COVERED CALIFORNIA POLICY AND ACTION ITEMS

January 14, 2021 Board Meeting

OVERVIEW OF COVERED CALIFORNIA'S RESPONSIBILITIES UNDER PROPOSITION 22

Katie Ravel, Director, Policy, Eligibility & Research Division

OVERVIEW

- Proposition 22 requires network companies (Uber, Lyft, etc.) to provide a healthcare stipend to qualifying app-based drivers, on a quarterly basis, based on certain criteria.
- Stipend amount is tied to the average statewide monthly premium for an individual Covered California bronze health insurance plan.
- Covered California must post the average statewide monthly premium for a bronze plan annually.
- Covered California may adopt and amend regulations to allow drivers to enroll in health plans through Covered California.

PROPOSITION 22 HEALTHCARE STIPEND – AMOUNT

- On or before **December 31, 2020** and **September 1 annually**, Covered California must publish the average statewide monthly premium for an individual for the following calendar year for a Covered California bronze health insurance plan.
- The stipend is tied to the “average ACA contribution” of the posted premium, defined as 82% of the premium.

PROPOSITION 22 HEALTHCARE STIPEND – ELIGIBILITY

- Eligibility for the healthcare stipend is assessed on a quarterly basis, based on “engaged time” (time from accepting rideshare/delivery to time completed).
- Drivers who average 25 hours or more per week: at least 100% of the average ACA contribution for each month in the quarter (82% of posted average bronze premium).
- Drivers who average at least 15 hours but less than 25 hours per week: at least 50% of the average ACA contribution for each month in the quarter (50% of 82% of posted average bronze premium).
- Note: Covered California will not know which enrollees are drivers and whether they meet the required hours to qualify for the stipend.

PROPOSITION 22 HEALTHCARE STIPEND – PAYMENT LOGISTICS

- The network company provides drivers with a statement regarding their engaged hours at the end of each earnings period (at least every 14 days).
- Payments must be made either within 15 days of the end of the calendar quarter or within 15 days of the driver's submission of proof of enrollment, whichever is later.

INTERACTION OF HEALTHCARE STIPEND WITH MARKETPLACE PREMIUM CREDITS

- App-based drivers who enroll in coverage through Covered California will be eligible for the federal Premium Tax Credit, Cost Sharing Reductions, and the California Premium Subsidy as long as they meet eligibility requirements for those programs.
- App-based driver healthcare stipend will be counted as income for purposes of eligibility for the federal Premium Tax Credit, Cost Sharing Reductions, and the California Premium Subsidy.

OVERVIEW OF HEALTHCARE STIPEND

METHODOLOGY FOR CALCULATING THE AVERAGE STATEWIDE MONTHLY BRONZE PREMIUM

- The average statewide monthly bronze premium is based on the average bronze premium for a 21-year old published by Covered California for the individual mandate penalty, adjusted by the average age of Covered California enrollees.
- Covered California engaged Milliman to review calculations for completeness and accuracy.

2021 AVERAGE STATEWIDE MONTHLY BRONZE PREMIUM AND HEALTHCARE STIPEND

- The average statewide monthly bronze premium for 2021 is $499.
- The stipend is tied to the “average ACA contribution” of the posted premium, defined as 82% of the premium or $409.
- Drivers who average 25 hours or more per week would receive at least 100% of the average ACA contribution for each month in the quarter or $409 per month.
- Drivers who average at least 15 hours but less than 25 hours per week would receive at least 50% of the average ACA contribution for each month in the quarter or $205 per month.

PROCESS FOR PUBLISHING THE AVERAGE STATEWIDE MONTHLY BRONZE PREMIUM

- The average statewide monthly bronze premium for 2021 was published on December 31 and is available at: https://www.hbex.ca.gov/stakeholders/.
- Covered California is promulgating regulations related to Proposition 22 healthcare stipend.

OTHER PROPOSITION 22 IMPLEMENTATION ACTIVITIES

COVERED CALIFORNIA IMPLEMENTATION ACTIVITIES

- Covered California is developing criteria for a special enrollment period for qualified app-based drivers.
- Covered California is developing a service to provide a proof of enrollment statement for drivers enrolled in a health plan through Covered California.

KEY MILESTONES AND NEXT STEPS

Key Milestone	Timeframe
Covered California publishes 2021 average statewide monthly bronze premium	December 31, 2020
Covered California presents implementing regulations for discussion and action	Quarter 1 2021
Covered California implements special enrollment period	Tentatively Quarter 1 of 2021
Covered California publishes 2022 average statewide monthly bronze premium	September 1, 2021

PROPOSED REGULATIONS

PROPOSED REGULATIONS: AVERAGE STATEWIDE MONTHLY PREMIUM

- Covered California staff are proposing to promulgate a regulation to specify the methodology for calculating the average statewide monthly bronze premium:
  - One-twelfth of the state average premium for an individual, as calculated annually pursuant to section 61015, subdivision (a)(2) of the Revenue and Taxation Code, adjusted to account for the average age of a Covered California enrollee in the current calendar year.
- Covered California would then post the calculation on or before each September 1 of each year using the methodology specified in the regulations

PUBLIC COMMENT

CALL: (877) 336-4440
PARTICIPANT CODE: 6981308

- To request to make a comment, press 10; you will hear a tone indicating you are in the queue for comment. Please wait until the operator has introduced you before you make your comments.
- If watching via the live webcast, please mute your computer to eliminate audio feedback while calling in. Note, there is a delay in the webcast.
- The call-in instructions can also be found on page two of the Agenda.

EACH CALLER WILL BE LIMITED TO TWO MINUTES PER AGENDA ITEM

NOTE: Written comments may be submitted to BoardComments@covered.ca.gov.

2022 QUALIFIED HEALTH PLAN CONTRACT AND CERTIFICATION PROCESS

James DeBenedetti, Director, Plan Management Division

APPROACH TO 2022 CONTRACTING AND CERTIFICATION

2022 Model Contract

- **Attachment 7:** Focus on incremental changes to set the foundation for more transformational changes in 2023 related to improving health care quality, reducing disparities, and reforming the delivery system
- **Attachment 14:** Transition to penalty-only approach to prepare issuers for a Quality Transformation Fund in 2023, which will have far greater financial incentives to improve health care quality
- **Other Changes:** Primarily to account for recent changes in State and Federal policy

2022 Certification Application

- Accepting new and currently contracted health plans for 2022, with a more comprehensive review process for 2023
- Updated to align with changes to the Model Contract

2022 Benefit Design

- Lower cost-sharing for the Silver plans to enhance their attractiveness and reduce the impact of deductibles and out-of-pocket maximums

2022 QUALIFIED HEALTH PLAN ISSUER MODEL CONTRACT

James DeBenedetti, Director, Plan Management Division

GUIDING PRINCIPLES FOR DEVELOPING EXPECTATIONS OF HEALTH PLANS - 2020 REVISION

1. Contract expectations are driven by the desire to improve the health of the population, improve care delivered, reduce the cost of care and reduce health disparities by assuring three complementary and overlapping objectives are met by health plans:
   - **Assuring Quality Care:** Ensuring our enrollees receive the right care, at the right time, in the right setting, at the right price.
   - **Fostering Improvements in Care Delivery:** Promoting value-enhancing strategies that have the potential to reform the delivery system in the near and long term.
   - **Promoting Health Equity:** Acknowledging the role of social determinants and systemic racism, Covered California expects its issuers and partners to address the impact of social needs and health disparities experienced by Covered California enrollees.
2. Success will be assessed by outcomes, measured at the most appropriate level, in preference to adoption of specific strategies.
3. Prioritizing requirements that meet multiple objectives and leveraging existing initiatives and mechanisms will reduce administrative burden.
4. Promoting alignment with other purchasers will maximize impact, elevate shared priority objectives and increase efficiency.
5. Enrollees will have access to networks offered through the issuers that are based on high quality and efficient providers.
6. Enrollees will have the tools needed to be active consumers, including tools for provider selection and shared clinical decision making.
7. Payment will increasingly be aligned with value and proven delivery models.
8. Actively monitoring and reducing variations in quality and cost of care will ensure better outcomes across the network for all Covered California Enrollees.

COVERED CALIFORNIA'S FRAMEWORK FOR HOLDING PLANS ACCOUNTABLE FOR QUALITY CARE AND DELIVERY REFORM

Assuring Quality Care

INDIVIDUALIZED, EQUITABLE CARE

- Population Health Management: Assessment and Segmentation
- Health Promotion and Prevention
- Mental Health and Substance Use Disorder Treatment
- Acute, Chronic and Other Conditions
- Complex Care

Effective Care Delivery Strategies

ORGANIZING STRATEGIES

- Effective Primary Care
- Promotion of Integrated Delivery Systems and ACOs
- Networks Based on Value

Sites and Expanded Approaches to Care Delivery

Appropriate Interventions

Key Drivers of Quality Care and Effective Delivery

Covered California recognizes that promoting change in the delivery system requires aligning with other purchasers and working with all relevant payers to reform health care delivery in a way that reduces burdens on providers.

- Benefit Design
- Measurement for Improvement Choice and Accountability
- Payment
- Patient-Centered Social Needs
- Patient and Consumer Engagement
- Data Sharing and Analytics
- Administrative Simplification
- Quality Improvement and Technical Assistance
- Certification, Accreditation and Regulation

Community Drivers: Community-Wide Social Determinants, Population and Public Health, and Workforce

January 2020

OVERALL APPROACH TO 2022 CONTRACT

- 2022 is a transitional year that focuses on a narrowed set of issuer requirements to lay the foundation for more transformational requirements in 2023+
- Covered CA staff engaged issuers, providers, consumer advocates, and other stakeholders throughout 2020 to develop the 2022 contract, and will continue engaging with these stakeholders throughout this year to develop the 2023+ contract
- Stakeholders are largely in agreement with our guiding principles, areas of focus, and approaches to improve the quality of care delivered to consumers
- Areas of significant change expected for 2023+ include:
  - Replacement of existing performance penalties with a Quality Transformation Fund that has significant financial incentives to provide high quality care
  - Expanded health equity agenda through aligned and coordinated efforts with public and private stakeholders and investments in data collection, infrastructure, and data quality
  - Increased focus on behavioral health – expanding integration with primary care and moving towards patient-reported outcome measures
  - Expanded population health management, including screening for social needs

FOCUS OF 2022 ATTACHMENT 7 REVISIONS

Health Equity	• Strengthened current requirements; added requirements to build health plan capacity and culture of equity, including achievement of NCQA Multicultural Health Care Distinction by year-end 2022
Population Health Management	• Added requirements for issuers to develop a Population Health Management plan
Behavioral Health	• Strengthened current requirements; added requirement to track new measures for depression screening and opioid use disorder
Effective Primary Care	• Strengthened current requirements; added requirement to participate in piloting a measure set to track the performance of primary care practices
Telehealth	• Added requirement for issuers to offer telehealth for behavioral health
Patient-Centered Social Needs	• Added requirement for issuers to screen all enrollees receiving plan-based services for at least housing instability and food insecurity
Accreditation	• Achieve NCQA Accreditation by year end 2024 to set a base standard of core health plan functions across all issuers

REVISED ATTACHMENT 14 (PERFORMANCE PENALTIES)

Performance Standards with Penalties	Current % at Risk	Proposed % at Risk
2.1 HEI Data	5%	10%
3.1 Quality Rating System – Clinical Quality Management Summary Rating	3.5%	33.5%
3.2 Quality Rating System – QHP Enrollee Experience Summary Rating	3.5%	16.5%
3.3 Reducing Health Disparities a) Race/Ethnicity Self-Identification Capture 80% in HEI Data b) Disparity Reduction c) NEW: Proposed 2% Credit for early achievement of NCQA MHCD	 2% 3%	 7.5% 7.5%
3.4 Primary Care Payment Strategy	3%	10%
3.5 Accountable Care Organizations	5%	10%
3.6 Appropriate Use of C-Sections	4.5%	5%
Total at Risk - Quality (90%) and HEI data (10%) Standards		100%

OTHER CHANGES

	Proposed Changes	IND	CCSB	QDP
2.2.1	Open Enrollment, Auto Enrollment, and Special Enrollment Periods. Updated to reflect SB 260, addressing a consumer's auto-enrollment into Covered California when they no longer qualify for Medi-Cal or the State's Children's Health Insurance Program.	✓		
2.2.2	Covered California for the Individual Market Coverage Effective Dates. Updated to reflect SB 260 changes to ensure no breaks in coverage by elimination of the 1-month delay in startup if binder payment is made after the 15th day of the month (15 Day Rule).	✓		✓
3.1.3	Accreditation. Moved to Attachment 7.	✓	✓	
3.5.2	Covered California for the Individual Market Rates. Updated language allocating windfall issuer profits (or losses) due to unanticipated ACA-related judgements or changes in federal policy into future premiums.	✓		
5.1.3	Covered California for the Individual Market Participation Fees. New language allows Covered California to offset participation fees in situations where payment or reimbursement to issuers is required.	✓		✓

NEXT STEPS

- The Model Contract draft, revised Attachment 7 draft, and revised Attachment 14 draft will be posted for public comment on January 14, 2021
- Public comment period for the 2022 Model Contract: January 14, 2021 – February 4, 2021
- Edits based on public comments received will occur in February
- The FINAL draft of 2022 Model Contract will be presented to the Board for approval at the March 2021 Board meeting
- Please send questions and comments to PMDContractsUnit@covered.ca.gov

APPENDIX
DETAILED PROPOSED 2022 ATTACHMENT 7 CHANGES AND SUMMARY OF PUBLIC COMMENTS

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 1: Individualized Equitable Care

- Issuers will continue to meet 80% capture of member race/ethnicity self-identification, assessed in Healthcare Evidence Initiative (HEI) data submission
- Issuers will submit patient level data files for required disparities measures instead of reporting disparities measures rates aggregated across lines of business
- Issuers will participate in collaborative effort to identify opportunities for aligned statewide disparity work
- Issuers must achieve and maintain NCQA Multicultural Health Care Distinction by year-end 2022

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 1: Individualized Equitable Care

Notable Changes to Draft Attachment 7	Rationale
1.02 Identifying Disparities in Care Added new proposed measures for HEDIS patient-level file submission: 1) Comprehensive Diabetes Care: HbA1c Control <8.0% 2) Comprehensive Diabetes Care: Eye exam (retinal) performed [new] 3) Comprehensive Diabetes Care: Medical attention for nephropathy [new] 4) Controlling High Blood Pressure for Hypertension (CBP)	Addition of two Comprehensive Diabetes Care measures for which Issuers will submit HEDIS measure sample patient level data files, as part of an increased emphasis on standard measures and a transition to internal disparities analyses conducted using HEI data submitted by QHP Issuers. *(See full proposed Disparities Measures Set for 2021-2022)*
1.03 Disparities Reduction Intervention Considering updated requirement to establish performance level of improved intervention population outcomes and analysis of results including potential to replicate or scale rather than demonstrating reduction in disparity in 2022.	Covered California is working with QHP Issuers to implement disparities reduction intervention best practices and may adjust baseline data measurement to better assess the impact of the interventions.
1.04 Statewide Focus on Health Equity Collaborative Efforts Updating to clarify participation requirements and goals of statewide focus.	Language revisions will clarify requirement objective to identify opportunities for coordinated, aligned statewide efforts, potentially focused on a single disparity to maximize impact.
1.05 Culture of Health Equity Capacity Building Considering extension of deadline to achieve NCQA Multicultural Health Care Distinction to year-end 2023.	Covered California is assessing the impacts of current and new disparities reduction requirements and other new requirements across Attachment 7 to determine a reasonable deadline for achieving NCQA's Distinction.

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 1: Individualized Equitable Care

Proposed Disparities Measures Set Reporting Years 2021 – 2023		
Domain	**HEDIS patient-level file measures (MY2018-MY2022) Report starting Q3 2021**	**Proposed HEI Measures To be calculated and monitored by Covered CA staff**
Mental Health		Antidepressant Medication Management (Effective Acute Phase Treatment)
Mental Health		Antidepressant Medication Management (Effective Continuation Phase Treatment)
Diabetes	Diabetes Care: HbA1c Control < 8.0%	
Diabetes		Diabetes Care: Hemoglobin testing (HbA1c)
Diabetes	Diabetes Care: Eye exam (retinal) performed	Proportion of Days Covered: Diabetes All Class
Diabetes	Diabetes Care: Medical attention for nephropathy	
Hypertension	Controlling High Blood Pressure for Hypertension (CBP)	
Hypertension		Proportion of Days Covered: RAS Antagonists (e.g., hypertension tx)
Asthma		Asthma Medication Ratio Ages 5-85 (Future HEI measure)
Health Promotion		Breast cancer screening
Health Promotion		Well Child Visits Ages 3-6
Access to Care		Adult Preventive Care Visits/1000
Access to Care		Emergency Room Visits/1,000 and Avoidable ER visits/1,000

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 2: Population Health Management

- Issuers will submit copy of NCQA Population Health Management Plan: Standard 1 (Population Health Management Strategy) and Standard 2 (Population Stratification and Resource Integration) to demonstrate population assessment and segmentation approach or submit a comparable plan

Notable Changes to Draft Attachment 7	Rationale
Updated the requirement to submit NCQA Population Health Management Plan: Standard 1 and Standard 2 to allow issuers to submit either the NCQA plan or a comparable plan	Issuers expressed concerns about submitting NCQA accreditation reports to Covered California, which contain information on products that are not subject to Covered California oversight. The intent of this requirement is to reduce burden and duplicative work for issuers by submitting the same reports required for NCQA accreditation. However, Covered California will amend draft Attachment 7 to accept a separate plan for their Covered California population with equivalent components as described in the contract.

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 3: Health Promotion and Prevention

- Issuers will continue to report on tobacco cessation program and weight management program utilization
- Issuers will report strategies to improve rates of Medical Assistance with Smoking and Tobacco Use Cessation and Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents measures
- Issuers will be required to offer Diabetes Prevention Programs (DPP) as both online and in-person formats

Notable Changes to Draft Attachment 7	Rationale
No change for requirement for issuers to report their strategies to improve rates of two QRS measures: • *Medical Assistance with Smoking and Tobacco Use Cessation* • *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* measures	Issuers expressed concerns about the inclusion of tracking two new measures that are not a part of IHA's AMP set. Covered California will not change this requirement. Our health promotion focus aligns with DHCS priorities per its quality strategy emphasis on smoking cessation and its inclusion of the WCC measure as a Managed Care Plan incentive metric. Though these two measures are not part of the IHA's AMP set, we will be working with IHA and others to advance the use of these and other measures that focus on two of the most important health behaviors challenges.
No change for requirement for issuers to offer Diabetes Prevention Programs (DPP) as BOTH online and in-person formats	Issuers requested that the requirement for *both* online and in-person DPP be changed to online *or* in-person, citing a limited number of in-person programs and low attendance. Covered California will not amend the recommendation at this time. We are committed to ensuring that all Enrollees have access to preventative diabetes care and education. Providing both in-person and online DPP services ensures Enrollees have equitable access to these services.

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 4: Behavioral Health

- Submit NCQA Health Plan Accreditation Network Management reports (or a comparable report) for the elements related to the issuer's behavioral health provider network
- Offer telehealth for behavioral health services and provide Enrollee education about how to access telehealth services; Covered CA will monitor utilization of telehealth services through HEI
- Annually report *Depression Screening and Follow Up (NQF #0418)* measure results for Covered CA enrollees; Covered CA will engage with issuers to review their performance
- Covered CA will monitor the following measures through HEI and engage with issuers to review their performance:
  - *Antidepressant Medication Management (NQF #0105)*
  - *Follow-Up After Hospitalization for Mental Illness (7-Day Follow-Up) (NQF #0576)*
  - *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (NQF #0004)*
  - *Use of Pharmacotherapy for Opioid Use Disorder (NQF #3400)*
  - *Concurrent Use of Opioids and Benzodiazepines (NQF #3389)*
  - *Use of Opioids at High Dosage in Persons Without Cancer (NQF #2940)*
  - *Concurrent Use of Opioids and Naloxone*
- Measure and report the number of active X waiver licensed prescribers in network and the number of total X waiver licensed prescribers in their network
- Report how issuers are promoting the integration of behavioral health services with medical services, report the percent of Enrollees cared for under integrated models, and whether the issuer reimburses for the Collaborative Care Model claims codes

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 4: Behavioral Health

Notable Changes to Draft Attachment 7	Rationale
Updated the requirement to submit NCQA Health Plan Accreditation Network Management reports for the elements related to the issuer's behavioral health provider network to allow issuers to submit a comparable report	Issuers expressed concerns about submitting NCQA accreditation reports to Covered California, which contain information on products that are not subject to Covered California oversight. Covered California will amend draft Attachment 7 to accept a separate report for their Covered California population with equivalent components.
Added language to the telehealth requirements to encourage issuers to use network providers for telehealth and promote the integration and coordination of care between telehealth vendors and network providers	The California Medical Association recommended telehealth services be offered by in-network providers when possible. Covered California will revise Attachment 7 to encourage the use of in-network providers and add a requirement for issuers to report how they are promoting coordination between in-network providers and telehealth vendors.
Specified the Medication Assisted Treatment (MAT) prescriptions that require an X waiver license	Issuers suggested further defining the prescriptions that require an X waiver license so Covered California has specified those prescriptions in Attachment 7.
No changes will be made to the requirement for issuers to collect Depression Screening and Follow-Up Plan (NQF #0418) measure results and annually report results	Issuers expressed concerns with reporting on this measure since it is not a HEDIS measure. Covered California will not change this requirement as the use of this measure is aligned with IHA, CMS, CalPERS, and others. We are looking to implement patient-reported outcome measures in 2023 which build on this measure.
No changes will be made to the requirement for issuers to measure and report the number of active X waiver prescribers in their network	Issuers expressed concerns with reporting on active X waiver prescribers as this is not currently tracked by issuers. Covered California will not change this requirement as this is critical to understanding access to MAT within an issuer's network.

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 5: Acute, Chronic and Other Conditions

- Issuers will continue to engage with Covered California to review QRS measure performance related to acute and chronic conditions
- Issuers will continue to support transition of enrollment for at-risk enrollees

Notable Changes to Draft Attachment 7	Rationale
Removed “sensitive diagnoses” language in the requirement to support transition of enrollment for at-risk enrollees	Issuers suggested further defining at-risk enrollees with a sensitive diagnosis. Covered California will amend draft Attachment 7 to clarify our intent.

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 6: Complex Care

- Issuers will describe methods to ensure, support, and monitor contracted hospitals' compliance with Medicare Condition of Participation rules to have electronic information exchange to notify primary care providers of Admission, Discharge, Transfer (ADT) events
- Issuers will continue requirements for at-risk enrollee engagement and Centers of Excellence

Notable Changes to Draft Attachment 7	Rationale
Updated language within the ADT requirement to align with the annual certification application	Issuers expressed concerns with reporting on mechanisms in place to remedy non-adherence with the ADT requirement. They noted that although issuers can report on implemented actions, there are limitations to remedy non-adherence. Covered California's goal is to align with the federal requirement as we believe this data is critical to ensuring continuity of care. We will amend draft Attachment 7 to clarify our intent and align language with the annual certification application.
Clarified the definition of hospitals in the ADT requirement so that it aligns with the CMS Final Rule	Issuers suggested further defining hospitals in the ADT requirement. Covered California will amend draft Attachment 7 to clarify the facilities need to implement the ADT requirement. The CMS Final Rule states that hospitals, including psychiatric hospitals and critical access hospitals, are required to send electronic patient event notifications.

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 7: Effective Primary Care

- Continue to match enrollees with PCPs and report the number of enrollees who select a PCP vs. those who are assigned a PCP
- Report the quality improvement and technical assistance being provided to physician groups to implement or support advanced primary care models
- Continue to require primary care payment reporting and increase the number of PCPs paid through shared savings and population-based payment models
- Pilot a quality measure set for advanced primary care to assess the prevalence of high-quality, advanced primary care practices within the issuer's network in collaboration with the California Quality Collaborative (CQC) and the Integrated Healthcare Association (IHA)

Notable Changes to Draft Attachment 7	Rationale
No changes will be made to the requirement for issuers to pilot a measure set for advanced primary care	Issuers, the California Medical Association and the California Academy of Family Physicians had several questions and comments about the development of the advanced primary care measure set. Covered California will be engaging issuers and stakeholders, along with IHA and CQC, in the development of the measure set throughout 2021 and 2022.

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 8: Promotion of Integrated Delivery Systems (IDS) and Accountable Care Organizations (ACOs)

- Participate in the Integrated Healthcare Association (IHA), submit data for the IHA Commercial HMO and ACO measure sets (as applicable), and report performance on the measure sets to Covered California annually
- Report the characteristics of the issuer's IDS and ACO systems such as payment model, leadership structure, quality incentive programs, data exchange processes, etc.
- Continue to require reporting the number of enrollees in IDS and ACO systems and increase the number of enrollees cared for under IDS and ACO systems

Notable Changes to Draft Attachment 7	Rationale
No changes will be made to the requirement for issuers to report the characteristics of their IDS and ACO systems	Issuers, the California Medical Association and the California Academy of Family Physicians had several questions and comments about how reporting will occur and what IDS and ACO characteristics will be tracked. Covered California will be engaging issuers and stakeholders, along with IHA, in the development of the list of characteristics throughout 2021.

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 9: Networks Based on Value

- Continue to require issuers to include quality and cost in all provider and facility selection criteria
- Continue to require issuers to notify poor performing hospitals and engage these hospitals in improvement efforts to reduce variation in performance across contracted hospitals and report the rationale for continuing to contract with poor performing hospitals
  - Covered California has defined poor performance as hospitals performing in the lowest decile on state or national benchmarks for quality and safety
- Participate in the IHA Align Measure Perform (AMP) program and report contracted physician group performance results to Covered California
- Work collaboratively with Covered California and other issuers to define poor performing physicians and physician groups, notify poor performers, and engage physician groups in improvement efforts to reduce variation in performance across contracted physician groups
  - Covered California will use the IHA AMP program to profile and analyze variation in physician groups performance on quality measures and total cost of care

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 9: Networks Based on Value

Notable Changes to Draft Attachment 7	Rationale
Clarified the definition of the lowest decile in hospital performance such that the performance for all eligible hospitals, statewide, can be arrayed on 0 to 100% rate and the lowest decile of that distribution can be computed	Issuers requested further clarity on how to determine the lowest decile of hospital performance. Covered California will add more details to Attachment 7 to define the lowest decile of hospital performance.
No changes will be made to the requirement for issuers to collaborate with Covered California to define poor performing physicians	Issuers, the California Medical Association and the California Academy of Family Physicians noted that currently there is not an industry standard for defining individual physician performance and there are several barriers to this effort. Covered California will be engaging with issuers and stakeholders in 2021 and 2022 to collaboratively work to measure individual physician performance and address these barriers.
No changes will be made to the requirement for issuers to define poor performing physician groups, notify poor performers, and engage physician groups in improvement efforts to reduce variation in performance across contracted physician groups	Issuers requested further clarification on how physician group performance will be monitored. Covered California will update Attachment 7 to clarify that the IHA AMP program will be used to profile and analyze variation in physician groups performance on quality measures and total cost of care.

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 10: Sites and Expanded Approaches to Care Delivery

- Continue requirements for tracking and reducing hospital associated infections (HAI) and NTSV C-sections to improve hospital quality and safety
- Continue to require issuers to track and report on telehealth utilization and payment

Notable Changes to Draft Attachment 7	Rationale
Updated language to reflect that the requirement for hospital payments subjected to a bonus payment for quality performance is at a minimum 2% of reimbursement by year-end 2022.	Issuers expressed concerns that increasing the hospital payment percentage tied to quality performance will add significant costs to consumers as providers would be unwilling to take on more financial risk. Covered California also found that issuers were having difficulty in achieving the 2% minimum. Covered California intends to re-evaluate this requirement for the 2023-2025 Attachment 7 contract.

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 11: Appropriate Interventions

- Continue requirements for issuers to report how it considers value in its medications formulary
- Continue requirements for issuers to ensure Enrollees have access to cost and quality information as well as shared decision-making tools

Notable Changes to Draft Attachment 7	Rationale
There are no significant changes to the draft Attachment 7.	

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 12: Key Drivers of Quality Care and Effective Delivery

- Article 12 defines and summarizes the Key Drivers
- Key Drivers with their own article:
  - Article 13: Measurement for Improvement, Choice, and Accountability
  - Article 14: Patient-Centered Social Needs
  - Article 15: Data Sharing and Analytics
  - Article 16: Quality Improvement and Technical Assistance
  - Article 17: Certification, Accreditation, and Regulation
- Key Drivers as an appendix:
  - Appendix A: Measurement for Improvement, Choice, and Accountability
  - Appendix B: Payment
  - Appendix C: Patient and Consumer Engagement
  - Appendix D: Quality Improvement and Technical Assistance

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 13: Measurement for Improvement, Choice, and Accountability

- Continue requirements related to data submission for the Quality Rating System and NCQA Quality Compass
- Consolidated and re-arranged the current measurement requirements in the draft 2022 Attachment 7

Notable Changes to Draft Attachment 7	Rationale
There are no significant changes to the draft Attachment 7.	

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 14: Patient-Centered Social Needs

- Issuers must screen all enrollees receiving plan-based services (such as complex care management or case management) for at least housing instability and food insecurity; report aggregated counts of members screened and positive screens for housing instability and food insecurity
- Maintain community resources inventory by region served to support linkage to appropriate social services; submit documented process for referrals for housing instability and food insecurity

Notable Changes to Draft Attachment 7	Rationale
Considering the potential removal of health education and health promotion programs from the list of required plan-based services in which social needs screening is required in 2022.	While these programs are an important opportunity for the plan or provider to assess social needs which might significantly impact a member's successful participation in these programs, Covered California recognizes internal workflows may differ for these programs and implementing screening and reporting may require additional time.

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 15: Data Sharing and Analytics

- Issuers will implement and maintain a secure, standards-based Patient Access Application Programming Interfaces (API) consistent with the Federally Facilitated Marketplace (FFM) rule
- Issuers will continue requirements to support data exchange with providers and data aggregation across plans

Notable Changes to Draft Attachment 7	Rationale
Added language to the data exchange with providers requirement to include an "Other Health Information Exchange" option so that issuers are not limited to the listed HIE examples	Issuers and other stakeholders expressed concerns that the HIE list included in the contract was not an exhaustive list of HIEs. Covered California will amend draft Attachment 7 to clarify that participation in other qualified HIEs should be described.
Updated language to the data exchange with providers requirement to clarify physician reporting requirement level	Issuers suggested further defining "professional providers". Issuers also expressed concerns with the physician reporting requirement level. Issuers noted that although some physician groups participate in HIE, an individual physician within that physician group may not. Covered California will amend draft Attachment 7 to clarify reporting at an individual clinician level. The intent of this requirement is to understand and strengthen network participation in HIEs. As noted in issuers comments, reporting physician group participation may not accurately depict engagement. We recognize the additional effort by QHPs to meet this requirement.

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 16: Quality Improvement and Technical Assistance

- Continue issuer reporting on participation in any quality improvement collaborative and data sharing initiatives in the annual application for certification
- Continue the requirement for issuers to adopt and implement Smart Care California guidelines supporting the appropriate use of C-sections and Opioids

Notable Changes to Draft Attachment 7	Rationale
There are no significant changes to the draft Attachment 7.	

PROPOSED 2022 ATTACHMENT 7 CHANGES

Article 17: Certification, Accreditation and Regulation

- Proposing to require issuers to be accredited by NCQA by year end 2024
  - Previously Covered California allowed issuers to be accredited by one out of three accrediting bodies (NCQA, AAAHC, or URAC)
- Proposing to align with the CMS accreditation timeline and 30-day written notification of changes or actions affecting an issuer's accreditation status

Notable Changes to Draft Attachment 7	Rationale
There are no significant changes to the draft Attachment 7.	

2022 CERTIFICATION APPLICATION

Jan Falzarano, Deputy Director of Plan Management Division

Discussion

QUALIFIED HEALTH AND DENTAL PLAN CERTIFICATION

Plan Year 2022 Qualified Health Plan (QHP) and Qualified Dental Plan (QDP) Certification Applications are open to:

- Individual Marketplace
  - Existing and New Issuers offering QHPs or QDPs

- Covered California for Small Business
  - Existing and New Issuers offering QHPs or QDPs

Currently Contracted Applicants

- For Sections 1-17, QHP and QDP Carriers contracted for Plan Year 2021 will continue to complete a simplified Certification Application for Plan Year 2022.

KEY APPLICATION CHANGES

Section 5 – Benefit Design – Added a Telehealth Attachment to better understand the Applicants' telehealth capabilities.

Section 14 – Sales Channels – Added questions to better understand the Applicants' Agent of Record, agent communication, and sales strategies.

Section 18 – Quality – Added and deleted questions to align with the contract.

PUBLIC COMMENTS

Plan Management Division received 27 public comments across the four Applications. The comments were technical in nature technical or for clarification.

The Public Comment Summary is available at: https://hbex.coveredca.com/stakeholders/plan-management/qhp-certification/

KEY DATES

February 1 through February 12, 2021 - Letters of Intent due

March 1, 2021 - Individual and Small Business Certifications Applications go live

April 30, 2021- Individual and Small Business Applications due

PROPOSED CERTIFICATION MILESTONES

Release Draft 2022 QHP & QDP Certification Applications	December 2020
Draft Application Comment Periods End	December 2020
Plan Management Advisory: Benefit Design & Certification Policy Recommendation	January 2021
January Board Meeting: Discussion of Benefit Design & Certification Policy Recommendation	January 2021
Letters of Intent Accepted	February 1-12, 2021
Final AV Calculator Released*	February 2021
Applicant Trainings (electronic submission software, SERFF submission and templates*)	February 2021
March Board Meeting: Anticipated approval of 2022 Patient-Centered Benefit Plan Designs & Certification Policy	March 2021
QHP & QDP Applications Open	March 1, 2021
QHP & QDP Application Responses (Individual and CCSB) Due	April 30, 2021
Evaluation of QHP Responses & Negotiation Prep	May - June 2021
QHP Negotiations	June 2021
QHP Preliminary Rates Announcement	July 2021
Regulatory Rate Review Begins (QHP Individual Marketplace)	July 2021
Evaluation of QDP Responses & Negotiation Prep	June – July 2021
QDP Negotiations	July 2021
CCSB QHP Rates Due	July 2021
QDP Rates Announcement (no regulatory rate review)	August 2021
Public Posting of Proposed Rates	July 2021
Public Posting of Final Rates	September – October 2021

*Final AV Calculator and final SERFF Templates availability dependent on CMS release
TBD = dependent on CCIIO rate filing timeline requirements

2022 BENEFIT DESIGN

Jan Falzarano, Deputy Director of Plan Management

BENEFIT PLAN DESIGN OVERVIEW

The Affordable Care Act requires that each plan offered on the Exchange include 10 Essential Health Benefits (EHBs).

Actuarial Value (AV) describes the average consumer's share of cost and is calculated based on the provision of EHBs at four tiers: Bronze (60% AV), Silver (70% AV), Gold (80% AV), Platinum (90% AV).

California law mandates an allowable *de minimis* variation range for AV of +/- 2% (Bronze is allowed a variation of +5%/-2%).

In the fall of each year, the federal Office of Management and Budget (OMB) releases a draft AV Calculator (AVC) and Notice of Benefit and Payment Parameters (NBPP). The AVC and NBPP are used to model how benefit cost shares can be changed to ensure all plans fit within the *de minimis* range for each metal tier. The final NBPP and AVC are released in spring.

FACTORS INFLUENCING 2022 BENEFIT PLAN DESIGNS

The draft 2022 AVC and NBPP were released on December 4, 2020.

The AVC assumes a 0% increase in cost trend from 2021 to 2022, allowing room for small adjustments.

Covered California uses a stair-step approach to benefit design; plans with a higher AV (and higher premium) have lower out-of-pocket costs.

Platinum and Gold coinsurance plans remain close to the upper AV *de minimis* range. Bronze is also at the upper *de minimis* range.

To preserve the stair-step approach between metal tiers, proposed 2022 changes are only possible within the Silver tier.

2022 PROPOSED BENEFIT PLAN DESIGN CHANGES

Proposed Silver tier benefit changes to plans with cost sharing reductions:

- Silver 94: 100% - 150% Federal Poverty Level (FPL)
  - reduced MOOP from $1,000 to $800
- Silver 87: 150% - 200% FPL
  - reduced the medical deductible from $1,400 to $800
  - eliminated the Rx deductible
- Silver 73: 200% - 250% FPL
  - reduced the Rx deductible from $275 to $50
  - reduced Tier 1 Rx copay from $16 to $15

2022 PROPOSED BENEFIT PLAN DESIGN CHANGES, con't

Proposed Silver 70 tier benefit changes

- reduced Rx deductible from $300 to $50,
- copays for: primary care, behavioral health, and speech/occupational/physical therapy visits reduced from $40 to $35
- reduced Tier 1 Rx copay from $16 to $15

COVERED CALIFORNIA FOR SMALL BUSINESS

COVERED CALIFORNIA FOR SMALL BUSINESS – 2022 BENEFIT DESIGN

To ensure CCSB products remain competitive in the marketplace, benefit designs are being held constant for 2022

Refer to the handout “Proposed 2022 Plan Designs Side-by-Side View”

DENTAL UPDATE

2022 DENTAL BENEFIT PLAN DESIGNS

The 2022 Standard Benefit Dental Plan Designs remain unchanged

- Cost sharing is detailed on the 2022 Copay Schedule which has been completed and reviewed by Milliman
- CDT code changes have been updated (additions, deletions, edits, cost share changes)

End Note #11 has been changed from “comprehensive” to “comparable” to promote improved consumer understanding

- Example: “…waiting period for major services must be waived upon a member’s provision of proof of prior comparable dental coverage…”

NEXT STEPS

NEXT STEPS

The plan designs proposed today are **preliminary**, pending review and comments by stakeholders, release of the final 2022 AVC, and Milliman's AV certification.

Plan Management will continue to accept comments after the January Board meeting and will make changes as necessary prior to presenting the plan designs for Board approval in March.

APPENDIX

AV INCREASES FROM 2021 TO 2022

Refer to the handout "Proposed 2022 Plan Designs Side-by-Side View"

	Bronze		Silver				Gold		Platinum	
	HDHP	Standard	Silver	Silver 73	Silver 87	Silver 94	Copay	Coins	Copay	Coins
AV Target	60	60	70	73	87	94	80	80	90	90
Deviation Allowance	+5 /-2%	+5 /-2%	+/-2.0%	+/-1.0%	+/-1.0%	+/-1.0%	+/-2.0%	+/-2.0%	+/-2.0%	+/-2.0%
2021 AV	64.60	64.90	70.45	73.26	87.82	94.09	78.01	81.90	89.25	91.59
Change due to custom inputs			-0.04	-0.001	-0.15	-0.09				
AV baseline in 2022 AVC	64.60	64.90	70.41	73.26	87.67	94.00	78.01	81.90	89.25	91.59
2022 AV	**64.60**	**64.84***	**70.47***	**73.30***	**87.64***	**94.00**	**78.01**	**81.90**	**89.25**	**91.59**

CCSB ONLY	Silver			Gold		Platinum	
	Copay	Coins	HDHP	Copay	Coins	Copay	Coins
AV Target	70	70	70	80	80	90	90
Deviation Allowance	+/-2.0%	+/-2.0%	+/-2.0%	+/-2.0%	+/-2.0%	+/-2.0%	+/-2.0%
2021 AV	70.62	71.30	71.78	79.43	78.22	88.29	90.47
Change due to custom inputs	-0.02	-0.04	-0.03		-0.12		
AV baseline in 2022 AVC	70.60	71.26	71.75	79.43	78.10	88.29	90.47
2022 AV	**70.92***	**71.55***	**71.75**	**79.43**	**78.08***	**88.29**	**90.47**

*Final AV includes 2021 copay accumulation additive adjustment – will update with final screenshots

Red text: AV is outside *de minimis* range

Blue text: AV is within *de minimis* range

2022 ANNUAL LIMITATION ON COST SHARING - MOOP

	2019	2020	2021	2022
Maximum annual limitation on cost-sharing (federal)	$7,900 / $15,800	$8,150 / $16,300	$8,550 / $17,100	$9,100 / $18,200
Less CA MOOP ($350) for dental	$7,550 / $15,100	$7,800 / $15,600	$8,200 / $16,400	$8,750 / $17,500
CSR 73 Maximum annual limitation	$6,300 / $12,600	$6,500 / $13,000	$6,800 / $13,600	$7,250 / $14,500
CSR 87 Maximum annual limitation	$2,600 / $5,200	$2,700 / $5,400	$2,850 / $5,700	$3,000 / $6,000
CSR 94 Maximum annual limitation	$2,600 / $5,200	$2,700 / $5,400	$2,850 / $5,700	$3,000 / $6,000

PUBLIC COMMENT

CALL: (877) 336-4440
PARTICIPANT CODE: 6981308

- To request to make a comment, press 10; you will hear a tone indicating you are in the queue for comment. Please wait until the operator has introduced you before you make your comments.
- If watching via the live webcast, please mute your computer to eliminate audio feedback while calling in. Note, there is a delay in the webcast.
- The call-in instructions can also be found on page two of the Agenda.

EACH CALLER WILL BE LIMITED TO TWO MINUTES PER AGENDA ITEM

NOTE: Written comments may be submitted to BoardComments@covered.ca.gov.