ATTACHMENT 1 TO COVERED CALIFORNIA FOR SMALL BUSINESS 2026-2028 QUALIFIED HEALTH PLAN ISSUER CONTRACT: ADVANCING EQUITY, QUALITY, 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 Attachment 1 is focused on key areas that Covered California believes require systematic focus and investment in order to ensure Covered California Enrollees and all Californians receive high-quality, equitable care. These include a commitment to advanced primary care, behavioral health, disparities reduction, cost, and data exchange and an emphasis on member-centered values and sustaining a robust health professional workforce.

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 Contractor's entire California membership.

Contractor shall comply with the requirements in this Attachment 1 by January 1, 2026, unless otherwise specified.

Contractor must complete and submit information, including reports, plans, and data, as described in this Attachment 1 annually at a time and in a manner determined by Covered California unless otherwise specified. Information will be used to assess compliance with requirements, evaluate performance, and for negotiation and evaluation purposes regarding any extension of this Agreement. When submitting its information to Covered California, Contractor shall clearly identify any information it deems confidential, a trade secret, or proprietary. Covered California will use Healthcare Evidence Initiative (HEI) data and measures to monitor Contractor performance and evaluate HEI measures' effectiveness in assessing Contractor performance. Contractor agrees to engage and work with Covered California to review its performance on all HEI generated measures, not only those measures specifically described in this Attachment 1. Contractor agrees to meet with Covered California at least twice a year to review its performance on HEI analysis. Based on these reviews, Covered California may revise the HEI measures during the contract period or in future contract years.

Contractor shall submit all required information 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 Centers for Disease Control and Prevention adopted the definition of health equity as "the state in which everyone has a fair and just opportunity to attain their highest level of health" and health disparities as "preventable differences in the burden of disease, injury, violence or opportunities to achieve optimal health that are experienced by socially disadvantaged populations"[1].

To achieve health equity requires a comprehensive dismantling of the factors impeding health and wellness. The Federal Plan for Equitable Long-Term Recovery and Resilience outlines the seven vital conditions for Health and Well-Being, which include Basic Needs for Health and Safety, Human Housing, Reliable Transportation, Meaningful Work and Wealth, Thriving Natural World, Belonging and Civic Muscle, and Lifelong Learning.[2] Addressing health equity and disparities in healthcare is integral to the mission of Covered California. Covered California and Contractor will work in partnership with others to achieve these vital conditions for Covered California Enrollees.

1.01 Demographic Data Collection

Collection of accurate and complete member demographic data is critical to effective measurement and reduction of health disparities. Contractor will collect member self-reported race and ethnicity using the Centers for Disease Control and Prevention (CDC) Race and Ethnicity Codes Set that maps to the Office of Management and Budget (OMB) defined race and ethnicity categories. The collection and analysis of this disaggregated data will allow for the development of more focused and appropriate interventions to support health equity.

1.01.1 Expanded Demographic Data Collection

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

1) 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. Member demographic data of interest includes:

[1] *What is Health Equity* (June 11, 2024) Ctrs. for Disease Control & Prevention, https://www.cdc.gov/health-equity/what-is/index.html.
[2] *Fed. Plan for Equitable Long-Term Recovery & Resilience* (Jan. 20, 2022) https://health.gov/sites/default/files/2022-04/ELTRR-Report_220127a_ColorCorrected_2.pdf.

a) Income

b) Race

c) Ethnicity

d) Preferred spoken language

e) Preferred written language

f) Disability status

g) Sexual orientation

h) Gender identity

1.02 Identifying Disparities in Care

Covered California recognizes that the underlying causes of health disparities are multifactorial 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 to specific populations and targeting select measures. As Covered California transitions to expanded use of the HEI data to assess improvements in healthcare quality and equity, Covered California expects that 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 address health disparities identified by Covered California.

1.03 Health Equity Capacity Building

Attaining health equity requires organizational investment in building a culture of health equity. Covered California remains committed to advancing health equity and ensuring that all Californians have access to high-quality, equitable care. ~~Meeting the standards for the Health Equity Accreditation by the National Committee for Quality Assurance (NCQA) (previously Multicultural Health Care Distinction (MHCD)) provides the necessary structure to build a program to reduce documented disparities and to develop culturally and linguistically appropriate communication strategies.~~

1.03.1 Health Equity Accreditation

Though no longer active, NCQA Health Equity Accreditation remains a recognized benchmark for advancing health equity practices. Covered California will consider requiring Contractor to achieve comparable health equity accreditation for future contract years and may consider additional health equity capacity building requirements in a future contract amendment. ~~Contractor must submit evidence of current NCQA Health Equity Accreditation to Covered California by January 30, 2026, or achieve NCQA Health Equity Accreditation by the end of its first Plan Year contracted with Covered California. A Contractor that has not yet achieved NCQA Health Equity Accreditation shall submit documentation to Covered California regarding its progress during its first Plan Year contracted with Covered California, in the following schedule:~~

~~1) Last day of January: Submit Workplan submitted to NCQA.~~

~~2) Last day of May: Submit first Progress Report.~~

~~3) Last day of August: Submit second Progress Report.~~

~~Last day of December: Submit evidence of NCQA Health Equity Accreditation achievement.~~

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1.03.2 Workforce

Developing and sustaining a diverse workforce representative of the population served is critical to achieving equitable health outcomes. Contractor must report on processes and initiatives to achieve and retain this workforce to best serve enrollee needs. To meet this requirement, Contractor may either: submit documentation demonstrating compliance with NCQA Health Equity Accreditation Standards from the 2024 standards year, as outlined in subsection 1, or provide requested documentation demonstrating efforts to achieve and maintain a diverse workforce representative of the population served, as outlined in subsection 2.

1. Contractor may submit the following NCQA Health Equity Accreditation Standards reports:

a. Health Equity Standard 1: Organizational Readiness

If Contractor submitted evidence of NCQA Health Equity Accreditation during Plan Year 2026, it is not required to submit another report during this contract period to meet this requirement.

2. Contractor may complete and submit a report to Covered California that addresses each of the following components:

a. How Contractor assesses alignment between workforce representation and

the population served and implements measures to address any identified misalignment;

b. How Contractor assesses if its recruitment or hiring practices create barriers to qualified applicants from certain groups, especially historically disadvantaged groups and implements measures to adjust identified recruitment or hiring practices accordingly;

c. How Contractor assesses workforce cultural humility and implements measures to address any identified gaps in cultural humility;

~~4)~~d. Inventory of staff and provider trainings provided related to cultural humility, racial humility, implicit bias, or other related topics. Inventory must specify which trainings are required and optional.

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Culturally and Linguistically Appropriate Care

1.03.~~2~~3 Evidence of Culturally and Linguistically Appropriate Services

Contractor must demonstrate provision of culturally and linguistically appropriate services to Enrollees. To meet this requirement, Contractor may either: submit documentation demonstrating compliance with NCQA Health Equity Accreditation Standards from the 2024 standards, as outlined in subsection 1, or provide requested documentation demonstrating culturally and linguistically appropriate services, as outlined in subsection 2. NCQA Health Outcomes Accreditation, including its associated 2026 standards reporting, will not be accepted to fulfill this requirement.

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1) Contractor ~~must~~ may submit the following NCQA Health Equity Accreditation Standards reports:

   a) Health Equity Standard 3: Access and Availability of Language Services

   b) Health Equity Standard 4: Practitioner Network Cultural Responsiveness

   c) Health Equity Standard 5: Culturally and Linguistically Appropriate Services Programs

~~c)~~ If Contractor submitted the required components of the NCQA Health Equity Accreditation report during Plan Year 2026, it is not required to submit another report during this contract period to meet this requirement.

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~~2) Contractor must submit reports once every three years in accordance with the three-year NCQA Health Equity Accreditation cycle. Covered California will not require annual submission of the specified NCQA Health Equity Accreditation Standards unless changes are made during the three-year cycle at which point~~

~~Contractor must resubmit the revised reports to Covered California.~~

~~3)~~2) ~~If Contractor has not yet attained the NCQA Health Equity Accreditation or is unable to provide components of the NCQA Health Equity Accreditation Standards required in this Section,~~ Contractor ~~must~~ may complete and submit a report to Covered California that addresses each of the following components:

a) Access and Availability of Language Services

i. Vital information provided to Enrollees in threshold languages, including assessment of the use of competent translators based on proficiency in the source and target language, and whether translation is provided in a timely manner. For guidance on translation competency and timely access, see NCQA Health Equity Accreditation Standard 3.

ii. Use of competent interpreter, as defined by NCQA Health Equity Accreditation Standard 3, or bilingual services to communicate with individuals who need to communicate in a language other than English. Support for providers in providing competent language services.

iii. Annual distribution of a written notice communicating in English and threshold languages spoken by Limited-English-proficient (LEP) Individuals in California, the availability of free language assistance and how individuals can obtain language assistance in English and in threshold languages. For the purposes of this reporting, threshold languages are languages spoken by 1% of individuals served by the organization or by 200 individuals, whichever is less.

~~4~~3) Provider Network Cultural Responsiveness

a) How Contractor maintains a provider network that can serve its diverse membership and is responsive to member language needs and preferences.

b) If and how Contractor:

i) Collects languages in which a provider is fluent when communicating about medical care.

ii) Collects language services available through the practice.

iii) Collects provider race/ethnicity data.

iv) Publishes provider languages in the provider directory.

v) Publishes language services available through practices in the provider directory.

vi) Provides provider race/ethnicity on request.

vii) At least every three years, analyzes the capacity of its network to meet the language needs of members.

viii) At least every three years, analyzes the capacity of its network to meet the needs of members for culturally appropriate care.

ix) Develops a plan to address gaps identified as a result of analysis, if applicable.

x) Acts to address gaps based on its plan, if applicable.

~~5~~4) Culturally and Linguistically Appropriate Services and Programs

a) Program description for improving culturally and linguistically appropriate services (CLAS) that includes the following elements:

i) A written statement describing ~~the Contractor~~Contractor's overall objective for serving a culturally and linguistically diverse population.

ii) A process to involve members of the culturally diverse community in identifying and prioritizing opportunities for improvement.

iii) A list of measurable goals for the improvement of CLAS and reduction of health care disparities.

iv) An annual work plan.

v) A plan for monitoring against the goals.

vi) Annual approval by the governing body.

b) If and how Contractor conducts an annual written evaluation of the CLAS program.

ARTICLE 2 - BEHAVIORAL HEALTH

Behavioral health services include 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 health services 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. Covered California will evaluate Contractor's efforts to ensure access to medically necessary behavioral health services, as specified in this Section.

2.01.1 Behavioral Health Provider Network

1) Contractor must submit the following National Committee for Quality Assurance (NCQA) Health Plan Accreditation Network Management reports:

    a) Network Standard 1, Element A: Cultural Needs and Preferences (including behavioral health providers);

    b) Network Standard 1, Element D: Practitioners Providing Behavioral Healthcare;

    c) Network Standard 2, Element B: Access to Behavioral Healthcare; and

    d) Network Standard 3, Element C: Opportunities to Improve Access to Behavioral Healthcare Services.

Contractor must submit the Network Management reports once every three years in accordance with the three-year NCQA accreditation cycle. Covered California will not require annual submission of the Network Management reports unless changes are made to the Network Management reports during the three-year cycle at which point Contractor must resubmit the revised reports to Covered California.

If Contractor's data upon which its Network Management report is based is older than four years at the time of health plan accreditation, Contractor shall provide to Covered California an updated data submission that addresses the NCQA Network Management standards for behavioral health listed above.

2) 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 once every three years for its Covered California population that addresses each of the NCQA Network Management standards for behavioral health listed in 1) above. These reports can be from Contractor's accrediting body, Utilization Review Accreditation (URAC),the Accreditation Association for Ambulatory Health Care (AAAHC), or supplemental reports that include a description of (1) Contractor's behavioral health provider network, (2) how cultural, ethnic, racial and linguistic needs of Enrollees are met, (3) access standards, (4) the methodology for monitoring access to behavioral health appointments, and (5) at least one intervention to improve access to behavioral health services and the effectiveness of this intervention.

2.01.2 Offering Virtual Care for Behavioral Health

Virtual care, including 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. As used in this Section, "virtual care" refers to all means to digitally interact with patients, including interactions conducted via telehealth and digital technologies such as remote patient monitoring or application-based interventions. Virtual care includes synchronous and asynchronous patient-provider communication, remote patient monitoring, e-consults, hospital at home, and other virtual care services.

Virtual care is not a replacement for Contractor developing a network of in-person behavioral health providers. However, given persistent and extensive workforce challenges, to strengthen access to behavioral health services, Contractor must offer virtual care for behavioral health services when clinically appropriate based on a Covered California 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 virtual care for behavioral health services whenever possible. Contractor must continue to comply with applicable network adequacy standards for in-person services for behavioral health.

2.01.3 Promoting Access to Behavioral Health Services

To ensure Covered California Enrollees are aware of the availability of

behavioral health services, including services available through virtual care, Contractor must:

Clearly and prominently display the types of behavioral health services that are covered on key Covered California Enrollee webpages, such as the home page in its member portal and the provider directory page, accessible in different languages. Contractor shall submit evidence of compliance to Covered California annually such as through a website link, a screenshot of its homepage or other relevant resources.

1) Explain to consumers the scope and availability of behavioral health services, including virtual care, at minimum, in plan documents, such as Evidence of Coverage and Disclosure Forms, and educate Covered California Enrollees how to access behavioral health services, including through virtual care;

2) Inform primary care clinicians of the referral process for Covered California Enrollees for behavioral health services and available behavioral health resources for Covered California Enrollees;

3) Ensure that Contractor's provider directory displays which providers offer behavioral health services, including through virtual care (e.g., Jane Doe, Ph.D. Psychologist, virtual care video/phone), or other member portal navigation features;

4) Promote integration and coordination of care between third party virtual care vendor services and primary care and other network providers; and

5) Implement at least one intervention during contract cycle focused on enhancing access for an identified sub-population that is not accessing necessary services at a rate similar to other subpopulations. Contractor will determine such underutilizing sub-populations using its own historic utilization data and analyses of HEI data conducted and provided by Covered California. Representative interventions include developing culturally appropriate materials, enhancing language options on a digital platform, engaging a member or community advisory board, or establishing a collaborative partnership with a community-based organization to facilitate equitable power sharing and the co-creation of solutions. Contractor must submit proposed intervention plan including proposed outcome measures to Covered California for approval prior to implementation. Covered California will work with Contractor in its first year contracting with Covered California to identify a qualifying activity to meet this requirement in the absence of historic utilization data.

6) Submit to Covered California Enrollee educational materials required by this Section regarding scope, availability and access to behavioral health services, inclusive of virtual care.

2.01.4 Monitoring Behavioral Health Service Utilization

Contractor agrees to engage and work with Covered California to review its behavioral health service utilization, 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~~Contractor's network.

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, including primary care clinicians, to collect Depression Screening and Follow-Up for Adolescents and Adults (DSF-E) measure results, stratified by race and ethnicity, for its Covered California Enrollees.

Covered California strongly encourages Contractor to use the Patient Health Questionnaire-2 and 9 (PHQ-2, PHQ-9) in a culturally and linguistically appropriate manner as standardized depression screening and measurement tools when implementing this measure. If a different tool is used, Contractor must specify the tool when it reports the measure results.

2.02.2 Monitoring Quality Rating System Behavioral Health Measures

To monitor the quality of Contractor's behavioral health services, Contractor agrees to engage and work 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 Substance Use Disorders

Contractor shall work to address Covered California Enrollee substance use disorders which have a significant impact on individual health, leading to chronic health conditions, a decreased quality of life and higher mortality rates. Untreated substance use contributes to increased health care costs through emergency department visits, hospital admissions and the need for more intensive care. Effective integration of prevention, treatment, and recovery services is key to

addressing substance use across the life span of Enrollees. Proactively addressing substance use can lead to cost savings for QHP Issuers and Enrollees, and promotes safer communities. This holistic approach ensures Enrollees receive the support necessary at each stage in their steps toward recovery, leading to healthier Enrollees and a reduced strain on healthcare systems. In addition, Contractor's efforts to reduce substance use support broader public health goals.

2.03.1 Guidelines for 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.

Contractor shall implement policies and programs that align with the guidelines from Smart Care California to promote the appropriate use of opioids by its contracted providers. Contractor's policies and programs shall use a harm reduction framework and an individualized approach to treatment planning and should consider Smart Care California guidelines when making formulary decisions (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: use opioids sparingly, with lower doses and shorter durations when medically appropriate; support non-pharmacological approaches to pain management such as removing prior authorizations for physical therapy;

2) Manage: identify patients on risky drug regimens such as high-dose opioids or opioids and sedatives; ensure providers co-prescribe naloxone with chronic opioid prescriptions; ensure providers develop individualized treatment plans; ensure providers are using appropriate medical standards of care to determine the need for and proper dosage of opioids for pain management while avoiding mandatory tapers;

3) Treat: streamline access to evidence-based treatment for opioid 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.

2.03.2 Monitoring Opioid Use Disorder Treatment

To monitor access to opioid use disorder treatment, Contractor agrees to engage

and work with Covered California to review its Medication Assisted Treatment (MAT) prescriptions, and to review its concurrent prescribing of opioids and naloxone rate using HEI data submitted in accordance with Article 5.02.1.

Contractor must collect Pharmacotherapy for Opioid Use Disorder (POD) measure results for its Covered California Enrollees and report those results, stratified by race and ethnicity.

2.03.3 Tobacco Treatment

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

Contractor must ensure that Covered California Enrollees have access to medically necessary, comprehensive tobacco treatment services, including FDA-approved medications and pharmacotherapy, without undue barriers. These services shall be provided in accordance with evidence-based guidelines and best practices for tobacco treatment. Contractor must actively work to reduce financial, administrative, and other barriers that may hinder Covered California Enrollees' access to these medications and pharmacotherapy, thereby promoting successful tobacco treatment outcomes among Covered California Enrollee populations. To analyze Contractor's tobacco treatment programs, Contractor must report:

1) Analysis of outcomes and results for Covered California Enrollees who use tobacco and enroll in tobacco treatment programs trended over time, inclusive of evidenced-based counseling and appropriate pharmacotherapy, in accordance with current QRS measures. The analysis shall utilize administrative, claims, encounter, and other applicable relevant data and include evaluation of the following methods:

    a) Advise Smokers and Tobacco Users to Quit;
    b) Discuss Treatment Medications; and
    c) Discuss Treatment Strategies.

2.03.4 Other Substances

1) To monitor the quality of Contractor's substance use services, Contractor must meet with Covered California to review its performance on substance use measures reported by Contractor to CMS for the Quality Rating System (QRS) submitted in accordance with Article 5.01.1. Contractor must participate in engagement activities to address findings identified by Covered

California and reported to Contractor in such performance meetings.

2) Contractor must additionally collaborate across QHP Issuers and with community through a minimum of one (1) learning session, working group, or community engagement activity related to the quality of substance use services during the Plan Year. To meet this requirement, Contractor must host or attend an activity that was expressly pre-approved or suggested by Covered California, and provide documentation of attendance. Contractor may submit additional relevant activities for consideration to Covered California to meet this requirement. Documentation of completed pre-approved activities must be received by Covered California no later than 30 days after each pre-approved activity.

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 Advancing Integrated Mental Health Solutions (AIMS) Center at the University of Washington, is a best practice among integrated behavioral health models (https://aims.uw.edu/collaborative- care).

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

2.04.1 Promotion of Integrated Behavioral Health

To monitor the adoption of integrated behavioral health, Contractor must report:

1) How it is promoting the integration of behavioral health services with primary care, including data exchange between Contractor, its contracted primary care clinicians, and its behavioral health providers.

2.05 Behavioral Health Subcontractor, Downstream Entity, and Behavioral Health Network Provider Oversight

To ensure high-quality, equitable care is provided to Enrollees, Contractor shall be accountable for its delegated functions related to compliance with applicable provisions in Article 2 of Attachment 1. Contractor must hold its delegated entities accountable for meeting the health equity, quality, access, and delivery system reform requirements within Article 2 of Attachment 1. For the purposes of this Section, “delegated entities” are Contractor’s behavioral health Subcontractors, Downstream Entities, and behavioral health network providers.

Contractor must demonstrate compliance with the requirements specified in Article 2.05 by December 31, 2027, or by the end of ~~the Contractor~~Contractor's second Plan Year contracted with Covered California.

2.05.1 Contractor Accountability, Duties, and Obligations

Contractor shall demonstrate robust compliance, monitoring, and oversight programs for all behavioral health delegated entities to ensure Covered California Enrollees receive quality behavioral health care and have access to behavioral health services. Contractor must disclose delegation arrangements and include justification for the use of delegated entities.

1) Contractor remains fully responsible for the performance of all duties, obligations, and services undertaken by its delegated entities.

2) Contractor must evaluate each prospective delegated entity's ability to perform the contracted services or functions.

3) Contractor must maintain policies and procedures to ensure that delegated entities fully comply with the terms and conditions of Article 2 of Attachment 1.

4) To ensure each delegated entity's compliance, Contractor must:

    a) Include all duties and obligations in Article 2 of Attachment 1, relating to the delegated duties, in all behavioral health Subcontractor agreements;

    b) Ensure the behavioral health Subcontractor includes all obligations under Article 2 of Attachment 1, relating to the delegated duties, in all behavioral health Downstream Entity agreements;

    c) Review behavioral health Subcontractors' policies and procedures applicable to the delegated functions;

    d) Monitor and oversee all delegated functions, including those that may flow down to behavioral health Downstream Entities;

    e) Ensure behavioral health network providers comply with all applicable requirements under Article 2 of Attachment 1 and all requirements set forth in their provider network agreements; and

    f) Disclose all delegated relationships and submit a delegation report as specified in Article 2.05.3.

2.05.2 Quality and Health Equity Oversight

Contractor shall monitor and evaluate the quality of behavioral health care

delivered by all its delegated entities and implement necessary improvements in any setting. Contractor must also monitor health disparities in behavioral health care using at minimum the measures described in Article 1.02.1. Contractor is responsible for the quality and health equity of all behavioral health services regardless of whether those services have been delegated.

1) Contractor must deliver quality behavioral health care that enables Covered California Enrollees to maintain, improve, or manage their behavioral health. This includes ensuring quality behavioral health care in each of the following areas:

    a) Clinical quality of behavioral health care;

    b) Access to behavioral health care providers and services;

    c) Continuity and care coordination across physical health care and behavioral health care settings, including in-person and virtual health, as well as coordination between levels of care and transitions in care to establish stable provider-patient relationships; and

    d) Overall Covered California Enrollee experience with behavioral health services.

2) Contractor shall be accountable for all access, quality improvement, and health equity functions for behavioral health services, including responsibilities that are delegated. Contractor shall specify the following requirements in its delegated entity agreements, as applicable:

    a) Access, quality improvement, and health equity responsibilities for behavioral health services and specific subcontracted functions and activities of delegated entities;

    b) Schedule for Contractor's ongoing oversight, monitoring, and evaluation of delegated entities; and

    c) Actions and remedies if a delegated entity's obligations are not satisfactorily performed.

3) Contractor shall maintain oversight procedures for behavioral health services to ensure its delegated entities compliancy with all access, quality improvement, and health equity delegated activities that:

    a) Evaluate a delegated entity's ability to provide behavioral health services, including an initial determination that a behavioral health Subcontractor and Downstream Entity has the administrative capacity, experience, and

budgetary resources to fulfill their contractual obligations;

b) Ensure delegated entities meet access, quality improvement, and health equity standards; and

c) Include continuous monitoring, evaluation, and approval of its delegated functions to the delegated entity.

2.05.3 Delegation Reporting

1) Contractor must provide a delegation report that describes:

   a) All contractual relationships with delegated entities including:

      i. Name of delegated entity;

      ii. Type of delegated entity;

      iii. Description of all delegated and sub-delegated functions; and

      iv. Purpose and justification for delegation.

   b) Contractor's oversight responsibilities for all delegated obligations.

   c) How Contractor oversees or intends to oversee access, parity, quality improvement, and health equity functions that are delegated to delegated entities.

   d) How Contractor oversees or intends to oversee all delegated activities, including details regarding key personnel who will be overseeing such delegated functions.

2) Contractor must submit a delegation report by December 31,2027, or by the end of Contractor's second Plan Year contracted with Covered California.

   To reduce administrative burden, Contractor may provide Covered California with delegation reports that are submitted by Contractor to the California Department of Health Care Services (DHCS) or the California Public Employees' Retirement System (CalPERS) if Contractor uses the same delegation arrangements for the products offered under these programs.

ARTICLE 3 - POPULATION HEALTH

Covered California and Contractor recognize the importance of population health, including ensuring the use of health promotion and prevention services, increasing utilization of high value services, risk stratifying Enrollees, and developing targeted interventions based on risk. To improve the health of Covered California Enrollees, Contractor shall identify opportunities, conduct outreach, and engage all Covered California Enrollees, not just Covered California Enrollees who obtain services from providers, in population health activities.

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 of a Population Health Management plan is a requirement for health plan accreditation by the National Committee for Quality Assurance (NCQA). 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 Enrollees with complex needs. 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.

1) Contractor must submit the following components of its NCQA Population Health Management plan:

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

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

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

2) Contractor must submit the Population Health Management plan once every three years in accordance with the three-year NCQA accreditation cycle. Covered California will not require annual submission of the Population

Health Management plan unless changes are made to the Population Health Management plan during the three-year cycle at which point Contractor must resubmit the revised plan to Covered California.

3) If Contractor is not yet NCQA accredited or is unable to provide components of its NCQA Population Health Management plan as specified in 1), 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 Enrollees healthy, managing Enrollees 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 Enrollee interventions.

        iv. Coordination of Enrollee 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 Enrollee data to assess the needs of the population and determine actionable categories for appropriate intervention, including 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~~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 Enrollees;

(2) Needs of specific Enrollee subpopulations; and

(3) Needs of children and adolescents, Enrollees 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 Enrollee needs. Also, how Contractor reviews community resources for integration into program offerings to address Enrollee needs.

iv. Its process, including data sources and 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, including 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.

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 more costly 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 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. Contractor must:

1) 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 Covered California Enrollees. The DPP must be available both in-person and online to ensure Covered California Enrollees have equitable access to these services in the event of service area challenges such as rural locations or limited program availability and to allow Covered California Enrollees a choice of modality (in-person, online, distance learning, or a combination of modes). The DPP must be accessible to eligible Covered California Enrollees with limited English proficiency (LEP) and eligible Covered California Enrollees with disabilities. The DPP is covered as a diabetes education benefit with zero cost sharing pursuant to the Patient-Centered Benefit Plan Designs. Contractor's DPP must have preliminary or full recognition by the CDC as a DPP, published on The National Registry of Recognized Diabetes Prevention Programs.

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 Enrollees during transitions 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. Requirements included in Article 3.03 will be applied to the CCSB line of business.

3.03.1 Enrollee Transition Plan

In the event of a service area reduction such that Contractor withdraws its existing, approved network from any geographic region or modifies any portion of its service area, Contractor must comply with an Enrollee Transition Plan to facilitate transitions of care with minimal disruption for At-Risk and High-Risk Covered California Enrollees who are transitioning from one QHP Issuer to

another QHP Issuer. In such events, Covered California may automatically transition Contractor's Covered California Enrollees in a different QHP Issuer to avoid gaps in coverage. If Contractor receives Covered California Enrollees from another QHP Issuer pursuant to a service area reduction, Contractor must implement policies and programs to facilitate transitions of care.

1) Data transfers

    a) Covered California shall facilitate the seamless transition of health information data for Covered California Enrollees between departing and receiving QHP Issuers. This transmission includes the secure transfer of personal health information submitted by departing QHP Issuer pursuant to this Section, enrollment records, and any other relevant data necessary to ensure no disruption in coverage and services for Covered California Enrollees. Special attention will be given to At-Risk and High-Risk Enrollees, ensuring their transition is managed with the highest priority and sensitivity to prevent any lapse in necessary medical care or services. These efforts are aimed at ensuring appropriate continuity of care for Covered California Enrollees, thereby minimizing any potential impact on their ongoing treatment and health outcomes.

    b) Covered California will coordinate with both departing and receiving QHP Issuers to establish a timeline and protocol for data transfer, ensuring compliance with all applicable laws and regulations governing the privacy, security, and confidentiality of such information.

2) If Contractor is terminating Covered California Enrollees, Contractor must:

    a) Conduct outreach to alert all Covered California Enrollees impacted by the service area reduction that their QHP will be ending. Outreach must include instructions, timing, and options for enrolling with a new QHP Issuer. Outreach must notify Enrollees that they may contact their new QHP Issuer to request continuity of care.

    b) Pursuant to the Enrollee Transition Plan, send Covered California and the Enrollee's new QHP Issuer health information relevant to creating transitions of care for transitioning Covered California Enrollees as follows:

        i. For all terminating Covered California Enrollees impacted by the service area reduction, send primary care clinician information on record.

        ii. For At-Risk Covered California Enrollees, send relevant personal

health information.

c) Conduct outreach to providers in impacted service areas to facilitate Covered California Enrollee transitions with minimal disruption.

3) If Contractor receives terminating Covered California Enrollees from another QHP Issuer pursuant to a service area reduction, Contractor must:

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 Covered California Enrollees have effectuated coverage).

b) Engage and conduct outreach to Covered California Enrollees including At-Risk Enrollees within 60 days of receiving health information from the departing Contractor or Covered California to ensure continuity of care and minimal to no disruption to health services.

c) Ensure At-Risk Enrollees care transitions account for their 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.

d) 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.

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

f) Consider receipt of High-Risk Enrollee health information as the Enrollee's request for continuity of care pursuant to Health and Safety Code, § 1373.96, or Insurance Code, § 10133.56.

g) Ensure the new At-Risk 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. Contractor will make good faith efforts to identify and meet members' social needs.

3.05 Use of Generative Artificial Intelligence in QHP Issuer Operations

This section acknowledges the transformative potential of Patient Care Decision Support Tools, including Generative Artificial Intelligence (GenAI), to enhance health plan operations and member experiences while promoting health equity. It sets forth a framework for the responsible use of Patient Care Decision Support Tools by QHP Issuers, emphasizing compliance, bias mitigation, transparency, continuous improvement, and collaboration with shared learning.

Definitions:

1) Patient Care Decision Support Tools: Patient Care Decision Support Tools has the same meaning as defined in 45 C.F.R. § 92.4. Patient Care Decision Support Tools includes Artificial Intelligence and Generative Artificial Intelligence.

2) Artificial Intelligence: Artificial Intelligence has the same meaning as defined in Health and Safety Code, § 1367.01, subdivision (k) and Insurance Code, § 10123.135, subdivision (j). Artificial Intelligence includes Generative Artificial Intelligence.

3) Generative Artificial Intelligence (GenAI): Generative Artificial Intelligence is a subset of Artificial Intelligence that includes systems capable of creating content, predictions, or decisions from data inputs. This encompasses machine learning, natural language processing, and neural network technologies.

4) Human-in-the-Loop (HITL): A model where human judgment is incorporated into GenAI outputs to guide, review, or alter GenAI-made decisions or predictions.

5) Governance Structure: A written framework of systems and processes adopted

by an organization to appropriately and ethically manage decision-making regarding use of Patient Care Decision Support Tools in the organization's operations.

3.05.1 Mitigating Bias in Use of Patient Care Decision Support Tools

To minimize bias in the usage of Patient Care Decision Support Tools Usage, Contractor must:

1) Refrain from discrimination on the basis of race, color, national origin, sex, age, or disability in its health programs or activities through the use of Patient Care Decision Support Tools. In accordance with 45 C.F.R. § 92.210, Contractor has an ongoing duty to make reasonable efforts to identify uses of Patient Care Decision Support Tools in its health programs or activities that employ input variables or factors that measure race, color, national origin, sex, age, or disability, and must make reasonable efforts to mitigate the risk of discrimination resulting from the Tool's use in its health programs or activities.

3.05.2 Use of Best Practice in Patient Care Decision Support Tools

Contractor must adhere to the following requirements:

1) Stay abreast of and integrate best practices for Patient Care Decision Support Tools, reflecting both state and national developments as technologies, guidance, laws, and regulations evolve.

2) Establish and maintain protocols, including a Governance Structure, to identify and address bias within Patient Care Decision Support Tools.

3) Collaborate across QHP Issuers and Covered California through a minimum of one (1) learning session, working group or community engagement activity during the Plan Year to share insights, challenges, and strategies for bias mitigation, emerging use cases, and sharing of best practices. To meet this requirement, Contractor must host or attend an activity that was expressly pre-approved or suggested by Covered California, and provide documentation of attendance. Contractor must submit additional relevant activities for consideration to Covered California to meet this requirement. Documentation of completed pre-approved activities must be received no later than 30 days after each pre-approved activity.

3.05.3 Use of Artificial Intelligence in Utilization Management

Contractor shall comply with requirements in Health and Safety Code, § 1367.01, subdivision (k) or Insurance Code, § 10123.135, subdivision (j), as applicable, if Contractor uses an artificial intelligence including GenAI, algorithm, or other

software tool for the purpose of utilization review or utilization management functions.

3.05.4 Enrollee Transparency

To ensure openness and effective communication, Contractor must:

1) Provide written notice to a Covered California Enrollee when Contractor uses artificial intelligence including GenAI, algorithm, or other software for the purpose of utilization review or utilization management functions, based in whole or in part on medical necessity under the benefits provided by the QHP, at the time Contractor makes the decision available to the Enrollee. Notice may include information regarding Contractor's use of bias mitigation strategies used in the decision.

2) Notify a Covered California Enrollee when Contractor uses GenAI in written interactive communications with the Enrollee about their benefits, such as chatbots.

3.05.5 Reporting Requirements for use of Artificial Intelligence

Contractor must provide to Covered California, as directed:

1) Comprehensive reports on the measures taken to identify and mitigate bias when Contractor uses an artificial intelligence including GenAI, algorithm, or other software for the purpose of utilization review or utilization management functions, based in whole or in part on medical necessity, under the benefits provided by the QHP for Covered California Enrollees.

2) A description of the Governance Structure established to oversee use of GenAI when Contractor uses an artificial intelligence including GenAI, algorithm, or other software GenAI for the purpose of utilization review or utilization management functions, based in whole or in part on medical necessity, under the benefits provided by the QHP for Covered California Enrollees, including frameworks for ethical use, transparency, and accountability in GenAI deployments and representative use cases.

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. Covered California and Contractor shall work collaboratively to achieve the goals of the Institute of Medicine's Quintuple Aim: improving population health, enhancing the care experience, reducing costs, addressing health care professional wellbeing, and advancing health equity. Contractor shall work with Covered California to promote advanced primary care, increase integration and coordination within the healthcare system, and manage and design networks based on value. Covered California and Contractor will align and collaborate with the Department of Health Care Services (DHCS) and the California Public Employees' Retirement System (CalPERS) as well as the Office of Health Care Affordability (OHCA) to enhance primary care investment, lower the total cost of care, and improve member affordability. Such coordinated efforts are crucial in realizing a transformed healthcare landscape in California.

4.01 Advanced Primary Care

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

4.02 Networks Based on Value

Contractor shall curate and manage its networks to address variation in quality and cost performance across network hospitals and providers, with a focus on improving underperforming hospitals and providers and reducing low value care and variation. As used in this Section, low-value care refers to services or treatments that offer minimal clinical benefit, deviate from evidence-based guidelines, or have safer, more cost-effective alternatives. Efforts to reduce low-value care are integral to enhancing quality, affordability, and equity within the healthcare system. Affordability is core to Covered California's mission to expand the availability of insurance coverage and prevent barriers to accessing

care. Variation in unit price and total costs of care irrespective of quality, is a key contributor to the high cost of coverage and medical services. Contractor shall hold its contracted hospitals and providers accountable for improving quality, managing and reducing cost and shall collaborate and provide support to its contracted hospitals and providers to monitor and 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**.**

4.03 Use of Virtual Care

Virtual care 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. As used in this Section, "virtual care" refers to all means to digitally interact with patients, including interactions conducted via telehealth and digital technologies such as remote patient monitoring or application-based interventions. Virtual care includes synchronous and asynchronous patient-provider communication, remote patient monitoring, e-consults, hospital at home, and other virtual health services.

4.03.1 Virtual Care Offerings

Contractor shall report the extent to which Contractor is supporting the use of virtual care when clinically appropriate to assist in providing high quality, accessible, patient-centered care. Covered California encourages Contractor to use network providers to provide virtual care whenever possible. Contractor must continue to comply with applicable network adequacy standards for in-person services.

To monitor Contractor's virtual care services, Contractor must report:

1) The types and modalities of virtual care health services that Contractor offers to Covered California Enrollees, as well as the goal or desired outcome from the service (e.g., decreased emergency department 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) An inventory of the third party virtual care vendors serving Covered California enrollees, including each vendor's:

a) Taxpayer Identification Number (TIN) and National Provider Identifier (NPI),

b) Specialty designation (e.g., Urgent Care, Primary Care, Behavioral Health, etc.),

c) Modality offerings (including those modalities specified in 1) above),

d) Start and end dates for the vendor serving Covered California Enrollees, and

e) NCQA Virtual Care Accreditation status, URAC Digital/Telehealth Accreditation status, or both statuses if applicable.

3) How Contractor is communicating with and educating Covered California Enrollees about virtual care services including:

a) Explaining service availability on key Covered California Enrollee website pages, such as the home page and provider directory page;

b) Explaining service cost-share on key Covered California Enrollee website pages like the summary of benefits and coverage page and medical cost estimator page; and

c) Explaining the availability of interpreter services for virtual care on key Covered California Enrollee website pages, such as the home page and provider directory page.

4) How Contractor facilitates the integration and coordination of care between third party virtual care vendor services and primary care and other network providers, particularly if the virtual care service is for urgent care, chronic disease

management, or behavioral health.

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

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

   a) Virtual care modalities, including voice only when appropriate, and comparable in-person services.

   b) Virtual care vendor and contracted provider rendered virtual care services.

7) The impact virtual care has on cost and quality of care provided to Covered California Enrollees, including the extent to which virtual care replaces or adds to utilization of specialty care, emergency department, or urgent care services.

8) Contractor agrees to establish use of quality monitoring measures for virtual care and to submit monitoring measures results to Covered California as annually requested.

4.03.2 Monitoring Virtual Care Utilization

Contractor agrees to engage and work with Covered California to review its utilization of virtual care services using HEI data submitted in accordance with Article 5.02.1. Contractor must submit an improvement plan to address outliers identified during the review process. Contractor must report strategies utilized to reduce fragmented and duplicate services.

4.04 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, clinicians, and other providers of care. Covered California encourages Contractor participation in established statewide and national collaborative initiatives for quality improvement, addressing health disparities, and improving data sharing.

Contractor must report its participation in quality collaboratives or initiatives, including the amount of financial support (if any) Contractor provides.

ARTICLE 5 - MEASUREMENT AND DATA SHARING

Measurement is foundational to assessing the quality, equity, and value of care provided by Contractor to Enrollees. As a result, Covered California uses a variety of measures in its assessment of QHP performance, and has developed a robust Healthcare Evidence Initiative (HEI) 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, HEI measures, and others.

With the healthcare industry increasingly using electronic health records, data sharing between patients, providers, hospitals, and 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. Efficient data sharing decreases healthcare costs, reduces paperwork, improves outcomes, and gives 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 it informs measure alignment with other purchasers and measure sets.

1) Contractor shall 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 measures and may also include data for other types of measures included in the Quality Rating System. Contractor must provide all collected data to Covered California each year regardless of CMS submission and reporting requirements.

2) Covered California reserves the right to use Contractor-reported data to construct Contractor quality ratings that Covered California may use for purposes such as supporting consumer choice, quality improvement efforts, financial accountability, establishing performance standards, and other activities related to Covered California's role as a Health Oversight Agency. Covered California will publicly report the Quality Rating System scores and ratings each

year.

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. To enable performance measure comparisons to national benchmarks, Contractor shall:

1) Collect and report HEDIS scores to the National Committee for Quality Assurance (NCQA) Quality Compass for its commercial (which includes Covered California Enrollees) 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) Submit to Covered California HEDIS 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 scores for the NCQA Quality Compass measures set must still be submitted to Covered California if requested.

3) Report such information to Covered California in a form that is mutually agreed upon by ~~the Contractor~~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 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 feasibly possible, 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) Merative is the current HEI Vendor. Merative is the measure developer for select measures used by Covered California. The measure definitions are derived from the Merative Health Insights® solution for these select measures.

7) HEI Data Submission Issue Resolution

a) Contractor must regularly engage with Covered California and Merative to identify and address HEI data issues through:

i. Attending and participating in regular, standing meetings,

ii. Receiving and reviewing monthly reports which highlight gaps in accordance with assessment criteria, and

iii. As needed, participating in technical assistance provided or facilitated by Covered California for Contractor to develop plans and timelines for remediation (which may include data replacement).

b) If issues identified and addressed by (a) continue to persist in Contractor's HEI data, Covered California will issue Contractor a written warning regarding progression to a potential Corrective Action Plan (CAP). Upon notice of potential CAP, Contractor must address identified data issue(s).

c) If data issue(s) persists, Covered California will issue a CAP. Contractor shall address data gaps detailed in the CAP within the specified timeline. If Contractor fails to comply with the CAP, Covered California may pursue available remedies in this Agreement, including those in Section 8.2.4.

d) Requirements included in Article 5.02.1 will be applied to the CCSB line of business.

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 Enrollee and provider access to health records, will also give Enrollees greater control of their health information to support self-management. Contractor will make good faith efforts: to support data interoperability.

5.02.3 Data Exchange

Covered California and Contractor recognize that data sharing between patients, providers, hospitals, and payers is a critical quality of care driver. Contractor agrees to engage and work with Covered California to make patient data available and accessible to support population health management, clinical care, and coordination. Efficient data sharing decreases healthcare costs, reduces paperwork, improves outcomes, and gives patients more control over their healthcare.

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.

ARTICLE 6 - CERTIFICATION, ACCREDITATION, AND REGULATION

Covered California seeks to align with the standard measures and annual benchmarks for equity and quality in healthcare delivery established by the Department of Managed Health Care as required by Health and Safety Code section 1399.871. 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 NCQA Health Plan Accreditation

Contractor must obtain and maintain current NCQA health plan accreditation for its Covered California membership throughout the term of the Agreement. Contractor shall authorize NCQA 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.

Contractor shall submit evidence of NCQA health plan accreditation to Covered California, annually at the end of Open Enrollment, if requested.

6.01.2 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 submit to Covered California a copy of the assessment report within thirty (30) Days of receiving the report.

6.01.3 Changes in Accreditation Status

If Contractor receives any status other than Accredited in any category, including, Under Corrective Action, Scheduled, Accredited-Interim, Accredited-Provisional, Expired, In-Process, and Denied, loses an accreditation, or fails to maintain a current and up to date accreditation, Contractor shall:

1) Notify Covered California within ten (10) business days of such status change. Contractor must implement strategies to address Contractor's status to achieve a level of Accredited or to reinstate accreditation.

2) Submit to Covered California any Corrective Action Plan (CAP) issued by NCQA that it is subject to, regardless of whether Contractor's accreditation status has changed, within thirty (30) days of receiving the CAP. Contractor shall submit to Covered California any relevant updates to the CAP and progress, such as documentation and final rulings associated with the CAP.

3) Following the initial submission of the CAP, submit a written report to Covered California, when requested, but no less than quarterly, regarding the status and, if applicable, 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.

4) Proceed with any pre-NCQA Accreditation application submission steps to become newly accredited or re-accredited by NCQA.

5) Coordinate improvement efforts and the CAP, as applicable, with any improvement efforts and corrective action plan(s) imposed by the Department of Managed Health Care pursuant to Health and Safety Code, § 1399.872.

6.01.4 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.