ATTACHMENT 1 TO COVERED CALIFORNIA 2023-2025 COVERED CALIFORNIA FOR SMALL BUSINESS QUALIFIED HEALTH PLAN ISSUER CONTRACT: QUALITY, EQUITY, AND DELIVERY SYSTEM TRANSFORMATION REQUIREMENTS AND IMPROVEMENT STRATEGY

PROMOTING QUALITY, EQUITY AND VALUE

The mission of Covered California is to increase the number of insured Californians, improve healthcare quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value.

Health Insurance Issuers contracting with Covered California to offer Qualified Health Plans (QHPs) are integral to Covered California's ability to achieve its mission of improving the quality, equity, and value of healthcare services available to enrollees. QHP Issuers have the responsibility to work with Covered California to support models of care that promote the vision of the Affordable Care Act and meet enrollee needs and expectations.

Given the unique role of Covered California and QHP Issuers in the State's healthcare ecosystem, Contractor is expected to contribute to broadscale efforts to improve the delivery system and health outcomes in California. For there to be a meaningful impact on overall healthcare cost, equity, and quality, solutions and successes need to be sustainable, scalable, and must expand beyond local markets or specific groups of individuals. This will require both Covered California and Contractor to coordinate with and promote alignment with other purchasers and payers, and strategically partner with organizations dedicated to delivering better quality, more equitable care, at higher value. In addition, QHP Issuers shall collaborate with and support their contracted providers in continuous quality and value improvement, which will benefit both Covered California Enrollees and the QHP Issuer's entire California membership.

Covered California is committed to balancing the need for QHP Issuer accountability with reducing the administrative burden of Attachment 1 by intentionally aligning requirements with other major purchasers, accreditation organizations, and regulatory agencies. In the same spirit, Covered California expects all QHP Issuers to streamline requirements and reduce administrative burden on providers as much as possible.

This Quality, Equity, and Delivery System Transformation Requirements and Improvement Strategy is focused on key areas that Covered California believes require systematic focus and investment in order to ensure its Enrollees and all Californians receive high-quality, equitable care.

By entering into this Agreement, Contractor affirms its commitment to be an active and engaged partner with Covered California, and agrees to work collaboratively with

Covered California to develop and implement policies and programs that will promote quality and health equity, and lower costs for the Contractor's entire California membership.

The Contractor shall comply with the requirements in this Attachment 1 by January 1, 2023 unless otherwise specified.

This Attachment 1 contains numerous reports that will be required as part of the annual application for certification and contracting process with QHP Issuers and will be used for negotiation and evaluation purposes regarding any extension of this Agreement. Contractor shall submit all required reports as defined in Attachment 1 and listed in the annual "Contract Reporting Requirements" table found on Covered California's Extranet site (Hub page, PMD Resources library, Contract Reporting Compliance folder).

Covered California will use information on cost, quality, and health disparities provided by Contractor to evaluate and publicly report both QHP Issuer performance and its impact on the healthcare delivery system and health coverage in California.

ARTICLE 1 - EQUITY AND DISPARITIES REDUCTION

The Institute of Medicine defines health care equity as “providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.” Healthy People 2020 defines disparities as “a particular type of health difference that is closely linked with social, economic and/or environmental disadvantage.” Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.

Addressing health equity and disparities in healthcare is integral to the mission of Covered California. In order to have impactful and meaningful change, Covered California and Contractor recognize that addressing health disparities requires alignment, commitment, focus, and accountability.

1.01 Demographic Data Collection

Collection of accurate and complete member demographic data is critical to effective measurement and reduction of health disparities.

Contractor agrees that collection of member demographic data to measure and address health disparities is important for providing high-quality, equitable, and affordable care. Contractor will make good faith efforts to collect member demographic data through collaborative efforts and strategic decisions for its other products and lines of business. While Contractor builds its small group business, requirements included in Article 1.01 will not be applied to the CCSB line of business.

1.01.1 Expanded Demographic Data Collection

Contractor shall work with Covered California to extend the disparity identification and improvement requirements in this article for 2023 and beyond. Covered California intends to proceed with measures stratification by income for disparities identification and monitoring purposes. Areas for consideration include:

1) Disability status
2) Sexual orientation
3) Gender identity

1.01.2 Race, Ethnicity, and Language Data Collection

For Measurement Years 2023-2025, Contractor must collect self-identified race and ethnicity data for at least eighty percent (80%) of its Enrollees. Contractor must demonstrate compliance by including a valid race and ethnicity attribute for at least 80% of its Enrollees in its Healthcare Evidence Initiative (HEI) data submissions.

Contractor must engage with Covered California to review its race and ethnicity data for off-Exchange members.

For Measurement Years 2023-2025, Contractor must collect data on Enrollees' preferred spoken and written languages and submit that data in its HEI submissions to ensure effective communication with providers and timely access to healthcare services. By year-end 2025, Contractor must collect written and spoken language preferences for a minimum of eighty percent (80%) of its Enrollees. Covered California will negotiate an annual target for 2024 based on 2023 baseline performance.

1.02 Identifying Disparities in Care

Covered California recognizes that the underlying causes of health disparities aremultifactorial and include social and economic factors that impact health. While the healthcare system cannot single handedly eliminate health disparities, there is evidence to show that when disparities are identified and addressed in the context of healthcare, they can be reduced over time through activities tailored tospecific populations and targeting select measures. Therefore, Covered California is requiring Contractor to regularly collect data and report on its Enrollees as specified in this article to identify disparities, measure disparities over time, and determine disparity reduction efforts and targets to be determined by Covered California and Contractor. As Covered California transitions to expanded use of the Healthcare Evidence Initiative (HEI) data to assess improvements in healthcare quality and equity, Covered California expects that certain measures previously submitted by Contractor for disparities monitoring will be generated using HEI data and stratified by demographic factors.

Contractor agrees that measuring care to address health disparities is important for providing high-quality, equitable, and affordable care. Contractor will make good faith efforts to identify health disparities through collaborative efforts and strategic decisions for its other products and lines of business. While Contractor builds its small group business, requirements included in Article 1.02 will not be applied to the CCSB line of business.

1.02.1 Disparities Measurement: Patient Level Data File

For Measurement Years 2023-2025, Contractor must submit annually the following Healthcare Effectiveness Data and Information Set (HEDIS) hybrid measure patient level data files for its Enrollees:

1) Prenatal Depression Screen and Follow-up (PND-E)
2) Postnatal Depression Screen and Follow-up (PDS-E)
3) *[to be populated with Quality Transformation Initiative measures once finalized].*

Contractor must submit a patient level data file that includes a unique person identifier for each person in the denominator. Contractor must also submit numerator and denominator totals and rates at the summary level.

Covered California will modify the measures set over time, with stakeholder input, to track disparities in care and health outcomes in additional areas, including behavioral health. Covered California will work with public purchaser partners to assess and monitor disparities across enrolled populations.

1.02.2 Disparities Measurement: Healthcare Evidence Initiative

Contractor must engage with Covered California to review its performance on the disparities measures using HEI data, submitted in accordance with Article 5.02.1, including the following measures:

1) Comprehensive Diabetes Care (CDC): Hemoglobin A1c (HbA1c) Testing (NQF #0057);
2) Ambulatory Emergency Room (ER) Visits© per 1,000;
3) Avoidable Ambulatory Emergency Room (ER) Visits© per 1,000;
4) Adult Preventive Visits© per 1,000;
5) Breast Cancer Screening (BCS) (NQF #2372); and
6) Proportion of Days Covered: Three Rates by Therapeutic Category (NQF #0541)
    a) Diabetes All Class (PDC-DR)
    b) RAS Antagonists (PDC-RASA)
    c) Statins (PDC-STA)

1.03 Disparities Reduction

Achieving disparities reduction in care is critical for delivery of individualized, equitable care and promotion of health equity.

Contractor agrees that narrowing health disparities through quality improvement activities is important for providing high-quality, equitable, and affordable care. Contractor will make good faith efforts to narrow health disparities through collaborative efforts and strategic decisions for its other products and lines of business. While Contractor builds its small group business, requirements included in Article 1.03 will not be applied to the CCSB line of business.

1.03.1 Disparities Reduction Intervention

Contractor will meet a multi-year disparities reduction target. Contractor must report progress toward this target by submitting specified progress reports. Covered California will assess Contractor's performance based on the submitted.

HEDIS measures sample per Article 1.02 specified progress reports and its disparities reduction intervention results.

If Covered California previously approved a disparity reduction project for a measure not specified in Article 1.02.1, Contractor must additionally submit the patient level HEDIS measure file for such measure.

1.04 Health Equity Capacity Building

Attaining health equity requires organizational investment in building a culture of health equity. Meeting the standards for the Health Equity Accreditation by the National Committee for Quality Assurance (NCQA) (previously Multicultural Health Care Distinction (MHCD)) is necessary to build a program to reduce documented disparities and to develop culturally and linguistically appropriate communication strategies.

1.04.1 Health Equity Accreditation

Contractor must achieve or maintain NCQA Health Equity Accreditation by year-end 2023. If Contractor has previously achieved NCQA Multicultural Health Care Distinction (MHCD), Contractor must provide its transition plan to attain the NCQA Health Equity Accreditation at the expiration of the MHCD period. Contractor must demonstrate compliance by submitting the following to Covered California:

1) Contractor must submit evidence of NCQA Health Equity Accreditation or

MHCD by January 31, 2023 or adhere to the following schedule:

a) January 31, 2023: Submit first Progress Report

b) August 31, 2023: Submit second Progress Report

c) December 29, 2023: Submit evidence of NCQA Health Equity Accreditation achievement or transition plan to achieve Health Equity Accreditation at the expiration of the current MHCD period.

ARTICLE 2 - BEHAVIORAL HEALTH

Mental health and substance use disorder services – collectively referred to as behavioral health services – includes identification, engagement, and treatment of those with mental health conditions and substance use disorders. Consistent with evidence and best practices, Covered California expects Contractor to ensure enrollees receive timely and effective behavioral healthcare that is integrated with medical care, and in particular primary care. Covered California and Contractor recognize the critical importance of behavioral health services, as part of the broader set of healthcare services provided to enrollees, in improving health outcomes and reducing costs.

2.01 Access to Behavioral Health Services

Monitoring and improving access to behavioral health services is necessary to ensure Enrollees are receiving appropriate and timely behavioral health services.

2.01.1 Behavioral Health Provider Network

For Covered California to evaluate how Contractor tracks access to behavioral health services and the strategies Contractor implements to improve access to behavioral health services for Enrollees, Contractor must submit to Covered California its National Committee for Quality Assurance (NCQA) Health Plan Accreditation Network Management reports as follows:

1) Network Standard 1, Element A: Cultural Needs and Preferences (including behavioral health providers);
2) Network Standard 1, Element D: Practitioners Providing Behavioral Healthcare;
3) Network Standard 2, Element B: Access to Behavioral Healthcare; and
4) Network Standard 3, Element C: Opportunities to Improve Access to Behavioral Healthcare Services.

Contractor must submit the Network Management reports in accordance with the three-year NCQA accreditation cycle. If significant changes are made to the Network Management reports during the three-year cycle, Contractor must resubmit the reports to Covered California.

Alternatively, if Contractor is not yet NCQA accredited or is unable to provide components of its NCQA Network Management reports, Contractor must submit

a separate report for its Covered California population that addresses each of the NCQA Network Management standards for behavioral health. These reports can be from Contractor's accrediting body, either URAC or the Accreditation Association for Ambulatory Health Care (AAAHC), or supplemental reports that include a description of Contractor's behavioral health provider network, how cultural, ethnic, racial and linguistic needs of Enrollees are met, access standards, the methodology for monitoring access to behavioral health appointments, and at least one intervention to improve access to behavioral health services and the effectiveness of this intervention.

When submitting its reports to Covered California, Contractor shall clearly identify any information it deems confidential, trade secret, or proprietary.

2.01.2 Offering Telehealth for Behavioral Health

Telehealth has the potential to address some of the access barriers to behavioral health services such as cost, transportation, and the shortage of providers, particularly for linguistically and culturally diverse enrollees and for rural areas.

Telehealth is not a replacement for the Contractor's developing a network of in-person behavioral health providers. However, given workforce issues, to strengthen access to behavioral health services, Contractor must offer telehealth for behavioral health services when clinically appropriate based on an Enrollee's needs and at a cost share equal to or less than the cost share for in-person behavioral health services. Covered California encourages Contractor to use network providers to provide telehealth for behavioral health services whenever possible. Contractor must continue to comply with applicable network adequacy standards for in-person services for behavioral health.

Contractor will demonstrate compliance with the requirement through reporting in the annual application for certification.

2.01.3 Promoting Access to Behavioral Health Services

To ensure Enrollees are aware of the availability of behavioral health services, including services available through telehealth, Contractor must:

1) Display coverage of behavioral health services clearly and prominently on key Enrollee pages, such as the home page in its member portal and the provider directory page;

2) Explain scope and availability of behavioral health services, including telehealth;

3) Educate Enrollees about how to access behavioral health services, including

through telehealth;

4) Ensure that Enrollees can easily find behavioral health services by utilizing a provider search attribute, including availability of telehealth services in the provider profile (e.g. Jane Doe, Ph.D. Psychologist telehealth video/phone), or other member portal navigation features; and

5) Promote integration and coordination of care between third party telehealth vendor services and primary care and other network providers.

Contractor will demonstrate compliance with the requirements through reporting in the annual application for certification.

2.01.4 Monitoring Behavioral Health Service Utilization

Contractor must engage with Covered California to review its depression treatment penetration rate and its behavioral health service utilization rate, which will be calculated by Covered California using HEI data, submitted in accordance with Article 5.02.1, to further understand Enrollees' access to behavioral health services within the Contractor's network. Penetration rate is determined by dividing the number of members who receive a behavioral health service by the expected prevalence rate of behavioral health needs within a state or region, multiplied by 100 to report as a percent; this data will be analyzed separately for in-person and telehealth services.

2.02 Quality of Behavioral Health Services

Measuring and monitoring quality is necessary to ensure Enrollees receive appropriate, evidence-based treatment and to inform quality improvement efforts.

2.02.1 Screening for Depression

Contractor must work with its contracted providers to collect Depression Screening and Follow-Up Plan (NQF #0418) measure results for its Enrollees and report results in the annual application for certification. Contractor must engage with Covered California to review its performance.

Covered California strongly encourages Contractor to use the Patient Health Questionnaire-2 and 9 (PHQ-2, PHQ-9) as standardized depression screening

tools when implementing this measure. If a different tool is used, this must be reported with the measure results.

2.02.2 Monitoring Quality Rating System Behavioral Health Measures

Contractor must engage with Covered California to review its performance on the behavioral health measures reported by Contractor to CMS for the Quality Rating System (QRS) submitted in accordance with Article 5.01.1.

2.03 Appropriate Use of Opioids

Appropriate use of opioids and evidence-based treatment of opioid use disorder, including Medication Assisted Treatment (MAT), can improve outcomes, reduce inappropriate healthcare utilization, and lower opioid overdose deaths.

2.03.1 Guidelines for Appropriate Use of Opioids

Contractor shall implement policies and programs that align with the guidelines from Smart Care California to promote the appropriate use of opioids using a harm reduction framework and individualized approach to treatment planning (https://www.iha.org/wp-content/uploads/2021/02/Curbing-Opioid-Epidemic-Checklist-Health-Plans-Purchasers.pdf). Contractor's policies and programs must include the following priority areas:

1) Prevent: avoid new starts by using opioids sparingly, implement quantity limits for new starts, and support non-pharmacological approaches to pain management such as removing prior authorizations for physical therapy and adding chiropractic and acupuncture services as benefits;

2) Manage: identify patients on risky regimens (high-dose or opioids and sedatives); co-prescribe naloxone with chronic opioid prescriptions; develop individualized treatment plans, avoiding mandatory tapers, for continuing opioid therapy, tapering down or off opioid therapy; transition to buprenorphine; or add non-opioid options;

3) Treat: streamline access to evidence-based treatment for substance use disorder, including Medication Assisted Treatment (MAT) medications such as buprenorphine, methadone, and naltrexone and behavioral therapy, by addressing cost and logistical barriers at all points in the healthcare system; and

4) Stop deaths: promote data-driven harm reduction strategies, such as

naloxone access and syringe exchange.

Contractor must report in the annual application for certification how it is implementing such policies and programs in accordance with the Smart Care California guidelines.

2.03.2 Monitoring Opioid Use Disorder Treatment

To monitor access to opioid use disorder treatment, Contractor must engage with Covered California to review its Medication Assisted Treatment (MAT) prescriptions by provider and by region and to review its concurrent prescribing of opioids and naloxone rate using HEI data submitted in accordance with Article 5.02.1.

Contractor must also engage with Covered California to review its performance on the Pharmacotherapy for Opioid Use Disorder (POD) measure constructed from HEI data submitted in accordance with Article 5.02.1.

2.04 Integration of Behavioral Health Services with Medical Services

Integrated behavioral health services with medical services, particularly primary care services, increases access to behavioral health services and improves treatment outcomes. Evidence suggests the Collaborative Care Model, as defined by the AIMS Center at the University of Washington, is a best practice among integrated behavioral health models (https://aims.uw.edu/collaborative-care).

Contractor shall pay its contracted providers through population-based payment and other alternative payment models, in accordance with Article 4.01.3, to support behavioral health integration with primary care.

2.04.1 Promotion of Integrated Behavioral Health

Contractor must report in the annual application for certification:

1) How it is promoting the integration of behavioral health services with primary care including bi-directional data exchange;

2) The percent of its Enrollees and the percent of enrollees outside of Covered California cared for under an integrated behavioral and primary care model such as Primary Care Behavioral Health and the Collaborative Care Model; and

3) Whether it reimburses for the Collaborative Care Model claims codes and if so, in what settings and to which entities. If Contractor does not reimburse for the Collaborative Care Model claims codes, Contractor must describe the barriers to reimbursing for these codes.

2.04.2 Monitoring Collaborative Care Model Utilization

Contractor must engage with Covered California to review its utilization of the Collaborative Care Model services using HEI data submitted in accordance with Article 5.02.1.

ARTICLE 3 - POPULATION HEALTH

QHP Issuers shall address population health, including promoting the use of health promotion and prevention services, increasing utilization of high value services, risk stratifying enrollees, and developing targeted interventions based on risk. QHP Issuers are responsible for addressing the health of all their Enrollees, not just Enrollees who utilize services.

3.01 Population Health Management

Covered California and Contractor recognize that Population Health Management ensures accountability for delivering quality care. Population Health Management provides focus and a framework for improving health outcomes through registries, care coordination and targeted patient engagement.

3.01.1 Population Health Management Plan Submission

The Population Health Management plan provides a vehicle for establishing a formal strategy to optimize population health outcomes, including a defined approach for population identification and stratification, with attention to care management for complex enrollees. The Population Health Management plan is a critical part of achieving improvement in Enrollee health outcomes and is interrelated with all other quality care domains. Submission of a Population Health Management plan is a requirement for health plan accreditation by the National Committee for Quality Assurance (NCQA).

Contractor must submit components of its NCQA Population Health Management plan to Covered California as follows:

1) Population Health Management Standard 1: Population Health Management Strategy;

2) Population Health Management Standard 2: Population Identification; and

3) Population Health Management Standard 6: Population Health Management Impact.

Contractor must submit the Population Health Management plan in accordance with the three-year NCQA accreditation cycle. If significant changes are made to the Population Health Management plan during the three-year cycle, Contractor must resubmit the plan to Covered California.

Alternatively, if Contractor is not yet NCQA accredited or is unable to provide

components of its NCQA Population Health Management plan, Contractor must submit a separate Population Health Management plan for its Covered California population that addresses each of the following components:

a) A Population Health Management Strategy for meeting the care needs of its Enrollees that includes the following:

   i. Goals, focus populations, opportunities, programs, and services available for keeping members healthy, managing members with emerging risk, patient safety or outcomes across settings, and managing multiple chronic illnesses.

   ii. Mechanism for informing Enrollees eligible for interactive programs with details of how to become eligible for participation, how to use program services, and how to opt in or out of a program.

   iii. Activities performed by Contractor targeted at populations or communities as a part of the Population Health Management strategy that are not direct member interventions.

   iv. Coordination of member programs across settings, providers, external management programs, and levels of care to minimize confusion and maximize reach and impact.

b) Evidence of systematic collection, integration, and assessment of member data to assess the needs of the population and determine actionable categories for appropriate intervention. Contractor must describe the following:

   i. How Contractor integrates multiple sources of data for use in Population Health Management functions that includes: medical and behavioral claims or encounters, pharmacy claims, laboratory results, health appraisal results, a copy of individual risk assessment questions, electronic health records, health programs delivered by the Contractor, and other advanced data sources.

   ii. Contractor's process for at least annually assessing the following:

      (1) Characteristics and needs, including health related social needs of its members;

      (2) Needs of specific member subpopulations; and

      (3) Needs of children and adolescents, members with disabilities, and members with serious and persistent mental illness.

iii. How Contractor uses the population assessment at least annually to review and update its Population Health Management activities and resources to address member needs. Also, how Contractor reviews community resources for integration into program offerings to address member needs.

iv. Its process, including the data sources and the population health categories, to stratify its Covered California population into subsets for targeted intervention at least annually.

c) A systemic process of measuring the effectiveness of its Population Health Management strategy to determine if Population Health Management goals are met and to gain insights into areas needing improvement. Contractor must describe the following:

i. How Contractor conducts its annual comprehensive analysis of the impact of its Population Health Management strategy that includes the following:

(1) Quantitative results of relevant clinical, cost and utilization, and experience measures;

(2) Comparison of results with a benchmark or goal; and

(3) Interpretation of results.

ii. Its process to identify and address opportunities for improvement, using the results from the Population Health Management impact analysis at least annually.

When submitting its plan to Covered California, Contractor shall clearly identify any information it deems confidential, trade secret, or proprietary information.

3.02 Health Promotion and Prevention

Health promotion and prevention are key components of high value healthcare. Research shows that treating those who are sick is often far costlier and less effective than preventing disease from occurring and keeping populations healthy. Covered California's health promotion and prevention requirements are centered on identifying Enrollees who are eligible for certain high value preventive and wellness benefits, notifying Enrollees about the availability of these services, making sure those eligible receive appropriate services and care coordination, and monitoring the health status of these Enrollees.

3.02.1 Tobacco Cessation Program

Tobacco use is preventable and contributes to high morbidity and mortality. Reducing tobacco use will have greater impact on health outcomes in marginalized communities which have disproportionately higher rates of use.

1) Contractor must report to Covered California in the annual application for certification:

   a) Analysis of performance trended over time of Enrollees who use tobacco who enroll in tobacco cessation programs, inclusive of evidenced-based counseling and appropriate pharmacotherapy; and

   b) Whether its strategies to improve tobacco use prevention were successful and if the smoking prevalence of Enrollees has decreased over time.

   c) Its strategies to improve its rates on the Medical Assistance with Smoking and Tobacco Use Cessation measure (NQF #0027), which may include evidence-based interventions or participation in quality collaboratives. Contractor must engage with Covered California to review its performance.

3.02.2 Diabetes Prevention Programs

Diabetes contributes to high rates of morbidity and mortality. Access to diabetes prevention programs is critical in the prevention of diabetes related complications.

1) Contractor must provide a Centers for Disease Control and Prevention (CDC)-recognized Diabetes Prevention Lifestyle Change Program, also known as a Diabetes Prevention Program (DPP) to its eligible Enrollees. The DPP must be available both in-person and online to allow Enrollees a choice of modality (in-person, online, distance learning, or a combination of modes). The DPP must be accessible to eligible Enrollees with limited English proficiency (LEP) and eligible Enrollees with disabilities. The DPP shall be available to all eligible Enrollees in the geographic service area and covered under the $0 preventive services benefit or diabetes education benefit in the Patient-Centered Benefit Plan Designs. Contractor's DPP must have pending or full recognition by the CDC as a DPP. A list of recognized programs in California can be found at: https://nccd.cdc.gov/DDT_DPRP/Registry.aspx.

2) Contractor must report to Covered California in the annual application for

certification:

a) Analysis of performance trended over time of utilization rates of eligible Enrollees who enroll in the Diabetes Prevention Program in relation to expected rates. This includes total eligible enrollees identified as high risk for diabetes and total eligible enrollees who should have been identified as high risk for diabetes, which can be projected using the CDC Diabetes Prevention Impact Toolkit (https://nccd.cdc.gov/Toolkit/DiabetesImpact/); and

b) Its strategies to close the gap between the Diabetes Prevention Program utilization rates by eligible Enrollees in relation to expected rates.

3) If there is a gap between utilization rates and expected rates, Contractor must develop a corrective action plan to close the gap. The corrective action plan is subject to review and approval by Covered California.

3.03 Supporting At-Risk Enrollees Requiring Transition

An Enrollee transition plan allows for a clear process to transfer critical health information for at-risk members during movement between healthcare coverage. Covered California is particularly concerned about At-Risk Enrollees who are transitioning from one QHP Issuer to another, which includes Enrollees who are: (1) in the middle of acute treatment, third trimester pregnancy, or those who would otherwise qualify for Continuity of Care under California law, (2) in case management programs, (3) in disease management programs, or (4) on maintenance prescription drugs for a chronic condition.

3.03.1 Submission of Transition Plan

In the event of a service area reduction, Contractor must submit an evaluation and formal transition plan to facilitate transitions of care with minimal disruption for At-Risk Enrollees who are transitioning from one QHP Issuer to another or into or out of Covered California. If this occurs, Covered California may automatically transition Contractor's Enrollees into a different QHP Issuer to avoid gaps in coverage. If Contractor receives terminating Enrollees, Contractor must implement policies and programs to facilitate transitions of care.

1) In such events, Contractor must submit a transition plan to Covered California that meets the following requirements. Contractor terminating Enrollees must:

a) Conduct outreach to alert all impacted Enrollees that their QHP will be ending. Outreach will include instructions, timing, and options for enrolling

with a new QHP Issuer.

b) Conduct outreach to At-Risk Enrollees, giving them the option to authorize Contractor to send their personal health information to the Enrollee's new QHP Issuer with the goal of improving the transition of care.

c) Send Enrollee health information relevant to creating transitions of care with minimal disruption to the Enrollee's new QHP Issuer for those Enrollees who have provided authorization to do so, as follows:

   i. For all terminating Enrollees, send Primary Care Provider information on record.

   ii. For At-Risk Enrollees, send relevant personal health information.

d) Conduct outreach to providers in impacted service areas to create Enrollee transitions with minimal disruption.

2) If Contractor receives terminating Enrollees from another QHP Issuer pursuant to a service area withdrawal, Contractor must do the following:

a) Identify At-Risk Enrollees, either through existing Contractor practices, or through receipt of both health information from the prior QHP Issuer and the data file with transitioning enrollment information from Covered California (which would occur after these Enrollees have effectuated coverage).

b) Ensure At-Risk Enrollee care transitions account for the Enrollee's medical situation, including participation in case or disease management programs, locating in-network Providers with appropriate clinical expertise, and any alternative therapies, including specific drugs.

c) Establish internal processes to ensure all parties involved in the transition of care for At-Risk Enrollees are aware of their responsibilities. This includes anyone within or outside of Contractor's organization who are needed to ensure the transition of prescriptions or provision of care.

d) Provide information on continuity of care programs, including alternatives for transitioning to an in-network provider.

e) Ensure the new Enrollees have access to Contractor's formulary information prior to enrollment.

3.04 Social Health

Given the strong evidence of the role of social factors on health outcomes, addressing health-related social needs is an important step in advancing Covered California's goal to ensure everyone receives the best possible care.

Covered California acknowledges the importance of understanding patient health-related social needs – an individual's socioeconomic barriers to health – to move closer to equitable care and seeks to encourage the use of social needs informed and targeted care. As social needs are disproportionately borne by disadvantaged populations, identifying and addressing these barriers at the individual patient level is a critical first step in improving health outcomes, reducing health disparities, and reducing healthcare costs.

Identification and information sharing of available community resources is critical to meeting identified member social needs.

While Contractor builds its small group business, requirements included in Article 3.04 will not be applied to the CCSB line of business. When this requirement pertains to CCSB, Contractor will be required to report on this requirement annually.

3.04.1 Screening for and Addressing Social Needs

Contractor must screen all Enrollees for a minimum of two standard social needs: food insecurity and housing instability or homelessness. Screening in coordination with contracted providers is highly encouraged.

Contractor must address Enrollees' identified health-related social needs and support linkages to appropriate social services throughout all regions covered. This requirement may be met through contracting with a vendor that maintains a resource directory or community resource platform applicable to Contractor's geographic licensed service area.

Contractor must annually report to Covered California:

1) Its process for screening Enrollees for social needs, including which Enrollee touch points include social need screening, whether the screening is performed by Contractor's staff, vendor, or network providers, and which questions are used to screen for food insecurity and housing instability or homelessness.

2) The social needs screening efforts by its provider network and the actions Contractor takes to coordinate screening and linkage to services with its provider network, including what support Contractor provides to contracted providers to connect Enrollees.

3) Its process for linking members with food insecurity or housing instability or homelessness to resources and how Contractor tracks if or when the social need has been addressed.
4) The total number of Enrollees screened for food insecurity and housing instability or homelessness, the number and percent who screened positive for each, and the number and percent who screened positive that were successfully linked to resources to meet the social need.

Contractor must engage with Covered California to review its performance on screening for and addressing health-related social needs.

ARTICLE 4 - DELIVERY SYSTEM AND PAYMENT STRATEGIES TO DRIVE QUALITY

Contractor is expected to contribute to broadscale efforts to improve the healthcare delivery system in California. To meet goals of the Triple Aim and the goal of a safe, timely, effective, efficient, equitable and patient-centered (STEEEP) healthcare system as set forth by the Institute of Medicine, Contractor shall work with Covered California to promote effective primary care, increase integration and coordination within the healthcare system, and manage and design networks based on value. These delivery system reform efforts must be supported with value-based payment models.

4.01 Effective Primary Care

Covered California and Contractor recognize that providing high-quality, equitable, and affordable care requires a foundation of effective and patient-centered primary care. Effective primary care is data driven, team-based, and supported by alternative payment models such as population-based payment and shared savings. Contractor shall actively promote the development and use of advanced primary care models that promote access, care coordination, and quality while managing the total cost of care.

Contractor shall work with Covered California to provide comparison reporting for the requirements specified below for all lines of business to compare performance and inform future Covered California requirements.

Contractor agrees that effective primary care is important for providing high-quality, equitable, and affordable care. Contractor will make good faith efforts to promote advanced primary care through collaborative efforts and strategic decisions for its other products and lines of business. While Contractor builds its small group business, requirements included in Article 4.01 will not be applied to the CCSB line of business.

4.01.1 Encouraging Use of Primary Care

Ensuring all Enrollees have a primary care clinician is foundational for promoting access to and encouraging the use of primary care.

1) Contractor must ensure that upon enrollment all Enrollees are informed about the role and benefits of primary care and are given the opportunity to select a primary care clinician. Within sixty (60) days of effectuation into the plan, if an Enrollee does not select a primary care clinician, Contractor must provisionally assign the Enrollee to a primary care clinician, inform the Enrollee of the assignment, and provide the Enrollee with an opportunity to select a different primary care clinician. When assigning a primary care

clinician, Contractor shall use commercially reasonable efforts to assign a primary care clinician consistent with an Enrollee's stated gender, language, ethnic and cultural preferences, geographic area, existing family member assignment, and any prior primary care clinician.

2) Contractor must report in the annual application for certification the number and percent of Enrollees who select a clinician and the number and percent of Enrollees who are assigned to a primary care clinician.

3) Covered California will evaluate the effectiveness of this policy in collaboration with Contractor and other stakeholders. Contractor shall provide Covered California with data and other information to perform this evaluation.

4.01.2 Measuring Advanced Primary Care

Advanced primary care is patient-centered, accessible, team-based, data driven, supports the integration of behavioral health services, and provides care management for patients with complex conditions. Primary care clinicians should have access to data related to the care their patients receive throughout the delivery system to enable primary care clinicians to provide integrated care. Measuring the performance of primary care practices within Contractor's network is important to ensure Enrollees receive high-quality care, to inform quality improvement and technical assistance efforts, and to support the adoption of alternative payment models.

1) Contractor must implement a measure set that includes quality and cost-driving utilization measures for advanced primary care to assess the prevalence of high-quality, advanced primary care practices within Contractor's network. Contractor will collaborate with Covered California, the Integrated Healthcare Association (IHA), California Quality Collaborative (CQC), and other stakeholders to implement the measure set.

2) Contractor must submit data to IHA to implement the measure set. Contractor must annually report its performance on the measure set to Covered California or allow IHA to submit results to Covered California on Contractor's behalf.

3) Contractor must engage with Covered California to evaluate the performance of its contracted primary care practices using the measure set.

4.01.3 Payment to Support Advanced Primary Care

1) Covered California and Contractor recognize the importance of adopting and expanding primary care payment models that provide the necessary

revenue to fund accessible, data-driven, team-based care with accountability for providing high-quality, equitable care, and managing the total cost of care. Contractor must report on its primary care payment models using the Health Care Payment Learning and Action Network Alternative Payment Model (HCP LAN APM) categories and associated subcategories of fee for service with no link to quality and value (Category 1), fee for service with a link to quality and value (Category 2), alternative payment models built on a fee for service structure such as shared savings (Category 3), and population-based payment (Category 4). A combination of payment models across categories may be the most effective to support advanced primary care. Contractor must report in the annual application for certification:

a) The number and percent of its contracted primary care clinicians paid using each HCP LAN APM category and associated subcategories;

b) Total primary care spend, as defined by the Integrated Healthcare Association (IHA), and the percent of spend within each HCP LAN APM category and associated subcategory; and

c) A description of the Contractor's payment model for its 5 largest physician groups, as defined by the number of providers, and how their primary care clinicians are paid.

2) Contractor must adopt and progressively expand the percent of primary care clinicians paid through the HCP LAN APM categories of population-based payment (Category 4) and alternative payment models built on a fee for service structure such as shared savings (Category 3).

3) Contractor shall work with Covered California and other stakeholders to analyze the relationship between the percent of spend for primary care services with performance of the overall delivery system. If the evidence shows that rebalancing to increase primary care spend improves quality or drives lower total cost of care, Covered California may set a target or floor for primary care spend in future Covered California requirements.

4.02 Promotion of Integrated Delivery Systems (IDSs) and Accountable Care Organizations (ACOs)

Evidence suggests the adoption and expansion of integrated, coordinated, and accountable systems of care such as IDSs or ACOs can lead to improved quality and reduced costs. An IDS is defined as an organized healthcare delivery system in which payers, hospitals, and providers coordinate to provide patient care, integrate care across settings, and share responsibility for patient outcomes and

resource use. IDS partners are generally managed by the same organization. An ACO is defined as a system of population-based care coordinated across the continuum including multidisciplinary physicians and physician groups, hospitals, and ancillary providers with combined risk sharing arrangements and shared incentives between providers or between payers and providers. Ideally ACO partners are held accountable for nationally recognized clinical, financial, and operational performance. As providers accept more accountability under this provision, Contractor shall ensure that providers have the capacity to manage the risk. There are many variations of ACO implementation with evidence suggesting that there are key characteristics of an ACO model that influence its success.

Contractor shall work with Covered California to provide comparison reporting for the requirements specified below for all lines of business to compare performance of its IDSs and ACOs and inform future Covered California requirements.

Contractor agrees that integrated, coordinated, and accountable systems of care are important for providing high-quality, equitable, and affordable care. Contractor will make good faith efforts to promote IDSs and ACOs through collaborative efforts and strategic decisions for its other products and lines of business. While Contractor builds its small group business, requirements included in Article 4.02 will not be applied to the CCSB line of business.

4.02.1 Enrollment in IDSs and ACOs

Contractor shall work with Covered California to increase enrollment in integrated, coordinated, and accountable systems of care with the goal of improved quality and decreased cost. Achieving these goals requires not only increased enrollment, but also continued improvement within IDSs and evolving ACOs.

1) Contractor must report in the annual application for certification:

   a) The characteristics of their IDS and ACO systems, such as the payment model including risk sharing structure, leadership structure, quality incentive programs, data exchange processes, and the number and type of partner organizations. Contractor will work collaboratively with Covered California and other stakeholders to define a registry of characteristics to support this reporting.

   b) The number and percent of Enrollees who are cared for within an ACO or IDS.

   c) The percent of spend under ACO and IDS contracts compared to its overall spend on healthcare services.

4.02.2 Measuring IDS and ACO Performance

Measuring the performance of IDSs and ACOs is important to ensure Enrollees receive high-quality, equitable, and affordable care, to inform improvement efforts, and to establish best practices.

1) Contractor must submit data to IHA for use in the IHA Commercial ACO Measure Set and Commercial HMO Measure Set, as applicable for its delivery system model. Contractor must annually report its performance on the IHA Commercial ACO and HMO Measure Set for all lines of business to Covered California or allow IHA to submit results to Covered California on Contractor's behalf.
2) Contractor must engage with Covered California to evaluate its performance using the results of the IHA Commercial ACO and HMO reports and the characteristics of different IDS and ACO systems to establish best practices to inform future requirements.

4.03 Networks Based on Value

QHP Issuers shall curate and manage their networks to address variation in quality and cost performance across network hospitals and providers, with a focus on improving the performance of hospitals and providers. Contractor is accountable for measuring, analyzing, and reducing variation to achieve consistent high performance for all network hospitals and providers. Affordability is core to Covered California's mission to expand the availability of insurance coverage. The wide variation in unit price and total costs of care, with some providers and facilities charging far more for care irrespective of quality, is a key contributor to the high cost of medical services. Contractor shall hold its contracted hospitals and providers accountable for improving quality and managing or reducing cost and provide support to its contracted hospitals and providers to improve performance.

Contractor agrees that network design based on value is important for providing high-quality, equitable, and affordable care. Contractor will make good faith efforts to design and manage networks based on value, promote hospital value-based purchasing, reduce hospital acquired conditions, and implement strategies to improve maternal health, including promoting appropriate use of C-sections, through collaborative efforts and strategic decisions for its other products and lines of business. While Contractor builds its small group business, requirements included in Article 4.03 will not be applied to the CCSB line of business.

4.03.1 Designing and Managing Networks Based on Value

Contractor shall design and manage its networks based on cost, quality, safety, patient experience, and equity to ensure that all Enrollees receive high-quality, affordable, and equitable care.

1) Contractor must include quality – which should include clinical quality, equity, patient safety, patient experience – and cost in the evaluation and selection criteria for all providers, including physicians and physician groups, and all facilities, including hospitals, when designing and managing networks for its QHPs.
2) Contractor must report in the annual application for certification how it meets this requirement and the basis for the selection and review of providers and facilities in networks for QHPs and if applicable, the rationalefor excluding a provider or facility. Reports must include a detailed description of how cost, quality, patient safety, patient experience, or other factors are considered in network design and provider and facility selection and review. Information submitted may be made publicly available by Covered California.
3) Contractor must engage with Covered California to review its unit price range and trends and quality indicators of network performance using HEI data submitted in accordance with Article 5.02.1.

4.03.2 Payment to Support Networks Based on Value

To continue to build and strengthen networks based on value, QHP Issuers must support their providers through value-based payment models that promote high-quality, affordable, and equitable care.

1) Contractor must report on its network payment models using the Health Care Payment Learning and Action Network Alternative Payment Model (HCP LAN APM) categories and associated subcategories of fee for service with no link to quality and value (Category 1), fee for service with a link to quality and value (Category 2), alternative payment models built on a fee for service structure such as shared savings (Category 3), and population-based payment (Category 4). Contractor must report the percent of spend within each HCP LAN APM category and associated subcategory compared to its overall budget in the annual application for certification.

4.03.3 Provider Value

Contractor shall contract with providers, including physicians and physician groups, that demonstrate they provide quality care and promote the safety of

Enrollees at a reasonable price. Contractor shall improve quality and cost performance across its contracted providers.

1) To meet this expectation, Covered California will work with the Integrated Healthcare Association (IHA), California providers, and QHP Issuers to profile and analyze variation in performance on provider quality measures. This profile and analysis will be based on national and state benchmarks, variation in provider performance, best existing science of quality improvement, and informed by effective engagement of stakeholders. The Contractor must:

    a) Participate in the IHA Align.Measure.Perform (AMP) program for physician groups and report AMP performance results for each contracted physician group that participates in QHPs to Covered California annually or allow IHA to submit results to Covered California on Contractor's behalf. Contractor shall use AMP performance results to profile and analyze variation in performance on quality measures and total cost of care.

    b) Submit an intervention plan to address low quality and high cost providers if Contractor contracts with physicians and physician groups performing in the lowest decile on state or national benchmarks for quality and highest decile on cost. The intervention plan may include quarterly provider performance reviews, providing technical assistance for specific quality and cost domains, tying provider payment to quality and cost, or excluding the provider from the QHP network. Contractor must continue to comply with applicable network adequacy standards, with attention to access for rural and traditionally underserved populations. The intervention plan is subject to review and approval by Covered California.

2) Covered California encourages collaboration among QHP Issuers in order to achieve maximum quality and safety performance in provider networks. To this end, Covered California will provide technical assistance to foster this collaborative effort through the Clinical Leaders Forum, Plan Management Advisory group, and other venues as helpful.

3) To demonstrate Contractor is managing provider costs, Contractor must report in the annual application for certification:

    a) The factors Contractor considers in assessing relative unit prices and total cost of care;

    b) Contractor's analysis of variation in unit prices including capitation rates;

c) The extent to which Contractor adjusts for or analyzes the reasons for cost factors based on elements such as area of service, population served, market dominance, services provided by the facility (e.g., trauma or tertiary care), or other factors;

d) How unit prices, capitation rates, and total cost of care are used in the selection of providers in networks for QHPs; and

e) Each provider by region and their distribution by cost deciles or describe other ways providers and facilities are grouped by costs such as comparison of costs as a percentage of Medicare costs and the percentage of costs for Contractor that are expended in each cost decile.

4.03.4 Hospital Value

Contractor shall contract with hospitals that demonstrate they provide high-quality, affordable, and equitable care and promote the safety of Enrollees. Contractor shall improve quality and cost performance across its contracted hospitals.

1) To meet this expectation, Covered California will work with Cal Hospital Compare, California hospitals, and QHP Issuers to profile and analyze variation in performance on hospital quality measures. Analysis will be based on best available national and state benchmarks, variation in hospital performance considering hospital case mix and services provided, best existing science of quality improvement including the challenges of composite measures, and informed by effective engagement of stakeholders. Assessment of hospital quality and safety shall not be based on a single measure alone. Contractor must:

   a) Submit an intervention plan to address low quality hospitals if Contractor contracts with hospitals performing in the lowest decile on state or national benchmarks for quality and safety. The intervention plan may include quarterly hospital performance reviews, providing technical assistance for specific quality and safety domains, implementation of corrective action plans, tying hospital payment to quality and safety, or excluding the hospital from the QHP network. Contractor must continue to comply with applicable network adequacy standards, with attention to geographical access needs and specific specialty service needs. The intervention plan is subject to review and approval by Covered California.

2) Covered California encourages collaboration among QHP Issuers in order to achieve maximum quality and safety performance in hospital networks. To

this end, Covered California will provide technical assistance to foster this collaborative effort through the Clinical Leaders Forum, Plan Management Advisory group, and other venues as helpful.

3) To demonstrate Contractor is managing hospital and facility costs, Contractor must report in the annual application for certification:

   a) The factors Contractor considers in assessing relative unit prices and total cost of care;

   b) The extent to which Contractor adjusts for or analyzes the reasons for cost factors based on elements such as area of service, population served, market dominance, services provided by the facility (e.g., trauma or tertiary care), or other factors;

   c) How unit prices, total cost of care, and data obtained from the CMS Hospital Price Transparency Rule are used in the selection of facilities in networks for QHPs; and

   d) Each facility by region and their distribution by cost deciles, or describe other ways facilities are grouped by costs such as comparison of costs as a percentage of Medicare costs and the percentage of costs for Contractor that are expended in each cost decile.

4) Covered California supports price transparency as a resource for Enrollees to make better informed decisions about their health care. In alignment with the CMS Hospital Price Transparency rule, Contractor shall annually report:

   a) A list of network hospitals by region that do not provide a machine-readable file that includes payer-specific negotiated amounts for all the services that could be provided by the hospital on an inpatient or outpatient basis; and

   b) The number and percent of network hospitals by region that provide information on the 70 CMS-specified shoppable services through a machine-readable file or a price estimator tool that provides consumers with an individualized estimate of their out-of-pocket costs; and

   c) The number and percent of network hospitals that do not provide price information for shoppable services.

4.03.5 Hospital Payments to Promote Quality and Value

Hospitals play a pivotal role in providing critical care to those in the highest need and should be supported with coordinated efforts across health plans and purchasers. Value based payments can be a driver to promote and reward better

quality care rather than payment based on service volume.

1) Contractor shall adopt a hospital payment methodology for each general acute care hospital in its QHP networks that ties payment to quality performance.

   CMS Critical Access Hospitals, as defined by the Centers for Medicare and Medicaid, and Long Term Care hospitals, Inpatient Psychiatric hospitals, Rehabilitation hospitals, and Children's hospitals are not subject to this requirement. Contractor is accountable for the quality of care and safety of Covered California Enrollees receiving care in these hospitals.

2) In developing payment methodology, Contractor shall consider data from Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), Leapfrog hospital safety scores, and Cal Hospital Compare Patient Safety Honor Roll.

3) Implementation of this requirement may differ for integrated delivery systems and accountable care organizations and require alternative mechanisms for linking payment to performance. Those hospitals participating in an IDS or ACO that have shared risk or other accountability for total cost of care shall be considered to have met this performance-based payment requirement as outlined in Article 4.03.5.

4) Contractor must report in the annual application for certification:

   a) The amount and structure for its hospital performance-based payment strategy, including the shared-risk and performance payment structure to hospitals participating in ACOs, if applicable.

   b) The metrics that are applied for performance-based payments such as: mortality, Hospital Associated Infections (HAIs), adherence to sepsis management guidelines, readmissions, or satisfaction as measured through HCAHPS. Such metrics should be commonly in use in hospitals and endorsed by the National Quality Forum to limit hospital measurement burden or in current use by the CMS Value Purchasing programs for Inpatient, Outpatient and Ambulatory Surgery.

   c) The percent of network hospitals operating under contracts reflecting this payment methodology.

   d) The dollars and percent, or best estimate, that is respectively paid or withheld to reflect value, including the extent to which the "at-risk" payments take the form of bonuses, withholds, or other performance-based payment mechanisms.

   e) The dollars and percent, or best estimate, of hospital payments that are

tied to hospital “improvement” versus “attainment” of a performance threshold.

5) Contractor shall work with Covered California to provide comparison reporting for the requirements in Article 4.03.5 for all lines of business to compare performance and inform future Covered California requirements in this area.

4.03.6 Hospital Patient Safety

Covered California has focused on aligned and collaborative efforts to promote hospital safety based on the recognition that improving hospital performance in this area requires a comprehensive and cross-payer approach. Monitoring and improving hospital safety measures will improve clinical outcomes and reduce wasteful healthcare spending.

1) Contractor shall work with Covered California to support and enhance acute general hospitals’ efforts to promote safety for their patients.

   CMS Critical Access Hospitals, as defined by the Centers for Medicare and Medicaid, and Long Term Care hospitals, Inpatient Psychiatric hospitals, Rehabilitation hospitals, and Children’s hospitals are excluded from this requirement.

2) Covered California has identified a set of patient safety measures for quality improvement focus consisting of five hospital associated infections (HAIs) measures and sepsis management (SEP-1) measure. Substituting patient safety measures in future years will be done so in a transparent manner and in collaboration with stakeholders. The required patient safety measures are:

   a) Catheter-associated Urinary Tract Infection (CAUTI) (NQF #0138);

   b) Central Line Associated Blood Stream Infection (CLABSI) (NQF #0139);

   c) Surgical Site Infection (SSI) with focus on colon (NQF #0753);

   d) Methicillin-resistant Staphylococcus aureus (MRSA) (NQF #1716);

   e) Clostridioides difficile colitis (C. Diff) infection (NQF #1717); and

   f) Sepsis Management (SEP-1).

3) Contractor must report its strategies to improve safety in network hospitals in the annual application for certification. The quality improvement strategies will be informed by review of specified patient safety measures in in Article 4.03.6.2 for all network hospitals.

4) The Contractor shall work with its contracted hospitals to continuously pursue a Standardized Infection Ratio (SIR) of 1.0 or lower for each of the specified HAIs. The Contractor shall also work with its contracted hospitals to improve adherence to the Sepsis Management (SEP-1) guidelines.

5) Covered California is committed to addressing the opioid epidemic and continues to pursue improvement in the appropriate use of opioids in both the outpatient and hospital settings. Article 2.03.1 addresses opioid use in the outpatient setting. To support the appropriate use of opioids in the hospital setting:

   a) Contractor must report its strategies to improve the appropriate use of opioids in its network hospitals in the annual application for certification.

   b) Covered California expects Contractor to encourage all network hospitals to utilize the Opioid Management Hospital Self-Assessment which outlines key milestones to achieving opioid safety, and to participate in the Opioid Care Honor Roll program from Cal Hospital Compare. The self-assessment can be accessed from: https://calhospitalcompare.org/wp-content/uploads/2021/05/Opioid-Mgmt-Hospital-Self-Assessment_2021_FINAL.pdf.

4.03.7 Maternity Care

According to the World Health Organization, maternal health refers an individual's health during pregnancy, childbirth, and the postpartum period. Covered California is committed to addressing all three phases to provide a comprehensive approach to maternal health.

1) Cesarean sections (C-sections) can be lifesaving, but significant numbers of low-risk, first-time pregnancies are undergoing this invasive surgery when it is not medically necessary. Reducing the rate of unnecessary C-sections improves health outcomes and patient safety. To avoid unnecessary C-sections, Contractor must:

   a) Work collaboratively with Covered California to promote and encourage all network hospitals that provide maternity services to use the resources provided by California Maternity Quality Care Collaborative (CMQCC) and enroll in the CMQCC Maternal Data Center (MDC).

   b) Review information on C-section rate for Nulliparous, Term, Singleton, Vertex (NTSV) deliveries and use it to inform a hospital engagement strategy to reduce NTSV C-sections, such as quarterly hospital and provider performance reviews, providing technical assistance for specific quality and safety domains, and other similar activities.

c) Adopt value-based payment strategies structured to support only medically necessary care with no financial incentive to perform C-sections for all contracted physicians and hospitals by year end 2023.

These value-based payment strategies include:

i. Blended case rate payment for both physicians and hospitals;

ii. Including a NTSV C-section metric in existing hospital and physician quality incentive programs; and

iii. Population-based payment models, such as maternity episode payment models.

d) Contractor must annually report in the application for certification:

i. How it is engaging with providers and Enrollees to promote the appropriate use of C-sections; and

ii. Its payment strategy for maternity care, including how this strategy promotes the appropriate use of C-sections, and the number and percent of network maternity hospitals under each strategy.

e) Covered California expects Contractor to encourage providers with high rates of NTSV C-section delivery to pursue CMQCC coaching. Covered California expects the Contractor to consider NTSV C-section rate, improvement trajectory, and willingness to engage in coaching as part of its maternity hospital contracting decisions and terms by year end 2023 and annually thereafter. Covered California does not expect Contractor to base potential network removal decisions on one measure alone.

2) Maternal health disparities exist across the full spectrum of maternal health, from preconception, to pregnancy, and the postpartum period. Disparities in maternal health disproportionately affect Black and Latino populations at higher rates than other racial groups. Reducing and eliminating gaps in maternal health requires a multifaceted approach. To accomplish this, Contractor must:

a) Annually submit patient level data files for the following HEDIS measures in accordance with Article 1.02.1:

i. Prenatal Depression Screen and Follow-up (PND-E)

ii. Postnatal Depression Screen and Follow-up (PDS-E)

b) Annually report in the application for certification:

i. How it is engaging with its contracted providers to improve performance on the maternal health measures in 4.03.7.2, which may include performance reviews, evidence-based interventions, and participation in quality collaboratives.

ii. How it identifies maternal health disparities among its maternity Enrollees.

iii. How it engages with hospitals and providers to address maternal health disparities. Engagement may include quarterly performance reviews, data analysis on race and ethnicity of its maternity Enrollees and outcomes, implementation of corrective action plans, or trainings on implicit bias for perinatal staff.

iv. How it supports its maternity Enrollees, such as access to culturally and linguistically appropriate maternity care, referrals to group prenatal care or community-centered care models for patients, in home lactation and nutrition consultants, doulas for postpartum care, and related services.

c) Contractor must engage with Covered California to review its performance on the Prenatal and Postpartum Care (PPC) (NQF #1517) measure, the Prenatal Depression Screen and Follow-up (PND-E), Postnatal Depression Screen and Follow-up (PDS-E), and the strategies reported in accordance with Article 4.03.7.

d) Work collaboratively with Covered California to promote and encourage all in-network hospitals that provide maternity services to use the resources provided by California Maternity Quality Care Collaborative (CMQCC) and the California Department of Public Health's Maternal, Child and Adolescent Health (MCAH) Division to address maternal health disparities.

4.04 Telehealth

Telehealth includes synchronous and asynchronous patient-provider communication, remote patient monitoring, e-consults, hospital at home, and other virtual health services. Telehealth has the potential to improve access to and cost of care when used for the right conditions under the right payment models. Potential benefits include addressing barriers to care such as transportation, childcare, limited English proficiency (LEP), and time off work which may exist for Enrollees.

4.04.1 Telehealth Offerings

In the annual application for certification, Contractor shall report the extent to which Contractor is supporting the use of telehealth, remote patient monitoring, and other technologies when clinically appropriate to assist in providing high quality, accessible, patient-centered care. Covered California encourages Contractor to use network providers to provide telehealth whenever possible. Contractor must continue to comply with applicable network adequacy standards for in-person services. Specifically, Contractor must report:

1) The types and modalities of telehealth and virtual health services that Contractor offers to Enrollees, as well as the goal or desired outcome from the service (e.g. decreased ED visits, better access to specialty care, improved diabetes management, etc.), including:
    a) Interactive dialogue over the phone (voice only encounter)
    b) Interactive face to face (video and audio encounter)
    c) Asynchronous via email, text, instant messaging or other
    d) Remote patient monitoring (e.g. blood pressure, glucose control, etc.)
    e) e-Consult
    f) Hospital at Home
    g) Other modalities
2) How Contractor is communicating with and educating Enrollees about telehealth services including:
    a) Service availability explained on key Enrollee website pages, such as the home page and provider directory page;
    b) Service cost-share explained on key Enrollee website pages like the summary of benefits and coverage page and medical cost estimator page; and
    c) Interpreter service availability for telehealth explained on key Enrollee website pages, such as the home page and provider directory page.
3) How Contractor facilitates the integration and coordination of care between third party telehealth vendor services and primary care and other network providers, particularly if the telehealth service is for urgent care, chronic disease management, or behavioral health.

4) How Contractor screens for Enrollee access barriers to telehealth services such as broadband affordability, digital literacy, smartphone ownership, and the geographic availability of high-speed internet services.

5) A description of Contractor's telehealth reimbursement policies for network providers and for third party telehealth vendors, including payment parity between:

   a) Telehealth modalities, including voice only when appropriate, and comparable in-person services

   b) Telehealth vendor and contracted provider rendered telehealth services.

6) The impact telehealth has on cost and quality of care provided to Enrollees, including the extent to which telehealth replaces or adds to utilization of specialty care, Emergency Department, or urgent care services.

4.04.2 Monitoring Telehealth Utilization

Contractor must engage with Covered California to review its utilization of telehealth services using HEI data submitted in accordance with Article 5.02.1.

4.05 Participation in Quality Collaboratives

Improving healthcare quality and reducing overuse and costs can only be done over the long-term through collaboration, data sharing, and effective engagement of hospitals, providers, and other providers of care. There are several established statewide and national collaborative initiatives that are aligned with Covered California's requirements and expectations for quality improvement, addressing health disparities, and improving data sharing.

Covered California and Contractor will collaboratively identify and evaluate the most effective programs for improving care for Enrollees. Covered California may require participation in specific quality improvement collaboratives and data sharing initiatives in future years. To inform this process, Contractor must report its participation in any of the following collaboratives or initiatives, including the amount of financial support (if any) the Contractor provides, in the annual application for certification:

   a) American Joint Replacement Registry (AJRR) for California

   b) Cal Hospital Compare

   c) California Maternal Quality Care Collaborative (CMQCC)

d) California Quality Collaborative (CQC)

e) Collaborative Healthcare Patient Safety Organization (CHPSO)

f) California Improvement Network (CIN)

g) California Right Meds Collaborative

h) Leapfrog

i) Integrated Healthcare Association (IHA)

j) Symphony Provider Directory

k) Health Care Payments Data (HPD) System

l) Other similar collaboratives or initiatives

ARTICLE 5 - MEASUREMENT AND DATA SHARING

Measurement is foundational to assessing the quality, equity, and value of care provided by QHP Issuers to Enrollees. Because of this, Covered California uses a variety of HEDIS and CAHPS measures in its assessment of QHP performance, and is developing a robust Healthcare Evidence Initiative to assess further dimensions of quality, equity, and value. Contractor agrees to work with Covered California to exchange and prioritize feedback on measure development and measure sets. This includes measurement refinements related to the National Committee for Quality Assurance (NCQA) Electronic Clinical Data System, the Quality Rating System, and Healthcare Evidence Initiative measures.

With the healthcare industry increasingly using electronic health records, data sharing along the healthcare continuum from patient to providers to hospitals to payers is a critical driver of quality of care. Covered California is committed to making patient data available and accessible to support population health management, clinical care, and coordination, decrease healthcare costs, reduce paperwork, improve outcomes, and give patients more control over their healthcare.

5.01 Measurement and Analytics

5.01.1 Covered California Quality Rating System Reporting

Contractor and Covered California recognize that the Quality Rating System is an important mechanism to monitor QHP Issuers for quality performance, a standardized source of consumer information for Enrollees and the public, and can inform measure alignment with other purchasers and measure sets.

1) Contractor shall annually collect and report to Covered California, for each QHP product type, its numerators, denominators, and rates for the measures included in the CMS Quality Rating System Measure Set. This includes data for select HEDIS and CAHPS measures and may also include data for other types of measures included in Quality Rating System. Contractor must provide such data to Covered California each year regardless of the extent to which CMS uses the data for public reporting or other purposes.

2) Contractor shall work with Covered California, including participating in quality assurance activities, in order for Covered California to produce the Quality Rating System ratings each year.

3) Covered California reserves the right to use Contractor-reported data to

construct Contractor summary quality ratings that Covered California may use for purposes such as supporting consumer choice, quality improvement efforts, establishing performance standards, and other activities related to Covered California's role as a Health Oversight Agency.

5.01.2 National Committee for Quality Assurance (NCQA) Quality Compass Reporting

Contractor and Covered California recognize that performance measure comparison for the Covered California population to national benchmarks for commercial and Medicaid lines of business promotes health equity, informs efforts to address health disparities, and ensures consistent quality of care across all populations.

1) Contractor shall annually collect and report HEDIS and CAHPS scores to the National Committee for Quality Assurance (NCQA) Quality Compass for its commercial (which includes the Covered California population) and Medi-Cal lines of business. This submission to NCQA Quality Compass shall include the numerator, denominator, and rate for the NCQA Quality Compass required measures.

2) Contractor shall submit to Covered California HEDIS and CAHPS scores including the measure numerator, denominator, and rate for the required measures that are reported to the NCQA Quality Compass and DHCS, for each product type for which it collects data in California, if requested. For Contractors that have commercial lines of business that do not permit public reporting of their results to NCQA Quality Compass, HEDIS and CAHPS scores for the NCQA Quality Compass measures set must still be submitted to Covered California.

3) Contractor shall report such information to Covered California in a form that is mutually agreed upon by the Contractor and Covered California and participate in quality assurance activities to validate measure numerator, denominator, and rate data.

5.02 Data Sharing and Exchange

5.02.1 Data Submission (Healthcare Evidence Initiative)

Contractor must comply with the following data submission requirements:

1) General Data Submission Requirements

a) California law requires Contractor to provide Covered California with information on cost, quality, and disparities to evaluate the impact of Covered California on the healthcare delivery system and health coverage in California.

b) California law requires Contractor to provide Covered California with data needed to conduct audits, investigations, inspections, evaluations, analyses, and other activities needed to oversee the operation of Covered California, which may include financial and other data pertaining to Covered California's oversight obligations. California law further specifies that any such data shall be provided in a form, manner, and frequency specified by Covered California.

c) Contractor is required to provide Healthcare Evidence Initiative Data ("HEI Data") that may include data and other information pertaining to quality measures affecting enrollee health and improvements in healthcare quality and patient safety. This data may likewise include enrollee claims and encounter data needed to monitor compliance with applicable provisions of this Agreement pertaining to improvements in health equity and disparity reductions, performance improvement strategies, alternative payment methods, as well as enrollee specific financial data needed to evaluate enrollee costs and utilization experiences. Covered California shall only use HEI Data for those purposes authorized by law.

d) The Parties mutually agree and acknowledge that financial and other data needed to evaluate enrollee costs and utilization experiences includes information pertaining to contracted provider reimbursement rates and historical data as required by applicable California law.

e) Covered California may, in its sole discretion, require that certain HEI Data submissions be transmitted to Covered California through a vendor (herein, "HEI Vendor") which will have any and all legal authority to receive and collect such data on Covered California's behalf.

2) Healthcare Evidence Initiative Vendor

a) Contractor shall work with any HEI vendor which Covered California contracts with to assist with its statutory obligations.

b) The parties acknowledge that any such HEI Vendor shall be retained by Covered California and that Covered California shall be responsible for HEI Vendor's protection, use and disclosure of any such HEI Data.

c) Notwithstanding the foregoing, Covered California acknowledges and agrees that disclosures of HEI Data to HEI Vendor or to Covered California shall at all times be subject to conditions or requirements imposed under applicable federal or California State law.

3) HEI Vendor Designation

a) Should Covered California terminate its contract with its then-current HEI Vendor, Covered California shall provide Contractor with at least thirty (30) days' written notice in advance of the effective date of such termination.

b) Upon receipt of the aforementioned written notice from Covered California, Contractor shall terminate any applicable data-sharing agreement it may have with Covered California's then-current HEI Vendor and shall discontinue the provision of HEI Data to Covered California's then-current HEI Vendor.

4) Covered California shall notify Contractor of the selection of an alternative HEI Vendor as soon as reasonably practicable and the parties shall at all times cooperate in good faith to ensure the timely transition to the new HEI Vendor.

5) HIPAA Privacy Rule

a) PHI Disclosures Required by California law:

i. California law requires Contractor to provide HEI Data in a form, manner, and frequency determined by Covered California. Covered California has retained and designated an HEI Vendor to collect and receive certain HEI Data on its behalf.

ii. Accordingly, the parties mutually agree and acknowledge that the disclosure of any HEI Data to Covered California or to HEI Vendor which represents PHI is permissible and consistent with applicable provisions of the HIPAA Privacy Rule which permit Contractor to disclose PHI when such disclosures are required by law (45 CFR §164.512(a)(1)).

b) PHI Disclosures for Health Oversight Activities:

i. The parties mutually agree and acknowledge that applicable California law (CA Gov Code §100503.8) requires Contractor to provide Covered California with HEI Data for the purpose of engaging in health oversight activities and declares Covered California to be a health

oversight agency for purposes of the HIPAA Privacy Rule (CA Gov Code §100503.8).

ii. The HIPAA Privacy Rule defines a "health oversight agency" to consist of a person or entity acting under a legal grant of authority from a health oversight agency (45 CFR §164.501) and HEI Vendor has been granted legal authority to collect and receive HEI Data from Contractor on Covered California's behalf.

iii. Accordingly, the parties mutually acknowledge and agree that the provision of any HEI Data by Contractor to Covered California or HEI Vendor which represents PHI is permissible under applicable provisions of the HIPAA Privacy Rule which permit the disclosure of PHI for health oversight purposes (45 CFR §164.512(d).

c) Publication of Data and Public Records Act Disclosures

i. Contractor acknowledges that Covered California intends to publish certain HEI Data provided by Contractor pertaining to its cost reduction efforts, quality improvements, and disparity reductions.

ii. Notwithstanding the foregoing, the parties mutually acknowledge and agree that data shall at all times be disclosed in a manner which protects the Personal Information (as that term is defined by the California Information Privacy Act) of Contractor's enrollees or prospective enrollees.

iii. The parties further acknowledge and agree that records which reveal contracted rates paid by Contractor to healthcare providers, as well as any enrollee cost share, claims or encounter data, cost detail, or information pertaining to enrollee payment methods, which can be used to determine contracted rates paid by Contractor to healthcare providers shall not at any time be subject to public disclosure and shall at all times be deemed to be exempt from compulsory disclosure under the Public Records Act. Accordingly, Covered California shall take all reasonable steps necessary to ensure such records are not publicly disclosed.

6) IBM Watson Health is the current HEI Vendor. IBM Watson Health is the measure developer for select measures used by Covered California. The measure definitions are derived from the IBM Health Insights® solution for these select measures.

5.02.2 Interoperability and Patient Access

Covered California and Contractor recognize that interoperability is critical to improved data exchange which in turn is foundational to providing less fragmented, more coordinated care. Data interoperability, as well as patient and provider access to health records, will also give patients greater control of their health information to support self-management.

1) Contractor must implement and maintain a secure, standards-based Patient Access API consistent with the existing Centers for Medicare & Medicaid (CMS) Interoperability & Patient Access final rule (CMS-9115-F) and any technical updates associated with the new CMS Reducing Provider & Patient Burden by Improving Prior Authorization Processes, and Promoting Patients' Electronic Access to Health Information final rule (CMS-9123-P) for Federally Facilitated Marketplaces that is effective starting January 1, 2023.

2) Contractor must enhance QHP Issuer information services for enrollees consistent with the existing CMS Interoperability and Patient Access final rule (CMS-9115-F) and any technical updates consistent with the new CMS Reducing Provider and Patient Burden by Improving Prior Authorization Processes, and Promoting Patients' Electronic Access to Health Information final rule (CMS-9123-P) that requires QHP Issuer participation in payer-to-payer data exchange and consumer education for Federally Facilitated Marketplaces effective starting January 1, 2023. Specifically, Contractor must:

    a) Participate in payer-to-payer data exchange at enrollment; and

    b) Educate consumers about opting in to authorize data transfers from their prior health plan to their new health plan.

While Contractor builds its small group business, requirements included in Article 5.02.2 will not be applied to the CCSB line of business. When this requirement pertains to CCSB, Contractor will be required to report on this requirement annually.

5.02.3 Data Exchange

1) Contractor must participate in a Health Information Exchange (HIE) that is a member of the California Trusted Exchange Network (CTEN).

2) Contractor must bi-directionally exchange information with HIEs as characterized by:

    i. Contractor receipt of information from an HIE(s); and

ii. Contractor dissemination of information to an HIE(s).

3) Contractor must report on the following activities to support data exchange with providers and hospitals in the annual application for certification:
   a) Bi-directional exchange of information with one or more HIE(s) that participates in CTEN.
   b) Data exchange initiatives that enhance health equity and access, specifically steps taken to support enhanced demographic and social risk factor data capture.
4) Contractor agrees to work with Covered California and other stakeholders regarding a transition to a statewide approach to streamline Health Information Exchange participation and other efforts that could improve the exchange of data. This includes participation in the development of the "California Health and Human Services Data Exchange Framework" and plan of action associated with Health and Safety Code § 130290 (A.B. 133 (2021)), adoption of the 2015 Office of the National Coordinator for Health Information Technology Electronic Health Records standards, and discussions to develop future requirements beyond the existing federal standards.
5) Contractor is required to support and monitor its hospitals consistent with the existing CMS Interoperability and Patient Access final rule (CMS-9115-F) in the application of the Medicare Condition of Participation to have electronic information exchange to notify primary care providers of Admission, Discharge, Transfer (ADT) events for Enrollees. Contractor must report the following in its annual application for certification:
   a) Description of Contractor's actions to ensure hospitals, including psychiatric hospitals and critical access hospitals, are complying with the ADT notification requirements specified above;
   b) Number and percent of hospitals, including psychiatric hospitals and critical access hospitals, that have implemented ADT notification for Enrollees; and
   c) Description of the mechanisms Contractor has implemented to assist those hospitals not yet exchanging ADT data with primary care providers for Enrollees.
6) Contractor agrees that improving data exchange among providers is important for providing high-quality, equitable, and affordable care. Contractor will make good faith efforts to improve data exchange through collaborative efforts and strategic decisions for its other products and lines of business. While Contractor builds its small group business, requirements

included in Article 5.02.3 will not be applied to the CCSB line of business.

5.02.4 Data Aggregation

Covered California and Contractor recognize that aggregating data across purchasers and payors to more accurately understand the performance of providers that have contracts with multiple QHPs can improve performance, contracting, and public reporting. As such:

1) Contractor must participate in the Integrated Healthcare Association's Align.Measure.Perform (AMP) Programs and must contribute data to the AMP Programs and the California Regional Healthcare Cost & Quality Atlas. Contractor must report performance results to Covered California annually or allow IHA to submit Contractor's performance results to Covered California on Contractor's behalf.
2) Contractor must submit data to IHA for use in the Advanced Primary Care Measure Set, the Commercial ACO Measure Set, and the Commercial HMO Measure Set as specified in Article 4. Contractor must report performance results to Covered California annually or allow IHA to submit Contractor's performance results to Covered California on Contractor's behalf.

Contractor agrees that aggregation of claims and clinical data across purchasers and payers is important for providing high-quality, equitable, and affordable care. Contractor will make good faith efforts to support data aggregation through collaborative efforts and strategic decisions for its other products and lines of business. While Contractor builds its small group business, requirements included in Article 5.02.4 will not be applied to the CCSB line of business.

ARTICLE 6 - CERTIFICATION, ACCREDITATION, AND REGULATION

Covered California seeks to align with the standard measures and annual benchmarks for equity and quality in health care delivery established by the Department of Managed Health Care as required by Health and Safety Code § 1399.871 (A.B.133 (2021)). This furthers Covered California's goal to establish a common standard of core health plan functions across all QHP Issuers. Using a common standard will allow Covered California to phase in higher standards aimed at improving Enrollee outcomes that are aligned with a single health plan accreditation process and enhance coordinated improvement actions.

6.01 QHP Accreditation

6.01.1 Health Plan Accreditation

Contractor must maintain current health plan accreditation for its Covered California membership throughout the term of the Agreement. Contractor shall authorize the accrediting agency to provide information and data to Covered California relating to Contractor's accreditation, including the NCQA submissions and audit results, and other data and information maintained by its accrediting agency as required by 45 C.F.R. § 156.275.

6.01.2 NCQA Health Plan Accreditation

Contractor shall achieve NCQA health plan accreditation by year end 2024.

If Contractor is not currently accredited by NCQA health plan accreditation:

1) Contractor shall provide a plan to Covered California at least annually regarding the status and progress of the pre-NCQA accreditation process to achieve NCQA health plan accreditation by year end 2024.

2) Contractor shall be currently accredited by URAC or AAAHC health plan accreditation until NCQA health plan accreditation is achieved.

6.01.3 Accreditation Review

Contractor shall notify Covered California of the date of any accreditation review scheduled during the term of this Agreement and the results of such review. Upon completion of any health plan accreditation review conducted during the term of this Agreement, Contractor shall provide Covered California with a copy of the Assessment Report within thirty (30) days of receiving the report.

6.01.4 Changes in Accreditation Status

If Contractor receives a rating of less than accredited in any category, loses an accreditation, or fails to maintain a current and up to date accreditation:

1) Contractor shall notify Covered California within ten (10) business days of such rating(s) change. Contractor must implement strategies to raise Contractor's rating to a level of at least accredited or to reinstate accreditation. Contractor will submit a written corrective action plan (CAP) to Covered California within thirty (30) days of receiving its initial notification of the change in rating or loss of accreditation.

2) Following the initial submission of the corrective action plan (CAP), Contractor shall provide a written report to Covered California, when requested, but no less than quarterly, regarding the status and progress of the accreditation reinstatement. Contractor shall request a follow-up review by the accreditation entity no later than twelve (12) months after loss of accreditation and submit a copy of the follow-up Assessment Report to Covered California within thirty (30) days of receipt, if applicable.

3) Contractor shall proceed with any pre-NCQA Accreditation application submission steps to become newly accredited or re-accredited by NCQA.

4) Contractor shall coordinate improvement efforts and the corrective action plan, as applicable, with any improvement efforts and corrective action plan(s) required by Health and Safety Code § Article 11.9 (A.B.133 (2021)).

6.01.5 Disciplinary and Enforcement Actions

1) In the event Contractor's overall accreditation is suspended, revoked, or otherwise terminated, or in the event Contractor has undergone review prior to the expiration of its current accreditation and reaccreditation is suspended, revoked, or not granted at the time of expiration, Covered California reserves the right to terminate this agreement, decertify Contractor’s QHPs, or suspend enrollment in Contractor's QHPs, to ensure Covered California is in compliance with the federal requirement that all participating issuers maintain a current approved accreditation pursuant to 45 C.F.R. § 156.275(a).

2) Upon request by Covered California, Contractor will identify all health plan certification or accreditation programs undertaken, including any failed accreditation or certifications, and will also provide the full written report of such certification or accreditation undertakings to Covered California.