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 (CBE ID #0018);

3) Glycemic Status Assessment for Patients with Diabetes: Glycemic Status (>9.0%) (CBE ID #0575);

4) Colorectal Cancer Screening (COL-E) (CBE ID #0034);

5) Colorectal Cancer Screening (CBE ID #0034);

6) Childhood Immunization Status (Combo 10) (CIS-E) (CBE ID #0038);

7) Childhood Immunization Status (Combo 10) (CBE ID #0038);

8) Depression Screening & Follow-Up for Adolescents & Adults (DSF-E) (CBE ID #0418);

9) Pharmacotherapy for Opioid Use Disorder (POD) (CBE ID #3400);

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) (CBE ID #0031);

4) Child and Adolescent Well-Care Visits (WCV);

5) Follow-Up After Hospitalization for Mental Illness (FUH) (7 day & 30-day follow-up) (CBE ID #0576);

6) Initiation and Engagement of Substance Use Disorder (IET) (Submission Tool and Repository Measure Database I Partnership for Quality Measurement);

7) Proportion of Days Covered: Three Rates by Therapeutic Category (CBE ID

#0541)

a) Diabetes All Class (PDC-DR) (CBE ID #0541)

b) RAS Antagonists (PDC-RASA) (CBE ID #0541)

c) Statins (PDC-STA) (CBE ID #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. 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

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.

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

1.05 Culturally and Linguistically Appropriate Care

1.05.1 Evidence of Culturally and Linguistically Appropriate Services

1) Contractor must 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

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) 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 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) 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) 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'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.

2) 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.

3) 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.

4) 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 health 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, Covered California encourages Contractor to use network providers to provide virtual care for behavioral health services whenever possible.

1) Contractor must offer telehealth, as defined in Business and Professions Code, section 2290.5, 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.

2) 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:

1) 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.

2) 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 educate Covered California Enrollees how to access behavioral health services, including through virtual care;

    1) 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;

    2) 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;

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

    4) 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.

    5) 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 Contractor's network.

2.01.5 Payment to Support Behavioral Health

Covered California and Contractor acknowledge the significance of embracing and broadening behavioral health payment frameworks that ensure sufficient funding to support accessible, data-driven, team-based care. This approach comes with a responsibility for delivering high-quality, equitable care and overseeing the overall cost of care.

To support behavioral health, Contractor must:

1) Report annually on its total behavioral health expenditure by product, in alignment with the Office of Health Care Affordability (OHCA) guidelines. Contractor shall follow the methodology provided by Covered California. Covered California will review and monitor progress toward OHCA designated benchmarks.

2) Share progress in meeting benchmarks by engaging in collaborative efforts among QHP Issuers and with the community. This includes participation in learning sessions, working groups, and community engagement initiatives, as facilitated by Covered California. Additionally, Contractor submit relevant activities for consideration by Covered California to fulfill this obligation.

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 and submit patient level data files in accordance with Article 1.02.1.

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 lifespan 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, in accordance with Article 1.02.1.

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, in accordance with Article 4.01.3, 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 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 comply 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, 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.

2) Report how Contractor informs eligible Covered California Enrollees about the availability of the DPP and how to enroll in the program.

3.03 Supporting At-Risk Enrollees Requiring Transition

Covered California is concerned about the impact that transitions of care from one QHP Issuer to another has on Covered California Enrollees, especially At-Risk Enrollees and High-Risk Enrollees. An Enrollee transition plan allows for a clear process to transfer critical health information for Covered California Enrollees, including At-Risk Enrollees and High-Risk Enrollees during transitions between healthcare coverage.

As used in this section, the following definitions shall apply:

1) An “At-Risk Enrollee” is a Covered California Enrollee who is:

    a) in the middle of acute treatment or those who would otherwise qualify for Continuity of Care under California law,

    b) in case management programs,

    c) in disease management programs, or

    d) on maintenance prescription drugs for a chronic condition.

2) A “High-Risk Enrollee” is an At-Risk Enrollee who is:

    a) Pregnant,

    b) Undergoing active cancer treatment,

    c) Scheduled for a planned procedure or surgery, or

    d) Undergoing medication assisted treatment for substance use disorders.

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 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.

3.04.1 Screening for and Addressing Social Needs

1) Contractor must screen all Covered California Enrollees at least annually for unmet food, housing, and transportation needs, using one or more screening instruments specified in the Social Need Screening and Intervention (SNS-E) measure specifications. Screening for additional health-related social needs and screening in coordination with contracted providers is highly

encouraged.

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

3) To demonstrate Contractor is screening for and addressing health-related social needs, Contractor must report, as annually requested by Covered California:

   a) Its process for screening Covered California Enrollees for social needs and collecting data for the Social Need Screening and Intervention (SNS-E) measure, including which Covered California Enrollee touch points include social need screening, whether the screening is performed by Contractor's staff, vendor, or network providers, and which screening instrument(s) are used to screen for health-related social needs.

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

   c) Its process for linking Covered California Enrollees with food insecurity or other health-related social needs to resources and how Contractor tracks if or when the social need has been addressed.

   d) Measurement Year 2026, 2027, and 2028 performance on the Social Need Screening and Intervention (SNS-E) measure, stratified by race and ethnicity, and submitted via patient level data file in accordance with Article 1.02.1.

   e) The Enrollee screen positive rate for each of the three subcomponents of the Social Need Screening and Intervention (SNS-E) measure.

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 knowingly 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 communicates the decision to the Enrollee in writing, including electronically. Notice may include information regarding Contractor's use of bias mitigation strategies. This requirement shall not apply to Contractor's medical groups or other delegated entities.

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.

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

4.01.1 Encouraging Use of Advanced Primary Care

Ensuring Enrollees have a primary care clinician is foundational for promoting access to and encouraging the use of advanced primary care. To encourage the use of primary care, Contractor must:

1) Ensure that upon enrollment, Covered California Enrollees are informed about the role and benefits of primary care and are given the opportunity to select a primary care clinician. Within sixty (60) Days of effectuation into the plan, if a Covered California Enrollee does not select a primary care clinician,

Contractor must provisionally assign the Covered California Enrollee to a primary care clinician, inform the Covered California Enrollee of the assignment, and provide the Covered California Enrollee with an opportunity to select a different primary care clinician. When assigning a primary care clinician, Contractor shall use commercially reasonable efforts consistent with the Covered California Enrollee's stated gender, language, ethnic and cultural preferences, geographic area, existing family member assignment, and any prior primary care clinician.

2) Engage and collaborate with Covered California to review the number and percent of Covered California Enrollees who select a clinician and who are assigned to a primary care clinician using HEI data submitted in accordance with Article 5.02.1.

3) Contractor agrees to provide Covered California with data and other information necessary to perform the evaluation in 2) above.

4.01.2 Measuring Advanced Primary Care

Advanced primary care is patient-centered, accessible, team-based, data driven, supports the integration of behavioral health services, and provides care management for patients with complex conditions. To support advanced primary care, primary care clinicians should have access to data related to the care their patients receive throughout the delivery system to promote integrated, continuous, and coordinated care.

1) Primary Care Clinician Selection

    a) Covered California will determine if Contractor's Covered California Enrollees utilized their assigned primary care clinician, another plan-identified primary care clinician, sought healthcare services elsewhere, or had no healthcare activity by comparing claims data with the primary care clinician National Provider Identifier (NPI).

    b) Contractor shall work with Covered California to review and improve primary care clinician selection and healthcare utilization using HEI submitted data in accordance with Article 5.02.1.

2) Member Value and Engagement in Care

    a) Contractor must ensure active engagement of Enrollees in care to improve health outcomes and member satisfaction. Through proactive engagement and outreach, Contractor enables Enrollees to access preventive services, manage chronic conditions, and

avoid unnecessary emergency room care and hospitalizations.

b) Contractor must monitor and increase the portion of Covered California Enrollees with continuous enrollment in Contractor's QHP throughout the prior Plan Year who have at least one medical or prescription drug claim during the Plan Year. This requirement aims to reduce the number of Enrollees without any healthcare activity and improve utilization of medically necessary care. By tracking claims data and engaging Enrollees through targeted outreach and coordinated care, Contractor can address gaps in care and ensure Enrollees utilize necessary health services, enhancing outcomes and maximizing the value of coverage.

3) Continuity of Care

a) Covered California will measure continuity of care for Contractor's Covered California Enrollees using the continuity of care index. The continuity of care index assesses the percentage of visits with the same provider, yielding an index ranging from 0 to 1, where 0 indicates all visits with different providers and 1 indicates all visits with the same provider. Using HEI submitted data in accordance with Article 5.02.1, Covered California will measure continuity of care for Covered California Enrollees with continuous enrollment in Contractor's QHP throughout the prior Plan Year and two or more primary care visits with any primary care clinician during the prior Plan Year.

b) Contractor shall collaborate with Covered California to establish benchmarks and improvement targets around continuity of care, and work with Covered California to review and improve Enrollee continuity of care.

4.01.3 Payment to Support Advanced Primary Care

Covered California and Contractor recognize the importance of adopting and expanding primary care payment models that provide the necessary revenue to fund accessible, data-driven, team-based care with accountability for providing high-quality, equitable care, and managing the total cost of care. To support advanced primary care, Contractor must:

1) Report annually on Contractor's total primary care spend by Contractor product in alignment with the Office of Health Care Affordability (OHCA). Contractor shall follow methodology provided by Covered California. Covered California will review and monitor progress toward OHCA designated

benchmarks.

2) Work with Covered California and other stakeholders to analyze the relationship between the percent of spend for primary care services with the total cost of health care expenditures (TCHE) and network performance of the overall delivery system, including assessing quality and equity.

3) To share progress on achieving benchmarks, Contractor must participate in collaboration across QHP Issuers **and** with community through learning sessions, working groups, and community engagement activities, as hosted by Covered California. Contractor may submit additional relevant activities for consideration to Covered California to meet this requirement.

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.

4.02.1 Designing and Managing Networks Based on Value

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

1) Include cost, quality, safety, patient experience, and equity in evaluation and selection criteria for all providers, including physicians and physician groups, and all facilities, including hospitals, when designing and managing networks for its QHPs.

2) Report on Contractor's selection criteria and review of providers and facilities in networks for QHPs and if applicable, the rationale for excluding a provider or facility. Reports must include a detailed description of how cost, quality,

patient safety, patient experience, or other factors are considered in network design and provider and facility selection and review. Information submitted may be made publicly available by Covered California.

4.02.2 Payments to Support Networks Based on Value

To continue to build and strengthen networks based on value, Contractor must support its providers through value-based payment models that promote high-quality, affordable, and equitable access and care, and report on these efforts as specified in this Section:

1) Contractor must monitor and report on the total cost of health care expenditures by Contractor product annually, in alignment with OHCA. Contractor shall follow methodology provided by Covered California using HEI data submitted in accordance with Article 5.02.1. Covered California will review and monitor progress toward OHCA designated benchmarks.

2) Contractor must report on its network payment models using the Health Care Payment Learning and Action Network Alternative Payment Model (HCP LAN APM) categories and associated subcategories of fee for service with no link to quality and value (Category 1), fee for service with a link to quality and value (Category 2), alternative payment models built on a fee for service structure such as shared savings (Category 3), and population-based payment (Category 4). Contractor must report the percent of spend within each HCP LAN APM category and associated subcategory compared to its overall budget and the percent of members attributed to each HCP LAN APM Category by Contractor product annually in alignment with OHCA. Contractor shall follow methodology provided by Covered California. Covered California will review and monitor progress towards OHCA designated benchmarks.

3) To share progress on achieving benchmarks, Contractor must collaborate across QHP Issuers and with community through a minimum of one (1) learning session, working group, or community engagement activity. 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.

4.02.3 Provider Value

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

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

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

    a) Submit all necessary data to IHA and participate in the IHA Align. Measure. Perform (AMP) program for provider organizations and report AMP performance results for each contracted provider organization and each primary care practice that participates in its QHPs to Covered California or allow IHA to submit results to Covered California on Contractor's behalf. Contractor shall use AMP performance results to profile and analyze variation in performance on quality measures and total cost of care.

    b) To achieve maximum quality and safety performance in provider networks Contractor must participate in collaboration across QHP Issuers and with community through learning sessions, working groups, and community engagement activities, as hosted by Covered California. Contractor may submit additional relevant activities for consideration to Covered California to meet this requirement.

    c) To demonstrate Contractor is managing provider costs, Covered California may request copies of Contractor's medical management policy. In addition, Contractor must report:

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

        ii) Contractor's analysis of variation in unit prices including capitation and reimbursement rates;

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

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

v) Details regarding identified barriers to providing affordable care and meeting OHCA targets, including challenges with provider contracting and rate setting; and

vi) The distribution of providers by region and by cost decile or describe other ways providers and facilities are grouped by costs, such as comparison of costs as a percentage of Medicare costs and the percentage of costs for Contractor that are expended in each cost decile.

4.02.4 Hospital Quality, Value, and Safety

Covered California has focused on aligned and collaborative efforts to promote hospital safety care coordination and patient experience. Covered California recognizes that improving hospital performance requires a comprehensive and cross-payer collaborative multi-stakeholder approach. Monitoring and improving hospital safety measures will improve clinical outcomes and reduce low value healthcare spending.

Contractor shall work with Covered California to support and enhance general acute care hospitals' efforts to achieve quality goals and contract with hospitals that demonstrate they provide high-quality, affordable, and equitable care and promote the safety of Enrollees. Contractor shall improve quality and cost performance across its contracted hospitals and track and report progress and strategies.

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

1) Contractor must report the quality improvement support and technical assistance provided by Contractor or partner organization to strengthen performance of hospitals. Contractor must also report the extent and nature of its participation in improvement collaboratives such as Cal Healthcare Compare or equally qualified public reporting entities for patient safety quality and performance ratings in California.

2) Contractor must additionally participate in collaboration across QHP Issuers and with community through a minimum of one (1) learning session, working group, or community engagement activity during the Plan Year related to

quality improvement support and technical assistance to strengthen hospital quality and safety performance. 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.

3) To demonstrate Contractor is managing hospital and facility cost and quality, Covered California may request information including:

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

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

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

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

    e. The shared efforts, findings, and progress made from joint initiatives, collaborative workshops or research projects to mitigate barriers to high value care.

4) Covered California supports price transparency as a resource for Enrollees to make better informed decisions about their healthcare services. Contractor shall require all contracted hospitals to adhere to the hospital price transparency requirements in Section 2718(e) of the Public Health Service Act and implementing regulations. This compliance includes establishing, updating, and publicly posting a comprehensive list of standard charges for items and services in a machine-readable format (MRF), using a CMS-provided template for uniformity. Contractor must verify that hospitals comply with the required display of standard charges, including the gross charge, discounted cash price, payer-specific negotiated charge, and the de-identified minimum and maximum negotiated charges. In alignment with the CMS

Hospital Price Transparency rule, Contractor shall report:

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

b. The number and percent of network hospitals by region that provide a consumer friendly, searchable display of current standard charges and information on the 300 CMS-specified shoppable services or as many services as the hospital provides as a comprehensive MRF with all items and services and in a display of shoppable services in a consumer-friendly format.

5) Contractor shall work with Covered California to provide comparison reporting for the requirements in Article 4.02.4 for all lines of business to compare performance and inform future Covered California requirements in this area.

4.02.5 Hospital Patient Safety

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

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

2) Covered California is committed to addressing the opioid epidemic and continues to pursue improvement in the appropriate use of opioids and access to treatment for substance use disorder in both the outpatient and hospital settings. Article 2.03.1 addresses opioid use in the outpatient setting. To support the appropriate use of opioids in the hospital setting, Contractor must:

a) Report its strategies to improve the appropriate use of opioids and access to treatment for substance use disorder in its network hospitals.

b) Encourage all network hospitals to utilize Healthcare Organizations Leading Substance Use Disorder (SUD) Care, which outlines key milestones to achieving opioid safety, and to participate in the Substance Use Disorder Care Honor Roll program from Cal Healthcare Compare. The self-assessment can be accessed from: https://calhospitalcompare.org/programs/opioid-care-honor-roll/

4.02.6 Comprehensive Pregnancy and Postpartum Care

According to the World Health Organization, maternal health refers to a woman's health during pregnancy, childbirth, and the postpartum period. Covered California recognizes that not all people who become pregnant or give birth identify as women. While Covered California primarily uses the term "pregnancy and postpartum" the term 'maternal' may also be used when appropriate.

Covered California is committed to ensuring access to high-quality, equitable pregnancy and postpartum care that addresses the full spectrum of needs related to pregnancy, childbirth, and the postpartum period and provides a comprehensive approach to improving maternal health outcomes. Contractor will:

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

2) Report annually on efforts made to engagie with providers and Enrollees undergoing pregnancy, childbirth, and postpartum care to promote:

    a) The patients' right to choose a pregnancy and postpartum care provider, who aligns with their needs and may reflect their demographic characteristics, including race, ethnicity, language, socioeconomic status, sexual orientation, and gender identity.

    b) Pregnant and postpartum care options for the delivery of high-value care—right provider, right setting, right price—with accessible care options including same-day services for urgent needs and special considerations for patients with high-risk pregnancies, ensuring comprehensive safe and supportive pregnancy and postpartum care that promotes health, resilience, and disease prevention for the pregnant and postpartum patient and their family.

    c) Education and support throughout all phases of pregnancy and postpartum care to empower informed decision-making and promote positive health outcomes. This includes sharing safety ratings, promoting the appropriate use of C-sections, and offering educational resources to individuals and families to ensure they receive patient-centered, appropriate care while avoiding unnecessary interventions.

    d) Whole person care as defined by Cal Healthcare Compare's Maternity Honor Roll Program.

e) Information and awareness regarding accessibility of enterprise and local social support services available, such as food, housing, and transportation programs and resources.

3) Track and report the number in-network doulas, certified nurse midwives, and licensed midwives and include in development and submission of a network expansion strategy for the recruitment of a diverse network of care navigators, for racial and ethnic congruency between provider and members and increased access to Maternal health services that encompass the full spectrum of pregnancy, childbirth, and postpartum care. The network expansion strategy must prioritize access to doula and midwifery care when delivering services that are included as essential health benefits, including birth centers and home birth, to reduce administrative barriers and incentivize coordinated team-based care.

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

   a) Monitor and reduce maternal mental health disparities by providing medically necessary therapy, crisis intervention for perinatal mood disorders, and evidence-based SUD programs, including Medication-Assisted Treatment (MAT) and harm reduction strategies, with coordinated care across behavioral health, obstetric, and pediatric providers.

   b) Collect measure results, stratified by race and ethnicity, for its Covered California Enrollees and submit patient level data files for the following HEDIS measures in accordance with Article 1.02.1 for:

      i) Prenatal Depression Screening and Follow-up (PND-E), and

      ii) Postpartum Depression Screening and Follow-up (PDS-E)

   c) Review its performance, stratified by race and ethnicity, on the Prenatal and Postpartum Care (PPC) (CBE ID #1517) measure results generated by Covered California using Contractor's HEI data.

   d) Use available measure results to determine a maternal health disparity among subpopulations of Enrollees undergoing pregnancy, childbirth, and postpartum care. Contractor must implement at least one pre-approved intervention each Plan Year, or at least one multi-year

intervention with activities spanning each Plan Year during the contract cycle, focused on improving outcomes for a specific subpopulation identified. Representative interventions include: engaging with hospitals and providers, to address maternal health disparities; ensuring that its network perinatal providers, staff, and facilities are complying with the California Dignity in Pregnancy and Childbirth Act, which mandates implicit bias training in order to reduce the effects of implicit bias in pregnancy, childbirth, and postnatal care; or supporting its maternity care Enrollees, in accessing culturally and linguistically appropriate care, referrals to group prenatal care or community-centered care models for patients, in home lactation and nutrition consultants, doula support for prenatal, labor, delivery, and postnatal and postpartum care, and related services. 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 available measure results.

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.

5.01.1 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 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.

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. To support data interoperability, Contractor must:

1) Implement and maintain a secure, standards-based Patient Access API consistent with the existing Centers for Medicare & Medicaid (CMS) Interoperability & Patient Access final rule (CMS-9115-F) and any technical updates in the same time and manner imposed on QHP issuers operating in the Federally Facilitated Marketplaces pursuant to 45 C.F.R. §§ 156.221, 156.222, 156.223. Contractor must report:

    a) The number and percent of patients accessing their Patient Access Application Programming Interface (API).

2) Enhance QHP Issuer information services for Covered California Enrollees consistent with the existing CMS Interoperability and Patient Access final rule (CMS-9115-F) and any technical updates in the same time and manner imposed on QHP issuers operating in the Federally Facilitated Marketplaces pursuant to 45 C.F.R. §§ 156.221, 156.222, 156.223 that requires QHP Issuer participation in payer-to-payer data exchange and consumer education. Contractor must:

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

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

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. Efficient data sharing decreases healthcare costs, reduces paperwork, improves outcomes, and gives patients more control over their healthcare. Covered California and Contractor agree these goals are achievable only if providers, hospitals, and payers make patient data available and accessible in accordance with the California Health and Human Services Data Exchange Framework (DxF), Data Sharing Agreement (DSA), and shared Policies and Procedures (P&Ps). Covered California and Contractor recognize that Qualified Health Information Organizations (QHIOs) are DxF designated intermediaries that can assist DxF Participants to meet the requirements of the DSA. Contractor must:

1) Execute the DSA as required by Health and Safety Code section 130290.

2) Participate in at least one QHIO, that will share data to support quality measurement and operations purposes and report on its use of that QHIO's services and functions to support the following activities:

a) Contractor's DSA obligations set forth in the DxF P&Ps, including sharing data that Contractor is required to provide access to or exchange under the Data Elements to Be Exchanged P&P.

b) Request, receive, and use information from providers, hospitals, and other DxF Participants as needed by Contractor to support population health management, clinical care, and coordination initiatives for its Covered California Enrollees. These include the Quality Transformation Initiative, Healthcare Evidence Initiative, and Quality Rating System.

c) Enhance demographic and social risk factor data capture to improve health equity and access.

d) Monitor network hospitals' compliance with the requirement under the Technical Requirements for Exchange P&P.

3) Send Notification of Admit, Discharge, and Transfer (ADT) Events when requested by a DxF Participant for Covered California Enrollees. As requested by Covered California, Contractor must report:

    a) A list of network hospitals by region, including psychiatric hospitals and critical access hospitals, that have not sent requested Notification of ADT Events to at least one QHIO.

    b) For the above list, a description of whether and how these hospitals are sending Notification of ADT Events using methods that are acceptable to all requesting DxF Participants, as required by the Technical Requirements for Exchange P&P.

4) Unless prohibited by law, share information on Covered California Enrollees with primary care practices using standard file formats for assigned and selected members monthly. This benefits the primary care practices by supporting improvement on their quality measure performance, identifying and managing key populations to improve specific outcomes, and supporting partnership between practices and QHP Issuers on high risk and high cost populations.

    a) Data types to share include: Member enrollment/eligibility file, medical claims, behavioral health claims, pharmacy claims (no cost included in claims file), ADT feeds when available, and member assessment and care management data collected by the plan.

5.02.4 Data Aggregation

Covered California and Contractor recognize that aggregating data across purchasers, payers, and providers to more accurately understand the performance of providers that have contracts with multiple QHP Issuers can improve performance, contracting, and public reporting. To support data aggregation, Contractor must:

1) Submit all necessary data, including supplemental clinical data, to IHA and participate in the IHA Align. Measure. Perform (AMP) program and the IHA California Regional Healthcare Cost & Quality Atlas. Contractor must report AMP and Atlas performance results, sourced from IHA to Covered California or allow IHA to submit Contractor's performance results to Covered California on Contractor's behalf.

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.