



Comments to the Board

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**Covered California
Qualified Health Plan Contract
between**

**Covered California, the California Health Benefit Exchange
and**

_____ (“Contractor”)

List of Attachments to QHP Model Contract, Revised Draft Draft, April 22, 2013

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Attachment 1 Contractor’s QHP List [to be attached specifically for each Issuer]

Attachment 2 Benefit Plan Designs [to be attached specifically for each Issuer]

Attachment 3 Good Standing

Definition of Good Standing

Agency

Verification that issuer holds a state health care service plan license or insurance certificate of authority.

Approved for applicable lines of business (e.g. commercial, small group, individual)

DMHC

Approved to operate in what geographic service areas

DMHC

Most recent financial exam and medical survey report

DMHC

Most recent market conduct exam

CDI

Affirmation of no material statutory or regulatory violations, including penalties levied, in the prior year in relation to any of the following, where applicable:

Financial solvency and reserves

DMHC and
CDI

Administrative and organizational capacity

DMHC

Benefit Design

DMHC and
CDI

- State mandates (to cover and to offer)

<input type="checkbox"/> Essential health benefits (as of 2014)	DMHC and CDI
<input type="checkbox"/> Basic health care services	DMHC and CDI
<input type="checkbox"/> Copayments, deductibles, out-of-pocket maximums	DMHC and CDI
<input type="checkbox"/> Actuarial value confirmation (classification of metal level as of 2014)	DMHC and CDI
Network adequacy and accessibility standards	DMHC and CDI
<input type="checkbox"/> Provider contracts	DMHC and CDI
Language Access	DMHC and CDI
Uniform disclosure (summary of benefits and coverage)	DMHC and CDI
Claims payment policies and practices	DMHC and CDI
<input type="checkbox"/> Provider complaints	DMHC and CDI
Utilization review policies and practices	DMHC and CDI
Quality assurance/management policies and practices	DMHC
Enrollee/Member grievances/complaints and appeals policies and practices	DMHC and CDI
Independent medical review	DMHC and CDI
Marketing and advertising	DMHC and CDI
Guaranteed issue individual and small group (as of 2014)	DMHC and CDI
Rating Factors	DMHC and CDI
Medical Loss Ratio	DMHC and CDI
Premium rate review	DMHC and CDI
<input type="checkbox"/> Geographic rating regions	DMHC and CDI
<input type="checkbox"/> Rate development and justification is consistent with the Affordable Care Act requirements	DMHC and CDI
<input type="checkbox"/> Reasonableness Review	DMHC and CDI

1 "Material" violations are defined in Section 3.02 of the Agreement.

Attachment 4 Service Area Listing [to be attached specifically for each Issuer]

Attachment 5 Provider Agreement - Standard Terms

Contractor shall ~~include in all of its contracts with Participating Providers the requirement that cause~~ the following provisions to be included in each: (i) Provider Agreement entered into by and between Contractor and a Participating Provider, and (ii) any subcontracting arrangement entered into by a Participating

Comment [AC1]: Provider Contracting attachment has not been updated for changes in the main agreement (e.g. compliance/grievances and appeals) and seems to require amendments of provider contracts by January 2014 to comply with various sections, which is not in most cases feasible.

Provider. ~~To the extent that such terms are not included in the Contractor's current agreements, Contractor shall take such action as is reasonably necessary to assure that such provisions are included upon contract renewal on or after 1/1/2014, in the contract by January 1 2014.~~ Except as expressly set forth herein, capitalized terms set forth herein shall have the same meaning as set forth in the Agreement between Contractor and the Exchange; provided that Contractor may use different terminology as necessary to be consistent with the terms used in the Provider Agreement or subcontracting arrangements entered into by Participating Providers so long as such different terminology does not change the meaning set forth herein and the Agreement.

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Comment [AC2]: We have significant concerns about the Exchange dictating contents of provider agreements. If additional terms will be dictated by the Exchange, wording should be included that allows changes to be made to those contracts renewed after the launch of the Exchange.

1. Provision of Covered Services. Contractor shall include in all of its contracts with Participating Providers the requirement that each Participating Provider to assure that each Participating Provider Agreement and each subcontracting arrangement entered into by each Participating Provider shall comply with, the applicable terms and conditions set forth in the Agreement, as mutually agreed upon by the Exchange and Contractor, and which may include the following:

- Coordination with the Exchange and other programs and stakeholders (Section 1.06);
- Relationship of the parties as independent contractors (Section 1.08(a)) and Contractor's exclusive responsibility for obligations under the Agreement (Section 1.08(b));
- Participating Provider directory requirements (Section 3.05(c));
- Implementation of processes to enhance stability and minimize disruption to provider network (Section 3.05(d) and (e));
- Notice, network requirements and other obligations relating to costs of out-of-network and other benefits (Section 3.1);
- Credentialing, including, maintenance of licensure and insurance (Section 3.16);
- Customer service standards (Section 3.18);
- Utilization review and appeal processes (Section 3.17);
- Maintenance of a corporate compliance program (Section 3.19);
- Enrollment and eligibility determinations and collection practices (Sections 3.20 to 3.25)
- Appeals and grievances (Section 3.26);
- Enrollee and marketing materials (Section 3.27);
- Disclosure of information required by the Exchange, including, financial and clinical (Section 3.31; Quality, Network Management and Delivery System Standards (Article 4) and other data, books and records (Article 10));
- Nondiscrimination (Section 3.32);
- Conflict of interest and integrity (Section 3.33);
- Other laws (Section 3.35);
- Quality, Network Management and Delivery System Standards to the extent applicable to Participating Providers (Article 4), including, disclosure of contracting arrangements with Participating Providers as required under Section 7.01 of the Quality, Network Management and Delivery System Standards;
- Performance Measures, to the extent applicable to Participating Providers (Article 6)
- Continuity of care, coordination and cooperation upon termination of Agreement and transition of Enrollees (Article 7);
- Security and privacy requirements, including, compliance with HIPAA (Article 9); and
- Maintenance of books and records (Article 10).

2. In addition to the foregoing, Contractor shall include in each Provider Agreement a requirement that Participating Providers comply with other applicable laws, rules and regulations.

3. The descriptions set forth in this Attachment shall not be deemed to limit the obligations set forth in the Agreement, as amended from time to time.

Attachment 6: Customer Service Standards

Customer Service Standards

A. Customer Service Call Center

Comment [AC3]: It should be clear that these standards only apply to the contractor and not to participating providers or subcontractors.

(i) During Open Enrollment Period, call center hours shall be Monday through Saturday eight o'clock (8:00) a.m. to eight o'clock (8:00) p.m. (Pacific Standard Time). During non-Open Enrollment periods, call center hours shall be Monday through Friday eight o'clock (8:00) a.m. to six o'clock (6:00) p.m. (Pacific Standard Time) and Contractors shall inform the Exchange of additional call center hours their service centers are open.

(ii) The center will be staffed at such levels as reasonably necessary to handle call volume and achieve compliance with Performance Measurement Standards set forth in Article 6. Contractor shall staff the Call Center with highly trained individuals to provide detailed benefit information, answer Enrollee questions about the QHP, and resolve claim and benefit issues.

(iii) Contractor shall use a telephone system that includes welcome messages in English, Spanish and other languages as required by State and Federal laws, rules and regulations.

(iv) Oral interpreter services shall be available at no cost for non-English speaking or hearing- impaired Enrollees during regular business hours as required by Federal and State law. Contractor shall monitor the quality and accessibility of call center services on an ongoing basis. Contractor shall report to the Exchange, in a format and frequency to be determined by the Exchange, but no more frequently than monthly, on the volume of calls received by the call center and Contractor's ability to meet the Performance Measurement Standards.

(v) As required under Section 3.18(b), for 2014 the Contractor shall meet all State requirements for language assistance services for all of its commercial lines of business. The Exchange and Contractor agree to assess the adequacy of the language services during 2014, both phone and written material, and consider the adoption of additional standards in 2015.

B. Customer Service Transfers.

(i) During Contractor's regularly scheduled customer service hours, Contractor shall have the capability to accept and handle calls transferred from the Exchange to respond to callers requesting additional information from Contractor. Contractor shall maintain such staffing resources necessary to comply with Performance Measurement Standards and to assure that the Exchange can transfer the call to a live representative of Contractor prior to handing off the call. Contractor shall also maintain live call transfer resources to facilitate a live transfer (from the Exchange to Contractor) of customers who call the Exchange with issues or complaints that need to be addressed by Contractor.

(ii) During Contractor's regularly scheduled customer service hours, Exchange shall have the capability to accept and handle calls transferred from the Contractor to respond to callers requesting additional information from the Exchange. The Exchange shall maintain such staffing resources necessary to assure that Contractor can transfer the call to a live representative of the Exchange prior to handing off the call. The Exchange shall also maintain a live all transfer resource to facilitate a live transfer (from Contractor to the Exchange) of customers who call Contractor with issues or complaints that need to be addressed by the Exchange.

(iii) Examples of issues or complaints include but are not limited to premium billing or claims issues; benefit coverage questions (before and after enrollment); complaints; network or provider details; and Issuer-specific questions or issues.

(iv) Contractor shall refer Enrollees and applicants with questions regarding premium tax credit and the Exchange eligibility determinations to the Exchange's website or Service Center, as appropriate.

(v) Contractor shall work with the Exchange to develop a mechanism to track handling and resolution of calls referred from the Exchange to Contractor (such as through the use of call reference numbers).

C. Customer Care

(i) Contractor shall comply with the applicable requirements of the Americans with Disabilities Act and provide culturally competent customer service to all the Exchange enrollees in accordance with the applicable provisions of 45 C.F.R. §155.205 and §155.210, which refer to consumer assistance tolls and the provision of culturally and linguistically appropriate information and related products.

(ii) Contractor shall comply with HIPAA rules and other laws, rules and regulations respecting privacy and security, as well as establish protocols for handling the Exchange customers who have documented domestic violence or other security concerns. Contractor shall monitor compliance and file these protocols with the Exchange yearly.

D. Notices

Comment [AC4]: Please clarify what is meant by this.

(i) For all forms of notices required under state and federal Law to be sent to Enrollees regarding rates, benefit design, ~~network changes~~, or security/HIPAA references, Contractor shall submit an electronic copy to the Exchange at least five (5) business days in advance of the message transaction. If Contractor is unable to notify the Exchange in advance due to federal or state notice requirements, Contractor shall send the Exchange notification simultaneously.

Comment [AC5]: There is already a process in place with the regulators for this.

(ii) Contractor shall provide a link to the Exchange website on its website.

(iii) When Contractor provides director contacts for getting membership assistance, Contractor shall also include the Exchange website for Exchange-related issues.

(iv) All legally required notices sent by Contractor to Enrollees shall be translated into and available in languages other than English as required under applicable State and Federal laws, rules and regulations, including, Health and Safety Code 1367.04.

(v) Contractor shall release notices in accordance with Federal and State law. All such notices shall meet the accessibility and readability standards in the Exchange regulations (45 C.F.R. Parts 155 and 156) located in 10 CCR Sections 6400 et. seq.

E. Issuer-Specific Information

(i) Upon request, Contractor shall provide training materials and participate in the Exchange customer service staff training.

(ii) Contractor shall provide summary information about its administrative structure and the QHPs offered on the Exchange. This summary information will be used by the Exchange customer service staff when referencing Contractor or QHP information. The Exchange will develop a form to collect uniform information from Contractor.

G. Enrollee Materials

(i) Contractor shall provide or make available to Enrollees Plan materials required under the terms of the Agreement and applicable laws, rules and regulations. Such materials shall be available in threshold languages as required by law and receive any necessary regulatory approvals from Health Care Regulators and be provided to the Exchange as directed by the Exchange and shall include information brochures ~~a summary of the Plan~~ **Summary of Benefits and Coverage (SBC)** that accurately reflects the coverage available under the Plan (such summary plan description or other summary hereinafter referred at times as "Plan Summary") and related communication materials. Contractor shall, upon request by the Exchange, provide copies of enrollee communications and give the Exchange the opportunity to comment and suggest changes in such material.

Comment [AC6]: This section uses three different reference points for standards (within 10 days of receiving information, 10 days of verification, and 10 days of receiving premium. We request that a consistent standard be used.

Comment [AC7]: This section needs to clarify that this requirement can be met by providing the SBC as required under state and federal law.

(ii) Enrollee materials shall be available in English, Spanish and other languages as required by applicable laws, rules and regulations. Contractor shall comply with Federal and State laws, rules and regulations regarding language access. To the extent possible the Enrollee materials shall be written in plain language, as that term is defined in applicable laws, rules and regulations. Plan materials that require the Exchange notification before usage are those that communicate specific eligibility and enrollment and other key information to Enrollees. Such materials may include, but are not limited to:

- a. Welcome letters
- b. Billing notices and statements
- c. Notices of actions to be taken by Plan that may impact coverage or benefit
- d. Termination letters
- e. Grievance process materials
- f. **Drug formulary information**
- g. Uniform summary of benefits and coverage
- h. Other materials required by the Exchange.

Comment [AC8]: This should be limited to the instruction portion.

(iii) New Enrollee Enrollment Packets.

a. Contractor shall mail, or provide online ~~if an Enrollee opts to receive information online~~, enrollment packets to all new Enrollees within ten (10) business days of receiving enrollment verification from the Exchange. Contractor may deliver enrollee materials pursuant to other methods that are consistent with (i) Contractor's submission of materials to enrollees of its other plans, (ii) the needs of Enrollees, (iii) the consent of the Enrollee, and (iv) with applicable laws, rules and regulations Contractor shall report to the Exchange monthly, in a format mutually agreed upon by the Exchange and Contractor on the number and accuracy rate of identification cards that were sent to new Enrollees and Contractor's compliance with the Performance Measurement Standards set forth in this Agreement. The enrollment packet shall include, at the minimum, the following:

Comment [AC9]: We appreciate the changes the Exchange made to accommodate online information. However, this language requires an opt-in standard where many plans currently have an opt-out standard where on-line enrollment is the default.

We also note that there is a conflict here with the language in Attachment 14-4, which states that ID cards must be sent within 10 business days of receiving enrollment premium. Does the Exchange intend to have ID cards sent at a different time than the enrollment packet?

- i. Welcome letter;
- ii. Enrollee ID card;
- iii. Benefit summary;
- iv. Pharmacy benefit information;
- v. Nurse advice line information; and
- vi. Other materials required by the Exchange.

Comment [AC10]: There are concerns with translating the ID card since it is also for use by the provider.

b. Contractor shall maintain access to enrollment packet materials, Summary of Benefits and Coverage (“SBC”), claim forms and other Plan-related documents in both English and Spanish and any other languages required by State and Federal laws, rules and regulations to the extent required to timely meet all requirements of this Agreement for timely mailing and delivery of Plan materials to Enrollees. Contractor shall be responsible for printing, storing and stocking, as applicable, all materials.

(iv) Summary of Benefits and Coverage. Contractor shall develop and maintain an SBC as required by Federal and State laws, rules and regulations. The SBC will be available online and the hard copy sent to Enrollees on request shall be available to Enrollees in English, Spanish, and other languages as required by Federal and State laws, rules and regulations. Contractor shall update the SBC annually and Contractor shall make the SBC available to Enrollees pursuant to Federal and State laws, rules and regulations.

(v) Electronic Listing of Participating Providers. Contractor shall create and maintain a continually updated electronic listing of all Participating Providers and make it available online for Enrollees, potential Enrollees, and Participating Providers, 24 hours a day, 7 days a week. The listing shall comply with the requirements required under applicable laws, rules and regulations, including, those set forth at 45 C.F.R. Section 156.230 relating to identification of providerproviders who are not accepting new Enrollees.

(vi) Enrollee Identification Card. No later than 10 business days after receiving enrollment information from the Exchange, Contractor shall distribute to each Enrollee an identification card in a form that is approved by the Exchange.

(vii) Access to Medical Services Pending ID Card Receipt. Contractor shall promptly coordinate and ensure access to medical services for Enrollees who have not received ID cards but are eligible for services.

(viii) Explanation of Benefits. Contractor shall send each Enrollee, by mail, an Explanation of Benefits (EOB) to Enrollees in Plans that issue EOBs or similar documents as required by Federal and State laws, rules and regulations. The EOB and other documents shall be in a form that is consistent with industry standards.

(ix) Secure Plan Website for Enrollees and Providers. Contractor shall maintain a secure web site, 24 hours, 7 days a week. All content on the secure Enrollee website shall be available in English upon implementation of Plan and in Spanish within ninety (90) days after the Effective Date and any other languages required under applicable laws, rules or regulations. The secure web site shall contain information about the Plan, including, but not limited to, the following:

- a. Upon implementation by Contractor of benefit descriptions information relating to covered services, cost sharing and other information available.;
- b. Ability for Enrollees to view their claims status such as denied, paid, unpaid;
- c. Ability to respond via e-mail to customer service issues posed by Enrollees and Participating Providers;
- d. Ability to provide online eligibility and coverage information for Participating Providers;
- e. Support for Enrollees to receive Plan information by e-mail; and
- f. Enrollee education tools and literature to help Enrollees understand health costs and research condition information.

H. Standard Reports. Contractor shall submit standard reports as described below, pursuant to timelines, periodicity, rules, procedures, demographics and other policies mutually established by the Exchange and Contractor, which may be amended by mutual agreement from time to time. Standard reports shall include, but are not limited to:

- (i) Enrollee customer service reports including phone demand and responsiveness, first call resolution, response to written correspondence, and number/accuracy/timeliness of ID card distribution;

- (ii) Nurse advice line volume, talk time, and topics discussed;
- (iii) Use of Plan website;
- (iv) Quality assurance activities;
- (vi) Enrollment reports; and
- (vii) Premiums collected.

J. Performance Measurement Standards for Subcontractors. Contractor shall, as applicable, ensure that all Subcontractors comply with all Agreement requirements and Performance Measurement Standards, including, but not limited to, those related to Customer Service. Subcontractor's failure to comply with Agreement requirements and all applicable Performance Measurement Standards shall result in specific remedies referenced in Attachment 3 applying to Subcontractor.

Comment [AC11]: Please clarify that subcontractors are vendors that provide administrative services.

K. Contractor Staff Training about the Exchange

- (i) Contractor shall arrange for and conduct their staff training regarding the relevant laws, mission, administrative functions and operations of the Exchange including the Exchange program information and products in accordance with Federal and State laws, rules and regulations and using training materials developed by the Exchange as applicable.
- (ii) Contractor shall provide the Exchange with a monthly calendar of the Exchange staff trainings. Contractor shall make available training slots for the Exchange staff upon request.

L. Customer Service Training Process. Contractor shall demonstrate to the Exchange that it has in place initial and ongoing customer service protocols, training, and processes to appropriately interface with and participate in the Exchange. As part of this demonstration, Contractor shall permit the Exchange to inspect and review its training materials. The Exchange will share its customer service training modules with Contractor.

Attachment 7: Quality, Network Management and Delivery System Standards Quality, Network Management and Delivery System Standards

Preamble

PROMOTING HIGHER QUALITY AND BETTER VALUE

The mission of Covered California (the "Exchange") is to increase the number of insured Californians, improve health care quality and access to care, promote better health, lower costs, and reduce health disparities through an innovative and competitive marketplace that empowers consumers to choose the health plan and providers that offer the best value. The Exchange's "Triple Aim" framework seeks to improve the patient care experience including quality and satisfaction, improve the health of the population, and reduce the per capita cost of health care services. The Exchange and Contractor recognize that promoting better quality and value will be contingent upon smooth implementation and large enrollment in the Exchange.

Qualified Health Plans ("QHP" or "Contractor") are central partners for the Exchange in achieving its mission. By entering into an agreement with the Exchange ("Agreement"), QHPs agree to work in partnership with the Exchange to develop and implement policies and practices that will promote the Triple Aim, impacting not just the Enrollees of the Exchange but the Contractor's -California membership. QHPs have the opportunity to take a leading role in helping the Exchange support new models of care which promote the vision of the Affordable Care Act and meet consumer needs and expectations. At the same time, the Contractor and the Exchange can promote improvements in the entire care delivery system. The Exchange will seek to promote care that reduces excessive costs, minimizes unpredictable quality and reduces inefficiencies of the current system. For there to be a meaningful impact on overall healthcare cost and quality, solutions and successes need to be sustainable, scalable and expand beyond local markets or specific groups of individuals. The Exchange expects its QHP partners to engage in a culture of continuous quality and value improvement, which will benefit all enrollees.

These Quality, Network Management and Delivery System Standards ("Quality, Network Management and Delivery System Standards") outline the ways that the Exchange and the Contractor will focus on the promotion of better care and higher value for the Plan Enrollees and for other California health care consumers. This focus will require both the Exchange and the Contractor to coordinate with and promote alignment with other organizations and groups that seek to deliver better care and higher value. By entering into the Agreement with the Exchange, Contractor affirms its commitment to be an active and engaged

partner with the Exchange and to work collaboratively to define and implement additional initiatives and programs to continuously improve quality and value.

Article 1. Accreditation: NCQA or URAC

1.01 If Contractor does not already possess NCQA or URAC health plan accreditation, Contractor shall obtain such accreditation no later than the end of Contract Year 2016.

1.02 If Contractor is currently accredited, Contractor shall maintain its NCQA or URAC health plan accreditation throughout the term of the Agreement. Contractor shall notify the Exchange of the date of any NCQA or URAC accreditation review scheduled during the term of this Agreement and the results of such review.

1.03 Upon completion of any NCQA or URAC health plan review conducted during the term of this Agreement, Contractor shall provide the Exchange with a copy of the NCQA or URAC Assessment Report within forty-five (45) days of receipt from NCQA or URAC.

1.04 If Contractor receives a rating of less than "accredited" in any NCQA or URAC category, Contractor shall notify the Exchange within ten (10) business days of such rating(s) change and shall be required to provide the Exchange with all corrective action(s) that will be taken to raise the category rating to a level of at least "accredited". Contractor will submit a written corrective action plan (CAP) to the Exchange within forty-five (45) days of receiving its initial notification of the change in NCQA or URAC category ratings.

1.05 Following the initial submission of the corrective action plans ("CAPs"), Contractor shall provide a written report to the Exchange on at least a quarterly basis regarding the status and progress of the submitted corrective action plan(s). Contractor shall request a follow-up review by NCQA or URAC at the end of twelve (12) months and a copy of the follow-up Assessment Report will be submitted to the Exchange within thirty (30) days of receipt.

1.06 In the event, Contractor's overall NCQA or URAC accreditation is suspended, revoked, or otherwise terminated, or in the event, Contractor has undergone NCQA or URAC review prior to the expiration of its current NCQA or URAC accreditation and NCQA or URAC reaccreditation is suspended, revoked, or not granted at the time of expiration, the Exchange reserves the right to terminate any agreement by and between Contractor and the Exchange.

1.07 Upon request by the Exchange, Contractor will identify all health plan certification or accreditation programs undertaken, including any accreditation or certifications that were failed, and will also provide the full written report of such certification or accreditation undertakings to the Exchange.

Article 2. Quality Of Care

2.01 HEDIS and CAHPS Reporting

(a) Contractor shall collect its HEDIS and CAHPS data consistent with the standard measures set that is reported to NCQA Quality Compass and any applicable DHCS County-level reporting for those periods. Contractor is not required to collect DHCS County-level reporting HEDIS or CAHPS information if not already doing so for existing Line of Business.

(i) Contractor shall report scores for Measurement Year ("MY") 2011, MY2012, MY2013 and MY2014 based on data reported to NCQA Quality Compass and/or DHCS County-level Product reporting for those periods . Contractor shall report these scores directly to the Exchange in addition to NCQA and DHCS.--

(ii) Contractor shall report scores separately for each Quality Compass Product Type and/or DHCS County-level product (e.g. each of the Contractor's lines of business (LOB): commercial HMO/POS, commercial PPO, Medicaid HMO), for California, that corresponds to the Contractor's Exchange products. Contractor shall include Exchange population as part of its commercial population by LOB for MY 2014 and 2015. Beginning in MY 2016, Contractor shall report scores for the Exchange population separately.-

(iii) For the purposes of determining Performance Measurement Standards (see Attachment 14), the Exchange shall use the most appropriate Product Type based on the plan design and network operated for the Exchange. If appropriate, the Exchange may blend Product Type scores (e.g., combining Commercial and Medi-Cal scores).

(iv) Contractor may be required to conduct QHP Product Type CAHPS measurement and reporting effective MY 2014 and annually thereafter

(v) Subject to changes in federal requirements, Contractor shall not be required to collect and report QHP-specific HEDIS measures.

(vi) The timeline for Contractor's HEDIS and CAHPS quality reporting shall be consistent with reporting to the NCQA Quality Compass and/or DHCS.

(b) Effective MY2014, and on an annual basis thereafter, Contractor shall submit directly to the Exchange or through an accepted third party (e.g., NCQA or DHCS) HEDIS and CAHPS scores to include the measure numerator, denominator and rate for the required measures set that is reported to NCQA Quality Compass, per each Product Line for which it collects data in California. The Exchange reserves the right to use the

Comment [AC12]: This will provide the Exchange will more accurate data on the Exchange population and allow plans to better target interventions to improve care for this population.

Contractor reported measures scores to construct Contractor summary quality ratings that the Exchange may use for such purposes as supporting consumer choice and the Exchange's plan oversight management.

(c) The Exchange reserves the right to add new measures to the standard HEDIS measures and will provide Contractor sufficient prior notice of intent to add new measures to the existing measure set. Any new measures shall be in agreement with industry standards.

(d) Contractors electing to pursue URAC plan accreditation, instead of NCQA accreditation per Article 2, are not exempt from these requirements.

(e) In the event that reporting timelines established by the NCQA Quality Compass conflict with timelines established by the Exchange, the timelines established by the NCQA timelines will take precedence.

2.02 Participation in Quality Initiatives. Contractor shall participate in one or more established statewide and national collaborative initiatives for quality improvement. Contractors shall demonstrate active participation in such collaborative initiatives and will document specific support related activities. Contractor will provide to the Exchange evidence of their participation within such collaborative initiatives and demonstrate their engagement with providers and other contracting partners in the collaboratives. Specific collaborative initiatives may include, but are not limited to:

(a) Leapfrog

(b) California Maternal Data Center (sponsored by the California Maternal Quality Care Collaborative (CMQCC))

(c) California Joint Replacement Registry developed by the CHCF, California Orthopedic Society and Pacific Business Group on Health (PBGH)

(d) NCDR® (National Cardiovascular Data Registry that currently includes seven specific registry programs)

(e) Society of Thoracic Surgeons National Database for the collection of general thoracic surgery clinical data,

(f) National Neurosurgery Quality and Outcomes Database (N2QOD)

(g) Integrated Healthcare Association's (IHA) Pay for Performance Program

(h) IHA Payment Bundling demonstration

(i) Centers for Medicare and Medicaid Innovation (CMMI) Bundled Payments for Care Improvement initiative (BPCI)

(j) CMMI Comprehensive Primary Care initiative (CPC)

(k) CMMI Shared Savings Program (including Pioneer, Advanced Payment and other models)

(l) Contractor-sponsored accountable care programs

(m) California Quality Collaborative

Contractor will provide the Exchange with information on its participation of any of the collaborative, including, such information which may include: (1) the percentage of total Participating Providers, as well as the percentage of the Exchange specific providers participating in the programs and (2) the number and percentage of potentially eligible Plan Enrollees who participate through the Contractor in the Quality Initiative..

The Exchange and Contractor will in collaboration identify and evaluate the most effective programs for improving care for enrollees and the Exchange and Contractor may consider participation by Contractor as a requirement for future certification

2.03 Data Submission Requirements to the Exchange

By 2015 Contractor shall submit a complete data set, for mutually agreed upon data for the Exchange population inclusive of- all member- and provider-identified data, claims, encounter and pharmacy data, on a quarterly basis to ~~the Exchange or~~ the Exchange's designated recipient, who shall be a vendor contracting as a Business Associate with the Contractor, to be used by the Exchange as determined through a Steering Committee comprised of Contractor and Exchange staff, as it determines to be necessary.—Such submissions will conform to all applicable State and Federal personal health information and related privacy laws, rules and regulations, and shall comply with the terms and conditions set forth in the Agreement by and between Contractor and the Exchange. Contractor will bear the full cost of data collection, extraction and submission; provided, however, that except as expressly set forth in this Attachment or the Agreement, Contractor will not be required to pay for any expenses related to the analysis of that data in order to comply with the terms of this Agreement. Data shall be submitted to a vendor for the Exchange that is a Business Associate of the Contractor that shall protect the information provided to the extent required under applicable laws, rules and regulations. It is understood and agreed that any reports or information provided to the Exchange by the vendor shall fully comply with all applicable state and federal laws regarding confidentiality of medical information and shall not identify any specific enrollee.

Contractor shall submit such information at such times and in accordance with the data file formats attached as identified in Appendix 1 to this Attachment 7 , including, the technical specifications set forth in this Attachment 7. .

Comment [AC13]: How does the Exchange intend to assist with this requirement. One provider may be contracted with many plans and it would be an undue provider burden to request this information from each plan.

Comment [AC14]: As noted previously and in the contract. We are concerned about the release of identified enrollee data and we suggest that the Exchange and health plan HIPAA experts have subsequent conversations to ensure that this agreement does not violate any state or federal laws regarding PHI.

We are also concerned that many plans do not collect this data today and there needs to be time given to implement such data collection.

- Plan
- Member
- Member History
- Contracted PMGs

- Providers (all providers with paid claims, including non-contracted)
- Hospitals (all providers with paid claims, including non-contracted)
- Professional Claims
- Hospital Claims Header
- Hospital Claims Detail
- Drug Claims
- Total Medical Expense(non-claims payment)
- ~~Biometrics and Health Assessment (provisional)~~

- In the event Contractor does not pay claims, it shall provide full and complete encounter data contained in contractor's reporting systems.

Comment [AC15]: Many HMO delegated models will not have complete encounter data available.

The Exchange has provided the data file formats contained in Appendix 1 to this Attachment 7 as its initial expectation of Contractors' provision of data to support oversight requirements(actuarial review ,clinical quality improvement, network management and fraud and waste reduction), delivery system reform goals, consumer information and research. Additional data and expanded file formats may be requested in the future in support of statewide collaborative efforts to advance development of an all payer claims database.

Additional Data Elements Expected

Covered California and the Contractor recognize the importance of having appropriate data about Enrollees to address health disparities and health equity as well as provide appropriate quality care. Because of this, Contractor agrees to work with the Exchange to add additional data elements critical to the Exchange's Enrollees and in order to refine existing quality related assessments.

By 2015, ~~Contractor-Exchange~~ shall collect, on a basis voluntary to the Enrollee as part of the application process, Enrollee data based on the following characteristics and share this information with Contractors:

- (i) Race
- (ii) Ethnicity
- (iii) Gender
- (iv) Primary language
- (v) Disability status
- (vi) Sexual orientation
- (vii) Gender identity

~~Such information will be included in the data provided to the Exchange under this Section.~~

Comment [AC16]: We suggest that the Exchange collect all of this data except for primary language, which the plan will need to know.

2.04 Specific Quality Reports and Oversight Required.

Contractor shall provide quarterly de-identified reports to the Exchange related to Enrollees of the Exchange. Contractor shall follow all report requirements and formats, as mutually agreed to between Contractor and the Exchange. Mutually agreed to reports will include:

- (a) Utilization and claims spend by provider type
- (b) High cost Plan Enrollee analysis
- (c) Paid claims - in network vs. out of network

If not already in place, by January 1, 2015, Contractor agrees to develop and implement oversight programs targeting the following areas related to hospital-based services, as outlined by the Center for Medicare and Medicaid Services (CMS) Hospital Compare Program, including:

- (a) Deaths and readmissions
- (b) Serious complications related to specific conditions
- (c) Hospital acquired conditions
- (d) Healthcare associated infections

These oversight programs should be consistent with Medicare performance areas whenever possible and should reflect the overall performance of the hospital. Contractor agrees to provide/submit regular reporting of program(s) results from Contractor. Standard reporting requirements, including format, frequency and other technical specifications will be mutually agreed upon between the Exchange and Contractor.

Comment [AC17]: It is not feasible for all plans to collect this data by 2015. We request a longer phase-in period.

2.05 eValue8 Submission. During each Contract Year, Contractor shall submit to the Exchange to the

extent possible certain information that is a required disclosure under the eValue8 reporting system. Such information will be used by the Exchange to evaluate Contractor's performance under the terms of the Quality, Network Management and Delivery System Standards and/or in connection with the evaluation regarding any extension of the Agreement and/or the recertification process. The timing, nature and extent of such disclosures will be (i) established by the Exchange based on its evaluation of various quality-related factors, including, disclosure requirements included in the Solicitation.. Contractor's response shall include information relating to all of Contractor's then-current California-based business and Contractor shall disclose any information that reflects national or regional information that is provided by Contractor due to Contractor's inability to report on all California business. Contractor shall also provide a break down by products offered in the SHOP and the Individual Exchange in the event that Contractor offers products in both the Individual Exchange and SHOP.

Article 3. Preventive Health and Wellness

3.01 Benefit Plan Designs Requiring Primary Care Provider Assignments. Regardless of benefit plan design, Contractor shall report to the Exchange the extent to which all new applicable Enrollees of the Exchange are assigned by Contractor to a Primary Care Provider, Health Center or a Patient-Centered Medical Home (PCMH) within sixty (60) days of enrollment. Contractor will encourage Plan Enrollees to make a primary care selection. In the event the Enrollee does not select a primary care provider (PCP) within the allotted timeframe, the Enrollee may be auto-assigned to a PCP and the assignment shall be communicated to the Plan Enrollee. PCP assignment will be consistent with an Enrollee's stated gender, language, ethnic and cultural preferences, and will consider geographic accessibility and existing family member assignment or prior provider assignment. To the extent assignment of an enrollee to a provider would require changes in the Contractor's provider agreements or significant systems changes, Contractor shall provide the Exchange with a transition plan to amend such agreements, or systems.

3.02 Health and Wellness Services. Contractor and Participating providers are required to offer, encourage and monitor the extent to which Plan Enrollees obtain preventive health and wellness services within the first year of enrollment. At a minimum, Contractor shall make available and report on the participation by Plan Enrollees in:

- (a) necessary preventive services appropriate for each enrollee;
- (b) tobacco cessation intervention, inclusive of evidenced based counseling and appropriate pharmacotherapy, if applicable; and
- (c) obesity management, if applicable.

Contractor agrees to incorporate documentation of all Enrollee's health and wellness services into Contractor's Enrollee data and information specific to each individual Enrollee. This Enrollee's data is Contractor's most complete information on each Enrollee and is distinct from the Enrollee's medical record maintained by the providers..

When reporting on the extent to which preventive health and wellness services are provided, Contractor's reporting shall detail for Plan Enrollees whether: (1) Enrollee has received preventive services within the previous twelve (12) months and Contractor is able to provide documentation of such services; (2) Enrollee "self-reports" a visit at time of enrollment during the last twelve (12) months; or (3) Enrollee has refused such services or (4) Enrollee does not respond to reasonable attempts by Contractor to provide information about preventive services.

3.03 Community Health and Wellness Promotion. The Exchange and Contractor recognize that promoting better health for Plan Enrollees also requires engagement and promotion of community-wide initiatives that foster better health, healthier environments and the promotion of healthy behaviors across the community. Contractor shall report annually in a mutually agreed upon form the initiatives, programs and/or projects that it supports that promote wellness and better community health that specifically reach beyond the Contractors enrollees. Such programs may include, but are not limited to partnerships with local or state public health departments and voluntary health organizations which operate preventive and other health programs.

3.04 Reporting Requirements. Contractor shall develop and provide reports on how it is (1) maximizing Plan Enrollees access to preventive health and wellness services and (2) participating in community health and wellness promotion. Such reports will be submitted by Contractor at least annually in a mutually agreed upon format. Report requirements will be coordinated with existing national measures, whenever possible.

3.05 Health and Wellness Documentation Process. Upon Contractor plan certification, Contractor shall submit to the Exchange the following information:

- (a) Documentation of process to include, as appropriate, a summary of personal information about Plan Enrollees, as further described in Article 5 of these Quality, Network Management and Delivery System Standards.

Comment [AC18]: We need clarification on what is required under this provision. We are still of the view that this requirement doesn't make sense for a PPO model. One of the reasons an enrollee has likely selected the PPO product is that they want the ability to go to any physician of their choice. Assigning a PCP in this circumstance will just create confusion and likely resentment from the enrollee. We could encourage an enrollee to find a personal in-network physician to help them manage and better coordinate their care. This encouragement could be required in marketing materials or in the EOC.

We also have concerns around the definition of a PCP which does not appear in the PPO EOCs.

If the Exchange insists on this provision, we can agree to reporting only in 2014, with a transition to auto assignment in later years, as long as we have the following addition on what is allowed for transitional reporting.

Comment [AC19]: Not all plans currently collect this data and it will not be possible to it by 1/1/14. We request a phase-in.

- (b) Health and wellness communication process to Enrollee and Participating Provider, or other caregiver,
- (c) Process to ensure network adequacy required by State or Federal laws, rules and regulation given the focus on prevention and wellness and the impact it may have on network capacity, as outlined in Article 7.

Article 4. Services for At Risk Plan Enrollees

4.01 At Risk Enrollees Requiring Transition

(a) Contractor shall have an evaluation and transition plan in place for the Enrollees of the Exchange with existing health coverage including, but not limited to, those members transferring from Major Risk Medical Insurance Program, Pre-Existing Condition Insurance Plan, AIDS Drug Assistance Program, or other individuals under active care for complex conditions and who require therapeutic provider and formulary transitions.

(b) The evaluation and transition plan will include the following:

- (i) Identification of In-network providers with appropriate clinical expertise or any alternative therapies including specific drugs when transitioning care;
- (ii) Clear process to communicate Enrollee's continued treatment using a specific therapy, specific drug or a specific provider when no equivalent is available in-network;
- (iii) Advanced notification and understanding of out-of-network provider status for treating and prescribing physicians, with documented cost and quality implications; and
- (iv) A process to allow incoming Enrollees access to Contractor's formulary information prior to enrollment.

4.02 Identification and Services for At Risk Enrollees. Upon enrollment Exchange will provide

Contractors with member level files that provide information on member conditions and the programs they are currently enrolled in. Contractor agrees to identify and proactively manage the Plan Enrollees with existing and newly diagnosed chronic conditions and who are most likely to benefit from well-coordinated care ("at-risk plan enrollees"). Contractor will target the highest risk individuals, typically with one or more conditions, including, but not limited to, diabetes, asthma, heart disease or hypertension. Contractor shall encourage new Enrollees to complete a Health Assessment that includes identification of chronic conditions and other significant health needs within the first one hundred twenty (120) days of enrollment. Contractor will provide the Exchange with a documented process, care management plan and strategy for targeting these specific Enrollees, which will include the following:

- (a) Methods to identify and target At Risk Enrollees;
- (b) Description of Contractor's predictive analytic capabilities to assist in identifying At Risk Plan Enrollees who would benefit from early, proactive intervention;
- (c) Communication plan for known At Risk Enrollees to receive information prior to provider visit;
- (d) Process to update At Risk Enrollee medical history in the Contractor maintained Plan Enrollee health profile;
- (e) Mechanisms to evaluate access within provider network, on an ongoing basis, to ensure that an adequate network is in place to support a proactive intervention and care management program for At Risk Enrollees;
- (f) Care and network strategies that focuses on supporting a proactive approach to at-risk Plan Enrollee intervention and care management. Contractor agrees to provide the Exchange with a documented plan and include "tools" and strategies to supplement and/or expand care management and provider network capabilities, including an expansion and/or reconfiguration of specialties or health care professionals to meet clinical needs of At Risk Enrollees.
- (g) Strategies or "tools" not otherwise described in Section 7.01 may include but are not limited to the following:
 - (i) Enrollment of At Risk Enrollees in care, case and disease management program(s); and
 - (ii) At Risk Plan Enrollee's access to Accountable Care Organizations (ACOs), Patient Centered Medical Homes (PCMH), Ambulatory ICUs or other delivery models designed to focus on individual chronic condition management and focused intervention. If new models exist, Contractor shall provide the Exchange with Contractor's available capacity to accept new Plan Enrollees.

4.03 Reward-based Consumer Incentive Programs. Contractor may, to the extent permitted by law, maintain or develop a Reward-based Consumer Incentive Program to promote evidence-based, optimal care for Plan Enrollees with identified chronic conditions. To the extent Contractor implements such a program for Plan Enrollees and to the extent such information is known, Contractor shall report participation rates and outcomes results, including clinical, patient experience and cost impacts, to the Exchange.

Article 5. Enrollee Health Assessment

5.01 Contractor shall demonstrate the capacity and systems to collect, maintain and use individual information about Plan Enrollees' health status and behaviors to promote better health and to better manage Enrollees' health conditions.

5.02 To the extent the Contractor uses or relies upon Health Assessments to meet the requirement of

Comment [AC20]: Plans can provide the HRA and encourage enrollees to complete this, but in reality very few people will complete this assessment unless required as a condition of enrollment, which would create barriers to care that we do not recommend. Thus completing these reports is a lot of work for very little value. We suggest the Exchange keep the requirement to encourage the use of HRA but delete the reporting requirement.

Section 5.01, Contractor shall offer, upon initial enrollment and on a regular basis thereafter a Health Assessment to all Plan Enrollees over the age of 18, including those Plan Enrollees that have previously completed such an assessment.

5.03 Contractor may use current Health Assessment tool or select a new tool that adequately evaluate' s Plan Enrollees current health status, based on Contractor program objectives, and provides a mechanism to conduct ongoing monitoring for future intervention(s).

5.04 Contractor shall -provide to the Exchange, in a format threshold and detail that shall be mutually agreed upon, information on how it collects and reports, at both individual and aggregate levels, changes in Plan Enrollee's health status. Reporting -may include a comparative analysis of health status improvements across geographic regions and demographics.

5.05 Contractor shall report to the Exchange its process to monitor and track Plan Enrollees health status, which may include its process for identifying individuals who show a decline in health status and referral of such Plan Enrollees to Contractor care management and chronic condition program(s) as defined in Section 4.02, for the necessary intervention. Contractor shall annually report to the Exchange the number of Plan Enrollees who are identified through their selected mechanism and the results of their referral to receive additional services.

5.06 Contractor agrees to work with the Exchange to standardize (1) indicators of Plan Enrollee risk factors; (2) health status measurement and (3) health assessment questions across all Contractors, with the goal of having standard measures used across the Exchange's Contractors in a period of time mutually agreed upon by Contractor and the Exchange.

Article 6. Patient-Centered Care Initiatives and Plan Enrollee Communication

6.01 Contractor shall provide the Exchange with its plan, measures and process to provide Plan Enrollees with current cost and quality information for network providers, including at the individual physician and hospital level, using the most current nationally recognized or endorsed measures, including National Quality Forum (NQF), in accordance with the principles of the Patient Charter for Physician Performance Measurement. At a minimum, Contractor shall document its plans to make available to Plan Enrollees information provided for public use that reflects -the CMS Hospital Compare Program and CMS Physician Quality Reporting System Contractor shall report how it is or intends to make provider specific cost and quality information available by region, and the processes by which it updates the information. Information delivered through Contractor's Provider performance programs should be meaningful to Plan Enrollees and reflect a diverse array of Provider clinical attributes and activities, including, but not be limited to: provider background, quality performance, patient experience, volume, efficiency, price of services, and should be integrated and accessible through one forum providing Plan enrollees with a comprehensive view.

6.02 The Exchange understands that Contractor negotiates Agreements with providers, including physicians, hospitals, physician groups and other clinical providers, which may result in varied provider reimbursement levels for identical services and or procedures. In the event that Contractor's provider contracts result in different provider reimbursement levels that have an impact on Plan Enrollee costs within a specific region, as defined by paid claims for like CPT, ICD9/10 and DRG based services, Contractor agrees to provide the Exchange with its plan measures and process to provide Plan Enrollees with total cost and out-of-pocket cost information for identified individual service(s) and or procedure(s). Contractor also agrees to report to the Exchange the extent to which it provides Plan Enrollees with an updated listing of the top ten (10) most frequent bundled procedures and top ten (10) episodes of care for the Contractor within that region. The availability of this pricing information shall be prominently displayed and made available to both Plan Enrollees and contracted Contractor providers to the extent permitted by provider contracts. This information shall be updated on at least an annual basis unless there is a contractual change that would change enrollee out-of-pocket costs by more than 10%. In that case, information must be updated within 30 days of the effective date of the new contract.

6.03 Contractor shall provide Plan Enrollees with current information regarding annual out-of-pocket costs, status of deductible and total health care services received to date.

6.04 By 2015, Contractor shall demonstrate effective engagement of enrollees with information, decision support, and strategies to optimize self-care and make the best choices about their treatment, with materials from sources such as Consumer Reports, developed as part of the American Board of Internal Medicine ("ABIM") Foundation campaign, "Choosing Wisely" or structured shared decision-making programs.

By 2015, Contractor shall also provide specific information to the Exchange regarding the number of Plan Enrollees who have accessed consumer information and/or have participated in a shared decision-making process prior to reaching an agreement on a treatment plan. For example, Contractor may adopt shared-decision-making practices for preference-sensitive conditions, including but not limited to breast cancer, prostate cancer, and knee and hip replacements, that feature patient-decision-making aids in addition to physician opinions and present trade-offs regarding quality or length of life. Contractor shall report the

Comment [AC21]: We suggest that the Exchange collect this information. It would be an undue burden on providers to get these requests from several plans. We are unsure of the value of individual-level physician analysis that would be required by this section.

With respect to provider quality performance measures, patient experience, or volume by provider, many plans do not currently collect this information and would need time to build up the capacity. Many contracts will not permit the sharing of cost data.

Comment [AC22]: To be consistent with the changes in section 6.01 above.

Comment [AC23]: Depending on how this information is presented (provider specific v. aggregated by geography) this continue to present a problem with plan provide confidentiality obligations.

percentage of Enrollees with identified health conditions above who received information that allowed the Enrollee to share in the decision-making process prior to agreeing to a treatment plan. Contractor shall report annually to the Exchange documenting participation in these programs and their results, including clinical, patient experience and costs impacts,

Article 7. Promoting Care Coordination and Higher Value

7.01 Contractor will actively promote access expansion through the development of care models that promote care coordination and value. Such models may include, but are not limited to:

- (a) Accountable Care Organizations (ACO);
- (b) Patient Centered Medical Homes (PCMH);
- (c) Bundled Payments;
- (d) Participation in shared risk and or gain sharing arrangements with provider organizations;
- (e) Use a patient-centered, team-based approach to care delivery and member engagement;
- (f) Focus on additional primary care recruitment, use of mid-level practitioners and development of new primary care and specialty clinics;
- (g) Focus on expanding primary care access through payment systems and strategies;
- (h) Use an intensive outpatient care programs (“Ambulatory ICU”) for enrollees with complex chronic conditions;
- (i) Use qualified health professionals to deliver coordinated patient education and health maintenance support, with a proven approach for improving care for high-risk and vulnerable populations;
- (k) Support physician and patient engagement in shared decision-making;
- (l) Provide patient access to their health information;
- (m) Promote team care;
- (n) Use telemedicine;
- (o) Promote the use of remote patient monitoring;
- (p) Promote the use of condition and procedure specific Centers of Excellence within the United States

Contractor shall report annually, in a format to be mutually agreed upon between Contractor and Exchange, on: (1) the enrollment of Plan Enrollees in such models and (2) the results of such enrollment, including clinical, patient experience and costs impacts. In the event that the reporting requirements identified herein include Personal Health Information (PHI) Contractor shall provide the Exchange only with de-identified PHI as defined in 45 C.F. R. Section 164.514. All information provided to the Exchange in this section shall be treated by the Exchange as confidential information.

Contractor shall not be required to provide the Exchange any data, information or reports that would violate peer review protections under applicable laws, rules and regulation.

7.02 Value Based Reimbursement Inventory and Performance

By the end of 2014, Contractor will provide an inventory of all current value based provider reimbursement methodologies within the geographic regions served by the Exchange. Value based reimbursement methodologies will include those payments to hospitals and physicians that are linked to quality metrics,

Comment [AC24]: Plans do not all have access to information about which patients access these different systems. This section is confusing and it is not clear how it will tell the plan anything about the effect on enrollees.

performance, cost and/or value measures. Integrated care models that receive such value based reimbursements may be included, but are not limited to, those referenced in Section 7.01

This inventory must include:

- (a) The percentage of total valued based reimbursement to providers, by provider and provider type.
- (b) The total number of Contractor Plan Enrollees accessing participating providers reimbursed under value based payment methodologies.
- (c) The percentage of total Contractor Network Providers participating in value based provider payment programs.
- (d) An evaluation of the overall performance of Contractor network providers, by geographic region, participating in value based provider payment programs.

For 2015, Contractor and the Exchange shall agree on the targeted percentage of providers to be reimbursed under value based provider reimbursement methodologies.

7.03 Value Based Reimbursement and Adherence to Clinical Guidelines. If not already in place, by January 1, 2016, Contractor agrees to develop and/or implement alternative reimbursement methodologies promote adherence to clinical guidelines. Methodologies will target the highest frequency conditions and procedures as mutually agreed upon by the Exchange and Contractor.

When considering the implementation of value based reimbursement programs, Contractor shall demonstrate and design approaches to payment that reduce waste and inappropriate care, while not diminishing quality..

7.04 Value-Pricing Programs. Contractors agrees to provide the Exchange with the details of any value-pricing programs for procedures or in service areas that have the potential to improve care and generate savings for the Exchange enrollees. Contractor agrees to share the results with the Exchange of programs that may focus on high cost regions or those with the greatest cost variation(s). These programs may include but are not limited to payment bundling pilots for specific procedures where wide cost variations exist.

7.05 Payment Reform and Data Submission

~~-(a) Contractor will provide information to the Exchange noted in all areas of this Article 7 understanding that the Exchange will provide such information to the Catalyst for Payment Reform's (CPR) National Scorecard on Payment Reform and National Compendium on Payment Reform.—~~

~~-(b) The CPR National Scorecard will provide a view of progress on payment reform at the national level and then at the market level as the methodology and data collection mechanisms allow.~~

(c) The CPR National Compendium will be an up-to-date resource regarding payment reforms being tested in the marketplace and their available results. The Compendium will be publicly available for use by all health care stakeholders working to increase value in the system.

Article 8. Drug Formulary Changes

Except in cases where patient safety is an issue, Contractor shall give the Exchange Plan Enrollee(s), and their prescribing physician(s), sixty (60) calendar days, unless it is determined that a drug must be removed for safety purposes more quickly, written notice prior to the removal of a drug from formulary status. Notice shall apply only to single source brand drug and will include information related to the appropriate substitute. It will also include a statement of the requirements of the Health and Safety Code and Insurance Code prohibiting Contractor from limiting or excluding coverage for a drug to a Plan Enrollee if the drug had been previously approved for coverage by Contractor for a medical condition of the Plan Enrollee, except under specified conditions. An exception to the notice requirement will be allowed when Contractor continues to cover a drug prescribed for a Plan Enrollee without interruption and under the same conditions, including copayment and limits that existed prior to the removal of the drug from formulary status.

Quality, Network Management and Delivery System Standards

Glossary of Key Terms

Accountable Care Organization (ACO) - A healthcare organization characterized by a payment and care delivery model that seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients. An ACO is intended to provide incentives for participating providers (i.e. clinics, hospitals and physicians) to collectively share financial risk, working towards common goals to 1) reduce medical costs, 2) reduce waste and redundancy, 3) adhere to best care practices (i.e. evidence-based care guidelines, and 4) improve care quality. Care Management and Population Health Management are critical program components that are intended to enable ACOs to achieve favorable financial outcomes as the result of improved care outcomes.

Active Purchaser - Health care purchasers, typically employers or employer coalitions, that proactively define and manage performance expectations through their health plan contracts or direct contracting

arrangements with providers. These expectations include a range of service models including (but not limited to) benefit design and incentives, health and wellness, service delivery for enrollees, transaction processing, delivery system performance and reform, health information technology adoption and use, quality of care for enrollees, and other innovation models. Further, these expectations may also include active development, financial support, and contractual expectations for collaborative participation in accordance with applicable laws, rules and regulations, among multiple payers and/or providers that collectively serve a specific geographic area and/or multiple purchasers

Bundled Payments (also known as Global Payment Bundles, episode-of-care payment, or global case rates) – An alternative payment method to reimburse healthcare providers for services that provides a single payment for all physician, hospital and ancillary services that a patient uses in the course of an overall treatment for a specific, defined condition, or care episode. These services may span multiple providers in multiple settings over a period of time, and are reimbursed individually under typical fee-for-service models. The Payment Bundle may cover all inpatient/outpatient costs related to the care episode, including physician services, hospital services, ancillary services, procedures, lab tests, and medical devices/implants. Using Payment Bundles, providers assume financial risk for the cost of services for a particular treatment or condition, as well as costs associated with preventable complications, but not the insurance risk (that is, the risk that a patient will acquire that condition, as is the case under capitation)

Care Management - Healthcare services, programs and technologies designed to help individuals with certain long-term conditions better manage their overall care and treatment. Care management typically encompasses Utilization Management (UM), Disease Management (DM) and Case Management (CM). Care Management's primary goal is to prevent the sick from getting sicker, and avoiding acute care events. Care Management is usually considered a subset of Population Health Management.

Complex Conditions- Clinical conditions that are of a complex nature that typically involve ongoing case management support from appropriately trained clinical staff. Frequently, individuals have multiple chronic clinical conditions that complicate management ("polychronic") or may have a complex, infrequent specialty condition that requires specialized expertise for optimal management

Delivery System Transformation- A set of initiatives taken by purchasers, employers, health plans or providers, together or individually, to drive the creation and preferred use of care delivery models that are designed to deliver higher value aligned with the "triple aim" goals of patient care experience including quality and satisfaction, improve the health of the populations, and reduce the per capita cost of health care services. Generally these models require improved care coordination, provider and payer information sharing and programs that identify and manage populations of individuals through care delivery and payment models.

Patient Centered Medical Home - A health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner. The medical home is best described as a model or philosophy of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety.

Population Health Management - A management process that strives to address health needs at all points along the continuum of health and wellbeing, through participation of, engagement with and targeted interventions for the population. The goal of a Population Health Management program is to maintain and/or improve the physical and psychosocial wellbeing of individuals through cost-effective and tailored health solutions.

Preventive Health and Wellness Services - The provision of specified preventive and wellness services and chronic disease management services, including preventive care, screening and immunizations, set forth under Section 1302 of the Affordable Care Act (42 U.S.C. Section 18022) under the Section 2713 of the Affordable Care Act (42 U.S.C. Section 300gg-13), to the extent that such services are required under the California Affordable Care Act.

Reference Pricing - A payor contracting, network management and enrollee information process that identifies and differentially promotes delivery system options for care based on transparent display of comparative costs for identical services or procedures, typically after each provider has passed a quality assessment screen. In some cases, value pricing will identify the individual enrollees out of pocket costs accounting for plan design and deductible status. While quality is incorporated in the process, typically there is no differentiation based on comparative quality once a threshold performance level is achieved.

Remote Patient Monitoring - A technology or set of technologies to enable monitoring of patients outside of conventional clinical settings (e.g. in the home), which may increase access to care and decrease healthcare delivery costs.

Retail Clinics - A non-traditional setting for obtaining primary care services distinguished from traditional primary care in its setting, access, method of care delivery, technology use, and scope of services provided. Generally, services are limited to treatment of a set of common medical ailments. Some clinic operators also offer a suite of preventive care, including physicals and diagnostic screening.

Reward Based Consumer Incentive Program- (aka: Value-Based Insurance Design) individualizes the benefits and claims adjudication to the specific clinical conditions of each high risk member and to reward participation in appropriate disease management & wellness programs. Positive Consumer Incentive programs help align employee incentives with the use of high-value services and medications, offering an opportunity for quality improvement, cost savings and reduction in unnecessary and ineffective care.

Shared Decision Making- the process of making decisions regarding health care diagnosis and treatment that are shared by doctors and patients, informed by the best evidence available and weighted according to the specific characteristics and values of the patient. Shared decision making combines the measurement of patient preferences with evidence-based practice.

Team Care - A plan for patient care that is based on philosophy in which groups of professional and non-professional personnel work together to identify, plan, implement and evaluate comprehensive client-centered care. The key concept is a group that works together toward a common goal, providing qualitative comprehensive care. The team care concept has its roots in team nursing concepts developed in the 1950's.

Telemedicine - Professional services given to a patient through an interactive telecommunications system by a practitioner at a distant site. Telemedicine seeks to improve a patient's health by permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site. This electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment.

Value Pricing - A payor contracting, network management and enrollee information process that identifies and differentially promotes delivery system options for care that provide better value through the identification and transparent display of comparative total cost, out of pocket cost for enrollees and standardized quality performance to allow for informed consumer choice and provider referrals for individual services and bundles of services.

Value Based Reimbursement - Payment models that rewards physicians and providers for taking a broader, more active role in the management of patient health, and provides for a reimbursement rate that reflects results and quality instead of solely for specific visits or procedures.

[Insert Data File Formats as Appendix 1 here]

Plan Layout

Field #	Field Name	Description	Field Type/ Format	Length	Notes
1	Plan_Name	Plan Name	Character	30	

2	Plan_CCCode	Covered California plan ID number for carrier (to be assigned)	Character	8	
3	Group_No	Plan-assigned Group number	Character	15	CC Exchange-specific number Optional
4	Group_No_Suffix	Plan-assigned Group number with Suffix if applicable	Character	15	
5	Product_Type	Health Plan Product: P=PPO, E=EPO, H= HMO or S= POS	Character	1	
6	Benefit_Design	Coding TBD pending selection of plan designs/alt plans	Character	2	
7	Metal	Metal level associated with benefit design	Character	10	
8	HealthAssessment	Name of Health Assessment tool or vendor (list Internal if internally developed)	Character	40	

Member File Layout

Field #	Field Name	Description	Field Type/Format	Length	Notes
1	CC_MemberID	Unique code assigned by CC to the member	Character	20	
2	Plan_MemberID	Unique code assigned by health plan to identify a member	Character	20	
3	Dep_Suffix	Unique code assigned by the health plan to identify dependents (spouse, children, etc.)	Character	5	
4	SSN	Member's SSN	Character	9	
5	Group_No	Plan-assigned Group number	Character	15	
6	Group_No_Suffix	Plan-assigned Group number with Suffix if applicable	Character	15	
7	M_Lname	Member's last name	Character	30	
8	M_Fname	Member's first name	Character	20	
9	M_MI	Member's middle initial	Character	5	
10	M_DOB	Member's date of birth	Date; mmddyyyy	8	
11	M_Gender	Member's Gender: M=male F=female U=unknown	Character	1	
12	M_Language	Member Primary Language	Character	10	Use ICEforHealth standard abbreviations
13	M_Race	Member Race	Character	10	
14	M_Ethnicity	Member Ethnicity	Character	10	

15	M_Addr1	Member's Street Address	Character	40	
16	M_Addr2	Member's Street Address2	Character	40	
17	M_City	Member's City	Character	40	
18	M_State	Member's State	Character	2	
19	M_Zip	Member zip code	Character	5	5 digit zip
20	M_ZipSuffix	Member zip code suffix	Character	4	4 digit zip suffix
21	M_Phone	Member phone	Character	15	
22	Eff_Date	Effective date of coverage	Date; mmddyyyy	8	Current effective date of coverage with benefit design
23	Term_Date	Termination date - Last day of continuous coverage	Date; mmddyyyy	8	

Member File Layout

Field #	Field Name	Description	Field Type/Format	Length	Notes
24	Eff_Date_Init	Original effective date of coverage	Date; mmddyyyy	8	Same as Eff_Date unless there is a break in coverage
25	Subsidy_Elig	Status of eligibility for subsidy (Y=Yes, N=No, P=Pending)	Character	1	Coding to be determined
26	Subsidy_Type	Subsidy level (1=1xFPL, 2=2xFPL, 3=3xFPL, 4=4xFPL)	Character	6	Coding to be determined
27	Product_Type	Health Plan Product: P=PPO, S=HSA, E=EPO, H= HMO or O= POS	Character	1	
28	Benefit_Design	Coding TBD pending selection of plan designs/alt plans	Character	2	To be confirmed
29	PCP_ID	NPI of Primary Care Physician	Character	16	
30	Plan_PID	Plan ID for Primary Care Physician if NPI not available	Character	16	
31	Update	Add/Change/Delete (if change in member status)	Character	1	Optional

Member History File Layout

Field #	Field Name	Description	Field Type/ Format	Length	Notes
1	CC_MemberID	Unique code assigned by CC to the member	Character	20	
2	Plan_MemberID	Unique code assigned by health plan to identify a member	Character	20	
3	Dep_Suffix	Unique code assigned by the health plan to identify dependents (spouse, children, etc.)	Character	5	
4	SSN	Member's SSN	Character	9	
5	M_Lname	Member's last name	Character	30	
6	M_Fname	Member's first name	Character	20	
7	M_MI	Member's middle initial	Character	5	
8	M_DOB	Member's date of birth	Date; mmdyyy	8	
9	M_Gender	Member's Gender: M=male F=female U=unknown	Character	1	
10	Eff_Date	Effective date of coverage	Date; mmdyyy	8	Current effective date of coverage with benefit design
11	Term_Date	Termination date - Last day of continuous coverage	Date; mmdyyy	8	
12	Subsidy_Elig	Status of eligibility for subsidy	Character	1	
13	Subsidy_Type	Subsidy level (coding TBD)	Character	6	Coding to be determined
14	Product_Type	Health Plan Product: P=PPO, E=EPO, H= HMO or S= POS	Character	1	
15	Benefit_Design	Coding TBD pending selection of plan designs/alt plans	Character	2	To be confirmed
16	PCP_ID	NPI of Primary Care Physician	Character	16	
17	Plan_PID	Plan ID for Primary Care Physician if NPI not available	Character	16	

Physician Medical Group File

Field #	Field Name	Description	Field Type/ Format	Length	Notes
1	PMGID	Plan ID for Physician Medical Group	Character	12	
2	PMG	Provider Group Name	Character	30	

3	PMG_TaxID	Tax ID for Physician Medical Group	Character	12
4	DMHC ID	DMHC ID for Physician Medical Group	Character	20

Provider File

Field #	Field Name	Description	Field Type/Format	Length	Notes
1	P_Fname	Physician First Name	Character	20	
2	P_MI	Physician Middle Name or Initial	Character	5	
3	P_Lname	Physician Last Name	Character	30	
4	P_Suffix	Physician Type Suffix (e.g., MD, DO, etc.)	Character	20	
5	P_DOB	Physician Date of Birth (MM/DD/YYYY)	Date; mmddyyyy	8	
6	P_TaxID	Physician Tax ID Number	Character	12	
7	P_SSN	Physician SSN	Character	12	
8	NPI	Physician type-1 National Provider Identifier (NPI)	Character	12	
9	NPI2	Physician NPI Number (type-2 organizational)	Character	12	
10	DEA	Physician DEA Number	Character	12	Optional if Rx file contains provider NPI
11	Plan_PID	Physician ID Number Assigned by Plan	Character	20	Must match Field #29 from Member file layout
12	LicenseNo	Physician State Medical License Number (DO or NP license if acting as PCPs)	Character	20	Define if leading 0's added
13	P_Addr1	Physician Address Line 1	Character	30	
14	P_Addr2	Physician Address Line 2	Character	30	
15	P_City	Physician City	Character	30	
16	P_State	Physician State	Character	2	
17	P_Zip	Physician Zip Code	Character	10	
18	P_Phone	Physician Phone Number	Character	20	
19	Spec1	Physician Specialty 1 (primary)	Character	30	Provide summary table if abbreviations are used
20	Spec2	Physician Specialty 2 (secondary)	Character	30	
21	Spec3	Physician Specialty 3 (tertiary)	Character	30	

22	PMGID	Provider Group (Primary affiliation)	Character	12	Plan Number or code for contracted PMGs
23	PMGID2	Provider Group2 (Secondary affiliation)	Character	12	Plan Number or code for contracted PMGs
24	PMGID3	Provider Group3 (Tertiary affiliation)	Character	12	Plan Number or code for contracted PMGs
25	P_HMO	Physician HMO Contract Flag (Y/N)	Character	1	
26	P_PPO	Physician PPO Contract Flag (Y/N)	Character	1	
27	P_HPND	Physician Narrow Network Flag (Y/N)	Character	1	
28	P_ACO	Physician ACO Contract Flag (Y/N)	Character	1	

Hospital File

Field #	Field Name	Description	Field Type/Format	Length	Notes
1	H_TaxID	Facility Tax ID Number	Character	30	
2	H_ID	Facility ID Number Assigned by Health Plan	Character	20	
3	H_StateID	Facility ID Number Assigned by State Licensing Agency	Character	20	
4	H_Addr1	Facility Address Line 1	Character	30	
5	H_Addr2	Facility Address Line 2	Character	30	
6	H_City	Facility City	Character	30	
7	H_State	Facility State	Character	2	
8	H_Zip	Facility Zip Code	Character	10	
9	H_Phone	Facility Phone Number	Character	20	
10	H_HMO	Facility HMO Contract Flag (Y/N)	Character	1	
11	H_PPO	Facility PPO Contract Flag (Y/N)	Character	1	
12	H_HPND	Physician Narrow Network Flag (Y/N)	Character	1	
13	H_ACO	Physician ACO Contract Flag (Y/N)	Character	1	
14	H_Cap	Service is/is not capitated (Y/N)	Character	1	

Professional Claims

Field #	Field Name	Description	Field Type/Format	Length	Notes
1	P_Claim_ID	Plan internal claim number.	Character	20	

2	Plan_MemberID	Unique code assigned by health plan to identify a particular patient within their system.	Character	20	Needs to match # in member file layout
3	Dep_Suffix	Unique code assigned by the health plan to identify dependents (spouse, children, etc.)	Character	5	Needs to match # in member file layout
4	Line_No	The detail line number for the service on the claim.	Character	3	
5	DatePaid	Date the claim was paid.	Date; mmddyyyy	8	
6	SvcCount	A count of the number of services rendered by the provider.	Character	2	
7	Place	Code indicating the place of service (e.g., Acute Care Hospital, Office, Patient's Home, etc.). CMS standard values preferred.	Character	4	
8	Init_Date	Date of the first service reported on the claim.	Date; mmddyyyy	8	
9	Last_Date	Date of the last service reported on the claim.	Date; mmddyyyy	8	
10	Dx1	Primary diagnosis code from the claim line	Character	10	The diagnosis codes use the ICD-9-CM coding system but will transition to ICD-10. Confirm format re decimal placement
11	Dx2	Secondary diagnosis code from the claim line	Character	10	
12	Dx3	Third diagnosis code from the claim line	Character	10	
13	Dx4	Fourth diagnosis code from the claim line	Character	10	
14	Proc1	Procedure Code for line on a CMS-1500 claim form.	Character	5	

Professional Claims

Professional Claims

Field #	Field Name	Description	Field Type/Format	Length	Notes
15	Mod1	The 2-character code of the first procedure code modifier on the professional claim. Procedure modifiers only apply to CPT procedure codes.	Character	2	
16	Mod2	The 2-character code of the second procedure code modifier on the professional claim. Procedure modifiers only apply to CPT procedure codes.	Character	2	
17	Mod3	The 2-character code of the third procedure code modifier on the professional claim. Procedure modifiers only apply to CPT procedure codes.	Character	2	
18	Mod4	The 2-character code of the fourth procedure code modifier on the professional claim. Procedure modifiers only apply to CPT procedure codes.	Character	2	
19	RenderingPhysNPI	NPI for the provider who rendered or supervised the care.	Character	16	
20	RenderingPhysPlanID	The plan ID for the provider who rendered or supervised the care.	Character	20	not needed if Rendering Physician NPI provided
21	RenderingPhysID	The ID for the provider who rendered or supervised the care based on original claims submission (eg license #)	Character	16	
22	BillingOrgNPI	National Provider Identifier Type 1 for the provider who rendered or supervised the care.	Character	16	
23	BillingProviderID	The plan ID for the billing provider or group	Character	20	not needed if Billing Provider NPI provided
24	BillingProvider	The ID for the provider who rendered or supervised the care based on original claims submission (egTaxID #)	Character	16	
25	P_BilledAmt	Amount billed for procedure	Numeric or dollar amt (####.##)	12	
26	P_Allowed	Amount allowed for procedure	Numeric or dollar amt (####.##)	12	

27	P_Deductible	Applied to deductible (Y/N)	Numeric or dollar amt	12
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Field #	Field Name	Description	Field Type/ Format	Length	Notes
			(####.##)		
28	P_MemberOOP	Amount paid by member	Numeric or dollar amt (####.##)	12	
29	P_Cap	Service is/is not capitated (Y/N)	Character	1	

Facility Claim Header

Field #	Field Name	Description	Field Type/Format	Length	Notes
1	H_Claim_ID	Plan internal claim number.	Character	20	
2	H_TaxID	Facility Tax ID Number	Character	30	
3	H_ID	Facility ID Number	Character	20	
4	Plan_MemberID	Assigned by Health Plan Unique code assigned by health plan to identify a member	Character	20	Needs to match # in member file layout
5	Dep_Suffix	Unique code assigned by the health plan to identify dependents (spouse, children, etc.)	Character	5	Needs to match # in member file layout
6	DatePaid	Date the claim was paid.	Date; mmddyyyy	8	
7	Bill_Type	The UB-04 standard code for the billing type, indicating type of facility, bill classification, and frequency of bill.	Character	3	
8	Place	Code indicating the place of service (e.g., Acute Care Hospital, Office, Patient's Home, etc.). CMS standard values preferred.	Character	2	
9	Init_Date	Date of the first service reported on the claim.	Date; mmddyyyy	8	

10	Last_Date	Date of the last service reported on the claim.	Date; mmddyyyy	8	
11	Adm_Date	Date the patient was admitted to the facility	Date; mmddyyyy	8	
12	Dc_Date	Date the patient was discharged from the facility	Date; mmddyyyy	8	
13	Dc_Disposition	The UB-04 standard patient status code, indicating patient disposition at the time of billing.	Character	3	
14	Dx1	Primary diagnosis code from the claim line	Character	10	The diagnosis codes use the ICD-9-CM coding system but will transition to ICD-10. Confirm format re decimal placement
15	Dx2	Secondary diagnosis code from the claim line	Character	10	
16	Dx3	Third diagnosis code from the claim line	Character	10	

Facility Claim Header

Facility Claim Header

Field #	Field Name	Description	Field Type/Format	Length	Notes
17	Dx4	Fourth diagnosis code from the claim line	Character	10	
18	Dx5	Fifth diagnosis code from the claim line	Character	10	
19	Dx6	Sixth diagnosis code from the claim line	Character	10	
20	Proc1	The primary ICD-9 procedure code on the facility claim.	Character	7	
21	Proc2	The secondary ICD-9 procedure code on the facility claim.	Character	7	
22	Proc3	The third ICD-9 procedure code on the facility claim.	Character	7	
23	Proc4	The fourth ICD-9 procedure code on the facility claim.	Character	7	
24	Proc5	The fifth ICD-9 procedure code on the facility claim.	Character	7	
25	Proc6	The sixth ICD-9 procedure code on the facility claim.	Character	7	

26	AdmittingProviderID	NPI for the admitting provider	Character	20	
27	AttendingProviderID	NPI for the rendering provider	Character	20	
28	AdmittingProviderID	PlanID for the admitting provider	Character	10	Optional if NPI is reported Optional if NPI is reported (W,N,Y,U, 1 etc.)
29	AttendingProviderID	PlanID for rendering provider	Character	10	
30	POA1	CMS Code indicating whether primary Dx was present on admission	Character	1	
31	POA2	CMS Code indicating whether secondary Dx was present on admission	Character	1	
32	POA3	CMS Code indicating whether tertiary Dx was present on admission	Character	1	(W,N,Y,U, 1 etc.)
33	POA4	CMS Code indicating whether quaternaryDx was present on admission	Character	1	(W,N,Y,U, 1 etc.)
34	H_BilledAmt	Amount billed for admission	Numeric or dollar amt (####.##)	12	
35	H_Allowed	Amount allowed for admission	Numeric or dollar amt (####.##)	12	
36	H_Deductible	Applied to deductible (Y/N)	Numeric or dollar amt (####.##)	12	

Field #	Field Name	Description	Field Type/Format	Length	Notes
37	H_MemberOOP	Amount owed/paid by member	Numeric or dollar amt (####.##)	12	

Facility Claim Detail					
Field #	Field Name	Description	Field Type/Format	Length	Notes
1	H_Claim ID	The carrier's internal claim number.	Character	20	Needs to match #1 in hospital claim header

2	Plan_MemberID	Unique code assigned by health plan to identify a particular patient within their system.	Character	20	Needs to match # in member file layout
3	Dependent_Suffix	Unique code assigned by the health plan to identify dependents (spouse, children, etc.)	Character	5	Needs to match # in member file layout
4	Line Number	The detail line number for the service on the claim.	Character	3	
5	Service Count	A count of the number of services/units rendered by the provider.	Character	3	
6	Service_Date	The date of service for this detail record.	Date; mmddyyyy	8	
7	H_Procedure_Code	The CPT procedure code for the service record.	Character	5	
8	Rev_Code	The CMS standard revenue code from the facility claim.	Character	3	
9	D_BilledAmt	Amount billed for procedure	Numeric or dollar amt (####.##)	12	
10	D_Allowed	Amount allowed for procedure	Numeric or dollar amt (####.##)	12	
11	D_Deductible	Applied to deductible (Y/N)	Numeric or dollar amt (####.##)	12	
12	D_MemberOOP	Amount paid by member	Numeric or dollar amt (####.##)	12	

Drug Claims Layout

Field #	Field Name	Description	Field Type/Format	Length	Notes
1	Claim ID	The carrier's internal claim number (ICN).	Character	20	
2	Plan_MemberID	Unique code assigned by health plan to identify a particular patient within their system.	Character	20	
3	Dependent_Suffix	Unique code assigned by the health plan to identify dependents (spouse,	Character	5	

children, etc.)

4	NDC Number Code	The FDA (Food and Drug Administration) registered number for the drug, as reported on the prescription drug claims.	Character	11	
5	Days Supply	The number of days of drug therapy covered by this prescription.	Character	2	
6	Metric Quantity Dispensed	The number of units dispensed for the prescription drug claim, as defined by the NCPDP (National Council for Prescription Drug Programs) standard format.	Character	10	
7	Date of Service	The date of service for the drug claim.	Date; mmddyyyy	8	
8	Date Paid	The date the claim was paid.	Date; mmddyyyy	8	
9	Ordering Provider ID	Prescribing provider's ID as supplied by plan (likely DEA)	Character	20	Optional if NPI is provided
10	Provider ID	Provider (Pharmacy) that submitted the claim as supplied by plan (TIN or other)	Character	12	Optional if NPI is provided
11	Prescriber NPI	Prescribing provider's National Provider Identifier Type 1	Character	10	
12	Attending Physician NPI	Attending Provider Submitted National Provider Identifier Type 1	Character	10	may be same as #10

Total Medical Expense Reporting (non-claims payments)

Field #	Field Name	Description	Field Type/Format	Length	Notes
1	H_TaxID	Facility Tax ID Number	Character	30	Leave blank if payment not applicable
2	H_ID	Facility ID Number Assigned by Health Plan	Character	20	Leave blank if payment not applicable
3	PMGID	Plan ID for Physician Medical Group	Character	12	Leave blank if payment not applicable
4	PMG	Provider Group Name	Character	30	Leave blank if payment not applicable
5	PMG_TaxID	Tax ID for Physician Medical Group	Character	12	Leave blank if payment not applicable

6	DMHC ID	DMHC ID for Physician Medical Group	Character	20	Leave blank if payment not applicable
7	PaymentType	Type of payment C=Case Management or PMPM fee E=Episode-based payment I=Incentive Program R=Risk Settlement S=Salary-based incentive O=Other			Include multiple entries as needed
8	BegDate	Beginning Date of Measurement/Reward period	Date; MMDDYYYY	8	
9	EndDate	Beginning Date of Measurement/Reward period	Date; MMDDYYYY	8	
10	PaymentAmt	Dollar value of payment	Numeric (no decimals)	10	
11	CC_Applied	Indicate if dollars are solely applicable to Exchange membership (Y/N)	Character	1	
11	ExchangeMM	Total MM for Exchange Enrollment for the period of the payment.	Numeric	12	Used to apportion payment dollars if dollars reported are not specific to Exchange membership
12	TotalMM	Total MM for Book of Business for which payment is applicable for the period reported above.	Numeric	16	

Biometric/Health Assessment Layout (provisional)

Field #	Field Name	Description	Field Type/Format	Length	Notes
1	Plan_MemberID	Unique code assigned by health plan to identify a particular patient within their system.	Character	20	
2	Dependent_Suffix	Unique code assigned by the health plan to identify dependents (spouse, children, etc.)	Character	5	
3	Date	Date completed	Date; mmddyyyy	8	
4	ScoreNum	Numerator of Health Assessment Score	Character	20	
5	ScoreDen	Denominator of Health Assessment Score	Character	20	

6	HlthEducRef	Referred for health education or coaching (Y/N)	Character	1
7	DMReferral	Referred for condition management (Y/N)	Character	1
8	Vital Sign Collection Date	Beginning date that the vital sign was measured.	Date; mmddyyyy	8
9	Vital Sign Collection Time	The time of day the vital sign was measured.	Character	10
10	Systolic BP	The systolic portion of the blood pressure in mmHg units.	Character	4
11	Diastolic BP	The diastolic portion of the blood pressure in mmHg units.	Character	4
12	Temperature	The temperature of the patient (numeric with one decimal).	Numeric	5
13	Temperature Unit	The unit that the temperature was measured in. i.e. C or F.	Character	1
14	Temperature Type	The type of temperature measured, i.e. O=Oral, R=Rectal, T=Tympanic.	Character	1
15	Weight	Patient's weight.	Character	1
16	Weight Unit	The unit that the weight was recorded in, i.e. Lbs or Kg.	Character	5
17	Height Feet	The feet portion of height of the patient if the measurement was recorded in feet and inches.	Numeric	4
18	Height Inches	The inches portion of the height of the patient if the measurement was recorded in feet and inches.	Numeric	2
19	Height Unit	The units of the height measurement given in the Height column. i.e. Meters, Centimeters, Decimal Feet, etc.	Character	1
20	Respiration	The number of respirations per minute observed.	Numeric	2
21	Pulse	The number of heart beats per minute observed.	Numeric	2
22	BMI	The calculated BMI reported with 1 decimal	Numeric	4
23	Weight-Nutrition Counseling	A Y/N flag that indicates if patient with BMI > 35 or < 18 has been counseled about	Character	1

Biometric/Health Assessment Layout (provisional)

Field #	Field Name	Description	Field Type/Format	Length	Notes
		nutrition and/or weight management			
24	Past Smoking Flag	A Y/N flag that indicates if the patient has smoked in the past.	Character	1	
25	Past Smoking Amount	The numeric amount that the patient typically smoked in the past	Number	2	
26	Past Smoking Amount Unit	The unit that describes the amount the patient smoked in the past. i.e. Packs/day, Cigarettes/day.	Character	20	
27	Past Smoking Quit Year	The year that the former smoker quit.	Date (YYYY)	4	
28	Current Smoking Flag	A Y/N flag that indicates if the patient is currently a smoker.	Character	1	
29	Current Smoking Amount	The numeric amount that the patient typically smokes.	Number	2	
30	Current Smoking Amount Unit	The unit that describes the amount the patient smoked in the past. i.e. Packs/day, Cigarettes/day.	Character	20	
31	Tobacco Counseling	A Y/N flag to indicate if member has been offered counseling or medication assistance	Character	1	
32	Alcohol Use Flag	A Y/N flag that indicates if the patient is currently consumes alcohol.	Character	1	
33	Alcohol Use Amount	The numeric amount that the patient typically consumes alcohol.	Number	2	
34	Alcohol Use Amount Unit	The unit that describes the amount the patient smokes. i.e. drinks/day, drinks/week.	Character	20	
35	Alcohol Use Counseling	A Y/N flag to indicate if member has been offered counseling or medication assistance	Character	1	
36	Other Lab Codes	Subject to availability, the Exchange may add laboratory codes based on LOINC format			

Attachment 8 Monthly Rates - Individual Exchange [to be attached specifically for each Issuer]

Attachment 9 Rate Updates - Individual Exchange [to be attached specifically for each Issuer]

Attachment 10 Monthly Rates- SHOP [to be attached specifically for each SHOP Issuer]

Attachment 11 Rate Updates - SHOP [to be attached specifically for each Issuer]

Attachment 12 Participation Fee Methodology - Individual Exchange

Attachment 13 Participation Fee Methodology - SHOP

Attachment 14 Performance Measurement Standards [Note: UPDATING IS IN PROCESS]

Comment [AC25]: While we realize this Attachment has been delayed we are anxious to start discussions with the Exchange on this and provide the following information for your consideration:

Issue: Performance Goals: Quality, Network Management and Delivery System Standards: For the first year or two of the Exchange, we strongly believe that performance goals established between the Exchange and issuers should focus primarily on the execution of operational and service metrics. We agree with the Exchange's original proposal where performance goals were set for customer service, subscriber material production and distribution, and interface standards. The Exchange has one chance to create a favorable first impression and to demonstrate that Covered California is an effective and efficient distribution channel where consumers can easily select and enroll in the plan of their choice. A first class consumer experience is critical for establishing trust and should be the top priority for Exchange/issuer performance goals in the initial years of the Exchange's operation.

Recommendation: We recommend the proposed quality and network management goals included in this draft be removed for at least the first year as it is too early to determine the needs of the members and there are already reporting requirements for composite measures. We suggest instead that during the last quarter of 2014, the plans and the Exchange collaborate on a particular area of interest based on actual baseline experience with the exchange population for a 3-year Quality Improvement Project. The plans would all be asked to work on improving care in a particular area with the flexibility to innovate their approaches. Plans would be rewarded at the end of the 3-year period for demonstrated improvement or penalized for not meeting targets in that particular area. This approach is similar to what CMS has put in place with contractors for Medicare and state approaches with Medicaid managed care contractors. This also will allow issuers who are seeking NCQA accreditation for the first time, an opportunity to focus on quality and outcome metrics, once they have met the initial technical and operational goals.

Issue: Performance Goals: Operational and Service Metrics

We support the concept of performance guarantees and agree that there should be penalties for poor performance and credits for exceptional performance. We provide some modifications to the targets set forth to match them to our performance guarantees with other large purchasers, such as CalPERS. We fully intend to provide the Exchange and Exchange enrollees a similar level of operational and customer service standards as other purchasers, but do not believe we should provide levels of service that exceed those we provide to other large purchasers. Higher goals will require further staffing than the additional staffing we have already planned for in our budgets and will impact premium costs.

[Note: The Performance Measurement Standards will be considered by the Covered California Board at its May 2013 meeting.]

In the event that the reporting requirements identified herein include PHI, Contractor shall provide the Exchange only with de-identified PHI as defined in 45 C.F.R. Section 164.514. Contractor shall not be required to provide the Exchange any data, information or reports that would violate peer review protections under applicable laws and regulations.

During the term of this Agreement, Contractor shall meet or exceed the Performance Measurement Standards identified in this Attachment. Contractor shall be liable for payment of penalties that may be assessed by the Exchange with respect to Contractor's failure to meet or exceed the Performance Measurement Standards in accordance with the terms set forth at Section 6.01 of the Agreement and this Attachment.

The assessment of the penalties by the Exchange shall be determined in accordance with the computation methodology set forth in the appendix to this Attachment 14 and shall be based on the following conditions: (i) the aggregate amount at risk with respect to Contractor's failure to comply with each of the Performance Measurement Standards shall not exceed ten percent (10%) of the total Participation Fee that is payable to the Exchange in accordance with the terms set forth in Section 5.03 of the Agreement, (ii) the performance penalties shall be based on the weighted average assigned to each Performance Measurement Standard that the Contractor fails to meet or exceed, as such weighted averages are set forth in the table below ("Performance Measurement Table"), and (iii) the amount of performance penalty to be assessed with respect to Contractor's failure to meet a Performance Measurement Standard shall be offset (i.e., reduced) by a "credit" that is provided in the event that Contractor exceeds a Performance Measurement Standard in a separate category; provided, however, that in no event shall the credit to Contractor exceed the amount of aggregate amount of the performance penalty that may be assessed during any applicable period.

Any amounts collected as performance penalties under this Attachment shall be used for Exchange operations to reduce future collective Participation Fees.

Call Center Operations

A. Baseline Period

During the first six (6) months Contractor begins to take operational calls under this Agreement ("Baseline Period"), the parties will collaborate to evaluate and refine Performance Measurement Standards based upon the call volumes and arrival patterns established during the Baseline Period. Contractor shall take reasonable efforts to staff sufficiently during the Baseline Period to meet or exceed the Performance Measurement Standards listed below.

B. 800 Number

Contractor shall make information available regarding the Exchange pursuant to Contractor's toll-free hotline (i.e., 1-800 number) that shall be available to enrollees of Contractor both inside and outside the Exchange. The hotline and information services shall be staffed and operated in accordance with the Customer Service Standards set forth at Section 3.18 to provide support Exchange Enrollees and in a manner designed to assure compliance with these Performance Measurement Standards.

C. Reporting

Contractor shall provide the following minimum reports to the Exchange at the specified time and frequency at no additional charge to the Exchange:

Switch reporting: monthly, quarterly and annually.

Phone statistics, Performance Measurement Standards reporting and operations reporting: monthly, quarterly and annually.

Accumulative monitoring scoring: weekly and monthly.

Performance Measurement Standards Reporting

Monthly Performance Report

Beginning the first full calendar month after the expiration of the Baseline Period, Contractor shall monitor and track its performance each month against the Performance Measurement Standards set forth below. Contractor shall provide detailed supporting information (as mutually agreed by the parties) for each Monthly Performance Report to the Exchange in electronic format.

Measurement Rules

Except as otherwise specified below in the Performance Measurement Standards table, the measurement period for each Performance Guarantee shall be one calendar month; all references to time of day shall be to Pacific Standard Time; all references to hours will be actual hours during a calendar day; and all references to days, months, and quarters shall be to calendar days, calendar months, and calendar quarters, respectively.

Performance Measurement Standards

General

The Performance Measurement Table sets forth the categories of Performance Measurement Standards and their associated measurements. In performing its services under this Agreement, Contractor shall use commercially reasonable efforts to meet or exceed the Performance Measurement Standards.

Root Cause Analysis/Corrective Action

If Contractor fails to meet any Performance Measurement Standard in any calendar month (whether or not the failure is excused), Contractor shall promptly (a) investigate and report on the root cause of the problem; (b) develop a corrective action plan (where applicable); (c) to the extent within Contractor's control, remedy the cause of the performance failure and resume meeting the affected Performance Measurement Standards; (d) implement and notify the Exchange of measures taken by Contractor to prevent recurrences if the performance failure is otherwise likely to recur; and (e) make written recommendations to the Exchange for improvements in procedures.

Performance Guarantee Exceptions

Contractor shall not be responsible for any failure to meet a Performance Guarantee if and to the extent that the failure is excused pursuant to Section 12.07 of the Agreement (Force Majeure) or the parties agree that the lack of compliance is due to the Exchange's failure to properly or timely perform (or cause to be properly or timely performed) any responsibility, duty, or other obligation under this Agreement, provided that Contractor timely notifies the Exchange of the problem and uses commercially reasonable efforts to perform and meet the Performance Measurement Standards notwithstanding the Exchange's failure to perform or delay in performing.

If Contractor wishes to avail itself of one of these exceptions, Contractor shall indicate in the applicable performance report delivered in the second month following the failure to meet such Performance Measurement Standard: (a) the identity of the Performance Measurement Standard that is subject to the exception, and (b) the circumstances that gave rise to the exception in sufficient detail to permit the Exchange to evaluate whether Contractor's claim of exception is valid. Notwithstanding anything to the contrary herein, in no event shall any failure to meet a Customer Satisfaction Performance Guarantee fall

within an exception.

The Exchange will also comply with the Performance Measurement Standards set forth herein to the extent that such measurements are applicable to Exchange's operations. In the event that Exchange fails to meet a Performance Measurement Standard with respect to its operations for any applicable period, the additional fees that may be assessed by the Exchange under this Attachment will not be imposed on Contractor with respect to Contractor's failure to meet the same Performance Measurement Standard.

Agreed Adjustments/Service Level Relief

In addition, the Parties may agree on Performance Measurement Standard relief or adjustments to Performance Measurement Standards from time to time, including, the inclusion of new and/or temporary Performance Measurement Standards.

Performance Measurement Defaults

If the Exchange elects to assess sanctions for failure to meet Performance Measurement Standards, it will so notify Contractor in writing following the Exchange's receipt of the Monthly Performance Report setting forth the performance level attained by Contractor for the calendar quarter to which the sanctions relate. If Contractor does not believe it is appropriate for the Exchange to assess sanctions for a particular calendar quarter or calendar year (as applicable), it shall so notify the Exchange in writing within thirty (30) days after receipt of the Exchange's notice of assessment and, in such event, the Exchange will meet with Contractor to consider, in good faith, Contractor's explanation of why it does not believe the assessment of sanctions to be appropriate; provided, however, that it is understood and agreed that the Exchange, acting in good faith, will make the final determination of whether or not to assess the sanctions.

Service Level Credits

For certain of the performance standards set forth in the Performance Guarantee table, Contractor will have the opportunity to earn service level credit ("Service Level Credits") for performance that exceeds the Performance Measurement Standards. The Service Level Credits shall be used to offset (i.e., reduce) any sanctions that are imposed during any Contract Year.

Performance Guarantee Tables

The Performance Measurement Standards are set forth in the Chart 1. Covered California Performance Standards below:

Chart: Covered California Performance Standards

**Customer Service
25% of Performance Penalty**

Customer Service Measures	Covered California Performance Requirements
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Call Answer Timeliness	Expectation: 80% of calls answered 30 seconds. 5% of total performance penalty at risk. Performance Level: <80% 5% performance penalty. 80%-90% no penalty. >90% 5% performance credit. Expectation: 80% of calls answered 30 seconds. 5% of total performance penalty at risk. Performance Level: <80% 5% performance penalty. 80%-90% no penalty. >90% 5% performance credit.
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Expectation: 70% of calls answered 30 seconds. 5% of total performance penalty at risk. Performance Level: <70%- 5% performance penalty. 70%-80% no penalty. >80%- 5% performance credit

Processing ID Cards

Expectation: 100% sent within 10 days of receiving enrollment premium. 5% of total performance requirement expected. Performance Level: <50%- 5% penalty of total performance requirement. 50-99% 2.5% penalty of total performance requirement. 100% no penalty. Expectation: 100% sent within 10 days of receiving enrollment info from the Exchange. 5% of total performance penalty at risk.

Performance Level: <100% sent within 10 days 5% performance penalty. 100% sent within 10 days no penalty. 100% sent within 5 days 5% performance credit.

Penalty Target = 93% sent within 10 business days of receiving enrollment information from the Exchange. 5% of total performance penalty at risk.

Credit Target = 99%. 5% of total performance penalty at risk.

In order for this penalty or credit to be in force, receipt of enrollment information from Covered California must include the payment.

Telephone Abandonment Rate

Expectation: No more than 3% of incoming calls in a calendar month. 5% of total performance penalty at risk.
Performance Level: >3% abandoned- 5% performance penalty. 2-3% abandoned- no penalty. <2% abandoned- 5% performance credit.

Initial Call Resolution

Expectation: 90% of enrollee issues will be resolved within the same business day two business days from when the issue was received. 5% of total performance penalty at risk.

Performance Level: <90%- 5% performance penalty. 90-95%- no penalty. >95%- 5% performance credit.

~~Expectation: 90% of enrollee issues will be resolved within the same business day the issue was received. 5% of total performance penalty at risk.~~

~~Performance Level: <90%- 5% performance penalty. 90-95%- no penalty. >95%- 5% performance credit.~~

Complaint Resolution

Expectation: 95% of enrollee complaints resolved within 30 calendar days. 5% of total performance penalty at risk. Performance Level: <95% resolved within 30 calendar days- 5% performance penalty. 95% or greater resolved within 30 calendar days- no penalty. 95% or greater resolved within 15 calendar days- 5% performance credit

Chart: Covered California Performance Standards

**Operational Standards
25% of Performance Penalty
Operational Standards**

Covered California Performance Requirements

Enrollment and payment transactions

~~Expectation: The Exchange will receive the 999 file within one business day of receipt of the 834/820 file 85% of the time and within 3 bus days of receipt of the 834/820 file 99% of the time within any given month. 2.5% of total performance penalty at risk.~~

~~Performance Level: <85% within one day AND <99% within 3 days 2.5% performance penalty. <85% within one day OR <99% within 3 days no penalty. >85% within one day AND >99% within 3 days 2.5% performance credit.~~

Expectation: The Exchange will receive the 999 file within one business day of receipt of the 834/820 file 85% of the time and within 3 bus days of receipt of the 834/820 file 99% of the time within any given month. 2.5% of total performance penalty at risk.

Performance Level: <85% within one day AND <99% within 3 days 2.5% performance penalty. <85% within one day OR <99% within 3 days no penalty. >85% within one day AND >99% within 3 days 2.5% performance credit.

The Exchange will receive the 999 file within one business day of receipt of the 834/820 file XX% of the time. 2.5 % of total performance penalty at risk.

Expectation and Performance Level and methodology to be determined after pilot period.

Effectuation of enrollment upon receipt of payment

~~Expectation: The exchange will receive the 834 file within one business day of receipt of the member's initial payment file 85% of the time and within 3 bus days of receipt of the member's initial payment 99% of the time within any given month. 2.5% of total performance penalty at risk.~~

~~Performance Level: <85% within one day and <99% within 3 days 2.5% performance penalty. <85% within one day OR <99% within 3 days no penalty. >85% within one day AND >99% within 3 days 2.5% performance credit~~
Expectation: The exchange will receive the 834 file within one business day of receipt of the member's initial payment file 85% of the time and within 3 bus days of receipt of the member's initial payment 99% of the time within any given month. 2.5% of total performance penalty at risk.

Performance Level: <85% within one day and <99% within 3 days 2.5% performance penalty. <85% within one day OR <99% within 3 days no

~~penalty. >85% within one day AND >99% within 3 days 2.5% performance credit.~~

~~The Exchange will receive the 834 file within one business day of receipt of the member's initial payment file XX% of the time. 2.5 % of total performance penalty at risk.~~

~~Expectation and Performance Level and methodology to be determined after pilot period.~~

~~Expectation: The Exchange will receive the 820 file within one business day of receipt of the member's payment file 95% of the time and within 3 business days of receipt of the member's payment 99% of the time within any given month. 2.5% of total performance penalty at risk.~~

~~Performance Level: <95% within one day and <99% within 3 days 2.5% performance penalty. <95% within one day OR <99% within 3 days no penalty. >95% within one day AND >99% within 3 days 2.5% performance credit. Expectation: The Exchange will receive the 820 file within one business day of receipt of the member's payment file 95% of the time and within 3 business days of receipt of the member's payment 99% of the time within any given month. 2.5% of total performance penalty at risk.~~

~~Performance Level: <95% within one day and <99% within 3 days 2.5% performance penalty. <95% within one day OR <99% within 3 days no penalty. >95% within one day AND >99% within 3 days 2.5% performance credit.~~

~~The Exchange will receive the 820 file within three business days of receipt of the member's payment XX% of the time. 2.5 % of total performance penalty at risk.~~

~~Expectation and Performance Level and methodology to be determined after pilot period.~~

~~Expectation: The Exchange will receive the 834 file within one business day of receipt of change of the members' status 95% of the time and within 3 business days of receipt of change of the members' status 99% of the time within any given month. 2.5% of total performance penalty at risk.~~

~~Performance Level: <95% within one day and <99% within 3 days 2.5% performance penalty. <95% within one day OR <99% within 3 days no penalty. >95% within one day AND >99% within 3 days 2.5% performance credit. Expectation: The Exchange will receive the 834 file within one business day of receipt of change of the members' status 95% of the time and within 3 business days of receipt of change of the members' status 99% of the time within any given~~

Member payment

Enrollment change upon non-receipt of member payment, 30 day notice and termination

month. 2.5% of total performance penalty at risk.

Performance Level: <95% within one day and <99% within 3 days- 2.5% performance penalty. <95% within one day OR <99% within 3 days- no penalty. >95% within one day AND >99% within 3 days- 2.5% performance credit.

The Exchange will receive the 834 file within one business day of receipt of change of the members status XX% of the time. 2.5 % of total performance penalty at risk.

Expectation and Performance Level and methodology to be determined after pilot period.

Operational Standards

Covered California Performance Requirements

Member Inquiries

Expectation: 90% response within 15 working days of inquiry. 5% of total performance requirement expected.

Performance Level: <70% 5% penalty of total performance requirement. 70-90% 2.5% penalty of total performance requirement. 90% or greater- no penalty Expectation:

Correspondence - 90% response within 30 15-working days of inquiry.

Emails - 80% response within 2 working days of inquiry.

5% of total performance requirement expected.

Performance Level: <70%- 5% penalty of total performance requirement. 70-90%- 2.5% penalty of total performance requirement. 90% or greater- no penalty.

Member Call Volume

Track Only- No performance requirement or penalty assessment

Data Submission

Expectation: Full and regular submission of data according to the standards outlined. 5% of total performance requirement expected. Performance Level: Incomplete, irregular, late or non useable data submission- 5% penalty of total performance requirement. Full and regular submission according to the formats specified and useable by Covered California within 30 days of each quarter end- no penalty.

Reporting Expectation: Submission of all required reports to Covered California within contractually specified times (varies by report or type of report). 5% of total performance requirement expected.

Performance Level: one or more reports submitted more than 4 months after required submission date- 5% penalty of total performance requirement. One or more reports submitted after 30 days of required submission date-2.5% penalty of total performance requirement. All required reports submitted within 5 business days of required submission- no penalty.

**Chart: Covered California Performance Standards
Quality, Network Management and Delivery System Standards
50% of Performance Penalty**

Quality, Network Management and Delivery Systems Standards	Covered California Performance Requirements
Quality and Network Management – Quality Reporting System (QRS)	<p>Expectation: Getting the Right Care- HEDIS Clinical Effectiveness measure set summary (LOB reporting)- 10% of total performance requirement expected.</p> <p>Performance Level: <50th PCT-10% penalty of total performance requirement/51-90th percentile- no penalty; >90th PCT 10% performance credit (vs. national benchmark)</p>
Quality and Network Management - QRS	<p>Expectation: Access to Care- HEDIS/CAHPS measure set summary(LOB reporting)- 10% of total performance requirement expected.</p> <p>Performance Level: <50th PCT-10% penalty of total performance requirement/51-90th percentile- no penalty; >90th PCT 10% performance credit (vs. national benchmark)</p>
Quality and Network Management - QRS	<p>Expectation: Staying Healthy/Prevention- HEDIS/CAHPS measure set summary-(LOB reporting)- 10% of total performance requirement expected.</p> <p>Performance Level: <50th PCT-10% penalty of total performance requirement/51-90th percentile- no penalty; >90th PCT 10% performance credit (vs. national benchmark)</p>
Quality and Network Management - QRS	<p>Expectation: Plan Service- CAHPS measure set summary (LOB reporting)- 10% of total performance requirement expected.</p> <p>Performance Level: <50th PCT-10% penalty of total performance requirement/51-90th percentile- no penalty; >90th PCT 10% performance credit (vs. national benchmark)</p>

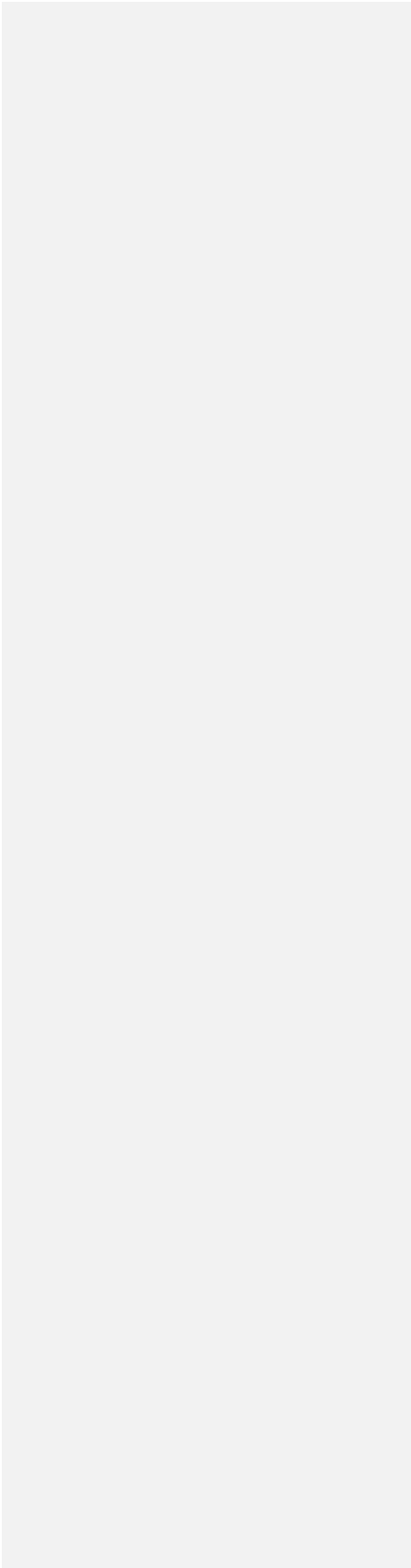
eValue8

Expectation: Total Covered California eValue8 performance, 795.5 points total. 5% of total performance penalty at risk.

Performance Level: < 40% of total points: 5% performance penalty. 40-74% of total points-no penalty. 75% or greater of total points- 5% performance credit.

Quality, Network Management and Delivery System Standards

Covered California Performance Requirements



Quality and Network Management- Preventive Health and Wellness

Expectation: Adults' Access to Preventive/Ambulatory Health Services (20 to 44 years and 45 to 64 years). The percentage of members 20 years and older who had an ambulatory or preventive care visit.

The organization reports three separate percentages for each product line.

- Medicaid and Medicare members who had an ambulatory or preventive care visit during the measurement year.
- Commercial members who had an ambulatory or preventive care visit during the measurement year or the two years prior to the measurement year.

Child and Adolescent Access to Primary Care Practitioners- The percentage of members 12 months–19 years of age who had a visit with a PCP.

The organization reports four separate percentages for each product line.

- Children 12–24 months and 25 months–6 years who had a visit with a PCP during the measurement year.
- Children 7–11 years and adolescents 12–19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year.

5% of total performance requirement expected. Performance Level: <50th PCT on any measure- 5% penalty of total performance requirement. 51-90th PCT on 4 measures- no penalty. >90th PCT on 2 or more measures; none <50th PCT- 5% performance credit

Quality and Network Management- At Risk Enrollees

Year 1- Track only; Year 2-3 performance measure based on Year 1 determined performance with preliminary target of exceeding QHP 50th percentile to avoid penalty

Quality and Network Management- Health Assessment

Year 1- Track only; Year 2-3 performance measure based on Year 1 determined performance with preliminary target of exceeding QHP 50th percentile to avoid penalty

Quality and Network Management- New Care Models

Year 1- Track only; Year 2-3 performance measure based on Year 1 determined performance with preliminary target of exceeding QHP 50th percentile to avoid penalty

**Appendix - Computation of Performance Measurement Standards [to be attached]
Attachment 15 Business Associate Agreement**

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement (this "Agreement") dated _____, 2013 between the California Health Benefit Exchange ("Covered Entity") and _____ ("Business Associate") is entered into in accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as codified at 42 U.S.C. §1320d-d8, and its implementing regulations at 45 C.F.R. Parts 160, 162 and 164 (the "HIPAA Regulations") and attendant guidance; and the Health Information Technology for Economic and Clinical Health Act, enacted as part of the American Recovery and Reinvestment Act of 2009, and its attendant regulations and guidance (the "HITECH Act"). HIPAA, the HIPAA Regulations and the HITECH Act are sometimes referred to collectively herein as "HIPAA Requirements."

I. Purpose of the Agreement.

Business Associate provides certain services on behalf of Covered Entity that require the Covered Entity to disclose certain identifiable health information to Business Associate. The parties desire to enter into this Agreement to permit Business Associate to have access to such information and comply with the business associate requirements of HIPAA, the HIPAA Regulations, and the HITECH Act, as each may be amended from time to time in accordance with the terms and conditions set forth in this Agreement.

II. Definitions.

Unless otherwise specified in this Agreement, all capitalized terms used in this Agreement not otherwise defined have the meaning established for such terms under 45 C.F.R. Parts 160 and 164 and the HITECH Act, each as amended from time-to-time.

III. Terms and Conditions.

Business Associate and Covered Entity (hereinafter, the "Parties") agree to the terms and conditions set forth herein.

A. Business Associate Obligations.

1. Applicable Law. The terms and conditions set forth in this Agreement shall become effective on the later of the Effective Date of this Agreement, April 14, 2003, or any new mandatory compliance date established for HIPAA, the HIPAA Regulations and/or the HITECH Act. The parties acknowledge and agree that HIPAA, the HIPAA Regulations and the HITECH Act may be amended and additional guidance and/or regulations may be issued after the date of the execution of this Agreement and may affect the Parties' obligations under this Agreement ("Future Directives"). The Parties agree to abide by such Future Directives as these Future Directives may affect the obligations of the Parties under the Covered California Qualified Health Plan contract (Exchange Agreement) and/or this Agreement. If Future Directives affect the obligations of the Parties, then Covered Entity shall notify Business Associate of Future Directives in writing within thirty (30) days before Future Directives are effective. The notification of Business Associate by Covered Entity of Future Directives that affect the obligations of the Parties related to the Business Associate relationship shall be considered amendments to this Agreement binding on both parties. Covered Entity's failure to notify Business Associate of Future Directives shall not relieve Business Associate of any obligations it may otherwise have under HIPAA Requirements.

2. Permitted Uses and Disclosures. Business Associate shall not, and shall ensure that its directors, officers, employees, contractors and agents do not, further use or disclose patient individually identifiable health information ("Protected Health Information" or "PHI")

received from or created for the Covered Entity in any manner that would violate HIPAA, the HIPAA Regulations, the HITECH Act or Future Directives. Business Associate agrees to abide by the HIPAA Requirements with respect to the use or disclosure of Protected Health Information it creates, receives from, maintains, or electronically transmits for the Covered Entity. Business Associate further agrees that it will not use or disclose Protected Health Information beyond the purposes set forth in the Agreement or as required by law as defined in 45 C.F.R §164.103. Except as otherwise limited in this Agreement, Business Associate may use or disclose PHI to perform functions, activities, or services for, or on behalf of, the Covered Entity as specified in the Exchange Agreement between the Parties, provided that such use or disclosure would not violate HIPAA, the HIPAA Regulations or the HITECH Act if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity.

3. Compliance with Business Associate Agreement and HITECH Act. Effective February 17, 2010, Business Associate may use and disclose PHI that is created or received by Business Associate from or on behalf of Covered Entity if such use or disclosure, respectively, is authorized by this Agreement and complies with each applicable requirement of 45 C.F.R. § 164.504(e) and the HITECH Act. The additional requirements of Subtitle D of the HITECH Act that relate to privacy and that apply to covered entities also will apply to Business Associate and are incorporated into this Agreement by reference.

4. Use of PHI for Administrative Activities. Notwithstanding Section III.A.2 above, Business Associate may use or disclose PHI for management and administrative activities of Business Associate or to comply with the legal responsibilities of Business Associate; provided, however, the disclosure or use must be required by law or Business Associate must obtain reasonable assurances from the third party that receives the Protected Health Information that they will (i) treat the Protected Health Information confidentially and will only use or further disclose the Protected Health Information in a manner consistent with the purposes that the Protected Health Information was provided by Business Associate; and (ii) promptly report any breach of the confidentiality of the Protected Health Information to Business Associate. Provided further that, Business Associate will notify Covered Entity immediately upon receipt of a request for any disclosure of PHI required by law.

5. Accounting. Business Associate agrees to document disclosures of PHI and collect information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528 and, if required by and upon the effective date of, Section 13405(c) of the HITECH Act and related regulatory guidance.

a). Business Associate agrees to provide to Covered Entity or an Individual upon Covered Entity's request, information collected in accordance with this Section, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528 and, if required by and upon the effective date of, Section 13405(c) of the HITECH Act and related regulatory guidance.

6. Restriction. Effective February 17, 2010, and notwithstanding 45 C.F.R. § 164.522(a)(1)(ii), Business Associate must comply with an Individual's request under 45 C.F.R. § 164.522(a)(1)(i)(A) that Business Associate restrict the disclosure of PHI of the Individual if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the PHI pertains solely to a health care item or service for which the health care provider involved has been paid out of

pocket in full.

7. Fundraising. Any written fundraising communication occurring on or after February 17, 2010 that is a health care operation shall, in a clear and conspicuous manner and consistent with guidance to be provided by the Secretary, provide an opportunity for the recipient of the communications to elect not to receive any further such communication. An election not to receive any further such communication shall be treated as a revocation of authorization under Section 45 C.F.R. § 164.508. However, no communication pursuant to this Section may be made by Business Associate without prior written authorization by Covered Entity.

8. Sale of PHI. Upon the effective date of Section 13405(d) of the HITECH Act, Business Associate shall not directly or indirectly receive remuneration in exchange for PHI that is created or received by Business Associate from or on behalf of Covered Entity unless: (1) pursuant to an authorization by the Individual in accordance with 45 C.F.R. § 164.508 that includes a specification for whether the PHI can be further exchanged for remuneration by the entity receiving PHI of that Individual; or (2) as provided for and consistent with Section 13405(d)(2) of the HITECH Act and regulations to be issued by the Secretary, upon the effective date of such regulations. However, in no instance may Business Associate receive remuneration pursuant to this Section without prior written authorization by Covered Entity.

9. Marketing. A communication occurring on or after February 17, 2010 by Business Associate that is described in the definition of marketing in 45 C.F.R. § 164.501(1)(i), (ii) or (iii) for which Covered Entity receives or has received direct or indirect payment (excluding payment for treatment) in exchange for making such communication, shall not be considered a health care operation unless: (1) such communication describes only a drug or biologic that is currently being prescribed for the recipient of the communication and any payment received in exchange for making such a communication is reasonable in amount; or (2) the communication is made by Business Associate on behalf of the Covered Entity and the communication is otherwise consistent with this Agreement. However, no communication pursuant to this Section may be made by Business Associate without prior written authorization by Covered Entity.

10. Safeguarding the Privacy of PHI. Business Associate agrees that it shall utilize physical, administrative and technical safeguards to ensure that PHI is not used or disclosed in any manner inconsistent with this Agreement or the purposes for which Business Associate received PHI from or created PHI for the Covered Entity. Business Associate further agrees to implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of any PHI that Business Associate creates, receives, maintains or transmits electronically on behalf of Covered Entity under the Agreement. Upon request, Business Associate shall provide the Covered Entity with a written description of the physical, administrative and technical safeguards adopted by Business Associate to meet its obligations under this Section.

11. Security Safeguards. Business Associate acknowledges that, effective February 17, 2010, 45 C.F.R. §§ 164.308, 164.310, 164.312 and 164.316 will apply to Business Associate in the same manner that such sections apply to covered entities and are incorporated into this Agreement by reference. The additional requirements of the HITECH Act that relate to security and that apply to covered entities also will apply to Business Associate and are incorporated into this Agreement by reference. Business Associate agrees to implement the technical safeguards provided in guidance issued annually by the Secretary for carrying out the obligations under the Code of Federal

Regulation

sections cited in this Section and the security standards in Subpart C of Part 164 of Title 45 of the Code of Federal Regulations.

12. Employee Training. Business Associate shall train its workforce members who assist in the performance of functions and activities under this Agreement, and who access or disclose PHI, on information privacy and security requirements. Business Associate shall impose appropriate disciplinary measures on members who intentionally violate Business Associate's privacy and security requirements, including termination of employment if appropriate.

13. Sanctions. Business Associate understands that a failure to comply with HIPAA, the HITECH Act and the HIPAA Regulations that are applicable to Business Associate may result in the imposition of sanctions and/or penalties on Business Associate under HIPAA, the HITECH Act and the HIPAA Regulations.

14. Breach Notification. Business Associate agrees to implement response programs and record-keeping systems to enable Business Associate to comply with the requirements of this Section and 13402 of the HITECH Act and the regulations implementing such provisions, currently Subpart D of Part 164 of Title 45 of the Code of Federal Regulations, when Business Associate detects or becomes aware of unauthorized access to information systems or documents that contain PHI. Business Associate agrees to mitigate any effects of the inappropriate use or disclosure of PHI by Business Associate.

a) Business Associate agrees to notify Covered Entity, by facsimile or telephone, of any breach or suspected breach of its security related to areas, locations, systems, documents or electronic systems which contain unsecured PHI, including, without limitation, any Security Incident, instance of theft, fraud, deception, malfeasance, or use, access or disclosure of PHI which is inconsistent with the terms of this Agreement (an "Incident") immediately upon having reason to suspect that an Incident may have occurred, and typically prior to beginning the process of verifying that an Incident has occurred or determining the scope of any such Incident, and regardless of the potential risk of harm posed by the Incident. Notice shall be provided to the Covered Entity's representative designated in this Agreement. Upon discovery of a breach or suspected Incident, Business Associate shall take:

i. Prompt corrective action to mitigate any risks or damages involved with the breach and to protect the operating environment; and

ii. Any action pertaining to such unauthorized disclosure required by applicable Federal and State laws and regulations.

b) In the event of any such Incident, Business Associate shall further provide to Covered Entity, in writing, such details concerning the Incident as Covered Entity may request, and shall cooperate with Covered Entity, its regulators and law enforcement to assist in regaining possession of such unsecured PHI and prevent its further unauthorized use, and take any necessary remedial actions as may be required by Covered Entity to prevent other or further Incidents. Business Associate and Covered Entity will cooperate in developing the content of any public statements.

c) If Covered Entity determines that it may need to notify any Individual(s) as a result of such Incident that is attributable to Business Associate's breach of its obligations under this Agreement, Business Associate shall bear all reasonable direct and indirect costs associated with such determination including, without limitation, the costs associated with providing notification to the affected Individuals, providing fraud monitoring or other services to affected Individuals and any forensic analysis required to determine the scope of the Incident.

d) In addition, Business Associate agrees to update the notice provided to Covered Entity under Section 14(a) of this Agreement of such Incident to include, to the extent possible and as soon as possible working in cooperation with Covered Entity, the identification of each Individual whose unsecured PHI has been, or is reasonably believed by Business Associate to have been accessed, acquired, used or disclosed during the Incident and any of the following information Covered Entity is required to include in its notice to the Individual pursuant to 45 C.F.R. § 164.404(c):

- i. A brief description of what happened, including the date of the Incident and the date of discovery of the Incident, if known;
- ii. A description of the types of unsecured PHI that were involved in the Incident (e.g., Social Security number, full name, date of birth, address, diagnosis);
- iii. Any steps the Individual should take to protect themselves from potential harm resulting from the Incident;
- iv. A brief description of what is being done to investigate the Incident, mitigate the harm and protect against future Incidents; and
- v. Contact procedures for Individuals to ask questions or learn additional information which shall include a toll-free number, an e-mail address, Web site, or postal address (provided, Subsection v is only applicable if Covered Entity specifically requests Business Associate to establish contact procedures).

e) Such additional information must be submitted to Covered Entity immediately at the time the information becomes available to Business Associate.

f) If the cause of a breach of PHI is attributable to Business Associate or its agents, subcontractors or vendors, Business Associate is responsible for all required notifications and reporting of the breach as specified in 42 U.S.C. § 17932 and its implementing regulations, including, without limitation, individual notifications, notification to media outlets and to the Secretary of the Department of Health & Human Services. If a breach of unsecured PHI involves more than 500 residents of the State of California or its jurisdiction, Business Associate shall notify the Secretary of the breach immediately upon discovery of the breach. Such notification(s) and required reporting shall be done in cooperation with Exchange and subject to Exchange's review and approval. If Business Associate has reason to believe that duplicate reporting of the same breach or incident may occur because its subcontractors, agents or vendors may report the breach or incident to Covered Entity in addition to Business Associate, Business Associate shall notify Covered Entity, and Covered Entity and Business Associate may take appropriate action to prevent duplicate reporting.

15. Subcontractors and Agents of Business Associate. Business Associate agrees to enter into written contracts with any of its agents or independent contractors (collectively, "subcontractors") who receive PHI from Business Associate or create, maintain, or transmit electronically, PHI on behalf of the Covered Entity, as a subcontractor to Business Associate, and such contracts shall obligate Business Associate's subcontractors to abide by the same conditions and terms as are required of Business Associate under this Agreement. Upon request, Business Associate shall provide the Covered Entity with a copy of any written agreement or contract entered into by Business Associate and its subcontractors to meet the obligations of Business Associate under this Section.

a) Business Associate shall, upon knowledge of a material breach by a subcontractor of the subcontractor's obligations under its contract with Business Associate, either notify such subcontractor of such breach and provide an opportunity for subcontractor to cure the breach; or, in the event subcontractor fails to cure such breach or cure is not possible, Business Associate shall immediately terminate the contract with subcontractor.

b) To the extent that any of Business Associate's subcontractors will have access to any PHI that is received, created, maintained or transmitted electronically, Business Associate shall require such agents and subcontractors to agree to implement reasonable and appropriate safeguards to protect such electronic PHI.

16. Availability of Information to Covered Entity and Individuals. Business Associate agrees to provide access and information as follows:

a) Business Associate shall provide access as may be required, and in the time and manner designated by Covered Entity (upon reasonable notice and during Business Associate's normal business hours) to PHI in a Designated Record Set, to Covered Entity (or, as directed by Covered Entity), to an Individual, in accordance with 45 C.F.R. § 164.524. Designated Record Set means the group of records maintained for Covered Entity that includes medical, dental and billing records about individuals; enrollment, payment, claims adjudication, and case or medical management systems maintained for Covered Entity health plans; or those records used to make decisions about individuals on behalf of Covered Entity. Business Associate shall use the forms and processes developed by Covered Entity for this purpose and shall respond to requests for access to records transmitted by Covered Entity within fifteen (15) calendar days of receipt of the request by producing the records or verifying that there are none.

b) If Business Associate maintains an Electronic Health Record with PHI, and an individual requests a copy of such information in an electronic format, Business Associate shall provide such information in an electronic format to enable Covered Entity to fulfill its obligations under the HITECH Act, including but not limited to, 42 U.S.C. § 17935(e).

c) If Business Associate receives data from Covered Entity that was provided to Covered Entity by the Social Security Administration, upon request by Covered Entity, Business Associate shall provide Covered Entity with a list of all employees, contractors and agents who have access to the Social Security data, including employees, contractors and agents of its subcontractors and agents.

17. Access by Covered Entity and Secretary of U.S. Department of Health & Human Services. Business Associate agrees to allow Covered Entity and the Secretary of the U.S. Department of Health & Human Services ("Secretary") access to its books, records and internal practices with respect to the disclosure of PHI for the purposes of determining the Business Associate's compliance with the HIPAA Privacy Regulations. If Business Associate is the subject of an audit, compliance review, or complaint investigation by the Secretary or the Office of Civil Rights, U.S. Department of Health and Human Services, that is related to the performance of its obligations pursuant to this HIPAA Business Associate Agreement, Business Associate shall notify Covered Entity and provide Covered Entity with a copy of any PHI that Business Associate provides to the Secretary or the Office of Civil Rights concurrently with providing such PHI to the Secretary. Business Associate is responsible for any civil penalties assessed due to an audit or investigation of Business Associate, in accordance with 42 U.S.C. § 17934(c).

B. Termination of Agreement.

1. **Termination Upon Material Breach.** The Covered Entity may, in its sole discretion, terminate the Exchange Agreement, including this Agreement, upon determining that Business Associate violated a material term of this Agreement. If the Covered Entity makes such a determination, it shall inform Business Associate in writing that the Covered Entity is exercising its right to terminate this Agreement under this Section III.B and such termination shall take effect immediately upon Business Associate receiving such notification of termination. In accordance with Section 13404(b) of the HITECH Act and to

the extent required by the HIPAA Regulations, if Business Associate knows of a material breach or violation by Covered Entity, it shall take all actions required under the HITECH Act and HIPAA Regulations.

2. Reasonable Steps to Cure Material Breach. At the Covered Entity's sole option, the Covered Entity may, upon written notice to Business Associate, allow Business Associate an opportunity to take prompt and reasonable steps to cure any violation of any material term of this Agreement to the complete satisfaction of the Covered Entity within ten (10) calendar days of the date of written notice to Business Associate. Business Associate shall submit written documentation acceptable to the Covered Entity of the steps taken by Business Associate to cure any material violation. If Business Associate fails to cure a material breach within the specified time period, then the Covered Entity shall be entitled to terminate this Agreement under Section III.B above, if feasible.

3. Amendment. Covered Entity may in its sole discretion terminate the Exchange Agreement, including this Agreement upon thirty (30) calendar days written notice in the event (i) Business Associate does not promptly enter into negotiations to amend this Agreement when requested by Covered Entity pursuant to Section III.A.1 and Section III.F of this Agreement, or (ii) Business Associate does not enter into an amendment to this Agreement providing assurances regarding the safeguarding of PHI that Covered Entity, in its sole discretion, deems sufficient to satisfy the standards and requirements of HIPAA, the HIPAA Regulations and/or the HITECH Act.

4. Return of PHI to Covered Entity Upon Termination. Upon termination of the Agreement for any reason, Business Associate shall return all PHI to the Covered Entity. The Covered Entity may request in writing that Business Associate destroy all PHI upon termination of this Agreement rather than returning PHI to the Covered Entity. If the return or destruction of PHI is not feasible upon termination of the Agreement, then Business Associate shall explain in writing, directed to the Covered Entity's Chief Privacy Officer, why such return or destruction is not feasible. If such return or destruction is not feasible, then Business Associate agrees that it shall extend its obligations under this Agreement to protect the PHI. The Business Associate shall limit its use or disclosure of such PHI to only those purposes that make it infeasible to return or destroy the PHI and shall maintain such PHI only for that period of time that return or destruction of PHI remains infeasible.

C. Conflicts. The terms and conditions of this Agreement will override and control over any conflicting term or condition of other agreements between the Parties. All non-conflicting terms and conditions of such agreements shall remain in full force and effect.

D. No Third-Party Beneficiary Rights. Nothing express or implied in this Agreement is intended or shall be interpreted to create or confer any rights, remedies, obligations or liabilities whatsoever in any third party.

E. Notice. Except as otherwise provided in Section I.A.14(a), any notice permitted or required by this Agreement will be considered made on the date personally delivered in writing or mailed by certified mail, postage prepaid, to the other party at the address set forth in the execution portion of this Agreement.

F. Amendment. The Parties agree to take such action as is necessary to implement the standards, requirements, and regulations of HIPAA, the HIPAA Regulations, the HITECH Act, and other applicable laws relating to the security or confidentiality of health information. Upon Covered Entity's request, Business Associate agrees to promptly enter into negotiations with Covered Entity concerning the terms of any amendment to the Agreement consistent with the standards, requirements and regulations of HIPAA, the HIPAA Regulations, the HITECH Act or other applicable laws.

G. Relationship of the Parties. The Parties hereto acknowledge that Business

Associate shall be and have the status of independent contractor in the performance of its obligations under the terms of this Agreement as to Covered Entity. Nothing in this Agreement shall be deemed or construed to create a joint venture or partnership between Covered Entity and Business Associate, nor create an agency relationship between Covered Entity and Business Associate.

H. Indemnification by Business Associate. Business Associate shall protect, indemnify and hold harmless the Covered Entity, its officers and employees from all claims, suits, actions, attorney's fees, costs, expenses, damages, penalties, judgments or decrees arising out of the failure by Business Associate to comply with the requirements of this Agreement, the HIPAA Requirements and all Future Directives; provided however that such indemnification shall be conditioned upon the Covered Entity's giving prompt notice of any claims to Business Associate after discovery thereof and cooperating fully with Business Associate concerning the defense and settlement of claims.

I. Miscellaneous.

1. Exception to Limitations and Exclusions. Business Associate's obligations under this Agreement and any breach by Business Associate of the obligations in this Agreement shall not be subject to any limitations on damages suffered by Covered Entity that may be specified in any agreement, invoice, statement of work or similar document setting forth the services Business Associate is providing to Covered Entity ("Contract"). No limitation or exclusion in any Contract shall limit Covered Entity's rights to recover from Business Associate damages, losses or sanctions suffered by Covered Entity to the extent of amounts recovered by, or sanctions awarded to, a third party which are caused by Business Associate's breach of the obligations in this Agreement, regardless of how such amounts or sanctions awarded to such third party are characterized.

2. Assistance in Litigation or Administrative Proceedings. Business Associate shall make itself and any subcontractors, employees or agents assisting Business Associate in the performance of its obligations under this Agreement, available to Covered Entity at no cost to Covered Entity to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against Covered Entity, its directors, officers or employees based upon claimed violation of HIPAA, the HIPAA Regulations, the HITECH Act or other laws relating to security and privacy, which involve inactions or actions by the Business Associate, except where Business Associate or its subcontractor, employee or agent is a named adverse party.

3. Modification. This Agreement will be modified only by a written document signed by each party.

4. Waiver. The waiver by Business Associate or Covered Entity of a breach of this Agreement will not operate as a waiver of any subsequent breach. No delay in acting with regard to any breach of this Agreement will be construed to be a waiver of the breach.

5. Assignment. This Agreement will not be assigned by Business Associate without prior written consent of the Covered Entity. This Agreement will be for the benefit of, and binding upon, the parties hereto and their respective successors and permitted assigns.

6. Interpretation. The terms and conditions in this Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA, the HITECH Act, the HIPAA Regulations and applicable state or federal laws. The parties agree that any ambiguity in the terms and conditions of this Agreement shall be resolved in favor of a meaning that complies and is consistent with HIPAA, the HITECH Act and the HIPAA regulations.

7. Governing Law. The interpretation and enforcement of this Agreement will be governed by the laws of the State of California. Exclusive venue shall be in Sacramento County, California.

8. Headings. The section headings contained in this Agreement are for reference purposes only and will not affect the meaning of this Agreement.

9. Counterparts. This Agreement may be executed in counterparts, each of which will be deemed to be an original, but all of which together will constitute one and the same.

IN WITNESS WHEREOF, Covered Entity and Business Associate execute this Agreement to be effective on the last date written below, or, if no date is inserted, the Execution Date of the other Agreement referenced above (the "Effective Date").

COVERED HEALTH ENTITY: The California Health Benefit Exchange

BUSINESS ASSOCIATE: _____

By: _____

By: _____

Printed Name: _____

Printed Name: _____

Title: _____

Title: _____

Date: _____

Date: _____

Notice Address: _____

Notice Address: _____

Telephone: _____

Telephone: _____

Fax: _____

Fax: _____

Email: _____

Email: _____

Attachment 16: Required Reports

Contractor shall provide such reports, data, documentation and other information reasonably requested by the Exchange and as reasonably necessary to document and evaluate Contractor's provision of Services in accordance with the terms and conditions set forth in the Agreement and under applicable laws, rules and regulations, including without limitation, the following items:

- Collaborative marketing and enrollment efforts, including, Contractor's marketing plan and documentation relating to testing of interfaces with Exchange's eligibility and enrolment system (Section 1.05(b));
- Evaluation of Contractor's performance (Section 1.10);
- Compliance with requirements for status as a Certified QHP (Section 3.01);
- Licensure and good standing (Section 3.02);
- Benefit plan design (Section 3.03);
- Sales and marketing practices for products through the Exchange and outside the Exchange (Section 3.04);
- Network adequacy standards (Section 3.05(a));
- Service Area (Section 3.05(b));
- Participating Provider Directory (Section 3.05(c));
- Participating Provider recruitment and retention (Section 3.05(d), (e));
- Changes in Participating Provider network (Section 3.05(f));
- Geographic distribution and changes in ECP network (Section 3.06);
- Applications and notices (Section 3.07);
- Rate information provided to Health Insurance Regulators and in such form as required by Exchange (Section 3.08, 3.09)
- Transparency in coverage (Section 3.10);
- Accreditation (Section 3.11);
- Segregation of funds (Section 3.12);
- Compliance with special rules governing American Indians or Alaskan Natives;
- Participating Provider Agreements (Section 3.14);

Comment [AC26]: It is not feasible for carriers to provide the Exchange with the number and extent of the reports listed. The Exchange should reduce this list and ensure that any required reports are linked to specific provisions in the contract. We suggest further discussions on this Attachment.

- Out-of-network, other benefit costs and network requirements (Section 3.15);
- Credentialing (Section 3.16)
- Utilization review and appeals (Section 3.17);
- Customer service standards (Section 3.18) (see further listing below);
- Compliance programs (Section 3.19);
- Enrollment and eligibility reconciliations (Section 3.20 to 3.22);
- Minimum Participation Rates (section 3.23);
- Premium information and reconciliation (Section 3.24);
- Collection practices (Section 3.25);
- Appeals and grievances (Section 3.26);
- Enrollee and marketing materials (Section 3.27);
- Agent compensation, appointment and conduct (Section 3.28 and 3.29);
- Notice of changes (Section 3.30);
- Other financial information, including business plans, audited financial statements, annual profit and loss statement and other financial information (Section 3.31);

- Nondiscrimination (Section 3.32);
- Conflict of interest (Section 3.33);
- Disaster recovery plans (Section 3.34);
- Compliance with other laws (Section 3.35);
- Transition plan (Section 3.36);
- Contractor's representations and warranties (Section 3.37);
- Quality, Network Management and Delivery System Standards (Article 4). See further discussion below.

- Rate updates, premium collection and remittance (Section 5.01, 5.02)
- Participation fee, including, allocation of fee across entire risk pool (5.03(a)), payment information (Section 5.03(b) and information necessary to conduct evaluations (Section 5.03(c));
- Performance measures (Article 6);
- Recertification process (Section 7.02);
- Breach of agreement (Section 7.04);
- Insolvency (Section 7.06);
- Duties upon termination (Section 7.07);
- Further assurance regarding transition and continuity of care (Section 7.08, 7.09);
- Insurance (Article 8);
- Privacy and security standards (Article 9);
- Books records and data, including, clinical records (Section 10.01), financial records (including electronic commerce standards) (Section 10.02); storage and back up (Sections 10.03 and 10.04), examination and audit (Section 10.05 and 10.06), and tax reporting (Section 10.08);
- Intellectual Property (Article 11);
- Quality, Network Management and Delivery System Standards (Attachment 7) (all following references are to sections in Quality, Network Management and Delivery System Standards unless otherwise indicated):
 - Accreditation (Section 3.11 of the Agreement; Article 1 of the Quality, Network Management and Delivery System Standards)
 - HEDIS and CAPHS reporting (Section 2.01)
 - Participation in quality initiatives (Section 2.02)
 - Data sets (Section 2.03)
 - Enrollee reports (e.g., claims, utilization) (Section 2.04)
 - Hospital Compare program requirements (e.g., readmissions, hospital acquired conditions (Section 2.04)
 - eValue8 information (Section 2.05)

- Health and wellness services (Article 3)
- Chronic conditions (Article 4)
- Health assessment (Article 5)
- Patient Centered Care and Shared decision making (Article 6)
- Development of care models (Section 7.01)
- Value-based reimbursement and performance (Sections 7.02 through 7.04)
- Payment reform (Section 7.05)
- Customer Service Standards, including (Attachment 6)
- Customer call volumes

- Telephone responsiveness
- Responsiveness to written correspondence
- Number, accuracy, and timeliness of ID card distribution
- Nurse advice line volume, talk time, and topics discussed
- Use of Contractor's website

The information set forth in this Attachment shall not limit the Exchange's right to obtain information in accordance with the terms set forth in the Agreement and/or applicable laws, rules and regulations.

**COVERED CALIFORNIA QUALIFIED HEALTH PLAN CONTRACT
between
Covered California, the California Health Benefit Exchange (the
“Exchange”)
and
_____ (“Contractor”)**

DISCUSSION DRAFT

Please Comment to QHP@covered.ca.gov by April 26, 2013

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COVERED CALIFORNIA QUALIFIED HEALTH PLAN CONTRACT between Covered California, California Health Benefit Exchange (the "Exchange") and _____ ("Contractor")

THIS QUALIFIED HEALTH PLAN CONTRACT (this or the "Agreement") is entered into on the date set forth below, by and between the California Health Benefit Exchange, an independent entity established within the government of the State of California doing business as Covered California (the "Exchange"), and _____, a [California] corporation and a health insurance issuer as defined in Title 10 California Code of Regulations ("CCR") § 6410 ("Contractor"). (Except as otherwise expressly defined, capitalized terms shall have the meaning set forth at Article 13 Definitions).

RECITALS

A. The Exchange is authorized under the Federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the Federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) (collectively, "Affordable Care Act"), and the California Patient Protection and Affordable Care Act, (Chapter 655, Statutes of 2010) and Chapter 659, Statutes of 2010) ("California Affordable Care Act") to selectively contract with Health Insurance Issuers in order to make available to enrollees of the Exchange health care coverage choices that seek to provide the optimal combination of choice, value, access, quality and service to Qualified Individuals, Employers and Employees;

B. The contracting solicitation process conducted by the Exchange is based on the assessment of certain requirements, criteria and standards that: (i) the Exchange determines are reasonable and necessary for bidding Health Insurance Issuers to market, offer, and sell Qualified Health Plans through the Exchange, (ii) are set forth in that certain Final Qualified Health Plan Solicitation dated November 16, 2012, as amended December 28, 2012 ("Solicitation") and/or (iii) are required under applicable laws, rules and regulations or otherwise necessary to meet the needs of enrollees in the Exchange, including, those set forth at 45 C.F.R. Part § 155 *et seq.*;

C. In connection with the evaluation of the responses to the Solicitation received from Health Insurance Issuers, the Exchange is required under 10 CCR § 6440: (i) to evaluate the proposed QHP's compliance with requirements imposed under the Solicitation, and (ii) to give greater consideration to potential QHPs that further the mission of the Exchange by promoting, among other items, the following: (1) affordability for the consumer and small employer – both in terms of premium and at point of care, (2) "value" competition based upon quality, service, and price, (3) competition based upon meaningful QHP choice and ability to demonstrate product differentiation within the required guidelines for standard benefit plans, (4) competition throughout the State, (5) alignment with Providers and delivery systems that serve the low-income population, (6) delivery system improvement, effective prevention programs and payment reform, and (7) long-term collaboration and cooperation between the Exchange and Health Insurance Issuers;

D. Contractor is a Health Insurance Issuer authorized to provide Health Care Services to Enrollees under applicable laws, rules and regulations pursuant to: (i) a certificate of authority issued by the California Department of Insurance ("CDI") under § 699 *et seq.* of the California Insurance Code, and/or (ii) a license issued by the Department of Managed Health Care ("DMHC") pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (§ 1340 *et seq.* of the California Health and Safety Code). (Except as otherwise stated, references to "Codes" set forth herein shall refer to the laws of the State of California.);

E. Based on the Exchange's evaluation of the proposal submitted by Contractor in response to the Solicitation ("Proposal") and its consideration of other factors required to be considered under applicable laws, rules and regulations and/or otherwise necessary to meet the needs of Enrollees, the Exchange intends to designate Contractor as a QHP Issuer (as defined at 10 CCR § 6410) pursuant to the Exchange's determination that Contractor's proposed QHPs meet the requirements necessary to provide health insurance coverage as a Certified QHP (as defined at 10 CCR § 6410) to qualified individuals and employers who purchase health insurance coverage through the Exchange;

F. Contractor desires to participate in the Exchange as a QHP Issuer (as defined at 10 CCR § 6410) ; and

G. Contractor and the Exchange desire to enter into this Agreement to set forth the terms and conditions of Contractor's role as a QHP Issuer and operation of the Certified QHPs through the Exchange.

Article 1. Organization; Relationship of the Parties

1.01 Purpose. The Agreement is intended to further the mission of the Exchange to increase the number of insured Californians, improve health care quality and access to care, promote health, lower costs, and reduce health disparities. The Exchange seeks to accomplish its mission by creating an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that offer the best value. The Exchange's "triple aim" framework seeks to improve the patient care experience including quality and satisfaction, improve the health of the population, and reduce the per capita cost of health care services. This Agreement sets forth the expectations of the Exchange and Contractor with respect to: (i) the delivery of services and benefits to Enrollees, (ii) the coordination and cooperation between the Exchange and the Contractor on the promotion of better care and higher value for Enrollees and other health care consumers, and (iii) an enhanced alignment between Contractor and its Participating Providers to deliver better care and higher value. By agreeing to these expectations as set forth in this Agreement, Contractor and the Exchange acknowledge a commitment to be active and engaged participants to promote change and to work collaboratively to define and implement additional initiatives to continuously improve quality and value.

1.02 Application of Laws. This Agreement is not intended to limit the obligations imposed on Contractor under applicable laws, rules and regulations, including, without limitation, the Affordable Care Act and the California Affordable Care Act, in existence as of the date of this Agreement or as may be enacted or modified during the term of this Agreement. The failure to reference a regulatory requirement in this Agreement does not affect the applicability of such requirement to Contractor and the Exchange. Subject to the requirements set forth in 12.14, in those instances where the Exchange has affirmatively elected to impose a requirement authorized by the Exchange in accordance with the California Affordable Care Act that exceeds a lesser threshold that may be applicable under the Affordable Care Act or other Federal law, the State law shall be deemed controlling unless otherwise required under applicable laws, rules and regulations.

1.03 Role of Contractor.

(a) Contractor and the Exchange acknowledge and agree that Contractor's Certified QHPs are important to furthering the goal of the Exchange with respect to delivering better care and higher value. Contractor agrees that Contractor's QHPs identified at Attachment 1 ("Contractor's QHP List") shall be offered through the Exchange to provide access to Health Care Services to Enrollees in accordance with the terms and conditions required by this Agreement and as required for designation of each health insurance plan as a Certified QHP, including, without limitation, those set forth in this Agreement, the Affordable Care Act, the California Affordable Care Act and implementing regulations set forth at 45 C.F.R. Part 156 *et seq.* (Subpart C, Qualified Health Plan Minimum Certification Standards), 10 CCR 6400 *et seq.* and other applicable laws, rules and regulations.

1.04 Transition between Exchange and Other Coverage. In order to further the Exchange's mission regarding continued access to health insurance coverage to employees, Contractor shall cooperate with reasonable requests from the Exchange to facilitate the transition of Enrollees and other consumers to and from the Medi-Cal program and other governmental health care programs and coverage provided under employers, including, coverage required by the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") and the California Continuation Benefits Replacement Act, or Health and Safety Code § 1366.20 *et seq.* ("Cal-COBRA").

1.05 Coordination and Cooperation.

(a) Exchange. The Exchange recognizes that the successful delivery of services to Enrollees depends on a successful coordination with Contractor. The Exchange will take such action as it deems is necessary and feasible to develop and implement programs and activities to support Contractor in its marketing and enrollment efforts, in accordance with applicable laws, rules and regulations. Such activities may include making available the following programs and resources for use by Contractor:

(i) A subsidy calculator available by electronic means to facilitate a comparison of QHPs that is consistent with tools the Exchange will use for its own eligibility screenings, to ensure that preliminary eligibility screenings use the same tool;

Comment [AC1]: Please clarify what "facilitate the transition" means.

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(ii) Education, marketing and outreach programs that will seek to increase enrollment through the Exchange and inform consumers, ~~including Contractor's current enrollees~~, that there is a range of QHPs available in the Exchange in addition to Contractor's QHPs; in a manner to be mutually agreed upon by the Exchange and Contractor.

Comment [AC2]: As written this language implies that plans must notify enrollees who may have been placed by a broker. We suggest deleting or adding an exception.

(iii) Systems for electronic exchange of information with the Exchange's full quoting and enrollment system called California Healthcare Eligibility, Enrollment and Retention System ("CalHEERS") for use in converting Contractor's existing members who are eligible for Federal subsidies. On or before the commencement of the 2015 Open Enrollment Period, the Exchange expects to offer CalHEERS from Contractor's technology environment using certain agents employed by or otherwise working exclusively for Contractor (i.e., a captive agent) to support enrollment of individuals who are eligible for subsidized coverage following agreed upon protocols;

(iv) A standard interface through which Contractor may electronically accept the initial binding payment (via credit card, debit card, ACH or other mutually acceptable means to effectuate coverage in the Individual Exchange);

(v) A standard interface through which Contractor may electronically accept from the Exchange the initial binder payment (via ACH or EFT) to effectuate coverage and accept subsequent premium payment in the SHOP;

(vi) Complete documentation and reasonable testing timelines for interfaces with the Exchange's eligibility and enrollment system;

(vii) A dedicated team member responsible for working with Contractor to resolve any and all issues that arise from the implementation of the Exchange;

(viii) Eligibility and enrollment training for Contractor's staff and for licensed agents and brokers;

(ix) Joint marketing programs to support rollover to the Exchange of existing members of Contractor's health insurance plans so that such members can remain with the Contractor if they choose, but will be eligible who are eligible for the Federal subsidies;

(x) Joint marketing activities of the Exchange, Contractor and other Health Insurance Issuers designed to drive awareness and enrollment in the Exchange, with marketing plans;

(xi) Confidential treatment of all Contractor marketing plans and materials; and

(xii) Customer service support that will include substantially extended customer service hours during Open Enrollment Periods.

(b) Contractor's Support Responsibilities. To support the collaborative marketing and enrollment effort, Contractor shall:

(i) Within a reasonable time after the receipt of and determination of its compatibility with Contractor's system, the Contractor shall prominently display the subsidy calculator on its website;

(ii) Have its inside sales staff certified as Exchange agents to the extent required by the Exchange's policy and have those agents use the Exchange's quoting and enrollment system for those individuals who may be eligible for subsidized coverage. In offering Exchange-based coverage to present members of Contractor's health insurance plan, these agents are required to disclose to these members or prospective members using scripts developed or approved by the Exchange ~~approved scripts~~ which will include statements that other Health Insurance Issuers also offer Qualified Health Plans;

(iii) Educate its agents that part of being an Exchange agent is to strive for annual recertification of the Agent and that a prospective Enrollee's health status is irrelevant to advice provided with respect to health plan selection other than as it informs out-of-pocket calculation estimates;

(iv) Work with the Exchange to efficiently educate its agents and brokers about the Exchange's individual and small group marketplaces;

(v) Provide education and awareness regarding eligibility for Federal tax credits, plan offerings and benefits available through the Exchange in connection with any applicable outreach to Contractor's existing members, as mutually agreed;

(vi) Comply with the Exchange's financial interface requirements at its own cost that allows an Exchange-certified entity to transfer initial premiums directly into Contractor's account, subject to compliance with initial premium payment requirements of the Exchange that shall be processed through a third-party payment gateway;

Comment [AC3]: Please clarify what the financial interface requirements are.

(vii) Cooperate with the Exchange to develop and implement an Enrollee retention plan;

(viii) Submit to the Exchange a marketing plan in a form required by the Exchange that details the objectives of promoting new enrollment and retaining the Exchange-based enrollment part of the annual renewal process; and

(ix) Have successfully tested interfaces with the Exchange's eligibility and enrollment system, or be prepared to complete successful interface tests by dates established by the Exchange.

1.06 Coordination with Other Programs.

(i) Contractor and the Exchange recognize that the performance of Services under this Agreement depends upon the joint effort of the Exchange, Contractor, Participating Providers and other authorized

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subcontractors of Contractor. Contractor shall coordinate and cooperate with Participating Providers and such subcontractors to the extent necessary and as applicable to promote compliance by Participating Providers and such subcontractors with the terms set forth in this Agreement. Contractor shall also coordinate and comply with requirements of other State agencies that affect its Enrollees, including, the Department of Health Care Services ("DHCS") (regarding Medi-Cal) regarding the development and implementation of CalHEERS with respect to eligibility and enrollment considerations or as may be required under inter-governmental agency agreements or other laws, rules, regulations or program instructions.

(ii) The Contractor shall cooperate with the Exchange and DHCS to implement coverage or subsidy programs to complement existing programs that are administered by DHCS. Such programs may provide State and/or federal funding for all or a portion of enrollee premiums or subsidies to reduce or eliminate cost-sharing charges. These programs may require ~~special authorization coverage~~ of certain health benefits for individuals enrolled under these special programs which may not otherwise be covered by a QHP.

1.07 Administration.

Contractor will designate a liaison to serve as the primary contact person to coordinate and cooperate with the Exchange with respect to Contractor's performance of this Agreement. Liaison shall be available, and/or shall make other Contractor personnel available, to the Exchange at such times and to such extent as is reasonably required to fulfill Contractor's duties under this Agreement.

1.08 Relationship of the Parties.

(a) Independent Contractors. The parties acknowledge and agree that, as required by 45 C.F.R. § 155.200(e), in carrying out its responsibilities, the Exchange is not operating on behalf of Contractor or Contractor's QHPs or any authorized subcontractor of Contractor. In the performance of this Agreement, each of the Exchange and Contractor shall at all times be acting and performing as an independent contractor, and nothing in the Agreement shall be construed or deemed to create a relationship of employer and employee or partner or joint venturer or principal and agent between the Exchange and Contractor. Neither Contractor nor Participating Providers, authorized subcontractors, or any agents, officers or employees of Contractor are agents, officers, employees, partners or associates of the Exchange.

(b) Use of Subcontractors. Contractor shall require any subcontractor or assignee to agree to be bound by all applicable provisions of this Agreement; provided however that nothing in this Section shall limit Contractor's ability to hold subcontractor liable for performance under the contract between Contractor and subcontractor. The obligation of Contractor to comply with responsibilities under this Agreement and applicable laws, rules and regulations shall remain and shall not be waived or released if Contractor subcontracts or otherwise delegates any Services required to be performed by Contractor under this Agreement or by laws, rules or regulations or any other obligations under this Agreement. Notwithstanding the foregoing, the parties understand and agree that Contractor may delegate, without recourse, the financial responsibility for Services hereunder, as otherwise may be permitted by applicable law and regulation."

Contractor shall be solely responsible for (i) exercising appropriate diligence in connection with its selection of its subcontractors, (ii) monitoring and auditing the services provided by such subcontractor to assure that the services provided by such subcontractors are provided in accordance with the terms set forth in this Agreement or imposed by Health Insurance Regulators or under other applicable laws, rules and regulations regarding arrangements by and between Contractor and subcontractors.

1.09 Changes in Requirements. The parties acknowledge that prospective changes to benefits and services may be made by the Exchange during a Contract Year to incorporate changes (1) required as a result of changes in State or Federal laws, rules or regulations; (2) imposed by regulators; or (3) as mutually agreed upon by the parties. The projected cost of any such benefit or service change will be included in the cost of health care projections and changes to the Monthly Rates will be implemented after Contractor has demonstrated the cost impact of the benefit or service change in accordance with the requirements set forth in Article 5.

1.10 Evaluation. The performance by Contractor with respect to fulfillment of its obligations set forth herein shall be evaluated by the Exchange on an ongoing basis, including, but not limited to, during the 90 day period prior to the each anniversary of the Agreement Effective Date set forth in Section 7.01 so long as the Agreement remains in effect. In the event the evaluations conducted by the Exchange disclose a significant problem or pattern of non-compliance with terms of this Agreement as reasonably determined and documented by the Exchange, the Exchange shall have the right, ~~without limitation,~~ to conduct reasonable additional reviews of Contractor's compliance and operational performance. Such evaluations shall also be considered in connection with decisions relating to re-certification and de-certification in accordance with the terms set forth at Article 7 below.

Article 2. Exchange Responsibilities

The Exchange is approved by the United States Department of Health Services ("DHHS") pursuant to 42

Comment [AC4]: The process of authorization applies only to covered benefits. If the intent is to require Contractors to cover certain benefits that would not be covered for other Enrollees, the language needs to be modified as indicated.

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C.F.R. § 155.106 and shall perform its duties in accordance with the terms and conditions ~~required~~ of this Agreement pursuant to applicable laws, rules and regulations, including, the California Affordable Care Act and the Affordable Care Act. The duties of the Exchange shall include those relating to: non-interference with Federal law and nondiscrimination standards (45 C.F.R. § 155.120), consultation with stakeholders (45 C.F.R. § 155.130), financial support for continued operations of the Exchange (45 C.F.R. § 155.160), oversight, financial and quality activities (45 C.F.R. § 155.200), consumer assistance tools and programs, including, but not limited to operation of a toll-free call center and Internet website (45 C.F.R. § 155.205 and 45 U.S.C. § 18031(d)), navigator program standards designed to raise awareness of the Exchange by, among other items, providing consumer access to education and other resources regarding eligibility, enrollment, and program specifications (45 C.F.R. § 155.205), participation of brokers to enroll qualified individuals or employers in Certified QHPs (45 C.F.R. § 155.220), notices to Enrollees (45 C.F.R. § 155.230), payment of premiums (45 C.F.R. § 155.240), privacy and security of personally identifiable information (45 C.F.R. § 155.260), use of standards and protocols for electronic transactions (45 C.F.R. § 155.270), eligibility and enrollment, as well as exemption determinations in the Individual Exchange and Small Business Health Options Program (“SHOP”) (45 C.F.R. Part 155, Subparts D, E, H, I), and certification of QHPs (45 C.F.R. Part 155, Subpart K). The Exchange also has a duty, as part of its management of CalHEERS, to determine how information about the cost, quality and provider availability is presented to consumers to inform their selection of a health plan and benefit design in the Exchange. The Exchange shall solicit comment from the Contractor on the designs, but shall make design and presentation decisions at its sole discretion.

2.01 Individual Exchange. The Exchange shall be responsible for the determination of eligibility and enrollment of individuals in the Exchange in accordance with the requirements set forth at 45 C.F.R. Part 155, and other applicable laws, rules and regulations. The Exchange will assume obligations required as part of initial enrollment that would be otherwise carried out by the Contractor, such as assuring completion of agent attestation if applicable. ~~The Exchange will assume any statutory obligations required as part of initial enrollment such as assuring completion of agent attestation, if applicable.~~ In addition, the Exchange shall issue certifications of individual exemption consistent with the Affordable Care Act standards in a timely manner. The enrollment of eligible individuals in the Exchange shall be made by the Exchange pursuant to its management and participation in CalHEERS, a project jointly sponsored by the Exchange and DHCS with the assistance of the Office of Systems Integration. The Exchange and CalHEERS shall develop, implement and maintain processes to make the eligibility and enrollment decisions regarding the Exchange and other California health care programs and submit that information to Contractor in a timely manner in accordance with Federal and State laws, rules and regulations and the terms set forth in this Agreement.

2.02 Small Business Health Options Program (“SHOP”). The Exchange shall establish SHOP to assist Employers by facilitating enrollment of Employees into QHPs. The Exchange will assume obligations required as part of initial enrollment that would be otherwise carried out by the Contractor, such as assuring completion of agent attestation if applicable. All specified Employees, and their Family Members, of Employers who are eligible in accordance with the Affordable Care Act, California Affordable Care Act, and Regulations may obtain coverage through SHOP as permitted by State and Federal laws, rules and regulations, including the regulations set forth at 45 C.F.R. Subpart H, § 155.700 *et seq.* Contractor shall process SHOP enrollments from small businesses determined by the Exchange to be eligible for coverage in the SHOP in accordance with the terms set forth in this Agreement and State and Federal laws, rules and regulations.

Article 3. Contractor’s Responsibilities

During the term of this Agreement, Contractor shall operate those QHPs identified in Contractor’s QHP List at Attachment 1 to provide the benefits and services at the cost-sharing and actuarial cost levels described in the Benefit Plan Design - Summary of Benefits and Coverage, as summarized at Attachment 2 (“Benefit Plan Designs”), and as may be amended from time to time as required under applicable laws, rules and regulations or as otherwise authorized under this Agreement. Contractor shall comply with requirements for Certified QHPs set forth in this Agreement and under the California Affordable Care Act, and, as applicable, the Affordable Care Act and other laws, rules and regulations, including, those set forth at 45 C.F.R. Part 156, Subpart C, § 156.200 *et seq.*

3.01 Certification. Contractor shall maintain compliance with standards required for certification that are issued, adopted or recognized by the Exchange on a timely basis to demonstrate that each health plan it offers in the Exchange qualifies as a QHP under applicable laws, rules and regulations, including, 10 CCR § 6400 *et seq.*, and as applicable, 45 C.F.R. § 155.200(a).

3.02 Licensed and Good Standing

Contractor shall be licensed and in good standing to offer health insurance coverage through its QHPs offered under this Agreement. For purposes of this Agreement, each QHP issuer must be in “good

Comment [AC5]: This is broker attestation language that is necessary and has been added here and to Section 2.02.

Comment [AC6]: . We believe good standing is ordinarily a regulator’s determination, and the Exchange is adding additional criteria to give it additional authority in this regard. This appears to go beyond the language of the CFR as to good standing. Additionally, what are normal business standards, as distinguished from regulatory requirements? What is material in regard to penalties? Is there a dollar threshold or ratio to overall revenues to size “material”? Alternatively, recommend define “material” as affecting contractor’s ability to carry out its responsibilities under the agreement.

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standing," which is determined by the Exchange pursuant to 45 C.F.R. § 156.200(b)(4) and shall require: (i) Contractor to hold a certificate of authority from CDI or a health care service plan ("HCSP") license from DMHC, as applicable, and (ii) the absence of any material statutory or regulatory violations, including penalties, during the year prior to the date of the Agreement and throughout the term of Agreement, with respect to the regulatory categories identified at Attachment 3 ("Good Standing"). For purposes of this Agreement, "material" violations shall represent a relevant and significant departure from normal business standards required to be adhered to by a Health Insurance Issuer.

3.03 Benefit Design. Each QHP operated by Contractor under the terms of this Agreement shall provide essential health benefits in accordance with the Benefit Plan Design requirements set forth at Attachment 2, and as required under this Agreement, and applicable laws, rules and regulations, including California Health and Safety Code Section 1367.005, California Government Code § 100503(e) and as applicable, 45 C.F.R. § 156.20(b)..

3.04 Offerings Outside of Exchange. Contractor acknowledges and agrees that QHPs and substantially similar plans offered by Contractor outside the Exchange must be offered at the same rate whether offered inside the Exchange or whether the plan is offered outside the Exchange directly from the issuer or through an agent as required under applicable laws, rules and regulations, including, those required under 45 C.F.R. § 156.255(b), 42 U.S.C. § 18021, 42 U.S.C. § 18032. In accordance with Government Code Section 100503(f), Insurance Code Section 10112.3(c), and Health and Safety Code Section 1366.6(c), and other applicable State and Federal laws, regulations or guidance in the event that Contractor sells products outside the Exchange, Contractor shall fairly and affirmatively offer, market and sell all products made available to individuals and small employers in the Exchange to individuals and small businesses purchasing coverage outside the Exchange. For purposes of this subdivision, "product" does not include contracts entered into pursuant to Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code between the Managed Risk Medical Insurance Board and health care service plans for enrolled Healthy Families beneficiaries or to contracts entered into pursuant to Chapter 7 (commencing with Section 14000) of, or Chapter 8 (commencing with Section 14200) of, Part 3 of Division 9 of the Welfare and Institutions Code between the DHCS and health care service plans for enrolled Medi-Cal beneficiaries.

3.05 Network Requirements.

(a) General. Contractor's QHPs shall comply with the network adequacy standards established by the applicable Health Insurance Regulator responsible for oversight of Contractor, including, those set forth at Health and Safety Code § 1367.03 and 28 CCR § 1300.67.2 (if Contractor is a licensed health care service plan) or Insurance Code § 10133.5 (if Contractor is regulated by CDI), and, as applicable, other laws, rules and regulations, including, those set forth at 45 C.F.R. 156.230. The information provided to the Exchange shall take into consideration the ethnic and language diversity of providers available to serve Enrollees of the Exchange. Contractor shall cooperate with the Exchange to implement network changes as necessary to address concerns identified by the Exchange.

(b) Service Area.

(c) Provider Directories. The Exchange shall update the centralized provider directory every month.

(i) Withdrawal. Contractor shall not withdraw from any geographic region (as defined in Health and Safety Code § 1357.512 and California Insurance Code Section 10753.14 for the individual market) or modify any portion of its Service Area where Contractor provides Health Care Services to Enrollees without providing prior written notice to, and obtaining prior written approval from the ~~Exchange, which shall not be unreasonably denied, and to the extent required, the~~ Health Insurance Regulator with jurisdiction over Contractor.

(ii) Service Area Listing. During each year of this Agreement, in conjunction with the establishment of Monthly Rates payable to Contractor under Article 5 below for each of the Contract Years, the Service Area listing set forth in Attachment 4 ("Service Area Listing") shall be amended to reflect any changes in the Service Area of QHPs. Any such changes shall be effective as of January 1 of each of the applicable Contract Year. In the event ZIP codes are added to the current Service Area by the United States Postal Service, the parties agree such added ZIP codes shall be automatically included in the Service Area and shall be reflected in the next scheduled update of the Service Area Listing.

(1) Contractor shall comply with the Exchange's standards, developed in consultation with Health Insurance Issuers regarding the development of Service Area listing based on the ZIP Code, including, those relating to: (i) the timing of such submissions prior to the Open Enrollment Period, (ii) the assignment of enrollees residing in ZIP codes split across two rating regions, and (iii) required updates and notice of changes in ZIP Codes within Contractor's region.

(iii) Eligibility. In order to facilitate the Exchange's compliance with 45 C.F.R. § 155.710(b) and 45 C.F.R. § 155.305(a), Contractor shall monitor information it receives directly, or indirectly or through its subcontractors to assure continued compliance with eligibility requirements related to: (i) participation by Employers in SHOP, including, those requirements related to the Employer's principal place of business or

Comment [AC7]: It is unclear who is responsible for providing this information to the Exchange.

Comment [AC8]: Plans would like an assurance that these will be updated monthly by the Exchange.

Comment [AC9]: We do not believe it is appropriate to require plans to ask the Exchange for permission to withdraw from a region. The regulators oversee service area withdrawals.

Comment [AC10]: The Exchange should investigate concerns about eligibility, not the contractor.

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primary worksite in the Service Area or (ii) participation of Qualified Individuals in the Individual Exchange, including, requirements related to residency. Contractor shall notify the Exchange if it becomes aware that an Employer or individual Enrollee enrolled in a QHP of Contractor no longer meets the requirements for eligibility, based on place of business, primary worksite or residence. The Exchange will evaluate, or cause CalHEERS to evaluate, such information to determine Enrollee's continuing enrollment in the Contractor's Service Area under the Exchange's policies which shall be established in accordance with applicable laws, rules and regulations. Contractor and its subcontractors will have no duty to investigate representations made by Employers regarding eligibility; provided, however, that Contractor shall notify the Exchange in the event that it becomes aware that such representation may not be accurate.

(c) Participating Provider Directory. Contractor shall make its provider directory electronically available to

(i) the Exchange for publication online in ~~a format mutually agreed by the Contractor and the Exchange~~~~accordance with guidance from the Exchange~~, and (ii) in hard copy when potential Enrollees make such request. Contractor shall provide information describing Participating Providers in its QHP networks in a format prescribed by the Exchange on a monthly basis to support the Exchange's centralized provider directory containing every QHP's network providers.

(d) Participating Provider Stability. Contractor shall maintain policies and procedures that are designed to preserve and enhance Contractor's network development by facilitating the recruitment and retention of Participating Providers necessary to provide access to Health Care Services. Such policies and procedures shall be consistent with applicable laws, rules and regulations and will include an ongoing assessment of turnover rates of its Participating Providers to ensure that the turnover rates do not disrupt the delivery of quality care.

(e) Network Disruption.

(i) Contractor shall implement policies and practices designed (i) to reduce the potential for disruptions in Contractor's provider networks, and (ii) to minimize the amount of uncertainty, disruption, and inconvenience of Enrollees in the execution of the transition of care as required under State laws, rules and regulations in connection with any such disruption. Contractor agrees to maintain adequate records, reasonably satisfactory to the Exchange, documenting its policies and its compliance with these requirements by Contractor and Participating Providers.

(ii) If Contractor experiences provider network disruptions that require a block transfer of Enrollees from a terminated Participating Physician or Participating Hospital to a new Participating Physician or Participating Hospital, Contractor shall provide the Exchange with copies of the written notices the Contractor ~~proposes to send~~ to affected Enrollees, approved by the regulator as required under Health and Safety Code 1373.65 ~~prior to mailing to Enrollees~~.

(iii) If Contractor experiences provider network disruptions or other similar circumstances that make it necessary for Enrollees to change QHPs or Participating Providers, Contractor agrees to provide ~~prior~~ notice to the Exchange ~~based on the notice filed with the~~ and Health Insurance Regulator, in accordance with advance notice, meeting, and other requirements set forth in applicable laws, rules and regulations, including, Insurance Code 10199.1 and Health and Safety Code 1367.23 and 1366.1.

~~(iv) In the event of a change in Participating Providers or QHPs under paragraphs (ii) or (iii) above, Contractor shall, and shall cause Participating Providers to, cooperate with the Exchange in planning plan for the orderly transfer of Enrollees as necessary and as required under applicable laws, rules, and regulations including, those relating to continuation of care, including, those set forth at Health and Safety Code Section 1373.95 and Insurance Code 10133.55.~~

(f) Change in Disclosures. Contractor shall notify the Exchange with respect to any material changes in its provider network as of and throughout the term of this Agreement with respect to prior disclosures made by Contractor in its Proposal. For purposes of this Agreement, a material change in the disclosures shall relate to an event or other information that may reasonably impact Contractor's ability to perform under this Agreement in comparison with the information previously disclosed by Contractor in the Proposal.;

3.06 Essential Community Providers.

Except if Contractor has qualified under the alternate standard for essential community providers provided by the Affordable Care Act as has been determined by the Exchange, Contractor shall maintain a network that includes a sufficient geographic distribution of essential community providers ("ECP") that are available through Contractor to provide reasonable and timely access to Health Care Services to low-income populations in each geographic region where Contractor's QHPs provide services to Enrollees.

(a) For purposes of this Section, "sufficient geographic distribution" of ECP providers shall be determined by the Exchange in its reasonable discretion in accordance with the conditions set forth in the Solicitation and based on a consideration of various factors, including, (i) the nature, type and distribution of Contractor's ECP contracting arrangements in each geographic region in which Contractor's QHPs provides Health Care Services to Enrollees, (ii) the balance of hospital and non-hospital ECPs in each geographic region, (iii) the inclusion in Contractor's provider contracting network of at least 15% of entities in each applicable geographic region that participate in the program for limitation on prices of drugs

Comment [AC11]: Format changes require time to implement and this will be hard to accomplish by October

Comment [AC12]: It is not clear what this means, because most provider terminations are based on rate disagreement. We can't write a policy that says we will agree to unreasonable rates.

Comment [AC13]: Suggest deleting this section because it requires plans to "cause Participating Providers" to cooperate in the transfer of care per Section 1373.95, which is discretionary and it is not appropriate for a plan to require or "cause" a provider to do something that is discretionary in law.

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purchased by covered entities under Section 340B of the Public Health Service Act (42 U.S.C. § 256B) ("340B Entity"), (iv) the inclusion of at least one ECP hospital in each region, (v) the inclusion of Federally Qualified Health Centers, school-based health centers and county hospitals, and (vi) other factors as mutually agreed upon by the Exchange and the Contractor regarding Contractor's ability to serve the low income population.

(b) "Low-income populations shall be defined as families living at or below 200% of Federal poverty level. ECPs shall consist of participating entities in the following programs: (i) 340B, per the providers list as of November 9, 2012, (ii) California Disproportionate Share Hospital Program, per the Final DSH Eligibility List FY (CA DHCS 2011-12), (iii) Federally designated 638 Tribal Health Programs and Title V Urban Indian Health Programs, (iv) Community Clinic or health centers licensed as either a "community clinic" or "free clinic", by the State under Health and Safety Code section 1204(a), or is a community clinic or free clinic exempt from licensure under Health and Safety Code Section 1206, (v) Providers with approved applications for the HI-TECH Medi-Cal Electronic Health Record Incentive Program.

(c) Contractor shall notify the Exchange with respect to any material changes as of and throughout the term of this Agreement to its contracting arrangements, geographic distribution, percentage coverage, ECP classification type (e.g., 340B), and other information relating to ECPs from prior disclosures made by Contractor in its Proposal to Section II.B.3 of Solicitation and related attachments.

(d) Contractor shall comply with other laws, rules and regulations relating to arrangements with ECPs, as applicable, including, those rules set forth at 45 C.F.R. § 156.235.

3.07 Applications and Notices. Contractor shall provide applications, forms and notices to applicants and Enrollees in plain language and in a manner that is accessible and timely to individuals (1) living with disabilities, ~~in a manner that is compliant including accessible web sites and the provision of auxiliary aids and services at no cost to the individual in accordance~~ with the Americans with Disabilities Act and section 504 of the Rehabilitation Act, or (2) with limited English language proficiency. Contractor shall provide applications, forms, and notices in a manner that is accessible and timely to individuals who are limited English proficient as required by Health and Safety Code Section 1367.04 and Insurance Code Section 10133.8. Contractor shall ~~inform individuals of the availability of the services described in this Section and otherwise~~ comply with notice requirements imposed under applicable laws, rules and regulations, including, those set forth at 45 C.F.R. § 156.250 and Government Code § 100503(k).

3.08 Rating Variations. Contractor shall (i) charge the premium rate in each geographic rating area for each of Contractor's QHPs as agreed upon with the Exchange, and (ii) may vary premiums by geographic area as permitted by State law, including the requirements of Health Insurance Regulators regarding rate setting and variations set forth at Health and Safety Code Sections 1385 *et seq.* and 1385.07(a), Insurance Code Section 10181 *et seq.*, Insurance Code Section 10293, 10 CCR 2222.12 and as applicable, other laws, rules and regulations, including, 45 C.F.R. § 156.255(b).

3.09 Rate Information.

(a) Contractor shall comply with rate filing requirements imposed by Health Insurance Regulators, including, those set forth under Insurance Code § 10181 *et seq.* (if Contractor is an insurer regulated by CDI) or Health and Safety Code § 1385 *et seq.* (if Contractor is a licensed HCSP regulated by DMHC) and as applicable, other laws, rules and regulations.

(b) Individual Exchange: For the Individual Exchange, rates shall be established through an annual negotiation process between the Contractor and the Exchange and are set for the following calendar year. The parties acknowledge that (1) the Agreement does not contemplate any mid-year rate changes for the Individual Exchange in the ordinary course of business, and (2) the annual negotiation process must be supported by Contractor through the submission of information in such form and at such date as shall be established by the Exchange to provide Contractor with sufficient time for necessary analysis and actuarial certification.

(c) SHOP: SHOP rates for 2014 will be established through a bid solicitation process which calls for rates to be filed with Contractor's regulators by July of 2013. If the term of the Agreement is longer than one (1) year, Contractor shall also submit rate information in such form and at such date as shall be established by the Exchange to provide Contractor with sufficient time for necessary analysis and actuarial certification.

~~The Exchange will allow may authorize~~ an update of rates no more frequently than on a quarterly basis, as such updates shall be determined in accordance with requirements and update schedules to be determined by the Exchange no later than October 1, 2013.

(d) Contractor shall prominently post rate filing information on its web site in accordance with requirements set forth at 45 C.F.R. § 155.210 and as applicable, Insurance Code § 10181.7(d) or Health and Safety Code § 1385.07(d).

(e) Contractor shall provide, upon the Exchange's request, in connection with any contract negotiation or recertification process as reasonably requested by the Exchange, detailed documentation on the Exchange-specific rate development methodology. Contractor shall provide justification, documentation and support used to determine rate changes, including providing adequately supported cost projections.

Comment [AC14]: Plans must be given the assurance that they will be allowed to impose quarterly rate changes. This is allowed under federal law and will be standard in the FFE. Without such assurance plans will have to be more conservative in their initial small group rates

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Cost projections include factors impacting rate changes, assumptions, transactions and other information that affects the Exchange specific rate development process. Information pertaining to the key indicators driving the medical factors on trends in medical, pharmacy or other healthcare Provider costs may also be requested to support the assumptions made in forecasting and may be supported by information from the Plan's actuarial systems pertaining to the Exchange-specific account.

(f) To the extent permitted by law and contracts with Participating Providers, Contractor agrees that the information to be provided to the Exchange under this Agreement may include information relating to contracted rates between Contractor and a provider that is treated as confidential information by Health Insurance Regulators pursuant to Insurance Code § 10181.7(b) or Health and Safety Code § 1385.07(b). ~~To the extent that any Participating Providers' rates are prohibited from disclosure to the Exchange by contract, the Contractor shall identify these Participating Providers.~~

3.10 Transparency in Coverage. Contractor shall provide the Exchange and Enrollees with information reasonably necessary to provide transparency in Contractor's coverage, in accordance with the requirements set forth at 45 C.F.R. § 156.220, including information relating to claims payment policies and practices, financial disclosures, enrollment, disenrollment, denials, rating practices, cost-sharing, out-of-network coverage, and Enrollee rights. Contractor shall timely respond to an Enrollee's request for cost sharing information and shall make cost sharing information available to individuals through the internet and pursuant to other means for individuals without internet access in a timely manner upon request. Contractor shall provide information required under this Section to the Exchange and Enrollees in plain language, in accordance with 45 C.F.R. § 156.220(c).

3.11 Accreditation. Contractor shall maintain, and/or shall take any such further action as reasonably required to comply with URAC or NCQA accreditation requirements set forth in the Exchange's Quality, Network Management and Delivery System Standards at Article 4. Contractor shall authorize the accrediting agency to provide information and data to the Exchange relating to Contractor's accreditation, including, the most recent accreditation survey and other data and information maintained by accrediting agency as required under 5 C.F.R. § 155.275.

3.12 Segregation of Funds. Contractor shall comply with requirements relating to the required segregation of funds received for abortion services in accordance with the Affordable Care Act Section 1303 and 45 C.F.R. 156.280.

3.13 Special Rules Governing American Indians and Alaskan Natives. Contractor shall comply with applicable laws, rules and regulations relating to the provision of Health Care Services to any individual enrolled in Contractor's Certified QHP in the Individual Exchange who is determined by the Exchange to be an eligible American Indian or Alaskan Native as defined in section 4(d) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(d)), Such requirements include the following:

(a) Contractor shall cover Health Care Services furnished through a health care provider pursuant to a referral under contract for directly furnishing an item or service to an American Indian with no cost-sharing as described in the Affordable Care Act Section § 1402(d)(2).

(b) Contractor shall not impose any cost-sharing on such individuals under three hundred (300) percent of federal poverty level ("FPL") in accordance with the Affordable Care Act § 1401(d)(1). The Exchange will have a transparent process to identify Alaskan Natives and American Indians, including a specific identification of those under 300% of FPL so the Contractor has information necessary to comply with Federal law.

(c) Contractor shall provide monthly special enrollment periods for American Indian or Alaskan Native enrolled through the Exchange.

(d) Contractor shall comply with other applicable laws, rules and regulations relating to the provision of Health Care Services to American Indians, including, the Indian Health Care Improvement Act Sections 206 (25 U.S.C. 1621e) and 408 (25 U.S.C. 1647a).

3.14 Participating Provider Arrangements. Contractor shall include in all of its contracts with Participating Providers the requirement for all Health Care Services to be provided by duly licensed, certified or accredited Participating Providers consistent with the scope of their license, certification or accreditation and in accordance with applicable laws, rules, regulations, the standards of medical practice in the community and the terms set forth in agreements entered into by and between Contractor and Participating Providers ("Provider Agreement"). ~~The Provider Agreement shall cause Participating Provider to comply with the terms and conditions of this Agreement, including those terms and provisions set forth at Attachment 5 ("Provider Agreement Standard Terms").~~

3.15 Enrollee's Out-of-Network and Other Costs; Network Requirements. Contractor shall, and shall cause Participating Providers to, comply with applicable laws, rules and regulations governing liability of Enrollees for Health Care Services provided to Enrollees, including, those relating to holding an Enrollee harmless from liability in the event Contractor fails to pay an amount owing by Contractor to a Participating Provider as required by Federal and State laws, rules and regulations.

Comment [AC15]: While we appreciate the amendments to the previous language in this section, most (if not all) provider agreements contain confidentiality provisions that would preclude the disclosure of rates under these circumstances. In this and several other places throughout the contract the Exchange requests such information (rates, marketing plans etc.) and maintains that it will be kept confidential but we are unclear what protections the Exchange can provide from a Public Records Act request. If plans give DMHC provider rates it can keep them confidential because the Knox-Keene Act deems that information confidential. We are unclear that the Exchange has the authority to grant such treatment, which makes disclosure of sensitive information to the Exchange very problematic.

Comment [AC16]: This requirement should be phased in for new and renewing contracts. Additionally, the suggested deletion is because we have concerns that providers will not agree to be bound by the requirements in the Exchange contract. We also have concern, here and throughout the contract that plans are unable to "cause" providers to comply with certain provisions and we request that edits be made to all sections of the contract that have such a requirement.

(i) To the extent that Contractor's QHPs either (i) provide coverage for out-of-network services and/or (ii) impose additional fees for such services, Contractor shall disclose to the Enrollee the amount it ~~will pay~~would typically pay (if known) for covered proposed non-emergent out-of-network services when requested by the Enrollee.

~~(ii) Contractor shall require its Participating Providers to inform every Enrollee in a manner that allows the Enrollee the opportunity to act upon that Participating Provider's proposal or recommendation regarding (i) the use of a non-network provider or facility or (ii) the referral of an Enrollee to a non-network provider or facility for proposed non-emergent Covered Services. Contractor shall cause Participating Providers to disclose to the Enrollee who is proposing or considering using out-of-network non-emergent services if a non-network provider or facility will be used as part of the network provider's plan of care. The Contractor's obligation for this provision can be met through an update to their providers' contract manual that is effective as of January 1, 2014. Participating Providers may rely on Contractor's provider directory in fulfilling their obligation under this provision.~~

3.16 Credentialing. Contractor shall perform, or may delegate activities related to, credentialing and re-credentialing Participating Providers in accordance with process as reviewed and approved by the appropriate Health Insurance Regulator.

3.17 Utilization Review and Appeals Process. Contractor shall maintain a utilization management program that complies with applicable laws, rules and regulations, including, Health and Safety Code 1370 and other requirements established by the Health Insurance Regulator responsible for oversight of Contractor.

3.18 Customer Service.

Contractor acknowledges that superior customer service is a priority of the Exchange. Contractor shall work closely with the Exchange in an effort to ensure that the needs of the Exchange Enrollees are met. Contractor shall provide and maintain all processes and systems required to ensure customer service, record protection and uninterrupted service to the Exchange and Contractor's Enrollees in the Exchange in accordance with the standards set forth at Attachment 6 ("Customer Service Standards"), applicable laws, rules and regulations, including, those consumer assistance tools and programs required to be offered through the Exchange as set forth at 45 C.F.R. § 155.205 and 45 C.F.R. § 155.210.

For 2014, Contractor shall meet all State requirements for language assistance services that are applicable to its commercial lines of business. The Exchange and Contractor will evaluate the adequacy of language services provided for verbal and written communications during 2014 and consider the adoption of additional standards in 2015.

3.19 Compliance Programs.

~~(a) General. Contractor shall, and shall cause Participating Providers and all subcontractors to, comply with all applicable federal, state, and local laws, regulations, executive orders, ordinances and guidance, including without limitation, the Affordable Care Act and the California Affordable Care Act; the Americans with Disabilities Act, the Anti-Kickback Statute, the Public Contracts Anti-Kickback Act, the Stark Law, and the Knox Keene Health Care Service Plan Act of 1975 and/or California Insurance Code, as applicable.~~

~~(b) Fraud, Waste and Abuse; Ethical Conduct. Contractor shall maintain and enforce policies, procedures, processes, systems and internal controls (i) to reduce fraud, waste and abuse, and (ii) to enhance compliance with other applicable laws, rules and regulations in connection with the performance of Contractor's obligations under this Agreement. Contractor shall maintain an effective compliance program that meets the requirements of applicable laws, rules and regulations. Contractor shall provide evidence of such compliance program as reasonably requested by the Exchange. Contractor shall timely communicate to the Exchange any material concerns identified by Contractor or by a regulatory agency related to regulatory compliance as such may impact performance under this Agreement.~~

~~(i) Contractor shall provide the Exchange with a description of its fraud, waste and abuse detection and prevention programs and report total moneys recovered by Contractor in the most recent 12-month period in relation to Services provided to Enrollees. This description shall be provided upon the request of the Exchange and will be updated during each year that this Agreement is in effect and shall include an overview of fraud and abuse detection and prevention program activities conducted by Contractor, Participating Providers, other subcontractors and/or their authorized agents, including a summary of key findings and the development, implementation and enforcement of any corrective action plans for changing, upgrading, or improving these programs.~~

~~(ii) Contractor shall maintain and enforce a code of ethical conduct that shall be made available to the public through posting on a website.~~

3.20 Enrollment and Eligibility.

(a) Acceptance of Enrollment. Contractor shall comply with the eligibility and enrollment determinations that shall be made for Enrollees by the Exchange in coordination with CalHEERS. The Exchange shall

provide information regarding enrollment in Contractor's QHPs to Contractor in a timely fashion. Contractor shall accept all Enrollees assigned by the Exchange except as otherwise authorized by policies and procedures of the Exchange ~~or upon the approval of the Exchange.~~ Contractor Exchange shall send enrollment information to the Exchange-Contractor on a daily basis and Contractor shall reconcile Enrollment information received from the Exchange with Contractor's enrollment data on a monthly basis. The Exchange shall be solely responsible for enrollment and eligibility determinations and Contractor shall rely upon the accuracy of current eligibility and enrollment information furnished by the Exchange during the term of this Agreement; provided, however, that Contractor shall (i) reconcile premium payment information with enrollment and eligibility information received from the Exchange on a monthly basis, and (ii) timely notify the Exchange of any differences between premium payments and the enrollment and eligibility information. Changes to eligibility information submitted by Employers or Enrollees shall be accepted only when the Exchange notifies or confirms such change to Contractor.

Comment [AC17]: The Exchange should not be able to assign an Enrollee unless consistent with established policies.

Comment [AC18]: Exchange is responsible for sending enrollment information to Contractors.

(b) Enrollment Periods. Contractor acknowledges and agrees that the Exchange is required (i) to allow qualified individuals to enroll in a QHP or change a QHP during annual Open Enrollment Periods, (ii) to allow certain qualified individuals to enroll in or change QHPs during Special Enrollment Periods as a result of specified triggering events per applicable Federal and State laws, rules and regulations and (iii) to allow Employers and Employees to purchase coverage in SHOP (1) during an initial Open Enrollment Period in 2013, (2) at any point during the year after the initial Open Enrollment Period ("rolling enrollment period") and (3) as a result of specified triggering events, during Special Enrollment Periods. Contractor agrees to accept new Employers and Employees in SHOP and individual Enrollees in the Individual Exchange who enroll during these periods.

(c) Redetermination. Contractor shall accept changes to enrollment received from the Exchange other than during the Employer's Open Enrollment period for qualifying events as required under applicable laws, rules and regulations, including those set forth at 45 C.F.R. § 155.330.

(d) Law. Contractor shall comply with all Federal and State eligibility and enrollment statutes and regulations, including, but not limited to, the Affordable Care Act § 1411 *et seq.* (42 U.S.C. 18081 *et seq.*) Government Code § 100503, and 10 CCR § 6400 *et seq.*

3.21 Enrollment: Commencement of Coverage. The provisions of this Section 3.21(a) shall apply with respect to the Individual Exchange.

(a) Individual Exchange

(i) The Exchange shall (i) notify Contractor regarding each eligible applicant who has completed an application for enrollment and designated Contractor as the Certified QHP, and (ii) transmit information required for Contractor to enroll the applicant within five (5) business days of verification of eligibility and selection of Contractor's QHP. Contractor shall ensure a coverage effective date for the Enrollee as of (1) the first day of the next subsequent month for a QHP selection notice received by the Exchange between the first day and fifteenth (15) day of the month, or (2) the first day of the second following month for QHP selections received by the Exchange from the sixteenth day through the last day of a month, or (3) such other applicable dates specified in 45 C.F.R. 155. § 410 for the Open Enrollment Period and 45 C.F.R. § 155.420 for the Special Enrollment Period and/or as otherwise established by Contractor in accordance with applicable laws, rules and regulations. The Exchange shall require payment of one hundred percent (100%) of the entire first month premium ~~from the enrollee~~ to be received by the Exchange on or before the fourth (4th) remaining business day of the month in order to commence coverage as of the first (1st) day of the following month.

(ii) Contractor shall provide the Exchange with information necessary to confirm Contractor's receipt of premium payment from Enrollee that is required to commence coverage. The specific terms and conditions relating to commencement of coverage, including, the administration of advance payments of the premium tax credit and cost sharing reductions and cancellation or postponement of the effective date of coverage in the event of nonpayment or partial payment of an initial premium, shall be established by the Exchange in accordance with applicable laws, rules and regulations ~~and in consultation with Health Insurance Issuers.~~

(b) Commencement of Coverage - SHOP. The provisions of this Section 3.21(b) shall apply with respect to the SHOP.

(i) Contractor shall coordinate and cooperate with Exchange to the extent necessary during the Exchange's enrollment process that shall commence following the Exchange's acceptance of the single employer and single employee application forms. Contractor shall provide Services as may be required to support the Exchange during the enrollment process conducted by the Exchange in accordance with the Exchange's responsibilities under 45 C.F.R. § 155.720 and other applicable laws, rules and regulations. Such Services shall include support of the Exchange's performance of the following activities that must occur before the effective date of coverage: (i) determination of Employer eligibility, (ii) selection of Contractor's QHPs coverage levels by Employers and Employees, and (iii) verification of Employee's eligibility. Upon verification of eligibility and selection of Contractor's QHP, the Exchange shall (1) process

Comment [AC19]: It is not clear who is collecting the initial payment in the Individual Exchange. There have been several conflicting explanations over the past week and we request clarification in the contract and in writing sooner so plans can continue with implementation planning.

Comment [AC20]: Contractors will need to provide input regarding these policies to ensure that they can be implemented in a cost-efficient manner.

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enrollment of Employees into Contractor's QHPs, (2) establish effective dates of Employee coverage, and (3) transmit enrollment information for [Employer and Employees to Contractor within five \(5\) business days of verification of eligibility and selection of QHP](#) and Contractor shall notify Employee of the effective date of coverage.

(ii) Coverage shall commence on the first (1st) day of a month or such other date as may be established by the Exchange under its enrollment timeline and processes in accordance with the requirements set forth at 45 C.F.R. § 155.720(b)(7).

(iii) The specific terms and conditions relating to commencement of coverage, including, cancellation or postponement of the effective date of coverage in the event of nonpayment or partial payment of an initial premium will be determined in accordance with applicable laws, rules and regulations [and in consultation with Health Insurance Issuers.](#)

3.22 Enrollment: Termination of Coverage.

(a) Individual. The provisions of this Section 3.22(a) shall apply with respect to the Individual Exchange.

(i) Coverage will be terminated in a Contractor's QHP in accordance with the requirements established by the Exchange based on requirements set forth at 45 C.F.R. 155.430 and other applicable State and Federal laws, rules and regulations.

(ii) Coverage will be terminated for an individual Enrollee's non-payment of premium effective as of: (i) the last day of the first month of a three (3) month grace period provided in the event of nonpayment of premiums by individuals receiving advance payments of the premium tax as required under 45 C.F.R. 155.430(d)(4), or (ii) the last day of coverage established by grace periods under applicable State law, including requirements relating to Health and Safety Code § 1365 and Insurance Code § 10713.

Contractor shall report information to the Exchange regarding delinquent full or partial payments of premium owing by Qualified Individuals in such format and intervals as is reasonably requested by the Exchange based on consultation with the Contractor.

(iii) The specific terms and conditions relating to termination of coverage, including, Contractor's right to terminate in connection with the receipt of partial payments, shall be determined by the Exchange in accordance with applicable State and Federal laws, rules and regulations [and in consultation with Health Insurance Issuers.](#)

(iv) The Exchange will notify Contractor within five (5) business days of any individual Enrollee termination.

(b) Termination - SHOP. The provisions of this Section 3.22(b) shall apply with respect to the SHOP.

(i) Contractor acknowledges and agrees that the Exchange shall be responsible for the aggregation and administration of premiums for SHOP. The Exchange shall be responsible for: (1) the submission of bills to each Employer on a monthly basis in a form that identifies Employer and Employee contributions and the total amount due, (2) collecting the amounts due from each Employer, and (3) making payments to Contractor for Enrollees in Contractor's QHPs on a monthly basis or such other intervals as mutually agreed upon by the Exchange and Contractor. In no event shall the Exchange be liable to Contractor with respect to any interest or other charges relating to premium funds received by the Exchange that are not yet disbursed by the Exchange to Certified QHPs.

(ii) The specific terms and conditions relating to terminations, including, Contractor's right to terminate an Employer in connection with the receipt of nonpayment or partial payments from Employers, shall be established by the Exchange in accordance with applicable laws, rules and regulations [and in consultation with Health Insurance Issuers.](#)

(iii) Except as otherwise required under applicable laws, rules or regulations, an Employee's enrollment through Employer may be terminated in connection with the termination of Employer's coverage and/or with respect to the events described in paragraph (a) above. With respect to an Employee, his or her eligibility shall cease at such time as he/she is no longer a qualified Employee to whom Employer has offered coverage. The Exchange will notify Contractor within five (5) business days [of the Exchange being notified](#) of any Employer or Employee termination.

3.23 Minimum Participation Rates - SHOP. Contractor shall comply with minimum participation rates for Employers participating in SHOP that shall require (i) participation of a specified percentage of Employer's eligible employees in the Exchange, (ii) Employer's contribution in an amount equal to a specified percentage of the Employees premium and (iii) compliance with applicable laws, rules and regulations. Participation rates shall be established by the Exchange in consultation with Health Insurance Issuers and may be modified by the Exchange no more frequently than annually based on consideration of various factors, including, prevailing market standards and changes in applicable laws, rules and regulations.

3.24 Premiums.

(a) Contractor shall not pursue collection of any delinquent premiums from the Exchange for an Enrollee enrolled in the Individual Exchange who is responsible for directly paying for his/her premium to Contractor.

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Comment [AC21]: Contractors need to receive complete and timely enrollment information.

Comment [AC22]: It is not clear who takes action regarding cancellation/postponement in the event of nonpayment of initial premium. Please clarify.

(b) Contractor shall not be entitled to collect from Enrollees and/or receive from Employers any amounts or receive funds from the Employers above the premium amounts except with respect to cost-sharing amounts or to the extent that such payment (i) is expressly authorized under the Certified QHPs, such as out-of-network services that comply with the notice requirements set forth at Section 3.15 above, or (ii) relates to a charge for non-sufficient funds transactions initiated by Enrollee at rates that are reasonable and customary for such transaction.

(c) Contractor shall review and reconcile information received from the Exchange on a monthly basis relating to the administration of premium payments, including information required under 45 C.F.R. § 155.705 and other applicable laws, rules and regulations necessary to the administration of premiums. Such reconciliation process will include the Contractor's review of information relating to the receipt of premium amounts due to (1) the Exchange from each Employer and Employee in SHOP, and (2) due to Contractor from each individual in the Individual Exchange. Contractor shall provide the Exchange notice of any reconciling enrollment information with premium payment information, which shall be evaluated by the Exchange in consultation with Contractor.

3.25 Collection Practices. Contractor shall maintain fair and reasonable collection practices that comply with applicable laws, rules and regulations. Contractor shall monitor the collection activities and provide the Exchange with documentation reasonably requested by the Exchange to facilitate the Exchange's monitoring, tracking or reporting with respect to Contractor's collection efforts, including, policies and procedures and copy of any form of delinquency or termination warning or notice ~~form letters sent to an Enrollee or Employer.~~

3.26 Appeals and Grievances.

(a) Internal. Contractor shall maintain an internal review process to resolve Enrollee's appeals of claims and benefit determinations, including, those relating to the scope of Covered Services required to be provided under the QHP and/or relating to Medical Necessity. Contractor's processes shall comply with applicable laws, rules and regulations, including, those set forth at Health and Safety Code Section 1370.2.

(b) Independent Medical Review. Contractor shall comply with applicable laws, rules and regulations relating to the external independent medical review process available to Enrollees for Health Care Services that are disputed due to denial, modification, delay, or other limitation imposed by Contractor or a Participating Provider. The external medical review process shall be conducted in accordance with the requirements set forth at Insurance Code Section 10169 *et seq.* (or Health and Safety Code Section 1374.30 *et seq.*, as applicable

(c) Grievances. Contractor shall also maintain a grievance process for the review of clinical and non-clinical grievances which shall comply with requirements set forth at Health and Safety Code Section 1368.02 and 1368.03.

3.27 Enrollee Materials; Branding Documents. Contractor shall comply with the Exchange co-branding requirements relating to the format and use of the Exchange logo and information on premium invoices, ID cards and Enrollee termination notices. The Contractor shall include Exchange logo and other information in notices and other materials based upon the mutual agreement of the Exchange and Contractor regarding both which materials should include the Exchange logo and timing of its inclusion in Contractor-generated notices and other materials.

(a) Enrollee Materials. Upon request, Contractor shall provide the Exchange with at least one (1) copy, unless otherwise specified, of any information Contractor intends to mail to all the Exchange Enrollees, including, but not limited to, Evidence of Coverage and disclosure forms, enrollee newsletters, new enrollee materials, health education materials, and special announcements. Such copies will be templates only and will not include any PHI. The materials provided to the Exchange under this Section will not require prior-approval by the Exchange before the Contractor distributes such materials; provided, however, that Contractor shall duly evaluate any changes proposed by the Exchange with respect to such materials. Contractor shall maintain an electronic file that is open to the Exchange. Such file shall be accessible by the Exchange as required by applicable laws, rules and regulations and as otherwise mutually agreed upon by the parties.

(b) Distribution of Enrollment Materials. Contractor agrees to distribute to prospective Enrollees the Open Enrollment publications developed and printed by the Exchange as reasonable for Enrollees prior to the Open Enrollment Period at a time and extent mutually agreed to by the Contractor and the Exchange. Contractor shall be responsible for reasonable ~~the~~ mailing cost associated with these publications. Contractor shall be given the option of distributing such materials electronically, if they can confirm receipt of these documents by prospective Enrollees.

(c) Marketing Materials. In order to promote the effective marketing and enrollment of individuals inside and outside the Exchange, Contractor shall provide the Exchange with marketing material and all related collateral used by Contractor for the Exchange ~~and non-Exchange plans~~ on an annual basis and at such other intervals as may be reasonably requested by the Exchange. The Exchange shall treat such

Comment [AC23]: Revised to make it clear that the Exchange will receive copies of form letters, not every individual letter addressed to an Enrollee.

Comment [AC24]: There is also Section 1374.30 (for medical necessity) and Section 1370.4 (for experimental). The parallel Insurance Code should be added here as well.

Comment [AC25]: Plans can accommodate co-branding but need to be sure that it does not conflict with any of their company rules and branding requirements. This is in addition to the time and resources it will take to make such changes. We request additional dialogue about how to implement this.

Comment [AC26]: It is not clear if this is any material sent to an Exchange member or only those sent exclusively to Exchange members.

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Comment [AC27]: Plans need to understand the nature and extent cost of the distribution of these materials.

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marketing materials as confidential information, and the obligation of the Exchange to maintain confidentiality of the information shall survive termination or expiration of this Agreement. -

(d) Identification Cards. Contractor shall issue identification cards to Enrollees in a form that shall be agreed to by the Exchange.

(e) Mailing Addresses; Other Information. The Exchange and Contractor shall coordinate with respect to the continuous update of changes in an Enrollee's address or other relevant information.

(f) Evidence of Coverage Booklet on Contractor's Web Site. During each year of this Agreement which carries over into a subsequent Contract Year, Contractor shall make the Evidence of Coverage booklet for the next benefit year available on Contractor's web site no later than the first day of the Open Enrollment Period provided that Contractor has received any revisions in the material that is to be included in the Evidence of Coverage from the Exchange and the applicable regulator in sufficient time to allow for posting on the first day of Open Enrollment. The Evidence of Coverage booklet for the then-current benefit year shall remain on Contractor's web site through December 31 of the then-current benefit year.

(g) Marketing Plans. Contractor and the Exchange recognize that Enrollees and other health care consumers benefit from efforts relating to outreach activities designed to increase health awareness and encourage enrollment. The parties shall share marketing plans on an annual basis and with respect to periodic updates of material changes. The marketing plans of each of the Exchange and Contractor shall include proposed marketing approaches for plans marketed in the Exchange and channels and shall provide samples of any planned marketing materials and related collateral, ~~as well as planned, and when completed, expenses for the marketing budget.~~ The Contractor shall include this information for both the Exchange ~~and the outside individual~~ market. The Exchange shall treat all marketing information provided under this Section as confidential information, and the obligation of the Exchange to maintain confidentiality of the information shall survive termination or expiration of this Agreement.

(h) Customer Service. Contractor shall also comply with the requirements relating to enrollment materials required under the customer service standards in accordance with the requirements set forth at Section 3.18.

3.28 Agents in the Individual Exchange.

(a) Compensation. The provisions of this Section 3.28 apply to agents who sell Contractor's QHPs through the Individual Exchange.

(i) Compensation Methodology. Contractor shall be solely responsible for compensating agents who sell Contractor's QHP through the individual market of the Exchange. Contractor shall use a standardized agent compensation program with levels and terms that shall result in the same aggregate compensation amount to agents whether products are sold within or outside of the Exchange. Contractor shall provide the Exchange with a description of its standard agent compensation program on an annual basis. Contractor shall assure that aggregate compensation paid to an agent during the first year of coverage is equal to amounts paid to agent during any subsequent year of the policy.

(b) Incentive Compensation Program. In order to enhance consistency in sales efforts for products offered inside and outside of the Exchange, Contractor shall add the agent's sale of Certified QHPs through the Exchange to the agent's sale of Contractor's policies outside the Exchange to determine agent's aggregate sales that are used by Contractor to determine incentive or other compensation payable by Contractor to agent. Contractor shall provide information as may reasonably be required by the Exchange from no more frequently than annually ~~time to time~~ to monitor Contractor's compliance with the requirements set forth in this Section.

(c) Agent Appointments. Contractor shall maintain a reasonable appointment process for appointing agents who contract with Contractor to sell Contractor's QHPs to individuals through the Exchange. Such appointment process shall include: (i) providing or arranging for education programs to assure that agents are trained to sell Contractor's QHP through the Exchange, (ii) providing or arranging for programs that enable agents to become certified by the Exchange; provided, however, that certification by the Exchange shall not be a required condition for an agent to sell Contractor's QHP on the individual market and (iii) confirmation of agent's compliance with State laws, rules and regulations applicable to agents, including those relating to confidentiality and conflicts of interest, and such other qualifications as determined in Contractor's reasonable discretion.

(d) Agent Conduct. Contractor shall implement policies and procedures to assure only agents who have been duly certified by the Exchange and maintain that certification shall receive compensation for enrolling individuals in the Exchange.

3.29 SHOP Agents. The provisions of this Section 3.29 apply to agents who sell Contractor's QHPs through SHOP.

(a) Agent Commissions. Contractor's Reimbursement for SHOP Agents. In order to facilitate the Exchange's ability to administer enrollment in SHOP based on efforts that are consistent for non-Exchange products and to achieve consistency in compensation arrangement for products sold inside and outside the Exchange: (i) the Exchange shall enter into arrangements with agents to sell Contractor's QHPs

Comment [AC28]: If the Exchange requires a change to the EOC, plans must file that change for approval with the DMHC.

through SHOP, (ii) the Exchange will be responsible for payment of agents, (iii) the Exchange will provide Enrollee specific and agent-specific information to Contractor regarding commissions paid, and (iv) Contractor will reimburse the Exchange for the Exchange's payment of a standard agent commission through the Exchange's offset of agent commissions owing to the Exchange from the SHOP premiums collected by the Exchange, as such offset shall be performed in accordance with the offset procedures set forth at Section 5.03 below. The commission rate payable to a general agent by the Exchange shall be established by the Exchange based on its evaluation of market data, including, pricing information submitted in connection with its rate bids and/or pursuant to other policies that shall be established by the Exchange from time to time. The Exchange will contract with multiple general agents to represent the SHOP beginning in October, 2014 and Contractor agrees to amend any of its agreements with such agents to include a standard general agent override commission for authorized general agents to assure that payments made to agents are consistent with the rate set forth in the agreement between the Exchange and such agent. The Exchange's intent is to pay market level broker and general agent commissions.

(b) Incentive Compensation Program. In order to enhance consistency in sales efforts for products offered inside and outside of the Exchange, Contractor shall consider information provided by the Exchange regarding sales commissions in order to credit the agent's sale of Certified QHPs through SHOP to the agent's sale of Contractor's policies outside the Exchange for purposes of determining agent's aggregate sales that shall be used by Contractor to determine incentive or other compensation payable by Contractor to agent. Contractor shall provide information as may reasonably be required by the Exchange no more frequently than annually from time to time to monitor Contractor's compliance with the requirements set forth in this section.

(c) Agent Appointments. Agents enrolling Employers in SHOP shall be appointed exclusively by the Exchange in accordance with the standards to be determined by the Exchange in accordance with applicable laws, rules and regulations.

(d) Agent Conduct. The Exchange shall implement policies, procedures, training and monitoring and other processes to assure that agents who sell Contractor's QHPs through SHOP will fairly and objectively represent all Health Insurance Issuers and all products offered on the Exchange that market through agents in order to present health plan options in a manner that is minimizes steerage by presenting plan options in an unbiased manner. Such processes shall include, without limitation, practices that implement the following standards:

(i) Agents shall receive training and certification in order to promote the offer of the broad array of potential products available to potential enrollees;

(ii) The Exchange's appointment standards are intended to allow all qualified agents who sell for SHOP to maintain or receive an appointment; provided, however that not all qualified agents shall be required to receive an appointment to sell Certified QHPs through the Exchange.

(iii) Contractor shall not take any action that may restrict agents certified by the Exchange from becoming appointed by all Health Insurance Issuers that elect to market products through an agent.

3.30 Required Notice of Contractor Changes. Contractor shall notify the Exchange in writing upon the occurrence of any of the following events:

(a) ~~Contractor is in breach of any of its obligations under this Agreement~~

(b) Change in the majority ownership, control, or business structure of Contractor;

(c) Change in Contractor's business, partnership or corporate organization that may reasonably be expected to have a material impact on Contractor's performance of this Agreement or on the Exchange's rights under this Agreement;

(d) ~~Material b~~reach by Contractor of any term set forth in this Agreement and/or Contractor otherwise ceases to meet the requirements for a Certified QHP, including, those set forth at and 45 C.F.R. § 156.200 *et seq.* (Subpart C—Qualified Health Plan Minimum Certification Standards);

(e) Significant changes in operations of Contractor that may reasonably be expected to significantly impair Contractor's the operation of Certified QHPs and/or delivery of Health Care Services to Enrollees.

Except as set forth below, such notice shall be provided by Contractor promptly within ten (10) days following Contractor's knowledge of such occurrence; provided, however, (i) such notice shall be provided immediately if such occurrence may reasonably be deemed to adversely affect the quality of care or safety of Enrollees and (ii) in no event shall notice be provided by Contractor beyond the thirty (30) day period

following the date of ~~Contractor's knowledge of such~~ occurrence. All written notices from Contractor pursuant to this section shall contain sufficient information to permit the Exchange to evaluate the events under the same criteria that were used by the Exchange in its award of this Agreement to Contractor. Contractor agrees to provide the Exchange with such additional information as the Exchange may request. If Contractor requests confidential treatment for any information it provides, the Exchange shall treat the information as confidential, subject to the terms of this Agreement and applicable law.

3.31 Other Financial Information. In addition to financial information to be provided to the Exchange

Comment [AC29]: Deleted because requirement is covered by subsections below.

Comment [AC30]: The Exchange should also be required to provide notice on material changes in its operations.

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under other provisions of this Agreement or pursuant to applicable laws, rules and regulations, at the request of the Exchange, Contractor shall provide the Exchange with financial information that is (i) provided by Contractor to Health Insurance Regulators or other regulatory bodies, or (ii) reasonable and customary information that is prepared by Contractor, including, supporting information relating to Contractor's QHP Enrollees.

3.32 Nondiscrimination.

(a) Services and Benefits. During the performance of this Agreement, Contractor shall not, and shall ~~cause include in all of its contracts with Participating Providers the requirement that~~ Participating Providers and other subcontractors, as well as their agents and employees to not, in accordance with the Affordable Care Act Section 1557 (42 U.S.C. 18116), cause an individual to be excluded on the grounds prohibited under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d *et seq.*), Title IX of the Education Amendments of 1972 (20 U.S.C. 1681 *et seq.*), the Age Discrimination Act of 1975 (42 U.S.C. 6101 *et seq.*), or section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), or subject to any other applicable State and Federal laws, from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity offered through the Exchange.

~~(b) Employment; Workplace. Contractor shall not, and shall cause Participating Providers and other subcontractors, as well as their agents and employees to not, unlawfully discriminate, harass or allow harassment, against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability (including Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS)), mental disability, medical condition (including health impairments related to or associated with a diagnosis of cancer for which a person has been rehabilitated or cured), age (40 or over), marital status, genetic information, sexual orientation, gender identity or use of family and medical care leave. Contractor shall, and shall cause Participating Providers and other subcontractors, as well as their agents and employees to, evaluate and treat employees and applicants for employment in a manner that is free from such discrimination and harassment. Contractor shall, and shall cause Participating Providers and subcontractors, as well as their agents and employees to, comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900, *et seq.*) and the applicable regulations promulgated thereunder (2 CCR 7285.0, *et seq.*). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12900, set forth in CCR Chapter 5 of Division 4 of Title 2, including, 2, CCR Section 8103, *et seq.*, are incorporated into this Agreement by reference and made a part hereof as if set forth in full. Contractor, shall, and shall cause Participating Providers and other subcontractors to give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. Contractor shall include the nondiscrimination and compliance provisions of this clause in all subcontracts to perform work under this Agreement.~~

3.33 Conflict of Interest; Integrity.

(a) Conflicts of Interest. Contractor shall, and shall ~~include in all of its contracts with Participating Providers the requirement that~~ Participating Providers to, be free from any conflicts of interest with respect to Services provided under this Agreement. Contractor represents that Contractor and its personnel, ~~to the best of its knowledge,~~ do not currently have, and will not have throughout the term of the Agreement, any direct or interest which may present a conflict in any manner with the performance of Services required under this Agreement. Contractor also ~~represents that it is not aware of any conflicts of interest of~~ ~~shall require~~ any Participating Provider ~~or any basis for potential violations of Contractor or Participating Provider with respect to~~ ~~comply with~~ laws, rules and regulations that govern referrals required for the provision of certain Health Care Services, including, Federal and State anti-kickback and anti-self referral laws, rules and regulations. Contractor shall immediately (1) identify any conflict of interest that is identified during the term of the Agreement and (2) take any necessary action to assure that any activities are not ~~im~~properly influenced by a conflict of interest.

(b) Contractor shall comply with ~~any and all~~reasonable other policies adopted by the Exchange regarding conflicts of interest and ethical standards, copies of which shall be made available by the Exchange for review and comment by the Contractor prior to implementation.

3.34 Other Laws. Contractor shall comply with applicable laws, rules and regulations, including the following:

(a) Americans with Disabilities Act. Contractor shall comply with the Americans with Disabilities Act (ADA) of 1990, (42 U.S.C. 12101, *et seq.*), which prohibits discrimination on the basis of disability, as well as all applicable regulations and guidelines issued pursuant to the ADA, unless specifically exempted.

(b) Drug-Free Workplace. Contractor shall comply with the requirements of the Drug-Free Workplace Act of 1990 (Government Code Section 8350, *et seq.*).

(c) Child Support Compliance Act. Contractor shall fully comply with all applicable State and Federal laws relating to child and family support enforcement, including, but not limited to, disclosure of information and compliance with earnings assignment orders, as provided in Chapter 8 (commencing with Section 5200) of

Part 5 of Division 9 of the Family Code.

(d) Domestic Partners. Contractor shall fully comply with Public Contract Code Section 10295.3 with regard to benefits for domestic partners.

(e) Environmental. Contractor shall comply with environmental laws, rules and regulations applicable to its operations, including, those relating to certifies compliance with the requirements of the Electronic Waste Recycling Act of 2003, Chapter 8.5, Part 3 of Division 30, commencing with Section 42460 of the Public Resources Code, relating to hazardous and solid waste.

(f) Other Laws. Contractor shall comply with any and all other State and Federal laws, rules and regulations applicable to this Agreement and/or the operation of the Exchange and Contractor's provision of Services under this Agreement.

3.35 Transition Plan. On or before August 1, 2013, Contractor shall submit to the Exchange a transition plan for notification of the benefits available through the Exchange to Contractor's current enrollees in individual coverage who may be eligible for subsidies in the Exchange. The plan shall include, ~~without limitation~~, a description of Contractor's plan with respect to the following:

(a) Identifying and targeting specific populations who may be eligible for subsidies, including (i) non-group incumbents, (ii) COBRA incumbents and (iii) all incumbents terminating coverage, including 25-year-old dependents

(b) Processes for identification, outreach and enrollment of subsidy-eligible individuals who respond to Contractor's normal marketing efforts.

(c) Estimates of the number of enrollees in each target population category above and the number of incumbent individuals in each grandfathered and non-grandfathered plan.

(d) Deployment of the subsidy calculator when provided by the Exchange pursuant to Section 1.05 for marketing purposes so as to estimate the level of Federal subsidies that may be available to Enrollees.

(e) Plan for educating enrollees of Contractor's other health plans, minimizing market confusion, and easing the seamless transition of subsidy-eligible enrollees into Qualified Health Plans in the Exchange, along with customer service scripts and website presentations that inform subsidy-eligible incumbents of their options under the Affordable Care Act and in the Exchange.

3.36 Contractor's Representations and Warranties. Contractor represents and warrants that ~~neither it is not aware~~ the execution of this Agreement by Contractor, nor the acts contemplated hereby, nor compliance by Contractor with any provisions hereof will:

(i) Violate any provision of the charter documents of Contractor;

(ii) Violate any laws, rules, regulations or any judgment, decree, order, regulation or rule of any court or governmental authority applicable to Contractor; or

(iii) Violate, or be in conflict with, or constitute a default under, or permit the termination of, or require the consent of any person under, any agreement to which Contractor may be bound, the occurrence of which in the aggregate would have a material adverse effect on the properties, business, prospects, earnings, assets, liabilities, or condition (financial or otherwise) of Contractor.

(b) Due Organization. Contractor represents and warrants that it is duly organized, validly existing, and in good standing under the laws of the state of its incorporation or organization.

(c) Power and Authority. Contractor represents and warrants that: (i) it has the power and authority to enter into this Agreement and to carry out its obligations hereunder; (ii) the execution of this Agreement has been duly authorized and executed by Contractor and no other internal proceeding on the part of Contractor is necessary to authorize this Agreement; and, (iii) to the best of its knowledge, Contractor has completed, obtained, and performed all registrations, filings, approvals, authorizations, consents, or examinations required by any Health Insurance Regulators and other government or governmental authority for its acts contemplated by this Agreement.

Article 4. Quality, Network Management and Delivery System Standards

4.01 Certified QHPs. The parties acknowledge and agree that furthering the goals of the Exchange require Contractor to work with the other Certified QHPs and its contracted providers to play an active role in building and supporting models of care to meet consumer and social needs for providing better care, promoting health and lowering per capita costs through improvement. Contractor agrees to work with the Exchange to develop or participate in initiatives to promote models of care that (i) target excessive costs, (ii) minimize unpredictable quality, (iii) reduce inefficiencies of the current system, and (iv) promote a culture of continuous quality and value improvement, health promotion, and the reduction of health disparities to the benefit of all Enrollees and, to the extent feasible, other health care consumers. In order to further the mission of the Exchange with respect to these objectives and provide the Covered Services required by Enrollees, the Exchange and Contractor shall coordinate and cooperate with respect to quality activities conducted by the Exchange in accordance with the mutually agreeable terms set forth in Section 4.02 hereof and in the Exchange's Quality, Network Management and Delivery System Standards set forth at Attachment 7 ("Quality, Network Management and Delivery System Standards").

4.02 Contractor Quality Management Program. Contractor shall maintain a quality management

program to review the quality of Health Care Services provided by Participating Providers and other subcontractors. Contractor's quality management program shall be subject to review by the Exchange annually to evaluate Contractor's compliance with requirements set forth in the Quality, Network Management and Delivery System Standards. Contractor shall coordinate and cooperate with the Exchange in developing the Quality, Network Management and Delivery System Standards, including (i) participating in meetings and other programs as reasonably requested from time to time by the Exchange, and (ii) providing mutually agreed upon data and other information required under the Quality, Network Management and Delivery System Standards and/or (iii) as otherwise reasonably requested by the Exchange. The parties acknowledge and agree that quality related activities contemplated under this Article 4 will be subject to and conducted in compliance with any and all applicable laws, rules and regulations including those relating to the confidentiality of medical information and will preserve all privileges set forth at Health and Safety Code 1370.

Article 5. Compensation; Funding

5.01 Financial Provisions for Individual Exchange. The provisions of this Section 5.01 shall apply with respect to the Individual Exchange.

(a) Schedule of Rates. The Exchange and Contractor have agreed upon monthly premium rates ("Monthly Rates") payable to Contractor as compensation for Services provided under this Agreement. The Monthly Rates for the Individual the Exchange for plan year 2014-XXXX are set forth at Attachment 8 ("Monthly Rates - Individual Exchange"). The parties acknowledge and agree that the premium amounts set forth under the Monthly Rates are actuarially determined to assure that premium revenues and cost sharing contributions will provide the total dollar amount necessary to support (i) the provision of Covered Services by Contractor through its Certified QHPs, (ii) administrative expenses and reasonable reserves required by Contractor to meet the requirements outlined in this Agreement and in accordance with applicable laws, rules and regulations, and (iii) the payment by Contractor of the Participation Fee, as further described in Section 5.03.

(b) Updates. If the Term of this Agreement is longer than one year, the Monthly Rates for each subsequent year of the Agreement will be established no more frequently than annually in accordance with the procedures set forth at and Section 3.09 and Attachment 9 ("Rate Updates - Individual Exchange").

(c) Collection and Remittance. Contractor understands that Contractor is responsible for collection and the Enrollee is responsible for remittance of the agreed-upon premium rates to Contractor in a timely manner. Contractor understands that individual Enrollees will remit their monthly premium payments directly to Contractor, and the Exchange will not aggregate premiums. The failure by an Enrollee to timely pay premiums may result in a termination of coverage pursuant to the terms set forth at Section 3.22 above. Contractor further understands that the premium payment collected by Contractors includes amounts allocated to the Participation Fee due to the Exchange. The Participation Fees shall be billed by the Exchange to Contractor and payable by Contractor to the Exchange in accordance with the requirements set forth at Section 5.03.

(d) Financial Consequences of Non-Payment of Premium.

(i) Contractor is responsible for enforcement of premium payment rules at its own expense, as outlined in the terms set forth in the Evidence of Coverage regarding the failure by Enrollee to pay the premium in a timely manner as directed by the Enrollee policy agreement and in accordance with applicable laws, rules and regulations. Enforcement by Contractor shall include, but not be limited to, delinquency and termination actions and notices, grace period requirements and partial payment rules. Such enforcement shall be conducted in accordance with requirements set forth in Section 3.25 and consistent with applicable laws, rules and regulations.

(ii) In the event Contractor terminates an Enrollee's coverage in a QHP due to non-payment of premiums, loss of eligibility, fraud or misrepresentation, change in Enrollees selection of QHP, decertification of Contractor's QHP and/or as otherwise authorized under 3.22 above, Contractor must include the Health Insurance Regulator-approved appeals language in its notice of termination of coverage to the Enrollee.

(iii) Contractor acknowledges and agrees that applicable laws, rules and regulations, including the Affordable Care Act and implementing regulations specify a grace period for individuals who receive advance payments of the premium tax credit through the Exchange and that the Knox-Keene Act and Insurance Code set a grace period for other individuals with respect to delinquent payments. Contractor agrees to abide by the requirements set forth at Section 3.22 and required under applicable laws, rules and regulations with respect to these grace periods.

5.02 Financial Provisions for SHOP. The provisions of this Section 5.02 shall apply with respect to the SHOP.

(a) Schedule of Rates. The rates for the SHOP plan year 2014-XXXX are set forth in Attachment 10 ("Monthly Rates - SHOP"). The parties acknowledge and agree that the premium rates for SHOP are actuarially determined to assure that premium revenues and cost sharing contributions will provide the total dollar amount necessary to support (i) the provision of Covered Services by Contractor through its

Certified QHPs, (ii) administrative expenses and reasonable reserves required by Contractor to meet the requirements outlined in this Agreement and in accordance with applicable laws, rules and regulations, and (iii) the Contractor's payment of the Participation Fee to the Exchange. The Participation Fee payable with respect to Enrollees in SHOP includes a fee specified by the Exchange as necessary to support payment of agent and general agent commissions. Contractor acknowledges and agrees that any Participation Fees due to the Exchange from Contractor shall be withheld by the Exchange before passing through any premium payments received by the Exchange from Employers and Employees to Contractor in accordance with paragraph (c) of this Section 5.02.

(b) Updates. The Monthly Rates shall be established in accordance with the procedures set forth at Section 3.09 and in Attachment 11 ("Rate Updates - SHOP"). The Exchange may authorize an update of rates no more frequently than on a quarterly basis in the SHOP, as such updates shall be determined by the Exchange in accordance with requirements and update schedules to be determined by the Exchange.

(c) Rate Determinations. Rates will be determined ~~by the Exchange~~ in accordance with applicable laws, rules and regulations. Rates for an Employer will be determined by Employee ZIP Code. Rates for an Employer and all covered Employees will be determined and frozen at initial enrollment, or upon renewal, for twelve (12) months, until the next group renewal. Rates for all Employees including new Employees or Employees with qualifying events during the Employer plan year will be determined by the prevailing rates at group enrollment.

(d) Collection and Remittance. Contractor understands that the Exchange is responsible for collection and the Employee and/or Employer is responsible for remittance, of these monthly premium rates, except with respect to payments of the initial premium that will be through a third-party payment gateway in accordance with procedures established by the Exchange. The Exchange agrees to perform collection and aggregation of monthly premiums with respect to Contractor's QHPs and will remit said premiums, net of (i) Participation Fees payable to the Exchange and (ii) the fee associated with agent commissions paid by the Exchange pursuant to Section 3.29(a). The Exchange's collection of premiums and remittance of net amounts to Contractor's as described in this Section shall be made on a monthly basis or such other intervals as mutually agreed upon by the Exchange and Contractor.

(e) Grace Period. Contractor acknowledges and agrees that applicable laws, rules and regulations, including, the Knox-Keene Act and Insurance Code, set a grace period with respect to the delinquent payment of premiums for the small group market. Contractor agrees to comply with the requirements set forth at Section 3.21 and required under applicable laws, rules and regulations with respect to these grace periods.

5.03 Participation Fee. Contractor understands and agrees that (i) under the Affordable Care Act and the California Affordable Care Act, the Exchange may generate funds through a participation fee ("Participation Fees") on Contractor's Certified QHPs and (ii) Contractor is responsible for the timely payment of any Participation Fees to the Exchange.

(a) Contractor Allocation and Collection of Participation Fee. Contractor recognizes that the total cost of all Participation Fees for the Exchange must be collected by Contractor by spreading the cost across the premiums charged to Contractor's entire individual risk pool (both inside and outside the Exchange) for the Individual Exchange Participation Fees and across the small employer risk pool (both inside and outside the Exchange) for SHOP Participation Fees. No rate charged to an Enrollee can have a higher per member per month fee to cover this overall Participation Fee than is charged to all other enrollees of the respective risk pool.

(i) Individual Exchange. The Participation Fee payable to the Exchange during each month of this Agreement shall be equal to a per member per month ("PMPM") rate of \$13.95 multiplied by the number of Enrollees in Contractor's QHPs for such month. The Participation Fee is based on the Exchange's estimates of the revenue required to support the transition of the Exchange to being self-sufficient beginning in 2015. The Participation Fee is based on a rate equivalent to approximately three percent (3%) of the estimated individual market premium of \$465 per month, an amount which represents the Exchange's planning estimate of total premium paid to plans for each Enrollee in the Individual Exchange, inclusive of Federal subsidies. The Participation Fee will be assessed by the Exchange and payable monthly by Contractor based on enrollment in Contractor's QHPs sold through the Individual Exchange.

(ii) SHOP. The Participation Fee payable to the Exchange during each month of this Agreement shall be equal to a per member per month ("PMPM") rate of \$18.90 multiplied by the number of Enrollees in Contractor's QHPs for such month plus additional fees as necessary to pay agent commissions. This Participation fee is based on the Exchange's estimates of the revenue required to support the transition of the Exchange to being self-sufficient beginning in 2015. This Participation fee is based on a rate equivalent to approximately four percent (4%) of the aggregate premiums relating to all QHP products and policies sold through SHOP. The Participation Fee will be assessed by the Exchange and payable monthly by Contractor based on enrollment in Contractor's QHPs sold through the ~~Individual Exchange~~SHOP.

(b) Payment:

Comment [AC31]: Suggest deleting because it suggests that the Exchange is determining rates.

(i) Individual Exchange. Participation Fee invoices will be issued by the Exchange prospectively to Contractor on the 15th of the month for the coming month. Contractor's Participation Fee obligation will be determined by evaluating Contractor's then-current effective Certified QHP enrollment in the Individual Exchange, and may be subject to adjustment to reflect enrollment adjustments that may occur. Participation Fee payments will be due on the 1st of the month the Participation Fee covers. For Participation Fees received after the 15th of the month in which the Participation Fee is due, the Exchange will charge, and Contractor shall owe a 1% per month late fee. Additional rules, including but not limited to, the manner of payment, grace period, delinquency penalty, and termination due to breach will be established by the Exchange in accordance with applicable laws, rules and regulations and based on consultation with Contractor.

(ii) SHOP. With respect to SHOP, Contractor acknowledges that (i) the Exchange is responsible for collecting premiums from Employers and Employees, and (ii) the Exchange will remit applicable Employer and Employee premiums collected by the Exchange to Contractor, net of (1) Participation Fees computed in accordance with the Participation Methodology - SHOP), and (2) agent commissions determined in accordance with the terms set forth at Section 3.29. The Exchange shall transfer funds to Contractor on a monthly basis or such other intervals as mutually agreed upon by the Exchange and Contractor and shall establish a process to resolve any disagreements on premium amounts due in a timely manner and prior to transfer of funds to Contractor as required under this Section.

(iii) In the event that Contractor disputes the amount of Participation Fees billed or deducted by the Exchange, Contractor shall submit a written notice of such dispute to the Exchange within thirty (30) days following receipt of such bill or deduction by the Exchange. Contractor's notice will document the nature of the discrepancies, including, reconciliation of any differences identified by Contractor in enrollment or premiums collected. The Exchange will respond to Contractor within thirty (30) days of receipt of the notice by either (i) paying the amount claimed by Contractor or (ii) providing a detailed explanation for the denial of the refund. If the Contractor still disputes the findings of the Exchange, Contractor may pursue additional remedies in accordance with Section 12.01.

(c) Contractor agrees to an annual audit or other annual examination by the Exchange or its designee regarding the computation and payment of Participation Fees. In the case of material non-compliance with Participation Fee payments, Contractor shall implement any necessary corrective action and follow up audits or examinations may be performed by the Exchange more frequently than annually as reasonably required to monitor Contractor's implementation of such corrective actions.

5.04 Funding Payments to Exchange. Contractor acknowledges that the Exchange is required under Government Code § 100520(a) to maintain a prudent reserve as determined by the Exchange.

Article 6. Performance Measures, Penalties And Credits

6.01 Performance Measurement Standards.

(a) Contractor shall comply with the performance measurement standards set forth in Attachment 14 ("Performance Measurement Standards"). Exchange shall conduct, or arrange for the conduct of, a review of Contractor's performance under the Performance Measures. The Exchange shall be responsible for the actual and reasonable costs of the review, including, the costs of any third-party designated by the Exchange to perform such review. The review shall be in addition to any ongoing monitoring that may be performed by the Exchange with respect to the Performance Measures.

(b) The Exchange and Contractor shall agree to performance standards for the Exchange, which, if not satisfied, will provide credits to Contractor which can be applied to any penalties accrued to Contractor. Such credits may reduce up to 25% of Contractor's performance penalties that may be assessed under Section 6.02 below.

6.02 Performance Penalties and Credits. The Exchange may impose penalties ("Penalties") in the event that Contractor fails to comply or otherwise act in accordance with the Performance Measures. The Exchange shall also administer and calculate credits ("credits") that may offset or reduce the amount of any performance penalties, but in no event shall such credits exceed the total amount of the penalty levied.

In the event that Contractor disputes the amount of penalties imposed or credits issued by the Exchange, Contractor shall submit a written notice of such dispute to the Exchange within thirty (30) days following receipt of such bill or deduction by the Exchange. Contractor's notice will document the nature of the discrepancies, including, reconciliation of any differences identified by Contractor. The Exchange will respond to Contractor within thirty (30) days of receipt of the notice by either (i) paying the amount claimed by Contractor or (ii) providing a detailed explanation for the denial of the refund. If the Contractor still disputes the findings of the Exchange, Contractor may pursue additional remedies in accordance with Section 12.01.

6.03 No Waiver. The Exchange and Contractor agree that the failure to comply with the Performance Measurement Standards may cause damages to the Exchange and its Enrollees which may be uncertain and impractical or difficult to ascertain. The parties agree that the Exchange shall assess, and Contractor

Comment [AC32]: We request an opportunity to review Attachment 14 with the Exchange. The

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promises to pay the Exchange, in the event of such failed, delayed, and/or other performance that does not meet the Performance Measurement Standards, the amounts to be determined in accordance with the Performance Measurement Standards set forth at Attachment 14. The assessment of fees relating to the failure to meet Performance Measurement Standards shall (1) be determined in accordance with the amounts and other terms set forth in the Performance Measurement Standards, (2) be cumulative with other remedies available to the Exchange under the Agreement (3) not be deemed an election of remedies, and (4) not constitute a waiver or release of any other remedy the Exchange may have under this Agreement for Contractor's breach of this Agreement, including, without limitation, Contractor's right to terminate this Agreement, and the Exchange shall be entitled in its discretion to recover actual damages caused by Contractor's failure to perform its obligations under this Agreement. **Notwithstanding the foregoing, the amount of any actual damages to which the Exchange is entitled as a result of Contractor's failure to satisfy the Performance Measures shall be reduced by the amount of Penalties imposed upon Contractor for such failure.**

Article 7. Term; Recertification; Termination; and De-Certification .

7.01 Term. The term of this Agreement shall commence on the date on which Contractor's QHPs are certified and the Agreement is executed by all parties ("Agreement Effective Date"), and expire on [December 31, 2014] ("Expiration Date"), unless terminated earlier or extended in accordance with the provisions of this Agreement

7.02 Recertification Process. During each year of this Agreement, the Exchange will evaluate the recertification of Contractor based on an assessment process that shall be conducted by the Exchange in accordance with its procedures and on a basis consistent with applicable laws, rules and regulations, including, the requirements set forth under the California Affordable Care Act, 10 CCR 6400 *et seq.*, and the Affordable Care Act. Contractor will be considered in the Exchange's recertification evaluation process that shall be conducted by the Exchange prior to the Expiration Date unless (i) the Agreement is terminated sooner than the Expiration Date by the Exchange in accordance with the requirements set forth at Section 7.03 below or pursuant to other terms set forth in the Agreement, or (ii) Contractor makes a Non-Recertification Election pursuant to Section 7.07 below.

7.03 Termination.

(a) The Exchange may, by ninety (90) calendar days' written notice to Contractor, and without prejudice to any other of the Exchange remedies, terminate this Agreement for cause based on one or more of the following occurrences:

- (i) Contractor fails to fulfill an obligation that is material to its status as a Certified QHP and/or its performance under the Agreement;
- (ii) Contractor no longer holds a license or certificate that is required for Contractor to perform its obligations under this Agreement and/or Contractor otherwise fails to maintain compliance with the "good standing" requirements pursuant to Section 3.02 above and which impairs Contractor's ability to provide Services under the Agreement;
- (iii) Contractor breaches any material term, covenant, warranty, or obligation under this Agreement that is not cured or substantially cured to the reasonable satisfaction of the Exchange within forty-five (45) calendar days after receipt of notice of default from the Exchange; provided, however, that such cure period may not be required and the Exchange may terminate the Agreement immediately if the Exchange determines pursuant to subparagraph (e) below that Contractor's breach threatens the health and safety of Enrollees;
- (iv) Contractor knowingly has a director, officer, partner, or person with a beneficial ownership of more than five percent (5%) of Contractor's equity or has an employment, consulting or other subcontractor agreement for the provision of Services under this Agreement who is, or has been: (A) excluded, debarred, or suspended from participating in any federally funded health care program, (B) suspended or debarred from participation in any state contract or procurement process, or (C) convicted of a felony or misdemeanor (or entered a plea of nolo contendere) related to a crime or violation involving the acquisition or dispersal of funds or delivery of Health Care Services to beneficiaries of any State or Federal health care program;
- (v) The Exchange reasonably determines that the welfare of Enrollees is in jeopardy if this Agreement continues, as such determination shall be made in the reasonable discretion of the Exchange based on consideration of professionally recognized standards and benchmarks, requirements imposed by accreditation agencies and applicable laws, rules and regulations; or
- (vi) Contractor fails to comply with a change in laws, rules or regulations occurring during the term of this Agreement and/or does not take any and all actions that may be required to amend the Agreement and otherwise establish and document compliance with any such changes, and the Exchange reasonably determines, based on consultation with legal counsel and/or other regulators and/or other State-based or Federal health benefit exchanges, that it may be at risk of being found noncompliant with Federal or State laws, rules or regulations **as a result of Contractor's failure.**

(b) By Contractor. Contractor may, by ninety (90) calendar days' written notice to ~~the Exchange~~ Contractor, and without prejudice to any other of the remedies, terminate this Agreement for cause based on one or more of the following occurrences:

- (i) The Exchange fails to fulfill an obligation that is material to its status as a Certified QHP and/or its performance under the Agreement;
- (ii) The Exchange breaches any material term, covenant, warranty, or obligation under this Agreement that is not cured or substantially cured to the reasonable satisfaction of the Contractor within forty-five (45) calendar days after receipt of notice of default from the Exchange; or
- (iii) The Exchange fails to comply with a change in laws, rules or regulations occurring during the term of this Agreement and/or does not take any and all actions that may be required to amend the Agreement and otherwise establish and document compliance with any such changes, and Contractor reasonably determines, based on consultation with legal counsel and/or other regulators and/or other State-based or Federal health benefit exchanges, that it may be at risk of being found noncompliant with Federal or State laws, rules or regulations as a result of the Exchange's failure.

7.04 Notice of Termination.

(a) If the Exchange ~~determines~~, based on reliable information, describes to Contractor new circumstances or conditions that cause the Exchange to reasonably conclude that there is a substantial probability that: Contractor will be unable to continue performance under this Agreement; or, Contractor will be in material breach of this Agreement in the next thirty (30) days, (the "Anticipated Period of Breach"), (ii) such material breach is likely to cause harm to the Exchange, any enrollee or any prospective enrollee and (iii) such breach is not likely to be cured by Contractor within 45 days after its occurrence, then the Exchange shall have the option to demand that Contractor provide the Exchange with a reasonable assurance of performance. Upon Contractor's receipt of such a demand from the Exchange, Contractor shall provide to the Exchange a reasonable assurance of performance responsive to the Exchange's demand. If Contractor fails to provide such an assurance within ten (10) days of the Exchange's demand that demonstrates Contractor's reasonable ability to avoid such ~~default breach~~ or to cure the breach within the time period permitted by this agreement, the Exchange may suspend Contractor's participation in the Exchange for the remaining portion of the Anticipated Period of Breach. within a reasonable time period not to exceed thirty (30) days, the failure shall constitute a breach by Contractor justifying termination of the Agreement by the Exchange.

Comment [AC33]: The Exchange should provide a reasonable assurance of its performance.

(b) In case a party elects to terminate this Agreement in whole or in part under Section 7.03, the notifying party shall give the other party ninety (90) days written notice of termination for default, specifying the default or defaults justifying the termination. The termination shall become effective after the expiration of such notice period if the defaults specified by the notifying party in its notice remain uncured at that time; provided, however, that the Exchange may require Contractor to discontinue the provision of certain Services if the Exchange determines that the continuing provision of services may cause harm to Enrollees, Participating Providers or other stakeholders.

(c) The Exchange shall be entitled to retain any disputed amounts (less the total of any credits owed to Contractor) that remain in the possession of the Exchange until final resolution of all claims by the parties against each other arising out of any Contractor default alleged by the Exchange.

7.05 Remedies in Case of Contractor Default. The Exchange shall have all rights afforded by law in case of Contractor default, including, but not limited to: Decertification of Contractor's QHPs and termination of this Agreement.

Comment [AC34]: Plans should be able to dispute amounts when there is a dispute about payment.

Comment [AC35]: Plans remedies should be cumulative in case of Exchange default.

(a) Recovery of damages to the Exchange caused by Contractor's unexcused delay or non-performance;

(b) Imposing sanctions under the Performance Measures;

(c) Specific performance of particular covenants made by Contractor hereunder but only to the extent such covenants expressly describe specific performance as a remedy; and

(d) Initiating an action or proceeding for damages, declaratory or injunctive relief.

All remedies of the Exchange under this Agreement for Contractor default are cumulative to the extent permitted by law.

7.06 Contractor Insolvency. Contractor shall notify the Exchange immediately in writing in the event that Contractor files any federal bankruptcy action or state receivership action, any federal bankruptcy or state receivership action is commenced against Contractor, Contractor is adjudicated bankrupt, or a receiver is appointed and qualifies. In case any of the foregoing events occurs, the Exchange may terminate this Agreement upon five (5) days written notice. If the Exchange does so, the Exchange shall have the right to recover damages from Contractor as though the Agreement had been terminated for Contractor default.

7.07 Non-Recertification Election. Contractor shall provide the Exchange with notice on or before July 1 during any Contract Year regarding Contractor's election to not seek re-certification of Contractor's QHP as of the expiration of the Agreement ("Non-Recertification Election"). Contractor shall comply with conditions set forth in this Section 7.07 with respect to continuation of coverage and transition of Enrollees to new QHPs following the Exchange's receipt of Non-Recertification Election.,

Comment [AC36]: The provisions about how long plans are to provide coverage post termination are confusing. We suggest the Exchange relay on existing regulatory standards and reference those here to avoid confusion.

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(a) Continuation and Transition of Care. Except as otherwise set forth in this Section 7.07, Contractor shall continue to provide Health Care Services to Enrollees in accordance with the terms set forth in the Agreement from and after Contractor's Non-Recertification Election up through the termination of coverage for Enrollees, as such termination of coverage shall be determined in accordance with the requirements set forth in this Section 7.07.

(b) SHOP. In the event that Contractor continues to offer small group coverage in the State following the Notice of Non-Recertification Election, Contractor shall comply with applicable laws, rules and regulations relating to the discontinuation of a benefit package, including those set forth at Section 1357.11 of the Health and Safety Code and Section 10713 of the Insurance Code. The termination of the Agreement shall occur upon the termination of coverage which shall be determined as follows:

(i) In the event that an Employer's plan year, as determined in accordance with 45 C.F.R. § 155.725, expires between the July 1 effective date of the Non-Recertification Election and the expiration of the Contract Year on December 31, Contractor shall provide coverage to Employers and Employees until the termination of the Agreement that shall be effective upon the expiration of the Employer's first plan year that commences after the Non-Recertification Election.

(ii) In the event that an Employer's plan year terminates between January 1 and the July 1 effective date of the Notice of Non-Recertification, Contractor shall provide coverage until the termination of the Agreement effective upon the expiration of Employer's first plan year that commences prior to the July 1 effective date of the Notice of Non-Recertification.

(iii) In the event that an Employer's plan year expires more than ninety (90) days following the Notice of Non-Recertification Election, the Exchange shall notify Employers and Employees in a format approved by the Exchange that Contractor's QHP will not be available upon the next renewal anniversary date.

(iv) Contractor shall comply with other requirements of the Exchange relating to the continuation and transition of coverage following Contractor's Non-Recertification Election, including, without limitation, those relating to protocols and timing for the removal of Contractor from the listing of Certified QHPs to be selected by Employers and Employees, the commencement of coverage for new Employers and Employees, and termination and transition of coverage.

(c) Individual Exchange. The following provision shall apply to the Individual Exchange.

(i) During the thirty (30) day period following the Exchange's receipt of the Non-Recertification Election, Contractor shall (i) be removed from the enrollment and eligibility assignment process, and (ii) no longer receive assignment of new Enrollees;

(ii) Contractor will provide coverage for Enrollees assigned to Contractor as of the date of the Non-Recertification Election if coverage commences within the sixty (60) day period following the Notice of Non-Recertification. Contractor shall provide coverage for such Enrollees until the earlier of (i) the end of the Contract Year, or (ii) the Enrollee's transition to another QHP during the Special Enrollment Period;

(iii) Contractor shall provide coverage for Enrollees until the earlier of (i) the end of the Contract Year, or (ii) the Enrollee's transition to another QHP during Special Enrollment Period.

(d) Communications. Contractor shall coordinate and cooperate with respect to communications to Enrollees in the Individual Exchange, Employers and Employees in SHOP and other stakeholders regarding the transition of Enrollees to another QHP;

(e) Other Acts. Contractor shall take any further action reasonably required by the Exchange to provide Health Care Services to Enrollees and transition care following the Non-Recertification Election;

(f) Effect of Decertification. Notwithstanding any other language set forth in this Section 7.07, the Agreement shall expire on the Expiration Date set forth in Section 7.01 in the event that the Exchange elects to decertify Contractor's QHP based on the Exchange's evaluation of Contractor's QHP during the recertification process that shall be conducted by Exchange pursuant to Section 7.02 above.

7.08 Effect of Termination.

(a) This Agreement shall terminate on the Expiration Date unless otherwise terminated earlier in accordance with the provisions set forth in this Agreement.

(b) Contractor's Certified QHPs shall be deemed decertified and shall cease to operate as a Certified QHPs as defined at 10 CCR § 6410 immediately upon termination or expiration of this Agreement in the event uninterrupted continuation of agreement between the Exchange and Contractor is not achieved pursuant to either: (i) an extension of the term of the Agreement based upon the mutual agreement of the parties that is documented pursuant to a written amendment, or (ii) Contractor and the Exchange enter into a new agreement that is effective immediately upon the expiration of this Agreement. There shall be no automatic renewal of this Agreement or recertification of Contractor's QHPs upon expiration of the term of this Agreement. Contractor may appeal the decertification of its QHP that will result in connection with the termination of this Agreement and such appeal shall be conducted pursuant to the Exchange's process in accordance with applicable laws, rules and regulations.

(c) All duties and obligations of the Exchange and Contractor shall cease upon termination of the

Agreement and the decertification of Contractor's Certified QHPs that shall occur upon the termination of this Agreement, except as set forth below or otherwise provided in the Agreement:

(i) Each party shall remain liable for any rights, obligations, or liabilities that have accrued or arise from activities carried on by it under this Agreement prior to the effective date of termination.
(ii) Any information of the other party that is in the possession of the other party will be returned promptly, or upon the request of owner of such property, destroyed using reasonable measures to protect against unauthorized access to or use of the information in connection with its destruction, following the earlier of: (i) the termination of this Agreement, (ii) receipt of a written request to return or destroy the Information Assets, or (iii) the termination of the business relationship between the Parties. If both Parties agree that return or destruction of information is not feasible or necessary, the receiving Party will continue to extend the protections outlined in this Agreement to all assets in its possession and will limit further use of that information to those purposes that make the return or destruction of the information or assets. ~~The Each party~~Exchange reserves the right to inspect the storage, processes, and destruction of any ~~of its~~ Information Assets provided under this Agreement.

(d) Contractor shall comply with the requirements set forth at Section 7.07 above in the event that Contractor makes a Non-Recertification Election.

(e) Contractor shall cooperate fully to effect an orderly transfer of Health Care Services to another QHP during (i) any notice period set forth at Sections 7.04, 7.06 or 7.07, and (ii) if requested by the Exchange to facilitate the transition of care and/or otherwise required under Section 7.09 below, following the termination of this Agreement. Such cooperation shall include, without limitation, the following:

(1) Upon termination, Contractor, if offering a HMO, shall complete the processing of all claims for benefit payments under the QHP for Health Care Services other than Capitated Services, and if offering a PPO, shall complete the processing of all medical claims for benefit payments under Contractor's QHP for Health Care Services rendered on or before the termination date, ~~and received by Contractor for a period of twelve (12) months after the termination date as determined by the Exchange pursuant to QHP requirements.~~

(2) Contractor will provide communications developed or otherwise approved by the Exchange, to communicate new QHP information to Enrollees and Employers in accordance with a timeline to be established by the Exchange.

(3) In order to assure the proper transition of Services provided prior to, and subsequent to, termination, Contractor will forward to any new QHP the electronic and direct paper claims that are received by Contractor but which relate to Services provided by new contractor. Any such information shall be subject to compliance with applicable laws, rules and regulations and shall be sent at such time periods and in the manner requested by the Exchange for a period of up to three (3) months following the termination date.

(4) Contractor shall provide customer service to support the processing of claims for Health Care Services rendered on or before the termination date for a period of two (2) months or such other longer period reasonably requested by the Exchange at a cost to be mutually agreed upon per Enrollee.

(5) If so instructed by the Exchange in the termination notice, Contractor shall promptly discontinue the provision of Services requested by the Exchange to be discontinued as of the date requested by the Exchange.

(6) Contractor will perform reasonable and necessary acts requested by the Exchange and as required under applicable laws, rules, regulation and consistent with industry standards to facilitate transfer of Health Care Services herewith to a succeeding Contractor. Contractor shall comply with requirements reasonably imposed by the Exchange relating to (i) the discontinuation of new enrollment or re-enrollment in Contractor's QHP, (ii) ~~making available the transfer of~~ Enrollee coverages to another QHP prior to the commencement date, (iii) the expiration of existing quotes and (iv) such other protocols that may reasonably be established by the Exchange.

(7) Contractor will reasonably cooperate with the Exchange and any successor QHP in good faith with respect to taking such actions that are reasonably determined to be the best interest of the QHP, Enrollees, and Employers.

(8) Contractor shall cooperate with the Exchange's conduct of an accounting of amounts paid or payable and Enrollees enrolled during the month in which termination is effective in order to assure an appropriate determination of premiums earned by and payable to Contractor for Services rendered prior to the date of termination, which shall be accomplished as follows:

(a) Mid-Month Termination: For a termination of this Agreement that occurs during the middle of any month, the premium for that month shall be apportioned on a pro rata basis. Contractor shall be entitled to premiums from Enrollees for the period of time prior to the date of termination and Enrollees shall be entitled to a refund of the balance of the month.

(b) Responsibility to Complete Contractual Obligations: Contractor is responsible for completing submission and corrections to Encounter Data for Health Care Services received by Enrollees during the period of the Agreement. Contractor is responsible for submitting any outstanding financial or other

Comment [AC37]: Deleting because this language appears to limit a plans obligation to pay run-out claims to those received within 12 months of the termination date. This is not appropriate as plans have a legal obligation to adjudicate any and all claims for services incurred while the contract term was in effect, whenever received. While they may ultimately be denied for being late those claims must still be processed.

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reports required for Health Care Services rendered or Claims paid during the term of the Agreement.

(9) Contractor shall (i) provide such other information to the Exchange, Enrollees and/or the succeeding QHP, and/or (ii) take any such further action as is required to effect an orderly transition of Enrollees to another QHP in accordance with requirements set forth under this Agreement and/or necessary to the continuity and transition of care in accordance with applicable laws, rules and regulations.

7.09 Coverage Following Termination and Decertification.

(a) Upon the termination of the Agreement and decertification of one or more of Contractor's Certified QHP Contractor shall cooperate fully with the Exchange in order to effect an orderly transition of Enrollees to another Certified QHP as directed by the Exchange. This cooperation shall include, ~~without limitation~~, (i) attending such post- termination meetings, (ii) providing or arranging for the provision of Health Care Services as may be deemed necessary by Participating Providers to assure the appropriate continuity of care, and/or (iii) communicating with affected Enrollees in cooperation with the Exchange and/or the succeeding contractor, each as shall be reasonably requested by the Exchange.

(b) In the event of the termination or expiration of the Agreement requires the transfer of some or all Enrollees into any other health plan, the terms of coverage under Contractor's QHP shall not be carried over to the replacement QHP but rather the transferred Enrollees shall be entitled only to the extent of coverage offered through the replacement QHP as of the effective date of transfer to the new QHP.

(c) Notwithstanding the foregoing, the coverage of Enrollee under Contractor's QHP may be extended to the extent that an Enrollee qualifies for an extension of benefits including, those to effect the continuity of care required due to hospitalization or disability pursuant to Health and Safety Code section 1399.62. For purposes of this Agreement, "disability" means that the Enrollee has been certified as being totally disabled by the Enrollee's treating physician, and the certification is approved by Contractor. Such certification must be submitted for approval within thirty (30) calendar days from the date coverage is terminated. Recertification of Enrollee's disability status must be furnished by the treating Provider not less frequently than at sixty (60) calendar day intervals during the period that the extension of benefits is in effect. The extension of benefits shall be solely in connection with the condition causing total disability. This extension, which is contingent upon payment of the applicable premiums, shall be provided for the shortest of the following periods:

(i) Until total disability ceases;

(ii) For a maximum period of twelve (12) months after the date of termination, subject to plan maximums;

(iii) Until the Enrollee's enrollment in a replacement plan; or

(iv) Recertification.

Article 8. Insurance and Indemnification

8.01 Insurance. Without limiting the Exchange's right to obtain indemnification or other form of remedies or relief from Contractor or other third-parties, Contractor shall, at its sole cost and expense, obtain, and, during the term of this Agreement, maintain, in full force and effect, the insurance coverage ~~described in this Section and/or as otherwise required by law,~~ including, without limitation, coverage required to be provided and documented pursuant to Section 1351 of the Health and Safety ~~Code and relating to insurance coverage or self insurance: (i) to respond to claims for damages arising out of the furnishing of Health Care Services, (ii) to protect against losses of facilities where required by the director, and (iii) to protect against workers' compensation claims arising out of work related injuries that might be brought by the employees and staff of Contractor. All insurance shall be adequate to provide coverage against losses and liabilities attributable to the acts or omissions of Contractor in performance of this Agreement and to otherwise protect and maintain the resources necessary to fulfill Contractor's obligations under this Agreement. The minimum acceptable limits shall be as indicated below:—~~

~~(a) Commercial general liability or equivalent self insurance covering the risks of bodily injury (including death), property damage and personal injury, including coverage for contractual liability, with a limit of not less than \$1 million per occurrence/\$2 million general aggregate;—~~

~~(b) Comprehensive business automobile liability (owned, hired, or non-owned vehicles used by Contractor in connection with performance of its obligations under this Agreement) covering the risks of bodily injury (including death) and property damage, including coverage for contractual liability, with a limit of not less than \$1 million per accident;—~~

~~(c) Employers liability insurance covering the risks of Contractor's employees and employees' bodily injury by accident or disease with limits of not less than \$1 million per accident for bodily injury by accident and \$1 million per employee for bodily injury by disease and \$1 million disease policy limit;—~~

~~(d) Umbrella policy providing excess limits over the primary general liability, automobile liability and employer's liability policies in an amount not less than \$10 million per occurrence and in the aggregate;—~~

~~(e) Crime coverage at such levels consistent with industry standards and reasonably determined by Contractor to cover occurrences falling in the following categories: computer and funds transfer fraud; forgery; money and securities; and employee theft; and—~~

~~(f) Professional liability or errors and omissions with coverage of not less than \$1 million per claim/\$2~~

Comment [AC38]: The Exchange should indemnify contractors in the same manner it expects of plans.

Comment [AC39]: Per our last redline we still believe these insurance requirements are not appropriate and have suggested these amendments.

~~million general aggregate.~~

8.02 Workers' Compensation. Contractor shall, in full compliance with State law, provide or purchase, at its sole cost and expense, and, statutory California's workers' compensation coverage which shall remain in full force and effect during the term of this Agreement.

8.03 Subcontractors. Contractor shall require all subcontractors that may be authorized to provide Services on behalf of Contractor or otherwise under this Agreement to maintain insurance commensurate with the nature of such subcontractors' work and all coverage for subcontractors shall be subject to all the requirements set forth in this Agreement and applicable laws, rules and regulations. Failure of subcontractor(s) to comply with insurance requirements does not limit Contractor's liability or responsibility.

8.04 Premium Notices. Premium on all insurance policies shall be paid by Contractor or its subcontractors. Contractor shall provide 30 days' notice of cancellation to the Exchange. Contractor shall furnish to the Exchange copies of certificates of all required insurance prior to the Execution Date, and copies of renewal certificates of all required insurance within 30 days after the renewal date. The Exchange reserves the right to review the insurance requirements contained herein to ensure that there is appropriate coverage that is in accordance with this Agreement. The Exchange is to be notified by Contractor promptly if any aggregate insurance limit is exceeded. In such event, Contractor must purchase additional coverage to meet these requirements.

8.05 Coverage. For professional liability and errors and omissions coverage and crime coverage, Contractor shall continue such coverage beyond the expiration or termination of this Agreement. In the event Contractor procures a claim made policy as distinguished from an occurrence policy, Contractor shall procure and maintain prior to termination of such insurance, continuing extended reporting coverage for the maximum terms provided in the policy so as to cover any incidents arising during the term of this Agreement. Contractor shall arrange for continuous insurance coverage throughout the term of this Agreement.

8.06 Indemnification. Contractor shall indemnify, defend and hold harmless the Exchange, the State, and all of the officers, trustees, agents and employees of the foregoing, from and against any and all demands, claims, actions, losses, costs, liabilities, damages or deficiencies, including interest, penalties and reasonable attorneys' fees, which

(a) Arise out of or are due to a breach by Contractor of any of its representations, warranties, covenants or other obligations contained in this Agreement; or

(b) Are caused by or resulting from Contractor's acts or omissions constituting bad faith, willful misfeasance, negligence or reckless disregard of its duties under this Agreement or applicable laws, rules and regulations; or

(c) Accrue or result to any of Contractor's subcontractors, material men, laborers or any other person, firm or entity furnishing or supplying services at the request of Contractor, material or supplies in connection with the performance of this Agreement caused by acts or omissions constituting bad faith, willful misfeasance, gross negligence or reckless disregard of its/their duties.

Article 9. Protection of Personally identifiable Data and Information Assets

9.01 Privacy and Security Requirements for Personally Identifiable Data.

(a) Contractor agrees to comply with applicable provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), including the Administrative Simplification Provisions of HIPAA, as codified at 42 U.S.C. § 1320d *et seq.* the Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH"), and any current and future regulations promulgated under HITECH or HIPAA, all as amended from time to time and collectively referred to herein as the "HIPAA Requirements."

Contractor agrees not to use or further disclose any PHI, other than as permitted or required by the HIPAA Requirements and the terms of this Agreement to the extent that such use or disclosure is compliant with the HIPAA requirements.

(b) **Exchange Requirements.** Contractor agrees to comply with the privacy and security requirements applicable to PII under the Exchange Establishment and Eligibility Rules at 45 C.F.R. Part 155 ("the Exchange Requirements"), promulgated pursuant to the Act.

(c) **California Requirements.** Contractor agrees to comply with all applicable California state health information privacy and security laws applicable to PII, including but not limited to the CMIA., the IIPPA, and the IPA, all collectively referred to as "California Requirements."

(d) **Interpretation.** Notwithstanding any other provisions in this section, to the extent a conflict arises between the permissibility of a use or disclosure of PHI or PII under the HIPAA Requirements, the Exchange Requirements, or California Requirements, the applicable requirements imposing the more stringent privacy and security standards to such uses and disclosures shall apply. In addition, any ambiguity in this Agreement regarding the privacy and security of PHI and/or PII shall be resolved to permit the Exchange and Contractor to comply with the most stringent of the applicable privacy and security laws or regulations.

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Comment [AC40]: •There is way too much about HIPAA in the Agreement in Article 9-- making the Exchange a health information use and disclosure regulator and it continues to impliedly assume that the Exchange is a covered entity. It would be best to make sure that the Exchange and the Contractor each other informed of PHI issues-that is consistent with a large purchaser who is interested in the track record of its health plan in keeping the beneficiary information private and in a health plan wanting to keep track of its enrollment/marketing arm. Also, there are numerous references to restricting use of PHI to purposes of this Agreement. (see other bullet points on this) Health insurers need to use PHI obtained under this Agreement for medical records, providing health care etc. Overall, Article 9 still needs an end to end review and philosophical agreement between the Exchange and the Contractors about the divisions of responsibilities for PHI protection, use and disclosure during the term of Agreement and thereafter.

As has been previously stated we request a meeting with Exchange to discuss these technical issues.

Comment [AC41]: 45 CFR §155.260 and §155.270 address how an Exchange must handle the privacy and security of PII and compliance with HIPAA requirements for electronic transactions. The Exchange should commit in the Agreement to complying with these two sections. The Agreement in Section 9.01 (b) incorrectly imposes responsibility for compliance on Contractor. Also 9.01 (c) mentions Contractor's compliance with the "IPA" which is not defined. If it means the Information Practices Act [Cal. Civ. Code §1798 *et seq.*], Contractor is not subject to those requirements because it's not a state agency. The Exchange may be a state agency and the section will need to be revised accordingly.

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(e) Contractor Obligations

(i) Uses and Disclosures. Pursuant to the terms of this Agreement, Contractor may receive from the Exchange PHI and/or PII that is protected under applicable federal and state laws and regulations. Contractor shall not use or disclose such PHI or PII other than as is permitted or required by the HIPAA requirements or expressly permitted under the Exchange Requirements and only to the extent necessary in performing functions under this Agreement to assist applicants with securing health insurance coverage.

(ii) Fair Information Practices. Contractor shall implement reasonable and appropriate fair information practices to support the operations of the Exchange that are consistent with the Exchange Requirements and address, at a minimum:

(1) Individual Access. Contractor shall provide access to, and permit inspection and copying of PHI and PII in either an electronic or hard copy format as specified by the individual and as required by law, within ten (10) calendar days of such request from the individual. In the event any individual requests access to PHI or PII maintained by the Exchange or another health plan directly from Contractor, Contractor shall within five (5) calendar days forward such request to the Exchange and the relevant health plan as needed.

(2) Amendment. Contractor shall provide an individual with the right to request an amendment of inaccurate PHI and PII. Contractor shall respond to such individual within ten (10) calendar days of such a request either by making the correction and informing the individual of such correction or notifying the individual that the request was denied and providing an explanation for the denial.

~~(3) Openness and Transparency. Contractor shall make available to individuals applicable policies, procedures, and technologies that directly affect such individuals and/or their PHI and PII.~~

~~(4) Choice. Contractor shall provide individuals with a reasonable opportunity and capability to make informed decisions about the collection, use, and disclosure of their PHI and PII.~~

(5) Limitations. Contractor represents and warrants that all PHI and PII shall be collected, used, and/or disclosed under this Agreement only as permitted by law to the extent necessary to accomplish a specified purpose under the terms of this Agreement and never to discriminate inappropriately.

(6) Data Integrity. Contractor shall implement policies and procedures reasonably intended to ensure that PHI and PII in its possession is complete, accurate, and current, to the extent necessary for the Contractor's intended purposes, and has ~~not~~ been altered or destroyed only as permitted by law in an unauthorized manner.

(7) Safeguards. Contractor shall have in place administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI and PII that it creates, receives, maintains or transmits pursuant to the Agreement and to prevent the use or disclosure of PHI and/or PII other than as provided for in this Agreement, or as required by law. In furtherance of compliance with such requirements, Contractor shall:

(a) use commercially reasonable efforts to secure all electronic PHI and/or PII transmitted, i.e., to render all PHI and/or PII unusable, unreadable, or indecipherable, consistent with applicable federal and state laws, regulations and agency guidance, including but not limited to the U.S. Department of Health and Human Services Guidance Specifying the Technologies and Methodologies That Render Protected Health Information Unusable, Unreadable, or Indecipherable to Unauthorized Individuals for Purposes of the Breach Notification Requirements or issued by the National Institute for Standards and Technology ("NIST") concerning the protection of identifiable data such as PHI and/or PII;

(b) ensure that encryption is used in the electronic transmission of PHI and/or PII using commercially reasonable means and consistent with applicable industry standards such as NIST guidelines;

(c) implement a contingency plan for responding to emergencies and/or disruptions to business that in any way affect the use, access, disclosure or other handling of PHI and/or PII;

(d) maintain and exercise a plan to respond to internal and external security threats and violations;

(e) maintain an incident response plan;

(f) maintain technology policies and procedures that provide reasonable safeguards for the protection of PHI and PII stored, maintained or accessed on hardware and software utilized by Contractor and its subcontractors and agents;

(g) mitigate to the extent practicable, any harmful effect that is known to Contractor of any Security Incident related to PHI and/or PII or of any use or disclosure of PHI and/or PII by Contractor or its subcontractors or agents in violation of the requirements of this Agreement or applicable privacy and security laws and regulations and agency guidance;

(h) destroy PHI and PII in a manner consistent with applicable state and federal laws, regulations, and agency guidance on the destruction of PHI and PII; and

(i) comply with all applicable Exchange Protection of Information policies as specified in accordance with the terms and conditions set forth herein and as detailed in Section 9.02, Protection of Information Assets, including, but not limited to, executing non-disclosure agreements and other documents required by such

Comment [AC42]: This Section remains redundant and, among other things, indicate that plans need to return information received from the Exchange after termination. (9.01(n)). The info from the exchange is plan enrollment information and goes into the medical record and our other health plan records, even after a member terminates or the plan is no longer part of the Exchange. (See 9.01(e)(i) which says that Contractors can only use the information they get from the Exchange "to perform functions to assist applicants in securing health insurance"); similar issues in 9.01(e)(ii)(5)

Comment [AC43]: It is unclear if the basis for a plan to provide access to records within 10 calendar days. HIPAA (45 C.F.R. 164.524 (b)(2)) allows 30 days plus a 30 day extension.

Comment [AC44]: It is unclear the basis for a plan to respond to an amendment request within 10 calendar days. HIPAA (45 C.F.R. 164.526 (b)(2)) allows 60 days plus a 30 day extension.

Comment [AC45]: The intent behind making the plan's "technologies" available to individuals is unclear and as written appears inappropriate.

Comment [AC46]: The Exchange should have the same PHI safeguards.

policies. Contractor shall also require any subcontractors and agents to comply with all ~~the such~~ Exchange Protection of Information policies.

(iii) **Breach Notification.** Contractor shall report to the Exchange: (i) any use or disclosure of PHI and/or PII not permitted by this Agreement; (ii) ~~any Security Incident; and/or~~ (iii) any breach as defined in the HIPAA Requirements or California Requirements (each of which shall be referred to herein as a "Breach"). Contractor shall, without unreasonable delay, but no later than within three (3) ~~calendar-business~~ days after Contractor's discovery of a Breach, report such Breach to the Exchange.

Such report will be made on a form made available to Contractor, or by such other reasonable means of reporting as may be communicated to Contractor by the Exchange. Contractor shall cooperate with the Exchange in investigating the Breach and in meeting the Exchange's obligations under applicable state and federal security breach notification laws, regulatory obligations or agency requirements. If the cause of the Breach is attributable to Contractor or its agents or subcontractors, Contractor shall be responsible for Breach notifications and reporting as required under applicable federal and state laws, regulations and agency guidance. Such notification(s) and required reporting shall be done in cooperation with the Exchange. To the extent possible, Contractor's initial report shall include: (i) the names of the individual(s) whose PHI and/or PII has been, or is reasonably believed by Contractor to have been accessed, acquired, used or disclosed; (ii) a brief description of what happened including the date of the incident and the date of the discovery of the incident, if known; (iii) a description of the types of PHI and/or PII that were involved in the incident; (iv) a brief description of what Contractor is doing or will be doing to investigate, to mitigate harm to the individual(s), and to protect against recurrences; and (v) any other information that the Exchange determines it needs to include ~~if appropriate~~ in notifications to the individual(s) or relevant regulatory authorities under applicable privacy and security requirements. After conducting its investigation, and within fifteen (15) calendar days, unless an extension is granted by the Exchange, Contractor shall file a complete report ~~to the extent practicable~~ with the information listed above, if available. Contractor and the Exchange will cooperate in developing content for any public statements.

(iv) **Subcontractors and Agents.** Contractor shall enter into an agreement with any agent or subcontractor that will have access to PHI and/or PII that is received from, or created or received by, Contractor on behalf of the Exchange or any of its contracting Plans pursuant to which such agent or subcontractor agrees to be bound by the same restrictions, terms and conditions ~~that are at least as protective of PHA and PII as those~~ that apply to Contractor pursuant to this Agreement with respect to such PHI and PII.

(f) **Exchange Operations.** As permitted by state and federal laws, the Exchange shall be entitled to receive de-identified patient medical and pharmaceutical information from Contractor in order to effectively oversee and administer the Plans. As used in this subsection (f), the term "de-identified" shall have the meaning set forth in 45 C.F.R. § 164.514.

(g) **Records and Audit.** Contractor agrees to make its internal practices, books and records relating to the use and disclosure of PHI and/or PII received from the Exchange, or created or received by Contractor on behalf of the Exchange available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining the Contractor's and/or the Exchange's compliance with HIPAA Requirements. In addition, Contractor shall provide the Exchange with information concerning its safeguards described throughout this Section and/or other information security practices as they pertain to the protection of PHI and PII, as the Exchange may from time to time request. Failure of Contractor to complete or to respond to the Exchange's request for information within the reasonable timeframe specified by the Exchange shall constitute a material breach of this Agreement. In the event of a Breach ~~or Security Incident~~ related to PHI and/or PII or any use or disclosure of PHI and/or PII by Contractor in violation of the requirements of this Agreement, the Exchange will be permitted access to Contractor's facilities in order to review policies, procedures and controls relating solely to compliance with the terms of this Agreement.

(h) **Electronic Transactions Rule** In conducting any electronic transaction that is subject to the Electronic Transactions Rule on behalf of any Plan, Contractor agrees to comply with all applicable requirements of the Electronic Transactions Rule set forth in 45 C.F.R. Part 162. Contractor agrees to require that any agent, including a subcontractor, of Contractor that conducts standard transactions with PHI and/or PII of the Plan comply with all applicable requirements with the Electronic Transactions Rule.

(i) **Minimum Necessary.** ~~Consistent with the HIPAA requirements~~ Contractor agrees to request and use only the minimum necessary type and amount of PHI required to perform its services and will comply with any regulations promulgated under the HIPAA Requirements and agency guidance concerning the minimum necessary standard pertaining to PHI. Contractor will collect, use and disclose PII only to the extent necessary to accomplish a specified purpose under this Agreement.

(j) **Indemnification.** Contractor shall indemnify, hold harmless, and defend the Exchange from and against any and all costs (including mailing, labor, administrative costs, vendor charges, and any other costs determined to be reasonable by the Exchange in its ~~sole-reasonable~~ discretion), losses, penalties, fines, and liabilities ~~arising from or associated with~~ caused by a Breach or other non-permitted use or

Comment [AC47]: The Exchange should notify the plans of security breaches and it should indemnify the plans.

The Exchange should have the same rules about electronic commerc.

disclosure of PHI and/or PII by Contractor or its subcontractors or agents, including without limitation, (1) damages resulting from any action under (a) HIPAA Requirements, (b) the Exchange Requirements or (c) California Requirements, and (2) to the extent such activities are not undertaken by Contractor, the costs of the Exchange ~~actions taken~~ to: (i) notify the affected individual(s) and other entities of and to respond to the Breach; (ii) mitigate harm to the affected individual(s); and (iii) respond to questions or requests for information about the Breach or other impermissible use or disclosure of PHI and/or PII.

~~(k) **Business Associate**. In instances when the Exchange acts as a Covered Entity as defined under the HIPAA Requirements, and Contractor, on behalf of the Exchange, receives, creates, transmits, and/or maintains PHI for a function or activity defined as a business associate activity under the HIPAA Requirements, then the provisions of Attachment 16 ("Business Associate Agreement") to this Agreement shall apply to Contractor.~~

(l) **Notice of Privacy Practices**. The Exchange shall notify Contractor of any limitation(s) in its notice of privacy practices in accordance with 45 C.F.R. § 164.520, other provisions within the HIPAA Requirements, or any other applicable state and federal laws, regulations or agency guidance, to the extent that such limitation may affect Contractor's use or disclosure of PHI and/or PII.

(m) **Reporting Violations of Law**. Contractor may use PHI to report violations of law to appropriate federal and state authorities, consistent with 45 C.F.R. § 164.502(j)(2), other provisions within the HIPAA Requirements, or any other applicable state or federal laws or regulations.

(n) **Survival**. Notwithstanding anything to the contrary in the Agreement, the provisions of this Section 9.01 on the Protection of Personally Identifiable Information shall survive termination of the Agreement until such time as all PII and PHI provided by the Exchange to Contractor, or created, received or maintained by Contractor on behalf of the Exchange, is destroyed or returned to the Exchange, in a manner that is reasonably acceptable to the Exchange.

(o) **Contract Breach**. Without limiting the rights of the parties pursuant to this Agreement, if Contractor materially breaches its obligations under this Section, the Exchange may, at its option: (a) exercise any of its rights of access and inspection under this Agreement; (b) require Contractor to submit to a plan of monitoring and reporting, as the Exchange may determine necessary to maintain compliance with this Agreement and such plan shall be made part of this Agreement; or (c) notwithstanding any other provisions of this Agreement, terminate this Agreement, with or without opportunity to cure the breach, but only if termination is necessary to prevent harm to the Exchange, any enrollee or any prospective enrollee. The Exchange's remedies under this Section and any other part of this Agreement or provision of law shall be cumulative, and the exercise of any remedy shall not preclude the exercise of any other.

9.02 Protection of Information Assets.

(a) The following terms shall be given the meaning shown:

(i) **"Information Assets"** means any information, including Confidential Information, necessary to the operation of either party that is created, stored, transmitted, processed or managed on any hardware, software, network components, or any printed form.

(ii) **"Confidential Information"** Includes, but is not limited to, any information (whether oral, written, visual or fixed in any tangible medium of expression), relating to either party's services, operations, systems, programs, inventions, techniques, suppliers, customers and prospective customers (excluding the Exchange), cost and pricing data, trade secrets, know-how, processes, plans, reports, designs and any other information of or relating to the business or either party, including Contractor's programs, but does not include information that (a) is described in the Evidence of Coverage booklets; (b) was known to the Receiving Party before it was disclosed to the Receiving Party by the Disclosing Party, (c) was or becomes available to the Receiving Party from a source other than the Disclosing Party, provided such fact is evidenced in writing and the source is not bound by a confidentiality obligation regarding such information to Disclosing Party, or (d) is developed by either party independently of the other party's Confidential Information, provided that such fact can be adequately documented.

(iii) **"Disclosing Party"** means the party who sends Information Assets that it owns to the other party for the purposes outlined in this Agreement.

(iv) **"Receiving Party"** means the party who receives Information Assets owned by the other.

(b) The Receiving Party shall hold all Information Assets of the Disclosing Party in trust and confidence and will not use any of the Disclosing Party's Information Assets for any purpose, except as set forth in this Agreement, or as otherwise required by law, regulation or compulsory process.

(c) The Receiving Party must take all reasonable and necessary steps to prevent the unauthorized disclosure, modification or destruction of the Disclosing Party's Information Assets. The Receiving Party must, at a minimum, use the same degree of care to protect the Disclosing Party's Information Assets that it uses to protect its own Information Assets.

(d) The Receiving Party agrees not to disclose the Disclosing Party's Information Assets to anyone, except to employees or third parties who require access to the Information Assets pursuant to this Agreement, but

Comment [AC48]: As noted previously we do not believe that the Exchange would ever be a covered entity. If this provision is not deleted then we believe it will never be triggered and the Attachment 16 will not be used.

only where such third parties have signed agreements regarding the Information Assets containing terms that are equivalent to, or stricter than, the terms of this Section, or as otherwise required by law.

(e) In the event the Receiving Party is requested to disclose the Disclosing Party's Information Assets pursuant to a request under the California Public Records Act (PRA), a summons, subpoena or in connection with any litigation, or to comply with any law, regulation, ruling or government or public agency request, the Receiving Party shall, to the extent it may do so lawfully, give the Disclosing Party timely notice of such requested disclosure and afford the Disclosing Party the opportunity to review the request before Receiving Party discloses the Information Assets. The Disclosing Party shall, in accordance with applicable law, have the right to take such action as it reasonably believes may be necessary to protect the Information Assets, and such action shall not be restricted by the dispute resolution process of this Agreement. If such request is pursuant to the PRA, the Exchange shall give Contractor sufficient notice to permit Contractor to consult with the Exchange prior to disclosure of any Confidential Information. This subdivision shall not apply to restrict disclosure of any information to the State or in connection with a dispute between the Exchange and Contractor or any audit or review conducted pursuant to this Agreement.

(f) The Receiving Party shall notify the Disclosing Party in writing of any unauthorized disclosure, modification or destruction of the Disclosing Party's Information Assets by the Receiving Party, its officers, directors, employees, contractors, agents or third parties. The Receiving Party shall make this notification promptly upon becoming aware of such disclosure, modification or destruction, but in any event, not later than four (4) calendar days after becoming aware of the unauthorized disclosure, modification or destruction. After such notification, the Receiving Party agrees to cooperate reasonably, at the Receiving Party's expense, with the Disclosing Party to remedy or limit the unauthorized disclosure, modification or destruction and/or its effects.

(g) The Receiving Party understands and agrees the Disclosing Party may suffer immediate, irreparable harm in the event the Receiving Party fails to comply with any of its obligations under this Section, that monetary damages will be inadequate to compensate the Disclosing Party for such breach and that the Disclosing Party shall have the right to enforce this section by injunctive or other equitable remedies. The provisions of this Section shall survive the expiration or termination, for any reason, of this Agreement.

(h) To the extent that information subject to this Section on Protection of Information Assets is also subject to HIPAA Requirements, the Exchange Requirements or California Requirements in Section 9.01(b) and

(c) and in the event of a conflict or inconsistency between the requirements of the various applicable sections and attachments of this Agreement, ~~Contractor each party~~ shall comply with the provisions that provide the greatest protection against access, use or disclosure.

(i) Survival. Notwithstanding anything to the contrary in the Agreement, the provisions of this Section 9.02 on Information Assets shall survive termination of the Agreement until such time as all information assets provided by the Exchange to Contractor, or created, received or maintained by Contractor on behalf of the Exchange, is destroyed or returned to the Exchange, in a manner that is acceptable to the Exchange, or Contractor receives written permission from the Exchange to retain the Information Assets.

Article 10. Books, Records and Data Collection

10.01 Clinical Records. ~~Except with respect to any longer periods that may be required under applicable laws, rules and regulations, Contractor shall maintain, and require each Participating Provider and subcontractor to maintain, a medical record documentation system adequate to fully disclose and document the medical condition of each Enrollee and the extent of Health Care Services provided to Enrollees. Clinical records shall be retained for at least seven (7) years following the year of the final Claims payment. Except as otherwise required by State and Federal laws, rules and regulations, if an audit, litigation, research, evaluation, claim or other action involving the records has not been concluded before the end of the seven (7) year minimum retention period, the clinical records must be retained until all issues arising out of the action have been resolved. If responsibility for maintenance of medical records is delegated by Contractor to a Participating Provider or subcontractor, Contractor shall cause such Participating Provider or other subcontractor to comply with the document retention requirements set forth in this Agreement and as otherwise required by applicable laws, rules and regulations.~~

10.02 Financial Records. Except as otherwise required to be maintained for a longer period by law or this Agreement, financial records, supporting documents, statistical records and all other records pertinent to amounts paid to or by Contractor in connection with this Agreement shall be retained by Contractor for at least seven (7) years from the date of the final claims payment. Contractor shall maintain accurate books, accounts, and records and prepare all financial statements in accordance with Generally Accepted Accounting Principles, applicable laws, rules and regulations and requirements imposed by any governmental or regulatory authority having jurisdiction over Contractor. The information and reports to be provided by Contractor under this Agreement shall include, without limitation, those certain items identified in Attachment 17 ("Required Reports")

(a) Contractor shall maintain ~~adequate~~ data customarily maintained and reasonably necessary to properly

Comment [AC49]: Maintenance of medical records is a physician responsibility, not health plans or subcontractors.

Comment [AC50]: We request that the Exchange clarify what is considered "adequate".

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document each of its transactions with Participating Providers, the Exchange, and Enrollees during the period this Agreement remains in force and will keep records of claims, including medical review and high dollar special audit claims, for a period of ten (10) years or for such length of time as required by federal or state law, whichever is longer. Subject to compliance with applicable laws, rules and regulations, including, those relating to confidentiality and privacy, ~~at the end of the ten (10) year retention period, at the option of the Exchange, records shall either be transferred to the Exchange at its request or destroyed. All such records are the property of the Exchange and must be returned to the Exchange or its authorized representatives upon demand.~~

Comment [AC51]: We believe this is a violation of HIPAA.

(b) Contractor shall maintain historical claims data and other records and data relating to the utilization of Health Care Services by Enrollees on-line for two (2) years from date that the Agreement is terminated with respect to Health Care Services provided to Enrollees during the term of this Agreement. These records shall include, but are not limited to, the data elements necessary to produce specific reports mutually agreed upon by the Exchange and Contractor and in such form reasonably required by the Exchange that is consistent with industry standards and requirements of Health Insurance Regulators regarding statistical, financial and/or data reporting requirements, including information relating to diagnosis, treatment, amounts billed (allowed and paid), dates of service, procedure numbers, deductible, out-of-pocket and other cost sharing for each claim.

10.03 Storage. Such books and records shall be kept in a secure location at the Contractor's office(s), and books and records related to this Agreement shall be available for inspection and copying by the Exchange, the Exchange representatives, and such consultants and specialists as designated by the Exchange, at any time during normal business hours as provided in Section 10.5 hereof and upon reasonable notice. ~~Books and records shall be made available for inspection and copying by the Exchange only to the extent permitted by State and Federal laws and regulations. Contractor shall also ensure require that related Contractor shall also ensure that related~~ books and records of Participating Providers and subcontractors shall be accurately maintained. If any inquiry, audit, investigation, litigation, claim or other action involving the records is ongoing and has not been finally concluded before the end of the seven (7) year minimum retention period, the applicable financial records must be retained until all issues arising out of the action have been resolved.

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10.04 Back-Up. Contractor shall maintain a separate back-up system for its electronic data processing functions and a duplicate data file which is updated regularly and stored off-site in a secured, controlled environment. Contractor's back-up system shall comply with applicable laws, rules and regulations, including, those relating to privacy and confidentiality and shall be designed to meet or exceed industry standards regarding the preservation of access to data.

~~**10.05 Examination and Audit Results.** Contractor shall notify the Exchange, and make available, upon request, to the Exchange the results of final financial, market conduct, or special audits performed by the DMHC, CDI, DHCS, DHHS, and/or any other regulatory entity in a State or jurisdiction where Contractor serves Enrollees.~~

10.06 Notice. Contractor shall promptly notify the Exchange in writing of any inquiry, audit, investigation, litigation, claim, examination, or other proceeding involving Contractor, or any Contractor personnel, Participating Provider or other authorized subcontractor that is threatened or commenced by any regulatory agency or other party that a reasonable person might believe could materially affect the ability of Contractor to perform in accordance with the terms set forth in this Agreement. Such notice shall be provided by Contractor to the Exchange within ten (10) days' of Contractors' receipt of notice regarding such action; provided, however, that any such exchange of information shall be subject to compliance with applicable laws, rules and regulations, and shall not occur to the extent prohibited by order of the court, administrative agency, or other tribunal or regulatory authority having jurisdiction over the matter or by the laws and regulations governing the action. This section shall not be required with respect to disputes relating to claims and other matters noticed to the Exchange in the ordinary course of business pursuant to other terms and conditions set forth in this Agreement or required by law.

10.07 Confidentiality. The Exchange understands and agrees that Contractor shall only be obligated to provide access to such information to the extent that: (1) access to such information is permitted by applicable State and Federal law and regulation, including, but not limited to, State and Federal law or regulation relating to confidential or private information; and (2) it would not cause Contractor to breach the terms of any contract to which Contractor is a party. Contractor shall use efforts reasonably acceptable to obtain any necessary consents relating to Contractor's access to information.

10.08 Tax Reporting. Contractor shall provide such information to the Exchange upon request and in such form as mutually agreed upon by the parties and reasonably required to document Contractor's compliance with, and/or to fulfill the Exchange's obligations with respect to, income tax eligibility, computation and reporting requirements required under applicable laws, rules and regulations that applicable to the operation of the Exchange, including, those relating premium tax credit and other operations of the Exchange set forth at 45 C.F.R. § 155 *et seq.*

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10.09 Electronic Commerce. Contractor shall use commercially reasonable efforts, which shall include, without limitation, Contractor's development, implementation and maintenance of processes and systems consistent with industry standards, to comply with the requirements of the Exchange and applicable laws, rules and regulations relating to Contractor's participation in electronic commerce activities required under the terms of this Agreement.

Article 11. Intellectual Property

11.01 Warranties

(a) Contractor represents, warrants and covenants to the best of its knowledge that:

(i) It has secured and will secure all rights and licenses necessary for its performance of this Agreement, including but not limited to consents, waivers, releases from all authors of or owners of any copyright interests in music or performances used, individuals, and talent (radio, television, and motion picture talent), owners of any interest in and to real estate site, locations, property, or props that may be used or shown.

(ii) To the best of the Contractor's knowledge, neither Contractor's performance of this Agreement, nor the exercise by either Party of the rights granted in this Agreement, nor any use, reproduction, manufacture, sale, offer to sell, import, export, modification, public and private display/performance, distribution, and disposition of the Intellectual Property made, conceived, derived from, or reduced to practice by Contractor and which result directly or indirectly from this Agreement will infringe upon or violate any Intellectual Property right, non-disclosure obligation, or other proprietary or contractual right or interest of any third-party or entity now existing under the laws of, or hereafter existing or issued by, any state, the United States, or any foreign country. There is currently no actual or threatened claim by any such third party based on an alleged violation of any such right by Contractor.

(iii) Neither Contractor's performance nor any part of its performance will violate the right of privacy of, or constitute false or misleading advertising or a libel or slander against any person or entity, misuse of social media, or violate privacy rights.

(iv) It has not granted and shall not grant to any person or entity any right that would or might derogate, encumber, or interfere with any of the rights granted to the Exchange in this Agreement.

(v) It has appropriate systems and controls in place to ensure that state funds will not be used in the performance of this Agreement for the acquisition, operation or maintenance of computer software in violation of copyright laws.

(vi) It has no knowledge of any outstanding claims, licenses or other charges, liens, or encumbrances of any kind or nature whatsoever that could affect in any way Contractor's performance of this agreement.

(b) EXCEPT AS EXPRESSLY STATED ELSEWHERE IN THIS AGREEMENT, EXCHANGE AND CONTRACTOR MAKE NO WARRANTY AND EXPRESSLY DISCLAIM ANY WARRANTY, EXPRESS OR IMPLIED, THAT THEIR INTELLECTUAL PROPERTY OR THE INTELLECTUAL PROPERTY RESULTING FROM THIS AGREEMENT IS MERCHANTABLE, FIT FOR A PARTICULAR PURPOSE, OR DOES NOT INFRINGE UPON ANY PATENT, TRADEMARK, COPYRIGHT OR THE LIKE, NOW EXISTING OR SUBSEQUENTLY ISSUED.

11.02 Intellectual Property Indemnity

(a) Subject to subsection (c) hereof, Contractor agrees to ~~indemnify and hold the Exchange harmless from any expense, loss, damage or injury; to~~ defend at its own expense any and all claims, suits and actions; and to pay any judgments or settlements against the Exchange to the extent they arise from or are due to infringement of third-party intellectual property rights enforceable in the U.S.; misuse of third-party confidential or trade secret information; failure to obtain necessary third-party consents, waivers or releases; violation of the right of privacy or publicity; false or misleading advertising; libel or slander; or misuse of social media ~~caused~~ by Contractor or any Contractor Intellectual Property. Contractor's indemnification obligations under this section are subject to Contractor receiving prompt notice of the claim after the Exchange becomes aware of such claim, and being given the right to control the defense of such claim. The Exchange shall cooperate with Contractor in the defense of any claim subject to indemnification hereunder. Should any Intellectual Property licensed by the Contractor to the Exchange under this Agreement become the subject of an Intellectual Property infringement claim or other claim for which Contractor is obligated to indemnify the Exchange, Contractor will promptly take steps reasonably and in good faith to preserve the Exchange's right to use the licensed Intellectual Property in accordance with this Agreement at no expense or disruption to the Exchange, except as otherwise stated in this Agreement. The Exchange shall have the right to monitor and appear through its own counsel (at Exchange's expense) in any such claim or action. In the defense or settlement of the claim, Contractor may obtain the right for the Exchange to continue using the licensed Intellectual Property; or, replace or modify the licensed Intellectual Property so that the replaced or modified Intellectual Property becomes non-infringing provided that such replacement or modification is functionally equivalent to the original licensed Intellectual Property, as its sole remedy.

Comment [AC52]: This section remains redundant and requires the plan to give IP rights to the Exchange that are not appropriate. We request further discussion on this Article.

Comment [AC53]: Both parties ought to indemnify the other for use of IP that is a third party's or the narrow IP that is licensed from one to the other (logos etc.) for operating this Agreement. The general representations about IP are too broad and conflict with other representations.

(b) Notwithstanding anything to the contrary in this Agreement, any such indemnification obligation of Contractor shall not extend to any infringement or alleged infringement to the extent that such infringement or alleged infringement resulted from (i) specific instructions to use certain Intellectual Property given to Contractor by or on behalf of the Exchange; (ii) the ~~Exchange's unauthorized~~ modification of Contractor Intellectual Property by anyone other than Contractor or those acting on Contractor's behalf; (iii) the Exchange's use of Contractor Intellectual Property in combination with any service or product not supplied, recommended or approved by Contractor, or used by the Exchange in a manner for which it was not authorized; or (iv) Intellectual Property created or derived by the Exchange.

(c) Contractor agrees that damages alone would be inadequate to compensate the Exchange for breach of any term of this Article by Contractor. Contractor acknowledges the Exchange ~~would~~ may suffer irreparable harm in the event of such breach and agrees the Exchange shall be entitled to seek equitable relief, including without limitation an injunction, from a court of competent jurisdiction, without restriction or limitation of any other rights and remedies available at law or in equity.

11.03 Federal Funding. In any agreement funded in whole or in part by the federal government, the Exchange may acquire and maintain the Intellectual Property rights, title, and ownership, which results directly or indirectly from the agreement; except as provided in 37 Code of Federal Regulations part 401.14 and except as stated hereinabove however, the federal government shall have a non-exclusive, nontransferable, irrevocable, paid-up license throughout the world to use, duplicate, or dispose of such Intellectual Property throughout the world in any manner for governmental purposes and to have and permit others to do so.

11.04 Ownership and Cross-Licenses.

(a) Pre-existing Intellectual Property. As between Contractor and the Exchange, each Party shall remain at all times the sole and exclusive owner of all right, title and interest in and to the Intellectual Property that it owned or used prior to entry into this Agreement, or that it developed in the course of performance of this Agreement. Any rights not licensed to the other Party hereunder are expressly reserved exclusively by the originating Party.

(b) License of Intellectual Property. Each Party (a "Licensor") grants the other Party (a "Licensee") the non-exclusive, royalty-free, paid-up, worldwide, irrevocable, perpetual right to use the Licensor's Intellectual Property solely for the purposes of this Agreement and to carry out the Party's functions consistent with its responsibilities and authority as set forth in the enable legislation and regulations. Such licenses shall not give the Licensee any ownership interest in or rights to the Intellectual Property of the Licensor. Each Licensee agrees to abide by all third-party license and confidentiality restrictions or obligations applicable to the Licensor's Intellectual Property of which the Licensor has notified the Licensee in writing.

(c) Definition of Intellectual Property. For purposes of this Agreement, "Intellectual Property" means recognized protectable rights and interests such as: patents (whether or not issued), copyrights, trademarks, service marks, applications for any of the foregoing, inventions, Confidential Information, trade secrets, trade dress, domain names, logos, insignia, color combinations, slogans, moral rights, right of publicity, author's rights, contract and licensing rights, works, mask works, industrial design rights, rights of priority, know how, design flows, methodologies, devices business processes, developments, innovations, good will and all other legal rights protecting intangible proprietary information as may exist now and/or hereafter come into existence, and all registrations, renewals and extensions, regardless of whether those rights arise under the laws of the United States, or any other state, country or jurisdiction.

(d) Definition of Works. For purposes of the definition of Intellectual Property, "works" means all literary works, writings and printed matter including the medium by which they are recorded or reproduced, photographs, art work, pictorial and graphic representations and works of a similar nature, film, motion pictures, digital images, animation cells, and other audiovisual works including positives and negatives thereof, sound recordings, tapes, educational materials, interactive videos and any other materials or products created, produced, conceptualized and fixed in a tangible medium of expression. It includes preliminary and final products and raw materials and information developed for the purposes of producing those final products. Works do not include articles submitted to peer review or reference journals or independent research projects.

11.05 Survival. The provisions set forth herein shall survive any termination or expiration of this Agreement.

Article 12. Miscellaneous

12.01 Dispute Resolution.

(a) If any dispute arising out of or in connection with this Agreement is not resolved within thirty (30) days or such other reasonable period of time determined by Contractor and the Exchange staff normally responsible for the administration of this Agreement, the parties shall attempt to resolve the dispute through the submission of the matter for executive level involvement. The executive officer of each party or his or her designated representative shall meet and confer to attempt to resolve the dispute. If the

parties agree, a neutral third party mediator may be engaged to assist in dispute resolution at either the line employee level or the executive level, or both. If after expending reasonable efforts at executive level resolution of the dispute, no resolution can be reached within thirty (30) days or such other reasonable period determined by Contractor and the Exchange, then either party may seek its rights and remedies in a court of competent jurisdiction or otherwise available under this Agreement or applicable laws, rules and regulations.

(b) Each party shall document in writing the nature of each dispute and the actions taken to resolve any disputes utilizing this dispute resolution procedure. Each party shall act in good faith to resolve such disputes. Neither party may seek its rights and remedies in court respecting any such notice of termination for default without first following the dispute resolution process stated in this section, except as may be required to protect against the expiration of any applicable statute of limitations.

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(c) The Exchange and Contractor agree that, the existence of a dispute notwithstanding, they will continue without delay to carry out all their responsibilities under this Agreement which are not affected by the dispute.

(d) Either party may request an expedited resolution process if such party determines that irreparable harm will be caused by following the timelines set forth in Section 12.01(a) above. If the other party does not consent to such expedited process, the requesting party will hire, at its sole cost and expense, an independent mediator to determine whether such an expedited process is necessary to avoid or reduce irreparable harm. In the event that the mediator determines that irreparable harm may result from delays required under the thirty (30) day period required under Section 12.01(a), the parties will engage in an expedite process that will require the parties to resolve the dispute within five (5) business days or such other period as mutually agreed upon by the parties.

This section 12.01 shall survive the termination or expiration of this Agreement.

12.02 Attorneys' Fees. In the event of any litigation between the parties to enforce or interpret the provisions of this Agreement, the non-prevailing party shall, unless both parties agree, in writing, to the contrary, pay the reasonable attorneys' fees and costs of the prevailing party arising from such litigation, including outside attorneys' fees and allocated costs for services of in-house counsel, and court costs. These attorneys' fees and costs shall be in addition to any other relief to which the prevailing party may be entitled.

12.03 Notices. Any notice or other written communication that may or must be given hereunder shall be deemed given when delivered personally, or if it is mailed, three (3) days after the date of mailing, unless delivery is by express mail, telecopy, electronic mail or telegraph, and then upon the date of the confirmed receipt, to the following representatives:

For the Exchange: Covered California, the California Health Benefit Exchange
Attention: Contracts Officer 560 J Street, Suite 290 Sacramento, CA 95814 Telephone No. (916) _____
FAX No. (916) _____ Email: _____

For Contractor:

Name: Address: City, State, Zip Code: Telephone No. _____ FAX No. Email: _____

Either party hereto may, from time to time by notice in writing served upon the other as aforesaid, designate a different mailing address or a different or additional person to which all such notices or other communications thereafter are to be addressed.

12.04 Amendments.

(a) By the Exchange. In the event that any law or regulation is enacted or any decision, opinion, interpretive policy or guidance of a court or governmental agency is issued (any of the foregoing, a "Change in Law") that the Exchange determines, based on its consultation with legal counsel, other regulators or other state-based or Federal health benefit exchanges: (i) affects or may affect the legality of this Agreement or any provision hereof or cause this Agreement or any provision hereof to prevent or hinder compliance with laws, rules or regulations, or (ii) adversely affects or may adversely affect the operations of the Exchange or the ability of the Exchange or Contractor to perform its respective obligations hereunder or receive the benefits intended hereunder, the Exchange may, by written notice to Contractor, amend this Agreement to comply with or otherwise address the Change in Law in a manner reasonably determined by the Exchange to carry out the original intent of the parties to the extent practical in light of such Change in Law. Such amendment shall become effective upon sixty (60) calendar days notice, or such lesser period as required for compliance or consistency with the Change in Law or to avoid the adverse effect of the Change in Law. If Contractor objects to such amendment, it must notify the Exchange in writing within twenty (20) calendar days of receipt of notice from the Exchange. If the parties are unable to agree on an amendment within thirty (30) calendar days thereafter, the Exchange may terminate this Agreement.

Comment [AC54]: The ability to amend the agreement under these circumstances should be available to either party.

Comment [AC55R54]:

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(b) Other Amendments. Except as provided in Section 12.04(a), this Agreement may be amended only by mutual consent of the parties. Except as provided herein, no alteration or variation of the terms of this Agreement shall be valid unless made in writing and signed by the parties hereto, and no oral

understanding or agreement not incorporated herein shall be binding on any of the parties hereto.

12.05 Time is of the Essence. Time is of the essence in this Agreement.

12.06 Publicity. Contractor shall coordinate with the Exchange with respect to communications to third-parties regarding the existence or execution of this Agreement; provided, however, that no external publicity release or announcement or other such communication concerning this Agreement or the transactions contemplated herein shall be issued by Contractor without advance written approval by the Exchange unless such communication complies with standards that may be issued by the Exchange to Contractor based on consultation with Contractor from time to time.

Comment [AC56]: The Exchange should have the same rules.

12.07 Force Majeure. Except as prohibited by applicable laws, rules and regulations, including, 22 CCR Section 1300.67.05, neither party to this Agreement shall be in default breach of its obligations hereunder for delay or failure in performing that arises out of causes beyond the control and without the fault or negligence of either party and arising from an actual or threatened terrorism, a catastrophic occurrence or natural disaster, such as Acts of God or of the public enemy, acts of the State in its sovereign capacity, acts of the State Controller's Office or other State agency having an impact on the Exchange's ability to pay its obligations, acts of the State legislature, fires, floods, power failure, disabling strikes, epidemics, quarantine restrictions, and freight embargoes. However, each party shall utilize its best good faith efforts to perform under this Agreement in the event of any such occurrence.

Comment [AC57]: Wording should be added to ensure Contractor has the right to be able to discuss this agreement with its subcontractors and prospective subcontractors without running afoul of this provision.]

12.08 Further Assurances. Contractor and the Exchange agree to execute such additional documents, and perform such further acts, as may be reasonable and necessary to carry out the provisions of this Agreement.

12.09 Binding Effect. This Agreement, any instrument or agreement executed pursuant to this Agreement, and the rights, covenants, conditions, and obligations of Contractor and the Exchange contained therein, shall be binding upon the parties and their successors, assigns, and legal representatives.

12.10 Titles/Section Headings. Titles or headings are not part of this Agreement, are for convenience of reference only, and shall have no effect on the construction or legal effect of this Agreement.

12.11 Severability. Should one or more provisions of this Agreement be held by any court to be invalid, void, or unenforceable, such provision(s) will be deemed to be restated to affect the original intentions of the parties as nearly as possible in accordance with applicable law. The remaining provisions shall nevertheless remain and continue in full force and effect.

12.12 Entire Agreement/Incorporated Documents/Order of Precedence. This Agreement represents the entire understanding between the parties hereto with respect to the subject matter hereof. Any prior correspondence, memoranda, or agreements are replaced in total by this Agreement. This Agreement shall consist of:

- (a) The terms of this Agreement, including obligations set forth in other documents that are referenced herein;
- (b) All attached documents, which are expressly incorporated herein;
- (c) Terms and conditions set forth in the Solicitation, to the extent that such terms are expressly incorporated by reference in specific sections of this Agreement and/or otherwise not inconsistent with the Agreement or Proposal; and,
- (d) The Proposal, which is expressly incorporated herein to the extent that such terms are not superseded by the terms set forth in this Agreement.

In the event there are any inconsistencies or ambiguities among the terms of this Agreement and incorporated documents, the following order of precedence shall be used:

- (i) Applicable laws, rules and regulations;
- (ii) The terms and conditions of this Agreement, including attachments;
- (iii) Solicitation; and
- (iv) Proposal

12.13 Waivers. No delay on the part of either party in exercising any right, power, or privilege hereunder shall operate as a waiver thereof. No waiver on the part of either party of any right, power, or privilege hereunder, nor any single or partial exercise of any right, power, or privilege hereunder shall preclude any other or further exercise thereof or the exercise of any other right, power, or privilege hereunder.

12.14 Incorporation of Amendments to Applicable Laws. Any references to sections of Federal or State statutes or regulations shall be deemed to include a reference to any subsequent amendments thereof and any successor provisions thereto made from time to time from and after the date of this Agreement.

12.15 Choice of Law, Jurisdiction, and Venue. This Agreement shall be administered, construed, and enforced according to the laws of the State (without regard to any conflict of law provisions) to the extent such laws have not been preempted by applicable federal law. Any suit brought hereunder shall be brought in the state or federal courts sitting in Sacramento, California, the parties hereby waiving any claim or defense that such forum is not convenient or proper. Each party agrees that any such court shall have

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in personam jurisdiction over it and consents to service of process in any manner authorized by California law.

12.16 Counterparts. This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

12.17 Days. Wherever in this Agreement a set number of days is stated or allowed for a particular event to occur, the days are understood to include all calendar days, including weekends and holidays, unless otherwise specified.

12.18 Ambiguities Not Held Against Drafter. This Agreement having been freely and voluntarily negotiated by all parties, the rule that ambiguous contractual provisions are construed against the drafter of the provision shall be inapplicable to this Agreement.

12.19 Clerical Error. No clerical error shall operate to defeat or alter any terms of this Agreement or defeat or alter any of the rights, privileges or benefits of any Enrollee or Employer.

12.20 Administration of Agreement. The Exchange may adopt policies, procedures, rules and interpretations that are consistent with applicable laws, rules and regulations and deemed advisable by the Exchange to promote orderly and efficient administration of this Agreement. The parties shall perform in accordance with such policies and procedures; provided, however, that any changes to policies and procedures that are not disclosed to Contractor prior to the Agreement Effective Date shall not result in additional obligations and risks to Contractor existing at the Agreement Effective Date except as otherwise mutually agreed upon by the parties.

The Exchange shall provide ninety (90) days prior written notice by letter, newsletter, electronic mail or other media of any material change (as defined below) in Exchange's policies, procedures or other operating guidance applicable to Contractor's performance of Services. The failure by Contractor to object in writing to any material change within thirty (30) days following the Contractor's receipt of such notice shall constitute Contractor's acceptance of such material change. For purposes of this Section, "material change" shall refer to any change that could reasonably be expected to have a material impact on the Contractor's compensation, Contractor's performance of Services under this Agreement, or the delivery of Health Care Services to Enrollees.

Article 13. Definitions

Except as otherwise expressly defined, capitalized terms used in the Agreement and/or the Attachments shall have the meaning set forth below.

13.01 Affordable Care Act – The federal Patient Protection and Affordable Care Act, (P.L. 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111 -152), known collectively as the Affordable Care Act.

13.02 Agreement – This Agreement attached hereto, including attachments and documents incorporated by reference, entered into between the Exchange and Contractor.

13.03 Agreement Effective Date - The effective date of this Agreement established pursuant to Section 7.01 of this Agreement.

13.04 Behavioral Health – A group of interdisciplinary services concerned with the prevention, diagnosis, treatment, and rehabilitation of mental health and substance abuse disorders.

13.05 Board – The executive board responsible under Government Code Section 100500 for governing the Exchange.

13.06 California Affordable Care Act – The California Patient Protection and Affordable Care Act, AB 1602 and SB 900 (Chapter 655, Statutes of 2010 and Chapter 659, Statutes of 2010).

13.07 CAL COBRA - The California Continuation Benefits Replacement Act, or Health and Safety Code § 1366.20 *et seq.*

13.08 CalHEERS - The California Healthcare Eligibility, Enrollment and Retention System, a project jointly sponsored by the Exchange and DHCS, with the assistance of the Office of Systems Integration to maintain processes to make the eligibility determinations regarding the Exchange and other State health care programs and assist enrollees in selection of health plan.

13.09 COBRA - The Consolidated Omnibus Budget Reconciliation Act of 1985.

13.10 Case Management – Contractor's medical utilization and oversight systems that attempt to optimize available benefit coverage and resources for Enrollees with complex and exceptional needs due to chronic or catastrophic illness or injury.

13.11 CCR - The California Code of Regulations

13.12 CDI – The California Department of Insurance.

13.13 Confidentiality of Medical Information Act (CMIA) – The Confidentiality of Medical Information Act (California Civil Code section 56 *et seq.*) and the regulations issued pursuant thereto or as thereafter amended, to the extent applicable to operation of Contractor.

13.14 Contract Year – The full twelve (12) month period commencing on the effective date and ending on the day immediately prior to the first anniversary thereof and each full consecutive twelve (12) month period thereafter during which the Agreement remains in effect.

- 13.15 Contractor** – The Health Insurance Issuer contracting with the Exchange under the Agreement to operate a Certified QHP and perform in accordance with the terms set forth in the Agreement.
- 13.16 Covered Services** – The Health Care Services that are covered benefits under the applicable QHP and described in the EOC.
- 13.17 DHCS** - The California Department of Health Care Services
- 13.18 DHHS** - The United States Department of Health and Human Services
- 13.19 DMHC** – The California Department of Managed Health Care.
- 13.20 Effective Date** – The date on which a Plan’s coverage goes into effect.
- 13.21 Eligibility Information** – The information that establishes an Enrollee’s eligibility including, but not limited to: name, age, and Social Security Number.
- 13.22 Eligibility File** – The compilation of all Eligibility Data for an Enrollee or group of Enrollees into a single electronic format used to store or transmit the data.
- 13.23 Employee** – A “qualified employee,” as defined in 45 C.F.R. 155.20.
- 13.24 Employer** – A “qualified employer,” as defined in section 1312(f)(2) of the Act.
- 13.25 Encounter** – Any Health Care Service or bundle of related Health Care Services provided to one Enrollee by one Health Care Professional within one time period. Any Health Care Services provided must be recorded in the Enrollee’s health record.
- 13.26 Encounter Data** – Encounter information Contractor can use to demonstrate the provision of Health Care Services to Enrollees.
- 13.27 Enrollee** – Enrollee means qualified individual or an Employee enrolled in a QHP offered through the Exchange.
- 13.28 Evidence of Coverage (EOC) and Disclosure Form** – The booklet(s) which describe(s) the benefits, exclusions, limitations, conditions, and the benefit levels of the applicable Plan(s).
- 13.29 The Exchange** – The California Health Benefit Exchange, doing business as Covered California and an independent entity within the Government of the State.
- 13.30 Exclusive Provider Organization (EPO)** – EPO shall have the same meaning as that term is defined in California Insurance Code Section 10133(c).
- 13.31 Explanation of Benefits (EOB)** – A statement sent from the Contractor to an Enrollee listing services provided, amount billed, eligible expenses and payment made by the Plan.
- 13.32 Explanation of Payment (EOP)** – A statement sent from the Contractor to Providers detailing payments made for Health Care Services.
- 13.33 Family Member** – An individual who is within an Enrollee’s or Employee’s family, as defined in 26 U.S.C. 36B (d)(1).
- 13.34 Formulary** – A list of outpatient prescription drugs, selected by the Plan(s) and revised periodically, which are covered when Medically Appropriate and prescribed by a Participating Physician and filled at a participating pharmacy.
- 13.35 Grace Period** – A specified time following the premium due date during which coverage remains in force and an Enrollee or Employer or other authorized person or entity may pay the premium without penalty.
- 13.36 Health Care Professional** – An individual with current and appropriate licensure, certification, or accreditation in a medical or behavioral health profession, including without limitation, medical doctors (including psychiatrists), dentists, osteopathic physicians, psychologists, registered nurses, nurse practitioners, licensed practical nurses, certified medical assistants, licensed physician assistants, mental health professionals, chemical dependency counselors, clinical laboratory professionals, allied health care professionals, pharmacists, social workers, physical therapists, occupational therapists, and others to provide Health Care Services.
- 13.37 Health Care Services** – Any and all medical services, supplies and benefits provided under through Contractor’s QHP by Participating Providers to Enrollees, including medical, Behavioral Health, chemical dependency, inpatient and outpatient and all Medically Necessary Services that are Covered Services.
- 13.38 Health Information Technology for Economic and Clinical Health Act (HITECH Act)** – The Health Information Technology for Economic and Clinical Health Act, which was enacted as part of the American Recovery and Reinvestment Act of 2009, and the regulations issued pursuant thereto or as thereafter amended.
- 13.39 Health Insurance Issuer** – Health Insurance Issuer has the same meaning as that term is defined in 42 U.S.C. 300gg-91 and 45 C.F.R. 144.103.
- 13.40 Health Insurance Portability and Accountability Act of 1996 (HIPAA)** – The Health Insurance Portability and Accountability Act of 1996 and the regulations issued pursuant thereto or as thereafter amended.
- 13.41 Health Insurance Regulators** – CDI and DMHC, as applicable.
- 13.42 Health Maintenance Organization (HMO)** – A type of Health Care Service Plan (as that term is

Comment [AC58]: This definition is not necessary and we believe that to be consistent the Exchange should stick to covered services. See next comment.

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defined in California Health and Safety Code § 1345) holding a current license from and in good standing with DMHC.

13.43 Health Plan Employer Data and Information Set (HEDIS) – The data as reported and updated annually by the National Committee for Quality Assurance (NCQA).

13.44 High Performance / High Efficiency Network – A network of Participating Providers selected based on criteria including the ability to provide quality and cost-efficient care.

13.45 Individual Exchange – The Exchange through which Qualified Individuals may purchase Qualified Health Plans.

13.46 Individually Identifiable Health Information (IIHI) – The “individually identifiable health information” as defined under HIPAA.

13.47 Information Practices Act (“IPA”) – The California Information Practices Act, Civil Code section 1798, *et seq.* and the regulations issued pursuant thereto or as thereafter amended.

13.48 Insurance Information and Privacy Protection Act (IIPPA) - The California Insurance Information and Privacy Protection Act, Insurance Code section 791-791.28, *et seq.*, and the regulations issued pursuant thereto or as thereafter amended.

13.49 Integrated Healthcare Model or IHM – An integrated model of health care delivery in which there is organizational/operational/policy infrastructure addressing patient care across the continuum of care, population management and improvements in care delivery, information technology (IT) infrastructure to support care delivery, adherence to evidence-based medicine (EBM) behaviors from all providers of care, and financial risk sharing incentives for the Plan, hospital, and medical group that drive continuous improvement in cost, quality, and service.

13.50 Medicaid – The program of medical care coverage set forth in Title XIX of the Social Security Act and the regulations issued pursuant thereto or as thereafter amended.

13.51 Medical Group – A group of physicians or other Health Care Professionals that is clinically integrated, financially integrated, or that contract together to provide care to patients in a coordinated manner.

13.52 Medical Management – The process of properly allocating healthcare resources through programs such as Utilization Management and Case Management.

~~**13.53 Medical Necessity (Medically Necessary Services)** – Health Care Services as determined through the Plan’s review process and in accordance with applicable laws, rules, regulations and professional standards to be reasonable, necessary, appropriate, and established as safe and effective for the diagnosis and/or treatment of a Enrollee’s illness, injury, or condition.~~

13.54 Medical Policy and Technology Assessment – The process for reviewing and making decisions related to Medical Necessity and making experimental/investigational determinations for certain new medical technologies and/or procedures, and/or for new uses of existing technologies and/or procedures. The technologies include devices, biologics and specialty pharmaceuticals, and behavioral health services. Medical policies are intended to reflect the current scientific data and clinical thinking.

~~**13.55 Medically Appropriate** – Health Care Services that are Medically Necessary and that are determined in accordance with applicable laws, rules, regulations and professional standards to be (1) consistent with the symptoms of a health condition or treatment of a health condition, illness, or injury; (2) appropriate with regard to the most current standard of practice for the safe and effective assessment, treatment, or management of the applicable health condition, illness, or injury as determined by the relevant scientific community and professional bodies; (3) not solely for convenience of a Enrollee or the Health Care Professional providing the Health Care Services; and (4) more cost effective than alternative services or supplies that could be employed for the safe and effective assessment, treatment, or management of the applicable health condition, illness, or injury under prevailing standards of scientific knowledge and clinical practice among practitioners with like credentials providing Health Care Services in the State.~~

13.56 Medicare – The program of medical care coverage set forth in Title XVIII of the Social Security Act and the regulations issued pursuant thereto or as thereafter as amended.

13.57 Medicare Part D – The Medicare prescription drug program authorized under the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), effective January 1, 2006, and the regulations issued pursuant thereto or as thereafter.

13.58 Monthly Rates - The rates of compensation payable in accordance with the terms set forth at Article 5 to Contractor for Services rendered under this Agreement.

13.59 NCQA - The National Committee for Quality Assurance, a nonprofit accreditation agency.

13.60 Nurse Advice Line – An advice line staffed by registered nurses (RNs) who assess symptoms (using triage guidelines approved by the Plan to determine if and when the caller needs to be seen by a Provider); provide health information regarding diseases, medical procedures, medication usage and side effects; and give care advice for managing an illness or problem at home.

13.61 Open Enrollment or Open Enrollment Period – The fixed time period as set forth in 45 C.F.R.

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Comment [AC59]: As previously stated we do not believe that these definitions of medically appropriate or medical necessity are appropriate and we suggest deleting. There is concern that this will conflict with definitions approved by the regulators and cause confusion and we suggest that the Exchange simply reference covered services. It is not appropriate for the Exchange to be dictating specific medical requirements.

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155.410 for individual applicants and Enrollees to initiate enrollment or to change enrollment from one health benefits plan to another.

13.62 Participating Hospital – A hospital that, at the time of a Enrollee’s admission, has a contract in effect with Contractor to provide Covered Services to Enrollees.

13.63 Participating Physician – A physician or a member of a Medical Group or other entity that has a contract in effect with Contractor to provide Health Care Services to Enrollees.

13.64 Participating Provider – An individual Health Care Professional, hospital, clinic, facility, entity, or any other person or organization that provides Health Care Services and that, at the time care is rendered to a Enrollee, has (or is a member of a Medical Group that has) a contract in effect with Contractor to provide Covered Services to Enrollees and accept copayments for Covered Services.

13.65 Participation Fee – The user fee on Qualified Health Plans authorized under Section 1311(d)(5) of the Act, 45 C.F.R. Sections 155.160(b)(1) and 156.50(b), and Government Code 100503(n) to support the Exchange operations.

13.66 Performance Measurement Standard – A financial assurance of service delivery at levels agreed upon between the Exchange and Contractor.

13.67 Personally Identifiable Information (PII) - Any information that identifies or describes an individual, including, but not limited to, his or her name, social security number, physical description, home address, home telephone number, education, financial matters, medical or employment history, and statements made by, or attributed to, the individual. It also includes any identifiable information collected from or about an individual for purposes of determining eligibility for enrollment in a Qualified Health Plan, determining eligibility for other insurance affordability programs, determining eligibility for exemptions from the individual responsibility provisions, or any other use of such individual’s identifiable information in connection with the Exchange

13.68 Pharmacy Benefit Manager (PBM) – The vendor responsible for administering the Plan’s outpatient prescription drug program. The PBM may provide provides a retail pharmacy network, mail order pharmacy, specialty pharmacy services, and/or coverage management programs.

13.69 Plan(s) – The Qualified Health Plans the Exchange has entered into a contract with a Health Insurance Issuer to provide, hereinafter referred to as the Plan(s).

13.70 Plan Data – All the utilization, fiscal, and eligibility information gathered by Contractor about the Plans exclusive programs, policies, procedures, practices, systems and information developed by Contractor and used in the normal conduct of business.

13.71 Enrollee – An Enrollee eligible for and receiving benefits under the Plan.

13.72 Plan Year – Plan Year has the same definition as that term is defined in 45 C.F.R. 155.20.

13.73 Premium – The dollar amount payable by the Enrollee, Employer, or Employee to the Issuer to effectuate and maintain coverage.

13.74 Premium Rate or Monthly Rate – The monthly premium due during a plan year, as agreed upon by the parties.

13.75 Primary Care Physician (PCP) – For HCSPs licensed by the DMHC for HMO products, a California licensed doctor of medicine or osteopathy who is a general practitioner, board-certified or eligible family practitioner, internist, obstetrician/gynecologist or pediatrician who has a contract with Contractor as a primary care physician and who has the primary responsibility for providing initial and primary Health Care Services to Enrollees, initiating referrals for specialist and hospital care, and maintaining the continuity of the Enrollee’s medical care.

Comment [AC60]: Plans understand that Exchange intends to modify this definition.

13.76 Proposal – The proposal submitted by Contractor in response to the Solicitation.

13.77 Protected Health Information or PHI – Protected health information, including electronic protected health information (EPHI) as defined in HIPAA that relates to an Enrollee. PHI also includes “medical information” as defined by the California Confidentiality of Medical Information Act (CMIA) at California Civil Code section 56, *et seq.*

13.78 Provider – A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health professional that delivers Health Care Services.

13.79 Provider Claim(s) – Any bill, invoice, or statement from a specific Provider for Health Care Services or supplies provided to Enrollees.

13.80 Qualified Health Plan or QHP – QHP has the same meaning as that term is defined in Government Code 100501(f).

13.81 Qualified Individual – Qualified Individual has the same meaning as that term is defined in Section 1312(f)(1) of the Act.

13.82 Quality Management and Improvement – The process for conducting outcome reviews, data analysis, policy evaluation, and technical assistance internally and externally to improve the quality of care to Enrollees.

13.83 Quarterly Business Review or QBR – Quarterly in-person meetings between the Exchange and

Contractor at the Exchange headquarters to report and review program performance results including all Services and components of the program, i.e., clinical, financial, contractual reporting requirements, customer service, appeals and any other program recommendations.

13.84 Regulations – The regulations adopted by the Board. (California Code of Regulations, Title 10, Chapter 12, section 6400, *et seq.*)

13.85 Risk-Adjusted Premiums – Actuarially calculated premiums utilizing risk adjustment.

13.86 Risk-Based Capital or RBC – The approach to determine the minimum level of capital needed for protection from insolvency based on an organization’s size, structure, and retained risk. Factors in the RBC formula are applied to assets, premium, and expense items. The factors vary depending on the level of risk related to each item. The higher the risk related to the item, the higher the factor, and vice versa.

13.87 Risk Adjustment – An actuarial tool used to calibrate premiums paid to Health Benefits Plans or carriers based on geographical differences in the cost of health care and the relative differences in the health risk characteristics of Enrollees enrolled in each plan. Risk adjustment establishes premiums, in part, by assuming an equal distribution of health risk among Health Benefits Plans in order to avoid penalizing Enrollees for enrolling in a Health Benefits Plan with higher than average health risk characteristics.

13.88 Run-Out Claims – All claims presented and adjudicated after the end of a specified time period where the health care service was provided before the end of the specified time period .

13.89 Service Area – The designated geographical areas where Contractor provides Covered Services to Enrollees and comprised of the ZIP codes listed in Attachment 4.

13.90 Services - The provision of Services by Contractors and subcontractors required under the terms of the Agreement, including, those relating the provision of Health Care Services and the administrative functions required to carry out the Agreement.

13.91 SHOP – The Small Business Health Options Program described in Government Code 100502(m).

13.92 Solicitation – The Qualified Health Plan Solicitation released on November 16, 2012 and as amended by the Exchange.

13.93 State – The State of California

13.94 Special Enrollment Period – The period during which a qualified individual or enrollee who experiences certain qualifying events, as defined in applicable Federal and State laws, rules and regulations, may enroll in, or change enrollment in, a QHP through the Exchange outside of the initial and annual open enrollment periods.

13.95 Utilization Management – Pre-service, concurrent or retrospective review which determines the Medical Necessity of hospital and skilled nursing facility admissions and selected Health Care Services provided on an outpatient basis.

13.96 Utilization Review Accreditation Commission (URAC) – The independent and nonprofit organization that promotes health care quality through its accreditation and certification programs. It offers a wide range of quality benchmarking programs and Services and validates health care industry organizations on their commitment to quality and accountability.

13.97 Virtual Interactive Physician/Patient Capabilities – Capabilities allowing Enrollees to have short encounters with a physician on a scheduled or urgent basis via telephone or video chat from the Enrollee’s home or other appropriate location.

IN WITNESS THEREOF, the parties have executed this Agreement on the date set forth below and effective as of the Agreement Effective Date set forth in Section 7.01.

Covered California, The California Health Contractor: _____ **Benefit Exchange**

By: _____ By: _____
Name: _____ Name: _____
Title: _____ Title: _____
Date: _____ Date: _____

List of Attachments

- Attachment 1 Contractor’s QHP List
- Attachment 2 Benefit Plan Designs
- Attachment 3 Good Standing
- Attachment 4 Service Area Listing
- Attachment 5 Provider Agreement - Standard Terms
- Attachment 6 Customer Service Standards
- Attachment 7 Exchange Quality, Network Management and Delivery System Standards
- Attachment 8 Monthly Rates - Individual Exchange
- Attachment 9 Rate Updates - Individual Exchange
- Attachment 10 Monthly Rates- SHOP
- Attachment 11 Rate Updates - SHOP

Attachment 12 Participation Fee Methodology - Individual Exchange
Attachment 13 Participation Fee Methodology - SHOP
Attachment 14 Performance Measurement Standards
Attachment 15 Business Associate Agreement
Attachment 16 Required Reports



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April 26, 2013

Ms. Andrea Rosen
Covered California
Interim Health Plan Management Director
560 J Street, Suite 290
Sacramento, CA 95814

VIA ELECTRONIC MAIL: qhp@covered.ca.gov

Re: April 22, 2013 Version of the Model Contract

Dear Ms. Rosen:

The California Association of Health Plans (“CAHP”) represents 39 public and private health care service plans that collectively provide coverage to over 21 million Californians. We appreciate the opportunity to provide comments on the Draft Model Contract released on April 22, 2013.

We would also like to thank you and your staff for all of the hard work that went into making many important changes based on our input and for taking the time to review the extensive redline comments that were submitted on April 15, 2013. We realize that you are moving quickly and have many competing priorities and we appreciate the responsiveness of Covered California and its commitment to working with plans and other stakeholder to improve the model contract. We are glad to see that there is a stakeholder webinar scheduled for next week but we continue to believe that there is also a need for continued discussions with plans and we would appreciate the opportunity for another meeting with Exchange staff to discuss the outstanding items in detail.

Some of the issues we identified as problematic in our last comment letter have been addressed. For example, we are very pleased that the language assistance requirements follow more closely what is available in the existing commercial market instead of requiring very expensive and difficult changes for only Covered California. There was good progress made on many other issues as well.

However, there remain significant problems with the contract and most especially in Attachments 7 that warrant special attention because not all plans will be able to meet these contract obligations in time. We are also very interested in the status of Attachment 14 and would appreciate a clear timeline of how Covered California intends to move forward on performance guarantees.

Attached are redline versions of the April 22, 2013 model contract, in which we provide suggested edits. Below are specific areas of the most concern, which are further discussed in the redlined attachments.

- **PCP Assignment: Attachment 7, Section 3.01**
This requirement continues to not make sense from a PPO perspective. As was discussed at the Covered California Board Meeting there may be other ways besides PCP assignment to get at the underlying goal of ensuring that enrollees know the value of their plan and are able navigate the system and access care. We respectfully request that Covered California state the intended policy in the contract but leave flexibility as to how the goal is achieved.
- **Specific Quality Reports and Oversight Required: Attachment 7, Section 2.04**
It is not feasible for plans to collect all of the data listed in this section by 2015. We request a longer phase-in period.
- **At Risk Enrollees Requiring Transition: Attachment 7, Section 4.01**
We continue to believe that existing requirements for continuity of care are sufficient and have provided redlines that require plans to comply with current law.
- **Health and Wellness Services: Attachment 7, Section 3.02**
Again, not all plans currently collect this information and it will not be possible to have it available starting January 2014. We request a longer phase-in period.
- **Enrollee Health Assessment: Attachment 7, Section 5.04**
We agree that it is important for plans to encourage the complete of an HRA, but given the low rates of participation we continue to believe that reporting requirements provide very little value and we suggest that such provisions be deleted from the contract.
- **Promoting Care Coordination and Higher Value: Attachment 7, Section 7.01**
Plans do not have access to all of the different systems that are included in this portion of the contract. It is not clear how the requirements in this section will actually inform the plan about a certain program's effect on enrollees. We suggest removing this provision until it can be further defined and clarified to provide data that will be accessible to plans and useful in determining what programs are most effective in improving enrollee health.
- **Quality Performance Guarantees: Attachment 14**
Again, we request more detail on how Covered California will solicit input on Attachment 14 and we have provided some comments in the redlined attachments that provide alternative methods with an emphasis on operational and customer service performance guarantees initially. We believe that this is the most prudent approach until the parameters of additional metrics can be further defined.
- **Captive Agents: Contract Sections 1.05, 3.28, 3.29**
Covered California staff has indicated that they would be addressing how captive agents will be treated at a later time. We agree that this issue should be dealt with separately

and request that references to the captive agents be removed from the contract sections entirely.

- **HIPAA/Intellectual Property: Contract Sections 7, 9 and Attachment 16**
We would appreciate the opportunity to discuss these sections in more detail with Exchange legal staff to ensure compliance with federal and state laws, to resolve the rights to member and patient information gathered by Covered California and transmitted to the plans, to correctly allocate the respective responsibilities for privacy and to eliminate overlapping and redundant provisions which create ambiguity for all of us. We hope that these issues can be resolved in a technical workgroup setting in a timely fashion.
- **Small Group Market Changes: Contract Section 3-3.09**
We continue to request that Covered California provide an assurance that plans will be able to make quarterly rate changes. This flexibility is allowed under federal law and will be permitted in the Federally-Facilitated Exchanges. If plans are unable to make quarterly rate adjustments the initial rates will reflect this uncertainty and negatively impact the affordability of these products.
- **Marketing/Co-Branding: Contract Sections 1.05, 3.27**
We have suggested several redline changes to these sections. We are suggesting that Covered California consider lessening its role related to the review of marketing materials and not require the submission of any non-Exchange marketing materials. We remain concerned about the submission of marketing budget information and the ability of Covered California to keep this information confidential when presented with a Public Records Act request. We also request that transition time be built into the contract to give plans adequate time to make the system adjustments and review internal policies in order comply with these requirements.

We look forward to continuing to work with you on improvements to this model contract. And we thank you and your staff for all your hard work on this very important document. Please contact me if you have any questions or would like to discuss any of the items addressed in this letter or the attachments.

Sincerely,



Patrick Johnston
President & CEO

cc: Peter Lee, Executive Director



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Andrea Rosen
Covered California
Interim Health Plan Management Director
560 J Street, Suite 290
Sacramento, CA 95814

VIA ELECTRONIC MAIL: qhp@covered.ca.gov

Re: Proposed Additions to the Draft Model Contract

Dear Ms. Rosen:

The California Association of Health Plans (“CAHP”) represents 39 public and private health care service plans that collectively provide coverage to over 21 million Californians. While we appreciate the opportunity to comment on the proposed additions to the draft model contract released on April 25, 2013, we have not had time to do a sufficient review of these contract provisions and are therefore unable to provide you with comments at this time. We look forward to continuing to work with Covered California as the contract is finalized and hope that any subsequent comments will be considered.

Sincerely,

A handwritten signature in black ink, appearing to read "Athena Chapman", written in a cursive style.

Athena Chapman
Director of Regulatory Affairs

CONFIDENTIAL QHP Model Contract Comment Received via E-mail

Subject: FW: CAHP Comments on 4.22 Model Contract

From: Athena Chapman [<mailto:achapman@calhealthplans.org>]

Sent: Monday, April 29, 2013 11:49 AM

To: Rosen, Andrea (CoveredCA); QHP (CoveredCA)

Subject: RE: CAHP Comments on 4.22 Model Contract

Andrea- I received some last minute comments from my members that did not make it into our comments sent Friday. I know that you may not have time to consider these but I wanted to send them just in case.

13.16 Covered Services – The Health Care Services that are covered benefits under the applicable QHP and described in the EOC. [Substitute "Covered Services" for Health Care Services in each instance in the Agreement.]

13.34 Formulary – A list of outpatient prescription drugs, selected by the Plan(s) and revised periodically, which are ~~covered when Medically Appropriate~~ Covered Services and prescribed by a Participating Physician and filled at a participating pharmacy.

8.06 The Exchange should indemnify the Contractor for the same issues.

Thanks,
Athena Chapman
Director of Regulatory Affairs
California Association of Health Plans
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916-558-1546 (phone)
916-443-1037 (fax)
650-273-3947 (cell)
achapman@calhealthplans.org



Health Care Access for All

April 26, 2013

California Health Benefit Exchange
560 J Street, Suite 290
Sacramento, CA 95814

RE: CPCA Comments on Qualified Health Plan Model Contract v4

To Whom It May Concern:

The California Primary Care Association (CPCA) represents nearly 900 not-for-profit community clinics and health centers in California that provide comprehensive quality health care services to primarily low-income, uninsured, and underserved Californians.

CPCA appreciates the opportunity to provide feedback on the second draft of the Qualified Health Plan Model Contract. We thank the Covered California staff and Board for their efforts to engage and respond to the concerns of stakeholders and look forward to continuing our work together to ensure that the promise of the Affordable Care Act is accessible to all Californians.

1. General Comments

Covered California as a "Third Regulator"

CPCA understands Covered California's hesitance to serve as a "third regulator" and potentially overburden QHPs during this very busy time. However, the ACA specifically requires state Exchanges to regulate the provider networks of QHPs. Through the creation of ECP standards and by charging each state's Exchange to oversee the creation of and compliance with ECP network adequacy, Congress showed its clear intent that the Exchange oversee the adequacy of these networks which offer federally subsidized care. **CPCA urges Covered California staff to use its regulatory authority judiciously but asks Covered California to recognize its clear mandate to oversee and regulate network adequacy in the Exchange.**

Elimination of "Medi-Cal" – like Requirement Regarding Threshold Languages

CPCA is extremely disappointed that Covered California has revised the language access requirements in the latest version of the QHP Model Contract to reflect the minimal DMHC and CDI standards required of plans in the commercial market. The success of the Covered California marketplace depends upon the participation of a broad and diverse array of Californians. Without offering materials and care in the languages that Californians understand, the Exchange endangers its ability to appeal and enroll a broad swath of the population. **CPCA strongly disagrees with the Exchange's decision to adopt DMHC and CDI standards and encourages the Exchange to take a proactive approach to cultural competency and language access in the future by requiring QHPs to comply with meaningful standards, such as those in the Medi-Cal program.**

2. 1.06(ii) Coordination with Other Programs

CPCA is deeply concerned about the recently added placeholder language into the QHP Model Contract that would allow for Exchange coverage of legal permanent residents and pregnant women who, were they not added to the Exchange, would otherwise be eligible for Medi-Cal in 2014.

CPCA strongly supports your stated position during the April 23 Covered California Board Meeting that adding this placeholder language is “getting ahead of the legislature.” It provides symbolic support to a policy position that is extremely controversial and is not representative of current California law. Moreover, moving legal permanent residents and pregnant women from Medi-Cal eligibility to QHP coverage would be enormously detrimental for these two vulnerable populations and represents a step backwards for California. The implementation of the Affordable Care Act should not prompt a reduction in coverage for any Californian, but rather should extend coverage and options to everyone living and working in this state.

CPCA strongly believes that full-scope Medi-Cal is preferable to Exchange coverage for all low-income Californians and we are opposed to any plan that carves out a segment of the Medi-Cal eligible population to receive benefits in the Exchange.

There are numerous reasons that we offer the Exchange for not moving these populations into QHP coverage. First, even a nominal premium payment, co-pay, or deductible will be an obstacle for these low-income populations to receiving care. Even with access to federal premium tax credits and state-based premium and cost-sharing assistance, it will be confusing and frustrating for these Californians to be denied the benefit package and cost-sharing provisions of full-scope Medi-Cal, especially in mixed-coverage families. It is imperative that all Californians under 138% FPL and pregnant women up to 200% FPL have equitable access to the services available under full-scope Medi-Cal and find them equally affordable.

Second, hundreds of studies have documented the importance of prenatal care to women, especially low-income women. California should only move to strengthen our support and coverage for pregnant women and forcing pregnant women into the Exchange will absolutely result in low-income women losing access and necessary care that will lead to complications during the pregnancy and birth, as well as potentially negative consequences to the fetus. There will be absolutely no cost savings with this measure, and only additional costs to the system and families in California.

Lastly, the proposal to cover additional populations in the Exchange rather than through Medi-Cal represents a significant threat to the stability of the safety-net. CCHCs are struggling to be included within QHP networks due to inadequate essential community provider requirements. For those CCHCs who do get contracts with QHPs, the reimbursement rates are significantly lower than those in Medi-Cal. In some cases CCHCs have reported contracting to see Exchange patients at a loss in order to continue providing care to populations that they have served for generations. Safety net providers who are required to serve the uninsured cannot operate on substandard reimbursement rates, especially when the CCHC patient population is more complicated than a traditional commercial patient

population. Every life moved out of Medi-Cal and into the Exchange further erodes the financial stability of California's safety-net providers.

In light of the above reasons and because the legislature and the Brown Administration are working with a wide variety of stakeholders to negotiate the coverage of these populations through the legislative policy process, we believe it is inappropriate for Covered California to build in this placeholder language into the QHP Model Contract. **We ask Covered California to strike any reference to QHP coverage for Medi-Cal eligible populations by removing section 1.06(ii) from the QHP Model Contract.**

3. 3.05 Network Requirements; & Attachment 6, Part G(v)

Part (c): Participating Provider Directory & Part (v): Electronic Listing of Participating Providers

CPCA is disappointed that Covered California has not included a requirement that both the centralized Participating Provider Directory and the QHP's Electronic Listing of Participating Providers include both the names of individual providers and the names of health care facilities such as CCHCs so that enrollees can easily identify their preferred source of health care.

As stated in our comments on the Second Draft QHP Model Contract, the California Department of Medi-Cal Managed Care has recognized the importance of including the name of individual practitioners as well as the name of the health center within each participating health plan's provider directory. MMCD Policy Letter 00-02 clearly states that all participating health plans must include the primary care clinic name as well as the practitioner name within their directories. Despite this requirement, CPCA has been forced to intervene on behalf of health centers in some instances when managed care plans have neglected to follow this clear directive.

Without clear guidance requiring QHPs to list both provider name and facility name in their directories, CPCA believes that it will be even more difficult to convince some QHPs of the importance of including both the name of the facility and the name of individual providers in the provider directory. To alleviate enrollee confusion and support continuity of care for current health center patients, **CPCA requests that both facilities and individual providers employed by a facility be listed within the provider directory so that applicants can search by both provider name and facility name.**

4. 3.15 Enrollee's Out-of-Network and Other Costs; Network Requirements

CPCA remains concerned that Covered California's language regarding payment for non-contracted or out-of-network enrollees served by FQHCs fails to ensure payment of federally required PPS reimbursement. CPCA has consistently requested that Covered California issue guidelines that reflect the Center for Consumer Insurance Information and Oversight (CCIO) guidance that states that "if a QHP issuer does not have a contract with an FQHC, the QHP issuer must pay the FQHC the Medicaid PPS rate for the items and services provided to the QHP enrollee."

Unfortunately, Covered California’s latest model contract language does not provide the protection referenced in the federal guidance. **CPCA requests that Covered California add a section 3.15(iii) to the QHP Model Contract stating that the “Contractor shall comply with federal rules requiring that if a QHP issuer does not have a contract with an FQHC, the QHP issuer must pay the FQHC the relevant Medicaid PPS rate for the items and services provided to the QHP enrollee.”**

5. 3.22(v) Enrollment: Termination of Coverage

CPCA remains extremely concerned about the negative financial impact resulting from the three month grace period provided for nonpayment of premiums to individuals receiving advance payments of the premium tax. For safety-net providers operating on a razor-thin margin, absorbing months of denied claims will endanger their financial stability.

During the April 23 Board Meeting, Covered California staff requested feedback on the potential inclusion of a requirement that QHPs provide notice to providers when a patient has entered the second and third months of the grace period. **In the absence of a requirement that QHPs pay claims submitted during months two and three of the grace period, CPCA believes that a requirement for real-time notice of delinquency of premium payment is an absolute minimum standard.**

Should a health center receive real-time notice of delinquency when an enrollee within the grace period presents for care, many health centers would take the time to educate the patient on their responsibility to pay premiums to maintain coverage and could encourage immediate premium payment for continued enrollment. During the first phases of the Healthy Families program, some health centers maintained an “Angels Fund” which was used to help delinquent enrollees make payments and maintain coverage.

ATTACHMENT 7: QUALITY, NETWORK MANAGEMENT AND DELIVERY SYSTEM STANDARDS

3.01: Benefit Plan Designs Requiring Primary Care Provider Assignments.

CPCA was gratified to see Federally Qualified Health Centers (FQHC) specifically included as eligible to serve as primary care providers and receive patient assignments in the Covered California staff slideshow during the April 23 Board Meeting.

However, we note that the language in section 3.01 of the QHP Model contract has not been updated to reflect the specific inclusion of FQHCs. **We ask that Covered California update the language of section 3.01 to reflect the language presented to the Covered California Board which includes FQHCs as eligible to receive assignments.**

6.01: Patient-Centered Care Initiatives and Plan Enrollee Communication

CPCA commends Covered California for their efforts to ensure that physician and hospital level cost and quality information is available to plan enrollees. As a part of QHP provider networks, FQHCs plan to participate in such initiatives. However, FQHCs report on cost and quality information via the Health Resources and Services Administration’s Uniform Data System (UDS), and do not utilize the CMS Physician Quality Reporting System.



Health Care Access for All

Data reporting required by Covered California should be consistent with current practice and not create duplicative work for providers. By requiring QHPs to report cost and quality data that reflects the CMS Physician Quality Reporting System, Covered California is being overly prescriptive and may inadvertently create a barrier to participation for FQHCs. **CPCA requests that Covered California remove the reference to any specific reporting system from section 6.01.**

Thank you for the opportunity to respond to the above-referenced solicitation. Please do not hesitate to contact Meaghan McCamman by telephone at (916) 440-8170 or mmccamman@cpc.org if you have any questions or comment or if you require any clarification on the comments presented herein.

April 26, 2013

Mr. Peter Lee
Executive Director, Covered California
560 J Street, Suite 290
Sacramento, CA 95814

Dear Mr. Lee:

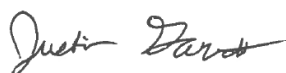
Thank you for the opportunity to provide comments on the updated April 22 version of draft Qualified Health Plan Model Contract. Given the significant changes, we appreciate the time provided to review and submit comments prior to the model contract being voted on by the Board.

On the issue of aggressiveness of quality standards that was highlighted in the presentation on changes to the model contract, we agree that a primary goal of the Exchange and Qualified Health Plans (QHP) needs to be recruitment and enrollment. However, the quality of services provided by QHPs also needs to remain a top priority. We are concerned with the shift to allowing the QHP to inform and report on quality efforts in year one and to then set specific quality requirements and metrics in year two. Specific to the March of Dimes priority measures, eight of which are included in the HEDIS measures, meeting standards and improving performance for these measures will lead to healthier pregnancies and healthier babies. With medical costs averaging \$51,600 for every infant born preterm, quality improvements can not only improve the health of infants but save the state money and quality requirements and metrics should be implemented for QHPs as early as possible. In addition, we would recommend the inclusion of the California Perinatal Quality Care Collaborative to the list of quality collaboratives in Section 2.02 of the attachments to the model contract.

For the suggestion of including placeholder language for QHPs to collaborate with Exchange partners, we are pleased to see that the Exchange is addressing the issue of ensuring that QHPs coordinate with the Department of Health Care Services for pregnant women who may be eligible for both an Exchange subsidy and Medi-Cal. We have concerns with the Administration's premium assistance proposal and its ability to allow for seamless continuity of care and are in fact supportive of legislation currently under consideration that would expand services available to pregnant women up to 200% FPL on Medi-Cal to full scope coverage during pregnancy. Even if this legislation is enacted, coordination between the Exchange and DHCS will still be required so that women can have access to both Exchange coverage and no-cost sharing Medi-Cal coverage while pregnant. Women should not be required to drop Exchange coverage and have to enroll separately in Medi-Cal coverage during their pregnancy, but should be able to access their needed health services with no interruption in coverage or change in access to chosen providers. We believe access to these two programs and the associated federal funding can be administered seamlessly behind the scenes and urge you to make the placeholder language reflective of this approach.

We appreciate this opportunity to provide input on the draft model contract. If you have any questions, please do not hesitate to contact me at 916-576-2836. Thank you for your consideration.

Sincerely,



Justin Garrett
State Director of Advocacy & Government Affairs
March of Dimes



**CALIFORNIA
HOSPITAL
ASSOCIATION**

*Providing Leadership in
Health Policy and Advocacy*

April 26, 2013

Peter V. Lee
Covered California
Executive Director
QHP@hbex.ca.gov

Subject: Comments on the April 22, 2013 Draft QHP Model Contract

Dear Mr. Lee:

The California Hospital Association, which represents more than 400 hospitals and health systems in California, appreciates the opportunity to provide further comment to the April 22, 2013 draft. We recognize the time constraints involved in completing this process and making the Covered California operational within statutory guidelines. Accordingly, we have limited our comments to a few key issues with suggested amendments, but continue to reference our previous comments.

CHA shares Covered California's goal to encourage cooperative relationships between plans and providers to provide the most affordable high quality care. In order to accomplish this, we recommend added flexibility that will allow plans and providers to negotiate the details of certain provisions. We are concerned regarding the level of mandated Provider Agreement contract terms and suggest that the language in Attachment 5 be amended to begin with the statement:

“To the extent agreeable to the Contractor and it's Participating Provider, Contractor shall make best efforts to cause the following provisions to be included in each...”

Conforming amendments should be made to the rest of the references in Attachment 5 and the contract to ensure consistency with this policy. We note that the April 22 version was amended to allow increased flexibility between the Exchange and the Contractor to determine which of the provisions should be included by allowing for “mutual agreement.” This same flexibility should be extended to providers as wells so that providers and plans may develop mutually agreeable and cooperative contracts.

For example, one of the mandated contract sections in Attachment 5 is “utilization review and appeal processes,” referencing Section 3.17 of the model contract. However, the April 22 amendments have significantly changed Section 3.17 and it no longer includes a contractual mandate on Participating Providers. However, Attachment 5 continues to require that this be included in the Provider Contract. This particular section has voluminous administrative burdens such as keeping and providing UM meeting minutes, and reports in addition to actual procedural mandates such as “pre-service utilization review” that may be in direct contadiction to extensive UM agreements between providers and plans today.

Another example of inappropriately mandated language is the Article 7 Continuity of Care language. The providers and plans may have current relationships where further benefits are provided to members in the case of continuity of care and the mandated language would cause a change in those current contractual

agreements. Thus, we are concerned with mandated contractual language that is not based in any particular regulatory requirement and request that Attachment 5 be a “may” rather than a “shall” section.

CHA appreciates the April 22 amendment to the first line of Section 3.09(f) now recognizing the legitimacy of provider contracts. However, further amendments then seem to ignore this policy and require plans to “identify” Participating Providers that exercise their legal and contractual right to protect sensitive information. Provider contracts and payment terms are proprietary, confidential and competitive. There is no policy reason for Covered California to have this detailed information since it is negotiating with the health plan issuer on premium rates – detailed proprietary contract information from specific providers is not necessary for the purpose of negotiating premiums. In addition, Covered California may obtain aggregated information from its contracted health plan issuers, which is sufficient to satisfy any legitimate policy purpose without need to access individual proprietary provider contracts. Therefore, we are concerned this sensitive information will not remain confidential and that it could be used by other parties inappropriately for anti-competitive reasons. Accordingly the following April 22 amendment should be further revised:

“To the extent that any Participating Providers’ rates are prohibited from disclosure to the Exchange by contract, ~~the Contractor shall identify these Participating Providers,~~ *those rates shall not be disclosed.*”

Similarly, the April 22 amendments to Section 2.03 of Attachment 7 address concerns regarding confidentiality of Personal Health Information (PHI) pursuant to HIPAA, but do not protect highly confidential pricing and rate information. Data with claims information, including highly confidential pricing and rate information, should be held confidential regardless of whether or not there was any PHI in that data set. We request the following amendment to Attachment 7, Section 2.03:

“Data submitted pursuant to this section shall be entitled to Confidential Treatment, cannot be disclosed to any other parties without the express written consent of the contractor and without express written agreement of the Providers.”

CHA appreciates your response to the April 23, 2013 joint plan, provider and hospital letter regarding other issues in Attachments 6 and 7. We look forward to participating in the discussion scheduled for April 30 and will provide further comment at that time.

Sincerely,



Amber Kemp
Vice President, Health Care Coverage

cc: Andrea Rosen



Emily Spitzer
Executive Director

April 26, 2013

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Andy Schneider
Washington, DC

Robert N. Weiner
Arnold & Porter, LLP

Via email

The Honorable Diana Dooley, Chair
Covered California
2535 Capitol Oaks Drive Suite 120
Sacramento, CA 95833

**RE: Covered California Qualified Health Plan Model Contract
Version 3.0**

Dear Chairwoman Dooley and Members of the Board:

The National Health Law Program and the Western Center on Law & Poverty are pleased to present our input on the latest version of Covered California's Qualified Health Plan Model Contract. Our recommendations and comments address both the issues raised in Andrea Rosen's presentation on the model contract as well as additional issues of particular importance to low-income consumers.

- **Issue # 1: Plans don't want Covered California to be a "third regulator."**

NHeLP and Western Center appreciate the importance of making sure that Covered California operates efficiently, and that QHPs are not over-burdened by duplicative regulatory review. *That said, given Covered California's role as an active purchaser, we urge the Board to ensure that it retains a role in reviewing and evaluating QHPs' performance in areas that are particularly important to Covered California's mission.* To that end, we support the modification to section 7.01 of the model contract to make contracts effective only until Dec 31, 2014, and then allow Covered California to recertify QHPs on an annual basis. A one-year contract term will provide Covered California the opportunity to modify contracts based on changes in law and issues that arise or lessons learned in the first year.

We are very supportive of Covered California's plan to retain an oversight role on changes to QHPs' service area and network

capacity given the centrality of these types of changes to enrollees' access to health care services. We are concerned that while Covered California staff stated during the April 23 Board meeting that Covered California would continue to oversee formulary changes, this oversight role is not clear in the current contract language; we suggest that Article 8 of Attachment 7 be amended to make this role clearer. We are pleased to see that the list of required reports includes network adequacy standards; changes in participating provider network; out-of-network, other benefit costs and network requirements; appeals and grievances; enrollee and marketing materials; further assurance regarding transition and continuity of care; quality, network management and delivery system standards; and customer service standards. By monitoring QHPs' performance in these important areas, Covered California will be well-positioned to call for improvements, where needed, and to work with QHPs so that they stay consumer-focused and affordable.

Covered California should similarly retain an oversight role with respect to marketing materials and notices. *We oppose the removal in section G(i) of Attachment 6 of the requirement that Covered California approve all marketing materials before they can be used by the QHP issuers.* Without prior approval, QHP issuers will be free to design materials that target healthier populations, creating a high risk of cherry picking. In addition, review of marketing materials is essential to help ensure against inaccuracies, misinformation and other types of deceptive marketing practices.

With respect to marketing materials, while Covered California need not duplicate the roles of existing regulators, it should seek to ensure that legally required accommodations are made for LEP plan members and those with disabilities. The model contract does not require that the QHPs provide Covered California with sufficient information to ensure that applicable standards under law are being met. In fact, it does not require QHPs to report to Covered California about their track record in communicating with LEPs and people with disabilities and providing reasonable accommodations. *At a minimum, QHPs should be required to demonstrate that they have consistently provided all materials translated into other languages as required by law, and tailored specifically to meet the particular needs of people with disabilities, including materials in Braille, large font, and other formats that comply with state and federal disability laws.*

- **Issue # 5: Concerns expressed about imposing language requirements other than English beyond what state law currently requires.**

NHeLP and Western Center oppose the deletion of the requirement that QHPs communicate with enrollees in Medi-Cal threshold languages in Attachment 6 to the most recent version of the model contract. Because of the large numbers of limited English proficient (LEP) individuals who will be purchasing insurance through the Exchange, it is absolutely critical that Covered California ensure that linguistically and culturally appropriate services are provided by the QHPs that are accepted for contracting with Covered California. We appreciate that this contract reinforces QHPs' legal obligations with respect to current state language access laws.

Under state law, QHPs will be required to provide oral interpretation in any language and written translations in a Plan's threshold languages as specified under Health and Safety Code 1367.04 and Insurance Code Section 10133.8-9. In addition, QHPs will have the legal

obligation to comply with the requirements of Title VI of the Civil Rights Act of 1964, Section 1557 of the ACA (non-discrimination), Health and Safety Code Section 1367.04 (SB 853), and applicable oversight agency regulations and guidelines. We appreciate the efforts of Covered California to ensure that the required accommodations are being made for LEP plan members. In particular, we laud the requirement in Attachment 6 to the model contract that the telephone system and enrollment materials be available in both English and Spanish, in recognition that Spanish is the second most common language spoken in California, and that many Exchange enrollees will be Spanish-speaking. But, given the large numbers of lower income Californians who speak languages other than English and Spanish, we urge Covered California to do more to ensure that LEP enrollees get crucial information in their primary languages. *We urge Covered California to put the requirement that QHPs use Medi-Cal threshold languages back in. If Covered California determines that this requirement is not feasible for 2014, staff should closely monitor QHPs' performance with respect to LEP enrollees, and phase in this requirement in subsequent years.*

Federal rules make it clear that programs in the Exchange, including QHPs, must be accessible to all consumers, including persons with disabilities and Limited-English Proficient applicants *and* enrollees. (45 C.F.R. §155.205 and §155.210) Accordingly, it will be important for Covered California to monitor how well the QHPs are meeting their legal obligations. We appreciate that section 3.18 of the model contract affirms that Covered California will evaluate the adequacy of language services provided for verbal and written communications during 2014 and that it will consider the adoption of additional standards in 2015. *We suggest adding language that QHPs be required to regularly report on how they are estimating the language needs of their expected enrollment population. They should be required to demonstrate that they are providing written translations of documents in accordance with applicable standards for any substantial percentages of their expected enrollment with particular language needs and that they provide tag lines in other languages that do not meet the threshold for full translations. They should be required to report on how they are providing sufficient access to customer service representatives who are bi-lingual in particular languages, and how they provide quickly-available oral translation services for those persons with needs in more uncommon languages. They should be required to demonstrate to Covered California that they are providing interpretation services on a 24-hour basis, at no cost to the member. They should be required to provide information on how they are ensuring the competency of the interpreting services they are providing.*

Additionally, we appreciate that section A(iv) of Attachment 6 to the model contract explicitly affirms that QHPs are required to provide no-cost oral interpreter services for all non-English speaking enrollees. *We urge Covered California to explicitly reference this important requirement in the Model Contract as well.* State language access law requires Health Plans to inform their enrollees of the availability of no-cost oral interpretation in any language. A model best practice for notifying members of these services is through the provision of taglines in non-English languages. *Covered California should at a minimum, require contractors to include taglines in 15 different languages on their materials and websites informing consumers of their right to interpreter services under state law.*

- **Issue #7: Plans concerned about collecting sensitive enrollee information, which is data not currently collected.**

NHeLP and Western Center oppose the revision to the model contract that relieves QHPs from the responsibility of collecting and reporting demographic data on race, ethnicity, primary language, disability status, sexual orientation and gender identity in 2014. We are concerned that the model contract may now be inaccurate and misleading to plans. Under Health and Safety Code §1367.04, many health plans are already required to collect data on the race, ethnicity and primary language of their enrollees. Specifically they must assess their enrollee population to develop a demographic profile every three years. We urge Covered California to put this requirement back into the model contract as an important reinforcement of QHPs' legal obligations under existing state law. With regards to the collection of other demographic data, Exchanges are subject to Section 1557 of the Affordable Care Act which extends non-discrimination protections to sexual orientation and gender identity. Thus, Covered California and QHPs are prohibited from discrimination on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation. We strongly urge Covered California to require QHPs to collect demographic data for these characteristics by 2015 as proper data collection will be paramount to ensuring Covered California and its contractors are meeting their obligations under federal and state laws.

- **Issue #10: Plans expressed concerns about a prescriptive approach to identification and management of “at risk” enrollees.**

NHeLP and Western Center agree that Covered California should not prescribe precise methods of care coordination for “at risk” enrollees. We are very concerned, however, that QHPs will be permitted to devise their own definitions of “at risk” enrollees for identification purposes. Covered California must ensure that at risk members are identified and cared for adequately, and not discriminated against because of health status. *To do so, Covered California should clearly define which enrollees are considered “at risk” and require all QHP issuers to use the same definition for identifying and reporting back about this population to Covered California.*

- **Issue # 12: Certain pregnant women may be eligible for both an Exchange subsidy and expanded services through the Medi-Cal Program. Also, newly Qualified Immigrant Citizens may be eligible for Exchange subsidy products.**

NHeLP and Western Center support the recommendation to include placeholder language requiring QHPs to cooperate with other Exchange partners with regard to pregnant women and certain immigrants. As a preliminary matter, we note that pregnant women, particularly low-income pregnant women, must have access to comprehensive, affordable health insurance coverage. To this end, Medi-Cal must provide pregnant women all medically necessary services; provisions in this contract must not undermine pregnant women’s access to comprehensive health care services in Medi-Cal. But, even if legislation securing pregnant women’s access to comprehensive health care services in Medi-Cal is enacted, coordination between affordability programs is necessary. Proposed federal rules permit a pregnant woman receiving pregnancy-related Medi-Cal coverage to take advantage of APTCs to purchase

insurance through Covered California, if she so desires and is otherwise eligible. To ensure that a pregnant woman is able to do so requires coordination between Medi-Cal, Covered California, and any optional bridge program or Basic Health Program. QHPs should share responsibility for providing a woman information about all of the programs for which the woman is eligible, including information about benefits and cost. QHPs should also coordinate with other programs to ensure that the woman can access her complete network of providers, as well as all of her covered benefits, in a seamless and timely manner. And, if a pregnant woman's eligibility for a program changes, QHPs must also play a role in coordinating with other coverage programs to ensure that the woman does not experience discontinuity of care or coverage.

Similar issues may arise for certain immigrants or those eligible for other condition-specific coverage. We urge Covered California to work closely with the Department of Health Care Services and other state agencies as appropriate to work through these issues, and determine what role QHPs should play in coordinating coverage.

We recommend that Covered California's placeholder language includes a requirement that there is a seamless process to ensure that pregnant women have access to their full provider networks, all of the health benefits for which they are eligible, as well as all of the subsidies and cost-sharing protections to which they are entitled.

- **Additional issue: Covered California should not require enrollees to pay their first month premium on or before the fourth remaining business day of the month in order to commence coverage on the first day of the following month.**

NHeLP and Western Center oppose the language at section 3.21(a)(i) of the model contract that would require enrollees to pay their first month premium on or before the fourth remaining business day of the month in order to commence coverage on the first day of the following month. Federal rules on effective coverage dates for initial open enrollment and annual open enrollment make no mention of paying premiums to the QHP before enrollment is effectuated. While Covered California staff stated on April 23 that they have received informal guidance from CCIO to the contrary, we continue to believe that such a requirement violates federal law. The federal regulations base effective coverage dates for initial open enrollment and annual open enrollment from the time the enrollee selects a QHP. See 45 C.F.R. §§ 155.410(c) & 155.410(f), both of which tie "effective coverage dates" to the date when the QHP selection is received by Covered California, not to the date when the premium is paid. Accordingly, effective coverage dates are "the first day of the following benefit year for a qualified individual who has made a QHP selection." 45 C.F.R. § 155.410(f). Nowhere in the federal law do the rules permit enrollment to be conditioned on the QHPs receiving the applicant's initial premium payment in full by a particular due date. Covered California cannot condition enrollment in an Exchange plan on proof of premium payment to the QHP issuer. This contract language should be deleted and replaced with language that reflects the federal rules: "For purposes of this section, enrollment shall be deemed complete when the applicant's coverage is effectuated, which shall occur when the qualified individual has made a QHP selection." At a minimum the QHP contract should be silent on the effective date of enrollment until this issue is settled with the federal authorities.

- **Additional issue: alternative benefit designs are rightly excluded from the contract, as are high deductible health plans.**

NHeLP and Western Center support the decision to postpone including alternative benefit designs in the first year of Covered California's operation. California has taken a huge step in support of standardizing benefit plans. The decision to limit QHP offerings to the standard plan designs will help to eliminate consumer confusion and give Covered California the opportunity to evaluate the success of those standard designs in the first year.

In addition, *NHeLP and Western Center oppose any proposal to establish separate High Deductible Health Plans (HDHPs) with Health Savings Accounts in the Covered California, especially in the silver tier.* HDHPs are confusing to consumers, and therefore should generally be discouraged in Covered California. HDHPs benefit healthier, wealthier consumers who can get the tax benefits and take the risk that they can pay the deductible if they have an accident or serious health condition. Too often, consumers are attracted to HDHPs due to their relatively low premiums, but they misunderstand their potential liability in terms of out-of-pocket costs. As a result, before meeting their deductible, consumers either end up with large medical bills that they can't afford, or go without needed care in an effort to save money. Covered California should look closely at proposed HDHP designs to evaluate whether they have sufficient consumer protections in place to avoid these results, and should also ensure that, to the extent HDHPs are permitted in Covered California, consumers receive enough information to make an informed decision about choosing an HDHP.

If Covered California continues to believe it has to offer HDHPs, we agree with the proposal to prohibit them from the Silver level plans. First, prohibiting HDHPs in the Silver tier will ensure that advanced premium tax credits are effective for consumers. If HDHPs are permitted in the silver tier, they will likely become the second-lowest cost silver plan, on which consumers' advanced premium tax credits will be based. As a result, many low income consumers may be forced to buy a lower value plan than they wish, because they cannot afford a higher value plan with their advanced premium tax credits. Second, the inclusion of HDHPs in the silver tier may also significantly impact Bridge plan participation. Unlike HDHPs, Bridge plans would provide products within Covered California with both reduced premiums and reasonable out of pocket costs, without compromising benefits. If an HDHP is the second lowest cost plan, Bridge plans would be required to offer a product below the cost of an HDHP, which could limit the number of participating Bridge plans. As a result, enrollment may drop significantly, such that more individuals will churn between Medi-Cal and Covered California.

- **Additional issue: Balance billing protections**

NHeLP and Western Center oppose the deletion of specific protections against balance billing in Section 3.15 of the model contract. Removing protections against balance billing will only lead to more costs for consumers, and will make coverage less affordable for enrollees, contrary to Covered California's core values. Avoiding balance billing will be especially important when issuers offer PPO products regulated under the Insurance Code. Those products are not required to provide timely access to services, which may result in extremely low-income consumers obtaining needed services out-of-network at great cost. *We urge Covered California to make clear that QHPs must ensure that consumers are held harmless*

when a needed service is not available in their plan's network so that they are forced to seek out-of-network care.

In addition, section 3.15(ii) of the contract should be modified to ensure that QHPs will hold enrollees harmless with respect to cost-sharing if their providers mistakenly inform them that a particular provider or facility is in-network, when in fact it is out-of-network. Consumers should not be liable for additional costs when they have reasonably relied on information from their health care provider.

Thank you for the opportunity to comment. We look forward to further discussion of these matters.

Sincerely,



Kim Lewis
Managing Attorney
National Health Law Program



Elizabeth Landsberg
Director of Legislative Advocacy
Western Center on Law & Poverty



Abbi Coursolle
Staff Attorney
National Health Law Program



April 26, 2013

Peter Lee, Executive Director
Andrea Rosen, Health Plan Management Director
Jeffrey Rideout, Medical Director
Ken Wood, Senior Advisor for Products, Marketing and Health Plan Relationships
Covered California

Re: Comments to Model Contract, version dated April 22, 2013

Via qhp@hbex.ca.gov

Dear Mr. Lee, Ms. Rosen, Dr. Rideout, and Mr. Wood:

We write to offer comments on substantive topics addressed in the Model Contract and Attachments, dated April 22, 2013 and the presentation at the April 23rd Board meeting.

We appreciate that a balance must be struck in contract requirements that can be effectuated in year one and those that need to be phased in over time, but are troubled that many of the changes in the new draft Model Contract appear to weaken important consumer protections and take a step back from the Exchange's objective to act as a catalyst for delivery system reform and to eliminate health disparities. As Dr. Ross so articulately pointed out, whenever there is a proposed change to health care practices, the industry pushes back. We hope that Covered California will continue to negotiate consistent with its mission, vision and values and not succumb to issuers' resistance to change at the expense of providing affordable and quality coverage for consumers.

High Deductible Plans

In response to the comment made by Mr. Lee at the Board meeting, we urge that Covered California prohibit HSA plans from being offered in the silver metal tier.

The inclusion of HSA plans in the silver metal tier could result in major affordability challenges for many low- and moderate-income consumers. If high-deductible HSA products are offered in the silver tier, they would likely become the second lowest cost plan option within Covered California and the basis for the federal subsidy. Consumers would thus be subject to a subsidized plan with high out-of-pocket costs, presenting an even greater challenge for low-income families who cannot afford high upfront health care expenses. Furthermore, because the price of these plans is likely to be noticeably lower than other non-HSA plans, consumers will have ever greater difficulty applying their federal subsidy to another product with lower deductibles and co-pays.

High-deductible plans would also undermine Covered California's effort to improve health outcomes for enrollees. Studies have shown that consumers in high-deductible plans tend to forego preventive services. By creating a structure that is more difficult for families to purchase non-HSA plans, families with limited income will likely forego or delay needed health care services. As health care providers and advocates who seek to ensure that individuals have full opportunities to better health outcomes, we are concerned that chronic illnesses and other health care needs may not be effectively addressed or prevented due cost barriers with HSA's.

In addition, the inclusion of HSA plans in the silver tier may also significantly impact Bridge Plan participation. Unlike high deductible plans, Bridge Plans would provide more affordable products within Covered California that include both reduced premiums and reasonable out-of-pocket costs, without compromising benefits. If an HSA plan is the second lowest cost plan, Bridge plans would be required to offer a product below the cost of an HSA plan, which could limit the number of participating Bridge plans. Consequently, fewer Bridge Plans could compromise Covered California's goals of maximizing enrollment through improved affordability, reducing churning between Medi-Cal and Covered California and ensuring participation of safety net providers in Covered California.

Thus, both for affordability reasons and concerns about having an adverse impact on Bridge Plan participation, we urge you to keep high deductible plans out of the silver metal tier and instead limit it to QHPs that support the mission and goals of Covered California.

"Enrollee health assessment" [Attachment 7-9, Article 5]

We support the goal of identifying consumers with particular health needs in order to help manage and improve their health conditions, and appreciate the current draft 's more sensible approach, providing options rather than relying solely on required Health Assessments.

Consideration of Wrap-Around Coverage [Contract Section 1.06]

We appreciate the Model Contract's placeholder language that requires Contractors to cooperate with other Exchange partners such as the Department of Health Care Services (DHCS) to allow for the coordination of subsidies, cost-sharing protections, and/or benefits for certain populations. We think it is important that QHP issuers contracting with Covered California understand and agree to partner with other state entities like DHCS, when requested, on innovative solutions to ensure low-income Californians can access more affordable coverage in the Exchange.

Language Access

We are disappointed by the elimination of language access requirements in the Model Contract that would have required Contractor's to translate written materials into the Medi-Cal Managed Care threshold languages. However, we appreciate the Exchange reinforcing health plans' legal obligations with respect to current state language access laws. Under state law, health plans are required to provide oral interpretation in any

language and written translations in a plan's threshold languages as specified under Health and Safety Code 1367.04 and Insurance Code Section 10133.8-9.

Because federal rules make it clear that programs in the Exchange including QHPs, need to be accessible to consumers, including persons with disabilities and Limited-English Proficient applicants *and* enrollees (45 C.F.R. §155.205 and §155.210). it will be important for the Exchange to monitor how well its Contractors' are meeting their legal obligations. We appreciate that the Exchange plans to evaluate the adequacy of language services provided for verbal and written communications during 2014 and that it will consider the adoption of additional standards in 2015 (p. 16 Model Contract). We also strongly support the Exchange's proposal to require QHPs to make their websites available in English and Spanish during year one. Forty percent of Californians speak a language other than English at home. Spanish is the second most common language spoken by the population, followed by Chinese. This additional requirement is a good first step towards ensuring LEP Californians are able to access services in a language they can understand.

Additionally, we support and thank Covered California for explicitly stating QHP requirements to provide no-cost oral interpreter services for all non-English speaking Enrollees (Attachment 6-1) and we urge Covered California to explicitly reference this important requirement in the Model Contract as well (page 12). State language access law requires health plans to inform their enrollees of the availability of no-cost oral interpretation in any language. An important way of notifying members of these services is through the provision of taglines in non-English languages. Covered California should at a minimum, require Contractor's to include taglines in 15 different languages on their websites informing consumers of their right to interpreter services under state law.

Data Collection on Disparities [Attachment 7-4 to 7-5]

We were very disappointed to learn that Covered California is no longer requiring Health Plans to collect demographic data on race, ethnicity, primary language, disability status, sexual orientation and gender identity starting in 2014. We are concerned that the Model Contract may now be inaccurate and misleading to health plans. Under Health and Safety Code §1367.04, health plans are already required to collect data on the race, ethnicity and primary language of their enrollees. However the new Model Contract states that they need not collect demographic data on their enrollee population until 2015. We urge the Exchange to clarify current state requirements for data collection in the Model Contract as an important reinforcement of health plans' legal obligations under existing state law.

With regard to the collection of other demographic data, Exchanges are subject to Section 1557 of the Affordable Care Act which extends non-discrimination protections to sexual orientation and gender identity. Thus, the Exchange and QHPs are prohibited from discrimination on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation. As noted above, we strongly support the Exchange in requiring health plans' to collect demographic data for these characteristics in 2014 as proper data collection will be paramount to ensuring the Exchange and its Contractors are meeting their obligations under federal and state laws. We urge Covered California to amend Attachment 7-5, Section 2.03 as follows:

By 2015, Contractor shall collect a demographic profile of their enrollees as specified under Health and Safety Code 1367.04 and Insurance Code Section 10133.8-9 based on the following characteristics:

Marketing Materials [Contract Sections 3.27 and 1.05]

Removing the requirement that Covered California approve of marketing materials before they can be used by the QHP issuers is a significant mistake (amended Section 3.27(a)). Without prior approval, QHP issuers will be free to design materials that target healthier populations to their plans, creating a high risk of cherry picking. In addition, review of marketing materials is essential to help ensure against inaccuracies, misinformation and other types of deceptive marketing practices.

In terms of the added provision requiring confidentiality of marketing plans and materials (section 1.05(a)(xi) and 3.27(g)), we understand the QHP issuers' confidentiality needs to protect marketing plans, but we disagree that marketing materials themselves should be confidential. Making marketing materials public is even more important given the proposal to remove the requirement for Covered California prior approval. Once the materials are published, they should not be kept confidential. Covered California and the public should be able to see the materials to monitor and to ensure the QHP issuers are conducting marketing that is consistent with the ACA and does not lead to adverse selection or mislead the public about the potential benefits of the Affordable Care Act.

Provider rates [Contract 3.09(f)]

One of the great steps forward in transparency of cost information in prior Model Contract drafts was the requirement that plans provide to the Exchange participating provider rates. We were, therefore, disappointed to see that provision eliminated in the April 22 draft. Allowing such rates to be deemed confidential "to the extent permitted by contract" allows for indefinite continuation of the confidentiality clauses that pervade the marketplace and hinder cost transparency. While some existing confidentiality clauses may make full openness in 2014 infeasible, this could be phased in. We suggest the following amendment:

To the extent permitted by law ~~and contracts with Participating Providers~~, ...To the extent that any Participating Providers' rates are prohibited from disclosure to the Exchange by contract at the signing of the Contract, the Contractor shall identify these Participating Providers. No new contracts between Participating Providers and Contractor shall contain confidentiality clauses prohibiting provider rates from being disclosed to the Exchange.

Balance billing protections [Contract Section 3.15, p. 14]

We are very concerned that the original Model Contract protections against balance billing have been removed from the April 22nd version. One of the steps forward in the prior versions of the Model Contract was a strong effort to inform consumers about out of network charges and protect them from liability for those extra charges. Covered California's mission and vision embrace the importance of affordability, and those prior provisions supported that mission. Removing protections against balance billing will only lead to more costs for consumers.

In addition, the new provision allowing Participating Providers to simply rely on the Contractors' provider directory in fulfilling the obligation to inform enrollees when they are proposing to use a non-participating provider does not provide sufficient assurance to enrollees. While we would like to think that in the new world after January 2014 provider directories will be flawless, we know from plan representations and consumer experience that currency of such directories is a continuing problem. We suggest the following amendments to 3.15:

Enrollee's Out-of-Network and Other Costs; Network Requirements.

Contractor shall, and shall cause Participating Providers to, comply with applicable laws, rules and regulations governing liability of Enrollees for Health Care Services provided to Enrollees, including those relating to: ... (ii) referrals, costs, and responsibility for payment for Health care Services rendered by Participating Providers and those provided by out-of-network providers, (iii) treatment of urgent and emergency services, (iv) documentation requirements for arrangements with Participating Providers and other providers... [re-instate (i)-(iv) as shown and re-number existing April 22nd (i) and (ii), to be (v) and (vi), with (vi) amended as below]

(vi) Contractor shall require its Participating Providers to inform every Enrollee The Contractor's obligation for this provision can be met through an update to their providers' contract manual that is effective as of January 1, 2014. ~~Participating providers may rely on Contractor's provider directory in fulfilling their obligation under this provision.~~

Co-branding [Contract Section 3.27]

Covered California's brand can have significant value in the years to come and be an indicator to the public of quality products and an institution to trust. The QHPs offered on the Exchange will have gone through a rigorous selection process and those chosen to offer coverage through the Exchange will be an essential part of Covered California's identity. Co-branding with plans, responsibly done on reviewed materials and text, is a way to build brand recognition and cement loyalty to the Exchange and government-sponsored insurance. Under the revised Model Contract, Covered California has reduced its opportunity to co-brand materials used by those selected QHPs to advertise and enroll qualified individuals. The proposal to narrow the co-branding to a very limited scope of materials (i.e. insurance id cards, premium bills and termination notices) places the Exchange's logo on materials least likely to instill dedication—bills and termination notices—and thus restricts the ability of Covered California to earn the public's trust and establish a name for itself in the minds of all Californians. While we see that the draft allows for broader co-branding on the basis of "mutual agreement" between the Exchange and Contractor, we urge re-visiting this to broaden the co-branding requirements.

Customer Service Standards [Contract Section 3.18, page 16]

Covered California has made a commitment to serve the needs of all individuals eligible for insurance through Covered California and to uphold its obligations under Federal law. The new provision under Customer Service does not recognize Federal law requirements, but only references that contractors meet state requirements for language

assistance services. The contract provision should be revised to ensure that the Contractor is satisfying language requirements under both State **and** Federal law:

“For 2014, Contractor shall meet all State and Federal requirements for language assistance services...”

Quality Reporting [Attachment 7-2 to 7-3]

We appreciate the clarification in the new Model Contract that plans shall report California level data (Attachment 7-3) for each line of business (LOB) and that Contractors may need to include Exchange population as part of the commercial population LOB in the first year due to low enrollment numbers. However, we urge three amendments. First, in subsequent years we want to see Exchange population separated out in order to assess whether the efforts Covered California is engaged in for delivery system reform and quality improvement are bearing fruit. Secondly, we want to be sure that each QHP collects the data for Exchange products offered in CA. As written it appears to allow them not to collect such data and only to report it if it does. Third, for Performance Measurement Standards we do not see the wisdom or proper incentive for plans of the Exchange blending product types (e.g. commercial and Medi-Cal). The current NCQA ratings show significant disparities between commercial and Medi-Cal LOBs, for example.

2.01 HEDIS and CAHPS Reporting

(a)(ii) Contractor shall report scores separately for each Quality Compass Product Type and/or DHCS County-level product... For the first year, Contractor shall may include the Exchange population as part of its commercial population by LOB, but thereafter shall separately report for the Exchange population.

(iii) For purposes of determining Performance Measurement Standards...the Exchange shall use the most appropriate Product Type based on the plan design and network operated for the Exchange. ~~If appropriate, the Exchange may blend Product Type scores (e.g. combining Commercial and Medi-Cal scores).~~

(b) Effective MY204411, and on an annual basis thereafter, Contractor shall submit directly to the Exchange...per each Product Line ~~for which it collects data~~ in California.

Identification of at-risk enrollees [Attachment 7-8]

This section raises several concerns. First, the definition of “at-risk” enrollee is left up to each individual QHP issuer. For Covered California to ensure comparable data, and that at-risk members are identified and cared for adequately and not discriminated against because of health status, the Exchange should clearly define what it means by “at-risk” and require all QHP issuers to use this same definition for identifying and reporting back about this population to Covered California. If this cannot be accomplished in the first year, at a minimum the Exchange should require each issuer to provide to the Exchange the issuer’s definition of at-risk enrollee, the methods for identifying them, and the approach for managing their care. With this base-line of information, the Exchange could then initiate efforts to improve care in future years.

Secondly, while we certainly concur on the goal of improved care and outcomes for those with chronic conditions or co-morbidities, we question whether this approach of having plans assume responsibility for this across the board will be effective. Identification of these enrollees may best be done by providers—ideally primary care providers—and may be difficult to achieve in a PPO model plan. In addition, consumers may be suspicious of, and thus not as receptive to, this approach from the plan side if they have not chosen a coordinated care model. We believe an approach more inclusive of consumer partnership, and perhaps starting with provider identification of at-risk enrollees and supplemented by plan resources may be more effective. We urge Covered California to develop language that requires plans to describe their program for working with providers to identify and manage care for at-risk enrollees, to whom they would offer appropriate voluntary education, tools and programs for health improvement. This would foster improved health care and outcomes, while allocating appropriate roles.

Privacy and Security

There are many positive provisions in the April 22nd version of the Model Contract that are appropriately protective of privacy and security. For example, we appreciate the requirement to abide by Exchange Privacy and Security Rules in 9.01(b), the requirement to implement fair information practices in 9.01(e)(ii), and the individual access provisions in 9.01(e)(ii)(1). We further recommend that encryption be required for “data at rest”, or at least data stored on portable media. This would involve adding the following to the end 9.01(e)(ii)(7)(f):

"Contractor and its subcontractors and agents shall use encryption (using commercially reasonable means and consistent with applicable industry standards such as NIST guidelines) to protect PHI and PII stored on portable media (for example, but not limited to, laptops, portable drives, smartphones and tablets)."

The majority of breaches experienced by HIPAA-covered entities and their business associates since the HITECH Act was enacted have involved lost or stolen portable media where the data was not encrypted. CalHEERs should take steps to remedy this. If encryption is required by this contract for transmission, it should also be required for data stored on portable devices, which are equally vulnerable.

We request an opportunity to discuss with you, in conjunction with privacy and security experts at Center for Democracy and Technology, a number of provisions related to personal health information about which we have concerns. For example, the provisions in 9.01(f)(ii) requiring Contractors to de-identify PII and PHI when submitting reports - and to obtain patient authorization for release of reports that are not de-identified - are problematic. Such a provision could really delay the issuance of needed reports on Contractor operations and in some cases, impair their validity, if data is missing because enrollees don't provide the necessary authorization. We urge you to require data in a less identifiable form - and ideally de-identified - in any circumstance where the Contractor is reporting data and aggregate data and where such de-identified data will fulfill the purposes for which the report is being filed. We suggest that the stricken language in 9.01(f)(ii) be substituted with the following:

"In reporting data for training, research, publication, and/or marketing purposes, Contractor shall use report PII and/or PHI in the least identifiable form, including in de-identified form, necessary to fulfill the lawful purpose for which the report is being filed."

Such reports shall be filed in compliance with the applicable provisions of federal and state law."

In addition, we are concerned about Section 10.01 which requires Contractors to maintain, and to require that its Participating Providers maintain, a "medical record documentation system adequate to fully disclose and document the medical condition of each Enrollee and the extent of Health Care Services provided to Enrollees." This implies that health plans compile "medical records" on their enrollees that fully disclose and document an enrollees' medical condition. Health plan enrollees generally would not expect (or perhaps want) their health plan to collect information beyond what is necessary to document care that needs to be paid for in the year in which the care is delivered. We have anecdotally heard of instances where health plans have tried to argue that they provide "treatment" to their enrollees, and therefore tried to claim the more extensive rights to data that are typically granted to health care providers. We question whether there is a reason why this contract even needs to include such recordkeeping provisions.

User participation fee

Participation fee now set by contract at \$13.95 PMPM, based on expected premium of \$465 PMPM. No allowance is made for differences in premiums. Premiums will vary based on issuer and geographic region as well as age. The range of premiums could be quite significant yet the participation fee is based on an estimated premium. While the Exchange may wish to provide predictability for year one, it seems imprudent to lock in a specific approach for future years. We remain deeply concerned that the Exchange in its zeal to minimize participation fees will underfund necessary administrative activities.

Contract effective dates [Contract Section 7.01]

We support the modification to the Model Contract that includes an effective date only until Dec 31, 2014, and then allows for recertification. We think this is important to provide Covered California the opportunity to modify contracts based on changes in law and lessons learned in the first year, etc.

Audits [Contract Section 10.05]

We are concerned that the new Model Contract eliminates entirely the ability of the Exchange to do audits. While we recognize that the prior draft language might have been overly broad, eliminating audits in their entirety is short-sighted. We would encourage Covered California to add back into the Model Contract some language that provides for the ability to conduct audits during the contract term.

Primary Care Provider (PCP) Assignments [Attachment 7-6, Section 3.01]

The new Model Contract requires Contractors to report to the Exchange the extent to which all Enrollees are assigned by Contractor to a PCP within 60 days of enrollment, rather than requiring such assignment, but also allows for auto-assignment if the consumer does not select a PCP within 60 days of enrollment. This may work for models of care, such as PPOs which do not presume primary care as the hub of medical care. However, for those plan models that require referrals by a PCP to specialists, i.e. for HMO models, plans should be required to assure enrollees have a PCP within 60 days.

We appreciate the addition of Health Center or Patient–Centered Medical Homes to the PCP Assignment list.

“Medical necessity” and “medically appropriate” definitions [Contract Sections 13.53 and .54, p. 68]

There is a body of law already defining “medical necessity,” including in the state law on independent medical review. We are unclear why any definition is needed here as it does not seem to appear anywhere else in the model Contract or attachments. It also does not appear to allow for wellness and prevention services required by law. We urge that it be deleted.

The definition of “medically appropriate”, which also does not appear to be elsewhere in the Model Contract of attachments, does not seem necessary and introduces a new wrinkle: the concept of cost-effectiveness.

We would add that there is substantial policy controversy over both the definition of medical necessity and medically appropriate care: we would prefer not to engage in this debate in this setting when the terms seem unnecessary to the model contract. Since some among us have spent months, if not years, in debates on these terms, we suggest that inclusion of them is an unnecessary distraction.

Contractor insolvency [Contract, Section 7.06, page 38]

The Model Contract requires Contractors to notify the Exchange of filing bankruptcy or going into state receivership. We suggest that plans also be required to notify the Exchange of solvency problems found by DMHC as these can be early warnings of network adequacy/capacity and related provider payment problems.

Insurance agents [Contract, Section 3.28]

We note that there are many changes to this section of the contract related to agents in the individual exchange, an important set of issues for our organizations. On compensation methodology, we recommend you restore the requirement that plans provide you, upon your request, with information requested about compensation of agents, rather than leaving to on an annual basis. It will be important for Covered California to get information as needed if irregularities or mid-year surprises are spotted in the marketplace.

We strongly support the change in Section 3.28(a)(i) to require equal compensation to agents in first and subsequent years. This will avoid incentives for churning consumers out of plans and into new ones periodically to get increased first year commissions, which happens in the current marketplace.

We note that the entire “Agent Conduct” section has been changed, deleting nearly all requirements, including prohibition on discriminatory practices relating to QHPs, in favor of certification by the Exchange. Our organization would prefer to see the specific requirements restored to ensure that plans (in addition to resource-strapped regulators) are accountable for creating agent standards that do not disadvantage the exchange.

Transitioning Subsidy-Eligible Individuals to the Exchange [Contract, Section 3.35]

We are deeply concerned that the model contract takes a big step backward in terms of meeting the Exchange's goal of maximizing enrollment of individuals who currently have coverage. Combined with the decision not to review marketing materials in advance, the changes to the transition plan means that the Exchange will not have prior knowledge of how the QHP issuer is characterizing the Affordable Care Act, the Exchange, the availability of financial assistance, or other information crucial to the individual consumer who may be eligible for advanced premium tax credits or cost sharing reductions. Some issuers may behave appropriately, encouraging enrollment in the Exchange and providing accurate information about the Affordable Care Act. Others may subtly discourage enrollment in the Exchange in an effort to retain profitable business in the outside individual market, while minimizing Exchange enrollment.

At a minimum the Exchange should not only receive a plan but review the materials to be provided to individual insureds and enrollees regarding the Affordable Care Act and the availability of subsidies. We would also encourage the Exchange to develop model language for educating consumers and test it in opinion research: we are not persuaded that the phrase "financial assistance" is understood at the 6th grade level and we are concerned that it has the demeaning implication of charity rather than a benefit to which an American is entitled if they do not receive affordable coverage through their employer.

Thank you for the opportunity to provide input. We look forward to continuing to work with you to refine the Model Contract. Please contact us if you have any questions about these comments.

Sincerely,



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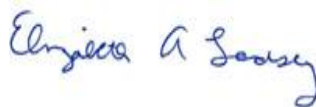
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Comments
Qualified Health Plan Model Contract
Updated Redline (4-22-13)

The Health Insurance Alignment Project (Project) has reviewed the model Qualified Health Plan (QHP) contract proposed by the California Health Benefit Exchange (Covered California) to solicit health insurance issuers in providing health care coverage. The Project engages in independent policy research, analysis and strategic assistance to advance the goals of reducing duplication, improving transparency and maximizing consumer protections in health insurance oversight in California. Kelch Policy Group administers the Project through a grant from the California HealthCare Foundation. Deborah Kelch serves as a member of the Covered California Health Plan Management Advisory Work Group.

With that as background, the Project offers the following comments on the proposed QHP model contract for consideration by the Board and staff of the Exchange.

The revised contract addresses several of the comments we previously submitted and the overall format and structure is easier to follow and review. In that sense, the revised contract is an improvement to the previous versions.

We raise the following remaining questions and issues with the revised contract as are possible for us to identify and articulate given the extraordinary short timeline for review of major and sweeping changes some of which were just proposed late on the prior business day. We would be happy to discuss any of the comments provided directly with staff or through the Health Plan Management Advisory Group. For questions about these comments or the Health Insurance Alignment Project, please contact Deborah Kelch of the Kelch Policy Group at dk@kelchpolicy.com

SPECIFIC COMMENTS

Uniform Model Contract

As an overarching policy, we continue to recommend that the model contract apply to all QHP issuers participating in the Exchange. Having one common contract will contribute to consistency, transparency and ultimately to the accountability needed to support informed consumer choice. The Exchange should not individually negotiate contract provisions with participating issuers except for those elements which are unique among issuers such provider network, service areas and rate provisions.

Licensed in Good Standing (3.02, p. 8)

The most recent version of the contract adds language that the Exchange will make the determination that a QHP issuer is appropriately licensed and in “good standing.” We do not believe that the Exchange has or will have the knowledge, information or expertise to make this determination. The determination of an issuer’s regulatory standing should be made by the Contractor’s respective health insurance

regulator, California Department of Insurance (CDI) or Department of Managed Health Care (DMHC) (pursuant to the definition that the Exchange has developed and which is included as Attachment 3) based on regulatory filings, investigations and oversight activities that are within the purview of the regulator. California must already work through having two regulators with different sets of laws and putting the Exchange in the role of evaluating issuer compliance with those respective requirements potentially adds a third regulator which could add confusion to the existing complexity. The Exchange is not a regulator but rather is a purchaser and has an inherent conflict in evaluating the extent to which issuers whose QHPs it hopes to offer are in compliance with state licensing requirements as a minimum standard for participation.

Importantly, the federal Affordable Care Act and the implementing federal rule cited in the revised contract (45 C.F.R. §156.200) do **not** require the Exchange to make this determination but only establishes “good standing” as a participation standard for Exchange QHPs.

To clarify this point we offer the following suggested amendment in red text below:

3.02 Licensure and Good Standing.

Contractor shall be licensed and in good standing to offer health insurance coverage through its Certified QHPs offered under this Agreement ~~and its other health plans offered outside the Exchange.~~ For purposes of this Agreement, **each QHP issuer must be in “good standing” which shall be determined by the Exchange pursuant to 45 C.F.R. §156.200 (b)(4) based on and subject to verification by the Contractor’s respective health insurance regulator** shall require; (i) Contractor to hold a certificate of authority from CDI or a health care service plan (“HCSP”) license from DMHC, as applicable, and (ii) the absence of any material statutory or regulatory violations, including, penalties, during the last two years prior to the date of the Agreement and throughout the term of Agreement, with respect to the regulatory categories identified at Attachment 3 (“Good Standing”). For purposes of this Agreement, “material” violations shall represent a relevant and significant departure from normal business standards required to be adhered to by a Health Insurance Issuer.

Provider Directory

Government Code 100504 (a)(9) allows the Exchange to require issuers to provide regularly updated information on whether providers are accepting new patients which could be a selling point and marketing advantage for the Exchange and a helpful tool for consumers enrolled in the Exchange.

Primary Care Physicians

We continue to be concerned that the proposed requirement to assign primary care physicians in all coverage model types is based on flawed assumptions and will be confusing to consumers. Physicians in most PPOs are not contracted, obligated or reimbursed to function as primary care physicians **which means much more than being a physician practicing in a primary care specialty**. Physicians contracted to function as PCPs should be involved in care coordination, speaking to other physicians and specialists and tracking referrals, enlisting family members as partners and performing any of a host of other activities required to manage an enrollee’s health and health care.

Therefore, if the Exchange continues to persist in its goal of mandatory assignment of PCPs in all coverage models, the model contract should require that issuers assign enrollees only to physicians contracted to serve as PCPs. Alternatively, the model contract could require issuers to assign all enrollees to a contracted *physician* as a starting point for an enrollee seeking care but not specifically imply or communicate with enrollees that those physicians will fully function as PCPs or primary care medical homes unless the physicians are contracted and obligated to do so.

Definitions

- **Exclusive Provider Organization (EPO).** It remains unclear how the Insurance Code definition of EPO cited in the contract (p. 68, 13.30) could effectively apply to QHP issuers in the individual Exchange since they could be offering individual coverage regulated by either CDI or DMHC. Insurance Code §10133 (c) refers only to the ability of *insurers*, not DMHC-regulated health plans, to offer EPO coverage in the *group* market, and not the individual market, and does not adequately describe the EPO model of health coverage from either the provider or the consumer perspective.

Insurance Code §10133...

*(c) Alternatively, insurers may, by agreement with **group policyholders**, [emphasis added] limit payments under a policy to services secured by insureds from institutional providers, and after July 1, 1983, from professional providers, charging alternative rates pursuant to contract with the insurer....*

It is not clear why a definition of EPO is needed in the contract since, as of the last writing, there is no definition of either a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO). The proposed HMO “definition” is simply a reference to the broader category of health care service plans licensed under Knox-Keene which includes but is not limited to HMOs. If a definition of EPO is included, the following definition is suggested as alternative:

An exclusive provider organization is a health coverage plan that limits coverage of nonemergency care to contracted health care providers. In an EPO, providers may be paid on a discounted fee-for-service or prepaid basis depending on the licensure requirements of the issuer.

- **Health Maintenance Organization.** If a definition of HMO is included, we continue to suggest a textual definition of HMO similar to what is below (p. 69, 13.42).

“Health maintenance organization” means [a health care service plan licensed pursuant to Health and Safety Code §1345] and either of the following:

(1) Comprehensive group practice prepayment plans which offer benefits, in whole or in substantial part, on a prepaid basis, with professional services thereunder provided by physicians or other providers of health services practicing as a group in a common center or centers. This group shall include physicians representing at least three major medical

specialties who receive all or a substantial part of their professional income from the prepaid funds.

(2) Individual practice prepayment plans or network model prepayment plans which offer health services in whole or in part on a prepaid basis, with professional services thereunder provided by individual physicians or groups of physicians or other providers of health services who agree to accept the payment provided by the plans as full payment for covered services rendered by them.”

- **Medical Necessity and Medically Appropriate – We continue to have concerns with the inclusion of these definitions in the model contract and recommend that they be deleted.**

California law does not define these terms for products regulated by the CDI or DMHC, thereby allowing issuers to develop their own definitions through various means such as medical research, practice guidelines, and market considerations. Despite this lack of legal definition, California courts have been solicitous over patient welfare, typically resolve uncertainties about the reasonableness of treatment in favor of coverage, and do not allow issuers to make coverage decisions that are arbitrary and capricious or otherwise “significantly at variance with standards of the medical community.”¹ The proposed contract definitions only add confusion and could be applied by issuers in an arbitrary manner. For example, some services under the definition of “medically appropriate” could be, but are not necessarily, provided by non-physicians with more limited licenses, such as nurses. The proposed definition of medically appropriate suggests that where non-physicians with “like credentials” could perform such services, then the service would not be medically appropriate and therefore not covered by Exchange issuers. Such a definition is inconsistent with the law and is potentially harmful to consumers.

Second, we are unclear as to why these terms are even defined in the model contract since the terms are not contained in the contract itself but only appear in other definitions. Coverage for medically necessary basic health care services is a core component of California’s essential health benefits requirement (Health and Safety Code §1367.005, Insurance Code §10112.7). Where the terms are used in the contract, they are used in a confusing and inconsistent manner. The only time the phrase “medically appropriate” actually appears in the contract is in the definition of “formulary.” Pursuant to the essential health benefits legislation, drugs are covered where “medically necessary” and the definition of medically appropriate makes no sense in the context of a drug formulary.

Similarly, the inclusion of the term “medically necessary” in the definition of “health care services” is ambiguous. Pursuant to paragraph 13.37, “Health Care Services” is defined as “Any and all medical services, supplies and benefits provided under through Contractor’s QHP by Participating Providers to Enrollees, including medical, Behavioral Health, chemical dependency, inpatient and outpatient and all Medically Necessary Services that are Covered Services.” Given the placement of “medically necessary,” it does not appear that medical services need to be medically necessary to be covered but that all other non-specified services must be.

Quality Initiatives

The model contract and proposed quality changes in Attachment 7 still do not establish with clarity a set of specific and clear quality initiatives for the initial first year of the contract to promote uniformity and allow for reasonable monitoring and evaluation. Rather than trying to address many potential quality improvement activities and existing known strategies across a wide spectrum of topics, the Exchange has the opportunity to select a few quality initiatives based on emerging evidence, existing national benchmarks and the diverse needs of expected Exchange enrollees.

The most recent contract version appears to reduce the number of mandatory expectations and change them to primarily reporting and data collection, but fails to set forth a clear path for the Exchange related to quality improvement. A few specific quality initiatives in the first year, with a focus on the appropriate role of health plans as the locus of responsibility, along with uniform reporting on the additional models, initiatives and collaboratives issuers are implementing once 2014 open enrollment is completed, could form the basis for deliberative staff and stakeholder work on further quality initiatives in 2015 and 2016. Clearly identified and specific first year initiatives, as well as clear and simple contract language requiring Contractors to help develop and implement additional quality initiatives in future contract years, could launch the Exchange as a leader in quality measurement and improvement while providing sufficient time to carefully consider year-to-year progress that is realistic, measurable, and achievable given the role the Exchange plays as a contractor with health plans.

¹ See, for example, *Saffle v. Sierra Pacific Power Co. Bargaining Unit* 85 F.3d 455 (9th Cir. 1996); see also *Hughes v. Blue Cross of California* 215 Cal. App. 3d 832 (1989).



California Medical Association
Physicians dedicated to the health of Californians

April 25, 2013

Peter Lee, Director
Covered California Board
560 J Street, Suite 290
Sacramento, California 95814

Submitted electronically to QHP@hbex.ca.gov.

RE: Comments on Covered California QHP Model Contract – Fourth Draft

Dear Mr. Lee and Members of the Board:

On behalf of the California Medical Association (CMA) and its more than 37,000 member physicians, we want to thank you for considering our input on the Covered California Qualified Health Plan Model Contract – Version Four (dated April 22, 2013).

The comments herein will largely focus on those changes made from Version Three to Version Four, though a few remaining fundamental issues are highlighted in “General Remarks” below. We very much hope Covered California will take on these remaining substantial concerns of California’s physicians prior to the May 7th meeting of the Covered California Board.

Our comments, concerns, and requests for clarity regarding the California Qualified Health Plan (QHP) Model Contract – Version Four (hereinafter “Model Contract”), are provided below.

General Remarks

First, CMA is encouraged by Covered California’s increasing attention to the importance of accurate provider directories. Monitoring and enforcing accuracy in provider directories will be critical to connecting patients to the providers right for them. Coverage means little without meaningful access to health care.

Second, while CMA is highly appreciate of the commitment by Covered California staff to seek implementation of an advance notice to Participating Providers regarding a patient’s grace period status, we remain gravely concerned about the impact of the federal 90-day grace period on patient access, especially access to specialists and sub-specialists.

Sufficient advance notice will help to address some peripheral issues of fairness by making practice managers, as overseers of a small business’s finances, aware of potential liabilities. Furthermore, studies have shown the most common reason for non-payment of premium is simply forgetfulness – notice allows providers to give a person-to-person gentle reminder. The notice could also allow providers to be an extra point of contact for connecting patients with assistance in times of financial distress or providing education on Medi-Cal enrollment.

Advance notice, however, does not address the core issue of putting the financial burden of the grace period on those least capable of bearing it – patients and physicians. Covered California should utilize its active purchasing power to ensure health plans accept the financial risk of submitted claims in the second and third months of the grace period for subsidized enrollees. The uncertainty on this issue is serving as a further deterrent to physicians, especially specialists, from signing onto QHP products.

Finally, physicians should be spending more time caring for patients and less time on administrative tasks. It is no secret that physicians are at their breaking point in terms of the myriad administrative demands being put on practices, which is one reason why bills were passed like SB 866 (Hernandez, 2011) to bring uniform medication prior authorization forms. Reducing administrative burdens across QHPs could serve as a huge selling point to physicians on participation in Covered California and, more importantly, allow more physician practices to invest more time and focus on caring for patients.

In presenting on the topic of Covered California to physicians and practice managers across the state, CMA staff continues to hear of the anxiety being felt by those responsible for a significant component of California’s delivery system. California already has more physicians retiring than entering practice – with those leaving practice disproportionately in rural areas. Growing administrative burdens are already cited as a primary reason physicians leave solo and small group practice. If Covered California is truly interested in serving all of California and attaining affordability, it should foster the ability of solo and small group practices to maintain independence, as well as bolster the standing of physician-led systems.

Recommendations for administrative simplification were adopted this past August by the Covered California Board in the QHP Policies and Strategies Recommendations Brief. However, much of the requirements in Attachment 7 of the Model Contract, among others, will run contrary to those recommendations. A number of the new monitoring and reporting requirements on QHPs in the Model Contract will be borne ultimately by the delivery system and will offer little in the way of improving care, as well as result in potentially significant administrative costs.

CMA’s more specific comments, concerns, and requests for clarity regarding the Model Contract are provided below.

Specific CMA Comments by Section	
Section	CMA Comments
<i>3.02: Licensure and Good Standing</i>	CMA opposes the reduction of the “good standing” look-back period from two years to one year and recommends a return to two years. We feel this reduction significantly weakens whatever deterrent effect this provision had and sends the wrong message on Covered California’s attitude towards bad actors.

<p>3.09: Rate Information</p>	<p>CMA remains opposed to Covered California’s wholesale collection of providers’ proprietary rates with individual health plan issuers without appropriately tailored conditions on the use of this information.</p> <p>CMA, furthermore, believes Covered California’s pursuit of price transparency could result in higher prices in most markets, as opposed to creating downward pressure on prices.</p> <p>First, Covered California’s standard benefit designs will still result in fairly low price sensitivity for most enrollees, as those at the low end of utilization will not experience much variable cost-sharing and those at the high end of utilization will exceed the annual out-of-pocket cost-sharing cap. This means demand will not be greatly impacted by price, and, as history and studies have shown us, suppliers migrate to the higher price in a fully price transparent environment under these circumstances. Take the following example:</p> <p style="padding-left: 40px;">In response to concerns that the highly concentrated suppliers of Ready-Mix Concrete were charging widely varying prices to different buyers, Danish antitrust authorities began publishing information on actual invoice prices on a quarterly basis, beginning in October 1993. The result was an increase in average prices of 15-20 percent within a year, as the lower prices in the market rose and the higher prices edged up.¹</p> <p>In New Hampshire, hospital prices did not decrease at all in the twelve months following the state’s publication of price information on imaging and other hospital-based services.</p> <p>Second, where providers know their prices will be fully disclosed, they are more reluctant to provide a discount to any payor, as other payors will insist on receiving the same discount once the discount is made public. This is a common dynamic in price negotiations and why so many contracts of this nature include very strict confidentiality terms.</p>
<p>3.14: Participating Provider Arrangements</p>	<p>CMA recommends the following amended language for the last sentence of Section 3.14:</p> <p style="padding-left: 40px;"><i>Through a separate written acknowledgement, the The Provider Agreement shall cause Participating Provider to</i></p>

¹ David Cutler, Ph.D., and Leemore Dafny, Ph.D. Designing Transparency Systems for Medical Care Prices. *N Engl J Med* 2011; 364:894-895.

	<p>comply with the terms and conditions of this Agreement, including those terms and provisions set forth at Attachment 5 (“Provider Agreement Standard Terms”).</p> <p>Covered California should ensure a separate assent is given regarding participation in Covered California products. Abuse of “all products” clauses and the amending of policy manuals has increasingly gotten worse, resulting in significant in-network provider turnover rates in areas of California (e.g., <i>Nordella v. Anthem</i> case is an example). Aside from the lack of fairness, it is difficult to get the “buy-in” from physicians that the Exchange will need to reform care delivery if physicians feel like they were surreptitiously signed onto these products or strong-armed into acceptance.</p>
<p>3.15: Enrollee’s Out-of-Network and Other Costs; Network Requirements</p>	<p>CMA supports Covered California’s inclusion of an allowance for physician reliance on plan-issued information sources.</p>
<p>3.16: Credentialing</p>	<p>CMA recommends that Covered California adopt a single credentialing process and procedure for QHPs to follow. Uniform standards of credentialing would serve as a significant encouragement for physicians to newly contract with Exchange plans and potentially bring about significant reductions in needless administrative costs.</p>
<p>3.19: Compliance Programs</p>	<p>Waste is mentioned as a target of these detection and prevention programs, but it does not appear health plans are being asked to report on their efforts at reducing the wasteful administrative costs being put on physician practices. CMA recommends adding “programs aimed at reducing unnecessary administrative burdens for Participating Providers” to the list of desired programs at subsection 3.19(b)(i).</p> <p>Further to this point, section 4.01 states that a central goal of QHPs working with the Exchange is to “reduce inefficiencies of the current system,” yet very little of this appears focused on helping reduce costs at the provider level.</p>
<p>3.22: Enrollment: Termination of Coverage</p>	<p>We are encouraged by the Exchange’s plans to implement an advance notice of grace period status for those enrollees in the second month of the federal grace period. Such notice is appropriate for the following reasons:</p> <ul style="list-style-type: none"> • Practice managers, as overseers of a small business’s finances, must be aware of a practice’s potential liabilities;

	<ul style="list-style-type: none"> • Studies have shown the most common reason for non-payment of premium is simply forgetfulness – this allows providers to give an in-person gentle reminder; and • Could allow providers to be an extra point of contact for connecting patients with assistance in times of financial distress or providing education on Medi-Cal enrollment. <p>However, advance notice does not address the core issue of putting the financial burden of the grace period on those least capable of bearing it – patients and physicians. Covered California should utilize its active purchasing power to ensure health plans accept the financial risk of submitted claims in the second and third months of the grace period for subsidized enrollees.</p>
<p>4.03: Contractor Quality Management Program</p>	<p>As stated above, administrative simplification and the general reduction of waste in the health care delivery system due to unnecessary administrative burdens could be one of Covered California’s biggest selling points to providers and significantly increase access to care for many patients. Unfortunately, the Model Contract appears to pay little attention to the need for administrative simplification – outside of broad strokes such as the “reduce inefficiencies of the current system” in Section 4.01.</p> <p>That being said, CMA recommends the addition of the following language to Section 4.03:</p> <p style="padding-left: 40px;"><i>Contractor shall seek to reduce to the greatest extent possible the administrative burdens on Participating Providers related to Contractor’s quality management program.</i></p> <p>CMA also strongly recommends the inclusion of “Participating Providers” as an integral participant in the “meetings and other programs” pursuant to the Contractor Quality Management Program.</p>
<p>Article 13: Definitions</p>	<p>All terms not used in the Model Contract or its attachments should be DELETED, especially “medically necessary” and “medically appropriate.” This deletion is particularly appropriate in light of Covered California’s deferment of the Administrative Manual.</p> <p>If Covered California will not delete these terms, will the contract at least clarify the intended treatment of such unattached terms. CMA staff has already gotten a number of questions from physician members as to the purpose of these</p>

	<p>definitions and we are struggling with what to communicate.</p>
<p><i>13.53: Medical Necessity (Medically Necessary Services)</i></p>	<p>For the reasons outlined above at Article 13, we recommend deletion of this term from the definitions list. The term is not used in the Model Contract or its attachments, outside of the “Covered Services” definition example above for which we recommend deletion of the “Medically Necessary” language.</p> <p>The term’s “as determined through the Plan’s review process” language appears to be inconsistent with California’s bar on the corporate practice of medicine.</p> <p>Additionally, the proposed definition does not appear to account for wellness and preventive services, which other areas of the Model Contract appear to encourage (e.g., Section 3.02 of Attachment 7).</p> <p>If Covered California is intent on keeping the term in Article 13, <u>we recommend the following substitute language:</u> Health Care Services as determined through the Plan’s review process and in accordance with applicable laws, rules, regulations and professional standards to be reasonable, necessary, appropriate, and established as safe and effective for the diagnosis and/or treatment of a Enrollee’s illness, injury, or condition.</p> <p><i>Health Care Services that a prudent treating physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (1) in accordance with generally accepted standards of medical practice; (2) clinically appropriate in terms of type, frequency, extent, site and duration; and (3) not primarily for the convenience of the patient, physicians, other health care provider, or for the financial benefit of the health plan or insurer.</i></p>
<p><i>13.55: Medically Appropriate:</i></p>	<p>For the reasons outlined above at Article 13, we recommend deletion of this term from the definitions list. The term is not used in the Model Contract or its attachments, and commonly used definitions of the term in industry are much less prescriptive than that found at Section 13.55, which could result in harm to both patients and providers.</p> <p>Furthermore, the definition’s cost-effectiveness requirement could result in significantly negative unintended consequences and fuel the rationing concerns of some. Medical appropriateness</p>

	<p>and fiscal appropriateness are independent concepts and should remain as such. For example, in the Los Angeles area, Kaiser-Permanente protocol calls for the administration of thrombolytics to ST segment myocardial infarction (STEMI) patients overnight instead of taking them to the catheter lab for primary percutaneous coronary intervention (PCI), because the former is more cost-effective than having a catheter lab team on-call. While the former may be more cost-effective, few, if any, cardiologists would agree it is the most medically optimal or appropriate course of treatment for these patients. Similarly, the Veterans Administration and Los Angeles County use stool samples to screen for colon cancer instead of colonoscopies, because this is more cost-effective. Again, few would argue that the former is the most medically appropriate option.</p> <p>If Covered California is intent on keeping the term in Article 13, <u>we recommend the following substitute language:</u> Health Care Services that are Medically Necessary and that are determined in accordance with applicable laws, rules, regulations and professional standards to be (1) consistent with the symptoms of a health condition or treatment of a health condition, illness, or injury; (2) appropriate with regard to the most current standard of practice for the safe and effective assessment, treatment, or management of the applicable health condition, illness, or injury as determined by the relevant scientific community and professional bodies in accordance with current standards of good medical practice in the service area of the State; (3) not solely for convenience of an Enrollee or the Health Care Professional providing the Health Care Services; and (4) more cost-effective than alternative services or supplies that could be employed for the safe and effective assessment, treatment, or management of the applicable health condition, illness, or injury under prevailing standards of scientific knowledge and clinical practice among practitioners with like credentials providing Health Care Services in the State <i>the most appropriate level or type of Covered Service which can safely be provided to the Enrollee.</i></p>
<p>Attachment 5 Provider Agreement – Standard Terms</p>	<p>CMA recommends the following added language after the first sentence of the Attachment 5 introductory paragraph: . . . arrangement entered into by a Participating Provider. <i>Assent to these provisions by a Participating Provider shall be made pursuant to a separate written acknowledgement, which may be within an existing Provider Agreement or provided independently.</i></p>

	<p>Covered California should ensure a separate assent is given regarding participation in Covered California products. Abuse of “all products” clauses and the amending of policy manuals has increasingly gotten worse, resulting in significant in-network provider turnover rates in areas of California (e.g., <i>Nordella v. Anthem</i> case is an example). Aside from the lack of fairness, it is difficult to get the “buy-in” from physicians that the Exchange will need to reform care delivery if physicians feel like they were surreptitiously signed onto these products or strong-armed into acceptance.</p>
<p><i>Attachment 6 Customer Service Standards</i></p>	<p>We strongly support the Exchange’s common sense requirement in subsection (v) that electronic provider listings be continually updated.</p> <p>Regarding the enrollee ID card discussed in subsection (vi), CMA recommends the following guidelines be followed as a means to reduce both patient and provider frustrations:</p> <ul style="list-style-type: none"> • “Covered California” should be prominently displayed on the ID card, preferably in type larger than that of the issuer’s logo, such that there can be little confusion on behalf of the patient or provider that it is an Exchange product. For instance, issues often arise in the County Medical Services Program (CMSP) due to enrollees misunderstanding their coverage on account of the ID card displaying Anthem Blue Cross most prominently on the card. This leads to CMSP enrollees presenting at non-CMSP Anthem Blue Cross participating providers. Insurers like Blue Shield have already publicly stated an attention to have Exchange product networks 40 to 45 percent of the size of the traditional PPO network. Such a simple font requirement could prevent the Exchange from having the Medicare Part D experience of “Why won’t my card work?” questions overloading customer service centers. • Require all ID cards be printed on a white background, as the increasingly common colored backgrounds make it difficult for staff to scan or copy the card. • Covered California should set a reasonable minimum font size for print on the cards for the sake of both patients and providers. • Patient ID numbers should be prohibited from including the letter O due to the erroneous denials and delays that occur when it is mistaken for a zero by staff in alphanumeric ID numbers.

<p><i>Attachment 7 Quality, Network Management and Delivery System Standards</i></p>	<p>The expansive data submission requirements at section 2.03 and cost-focused reports at section 2.04 should be the subject of further joint discussions among the Exchange, QHPs, and Participating Providers.</p> <p>CMA has the following comments on other sections of Attachment 7:</p> <ul style="list-style-type: none"> • CMA is supportive of the changes made to section 3.01 on PCP assignment and would like to stress the importance of properly amending physician contracts. • CMA is supportive of the transition plan for at-risk enrollees in section 4.01, but recommends the addition of “available” to “in-network providers” for clarity. This additional language would help to maintain consistency with subsection 4.02(e), recognizing that a physician who is not able to accept new patients should not be considered. We would also like to stress the importance that information on at-risk enrollees be available as soon as feasible for those providers and provider groups receiving these patients. • CMA requests clarity in section 5.05 as to what information the Exchange considers the “results of their referral to receive additional services.” • CMA is concerned with the potential for unintended consequences inherent in how, especially at the individual physician level, information like “patient experience, volume, efficiency, [and] price of services” is collected and reported publicly. This is certainly a subject where provider stakeholders must have a seat at the table as more specific guidelines are developed. These same concerns apply to section 6.02. • CMA is concerned with the administrative burdens passed down to physicians as the result of reporting requirements such as those at section 6.04, which require plans to report the “results, including clinical, patient experience, and costs impacts” of “shared decision-making processes.” <p>CMA strongly supports the deletion of section 7.07.</p>
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Conclusion

Thank you again for the opportunity to provide input on this critical component leading us into the October 2013 pre-enrollment efforts and beyond. We look forward to continuing to work with the Covered California Board and staff to realize the vision of improving the health of all Californians by assuring access to affordable, high quality care.

Respectfully Submitted,

A handwritten signature in black ink, appearing to read "Brett Johnson", written in a cursive style.

Brett Johnson, Associate Director, Medical & Regulatory Policy, CMA

Cc: David Panush, Director of Government Relations, California Health Benefit Exchange
Francisco Silva, Chief Counsel, CMA
Lisa Folberg, VP of Medical & Regulatory Policy, CMA



May 2, 2013

Peter Lee, Director
Covered California Board
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Submitted electronically to QHP@hbex.ca.gov.

RE: Comments on Covered California QHP Model Contract – Fifth Draft

Dear Mr. Lee and Members of the Board:

On behalf of the California Medical Association (CMA) and its more than 37,000 member physicians, we want to thank you for considering our input on the Covered California Qualified Health Plan Model Contract – Version Five (dated April 29, 2013) (hereinafter “Model Contract”).

While we understand that Covered California intends the April 29th to represent the final version of the Model Contract, we request clarity on a significant issue which has come to our attention after consultation with legal counsel regarding Article 9, Protection of Personally Identifiable Data and Information Assets, and Attachment 15, Business Associate Agreement:

Does Covered California intend to significantly expand the application of state and federal security and privacy law by requiring providers to report security incidents (as defined under 45 CFR § 164.304) within three (3) calendar days?

If this is not Covered California’s intent, **CMA recommends that Covered California clarify that application of its security and privacy provisions adheres to the definition of “subcontractor” under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), including the Administrative Simplification Provisions of HIPAA, as codified at 42 U.S.C. § 1320d *et seq.***

The Model Contract, namely at Article 9 and the Business Associate Agreement, is unclear whether when a qualified health plan (QHP) contractor uses the term “subcontractor” if it is referring to the HIPAA definition, whereby, generally physicians and hospitals are not included, or as any entity that contracts with the QHP, in which case physicians and hospitals will then be subject to the terms of the QHP contract provisions, including requirements to report security incidents to the plans and the Exchange within three calendar days. HIPAA defines subcontractor as “a person to whom a business associate delegates a function, activity, or service, other than in the capacity of a member of the workforce of such business associate.” (45 CFR § 160.103).

A three calendar day notification requirement for security incidents on all physicians and facilities would be a substantial new requirement, necessitating significant resources and extended timelines for compliance across California’s health care delivery system. **CMA**

requests guidance from Covered California as soon as practicable on the above point so that we may begin appropriately advising our physician members, a significant portion of which are small businesses.

Under HIPAA, any covered entity or business associate must have administrative safeguards in place to address security incidents. Further, business associates must report to the covered entity of any security incident of which it becomes aware. A security incident differs from a breach and may include circumstances, which after an investigation, does not amount to a security breach. Under the QHP contract language, if a health plan enters into an agreement with an “agent or subcontractor” that subcontractor is bound by the QHP contract requirements, including the requirement *to report security incidents within three days*. Attachment 5, Provider Agreement – Standard Terms, appears to support this reading by expressly including Article 9 in the terms of providers’ agreements without any qualifications whatsoever.

Physicians and hospitals, as covered entities, do have an obligation to implement policies and procedures to identify and respond to known security incidents, including documenting the security incidents and their outcomes. (45 CFR § 164.308(a)(6).) However, physicians and hospitals generally do not have an obligation to report security incidents. Without clarification in the contract, the QHP contract may subject physicians and hospitals to report any and all security incidents within three days to both the QHPs and the Exchange, which represents a considerable expansion of the current scope of California and federal law. Physicians and hospitals should not be required by the QHP contract to report security incidents at all.

Furthermore, although federal and state law requires covered physician entities to report breaches to patients, Department of Justice, California Department of Public Health, and the media in some cases, they generally do not have an obligation to report any breach to the health plans with which they are contracted. Requiring physicians to report breaches to either the Exchange or the QHP is beyond what is required under the law, and certainly not within a three calendar day timeframe. For the average small physician practice, which may be contracted with upwards of a dozen or more health plans, this would represent another potentially costly administrative burden accompanying QHP contracts.

Thank you again for the opportunity to provide input on this critical component leading us into the October 2013 pre-enrollment efforts and beyond. We look forward to continuing to work with the Covered California Board and staff to realize the vision of improving the health of all Californians by assuring access to affordable, high quality care.

Respectfully Submitted,



Brett Johnson, Associate Director, Medical & Regulatory Policy, CMA

Cc: Gary Baldwin, Deputy Dir. of Plan & Provider Relations, Dept. of Managed Health Care
Francisco Silva, Chief Counsel, CMA



May 1, 2013

Peter M. Lee
Executive Director
California Health Benefit Exchange
Sacramento CA 95814

Via Email and FedEx (info@hbex.ca.gov and qhp@covered.ca.gov)

Re: CAPG Comments on Covered California Model Contract Attachments,
Draft 2 (Revised), April 22, 2013

Dear Mr. Lee:

We are writing to provide you with comments on the Covered California Model Contract Draft 2 Revised version, dated April 22, 2013. These comments represent and are sent on behalf of our CAPG members.

As you know, the California Association of Physician Groups (CAPG) is the nation's largest professional association representing physician organizations that are dedicated to providing capitated, accountable, clinically integrated health services. More than half of the care delivered in California is provided by the approximately 60,000 physicians affiliated with CAPG's member groups.

Long before health reform became law, physician groups in California were demonstrating how to improve patient health outcomes and control costs through highly coordinated approaches to care. This commitment to quality and effectiveness is what defines and distinguishes the more than 160 leading multi-specialty physician groups and IPAs that make up CAPG's membership.

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www.capg.org

Driven by the principles of the Triple Aim, CAPG members have pioneered and continuously refined a highly effective model for capitated, coordinated, accountable, efficient care. This model is built on the foundation of front-line clinical excellence that is fueled by an increasingly sophisticated tool set, which includes: highly sophisticated decision support; empowered care coordination systems and personnel; HIT pathways; with effectively structured performance measurement, feedback and rewards.

CAPG groups embrace and share the Exchange's mission: to improve healthcare quality and access to care, promote better health, lower costs, and reduce health disparities. Most importantly, our delegated, capitated model has long demonstrated its success at optimizing patient experience, quality and satisfaction, improving the health of the population, and reducing the cost of healthcare. We will be your committed partners in the continuous pursuit of these objectives.

CAPG, the ACA and the California Exchange

The foundation of the Affordable Care Act is a move to coordinated, accountable population health. This intentional, rational migration away from traditional fee-for-service to fee-for-value and prospective payment is expected to guide the American healthcare system in the coming decades.

One of the ACA's key implementation tools is the California Health Benefits Exchange, Covered California, which is intended to significantly increase access to healthcare for millions of Californians as it advances coordinated care. We need to make this work in our State, the most populous and diverse in the nation.

CAPG and its member groups have worked closely with you and the Exchange team as you developed and refined your approach and product. We remain fully committed to delivering on the promise of health reform, and will continue to invest our experience and well tested innovative care models to partner with the Exchange to achieve this goal.

General Comments on the Model Contract Attachments dated April 22, 2013

Our comments will focus only on Attachment 7.

CAPG supports the Exchange's efforts to deliver better care and higher value. We recognize that many of the specific requirements spelled out in the QHP Model Contract will be explicitly delegated by QHPs to CAPG groups to deliver. While these

requirements may be a stretch beyond our current operational processes in some instances, please note that CAPG groups are fully prepared to make that stretch.

Specific Comments on the Articles in Attachment 7

Article 2: Quality of Care

2.03 Data Submission Requirements to the Exchange

In most cases, our groups submit annual reports to Plans, the IHA and others. We can ramp up to submit quarterly encounter data reports if this will contribute to Exchange quality and performance. While we are prepared to go to the effort and expense of doing this, we must candidly question whether reporting at this frequency will be of value to the Exchange and the QHPs and/or whether this quantity of data might inundate QHP and Exchange systems.

2.05 eValue8 Submission

We would be interested in seeing materials that describe the capacity and competence of eValue8.

Article 3: Preventive Health and Wellness

3.01 Benefit Plan Designs Requiring Primary Care Provider Assignments

As the cornerstone of the coordinated care model, CAPG fully supports PCP assignment. For our member groups, this has long been our mode of operation. Our experience has demonstrated its effectiveness in optimizing care, patient experience and outcomes.

3.02 Health and Wellness Services

We are concerned that it may prove difficult to update and synchronize individual patient dashboards that are maintained at the care site and at the QHP, as no statewide HIE yet exists. In addition, the Model Contract does not describe the model for the dashboard.

3.03 Community Health and Wellness Promotion

We would appreciate more specificity on this. Will satisfactory engagement require meaningful education and intervention at a broad community level, or to specialized segments of a community? Or will QHP funding of such efforts by others -- including the QHP's delegated providers, or community-based groups -- be sufficient to meet this requirement?

3.04 Health and Wellness Documentation Process

The specific submission requirements for QHP Health and Wellness program documentation appear to resemble our current MA/CMS reporting obligations, and present no compliance issues for us. The Network Adequacy documentation requirement, however, adds significantly to the manpower necessary for compliance. Further, we are concerned that niche providers that are a necessity to demonstrate and ensure network adequacy may use this requirement to leverage contract negotiations with QHPs and delegated providers.

Article 4: Services for At Risk Plan Enrollees

4.01 At Risk Enrollees Requiring Transition

CAPG member groups are fully prepared to do this from the start; this is a core value and operating principle of our model. We are concerned that, in the absence of prior health data, it may be a challenge to meet our high performance standard in this key area, as our sophisticated care management systems may depend upon delivery and maintenance of complete records by the QHP. We would appreciate more clarity on how this process differs from existing, detailed DMHC process for enrollee transitions.

We are concerned that transitioning new enrollees from former providers to new providers will require massive support staff to seek out and obtain records from multiple sources. We question whether this can be done at the QHP level. We would appreciate more specificity on how, and in what time frame, the medical records obtained by the QHP would be transmitted to delegated providers who are doing the assessments. We wonder whether the outcome might be that the QHP hires consultant providers to do assessments on a contract basis rather than fostering the PCP-patient relationship from the start, one of the priority goals of the Exchange.

4.02 Identification and Services for At Risk Enrollees

CAPG member groups are fully prepared to do this from the start; this is a core value and operating principle of our model. We are concerned that, in the absence of prior health data, it may be a challenge to meet our high performance standard in this key area, as our sophisticated care management systems will depend upon delivery and maintenance of complete records by the QHP.

Article 5: Enrollee Health Assessment

5.01 CAPG groups can do this; this has long been a core operating principle. We are concerned that this may not be attainable by QHPs. Certainly, contracting medical groups and IPAs will be best suited to collect, maintain, and use individual information about enrollees' health status and behaviors to promote better health and to better manage their health conditions.

5.02-5.05 These analytic tracking/trending reports will be an initial challenge, but CAPG member groups are prepared to ramp up these capabilities in our effort to contribute to the health of Californians.

Article 6: Patient-Centered Care Initiatives and Plan Enrollee Communication

6.02 Total cost and OOP cost will place a burden on groups but we are prepared and committed to working with the QHPs and IT system vendors to provide this information in a form that is useful for the QHP and the Enrollee.

Article 7: Promoting Care Coordination and Higher Value

7.01-7.05 CAPG groups are in full agreement on these guidelines and we are prepared to comply. We do want to point out that compliance with Payment Reform and Data Submission requirements will require significant HIT systems and staffing investment.

Article 14: Performance Measurement Standards

General comments:

- CAPG groups are fully prepared to comply with all performance measurement requirements, as they represent our core operating methods. We would like to

note that these performance measurement standards appear to vary widely from the existing Medicare Advantage and IHA P4P metrics, with regard to content and reporting frequency. The Exchange has repeatedly stated that it intended to leverage existing quality measurement systems. It is also unclear whether a QHP and contracted provider would have to submit data to a different clearinghouse than is currently used. It would be useful to generate a cross-comparison matrix to determine to what extent there is a duplication of data, so that collection and reporting could be leveraged more efficiently, and thus avoid unnecessary operating overhead cost increases in order to keep the ultimate premium costs down.

- The amount of data generated and submitted is likely massive. We wonder if there is sufficient confidence that by changing the long-standing format of data submittal from annual to quarterly, and even monthly, that a vendor will be able to produce usable analyses to guide the Exchange in its goal of increasing coordination of patient care, quality and accountability.
- It would be useful to learn about the source of influence that the Exchange referred to for the creation of this set of performance metrics. For example, which organizations are currently operating under a similar set of standards? If QHPs are going to be able to meet this metric set, it would be useful to see examples in the real world, since such a system does not currently exist within California or under CMS jurisdiction.

Specific comments:

14.01, first paragraph:

In the event that the reporting requirements identified herein include PHI, Contractor shall provide the Exchange only with de-identified PHI as defined in 45 C.F.R. Section 164.514. Contractor shall not be required to provide the Exchange any data, information or reports that would violate peer review protections under applicable laws and regulations.

Attachment 7, 3.02 as drafted in the 4/22/13 v4 version:

Contractor agrees to incorporate documentation of all Enrollee's health and wellness services into Contractor's most complete information on each Enrollee and is distinct from the Enrollee's medical record by the providers.

New language requires that any PHI be submitted in de-identified form. But in the Attachment 7, 3.02, personal patient information for all Exchange enrollees is required in order to build a “patient dashboard.” Is this because the information will go to different sources? Or is this just contradictory?

Further, the privacy requirements, which must be passed on to the QHP’s subcontractors via contract, go far beyond HIPAA requirements. We are concerned by: the requirements to report breaches to the Exchange within 3 days; the requirement to report security incidents, which are not well defined, prior to any investigation of them, which is not currently required by law; and the prohibition against fundraising without the prior written approval of the Exchange.

14.02, first paragraph: Minimum Reporting Frequency

Contractor shall provide the following minimum reports to the Exchange at the specified time and frequency at no additional charge to the Exchange:

- *Switch reporting: ~~daily~~, ~~weekly~~, monthly, quarterly and annually.*
- *Phone statistics, Performance Measurement Standards reporting and operations reporting: ~~daily~~, ~~weekly~~, monthly, quarterly and annually.*
- *Accumulating monitoring scoring: weekly and monthly*

Minimum reporting frequency. The frequency of reporting, often at the monthly level, is challenging. Some sections require monthly monitoring and correction within 30 days. If a problem comes up that involves an interaction between a plan, a delegated model physician group, and the DMHC, it is unlikely that the parties will be able to act decisively within such a narrow time frame. Systemic problems within organizations are also seldom identified and solved within a 30 day period.

We are also unclear on how the Exchange will interact with the DMHC. The Contract implies that the Exchange will take action, but the Knox Keene Act only recognizes enforcement of patient access and continuity of care through a statutory process run by the Help Center, with specified timelines, appeals processes and remedies. The Contract appears to create a parallel process, which will not work. A QHP will receive orders from the DMHC and the Exchange that could vary and contradict one another. That can only result in poor outcomes for the patient.

14.02, Root Cause Analysis/Corrective Action

If Contractor fails to meet any Performance Measurement Standard in any calendar month (whether or not the failure is excused), Contractor shall promptly (a) investigate and report on the root cause of the problem; (b) develop a corrective action plan (where applicable); (c) to the extent within Contractor's control, remedy the cause of the performance failure and resume meeting the affected Performance Measurement Standards; (d) implement and notify the Exchange of measures taken by Contractor to prevent recurrences if the performance failure is otherwise likely to recur; and (e) make written recommendations to the Exchange for improvements in procedures.

As cited in the General Comment above, this clause will create conflicts with statutory requirements under the Knox Keene Act and will create situations in which the QHP could be subject to contradictory direction from the DMHC Help Center and the Exchange.

14.09, Quality and Network Management

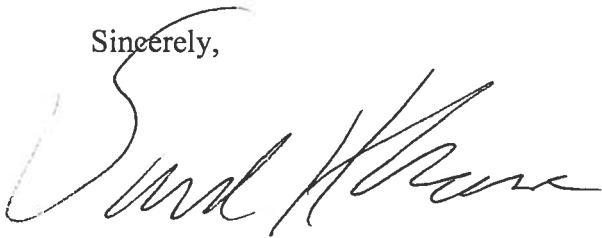
- *Expectation: Adults' Access to Preventive/Ambulatory Health Services (20 to 44 years and 45 to 64 years)*
- *The percentage of members 20 years and older who had an ambulatory or preventive care visit*
- *The organization reports three separate percentages for each product line*
- *Medicaid and Medicare members who had an ambulatory or preventive care visit during the measurement year*
- *Commercial members who had an ambulatory or preventive care visit during the measurement year or the two years prior to the measurement year*

This provision requires submittal of Medicare and Medicaid patient data. We are unclear concerning the need for the Exchange to collect patient-specific PHI on Medicare and Medicaid enrollees. These enrollees aren't customers of the Exchange. Is there a compelling reason that would trump the right of patient privacy?

Conclusion

In conclusion, please be assured that CAPG and its member groups are eager to apply all of our knowledge and skills in the effective delivery of clinically integrated, comprehensive coordinated care that improves the health of our fellow Californians and sustainably bends the cost curve. We strive daily to meet these goals, continuously developing and applying innovation and experience, and we are pleased to continue work with the Exchange and the selected QHPs to do so.

Sincerely,

A handwritten signature in black ink, appearing to read "Donald H. Crane". The signature is fluid and cursive, with a large initial "D" and "C".

DONALD H. CRANE

President & CEO

California Association of Physician Group



April 26, 2013

Mr. Peter Lee
Executive Director, California Health Benefit Exchange
560 J St, Suite 290
Sacramento, CA 95814

Subject: Response to Covered California's Inclusion of High-Deductible Health Savings Accounts in the Silver Metal Tier

Dear Mr. Lee,

The organizations listed above appreciate the opportunity to submit comments on Covered California's possible inclusion of high deductible Health Savings Account (HSA) plans in Covered California's silver metal tier. Although we are supportive of ensuring consumer choice, we have strong concerns that offering HSA plans in the silver metal tier could undermine efforts to ensure affordability for consumers and Bridge plan participation in Covered California. We recommend that Covered California prohibit HSA plans from being offered in the silver metal tier.

High Deductible Plans Undermine Affordability and Better Health

High deductible health plans are intended to offer consumers cheaper health plans with lower monthly premiums in return for considerable out of pocket risk. Although the savings accounts associated with these plans were created as an opportunity to assist with out of pocket costs, they are predicated on the notion that individuals will not have regular or chronic health needs triggering the high deductibles. Furthermore, it assumes these individuals have additional resources to save toward future health care expenses, which is unlikely if not impossible for many low-income families. According to a California HealthCare Foundation report, average HSA plan premiums in 2012 for individuals in California were \$425 per month and 60% had an annual deductible that exceeded \$2,000. This compares to a \$545 per month premium for an average CA individual health plan (HMO, PPO and HSA products), whereby only 13% had deductibles that exceeded \$2,000.

The inclusion of HSA plans in the silver metal tier could result in major affordability challenges for many

low and moderate income consumers. If high-deductible HSA products are offered in the silver tier, they would likely become the second lowest cost plan option within Covered California and the basis for the federal subsidy. Consumers would thus be subject to a subsidized plan with high out of pocket costs, presenting an even greater challenge for low-income families who cannot afford high upfront health care expenses. Furthermore, because the price of these plans is likely to be noticeably lower than other non-HSA plans, consumers will have ever greater difficulty applying their federal subsidy to another product with lower deductibles and co-pays.

High-deductible plans would also undermine Covered California's effort to improve health outcomes for enrollees. By creating a structure that is more difficult for families to purchase non-HSA plans, families with limited income will likely forgo or delay needed health care services. As health care providers and advocates who seek to ensure that individuals have full opportunities to better health outcomes, we are concerned that chronic illnesses and other health care needs may not be effectively addressed or prevented due cost barriers with HSA's.

Barriers for Bridge Plans

In addition, the inclusion of HSA plans in the silver tier may also significantly impact Bridge plan participation. Unlike high deductible plans, Bridge plans would provide more affordable products within Covered California that include both reduced premiums and reasonable out of pocket costs, without compromising benefits. If an HSA plan is the second lowest cost plan, Bridge plans would be required to offer a product below the cost of an HSA plan, which could limit the number of participating Bridge plans. Consequently, fewer Bridge plans could compromise Covered California's goals of maximizing enrollment, reducing churning between Medi-Cal and Covered California and ensuring participation of safety net providers in Covered California.

For these reasons, we urge you to keep high deductible plans out of the silver metal tier and instead promote the inclusion of QHP's that support and contribute toward the mission and goals of Covered California. We appreciate any efforts that may already be underway to address this issue and thank you for the opportunity to submit our comments. We look forward to continuing to identify ways to be supportive of Covered California's effort to maximize enrollment and improve health for all Californians.

Thank you,

California Association of Public Hospitals and Health Systems
California Primary Care Association
Consumers Union
Health Access
Local Health Plans of California
National Health Law Program
SEIU California
Western Center on Law and Poverty

April 30, 2013

Via email

The Honorable Diana Dooley, Chair
Covered California
560 J Street, Suite 290
Sacramento, CA 95814

Dear Chairwomen Dooley and Members of the Board:

RE: PPAC Comments on Qualified Health Plan Model Contract v4

Planned Parenthood Affiliates of California (PPAC) represents more than 100 community health centers throughout California that provide primary and reproductive health care services to primarily low-income, uninsured, and underserved Californians.

PPAC appreciates the opportunity to provide feedback on the second draft of the Qualified Health Plan Model Contract. We thank the Covered California staff and Board for their efforts to engage and respond to the concerns of stakeholders and look forward to continuing our work together to ensure that the promise of the Affordable Care Act is accessible to all Californians.

General Comments:

- **Covered California as a “Third Regulator”**

PPAC understands Covered California’s hesitance to serve as a “third regulator” and potentially overburden QHPs during this very busy time. However, the ACA specifically requires state Exchanges to regulate the provider networks of QHPs. Through the creation of ECP standards and by charging each state’s Exchange to oversee the creation of and compliance with ECP network adequacy, Congress showed its clear intent that the Exchange oversee the adequacy of these networks which offer federally subsidized care. ***PPAC urges Covered California staff to use its regulatory authority judiciously but asks Covered California to recognize its clear mandate to oversee and regulate network adequacy in the Exchange.***

- **Elimination of “Medi-Cal” – like Requirement Regarding Threshold Languages**

PPAC is disappointed that Covered California has revised the language access requirements in the latest version of the QHP Model Contract to reflect the minimal DMHC and CDI standards

required of plans in the commercial market. The success of the Covered California marketplace depends upon the participation of a broad and diverse array of Californians. Without offering materials and care in the languages that Californians understand, the Exchange endangers its ability to appeal and enroll a broad swath of the population. **PPAC urges Covered California to put the requirement that QHPs use Medi-Cal threshold languages back in. If Covered California determines that this requirement is not feasible for 2014, staff should closely monitor QHPs' performance with respect to LEP enrollees, and phase in this requirement in subsequent years.**

- **Plans concerned about collecting sensitive enrollee information, data not currently collected**

PPAC opposes the revision to the model contract that relieves QHPs from the responsibility of collecting and reporting demographic data on race, ethnicity, primary language, disability status, sexual orientation and gender identity in 2014. We are concerned that the model contract may now be inaccurate and misleading to plans. Under Health and Safety Code §1367.04, many health plans are already required to collect data on the race, ethnicity and primary language of their enrollees. Specifically they must assess their enrollee population to develop a demographic profile every three years. We urge Covered California to put this requirement back into the model contract as an important reinforcement of QHPs' legal obligations under existing state law. With regards to the collection of other demographic data, Exchanges are subject to Section 1557 of the Affordable Care Act which extends non-discrimination protections to sexual orientation and gender identity. Thus, Covered California and QHPs are prohibited from discrimination on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation. We strongly urge Covered California to require QHPs to collect demographic data for these characteristics by 2015 as proper data collection will be paramount to ensuring Covered California and its contractors are meeting their obligations under federal and state laws.

- **Certain pregnant women may be eligible for both an Exchange subsidy and expanded services through the Medi-Cal Program. Also, newly Qualified Immigrant Citizens may be eligible for Exchange subsidy products.**

PPAC supports the recommendation to include placeholder language requiring QHPs to cooperate with other Exchange partners with regard to pregnant women and certain immigrants.

For the suggestion of including placeholder language for QHPs to collaborate with Exchange partners, we are pleased to see that the Exchange is addressing the issue of ensuring that QHPs coordinate with the Department of Health Care Services for pregnant women who may be eligible for both an Exchange subsidy and Medi-Cal. We have concerns with the Administration's premium assistance proposal and its ability to allow for seamless continuity of

care and are in fact supportive of legislation currently under consideration that would expand services available to pregnant women up to 200% FPL on Medi-Cal to full scope coverage during pregnancy. Even if this legislation is enacted, coordination between the Exchange and DHCS will still be required so that women can have access to both Exchange coverage and no-cost sharing Medi-Cal coverage while pregnant. Women should not be required to drop Exchange coverage and have to enroll separately in Medi-Cal coverage during their pregnancy, but should be able to access their needed health services with no interruption in coverage or change in access to chosen providers. We believe access to these two programs and the associated federal funding can be administered seamlessly behind the scenes and urge you to make the placeholder language reflective of this approach.

We recommend that Covered California's placeholder language include a requirement that there is a seamless process to ensure that pregnant women have access to their full provider networks, all of the health benefits for which they are eligible, as well as all of the subsidies and cost-sharing protections to which they are entitled.

Similar issues may arise for certain immigrants or those eligible for other condition-specific coverage. We urge Covered California to work closely with the Department of Health Care Services and other state agencies as appropriate to work through these issues, and determine what role QHPs should play in coordinating coverage.

- **Network Requirements: Participating Provider Directory & Electronic Listing of Participating Providers**

PPAC is disappointed that Covered California has not included a requirement that both the centralized Participating Provider Directory and the QHP's Electronic Listing of Participating Providers include both the names of individual providers and the names of health care facilities such as community health centers like Planned Parenthood so that enrollees can easily identify their preferred source of health care.

Many of Planned Parenthood's patients, along those who access care at other community health centers, come to our health centers regularly but may see a different provider each time. While they know which health center they visit, they may not know the individual providers by name. These patients will be unable to locate our services or know that a community health center is in their network if we are only listed by provider name rather than facility. To better facilitate continuity of care for uninsured or underinsured Without clear guidance requiring QHPs to list both provider name and facility name in their directories, PPAC believes that it will be even more difficult to convince some QHPs of the importance of including both the name of the facility and the name of individual providers in the provider directory. To alleviate enrollee

confusion and support continuity of care for current health center patients, ***PPAC requests that both facilities and individual providers employed by a facility be listed within the provider directory so that applicants can search by both provider name and facility name.***

Thank you for the opportunity to respond to the above solicitation. Please do not hesitate to contact Brianna Pittman by telephone at (916) 446-5247 or brianna.pittman@ppacca.org if you have any questions or require any clarification on these comments.



April 25, 2013

California Health Benefit Exchange
560 J Street, Suite 290
Sacramento, CA 95814

Re: Comments on April 22 Draft of the Qualified Health Plan Model Contract

Dear Exchange Board Members and Staff:

On behalf of the Transgender Law Center, an organization advocating on behalf of lesbian, gay, bisexual and transgender (LGBT) Californians, we write to ask that the April 22 draft of the Qualified Health Plan Model Contract be revised so that it provides clear guidance on data collection, utilizes definitions of family consistent with California law, and makes clear the need for compliance with non-discrimination statutes. Our specific concerns are as follows:

Definition of Family Member

The definition "family member" under Article 13 of the model contract - "an individual who is within an Enrollee's or Employees family, as defined in 26 USC 36B" - is appropriate only for limited purposes of Exchange and Qualified Health Plan administration. While we recognize that under federal law, same-sex partners are treated differently with respect to the advanced premium tax credit and cost sharing reductions, use of this federal definition for the purposes of describing coverage eligibility ignores California's clear mandates to treat registered domestic partners and same-sex spouses equally to opposite-sex spouses in all aspects of state government, including the individual Exchange and the Small Business Health Options Program. Please see the following statutes:

- Family Code § 297.5(g) ("No public agency in this state may discriminate against any person or couple on the ground that the person is a registered domestic partner rather than a spouse or that the couple are registered domestic partners rather than spouses");
- Family Code § 308(c) ("...two persons of the same sex who contracted a marriage on or after November 5, 2008, that would be valid by the laws of the jurisdiction in which the marriage was contracted shall have the same rights, protections, and benefits, and shall be subject to the same responsibilities, obligations, and duties under law, whether they derive from the California Constitution, the United States Constitution, statutes, administrative regulations, court rules, government policies, common law, or any other provisions or sources of law, as are granted to and imposed upon spouses with the sole exception of the designation of "marriage");
- Health & Safety Code § 1374.58(a) ("...A plan shall not offer or provide coverage for a registered domestic partner that is not equal to the coverage provided to the spouse of an employee or subscriber"); and
- Insurance Code § 381.5(a) ("Every policy issued, amended, delivered, or renewed in this state shall provide coverage for the registered domestic partner of an insured or policyholder that is equal to,

and subject to the same terms and conditions as, the coverage provided to a spouse of an insured or policyholder”).

The only instance where the term “family member” is used in the model contract is in regard to coverage sold through the Small Business Health Options Program. Because that provision of the model contract (2.02) states that “All specified Employees, and their Family Members, of Employers who are qualified and eligible in accordance with the Affordable Care Act, California Affordable Care Act, and Regulations may obtain coverage through SHOP as permitted by State and Federal laws, rules and regulations...” the definition of “family member” established under Article 13 is inappropriate for the terms of the contract. Under California law, as described above, the definition of “family member” under 26 USC 36B would be insufficient for the purposes of establishing coverage eligibility. Therefore, the definition of “family member” for the purposes of this model contract should be amended to remove reference to 26 USC 36B. We recommend the following language (adapted from proposed 45 CFR 144.420(a)(2)):

“Family Member – An individual who is eligible for enrollment in a Qualified Health Plan because of a relationship to an Enrollee or Employee”

Nondiscrimination

While the draft contract integrates protections in the area of services and benefits through application of Affordable Care Act Section 1557 and “any other applicable State and Federal laws,” this section (3.32(a)) continues to omit explicit reference to federal regulations at 45 CFR 156.200(e) that speak directly to nondiscrimination requirements applicable to all QHPs. Additionally, the amendment in the April 22nd draft contains additional verbiage that renders the section unclear. To address both of these issues, we recommend the following language (strikethrough indicates removal, and bolded underline indicates addition to, the April 22 draft language):

(a) Services and Benefits. During the performance of this Agreement, Contractor shall not, and shall cause Participating Providers and other subcontractors, as well as their agents and employees to not, in accordance with the Affordable Care Act Section 1557 (42 U.S.C. 18116), cause an individual to be excluded on the grounds prohibited under Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), Title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), or section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), or subject to any other applicable State and Federal laws, including 45 CFR 156.200(e), from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity offered through the Exchange.

Data Collection

In the current draft of Attachment 7 to the model contract, the Exchange describes additional data elements expected of Contractors and requires collection of voluntarily reported data on demographic data by enrollees, including information on sexual orientation and gender identity. We strongly support the collection of data on sexual orientation and gender identity and believe this information will be key in addressing health disparities affecting LGBT Californians and ensuring provision of appropriate quality care to diverse plan enrollees.

Page 3 of 3

Should you have any questions or concerns, please contact Alice Kessler, Legislative Advocate, at akessler@lawpolicy.com or (916) 341-0808.

Sincerely,

A handwritten signature in black ink, appearing to read "Masen Davis", with a long horizontal flourish extending to the right.

Masen Davis
Executive Director
Transgender Law Center