COVERED CALIFORNIA POLICY AND ACTION ITEMS

January 19, 2023 Board Meeting

AVERAGE STATEWIDE MONTHLY PREMIUM PERMANENT REGULATIONS

Katie Ravel
Director
Policy, Eligibility, and Research Division

OVERVIEW

- Proposition 22 requires app-based network companies (Uber, Lyft, etc.) to provide a healthcare stipend to qualifying app-based drivers, on a quarterly basis, based on certain criteria.
- The stipend amount is tied to the average statewide monthly premium for an individual Covered California bronze health insurance plan.
- Covered California must post the average statewide monthly premium for a bronze plan annually.

AVERAGE STATEWIDE MONTHLY BRONZE PREMIUM AND CALCULATION METHODOLOGY

- On or before **September 1 annually**, Covered California must publish the average statewide monthly premium for an individual for the following calendar year for a Covered California bronze health insurance plan.
- The stipend is tied to the “average ACA contribution” of the posted premium, defined as 82% of the premium.
- The average statewide monthly bronze premium is based on the average bronze premium for a 21-year old published by Covered California for the individual mandate penalty, adjusted by the average age of Covered California enrollees.

REQUESTED ACTION: AVERAGE STATEWIDE MONTHLY PREMIUM

- Covered California adopted emergency regulations in March 2021 to specify the methodology for calculating the average statewide monthly bronze premium.
  - The average statewide bronze premium calculated when determining California's Individual Shared Responsibility Penalty pursuant to section 61015, subdivision (a)(2) of the Revenue and Taxation Code multiplied by the average age rating factor for individuals enrolled in Covered California in the prior calendar year.
- No changes have been made to the regulatory text.
- Staff request Board approval to take the final administrative actions to make the emergency regulations permanent.

PUBLIC COMMENT

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

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

EACH CALLER WILL BE LIMITED TO TWO MINUTES PER AGENDA ITEM

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

2024 QUALIFIED HEALTH PLAN CONTRACT AND CERTIFICATION PROCESS

2024-26 QUALIFIED DENTAL PLAN ISSUER MODEL CONTRACT

James DeBenedetti
Director, Plan Management Division

Taylor Priestley MPH, MSW
Deputy Director, Health Equity and Quality Transformation Division

DENTAL PROGRAM OVERVIEW

James DeBenedetti
Director, Plan Management Division

QUALIFIED DENTAL PLAN CONTRACTING

- Adult dental is not an EHB under the ACA
  - Not subject to a benchmark plan
  - No Actuarial Value (AV) requirement
  - No maximum out-of-pocket limit
  - Voluntary purchase
  - No financial assistance available to purchase benefits
- Standalone dental plans and adult dental benefits are not subject to many of the ACA market reforms, although Covered California extends these consumer protections to the Qualified Dental Plans (QDPs) by contract.
- Covered California balances benefit richness and consumer protections by contract with price sensitivity and potential burden on participating dental plans to maintain adequate and meaningful choice and coverage for adult dental consumers.

QUALIFIED DENTAL PLANS

- First offered for plan year 2016
- QDP issuers offer Family Dental Plans that combine child and adult dental benefits
  - Adults can enroll without enrolling children into Family Dental Plans
  - If a family enrolls one child, they must enroll all children and at least one adult
- QDPs must include pediatric EHB to be certified and offered by Covered California
  - California pediatric dental EHB benchmark plan is DHCS' 2014 children's dental benefit
- APTC cannot be applied
- Family Dental Plans only available during Open Enrollment, Special Enrollment, and after a Qualified Health Plan has been selected, per Covered California policy
- Federal ACA permits Qualified Health Plan (QHP) issuers not to offer children's dental benefit if standalone dental plans are also offered
  - All Individual Market QHPs include pediatric dental benefits
  - Pediatric dental commonly offered by QHP issuer subcontract

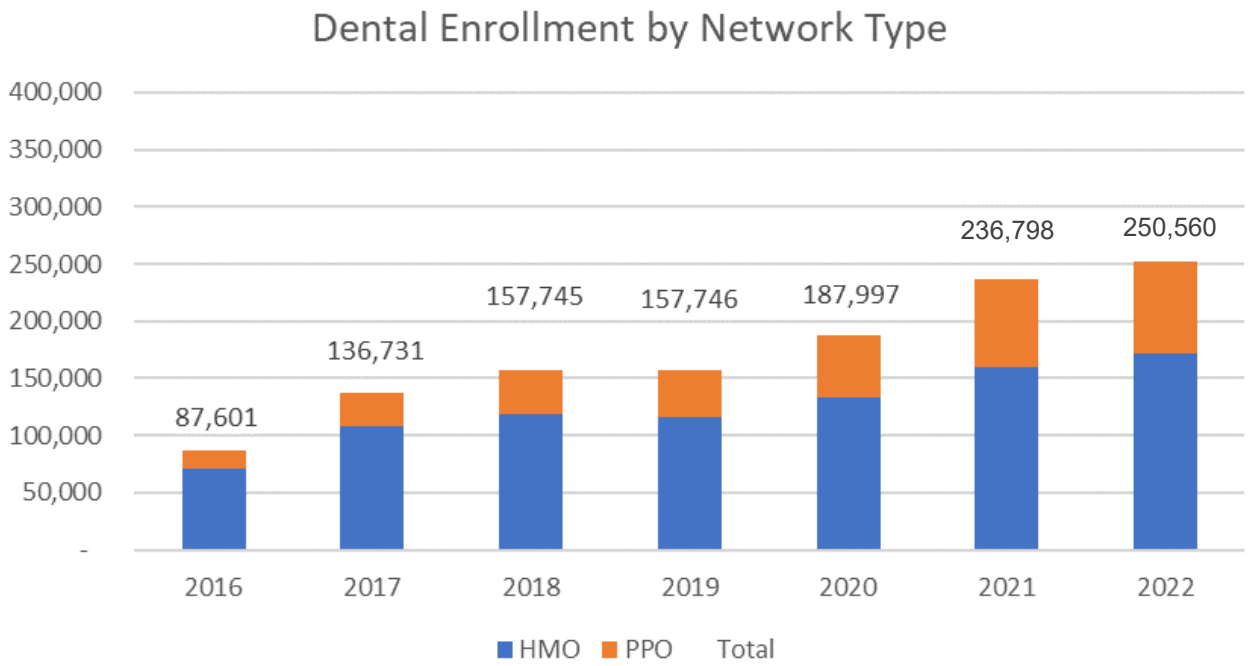
2023 DENTAL PLANS

Issuer Name	Total Enrollees
Anthem Blue Cross	28,334
Blue Shield	53,338
California Dental Network, Inc.	27,032
Delta Dental	120,532
Dental Health Services	1,559
Liberty	19,565
Total*	**250,360**

*As of December 31, 2022

QUALIFIED DENTAL PLAN ENROLLMENT GROWTH

QDP Enrollment Growth, 2016-2022

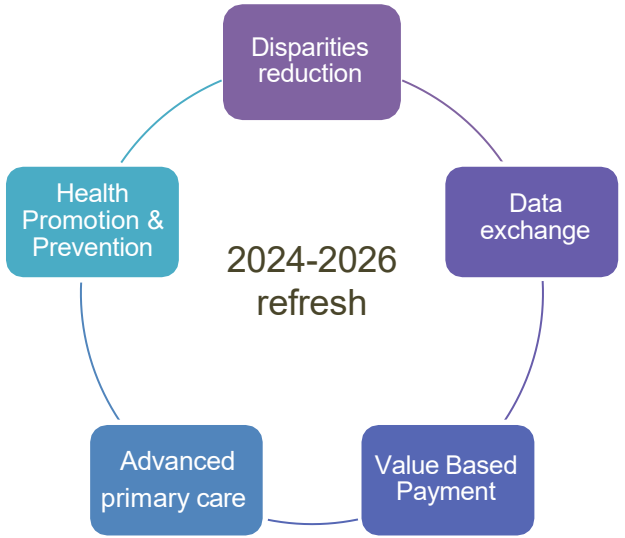


Source: CalHEERS, as of December 31, 2022
Enrollment status is "enrolled" (pending & terminated statuses are excluded)

CONTRACTING PRINCIPLES AND DENTAL STRATEGIC FOCUS AREAS

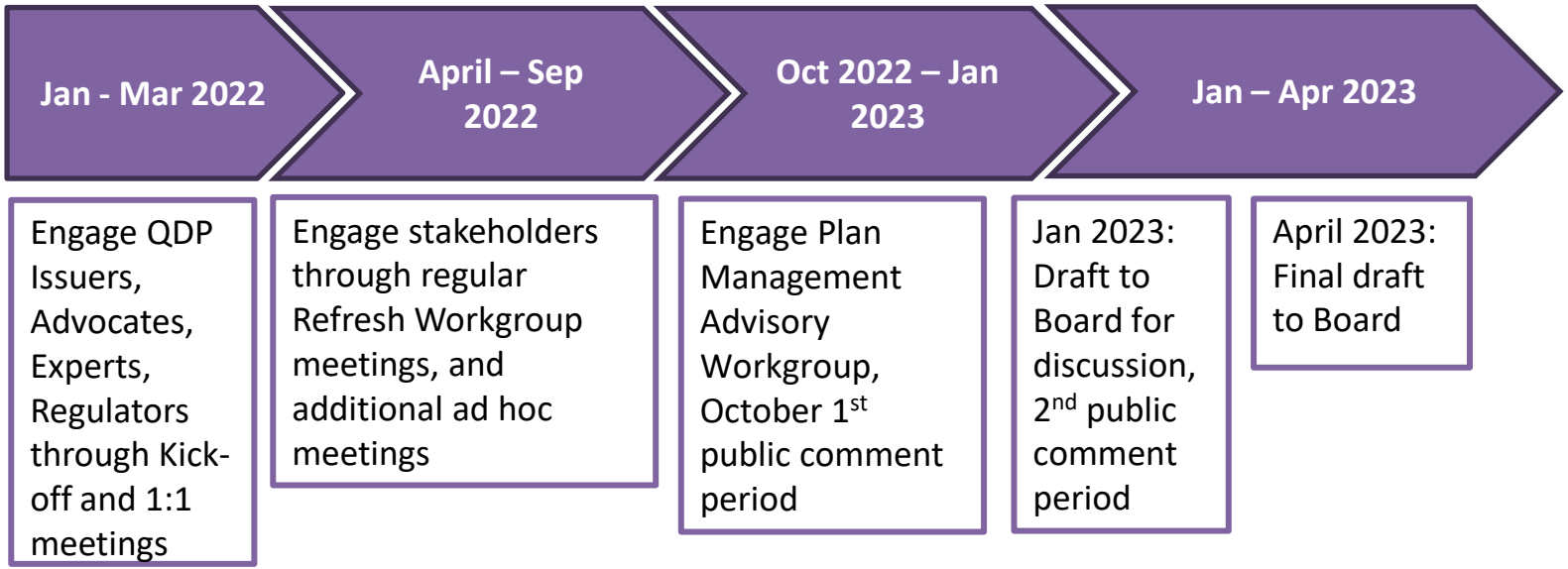
- Quality is central
- Equity is quality
- Measures that matter
- Make quality count
- Amplify through alignment
- Promote public good
- Care about cost

STRATEGIC FOCUS AREAS



Alignment with the Department of Healthcare Services (DHCS) Data analytics / Healthcare Evidence Initiative

2024 – 2026 QDP ISSUER MODEL CONTRACT DEVELOPMENT TIMELINE



2024-26 DENTAL CONTRACT REFRESH

Taylor Priestley MPH, MSW
Deputy Director
Health Equity and Quality Transformation Division

STAKEHOLDER ENGAGEMENT

Covered California began the work of developing quality and equity initiatives for the 2024-2026 QDP Issuer Model Contract Refresh in January 2022.

- Conducted kick-off meetings with all QDP carriers, DHCS, California Dental Association (CDA), regulators, consumer advocates, dental clinical and policy experts to communicate our QDP refresh approach, proposed framework and principles, then held individual meetings with each QDP carrier.
- Discussed focus areas and proposed changes to Attachments 1, 2, and 3. We engaged and obtained feedback from stakeholders through monthly Refresh Workgroup meetings.
- First public comment period from 10/13/22 – 11/11/22; responses to comments and revised Model Contract released for a second public comment period on January 12th, 2023.

STAKEHOLDER FEEDBACK

Principles and Strategic Focus Areas

- The right foundational strategies and priorities were identified by Covered California, but there are dental industry limitations in technology and collection of reliable data, particularly encounter data
- Any increase in administrative cost translates into an increase in premiums

Dental Utilization and Quality Measurement

- Prioritize efforts to increase encounter data collection, monitor data quality, focus on health promotion, prevention, and utilization as foundational efforts
- Select measures with strong evidence base, validity, administrative simplicity to collect, and amenable to current dental plan capacity of improvement efforts
- Nearly universal support for a focused, parsimonious set of performance measures
- Dental Quality Alliance (DQA) measures nationally recognized and widely used by dental plans and providers

PROPOSED 2024-2026 QUALITY DENTAL PLAN MODEL CONTRACT UPDATES

Section	QDP Model Contract Updates
5.2.1 (b) General Requirements	▪ Contractor shall take steps to foster a culture of equity within its dental plan operations and through its Participating Providers. ▪ Contractor shall maintain a disparities reduction program including collection of Enrollee demographic data, stratification of quality measures by demographic factors, and implementation and evaluation of interventions to reduce health disparities.
5.2.2 Payment Obligations for Quality and Health Equity Performance	▪ The maximum payment obligations collectively are 1% of Contractor's total annual Gross Premium per product as specified in Attachment 2 — Performance Standards with Penalties.

PROPOSED 2024-2026 QUALITY DENTAL PLAN MODEL CONTRACT UPDATES

Section	QDP Model Contract Updates
7.2 Corrective Action Plan (CAP)	▪ In the event Contractor fails to meet any of Contractor's Performance Standards, Contractor shall develop a Corrective Action Plan (CAP), that will specify steps necessary to resolve identified issues related to its failure to meet Contractor's Performance Standards. Contractor agrees to implement the CAP within ninety (90) Days.
7.4 Patterns of Noncompliance	▪ Covered California may consider Contractor's patterns of noncompliance with Contractor's Performance Standards, including repeated necessity for CAPs, as part of its annual Recertification and Decertification process.

PROPOSED QUALIFIED DENTAL PLAN ATTACHMENT 1 CONTRACTUAL REQUIREMENTS

Article 1 - Equity and Disparities Reduction

- Annual progress report describing efforts to establish or expand the infrastructure to successfully identify, monitor, and reduce disparities.

Article 2 - Population Health

- Submit a population assessment plan

Article 3 - Health Promotion and Prevention

- Actively outreach, engage, and educate enrollees on member benefits and cost-sharing, provider location and matching, and health assessments
- Conduct tailored outreach and education based on identified needs or health status

Article 4 - Delivery System and Payment Strategies to Drive Quality

- DHMO issuers required to report and implement primary dentist assignment
- Report provider payment type by HCP LAN APM category
- Report teledentistry offerings and utilization
- Report participation in dental collaboratives or initiatives

Article 5 - Measurement and Data Sharing

- Healthcare Evidence Initiative (HEI) data submission and participation

QDP ATTACHMENT 2 & 3 OVERVIEW

Propose change from 5% of participation fee to 1% of gross premium at risk for Attachment 2 - Performance Standards with Penalties

Attachment 2 - Performance Standards with Penalties:

Previously Attachment 14 Performance Standards

- Performance standards and penalties proposed reflect contract refresh priorities of improving dental care equity and quality, with data as a key driver

Attachment 3 - Performance Standards and Expectations:

Previously Attachment 14 Performance Standards

- Self-reported Customer Service Standards move to Attachment 3, performance publicly reported
- Operational Performance Standards move to Attachment 3, performance publicly reported
- Dental Loss Ratio – Expectation of 50% for all products

PROPOSED QDP ATTACHMENT 2 OVERVIEW

Performance Area	Performance Standards with Penalties	% of At-Risk 2024	% of At-Risk 2025	% of At-Risk 2026
Data Submission 50%	1.1 HEI; Incomplete, irregular, late or non-useable submission	15%	15%	15%
	1.2 HEI; Allowed amount total varies by more than plus or minus 2%	10%	10%	10%
	1.3 HEI; Rendering provider taxonomy and type missing/invalid	10%	10%	10%
	1.4 HEI; Rendering NPI and TIN missing/invalid	10%	10%	10%
	2. Provider Directory	5%	5%	5%
Oral Health 50%	3. Oral Evaluation, Dental Services for Children	10%	10%	10%
	4. Topical Fluoride for Children	10%	10%	10%
	5. Sealant Receipt on Permanent First Molars for Children	10%	10%	10%
	6. Preventive Services Utilization for Adults	20%	20%	20%
Total		100%	100%	100%

Covered California is continuing work to prepare the Adult Preventive Services measure specification inclusive of CDT codes.

*The total amount at risk for Contractor's failure to meet the Performance Standards is equal to 1.0% of the total Gross Premium for the applicable Plan Year (At-Risk Amount).

PROPOSED ATTACHMENT 2 ORAL HEALTH MEASURES PERFORMANCE STANDARDS

Measurement Year 2024	Measurement Year 2025	Measurement Year 2026
Contractor establishes a baseline rate for this measure using HEI data. Contractor does not establish baseline rate: 10% penalty Contractor establishes baseline rate of 0% or more: no penalty	Contractor demonstrates an increase of less than 10% over the baseline rate: 10% penalty Contractor demonstrates (a) an increase of 10% or more over the baseline rate or (b) if the baseline rate is 0%, demonstrates an absolute rate of at least 10%: no penalty	Contractor demonstrates an increase of less than 10% over prior year: 10% penalty Contractor demonstrates an increase of 10% or more over prior year: no penalty

2024 QUALIFIED HEALTH PLAN ISSUER MODEL CONTRACT UPDATE

James DeBenedetti
Director
Plan Management Division

2024 MODEL CONTRACT UPDATE

- Qualified Health Plan Issuer Model Contracts for the Individual and Small Business markets were significantly refreshed last year for the 2023-25 period.
- Proposed changes for the 2024 Individual and Small Business contracts are minor (primarily for purposes of clarification) outside of Attachments 1, 2, and 4.
- Responses to comments received on the initial proposed changes to the Individual and Small Business contracts have been posted at: https://hbex.coveredca.com/stakeholders/plan-management/

2024 PLAN YEAR AMENDMENT ATTACHMENTS 1, 2, AND 4

Taylor Priestley MPH, MSW
Deputy Director
Health Equity and Quality Transformation Division

PLAN YEAR 2024 AMENDMENT APPROACH

- Covered California is proposing several revisions within the Plan Year 2024 Attachment 1, Attachment 2, and Attachment 4 amendment to clarify or add to the 2023 contract requirements

- Covered California's approach to the Plan Year 2024 amendment includes:
  - Proposing revisions consistent with Covered California’s key priority areas for the 2023-2025 contract refresh
  - Adjusting requirements to reduce administrative burden on providers and health plans where feasible
  - Prioritizing use of standard measures when available
  - Implementing revisions that were previewed during the 2023-2025 contract refresh development
  - Further alignment with other public purchasers and organizations, especially DHCS, CalPERS, and NCQA

- Covered California solicited public comments on proposed revisions through a round public comments in November 2022

SUMMARY OF PROPOSED 2024 REVISIONS

Attachment 1: Advancing Equity, Quality, and Value

- Adding requirements to demonstrate provision of culturally and linguistically competent care
- Adding requirements for behavioral health subcontractor oversight and accountability
- Adjusting social needs screening measure and reporting
- Revising Healthcare Evidence Initiative (HEI) measures based on learnings from ongoing HEI work

Attachment 2: Performance Standards with Penalties

- Implementing performance standards for Patient Level Data file submission completeness and accuracy
- Defining oral health performance standards using standard measures

Attachment 4: Quality Transformation Initiative

- Specifying distribution of percent at risk between Attachment 2 and Attachment 4 for Plan Year 2024

2023-2025 CONTRACT
ATTACHMENT 1: ADVANCING EQUITY, QUALITY, AND VALUE

Attachment 1 Article	Summary of Requirements
Article 1: Equity and Disparities Reduction	• Collect race, ethnicity, and language demographic data • Submit quality measure data stratified by race and ethnicity • Implement disparities interventions and meet a multi-year disparities reduction target • Achieve NCQA Health Equity Accreditation by year end 2023
Article 2: Behavioral Health	• Promote access to behavioral health services; offer telehealth for behavioral health • Collect Depression Screening and Follow-Up measure results • Implement policies and programs to promote the appropriate use of opioids • Promote the integration of behavioral health services with primary care services
Article 3: Population Health	• Submit population health management plans • Conduct prevention efforts including tobacco cessation and diabetes prevention • Screen enrollees for food insecurity and support linkages to appropriate social services
Article 4: Delivery System and Payment Strategies to Drive Quality	• Match all enrollees to a PCP; increase value-based payment models for PCPs • Report on enrollment in IDSs or ACOs; measure and report on performance • Track provider organization and hospital quality and costs and report on improvement efforts • Monitor maternal health disparities and report on intervention efforts
Article 5: Measurement and Data Sharing	• Participate in QRS and submit QRS measure results to Covered California • Submit data to Covered California for the Healthcare Evidence Initiative (HEI) • Participate in a Health Information Exchange (HIE) • Submit data to the Integrated Healthcare Association (IHA)
Article 6: Accreditation	• Achieve NCQA health plan accreditation by year end 2024

2024 PROPOSED REVISIONS
ATTACHMENT 1: ADVANCING EQUITY, QUALITY, AND VALUE

Attachment 1 Article	Summary of Revisions
Article 1: Equity and Disparities Reduction	• Added requirements to demonstrate provision of culturally and linguistically competent care
Article 2: Behavioral Health	• Added requirements for behavioral health subcontractor oversight and accountability
Article 3: Population Health	• Adjusting social needs screening measure and reporting
Article 4: Delivery System and Payment Strategies to Drive Quality	• No changes proposed
Article 5: Measurement and Data Sharing	• No changes proposed
Article 6: Accreditation	• No changes proposed

ATTACHMENT 2: PERFORMANCE STANDARDS WITH PENALTIES

- Attachment 2 - Performance Standards with Penalties captures performance standards in the areas of health disparities, payment strategies, enrollee experience, data quality and completeness, and oral health, that are critical to Covered California meeting its mission
- For 2023 and 2024, Performance Standards with Penalties, the total amount at risk is 0.2% of premium

2024 PROPOSED REVISIONS FOR ATTACHMENT 2: PERFORMANCE STANDARDS WITH PENALTIES (1 OF 2)

Performance Standards With Penalties	2023 % at Risk	Proposed 2024 % at Risk	Proposed 2024 Change and Rationale
1. Reducing Health Disparities: Demographic Data Collection – Enrollee Race and Ethnicity Self-Identification	10%	5%	*No proposed changes*
2. Reducing Health Disparities: Demographic Data Collection – Spoken and Written Language	10% (for reporting)	5%	Revised to 5% total penalty for spoken **or** written language
3. Reducing Health Disparities: Disparities Reduction Intervention	10%	10%	*No proposed changes*
4. National Committee for Quality Assurance (NCQA) Health Equity Accreditation	0%	10%	*No proposed changes*
5. Primary Care Payment	10%	10%	*No proposed changes*
6. Primary Care Spend	10% (for reporting)	5%	*No proposed changes*
7. Payment to Support Networks Based on Value	10% (for reporting)	10%	*No proposed changes*
8. Quality Rating System – QHP Enrollee Survey Summary Rating	20%	20%	*No proposed changes*

Where applicable, scores are provided per product, and penalties are weighted based on the enrollment in each product.

2024 PROPOSED REVISIONS FOR ATTACHMENT 2: PERFORMANCE STANDARDS WITH PENALTIES (2 OF 2)

Performance Standards With Penalties	2023 % at Risk	Proposed 2024 % at Risk	Proposed 2024 Change and Rationale
9. HEI Data Submission	20%	20%	Added patient level data (PLD) submission standards to ensure complete and accurate submissions; updated refence list of California healthcare facilities
~~10. Dental Quality Alliance (DQA) Pediatric Measure Set~~	~~0%~~	~~5%~~	Removed to add measure-specific oral health performance standards aligned with DHCS priority measures and recently added non-QRS HEDIS measures
10. Oral Evaluation, Dental Services (OEV-CH-A) (NQF #2517) (Pediatric)	0%	2.5%	
11. Topical Fluoride for Children, Dental Services (TFL-CH-A) (NQF #2528) (Pediatric)	0%	2.5%	
Total	**100%**	**100%**	

Where applicable, scores are provided per product, and penalties are weighted based on the enrollment in each product.

2024 PROPOSED REVISIONS
ATTACHMENT 4: QUALITY TRANSFORMATION INITIATIVE

	2023 Percent at Risk	Proposed 2024 Percent at Risk
Attachment 2 – Performance Standards with Penalties	0.2% at risk	0.2% at risk
Attachment 4 – Quality Transformation Initiative (QTI)	0.8% at risk	1.8% at risk
Total	1%	2%

- The Quality Transformation Initiative (QTI) places a percent of health plan premium at-risk based performance on four core QTI measures tied to quality payments
- Covered California will continue to increase the total percent at-risk for Attachment 2 and Attachment 4 by 1% per year up to 4% maximum as described in the 2023-2025 QHP issuer model contract
- Covered California will consider an alternate distribution between Attachment 2 and Attachment 4 for 2025 with more advanced notice to plans

2024 QUALIFIED HEALTH PLAN CERTIFICATION

James DeBenedetti
Director, Plan Management Division

2024 APPLICATION PROCESS

Qualified Health Plans (QHP)

Currently contracted QHPs will have greatly reduced application response requirements. New entrants must complete the entire application.

Qualified Dental Plans (QDP)

The dental applications have been reorganized, edited for clarity, and updated to reflect equity and quality focus areas and proposed contractual requirements. All dental Issuers will be treated as new entrants for 2024 and must complete the entire application.

Plan Year 2024 Certification will be open to any applicant

CERTIFICATION SELECTION CRITERIA

Covered California's Board of Directors sets guidelines for the selection and oversight of Qualified Health Plans. These guidelines are:

- Promote Affordability and Value for the Consumer – Both in Premiums and at Point of Care
- Encourage Competition Based upon Quality
- Encourage Competition Based upon the Populations Served
- Encourage Competition Based upon Meaningful QHP Choice and Product Differentiation: Patient-Centered Benefit Plan Designs
- Encourage Competition throughout the State
- Encourage Delivery System Improvement, Effective Prevention Programs and Payment Reform
- Demonstrate Administrative Capability and Financial Solvency
- Encourage Robust Customer Service

DRAFT APPLICATION STATUS

- 2024 draft applications with crosswalks to the 2023 version were posted on Tuesday, 11/22/22 with public comments due back by Friday, 12/9/22.
- Outside of the quality and equity sections, changes mainly consisted of moving sections and questions or rewriting for clarity.
- The Plan Management and Health Equity and Quality Transformation Divisions received 75 public comments across the four Applications. Over half of the comments were regarding the equity and quality questions.
- Questions 16.7 (IND) / 15.7 (CCSB) have been added to the dental applications requiring QDPs to submit Dental Benefits and Coverage Disclosure Matrices. For DMHC's requirements, visit: www.dmhc.ca.gov. See Rule 1300.63.4(c)(1).
- The Public Comment Summary is available at: https://hbex.coveredca.com/stakeholders/plan-management/qhp-certification/

PROPOSED PY2024 CERTIFICATION MILESTONES

Release Draft 2024 QHP & QDP Certification Applications	December 2022
Draft Application Comment Periods End	December 2022
Plan Management Advisory: Benefit Design & Certification Policy Recommendation	January 2023
January Board Meeting: Discussion of Benefit Design & Certification Policy Recommendation	January 2023
Letters of Intent Accepted	February 1-15, 2023
Final AV Calculator Released*	February 2023
Applicant Trainings (electronic submission software, SERFF submission and templates*)	February 2023
March Board Meeting: Anticipated approval of 2024 Patient-Centered Benefit Plan Designs & Certification Policy	March 2023
QHP & QDP Applications Open	March 1, 2023
QHP & QDP Application Responses (Individual and CCSB) Due	April 28, 2023
Evaluation of QHP Responses & Negotiation Prep	May – June 2023
QHP Negotiations	June 2023
QHP Preliminary Rates Announcement	July 2023
Regulatory Rate Review Begins (QHP Individual Marketplace)	July 2023
Evaluation of QDP Responses & Negotiation Prep	June – July 2023
QDP Negotiations	July 2023
CCSB QHP Rates Due	July 2023
QDP Rates Announcement (no regulatory rate review)	August 2023
Public Posting of Proposed Rates	July 2023
Public Posting of Final Rates	September – October 2023

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

PUBLIC COMMENT

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

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PLANNING FOR THE END OF THE MEDICAID CONTINUOUS COVERAGE REQUIREMENT

Yingjia Huang
Assistant Deputy Director
Department of Health Care Services
&
Covered California Team

CONTEXT AND PRESENTATION OVERVIEW

- Medicaid redeterminations have been paused since March 2020 due to the COVID-19 pandemic.
- Enrollment in Medi-Cal enrollment has grown by over 2 million enrollees since the pandemic started.
- Medi-Cal redeterminations will begin in April and span a 14-month period.
- Over the last year, Covered California and the Department of Health Care Services have partnered closely to develop an auto-enrollment program for individuals losing Medi-Cal and gaining eligibility for subsidized coverage through Covered California (under the authority of Senate Bill 260).
- Today's presentation will highlight the planning and partnership of our departments to create a successful "unwinding" of the Medicaid continuous coverage requirement and launch of the Covered California auto-enrollment program.

DHCS MEDI-CAL CONTINUOUS COVERAGE UNWINDING

Yingjia Huang
Assistant Deputy Director
Health Care Benefits and Eligibility
Department of Health Care Services

January 2023

DHCS

CONSOLIDATED APPROPRIATIONS ACT OF 2023

- On December 29, 2022, President Biden signed into law the Consolidated Appropriations Act of 2023 which delinked the continuous coverage requirement from the public health emergency and established a March 31, 2023 end date to the continuous coverage requirement.
- When continuous coverage requirements end, states will need to conduct a full redetermination for all beneficiaries who would have otherwise been subject to redetermination
- As a result of the Consolidated Appropriations Act of 2023, CMS released updated guidance in a Centers for Medicaid and CHIP Services (CMCS) Informational Bulletin on January 5, 2023 that maintains the applicability of the unwinding rules from previous CMS guidance

DHCS MEDI-CAL COVID-19 PHE AND CONTINUOUS COVERAGE OPERATIONAL UNWINDING PLAN

- The Medi-Cal COVID-19 PHE and Continuous Coverage Unwinding Plan was originally released in May 2022 and last updated January 13, 2023 to incorporate policy changes as a result of the federal Consolidated Appropriations Act of 2023 and corresponding guidance released from CMS.

- **The plan includes two main components:**
  - **Part 1: Unwinding Medi-Cal Program Flexibilities**
    - Details PHE-related non-eligibility flexibilities obtained during the PHE that DHCS has already made permanent, seeks to make permanent, or will expire at the end of the PHE.
  - **Part 2: Resumption of Normal Medi-Cal Redetermination Operations**
    - Overviews the DHCS guiding principles and implementation approach for redeterminations, retention strategies, federal eligibility flexibilities, outreach, county/system readiness, and data reporting.

RESUMING NORMAL BUSINESS OPERATIONS

- When the continuous coverage requirement ends, counties will process annual renewals on the beneficiaries next normally scheduled annual renewal date.
- Counties will begin renewal activities on **April 1, 2023** for beneficiaries with a **June 2023** renewal date.
  - The first Medi-Cal discontinuances will occur **July 1, 2023.**
  - A detailed sequencing of annual renewal processing during the Continuous Coverage Unwinding is included in the Medi-Cal COVID-19 PHE and Continuous Coverage Operational Unwinding Plan.

CONTINUOUS COVERAGE FOR YOUNG ADULTS

- As enacted by Senate Bill 184 (Chapter 47, Statutes of 2022), California will implement state- funded full scope Medi-Cal to individuals age 26 through 49, regardless of immigration status if otherwise eligible beginning on January 1, 2024.
- Once Medi-Cal redeterminations begin at the end of the COVID-19 PHE, this population will most likely be determined ineligible for state-funded full scope Medi-Cal due to their age.
- To maintain continuity of coverage for these individuals who would have aged out during the PHE until the 26 through 49 expansion takes effect on January 1, 2024, DHCS will continue existing state-funded full scope Medi-Cal coverage for this population and have issued policy guidance instructing counties to deprioritize the post-PHE renewal towards the end of the PHE unwinding period.

FEDERAL FLEXIBILITIES

- **Timeliness concurrence** from CMS to allow "one time" of Medi-Cal case vs. touching it "three times" (once each calendar month for overdue/missed renewal since 2020). Relieves administrative burden on both State and county operations.

- **1902(e)(14)(A) waivers** approved by CMS on 5/4/2022, effective 5/1/2022 through the end of the PHE Unwinding Period:
  - **Ex parte renewals for zero-income individuals** verified within the last 12-months. Helps homeless individuals with this circumstance and gives them renewed eligibility for another 12-months.
  - **Asset Verification Program (AVP) flexibilities for both Non-MAGI application and renewals.** Allows states to confer eligibility for applications and renewals based on a state-determined reasonable timeframe after waiting for the AVP results (which can take over 30 days).
  - **The acceptance of updated contact information provided by Medi-Cal managed care plans without additional confirmation from the beneficiary to remove administrative barriers for both MCPs and counties.** This allows for more timely updates of critical contact info as states proceed to send out renewal packets once PHE ends.

FEDERAL FLEXIBILITIES

- **Additional 1902(e)(14)(A) waivers approved by CMS on 10/18/2022, with an effective date of 10/18/2022 through the end of the PHE Unwinding Period :**
  - Partnering with the National Change of Address (NCOA) Database and United States Postal Service (USPS) In-State Forwarding Address to Update Beneficiary Contact Information
  - Partnering with Program of All-Inclusive Care for the Elderly (PACE) Organizations to Update Beneficiary Contact Information

- The **State Fair Hearings** 1902(e)(14)(A) waiver flexibilities for hearing timeframes (extension from 90 to 120 days) are still outstanding with CMS for consideration as of November 7, 2022.

- **Adjusting reasonable compatibility to 20%** to allow for higher auto ex parte rates. During the PHE, the auto ex parte rates have decreased significantly across the nation due to stale data from the beneficiary's case record, when compared against the more updated federal databases (i.e. IRS). (ACWDL 22-17, June 17, 2022)

- **Use of *Reasonable Explanation*** for application and renewal verification. This is another administrative verification tool that relieves the administrative burden on beneficiaries to provide documentation of case discrepancy (income), and allow for a more seamless renewal or application intake. (ACWDL 22-22, August 8, 2022)

DHCS GUIDANCE TO COUNTIES

- DHCS issued a series of All County Welfare Directors Letters (ACWDLs) and Medi-Cal Eligibility Information Division Letters (MEDILs) to provide counties with specific instructions in 2020, 2021, and 2022 in preparation for the PHE termination, and also for managing the eligibility activities once the PHE Unwinding period begins.

- Several significant ACWDLs and MEDILs are listed below and also in Appendix:
  - **ACWDL 21-16 (September 14, 2021):** Case Processing Actions Allowed during the COVID- 19 PHE
  - **ACWDL 22-18 (June 24, 2022):** Case Processing Actions after the Conclusion of the COVID-19 PHE
  - **ACWDL 22-20 (July 11, 2022):** Senate Bill 260 Streamlines Transitioning to Covered California
  - **MEDIL 23-03 (January 13, 2023):** Updates to the County Readiness Toolkit for the Preparation of novel Coronavirus (COVID-19) Public Health Emergency (PHE) End of Continuous Coverage Requirement

COUNTY READINESS

- On January 13, 2023, DHCS issued MEDIL 23-03 (January 13, 2023): Updates to the County Readiness Toolkit for the Preparation for the End of the Continuous Coverage Requirement
- The County Readiness Toolkit is designed to help counties assess readiness in the three key areas of high impact:
  - Organization and Staffing
  - Staff Training for All Levels of Staff who Perform or Supervise Medi-Cal Related Case Activities
  - Lobby Management, Call Center, and Outreach
- Specifically, this MEDIL includes three components to support counties in their readiness:
  - County Readiness Checklist
  - County COVID-19 PHE Readiness Plan Template
  - County COVID-19 PHE Readiness Plan Recommended Strategies
- Counties are required to complete and submit this template to validate their readiness to complete COVID-19 PHE unwinding actions and resume normal operations. Counties must email their COVID-19 PHE Unwinding Readiness Plan to no later than February 21, 2023

DHCS OUTREACH EFFORTS

- **DHCS Coverage Ambassadors (in English and Spanish)**
  - Currently, we have **1600+** DHCS Coverage Ambassadors signed up to help DHCS spread the word on the COVID-19 PHE Unwinding Efforts
  - DHCS developed FAQs for our Coverage Ambassadors to assist with outreach efforts
  - DHCS conducted English and Spanish webinars for our Coverage Ambassadors in June 2022. The webinar recordings can be accessed here.

- **DHCS COVID-19 PHE Outreach Toolkits**
  - **COVID-19 PHE Toolkit – Phase 1 –** with DHCS approved graphics and messaging to be used by our Coverage Ambassadors.
  - **Phase 2 Toolkit** – Will be released February 1, 2023

DHCS OUTREACH EFFORTS

- **DHCS Outreach Communications Vendor for Media Campaigns (for both COVID-19 PHE and other Eligibility Expansions and Postpartum Extension)**
  - DHCS has awarded a direct contract with a media vendor for the DHCS outreach campaigns. The vendor will be responsible for implementing a statewide education and outreach communications campaign targeted to California's 14.8 million Medi-Cal beneficiaries during COVID-19 PHE, throughout the continuous coverage unwinding period, and for all the eligibility expansions (i.e. Asset Elimination, 26-49 Medi-Cal Expansion, Postpartum Extension).

  - One of the goals of DHCS' COVID-19 PHE unwinding outreach campaign is to maintain eligibility for Medi-Cal beneficiaries by providing outreach materials that inform beneficiaries about the steps necessary to maintain coverage after the COVID-19 public health emergency ends.

DATA REPORTING

- **DHCS COVID-19 PHE Unwinding Eligibility Dashboard:** To be posted monthly by statewide and county-level data with the following data:
  - Total Medi-Cal Enrollment
  - Applications
  - Redeterminations
  - Discontinuances

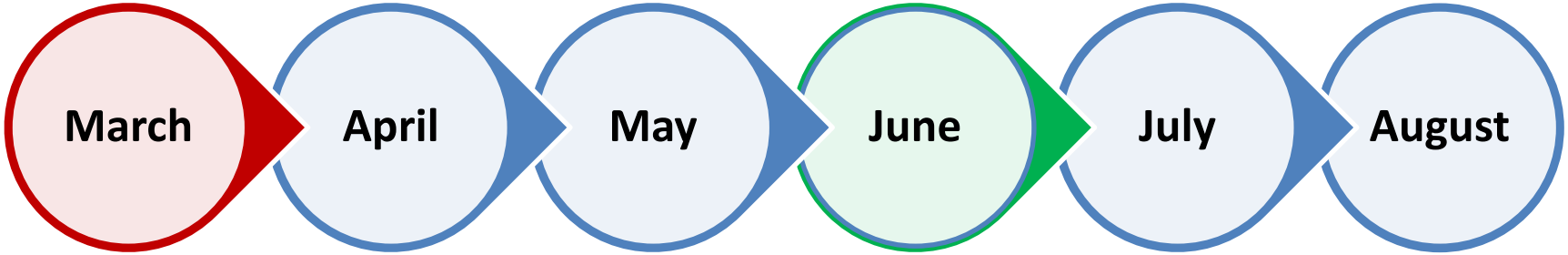
SB 260 CONSUMER JOURNEY AND SUPPORT

Karen Avakian
Deputy Director
Policy, Eligibility, & Research

OVERVIEW OF REQUIREMENT TO AUTOMATICALLY ENROLL INDIVIDUALS WHO LOSE MEDI-CAL COVERAGE

- California Senate Bill 260 (Chapter 845, Statutes of 2019) directs Covered California to automatically enroll individuals who lose Medi-Cal coverage and gain eligibility for subsidized coverage.
- Individuals will be enrolled in the lowest cost silver plan available, unless Covered California has information that enables enrollment with the individual's previous managed care plan.
- Enrollment is to occur before the Medi-Cal termination date.
- The first premium payment (binder payment) due date to be no sooner than the last day of the first month of enrollment.
- Covered California to provide a notice that includes the following information:
  - The plan in which the individual is enrolled.
  - The right to select another available plan and any relevant deadlines for that selection.
  - How to receive assistance to select a plan.
  - The right not to enroll in the plan.
  - Information for an individual appealing their previous coverage through Medi-Cal
  - A statement that services received during the first month of enrollment will only be covered by the plan if the premium is paid by the due date.

MEDICAID CONTINUOUS COVERAGE & SB 260 FACILITATED ENROLLMENT



MC MOE Ends

*For illustrative purposes, the Medicaid Continuous Coverage requirement ends in **March 2023**.*

Medi-Cal Renewal Activities

Medi-Cal Renewal Begins

*Medi-Cal Renewal activities begin for individuals with **June** renewal month.*

Medi-Cal Renewal Ends & Covered CA Facilitated Enrollment Begins

*Medi-Cal eligibility is redetermined and if found ineligible, the last day of Medi-Cal eligibility will be **6/30/2023**.*

If found eligible for financial help, Covered California SB 260 facilitated enrollment starts, and letters are sent to individuals to inform them of their options and next steps.

Special Enrollment Period (SEP)

Covered CA Coverage Begins

Covered CA SEP begins as soon as the re-determination is completed for individuals who lose Medi-Cal coverage.

*Covered CA coverage starts **7/1/2023**.*

*The individuals have until **7/31/2023** to make a payment or opt-in to keep the selected plan.*

SEP Ends

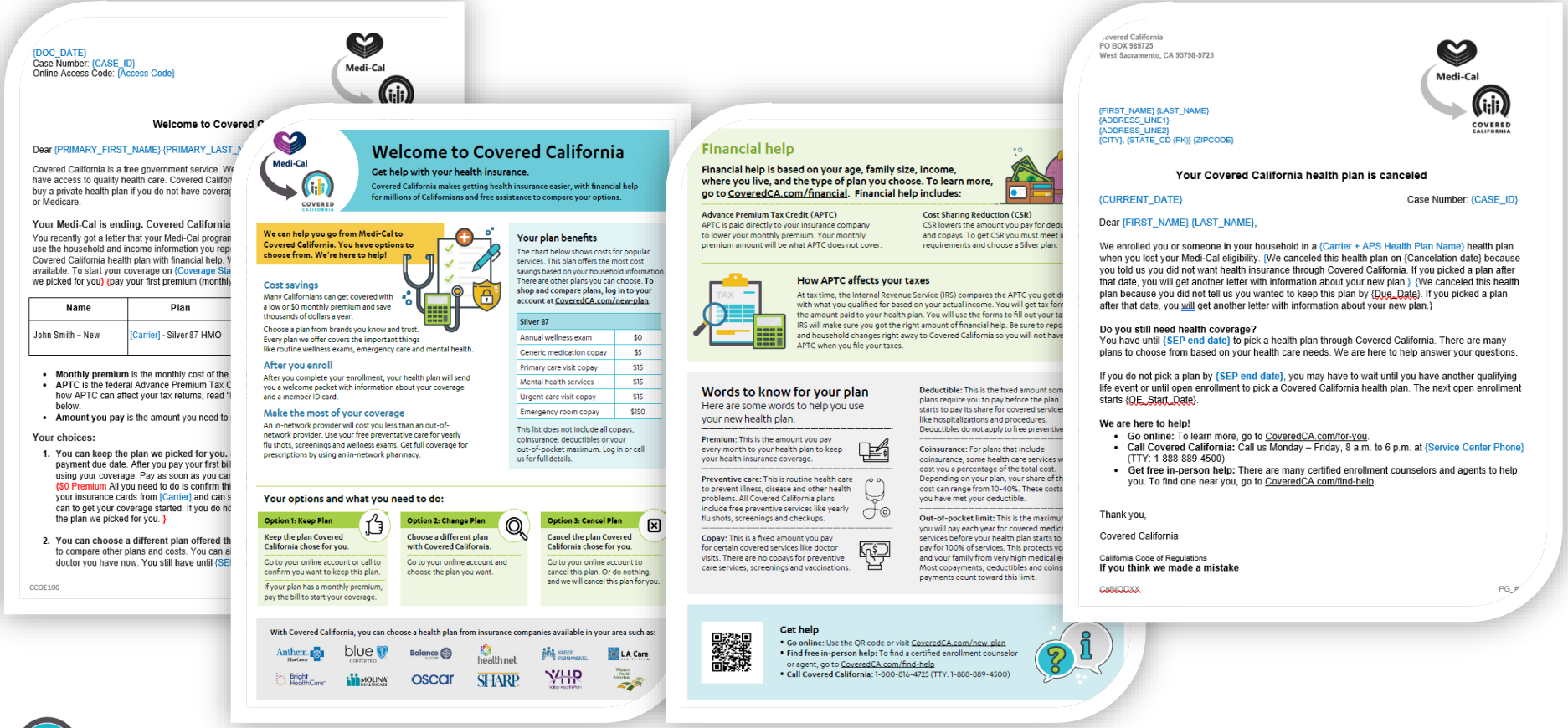
The individuals' SEP lasts until 8/29/2023.

Individuals who keep the selected plan can still change it during SEP.

Individuals who opt out or miss the payment/opt-in deadline can still shop for a plan during SEP.

Individuals who maintain income at or below 150% can enroll or change their plan anytime during the year

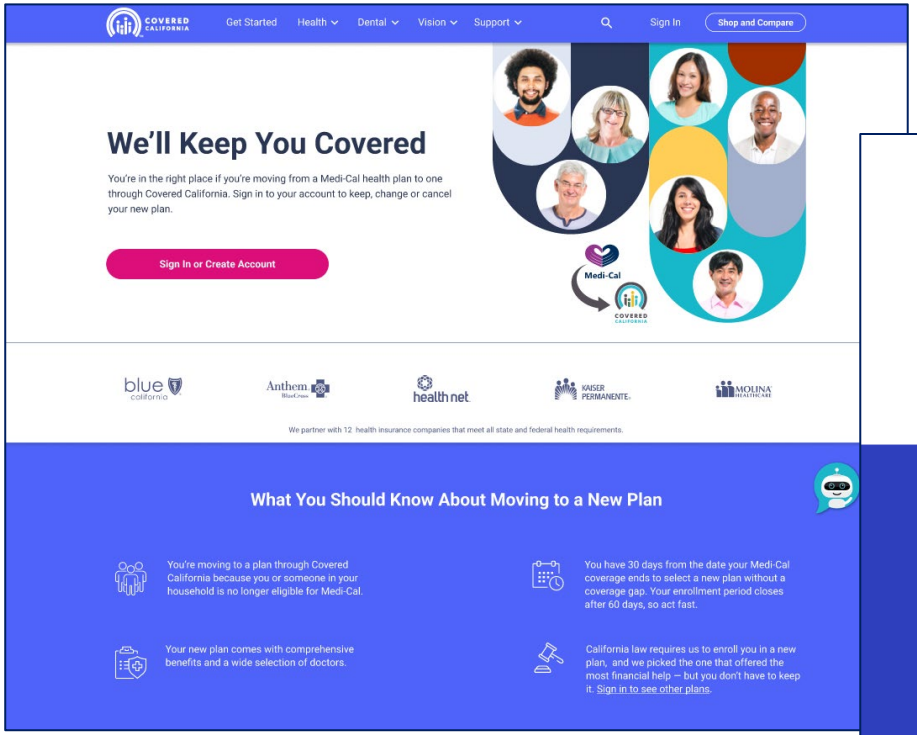
CONSUMER NOTICES

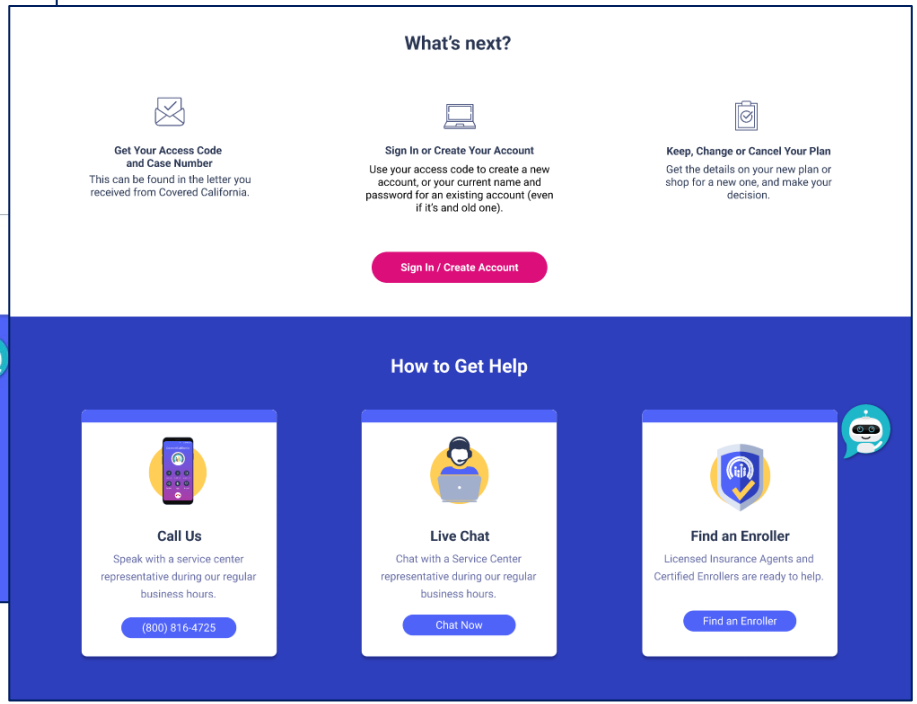


CONSUMER SUPPORT & OUTREACH

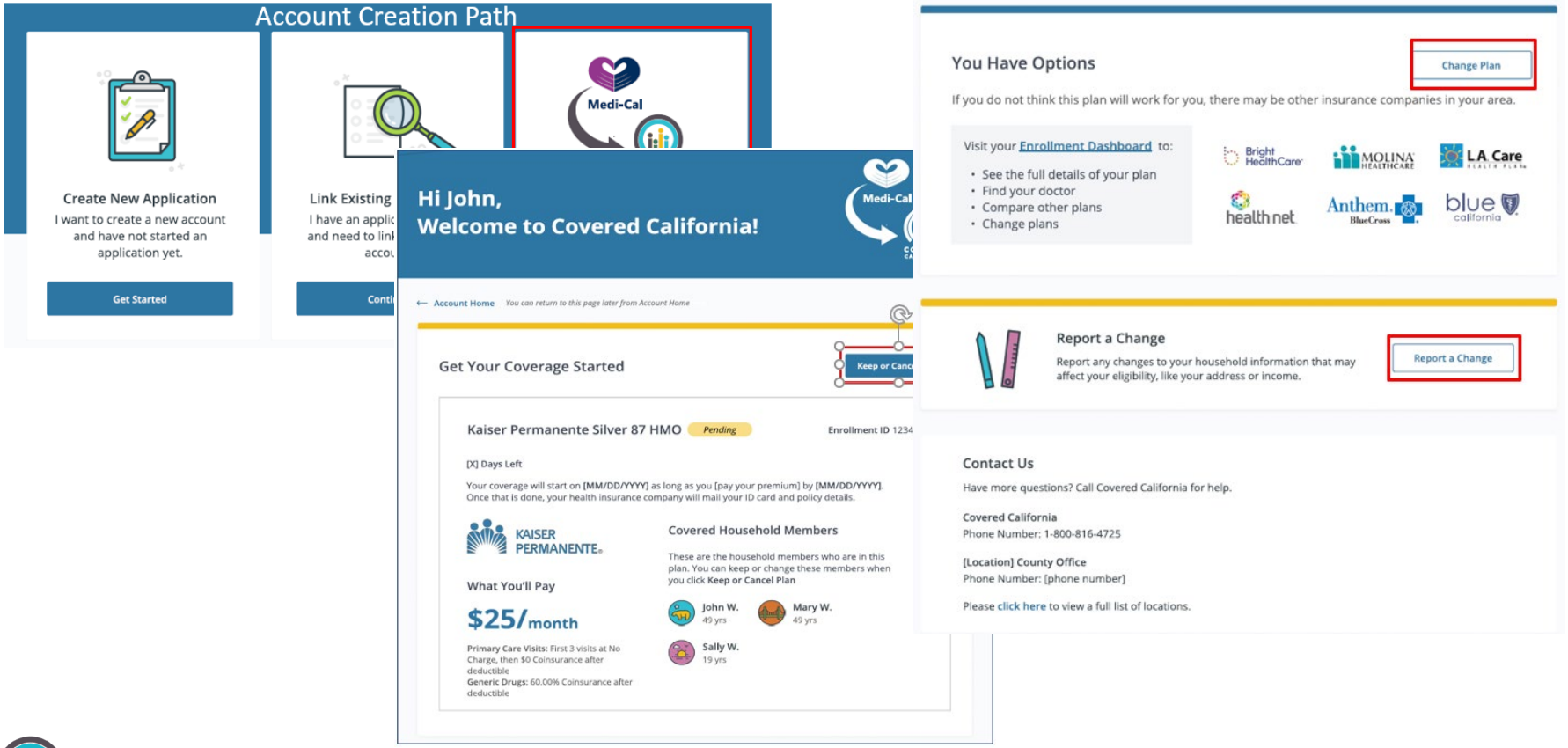
- Covered California will use a variety of methods to support consumers during their coverage transition.
  - Outbound outreach from Covered California as enrollment deadlines approach.
  - Connecting individuals to assistance through Agents and Navigators – including those they worked with during prior Covered California enrollment.
  - Enabling tailored consumer journeys and outreach by carriers through information passed in the auto-enrollment transaction.

COVEREDCA.COM EXPERIENCE

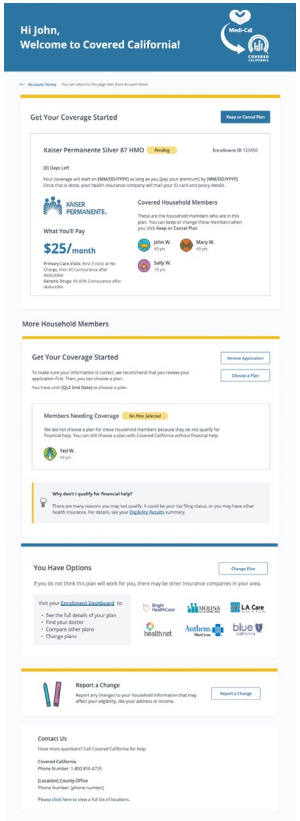


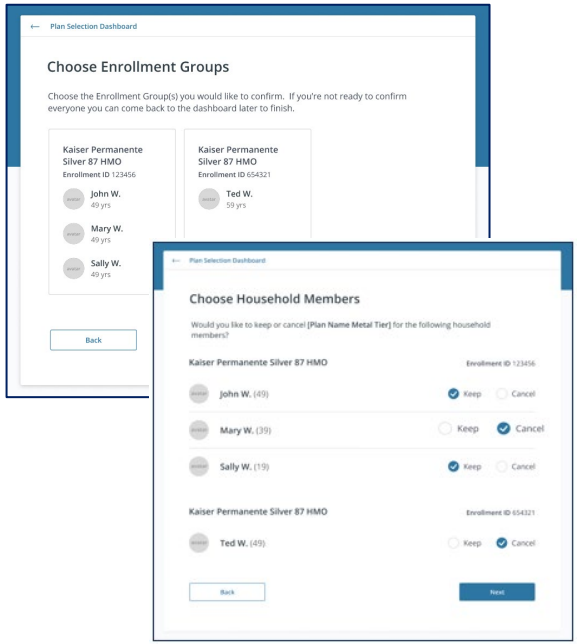


CALHEERS EXPERIENCE

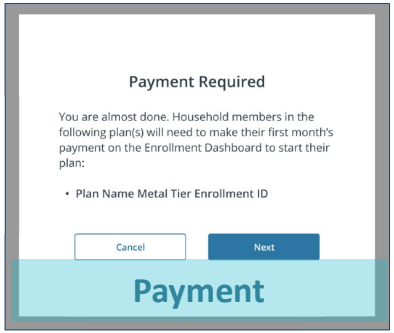


OPT-IN / OPT-OUT CALHEERS EXPERIENCE





Choose Enrollment Groups & Keep or Cancel



OPT-IN / OPT-OUT EXPERIENCE

Interactive Voice Response (IVR)

The Covered California Service Center IVR will be updated to allow consumers to complete their actions via phone.

- Consumers will need to complete the authentication process (Zip, DOB, Full SSN)
- Consumers will be able to Opt-In or Opt-out of coverage
- Consumers can request assistance from a Service Center Representative (SCR) anytime during the process if needed

ChatBot (CiCi)

The Covered California Chatbot, CiCi, will provide consumers with 24/7 online access to:

- Answers to frequently asked questions related to their transition from Medi-Cal to Covered California.
- Ability to authenticate (e.g., Zip, DOB, Full SSN) in order to Opt-in to keep or Opt-out to cancel their coverage
- Directions on how to change their plan online or by connecting with a Service Center Representative (SCR)
- LiveChat with a SCR.

HISTORICAL DATA AND PLANNED SB 260 REPORTING AND EVALUATION

Isaac Menashe
Deputy Director
Policy, Eligibility, & Research

BACKGROUND DATA ON MEDI-CAL TRANSITIONERS

- To prepare for the implementation of SB 260, Covered California used historical data on Medi-Cal transitioners to identify trends in prior marketplace eligibility and enrollment among this population.
- We refer to Medi-Cal transitioners in various stages of eligibility and enrollment as follows:
  - Medi-Cal transitioner (MCT): an individual who lost Medi-Cal eligibility and gained eligibility for Covered California with or without subsidies
  - Subsidy-eligible MCT: an individual who lost Medi-Cal eligibility AND gained eligibility for an advanced premium tax credit (APTC)
- Administrative data is supplemented with survey data to estimate the universe of Medi-Cal transitioners who may need coverage through the marketplace – whereas administrative data can only identify who may be eligible (without consideration of availability of other coverage).

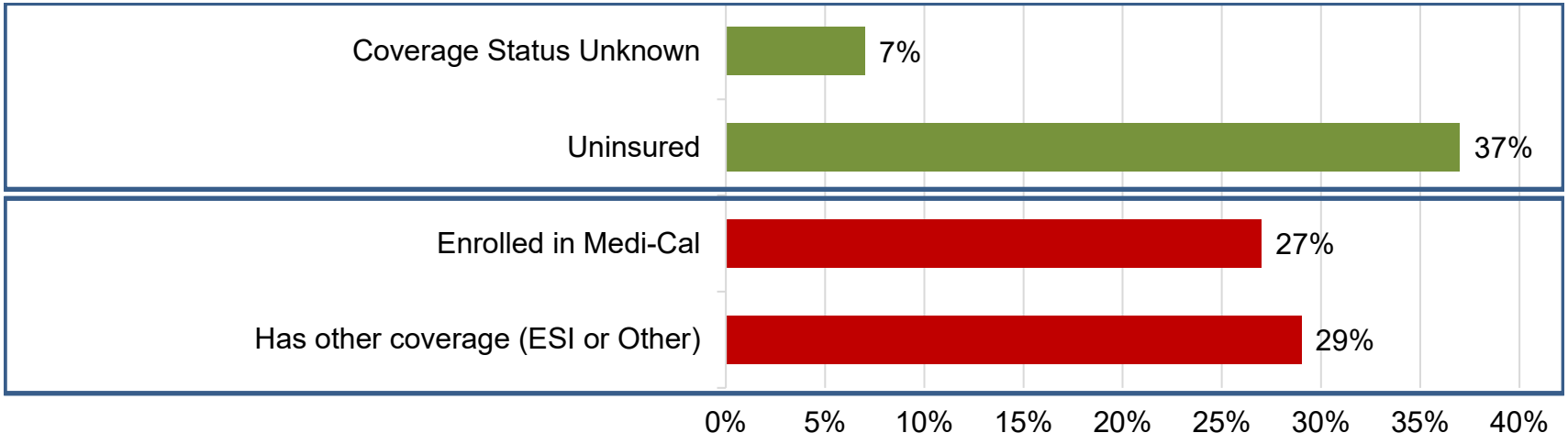
MEDI-CAL TRANSITIONER OVERVIEW

	2018	2019	2020	2021
MCTs- all	553,640	344,910	145,390	76,080
MCTs- subsidy eligible	330,880	213,690	77,480	31,790
Monthly average	27,570	30,530	8,610	5,300
MCTs with plan selection	71,540	43,310	23,720	10,070
Monthly average	5,960	6,190	2,640	1,680
Plan selection rate	22%	20%	31%	32%
Effectuations	62,540	37,030	20,030	8,000
Monthly average	5,210	5,290	2,230	1,330
Effectuation rate	87%	86%	84%	79%

Note: only 2018 represents a full year of data. 2019-2021 are based on partial year's data, which are accounted for in the monthly averages. Plan selection and effectuation rates only based on subsidy-eligible universe.

FINDINGS FROM THE 2018 NORC MEMBER SURVEY

- Among the Medi-Cal Transitioners who qualified for some form of premium assistance and did not enroll in Covered California (n=1057), about 29% stated to have coverage from other sources and 27% stated to have Medi-Cal enrollment.
- These survey statistics are used to estimate the number of consumers who appear to be eligible for financial help from the administrative data, but in reality are not eligible, because they have another source of Minimum Essential Coverage (MEC).



Source: MCT Insights from 2018 Member Survey – 4.18.19, Page 64, OE Consumer in Admin Data – "Percentage without those Enrolled in Covered CA".

AVAILABILITY OF $0 PLANS WITH ENHANCED SUBSIDIES

Applying the subsidy structure from the American Rescue Plan and Inflation Reduction Act to historical subsidy-eligible Medi-Cal transitioners, nearly half would have been eligible for a $0 Silver plan.

Share of Medi-Cal transitioners eligible for a $0 Silver plan, by FPL group

	2018	2019	2020	2021
<150% FPL	100%	100%	100%	100%
150-200% FPL	59%	56%	56%	54%
200-250% FPL	18%	18%	19%	12%
250-300% FPL	5%	6%	6%	4%
300-400% FPL	1%	2%	3%	1%
Total	49%	46%	49%	43%

SB 260 DATA AND REPORTING

Following the launch of SB 260, Covered California plans to publicly report on key outcomes for assessing effectiveness of the program. Reporting products currently planned for 2023 include:

- Monthly administrative data:
  - Volume of automatic plan selections
  - Take-up rates among plan-selected Medi-Cal transitioners
  - Plan choices (e.g. issuer, network, tier), and enrollee demographics
  - Channels for confirming enrollment (i.e., online portal, service center)
  - Volume of Medi-Cal transitioners who actively opt out of coverage
- Updates will also be provided to the Board throughout the unwinding of the Medicaid continuous coverage requirement.

CONSUMER RESEARCH – SURVEY EFFORTS

To support administrative data reporting, Covered California will be fielding a regular survey during the unwind of the Medicaid continuous coverage requirement to evaluate:

- Sources of coverage among Medi-Cal transitioners who do not effectuate coverage
  - These survey data will supplement administrative data to understand the effective take-up rate, accounting for those who have coverage elsewhere, such as with an employer, versus going uninsured.
- The Medi-Cal transitioner consumer experience, including questions such as:
  - To what extent did Medi-Cal transitioners know about and understand their options for coverage through Covered California?
  - To what extent did Medi-Cal transitioners find it easy to navigate the tailored enrollment process?

QUALITATIVE IMPLEMENTATION RESEARCH

- Covered California intends to partner with an outside entity to produce an evaluation of the organization's implementation process.
- This effort will focus on identifying and sharing of key lessons that guided the implementation process of SB 260.
- While this report will help Covered California identify areas for improvement, it will also serve as a guide for areas of consideration as other states weigh facilitated enrollment policies.

EVALUATING THE EFFECTIVENESS OF OUTREACH FOR MEDICAID TO MARKETPLACE TRANSITIONS

In 2017, Covered California tested the effect of email reminders, personalized phone outreach, and the combination of both, on Medi-Cal transitioners eligible for subsidized coverage.

Email reminders alone had no effect on enrollment, while phone calls paired with email reminders significantly increased enrollment.

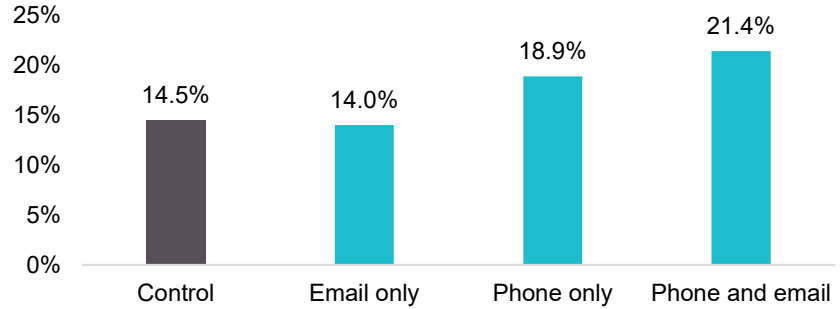
Covered California intends to continue rigorous testing of outreach and other interventions to help connect consumers to coverage during the unwind.

JAMA Health Forum

Research Letter

Effect of Personalized Outreach on Medicaid to Marketplace Coverage Transitions
A Randomized Clinical Trial

Katie Ravel, MPH; Jahan Ahrary, MPH; Karen Avakian, BA; Andrew Feher, PhD; Isaac Menashe, MPP



Ravel K, Ahrary J, Avakian K, Feher A, Menashe I. Effect of Personalized Outreach on Medicaid to Marketplace Coverage Transitions: A Randomized Clinical Trial. *JAMA Health Forum.* 2022;3(10): https://jamanetwork.com/journals/jama-health-forum/fullarticle/2797464

COVERED CALIFORNIA

OPPORTUNITIES FOR TESTING AND LEARNING

- Building on results from 2017 test of phone calls (see earlier slide), Covered California plans to continue testing how to best facilitate the transition from Medi-Cal using various forms of outreach that may be effective to encourage transitioners to complete their enrollment.
- Other outreach strategies may be leveraged to reach Medi-Cal transitioners who appear ineligible for subsidies – and thus not receiving an automatic plan selection. Many of these consumers may need to update their application in order to gain eligibility for tax credits.
- Covered California is also reviewing new federal guidance related to outreach methods that may be permitted (such as text messaging) to assist consumers during the unwinding of the Medicaid continuous coverage requirement.

SB 260 IMPLEMENTATION MONITORING AND FUTURE POLICY TOPICS

Katie Ravel
Director
Policy, Eligibility, & Research

SB 260 IMPLEMENTATION MONITORING AND FUTURE POLICY TOPICS

- Covered California will partner with DHCS, counties, health plans and consumer advocates to monitor SB 260 implementation to identify and address any implementation issues that may arise during launch.
- Covered California will begin to explore feasibility and considerations for auto-assigning Medi-Cal Transitioners to a health plan that would provide continuity of care with prior Medi-Cal enrollment. We will seek input in the coming months through the Plan Management Advisory group.

PUBLIC COMMENT

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

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

EACH CALLER WILL BE LIMITED TO TWO MINUTES PER AGENDA ITEM

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

APPENDIX

APPENDIX: QHP & QDP DENTAL ENROLLMENT OVERVIEW

2022 QUALIFIED DENTAL PLAN ENROLLMENT

As of December 31, 2022, **250,360** enrollees have selected a Qualified Dental Plan through Covered California.

QDP Issuer Name	Product Type	Adult (19+ years) Enrollment	Pediatric (0-18 years) Enrollment	Percent of total QDP Enrollment
Anthem Blue Cross	HMO	13,883	667	6%
Anthem Blue Cross	PPO	12,569	1,215	6%
Blue Shield of California	HMO	23,199	926	10%
Blue Shield of California	PPO	26,403	2,810	12%
California Dental Network, Inc.	HMO	25,281	1,751	11%
Delta Dental	HMO	72,750	2,980	30%
Delta Dental	PPO	40,664	4,138	18%
Dental Health Services	HMO	1,507	52	1%
Liberty	HMO	19,129	436	8%
Total		**235,385**	**14,975**	**100%**
Total QDP Enrollment		**250,360**		

The total QDP enrollment reflects the total number of plan selections, unique plan selections may be less than this total
Bright and Liberty are no longer participating in the Exchange even though they are included in the tables

2022 QUALIFIED HEALTH PLAN PEDIATRIC ENROLLMENT

As of December 31, 2022, Covered California has **193,553** pediatric QHP enrollees, eligible for embedded dental benefits.

QHP Issuer Name	Product Type	Pediatric Enrollment	% of Pediatric Enrollment in QHP
Anthem Blue Cross	EPO	8,700	4.49%
Anthem Blue Cross	HMO	8,175	4.22%
Blue Shield of California	HMO	13,541	7.00%
Blue Shield of California	PPO	55,776	28.82%
Bright HealthCare	HMO	79	0.04%
CCHP	HMO	147	0.08%
Health Net	EPO	78	0.04%
Health Net	HMO	5,541	2.86%
Health Net	PPO	5,428	2.80%
Kaiser	HMO	71,368	36.87%
LA Care	HMO	7,494	3.87%
Molina Health Care	HMO	3,966	2.05%
Oscar Health Plan	EPO	5,607	2.90%
SHARP Health Plan	HMO	4,876	2.52%
Valley Health	HMO	1,193	0.62%
Western Health	HMO	1,584	0.82%
Total		**193,553**	**100.00%**

Bright and Liberty are no longer participating in the Exchange even though they are included in the tables

APPENDIX 1:
PUBLIC COMMENTS AND PROPOSED REVISIONS TO 2024 PLAN YEAR
ATTACHMENTS 1, 2, AND 4

APPENDIX 1A:
2024 PLAN YEAR AMENDMENT
ATTACHMENT 1 PUBLIC COMMENT THEMES AND PROPOSED CONTRACT REVISIONS

2024 ATTACHMENT 1 PUBLIC COMMENT KEY THEMES, NO PROPOSED CHANGES

Article 1: Equity and Disparities Reduction Public Comment Themes

Advocates would like to see us **go further in collecting demographic data** but support other key equity initiatives:

- Encourage us to add disaggregated race and ethnicity data to the demographic data categories under consideration for future performance standards
- Support adding the SNS-E measures and Child, Adolescent Well-Care visits, and Diabetes Control to the patient level data (PLD) file requirements
- Support removing Adult Preventive Services proprietary measure from PLD file requirements

Article 1: Equity and Disparities Reduction Proposed Attachment 1 Changes

- No changes proposed

2024 ATTACHMENT 1 PUBLIC COMMENT KEY THEMES

Article 2: Behavioral Health

- **Advocates** expressed support for newly proposed **subcontractor oversight requirements**
- **Issuers** asked for clarification of the **scope of the subcontractor oversight requirements**
- **Issuers** expressed concern about adding **additional contract language to subcontractor agreements** that would trigger a re-contracting of all provider agreements
- **Issuers** expressed concern about the value and reasoning of the **delegation report requirement,** they expressed specific concern about the potential of high administrative costs due to their large volume of vendors

PROPOSED 2024 ATTACHMENT 1 CHANGES

Article 2: Behavioral Health

Notable Changes to Draft Attachment 1	Rationale
2.05 Subcontractor Oversight Section title changed to "2.05 *Behavioral Health* Subcontractor, Downstream Entity, and Behavioral Health Network Provider Oversight"	To emphasize this section applies to behavioral health service subcontracting only.
2.05.1 Contractor Accountability, Duties, and Obligations 4a) Clarified and revised expectations for behavioral health subcontractor agreements	To emphasize issuer responsibility for oversight and accountability of all behavioral health network providers, Subcontractors, or Downstream Entities; and to outline their role in ensuring the fulfillment of the health equity, quality, and delivery system reform requirements described in Article 2 of Attachment 1.
2.05.3 Delegation Reporting No change	Covered California is committed to ensuring behavioral health service quality and further understanding the delegation and oversight processes of all behavioral health subcontractors. This requirement aligns with CalPERS and DHCS.

PROPOSED 2024 ATTACHMENT 1 CHANGES

Article 2: Behavioral Health

Notable Changes to Draft Attachment 1	Rationale
Article 2 Changed Downstream Subcontractor to *Downstream Entity*	Revised term to be consistent across the entire contract; the following definitions have been added to the model contract: **Downstream entity** – An individual or an entity that has an agreement with a Subcontractor or another Downstream Entity that relates directly or indirectly to the performance of the Contractor's services under this Agreement. A provider is not a Downstream Entity solely because it enters into a provider agreement. **Subcontractor(s)** – An individual or entity that has an agreement with a Contractor that relates directly or indirectly to the performance of the Contractor's services under this Agreement. A provider is not a Subcontractor solely because it enters into a provider agreement.

2024 ATTACHMENT 1 PUBLIC COMMENT KEY THEMES AND PROPOSED CHANGES

Article 3: Population Health

- **Two issuers** asked for **removal of Social Needs Screening measure from PLD file submission** until public reporting is required by NCQA and screening codes are used regularly by providers
- **Advocates** support adding the SNS-E measure

Notable Changes to Draft Attachment 1	Rationale
3.04.1 Screening for and Addressing Social Needs Proposed SNS-E measure remains as proposed, but language has been added to clarify that results will not be shared publicly until national benchmarks are established.	This approach recognizes the logistic challenges of implementing a new measure while prioritizing standard measures going forward.

2024 ATTACHMENT 1 PUBLIC COMMENT KEY THEMES, NO PROPOSED CHANGES

Article 4: Delivery and Payment Strategies to Drive Quality Public Comment Themes

- **One issuer** recommended changing the **intervention plan requirement** in the Provider Value subsection (4.03.3 b.) of the Networks Based on Value section **to only address low quality providers** and not include high-cost providers
  - Issuer suggests that low quality and high-cost providers are separate populations and cannot be addressed together in the same implementation plan
  - Addressing high-cost providers would pose significant limitations as they generally have market leverage and cannot be excluded based on access requirements

Article 4: Delivery and Payment Strategies to Drive Quality Proposed Attachment 1 Changes

- No changes proposed
- Covered California will collaborate with issuers to analyze provider quality and cost and to determine appropriate intervention plans

2024 ATTACHMENT 1 PUBLIC COMMENT KEY THEMES, NO PROPOSED CHANGES

Article 5: Measurement and Data Sharing Public Comment Themes

- **One issuer encouraged use of NCQA HEDIS measures** and measures that have national benchmarks
- **Advocates** support the new Covered California requirement to meet with contracted issuers at least twice a year to review HEI analytic results and performance

Article 5: Measurement and Data Sharing Proposed Attachment 1 Changes

- No changes proposed

2024 ATTACHMENT 1 PUBLIC COMMENT KEY THEMES, NO PROPOSED CHANGES

Article 6: Certification, Accreditation, and Regulation Public Comment Themes

- None received

Article 6: Certification, Accreditation, and Regulation Proposed Attachment 1 Changes

- No changes proposed

2024 CCSB ATTACHMENT 1 PUBLIC COMMENT KEY THEMES, NO PROPOSED CHANGES

One issuer is **opposed to applying the following requirements** to Covered California for Small Business:

- Submitting NCQA Health Equity Accreditation reports for culturally and linguistically appropriate services (Article 1.05)
- PLD file reporting for Depression Screening and Follow-Up for Adolescents and Adults (2.02) and Pharmacotherapy for Opioid Use Disorder (2.03) results stratified by race and ethnicity
- Requiring behavioral health subcontractor agreements to hold subcontractors accountable for meeting health equity, quality, and delivery system reform requirements (2.05)
- Submitting NCQA Health Plan Accreditation Population Health Management plan (3.01)
- Supporting at-risk enrollees transitioning between plans (3.03)

Issuer is concerned about additional administrative costs these requirements would place on small business products, which will result in higher premiums for the CCSB products and overall loss of market-share compared to rest of the small business market.

Proposed CCSB Attachment 1 Changes

- Changes to the Individual Attachment 1 will be applied to CCSB Attachment 1 as applicable. No proposed changes specific to CCSB Attachment 1; many of these requirements can be met through combined Individual and CCSB reporting.

APPENDIX 1B:
2024 PLAN YEAR AMENDMENT
ATTACHMENT 2 PUBLIC COMMENT THEMES AND PROPOSED CONTRACT REVISIONS

PROPOSED CHANGES FOR 2024 ATTACHMENT 2: PERFORMANCE STANDARDS WITH PENALTIES (1 OF 2)

Performance Standards With Penalties	2023 % at Risk	Proposed 2024 % at Risk	Proposed 2024 Change and Rationale
1. Reducing Health Disparities: Demographic Data Collection – Enrollee Race and Ethnicity Self-Identification	10%	5%	*No proposed changes*
2. Reducing Health Disparities: Demographic Data Collection – Spoken and Written Language	10% (for reporting)	5%	Revised to 5% total penalty for spoken **or** written language
3. Reducing Health Disparities: Disparities Reduction Intervention	10%	10%	*No proposed changes*
4. National Committee for Quality Assurance (NCQA) Health Equity Accreditation	0%	10%	*No proposed changes*
5. Primary Care Payment	10%	10%	*No proposed changes*
6. Primary Care Spend	10% (for reporting)	5%	*No proposed changes*
7. Payment to Support Networks Based on Value	10% (for reporting)	10%	*No proposed changes*
8. Quality Rating System – QHP Enrollee Survey Summary Rating	20%	20%	*No proposed changes*

Where applicable, scores are provided per product, and penalties are weighted based on the enrollment in each product.

PROPOSED CHANGES FOR 2024 ATTACHMENT 2: PERFORMANCE STANDARDS WITH PENALTIES (2 OF 2)

Performance Standards With Penalties	2023 % at Risk	Proposed 2024 % at Risk	Proposed 2024 Change and Rationale
9. HEI Data Submission	20%	20%	Added patient level data (PLD) submission standards to ensure complete and accurate submissions; updated refence list of California healthcare facilities
~~10. Dental Quality Alliance (DQA) Pediatric Measure Set~~	~~0%~~	~~5%~~	Removed to add measure-specific oral health performance standards aligned with DHCS priority measures and recently added non-QRS HEDIS measures
10. Oral Evaluation, Dental Services (OEV-CH-A) (NQF #2517) (Pediatric)	0%	2.5%	
11. Topical Fluoride for Children, Dental Services (TFL-CH-A) (NQF #2528) (Pediatric)	0%	2.5%	
Total	**100%**	**100%**	

Where applicable, scores are provided per product, and penalties are weighted based on the enrollment in each product.

2024 ATTACHMENT 2 PUBLIC COMMENT KEY THEMES

Healthcare Evidence Initiative (HEI) Data Submission

- **Issuers** requested **clarification on the added patient level data (PLD) submission standards**

2024 Pediatric Oral Health Performance Standards

- **Issuers** requested **removing the penalty for one year** to allow for reporting of baseline only in Measurement Year 2024 for the Oral Evaluation, Dental Services (NQF #2517) and Topical Fluoride for Children, Dental Services (NQF #2528) measures
- **Advocate** supports the two proposed measures

Primary Care Spend (#6) and Payment to Support Networks Based on Value (#7)

- **One issuer** requested **extending reporting only** through 2024 for these performance standards to allow plans more time to meet the standards

PROPOSED IND 2024 ATTACHMENT 2 CHANGES

Notable Changes to Draft IND Attachment 2	Rationale
Performance Standard 6. Primary Care Spend Updated this performance standard to continue reporting only in 2024 and set thresholds for primary care spend using a negotiated annual target in 2025	Performance standards for 2024 and 2025 were not previously defined
Performance Standard 7. Payment to Support Networks Based on Value Updated this performance standard to continue reporting only in 2024 and set thresholds for network payment models using a negotiated annual target in 2025	Performance standards for 2024 and 2025 were not previously defined
Performance Standard 10-11. Oral Health Standards Performance standard revisions: Measurement Year 2024 – establish baseline rate; Measurement Year 2025 – set performance levels as (a) an increase of 10% or more over the baseline rate or (b) if the baseline rate is 0%, demonstrates an absolute rate of at least 10%	Specified performance levels for 2024 and 2025 for the measure-specific oral health performance standards

2024 CCSB ATTACHMENT 2 PUBLIC COMMENT KEY THEMES

Issuers recommend that no sections or any performance penalties be applied to CCSB until CCSB reaches material market share

Proposed CCSB Attachment 2 Changes

- No changes proposed
- Penalties for Performance Standard 2 & 3 (Oral Health Standards) will continue to apply

APPENDIX 1C:
2024 PLAN YEAR AMENDMENT
ATTACHMENT 4 PUBLIC COMMENT THEMES AND PROPOSED CONTRACT REVISIONS

2024 ATTACHMENT 2 AND 4 PUBLIC COMMENT KEY THEMES

- **Multiple issuers** requested **maintaining the prior distribution of the total premium at-risk** between Attachment 2 performance standards and Attachment 4 QTI for 2024
- **Multiple issuers** requested to **not shift the percent of premium at-risk** from Attachment 4 QTI to Attachment 2 performance standards
- **CAHP** and **one issuer** suggest any **funds generated through Attachment 2 performance standard penalties be used the same as Attachment 4 QTI** funds

PROPOSED 2024 ATTACHMENT 2 AND ATTACHMENT 4 PERCENT AT RISK

	2023 Percent at Risk	Proposed 2024 Percent at Risk
Attachment 2 – Performance Standards with Penalties	0.2% at risk	0.2% at risk
Attachment 4 – Quality Transformation Initiative (QTI)	0.8% at risk	1.8% at risk
Total	1%	2%

- Covered California proposes maintaining original 2024 anticipated percent at-risk distribution between Attachment 2 (0.2%) and Attachment 4 (1.8%)
- We will continue to increase the total percent at risk for Attachment 2 and Attachment 4 by 1% per year up to 4% maximum
- Covered California will consider an alternate distribution between Attachment 2 and Attachment 4 for 2025 with more advanced notice to issuers

PROPOSED 2024 ATTACHMENT 2 AND 4 CHANGES

Notable Changes to Draft Attachment 2 and 4	Rationale
Attachment 4 QTI QTI percent of premium at-risk will remain as originally anticipated with an increase in percent at-risk from 0.8% in 2023 to 1.8% in 2024	The total amount of premium at-risk for Attachment 4 QTI and Attachment 2 Performance Standards with Penalties will increase by 1% per year up to 4% maximum as stated in the 2023-2025 contract. Covered California will consider an alternate percent at-risk distribution between Attachment 2 and Attachment 4 in 2025.
Attachment 2 Performance Standards with Penalties Attachment 2 percent of premium at-risk will remain at 0.2% as originally anticipated Use of Attachment 2 penalties will not be changed	Attachment 2 premium at risk will remain at 0.2% in 2024. Attachment 2 will continue to be implemented as performance standards with penalties. Covered California will keep Attachment 2 penalty funds and QTI penalty funds separate. Covered California is committed to disbursing all QTI funds back to issuers equally and will continue to be transparent in the development of the QTI funds allocation process.

APPENDIX: PLANNING FOR THE END OF THE MEDICAID CONTINUOUS COVERAGE REQUIREMENT

RACE/ETHNICITY – AMONG SUBSIDY-ELIGIBLE MCTS

	2018		2019		2020		2021		2022 Total Subsidized Enrollment	
	Monthly average	Share of total	Monthly average	Share of total	Monthly average	Share of total	Monthly average	Share of total	Count	Share of Total
American Indian /Alaskan Native	120	1%	150	1%	30	0%	20	1%	3,520	0%
Asian/Pacific Islander	3,350	17%	3,660	16%	1,210	19%	790	19%	303,070	25%
Black or African American	1,380	7%	1,590	7%	460	7%	280	7%	31,800	3%
Latino	7,210	36%	8,060	36%	2,150	34%	1,330	33%	353,510	29%
White	6,550	32%	7,010	32%	1,990	31%	1,270	32%	400,430	33%
Other	1,550	8%	1,780	8%	550	9%	340	8%	126,220	10%
Total	20,160	100%	22,260	100%	6,380	100%	4,060	100%	1,218,450	100%
Non-respondent	*7,420*	*27%*	*8,270*	*27%*	*2,230*	*26%*	*1,240*	*23%*	*300,960*	*20%*

All % calculations except the non-respondents calculated out of respondents only. Non-respondent % is of total population of enrollees. 2022 Enrollment reflects totals from the 2022 June Active Member Profile among subsidy-receiving individuals. Grand totals shown may differ slightly from individual totals due to rounding.

INCOME OF SUBSIDY-ELIGIBLE MCTS BY PERCENT OF FEDERAL POVERTY LEVEL (FPL)

	2018		2019		2020		2021		2022 Total Subsidized Enrollment	
	Monthly average	Share of total	Monthly average	Share of total	Monthly average	Share of total	Monthly average	Share of total	Count	Share of Total
<150% FPL	6,480	23%	6,290	21%	2,190	25%	1,330	25%	256,710	17%
150-200% FPL	10,260	37%	11,690	38%	3,020	35%	1,880	35%	427,520	28%
200-250% FPL	4,620	17%	5,240	17%	1,410	16%	760	14%	256,760	17%
250-400% FPL	6,210	22%	7,320	24%	1,900	22%	1,150	21%	449,830	30%
400%+ FPL	10	0%	-	0%	100	1%	180	3%	126,500	8%
Total	27,570	100%	30,530	100%	8,610	100%	5,300	100%	1,519,500	100%

2022 Enrollment reflects totals from the 2022 June Active Member Profile among subsidy-receiving individuals. Grand totals shown may differ slightly from individual totals due to rounding.

ISSUER DISTRIBUTION AMONG SUBSIDY-ELIGIBLE MCTS WITH A PLAN SELECTION

	2018		2019		2020		2021		2022 Total Subsidized Enrollment	
	Monthly average	Share of total	Monthly average	Share of total	Monthly average	Share of total	Monthly average	Share of total	Count	Share of Total
Anthem	260	4%	350	6%	170	6%	120	7%	144,480	10%
Blue Shield	1,690	28%	1,640	27%	530	20%	500	30%	433,930	29%
CCHP	80	1%	80	1%	10	0%	10	0%	3,340	0%
Health Net	870	15%	830	13%	410	16%	150	9%	125,850	8%
Kaiser	2,160	36%	2,110	34%	1,030	39%	630	37%	543,080	36%
LA Care	370	6%	410	7%	140	5%	130	8%	106,960	7%
Molina	180	3%	360	6%	80	3%	50	3%	62,090	4%
Oscar	70	1%	120	2%	160	6%	70	4%	43,700	3%
SHARP	90	1%	50	1%	50	2%	30	2%	27,360	2%
Valley	160	3%	200	3%	70	3%	10	1%	19,420	1%
Western	40	1%	40	1%	20	1%	10	0%	8,800	1%
Total	5,960	100%	6,190	100%	2,640	100%	1,680	100%	1,519,500	100%

2022 Enrollment reflects totals from the 2022 June Active Member Profile among subsidy-receiving individuals. Grand totals shown may differ slightly from individual totals due to rounding.

SB 260 FORMATIVE CONSUMER RESEARCH

Research Objective: Covered California partnered with NORC and Slosar Research to conduct formative consumer research to inform SB 260 implementation, specifically:

- To understand consumers' reactions to the idea of auto-enrollment
- To understand the types of information and resources that transitioners will need to take action

Research Approach:

- Nine focus groups and 18 in-depth interviews, in both English and Spanish
- Among participants with diverse race/ethnicities, incomes, ages, and geographies
- With different coverage statuses:
  - Current Medi-Cal enrollees who could someday be eligible for Covered California
  - Medi-Cal Transitioners who enrolled with Covered California or employer-coverage, or who went uninsured
- Four focus groups with Service Center staff

IMPLEMENTATION DECISIONS INFORMED BY FINDINGS

Implementation Decision	Finding from Consumer Research
Reframe auto-enrollment as auto-plan selection	Consumers expressed that the term auto-enrollment implied they already had active coverage, which led to confusion and stress about the process.
Redesign materials to help consumers understand that their plan selection is a starting point and that they have options	Consumers repeatedly stated they wanted options, even if many said they would ultimately keep the plan chosen for them. Many also needed help understanding their options based on their coverage status (i.e., already had employer coverage)
Display both Medi-Cal and Covered California logos on the letter	Consumers trust Medi-Cal and said they are more likely to open notices that display that logo. Displaying both logos helps consumers understand the relationship between the two programs.
Give consumers the ability to actively opt-out in order to cancel their plan	Consumers want choices, including knowing they have the ability to decline coverage.
Provide an insert with cost-sharing information for their enhanced metal tier selection	Many transitioners will be new to private insurance and wanted help understanding aspects of the plan chosen for them.