COVERED CALIFORNIA POLICY AND ACTION ITEMS

February 18, 2016

RECOMMENDED 2017 CERTIFICATION

Anne Price, Director of Plan Management Division

2017 CERTIFICATION TIMELINE

Activity	Proposed Date
January Board Meeting: discussion of 2017 certification, benefit design & quality draft recommendation	January 21
Final AV Calculator Released	January 21
Plan Management Advisory Meeting	February 11
Carrier and Stakeholder Comment Feedback Ends	February 16
February Board Meeting: Request approval of 2017 certification and benefit design/ Review contract requirements	February 18
Letters of Intent Accepted	February 1 – February 19
QHP & QDP Applications for Individual Marketplace Open	March 1
April Board Meeting: Request approval of 2017 contract	April 7, 2016
QHP Application for Individual Marketplace Responses Due	May 2
Evaluation of QHP Responses & Negotiation Preparation	May 3 – June 5
QHP Negotiations	June 6 – June 17
Covered California for Small Business Applications Due (No rates)	June 17
QHP Preliminary Rates Announcement (Specific Date TBD)	July 5 – July 8
QHP Regulatory Rate Review Begins	July 5 – July 8
QDP Application for Individual Marketplace Responses Due	June 1
Evaluation of QDP Responses & Negotiation Preparation	June 2 – July 10
QDP Negotiations	July 11 – July 17
CCSB Rates Due	July 29
QDP Rates Announcement	August 1
Public posting of proposed rates *(if exception requested to CCIO by Covered California is accepted)*	August 31

Red font indicates change from January board discussion

2017 CRITERIA FOR PLAN SELECTION

Covered California seeks to offer health plans, plan designs and provider networks that are as affordable as possible to consumers both in premiums and cost sharing while fostering competition and stable premiums. This will be achieved by selecting health plans that:

- Offer value based on quality, service, and price, including
  - Adequate provider networks
  - Cultural and linguistic competency
  - Programs addressing
    - Health equity and disparities in care
    - Innovations in delivery system improvements
    - Payment reform
- Encourage competition based upon meaningful plan choice and product differentiation
- Enhance competition throughout the State, both statewide and within local communities
- Encourage alignment with providers and delivery systems that serve the low income population
- Demonstrate administrative capability and financial solvency

2017 CERTIFICATION UPDATE

- No significant comments were received on the 2017 certification approach that was presented to the board in January
- The only changes that are being made to the recommendations include a change to the exchange participation fee based on timing for board recommendation and a change in small business applications that will be considered off the annual certification cycle
- The exchange participation fee percentage is still being evaluated in relation to Covered California's Fiscal Year 16/17 budget and strategy work that is currently occurring in coordination with PwC
  - The percentage fee for all lines of business (individual, dental and small business) will be recommended to the board in April with final approval sought in May
  - Due to the timing of finalizing the participation fee, and the individual and dental application dues, we are providing initial guidance of the participation fee to use in premium rate setting for both individual and dental applications
  - Any changes to the final approved participation fee can be incorporated into the rates after the first negotiation prior to the rates being announced in July
  - Covered California for Small Business (CCSB) applications are not due until late July, so the participation fee that is approved in May will be available to use in setting the rates
- Small business applications can be submitted and will be considered off the annual certification cycle regardless if the carrier applying is currently contracted with certified plans in the Individual market

2017 INDIVIDUAL CERTIFICATION RECOMMENDATION

- For 2017, recommend one QHP Certification application that is open to all licensed health insurers. Covered California will review applications, negotiate with carriers and announce Qualified Health Plans in July 2016
- The 2017 application is for a multi-year contract term (2017 – 2019) with annual plan re-certification that includes review and Covered California approval of the following:
    - Contract compliance and performance review
    - Rates
    - Benefits
    - Networks
    - New products
    - Updates to performance targets and requirements if needed
- May allow new entrants in 2018 and 2019 if the carrier is newly licensed or a Medi-Cal managed care plan and the addition brings value to what is already being offered in the region(s)
- Carriers should include a 3.5% participation fee in the initial 2017 rates submitted on May 2nd, with the understanding that the percentage may increase or decrease based on final approval in the May board meeting
- The 2018 and 2019 participation fee will be annually reviewed and adjusted as necessary

Red font indicates change from January board discussion

2017 DENTAL CERTIFICATION RECOMMENDATION (INDIVIDUAL AND CCSB)

- For 2017, recommend one QDP Certification application that is open to all licensed dental plans
- The 2017 application is for a multi-year contract term (2017 – 2019) with annual plan certification that includes review and Covered California approval of the following:
  - Contract compliance and performance review
  - Rates
  - Benefits
  - Networks
  - New products
  - Updates to Performance Requirements

- May allow new dental issuer entrants in 2018 and 2019 if the issuer is newly licensed or the addition brings value to what is already being offered in the region(s)
- Carriers should include a 3.5% participation fee in the initial 2017 rates submitted on May 2nd, with the understanding that the percentage may increase or decrease based on final approval in the May board meeting
- The 2018 and 2019 participation fee will be annually reviewed and adjusted as necessary

Red font indicates change from January board discussion

2017 SMALL BUSINESS CERTIFICATION RECOMMENDATION

- Covered California for Small Business QHP certification application will be open to all licensed health insurers and not limited to carriers who offer QHPs for Individual
- Multi-year contract term (2017 – 2019) with annual carrier certification that includes review of premium competitiveness and stability, performance, and compliance with QHP contract requirements
- Allowance of new carrier entrants off annual certification cycle
- Allowance for quarterly change in rates, addition of new plans and networks (subject to Covered California approval)
- Exchange participation fee will be set at a percent of gross premium for 2017 and reviewed annually for 2018 and 2019 with the goal of reducing the percentage when possible

Red font indicates change from January board discussion

RECOMMENDED 2017 BENEFIT DESIGNS FOR INDIVIDUAL, SMALL BUSINESS AND FAMILY DENTAL

Anne Price, Director Plan Management Division

2017 STANDARD BENEFIT DESIGN UPDATE

- The final Actuarial Value (AV) calculator was released in January with no significant updates that required further changes to the benefit designs discussed at the January 21st board meeting

- There were minor comments received on the 2017 standard benefit designs that were presented to the board in January and as a result of those comments, the following changes have been made:
  - Language added to waive emergency room cost sharing if admitted to the hospital
  - Due to HDHP requirements, we must require that the deductible is applied to the "ER physician fee" in the Silver and Bronze HDHPs. Once the deductible is satisfied, there is no charge to the member for ER physician fees
  - Removed deductible from HDHP plans until updated value is provided by the IRS (expected in May 2016)
  - Corrected that the medical deductible does apply for emergency medical transportation for every plan that has a medical deductible which is consistent with 2016 benefits
  - Revised language for Endnote #18 to read "The inpatient physician cost share may apply for any physician who bills separately from the facility (e.g. surgeon). A member's primary care physician or specialist may apply the office visit cost share when conducting a visit to the member in a hospital or skilled nursing facility."
  - Removed end note #22 which defined tiering requirements that are no longer applicable because of state law

2017 DENTAL STANDARD BENEFIT DESIGN RECOMMENDATION

- **Copay Plan Design (Pediatric & Adult)**
  - Standardize copays for all procedure codes.

- **Coinsurance Design**
  - Include Periodontal Maintenance benefits in Basic Services.
  - Reduce out-of-network levels of coverage. Proposed plan coinsurance:
    - Diagnostic & Preventive: Plan pays 90%
    - Basic Services: Plan pays 70%
    - Major Services: Plan pays 50%
  - ***Adult benefits only***: Standardize the following exclusions: Tooth Whitening, Adult Orthodontia, and Implants.

- **Employer-Sponsored Adult Coinsurance Plan Design**
  - No waiting period for any service category.
  - Periodontal Services included in Basic Services.
  - Adult Endodontic Services included in Basic Services

****Red font indicates change from January board discussion***

APPENDIX

2017 DRAFT APPLICATION – PUBLIC COMMENT SUMMARY

Issue #	Section	Issue Area	Consolidated Comment	Covered California Response
1	Global	Clarifications	Clarifications requested regarding dates, instructions, appendices and attachments.	Covered CA will update all dates that have shifted since release of the draft application, as well as clarify instructions throughout the application. Each appendix and attachment is referenced in the specific question or requirements that refers to it. Plan proposal instructions will clearly explain the detailed requirements, including new language describing AI/AN plan variations.
2	Global	Document Structure	Does the QHP Certification Application for Individual Marketplace apply to Covered California for Small Business? Are currently contracted QHP Issuers expected to complete the entire application?	The 2017 certification applications will be separated for the separate marketplaces. All Applicants must complete the certification application for 2017 regardless of their status with the Exchange in 2016.
3	3	Benefits	Does requesting benefit deviations refer to allowing alternate benefit designs in the Individual Marketplace? Comments received that Covered CA should not allow for deviations from the standard benefit designs.	Alternate benefit designs are not permitted in the Individual Marketplace. Some issuers must adjust benefits to comply with regulatory requirements (e.g federal mental health parity compliance) or as a result of the issuer's delivery system. Covered CA requires a standardized mechanism for monitoring these requests and approving them as appropriate.
4	3	Benefits	Pediatric dental policy clarification.	While the Exchange encourages the inclusion of pediatric dental EHB in QHPs proposed for the Individual Marketplace, as a result of Board-adopted policy, Applicants are not required to embed the pediatric dental benefit.
5	3	Benefits	Covered CA should work closely with regulators to ensure EOC documents are in compliance with applicable laws and regulations.	Covered CA reviews member documents including SBCs and EOCs carefully and defers to the applicable state regulator for approval of these documents.

2017 DRAFT APPLICATION – PUBLIC COMMENT SUMMARY

Issue #	Section	Issue Area	Consolidated Comment	Covered California Response
6	Global	State and Federal law	Covered CA should state Applicants are required to comply with specific state laws in applicable questions and requirements.	Covered CA does not intend to re-state requirements dictated by federal or state laws.
7	3	Networks	"Preferred and non-preferred networks" could be construed to mean PPO network design.	Covered CA will remove "preferred and non-preferred networks" from language prohibiting tiered networks.
8	4.4.1	Networks	Covered CA should require demonstration of Applicant capacity to comply with SB 137 requirements related to provider directory updates. Covered CA should require the submission of additional information in Applicant provider data submissions.	Determination of the provider data elements currently requested is a result of extensive collaborative discussions to identify elements that can be consistently and accurately captured across a range of issuers. Covered CA will continue to defer to the applicable regulator for compliance with provider data regulations.
9	4.4.5	Networks	Covered CA should not require disclosure of provider contract details.	Covered CA does not intend to change the requirement of issuers to disclose contract provisions that prevent transparency.
10	5	Essential Community Providers	Importance of maintaining complete and accurate ECPs , and reviewing annually.	Covered CA is committed to regular review and maintenance of the ECP list in accordance with policy adopted by the Exchange Board. The ECP list remains publicly available for review and comment.
11	6.3.5	Customer Service	Applicants should be required to provide customer assistance in all threshold languages.	Final application requirements will include all threshold languages.
12	8	eValue8	Suggestions to revise information requested in the eValue8 tool, including reading level and language services.	All Applicants will complete the same eValue8 tool. The eValue8 tool can be modified for application to Exchange QHPs, including removal of references to tiered networks, but the questions embedded in the tool are standardized for use across all health plans.

2017 MODEL CONTRACT (DISCUSSION)

Anne Price, Director of Plan Management Division

KEY 2017 RECOMMENDED CONTRACT REQUIREMENTS

Highlights of revisions made to the 2017 – 2019 contract that are not related to Attachment 7 Quality requirements include the following:

1.17 Updated section which requires QHP Issuers to identify potential subsidy-eligible individuals, educate them about the Exchange, and assist them in enrolling in Qualified Health Plans in the Exchange

2.1.2 (b) Updated the appeals language to ensure both the QHP Issuer and Covered California are working together to implement appeals decisions in a timely manner

2.2.6 (b) and (c) Updated language on Agent Commissions to ensure all products are being offered to consumers consistently throughout the market. Contractor shall not vary Agent Commission levels by metal tier and shall offer the same commission level during both Open Enrollment and Special Enrollment Periods for each plan year

3.1.5 Operational Requirements and Liquidated Damages Section added to ensure the timely and accurate submission of QHP filings and documents to the Exchange

7.2.4 Remedies in case of QHP Issuer Default or Breach expanded. Additional remedies were added to help Covered California work with the QHP issuers in making improvements and in some instances protect consumers while improvements are in process

Attachment 14 – 5% penalty increased to 10% penalty for QHP Issuer failure to submit timely reconciliation reports

COVERED CALIFORNIA QUALITY AND DELIVERY SYSTEM REFORM

Dr. Lance Lang, Chief Medical Officer

COVERED CALIFORNIA AND A QUALITY DELIVERY SYSTEM

Covered California is focused on achieving the triple aim on behalf of all Californians

Guiding principals for raising the bar on quality requirements include the following:

- Quality is a team sport. Independent but not isolated practice is respected. Improving performance requires integration, coordination and collaboration.
- We will promote alignment with other purchasers including CMS, DHCS, CalPERS and employers as much as possible which will allow us to have similar focus and requirements across the delivery system.
- Certain requirements apply to a contracted health plan's entire book of business.
- Requirements will focus on tracking, trending and reducing healthcare disparities in care of chronic disease by race and ethnicity as well as gender.
- Consumers will have access to networks offered through the Contracted Health Plans that are based on high quality and efficient providers.
- Enrollees have the tools needed to be active consumers including both provider selection and shared clinical decision making.
- Payment will increasingly be aligned with value and proven delivery models.
- Variation in the delivery of quality care will be minimized challenging all providers implement best practices thus assuring that each provider at least meets minimum standards.

REVIEW OF ATTACHMENT 7 CHANGES FOR 2017

2014-2016	2017
1. Improving Care, Promoting Better Health and Lowering Costs	1. Improving Care, Promoting Better Health and Lowering Costs
2. Accreditation: NCQA, URAC or AAAHC	2. Provision & Use of Data and Information for Quality of Care
3. Provision and Use of Data and Information for Quality of Care	3. Reducing Health Disparities and Assuring Health Equity
4. Preventive Health and Wellness	4. Promoting Development and Use of Care Models
5. Access, Coordination, and At-Risk Enrollee Support	5. Hospital Quality
6. Patient-Centered Information and Communication	6. Population Health: Preventive Health, Wellness and At-Risk Enrollee Support
7. Promoting Higher Value Care	7. Patient-Centered Information and Communication
8. Drug Formulary Changes	8. Promoting Higher Value Care
	9. Accreditation: NCQA, URAC or AAAHC

ATTACHMENT 7 UPDATES -- BASED ON STAKEHOLDER INPUT

Staff presented potential revised (from 2016) Attachment 7 at the Board meeting on January 21st, and shared additional changes at the Plan Advisory meeting on February 11th. Changes from February 11th are below:

- Article 1- Improving Care, Promoting Better Health and Lowering Costs (restructured with section updates/additions)
  - Assuring Networks are Based on Value (1.02)
  - Demonstrating Action on High Cost Providers (1.03, new)
  - Demonstrating Action on High Cost Pharmaceuticals (1.04, new)
  - Quality Improvement Strategy (1.05, moved from Article 2)
  - Participation in Collaborative Quality Initiatives (1.06)
  - Data Exchange with Providers (1.08, moved from Article 4)
  - Data Aggregation Across Health Plans (1.09, new)
- Article 3 –Reducing Health Disparities and Assuring Health Equity.
  - Self identification and disparity measures clarified to refer to all lines of business (3.01 &3.02)
  - Limited English Proficiency added to list for expanded measurement in 2018-2019 (3.03)
- Article 4 – Promoting Development and Use of Care Models
  - Clarified that primary care assignment, PCMH and IHM/ACO standards relate only to Covered California lives (with data provided on entire book of business for reference)
- Article 5 – Hospital Quality
  - Clarified that hospital payments for value (6% by 2019) relates only to Covered California lives (with data provided on entire book of business for reference)
- Article 7 – Patient Centered Information and Support
  - Quality measurement added to consumer tools will be based on nationally endorsed quality information in accordance with the principles of the Patient Charter for Physician Performance Measurement (7.01)
- Article 8 – Payment Incentives to Promote Higher Value Care
  - Implementing new payment models will be required for care provided to Covered California enrollees(8.02)

1.02 ASSURING NETWORKS ARE BASED ON VALUE
Managing Variation in Performance

- Covered California proposes to require Contracted Health Plans to provide networks that are based on quality as well as cost to consumers.

- All performance standards, including clear definitions of “outlier poor performance”, will be established by Covered California based on:
  - National benchmarks
  - Analysis of variation in California performance
  - Best existing science of quality improvement
  - Effective engagement of stakeholders

- Quality Improvement Support is available for All Clinical Targets

- Covered California will require Contracted Health Plans to exclude outlier poor performing providers from networks by 2019 or provide rationale for continued contracting with each provider that is identified as a poor performing outlier and efforts the provider is undertaking to improve performance.

1.03 DEMONSTRATING ACTION ON HIGH COST PROVIDERS

Affordability is core to Covered California's mission. The wide variation in unit price and total costs of care charged by providers, with some providers charging far higher for care irrespective of quality, is a major contributors to high costs that does not lead to higher quality.

1) Contractor shall Report in its Application for Certification for 2017, and annually thereafter:

   - The factors it considers in assessing the relative unit prices and total costs of care;
   - The extent to which it adjusts or analyzes the reasons for cost factors based on elements such as area of service, population served, market dominance, services provided by the facility (e.g., trauma or tertiary care)
   - How such factors are used in the selection of providers or facilities in Covered California networks; and
   - The distribution of providers and facilities by cost deciles or other standardized processes.

2) In its Application for Certification for 2017, and annually thereafter, Contractor shall report on its strategies to assure that contracted providers are not charging unduly high prices, which may include but are not limited to:

   - Network Design, Telemedicine, Use of Centers of Excellence, Reference Pricing; and
   - Efforts to make variation in provider or facility cost transparent to consumers.

3) For contract year 2019, Contractor will be expected to exclude hospitals and other facilities that demonstrate outlier high cost from provider networks serving Covered California or to document each year in its Application for Certification the rationale for continued contracting with each facility that is identified as a high cost outlier and efforts that the hospital or facility is undertaking to lower its costs.

1.04 DEMONSTRATING ACTION ON HIGH COST PHARMACEUTICALS

Appropriate treatment with pharmaceuticals is often the best clinical strategy to treating conditions, as well as managing chronic and life threatening conditions. At the same time, Covered California is concerned at the trend in rising prescription drug costs, especially those in Specialty Pharmacy, which reflect a growing driver of total costs of care.

Contractor shall report in its annual application for certification a description of its approach to achieving value in delivery of pharmacy services, which may include strategies to:

1. Provide newer therapies based on independent assessments of the relative value to consumers and the health care system of such therapies within the Covered California standard benefit design.

2. Construct formularies based on total cost of care rather than on drug cost alone.

3. Monitor off-label use of pharmaceuticals and assure any off-label prescriptions are evidence-based.

4. Provide decision support for prescribers and consumers related to the clinical efficacy and cost impact of treatments and their alternatives.

1.07 DATA EXCHANGE WITH PROVIDERS

1) Covered California and Contractor recognize the critical role of sharing data across specialties and institutional boundaries as well as between health plans and contracted providers in improving quality of care and successfully managing total costs of care.

2) Examples that could impact the Contractor's success under this contract may include:

   a) Notifying PCPs when one of their empaneled patients is admitted to a hospital, a critical event that often occurs without knowledge of either the primary care or specialty providers who have been managing the patient on an ambulatory basis.
   b) Developing systems to collect clinical data as a supplement to the annual HEDIS process, such as HbA1c lab results or blood pressure readings which are important under Article 3.

3) Initiatives to make this exchange routine include various Health Information Exchanges including:

   a) Inland Empire Health Information Exchange (IEHIE)
   b) Los Angeles Network for Enhanced Services (LANES)
   c) Orange County Partnership Regional Health Information Organization (OCPRHIO)
   d) San Diego Health Connect
   e) Santa Cruz Health Information Exchange
   f) CalIndex.

1.08 DATA AGGREGATION ACROSS HEALTH PLANS

Covered California and Contractor recognize the importance of aggregating data across purchasers and payers to more accurately understand the performance of providers that have contracts with multiple health plans. Such aggregated data reflecting a larger portion of a provider, group or facility's practice can potentially be used to support performance improvement, contracting and public reporting.

Examples to date have included:

a) The Integrated Health Association (IHA) for Medical Groups
b) The California Healthcare Performance Information System (CHPI)
c) The CMS Physician Quality Reporting System
d) CMS Hospital Compare or
e) CalHospital Compare

Contractor shall report in its annual Application for Certification its participation in such initiatives to support the aggregation of claims and clinical data. Contractor should include its assessment of additional opportunities to improve measurement and reduce the burden of data collection on providers through such proposals as a statewide All Payer Claims Database.

NEXT STEPS

Continuing the multi-stakeholder collaboration on establishing standards:

- Finalize specifications for all metrics
- Approach to incorporating proxy racial/ethnic identification and to collecting data and measuring performance for assessing disparities
- For aligning terminology re selecting a Personal Care Physician
- For determining a PCP is practicing in a PCMH
- Source(s) of performance data and approach to assessing variation for Hospital Acquired Conditions
- Determining appropriate definitions and methodologies for “outlier” designation

2017 DRAFT ATTACHMENT 7– PUBLIC COMMENT SUMMARY

Issue #	Article	Issue Area	Consolidated Comment	Covered California Response
1	Article 1	Network Design based on Value	Adding quality elements to contracts requires time and collaboration, especially if re-opening contracts is involved.	Adding quality to contracting for payments and networks is part of a phased approach through 2019. All efforts that connect to payment reform or criteria for network participation have funded opportunities for providers to get coaching support through collaboratives.
2	Article 1	Data Exchange	Challenging for physicians to provide the data QHPs require to assess or improve performance.	Challenges go both ways. Physicians need more data such as notification of hospital and ER admissions to fulfill their responsibilities. Quality improvement requires both to engage in increased data exchange to benefit enrollees.
3	Article 1	Network Design based on Value	Some providers are impacted by variables, such as environment or population served, that could hamper ability to meet quality targets, which could lead to access issues.	Many quality targets are not determined by population characteristics including hospital complications. But QHPs can retain providers not meeting other targets if a rationale is provided.
4	Article 1	Network Design based on Value	Make QHP rationale for network inclusion or exclusion available to consumers.	Both current QHP network participation criteria and rationale for inclusion of providers that don't achieve performance goals may be made publicly available by Covered CA.
5	Article 1	Action on cost and pharmacy	A summary of Attachment 7 was distributed broadly to national experts for feedback after the last BOD meeting. Two subjects were identified as either missing or not sufficiently ambitious.	Covered CA added Sections 1.03 and 1.04.
6	Article 3	Disparities	Some quality initiatives have potential to increase health disparities if not implemented carefully.	Covered CA will be alert for unintended consequences through the use of balancing measures.
7	Article 3	Disparities	The 2019 goal of 85% for self-reported racial/ethnic identity is too high.	The target is reduced to 80%. However, two plans have attained 85%. Success will require increased data exchange with providers to take advantage of each contact to collect self-reported identity and for clinical data collection.

2017 DRAFT ATTACHMENT 7– PUBLIC COMMENT SUMMARY

Issue #				Covered California Response
8	Article 3	Disparities	Pace of data submission and requirements for improvement are not fast enough. Pace of data submission and requirements for improvement don't account for the challenges of data collection.	Covered CA recognizes that both views are legitimate and will work with all stakeholders to set a high bar but recognize operational challenges in implementation.
9	Article 3	Disparities	Definitions for "Health Disparities", "Healthcare Disparities" and "Health Equity" proposed.	Covered CA will add these definitions to the Attachment 7 Glossary.
10	Articles, 3.4,5 and 7	Data for all lines of business	QHPs should not have to submit data for any population other than Covered California enrollees.	Hospital Performance Data (C-sections and complications) is reported at the hospital level. Disparities in care can only be measured across broad populations. Other reporting requirements are for comparison only.
11	Article 4	Care Models	Integrated Healthcare Model (IHM) definition should focus on function, rather than structure.	Covered CA agrees, and IHM definition has been modified.
12	Article 4	Care Models	Concern for the future of the PPO.	Quality is a team sport. Independent but not isolated practice is respected. Improving performance requires integration, coordination and collaboration.
13	Article 4	Care Models	Please clarify why "Personal Care Physician is used instead of "Primary Care Physician".	Covered CA is emphasizing that in requiring that enrollees have a Personal Care Physician, there is no requirement to implement a gatekeeper model. Clarifying language on these terms has been added to the Attachment 7 Glossary. In addition, Covered CA will meet with plans to align lexicon when rolling this and other initiatives out to consumers to avoid confusion.
14	Article 4	Care Models	The process for connecting patients to Patient Centered Medical Homes (PCMHs), once defined, is complex and it will take time for QHPs to establish participation. it requires a concerted effort and active support from all key stakeholders.	We will work together to define PCMH, and are asking for a growing percent after determining baseline. Covered CA will facilitate broad stakeholder and expert engagement.

2017 DRAFT ATTACHMENT 7– PUBLIC COMMENT SUMMARY

Issue #	Article and Section	Issue Area	Consolidated Comment	Covered California Response
15	Article 4	Mental Health	Clarity needed on what is meant by integrating behavioral health with medical care.	Covered CA is not yet defining a preferred model, but is asking through the 2017 application what plans are currently doing, what barriers they are finding and how they are overcoming them before working with stakeholders to define a common approach.
16	Articles 4,5 and 8	Payment Reform	Strategies may not be fully defined in time for Application for Certification for 2017.	For some payment reform strategies, submission may be delayed until Q3 2017 if needed.
17	Article 5	QHPs setting quality targets	Is the role of QHPs to assure quality performance such as the target C-section rate.	Covered CA does expect QHPs to serve as our agents in developing provider networks based on both cost and quality performance.
18	Article 5	Target setting and data availability	There is a national target for low risk C-section rate but no similar target for hospital acquired conditions.	Covered CA will set targets based on national benchmarks, analysis of variation in California performance and best existing science of quality improvement and effective engagement of stakeholders.
19	Article 5	Hospital Associated Conditions (HACs)	Adverse Drug Events (ADE) measures are not NQF approved and may not be ready for inclusion in priority target hospital acquired conditions (HACs).	ADE has been one of the target HACs designated by CMMI under their Partnership for Patients program since 2011. But there was flexibility in this program and few hospitals have experience with the measure. Covered CA will phase it in starting with Opioid Overdose in 2017 and add others in future years as has been done with Sepsis Mortality.
20	Article 5	Hospital Payment to Promote Quality and Value	There is evidence that readmissions may be influenced by social determinants beyond the control of the health care system or social supports that a hospital can provide at discharge.	Covered CA requires at least 6% of payment to hospitals for Covered CA enrollees be at risk for quality. If Contractor includes readmissions as a measure under this provision, it shall not be the only measure.

2017 DRAFT ATTACHMENT 7– PUBLIC COMMENT SUMMARY

Issue #	Article and Section	Issue Area	Consolidated Comment	Covered California Response
21	Article 7	Cost and Quality Tools	Covered CA should provide as much specific cost/quality information as possible to both potential and current members now; or Covered CA should not require disclosure of confidentially negotiated contract terms.	Enrollees may be expected to spend up to $6800 out of pocket. Covered CA requires that enrollees have decision support including both cost and quality performance in choosing where to seek care. There is no current requirement that plans make specific treatment costs available to prospective enrollees.
22	Global	Network Exclusion Criteria	Outlier Poor Performance has not been precisely defined.	Criteria for defining "outlier poor performance" in a way that can be implemented consistently across Contractors will be will be established by Covered California based on national benchmarks, analysis of variation in California performance and best existing science of quality improvement and effective engagement of stakeholders.
23	Global	Metric Specifications	Specifications were published too late for thorough review and stakeholder input.	The Board will adopt the contract but not metric specifications. Plenty of time will be allowed to thoroughly review and improve the draft metric specifications.
24	Global	CCSB	Many of the requirements under Attachment 7 may be challenging to implement for Covered CA Small Business	Attachment 7 is written to apply to the individual market. Requirements for CCSB will be adopted at a later date.

COVERED CALIFORNIA

INDIVIDUAL ELIGIBILITY AND ENROLLMENT REGULATIONS READOPTION (DISCUSSION)

Bahara Hosseini, Legal

INDIVIDUAL ELIGIBILITY AND ENROLLMENT REGULATION CHANGES

- Covered California updated the definition of Qualified Health Plan to include Qualified Dental Plan (QDP), revised the definition of QDP, and removed the definitions of standalone dental, family dental, and children's dental plans. The regulations were also amended to include the eligibility requirements for enrollment in a QDP.
- Covered California added language to support the verification of qualifying life events that trigger a Special Enrollment Period.
- Covered California amended language regarding binder payments that will allow carriers to apply premium thresholds to initial payments as well as the subsequent premium payments.
- Covered California amended language regarding verbal unconditional withdrawal of an appeal request to make the regulations consistent with the current process.

CERTIFIED PLAN-BASED ENROLLMENT PROGRAM REGULATIONS FOR ADOPTION

Drew Kyler, Acting Deputy Director, Outreach and Sales Division

CERTIFIED PLAN-BASED ENROLLMENT PROGRAM

- On March 5, 2015, the Covered California Board approved the start of the Permanent Rulemaking process for the Certified Plan-Based Enrollment Program
- The Office of Administrative Law published the proposed regulations in the Notice Register on April 16, 2015, triggering the start of the one-year Permanent Rulemaking period
- On January 25, 2016, Covered California published a 15-Day Notice of Text Modifications and received no comments

CERTIFIED PLAN-BASED ENROLLMENT PROGRAM

Two Sections were modified:

§6704 Program Application

- (b)(10): Removed clause as applicant's status as non-profit, for profit, or governmental organization is not needed from a programmatic standpoint, and the information is available elsewhere.
- (d)(1): Clarified requirement for the PBE individual's application to require First and Last Name to ensure accurate identification.
- (e): Clarified the communication method (written) and timeframe (within 30 days) for the PBEE to notify the Exchange of the separation of an affiliated PBE.

CERTIFIED PLAN-BASED ENROLLMENT PROGRAM

Modified Sections, cont.:

§6706 Training and Certification Standards

- (a): Added the word "certification" to management training for clarity and consistency.
- (d): Clarified that the PBEs shall pass on an annual basis a "re-certification" exam.

ACTION: Request that the Board approve the filing of the Certificate of Compliance for permanent adoption of the Certified Plan-Based Enrollment Program Regulations

Resolution 2016-XX