

ATTACHMENT 1 TO COVERED CALIFORNIA 2026-2028 INDIVIDUAL MARKET QHP 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 its 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

Contractor shall work with Covered California to expand the disparity identification and improvement requirements in this article. Covered California will continue to stratify measures by income, race and ethnicity, preferred language, and region for disparities identification and monitoring purposes. Other areas for consideration include:

- 1) Disability status
- 2) Sex characteristics

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.

3) Veteran Status or Military Service

1.01.2 Race, Ethnicity, Language, Sexual Orientation and Gender Identity Data Collection

1) Race and Ethnicity Data Collection

- a) Contractor must collect self-reported race and ethnicity data for at least eighty percent (80%) of its Covered California Enrollees during the Plan Year. Contractor must demonstrate compliance by including a valid, acceptable, and reasonable Covered California Enrollee self-identified race and ethnicity attribute for at least 80% of its Covered California Enrollees in its Healthcare Evidence Initiative (HEI) data submissions. Covered California provides lists of valid and acceptable standard values and reasonableness criteria in a methodology document.
- b) New entrants. Contractor is required to collect self-identified race and ethnicity data during its first year contracting with Covered California. Contractor must demonstrate compliance by including a valid Covered California Enrollee self-identified race and ethnicity attribute for its Covered California Enrollees in its first year HEI data submissions. Contractor must meet the standard in (a) its second year contracted with Covered California.

2) Preferred Spoken and Written Language Data Collection

- a) Contractor must collect data on Covered California Enrollees' preferred spoken and written languages and submit valid, acceptable, and reasonable data on spoken or written languages in its HEI submissions to ensure effective communication with providers and timely access to healthcare services.
- b) New entrants. Contractor must collect data on Covered California Enrollees' preferred spoken and written languages and submit valid data on spoken or written languages in its HEI submissions to ensure effective communication with providers and timely access to healthcare services. Contractor must meet the standard in (a) in its second year contracted with Covered California.

3) Sexual Orientation and Gender Identity Data Collection

- a) Contractor must collect data on Covered California Enrollees' sexual orientation and gender identity. Contractor must demonstrate compliance

by including valid Covered California Enrollee self-identified sexual orientation and gender identity attributes for its Covered California Enrollees in its HEI data submissions.

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. Therefore, Covered California is requiring Contractor to regularly collect data and report on its Covered California Enrollees as specified in this article to identify disparities, measure disparities over time, and develop disparity reduction efforts and targets to be determined by Covered California and Contractor. Covered California will continue to use and stratify HEI data to assess improvements in healthcare quality and equity.

1.02.1 Monitoring Disparities: Patient Level Data File

As directed by Covered California, Contractor must submit Healthcare Effectiveness Data and Information Set (HEDIS) measure patient level data files for its Covered California Enrollees. Covered California may require submission of all or some of the following HEDIS measures:

- 1) Blood Pressure Control for Patients with Hypertension (BPC-E);
- 2) Controlling High Blood Pressure (NQF #0018);
- 3) Glycemic Status Assessment for Patients with Diabetes: Glycemic Status (>9.0%) (NQF #0059);
- 4) Colorectal Cancer Screening (COL-E) (NQF #0034);
- 5) Colorectal Cancer Screening (NQF #0034);
- 6) Childhood Immunization Status (Combo 10) (CIS-E) (NQF #0038);
- 7) Childhood Immunization Status (Combo 10) (NQF #0038);
- 8) Depression Screening & Follow-Up for Adolescents & Adults (DSF-E);
- 9) Pharmacotherapy for Opioid Use Disorder (POD);
- 10) Prenatal Depression Screening and Follow-up (PND-E);

11) Postpartum Depression Screening and Follow-up (PDS-E);

12) Social Need Screening and Intervention (SNS-E).

Contractor must submit a patient level data file that includes a unique person identifier as specified by Covered California and valid race and ethnicity attributes 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 Monitoring Disparities: Healthcare Evidence Initiative

Contractor must meet with Covered California to review its performance on disparities measures using HEI data submitted in accordance with Article 5.02.1, including all or some of the measures listed in this section. Contractor must participate in engagement activities to address findings identified by Covered California and reported to Contractor in such performance meetings. Engagement activities may include learning activities, additional meetings, quarterly performance reviews, and other forms of collaboration arranged and scheduled by Covered California. Covered California may address all or some of the following measures in performance meetings:

- 1) Adult Preventive Visits per 1,000 Members;
- 2) Emergency Room Visits per 1,000 Members;
- 3) Breast Cancer Screening (BCS-E) (NQF #2372);
- 4) Child and Adolescent Well-Care Visits (WCV);
- 5) Follow-Up After Hospitalization for Mental Illness (FUH) (7 day & 30-day follow-up);
- 6) Initiation and Engagement of Substance Use Disorder (IET);
- 7) Proportion of Days Covered: Three Rates by Therapeutic Category (NQF #0541)
 - a) Diabetes All Class (PDC-DR) (NQF #0541)

- b) RAS Antagonists (PDC-RASA) (NQF #0541)
- c) Statins (PDC-STA) (NQF #0541);
- 8) Behavioral Health Visits / 1000;
- 9) Behavioral Health Telehealth Visits / 1000;
- 10) Concurrent Use of Opioids and Benzodiazepines (COB);
- 11) Non-utilizer rates;
- 12) Primary Care Telehealth Visits / 1000;
- 13) Pharmacotherapy for Opioid Use Disorder (POD);
- 14) Primary Care Visits / 1000;
- 15) Use of High Dose Opioids (HDO).

1.03 Disparities Reduction

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

A multi-faceted approach in alignment with the Department of Managed Health Care (DMHC), the Department of Health Care Services/Medi-Cal (DHCS) and the California Public Employees Retirement System (CalPERS), will allow for sustained progress in reducing disparities for all Californians. Contractor must engage in the activities specified below for its Covered California Enrollees, in alignment with activities required by other California public purchasers and regulators. The requirements to monitor and intervene to address disparities are in addition to the health equity accountability requirements detailed in Attachment 4, Quality Transformation Initiative (QTI).

- 1) Contractor must participate in collaboration across QHP Issuers and with community through a minimum of one (1) equity focused learning session, working group, or community engagement activity. 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) Contractor must monitor and reduce identified health disparities, with a focus on addressing utilization disparities in Behavioral Health services as detailed in Article 2,
- 3) Contractor will monitor and reduce identified Maternal Health disparities in populations disproportionately affected, as outlined in Article 4.02.6.
- 4) Contractor must provide annual staff training focusing on cultural humility, effective collaboration with interpreters, and include the use of National Standards for Culturally and Linguistically Appropriate Services (CLAS).

1.04 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.

1.04.1 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.

1.04.2 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;
- 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.

1.05 Culturally and Linguistically Appropriate Care

1.05.1 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-year, 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.

- 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

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. -

- ~~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.~~
- 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.

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.

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 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.