COVERED CALIFORNIA
QUALIFIED HEALTH PLAN ISSUER CONTRACT FOR 2017 – 2022
FOR THE INDIVIDUAL MARKET – 2022 PLAN YEAR AMENDMENT

between

Covered California

and

xxx (“Contractor”)

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COVERED CALIFORNIA
QUALIFIED HEALTH PLAN ISSUER CONTRACT
between
Covered California
and
_____ ("Contractor")

THIS QUALIFIED HEALTH PLAN ISSUER CONTRACT ("Agreement") is entered into by and between Covered California, an independent entity established within the government of the State of California doing business as Covered California 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. Covered California 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 Covered California health care coverage choices that seek to provide the optimal combination of choice, value, access, quality, and service to Qualified Individuals;

B. The Application process conducted by Covered California is based on the assessment of certain requirements, criteria and standards that: (i) Covered California determines are reasonable and necessary for bidding Health Insurance Issuers to market, offer, and sell Qualified Health Plans (QHPs) through Covered California, (ii) are set forth in the Application, and (iii) are required under applicable laws, rules and regulations or otherwise necessary to meet the needs of Enrollees in Covered California, including, those set forth at 10 CCR § 6400 et seq. and 45 C.F.R. Part 155 et seq.;

C. In connection with the evaluation of the responses to the Application received from Health Insurance Issuers, Covered California is required under 10 CCR § 6428 et seq.: (i) to evaluate the proposed QHP Issuer's compliance with requirements imposed under the Application, and (ii) to give greater consideration to potential QHP Issuers that further the mission of Covered California by promoting, among other items, the following: (1) affordability for the consumer – 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 Issuer 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 Covered California and Health Insurance Issuers;

D. Contractor is a Health Insurance Issuer authorized to provide Covered 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, or (ii) a licensed 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 Covered California's evaluation of the proposal submitted by Contractor in response to the Application ("Proposal") and its consideration of other factors required to be considered under applicable laws, rules and regulations and/as otherwise necessary to meet the needs of Enrollees, Covered California intends to designate Contractor as a QHP Issuer (as defined at 10 CCR § 6410) pursuant to Covered California's determination that Contractor's proposed QHPs meet the requirements necessary to provide health insurance coverage as a QHP to Qualified Individuals who purchase health insurance coverage through Covered California;

F. Contractor desires to participate in Covered California as a QHP Issuer; and

G. Contractor and Covered California 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 QHPs through Covered California.

ARTICLE 1 – GENERAL PROVISIONS

1.1 Purpose

This Agreement sets forth the expectations of Covered California and Contractor with respect to: (a) the delivery of services and benefits to Enrollees; (b) the respective roles of Covered California and the Contractor related to enrollment, eligibility, and customer service for Enrollees; (c) coordination and cooperation between Covered California and Contractor to promote quality, high value care for Enrollees and other health care consumers; (d) Covered California's expectation of enhanced alignment between Contractor and its participating providers to deliver high quality, high value health care services; and (e) administrative, financial, and reporting relationships and agreements between Covered California and Contractor.

Covered California enters into this Agreement with Contractor to further its mission to increase the number of insured Californians, improve health care quality and access to care, promote health, lower costs, and reduce health disparities. Covered California seeks to accomplish this mission by creating an innovative and competitive marketplace that empowers consumers to choose the health plan and providers that offer the best value. Covered California'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 costs of Covered Services. Through the execution of this Agreement, Covered California and Contractor jointly commit to be actively engaged in promoting change and working collaboratively to define and implement additional initiatives to continuously improve quality and value.

1.2 Applicable Laws and Regulations

a) This Agreement is in accord with and pursuant to the California Affordable Care Act, Section 100500 et seq., Title 22 of the California Government Code (Chapter 655, Statues of 2010 and Chapter 659, Statutes of 2010) and the implementing regulations, Title 10, Chapter 12 of the California Code of Regulations, § 6400 et seq., as enacted or as modified during the course of this Agreement. This Agreement is also in accord with and pursuant to the Federal Patient Protection and Affordable Care Act and its implementing Federal regulations, as enacted or modified during the course of this Agreement, including but not limited to standards for QHP certification set forth at 45 C.F.R. Part 156 et seq. (Subpart C: Qualified Health Plan Minimum Certification Standards).

b) Contractor is subject to the obligations imposed on Contractor under applicable laws, rules and regulations of the Federal Affordable Care Act, the California Affordable Care Act, and any other applicable Federal, State or local laws, rules and regulations. The parties to this Agreement recognize and acknowledge there may be material changes to the above-referenced rules and regulations and other applicable Federal, State, or local laws, rules and regulations. Should such an event arise, the parties agree that revisions to this Agreement may be necessary to align provisions contained herein with the changes made to these laws. Nothing in this Agreement limits such obligations imposed on Contractor, including any failure to

reference a specific State or Federal regulatory requirement applicable to Covered California or Contractor. In those instances where Covered California imposes a requirement in accordance with the California Affordable Care Act or as otherwise authorized by California law that exceeds a requirement of the Federal Affordable Care Act or other Federal law, the State law and Covered California requirement shall control unless otherwise required by law, rules and regulations.

c) Compliance Programs. Contractor shall, and shall require 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, the California Affordable Care Act, the Americans with Disabilities Act, the Anti-Kickback Statute, the Public Contracts Anti-Kickback Act, the Stark Law, the Knox-Keene Health Care Service Plan Act of 1975, and California Insurance Code, as applicable.

1.3 Relationship of the Parties

a) Independent contractors. The parties acknowledge that in performance of the duties under this Agreement Covered California and the Contractor are acting and performing as independent contractors. Nothing in this Agreement shall be construed or deemed to create a relationship of employer or employee or partner or joint venture or principal and agent between Covered California and Contractor. In accordance with State and Federal law, Covered California is not operating on behalf of Contractor or any subcontractor of Contractor. Neither Contractor nor its Participating Providers, authorized subcontractors, or any agents, officers, or employees of Contractor shall be deemed as agents, officers, employers, partners, or associates of Covered California.

b) Subcontractors. Contractor shall require any subcontractor or assignee to comply with applicable requirements in this Agreement. Nothing in this Agreement shall limit Contractor's ability to hold subcontractor liable for performance under a contract between Contractor and its subcontractor(s). Contractor's obligations pursuant to this Agreement and applicable laws, rules and regulations shall not be waived or released if Contractor subcontracts or otherwise delegates services of this contract. Contractor shall exercise due diligence in the selection of subcontractors and monitor services provided by subcontractors for compliance with the terms of this Agreement and applicable laws, rules or regulatory requirements or orders.

1.4 General Duties of Covered California

Covered California is approved by the United States Department of Health and Human Services ("DHHS") pursuant to 45 C.F.R. § 155.105 and performs its duties in accordance with State and Federal laws and this Agreement. The duties of Covered California include:

a) Certification of QHP Issuers (45 C.F.R. Part 155, Subpart K);

b) Consultation with stakeholders (45 C.F.R. § 155.130);

c) Consumer assistance tools and programs, including but not limited to operation of a toll-free call center (45 U.S.C. § 18031 (d) and 45 C.F.R. § 155.205);

d) Eligibility and enrollment determinations in Covered California for the Individual Market (45 C.F.R. Part 155, Subparts D, E, H, I);

e) Financial support for continued operation of Covered California (45 C.F.R. § 155.160);

f) Navigator program standards, in accordance with Federal rules, designed to raise awareness of Covered California by providing consumer access to education and other resources regarding eligibility, enrollment, and program specifications (45 C.F.R. § 155.210);

g) Non-interference with Federal law and nondiscrimination standards (45 C.F.R. § 155.120);

h) Notices to Enrollees (45 C.F.R. § 155.230);

i) Oversight, financial, and quality activities (45 C.F.R. § 155.200);

j) Participation of brokers to enroll Qualified Individuals in QHPs (45 C.F.R. § 155.220);

k) Ensuring that individuals can pay premiums owed directly to QHP issuers and ensuring compliance with related Federal requirements (45 C.F.R. § 155.240);

l) Privacy and security of personally identifiable information (45 C.F.R. § 155.260);

m) Use of standards and protocols for electronic transactions (45 C.F.R. § 155.270);

n) Operation and management of CalHEERS. Covered California also has a duty, as part of its management of CalHEERS, to determine how CalHEERS presents information about cost, quality, and provider availability for consumers to inform their selection of issuer and benefit design in Covered California. Covered California shall solicit comment from Contractor on the design but retains final authority to make design and presentation decisions in its sole discretion; and

o) Covered California agrees to provide a dedicated team member responsible for working with Contractor to resolve any and all issues that arise from implementation of Covered California.

1.4.1 Confidentiality of Contractor Documents

Covered California shall treat as confidential and exempt from public disclosure all documents and information provided by Contractor to Covered California, or to the vendor for Covered California, providing the documents or information are deemed to be, or qualify for treatment as, confidential information under the Public Records Act, Government Code § 6250 et seq., or other applicable Federal and State laws, rules and regulations. Documents and information that Covered California will treat as confidential include, but are not limited to, provider rates and the Contractor's business or marketing plans.

1.5 General Duties of the Contractor

Contractor and Covered California acknowledge and agree that Contractor's QHPs are important to furthering the goal of Covered California with respect to delivering better care and higher value. Contractor agrees that Contractor's QHPs submitted and certified through the annual certification process for the current Plan Year, shall be offered through Covered California to provide access to Covered 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 QHP.

Contractor shall maintain the organization and administrative capacity to support and ensure implementation and operation of this Agreement. This requirement includes the following:

a) Contractor maintains the legal capacity to contract with Covered California and complies with the requirements for participation in Covered California pursuant to this Agreement and applicable Federal and State laws, rules and regulations;

b) A dedicated liaison is available as the primary contact person to coordinate and cooperate with Covered California in the implementation of this Agreement and the contact person and/or other personnel are available to Covered California as needed to fulfill Contractor's duties under this Agreement.

c) Contractor's QHPs are offered in accordance with the terms and conditions of this Agreement and compliance with the Affordable Care Act and the California Affordable Care Act and implementing regulations, and with applicable Federal and State laws, rules and regulations, as may be amended from time to time as required under applicable laws, rules and regulations, or as otherwise authorized under this Agreement;

d) Notify Covered California of:

   i. all routine or non-routine surveys and audits conducted by State and Federal Regulators concerning Contractor's Covered California lines of business;

   ii. any material concerns identified by Contractor or by State and Federal Regulators that may impact Contractor's performance under this Agreement; and

e) Provide Covered California with copies of any preliminary or final reports, findings, or orders related to Subsection (d) of this Section 1.5, within 48 hours of Contractor receiving them from State and Federal Regulators; and

f) Participate in quarterly, in-person meetings between Covered California and Contractor at Covered California's 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.

1.6 Transition between Covered California and Other Coverage

In order to further Covered California's mission regarding continued access to health insurance coverage, Contractor shall establish policies and practices to maximize smooth transitions and continuous coverage for Enrollees to and from the Medi-Cal program and other governmental health care programs and coverage provided by Employers, including coverage required by the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") and the California Continuation Benefits Replacement Act, Health and Safety Code § 1366.20 et seq. ("Cal-COBRA").

1.7 Coordination with Other Programs

Contractor and Covered California recognize that the performance of Services under this Agreement depends upon the joint effort of Covered California, Contractor, Participating Providers, and other authorized 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") (and the Medi-Cal program) 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.

The Contractor shall cooperate with Covered California and other relevant government agencies to implement coverage or subsidy programs. Such programs may provide State or Federal funding for all or a portion of Enrollee premiums or subsidies to reduce or eliminate cost-sharing charges.

1.8 Changes in Requirements

The parties agree that Covered California may make prospective changes to benefits and services during a contract year to incorporate changes in State or Federal laws, requirements imposed by State and Federal Regulators, or as mutually agreed by Covered California and Contractor. 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.

1.9 Evaluation of Contractor Performance

Covered California shall evaluate Contractor's performance with respect to fulfillment of its obligations under this Agreement on an ongoing basis, including, but not limited to, during the 90-day period prior to each anniversary of the Agreement Effective Date set forth in Section 7.1 so long as the Agreement remains in effect. In the event evaluations conducted by Covered California reveal a significant problem or pattern of non-compliance with terms of this Agreement as reasonably determined and documented by Covered California, Covered California 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.

1.10 Required Notice of Contractor Changes

Except as set forth below, notices pursuant to this Section 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 occurrence. All written notices from Contractor pursuant to this Section shall contain sufficient information to permit Covered California to evaluate the events under the same criteria that were used by Covered California in its award of this Agreement to Contractor. Contractor agrees to provide Covered California with such additional information as Covered California may request. If Contractor requests confidential treatment for any information it provides, Covered California shall treat the information as confidential, consistent with Section 1.4.1.

Contractor shall notify Covered California 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 Covered California's rights under this Agreement;

d) Breach by Contractor of any term set forth in this Agreement or Contractor otherwise ceases to meet the requirements for a QHP Issuer, including those set forth at and 45 C.F.R. § 156.200 et seq. (Subpart C Article 3-Qualified Health Plan Minimum Certification Standards);

e) Immediate notice 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; and

f) Changes in Contractor's Provider Network by notice consistent with Section 3.3.

i. Contractor shall notify Covered California with respect to any material changes to its Essential Community Provider (ECP) contracting arrangements consistent with Section 3.3; and

ii. Significant changes in operations of Contractor that may reasonably be expected to significantly impair Contractor's operation of QHPs or delivery of Covered Services to Enrollees.

1.11 Nondiscrimination

a) Services and Benefits. During the performance of this Agreement, Contractor shall not, and shall require 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 Covered California.

b) Employment and Workplace. Contractor shall not, and shall require 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 require 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 require 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 § 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 §12990, set forth in CCR Chapter 5 of Division 4 of Title 2, including, 2 CCR § 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 require 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.

1.12 Conflict of Interest; Integrity

Contractor shall, and shall require 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 do not currently have, and will not have throughout the term of the Agreement, any direct interest that 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 any Participating Provider or any basis for potential violations of Contractor or Participating Provider with respect to laws, rules and regulations that govern referrals required for the provision of certain Covered 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 properly influenced by a conflict of interest.

Contractor shall comply with any and all other policies adopted by Covered California regarding conflicts of interest and ethical standards, copies of which shall be made available by Covered California for review and comment by the Contractor prior to implementation.

1.13 Other Financial Information

In addition to financial information to be provided to Covered California under other provisions of this Agreement or pursuant to applicable laws, rules and regulations, at the request of Covered California, Contractor shall provide Covered California with financial information that is (i) provided by Contractor to State and Federal Regulators or other regulatory bodies, or (ii) reasonable and customary information prepared by Contractor, including supporting information relating to Contractor's QHP Enrollees. Possible requests may include (but not be limited to) annual audited financial statements and annual profit and loss statements.

1.14 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 § 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 § 5200) of Part 5 of Division 9 of the Family Code.

d) Domestic Partners. Contractor shall fully comply with Public Contract Code § 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 § 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, to the operation of Covered California, and to Contractor's provision of Services under this Agreement.

1.15 Contractor's Representations and Warranties

Contractor represents and warrants that neither the execution of this Agreement by Contractor, nor the acts contemplated hereby, nor compliance by Contractor with any provisions hereof will:

a) Violate any provision of the charter documents of Contractor;

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

c) 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.

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.

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 State and Federal Regulators and other government or governmental authority for its acts contemplated by this Agreement.

1.16 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 Covered California. Contractor shall timely communicate to Covered California any material concerns identified by Contractor or by State and Federal Regulators related to regulatory compliance that may impact performance under this Agreement.

Contractor shall provide Covered California with a description of its fraud, waste, and abuse detection and prevention programs and report total monies recovered by Contractor in the most recent 12-month period for Contractor's total book of business as well as, if available, total monies recovered for Covered California business only. This description shall be provided upon the request of Covered California and will be updated upon request 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 their authorized Agents, including a summary of key findings, relevant data analytics and fraud risk assessments to circumvent fraud, waste, and abuse, and the development, implementation, and enforcement of any corrective action plans for changing, upgrading, or improving these programs.

Contractor shall maintain and enforce a code of ethical conduct and make it available to Covered California upon request.

Contractor shall refer potential fraud activities identified through fraud detection and response measures to Covered California. Contractor shall follow the established Carrier Referral Process posted on the Contractor's extranet website provided by Covered California (Data Home, Contractor's folder, Fraud Referral folder).

Contractor shall not terminate Enrollee coverage for fraud without prior review and approval from Covered California.

1.17 Current Enrollee Notification

Contractor shall notify Contractor's individual Enrollees of the availability of Covered California coverage and potential eligibility for subsidies in Covered California as required in State and Federal law. Contractor shall identify potential subsidy-eligible individuals, educate them about Covered California coverage, and assist them in enrolling in QHPs in Covered California.

ARTICLE 2 – ELIGIBILITY AND ENROLLMENT

2.1 Eligibility and Enrollment Responsibilities

2.1.1 Covered California Responsibilities

a) Covered California shall be solely responsible for the determination of eligibility and enrollment of individuals in Covered California in accordance with applicable Federal and State laws, rules and regulations.

b) Covered California shall determine eligibility and enroll eligible individuals in Covered California pursuant to its management and participation in CalHEERS, a project jointly sponsored by Covered California and DHCS with the assistance of the Office of Systems Integration. Covered California and CalHEERS shall develop, implement, and maintain processes to make the eligibility and enrollment decisions regarding Covered California 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.

c) Covered California shall notify Contractor regarding each eligible applicant who has completed an application for enrollment and selected Contractor as the QHP Issuer. Covered California shall transmit information required for Contractor to enroll the applicant within five (5) business days of receipt of verification of eligibility and selection of Contractor's QHP.

d) Covered California shall send enrollment information to Contractor on a daily basis and Contractor shall reconcile specified enrollment information received from Covered California with Contractor's enrollment data on a monthly basis through the Reconciliation Process.

e) Covered California shall utilize the Dispute Process pursuant to Section 2.1.2 d) to resolve issues related to the Reconciliation Process.

2.1.2 Contractor Responsibilities

a) Contractor shall comply with all Federal and State eligibility and enrollment laws and regulations, including, but not limited to, the Affordable Care Act § 1411 et seq. (42 U.S.C. § 18081 et seq.), 45 C.F.R. § 155.400 et seq., Government Code §§ 100503 and 100503.4, and 10 CCR § 6400 et seq.

b) Contractor shall comply with all Covered California eligibility and enrollment determinations, including those made through CalHEERS and that result from an applicant's appeal of an Covered California determination. Within ten (10) days of receiving a request from Covered California to implement the appeals decision, Contractor shall implement appeals decisions and provide communication to Covered California with evidence the appeal resolution has been implemented. Contractor shall immediately notify Covered California if it receives an appeal decision that does not have all necessary data elements required for the Contractor to

implement the appeal decision. In the event that an Enrollee requires immediate care, the QHP Issuer will work closely with Covered California to implement any eligibility or enrollment changes as soon as reasonably possible. Contractor shall accept all Enrollees assigned by Covered California except as otherwise authorized by policies and procedures of Covered California or upon the approval of Covered California.

c) Contractor shall participate in the Reconciliation Process to review and compare the Covered California enrollment reconciliation file, distributed monthly, against the Contractor's membership enrollment and financial databases. Contractor shall prepare a comparison extract in accordance with the file validations and resolution timelines, as mutually agreed upon in the "Data Integrity Reconciliation Process Guide." Contractor shall provide Covered California with evidence through email confirmation that the enrollment and financial changes identified through the Reconciliation Process have been implemented within ten (10) business days. Further evidence of implementation is provided by individual records submitted in the next reconciliation cycle. Contractors are to follow the process as stated in the "Reconciliation Process Guide"

d) Contractor shall participate in the Dispute Process established by Covered California to resolve issues related to the Reconciliation Process. Contractor shall submit a supplemental file to dispute identified discrepancies found in the Covered California enrollment reconciliation file in accordance with the defined list of fields and technical requirements established by Covered California through the "Data Integrity Reconciliation Dispute Process Guide."

   The Contractor shall utilize Covered California's Dispute Process, prior to submitting premium tax credit disputes to the Center for Medicaid and Medicare Services or the Center for Consumer Information and Health Insurance Oversight.

e) Contractor shall rely upon Covered California as the system of record for eligibility and enrollment during the term of this Agreement; provided, however, that Contractor shall: (i) reconcile premium payment information with enrollment and eligibility information received from Covered California on a monthly basis, and (ii) Contractor shall only accept changes to eligibility information submitted by Enrollees when Covered California notifies or confirms such change to Contractor.

2.1.3 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 Covered California with reasonable documentation to facilitate Covered California'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 sent to an Enrollee or Employer. Contractor shall not initiate collection activities if they have knowledge of a pending appeal, including notice from the consumer, Covered California, or Contractor's State Regulators.

2.2 Covered California for the Individual Market

2.2.1 Open Enrollment, Auto Enrollment, and Special Enrollment Periods

Contractor acknowledges and agrees that Covered California is required to: (i) allow Qualified Individuals to enroll in a QHP or change QHPs during annual Open Enrollment Periods, (ii) automatically enroll specified qualified individuals in coverage pursuant to Government Code 100503.4, and (iii) allow certain Qualified Individuals to enroll in or change QHPs during Special Enrollment Periods (SEP) as a result of specified triggering events per applicable Federal and State laws, rules and regulations. Contractor agrees to accept new Enrollees in Covered California who enroll during these periods and shall coordinate and participate with Covered California vendor's automated system for verification of SEP triggering events through a mutually agreed upon process.

2.2.2 Covered California for the Individual Market Coverage Effective Dates

Contractor shall ensure coverage effective dates for the Enrollee consistent with applicable State law.

Covered California and Contractor shall require payment of premium in accordance with 10 CCR § 6500 and other applicable State law.

Contractor shall provide Covered California with information necessary to confirm Contractor's receipt of premium payment from Enrollee that is required to commence coverage. Covered California shall establish the specific terms and conditions relating to commencement of coverage, including the administration of state advance premium assistance subsidy, 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, in accordance with applicable laws, rules and regulations.

The first premium binder payment shall be either paid directly to the Contractor or processed through a third-party administrator and deposited into an account owned by the third-party administrator and settled by the third-party administrator to the Contractor's own bank account.

2.2.3 Premiums for Coverage in Covered California for the Individual Market

Contractor shall not be entitled to collect from Enrollees or receive funds above the premium amounts except with respect to cost-sharing amounts or to the extent that such payment (i) is expressly authorized under the QHPs, such as out-of-network services that comply with the notice requirements set forth at Section 3.4.3, or (ii) relates to a charge for non-sufficient funds or transaction fees initiated by Enrollee at rates that are reasonable and customary for such transactions. Contractor shall not pursue collections of any said fees from Covered California. Contractor shall not pursue collection of any delinquent premiums from Covered California for an Enrollee enrolled in Covered California for the Individual Market who is responsible for directly paying his or her premium to Contractor.

In the case of partial month enrollments Contractor shall follow the methodology specified in 10 CCR § 6500 (i).

The premium for coverage lasting less than one month shall equal the product of:

i. The premium for one month of coverage divided by the number of days in the month; and

ii. The number of days for which coverage is being provided in the month.

The same methodology shall apply to the proration of APTC, State premium assistance payments, and CSR amounts for a coverage lasting less than one month.

Premiums charged to individuals includes the assessment of the Participation Fee.

2.2.4 Terminations of Coverage

Contractor shall terminate coverage in a Contractor's QHP in accordance with the requirements established by Covered California pursuant to 10 CCR § 6506 and other applicable State and Federal laws, rules, and regulations.

Contractor shall terminate coverage for an individual Enrollee's non-payment of premium as follows: (i) effective as of the last day of the first month of a three (3) month grace period in the event of nonpayment of premiums by individuals receiving advance payments of the premium tax credit or State premium assistance payments; or (ii) effective 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 § 10273.6 for individuals not receiving advance payments of the premium tax credit or State premium assistance.

Contractor shall notify the Agent or Agency of Record a late payment notification at the same time the Enrollee receives notification.

Covered California and Contractor must send a termination transaction to the other party within ten (10) business days of any individual Enrollee termination.

Contractor shall request termination of an enrollee for fraud or misrepresentation through the Carrier Referral Process (posted on the Contractor's extranet website provided by Covered California (Data Home, Contractor's folder, Fraud Referral folder)) and provide Covered California with supporting documentation for each request to terminate. Contractor may not terminate for fraud or misrepresentation without prior approval from Covered California.

2.2.5 Notice to Provider Regarding Enrollee's Grace Period Status

a) In the event of nonpayment of premium by an individual Covered California Enrollee receiving advance payments of the premium tax credit or state advance premium assistance subsidy, or both, Contractor shall provide notice to its network providers in accordance with the applicable state and federal law.

b) Notwithstanding (a) above, this notice obligation does not relieve the QHP Issuer from compliance with existing state laws governing claims payment.

2.2.6 Agents in Covered California for the Individual Market

a) Compensation. The provisions of this Section apply to Agents who sell Contractor's QHPs though Covered California for the Individual Market.

b) Compensation Methodology. Contractor must pay a commission to Agents to ensure Contractor is fairly and affirmatively offering all of its products at each metal level during both Open and Special Enrollment Periods. Contractor shall be solely responsible for compensating Agents who sell Contractor's QHP through the individual market of Covered California. 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 Covered California. Contractor shall provide Covered California on an annual basis, a document describing its standard Agent compensation program. This document shall include a description of its Agent commission, and bonus or incentive programs, standard Agent contract, and Agent policies. Agent commission descriptions must detail both new and renewal enrollment commission rates.

c) Incentive Compensation Program. In order to enhance consistency in sales efforts for products offered inside and outside of Covered California, Contractor shall add the Agent's sale of Contractor's QHPs through Covered California to the Agent's sale of Contractor's individual policies outside Covered California to determine Agent's aggregate sales that are used by Contractor to determine incentive or other compensation payable by Contractor to Agent, to the extent such aggregation is necessary to determine Agent compensation under Contractor's applicable Agent agreement or compensation program. Contractor shall not change the Agent commission structure or rates during the Plan Year. Contractor must pay the same commission during the Open and Special Enrollment Periods for each Plan Year. Contractor shall not vary Agent commission levels by metal tier. Contractor shall approve and pay Agent commissions on all new Agent-of-record and change of Agent-of-record delegations as outlined in contract Sections 2.2.6 (f) and 2.2.6 (g). Contractor shall provide information as may reasonably be required by Covered California from time to time to monitor Contractor's compliance with the requirements set forth in this Section. Contractor's standard Agent compensation and incentive compensation programs entered into or in effect prior to January 1, 2014 shall not be subject to the requirements of this Section.

d) Agent Appointments. Contractor shall maintain a reasonable appointment process for appointing Agents who contract with Contractor to sell Contractor's QHPs to individuals through Covered California. Such appointment process shall include: (i) providing or arranging for education programs to assure that Agents are trained to sell Contractor's QHPs through Covered California, (ii) providing or arranging for programs that enable Agents to become certified by Covered California; provided, however, that certification by Covered California shall not be a required condition for an Agent to sell Contractor's QHPs outside of Covered California, 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. These appointment policies and procedures for both individual Agents and for Agencies must be submitted to Covered California on an annual basis and whenever revisions are made.

e) Agent Conduct. Contractor shall implement policies and procedures to ensure that only Agents who have been duly certified by Covered California and maintain that certification may receive compensation for enrolling individuals in Covered California.

f) Agent of Record. At initial enrollment, individuals may notify Covered California of an Agent delegation. Covered California shall send notice of the delegation to the Contractor via the 834 enrollment file. Upon receipt of the 834 enrollment file, Contractor shall approve the delegation (unless an Agent is not licensed or not appointed) and has five (5) days to update their system. Covered California recognizes that Contractor may contract with insurance agencies who employ or contract with Agents. Covered California further understands that Contractor may delegate an employed or contracted Agent writing business for the benefit of an Agency. If requested, the Contractor shall send an Agent of Record Exception Report which includes any changes Covered California requested, but were not made.

g) Change to Agent of Record. Individuals may notify Covered California of an Agent delegation change. Covered California shall send notice of the delegation change to the Contractor via the 834 maintenance file. Upon receipt of the notification, Contractor shall approve the delegation (unless an Agent is not licensed or not appointed) and has five (5) days to update their system to reflect this change upon receipt of all required information from Covered California. Contractor shall notify the existing agent of the delegation change within ten (10) business days. If requested, the Contractor shall send an Agent of Record Exception Report which includes any changes Covered California requested, but were not made. Covered California recognizes that Contractor may contract with insurance agencies who employ or contract with Agents. Covered California further understands that Contractor may delegate an employed or contracted Agent writing business for the benefit of an Agency.

h) Carrier Scorecard. Covered California will administer an annual Agent survey that rates the services Contractor provides to Agents, including those services required in this Section 2.2.6. Covered California will solicit comments from the QHP Issuers to develop the Agent Survey prior to finalization. Covered California will utilize the results of this survey to identify areas of improvement and work with QHP Issuers to improve performance.

2.3 Enrollment and Marketing Coordination and Cooperation

Covered California recognizes that the successful delivery of services to Enrollees depends on successful coordination with Contractor in all aspects including collaborative enrollment and marketing.

Covered California will take such action as it deems 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:

a) The Shop and Compare Tool available by electronic means to facilitate a comparison of QHPs that is consistent with tools Covered California will use for its own eligibility screenings, to ensure that preliminary eligibility screenings use the same tool;

b) Education, marketing, and outreach programs that will seek to increase enrollment through Covered California and inform consumers, including Contractor's current Enrollees, that there is a range of QHPs available in Covered California in addition to Contractor's QHPs;

c) A standard interface through which Contractor shall electronically accept the initial binding payment (via credit card, debit card, Automated Clearing House or other mutually acceptable means of electronic funds transfer, mutually acceptable web-based payments, which may include accepting online credit card payments, and all general-purpose pre-paid debit cards and credit card payment) to effectuate coverage in Covered California for the Individual Market;

d) Complete documentation and reasonable testing timelines for interfaces with Covered California's eligibility and enrollment system;

e) Eligibility and enrollment training for Contractor's staff and for licensed Agents and brokers;

f) Joint marketing programs to support renewal, retention, and enrollment in Covered California of existing members of Contractor's health insurance plans who are eligible for the Federal subsidies;

g) Joint marketing activities of Covered California, Contractor, and other Health Insurance Issuers designed to drive awareness and enrollment in Covered California;

h) Covered California will treat as confidential, all Contractor marketing plans, materials, and spend reports consistent with Section 1.4.1. The obligation of Covered California to maintain confidentiality of this information shall survive termination or expiration of this Agreement;

i) Covered California's annual marketing plans, including Open Enrollment Period (OEP), Special Enrollment Period (SEP), and retention and renewal efforts; and

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

To support the collaborative marketing and enrollment effort, Contractor shall:

k) Following Covered California making the technology available and within a reasonable time after the receipt of notice from Covered California about the technology, and determination of its compatibility with Contractor's system, the Contractor shall prominently display the Shop and Compare Tool on its website;

l) Educate its Agents on Contractor's QHPs offered in Covered California, work with Covered California to efficiently educate its Agents and brokers about Covered California's individual marketplace, and inform Agents that a prospective Enrollee's health status is irrelevant to

advice provided with respect to health plan selection other than informing individuals about their estimated out-of-pocket costs;

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

n) Cooperate with Covered California to develop and implement an Enrollee retention plan;

o) Submit to Covered California a marketing plan at least thirty (30) days prior to Open Enrollment that details the anticipated budget, objectives, strategy, creative messaging, and ad placement by medium promoting acquisition activities. Marketing plans for Retention and Renewal efforts should be submitted to Covered California within thirty (30) days after Open Enrollment begins;

p) Submit to Covered California actualized spend amounts for: (1) OEP within thirty (30) days after OEP closes, and (2) SEP for the calendar year, thirty (30) days after the calendar year ends, and (3) retention and renewal, thirty (30) days after OEP begins. OEP actualized spend submissions shall include spend by media channel to include distribution by Designated Market Area (DMA), brand versus direct response spend allocation, categorization of messaging and indication of co-branding efforts. Covered California shall treat as confidential consistent with Section 1.4.1; and

q) Have successfully tested interfaces with Covered California's eligibility and enrollment system or be prepared to complete successful interface tests by dates established by Covered California.

r) Contractor shall accept the following payment types for binder and monthly premium payments: credit card, debit card, Automated Clearing House, or other mutually acceptable means of electronic funds transfer; mutually acceptable web-based payments, which may include accepting online credit card payments, and all general-purpose pre-paid debit cards and credit card payment; as well as paper checks, cashier's checks, money orders, and cash from Enrollees for the Individual Market.

2.4 Enrollee Materials and Branding Documents

2.4.1 Co-branded Materials

a) Contractor shall include the Covered California logo on premium invoices, Enrollee identification cards, and Enrollee termination notices. Contractor shall include the Covered California logo and other information in notices and other materials based upon the mutual agreement of Covered California and Contractor as to which materials will include the Covered California logo. The materials provided to Covered California under this Section will not require prior approval by Covered California before the Contractor distributes such materials; provided, however, that Contractor shall make a good faith effort to incorporate any changes proposed by Covered California with respect to such materials.

b) Contractor shall comply with Covered California co-branding requirements related to the format and use of the Covered California logo as outlined in the Covered California Brand Style Guide. Covered California shall post the updated Brand Style Guide on the Contractors extranet website provided by Covered California (Marketing Home, in the Resources folder).

i. Identification Cards. Contractor shall issue identification cards to Enrollees in a form that shall be agreed to by Covered California. Contractor shall submit proposed identification cards to Covered California annually, at least thirty (30) days prior to Open Enrollment.

c) Contractor may, at its discretion, co-brand other marketing materials such as TV, radio, out-of-home, print, digital, social, etc.

d) Contractor shall comply with Covered California co-branding requirements related to the format and use of the Covered California logo as outlined in the Covered California Brand Style Guide. Covered California shall post the updated Brand Style Guide on the Contractors extranet website provided by Covered California (Marketing Home, in the Resources folder).

2.4.2 Marketing Materials that Must Be Submitted to Covered California

a) Co-branded Materials. Contractor must submit all co-branded marketing materials to Covered California at least ten (10) days prior to releasing materials publicly unless specified otherwise within this Section. The materials provided to Covered California under this Section will not require prior approval by Covered California before the Contractor distributes such materials; provided, however, that Contractor shall make a good faith effort to incorporate any changes proposed by Covered California with respect to such materials.

b) Acquisition Marketing Materials. Contractor shall provide Covered California with marketing materials and related collateral used by Contractor to promote enrollment of the individual market inside and outside Covered California, such as TV, radio, out-of-home, print, digital, social, or any other media channel used in the campaigns on an annual basis and at such other intervals as may be reasonably requested by Covered California. Materials submitted should be a representative sample of the larger body of work.

c) Marketing Plans. Contractor and Covered California 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 create and share marketing plans on an annual basis. The marketing plans of Covered California and Contractor shall include proposed and actual marketing approaches, spending amounts (proposed and actuals when available), messaging and channels, and provide samples of any planned marketing materials and related collateral. The Contractor shall include this information for both Covered California and the outside individual market.

d) Contact Guidelines. Covered California creates and posts an Enrollee Contact Guideline document for Contractors on the Marketing Resources page of the Covered California extranet

website. This document outlines the instances when Enrollees should contact the Contractor and when they should contact Covered California. Contractor shall provide Enrollees with information on the instances when Enrollees should contact the Contractor and when they should contact Covered California to resolve inquiries. Contractor may provide this information to Enrollees by: welcome letter or package, buck slip, insert, website or mail. Contractor shall submit to Covered California how the Enrollee Contact Guideline document was shared with Enrollees at least (30) days prior to Open Enrollment. The materials provided to Covered California under this Section will not require prior approval by Covered California before the Contractor distributes such materials; provided, however, that Contractor shall make a good faith effort to incorporate any changes proposed by Covered California with respect to such materials.

e) Contractor Logo. In the event of a logo modification or rebrand, Contractor shall submit new logo to Covered California in a high-resolution design file format. Covered California will make a reasonable effort to update the Contractor logo on all platforms in a timely manner. If Covered California advertising or collateral assets are already in production or live in market, Contractor acknowledges there may be some delay with incorporating the new version of the logo across all applicable assets.

2.4.3 Member Communications Materials

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

2.4.4 Mailing Addresses; Other Demographic Information

Contractor shall update an Enrollee's address and other demographic information on a continuous basis based on information Contractor receives from Covered California.

2.4.5 Evidence of Coverage Booklet on Contractor's Website

During each year of this Agreement which carries over into a subsequent Plan Year, Contractor shall make the Evidence of Coverage booklet, including any documents referenced in the Evidence of Coverage, for the next benefit year available on Contractor's website 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 Covered California and the State Regulators 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 website through December 31 of the then-current benefit year.

2.4.6 Distribution of Enrollment Materials

Contractor agrees to distribute to effectuated or pending enrollees on and off-exchange the Open Enrollment publications developed and printed by Covered California for Enrollees prior to the Open Enrollment Period at a time mutually agreed to by the Contractor and Covered California. Contractor shall be responsible for the mailing cost associated with these publications.

2.5 Additional Marketing Efforts

a) For the 2020 Plan Year, and any year thereafter, Covered California may engage in additional marketing activities to ensure consumers are aware of new laws and new programs that could impact consumers, such as the new State premium assistance program and State mandate. As part of those activities, Covered California may conduct marketing efforts co-branded with all QHP Issuers currently participating in Covered California or branded only with Covered California, including radio, television, or print advertisements, and make additional media buys using existing or new collateral and material, on behalf of Contractor.

b) Upon mutual agreement of the additional marketing activities, Contractor shall pay Covered California a mutually-agreed upon dollar amount to conduct those marketing activities, in accordance with Section 5.1.1 e).

ARTICLE 3 – QHP ISSUER PROGRAM REQUIREMENTS

3.1 Basic Requirements

3.1.1 Licensed in 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 standing," which is determined by Covered California 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 State Regulatory violations, including penalties, during the year prior to the date of the Agreement and throughout the term of Agreement, with respect to the State Regulators categories identified at Table 3.1.1 below ("Good Standing"). Covered California, in its sole discretion and in consultation with the appropriate State Regulators determines what constitutes a material violation for this purpose.

Table 3.1.1 Definition of Good Standing	Agency
Verification that issuer holds a state health care service plan license or insurance certificate of authority.	
• Approved for lines of business sought in Covered California (e.g. commercial, small group, individual)	DMHC and CDI
• Approved to operate in what geographic service areas	DMHC and CDI
• Most recent financial exam and medical survey report reviewed	DMHC
•Most recent market conduct exam reviewed	CDI
Affirmation of no material[1] statutory or regulatory violations, including penalties levied, during the year prior to the date of the Agreement or throughout the term of Agreement in relation to any of the following, where applicable:	
• Financial solvency and reserves reviewed	DMHC and CDI
• Administrative and organizational capacity acceptable	DMHC
• Benefit Design	
• State mandates (to cover and to offer)	DMHC and CDI
• Essential health benefits (State required)	DMHC and CDI
• Basic health care services	DMHC and CDI
• Copayments, deductibles, out-of-pocket maximums	DMHC and CDI
• Actuarial value confirmation (using the Federal Actuarial Value Calculator as applicable.)	DMHC and CDI
• Network adequacy and accessibility standards are met	DMHC and CDI
• 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
• Provider complaints	DMHC and CDI
• Utilization review policies and practices	DMHC and CDI
• Quality assurance/management policies and practices	DMHC and CDI
• 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	DMHC and CDI
• Rating Factors	DMHC and CDI
• Medical Loss Ratio	DMHC and CDI
• Premium rate review	DMHC and CDI
• Geographic rating regions	
• Rate development and justification is consistent with ACA requirements	DMHC and CDI

[1]Covered California, in its sole discretion and in consultation with the appropriate health insurance regulator, determines what constitutes a material violation for this purpose.

3.1.2 Certification

Contractor shall comply with requirements for QHPs set forth in this Agreement and under the California Affordable Care Act, the Affordable Care Act and other State and Federal laws, rules and regulations. Contractor shall maintain timely compliance with standards required for certification that are issued, adopted, or recognized by Covered California to demonstrate that each health plan it offers in Covered California qualifies as a QHP.

3.1.3 Plan Naming Conventions

Contractor must adhere to Covered California's Plan Naming Conventions on all State Regulators plan filings, marketing material, Enrollee material, and SERFF submissions.

3.1.4 Operational Requirements and Liquidated Damages

The timely and accurate submission of Contractor's QHP filings and documents to Covered California for upload into CalHEERS is critical to the successful launch of each Renewal and Open Enrollment Period. When submissions are late, or inaccurate, Covered California suffers financial harm with each resubmission and such actions put the Renewal and Open Enrollment process at risk. The parties agree that the liquidated damages below are proportional to the damages Covered California incurs from each respective error made by Contractor. Therefore, Contractor agrees to meet the following operational requirements:

SERFF Template Completion
Contractor must submit complete and accurate SERFF Templates to Covered California beginning with submissions for the 2017 Plan Year, and each year thereafter. Covered California will participate in two rounds of validation with the Contractor. Contractor agrees to pay liquidated damages in the amount of $5,000 for each additional round of validation beyond the first two rounds. Changes to any or all of Contractor's SERFF Templates counts as one round of validation. If instructions provided by Covered California include inaccurate information which necessitates an additional round of validation, or an additional round of validation is necessary due to required changes by Covered California or Contractor's State Regulators, those rounds of validation will not be counted in the two rounds of validations.

CalHEERS Test and Load Deadlines
Contractor must participate in CalHEERS testing and provide certification of plan data and documents in the CalHEERS pre-production environment. The pre-production environment is the test environment where the parties can validate templates and documents prior to the Renewal and Open Enrollment Periods. Following Contractor's certification of the QHPs in the pre-production environment, any subsequent upload required to correct Contractor's errors in the production environment will result in liquidated damages in the amount of $25,000 beginning with uploads for the 2017 Plan Year, and each year thereafter. One upload, for purposes of this paragraph, includes all plan data and documents that must be resubmitted to correct Contractor's errors including

Summary of Benefits and Coverage, Evidence of Coverage documents. Liquidated damages will not apply to additional uploads resulting from errors in the instructions provided by Covered California, or changes required by Covered California or Contractor's regulator.

If liquidated damages are applied by Covered California under this section then no other remedies under Section 7.2.4 will apply to the Contractor for that same or any related action.

Deadlines for Regulatory Approval
Covered California reserves the right to require that the Contractor receive regulatory approval for Licensure, rates, products, Summary of Benefits and Coverage, Evidence of Coverage documents, policy documents, Network, and Service Area prior to participating in the CalHEERS pre-production environment.

Communication with Plan Manager and Covered California
Contractor must notify Covered California in a timely manner of changes with operational impacts to Covered California, Enrollees or CalHEERS (e.g. Contractor changes vendors that interface with CalHEERS). Contractor shall attempt to avoid making any operational changes that may impact CalHEERS thirty (30) days prior to and during each Renewal and Open Enrollment Period.

3.2 Benefit Standards

3.2.1 Essential Health Benefits

Each QHP offered by Contractor under the terms of this Agreement shall provide essential health benefits in accordance with the Benefit Plan Design requirements described in the Covered California Patient-Centered Benefit Plan Designs as approved by the Board for the applicable Plan Year, and as required under this Agreement, and applicable laws, rules and regulations, including California Health and Safety Code § 1367.005, California Insurance Code § 10112.27, California Government Code § 100503(e), and as applicable, 45 C.F.R. § 156.200(b).

3.2.2 Patient-Centered Standard Benefit Designs

a) During the term of this Agreement, Contractor shall ensure its QHPs provide the benefits and services at the cost-sharing and actuarial cost levels described in the Covered California Patient-Centered Benefit Plan Designs as approved by the Board for the applicable Plan Year. Contractor must notify and receive approval from Covered California for deviations from the Patient-Centered Benefit Plan Designs during the annual certification process. Covered California may approve, on a case-by-case basis, Contractor's request to deviate from the Board approved Patient-Centered Standard Benefit Plan Designs during the term of this Agreement.

b) During the term of this Agreement, for any Plan Year that the cost of the cost-sharing reduction program is built into the premium for Contractor's Silver-level QHPs, Contractor shall offer a non-mirrored Silver-level plan, that is not a QHP, outside of Covered California that complies with the benefits and services at the cost-sharing and actuarial cost level described in the plan design at Attachment 3 ("Silver 70 Off-Exchange Plan, Non-Mirrored Silver Plan Design"). This plan must not have any rate increase or cost attributable to the cost of the cost-sharing reduction program.

3.2.3 Offerings Outside of Covered California

a) Contractor acknowledges and agrees that as required under State and Federal law, QHPs and plans that are identical in benefits, service area, and cost sharing structure offered by Contractor outside Covered California must be offered at the same premium rate whether offered inside Covered California or outside Covered California directly from the Contractor or through an Agent.

b) In the event that Contractor sells products outside Covered California, Contractor shall fairly and affirmatively offer, market, and sell all products made available to individuals in Covered California to individuals seeking coverage outside Covered California consistent with California law.

c) For purposes of this section, "product" does not include contracts entered into pursuant to Part 6.2 (commencing with § 12693) of Division 2 of the Insurance Code between the Department of Health Care Services (DHCS) and health care service plans for Healthy Families beneficiaries or to contracts entered into pursuant to Chapter 7 (commencing with § 14000) of, or Chapter 8 (commencing with §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.

3.2.4 Pediatric Dental Benefits

When Contractor elects to embed and offer Pediatric Dental Essential Health Benefit services either directly, or through a subcontract with a dental plan issuer authorized to provide Specialized Health Care Services, Contractor shall require its dental plan subcontractor to comply with all applicable provisions of this Agreement, including, but not limited to, standard benefit designs for the embedded pediatric dental benefit, as well as any network adequacy standards applicable to dental provider networks and any pediatric dental quality measures as determined by Covered California.

Coordination of Benefits. If a Contractor's QHP provides coverage for the Pediatric Dental Essential Health Benefit, Contractor shall include a Coordination of Benefits (COB) provision in its Evidence of Coverage or Policy Form that (i) is consistent with Health and Safety Code § 1374.19 or Insurance Code § 10120.2, and (ii) provides that the QHP is the primary dental benefit plan or policy under that COB provision. This provision shall apply to Contractor's QHPs offered both inside and outside of Covered California for the Individual Market, except

where 28 CCR § 1300.67.13 or 10 CCR § 2232.56 provides for a different order of determination for COB in the small group market.

3.2.5 Segregation of Funds

Contractor shall comply with federal 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.

3.2.6 Prescription Drugs

a) Formulary changes. Except in cases where patient safety is an issue, Contractor shall give affected Covered California Enrollees, and their prescribing physician(s), sixty (60) days written notice prior to the removal of a drug from formulary status, unless it is determined that a drug must be removed for safety purposes more quickly. If Contractor is not reasonably able to provide sixty (60) days written notice, the Contractor must provide affected Enrollees with a sixty (60) day period to access the drug as if was still on the formulary, that begins on the date the drug is removed from the formulary. This notice requirement shall apply only to single source brand drugs and the notice shall include information related to the appropriate substitute(s). The notice shall also comply with all requirements of the Health and Safety Code and Insurance Code, including provisions prohibiting Contractor from limiting or excluding coverage for a drug to a Plan Enrollee in cases where the drug had been previously approved for coverage by Contractor for a medical condition of the Plan Enrollee, except under specified conditions. To the extent permitted in State and Federal law, 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.

b) Internet Link to Formularies. Contractor shall comply with applicable State and Federal laws relating to prescription drug formularies, including posting the formularies for each product offered on the Contractor's website as required by Health and Safety Code § 1367.205 and Insurance Code § 10123.192. Contractor shall provide to Covered California and regularly update information necessary for Covered California to link to the Contractor's drug formularies for each of the QHPs Contractor offers so that Covered California can ensure it complies with its obligation under Government Code § 100503.1.

c) Contractor shall have an opt-out retail option for mail order drugs to allow consumers to receive in-person assistance, and this option shall have no additional cost. However, as specified in the standard benefit designs, Contractor may offer mail order prescriptions at a reduced cost-share.

d) Contractor shall provide consumers with an estimate of the range of costs for specific drugs.

e) Contractor shall have a sufficient number of customer service representatives available during call center hours for consumers and advocates to obtain clarification on formularies and consumer cost-shares for drug benefits.

3.3 Network Requirements

3.3.1 Service Areas

a) Service Area Listing. During each year of this Agreement, Contractor agrees to offer QHPs in the Service Area listing set forth in the applicable Plan Year SERFF templates tested and validated by the Contractor . Any such changes to Contractor's previous year's Service Areas shall be effective as of January 1 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.

Contractor shall comply with Covered California's standards, developed in consultation with Health Insurance Issuers, regarding the development of Service Area listings based on 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.

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

c) Service Area Eligibility. In order to facilitate Covered California's compliance with State and Federal law, Contractor shall monitor information it receives directly, or indirectly or through its subcontractors to assure continued compliance with eligibility requirements related to participation of Qualified Individuals in Covered California for the Individual Market, including requirements related to residency in the Contractor's service area.

Contractor shall notify Covered California if it becomes aware that an individual Enrollee enrolled in a QHP of Contractor no longer meets the requirements for eligibility, based on place of residence. Covered California will evaluate, or cause CalHEERS to evaluate, such information to determine Enrollee's continuing enrollment in the Contractor's Service Area under Covered California's policies which shall be established in accordance with applicable laws, rules and regulations.

3.3.2 Network Adequacy

a) Network standards. Contractor's QHPs shall comply with the network adequacy standards established by the applicable State Regulators 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 and 10 CCR § 2240 et seq. (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. Contractor shall cooperate with Covered California to implement network changes as necessary to address concerns identified by Covered California.

b) 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 Covered 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.

c) Notice of material network changes.

Contractor shall notify Covered California with respect to changes in its provider network as follows:

i. Contractor shall notify Covered California of any pending material change in the composition of its provider network within any of the regions it covers, or its participating provider contracts, of and throughout the term of this Agreement at least 60 days prior to any change or immediately upon Contractor's knowledge of the change if knowledge is acquired less than 60 days prior to the change, and cooperate with Covered California in planning for the orderly transfer of plan members; and

ii. Contractor shall ensure that Covered California Enrollees have access to care when there are changes in the provider network, including but not limited to, mid-year contract terminations between Contractor and Participating Providers.

3.3.3 Essential Community Providers

a) ECP standard. Unless Covered California determines that Contractor has qualified under the alternate standard for essential community providers pursuant to the Affordable Care Act, Contractor shall maintain a network that includes a sufficient geographic distribution of care, including essential community providers ("ECP"), and other providers available to provide reasonable and timely access to Covered Services for low-income, vulnerable, or medically underserved populations in each geographic region where Contractor's QHPs provide services to Enrollees. 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.

i. Reporting requirements for the ECP standard are contained within the required monthly provider data submission pursuant to Section 3.4.4. The Contractor must provide a provider data file to Covered California upon request for the purpose of determining compliance with the ECP standard. This file is separate and distinct from the files provided to the Integrated Health Care Association's Symphony Provider Directory as described in Section 3.4.5. Reporting requirements for the ECP standard are as follows:

1. Contractor to demonstrate provider agreements with at least 15% of 340B non-hospital providers in each applicable rating region.

2. Contractor to demonstrate provider agreements that reflect a mix of essential community providers (hospital and non-hospital) reasonably distributed to serve the low-income, vulnerable, or medically underserved populations.

ii. Reporting requirements for Covered California qualified Alternate Standard Contractors are contained within the annual Application for certification and are as follows:

1. Contractor to produce access map to demonstrate low income, medically underserved enrollee access to health care services. Low income, vulnerable, or medically underserved individuals shall be defined as those Covered California enrollees who fall below 200 percent of the Federal Poverty Level (FPL). Maps shall demonstrate the extent to which provider sites are accessible to and have services that meet the needs of specific underserved populations, including:

a. Individuals with HIV/AIDS

b. American Indians and Alaska Natives

c. Low income and underserved individuals seeking women's health and reproductive health services

d. Other specific populations served by Essential Community Providers in the service area such as STD Clinics, Tuberculosis Clinics, Hemophilia Treatment Centers, Black Lung Clinics, and other entities that serve predominantly low income, medically underserved individuals.

b) Sufficient geographic distribution. Covered California shall determine whether Contractor meets the requirement of a sufficient geographic distribution of care, including ECPs, and other providers in its reasonable discretion, in accordance with the conditions set forth in the Application, and based on a consideration of various factors, including: (i) the nature, type, and distribution of Contractor's ECP contracting arrangements in each geographic rating region in which Contractor's QHPs provides Covered Services to Enrollees, (ii) the balance of hospital and non-hospital ECPs in each geographic rating region, (iii) the inclusion in Contractor's provider contracting network of at least 15% of entities in each applicable geographic rating region that participate in the program for limitation on prices of drugs 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, and county hospitals, and

(vi) other factors as mutually agreed upon by Covered California and the Contractor regarding Contractor's ability to serve the low income population.

c) Low-income populations shall be defined for purposes of the ECP requirements as families living at or below 200% of Federal Poverty Level. ECPs shall consist of participating entities in the following programs: (i) 340B Entity, (ii) California Disproportionate Share Hospital Program, per the Final DSH Eligibility List for the current fiscal year, (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 § 1204(a), or is a community clinic or free clinic exempt from licensure under Health and Safety Code § 1206, and (v) Providers with approved applications for the HI-TECH Medi-Cal Electronic Health Record Incentive Program. Covered California will post a non-exhaustive essential community provider list annually.

d) Notice of changes to ECP network. Contractor shall notify Covered California with respect to any material change as of and throughout the term of this Agreement to its ECP contracting arrangements, geographic distribution, percentage coverage, ECP classification type (e.g. 340B), and other information relating to ECPs within thirty (30) business days of any change in ECP contracts.

   Contractor shall notify Covered California of any pending material change in its ECP contracting arrangements at least 60 days prior to any change or immediately upon Contractor's knowledge of the change if knowledge is acquired less than 60 days prior to the change, and cooperate with Covered California in planning for the orderly transfer of plan members.

e) Indian Health Care Providers. For Contractor's provider contracts entered into on or after January 1, 2015, Contractor shall reference the Centers for Medicare & Medicaid Services "Model QHP Addendum for Indian Health Care Providers" ("Addendum") available by search at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces . Contractor is encouraged to adopt the Addendum whenever it contracts with those Indian health care providers specified in the Addendum. Adoption of the Addendum is not required; it is offered as a resource to assist Contractor in including specified Indian providers in its provider networks.

3.3.4 Special Rules Governing American Indians and Alaskan Natives

Contractor shall comply with applicable laws, rules and regulations relating to the provision of Covered Services to any individual enrolled in Contractor's QHP in Covered California for the Individual Market who is determined by Covered California 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 Covered 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 § 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). Covered California 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 Indians or Alaskan Natives enrolled through Covered California.

d) Contractor shall comply with other applicable laws, rules and regulations relating to the provision of Covered 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).

3.3.5 Network Stability

a) 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 Covered California, documenting its policies and its compliance with these requirements by Contractor and Participating Providers.

b) Block Transfers. If Contractor experiences a termination of a Provider Group(s) or hospital(s) that constitutes a block transfer as defined in Health and Safety Code § 1373.65 and Title 28, C.C.R. § 1300.67.1.3, Contractor shall provide Covered California with copies of the written notices the Contractor proposes to send to affected Enrollees, in compliance with the notice requirements of Health and Safety Code § 1373.65, prior to mailing the notices to Enrollees.

c) Network Disruptions. 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 Covered California and State Regulators, 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.

d) Enrollee transfers. In the event of a change in Participating Providers or QHPs related to network disruption, block transfers, or other similar circumstances, Contractor shall, and shall require Participating Providers to, cooperate with Covered California in planning for the orderly transfer of Enrollees as necessary and as required under applicable laws, rules and regulations including, those relating to continuity of care.

3.4 Participating Providers

3.4.1 Provider Contracts

a) Contractor shall include in all of its contracts with Participating Providers the requirement for all Covered 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").

b) Contractor shall include in each Provider Agreement a requirement that Participating Providers comply with all other applicable laws, rules and regulations.

c) Contractor shall use commercially reasonable efforts to require the provisions of Subsection (d) 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 Provider.

d) Provision of Covered Services. Contractor shall undertake commercially reasonable efforts to ensure that each Participating Provider Agreement and each subcontracting arrangement entered into by each Participating Provider complies with the applicable terms and conditions set forth in this Agreement, as mutually agreed upon by Covered California and Contractor, and which may include the following:

   i. Coordination with Covered California and other programs and stakeholders;

   ii. Relationship of the parties as independent contractors (Section 1.3(a)) and Contractor's exclusive responsibility for obligations under the Agreement (Section 1.3(b));

   iii. Participating Provider Directory requirements (Section 3.4.4);

   iv. Symphony Provider Directory requirements (Section 3.4.5);

   v. Implementation of processes to enhance stability and minimize disruption to provider network (Section 3.3.5);

   vi. Notices, network requirements, and other obligations relating to costs of out-of-network services and other benefits (Section 3.4.3);

   vii. Provider credentialing, including, maintenance of licensure and insurance (Section 3.4.2);

   viii. Customer service standards (Section 3.6);

   ix. Utilization review and appeal processes (Section 4.3);

   x. Maintenance of a corporate compliance program (Section 1.2);

xi. Enrollment and eligibility determinations and collection practices (Article 2);

xii. Appeals and grievances (Section 3.6.2);

xiii. Enrollee and marketing materials (Section 2.4);

xiv. Disclosure of information required by Covered California, including, financial and clinical (Section 1.13), Quality, Network Management and Delivery System Standards (Article 4), and other data, books, and records (Article 10));

xv. Nondiscrimination (Section 1.11);

xvi. Conflict of interest and integrity (Section 1.12);

xvii. Other laws (Section 1.14);

xviii. 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 pursuant to Attachment 7 ("Quality, Network Management and Delivery System Standards");

xix. Performance Measures, to the extent applicable to Participating Providers (Article 6);

xx. Continuity of care, coordination and cooperation upon termination of Agreement and transition of Enrollees (Section 3.3.5 and Article 7);

xxi. Security and privacy requirements, including compliance with HIPAA (Article 9); and

xxii. Maintenance of books and records (Article 10).

3.4.2 Provider Credentialing

Contractor shall perform, or may delegate activities related to, credentialing and re-credentialing Participating Providers in accordance with a process reviewed and approved by State Regulators.

3.4.3 Enrollee Costs; Disclosure

Contractor shall, and shall require Participating Providers to, comply with applicable laws, rules and regulations governing liability of Enrollees for Covered 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.

To the extent that Contractor's QHPs either (i) provide coverage for out-of-network services, or (ii) impose additional fees for such services, Contractor shall disclose to the Enrollee, at the Enrollee's request, the amount Contractor will pay for covered proposed non-emergency out-of-network services.

Contractor shall require its Participating Providers to inform every Enrollee in a manner that allows the Enrollee the opportunity to act upon a 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-emergency Covered Services. Contractor shall require Participating Providers to disclose to an Enrollee considering accessing non-emergency services from a network provider 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 routine updates to its provider manual. Participating Providers may rely on Contractor's provider directory in fulfilling their obligation under this provision.

3.4.4 Covered California Provider Directory

Contractor shall make its provider directory available to (i) Covered California electronically for publication online in accordance with guidance from Covered California, and (ii) in hard copy when potential Enrollees make such request. Unless otherwise agreed to by Covered California, Contractor shall continue to provide information describing all Participating Providers in its QHP networks in a format prescribed by Covered California on a monthly basis to support Covered California's centralized provider directory containing every QHP's network providers, this includes testing, implementation, and continued evaluation. Contractor acknowledges that Covered California may use Contractor's Participating Provider data for any non-commercial purposes. If Covered California's centralized provider directory is not operational, Contractor shall continue to provide Participating Provider information to Covered California on a monthly basis.

The network and directory information provided to Covered California shall take into consideration the ethnic and language diversity of providers available to serve Enrollees of Covered California.

Once the Symphony Provider Directory is fully operational, Covered California will utilize it to populate Covered California's centralized provider directory as detailed in Article 3, Section 3.4.5.

3.4.5 Use of Symphony Provider Directory

1) In order to fulfill its obligation to assist Enrollees in making informed decisions when considering health care coverage choices and in choosing QHP Issuers and their associated network of Providers, Covered California is committed to implementing and participating in the Symphony Provider Directory, formerly known as the California Provider Directory Utility, being developed by the Integrated Health Care Association (IHA). Once fully operational, Covered California will utilize the Symphony Provider Directory to populate the Covered California Provider Directory.

   All QHP Issuers shall utilize the Symphony Provider Directory to populate, maintain, and continually update, provider network data including demographic, licensure, and other relevant information with respect to all their QHPs, as well as to provide information

regarding the terms and restrictions governing such Providers' participation in the QHPs offered by Contractor through Covered California.

2) Contractor agrees to participate in the Symphony Provider Directory, beginning on the first day of the first month of the full calendar quarter immediately following IHA's launch of the Symphony Provider Directory. In connection with such participation, Contractor shall:

   (a) Execute such reasonable participation, subscription, or other agreements required by Covered California or IHA or their vendors to participate in the Symphony Provider Directory;

   (b) Populate, maintain, and continually update the Symphony Provider Directory with all relevant information with respect to its contracted Providers' participation in its QHPs, including all information regarding the terms and restrictions governing such Providers' participation in the QHPs offered through Covered California, identifiers for Covered California providers, and provider network data for Contractor's embedded dental plans;

   (c) Once fully operational with sufficient health plan and provider participation, use the Symphony Provider Directory as the exclusive platform to populate and maintain the information published in the Covered California Online Provider Directory concerning its QHPs; and

   (d) Work with Covered California, IHA and their respective vendors to ensure that the Symphony Provider Directory serves its primary purpose of effectively and efficiently assisting Enrollees in making informed decisions in selecting QHPs and Providers.

3) At a time and manner mutually agreed upon by Covered California and Contractor, Contractor agrees to report on its strategies to ensure that Contractor, and its contracted Providers, maintain compliance with the provisions of this Section 3.4.5.

3.5 Premium Rate Setting

3.5.1 Rating Variations

Contractor shall charge the premium rate in each geographic rating area for each of Contractor's QHPs as agreed upon with Covered California. Contractor may vary premiums by geographic area as permitted by State law, including the requirements of State Regulators regarding rate setting and rate variation set forth at Health and Safety Code §§ 1357.512 and 1399.855, Insurance Code §§ 10753.14 and 10965.9, 10 CCR § 2222.12 and, as applicable, other laws, rules and regulations, including, 45 C.F.R. § 156.255(b).

Contractor shall comply with rate filing requirements imposed by State 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.

3.5.2 Covered California for the Individual Market Rates

For Covered California for the Individual Market, rates shall be established through an annual negotiation process between the Contractor and Covered California for the following calendar year. The parties acknowledge that: (1) the Agreement does not contemplate any mid-year rate changes for Covered California for the Individual Market 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 Covered California to provide Covered California with sufficient time for necessary analysis and actuarial certification.

In Covered California's review of the detailed rationale for each plan's rate development, it has generally taken the view that absent extraordinary circumstances, as determined by Covered California, profit margins over the range that have historically been considered to be reasonable would be unacceptable. Therefore, for future Plan Years should Contractor receive profits or incur losses due to shifts in Federal policy or ACA-related judgements favorable to the Contractor, Contractor should factor profits into a reduction of its premium rates, or increase its profit margin to recoup losses. These adjustments shall be consistent with applicable State and Federal laws, including the medical-loss ratio laws. Covered California will utilize the annual negotiation process in future years to consider how such profits or losses should be factored into future premium rates. In doing so, Covered California will consider the Contractor's documented historic profit margin with Covered California and the need for Contractor to maintain sufficient regulatory reserves. The parties understand that California's State Regulators conduct their own independent review of rates subsequent to the parties' negotiation. In the event the Contractor seeks to invoke this contract provision, Covered California would convey to the regulator its perspective on the reasonableness of profit margins and reserves given the exceptional circumstances.

3.5.3 Rate Methodology

Contractor shall provide, upon Covered California's request, in connection with any contract negotiation or recertification process as reasonably requested by Covered California, detailed documentation on Covered California-specific rate development methodology. Contractor shall provide justification, documentation, and support used to determine rate changes, including providing adequately supported cost projections. Cost projections include factors impacting rate changes, assumptions, transactions, and other information that affects the Covered California 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 Covered California-specific account.

3.6 Customer Service Standards

3.6.1 Basic Customer Service Requirements

Contractor acknowledges that superior customer service is a priority of Covered California. Contractor shall work closely with Covered California in an effort to ensure that the needs of Covered California Enrollees are met. Contractor shall provide and maintain all processes and systems required to ensure customer service, record protection and uninterrupted service to Covered California and Contractor's Enrollees in Covered California in accordance with the standards set forth in this Section 3.6, applicable laws, rules and regulations, including, those consumer assistance tools and programs required to be offered through Covered California as set forth at 45 C.F.R. § 155.205 and 45 C.F.R. § 155.210.

800 Numbers: Contractor shall make information available regarding Covered California pursuant to Contractor's toll-free hotline (i.e. 1-800 number) that shall be available to Enrollees of Contractor both inside and outside Covered California. The hotline and information services shall be staffed and operated in accordance with the Customer Service Standards set forth in this Section 3.6 to provide support to Covered California Enrollees and in a manner designed to assure compliance with these Performance Standards. Contractor shall meet all State requirements for language assistance services applicable to its commercial lines of business. Covered California and Contractor will continue to evaluate on an ongoing basis the adequacy of language services provided for verbal and written communications and consider the adoption of additional standards as appropriate. Contractor shall maintain call statistics for languages other than English similar to 1.4 and 1.5 in Group 1 of Attachment 14 ("Performance Measurement Standards"). The Contractor shall provide this information to Covered California upon request.

3.6.2 Enrollee Appeals and Grievances

a) Internal Grievances and Appeals. Contractor shall maintain an internal review process to resolve an Enrollee's written or oral expression of dissatisfaction regarding the Contractor and Participating Providers, including appeals of claim and benefit determinations, and complaints relating to the scope of Covered Services required to be covered under the QHP. Contractor's processes shall comply with State and Federal laws, rules and regulations relating to Enrollee rights and appeals processes, specifically including grievance requirements set forth at Health and Safety Code § 1368, regardless of the State Regulator for the Contractor's QHPs.

b) External Review. Contractor shall comply with State and Federal laws, rules and regulations relating to the external review process, including independent medical review, available to Enrollees for Covered Services.

3.6.3 Applications and Notices

a) 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, including accessible websites 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.

b) Contractor shall provide applications, forms, and notices, including correspondence, in a manner that is accessible and timely to individuals who are limited English proficient as required by Health and Safety Code §§ 1367.04, 1367.041, 1367.042, and Insurance Code §§ 10133.8, and 10133.11. 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).

3.6.4 Customer Service Call Center

a) During Open Enrollment Period, Contractor's call center hours shall be, unless otherwise agreed by Covered California, Monday through Friday eight o'clock (8:00) a.m. to eight o'clock (8:00) p.m., and Saturday eight o'clock (8:00) a.m. to six o'clock (6:00) p.m. (Pacific Standard Time), except on holidays observed by Covered California. During non-Open Enrollment Periods, the Contractor shall maintain call center hours Monday through Friday eight o'clock (8:00) a.m. to six o'clock (6:00) p.m., and Saturday eight o'clock (8:00) a.m. to five o'clock (5:00) p.m. (Pacific Standard Time), however, Contractor may adjust hours as required by customer demand with prior agreement of Covered California. Contractor shall inform Covered California of its standard call center hours and any changes to the call center hours during non-Open-Enrollment Periods.

b) Contractor's call center shall be staffed at levels reasonably necessary to handle call volume and achieve compliance with Performance 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 QHP benefits and coverage, and to resolve claim and benefit issues.

c) 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.

d) Contractor shall make oral interpreter services 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 Covered California monthly, in a format determined by Covered California, on the volume of calls received by the call center and Contractor's rate of compliance with related Performance Standards as outlined in Attachment 14 ("Performance Measurement Standards").

e) Contractor shall meet all State requirements for language assistance services for all of its commercial lines of business.

3.6.5 Customer Service Transfers

a) During Contractor's regularly scheduled customer service hours, Contractor shall have the capability to accept and handle calls transferred from Covered California and respond to callers requesting additional information from Contractor. Contractor shall maintain staff resources to comply with Performance Standards and sufficient to facilitate a live transfer (from Covered California to Contractor) of customers who call Covered California with escalated issues or complaints that need to be addressed by Contractor. Covered California shall maintain staff resources sufficient to facilitate a live transfer (from Contactor to Covered California) of customers who call Contractor with escalated issues, complaints, or address changes that need to be addressed by Covered California. Contractor and Covered California shall establish a designated customer service team available to handle the live transfer of escalated calls.

b) 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 Contractor-specific questions or issues.

c) Contractor shall refer Enrollees and applicants with questions regarding premium tax credits and Covered California eligibility determinations to Covered California's website or Service Center, as appropriate.

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

3.6.6 Customer Care

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

b) Contractor shall comply with HIPAA rules and other laws, rules and regulations respecting privacy and security.

3.6.7 Notices

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

b) Contractor shall provide a link to the Covered California website on its website.

c) When Contractor provides direct contacts for getting membership assistance, Contractor shall also include the Covered California website for Covered California-related issues.

d) Contractor shall use standardized member renewal language, developed by Covered California, and approved by DMHC and CDI for all Enrollee renewal notices.

e) All legally required notices sent by Contractor to Enrollees shall be translated into and available in languages other than English as required under applicable Federal and State laws, rules and regulations, including, Health and Safety Code §§ 1367.04, 1367.041, 1367.042, and Insurance Code §§ 10133.8, 10133.10, 10133.11.

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

3.6.8 Contractor-Specific Information

Upon request, Contractor shall provide training materials and participate in Covered California customer service staff training.

Contractor shall provide summary information about its administrative structure and the QHPs offered on Covered California. This summary information will be used by Covered California customer service staff when referencing Contractor or QHP information.

3.6.9 Enrollee Materials: Basic Requirements

a) 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 languages as required by Federal and State law and receive any necessary regulatory approvals from the relevant State Regulators, be provided to Covered California as directed by Covered California, and shall include information brochures, a summary of the Plan that accurately reflects the coverage available under the Plan (a Summary of Benefits and Coverage), and related communication materials. Contractor shall, upon request by Covered California, provide copies of Enrollee communications and give Covered California the opportunity to comment and suggest changes in such material.

b) 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, Enrollee materials shall be written in plain language, as that term is defined in applicable laws, rules and regulations. Plan materials that require Covered California 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:

i. Welcome letters;

ii. Enrollee ID card;

iii. Billing notices and statements;

iv. Notices of actions to be taken by QHP Issuer that may impact coverage or benefit letters;

v. Termination Grievance process materials;

vi. Drug formulary information;

vii. Uniform Summary of Benefits and Coverage; and

viii. Other materials required by Covered California.

3.6.10 New Enrollee Enrollment Packets

a) Contractor shall mail or provide online enrollment packets to all new Covered California for the Individual Market Enrollees in Covered California for the Individual Market QHPs within ten (10) business days of receiving complete and accurate enrollment information from Covered California and the binder payment. Contractor may deliver Enrollee materials pursuant to other methods that are consistent with: (1) Contractor's submission of materials to Enrollees of its other plans; (2) the needs of Enrollees; (3) the consent of the Enrollee; and (4) with applicable laws, rules and regulations. Contractor shall report to Covered California monthly, in a format mutually agreed upon by Covered California and Contractor, on the number and accuracy rate of identification cards that were sent to new Enrollees and

Contractor's compliance with the Performance Standards set forth in this Agreement. The enrollment packet shall include, at the minimum, the following:

i. Welcome letter;

ii. Enrollee ID card, in a form approved by Covered California;

iii. If Enrollee ID card is not included in the enrollment packet, Contractor must send a notice to the Enrollee that states the ID card will be sent separately, when the Enrollee should expect to receive it, and provide the information necessary for the Enrollee to receive services and for providers to file claims;

iv. Summary of Benefits and Coverage;

v. Pharmacy benefit information;

vi. Nurse advice line information; and

vii. Other materials required by Covered California.

b) Contractor shall maintain access to enrollment packet materials; Summary of Benefits and Coverage; 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.

3.6.11 Summary of Benefits and Coverage

Contractor shall develop and maintain a Summary of Benefits and Coverage as required by Federal and State laws, rules, and regulations. The Summary of Benefits and Coverage must 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 Summary of Benefits and Coverage annually and Contractor shall make the Summary of Benefits and Coverage available to Enrollees pursuant to Federal and State laws, rules, and regulations.

3.6.12 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 as required by Federal and State laws, rules, and regulations, including requirements to identify Providers who are not accepting new Enrollees.

3.6.13 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.

3.6.14 Explanation of Benefits

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

3.6.15 Secure Plan Website for Enrollees and Providers

Contractor shall maintain a secure website, 24 hours, 7 days a week. All content on the secure Enrollee website shall be available in English and Spanish and any other languages required under State and Federal law. If Contractor is new to offering coverage on Covered California, Contractor shall meet the requirements of this section within ninety (90) days after the Effective Date of this Agreement. The secure website shall contain information about the Plan, including, but not limited to, the following:

a) Upon implementation by Contractor, 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.

3.6.16 Required Reports

Contractor shall submit required reports as defined in this contract. For the contractor's convenience, all required reports are listed in the "Contract Reporting Requirements" table posted on the Contractors extranet website provided by Covered California (Plan Home, in the Resources folder, Contract Reporting Compliance subfolder).

Upon request, Contractor shall submit standard reports as described below in a mutually agreed upon manner and time:

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

b) Use of Plan website;

c) Enrollment reports; and

d) Premiums collected.

3.6.17 Contractor Staff Training about Covered California

Contractor shall arrange for and conduct staff training regarding the relevant laws, mission, administrative functions and operations of Covered California, including Covered California program information and products in accordance with Federal and State laws, rules and regulations, using training materials developed by Covered California.

Upon request by Covered California, Contractor shall provide Covered California with a list of upcoming staff trainings and make available training slots for Covered California staff to attend upon request.

3.6.18 Customer Service Training Process

Contractor shall demonstrate to Covered California that it has in place initial and ongoing customer service protocols, training, and processes to appropriately interface with and participate in Covered California. As part of this demonstration, Contractor shall permit Covered California to inspect and review its training materials. Covered California will share its customer service training modules with Contractor.

ARTICLE 4 – QUALITY, NETWORK MANAGEMENT AND DELIVERY SYSTEM STANDARDS

4.1 Covered California Quality Initiatives

The parties acknowledge and agree that furthering the goals of Covered California require Contractor to work with the other QHP Issuers 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 Covered California 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 Covered California with respect to these objectives and provide the Covered Services required by Enrollees, Covered California and Contractor shall coordinate and cooperate with respect to quality activities conducted by Covered California in accordance with the mutually agreeable terms set forth in this section and in Covered California's Quality, Network Management and Delivery System Standards set forth at Attachment 7 ("Quality, Network Management and Delivery System Standards").

4.2 Quality Management Program

Contractor shall maintain a quality management program to review the quality of Covered Services provided by Participating Providers and other subcontractors. Contractor's quality management program shall be subject to review by Covered California 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 Covered California 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 Covered California, (ii) providing mutually agreed upon data and other information required under the Quality, Network Management and Delivery System Standards, and (iii) as otherwise reasonably requested by Covered California. 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 the confidentiality of medical information and will preserve all privileges set forth at Health and Safety Code § 1370.

4.3 Utilization Management

Contractor shall maintain a utilization management program that complies with applicable laws, rules and regulations, including Health and Safety Code § 1367.01 and other requirements established by the applicable State Regulators responsible for oversight of Contractor.

4.4 Transparency and Quality Reporting

a) Pursuant to 45 C.F.R. § 156.220 and Centers for Medicare & Medicaid Services Transparency in Coverage requirements, Contractor shall provide Covered California and Enrollees with information reasonably necessary to provide transparency in Contractor's coverage, and report to Covered California and Enrollees, the data as required by Covered California. This includes information relating to claims payment policies and practices, periodic financial disclosures, enrollment, disenrollment, claims denials, appeals, rating practices, cost-sharing, payments with respect to any out-of-network coverage, and Enrollee rights. Contractor shall provide information required under this Section to Covered California and Enrollees in plain language.

b) 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.

4.5 Quality Rating System

Contractor shall collect and annually report to Covered California, for each QHP Product Type, its Health Care Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Health Care Providers and Systems (CAHPS) data, and other performance data (numerators, denominators, and rates) as required for the federal Quality Rating System and as outlined in Attachments 7 ("Quality, Network Management and Delivery System Standards") and 14 ("Performance Measurement Standards") of this Agreement.

4.6 Quality Improvement Strategy

As part of a new federal requirement in 2017, all health plans with two (2) years of state-based Covered California experience will participate in a Quality Improvement Strategy. (For more information, visit: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/QIS-Technical-Guidance-and-User-Guide.pdf.)

Covered California has harmonized federal Quality Improvement Strategy requirements to align with 2017 quality strategy and direction. As part of a federally mandated Quality Improvement Strategy, Contractor must identify the mechanisms planned to promote improvements in health care quality and access to care, population health outcomes, and making care more affordable for each Quality Improvement Strategy initiative listed in the Covered California Quality

Improvement Strategy (QIS) Section of the Qualified Health Plan Certification Applications. Contractor shall annually report to Covered California its Quality Improvement Strategy as part of the Application for Certification.

4.7 Data Submission Requirements

Contractor shall provide to Covered California information regarding Contractor's membership through Covered California in a manner consistent with applicable federal and California State law, as well as the terms and conditions of this Agreement as detailed in Attachment 7, Article 15, Section 15.01 Data Submission .

ARTICLE 5 – FINANCIAL PROVISIONS

5.1 Covered California for the Individual Market

5.1.1 Rates and Payments

a) Schedule of Rates. Covered California 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 Exchange for Plan Year 2017 are set forth at Attachment 8 ("Monthly Rates - Individual Exchange") and will be updated annually for Plan Years 2018, 2019, 2020, and 2021 in Attachment 9 (Updated Rates – Covered California for the Individual Market). The Monthly Rates for Plan Year 2022 are those rates submitted by Contractor during the Certification Process and subsequently uploaded and validated by Contractor through the SERFF Templates for the 2022 Plan Year. The parties acknowledge and agree that the premium amounts set forth under the Monthly Rates are actuarially determined to ensure 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 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 5.1.3.

b) Updates. If the Term of this Agreement is longer than one year and Contractor's QHPs are certified for another year, the Monthly Rates for each subsequent year of the Agreement will be established no more frequently than annually during the Certification Process and in accordance with the procedures set forth at and Section 3.5.

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 Covered California 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 2.2.4. Contractor further understands that the premium payment collected by Contractor includes amounts allocated to the Participation Fee due to Covered California. The Participation Fees shall be billed by Covered California to Contractor and payable by Contractor to Covered California in accordance with the requirements set forth at Section 5.1.3.

d) Advanceable Payments. Covered California will administer a State premium assistance program in accordance with Title 25 of the Government Code, commencing at Section 100800 et seq. Covered California shall remit advanceable State premium assistance payments to Contractor in accordance with the State premium assistance program design adopted by the Covered California Board for the applicable plan year. This subsidy payment will be

calculated and delivered by Covered California separate from the Participation Fee invoices set forth in Section 5.1.3.

e) Payment for Additional Marketing Activities. Should Covered California engage in additional marketing activities in accordance with Section 2.5, Covered California will invoice Contractor for the mutually-agreed upon dollar amount. This invoice will be billed by Covered California to Contractor and payable by Contractor separate from the Participation Fee invoices set forth in Section 5.1.3. If, after Covered California completes the additional marketing activities, Covered California has not expended the full amount paid by Contractor pursuant to this Section 5.1.1e), Covered California shall pay any such unexpended funds back to Contractor.

5.1.2 Financial Consequences of Non-Payment of Premium

a) Premium payment rules. 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, chargebacks, delinquency and termination actions and notices, grace period requirements, and partial payment rules. Such enforcement shall be conducted in accordance with requirements in this Agreement consistent with applicable laws, rules and regulations.

b) Enrollee Terminations. 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 or as otherwise authorized under Section 2.2.4, Contractor must include the applicable State Regulator-approved appeals language, and any Covered California-required appeals language, in its notice of termination of coverage to the Enrollee.

c) Enrollee Disenrollment. In the event an enrollee terminates coverage with a QHP for any reason, including termination due to non-payment of premium, Contractor may not charge the Enrollee any type of termination or disenrollment fee and the consumer must be allowed to re-enroll pursuant to federal and State open enrollment and special enrollment regulations.

d) Grace Period. 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 Covered California 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 2.2.4 and required under applicable laws, rules, and regulations with respect to these grace periods.

e) Offsets. Pursuant to Section 1365 (a) of the Health and Safety Code, Contractor shall return the advanced State premium assistance paid to Contractor on behalf of an enrollee who is

terminated for nonpayment of premiums for the second and third months of the three-month grace period. Such repayments will be calculated by Covered California and offset from future payments of the advanced State premium assistance paid pursuant to Section 5.1.1(d). In the event that an issuer is no longer contracted with Covered California, Covered California will bill the issuer for any repayments due.

5.1.3 Covered California for the Individual Market Participation Fees

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

b) Contractor recognizes that the total cost of all Participation Fees for Covered California must be spread across Contractor's entire book of business in the single risk pool (both inside and outside Covered California) for the Individual Market.

c) The Participation Fee payable to Covered California during each month of this Agreement shall be equal to three point twenty-five (3.25) percent of the gross premium attributable to each Enrollee in Contractor's QHPs for such month. The Participation Fee will be assessed by Covered California and payable monthly by Contractor based on Covered California's gross premium records attributable to effectuated Enrollees in Contractor's QHPs sold through Covered California for the Individual Market for 2017-2022.

The Participation Fee will be reviewed each year as part of Covered California's annual budget process. Should Covered California need to record any positive or negative adjustments to enrollment activity for prior years, the Participation Fee shall be calculated pursuant to the Contractor's Agreement that was in place during the applicable Plan Year or years.

d) Participation Fee invoices will be issued by Covered California to Contractor on the 15th of the month. Contractor's Participation Fee obligation will be determined and billed by evaluating Contractor's then-current QHP effectuated enrollment and may be subject to adjustment to reflect changes in enrollment that may have occurred in prior months (including additions, terminations and cancellations of enrollment). Covered California may reduce Contractor's Participation Fee in specified months as a result of such changes in enrollment. In situations where Covered California has previously authorized and agreed to reimburse Contractor in writing for specified activities, such as additional marketing activities, Covered California may also reduce the Participation Fee to offset Contractor's expenses. Participation Fee payments will be due 15 days from the date the invoice is emailed to Contractor. For invoices paid after 15 days from the date the invoice is emailed, Contractor may be assessed a 1% per month late fee on the unpaid balance as of that date. Covered California, in its sole discretion, may assess the late fee for any month that Contractor fails to make the payment by the due date. Participation Fee payments will be applied to the oldest outstanding invoice or overall balance, including prior month late fees, whichever is greater.

e) In the event that Contractor disputes the amount of Participation Fees billed or deducted by Covered California, Contractor shall submit a written notice of such dispute to Covered California within thirty (30) days following receipt of such bill or deduction by Covered California. Contractor's notice will document the nature of the discrepancies, including, reconciliation of any differences identified by Contractor in enrollment or premiums collected. Covered California will respond to Contractor within forty-five (45) 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 Covered California, Contractor may pursue additional remedies in accordance with Section 12.1.

f) Subject to the provisions of Section 10.5, Contractor agrees to a periodic audit or other examination by Covered California 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. Covered California may perform follow up audits or examinations more frequently than annually to monitor Contractor's implementation of such corrective actions.

g) Contractor acknowledges that Covered California is required under Government Code § 100520(c) to maintain a prudent reserve as determined by Covered California.

ARTICLE 6 – PERFORMANCE STANDARDS

6.1 Standards

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

6.2 Penalties and Credits

Covered California may impose penalties ("penalties") in the event that Contractor fails to comply or otherwise act in accordance with the Performance Measures. Covered California may 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. Penalties and credits will be calculated in accordance with Attachment 14 ("Performance Measurement Standards").

6.3 No Waiver

Covered California and Contractor agree that the failure to comply with the Performance Standards may cause damages to Covered California and its Enrollees which may be uncertain and impractical or difficult to ascertain. The parties agree that Covered California shall assess, and Contractor promises to pay Covered California, in the event of such delayed, or failed performance that does not meet the Performance Standards, the amounts to be determined in accordance with the Performance Standards set forth at Attachment 14 ("Performance Measurement Standards").

The assessment of fees relating to the failure to meet Performance Standards shall be subject to the following: (1) be determined in accordance with the amounts and other terms set forth in the Performance Standards, (2) be cumulative with other remedies available to Covered California under the Agreement, (3) not be deemed an election of remedies, and (4) not constitute a waiver or release of any other remedy Covered California may have under this Agreement for Contractor's breach of this Agreement, including, without limitation, Covered California's right to terminate this Agreement. Covered California shall be entitled, in its discretion, to recover actual damages caused by Contractor's failure to perform its obligations under this Agreement.

ARTICLE 7 – CONTRACT TERM; RECERTIFICATION AND DECERTIFICATION

7.1 Agreement Term

The term of this Agreement is specified on the STD 213, which is the signature page of this Agreement.

7.2 Agreement Termination

7.2.1 Covered California Termination

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

a) Contractor fails to fulfill an obligation that is material to its status as a QHP Issuer or its performance under the Agreement;

b) Contractor no longer holds a license or certificate that is required for Contractor to perform its obligations under this Agreement or Contractor otherwise fails to maintain compliance with the "good standing" requirements pursuant to Section 3.1.1 and which impairs Contractor's ability to provide Services under the Agreement;

c) Contractor breaches any material term, covenant, warranty, or obligation under this Agreement that is not cured or substantially cured to the reasonable satisfaction of Covered California within forty-five (45) days after receipt of notice of default from Covered California; provided, however, that such cure period may not be required and Covered California may terminate the Agreement immediately if Covered California determines pursuant to subparagraph (e) below that Contractor's breach threatens the health and safety of Enrollees;

d) 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 Covered Services to beneficiaries of any State or Federal health care program;

e) Covered California reasonably determines that (i) the welfare of Enrollees is in jeopardy if this Agreement continues, as such determination shall be made in the reasonable discretion of Covered California based on consideration of professionally recognized standards and benchmarks, requirements imposed by accreditation agencies, and applicable laws, rules, and regulations; or (ii) 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 (iii) Covered California reasonably determines, based on consultation with legal counsel and/or State and Federal 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.

7.2.2 Contractor Termination

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

a) Covered California 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) days after receipt by Covered California of notice from the Contractor; or

b) Covered California fails to comply with a change in laws, rules or regulations occurring during the term of this Agreement 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 State and Federal 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.

7.2.3 Notice of Termination

If Covered California determines, based on reliable information, 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, then Covered California shall have the option to demand that Contractor provide Covered California with a reasonable assurance of performance. Upon Contractor's receipt of such a demand from Covered California, Contractor shall provide to Covered California a reasonable assurance of performance responsive to Covered California's demand. If Contractor fails to provide assurance within ten (10) days of Covered California's demand that demonstrates Contractor's reasonable ability to avoid such default or cure 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 Covered California.

In case a party elects to terminate this Agreement in whole or in part under Section 7.2, 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 Covered

California may require Contractor to discontinue the provision of certain Services if Covered California determines that the continuing provision of services may cause harm to Enrollees, Participating Providers, or other stakeholders.

Covered California shall be entitled to retain any disputed amounts that remain in the possession of Covered California until final resolution of all claims by the parties against each other arising out of any Contractor default alleged by Covered California.

7.2.4 Remedies in Case of Contractor Default or Breach

a) In addition to the termination provisions in Section 7.2.1, Covered California shall have full discretion to institute any of the following remedies, in accordance with Subsection (b) of this Section, in case of Contractor's breach, whether material or not, or default:

   i. Changing the order in which Contractor's QHPs are displayed in CalHEERS;

   ii. Removing Contractor's provider directory from the Covered California website;

   iii. Freezing Contractor's Enrollment during Open or Special Enrollment Periods;

   iv. Recovery of damages to Covered California caused by the breach or default; and

   v. Specific performance of particular covenants made by Contractor hereunder.

b) Prior to instituting any of the remedies in Subsection (a), Covered California shall provide written notice to Contractor that Contractor is in breach or default of this Agreement, identify the basis for such breach or default, and provide Contractor with a thirty (30) day period to cure. During the cure period, the parties agree to meet and confer in an effort to informally resolve the breach or default. Contractor shall have thirty (30) days from the date Contractor received notice of the breach or default to fully cure the breach or default, unless the parties mutually agree to a longer cure period. If Contractor has not cured the breach or default within the thirty (30) day period, or a longer cure period that has been mutually agreed upon, Covered California may institute any of the remedies identified in Subsection (a) of this section. All remedies of Covered California under this Agreement for Contractor default or breach are cumulative to the extent permitted by law.

c) This section shall not apply to any contractual requirements that are associated with a performance guarantee in Attachment 14 ("Performance Measurement Standards") or for failure to meet any quality targets in Attachment 7 ("Quality, Network Management and Delivery System Standards").

7.2.5 Contractor Insolvency

Contractor shall notify Covered California 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, Covered California may terminate this Agreement upon five (5) days written notice. If Covered California does so, Covered California shall have the right to recover damages from Contractor as though the Agreement had been terminated for Contractor default.

7.3 Recertification

7.3.1 Recertification Process

During each year of this Agreement, Covered California will evaluate Contractor for recertification based on an assessment process conducted by Covered California 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. Covered California shall consider the Contractor for recertification unless (i) the Agreement is terminated sooner than the Expiration Date by Covered California in accordance with the requirements set forth at Section 7.2 or pursuant to other terms set forth in the Agreement, or (ii) Contractor makes a Non-Recertification Election pursuant to Section 7.3.2.

7.3.2 Non-Recertification Election

a) Contractor election. Contractor shall provide Covered California with notice on or before February 15th of each Plan Year whether Contractor will elect to not seek recertification of its QHPs for the following Plan Year ("Non-Recertification Election"). Contractor shall comply with conditions set forth in this Section 7.3.2 with respect to continuation of coverage and transition of Enrollees to new QHPs following Covered California's receipt of Contractor's Non-Recertification Election.

b) Continuation and Transition of Care. Except as otherwise set forth in this Section 7.3.2, Contractor shall continue to provide Covered 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 of this section.

   Contractor shall take any further action reasonably required by Covered California to provide Covered Services to Enrollees and transition care following the Non-Recertification Election.

   Contractor shall coordinate and cooperate with respect to communications to Enrollees in Covered California for the Individual Market and other stakeholders regarding the transition of Enrollees to another QHP.

c) Covered California for the Individual Market. The following provisions shall apply to Covered California for the Individual Market:

i. Following Covered California's receipt of the Non-Recertification Election, Contractor must continue to participate in the enrollment and eligibility assignment process, and may be assigned new Enrollees through the end of the calendar year;

ii. Contractor will provide coverage for Enrollees assigned to Contractor until the earlier of (i) the end of the calendar year, or (ii) the Enrollee's transition to another QHP during a Special Enrollment Period.

7.4 Decertification

Notwithstanding any other language set forth in this Section 7.4, the Agreement shall expire on the Expiration Date set forth in Section 7.1 in the event that Covered California elects to decertify Contractor's QHP based on Covered California's evaluation of Contractor's QHP during the recertification process that shall be conducted by Covered California pursuant to Section 7.2.

7.5 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 QHPs shall be deemed decertified and shall cease to operate as QHPs as defined at 10 CCR § 6410 immediately upon termination or expiration of this Agreement in the event uninterrupted continuation of agreement between Covered California 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 Covered California 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 Covered California's process and in accordance with applicable laws, rules and regulations.

c) All duties and obligations of Covered California and Contractor shall cease upon termination of the Agreement and the decertification of Contractor's 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. Covered California reserves the right to inspect the storage, processes, and destruction of any Information Assets provided under this Agreement.

d) Contractor shall comply with the requirements set forth at Section 7.3.2 in the event that Contractor makes a Non-Recertification Election.

e) Contractor shall cooperate fully to effect an orderly transfer of Covered Services to another QHP during (i) any notice period set forth at Sections 7.2.3, 7.2.5, or 7.3.2, and (ii) if requested by Covered California to facilitate the transition of care or otherwise required under Section 7.6, following the termination of this Agreement. Such cooperation shall include the following:

i. Upon termination, Contractor, if offering a HMO, shall complete the processing of all claims for benefit payments under the QHP for Covered 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 Covered Services rendered on or before the termination date.

ii. Contractor will provide communications developed or otherwise approved by Covered California to communicate new QHP information to Enrollees in accordance with a timeline to be established by Covered California.

iii. In order to ensure the proper transition of Services provided prior to, and subsequent to, termination, Contractor will forward to any new QHP Issuer 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 Covered California for a period of up to three (3) months following the termination date.

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

v. If so instructed by Covered California in the termination notice, Contractor shall promptly discontinue the provision of Services requested by Covered California to be discontinued as of the date requested by Covered California.

vi. Contractor will perform reasonable and necessary acts requested by Covered California and as required under applicable laws, rules, regulations, consistent with industry standards to facilitate transfer of Covered Services herewith to a succeeding Contractor. Contractor shall comply with requirements reasonably imposed by Covered California relating to (i) the discontinuation of new enrollment or re-enrollment in Contractor's QHP, (ii) 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 Covered California.

vii. Contractor will reasonably cooperate with Covered California and any successor QHP Issuer in good faith with respect to taking such actions that are reasonably determined to be the best interest of the QHP Issuer, and Enrollees.

f) Contractor shall cooperate with Covered California'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:

1) 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. Contractor shall follow the methodology specified in 10 CCR § 6500 (i) for the refund of any excess premiums paid.

The same methodology shall apply to proration of APTC and CSR amounts for a coverage lasting less than one month.

2) Responsibility to Complete Contractual Obligations: Contractor is responsible for completing submission and corrections to Encounter Data for Covered Services received by Enrollees during the period of the Agreement. Contractor is responsible for submitting any outstanding financial or other reports required for Covered Services rendered or Claims paid during the term of the Agreement.

g) Contractor shall (i) provide such other information to Covered California, Enrollees and/or the succeeding QHP Issuer, 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.

7.6 Coverage Following Termination and Decertification

a) Upon the termination of the Agreement or decertification of one or more of Contractor's QHPs, Contractor shall cooperate fully with Covered California in order to effect an orderly transition of Enrollees to another QHP as directed by Covered California. This cooperation

shall include: (i) attending post-termination meetings, (ii) providing or arranging for the provision of Covered Services as may be deemed necessary by Participating Providers to assure the appropriate continuity of care, and (iii) communicating with affected Enrollees in cooperation with Covered California and the succeeding contractor as applicable, as reasonably requested by Covered California.

b) In the event 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. 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) 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) 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

8.1 Contractor Insurance

8.1.1 Required Coverage

a) Without limiting Covered California's right to obtain indemnification or other forms 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 as otherwise required by law, including, without limitation, coverage required to be provided and documented pursuant to § 1351 (o) 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 Covered 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:

i. 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;

ii. 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;

iii. 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;

iv. 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;

v. 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

vi. Professional liability or errors and omissions with coverage of not less than $1 million per claim/$2 million general aggregate.

8.1.2 Workers' Compensation

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

8.1.3 Subcontractor Coverage

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.

8.1.4 Continuation of Required 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.

8.1.5 Premium Payments and Disclosure

Premium on all insurance policies shall be paid by Contractor or its subcontractors. Contractor shall provide thirty (30) days' notice of cancellation to Covered California. Contractor shall furnish to Covered California copies of certificates of all required insurance prior to the Execution Date, and copies of renewal certificates of all required insurance within thirty (30) days after the renewal date. Covered California reserves the right to review the insurance requirements contained herein to ensure that there is appropriate coverage that is in accordance with this Agreement. Covered California 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.

8.2 Indemnification

Contractor shall indemnify, defend, and hold harmless Covered California, 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 attorneys' fees, related to any of the following:

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, material, or supplies in connection with the performance of this Agreement.

The obligation to provide indemnification under this Agreement shall be contingent upon Covered California:

a) Providing Contractor with reasonable written notice of any claim for which indemnification is sought;

b) Allowing Contractor to control the defense and settlement of such claim; provided, however, that the Contractor consults with Covered California regarding the defense of the claim and any possible settlements and agrees not to enter into any settlement or compromise of any claim or action in a manner that admits fault or imposes any restrictions or obligations on Covered California without Covered California's prior written consent, which will not be unreasonably withheld; and,

c) Cooperating fully with the Contractor in connection with such defense and settlement. Indemnification under this section is limited as described herein.

ARTICLE 9 – PRIVACY AND SECURITY

9.1 Privacy and Security Requirements for Personally Identifiable Data

a) HIPAA Requirements. 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 Protected Health Information, other than as permitted or required by the HIPAA Requirements and the terms of this Agreement.

b) Covered California Requirements. With respect to Contractor Covered California Functions, Contractor agrees to comply with following privacy and security requirements and standards applicable to Personally Identifiable Information which have been established and implemented by Covered California in accordance with the requirements of 45 C.F.R. Part 155 (collectively, "Covered California Requirements"):

i. Uses and Disclosures. Pursuant to the terms of this Agreement, Contractor may receive from Covered California Protected Health Information and/or Personally Identifiable Information in connection with Contractor Covered California Functions that is protected under applicable Federal and State laws and regulations. Contractor shall not use or disclose such Protected Health Information or Personally Identifiable Information obtained in connection with Contractor Covered California Functions other than as is expressly permitted under Covered California Requirements and only to the extent necessary to perform the functions called for within this Agreement.

ii. Fair Information Practices. Contractor shall implement reasonable and appropriate fair information practices to ensure:

1. Individual Access. Contractor shall provide access to, and permit inspection and copying of Protected Health Information and Personally Identifiable Information in either an electronic or hard copy format as specified by the individual and as required by law, within thirty (30) days of such request from the individual. If the Contractor denies access, in whole or in part, the Contractor must provide a written denial within the time limits for providing access, which includes the basis for the denial and a statement of the individual's review rights, if applicable. In the event any individual requests access to Protected Health Information or Personally Identifiable Information maintained by Covered California or another health plan directly from Contractor, Contractor shall within five (5) days forward such request to Covered California and the relevant health plan as needed.

2. Amendment. Contractor shall provide an individual with the right to request an amendment of inaccurate Protected Health Information and Personally Identifiable Information. Contractor shall respond to such individual within sixty (60) days of such a request either by making the correction and informing the individual of such correction or notifying the individual in writing that the request was denied, which notice shall provide an explanation for the denial and explain that the individual may submit a statement of disagreement with 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 Protected Health Information and Personally Identifiable Information.

4. Choice. Contractor shall provide individuals with a reasonable opportunity and capability to make informed decisions about the collection, use, and disclosure of their Protected Health Information and Personally Identifiable Information.

5. Limitations. Contractor represents and warrants that all Protected Health Information and Personally Identifiable Information shall be collected, used, and/or disclosed under this Agreement only to the extent necessary to accomplish a specified purpose under the terms of this Agreement or as permitted by Covered California Requirements and never to discriminate inappropriately.

6. Data Integrity. Contractor shall implement policies and procedures reasonably intended to ensure that Protected Health Information and Personally Identifiable Information 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 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 Protected Health Information and Personally Identifiable Information that it creates, receives, maintains, or transmits pursuant to the Agreement and to prevent the use or disclosure of Protected Health Information and/or Personally Identifiable Information other than as provided for in this Agreement, or as required by law. In furtherance of compliance with such requirements, Contractor shall:

   a. Encrypt all Protected Health Information and/or Personally Identifiable Information that is in motion or at rest, including but not limited to data on portable media devices, using commercially reasonable means, 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 Protected Health Information and/or Personally Identifiable Information.

Data centers shall be encrypted or shall otherwise comply with industry data security best practices;

b. 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 Protected Health Information and/or Personally Identifiable Information;

c. Maintain and exercise a plan to respond to internal and external security threats and violations;

d. Maintain an incident response plan;

e. Maintain technology policies and procedures that provide reasonable safeguards for the protection of Protected Health Information and Personally Identifiable Information stored, maintained, or accessed on hardware and software utilized by Contractor and its subcontractors and Agents;

f. Mitigate to the extent practicable, any harmful effect that is known to Contractor of any Security Incident related to Protected Health Information and/or Personally Identifiable Information or of any use or disclosure of Protected Health Information and/or Personally Identifiable Information 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;

g. Ensure that each individual user, including any employees, sub-contractors, agents or other such individuals, of any Covered California computer system through which Protected Health Information and/or Personally-Identifiable Information is accessed be assigned and maintain his or her own unique user-id and password. Contractor shall immediately notify Covered California via e-mail through an e-mail address provided by Covered California once any such employees, sub-contractors, agents or other such individuals are no longer employed or retained by Contractor. Contractor shall likewise cooperate in good faith to ensure the accounts of any such individuals are de-activated to prevent unauthorized access to Protected Health Information and/or Personally-Identifiable Information through any such Covered California computer system; and

h. Destroy Protected Health Information and Personally Identifiable Information in a manner consistent with applicable State and Federal laws, regulations, and agency guidance on the destruction of Protected Health Information and Personally Identifiable Information, including but not limited to NIST special publication 800-88 “Guidelines for Media Sanitization; and

i. Comply with all applicable Covered California policies within Section 9.2. Protection of Information Assets, including, but not limited to, executing non-disclosure agreements and other documents required by such policies. Contractor

shall also require any subcontractors and Agents to comply with all such Covered California policies.

c) California Requirements. With respect to all provisions of information under this Agreement, Contractor agrees to comply with all applicable California state health information privacy and security laws applicable to Personally Identifiable Information, including but not limited to the confidentiality of the Medical Information Act, the California Insurance Information and Privacy Protection Act, and the Information Practices Act, 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 Protected Health Information or Personally Identifiable Information under the HIPAA Requirements, Covered California Requirements, or California Requirements with respect to Contractor Covered California Functions, 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 Protected Health Information and/or Personally Identifiable Information shall be resolved to permit Covered California and Contractor to comply with the most stringent of the applicable privacy and security laws or regulations.

e) Breach Notification.

i. Contractor shall report to Covered California any Breach or Security Incident reasonably calculated to result in the Breach of PII or PHI created or received in connection with Contractor Covered California Functions in accordance with the provisions set forth herein. For purposes of this Paragraph (e), a "Breach" shall, in accordance with the HIPAA Breach Notification Rule, mean the impermissible use or disclosure of PII or PHI within Contractor's custody or control which is reasonably calculated to compromise the security or privacy of any such PII or PHI [45 CFR § 164.400-414]. For purposes of this Paragraph (e), a "Security Incident" shall, in accordance with the HIPAA Security Rule, mean the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or the interference with system operations in an information system [45 CFR § 164.304].

ii. Contractor shall, without unreasonable delay, but no later than within three (3) business days after Contractor's discovery of a Breach or Security Incident reasonably calculated to result in a Breach of PII or PHI subject to this agreement, submit an initial report regarding any such Breach or Security Incident to Covered California. Reports shall be made on a form made available to Contractor by Covered California.

iii. Contractor shall cooperate with Covered California in investigating any such Breach or Security Incident and in meeting Covered California's obligations, if any, under applicable State and Federal security breach notification laws, regulatory obligations, or agency requirements. If the cause of the Breach or Security Incident 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 Covered California.

iv. To the extent possible, Contractor's initial report shall include: (a) the names of the individual(s) whose Protected Health Information and/or Personally Identifiable Information has been, or is reasonably believed by Contractor to have been accessed, acquired, used, or disclosed. In the event of a Security Incident, Contractor shall provide such information regarding the nature of the information system intrusion and any systems potentially compromised; (b) a brief description of what happened including the date of the incident and the date of the discovery of the incident, if known; (c) a description of the types of Protected Health Information and/or Personally Identifiable Information that were involved in the incident, as applicable; (d) a brief description of what Contractor is doing or will be doing to investigate, to mitigate harm to the individual(s) and to its information systems, and to protect against recurrences; and (e) any other information that Covered California determines it needs to include in notifications to the individual(s) or relevant regulatory authorities under applicable privacy and security requirements.

v. Within three (3) days of conducting its investigation, unless an extension is granted by Covered California, Contractor shall file a final report, which shall identify and describe the results and outcome of Contractor's above-referenced investigation and mitigation efforts. Contractor shall make all reasonable efforts to obtain the information listed above and shall provide an explanation if any information cannot be obtained. Contractor and Covered California will cooperate in developing content for any public statements.

f) Other Obligations. The following additional obligations apply to Contractor:

i. Subcontractors and Agents. Contractor shall enter into an agreement with any Agent or subcontractor that will have access to Protected Health Information and/or Personally Identifiable Information that is received from, or created or received by, Contractor on behalf of Covered California or in connection with this Agreement, or any of its contracting Plans pursuant to which such Agent or subcontractor agrees to be bound by the same or more stringent restrictions, terms and conditions as those that apply to Contractor pursuant to this Agreement with respect to such Protected Health Information and Personally Identifiable Information.

ii. Covered California Operations. Unless otherwise agreed to by the Contractor and Covered California, Contractor shall provide patient medical and pharmaceutical information needed by Covered California to fulfill its health oversight obligations under applicable law and effectively oversee and administer the Plans.

iii. Records and Audit. Contractor agrees to make its internal practices, books and records relating to the use and disclosure of Protected Health Information and/or Personally Identifiable Information received from Covered California, or created or received by Contractor on behalf of Covered California or in connection with this Agreement

available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining the Contractor's and/or Covered California's compliance with HIPAA Requirements. In addition, Contractor shall provide Covered California with information concerning its safeguards described throughout this section and/or other information security practices as they pertain to the protection of Protected Health Information and Personally Identifiable Information, as Covered California may from time to time request. Failure of Contractor to complete or to respond to Covered California's request for information within the reasonable timeframe specified by Covered California shall constitute a material breach of this Agreement. In the event of a Breach or Security Incident related to Protected Health Information and/or Personally Identifiable Information or any use or disclosure of Protected Health Information and/or Personally Identifiable Information by Contractor in violation of the requirements of this Agreement, Covered California 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.

iv. 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 Protected Health Information and/or Personally Identifiable Information of the Plan comply with all applicable requirements of the Electronic Transactions Rule.

v. Minimum Necessary. Contractor agrees to request and use only the minimum necessary type and amount of Protected Health Information 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 Protected Health Information. Contractor will collect, use, and disclose Personally Identifiable Information only to the extent necessary to accomplish a specified purpose under this Agreement.

vi. Indemnification. Contractor shall indemnify, hold harmless, and defend Covered California from and against any and all costs (including mailing, labor, administrative costs, vendor charges, and any other costs Covered California determines to be reasonable), losses, penalties, fines, and liabilities arising from or due to a Breach or other non-permitted use or disclosure of Protected Health Information and/or Personally Identifiable Information by Contractor or its subcontractors or Agents, including without limitation, (1) damages resulting from any action under applicable (a) HIPAA Requirements, (b) Covered California Requirements or (c) California Requirements, and (2) the costs of Covered California 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 Protected Health Information and/or Personally Identifiable Information.

g) Privacy Policy. Covered California shall notify Contractor of any limitation(s) in its Privacy Policy, to the extent that such limitation may affect Contractor's use or disclosure of Protected Health Information and/or Personally Identifiable Information.

h) Reporting Violations of Law. Contractor may use Protected Health Information 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.

i) Survival. Notwithstanding anything to the contrary in the Agreement, the provisions of this Section 9.1 on the Protection of Personally Identifiable Information shall survive termination of the Agreement with respect to information that relates to Contractor Covered California functions until such time as all Personally Identifiable Information and Protected Health Information is destroyed by assuring that hard copy Personally Identifiable Information and Protected Health Information will be shredded and electronic media will be cleared, purged, or destroyed consistent with National Institute of Standards and Technology Guidelines for Media Sanitization, or is returned to Covered California, in a manner that is reasonably acceptable to Covered California.

j) Contract Breach. Without limiting the rights of the parties pursuant to this Agreement, if Contractor breaches its obligations under this section, Covered California 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 Covered California 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, after giving Contractor opportunity to cure the breach, terminate this Agreement. If Contractor materially breaches its obligations under this section, Covered California may terminate this Agreement, with or without opportunity to cure the breach. Covered California'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.

9.2 Protection of Information Assets

a) The following terms shall apply as defined below:

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, or is communicated orally. "Information Assets" does not include information that has been transferred from the Disclosing Party to the Receiving Party under applicable laws, regulations, and agency guidance, and that is being maintained and used by the Receiving Party solely for purposes that are not Contractor Covered California Functions.

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 Covered California), 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 party.

b) The Receiving Party shall hold all Information Assets of the Disclosing Party in 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 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 five (5) business days' 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, Covered California shall

give Contractor five (5) business days' notice to permit Contractor to consult with Covered California 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 Covered California 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) 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, Covered California Requirements or California Requirements in Section 9.1(b) and (c), such information shall be governed by the provisions of Section 9.1. In the event of a conflict or inconsistency between the requirements of the various applicable sections and attachments of this Agreement, including Section 9.1 and this Section 9.2, Contractor 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 9.2 on Information Assets shall survive termination of the Agreement until such time as all Information Assets provided by Covered California to Contractor, or created, received, or maintained by Contractor on behalf of Covered California, is destroyed by assuring that hard copy Information Assets will be shredded and electronic media will be cleared, purged, or destroyed consistent with National Institute of Standards and Technology Guidelines for Media Sanitization or is returned to Covered California, in a manner that is reasonably acceptable to Covered California.

ARTICLE 10 – RECORDKEEPING

10.1 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 Covered 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 require 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.

10.2 Financial Records

a) 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 ten (10) 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 State or Federal Regulator having jurisdiction over Contractor.

b) Contractor shall maintain adequate data customarily maintained and reasonably necessary to properly document each of its transactions with Participating Providers, Covered California, 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 Covered California, records shall either be transferred to Covered California at its request or destroyed.

c) Contractor shall maintain historical claims data and other records and data relating to the utilization of Covered Services by Enrollees on-line for two (2) years from date that the Agreement is terminated with respect to Covered 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 Covered California and

Contractor and in such form reasonably required by Covered California 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.

10.3 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 Covered California, Covered California representatives, and such consultants and specialists as designated by Covered California, at any time during normal business hours as provided in Section 10.5 hereof and upon reasonable notice. 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 ten (10) year minimum retention period, the applicable financial records must be retained until all issues arising out of the action have been resolved.

10.4 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.

10.5 Examination and Audit Results

a) Contractor shall immediately submit to Covered California the results of final financial, market conduct, or special audits/reviews performed by State and Federal Regulators that have jurisdiction where Contractor serves Enrollees.

b) Contractor agrees to subject itself to Covered California for audits/reviews, either by Covered California or its designee, or the Department of General Services, California State Auditors, other state and federal regulatory agencies or their designee. Audits/reviews include the evaluation of the correctness of premium rate setting, Covered California's payments to Agents based on the Contractor's report, questions pertaining to Enrollee premium payments and advance premium tax credit payments and State premium assistance payments, participation fee payments which Contractor made to Covered California, Contractor's compliance with the provision set forth in this contract, and review of the Contractor's internal controls to perform the duties specified in this contract. Contractor also agrees to all audits subject to applicable State and Federal law regarding the confidentiality of and release of confidential Protected Health Information of Enrollees.

c) Contractor agrees that Covered California, the Department of General Services, the California State Auditors, other state and federal regulatory agencies, or their designated representative, shall, subject to applicable State and Federal law regarding the confidentiality and release of Protected Health Information of Enrollees, have the right to access, review and to copy any information and records and supporting documentation pertaining to the performance of this Agreement. Contractor agrees to maintain such records for possible audit for a minimum of three (3) years after final payment, unless a longer period of records retention is stipulated. Contractor agrees to allow the auditor(s) access to such records, information and supporting documentation during normal business hours and to allow interviews of any employees who might reasonably have information related to such records. Further, Contractor agrees to include a similar right of the State to audit records and interview staff in any subcontract related to performance of this Agreement.

d) Contractor agrees to implement corrective actions of an audit/review findings within ninety (90) days. In the instance Contractor cannot implement the corrective action of a finding within ninety (90) days, it shall submit a status report to Covered California stating why it cannot correct the finding within the specified time frame and shall propose another date for correction which shall also include a mitigation strategy. In all instances, Contractor and Covered California will do their best to resolve an audit/review finding within one hundred sixty (160) days. Should Contractor disagree with Covered California's management decision on an audit/review finding, it may appeal such management decision to Covered California Executive Director whose decision is final and binding on the parties, in terms of administrative due process.

10.6 Notice

Contractor shall promptly notify Covered California 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 State and Federal 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 Covered California within ten (10) days of Contractor's 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 State or Federal 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 Covered California in the ordinary course of business pursuant to other terms and conditions set forth in this Agreement or required by law.

10.7 Confidentiality

Covered California 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.

10.8 Tax Reporting

Contractor shall provide such information to Covered California 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 Covered California'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 Covered California, including, those relating to premium tax credit, and other operations of Covered California set forth at 45 C.F.R. Part 155.

10.9 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 Covered California and applicable laws, rules and regulations relating to Contractor's participation in electronic commerce activities required under the terms of this Agreement. Contractor shall comply with service levels and system interface specifications documented by Covered California in appropriate CalHEERS documentation.

ARTICLE 11 – INTELLECTUAL PROPERTY

11.1 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.

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 Covered California 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, COVERED CALIFORNIA 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.

11.2 Intellectual Property Indemnity

a) Subject to Subsection (c) hereof, Contractor agrees to indemnify and hold Covered California 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 Covered California to the extent they arise 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, 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 Covered California becomes aware of such claim and being given the right to control the defense of such claim. Should any Intellectual Property licensed by the Contractor to Covered California under this Agreement become the subject of an Intellectual Property infringement claim or other claim for which Contractor is obligated to indemnify Covered California, Contractor will promptly take steps reasonably and in good faith to preserve Covered California's right to use the licensed Intellectual Property in accordance with this Agreement at no expense or disruption to Covered California, except as otherwise stated in this Agreement. Covered California shall have the right to monitor and appear through its own counsel (at Covered California's expense) in any such claim or action. In the defense or settlement of the claim, Contractor may obtain the right for Covered California 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.

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 Covered California; (ii) Covered California's unauthorized modification of Contractor Intellectual Property; (iii) Covered California's use of Contractor Intellectual Property in combination with any service or product not supplied, recommended or approved by Contractor, or used by Covered California in a manner for which it was not authorized; or (iv) Intellectual Property created or derived by Covered California.

c) Contractor agrees that damages alone would be inadequate to compensate Covered California for breach of any term of this Article by Contractor. Contractor acknowledges Covered California would suffer irreparable harm in the event of such breach and agrees Covered California 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.

11.3 Federal Funding

If this agreement is funded in whole or in part by the federal government, Covered California may acquire and maintain the Intellectual Property rights, title, and ownership, which results directly or indirectly from the agreement; except as provided in 37 C.F.R. § 401.14 and except as stated herein. 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.

11.4 Ownership and Cross-Licenses

a) Intellectual Property Ownership. As between Contractor and Covered California, 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 Intellectual Property created by either Party in the performance of this Agreement shall not be considered a "work made for hire" of the other Party, as "work made for hire" is defined in the United States Copyright Act, 17 U.S.C. § 101. 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, right, during the term of this Agreement, 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. For the avoidance of doubt, Protected Health Information and Personally Identifiable Information are not included in the definition of Intellectual Property, and are addressed under Article 9.

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 nay 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.

11.5 Survival

The provisions set forth in this section shall survive any termination or expiration of this Agreement.

ARTICLE 12 – SPECIAL TERMS AND CONDITIONS

12.1 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 Covered California 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 Covered California, 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.

c) Covered California 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 12.1(a). 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 12.1(a), the parties will engage in an expedited 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.

e) This Section shall survive the termination or expiration of this Agreement.

12.2 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.

12.3 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 either the representative executing the STD 213 or the following representatives:

For Covered California:

Covered California
Attention: James DeBenedetti
1601 Exposition Blvd.
Sacramento, CA 95815
Telephone No. (916) 228-8665
Email: James.DeBenedetti@covered.ca.gov

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.

12.4 Amendments

a) By Covered California. 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 Covered California determines, based on its consultation with legal counsel, 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 Covered California or the ability of Covered California or Contractor to perform its respective obligations hereunder or receive the benefits intended hereunder, Covered California 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 Covered California 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) 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 Covered California in writing within twenty (20) days of receipt of notice from Covered California. If the parties are unable to agree on an amendment within thirty (30) days thereafter, Covered California may terminate this Agreement effective immediately.

b) Other Amendments. Except as provided in Section 12.4(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.

12.5 Time is of the Essence

Time is of the essence in this Agreement.

12.6 Publicity

Contractor shall coordinate with Covered California with respect to communications to third parties regarding 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 Covered California unless such communication complies with standards that may be issued by Covered California to Contractor based on consultation with Contractor from time to time.

12.7 Force Majeure

Except as prohibited by applicable laws, rules and regulations, neither party to this Agreement shall be in default 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 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 Covered California'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.

12.8 Further Assurances

Contractor and Covered California 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.

12.9 Binding Effect

This Agreement, any instrument or agreement executed pursuant to this Agreement, and the rights, covenants, conditions, and obligations of Contractor and Covered California 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 Application, 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.

e) 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:

1) Applicable laws, rules and regulations;

2) The terms and conditions of this Agreement, including attachments; and

3) Application.

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 in person 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

a) Covered California may adopt policies, procedures, rules and interpretations that are consistent with applicable laws, rules and regulations and deemed advisable by Covered California 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.

b) Covered California shall provide ninety (90) days prior written notice by letter, newsletter, electronic mail, or other media of any material change (as defined below) in Covered California'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 Covered Services to Enrollees.

12.21 Performance of Requirements

To the extent the Agreement requires performance under the Agreement by Contractor but does not specifically specify a date, the date of performance shall be based on the mutual agreement of Contractor and Covered California.

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.

Affordable Care Act (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.

Agent(s) – Individuals who are licensed and in good standing as a life licensee under Insurance Code § 1626 by the California Department of Insurance to transact in accident and health insurance. The term used in this Agreement will only apply to Agents certified by Covered California to transact business in Covered California for the Individual and Covered California for Small Business Markets.

Agreement – This Agreement attached hereto, including attachments and documents incorporated by reference, entered into between Covered California and Contractor.

Agreement Effective Date – The effective date of this Agreement established pursuant to Section 7.1 of this Agreement.

Accreditation Association for Ambulatory Health Care (AAAHC) – A nonprofit accrediting agency for ambulatory health care settings.

Application – The Qualified Health Plan Certification Application for Plan Years 2017-2022.

Behavioral Health – A group of interdisciplinary services concerned with the prevention, diagnosis, treatment, and rehabilitation of mental health and substance abuse disorders.

Board – The executive board responsible for governing Covered California under Government Code § 100500.

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).

CAL COBRA – The California Continuation Benefits Replacement Act, or Health and Safety Code § 1366.20 et seq.

CalHEERS – The California Healthcare Eligibility, Enrollment and Retention System, a project jointly sponsored by Covered California and DHCS, with the assistance of the Office of Systems Integration to maintain processes to make the eligibility determinations regarding Covered California and other State health care programs and assist Enrollees in selection of health plan.

CCR – The California Code of Regulations.

CDI – The California Department of Insurance.

COBRA – Federal law (Consolidated Omnibus Budget Reconciliation Act of 1985) requiring continuing coverage of group health benefits to employees and their families upon the occurrence of certain qualifying events where such coverage would otherwise be terminated.

Confidentiality of Medical Information Act (CMIA) – The Confidentiality of Medical Information Act (California Civil Code § 56 et seq.) and the regulations issued pursuant thereto or as thereafter amended, to the extent applicable to operation of Contractor.

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.

Contractor – The Health Insurance Issuer contracting with Covered California under this Agreement to offer a QHP and perform in accordance with the terms set forth in this Agreement.

Contractor Covered California Function – Any function that Contractor performs pursuant to this Agreement during which Contractor receives, maintains, creates, discloses or transmits PHI or Personally Identifiable Information gathered from Covered California, applicants, Qualified Individuals or Enrollees in the process of assisting individuals and entities with the purchase of health insurance coverage in QHPs or other functions under the Covered California program.

Covered California – The California Health Benefit Exchange, doing business as Covered California and an independent entity within the Government of the State.

Covered California for the Individual Market – The Covered California program providing coverage to Enrollees, formerly referred to as the Individual Exchange.

Covered California for Small Business (CCSB) Covered California program providing coverage to eligible small businesses, formerly referred to as the Small Business Health Options Program (SHOP) and described in Government Code 100502(m).

Covered Services – The Covered Services that are covered benefits under the applicable QHP and described in the Evidence of Coverage.

DHCS – The California Department of Health Care Services.

DHHS – The United States Department of Health and Human Services.

DMHC – The California Department of Managed Health Care.

Effective Date – The date on which a Plan's coverage goes into effect.

Eligibility Information – The information that establishes an Enrollee's eligibility.

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.

Employee – A "qualified employee," as defined in 45 C.F.R. § 155.20.

Employer – A "qualified employer," as defined in § 1312(f)(2) of the Affordable Care Act.

Encounter – Any Health Care Service or bundle of related Covered Services provided to one Enrollee by one Health Care Professional within one time period. Any Covered Services provided must be recorded in the Enrollee's health record.

Encounter Data – Detailed data about individual services provided by a capitated managed care entity. The level of detail about each service reported is similar to that of a standard claim form.

Enrollee – Enrollee means each and every individual enrolled for the purpose of receiving health benefits.

Enrollment – An Enrollee who has completed their application and for whom the initial premium payment has been received and acknowledged by the Contractor has completed Enrollment.

Evidence of Coverage (EOC) and Disclosure Form – The document which describes the benefits, exclusions, limitations, conditions, and the benefit levels of the applicable Plans.

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.

Explanation of Payment (EOP) – A statement sent from the Contractor to Providers detailing payments made for Covered Services.

Family Member – An individual who is within an Enrollee's family, as defined in 26 U.S.C. § 36B (d)(1).

Formulary – A list of outpatient prescription drugs, selected by the Plan(s) and revised periodically, which are available to Enrollees in a specific QHP.

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.

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 Covered Services.

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.

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.

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.

Health Plan Employer Data and Information Set (HEDIS) – The data as reported and updated annually by the National Committee for Quality Assurance (NCQA).

Individual Exchange – Covered California through which Qualified Individuals may purchase QHPs.

Individually Identifiable Health Information (IIHI) – The "individually identifiable health information" as defined under HIPAA.

Information Practices Act (IPA) – The California Information Practices Act, Civil Code § 1798, et seq. and the regulations issued pursuant thereto or as thereafter amended.

Insurance Information and Privacy Protection Act (IIPPA) – The California Insurance Information and Privacy Protection Act, Insurance Code §§ 791-791.28, et seq., and the regulations issued pursuant thereto or as thereafter amended.

Integrated Delivery Systems – An integrated delivery system (IDS) is a network of physicians and healthcare facilities that provide a continuum of healthcare services managed under one organization or one parent company. Similar to an ACO, an IDS includes population-based care coordinated across the continuum including multi-discipline physician practices, hospitals, and ancillary Providers with combined risk sharing arrangements and incentives between health plans and Providers, and among Providers across specialties and institutional boundaries. The IDS is held accountable for nationally recognized evidence-based clinical, financial, and operational performance, as well as incentives for improvements in population outcomes.

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.

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 amended.

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 amended.

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.

NCQA – The National Committee for Quality Assurance, a nonprofit accreditation agency.

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.

Open Enrollment or Open Enrollment Period – The fixed time period as set forth in 45 C.F.R. § 155.410, Health and Safety Code § 1399.849 (c)(3), and Insurance Code § 10965.3 (c)(3) for individual applicants and Enrollees to initiate enrollment or to change enrollment from one health benefits plan to another. For benefit years beginning on or after January 1, 2019, references to Open Enrollment include the allowance for special enrollment periods for all individuals as described in Health and Safety Codes § 1399.849(c)(3), and Insurance Code § 10965.3(c)(3).

Participating Hospital – A hospital that, at the time of an Enrollee's admission, has a contract in effect with Contractor to provide Covered Services to Enrollees.

Participating Physician – A physician or a member of a Medical Group that has a contract in effect with Contractor to provide Covered Services to Enrollees.

Participating Provider – An individual Health Care Professional, hospital, clinic, facility, entity, or any other person or organization that provides Covered 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.

Participation Fee – The user fee on QHPs authorized under § 1311(d)(5) of the Affordable Care Act, 45 C.F.R. §§ 155.160(b)(1) and 156.50(b), and Government Code § 100503(n) to support Covered California operations.

Performance Standard – A financial assurance of service delivery at levels agreed upon between Covered California and Contractor.

Personally Identifiable Information – 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 Covered California.

Pharmacy Benefit Manager (PBM) – The vendor responsible for administering the Plan's outpatient prescription drug program. The PBM provides a retail pharmacy network, mail order pharmacy, specialty pharmacy services, and coverage management programs.

Plan(s) – The QHPs Covered California has entered into a contract with a Health Insurance Issuer to provide, hereinafter referred to as the Plan(s).

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.

Plan Year – Plan Year has the same definition as that term is defined in 45 C.F.R. § 155.20.

Premium – The dollar amount payable by the Enrollee after any advanced premium tax credits are applied, if any, to the QHP Issuer to effectuate and maintain coverage.

Premium Rate or Monthly Rate – The monthly premium due during a Plan Year, as agreed upon by the parties.

Primary Care – The provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health needs, developing a sustained partnership with patients, and practicing in the context of family and community. (Institute of Medicine, 1978) Contractors may allow Enrollees to select Nurse Practitioners and Physician Assistants to serve as their Primary Care clinician. Covered California does not require that Primary Care clinicians serve as a "gatekeeper" or the source of referral and access to specialty care. Covered California recognizes Internal Medicine, OBGYN, Pediatrics, General Practice, and Family Medicine as primary care specialties.

Proposal – The proposal submitted by Contractor in response to the Application.

Protected Health Information or Personal Health Information – Protected health information, including electronic protected health information (EPersonal Health Information) as defined in HIPAA that relates to an Enrollee. Protected Health Information also includes "medical information" as defined by the California Confidentiality of Medical Information Act (CMIA) at California Civil Code § 56, et seq.

Provider – A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health professional that delivers Covered Services.

Provider Claim(s) – Any bill, invoice, or statement from a specific Provider for Covered Services or supplies provided to Enrollees.

Provider 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.

Qualified Health Plan or QHP– A health care service plan contract or policy of insurance offered by a QHP Issuer and certified by Covered California.

Qualified Health Plan Issuer or QHP Issuer – A licensed health care service plan or insurer that has been selected and certified by Covered California to offer QHPs through Covered California.

Qualified Individual – Qualified Individual has the same meaning as that term is defined in § 1312(f)(1) of the Affordable Care Act.

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.

Quarterly Business Review or QBR – Quarterly in-person meetings between Covered California and Contractor at Covered California 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.

Reconciliation Process – Covered California and CalHEERS engage in a cyclically occurring Reconciliation Process with each QHP and QDP Issuer participating in the individual market. The Reconciliation Process is leveraged to monitor and facilitate all eligibility and enrollment reconciliation efforts with the QHP and QDP Issuers as defined in the "Data Integrity Reconciliation Process Guide." As a component of the Reconciliation Process, the Dispute Process provides a platform for Issuer enrollment and eligibility disputes to be assessed. Assessment of each enrollment dispute includes focused analysis of operational cause, risk, and enterprise-wide impact.

Regulations – The regulations adopted by Covered California Board. (California Code of Regulations, Title 10, Chapter 12, §t 6400, et seq.)

Risk-Adjusted Premiums – Actuarially calculated premiums utilizing risk adjustment.

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.

Risk Adjustment – An actuarial tool used to calibrate premiums paid to Health Insurance Issuers 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.

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.

Security Incident – The attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with system operations in an information system.

Service Area – The designated geographical areas where Contractor provides Covered Services to Enrollees and comprised of the ZIP codes set forth in Contractor's current Plan Year SERFF templates tested and validated by the Contractor .

Services – The provision of Services by Contractors and subcontractors required under the terms of the Agreement, including, those relating the provision of Covered Services and the administrative functions required to carry out the Agreement.

State – The State of California

State Regulators – California Department of Insurance and Department of Managed Health Care, as applicable.

State and Federal Regulators – Department of Managed Health Care, California Department of Health Care Services, California Department of Insurance, US Department of Health and Human Services, and

any other regulatory entity within the State of California that has jurisdiction over Contractor, as applicable.

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 Covered California outside of the initial and annual Open Enrollment Periods.

Utilization Management – Pre-service, concurrent or retrospective review which determines the Medical Necessity of hospital and skilled nursing facility admissions and selected Covered Services provided on an outpatient basis.

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.

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.

Attachment 7 to Covered California 2017 Individual Market QHP Issuer Contract: Quality, Network Management, Delivery System Standards and Improvement Strategy

PROMOTING HIGHER QUALITY AND BETTER VALUE

Covered California's framework for holding Health Insurance Issuers accountable for quality care and delivery system reform seeks to lower costs, improve quality and health outcomes, and promote health equity, while ensuring a good choice of health plans for consumers. Covered California and the Contractor recognize that promoting better quality and value is contingent upon supporting providers and strategic, collaborative efforts to align with other major purchasers and payers to support delivery system reform. Health Insurance Issuers contracting with Covered California to offer Qualified Health Plans (QHPs) are integral to Covered California achieving its mission:

> *The mission of Covered California is to increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value.*

By entering into this Agreement with Covered California, the Contractor agrees to work with Covered California to develop and implement policies and practices that will promote quality and health equity, and lower costs for the Contractor's entire California membership. This Quality, Network Management, Delivery System Standards and Improvement Strategy is designed to hold QHP Issuers accountable for ensuring that Enrollees receive high-quality, equitable care, while QHP Issuers work to improve the healthcare delivery system and reduce costs.

All QHP Issuers have the opportunity to take a leading role in helping Covered California support models of care that promote the vision of the Affordable Care Act and meet consumer needs and expectations. The Contractor and Covered California can promote improvements in the entire healthcare delivery system. This focus will require both Covered California and Contractor to coordinate with and promote alignment with other purchasers, organizations, and groups that seek to deliver better care and higher value. By entering into this Agreement, Contractor affirms its commitment to be an active and engaged partner with Covered California and to work collaboratively to define and implement additional initiatives and programs to continuously improve quality, equity, and value.

In addition, Covered California expects all QHP Issuers to balance the need for accountability and transparency at the provider-level with the need to reduce administrative burden on providers as much as possible. 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. Covered California expects its QHP Issuers to support their providers to engage in a culture of continuous quality and value improvement, which will benefit both Covered California Enrollees and the QHP Issuer's entire California membership.

The Contractor shall comply with the requirements in this Agreement by January 1, 2022 unless otherwise specified.

This Attachment 7 contains numerous reports that will be required as part of the annual certification and contracting process with QHP Issuers. The Contractor shall submit all required reports as defined in Attachment 7 and listed in the annual "Contract Reporting Requirements" table found on Covered California's Extranet site (Plan Home, in the Resources folder, Contract Reporting Compliance subfolder).

This information will be used for negotiation and evaluation purposes regarding any extension of this Agreement and will be reported as required in the annual application for certification.

Covered California will use information on cost, quality, and disparities provided by Contractor to evaluate and publicly report both QHP Issuer performance and its impact on the healthcare delivery system and health coverage in California.

ARTICLE 1

INDIVIDUALIZED, EQUITABLE CARE

Covered California is committed to ensuring that care is individualized and equitable not only for Enrollees currently needing or receiving treatment, but also for Enrollees to stay healthy. The concept of individualized, equitable care means regardless of one's circumstances, race, gender, where one lives or other socioeconomic factors, every individual deserves the best possible, personalized, cost-effective care delivered in the right setting at the right time.

Addressing health equity and disparities in healthcare is integral to the mission of Covered California. In order to have impactful and meaningful change, Covered California and Contractor recognize that addressing health disparities requires alignment, commitment, focus, and accountability. To this end, Article 1 requirements support the continued commitment, focus, and accountability to ensure that everyone receives individualized, equitable care.

1.01 Demographic Data Collection

1.01.1 Collection of accurate and complete member demographic data is critical to effective measurement and reduction of health disparities.

The Contractor shall work with Covered California to assess the feasibility and impact of extending the disparity identification and improvement program for 2023 and beyond. Areas for consideration include:

1) Income
2) Disability status
3) Sexual orientation
4) Gender identity
5) Limited English Proficiency (LEP)
6) Spoken language

1.01.2 For Measurement Year 2022, the Contractor must achieve eighty percent (80%) self-identification of race and ethnicity data for Covered California Enrollees. The Contractor must demonstrate compliance by including a valid race and ethnicity attribute for at least 80% of Covered California Enrollees in its Healthcare Evidence Initiative (HEI) data submissions.

The Contractor must engage with Covered California to review its race and ethnicity data for off-Exchange members for Measurement Year 2022.

1.02 Identifying Disparities in Care

1.02.1 Covered California recognizes that the underlying causes of health disparities are multifactorial and include social and economic factors that impact health. While the healthcare system cannot single handedly eliminate health disparities, there is evidence to show that when disparities are identified and addressed in the context of health care, they can be reduced over time through activities tailored to specific populations and targeting select measures. Therefore, Covered California is requiring the Contractor to regularly collect data on its Covered California Enrollees to identify disparities, measure disparities over time, and determine disparity reduction efforts and targets to be mutually agreed upon by Covered California and the Contractor. As Covered California transitions to expanded use of the Healthcare Evidence Initiative (HEI) data to assess

improvements in healthcare quality and equity, Covered California expects that certain measures previously submitted by the Contractor for disparities monitoring will be generated using HEI data and stratified by demographic factors.

1.02.2 For Measurement Year 2022, the Contractor must submit the following Healthcare Effectiveness Data and Information Set (HEDIS) hybrid measure patient level data files for Covered California Enrollees:

1) Comprehensive Diabetes Care (CDC): HbA1c Control <8.0% (NQF #0575)
2) Comprehensive Diabetes Care (CDC): Medical attention for nephropathy (NQF #0062)
3) Comprehensive Diabetes Care (CDC): Eye exam (retinal) performed (NQF #0055)
4) Controlling High Blood Pressure (CBP) (NQF #0018)

The Contractor must submit a patient level measure file that includes a unique person identifier for each person in the denominator. The Contractor must also submit numerator and denominator totals and rates at the summary level. The Contractor must also submit HEDIS hybrid measure summary files including numerators and denominators by Race/Ethnicity category for all commercial product types for which it reports these HEDIS measures to the National Committee for Quality Assurance (NCQA) Quality Compass and for each Medi-Cal Managed Care product for which it reports these HEDIS measures to the Department of Health Care Services (DHCS).

Covered California will modify the measures set over time, with stakeholder input, to track disparities in care and health outcomes in additional areas, including behavioral health, for plan year 2023 and beyond.

1.02.3 The Contractor must engage with Covered California to review its performance on the disparities measures using HEI data.

1.03 Disparities Reduction Intervention

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

1.03.2 The Contractor will meet a mutually agreed upon target for improvement in quality for the disparities intervention target population based on the mutually agreed-upon health disparities intervention proposal. The Contractor must report progress through submission of specified progress reports. Covered California will assess the Contractor's performance based on the submitted HEDIS measures sample per Article 1, Section 1.02, specified progress reports and intervention results.

If the Contractor does not select a measure pursuant to Article 1, Section 1.02.2, the Contractor must additionally submit the patient level HEDIS measure file for their approved intervention HEDIS measure for Covered California Enrollees.

1.04 Statewide Focus Health Equity Collaborative Efforts

1.04.1 Identifying a statewide focus and aligning disparities reduction efforts across organizations will increase the impact of Covered California and Contractor's efforts to improve health equity in California. Covered California anticipates evolving its current disparities reduction contractual requirements in pursuit of coordinated, aligned, statewide efforts in 2023 and beyond.

1.04.2 The Contractor must participate in collaborative efforts to identify and align statewide disparity work. Covered California will convene these discussions or identify venues for collaborative

development of aligned activities. Participation is defined as regular attendance by the Contractor staff at a leadership level of the organization with appropriate content knowledge and background on disparities work.

1.05 Culture of Health Equity Capacity Building

1.05.1 Attaining health equity requires organizational investment in building a culture of health equity. Meeting the standards for the Multicultural Health Care Distinction (MHCD) by the National Committee for Quality Assurance (NCQA) is required to build a program to reduce documented disparities and to develop culturally and linguistically appropriate communication strategies.

1.05.2 The Contractor must achieve or maintain NCQA Multicultural Health Care Distinction (MHCD) by year end 2023. The Contractor must demonstrate compliance by submitting the following to Covered California:

1) By June 30, 2022, evidence of NCQA MHCD or workplan to achieve the Distinction.

2) For Contractors unable to demonstrate NCQA MHCD by December 30, 2022, for an early achievement credit per Attachment 14, the following schedule to achieve Distinction by year end 2023 must be met:

   a) June 30, 2022: Submit workplan to achieve NCQA MHCD by December 29, 2023

   b) January 31, 2023: 1st Progress Report

   c) August 31, 2023: 2nd Progress Report

   d) December 29, 2023: Evidence of NCQA MHCD achievement

ARTICLE 2

POPULATION HEALTH MANAGEMENT

Covered California and the Contractor recognize that Population Health Management ensures accountability for delivering quality care. Population Health Management shifts the focus from a disease-centered approach to the needs of Enrollees and provides focus for improving health outcomes through care coordination and patient engagement.

2.01 Population Health Management Plan Submission

2.01.1 The Population Health Management (PHM) plan provides a vehicle for establishing a formal strategy to optimize population health outcomes, including a defined approach for population identification and stratification. The PHM plan is a critical part of achieving improvement in Enrollee health outcomes and is interrelated with all other quality care domains. Submission of a PHM plan is a requirement for health plan accreditation by the National Committee for Quality Assurance (NCQA).

2.01.2 The Contractor must annually submit its NCQA PHM plan component (1), the Population Health Management Strategy, and component (2), Population Stratification and Resource Integration, in their entirety to Covered California. When submitting its plan to Covered California, the Contractor shall clearly designate any information it deems confidential, trade secret, or proprietary information as such.

Alternatively, the Contractor must submit a separate PHM plan for its Covered California population that addresses each of the following components:

1) A PHM Strategy for meeting the care needs of its Enrollees that includes the following:

    a) Goals, focus populations, opportunities, programs and services available for keeping members healthy, managing members with emerging risk, patient safety or outcomes across settings, and managing multiple chronic illnesses.

    b) Mechanism for informing Enrollees eligible for interactive programs with details of how to become eligible for participation, how to use program services, and how to opt in or out of a program.

    c) Activities performed by the Contractor targeted at populations or communities as a part of the PHM strategy that are not direct member interventions.

    d) Coordination of member programs across settings, providers, external management programs, and levels of care to minimize confusion and maximize reach and impact.

2) Evidence of systematic collection, integration, and assessment of member data to assess the needs of the population and determine actionable categories for appropriate intervention. The Contractor must describe the following:

    a) How the Contractor integrates multiple sources of data for use in PHM functions that includes: medical and behavioral claims or encounters, pharmacy claims, laboratory results, health appraisal results, a copy of individual risk assessment questions, electronic health records, health programs delivered by the Contractor, and other advanced data sources.

    b) The Contractor’s process for at least annually assessing the following:

        i) Characteristics and needs, including social determinants of health of its members;

ii) Needs of specific member subpopulations; and

iii) Needs of children and adolescents, members with disabilities, and members with serious and persistent mental illness.

c) How the Contractor uses the population assessment at least annually to review and update its PHM activities and resources to address member needs. Also, how the Contractor reviews community resources for integration into program offerings to address member needs.

d) Its process, including the data sources and the population health categories, to stratify its Covered California population into subsets for targeted intervention at least annually.

ARTICLE 3

HEALTH PROMOTION AND PREVENTION

Health promotion and prevention are key components of high-value health care. Research shows that treating those who are sick is often far costlier and less effective than preventing disease from occurring and keeping populations healthy. Covered California's health promotion and prevention requirements are centered on identifying Enrollees who are eligible for certain preventive and wellness benefits, notifying Enrollees about the availability of these services, making sure those eligible receive appropriate services and care coordination, and monitoring the health status of these Enrollees.

3.01 Health and Wellness Services Communication

3.01.1 Effective communication of health and wellness services to Enrollees ensures equitable access to these services.

3.01.2 To ensure the Enrollee health and wellness process is supported, the Contractor must report in the annual application for certification:

1) How it identifies Enrollees who are eligible for health and wellness services.
2) The number and percent of Enrollees who enroll in a health and wellness program.
3) The number and percent of Enrollees who complete a health and wellness program.
4) How it communicates its annual member benefits and education on no-cost preventive health benefits.
5) How it provides education and self-management tools on its portal. Example components of this reporting may include:
    a) Disseminating annual member "preventive coverage" communication;
    b) Member portal "prevention coverage section;" and
    c) How it gives prominence to health and wellness topics such as counseling for unhealthy weight or nutrition and smoking or tobacco use.

3.02 Tobacco Cessation Program

3.02.1 Tobacco use is preventable and contributes to high morbidity and mortality. Reducing tobacco use will have greater impact on health outcomes in marginalized communities which have disproportionately higher rates of use.

3.02.2 The Contractor must report to Covered California in the annual application for certification:

1) How it identifies Enrollees who use tobacco;
2) The number and percent of Enrollees who use tobacco who enroll in tobacco cessation programs, inclusive of evidenced-based counseling and appropriate pharmacotherapy;
3) Its strategies to improve tobacco use prevention; and
4) Its strategies to improve its rates on the Medical Assistance with Smoking and Tobacco Use Cessation measure (NQF #0027), which may include evidence-based interventions or participation in quality collaboratives.

3.03 Weight Management Program

3.03.1 Unhealthy weight and obesity contribute to high morbidity and mortality. Effective weight management programs will have greater impact on health outcomes in marginalized communities that have disproportionately higher rates of unhealthy weight and obesity.

3.03.2 The Contractor must report to Covered California in the annual application for certification:

1) How it identifies Enrollees who are at an unhealthy weight, defined as a BMI >30;
2) The number and percent of Enrollees who enroll in weight management programs, inclusive of evidenced-based counseling, physical activity benefits such as gym memberships, and appropriate pharmacotherapy;
3) Its strategies to improve uptake in weight management programs and other approaches to address unhealthy weight and its impact on Enrollee health; and
4) Its strategies to improve its rates on the Weight Assessment and Counseling for Nutrition & Physical Activity for Children and Adolescents measure (NQF #0024), which may include evidence-based interventions or participation in quality collaboratives.

3.04 Diabetes Prevention Programs

3.04.1 Diabetes contributes to high rates of morbidity and mortality. Access to diabetes prevention programs is critical in the prevention of diabetes related complications.

3.04.2 The Contractor must provide a Centers for Disease Control and Prevention (CDC)-recognized Diabetes Prevention Lifestyle Change Program, also known as a Diabetes Prevention Program (DPP) to its eligible Enrollees. The DPP must be available both in-person and online by year end 2022 to allow Enrollees a choice of modality (in-person, online, distance learning, or a combination of modes). The DPP must be accessible to eligible Enrollees with limited English proficiency (LEP) and eligible Enrollees with disabilities. The DPP shall be available to all eligible Enrollees in the geographic service area and covered under the $0 preventive services benefit or diabetes education benefit in the Patient-Centered Benefit Design Plans. The Contractor's DPP must have pending or full recognition by the CDC as a DPP. A list of recognized programs in California can be found at: https://nccd.cdc.gov/DDT_DPRP/Registry.aspx.

3.04.3 The Contractor must report to Covered California in the annual application for certification:

1) How it identifies eligible Enrollees for the Diabetes Prevention Program;
2) How it informs its Enrollees about the Diabetes Prevention Program;
3) The number and percent of its eligible Enrollees who enroll in the Diabetes Prevention Program (report program modes separately);
4) The number and percent of its eligible Enrollees who reach the CDC weight loss goal of 5% through the Diabetes Prevention Program (report program modes separately); and
5) How it monitors and evaluates the effectiveness of the Diabetes Prevention Program.

3.05 COVID-19 Gaps and Disparities

3.05.1 The COVID-19 pandemic has created gaps in quality due to deferred care and highlighted disparities in the health care delivery system. The following three metrics have been significantly impacted by the pandemic and continue to be areas of concern.

3.05.2 The Contractor will be expected to address gaps in care due to the COVID-19 pandemic with the goal of meeting the performance targets of: (1) greater than or equal to Measurement Year 2019 pre-COVID-19 pandemic performance level by January 1st, 2022 (Measurement Year 2021) and (2) greater than or equal to the national 50th percentile threshold by year end 2022 (Measurement Year 2022) on the following measures reported by the Contractor to CMS for the Quality Rating System (QRS):

1) Childhood Immunization Status (Combination 3) (NQF #0038) (Anticipated change to Combination 10 for Measurement Year 2022 in alignment with NCQA and QRS);
2) Immunizations for Adolescents (Combination 2) (NQF #1407); and
3) Colorectal Cancer Screening (NQF #0034).

The Contractor must engage with Covered California to review its performance on these measures.

ARTICLE 4

MENTAL HEALTH AND SUBSTANCE USE DISORDER TREATMENT

Mental health and substance use disorder treatment, collectively behavioral health services, includes identification, engagement, and treatment of those with mental health conditions and substance use disorders. Additionally, consistent with evidence and best practice, the Contractor should ensure Enrollees receive timely and effective behavioral health care that is integrated with primary care. Covered California and the Contractor recognize the critical importance of behavioral health services, as part of the broader set of medical services provided to Enrollees, in improving health outcomes and reducing costs.

4.01 Access to Behavioral Health Services

4.01.1 Monitoring and improving access to behavioral health services is necessary to ensure Enrollees are receiving appropriate and timely behavioral health services.

4.01.2 For Covered California to evaluate how the Contractor tracks access to behavioral health services and the strategies the Contractor implements to improve access to behavioral health services for Enrollees, the Contractor must submit annually its National Committee for Quality Assurance (NCQA) Health Plan Accreditation Network Management reports for the elements related to its behavioral health provider network. Specifically, the Contractor must provide reports for:

1) Network Standard 1, Element A: Cultural Needs and Preferences
2) Network Standard 1, Element D: Practitioners Providing Behavioral Healthcare;
3) Network Standard 2, Element B: Access to Behavioral Healthcare; and
4) Network Standard 3, Element C: Opportunities to Improve Access to Behavioral Healthcare Services.

Alternatively, the Contractor must submit a separate report for its Covered California population that addresses each of the NCQA Network Management standards for behavioral health. These reports can be from the Contractor's accrediting body, either URAC or the Accreditation Association for Ambulatory Health Care (AAAHC), or supplemental reports that include a description of the Contractor's behavioral health provider network, how cultural, ethnic, racial and linguistic needs of Enrollees are met, access standards, the methodology for monitoring access to behavioral health appointments, and at least one intervention to improve access to behavioral health services and the effectiveness of this intervention. When submitting its reports to Covered California, the Contractor shall clearly designate any information it deems confidential, trade secret, or proprietary information as such.

4.01.3 The Contractor must engage with Covered California to review its depression treatment penetration rate and its behavioral health service utilization rate, which will be calculated by Covered California using Health Evidence Initiative (HEI) data to further understand Enrollees' access to behavioral health services within the Contractor's network. Penetration rate is determined by dividing the number of members who receive a behavioral health service by the expected prevalence rate of behavioral health needs within a state or region, multiplied by 100 to report as a percent.

4.02 Offering Telehealth for Behavioral Health Services

4.02.1 Telehealth has the potential to address some of the access barriers to behavioral health services, particularly in rural areas, such as cost, transportation, and the shortage of providers.

4.02.2 To strengthen access to behavioral health services, the Contractor must offer telehealth for behavioral health services. Covered California encourages the Contractor to use network providers to provide telehealth for behavioral health services whenever possible. Additionally, the Contractor must:

1) Explain behavioral health telehealth services on its provider directory page or another primary page in its member portal;

2) Ensure that Enrollees can easily find behavioral health telehealth services through a telehealth provider search attribute, inclusion of telehealth service in the provider profile (e.g. Jane Doe, Ph.D. Psychologist telehealth video/phone), or other member portal navigation feature;

3) Educate Enrollees about how to access telehealth services, including behavioral health telehealth services;

4) Display coverage of behavioral health services and behavioral health telehealth services clearly and prominently; and

5) Promote integration and coordination of care between third party behavioral health telehealth vendor services and primary care and other network providers.

The Contractor will demonstrate compliance with the requirements through reporting in the annual application for certification.

4.02.3 The Contractor must engage with Covered California to review its utilization of behavioral health telehealth services using HEI data.

4.03 Quality of Behavioral Health Services

4.03.1 Measuring and monitoring quality is necessary to ensure Enrollees receive appropriate, evidence-based treatment and inform quality improvement efforts.

4.03.2 The Contractor must collect Depression Screening and Follow-Up Plan (NQF #0418) measure results for its Enrollees and annually report results in the annual application for certification. The Contractor must engage with Covered California to review its performance.

4.03.3 The Contractor must engage with Covered California to review its performance on the following behavioral health measures reported by the Contractor to CMS for the Quality Rating System (QRS):

1) Antidepressant Medication Management (NQF #0105);

2) Follow-Up After Hospitalization for Mental Illness (7-Day Follow-Up) (NQF #0576); and

3) Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (NQF #0004).

4.04 Appropriate Use of Opioids

4.04.1 Appropriate use of opioids and evidence-based treatment of opioid use disorder, including Medication Assisted Treatment (MAT), can improve outcomes, reduce inappropriate healthcare utilization, and lower opioid overdose deaths.

4.04.2 The Contractor shall implement policies and programs that align with the guidelines from Smart Care California to promote the appropriate use of opioids while considering an Enrollee's condition and lower opioid overdose deaths (https://www.iha.org/ourwork/insights/smart-care-

california/focus-area-opioids). The Contractor's policies and programs must include the following priority areas:

1) Prevent: decrease the number of new starts: fewer prescriptions, lower doses, shorter durations;
2) Manage: identify patients on risky regimens (high-dose, or opioids and sedatives) and develop individualized treatment plans, avoiding mandatory tapers;
3) Treat: streamline access to evidence-based treatment for substance use disorder at all points in the healthcare system; and
4) Stop deaths: promote data-driven harm reduction strategies, such as naloxone access and syringe exchange.

The Contractor must report in the annual application for certification how it is implementing such policies and programs in accordance with the Smart Care California guidelines.

4.04.3 To monitor access to opioid use disorder treatment, the Contractor must engage with Covered California to review its Medication Assisted Treatment (MAT) prescriptions by clinician and by region using HEI data.

4.04.4 The Contractor must engage with Covered California to review its performance on the following opioid use disorder measures constructed from HEI data:

1) Use of Pharmacotherapy for Opioid Use Disorder (NQF #3400);
2) Concurrent Use of Opioids and Benzodiazepines (NQF #3389);
3) Use of Opioids at High Dosage in Persons Without Cancer (NQF #2940); and
4) Concurrent Use of Opioids and Naloxone.

4.05 Integration of Behavioral Health Services with Medical Services

4.05.1 Integrated behavioral health services with primary care increases access to behavioral health services and improves treatment outcomes. Evidence suggests the Collaborative Care Model is a best practice among integrated behavioral health models.

4.05.2 Contractor must report in the annual application for certification:

1) How it is promoting the integration of behavioral health services with primary care;
2) The percent of its Covered California Enrollees and the percent of its enrollees outside of Covered California cared for under an integrated behavioral and primary care model such as Primary Care Behavioral Health and the Collaborative Care Model; and
3) Whether it reimburses for the Collaborative Care Model claims codes and, if so, in what settings and to which entities. If the Contractor does not reimburse for the Collaborative Care Model claims codes, the Contractor must describe the barriers to reimbursing for these services.

4.05.3 The Contractor must engage with Covered California to review its utilization of the Collaborative Care Model services using HEI data.

ARTICLE 5

ACUTE, CHRONIC AND OTHER CONDITIONS

Covered California and the Contractor recognize the importance of developing robust programs for acute and chronic conditions to serve enrollees along the continuum of health. Interventions to provide curative services to life-threatening emergencies, exacerbation of illnesses, and routine health problems should be integrated to strengthen healthcare delivery systems. In addition, appropriate medical management, systematic monitoring, and building capacity for effective patient engagement is critical for successful chronic disease management.

5.01 Measures Reported to the Marketplace Quality Rating System

5.01.1 Public reporting of quality performance measures to the Centers for Medicaid and Medicare Services' Marketplace Quality Rating System (QRS) is a critical mechanism for oversight and accountability. Embedded in this reporting are measures designed to drive quality in acute and chronic conditions.

5.01.2 The Contractor must engage with Covered California to review its performance on measures related to acute and chronic conditions reported by the Contractor for QRS.

5.02 Supporting At-Risk Enrollees Requiring Transition

5.02.1 An Enrollee transition plan allows for a clear process to transfer critical health information for at-risk members during movement between health care coverage. Covered California is particularly concerned about QHP Issuer transitions of enrollment for At-Risk Enrollees, which includes Enrollees who are: (1) in the middle of acute treatment, third trimester pregnancy, or those who would otherwise qualify for Continuity of Care under California law, (2) in case management programs, (3) in disease management programs, or (4) on maintenance prescription drugs for a chronic condition.

5.02.2 In the event of a service area reduction, the Contractor must submit an evaluation and formal transition plan to facilitate transitions of care with minimal disruption for At-Risk Enrollees who are switching from one QHP Issuer to another or into or out of Covered California. If this occurs, Covered California may automatically transition the Contractor's Enrollees into a different QHP Issuer to avoid gaps in coverage.

The Contractor must demonstrate compliance by submission of a plan to Covered California that meets the following requirements:

1) The Contractor terminating Enrollees must:

    a) Conduct outreach to alert all impacted Enrollees that their QHP will be ending. Outreach will include instructions, timing, and options for enrolling with a new QHP Issuer.

    b) Conduct outreach to At-Risk Enrollees, giving them the option to authorize Contractor to send their personal health information to the Enrollee's new QHP Issuer with the goal of improving the transition of care.

    c) Send Enrollee health information relevant to creating transitions of care with minimal disruption to the Enrollee's new QHP Issuer for those Enrollees who have provided authorization to do so, as follows:

        i) For all terminating Enrollees, send Primary Care Provider information on record.

        ii) For At-Risk Enrollees, send relevant personal health information.

d) Conduct outreach to providers in impacted service areas to create Enrollee transitions with minimal disruption.

2) If the Contractor receives terminating Enrollees from another QHP Issuer pursuant to a service area withdrawal, the Contractor must do the following:

a) Identify At-Risk Enrollees, either through existing Contractor practices, or through receipt of both health information from the prior QHP Issuer and the data file with transitioning enrollment information from Covered California (which would occur after these Enrollees have effectuated coverage).

b) Ensure At-Risk Enrollee care transitions account for the Enrollee's medical situation, including participation in case or disease management programs, locating in-network Providers with appropriate clinical expertise, and any alternative therapies, including specific drugs.

c) Establish internal processes to ensure all parties involved in the transition of care for At-Risk Enrollees are aware of their responsibilities. This includes anyone within or outside of the Contractor's organization who are needed to ensure the transition of prescriptions or provision of care.

d) Provide information on continuity of care programs, including alternatives for transitioning to an in-network provider.

e) Ensure the new Enrollees have access to the Contractor's formulary information prior to enrollment.

ARTICLE 6

COMPLEX CARE

Covered California and the Contractor recognize the importance of effectively managing complex conditions for individuals that require multiple high-cost specialty treatments or end of life care.

6.01 Complex Enrollee Engagement

6.01.1 Enrollees with existing and newly diagnosed complex conditions are the most likely to benefit from effective, proactive management for successful delivery of care.

6.01.2 Building on the National Committee for Quality Assurance (NCQA) Population Health Management plan submission requirement (Article 2, Section 2.01), the Contractor must demonstrate compliance by reporting the following details specific to care management of Complex Enrollees in the annual application for certification:

1) Description of process for identifying Complex Enrollees and the Contractor's definition or criteria for an Enrollee to be categorized as complex and benefitting from complex care management interventions;

2) Description of an outreach plan for Complex Enrollees, including:

   a) Modalities used (e.g. mail, email, telephone, text, patient portal);

   b) If more than one modality is used, an explanation of the multimodal approach or use of modalities in succession; and

   c) Number of outreach attempts per Enrollee.

3) Number and percent of Complex Enrollees successfully contacted; and

4) Number and percent of Complex Enrollees engaged in appropriate complex care management, and number and percent receiving other interventions or programs to support Complex patients.

6.02 Centers of Excellence

6.02.1 Centers of Excellence (COEs) allow for complex care patients to be seen in specialized settings that are focused on optimizing quality and outcomes for specific conditions or treatments. Covered California encourages the Contractor's use of COEs, which may include benefit design incentives for consumers.

6.02.2 The Contractor must report details on access to COE providers with documented experience and proficiency, based on volume and outcome data, that treat conditions which require highly specialized management (e.g. transplant patients and burn patients). Such report must be submitted in the annual application for certification and must include:

1) A description of how Enrollees gain access to COE providers or programs;

2) A list of COEs affiliated with the Contractor, including the condition treated by each institution;

3) For the three (3) top conditions based on volume and cost for Covered California (total joint, spine, and bariatric treatments), a description of the Contractor's criteria for inclusion of these COEs and the method used to promote consumers' usage of these Centers; and

4) For each condition identified with COEs in 2) as well as the top conditions for Covered California noted in 3):

a) The number and percent of Enrollees with each diagnosis qualifying for COE; and

b) The number and percent of Enrollees with the diagnosis who received care at each COE.

6.02.3 The Contractor must engage with Covered California to review its utilization of COEs using HEI data to better understand where care is delivered to Complex Enrollees and create a foundation for analysis of related outcomes.

6.03 Care Coordination

6.03.1 Provision of well-coordinated care requires timely communication between members of a care team. It is a critical component to improve experience of care, health outcomes, and reduce costs.

6.03.2 Contractor must support and monitor their hospitals in application of the Medicare Condition of Participation to have electronic information exchange to notify primary care providers of Admission, Discharge, Transfer (ADT) events for Covered California Enrollees. Contractor must report the following in its annual application for certification:

1) Description of actions taken to ensure implementation of ADT notification from hospitals, including psychiatric hospitals and critical access hospitals, to primary care providers, for Enrollees;

2) Number and percent of hospitals, including psychiatric hospitals and critical access hospitals, that have implemented ADT notification for Covered California Enrollees; and

3) Describe mechanisms in place to assist those hospitals not yet exchanging ADT data with primary care providers for Enrollees.

ARTICLE 7

EFFECTIVE PRIMARY CARE

Covered California and the Contractor recognize that providing high-quality, equitable and affordable care requires a foundation of effective and patient-centered primary care. Effective primary care is data driven, team-based and supported by alternative payment models such as population-based payment and shared savings. The Contractor shall actively promote the development and use of advanced primary care models that promote access, care coordination, and quality while managing the total cost of care.

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

7.01 Encouraging Use of Primary Care

7.01.1 Ensuring all Enrollees have a primary care clinician is foundational for promoting access to and encouraging the use of primary care.

7.01.2 The Contractor must ensure that all Enrollees either select or are provisionally assigned to a primary care clinician within sixty (60) days of effectuation into the plan. If an Enrollee does not select a primary care clinician, the Contractor must provisionally assign the Enrollee to a primary care clinician, inform the Enrollee of the assignment, and provide the Enrollee with an opportunity to select a different primary care clinician. When assigning a primary care clinician, the Contractor shall use commercially reasonable efforts to assign a primary care clinician consistent with an Enrollee's stated gender, language, ethnic and cultural preferences, geographic accessibility, existing family member assignment, and any prior primary care clinician.

The Contractor must report in the annual application for certification the number and percent of Enrollees who select a clinician and the number and percent of Enrollees who are assigned to a primary care clinician.

7.01.3 Covered California will evaluate the effectiveness of this policy based on criteria mutually agreed-upon between Covered California and the Contractor. The Contractor shall provide Covered California with data and other information to perform this evaluation.

7.02 Promotion of Advanced Primary Care

7.02.1 Advanced primary care is patient-centered, accessible, team-based, data driven, supports the integration of behavioral health services, and provides care management for patients with complex conditions. Primary care clinicians should have access to data related to the care their patients receive throughout the delivery system to enable primary care clinicians to provide integrated care. Many barriers prevent a large share of primary care practices from fulfilling their role as the foundation of a highly functioning delivery system.

7.02.2 The Contractor shall work with Covered California to promote and support advanced primary care models. Covered California strongly encourages the Contractor to support or provide quality improvement and technical assistance to primary care practices to implement or strengthen advanced primary care models such as providing practice coaches or investing in information technology. Additionally, Covered California strongly encourages the Contractor to participate in primary care improvement collaboratives.

The Contractor must report in the annual application for certification the quality improvement support and technical assistance being provided by the Contractor or other organization to implement or strengthen advanced primary care models. The Contractor must also report in the annual application for certification the extent and nature of its participation in primary care

improvement collaboratives such as the California Quality Collaborative (CQC) or the California Improvement Network (CIN).

7.03 Measuring Advanced Primary Care

7.03.1 Measuring the performance of primary care practices within the Contractor's network is important to ensure Enrollees receive high-quality care, to inform quality improvement and technical assistance efforts, and to support the adoption of alternative payment models.

7.03.2 The Contractor must pilot a measure set that includes quality and cost-driving utilization measures for advanced primary care to assess the prevalence of high-quality, advanced primary care practices within the Contractor's network. The Contractor will collaborate with Covered California, the Integrated Healthcare Association (IHA), CQC, and other stakeholders to develop and implement the measure set.

The Contractor must submit data to IHA to pilot the measure set. The Contractor must annually report its performance on the measure set to Covered California or allow IHA to submit results to Covered California on the Contractor's behalf.

7.03.3 The Contractor must engage with Covered California to evaluate the performance of its contracted primary care practices using the measure set.

7.04 Payment to Support Advanced Primary Care

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

7.04.2 The Contractor must report on its primary care payment models using the Health Care Payment Learning and Action Network Alternative Payment Model (HCP LAN APM) categories of fee for service with no link to quality and value (Category 1), fee for service with a link to quality and value (Category 2), alternative payment models built on a fee for service structure such as shared savings (Category 3), and population-based payment (Category 4). The Contractor must report in the annual application for certification:

1) The number and percent of its contracted primary care clinicians paid using the HCP LAN APM categories;
2) The number and percent of its Enrollees who are cared for by primary care clinicians paid using each HCP LAN APM category;
3) The percent of spend within each HCP LAN APM category compared to its overall primary care spend; and
4) If the Contractor participates in the annual HCP LAN APM survey, the Contractor shall share its survey responses and reports with Covered California. Covered California encourages the Contractor to participate in the annual HCP LAN APM Measurement Effort.

7.04.3 The Contractor must adopt and progressively expand the number and percent of primary care clinicians paid through the HCP LAN APM categories of population-based payment (Category 4) and alternative payment models built on a fee for service structure such as shared savings (Category 3) each year.

7.04.4 The Contractor shall work with Covered California and other stakeholders to analyze the relationship between the percent of spend for primary care services with performance of the

overall delivery system. If the evidence shows that rebalancing to increase primary care spend improves quality and drives lower total cost of care, Covered California may set a target for primary care spend in future Covered California requirements.

ARTICLE 8

PROMOTION OF INTEGRATED DELIVERY SYSTEMS (IDS) AND ACCOUNTABLE CARE ORGANIZATIONS (ACO)

Evidence suggests the adoption and expansion of integrated, coordinated, and accountable systems of care can lead to improved quality and reduced costs. As detailed in two Covered California reports [1], Integrated Delivery Systems (IDSs) have significantly outperformed network model, shared delivery systems on quality measures. Accountable Care Organizations (ACOs) are being developed and implemented within health plan networks with a shared delivery system in hope of emulating the success of Integrated Delivery Systems.

An ACO is defined as a system of population-based care coordinated across the continuum including multidisciplinary physicians and physician groups, hospitals, and ancillary providers with combined risk sharing arrangements and incentives between the Contractor and providers. ACO partners are held accountable for nationally recognized evidence-based clinical, financial, and operational performance. As providers accept more accountability under this provision, the Contractor shall ensure that providers have the capacity to manage the risk. There are many variations of ACO implementation with evidence suggesting that the characteristics of an ACO model influence its success. For example, ACOs with risk-based contracts that are physician-led are associated with greater savings and improved quality results.[2]

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

8.01 Enrollment in IDSs and ACOs

8.01.1 The Contractor shall work with Covered California to improve the healthcare delivery system and reduce provider and facility variation in performance on quality and cost. This requires continued improvement within IDSs, adopting, enhancing and evolving ACOs, as well as increasing enrollment in these coordinated systems of care.

8.01.2 The Contractor must meet a threshold for the number of Enrollees cared for within an ACO or IDS model each year. The Contractor must report in the annual application for certification:

1) The characteristics of their IDS and ACO systems such as the payment model, leadership structure, quality incentive programs, and data exchange processes. Contractor will work collaboratively with Covered California and other stakeholders to define a registry of characteristics to support this reporting.
2) The number and percent of Enrollees who are cared for within an ACO or IDS.
3) The percent of spend under ACO and IDS contracts compared to its overall spend on health care services.

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[1] Covered California. (2019). Covered California's First Five Years: Improving Access, Affordability and Accountability. https://hbex.coveredca.com/data-research/library/CoveredCA_First_Five_Years_Dec2019.pdf
Covered California. (2019). Covered California Holding Health Plans Accountable for Quality and Delivery System Reform. https://hbex.coveredca.com/data-research/library/CoveredCA_Holding_Plans_Accountable_Dec2019.pdf

[2] Covered California. (2019). Current Best Evidence and Performance Measures for Improving Quality of Care and Delivery System Reform. https://hbex.coveredca.com/stakeholders/plan-management/library/coveredca_current_best_evidence_and_performance_measures_07-19.pdf

8.02 Measuring IDS and ACO Performance

8.02.1 Measuring the performance of IDSs and ACOs is important to ensure Enrollees receive high-quality care, to inform improvement efforts, and to establish best practices.

8.02.2 The Contractor must participate in the Integrated Healthcare Association (IHA) and submit data to IHA for use in the IHA Commercial ACO Measure Set and Commercial HMO Measure Set, as applicable for its delivery system model. Contractor must annually report its performance on the IHA Commercial ACO and HMO Measure Set for all lines of business to Covered California or allow IHA to submit results to Covered California on the Contractor's behalf.

8.02.3 The Contractor must engage with Covered California to evaluate its performance using the results of the IHA Commercial ACO and HMO reports and the characteristics of different systems to establish best practices to inform future requirements.

ARTICLE 9

NETWORKS BASED ON VALUE

Covered California contracted QHP Issuers shall curate and manage their networks and address variation in quality and cost performance across network hospitals and providers, with a focus on improving the performance of hospitals and providers. The Contractor is accountable for measuring, analyzing, and reducing variation to achieve consistent high performance for all network hospitals and providers. Affordability is core to Covered California's mission to expand the availability of insurance coverage and ensure Enrollees receive high-quality, affordable, and equitable care. The wide variation in unit price and total costs of care, with some providers and facilities charging far more for care irrespective of quality, is one of the biggest contributors to high costs of medical services. The Contractor shall hold its contracted hospitals and providers accountable for improving quality and managing or reducing cost and provide the support needed to improve performance across its network.

Covered California will support the Contractor in analyzing data to understand variation in performance and holds the Contractor accountable for acting on such data to improve network performance. Covered California recognizes the limits of quality and cost performance data for hospitals and providers as such data can be imprecise and incomplete. Covered California also recognizes that the resources available to hospitals and providers, such as their payor mix, case mix, organizational structure, and the social determinants of health of populations served can influence the performance of hospitals and providers. Despite these challenges, the Contractor must curate and manage its networks and improve quality and cost performance across network hospitals and providers.

In accordance with Covered California's framework for assuring quality care and promoting delivery system reform, Article 10, Sites and Expanded Approaches to Care Delivery, covers hospital quality improvement requirements, while Article 9 describes the expectation of the Contractor to curate and manage their provider and hospital networks based on cost and quality.

9.01 Designing and Managing Networks Based on Value

9.01.1 The Contractor's networks must be designed and managed based on cost, quality, safety, patient experience, and equity to ensure that all Enrollees receive high-quality, affordable, and equitable care.

9.01.2 The Contractor must include quality, which may include clinical quality, patient safety, patient experience, and cost in the evaluation and selection criteria for all providers, including physicians and physician groups, and all facilities, including hospitals, when designing and managing networks for Covered California QHPs.

The Contractor must report in the annual application for certification how it meets this requirement and the basis for the selection and review of providers and facilities in networks for Covered California QHPs and if applicable, the rationale for excluding a provider or facility. Reports must include a detailed description of how cost, clinical quality, patient safety, patient experience, or other factors are considered in network design and provider and facility selection and review. Information submitted may be made publicly available by Covered California.

9.01.3 The Contractor must engage with Covered California to review its unit price range and trends and quality indicators of network performance using HEI data.

9.02 Hospital Networks Based on Value

9.02.1 The Contractor shall contract with hospitals that demonstrate they provide quality care and promote the safety of Enrollees at a reasonable price. Covered California expects Contractor to improve quality and cost performance across its contracted hospitals.

9.02.2 To meet this expectation, Covered California will work with Cal Hospital Compare, California hospitals, and its contracted QHP Issuers to profile and analyze variation in performance on hospital quality measures. For details on the hospital quality measures of focus, see Article 10, Section 10.03 Hospital Patient Safety and Section 10.04 Appropriate Use of C-sections. Analysis will be based on best available national and state benchmarks, variation in hospital performance considering hospital case mix and services provided, best existing science of quality improvement including the challenges of composite measures, and effective engagement of stakeholders. Assessment of hospital quality and safety shall not be based on a single measure alone. The Contractor must report in the annual application for certification:

1) How the Contractor is engaging with their network hospitals (particularly those with multiple signals of poor performance on safety and quality) and holding hospitals accountable to improve their performance. Components of this engagement and accountability may include quarterly performance reviews, tying hospital payment to quality and patient safety, supporting patient safety technical assistance programs, implementation of corrective action plans, assessment of hospital resources, or excluding hospitals with multiple signals of poor performance and no improvement from its networks.

2) Its rationale for continued contracting with each hospital performing in the lowest decile on state or national benchmarks for quality and safety as well as the strategies the hospital is undertaking to improve its performance and the progress resulting from these improvement activities. The decile formula is specific to the measure and eligible population. The performance for all eligible hospitals, statewide, is arrayed on 0 to 100% rate and the lowest decile of that distribution can be computed. Rationales for continued inclusion of hospitals may include geographical access needs, specific specialty service needs, or other justification provided by the Contractor.

Rationale and criteria for inclusion of hospitals with multiple signals of poor performance on cost, safety, and quality may be released to the public by Covered California.

9.02.3 To demonstrate the Contractor is managing hospital and facility costs, the Contractor must report in the annual application for certification:

1) The factors it considers in assessing relative unit prices and total cost of care;

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

3) How such factors are used in the selection of facilities in networks for Covered California QHPs; and

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

9.03 Physician Networks Based on Value

9.03.1 The Contractor shall contract with providers, including physicians and physician groups, that demonstrate they provide quality care and promote the safety of Enrollees at a reasonable price. Covered California expects the Contractor to improve quality and cost performance across its contracted providers.

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

1) Participate in the IHA Align.Measure.Perform (AMP) program for physician groups and report AMP performance results for each contracted physician group that participates in Covered California QHPs to Covered California annually or allow IHA to submit results to Covered California on the Contractor's behalf. The Contractor shall use AMP performance results to profile and analyze variation in performance on quality measures and total cost of care.

2) Report in the annual application for certification how the Contractor is engaging with its network physician groups (particularly physician groups with multiple indicators of poor quality and high cost performance) and holding physician groups accountable to improve their performance. Components of this engagement and accountability may include implementing alternative payment models such as shared savings and population-based payment, quarterly performance reviews, assessment of physician group resources, provision of technical assistance or support for infrastructure, implementation of corrective action plans, or excluding physician groups with multiple indicators of poor-quality performance and no improvement from its provider networks.

3) Report in the annual application for certification how the Contractor is analyzing variation in performance of independent, direct contracted physicians, engaging with its physicians (particularly physicians with multiple indicators of poor-quality performance and high cost performance), and holding physicians accountable to improve their performance. Components of this engagement may include implementing alternative payment models such as shared savings and population-based payment that cascade to the point of care, quarterly performance reviews, assessment of physician resources, provision of technical assistance or support for infrastructure, implementation of corrective action plans, or excluding poor performing physicians from its provider networks.

4) Report in the annual application for certification how the Contractor is providing or supporting quality improvement or technical assistance to physicians in their network with multiple indicators of poor quality to improve their performance. Quality improvement support or technical assistance may be provided by the Contractor, the contracted physician group, or other organization.

5) Report in the annual application for certification its rationale for continued contracting with physicians and physician groups performing in the lowest decile on state or national benchmarks for quality and highest decile on cost as well as the strategies the physicians and physician groups are undertaking to improve its performance and the progress resulting from these improvement activities. Rationales for continued inclusion of physicians and physician groups may include geographical access needs, specific specialty service needs, or other justification provided by the Contractor.

Rationale and criteria for inclusion of the lowest decile of physicians and physician groups on safety and quality and the highest decile on cost may be released to the public by Covered California.

9.03.3 To demonstrate the Contractor is managing provider costs, the Contractor must report in the annual application for certification:

1) The factors it considers in assessing relative unit prices and total cost of care;
2) The Contractor's analysis of variation in unit prices including capitation rates and whether including high cost physicians or physician groups results in underfunding of other providers or contributes to higher premiums and out of pocket costs for Enrollees;
3) The extent to which it adjusts for or analyzes the reasons for cost factors based on elements such as area of service, population served, market dominance, services provided by the facility (e.g., trauma or tertiary care), or other factors;
4) How such factors are used in the selection of providers in networks for Covered California QHPs; and
5) The identification of specific providers by region and their distribution by cost deciles or describe other ways providers and facilities are grouped by costs such as comparison of costs as a percentage of Medicare costs and the percentage of costs for Contractor that are expended in each cost decile.

ARTICLE 10

SITES AND EXPANDED APPROACHES TO CARE DELIVERY

Covered California is committed to improving how and where Enrollees receive health care. Improving hospital safety and reducing unnecessary medical procedures can improve health outcomes and reduce costs.

For Article 10, “Sites” refers to the traditional medical care settings of hospitals and physician offices. Because there is some overlap in requirements, care in primary care physician offices is covered in Article 7, Effective Primary Care. “Expanded approaches to care delivery” refers to care that goes beyond the traditional in-office service provided by a clinician, such as telehealth, and includes who provides care in addition to physicians including clinically appropriate providers such as registered nurses, pharmacists, midwives, nurse practitioners, physician assistants or non-licensed providers like community health workers.

Covered California has not yet developed contract requirements related to many of the existing and evolving sites of care or approaches to care delivery such as urgent care facilities, retail clinics, or home care. Ongoing discussions and engagement with stakeholders will inform future contract requirements in this article.

Covered California recognizes the importance of hospital quality metrics and reimbursement structure in a Contractor’s negotiation and contracting process with providers and hospitals. In accordance with Covered California’s framework for assuring quality care and promoting delivery system reform, Article 10 covers hospital quality improvement requirements, while Article 9, Networks Based on Value, covers the expectation of Contractors to curate and manage their provider and hospital networks based on cost and quality.

10.01 Telehealth

10.01.1 Telehealth offers expanded access to health care for Enrollees. Telehealth can be used to provide timely access to medical care, increase access to services like behavioral health in which there are particular access barriers due to a limited workforce, and improve self-care management through remote patient monitoring. Telehealth and other virtual health services offer additional access points to medical care that is responsive, patient centered, and reduces barriers such as transportation, childcare, limited English proficiency (LEP), and time off work which may exist for Enrollees.

10.01.2 In the annual application for certification, the Contractor shall report the extent to which the Contractor is supporting the use of telehealth, remote patient monitoring, and other technologies when clinically appropriate to assist in providing high quality, accessible, patient-centered care. The Contractor must report:

1) The types and modalities of telehealth and virtual health services that the Contractor offers to Enrollees, including:

    a) Interactive dialogue over the phone (voice only)

    b) Interactive face to face (video and audio)

    c) Asynchronous via email, text, instant messaging or other

    d) Remote patient monitoring

    e) e-Consult

f) Other modalities

2) How Contractor is communicating with and educating Enrollees about telehealth services including:

   a) Service availability explained on key Enrollee website pages like the home page and provider directory page; and

   b) Service cost-share explained on key Enrollee website pages like the summary of benefits and coverage page and medical cost estimator page.

3) The frequency of all-member communications to inform Enrollees of telehealth services.

4) How the Contractor facilitates the integration and coordination of care between third party telehealth vendor services and primary care and other network providers.

5) How the Contractor facilitates Enrollee access to telehealth services such as screening for and reporting on broadband affordability and lower-cost alternative modalities, digital literacy, availability of smartphones or other devices for internet connectivity, and the geographic availability of high-speed internet services.

6) Description of the Contractor's telehealth reimbursement policies for network providers and for third party telehealth vendors to include payment parity between:

   a) Telehealth including voice only when appropriate and comparable in-person or other non-telehealth services; and

   b) Telehealth vendor and contract provider rendered telehealth services.

7) How the Contractor evaluates the impact telehealth has on the cost and quality of care provided to Enrollees such as the extent to which telehealth replaces or adds to utilization of Emergency Department services.

10.01.3 The Contractor must engage with Covered California to review its utilization of telehealth services using HEI data.

10.02 Hospital Payments to Promote Quality and Value

10.02.1 Hospitals play a pivotal role in providing critical care to those in the highest need and should be supported with coordinated efforts across health plans and purchasers. Payment that is value based can be a driver to promote and reward better quality care rather than payment based on service volume.

10.02.2 The Contractor shall adopt a hospital payment methodology for the Contractor's Covered California business with each general acute care hospital that places the hospital at-risk or subject to a bonus payment for quality performance. At minimum, this methodology shall include two percent (2%) of reimbursement by year end 2022 with a plan for satisfying future increases in reimbursement.

The Contractor must adopt balancing measures such as Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) to track, address, and prevent unintended consequences from at-risk payments including exacerbation of health care disparities.

In alignment with CMS rules on payments to hospitals for inpatient hospital services, Critical Access Hospitals as defined by the Centers for Medicare and Medicaid, are excluded from this requirement. In addition, the following types of hospitals are excluded from this requirement:

1) Long Term Care hospitals;

2) Inpatient Psychiatric hospitals;

3) Rehabilitation hospitals; and

4) Children's hospitals.

The Contractor is accountable for the quality of care and safety of Covered California Enrollees receiving care in the hospitals described above.

Implementation of this requirement may differ for integrated delivery systems and require alternative mechanisms for linking payment to performance.

Those hospitals participating in an Accountable Care Organization, available in a Contractor's QHP network, that have shared risk or other accountability for total cost of care shall be considered to have met this performance-based payment requirement.

10.02.3 The Contractor must report in the annual application for certification:

1) The amount and structure for its hospital performance-based payment strategy, including the shared-risk and performance payment structure to hospitals participating in ACOs, if applicable.

2) The metrics that are applied for performance-based payments such as: mortality, Hospital Associated Infections (HAIs), adherence to sepsis management guidelines, readmissions, or satisfaction as measured through HCAHPS. Such metrics should be commonly in use in hospitals and endorsed by the National Quality Forum to limit hospital measurement burden.

3) The percent of network hospitals operating under contracts reflecting this payment methodology.

4) The dollars and percent, or best estimate, that is respectively paid or withheld to reflect value, including the extent to which the "at risk" payments take the form of bonuses, withholds, or other performance-based payment mechanisms.

5) The dollars and percent or best estimate of hospital payments that are tied to hospital "improvement" versus "attainment" of a performance threshold.

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

10.03 Hospital Patient Safety

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

10.03.2 The Contractor shall work with Covered California to support and enhance acute general hospitals' efforts to promote safety for their patients. Exclusions for this requirement include CMS Critical Access Hospitals as defined by the Centers for Medicare and Medicaid. In addition, the following types of hospitals are excluded: Long Term Care hospitals, Inpatient Psychiatric hospitals, Rehabilitation hospitals, and Children's hospitals.

1) The Contractor must report its strategies to improve safety in network hospitals in the annual application for certification. The quality improvement strategies will be informed by review of

specified patient safety measures in all network hospitals. Patient safety measure rates will be provided by Covered California from established sources of clinical data such as rates reported by hospitals to the National Healthcare Safety Network (NHSN) or the California Department of Public Health (CDPH).

2) Covered California has identified an initial set of patient safety measures for focus consisting of five hospital associated infections (HAIs) and sepsis management (SEP-1). Certain patient safety measures may be substituted for others if a common data source cannot be found. The decision to substitute patient safety measures will be made transparently and collaboratively with stakeholders. The patient safety measures that are currently the subject of the hospital safety initiatives are:

   a) Catheter Associated Urinary Tract Infection (CAUTI) (NQF #0138);

   b) Central Line Associated Blood Stream Infection (CLABSI) (NQF #0139);

   c) Surgical Site Infection (SSI) with focus on colon (NQF #0753);

   d) Methicillin-resistant Staphylococcus aureus (MRSA) (NQF #1716);

   e) Clostridioides difficile colitis (C. Diff) infection (NQF #1717); and

   f) Sepsis Management (SEP-1) (NQF #0500).

3) The Contractor shall work with its contracted hospitals to continuously pursue a Standardized Infection Ratio (SIR) of 1.0 or lower for each of the specified hospital associated infections prioritizing hospitals that care for a high-volume of the Contractor's Enrollees. The Contractor also shall work with its contracted hospitals to improve adherence to the Sepsis Management (SEP-1) guidelines.

10.04 Appropriate Use of C-sections

10.04.1 Cesarean sections (C-sections) can be life-saving, but significant numbers of healthy first-time mothers are undergoing this major surgery when it is not medically necessary. Reducing the rate of unnecessary C-sections improves health outcomes and patient safety.

10.04.2 The Contractor must:

1) Adopt and actively implement guidelines set by Smart Care California to promote the appropriate use of C-sections. Smart Care California is not currently active, but its guidelines remain endorsed by Covered California, DHCS, and CalPERS as well as major employers of Pacific Business Group on Health. Smart Care California has adopted the goal of reducing Nulliparous, Term Singleton, Vertex (NTSV) C-section (NQF #0471) rates to meet or exceed the national Healthy People 2020 target of twenty-three-point nine percent (23.9%) for each hospital in the state.

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

3) Review information on C-section rate for NTSV deliveries and use it to inform hospital engagement strategy to reduce NTSV C-sections.

4) Adopt a payment methodology structured to support only medically necessary care with no financial incentive to perform C-sections for all contracted physicians and hospitals serving

Enrollees by year end 2022. Smart Care California has outlined three payment strategies to align payment with medically necessary use of C-sections:

a) Adopt a blended case rate payment for both physicians and hospitals;

b) Include a NTSV C-section metric in existing hospital and physician quality incentive programs; and

c) Adopt population-based payment models, such as maternity episode payment models.

10.04.3 The Contractor must annually report in the application for certification:

1) How it has adopted and implemented Smart Care California guidelines to promote the appropriate use of C-sections.

2) Its payment methodology for maternity care, how this methodology aligns with the Smart Care California payment strategies, and the number and percent of network maternity hospitals under each strategy.

10.04.4 Covered California expects the Contractor to contract with hospitals that demonstrate they provide quality care and promote the safety of Enrollees. Though Covered California does not expect the Contractor to base poor performance, and potential network removal decisions, on one measure alone, it is expected that Contractor will encourage providers with high rates of NTSV C-section delivery to pursue CMQCC coaching. Covered California expects the Contractor to consider NTSV C-section rate, improvement trajectory, and willingness to engage in coaching as part of its maternity hospital contracting decisions and terms by year end 2022 and annually thereafter.

ARTICLE 11

APPROPRIATE INTERVENTIONS

Appropriate Interventions include examining clinical interventions, such as prescription and nonprescription pharmaceutical treatments, procedures (like surgery), diagnostic tests (lab tests, X-rays, MRIs, etc.) and devices (like implants and pacemakers), to ensure they are rooted in the National Academy of Medicine's six aims for ensuring every individual's care is safe, timely, effective, efficient, equitable, and patient-centered. Equally important is effective consumer and patient engagement that (1) supports consumers in making decisions about health care services, treatments, and providers that are consistent with their values and preferences and (2) fosters access to care.

Over the next few years, a wide range of innovations in care delivery will dramatically impact how care is provided, and the quality and cost of that care. Decision support to providers and patients at the point of care is particularly promising and bringing this information to where decisions are made appears to be critical to successful adoption. Covered California is continuously assessing the extent to which its contractual requirements can assist in prioritizing and standardizing implementation of best practices to benefit all Californians.

11.01 Demonstrating Action on High Cost Pharmaceuticals

11.01.1 Appropriate treatment with pharmaceuticals is often the best clinical strategy to treating conditions, as well as managing chronic and life-threatening conditions. Covered California expects the Contractor to ensure that its Enrollees receive timely access to appropriate prescription medications. Covered California is also concerned with the trend in rising prescription drug costs, including those in specialty pharmacy, and compounding increases in costs of generic drugs, which reflect a growing driver of total cost of care. Access to affordable and effective prescription medications ensures equitable health outcomes for all Enrollees.

11.01.2 The Contractor must report in the annual application for certification a description of its approach to achieving value in delivery of pharmacy services, which must include a strategy in each of the following areas:

1) How it considers value in its selection of medications for use in its formulary, including the extent to which it applies value assessment methodology developed by independent groups or uses independent drug assessment reports on comparative effectiveness and value to design benefits, negotiate prices, develop pricing for consumers, and determine formulary placement and tiering within Covered California standard benefit designs. The Contractor shall report the specific ways it uses a value assessment methodology or independent reports to improve value in pharmacy services and indicate which of the following sources it relies on:

    a) Drug Effectiveness Review Project (DERP)

    b) NCCN Resource Stratification Framework (NCCN-RF)

    c) ASCO Value of Cancer Treatment Options (ASCO-VF)

    d) ACC/AHA Cost/Value Methodology in Clinical Practice Guidelines

    e) Premera Value-Based Drug Formulary (Premera VBF)

    f) DrugAbacus (MSKCC) (DAbacus)

    g) The ICER Value Assessment Framework (ICER-VF)

h) Or other value assessment methodology

2) How its construction of formularies is based on total cost of care rather than on drug cost alone;

3) Its process for managing specialty pharmacy and biologics management; and

4) How it provides decision support for prescribers and consumers related to the clinical efficacy and cost impact of treatments and their alternatives.

11.02 Enrollee Healthcare Services Price and Quality Transparency Plan

11.02.1 Enrollee access to cost and quality information is essential for an Enrollee to make informed decisions about their health care. This information also allows transparency and accountability in ensuring there is equitable health care being delivered to Enrollees.

11.02.2 The Contractor must report in the annual application for certification its approach to providing healthcare shopping cost and quality information available to all Enrollees. Covered California does not require using a specific form or format and recognizes that the timeline and expectations will differ, based on variables such as the Contractor's membership size and current tool offerings. Regardless of how the requirement is fulfilled, the Contractor's planned approach must include:

1) Cost information:

a) That enables Enrollees to understand their exposure to out-of-pocket costs based on their benefit design, including real time information on member accumulation toward deductibles, when applicable, and out of pocket maximums. Health Savings Account (HSA) user information shall include account deposit and withdrawal or payment amounts.

b) That enables Enrollees to understand provider-specific consumer cost shares for prescription drugs and for care delivered in the inpatient, outpatient, and ambulatory surgery or facility settings. Such information must include the facility name, address, and other contact information and be based on the contracting rates to give the Enrollee estimates of out of pocket costs that are as accurate as possible.

c) Commonly used service information should be organized in ways that are useful and meaningful for consumers to understand.

2) Quality information:

a) That enables Enrollees to compare providers based on quality performance in selecting a primary care clinician or common elective specialty and hospital providers.

b) That is based on quality measurement consistent with nationally endorsed quality information.

3) The Contractor shall monitor care provided out of network to ensure that Enrollees understand that their cost share will be higher and are choosing out of network care intentionally.

4) If the Contractor enrollment exceeds 100,000 for Covered California business, the cost and quality information shall be provided through an online tool easily accessible across a variety of platforms. If Contractor enrollment is under 100,000 for Covered California business, the information may be provided by alternative means such as a call center.

11.02.3 The Contractor must report in the annual application for certification:

1) The number and percent of Enrollees in Covered California and all lines of business that have accessed each of the consumer tools offered.

2) How Enrollees in Covered California and all lines of business are using the cost and quality information to aid in their health care decisions and how the Contractor assesses the effectiveness of its consumer tools.

11.03 Enrollee Shared Decision-Making

11.03.1 Covered California requires deployment of decision-making tools to support Enrollees in understanding their medical diagnosis and treatment options to aid in discussion with their provider. Educating Enrollees on their diagnosis and alternative treatment options is a powerful evidence-based approach to reducing overuse or misuse of clinical interventions. Covered California encourages the incorporation of Choosing Wisely decision aids to promote decisions about appropriate and necessary treatment (https://www.choosingwisely.org/).

11.03.2 The Contractor shall promote and encourage patient engagement in shared decision-making with contracted providers. The Contractor must report in the annual application for certification for Enrollees in Covered California and all lines of business how the Contractor is encouraging contracted providers to implement Choosing Wisely guidelines or other evidence-based decision making tools to aid in conversations with Enrollees on appropriate and necessary care.

11.04 Enrollee Personalized Health Record Information

11.04.1 Accessibility to Enrollee personal health management information equips the Enrollee to be active and engaged in decisions about their coverage, care, and health. This transparency and personal authority contribute to achieving equitable health care.

11.04.2 To ensure accessibility of Enrollee health record information:

1) The Contractor must report in the annual application for certification, the services the Contractor provides for Enrollees in all lines of business, through its Enrollee portal, to easily access personalized information about their coverage and care. The Contractor shall explain services it makes available to Enrollees including:

   a) Personal Health Record information and functions including provider appointment scheduling, test results look-up, prescription drug refill ordering, preventive screenings and vaccination history, visit summaries, wellness care and program enrollment; and

   b) Coverage and cost information and functions including premium payment transactions, coverage and cost-share schedule, benefits cost accumulation year-to-date, explanation of benefits look-up, price and service comparisons for shopping.

2) The Contractor will provide access and log-in credentials for Covered California staff per mutually agreed-upon terms to safeguard Contractor proprietary information and services.

ARTICLE 12

KEY DRIVERS OF QUALITY CARE AND EFFECTIVE DELIVERY

Covered California's expectations of the Contractor are driven by its desire to improve health, improve quality of care delivered, reduce the cost of care, and reduce health disparities for all Enrollees. Covered California recognizes that achieving these goals within a delivery system shared among many purchasers and payors will require extensive alignment and coordination. To shape and organize this ongoing work, Covered California focuses its efforts on a number of key drivers, or leverage points, that have been shown to drive quality care and effective delivery. These key drivers have been selected after consulting industry leaders like the National Quality Strategy as well as consulting with key stakeholders.

Many of these key drivers are specifically articulated as expectations of Contractors throughout Attachment 7 as ways to ensure quality care, foster improvements in care delivery, and promote health equity (the appendix describes where each of the requirements tied to key drivers can be found throughout Attachment 7). While all of the key drivers are defined below, many of these drivers are also the subject of their own article (see Articles 13-17).

Finally, Attachment 7 necessarily focuses on the work of Covered California and its Contractors, but there are "community health drivers" that also play a large role in the health of all Enrollees. These community health drivers may be out of the scope of an individual Contractor's responsibility or Attachment 7, but it is important to recognize these drivers are a part of the context within which health care is delivered. Examples of community drivers are detailed after the roster of key drivers specific to the Contractor's work.

12.01 Definitions of Key Drivers

Covered California's Key Drivers of Quality Care and Effective Delivery are chosen because: (1) changes to policies around each of these parts of the healthcare delivery system have been shown to change how care is delivered, both negatively and positively, and (2) they are within the scope of activities performed or overseen by Covered California and its Contractors.

The key drivers that make the foundation of this contract are:

1) Benefit Design: Standardized, patient-centered benefit designs help consumers make informed decisions because they are easier to compare across QHPs. They can also incentivize access to the right care at the right time. Benefit designs may include incentives that encourage patients to use particular providers or sites of care and formulary design and other designs that encourage providers to use particular interventions as appropriate for the benefit of each patient and the cost of care generally. Standard benefit designs along with guaranteed issue and risk adjustment create a level playing field among QHP Issuers ensuring that competition is based on the quality of care and service, network design, and efficiency as translated into premium price.

2) Measurement for Improvement, Choice, and Accountability: Effectively analyzing, tracking and trending the best data available to monitor patient care, outcomes and experiences allows Covered California to provide meaningful and actionable performance feedback to providers, plans, and the public to inform improvement efforts, delivery system reforms, consumer choice and accountability (see Article 13 for requirements). For a list of the measurement-related requirements that are found throughout Attachment 7, refer to Appendix A.

3) Payment: Payment reforms reward and incentivize delivery of high-quality patient-centered care that promotes better health, quality improvement and value while also fostering innovation, improving efficiency and adopting evidence-based practices. Evidence shows that payment models focused on

enhancing value are a consistent critical ingredient in successful system transformation. For a list of the payment-related requirements that are found throughout Attachment 7, refer to Appendix B.

4) Patient-Centered Social Needs: An individual's social and economic barriers to health can play a significant role in shaping outcomes. Many people face barriers that prevent them from receiving the right care at the right time, such as lack of transportation or food insecurity. A healthcare system that identifies and appropriately addresses health related social needs can impact health, transform lives, and reduce costs to the system overall. These are also commonly referred to as health-related social needs (see Article 14 for requirements).

5) Patient and Consumer Engagement: An individual's engagement in managing one's health and making health care decisions is a critical component of achieving optimal health outcomes, appropriate resource use and a responsive and effective healthcare delivery system. Support and system navigation assistance for all consumers can increase the use of appropriate health care services and improve patient outcomes. Effective patient engagement can also include shared decision-making and consumer-directed care and services. For a list of the patient and consumer engagement-related requirements that are found throughout Attachment 7, refer to Appendix C.

6) Data Sharing: Effective data sharing means making patient data available and accessible to support clinical care and coordination, limit health care costs, reduce administrative complexity, improve outcomes and give patients more control over their health care. Advances in data interoperability across providers and patients, new data capture, and measurement systems are critical to support appropriate care, population health management, successful ACO performance, successful integrated care delivery, advanced primary care, and disparities reduction. Timely data exchange among providers and between providers and plans is central to supporting transitions in care, effective care delivery and coordination, and accountability. Incorporation of data on behavioral, physical, and social health, including health related social needs such as housing or food insecurity, enables providers and plans to provide holistic, patient-centered care (see Article 15 for requirements).

7) Data Analytics: Data analytics requires inspecting, transforming and modeling data to discover timely and reliable information that will aide in a patient or provider's decision-making processes. Access to timely, reliable and accurate data and analytics is critical to positive ACO performance and effective primary care. This includes the analytical capacity of health plans to support providers with performance measurement, financial benchmarking and patient attribution as well as provider capacity to assess quality of care, coordinate care, identify at-risk patients and develop appropriate interventions. Practices need patient-level data to coordinate and manage care for their assigned populations; and practice-level data to track performance and course correct as needed on key cost, quality, and utilization metrics (see Article 15 for requirements).

8) Administrative Simplification: Implementing system changes to maximize the time providers spend with patients and minimize unnecessary administrative burden creates a more effective health care system for all while also protecting against provider burnout. Covered California is committed to driving change that does not increase provider and system burden.

9) Quality Improvement and Technical Assistance: Systems are transformed when all stakeholders are aligned around initiatives that lead to better patient outcomes and improved care delivery approaches. Strategies include strengthening the evidence base to inform decision-making and fostering learning environments that offer training, resources, tools and guidance to help organizations achieve quality improvement goals. In many areas, the evidence remains incomplete, at times inconsistent, and is constantly changing. Covered California looks to support and drive

efforts to increase the evidence available to all as well as promote established initiatives that have been shown to be effective (see Article 16 for requirements). For a list of the quality improvement and technical assistance-related requirements that are found throughout Attachment 7, refer to Appendix D.

10) Certification, Accreditation and Regulation: Covered California and Contractor are expected to follow existing mandatory regulatory and accreditation processes as well as use appropriate accrediting standards when they are available and that have been shown to drive quality and healthcare delivery improvement. Covered California may use accrediting standards to ensure the Contractor meets foundational requirements for safety and quality (see Article 17 for requirements).

12.02 Definitions of Community Drivers

Along with the key drivers of healthcare delivery reform, Covered California recognizes that many factors beyond specific instances of healthcare influence the individual health of its enrollees. Below are three drivers of community health. Covered California has chosen these drivers because they have been shown to be a powerful way of identifying and analyzing the many social and structural barriers individuals face when attempting to make healthy choices or access appropriate healthcare. However, these drivers are not included above as key drivers and they are not linked to contract requirements because they represent policy choices that are largely outside of the scope of activities performed or overseen by Covered California and Contractors.

While these community drivers are outside of the scope of enforcement for this contract, Covered California seeks to better understand them, explore how they lead to health inequities, and build partnerships for collective action around them whenever possible.

The community drivers that Covered California is highlighting are:

1) Workforce: Investing in people to develop a diverse, intergenerational and effective healthcare workforce, including supporting life-long learning for those working in the health field. A diverse workforce calls for a diversity of roles (including nonclinical health workers such as promotores de salud and peer providers) and a diversity of backgrounds that are reflective of patient communities to be served.

2) Community-wide Social Determinants: Conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life-risks and outcomes.[3]

3) Population and Public Health: Improving health outcomes on a community and population level through education, policy making and broad interventions to promote health and safety such as immunizations, smoking prevention programs, promoting healthy eating, etc.

[3] Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved 10/7/2020, from https://health.gov/healthypeople/objectives-and-data/social-determinants-health.

ARTICLE 13

MEASUREMENT FOR IMPROVEMENT, CHOICE, AND ACCOUNTABILITY

Effectively analyzing, tracking and trending the best data available to monitor patient care, outcomes and experiences allows Covered California to provide meaningful and actionable performance feedback to providers, QHP Issuers, and the public to inform improvement efforts, delivery system reforms, consumer choice, and accountability. Covered California has described specific measurement requirements throughout the Attachment 7 contract as they relate to domains of care or care delivery strategies. Article 13 focuses on the submission and use of Quality Rating System measure data and subsequent comparison of Covered California performance to national benchmarks that cross multiple articles throughout Attachment 7. These two overarching requirements recognize that consistent measurement of QHP Issuers performance and benchmarks anchored in Quality Rating System and Quality Compass reporting requirements provide stakeholders with the opportunity to track and trend improvements over time. Furthermore, the Covered California measurement approach described herein will inform Healthcare Evidence Initiative (HEI) efforts, provider-level, and other QHP Issuer-level reporting described in other articles.

For a list of the measurement-related requirements that are found throughout Attachment 7, refer to Appendix A.

13.01 Covered California Quality Rating System Reporting

13.01.1 The Contractor and Covered California recognize that the Quality Rating System is an important component for overall performance accountability, an effective communication tool for Enrollees and the public, and can inform measure alignment with other purchasers and measure sets.

13.01.2 The Contractor shall annually collect and report to Covered California, for each QHP Issuer product type, its Quality Rating System HEDIS, CAHPS, and other performance data (numerators, denominators, and rates). The Contractor must provide such data to Covered California each year regardless of the extent to which CMS uses the data for public reporting or other purposes.

13.01.3 The Contractor shall work with Covered California, including participating in quality assurance activities, to produce the Quality Rating System summary quality ratings each year.

13.01.4 Covered California reserves the right to use the Contractor-reported data to construct Contractor summary quality ratings that Covered California may use for purposes such as supporting consumer choice, quality improvement efforts, performance standards, and other activities related to Covered California's role as a Health Oversight Agency of Contractor's QHPs.

13.02 National Committee for Quality Assurance (NCQA) Quality Compass Reporting

13.02.1 The Contractor and Covered California recognize that performance measure comparison for the Covered California population to national benchmarks for commercial and Medicaid lines of business promotes health equity, informs efforts to address health disparities, and ensures consistent quality of care among all populations.

13.02.2 The Contractor shall annually collect and report HEDIS and CAHPS scores for its commercial (inclusive of the Covered California population) and Medi-Cal lines of business to the National Committee for Quality Assurance (NCQA) Quality Compass. This submission to NCQA Quality Compass shall include the numerator, denominator, and rate for the NCQA Quality Compass-required measures set.

13.02.3 The Contractor shall submit to Covered California HEDIS and CAHPS scores to include the measure numerator, denominator, and rate for the required measures set that is reported to the NCQA Quality Compass and DHCS, for each product type for which it collects data in California. The Contractor shall report HEDIS and CAHPS quality data to Covered California through the annual application for certification. For Contractors that have commercial lines of business that do not permit public reporting of their results to NCQA Quality Compass, HEDIS and CAHPS scores for the NCQA Quality Compass measures set should still be submitted to Covered California.

The Contractor shall report such information to Covered California in a form that is mutually agreed upon by the Contractor and Covered California in addition to participating in quality assurance activities to validate measure numerator, denominator, and rate data throughout the year.

ARTICLE 14

PATIENT-CENTERED SOCIAL NEEDS

Given the strong evidence of the role of social determinants on health outcomes, addressing patient-centered social needs is an important step in advancing Covered California's goal to ensure everyone receives the best possible care. Covered California has identified key requirements to better understand the effectiveness of current approaches to addressing patient-centered social needs and to help develop evidence for effective patient-centered social needs interventions.

14.01 Social Needs Screening for Food Insecurity and Housing Instability or Homelessness

14.01.1 Covered California acknowledges the importance of understanding patient health-related social needs – an individual's social and economic barriers to health – to move closer to equitable care and seeks to encourage the use of social needs informed care and targeted care. As social needs are disproportionately borne by disadvantaged populations, identifying and addressing these barriers at the individual patient level is a critical first step in improving health outcomes, reducing health disparities, and reducing health care costs.

14.01.2 The Contractor must screen for a minimum of two standard social needs: food insecurity and housing instability or homelessness. At minimum, all Enrollees engaged in plan-based programs such as complex care management, case management, and health education or promotion programs must be screened. Screening in other populations, and in coordination with providers in the network, is also highly encouraged.

The Contractor must annually report to Covered California:

1) Its process for screening Enrollees for social needs, including which Enrollee touch points include social need screening, whether the screening is performed by Contractor's staff, vendor or network provider, and who performs the screening (clinician, Community Health Worker (CHW), or other non-clinical provider) and which social needs are routinely screened for.

2) The social needs screening efforts by its provider network and the actions the Contractor takes to coordinate screening and linkage to services with its provider network.

3) The total number of Enrollees screened for food insecurity and housing instability or homelessness, the number and percent who screened positive for each, and the number and percent who screened positive that were successfully linked to resources to meet the social need.

14.02 Community Resources Directory

14.02.1 Identification and information sharing of available community resources is critical to meeting identified member social needs.

14.02.2 The Contractor must develop and maintain an inventory of community resources by region covered to support linkages to appropriate social services. This requirement may be met through contracting with a vendor that maintains a resource directory or community resource platform applicable to Contractor's geographic licensed service area.

The Contractor must submit documentation of (1) the process for linking members with food insecurity or housing instability or homelessness to resources, and (2) how the Contractor tracks if or when the social need has been addressed.

ARTICLE 15

DATA SHARING AND ANALYTICS

Covered California is committed to making patient data available and accessible to support clinical care and coordination, decrease health care costs, reduce paperwork, improve outcomes and give patients more control over their health care. To allow for the discovery of timely and reliable information that will aid in a patient or provider's decision-making processes, Covered California will engage QHP Issuers in actively inspecting, transforming and modeling patient data.

15.01 Data Submission

15.01.1 Covered California and the Contractor recognize the importance of submitting timely and appropriate data for use in improving quality of care.

15.01.2 Contractor must comply with the following data submission requirements:

1) General Data Submission Requirements

   a) California law requires the Contractor to provide Covered California with information on cost, quality, and disparities to evaluate the impact of Covered California on the healthcare delivery system and health coverage in California.

   b) California law requires the Contractor to provide Covered California with data needed to conduct audits, investigations, inspections, evaluations, analyses, and other activities needed to oversee the operation of Covered California, which may include financial and other data pertaining to Covered California's oversight obligations. California law further specifies that any such data shall be provided in a form, manner, and frequency specified by Covered California.

   c) The Contractor is required to provide Healthcare Evidence Initiative Data ("HEI Data") that may include, but need not be limited to, data and other information pertaining to quality measures affecting enrollee health and improvements in healthcare care coordination and patient safety. This data may likewise include enrollee claims and encounter data needed to monitor compliance with applicable provisions of this Agreement pertaining to improvements in health equity and disparity reductions, performance improvement strategies, individual payment methods, as well as enrollee-specific financial data needed to evaluate enrollee costs and utilization experiences. Covered California agrees to use HEI Data for only those purposes authorized by applicable law.

   d) The Parties mutually agree and acknowledge that financial and other data needed to evaluate Enrollee costs and utilization experiences shall include, but need not be limited to, information pertaining to contracted provider reimbursement rates and historical data as required by applicable California law.

   e) Covered California may, in its sole discretion, require that certain HEI Data submissions be transmitted to Covered California through a vendor (herein, "HEI Vendor") which will have any and all legal authority to receive and collect such data on Covered California's behalf. Notwithstanding the foregoing, the parties mutually agree and acknowledge that the form, manner, and frequency wherein Covered California may require the submission of HEI Data may, in Covered California's discretion, require the use of alternative methods for the submission of any such data. Such alternative methods may include but need not be limited to data provided indirectly through an alternative vendor or directly to

Covered California either via the terms of this Agreement or the certification process for Covered California participation. Covered California will provide Contractor with sufficient notice of any such alternative method.

2) Healthcare Evidence Initiative Vendor (HEI Vendor)

   a) Covered California represents and warrants that any HEI Vendor which, in its sole discretion, Covered California should contract with to assist with its health oversight functions and activities shall have any and all legal authority to provide any such assistance, including but not limited to the authority to collect, store, and process HEI Data subject to this Agreement.

   b) The parties acknowledge that any such HEI Vendor shall be retained by and work solely with Covered California and that Covered California shall be responsible for HEI Vendor's protection, use and disclosure of any such HEI Data.

   c) Notwithstanding the foregoing, Covered California acknowledges and agrees that disclosures of HEI Data to HEI Vendor or to Covered California shall at all times be subject to conditions or requirements imposed under applicable federal or California State law.

3) HEI Vendor Designation

   a) Should Covered California terminate its contract with its then-current HEI vendor, Covered California shall provide the Contractor with at least thirty (30) days' written notice in advance of the effective date of such termination.

   b) Upon receipt of the aforementioned written notice from Covered California, the Contractor shall terminate any applicable data-sharing agreement it may have with Covered California's then-current HEI Vendor and shall discontinue the provision of HEI Data to Covered California's then-current HEI Vendor.

4) Covered California shall notify the Contractor of the selection of an alternative HEI Vendor as soon as reasonably practicable and the parties shall at all times cooperate in good faith to ensure the timely transition to the new HEI Vendor.

5) HIPAA Privacy Rule

   a) PHI Disclosures Required by California law:

      i) California law requires the Contractor to provide HEI Data in a form, manner, and frequency determined by Covered California. Covered California has retained and designated HEI Vendor to collect and receive certain HEI Data information on its behalf.

      ii) Accordingly, the parties mutually agree and acknowledge that the disclosure of any HEI Data to Covered California or to HEI Vendor which represents PHI is permissible and consistent with applicable provisions of the HIPAA Privacy Rule which permit Contractor to disclose PHI when such disclosures are required by law (45 CFR §164.512(a)(1)).

   b) PHI Disclosures for Health Oversight Activities:

      i) The parties mutually agree and acknowledge that applicable California law (CA Gov Code §100503.8) requires Contractor to provide Covered California with HEI Data for the purpose of engaging in health oversight activities and declares Covered

California to be a health oversight agency for purposes of the HIPAA Privacy Rule (CA Gov Code §100503.8).

ii) The HIPAA Privacy Rule defines a "health oversight agency" to consist of a person or entity acting under a legal grant of authority from a health oversight agency (45 CFR §164.501) and HEI Vendor has been granted legal authority to collect and receive HEI Data from Contractor on Covered California's behalf.

iii) Accordingly, the parties mutually acknowledge and agree that the provision of any HEI Data by Contractor to Covered California or HEI Vendor which represents PHI is permissible under applicable provisions of the HIPAA Privacy Rule which permit the disclosure of PHI for health oversight purposes (45 CFR §164.512(d).

c) Publication of Data and Public Records Act Disclosures

i) The Contractor acknowledges that Covered California intends to publish certain HEI Data provided by the Contractor pertaining to its cost reduction efforts, quality improvements, and disparity reductions.

ii) Notwithstanding the foregoing, the parties mutually acknowledge and agree that data shall at all times be disclosed in a manner which protects the Personal Information (as that term is defined by the California Information Privacy Act) of the Contractor's Enrollees or prospective enrollees.

iii) The parties further acknowledge and agree that records which reveal contracted rates paid by the Contractor to health care providers, as well as any enrollee cost share, claims or encounter data, cost detail, or information pertaining to enrollee payment methods, which can be used to determine contracted rates paid by the Contractor to health care providers shall not at any time be subject to public disclosure and shall at all times be deemed to be exempt from compulsory disclosure under the Public Records Act. Accordingly, Covered California shall take all reasonable steps necessary to ensure such records are not publicly disclosed.

15.02 Data Exchange with Providers

15.02.1 Covered California and the 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.

15.02.2 The Contractor must report on the following activities to support data exchange with providers in the annual application for certification:

1) The initiatives undertaken to improve routine exchange of timely information with providers to support their delivery of high-quality care. This requirement is supplemental to the mandatory implementation of electronic information exchange of admission, discharge, and transfer events outlined in Article 6, Section 6.03.

2) Describe participation in statewide or regional initiatives that seek to make data exchange routine, including the following Health Information Exchanges:

i) Manifest MedEx (formerly CalIndex)

ii) Los Angeles Network for Enhanced Services (LANES)

iii) Orange County Partnership Regional Health Information Organization (OCPRHIO)

iv) San Diego Health Connect

v) Santa Cruz Health Information Exchange

vi) Other Health Information Exchange(s)

3) Report number and percent of the following that participate in Health Information Exchanges:

i) Individual clinicians

ii) Hospitals

The Contractor agrees to engage with Covered California and other stakeholders in discussions regarding a transition to a statewide approach to streamline Health Information Exchange participation and other efforts that could facilitate an improved exchange of data.

15.02.3 The Contractor must use standard processes for encounter data exchange with its contracted providers, which include:

1) The use of the 837-P and 837-I industry standard transaction sets for encounter data intake. These standard transaction sets must include appropriate cost sharing and member out of pocket information.

2) The use of the 277 CA transaction set and industry standard code sets to communicate encounter data that was successfully processed, as well as any encounter data that was rejected and requires resubmission. If the Contractor uses a clearing house to process encounter data and the 277 CA is not utilized, the Contractor must provide a daily detailed file to the clearing house of all rejected records and corresponding reasons for rejections. The Contractor must ensure its contracted providers receive visibility to the specific reasons the encounter data was rejected to allow for both successful resubmissions and any process improvement needed to minimize future rejections.

The Contractor shall participate in industry collaborative initiatives for improving encounter data exchange processes in California.

15.03 Data Aggregation Across Health Plans

15.03.1 Covered California and the Contractor recognize that aggregating data across purchasers and payors to more accurately understand the performance of providers that have contracts with multiple health plans can potentially be used to support performance improvement, contracting and public reporting.

15.03.2 The Contractor shall report in the annual application for certification its participation in initiatives to support the aggregation of claims and clinical data across health plans. The Contractor must include its assessment of additional opportunities to improve measurement and reduce the burden of data collection on health plans and providers through such proposals as a statewide All Payor Claims Database.

15.04 Patient Access Application Programing Interface

15.04.1 Covered California and the Contractor recognize that transparency in health information such as costs and outcomes will promote a value-based health care system. To this intent, Patient Access Application Programming Interface (API) software provides the ability to give patients greater control of their health information and care management.

15.04.2 The Contractor must implement and maintain a secure, standards-based Patient Access API. Specifically, the Contractor must:

1) Implement and maintain a secure, standards-based Patient Access API consistent with the CMS Patient Access final rule for Federally Facilitated Marketplaces.
    a) Make the data available to 3rd-party application developers.
    b) Using the Fast Healthcare Interoperability Resource (FHIR) standard, make the following types of information available:
        i) Claims and encounters including encounters with capitated providers, provider remittance and enrollee cost-sharing data.
            (1) Must contain all covered services including subcontracted, capitated or delegated services.
            (2) Must contain claims data for payment decision that may be appealed, were appealed or are in the process of appeal.
        ii) Clinical data based on the United States Core Data for Interoperability (USCDI) data elements and classes, if maintained by Contractor.
    c) Make the information available no later than one (1) business day after it is received by the Contractor.
    d) Make API documentation publicly accessible.
    e) Must conduct routine testing and monitoring and update as appropriate to ensure API functions properly.
    f) Must provide educational materials about privacy and security considerations when selecting a 3rd-party application.
2) Report number and percent of patients accessing their Patient Access API in the annual application for certification.

ARTICLE 16

QUALITY IMPROVEMENT AND TECHNICAL ASSISTANCE

Covered California believes systems are transformed when all stakeholders are aligned around initiatives that lead to better patient outcomes and improved care delivery approaches. Strategies include strengthening the evidence base to inform decision-making and fostering learning environments that offer training, resources, tools, and guidance to help organizations achieve quality improvement goals. Covered California is also committed to supporting quality care collaboratives and data sharing initiatives that may lead to reductions in health disparities.

Covered California recognizes that hospitals have contracts with multiple health plans and are engaged in an array of quality improvement and efficiency initiatives. Hospitals play a pivotal role in providing critical care to those in the highest need and should be supported with coordinated efforts across health plans and purchasers. Providers also play a critical role in ensuring quality care and should be supported with resources and tools to improve the delivery of care.

Quality improvement and technical assistance requirements are described throughout the Attachment 7 contract as they relate to specific domains of care or care delivery strategies. Article 16 focuses on the overarching quality improvement strategies that cross multiple articles. These overarching requirements recognize that improving health care quality, reducing overuse, and reducing cost can be achieved when multiple stakeholders join collaboratively in quality improvement efforts.

For a list of the Quality Improvement and Technical Assistance requirements that are found in Attachment 7, refer to Appendix D.

16.01 Quality Improvement Strategy

16.01.1 The Contractor is required under the Affordable Care Act and regulations from CMS to implement a Quality Improvement Strategy (QIS). The core CMS requirement for the QIS is to align provider and Enrollee market-based incentives and reimbursement with delivery system and quality targets.

16.01.2 The Contractor shall align its Quality Improvement Strategy with the contractual requirements and initiatives of Covered California and to report on its multi-year strategy for implementing each initiative through the annual application for certification submitted to Covered California. The Contractor shall report such information in a form that is mutually agreed upon by the Contractor and Covered California and may include copies of reports used by the Contractor for other purposes. The Contractor understands that Covered California will seek increasingly detailed reports over time that will facilitate the assessment of the impacts of these strategies.

The annual application for certification serves as the reporting mechanism and measurement tool for assessing Contractor QIS work plans and progress in achieving improvement targets with respect to each of Covered California quality and delivery system reform strategy.

16.02 Participation in Quality Improvement Collaboratives and Data Sharing Initiatives

16.02.1 Covered California believes that improving health care quality, reducing overuse and reducing costs can only be done over the long-term through collaborative efforts that effectively engage and support hospitals, clinicians and other providers of care and promotes data sharing among health systems. There are several established statewide and national collaborative initiatives for quality improvement and data sharing that are aligned with priorities established by Covered California.

16.02.2 The Contractor must report its participation in any of the following collaboratives or initiatives or other similar activities in the annual application for certification:

1) American Joint Replacement Registry (AJRR) for California
2) The CalHIVE Network
3) Cal Hospital Compare
4) California Maternal Quality Care Collaborative (CMQCC)
5) California Quality Collaborative (CQC)
6) Collaborative Healthcare Patient Safety Organization (CHPSO)
7) Integrated Healthcare Association (IHA)
8) Leapfrog
9) Symphony Provider Directory

16.02.3 Covered California and the Contractor will collaboratively identify and evaluate the most effective programs for improving care for Enrollees. Covered California may require participation in specific quality improvement collaboratives and data sharing initiatives in future years.

16.03 Adoption and Implementation of Smart Care California Guidelines

16.03.1 Smart Care California is a multi-stakeholder purchaser-led work group that leveraged Choosing Wisely decision aids to develop guidelines to support and drive quality improvement in hospital and patient safety.[4] Smart Care California is not presently active, but its guidelines for management of opioids and a menu of payment options for maternity care remain endorsed by Covered California, DHCS, and CalPERS as well as the employers of Pacific Business Group on Health (PBGH). They can be found at https://www.iha.org/our-work/insights/smart-care-california.

16.03.2 The Contractor shall adopt and actively implement the Smart Care California guidelines supporting the appropriate use of C-sections for Nulliparous, Term, Singleton, Vertex (NTSV) deliveries (see Article 10, Section 10.04) and opioids (see Article 4, Section 4.04). The Contractor will report how it implements the guidelines from Smart Care California in the annual application for certification.

16.03.3 The Contractor will collaboratively work with Covered California to ensure that Smart Care guidelines are being implemented, to evaluate the effectiveness of the guidelines, and to update them as needed. Covered California will regularly monitor clinical outcomes and improvement strategies and engage with the Contractor to review its performance.

[4] Smart Care California is currently on a suspended state due to the 2020 COVID-19 pandemic and the state's budget crisis. Covered California will continue to endorse the Smart Care California quality improvement guidelines for the 2022 Attachment 7 contract.

ARTICLE 17

CERTIFICATION, ACCREDITATION AND REGULATION

Covered California seeks to align with external-validated, industry standards in quality and set a base standard of core health plan functions across all plans. Assurance of a base standard will allow Covered California to phase in higher standards aimed at improving Enrollee outcomes that are aligned with one core health plan quality and function framework and accreditation process.

17.01 QHP Accreditation

17.01.1 The Contractor must maintain current health plan accreditation for its Covered California membership throughout the term of the Agreement. The Contractor shall authorize the accrediting agency to provide information and data to Covered California relating to the Contractor's accreditation, including the NCQA submissions and audit results, and other data and information maintained by accrediting agency as required under 45 C.F.R. § 156.275.

17.01.2 If the Contractor is not currently accredited by NCQA health plan accreditation:

1) The Contractor shall provide a written workplan to Covered California at least annually regarding the status and progress of the submitted workplan to achieve NCQA health plan accreditation by year end 2024.

2) If the Contractor is not currently accredited by NCQA health plan accreditation, the Contractor shall be currently accredited by URAC or AAAHC health plan accreditation until NCQA health plan accreditation is achieved by year end 2024.

17.01.3 The Contractor shall notify Covered California of the date of any accreditation review scheduled during the term of this Agreement and the results of such review. Upon completion of any health plan accreditation review conducted during the term of this Agreement, the Contractor shall provide Covered California with a copy of the Assessment Report within thirty (30) days of report receipt.

17.01.4 If the Contractor receives a rating of less than accredited in any category, loses an accreditation, or fails to maintain a current and up to date accreditation:

1) The Contractor shall notify Covered California within ten (10) business days of such rating(s) change. The Contractor will implement strategies to raise the Contractor's rating to a level of at least accredited or to reinstate accreditation. The Contractor will submit a written corrective action plan (CAP) to Covered California within thirty (30) days of receiving its initial notification of the change in category ratings.

2) Following the initial submission of the corrective action plan (CAP), the Contractor shall provide a written report to Covered California, when requested and at least quarterly, regarding the status and progress of the accreditation reinstatement. The Contractor shall request a follow-up review by the accreditation entity no later than twelve (12) months after loss of accreditation and submit a copy of the follow-up Assessment Report to Covered California within thirty (30) days of receipt, if applicable.

17.01.5 In the event the Contractor's overall accreditation is suspended, revoked, or otherwise terminated, or in the event the Contractor has undergone review prior to the expiration of its current accreditation and reaccreditation is suspended, revoked, or not granted at the time of expiration, Covered California reserves the right to terminate any agreement by and between the Contractor and Covered California or suspend enrollment in the Contractor's QHPs, to ensure

Covered California is in compliance with the federal requirement that all participating issuers maintain a current approved accreditation pursuant to 45 C.F.R. § 156.275(a).

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

				Data Source			
NQF Endorsement/ID	Measure Name	Clinical Priority Area	Attachment 7 Article(s)	Quality Rating System	Healthcare Evidence Initiative	Direct from Issuer (Contractor submits to Covered CA)	Other
0004	Initiation and Engagement of Alcohol or Other Dependence Treatment	Behavioral Health	4.03, 13.01	X	X		
0105	Antidepressant Medication Management (AMM)	Behavioral Health	4.03, 13.01	Acute & Continuation Phases not listed separately	X		
0576	Follow-Up After Hospitalization for Mental Illness (Follow-Up Within 7 Days Post-Discharge) and 30 days	Behavioral Health	4.03, 13.01	X	X		
3400	Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)	Behavioral Health	4.04		X		
0418/0418e	Screening for Depression & Follow-Up Plan	Behavioral Health	4.03			X	
Not Endorsed	Annual Monitoring for Persons on Long-term Opioid Therapy (AMO)	Behavioral Health	13.01	X			
0018/0018e	Controlling High Blood Pressure	Cardiovascular	1.02, 1.03, 5.01, 13.01	X		Patient-Level Measure File	
0541	Proportion of Days Covered (PDC) by Medications: Statins	Cardiovascular	13.01	X	X		
0541	Proportion of Days Covered (PDC) by Medications: Renin Angiotensin System (RAS) Antagonists	Cardiovascular	13.01	X	X		
0541	Proportion of Days Covered (PDC) by Medications: Diabetes All Class	Cardiovascular	13.01	X	X		
0555	International Normalized Ratio (INR) Monitoring for Individuals on Warfarin	Cardiovascular	5.01, 13.01	X			
0055	Comprehensive Diabetes Care: Eye Exam (Retinal) Performed	Cardiovascular	1.02, 1.03, 5.01, 13.01	X		Patient-Level Measure File	
0575	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (< 8.0%)	Cardiovascular	1.02, 1.03, 5.01, 13.01	X		Patient-Level Measure File	
0062	Comprehensive Diabetes Care: Medical Attention for Nephropathy	Cardiovascular	1.02, 1.03, 5.01, 13.01	X	X	Patient-Level Measure File	
0541	Proportion of Days Covered by Medications: Oral Diabetes Medications (3 Rates by Therapeutic Category)	Cardiovascular	13.01	3 Rates listed separately	3 Rates listed separately		
1517	Prenatal and Postpartum Care (PPC)	Maternity	5.01, 13.01	X			
0471	PC-02 Cesarean Birth (Low Risk, First Time Cesarean Section Rate; NTSV C-Section)	Maternity	10.04				Cal Hospital Compare
0052	Use of Imaging Studies for Low Back Pain	Musculoskeletal	5.01, 13.01	X			
0006 & 0007 (CAHPS)	Access and Care Information	Patient Experience	5.01, 13.01	X			
0006 (CAHPS)	Care Coordination Composite	Patient Experience	5.01, 13.01	X			
0006 (CAHPS)	Overall Ratings of Care Composite (Rating of Doctor & Rating of All Healthcare)	Patient Experience	13.01	X			
0006 (CAHPS)	Rating of Personal Doctor	Patient Experience	13.01	X			
0006 (CAHPS)	Rating of Specialist	Patient Experience	13.01	X			

				Data Source			
NQF Endorsement/ID	Measure Name	Clinical Priority Area	Attachment 7 Article(s)	Quality Rating System	Healthcare Evidence Initiative	Direct from Issuer (Contractor submits to Covered CA)	Other
0006 (CAHPS)	Rating of Health Plan	Patient Experience	13.01	X			
0007 (CAHPS)	Access to Information	Patient Experience	13.01	X			
0006 (CAHPS)	Health Plan Customer Service (Plan Administration)	Patient Experience	13.01	X			
0024	Weight Assessment & Counseling for Nutrition and Physical Activity for Children/Adolescents	Prevention & Screening	3.03, 13.01	X			
0038	Childhood Immunization Status (Combo 3 & 10)	Prevention & Screening	13.01	Combo 3			
Not Endorsed	Adult BMI Assessment	Prevention & Screening	13.01	X			
2372	Breast Cancer Screening	Prevention & Screening	13.01	X	X		
0032	Cervical Cancer Screening	Prevention & Screening	13.01	X			
0033	Chlamydia Screening in Women	Prevention & Screening	13.01	X			
0034	Colorectal Cancer Screening	Prevention & Screening	13.01	X			
1407	Immunizations for Adolescents: Combination 2 (Meningococcal; Tdap; HPV series completed by 13th birthday) and Combo 1	Prevention & Screening	13.01	X			
0039	Flu Vaccinations for Adults age 18-64	Prevention & Screening	13.01	X			
1388	Annual Dental Visit (ADV)	Prevention & Screening	13.01	X			
0027	Medical Assistance With Smoking and Tobacco Use Cessation	Prevention & Screening	3.02, 13.01	X			
1392	Well-Child Visits in the First 15 Months of Life (Six or More Visits)	Prevention & Screening	13.01	X			
1516	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Prevention & Screening	13.01	X	X		
1768	Plan All-Cause Readmissions	Resource Use	5.01, 13.01	X			
1799	Medication Management for People With Asthma (75% of Treatment Period)	Respiratory	13.01	X			
0069	Appropriate Treatment for Children with Upper Respiratory Infection	Respiratory	5.01, 13.01	X			
0002	Appropriate Testing for Children With Pharyngitis	Respiratory	5.01, 13.01	X			
1800	Asthma Medication Ratio	Respiratory	5.01, 13.01	X	Investigating		
0058	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Respiratory	5.01, 13.01	X			
3389	Concurrent Use of Opioids and Benzodiazepines (COB)	Behavioral Health	4.04		Investigating		
2940	Use of Opioids at High Dosage in Persons Without Cancer	Behavioral Health	4.04		X		
0138	Catheter Associated Urinary Tract Infection (CAUTI)	Hospital Associated Infections	10.03				Cal Hospital Compare
0139	Central Line Associated Blood Stream Infection (CLABSI)	Hospital Associated Infections	10.03				Cal Hospital Compare
0753	Surgical Site Infections (Colon Surgery)	Hospital Associated Infections	10.03				Cal Hospital Compare
1716	Methicillin-resistant Staphylococcus aureus (MRSA)	Hospital Associated Infections	10.03				Cal Hospital Compare

APPENDIX A MEASUREMENT FOR IMPROVEMENT, CHOICE, AND ACCOUNTABILITY

				Data Source			
NQF Endorsement/ID	**Measure Name**	**Clinical Priority Area**	**Attachment 7 Article(s)**	**Quality Rating System**	**Healthcare Evidence Initiative**	**Direct from Issuer (Contractor submits to Covered CA)**	**Other**
1717	Clostridioides difficile colitis (C. Diff) infection	Hospital Associated Infections	10.03				Cal Hospital Compare
Not Endorsed	Sepsis Management (SEP-1)	Hospital Associated Infections	10.03				
Not Endorsed	Concurrent Use of Opioids and Naloxone	Behavioral Health	4.04		Investigating		

**For CAHPS measures, the CMS-ACO or IHA titles differ slightly from CAHPS titles. The IHA version uses the provider-level CAHPS tool ("CG-CAHPS") which differs to some degree with the health plan-level CAHPS but in most cases the construct is the same.

APPENDIX B PAYMENT

Payment reforms reward and incentivize delivery of high-quality patient-centered care that promotes better health, quality improvement and value while also fostering innovation, improving efficiency and adopting evidence-based practices. Evidence shows that payment models focused on enhancing value are a consistent critical ingredient in successful system transformation.

The following table describes where each of the requirements related to the key driver, Payment, can be found throughout Attachment 7.

Attachment 7 Article	Payment Requirement
Article 4, 4.05 Integration of Behavioral Health Services with Medical Services	4.05.2 Contractor must report in the annual application for certification: 3) Whether it reimburses for the Collaborative Care Model claims codes and, if so, in what settings and to which entities. If the Contractor does not reimburse for the Collaborative Care Model claims codes, the Contractor must describe the barriers to reimbursing for these codes.
Article 7, 7.04 Payment to Support Advanced Primary Care	7.04.2 The Contractor must report on its primary care payment models using the Health Care Payment Learning and Action Network Alternative Payment Model (HCP LAN) categories of fee for service with no link to quality and value (Category 1), fee for service with a link to quality and value (Category 2), alternative payment models built on a fee for service structure such as shared savings (Category 3), and population-based payment (Category 4). The Contractor must report in the annual application for certification: 1) The number and percent of its contracted primary care clinicians paid using the HCP LAN categories; 2) The number and percent of its Enrollees who are cared for by primary care clinicians paid using each HCP LAN category; 3) The percent of spend within each HCP LAN category compared to its overall primary care spend; and 4) If the Contractor participates in the annual HCP LAN survey, the Contractor shall share its survey responses and reports with Covered California. Covered California encourages the Contractor to participate in the annual HCP LAN APM Measurement Effort. 7.04.3 The Contractor must adopt and progressively expand the number and percent of primary care clinicians paid through the HCP LAN categories of population-based payment (Category 4) and alternative payment models built on a fee for service structure such as shared savings (Category 3) each year. 7.04.4 The Contractor shall work with Covered California and other stakeholders to analyze the relationship between the percent of spend for primary care services with performance of the overall

Attachment 7 Article	Payment Requirement
	delivery system. If the evidence shows that rebalancing to increase primary care spend improves quality and drives lower total cost of care, Covered California may set a target for primary care spend in future Covered California requirements.
Article 8, 8.01 Enrollment in IDSs and ACOs	8.01.2 The Contractor must meet a threshold for the number of Enrollees cared for within an ACO or IDS model each year. The Contractor must report in the annual application for certification: 1) The characteristics of their IDS and ACO systems such as the payment model, leadership structure, quality incentive programs, and data exchange processes. Contractor will work collaboratively with Covered California and other stakeholders to define a registry of characteristics to support this reporting. 2) The number and percent of Enrollees who are cared for within an ACO or IDS. 3) The percent of spend under ACO and IDS contracts compared to its overall spend on health care services.
Article 9, 9.01 Designing and Managing Networks Based on Value	9.01.3 The Contractor must engage with Covered California to review its unit price range and trends and quality indicators of network performance using HEI data.
Article 9, 9.02 Hospital Networks Based on Value	9.02.2 The Contractor must report in the annual application for certification: 1) How the Contractor is engaging with their network hospitals (particularly those with multiple signals of poor performance on safety and quality) and holding hospitals accountable to improve their performance. Components of this engagement and accountability may include quarterly performance reviews, tying hospital payment to quality and patient safety, supporting patient safety technical assistance programs, implementation of corrective action plans, assessment of hospital resources, or excluding hospitals with multiple signals of poor performance and no improvement from its networks.
Article 9, 9.02 Hospital Networks Based on Value	9.02.3 To demonstrate the Contractor is managing hospital and facility costs, the Contractor must report in the annual application for certification: 1) The factors it considers in assessing relative unit prices and total cost of care; 2) The extent to which it adjusts for or analyzes the reasons for cost factors based on elements such as area of service, population served, market dominance, services provided by the facility (e.g., trauma or tertiary care), or other factors;

Attachment 7 Article	Payment Requirement
	3) How such factors are used in the selection of facilities in networks for Covered California QHPs; and 4) The identification of specific facilities by region and their distribution by cost deciles or describe other ways facilities are grouped by costs such as comparison of costs as a percentage of Medicare costs and the percentage of costs for the Contractor that are expended in each cost decile.
Article 9, 9.03 Physician Networks Based on Value	9.03.3 To demonstrate the Contractor is managing provider costs, the Contractor must report in the annual application for certification: 1) The factors it considers in assessing relative unit prices and total cost of care; 2) The Contractor's analysis of variation in unit prices including capitation rates and whether including high cost providers results in underfunding of other providers; 3) The extent to which it adjusts for or analyzes the reasons for cost factors based on elements such as area of service, population served, market dominance, services provided by the facility (e.g., trauma or tertiary care), or other factors; 4) How such factors are used in the selection of providers in networks for Covered California QHPs; and 5) The identification of specific providers by region and their distribution by cost deciles or describe other ways providers and facilities are grouped by costs such as comparison of costs as a percentage of Medicare costs and the percentage of costs for Contractor that are expended in each cost decile.
Article 10, 9.01 Telehealth	10.01.2 In the annual application for certification, the Contractor shall report the extent to which the Contractor is supporting the use of telehealth, remote patient monitoring, and other technologies when clinically appropriate to assist in providing high quality, accessible, patient-centered care. The Contractor must report: 6) Description of the Contractor's telehealth reimbursement policies for network providers and for third party telehealth vendors to include payment parity between: a) Telehealth including voice only when appropriate and comparable in-person or other non-telehealth services; and b) Telehealth vendor and contract provider rendered telehealth services.
Article 10, 10.02 Hospital Payments to	10.02.2 The Contractor shall adopt a hospital payment methodology for the Contractor's Covered California business with each general acute

Attachment 7 Article	Payment Requirement
Promote Quality and Value	care hospital that places the hospital at-risk or subject to a bonus payment for quality performance. At minimum, this methodology shall include two percent (2%) of reimbursement by year end 2022 with a plan for satisfying future increases in reimbursement.
Article 10, 10.04 Appropriate Use of C-sections	10.04.2 The Contractor must: 4) Adopt a payment methodology structured to support only medically necessary care with no financial incentive to perform C-sections for all contracted physicians and hospitals serving Enrollees by year end 2022. Smart Care California has outlined three payment strategies to align payment with medically necessary use of C-sections: d) Adopt a blended case rate payment for both physicians and hospitals; e) Include a NTSV C-section metric in existing hospital and physician quality incentive programs; and f) Adopt population-based payment models, such as maternity episode payment models. 10.04.3 The Contractor must annually report in the application for certification: 1) How it has adopted and implemented Smart Care California guidelines to promote the appropriate use of C-sections. 2) Its payment methodology for maternity care, how this methodology aligns with the Smart Care California payment strategies, and the number and percent of network maternity hospitals under each strategy.
Article 11, 11.02 Enrollee Healthcare Services Price and Quality Transparency Plan	11.02.2 The Contractor must report in the annual application for certification its approach to providing healthcare shopping cost and quality information available to all Enrollees. Covered California does not require using a specific form or format and recognizes that the timeline and expectations will differ, based on variables such as the Contractor's membership size and current tool offerings. Regardless of how the requirement is fulfilled, the Contractor's planned approach must include: 1) Cost information: a) That enables Enrollees to understand their exposure to out-of-pocket costs based on their benefit design, including real time information on member accumulation toward deductibles, when applicable, and out of pocket maximums. Health Savings Account (HSA) user information shall

Attachment 7 Article	Payment Requirement
	include account deposit and withdrawal or payment amounts. b) That enables Enrollees to understand provider-specific consumer cost shares for prescription drugs and for care delivered in the inpatient, outpatient, and ambulatory surgery or facility settings. Such information must include the facility name, address, and other contact information and be based on the contracting rates to give the Enrollee estimates of out of pocket costs that are as accurate as possible. c) Commonly used service information should be organized in ways that are useful and meaningful for consumers to understand.

APPENDIX C PATIENT AND CONSUMER ENGAGEMENT

Patient and Consumer Engagement describes an individual's engagement in managing one's health and making health care decisions is a critical component of achieving optimal health outcomes, appropriate resource use and a responsive and effective healthcare delivery system. Support and system navigation assistance for all consumers can increase the use of appropriate health care services and improve patient outcomes. Effective patient engagement can also include shared decision-making and consumer-directed care and services.

The following table describes where each of the requirements related to the key driver, Patient and Consumer Engagement, can be found throughout Attachment 7.

Attachment 7 Article	Patient and Consumer Engagement
Article 11, 11.02 Enrollee Healthcare Services Price and Quality Transparency Plan	11.02.2 The Contractor must report its approach to providing healthcare shopping cost and quality information available to all Enrollees. These include: 1) Cost Information a. Consumer out-of-pocket costs, including real-time information on member accumulation toward their deductibles and out of pocket maximums b. Health Savings Account (HSA) user information shall include account deposit and withdrawal information or payment amounts c. Consumer cost shares for prescription drugs, inpatient care, outpatient care, and ambulatory surgery services 2) Quality Information a. Information must enable Enrollees to compare providers based on quality performance in selecting a primary care clinician, common elective specialty, and hospital b. Information must enable Enrollees to understand cost share for out-of-network vs. in-network 11.02.3 The Contractor must report in the annual application for certification: 1) The number and percent of Enrollees in Covered California and all lines of business that have accessed each of the consumer tools offered. 2) How Enrollees in Covered California and all lines of business are using the cost and quality information to aid in their health care decisions and how the Contractor assesses the effectiveness of its consumer tools.
Article 11, 11.03 Enrollee Shared Decision-Making	11.03.2 The Contractor shall promote and encourage patient engagement in shared decision-making with contracted providers. The Contractor must report in the annual application for certification for Enrollees in

Attachment 7 Article	Patient and Consumer Engagement
	Covered California and all lines of business, how the Contractor is promoting and encouraging contracted providers to implement Choosing Wisely guidelines or other evidence-based decision-making tools, to aid in conversations with Enrollees on appropriate and necessary care.
Article 11, 11.04 Enrollee Personalized Health Record Information	11.04.2 To ensure accessibility of Enrollee health record information: 1) The Contractor must report in the annual application for certification, the services the Contractor provides for Enrollees in all lines of business, through its Enrollee portal, to easily access personalized information about their coverage and care. The Contractor shall explain services it makes available to Enrollees including: a) Personal Health Record information and functions including provider appointment scheduling, test results look-up, prescription drug refill ordering, preventive screenings and vaccination history, visit summaries, wellness care and program enrollment; and b) Coverage and cost information and functions including premium payment transactions, coverage and cost-share schedule, benefits cost accumulation year-to-date, explanation of benefits look-up, price and service comparisons for shopping. 2) The Contractor will provide access and log-in credentials for Covered California staff per mutually agreed-upon terms to safeguard Contractor proprietary information and services.
Article 14, 14.02 Community Resources Directory	14.02.2 The Contractor must develop and maintain an inventory of community resources by region covered to support linkages to appropriate social services. This requirement may be met through contracting with a vendor that maintains a resource directory or community resource platform applicable to Contractor's geographic licensed service area. The Contractor must submit documentation of (1) the process for linking members with food insecurity or housing instability or homelessness to resources, and (2) how the Contractor tracks if or when the social need has been addressed.
Article 15, 15.04 Patient Access Application Programming Interface	15.04.2 The Contractor must implement and maintain a secure, standards-based Patient Access API. Specifically, the Contractor must: 1) Implement and maintain a secure, standards-based Patient Access API consistent with the CMS Patient Access final rule for Federally Facilitated Marketplaces.

Attachment 7 Article	Patient and Consumer Engagement
	a) Make the data available to 3rd-party application developers. b) Using the Fast Healthcare Interoperability Resource (FHIR) standard, make the following types of information available: i) Claims and encounters including encounters with capitated providers, provider remittance and enrollee cost-sharing data. (1) Must contain all covered services including subcontracted, capitated or delegated services. (2) Must contain claims data for payment decision that may be appealed, were appealed or are in the process of appeal. ii) Clinical data based on the United States Core Data for Interoperability (USCDI) data elements and classes, if maintained by Contractor. c) Make the information available no later than one (1) business day after it is received by the Contractor. d) Make API documentation publicly accessible. e) Must conduct routine testing and monitoring and update as appropriate to ensure API functions properly. f) Must provide educational materials about privacy and security considerations when selecting a 3rd-party application. 2) Report number and percent of patients accessing their Patient Access API in the annual application for certification.

APPENDIX D QUALITY IMPROVEMENT AND TECHNICAL ASSISTANCE

Quality Improvement and Technical Assistance describes strategies that lead to better patient outcomes and improved care delivery approaches. Strategies include strengthening the evidence base to inform decision-making and fostering learning environments that offer training, resources, tools and guidance to help organizations achieve quality improvement goals. In many areas, the evidence remains incomplete, at times inconsistent, and is constantly changing. Covered California looks to support and drive efforts to increase the evidence available to all as well as promote established initiatives that have been shown to be effective

The following table describes where each of the requirements related to the key driver, Quality Improvement and Technical Assistance, can be found throughout Attachment 7.

Attachment 7 Article	Quality Improvement and Technical Assistance
Article 4, 4.04 Appropriate Use of Opioids	4.04.2 The Contractor shall implement policies and programs that align with the guidelines from Smart Care California to promote the appropriate use of opioids while considering an Enrollee's condition and lower opioid overdose deaths (https://www.iha.org/previous-initiatives/). The Contractor's policies and programs must include the following priority areas: 1) Prevent: decrease the number of new starts: fewer prescriptions, lower doses, shorter durations; 2) Manage: identify patients on risky regimens (high-dose, or opioids and sedatives) and develop individualized treatment plans, avoiding mandatory tapers; 3) Treat: streamline access to evidence-based treatment for substance use disorder at all points in the healthcare system; and 4) Stop deaths: promote data-driven harm reduction strategies, such as naloxone access and syringe exchange. The Contractor must report in the annual application for certification how it is implementing such policies and programs in accordance with the Smart Care California guidelines.
Article 7, 7.02 Promotion of Advanced Primary Care	7.02.2 The Contractor shall work with Covered California to promote and support advanced primary care models. Covered California strongly encourages the Contractor to support or provide quality improvement and technical assistance to primary care practices to implement or strengthen advanced primary care models such as providing practice coaches or investing in information technology. Additionally, Covered California strongly encourages the Contractor to participate in primary care improvement collaboratives. The Contractor must report in the annual application for certification the quality improvement support and technical assistance being provided by the Contractor or other organization to implement or

Attachment 7 Article	Quality Improvement and Technical Assistance
	strengthen advanced primary care models. The Contractor must also report in the annual application for certification the extent and nature of its participation in primary care improvement collaboratives such as the California Quality Collaborative (CQC) or the California Improvement Network (CIN).
Article 10, 10.03 Hospital Patient Safety	10.03.2 The Contractor shall work with Covered California to support and enhance acute general hospitals' efforts to promote safety for their patients. Exclusions for this requirement include CMS Critical Access Hospitals as defined by the Centers for Medicare and Medicaid. In addition, the following types of hospitals are excluded: Long Term Care hospitals, Inpatient Psychiatric hospitals, Rehabilitation hospitals, and Children's hospitals. 1) The Contractor must report its strategies to improve safety in network hospitals in the annual application for certification. The quality improvement strategies will be informed by review of specified patient safety measures in all network hospitals. Patient safety measure rates will be provided by Covered California from established sources of clinical data such as rates reported by hospitals to the National Healthcare Safety Network (NHSN) or the California Department of Public Health (CDPH).
Article 10, 10.04 Appropriate Use of C-Sections	10.04.2 The Contractor must: 1) Adopt and actively implement guidelines set by Smart Care California to promote the appropriate use of C-sections. Smart Care California is not currently active, but its guidelines remain endorsed by Covered California, DHCS, and CalPERS as well as major employers of Pacific Business Group on Health. Smart Care California has adopted the goal of reducing Nulliparous, Term Singleton, Vertex (NTSV) C-section (NQF #0471) rates to meet or exceed the national Healthy People 2020 target of twenty-three-point nine percent (23.9%) for each hospital in the state. 2) Work collaboratively with Covered California to promote and encourage all in-network hospitals that provide maternity services to use the resources provided by California Maternity Quality Care Collaborative (CMQCC) and enroll in the CMQCC Maternal Data Center (MDC).
Article 16, 16.01 Quality Improvement Strategy	16.01.2 The Contractor shall align its Quality Improvement Strategy with the contractual requirements and initiatives of Covered California and to report on its multi-year strategy for implementing each initiative through the annual application for certification submitted to Covered California. The Contractor shall report such information in a form that is mutually agreed upon by the Contractor and Covered

Attachment 7 Article	Quality Improvement and Technical Assistance
	California and may include copies of reports used by the Contractor for other purposes. The Contractor understands that Covered California will seek increasingly detailed reports over time that will facilitate the assessment of the impacts of these strategies. The annual application for certification serves as the reporting mechanism and measurement tool for assessing Contractor QIS work plans and progress in achieving improvement targets with respect to each of Covered California quality and delivery system reform strategy.
Article 16, 16.02 Participation in Quality Improvement Collaboratives and Data Sharing Initiatives	16.02.2 The Contractor must report its participation in any of the following collaboratives or initiatives or other similar activities in the annual application for certification: 1) American Joint Replacement Registry (AJRR) for California 2) The CalHIVE Network 3) Cal Hospital Compare 4) California Maternal Quality Care Collaborative (CMQCC) 5) California Quality Collaborative (CQC) 6) Collaborative Healthcare Patient Safety Organization (CHPSO) 7) Integrated Healthcare Association (IHA) 8) Leapfrog 9) Symphony Provider Directory 16.02.3 Covered California and the Contractor will collaboratively identify and evaluate the most effective programs for improving care for Enrollees. Covered California may require participation in specific quality improvement collaboratives and data sharing initiatives in future years.
Article 16, 16.03 Adoption and Implementation of Smart Care California Guidelines	16.03.2 The Contractor shall adopt and actively implement the Smart Care California guidelines supporting the appropriate use of C-sections for Nulliparous, Term, Singleton, Vertex (NTSV) deliveries (see Article 10, Section 10.04) and opioids (see Article 4, Section 4.04). The Contractor will report how it implements the guidelines from Smart Care California in the annual application for certification. 16.03.3 The Contractor will collaboratively work with Covered California to ensure that Smart Care guidelines are being implemented, to evaluate the effectiveness of the guidelines, and to update them as needed. Covered California will regularly monitor clinical outcomes and improvement strategies and engage with the Contractor to review its performance.

QUALITY, NETWORK MANAGEMENT AND DELIVERY SYSTEM STANDARDS

GLOSSARY OF KEY TERMS

Accountable Care Organization (ACO) - An ACO is defined as a system of population-based care coordinated across the continuum including multidisciplinary physicians and physician groups, hospitals, and ancillary providers with combined risk sharing arrangements and incentives between the Contractor and providers. ACO partners are held accountable for nationally recognized evidence-based clinical, financial, and operational performance. As providers accept more accountability under this provision, the health plans shall ensure that providers have the capacity to manage the risk.

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.

Contractor - The Health Insurance Issuer contracting with Covered California under this Agreement to offer a QHP and perform in accordance with the terms set forth in this Agreement.

Covered California – The California Health Benefit Exchange, doing business as Covered California and an independent entity within the Government of the State.

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 Covered Services. Generally, these models require improved care coordination, Provider and payor information sharing, and programs that identify and manage populations of individuals through care delivery and payment models.

Enrollees – Enrollee means each and every individual enrolled for the purpose of receiving health benefits.

Health Disparities - Healthy People 2020 defines a health disparity as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to

health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion." Racial and ethnic disparities populations include persons with Limited English Proficiency (LEP).

Health Equity - Healthy People 2020 defines health equity as the "attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities."

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.

Integrated Delivery Systems – An integrated delivery system (IDS) is a network of physicians and healthcare facilities that provide a continuum of healthcare services managed under one organization or one parent company. Similar to an ACO, an IDS includes population-based care coordinated across the continuum including multi-discipline physician practices, hospitals, and ancillary Providers with combined risk sharing arrangements and incentives between health plans and Providers, and among Providers across specialties and institutional boundaries. The IDS is held accountable for nationally recognized evidence based- clinical, financial, and operational performance, as well as incentives for improvements in population outcomes.

Measurement Year - The calendar year that the activity being assessed is performed.

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 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.

Primary Care - The provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health needs, developing a sustained partnership with patients, and practicing in the context of family and community (NAM, 1978). Contractors may allow enrollees to select Nurse Practitioners and Physician Assistants to serve as their Primary Care clinician. Covered California does not require that Primary Care clinicians serve as a "gatekeeper" or the source of referral and access to specialty care. Covered California recognizes Internal Medicine, OBGYN, Pediatrics, General Practice, and Family Medicine as primary care specialties.

Qualified Health Plan or QHP– A health care service plan contract or policy of insurance offered by a QHP Issuer and certified by Covered California.

Qualified Health Plan Issuer or QHP Issuer - means a licensed health care service plan or insurer that has been selected and certified by Covered California to offer QHPs through Covered California.

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 enrollee's 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.

Reporting Year - The calendar year that performance data is reported to Covered California.

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-based Care - A plan for patient care that is based on philosophy in which groups of professional and non-professional personnel work together and share the work 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.

Telehealth – A mode of delivering professional health care and public health services to a patient through information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site.

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.

Attachment 14. Performance Standards

During the term of this Agreement, Contractor shall meet or exceed the Performance Standards identified in this Attachment. For those Performance Standards with Penalties, Contractor shall be responsible for payment of penalties for Contractor's failure to meet the Performance Standards in accordance with the terms set forth in Section 6.1 of the Agreement and this Attachment 14. Contractor shall submit the data required by the Performance Standards by the date specified by Covered California. Some of the data required applies to a window of time. Some of the data represents a point in time. This measurement timing is described in more detail in the sections within this Attachment.

Contractor shall monitor and track its performance each month against the Performance Standards and provide Covered California with a detailed Monthly Performance Report in a mutually-agreeable format. Contractor must report on Covered California business only and report Contractor's Enrollees in Covered California for the Individual Exchange separate from Contractor's Enrollees in Covered California for Small Business. Except as otherwise specified below in the Performance Standards Table, the reporting period for each Performance Standard shall be one calendar month. All references to days shall be calendar days and references to time of day shall be to Pacific Standard Time.

If Contractor fails to meet any Performance Standard in any calendar month (whether or not the failure is excused), Covered California may request and Contractor shall (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 Standards; (d) implement and notify Covered California of measures taken by Contractor to prevent recurrences, if the performance failure is otherwise likely to recur; and (e) make written recommendations to Covered California for improvements in Contractor's procedures.

As specified below, certain Performance Standards are subject to penalties. The total amount at risk is equal to ten percent (10%) of the total Participation Fee paid by Contractor in accordance with the terms set forth in Section 5.1.3 of the Agreement for the Individual Market (At-Risk Amount). Penalties will be determined on an annual basis at the end of each calendar year, based on Contractor's final year-end data for each Performance Standard. The amount of penalty will be reduced by any credit Contractor receives. Where applicable, performance is assessed for each product (HMO, PPO, EPO) the Contractor offers. Penalties are weighted by enrollment in the product for Contractor's with multiple products. Covered California has specified below when the At-Risk Amount or the performance requirements differ by product. In no event shall the total credits to Contractor exceed the total amount of the performance penalty owed to Covered California by Contractor.

Covered California will provide the Contractor an Initial Contractor Performance Standard Evaluation Report, covering preliminary year end data available, which Covered California will send to Contractor for review no later than February 28th of the following calendar year.

When the results of the Performance Standards are calculated, Covered California will provide Contractor with a Final Contractor Performance Standard Evaluation Report, along with an invoice, within 60 calendar days of receipt of the Performance Standards data requirements. Contractor shall remit payment to Covered California within 30 calendar days of receiving the Final Contractor Performance Measurement Evaluation Report and invoice.

If Contractor does not agree with either the Initial or Final Performance Standard Evaluation Report, Contractor may dispute the Report in writing within thirty (30) calendar days of receipt of that Report. The written notification of dispute shall provide a detailed explanation of the basis for the dispute. Covered California shall review and provide a written response to Contractor's dispute within thirty (30) calendar days of receipt of Contractor's notification of dispute. If the Contractor still disputes the findings of Covered California, Contractor may pursue additional remedies in accordance with Section 12.1 of the Agreement.

Contractor shall not be responsible for any failure to meet a Performance Standard if and to the extent that the failure is excused pursuant to Section 12.7 of the Agreement (Force Majeure), or the parties agree that the lack of compliance is due to Covered California'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 Covered California of the problem and uses commercially reasonable efforts to perform and meet the Performance Standards notwithstanding Covered California's failure to perform or delay in performing.

If Contractor wishes to avail itself of one of these exceptions, Contractor must notify Covered California in its response to the performance report identifying the failure to meet such Performance Standard. This response must include: (a) the identity of the Performance Standard that is subject to the exception, and (b) the circumstances that gave rise to the exception in sufficient detail to permit Covered California 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 Standard fall within an exception.

The Parties may adjust, suspend, or add Performance Standards from time to time, upon written agreement of the parties, without an amendment to this contract.

Performance Standards and Expectations				
Covered California will create an Annual Report of Performance Standards and Expectations, displaying Contractor's final Plan Year 2022 performance in Performance Standards and Expectations, Standards 1.1 - 1.11, to be posted publicly on Covered California's website. Covered California will continue public reporting of its service level performance metrics.				
Performance Standard		**Performance Requirements**	**Contractor Must Submit Data by the 10th of the following month**	**Measurement Period**
1.1	**Abandonment Rate**	Expectation: No more than 3% of incoming calls abandoned in a calendar month. Divide number of abandoned calls by the number of calls offered to a phone representative.	X	January 1, 2022-December 31, 2022
1.2	**Service Level**	Expectation: 80% of calls answered in 30 seconds or less.	X	January 1, 2022-December 31, 2022
1.3	**Grievance Resolution**	Expectation: 95% of Covered California enrollee grievances resolved within 30 days of initial receipt.	X	January 1, 2022-December 31, 2022
1.4	**Covered California member Email or Written Inquiries Answered and Completed**	Expectation: 90% of Covered California member email or written inquiries not relating to Urgent Access to Care issues answered and completed within 15 business days of the inquiry.	X	January 1, 2022-December 31, 2022
1.5	**ID Card Processing Time**	Expectation: 99% of ID cards issued within 10 business days of receiving complete and accurate enrollment information and binder payment for a specific consumer(s).	X	January 1, 2022-December 31, 2022

Performance Standards and Expectations				
Performance Standard		**Performance Requirements**	**Contractor Must Submit Data by the 10th of the following month**	**Measurement Period**
1.6	**Implementation of Appeals Decisions**	Expectation: 90% of Administrative Law Judge decisions will be implemented within ten (10) days of Contractor's receipt of all necessary data elements from Covered California required to implement the appeals decision.	X	January 1, 2022- December 31, 2022
1.7	**834 Processing**	Expectation: Covered California will receive a TA1 or 999 file, or both as appropriate within three business days of receipt of the 834 transaction 95% of the time.		Plan Year 2022, 834 transactions will begin with renewals. October 1, 2021 – December 31, 2022
1.8	**834 Generation – Effectuation and Cancellation Transactions**	Expectation: Covered California will successfully receive and process effectuation, and cancellation 834 transactions within 60 days from either the coverage effective date or transaction timestamp, whichever is later 95% of the time.		Plan Year 2022 834 transactions will begin with renewals. October 1, 2021 – December 31, 2022
1.9	**834 Generation – Termination Transactions**	Expectation: Covered California will receive termination 834 transactions within ten days of the grace period expiration 95% of the time.		Plan Year 2022 834 transactions will begin with renewals. October 1, 2021 – December 31, 2022

Performance Standards and Expectations				
Performance Standard		**Performance Requirements**	**Contractor Must Submit Data by the 10th of the following month**	**Measurement Period**
1.10	**Reconciliation Process**	Expectation: Covered California shall receive a comparison reconciliation extract in accordance with the file validations and resolution timelines, as mutually agreed upon in the Reconciliation Process Guide (Extranet, Data Home, Contractor's folder) 90% of the time for accuracy and timeliness.		January 1, 2022-December 31, 2022
1.11	**Provider Directory Data Submission**	Expectation: Full and regular submission of provider data according to the standards outlined in the Performance Standard contract specific to contract Section 3.4.4. Submissions occur every month pursuant to the submission schedule (Extranet, Plan Home, Resources, Provider Directory Resources, Covered California Provider Data Submission Schedule_Current Year).		January 1, 2022-December 31, 2022

Performance Standards and Expectations				
Performance Standard		**Performance Requirements**	**Contractor Must Submit Data by the 10th of the following month**	**Measurement Period**
1.12	**Essential Community Providers – Article 3, Section 3.3.3**	Expectation: 1. Contractor to demonstrate provider agreements with at least 15% of 340B non-hospital providers in each applicable rating region. 2. Contractor to demonstrate provider agreements that reflect a mix of essential community providers (hospital and non-hospital) reasonably distributed to serve the low-income, vulnerable, or medically underserved populations. Or meet Alternate Standard Contractor requirements. Refer to Article 3, Section 3.3.3.		January 1, 2022-December 31, 2022
1.13	**Hospital Safety – Attachment 7, Article 10, Section 10.02**	Contractor shall adopt a payment strategy that places hospital payments in Covered California networks either at risk or subject to a bonus payment for quality performance Contractor may structure this strategy according to its own priorities, with the exception that if the Contractor uses readmissions measure, it shall not be the only measure. Contractor shall report on its strategy and progress on adoption of the payment strategy annually. Expectation: At least 2% of payments to hospitals in Covered California network(s) are at-risk for quality performance by year-end 2021.		January 1, 2022-December 31, 2022

Performance Standards with Penalties		
Health Evidence Initiative (HEI) Data		
Definitions for Performance Standard 2.1 Incomplete: A file or part of a file is missing, or critical data elements are not provided. Irregular: Unexpected file or data element formatting, or record volumes or data element counts / sums deviate significantly from historical submission patterns for the data supplier. Late: Data is submitted on a date later than the supplier's agreed-upon submission date (i.e., between the 5th and 15th of the month) plus five business days. Non-Usable: HEI Vendor cannot successfully include submitted data in its database build, or HEI Vendor's or Covered CA's analysts determine that critical components of the submitted data cannot be used or relied upon in subsequent analytic work.		
Performance Standard		**Performance Requirements**
2.1	**HEI Data Submission specific to Attachment 7, Section 15.01 Data Submission.** 10% of At-Risk Amount.	Expectation: Full and regular submission of data according to the standards outlined in the Attachment 7 citations. The Contractor must work with Covered California and HEI vendor to ensure accuracy of data variables on an ongoing basis. Performance Levels: 1. Incomplete, irregular, late or non-useable submission of HEI data: 3% penalty of total performance requirement. Failure to submit required financials (e.g., allowed, copay, coinsurance, and deductible amounts) or dental claims covered under medical benefits constitutes incomplete submission. Full and regular submission according to the formats specified and useable by Covered California within 5 business days of each monthly reporting cycle: no penalty.

		2. Inpatient facility medical claim submissions for which the HEI Vendor cannot identify / match at least 95% of admissions to its Master Provider Index: 3% penalty of total performance requirement. Submission meeting or surpassing the 95% identification / matching threshold: no penalty. 3. Professional medical and Rx claim submissions with provider taxonomy or type missing or invalid on more than 1% of records: 2% penalty of total performance requirement. Submission meeting or surpassing the 99% populated and valid threshold: no penalty. 4. Enrollment or professional medical claim submissions with PCP NPI ID missing or invalid on more than 1% of records: 2% penalty of total performance requirement. Submission meeting or surpassing the 99% populated and valid threshold: no penalty.

Performance Standards with Penalties Quality, Network Management and Delivery System Standards	
The Parties may adjust, suspend, or add Performance Standards from time to time, upon written agreement of the parties, without an amendment to this contract. 90% of At-Risk Amount for Measurement Year 2022.	
Covered California and Contractor shall work together to periodically review and adjust the specific measures consistent with any applicable Federal regulations.	
Performance Standards 3.1 and 3.2	
QHP Issuers are required by CMS annually to collect and submit third-party validated QRS measure data, for the previous measurement year that will be used by CMS to calculate QHP scores and ratings. These measures will be determined by CMS. Covered California will publicly report the QRS scores and ratings that are produced by CMS and reserves the right to produce additional QRS scores from the CMS data for public release. QRS scores are based on surveys of both individual market and Covered California for Small Business Enrollees for those products offered in both marketplaces. Performance penalties will be calculated using the PMPM for individual market only. The Contractor will still be subject to an assessment of penalty or no penalty for Measurement Year 2021 (Plan Year 2023 QRS) if Covered California issues a rating score and CMS does not issue a rating score (as was done for Measurement Year 2019 (Plan Year 2021 QRS). However, if neither Covered California or CMS issues a rating score, then the Contractor will not be subject to an assessment of penalty or no penalty.	
Performance Standard	**Performance Requirements**

3.1	**Quality Rating System (QRS) – QHP Clinical Quality Management Summary Indicator Rating** 33.5% of At-Risk Amount	Expectation: QHP Clinical Quality Management Summary Indicator Rating (product type reporting): Performance Level: The rating score will be based on the QRS performance benchmarks supplied by CMS or adjusted, as appropriate, by Covered California. 1-2 Stars: **33.5% performance penalty**. 3-5 Stars: **no penalty**.
3.2	**Quality Rating System (QRS) QHP Enrollee Experience Summary Indicator Rating** 16.5% of At-Risk Amount	Expectation: QHP Enrollee Experience Summary Indicator Rating (product type reporting): Performance Level: The rating score will be based on the QRS performance benchmarks supplied by CMS or adjusted, as appropriate, by Covered California. 1-2 Stars: **16.5% performance penalty.** 3-5 Stars: **no penalty.**

Performance Standards with Penalties

Quality, Network Management and Delivery System Standards

Definitions for Performance Standards: 3.3 – 3.6
Measurement Year: The calendar year that activity being assessed is performed
Reporting Year: The calendar year that performance data is reported to Covered California
Assessment Year: The calendar year that performance data is evaluated, and Measurement Year performance level is determined

Performance Standard 3.3a)

3.3a) Reducing Health Disparities – Attachment 7, Article 1, Sections 1.01 and 1.02 – 7.5% of At-Risk Amount

Contractor will meet the target of eighty percent (80%) enrollee self-reported race or ethnicity data for Covered California Enrollees by year-end 2022. Contractor must demonstrate compliance by including valid race and ethnicity attributes for at least 80% of Covered California Enrollees in its Healthcare Evidence Initiative (HEI) data submissions.

Please note the following specifications:
a. See list of acceptable standard values in separate methodology document.
b. "Other", "mixed", "multi-racial", etc. values do apply toward meeting the 80% race and ethnicity thresholds.
c. "Null", "blank", "missing", "unknown", "not reported", "decline to state", etc. values DO NOT apply toward meeting the 80% race and ethnicity thresholds.

Performance Requirements 3.3a)

Measurement Year 2017	Measurement Year 2018	Measurement Year 2019	Measurement Year 2020	Measurement Year 2021	Measurement Year 2022
No Assessment for Measurement Year 2017.	Expectation: Meet 2018 intermediate milestone for self-reported racial or ethnic identify by the end of 2018. Performance Levels: Contractor achieves no improvement in self-reported identity from baseline: **2% penalty** Contractor shows improvement in self-	Expectation: Meet target of 80% self-reported racial or ethnic identify by the end of 2019. Performance Levels: Contractor achieves no improvement in self-reported identity from 2018 and does not meet 80% target: **2% penalty**	Expectation: Meet or continue to meet target of 80% self-reported racial or ethnic identity for Measurement Year 2020. Performance Levels: Contractor does not meet 80% target for self-reported identity: **2% penalty**	Expectation: Meet or continue to meet target of 80% self-reported racial or ethnic identity for Measurement Year 2021. Performance Levels: Contractor does not meet 80% target for self-reported	Expectation: Meet the target of 80% self-reported race or ethnic identity for Measurement Year 2022. Performance Levels: Contractor does not meet 80% target for self-reported identity for Covered California Enrollees: **7.5% penalty**

	reported identity, but does not meet incremental target by end of 2018: **No penalty** Contractor achieves incremental target for self-reported identity by end of 2018: **2% credit**	Contractor achieves improvement in self-reported identity, but does not meet 80% target: **No penalty** Contractor achieves 80% target for self-reported identity by end of 2019: **2% credit**	Contractor achieves 80% target for self-reported identity: **2% credit**	identity: **2% penalty** Contractor achieves 80% target for self-reported identity: **2% credit**	Contractor meets 80% target for self-reported identity for Covered California Enrollees: **no penalty**

Performance Standards with Penalties

Quality, Network Management and Delivery System Standards

Performance Standard 3.3b)

3.3b) Disparities Reduction Intervention – Attachment 7, Article 1, Sections 1.03 - 7.5% of At-Risk Amount

Contractor will demonstrate meaningful improvement for the selected disparity measure for the intervention population based on the mutually agreed upon intervention proposal and target improvement rate. Contractor must report progress, including analysis of outcomes and potential to scale or replicate intervention, through submission of an acceptable and approved disparities intervention progress report.

Performance Requirements 3.3b)

Measurement Year 2017	Measurement Year 2018	Measurement Year 2019	Measurement Year 2020	Measurement Year 2021	Measurement Year 2022
No Assessment for Measurement Year 2017	No Assessment for Measurement Year 2018	No Assessment for Measurement Year 2019	Performance Levels: Contractor does not select at least one disparity measure for reduction or does not meet mutually agreed upon milestone(s) selected for the 2020 disparity reduction target: **3% penalty** Contractor meets mutually agreed upon milestone(s) selected for the 2020 disparity target: **3% credit**	Performance Levels: Contractor does not meet mutually agreed upon milestone(s) selected for the 2021 disparity reduction target: **3% penalty** Contractor meets mutually agreed upon milestone(s) selected for the 2021 disparity target: **3% credit**	Performance Levels: Contractor submits progress reports AND Contractor does not meet target improvement rate in intervention population for identified disparity measure: **7.5% penalty** Contractor meets target improvement rate in intervention population for identified disparity measure: **no penalty**

Performance Standards 3.3c)

3.3c) Health Equity Capacity Building - Attachment 7, Article 1, Section 1.05 – 2% Credit

Contractor must achieve and maintain NCQA Multicultural Health Care Distinction (MHCD).

Performance Requirements 3.3c)

3.3c) Performance Level

Contractor demonstrates *early* compliance of NCQA Multicultural Health Care Distinction (MHCD) attainment (by December 30, 2022): **2% credit**

Performance Standards with Penalties

Quality, Network Management and Delivery System Standards

Performance Standard 3.4

3.4 Primary Care – Attachment 7, Article 7, Section 7.04
HMO Products: 10% of At-Risk Amount
PPO and EPO Products: 20% of At-Risk Amount

Contractor describes a payment strategy for adoption and progressive expansion of primary care payment models that provide the revenue necessary for Primary Care Providers (PCPs) to adopt accessible, data-driven, team-based care. The Contractor must progressively expand the number and percent of primary care clinicians paid through the HCP LAN APM categories of population-based payment (Category 4) and alternative payment models built on fee for service structure such as shared savings (Category 3) and meet a minimum threshold by end of Plan Year 2022.

Data from Measurement Year 2020 providing the percent of PCPs paid under the new payment strategy will be compared to Measurement Year 2019 data. Data from Measurement Year 2021 providing the percent of PCPs paid under the new payment strategy will be compared to Measurement Year 2020 data.

Performance requirements differ by product.

Performance Requirements 3.4

Measurement Year 2017	Measurement Year 2018	Measurement Year 2019	Measurement Year 2020	Measurement Year 2021	Measurement Year 2022
Expectation: Describe payment strategy and begin re-contracting by end of Plan Year 2017 Performance Levels: Contractor does not provide description of payment strategy or reports no PCPs contracted based on new payment strategy: **3% penalty**	Expectation: Describe payment strategy and begin re-contracting by end of Plan Year 2018. Performance Levels: Contractor does not provide description of payment strategy or reports no PCPs contracted based on new payment strategy**: 3% penalty** Contractor provides description of payment	Expectation: Describe payment strategy and begin re-contracting by end of Plan Year 2019. Performance Levels: Contractor does not provide description of payment strategy or reports no PCPs contracted based on new payment strategy: **3% penalty** Contractor provides description of payment	Expectation: Describe payment strategy and make further progress in re-contracting by end of Plan Year 2020. Performance Levels: Contractor reports no increase in the percentage of PCPs contracted under new payment strategy compared to Measurement Year 2019: **3% penalty**	Expectation: Describe payment strategy and make further progress in re-contracting by end of Plan Year 2021. Performance Levels: Contractor reports no increase in the percentage of PCPs contracted under new payment strategy compared to	Expectation: Contractor meets a minimum threshold of PCPs paid under HCP LAN APM Category 3 or Category 4 by end of Plan Year 2022. Performance Levels: HMO Products: Contractor demonstrates that 0 to <80% of PCPs are contracted under HCP

Contractor provides description of payment strategy and reports more than 0% but less than 10% of PCPs contracted under new payment strategy: **No penalty** Contractor provides description of payment strategy and reports 10% or more of PCPs contracted under new payment strategy: **3% credit**	strategy and reports more than 0% but less than 10% of PCPs contracted under new payment strategy: **No penalty** Contractor provides description of payment strategy and reports 10% or more of PCPs contracted under new payment strategy: **3% credit**	strategy and reports more than 0% but less than 10% of PCPs contracted under new payment strategy: **No penalty** Contractor provides description of payment strategy and reports 10% or more of PCPs contracted under new payment strategy: **3% credit**	Contractor reports an increase of more than 0% but less than 10% in the percentage of PCPs contracted under new payment strategy compared to Measurement Year 2019: **No penalty** Contractor reports an increase of 10% or more in the percentage of PCPs contracted under new payment strategy compared to Measurement Year 2019: **3% credit**	Measurement Year 2020: **3% penalty** Contractor reports an increase of more than 0% but less than 10% in the percentage of PCPs contracted under new payment strategy compared to Measurement Year 2020: **No penalty** Contractor reports an increase of 10% or more in the percentage of PCPs contracted under new payment strategy compared to Measurement Year 2020: **3% credit**	LAN APM Category 3 or Category 4: **10% penalty** Contractor demonstrates that between 80% and <90% of PCPs are contracted under HCP LAN APM Category 3 or Category 4: **5% penalty** Contractor demonstrates that between 90% and <95% of PCPs are contracted under HCP LAN APM Category 3 or Category 4: **2.5% penalty** Contractor demonstrates that ≥95% of PCPs are contracted under HCP LAN APM Category 3 or Category 4: **No penalty** <u>PPO and EPO Products:</u> Contractor demonstrates that 0 to <20% of PCPs are contracted under HCP LAN APM Category 3 or Category 4: **20% penalty**

					Contractor demonstrates that between 20% and <30% of PCPs are contracted under HCP LAN APM Category 3 or Category 4: **15% penalty** Contractor demonstrates that between 30% and <40% of PCPs are contracted under HCP LAN APM Category 3 or Category 4: **10% penalty** Contractor demonstrates that ≥40% of PCPs are contracted under HCP LAN APM Category 3 or Category 4: **No penalty**

Performance Standards with Penalties

Quality, Network Management and Delivery System Standards

Performance Standard 3.5

3.5 Accountable Care Organizations (ACOs) – Attachment 7, Article 8, Section 8.01
HMO Products: 10% of At-Risk Amount
PPO and EPO Products: 0% of At-Risk Amount

Contractor increases Covered California enrollment in ACOs (previously referred to as integrated healthcare models) and meets a minimum threshold for ACO enrollment by end of Plan Year 2022. An ACO is defined as a system of population-based care coordinated across the continuum including multidisciplinary physicians and physician groups, hospitals, and ancillary providers with combined risk sharing arrangements and incentives between the Contractor and providers.

Baseline identified from data reported in Measurement Year 2017 and 2018. Data from Measurement Year 2019 providing the percentage of Covered California membership in ACOs will be compared to baseline reported. Data from Measurement Year 2020 will be compared to Measurement Year 2019 data. Data from Measurement Year 2021 will be compared to Measurement Year 2020 data.

Performance requirements differ by product.

Performance Requirements 3.5

Measurement Year 2017	Measurement Year 2018	Measurement Year 2019	Measurement Year 2020	Measurement Year 2021	Measurement Year 2022
No Assessment for Plan Year 2017	No Assessment for Plan Year 2018	Expectation: Contractor increases the percentage of enrollment in IHMs by the end of 2019. Performance Levels: Contractor reports no increase in the percentage of membership attributed or assigned to IHMs: **5% penalty** Contractor reports an increase of more than	Expectation: Contractor increases the percentage of enrollment in ACOs by the end of 2020. Performance Levels: Contractor reports no increase in the percentage of membership attributed or assigned to ACOs compared to Measurement Year 2019: **5% penalty**	Expectation: Contractor increases the percentage of enrollment in ACOs by the end of 2021. Performance Levels: Contractor reports no increase in the percentage of membership attributed or assigned to ACOs compared to Measurement Year 2020: **5% penalty**	Expectation: Contractor meets a minimum threshold of enrollment in ACOs by the end of Plan Year 2022. Performance Levels: HMO Products: Contractor reports 0 to <60% of membership is attributed or assigned to ACOs: **10% penalty** Contractor reports 60 to <70% of membership is

		0% but less than 10% in membership attributed or assigned to IHMs: **No penalty** Contractor reports an increase of 10% or more in membership	Contractor reports an increase of more than 0% but less than 10% in membership attributed or assigned to ACOs compared to Measurement Year 2019: **No penalty**	Contractor reports an increase of more than 0% but less than 10% in membership attributed or assigned to ACOs compared to Measurement Year 2020: **No penalty**	attributed or assigned to ACOs: **5% penalty** Contractor reports 70 to <80% of membership is attributed or assigned to ACOs: **2.5% Penalty** Contractor reports ≥80% of membership is attributed or assigned to ACOs: **No penalty** <u>PPO and EPO Products</u>: Not applicable.

Performance Standards with Penalties

Quality, Network Management and Delivery System Standards

Performance Standard 3.6

3.6 Appropriate Use of C-Sections – Attachment 7, Article 10, Section 10.04 – 5% of At-Risk Amount

Contractor shall adopt a payment methodology progressively to include all contracted physicians and hospitals serving Enrollees, such that by year end 2022, payment is structured to support only medically necessary care and there is no financial incentive to perform C-sections. Smart Care California has outlined three payment strategies to align payment with medically necessary use of C-sections:

i. Adopt a blended case rate payment for both physicians and hospitals;
ii. Include a NTSV C-section metric in existing hospital and physician quality incentive programs; and
iii. Adopt population-based payment models, such as maternity episode payment models.

Contractor shall report on its strategy and progress on adoption of the payment strategy annually.

Performance Requirements 3.6

Measurement Year 2017	Measurement Year 2018	Measurement Year 2019	Measurement Year 2020	Measurement Year 2021	Measurement Year 2022
No Assessment for Plan Year 2017	No Assessment for Plan Year 2018	Expectation: All physicians and hospitals are re-contracted with new payment structure by the end of 2019. Performance Levels: Contractor is unable to demonstrate that >33% of physicians and >33% hospitals have been re-contracted to not incentivize NTSV C-section: **4.5% penalty** Contractor demonstrates that 33% to 66% of physicians and hospitals have	Expectation: All physicians and hospitals are re-contracted with new payment structure by the end of 2020. Performance Levels: Contractor is unable to demonstrate that >50% of physicians and >50% hospitals have been re-contracted to not incentivize NTSV C-section: **4.5% penalty** Contractor demonstrates that ≥50% to <80% of physicians and ≥50% to	Expectation: All physicians and hospitals are re-contracted with new payment structure by the end of 2021. Performance Levels: Contractor is unable to demonstrate that >50% of physicians and >50% of hospitals have been re-contracted to not incentivize NTSV C-section: **4.5% penalty** Contractor demonstrates that ≥50% to <80% of physicians and ≥50% to <80% of hospitals have been re-contracted to not	Expectation: All physicians and hospitals are re-contracted with new payment structure by the end of 2022. Performance Levels: Contractor demonstrates that 0 to <25% of physicians and 0 to <25% of hospitals have been re-contracted to not incentivize NTSV C-section: **5% penalty** Contractor demonstrates that between 25% and <50% of physicians and between 25% and <50% of hospitals have been re-contracted to not

		been re-contracted to not incentivize NTSV C-section: **No penalty** Contractor demonstrates that >66% of physicians and hospitals have been re-contracted to not incentivize NTSV C-section: **4.5% credit**	<80% of hospitals have been re-contracted to not incentivize NTSV C-sections: **No penalty** Contractor demonstrates that ≥80% of physicians and hospitals have been re-contracted to not incentivize NTSV C-sections: **4.5% credit**	incentivize NTSV C-sections: **No penalty** Contractor demonstrates that ≥80% of physicians and hospitals have been re-contracted to not incentivize NTSV C-sections: **4.5% credit**	incentivize NTSV C-section: **3% penalty** Contractor demonstrates that between 50% and <75% of physicians and between 50% and <75% of hospitals have been re-contracted to not incentivize NTSV C-section: **1.5% penalty** Contractor demonstrates that ≥75% of physicians and ≥75% hospitals have been re-contracted to not incentivize NTSV C-sections: **No penalty**

Performance Standards with Penalties

Dental Quality Alliance (DQA) Pediatric Measure Set

Pilot Period: January 1, 2021 – December 31, 2022

Contractor must annually report on the following Performance Standards for embedded pediatric dental for each plan year. Contractor must submit this report by April 30th of the following calendar year.

Measure		Description	Numerator	Denominator	QDP Performance Rate	Expectation
4.1	Utilization of Services	Percentage of all enrolled children aged 0 - 1 who received at least one dental service within the reporting year.	Unduplicated number of enrolled children aged 0 – 1 who received at least one dental service.	Unduplicated number of all enrolled children aged .0 - 1	NUM/DEN	10%
4.2	Utilization of Services	Percentage of all enrolled children aged 2 – under age 19 who received at least one dental service within the reporting year.	Unduplicated number of enrolled children aged 2 – under 19 who received at least one dental service.	Unduplicated number of all enrolled children aged 2 – under age 19.	NUM/DEN	50%
4.3	Oral Evaluation	Percentage of enrolled children under age 19 who received a comprehensive or periodic oral evaluation within the reporting year.	Unduplicated number of enrolled children under age 19 who received a comprehensive or periodic oral evaluation as a dental service.	Unduplicated number of enrolled children under age19.	NUM/DEN	50%
4.4	Sealants in 10 year olds	Percentage of enrolled children, who have ever received sealants on a permanent first molar tooth: (1) at least one sealant and (2) all four molars sealed by 10th birthdate.	Unduplicated number of enrolled children who ever received sealants on a permanent first molar tooth: (1) at least one sealant and (2) all four molars sealed.	Unduplicated number of enrolled children with their 10th birthdate in measurement year. Exclude children who received treatment (restorations, extractions, endodontic, prosthodontic, and other dental treatments)	NUM1/DEN; NUM2/DEN (after exclusions)	40%

Performance Standards with Penalties

Dental Quality Alliance (DQA) Pediatric Measure Set

Pilot Period: January 1, 2021 – December 31, 2022

Contractor must annually report on the following Performance Standards for embedded pediatric dental for each plan year. Contractor must submit this report by April 30th of the following calendar year.

Measure		Description	Numerator	Denominator	QDP Performance Rate	Expectation
				on all four first permanent molars in the 48 months prior to the 10th birthdate.		
4.5	Sealants in 15 year olds	Percentage of enrolled children, who have ever received sealants on a permanent second molar tooth: (1) at least one sealant and (2) all four molars sealed by the 15th birthdate.	Unduplicated number of enrolled children who ever received sealants on a permanent second molar tooth: (1) at least one sealant and (2) all four molars sealed.	Unduplicated number of enrolled children with their 15th birthdate in measurement year. Exclude children who received treatment (restorations, extractions, endodontic, prosthodontic, and other dental treatments) on all four second permanent molars in the 48 months prior to the 15th birthdate.	NUM1/DEN; Num2/DEN (after exclusions)	40%

Performance Standards with Penalties

Dental Quality Alliance (DQA) Pediatric Measure Set

Pilot Period: January 1, 2021 – December 31, 2022

Contractor must annually report on the following Performance Standards for embedded pediatric dental for each plan year. Contractor must submit this report by April 30th of the following calendar year.

Measure		Description	Numerator	Denominator	QDP Performance Rate	Expectation
4.6	Topical Fluoride for Children at Elevated Caries Risk	Percentage of enrolled children aged 1-18 years who are at "elevated" risk (i.e. "moderate" or "high") who received at least 2 topical fluoride applications within the reporting year.	Unduplicated number of enrolled children aged 1-18 years who are at "elevated" risk (i.e. "moderate" or "high") who received at least 2 topical fluoride applications as a dental service.	Unduplicated number of enrolled children aged 1-18 years at "elevated" risk (i.e. "moderate" or "high").	NUM/DEN	50%
4.7	Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children	Number of emergency department (ED) visits for caries-related reasons per 100,000 member months for all enrolled children.	Number of ED visits with caries-related diagnosis code among all enrolled children.	All member months for enrollees 0 through 18 years during the reporting year.	(NUM/DEN) x 100,000	Monitoring until claims data is received

Performance Standards with Penalties

Dental Quality Alliance (DQA) Pediatric Measure Set

Pilot Period: January 1, 2021 – December 31, 2022

Contractor must annually report on the following Performance Standards for embedded pediatric dental for each plan year. Contractor must submit this report by April 30th of the following calendar year.

Measure		Description	Numerator	Denominator	QDP Performance Rate	Expectation
4.8	Follow-Up After ED Visit by Children for Dental Caries	The percentage of caries-related emergency department visits among children 0 through 18 years in the reporting year for which the member visited a dentist within 7 days of the ED visit.	Number of caries-related ED visits in the reporting year for which the member visited a dentist within 7 days (NUM) of the ED visit.	Number of caries-related ED visits in the reporting year.	NUM/DEN	Monitoring until claims data is received
4.9	Follow-Up After ED Visit by Children for Dental Caries	The percentage of caries-related emergency department visits among children 0 through 18 years in the reporting year for which the member visited a dentist within 30 days of the ED visit.	Number of caries-related ED visits in the reporting year for which the member visited a dentist within 30 days (NUM) of the ED visit.	Number of caries-related ED visits in the reporting year.	NUM/DEN	Monitoring until claims data is received