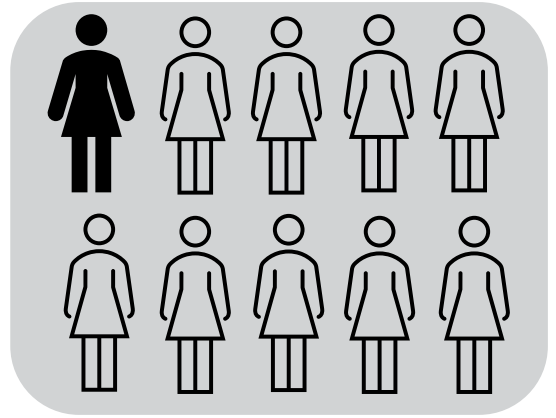
58% of new members who reported **food insecurity** had an FPL < 200%



16% were concerned that in the next 60 days, they **may not have stable housing**

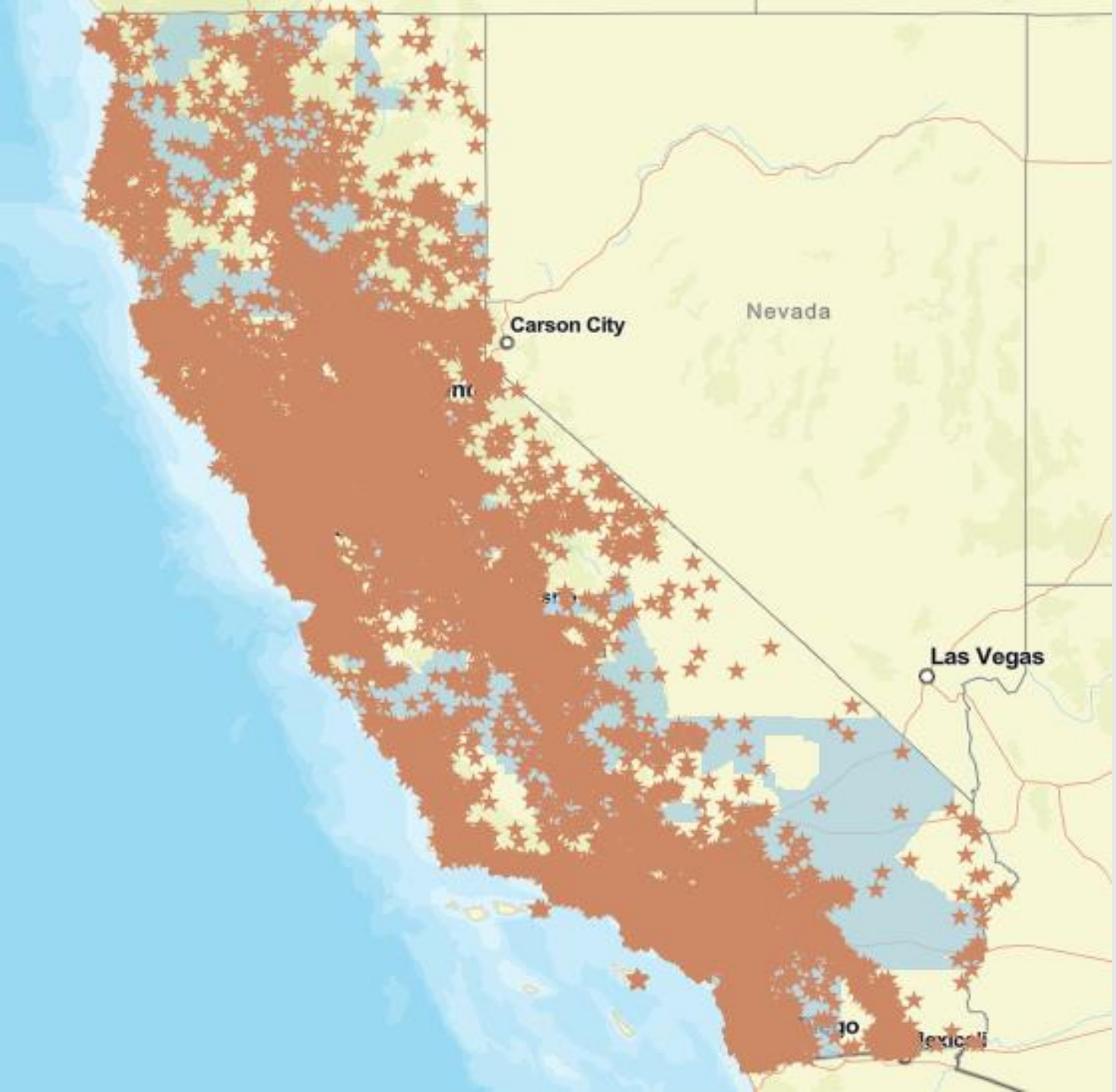


9% have **experienced homelessness** (2% in the past year and 1% currently)



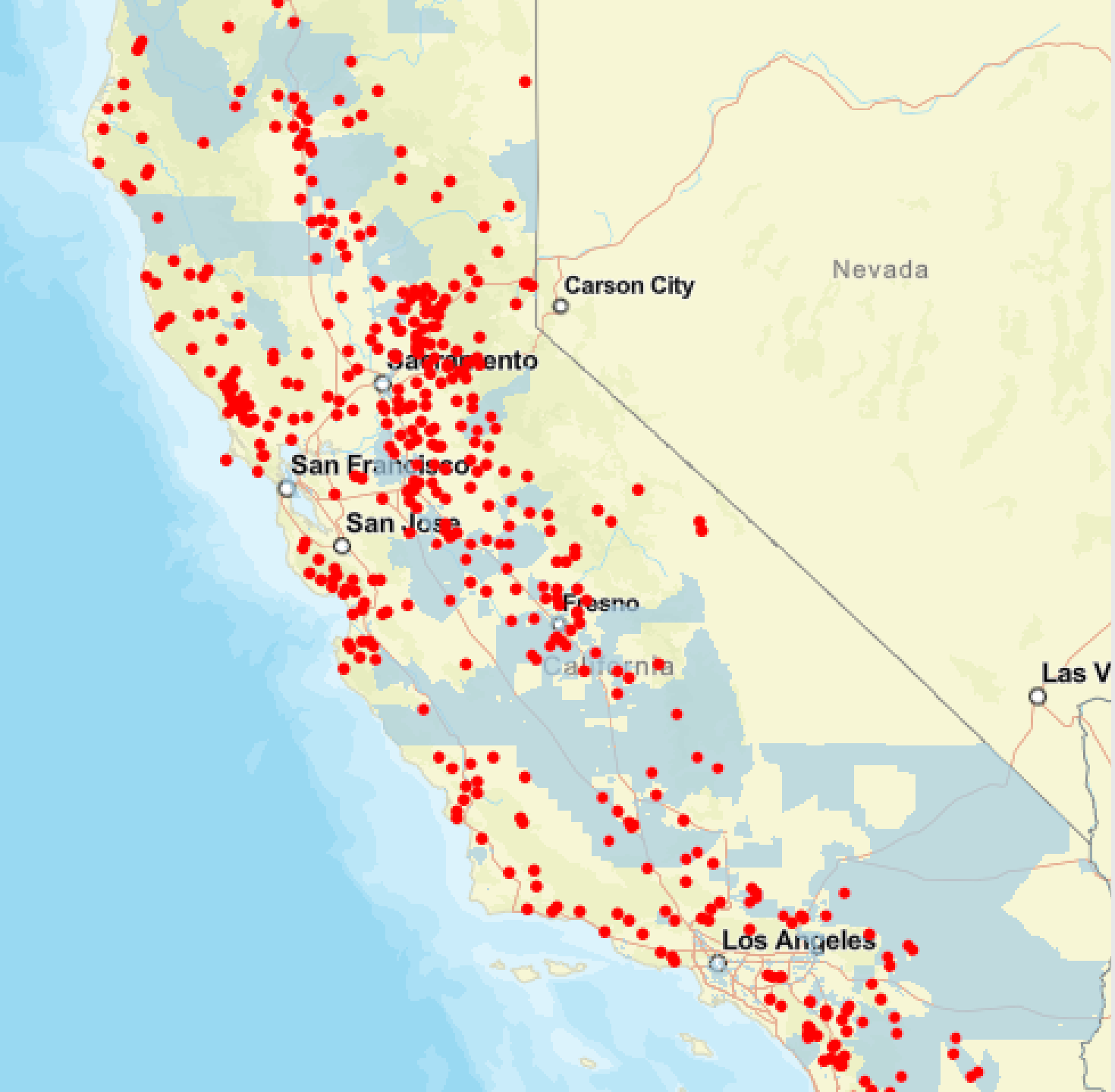
REGIONAL GEOMAPPING

Overlay of Covered California Rating Regions and Healthy Places Index Quartile 1 (Least Healthy Areas)



REGIONAL GEOMAPPING

Overlay of Healthy Places Index Quartile 1 and Covered California enrollees within FPL 200-250%



REGIONAL GEOMAPPING

Overlay of Healthy Places Index Quartile 1 and Covered California Rural Dwelling Population

Proposed Population Health Investment: Early Investments in Childhood Health and Wellness

PROPOSED STRUCTURE OF POPHI: EARLY INVESTMENTS IN CHILDHOOD HEALTH AND WELLNESS

Funding of CSA as the Incentive

Targeted population includes all newborns enrolled in Covered California and children under 2 years old, underscoring the critical nature of early vaccination for lifelong health.

+

Just-In-Time Nudges

Incentive deposited directly into CalKIDS 529 account tied specifically to vaccine series timing. Influenza vaccine series with larger incentive to increase adoption.

+

Scalable Outreach and Education

Culturally tailored tech-enabled outreach paired with on the ground trusted messengers in community starting during prenatal period to optimize uptake.

EARLY INVESTMENTS IN CHILDHOOD HEALTH AND WELLNESS

Meets Guiding Principles

- ✓ *Equity First*
- ✓ *Direct*
- ✓ *Evidence-Based*
- ✓ *Additive*

Addresses Population Need

- ✓ *Underperforming area for Issuers as well as California*

Is Feasible to Implement & Measure Impact

- ✓ *Builds on existing infrastructure*
- ✓ *Well-defined measures of success*

FEEDBACK THEMES TO DATE

1

Early Investments in Childhood Health and Wellness

- Support for addition of culturally and linguistically responsive **financial coaching**
- Interest in amplifying focus on the **influenza vaccine**
- Advised consideration of long-term versus short-term incentives and the importance of **addressing immediate enrollee needs**
- Support for **consistent messaging** across health plans, clinicians and other stakeholders
- Families would benefit from **funds immediately available** for their use
- Encouragement for a multi-pronged approach that also allows for **provider incentives**
- Concern over timing and **implementation cost** of PopHIs
- Concern that **non-duplication** of the work of QHP Issuers is a foundational element of PopHI selection

Proposed Population Health Investment: Direct Investments to Enhance Food Security

COVERED CALIFORNIA ENROLLEE SURVEY

Population Focus: Members with Chronic Conditions

English
819 total respondents
Email survey conducted June 6th - 27th, 2024

Spanish
139 total respondents
Email survey conducted June 13th – July 5th, 2024

Response Insights

Needs

- High rates of food insecurity
  - 38% of English respondents
  - 63% of Spanish respondents
- Transportation insecurity is prevalent
  - 16% of English respondents
  - 32% of Spanish respondents

Desired Help

- Assistance with food and transportation are most cared about
- Followed by financial support for higher education for kids

Maximizing Impact of Funds

- Minimum amount for impact is $80/m
  - 34% of English respondents
  - 39% of Spanish respondents
- Prefer smaller amounts but more frequent disbursements
  - 44% of English respondents
  - 47% of Spanish respondents

"I live in a rural area. The only grocery store is very **expensive**. Therefore, I have to **drive an hour** to a major chain grocery store. **The cost of transportation** is a major factor for me."

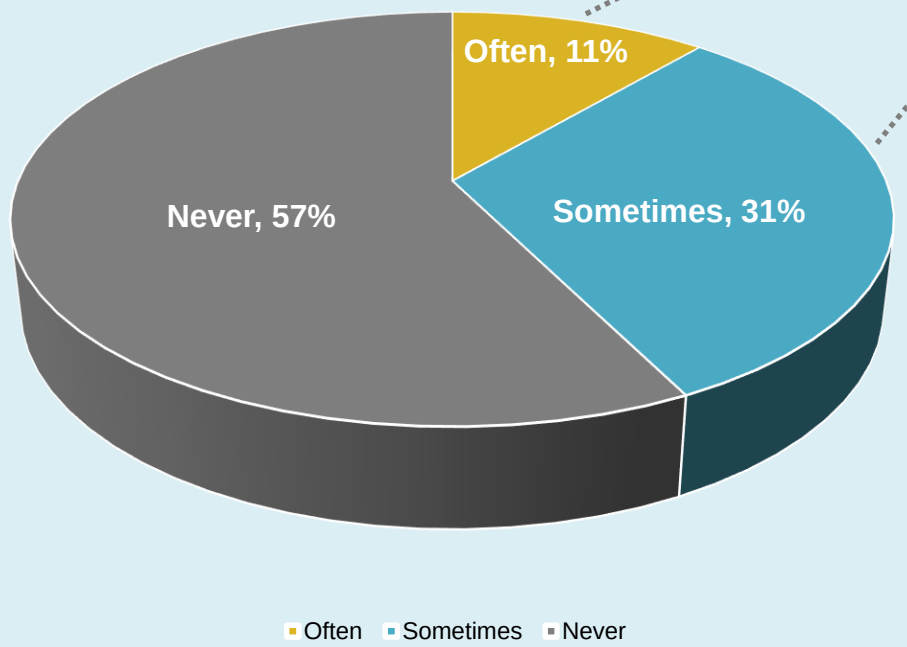
"Eating **healthy costs more** than, you know, than eating junk."

"It would have been helpful if someone had been like, oh, here's a **taxi voucher or let us call an Uber** for you."

"We **need assistance** with the cost of utilities, food, and medical. All have increased so much that **we cannot make it**."

HIGH PREVALENCE OF FOOD INSECURITY

Responses to Hunger Vital Sign Question #1 (n=958)

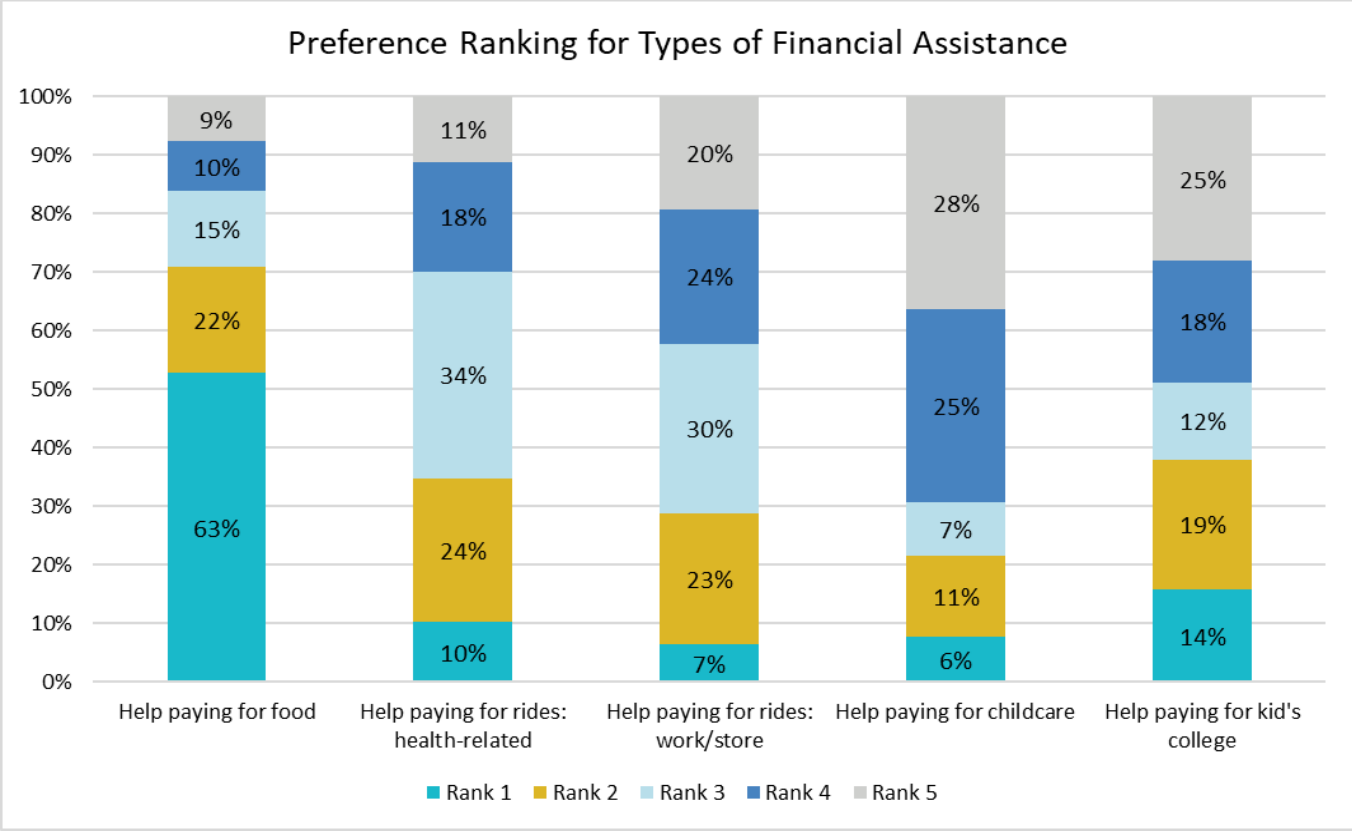


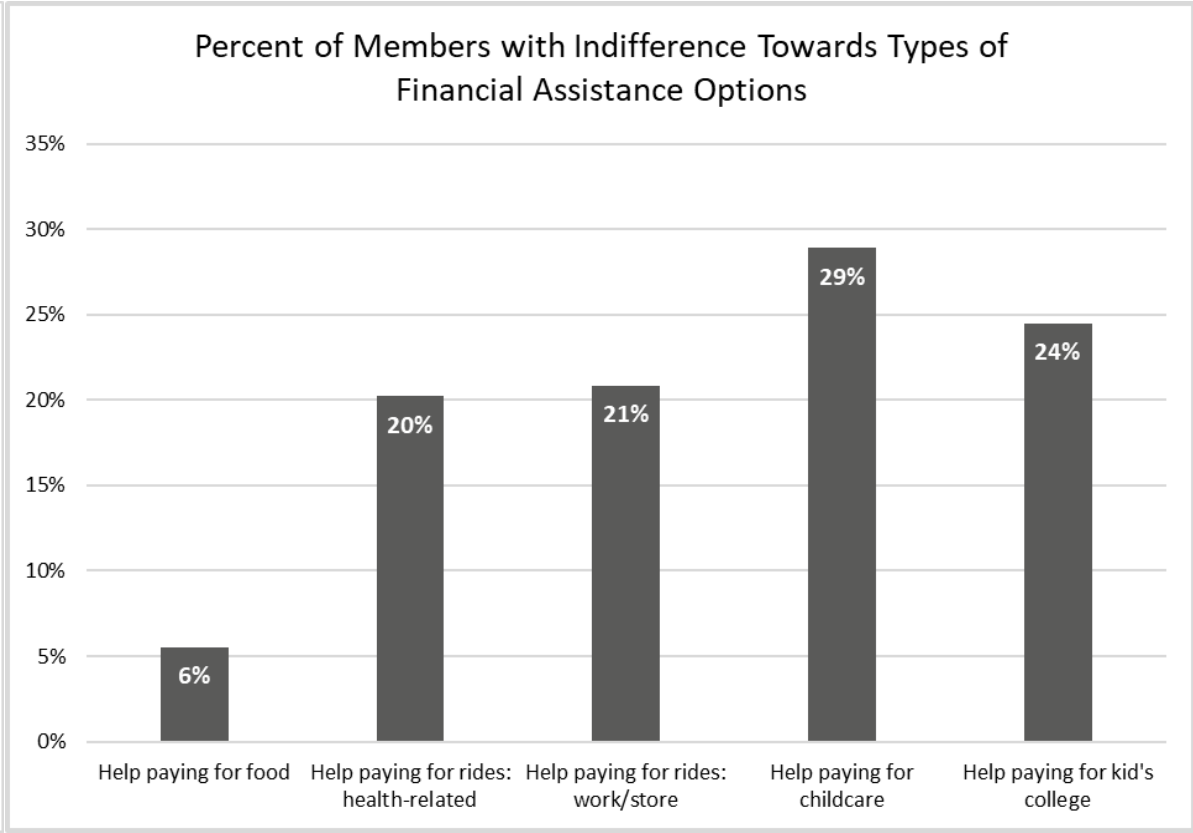
For people who endorsed food insecurity (answered “Often” or “Sometimes”), they requested help with:

- Health insurance costs such as premiums, deductibles
- Prescription drug costs
- Access to and affordability of healthy foods
- Affordability of utilities and housing assistance

PREFERENCES FOR FINANCIAL SUPPORT

Members endorsing food insecurity were asked to rank their preferences for what type of financial help would be most beneficial to them.





PROPOSED POPHI: DIRECT INVESTMENT TO ENHANCE FOOD SECURITY

Proposed PopHI Structure

- Eligible Population: FPL < 250% + Chronic Condition + Positive Screen for Food Insecurity

- Reusable card with funds loaded
- Merchant codes restricted to food retailers (inclusive of food retailers which sell other goods)

- Third party partner supports funds disbursement and survey data collection
- Participating enrollees are surveyed at regular intervals as part of funds dissemination on outcomes

- Utilization of cards as well as merchants accessed is tracked and reported on a monthly basis

DIRECT INVESTMENT TO ENHANCE FOOD SECURITY

Meets Guiding Principles

- ✓ *Equity First*
- ✓ *Direct*
- ✓ *Evidence-Based*
- ✓ *Additive*

Addresses Population Need

- ✓ *Financial insecurity and instability evident through quantitative and qualitative assessment*

Is Feasible to Implement & Measure Impact

- ✓ *Accepted metrics to track*

+/- Requires third party partner to implement

+/- Targeted outreach challenging

FEEDBACK THEMES TO DATE

2

Direct Investments to Enhance Food Security

- Support for **addressing immediate needs** and flexibility
- Consideration of **household size** and **composition**
- Inclusion of **chronic conditions** and **rising risk populations**
- Recommended **6-month lock-in** period for intervention
- Potential for **broadening the scope** of eligible purchases
- Advised **collaboration and alignment** with other programs such as CalFRESH and CalAIM via data-sharing and benefits counseling
- Support for a program with **controls** around what products members can purchase
- Support for **funding Community Based Organizations or providers** to develop culturally appropriate nutrition education programs for enrollees with poor blood control or hypertension

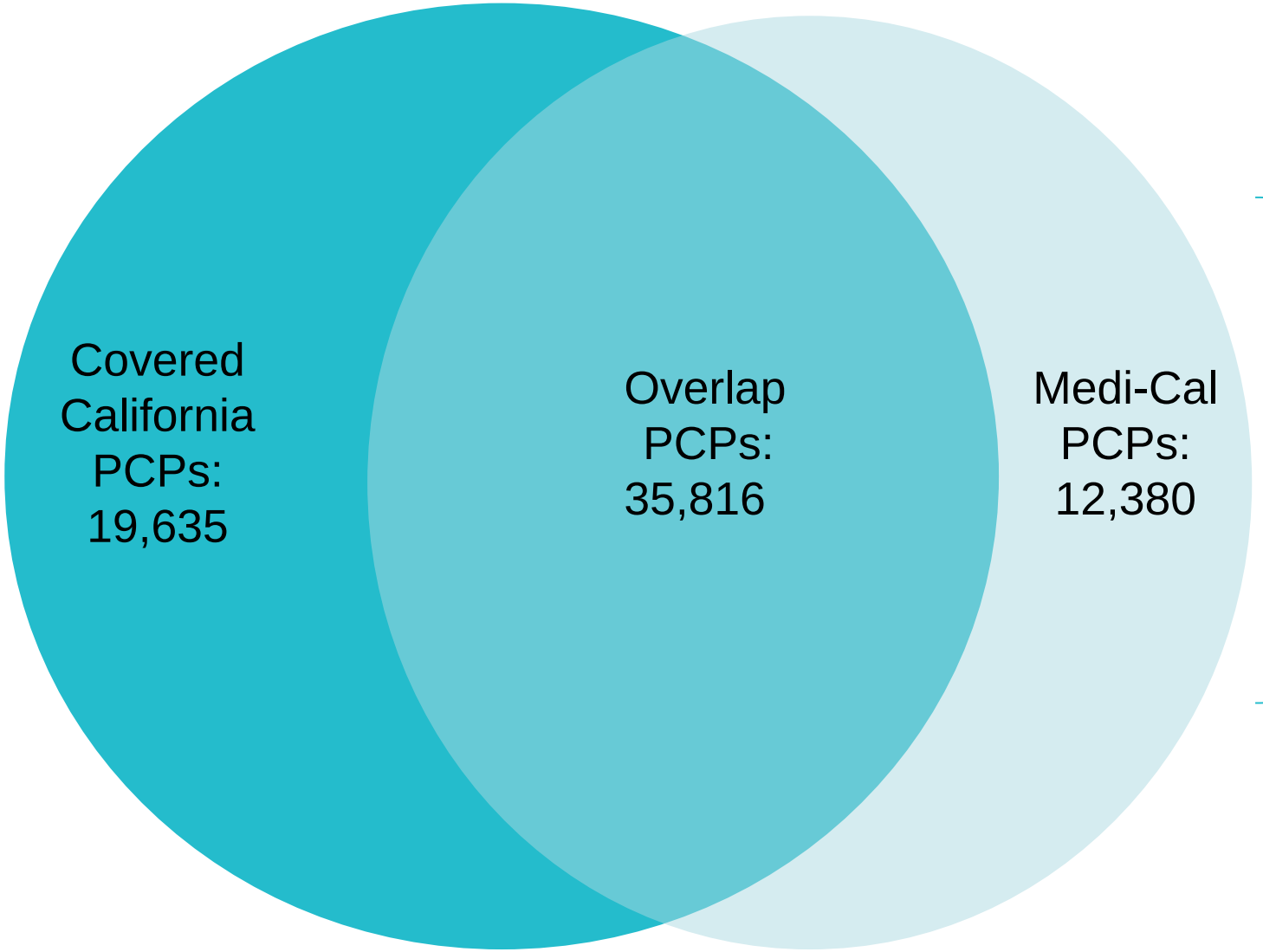
Proposed Population Health Investment: Equity and Practice Transformation

QTI 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
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
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. Screening reduces the risk of developing and dying from CRC cancer by 60-70%
Childhood Immunizations	Childhood immunizations prevent 10.5m diseases annually. For every $1 spent on immunizations, there is as much as $29 in savings

Success depends on presence of advanced primary care which is person-centered, accessible, team-based, data driven, and provides care coordination.

PRIMARY CARE PROVIDER NETWORK OVERLAP



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

Analysis used Primary Care Provider NPI from October 2023 Provider Files

MEDI-CAL EPT PROGRAM
INVESTMENT TO ADVANCE EQUITABLE CARE STATEWIDE

Goal: Improve primary care for Medi-Cal enrollees

- Advance equity
- Reduce COVID-19 driven care disparities
- Invest in upstream care models
- Fund practice transformation aligned with value-based payment models

EPT funding supports direct practice payments and technical assistance through the Learning Center to advance population health practice & outcomes in primary care

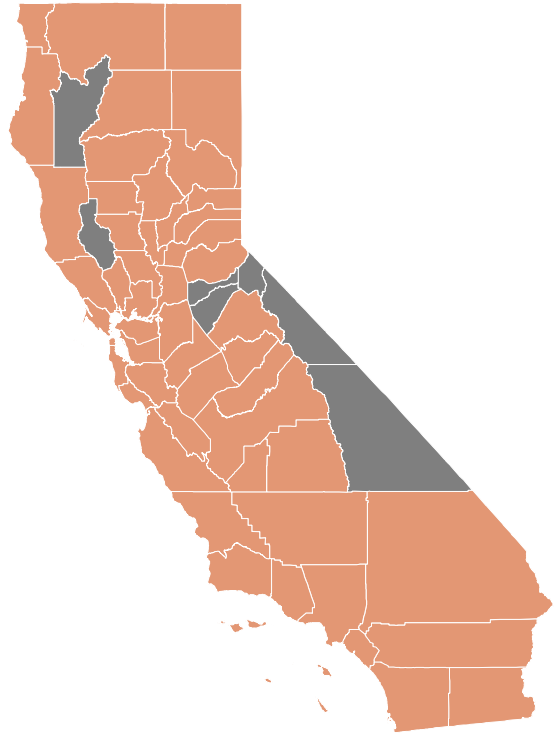
Practice transformation is achieved through:

- **Technical Assistance** to participating practices including training, tools, resources and peer learning to advance specific PHM capabilities.
- **Direct payments** to practices when program milestones are met, as evidenced by deliverables that demonstrate PHM competencies and achievement of outcomes

Practices accepted to EPT program include:

- Health Centers
- Independent Practices
- Public / County Hospitals
- Tribal Healthcare Practices

Many practices are small and in **under-resourced communities** (83% in Healthy Places Index Quartiles 1 or 2). Most CA counties are represented.



PROPOSED POPHI: EQUITY AND PRACTICE TRANSFORMATION

Proposed PopHI Structure

- Leverage EPT infrastructure to accelerate population health management capabilities in practices serving both Covered California and Medi-Cal enrollees

- Support high quality, 1:1 practice-level coaching
- Access to subject matter experts and consultants
- Participation in eLearning resource hub and regional learning communities

- Third party partner provides technical assistance at practice level
- Development of a responsive learning system to distill insights from a diverse practice cohort

- Output includes identification of factors most predictive of success as well as key infrastructure dependencies at a practice level
- Dissemination of promising models to primary care practices across the state

EQUITY AND PRACTICE TRANSFORMATION

Meets Guiding Principles

- ✓ *Equity First*
- ✓ *Direct*
- *+/- Evidence-Based*
- ✓ *Additive*

Addresses Population Need

- ✓ *Supports needed workforce investments and point of care transformation*

Is Feasible to Implement & Measure Impact

- ✓ *Aligned with DHCS, infrastructure in place*
- *+/- Measures of success for impact*

FEEDBACK THEMES TO DATE

3

Equity and Practice Transformation

- Concern regarding the **long-term sustainability** of efforts
- Importance of **avoiding duplication** of efforts with other organizations and initiatives and support for **partnering with existing entities**
- Push to focus on **high volume Covered California member practices** but also those who need investment based on underperformance on metrics
- Importance of collecting and tracking **provider demographic data**
- Concerns around ensuring **provider engagement**
- Encouragement for **clarity on metrics** and measures used to track success
- Interest in examining list of participating practitioners to determine whether scale will have **impact on QTI outcomes**
- Support for including providers already participating in **other initiatives** such as California Advanced Primary Care Initiative

Proposed Population Health Investments Summary

PROPOSED 2025 POPULATION HEALTH INVESTMENTS

1

Early Investments in Childhood Health and Wellness

- Funds deposited directly into CalKIDS Child Savings Account to incentivize timely vaccination and well-child visits
- Targets families with newborns enrolled in Covered California and children under 2 years old

2

Direct Investments to Enhance Food Security

- Reusable cards loaded with funds available for use at grocery stores and other retailers with food facilitated by a third-party for disbursement and data collection.
- Targets Covered California members with income levels below 250% of the Federal Poverty Level (FPL), with a chronic condition, and identified as food insecure

3

Equity and Practice Transformation

- Funds will accelerate adoption of practice transformation through high-quality, 1:1 coaching, subject matter expertise, and foster sustainable practice change and disseminate innovative models statewide.
- Targets primary care practices enrolled in DHCS EPT program and serving Covered California enrollees

MODIFICATIONS BASED ON FEEDBACK

1

Early Investments in Childhood Health and Wellness

- Exploring enhanced reporting capabilities to allow QHP issuers visibility into enrolled members
- Curating a resource guide for relevant non-Covered California operated benefits and programs
- Working with Covered California Community Engagement team on regional partnerships
- Adding in a financial coaching arm

2

Direct Investments to Enhance Food Security

- Household size adjustment being built into design
- Exploring enhanced reporting capabilities to allow QHP issuers visibility into enrolled members
- Curating a resource guide for relevant non-Covered California operated benefits and programs
- Working with Covered California Community Engagement team on regional partnerships

3

Equity and Practice Transformation

- Obtaining more detailed practice-level information and decision framework before selecting practices
- Explore informal conversation with EPT practice leadership on remaining needs and gaps
- Re-articulate desired impact and output of Covered California driven investment in EPT focused on practice profiles and predictive factors for success on QTI measures that can be scaled in future

EVALUATION OF POPULATION HEALTH INVESTMENTS

- Design of PopHI includes ability to randomize, control groups of sufficient size to power outcomes, and data collection to enable rigorous evaluation and output suitable for peer-review journal publication
- Partnerships for qualitative and quantitative assessment of impact currently in place with:
  - UCSF Social Intervention Research and Evaluation Team
  - UCLA Medical-Financial Partnership program

PROPOSED METRICS

Early Investments in Childhood Health and Wellness

Pediatric Care

- Completion of Vaccines - By Vaccine Series & Combo-10 Metric Overall
- Up-to-Date Vaccination Status At Key Child Ages
- Pediatric Primary Care Visit Attendance (on Periodicity Schedule)
- Retention in Care & Insurance Coverage

Parent/Caregiver Outcomes

- Self-Efficacy
- Health Status, including Mental Health
- Educational Expectations
- Financial Health and Well-Being

Child Outcomes

- Rate of Developmental Delay
- Socio-Emotional Development
- Early Relational Health

Direct Investments to Enhance Food Security

Health Outcomes

- Self-reported physical, emotional and mental health
- Healthy Days at home
- Depression as measured by PHQ9 (or PHQ2)
- Disease Self-Management
- Impact of medication use

Wellbeing Outcomes

- Individual and household stress
- Self-efficacy
- Impact on household finances; financial trade-offs
- Impact on employment

Health Care Utilization and Cost

Equity and Practice Transformation

Practice Self-Reported Data

- Population Health Management Capabilities, including
  - Leadership and culture
  - Data infrastructure
  - Financial performance
  - Empanelment and access
  - Team-based care
  - Population-based care
  - Behavioral and social health
- EPT milestones

Quality Outcomes

- HEDIS measures, including the 4 QTI measures

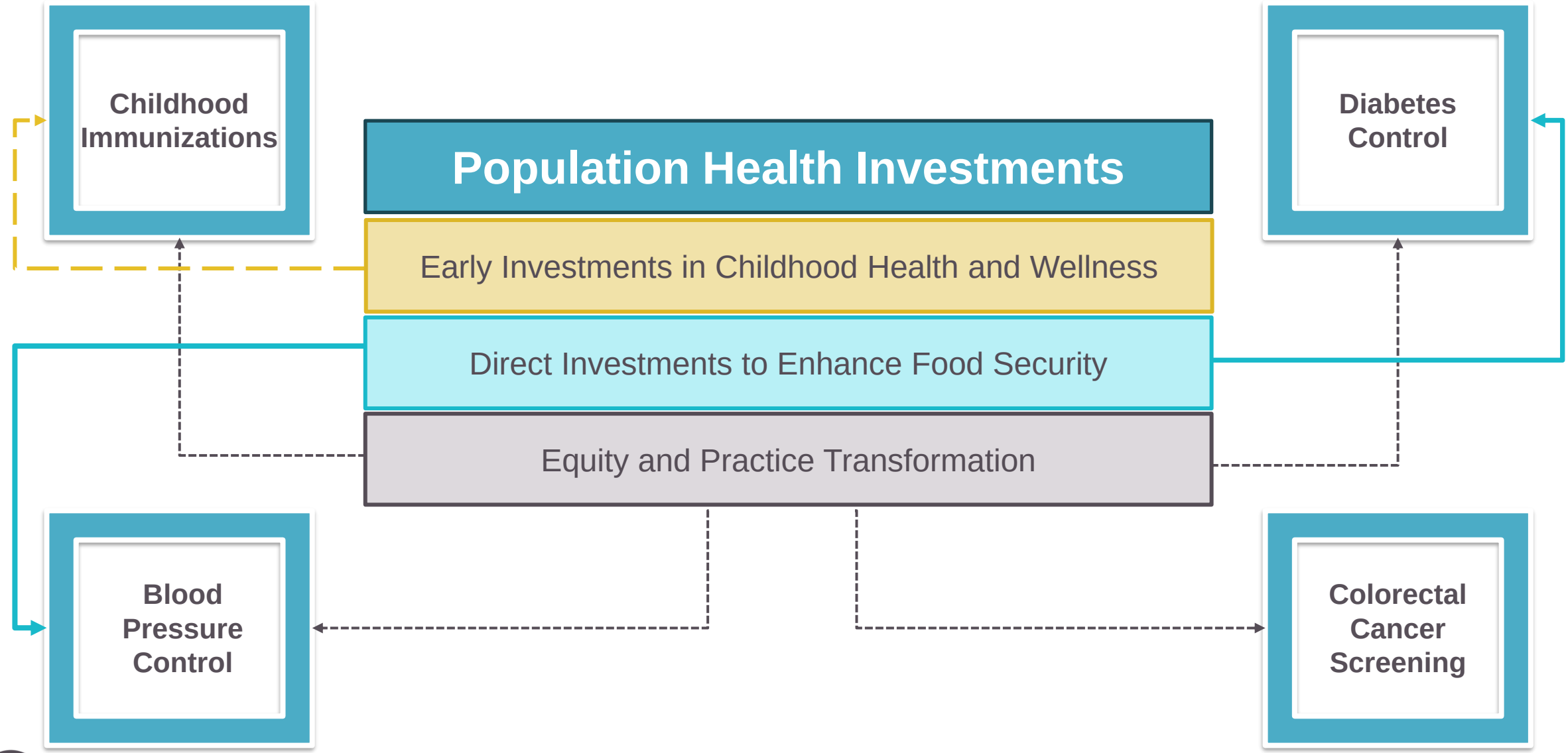
Engagement

- Participation in technical assistance offerings
- Utilization of eLearning Resource Hub

Experience

- Surveys administered to participating EPT practices and individuals
- Workforce well-being

MOVING THE NEEDLE ON QUALITY



PORTFOLIO APPRAISAL

Meets Guiding Principles

- ✓ *Equity First*
- ✓ *Direct*
- ✓ *Evidence-Based*
- ✓ *Additive*

+

Addresses Population Need

- ✓ *Supports members, providers, and QHP issuers*

+

Is Feasible to Implement & Measure Impact

- ✓ *Feasible*
- ✓ *Measurable*

Population Health Investments are aligned with DHCS/Medi-Cal's Initiatives such as Community Reinvestment and Community Supports

PUBLIC MATERIALS

- Written comments can be sent to EQT@covered.ca.gov
- Materials have been posted at: https://hbex.coveredca.com/stakeholders/plan-management/qti/

UPCOMING POPHI ADVISORY COUNCIL MEETINGS

Dates

- August 19th 1:30 pm – 3:00 pm PT

Population Health Investment Implementation

TIMELINE

Aug 2024

Proposed PopHI will be presented at the August Covered California Board meeting

Fall 2024

QHP issuers will be required to start establishing contracts with PopHI

Oct – Nov 2024

QTI Performance Reports Released

Covered California prepares and releases QTI performance reports and PopHI directives

Dispute Process

QHP issuers may dispute QTI performance Report within 60 days of receipt

Dec – Jan 2025

Payment Deadline

QHP issuers have 60 days upon receipt of final QTI performance reports to follow instructions in the PopHI directives for QTI payments

Jan – Feb 2025

QTI Payments Submitted

Funds will be transmitted from QHP issuers as outlined by PopHI directive

UPCOMING POPHI MILESTONES FOR QHP ISSUERS

Aug 2024	• Proposed PopHI for 2025 will be presented to Covered California Board
Aug - Sept 2024	• Covered CA<>QHP Issuer 1:1 Meetings
Sept - Oct 2024	• QRS Final Scores and Percentiles released by CMS
Oct - Nov 2024	• QTI Performance Reports will be released for each QHP Issuer • PopHI Directives released to each Issuer (which will include instructions for transmitting QTI Payments to PopHIs)
Oct 2024 - Jan 2025	• QHP Issuers will establish contract(s) if desired with third-party partners for relevant PopHI
Nov - Dec 2024	• Dispute period for QHP Issuers
Feb 2025	• QTI funds flow from QHP Issuers to PopHIs as directed by Covered California

2026 Contract Redlines:
Guiding Principles and Strategic Focus Areas

Taylor Priestley
Director EQT & Health Equity Officer

EQT Approach to 2026-2028 Contract Update

Our approach is guided by:

- Building on strong foundation of 2023-2025 contract development work
- Prioritizing alignment
- Emphasizing outcomes
- Pursuing administrative simplification

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

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

2026 Contract Development Guiding Principles

Equity is quality

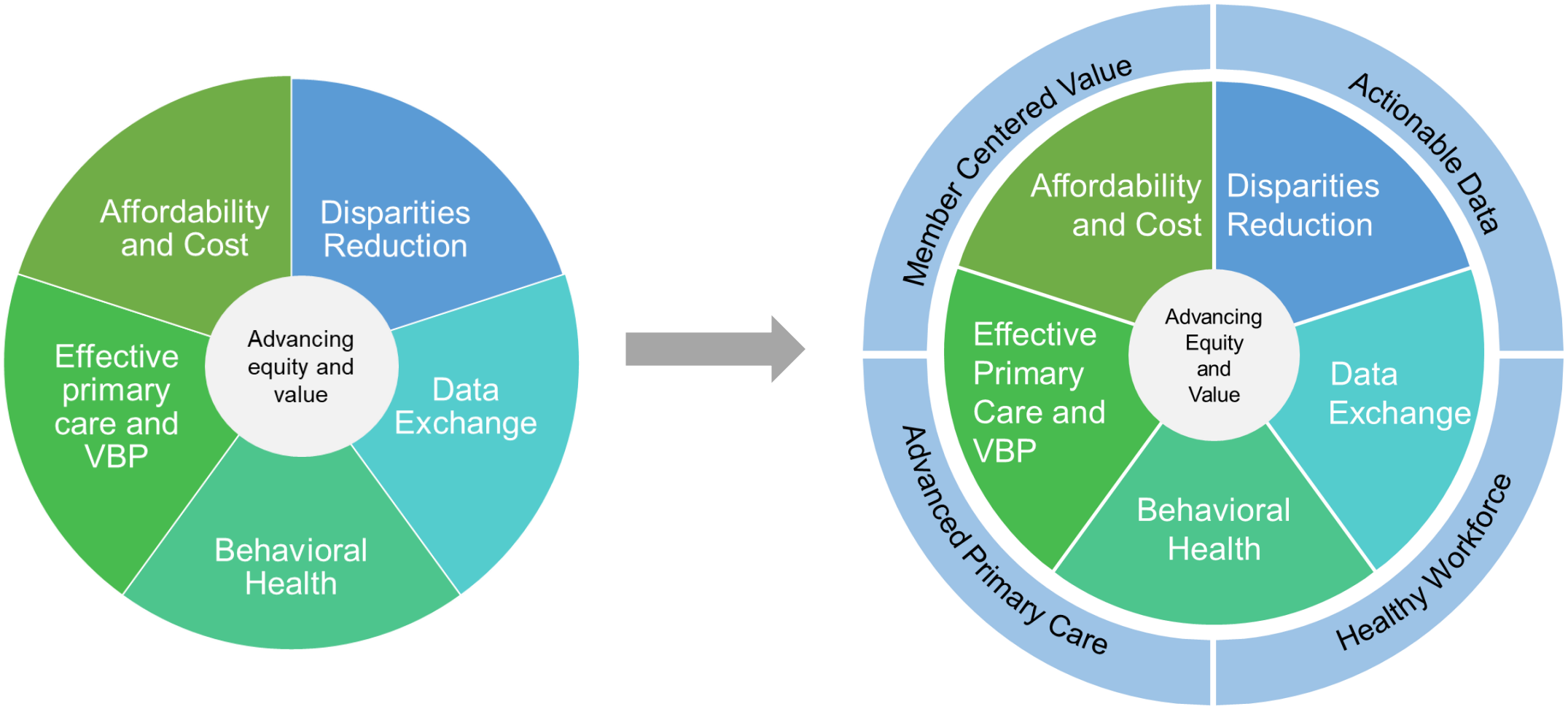
Center the member

Make it easy to do right

Amplify through alignment

Focused scope for high impact

2026-2028 Strategy Builds Upon 2023-2025 Focus Areas



2023-2025

2026-2028

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

EQT Team

COVERED CALIFORNIA

PROPOSED 2026-28 25/2/2 PROGRAM REQUIREMENTS

Model Contract Article 5 – Removal from the Exchange

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

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

Issuer Model Contract- Removal from the Exchange

- Multiple Issuers requested more details about inclusion of new measures and static benchmark year selection
- Multiple Issuers expressed support for updated benchmark year and inclusion of new QRS clinical measures in benchmark and composite scoring
- Multiple Issuers requested more details on the proposed requirement for Minimum Performance Level (MPL) action plans for individual measure scores beneath the 25th percentile for two consecutive years
- While one Issuer expressed support for proposed MPL action plan requirement, multiple Issuers expressed concerns regarding redundancy between individual measure expectations and composite performance assessments, advocating that the composite score sufficiently highlights performance gaps
- One Issuer suggested use of phased requirements prior to requiring MPL Action Plans for individual measure scores
- Advocates and Issuers expressed a shared desire for healthcare quality improvement and alignment with national standards as a commitment to patient centered care

PROPOSED 2026-28 ACCESS REQUIREMENTS

Model Contract Article 5 – 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 regulator, 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 5 – Access

- Public purchasers and a Provider Association expressed support for continued alignment on Access measurement and monitoring initiatives
- Multiple Issuers recommend aligning measures and monitoring approaches with DHCS and DMHC, cautioning against establishing potentially redundant or conflicting requirements
- Multiple Issuers requested clarifications, including:
  - How provider utilization rates will indicate patient access issues
  - If contracted health plans will receive secret shopper survey results as well as if penalties are at risk for survey results
  - How Access monitoring aligns with requirements from DMHC and CMS/NBPP
- One Issuer requested flexibility for plans to set policies for the provider-to-member ratio when applied to specialty providers (e.g. based on utilization)
- One Issuer requested significant lead time for HEI data testing and reporting
- One Issuer recommended collection of 2 years of baseline data prior to establishing plan-wide benchmarks for active providers

PROPOSED 2026-28 ACCESS CHANGES

Model Contract Article 5 – Access

Notable Changes to Draft	Rationale
Provider Availability and Accessibility For access and network measures generated from Covered California's Healthcare Evidence Initiative (HEI), two years of data collection will be pursued before setting any benchmarks	Learning and exploration mindset critical for any new measures
Service Utilization and Quality Any new survey, including secret shopper effort, will be done in alignment with DMHC and other public purchasers	Desire to limit administrative burden and create across-state alignment on access monitoring strategy

PROPOSED 2026-28 ECP REQUIREMENTS

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

- Issuers must meet ECP General Standard by maintaining a network with includes a sufficient geographic distribution of care to provide reasonable and timely access to low-income populations, individuals living in Health Professional Shortage Areas (HPSAs) and medically underserved individuals
- ECP General Standard Sufficiency Requirements:
  - Issuers must demonstrate sufficient geographic distribution of a mix of essential community providers reasonably distributed throughout the geographic service area
  - Issuers must demonstrate providers agreements with at least 15% of 340B non-hospital providers in each rating region in which it offers QHPs
  - Issues must demonstrate agreements with at least one ECP hospital per county requirement or per rating area in counties with multiple rating regions
- Issuers in an integrated delivery system may request the ECP alternative standards and must demonstrate compliance by mapping low-income and HPSA member populations and network providers and facilities offering services in all ECP categories

2026-28 ECP PUBLIC COMMENT KEY THEMES

Model Contract Article 4 – Essential Community Providers Requirements

- Multiple commenters requested further clarity to hospitals types to better outline the ‘Hospital’ categories under ECP
- Multiple Issuers expressed general support of the addition of HCAI workforce grant recipients as ECPs, with multiple Issuers requesting to review the HCAI workforce grant recipients
- One Issuer expressed support for certain providers in HPSAs as ECPs
- Multiple Issuers request additional details on the process to identify:
  - Providers with a minimum percentage of Medi-Cal members
  - Providers located in Healthy Places Index (HPI) Quartiles 1 and 2
  - Geographic areas and hospital contracting requirements
- One Issuer requested at least one year to comply with new ECP requirements once finalized and an updated ECP list twice per year instead of annually

Attachment 1 Advancing Equity, Quality, and Value

EQT Team

PROPOSED 2026-28 ATTACHMENT 1 REQUIREMENTS

Article 1: Equity and Disparities Reduction

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

2026-28 ATTACHMENT 1 PUBLIC COMMENT KEY THEMES

Article 1: Equity and Disparities Reduction

- Multiple Issuers and Public Purchasers expressed support for collection of SOGI data
- One Issuer expressed support for updated PLD File measures
- Multiple Issuers requested additional details and clarifications of PLD File requirements and HEI measures
- Multiple Issuers expressed concerns with potential administrative workload pertaining to updated reporting templates and expanded measures for HEI and PLD data.
- One Issuer expressed concerns with expectations that Enrollee sub-population measure results meet the 66th percentile threshold as part of QTI health equity accountability
- One Issuer expressed support for NCQA Health Equity Accreditation requirement

PROPOSED 2026-28 ARTICLE 2 REQUIREMENTS

Article 2: Behavioral Health

- 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
- Promote access to behavioral health services and offer telehealth for behavioral health services
- Address disparities in behavioral health utilization by deploying disparities reduction strategies based on stratified utilization data and informed by engagement with impacted member populations
- Monitor behavioral health and virtual behavioral health care quality through monitoring utilization and submission of selection criteria for behavioral health care vendors
- Provide staff cultural humility training and deploy culturally tailored materials and strategies for historically marginalized groups
- 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
- Report promotion of integration of behavioral health services with medical services
- 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.

2026-28 ARTICLE 2 PUBLIC COMMENT KEY THEMES

Article 2: Behavioral Health

- Many Issuers and public purchasers expressed strong support for reducing disparities and stigma in behavioral health, including the implementation of culturally tailored interventions to address disparities, along with the adoption of a 'Back to Basics' approach.
- Multiple Issuers requested clarification of proposed requirement to submit more current provider network data with NCQA Network Management reports, and some Issuers expressed concern about potential added administrative burden and duplication of data submissions
- Multiple Issuers expressed concerns with anticipated complexity and administrative burden of complying with proposed vendor selection criteria reporting requirements
- Multiple Issuers requested clarification of expectations for use of culturally tailored depression screening tools and practices
- Many Issuers and public purchasers expressed agreement with expanded SUD focus and proposed monitoring of stratified results for Initiation and Engagement of Substance Use Disorder (IET) and Follow-Up After Hospitalization for Mental Illness (7-Day and 30-Day Follow-Up) measures
- One Issuer recommended monitoring of Follow-up After Hospitalization for Substance Use Disorder (FUA) measure instead of IET for alignment with DHCS and due to challenges improving IET rates

PROPOSED 2026-28 ARTICLE 2 CHANGES

Article 2: Behavioral Health

Notable Changes to Draft Attachment 1	Rationale
Promoting Access to Behavioral Health Services Revised requirement to use the Advancing Health Equity Roadmap to Advance Health Equity	While Issuers are encouraged to use the Road Map to Reduce Health Equity, contract language will not require use of this tool in design and implementation of interventions that best address identified disparities
Substance Use Disorders Expansion of Substance Use Disorder to include Tobacco Cessation	Moved from Article 3 Population Health

PROPOSED 2026-28 ARTICLE 3 REQUIREMENTS

Article 3: Population Health

Population Health Management

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

Health Prevention and Promotion

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

PROPOSED 2026-28 ARTICLE 3 REQUIREMENTS

Article 3: Population Health

Supporting At-Risk Enrollees Requiring Transition

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

Social Health

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

PROPOSED 2026-28 ARTICLE 3 REQUIREMENTS

Article 3: Population Health Management

Use of Generative Artificial Intelligence in Qualified Health Plan Issuer Operations

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

2026-28 ARTICLE 3 PUBLIC COMMENT KEY THEMES

Article 3: Population Health

Health Promotion and Prevention

- Multiple Issuers support the removal of reporting requirements and reducing administrative burden related to offering health promotion and prevention programs

Supporting At-Risk Enrollees Requiring Transition

- Several Issuers advocated use of established guidelines and flexible timing to manage care transition activities for Enrollees in regions experiencing service reductions

Social Health

- Several Issuers requested clarification of SNS-E measure reporting method
- One Issuer expressed support for continued SNS-E measure and screening process reporting
- One Issuer raised concerns regarding the coding and data collection challenges for SNS-E, particularly for intervention rates, and advocated total population reporting only rather than stratified reporting

2026-28 ARTICLE 3 PUBLIC COMMENT KEY THEMES

Article 3: Population Health Management

Use of Generative Artificial Intelligence in Qualified Health Plan Issuer Operations

- Multiple Issuers requested more detail on proposed reporting requirements and one Issuer recommended reduced proposed annual reporting due to concerns with administrative burden
- Several Issuers commented that plans are in various stages of development and implementation of GenAI use cases
- One Issuer commented that plans require autonomy in developing governance approaches
- Multiple Issuers urged alignment with regulatory requirements and broader industry efforts and collaboration across issuers in implementing proposed contract requirements

PROPOSED 2026-28 ARTICLE 3 CHANGES

Article 3: Population Health: Supporting At-Risk Enrollees Requiring Transition

Notable Changes to Draft Attachment 1	Rationale
Submission of Transition Plan Added clarifying language about processes to complete file transmissions for Enrollees and adherence to timeline as specified in federal guidelines (28 CCR 1300.65.1(a)(2)(C), (D).)	This language clarifies requirements and timing for file transmissions.

PROPOSED 2026-28 ARTICLE 3 CHANGES

Article 3: Population Health: Use of Generative Artificial Intelligence in Qualified Health Plan Issuer Operations

Notable Changes to Draft Attachment 1	Rationale
Addition of language around Patient Care Decision Support Tools in accordance with 45 C.F.R § 92.210	▪ Aligning the contract to the 1557 Rule's new definition and requirements for Patient Care Decision Support Tools, which are appropriate for Covered California programs' use of technology. The interplay between HTI-1 and 1557 is discussed in the preamble to the Rule. ▪ Regulations are inclusive of, but not limited to, GenAI
Narrow focus of use case reporting requirements to center on instances where GenAI impacts a decision to authorize, modify, or deny health care services	▪ Aligns with UM statute ▪ Shifts focus to transparency on clinical use cases with most direct impact on health care access and outcomes

PROPOSED 2026-28 ARTICLE 4 REQUIREMENTS

Article 4: Delivery System and Payment Strategies to Drive Quality

Advanced Primary Care

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

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

PROPOSED 2026-28 ARTICLE 4 REQUIREMENTS

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

Hospital Value and Safety

- Collaboration with Covered California, Issuers and Cal Healthcare Compare (CHC) on poor performing hospitals

Comprehensive Maternity Care

- Report stratified performance on maternal health and maternal mental health measures
- Participation in data aggregation, data transparency, and performance accountability partnerships

Use of Virtual Care

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

Participation in Quality Collaboratives

- Contractors must report participation in quality collaboratives

2026-28 ARTICLE 4 PUBLIC COMMENT KEY THEMES

Article 4: Delivery System and Payment Strategies to Drive Quality

Advanced Primary Care

- Several Issuers support continuing the requirement to report on the proportion of enrollees who select or are assigned a PCP though several Issuers recommend removing this requirement due to administrative complexity or assertions that this distinction is not relevant to assessing primary care
- Issuers universally support retiring the related HEI Performance Standard 9.4 from Attachment 2
- Some issuers and one advocate support proposed continuity of care assessment for advanced primary care measurement though multiple Issuers expressed concerns about the timing of benchmarks and a need for further research or testing for continuity measures.
- Diverse stakeholders are broadly optimistic about aligning spending and investment targets with OHCA and adopting its reporting methodologies and benchmarks.
- All commenters support the removal of prior performance standards 5 Primary Care Payment & 6 Primary Care Spend.
- Some Issuers expressed concerns regarding the measurement of alternative payment models and called for adjustments to accurately track and enhance primary care investment.

2026-28 ARTICLE 4 PUBLIC COMMENT KEY THEMES

Article 4: Delivery System and Payment Strategies to Drive Quality

Networks Based on Value

- Issuers unanimously approve of removing IDS & ACO reporting requirements while advocates suggest reconsideration and further work to enhance the approach to tracking and measuring
- Collective support for retirement of Attachment 2 Performance Standard 7
- Most issuers expressed support for alignment with OHCA for network spend reporting and promoting Alternative Payment Models (APM) but are concerned about efficiency of standardized reporting across plans and products. Multiple Issuers also requested more information on detailed requirements and benchmarks.

Hospital Value and Safety

- Some issuers praised the shift from individual hospital interventions toward collaborative convening for poor performing hospitals while a few Issuers suggest that internal efforts are more effective.
- Issuers unanimously approve of retiring reporting requirements for hospital payments based on quality and value while advocates suggest reconsideration and further work to enhance the approach to tracking and measuring.

Comprehensive Maternity Care

- Some Issuers expressed support for participation with Cal Healthcare Compare but seek more detail regarding participation and cost, while some Issuers recommended not requiring this participation.
- Advocates and several Issuers applaud alignment with DHCS initiatives and doula tracking. Multiple Issuers expressed concerns with operationalizing proposed requirements, emphasizing the need for further clarification of reporting requirements.

2026-28 ARTICLE 4 PUBLIC COMMENT KEY THEMES

Article 4: Delivery System and Payment Strategies to Drive Quality

Use of Virtual Care

- One issuer expressed concern about reporting and NCQA Accreditation.
- One issuer expressed concern about effort involved in creation of HEI reports.

Participation in Quality Collaboratives

- Responding Issuers agree with reducing the list of required collaboratives, identifying a variety of collaboratives as highest value. Some recommendations to provide a menu of choices and have a threshold level of participation required.
- One quality collaborative recommended use of criteria to define a quality collaborative and issuer participation.
- Several Issuers expressed continued concerns with cost of participating in collaboratives, both financial and time required, and requested inclusion of low- and no-cost collaboratives to select.
- Mixed feedback on inclusion of proposed related performance standard and use of penalties to subsidize membership.

PROPOSED 2026-28 VIRTUAL CARE CHANGES

Article 4: Delivery System and Payment Strategies to Drive Quality

Notable Changes to Draft Attachment 1	Rationale
Advanced Primary Care Continuity of care measure will not have a benchmark set until at least two years of reporting	While the continuity of care measure is a validated measure (NQF # 3617) and is predictive of reduced mortality, reduced acute care utilization and lower cost, Covered California appreciates that a learning environment is needed before attaching penalties.
Participation in Quality Collaboratives Covered California will not mandate specific quality collaboratives but will require reporting on participation in quality collaboratives.	Covered California appreciates that issuers may have specific strategic initiatives and partnerships that advance their internal goals and are less applicable to all issuers. Covered California continues to encourage participation in quality collaboratives and will participate as a purchaser in efforts that have broader impacts for the health, access or affordability of care for all Californians. Covered California will continue to require participation in the data aggregation, data transparency and performance accountability organizations that have other requirements throughout the contract.

PROPOSED 2026-28 ARTICLE 5 REQUIREMENTS

Article 5: Measurement and Data Sharing

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

2026-28 ARTICLE 5 PUBLIC COMMENT KEY THEMES

Article 5: Measurement and Data Sharing

- Issuer and public purchaser expressed support for alignment of Data Exchange Framework and Medi-Cal expectations
- Unanimous agreement among commenters supporting proposed changes

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

- One Issuer expressed support for proposed requirement to submit NCQA Corrective Action Plan regardless of status change

Attachment 2 Performance Standards with Penalties

EQT

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

- Multiple Issuers agreed with removal of performance standards on primary care payment, primary care spend, networks based on value, and QRS enrollee experience summary indicator.
- One Issuer requested clarification on Health Equity Accreditation accountability if removed from Performance Standards.
- Multiple Issuers requested more details on Engagement in Collaboratives assessment criteria including if Covered California would specify which collaboratives are required or if there would be a menu of options to chose from with a minimum threshold
- Broad support for simplification of Performance Standard 9 – HEI data submission, but advocacy for longer timelines given data replacement and build complexities. One issuer expressed concern about the proposed 40% weighting for this performance standard.
- Multiple Issuers cautioned on setting benchmarks for continuity of care given newly being assessed.

PROPOSED 2026-28 ATTACHMENT 2 CHANGES

Notable Changes to Draft Attachment 2	Rationale
Performance Standard 3 - updated to Collaboration Across Issuers and with Community Covered California will assess attendance and engagement in scheduled learning sessions, cross-issuer collectives, community engagement events, clinical leaders' forum, CMO roundtables, and carrier calls. Proposed performance threshold is >/= 80% participation and engagement annually.	Covered California believes that cross-issuer convenings, which are low barrier to entry and participation, are critical to improve health outcomes, access and affordability for all Californians. Additionally, ensuring issuers are engaging with their enrollees as well as community-based organizations is critical to spur member-centered innovation.
Performance Standard 8 - Utilization & Primary Care: Monitoring Continuity of Care For continuity of care measure, penalty for MY2026 and MY2027 will be connected to QHP issuer participation in review of Covered California generated HEI output and engagement as well as establishment of a benchmark if appropriate. Performance on measure will only be assessed for MY2028 at the earliest.	While the continuity of care measure is a validated measure (NQF # 3617) and is predictive of reduced mortality, reduced acute care utilization and lower cost, Covered California appreciates that a learning environment is needed before attaching penalties for performance.

PROPOSED 2026-28 ATTACHMENT 2 CHANGES

Notable Changes to Draft Attachment 2	Rationale
Performance Standards 5 Pediatric Oral Evaluation & 6 Pediatric Topical Fluoride for Children Issuers must establish non-zero baseline rates for these measures.	▪ Covered California is unable to assess Performance Standards 5 & 6 when there are 0 claims nor encounters being transmitted ▪ Covered California is unable to produce dental quality metrics when the number of claims or encounters that is transmitted is 0.

Attachment 4 Quality Transformation Initiative

EQT

PROPOSED 2026-28 ATTACHMENT 4 REQUIREMENTS

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

2026-28 ATTACHMENT 4 PUBLIC COMMENT KEY THEMES

QTI Measure Set & Benchmarks

- Mixed response to continuing with CIS-10
  - One Issuer and one Consumer Advocate support retaining CIS-10
  - Majority of responding Issuers support switching to either Combo 3 or Combo 7
  - Few responding Issuers support switching to Well Child Visits
- Issuers universally and one public purchaser support maintaining Pharmacotherapy for Opioid Use Disorder (POD) as reporting only
  - One Issuer also recommended measure change to Use of Opioids at High Dosage or Annual Monitoring for Persons on Long-Term Opioid Therapy
  - One responding purchaser also supported keeping POD as reporting only
- Half of responding QHP issuers supported no ramp up period for QTI amount at risk for new entrants to the Exchange
  - Few responding issuers had no comment
  - One Issuer supported a ramp up period for new entrants
- Half of responding QHP issuers requested a reset percentage at risk back to 0.8% with new contract cycle

PROPOSED 2026-28 ATTACHMENT 4 CHANGES

QTI Measure Set and Benchmarks

Notable Updates to Draft Attachment 4	Rationale
QTI Scored Measures: ▪ No changes to the core measures, but the 5 measures will not be equally weighted with 75% of the amount at risk divided across diabetes control, blood pressure control and colorectal cancer screening	▪ Given the mixed feedback on measure substitution and the significant importance of remaining alignment across DHCS/Medi-Cal, CalPERS, DMHC and other state-wide initiatives, CIS-10 will remain a measure. However, given the smaller denominator sizes for CIS-10 and DSF-E they will be weighted lower than the remaining 3 measures.
Amount at Risk for Newly Contracted QHP Issuers: ▪ Newly contracted QHP issuers to start at 1% premium at risk in year 1 of QTI eligibility	▪ To support new QHP issuers during their first year of QTI eligibility and mitigate the steep onboarding challenges. ▪ This adjustment acknowledges that long-standing issuers had years to prepare for QTI before it was fully implemented.
Amount at Risk for Currently Contracted QHP Issuers: ▪ Amount at risk for QHP issuers already eligible for QTI will be up to 2.8 percent of premium for MY2026 and then up to 3.8% of premium for MY2027 and 2028 ▪ Variable weighting by measure with lower weight for measures with small denominator sizes and high variability in performance (i.e., CIS-E and DSF-E)	▪ The maximum amount at risk for MY2026 will be 2.8% of premium recognizing the importance of disparities reduction and the fact that there can be no quality without equity. Additionally, Covered California intends to continue the CIS-10 allowance initiative which generated substantial savings for issuers. At Covered California's discretion, however, a lower amount than 2.8% may be deployed pending additional insights from the transition to ECDS measures and the inclusion of DSF-E. ▪ Given the decision to continue with CIS-10, but the small denominator sizes for CIS-10 and DSF-E, the 5 QTI measures will not be equally weighted

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.

QDP Attachment 2
2026 Amendment

EQT

PROPOSED 2026 ATTACHMENT 2 CHANGES

Performance Standard 1

Notable Changes to Draft Attachment 2	Rationale
▪ Consolidate all components of current PS 1 into one performance standard ▪ Assess performance using a unified and comprehensive methodology document that outlines all timely and complete data expectations ▪ Incorporate use of Corrective Action Plan (CAP) to address gaps in HEI data submissions when assessed against methodology	▪ HEI data should be submitted to support high priority use cases to assess quality ▪ For every Issuer, potential data gaps are different and distinct ▪ This approach aligns with proposed approach for QHP Issuer 2026-2028 Att 2 PS 4

Wrap-up and Next Steps

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

2026 MODEL CONTRACT DRAFTS & PUBLIC COMMENT

- 2026-2028 QHP Individual and CCSB Contract Drafts, 2024-2026 QDP Contract Drafts, and Comment Templates will be posted to HBEX Friday, August 16, 2024: https://hbex.coveredca.com/stakeholders/plan-management/contract-listings/2026/
- Stakeholders will have until COB, **Monday, September 16, 2024,** to provide comments on all contract documents.

Any questions please email PMDContractsUnit@covered.ca.gov

2026-2028 CONTRACT UPDATES

Tara Di Ponti
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Plan Management Division
Health Equity & Quality Transformation Division

2026-28 CONTRACT UPDATES

Covered California is updating the Qualified Health Plan (QHP) Issuer Contracts for the Individual and Covered California for Small Business (CCSB) markets for a new contract duration of 2026-2028, as well as amending the 2024-2026 Qualified Dental Plan (QDP) Issuer Contract for the Individual and CCSB markets.

- Minimal content updates have been made to the Model Contracts (excluding Section 4.3.4 Essential Community Providers and Article 5 – Advancing Equity, Quality, and Value), with general updates throughout for clarity, accuracy, and alignment where applicable:
  - 2023-2025 QHP Individual Issuer Model Contract
  - 2023-2025 QHP CCSB Issuer Model Contract
  - 2024-2026 QDP Issuer Model Contract
- Attachment 3 for all contracts
  - Currently no content updates made
- The Health Equity and Quality Transformation Division (EQT) will provide updates for the Model Contract sections 4.3.4 & Article 5, Attachment 1, 2, and 4.

SUMMARY OF PROPOSED 2026-28 QHP MODEL CONTRACT UPDATES

2023-25 Current Requirements	2026-28 Proposed Requirements
QHP Individual, QDP **3.2.1.2 Contractors Activities to Promote Enrollment** Contractor shall support marketing and enrollment efforts such as: a.) Following Covered California making the technology available and within a reasonable time after the receipt of notice from Covered California about the technology, and determination of its compatibility with Contractor's system, Contractor shall prominently display the Shop and Compare tool on its website.	**QHP Individual, QDP** **3.2.1.2 Contractors Activities to Promote Enrollment** Contractor shall support marketing and enrollment efforts as follows: a.) Contractor shall prominently display a link to the Covered California website landing page, https://www.coveredca.com/, on its website, in a location that is easily accessible to consumers.
QHP Individual, QDP **4.1.4 Operational Requirements and Liquidated Damages** d) iii. Upon request, Contractor shall provide technical documentation to Covered California within fifteen (15) Days or as specified by Covered California. Technical documentation includes: Contractor's system lifecycle and release schedules, testing plan, system specification documents related to Contractor's integration and interface with the CalHEERS system, or other technical documentation as requested by Covered California.	**QHP Individual, QDP** **4.1.4 Operational Requirements and Liquidated Damages** d) iii. Upon request, Contractor shall provide technical documentation to Covered California within fifteen (15) Days or as specified by Covered California. Technical documentation includes: Contractor's system lifecycle and release schedules, testing plan, system specification documents related to Contractor's integration and interface with the CalHEERS system, Reconciliation and Dispute Process documentation, or other technical documentation as requested by Covered California.
Not Applicable	**QHP Individual, QHP CCSB** **4.2.7 Hearing Aid Coverage for Children Program** a) Contractor shall provide information to Enrollees regarding the availability of the California Department of Healthcare Service's (DHCS) Hearing Aid Coverage for Children Program (HACCP) within its Evidence of Coverage (EOC) and Disclosure Form. Information shall include notice that some Enrollees under age 21 in need of hearing aids and related benefits not covered in the QHP may be eligible for such benefits through the HACCP and provide contact information for the HACCP for Enrollees to find more information and apply for benefits.
Not Applicable	**QDP** **4.5.1 Rating Variations** Contractor shall comply with rate filing requirements imposed by its State Regulators, including, those set forth under Insurance Code § 10181 et seq. or Health and Safety Code § 1385.01 et seq. and as applicable, other laws, rules and regulations.

SUMMARY OF PROPOSED 2026-28 QHP MODEL CONTRACT UPDATES

2023-25 Current Requirements	2026-28 Proposed Requirements
Not Applicable	**QHP Individual** **Article 6 – Financial Provisions** **6.1.1 Rates and Payments** f) California Premium Credit Program: In accordance with Title 25 of the Government Code, commencing at Section 100503.5 - Exchange Payments to Individuals, Covered California will administer a State-funded credit program that shall provide payments equaling the cost of providing coverage of services described in Section 18023(b)(1)(B)(i) of Title 42 of the United States Code to individuals enrolled in a qualified health plan through the Exchange in the individual market. The payments shall not be less than one dollar ($1) per enrollee per month. This subsidy payment will be calculated and delivered by Covered California separate from the Participation Fee invoices set forth in Section 6.1.3.
Not Applicable	**QHP Individual** **Article 6 – Financial Provisions** **6.1.1 Rates and Payments** g) Cost Sharing Reduction Assistance Program: In accordance with Title 25 of the Government Code, commencing at Section 100520.5 - Health Care Affordability Reserve Fund, Covered California will develop and administer a program for providing cost sharing reduction subsidies to reduce cost sharing for low- and middle-income Californians. From these interim payments, the Exchange shall withhold 40 percent subject to reconciliation of the interim payments and the actual utilization of medical services by applicable return filers following the end of the plan year. The Exchange shall either make an additional payment to the qualified health plan issuer if the sum of interim payments is lower than the actual cost-sharing reduction cost or receive returned funds from the qualified health plan issuer if the sum of interim payments is higher than the actual cost-sharing reduction cost, up to the amount appropriated in item 4800-101-3381 of the Budget Act of 2024. This subsidy payment will be calculated and delivered by Covered California separate from the Participation Fee invoices set forth in Section 6.1.3.

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