



COVERED
CALIFORNIA

Plan Management Advisory Group

December 8, 2022

AGENDA

Time	Topic	Presenter
10:00 – 10:05	Welcome and Agenda Review	Rob Spector
10:05 – 10:20	2024 QHP Issuer Amendment for Individual Market	Lisa Schenck
10:20 – 10:55	2024-2026 QDP Attachment 1 Public Comment Themes	Health Equity and Quality Transformation Division (EQT)
10:55 – 11:20	Demographics Data Improvement Project	Kelly Bradfield
11:20 – 11:25	Certification	Meiling Hunter
11:25 – Noon	Open Forum	All

2024 QHP ISSUER AMENDMENT FOR INDIVIDUAL MARKET COMMENTS & RESPONSES

Plan Management Division

SUMMARY OF PROPOSED 2024 QHP ISSUER AMENDMENT REVISIONS

Model Contract

- Minimal updates have been made to the existing 2023-2025 QHP Issuer Contract
 - Updates have been made to contract documents providing clarifications as needed and based on comments received
 - A table of the significant comments for the 2024 QHP Issuer Model Contract Amendment follows:

2023-25 Current Requirements	2024 Proposed Requirements	2024 Comments Summary	2024 Comment Response
<p>1.5 d)ii. Notify Covered California of any material concerns identified by Contractor or by State and Federal Regulators that may impact Contractor's performance under this Agreement</p>	<p>1.5 d)ii. Notify Covered California of any material concerns identified by Contractor or material concerns, including any enforcement actions resulting in monetary penalties equal to or exceeding \$10,000, identified by State and Federal Regulators that may impact Contractor's performance under this Agreement;</p>	<ul style="list-style-type: none"> ▪ Current wording will probably result in reporting on enforcement actions beyond Covered California business ▪ Request the removal of "enforcement actions resulting in monetary penalties equal to or exceeding \$10,000," as this threshold is inconsistent with material concerns ▪ Due to absence of any statute of limitations or time constraints on regulator penalties DMHC often issue enforcement actions for incidents that occurred years ago 	<p>The requirement to report material concerns raised by State and Federal regulators has long existed in the QHP contract. However, QHP issuers have been inconsistent in how they interpret materiality for the purposes of reporting. Enforcement actions with penalties can indicate systemic issues that impact Covered California Enrollees. As such, Covered California wants to ensure that it is aware of any such concerns.</p> <p>Covered California is re-considering what an appropriate threshold for required reporting should be (which may vary based on issuer size) and will update the draft contract shortly with that amount.</p>

SUMMARY OF PROPOSED 2024 QHP ISSUER AMENDMENT REVISIONS

Significant comments for the 2024 QHP Issuer Model Contract Amendment

2023-25 Current Requirements	2024 Proposed Requirements	2024 Comments Summary	2024 Comment Response
<p>1.15 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</p>	<p>The updated text receiving comments in 1.15 Fraud, Waste and Abuse; Ethical Conduct - ...Contractor shall maintain an effective compliance program that includes... Contractor shall provide evidence of such compliance program as reasonably requested by Covered California. Contractor shall communicate within ten (10) Days to Covered California any material concerns identified by Contractor or material concerns, including any enforcement actions resulting in monetary penalties equal to or exceeding \$10,000, identified by State and Federal Regulators related to regulatory compliance that may impact performance under this Agreement following Contractor's knowledge of such occurrence; provided, however, such notification shall be provided immediately if such occurrence may reasonably be deemed to adversely affect the quality of care or safety of Covered California Enrollees</p>	<ul style="list-style-type: none"> ▪ Will there be a clearer definition for "material concerns"? ▪ Request the removal of ", including any enforcement actions resulting in monetary penalties equal to or exceeding \$10,000," as this threshold is inconsistent with material concerns. ▪ Is the reporting of enforcement actions of \$10k and above only required if it may impact Contractor's performance under the agreement? Or is it any and all enforcement matters equal to \$10k or above? ▪ Does the \$10,000 criteria apply to just enforcement actions resulting in monetary penalties, or does the money threshold also define a material concern or apply to Fraud, Waste and Abuse referrals as well? 	<p>The requirement to report material concerns raised by State and Federal regulators has long existed in the QHP contract. However, QHP issuers have been inconsistent in how they interpret materiality for the purposes of reporting. Enforcement actions with penalties can indicate systemic issues that may impact Contractor's performance under the agreement, including requirements related to quality, access to care, and customer service. Thus, all enforcement actions within the defined threshold are to be reported. Covered California is re-considering what an appropriate threshold for required reporting should be (which may vary based on issuer size) and will update the draft contract shortly with that amount. To clarify the different requirements between material concerns and enforcement action reporting from FWA compliance program reporting they will be separated paragraphs.</p>

SUMMARY OF PROPOSED 2024 QHP ISSUER AMENDMENT REVISIONS

Significant comments for the 2024 QHP Issuer Model Contract Amendment

2023-25 Current Requirements	2024 Proposed Requirements	2024 Comments Summary	2024 Comment Response
<p>2.2.4 Covered California and Contractor must send a termination transaction to the other party within ten (10) business days of any individual Covered California Enrollee termination</p>	<p>No change</p>	<ul style="list-style-type: none"> Contractor can only send terminations for Non-Payment of premium, and those are required to be sent with ten (10) Days (defined in the definition section as calendar days) of grace period expiration (which is also what is in the Performance Measure Standard). 	<p>Covered California agrees to update the contract language that contractor must send a termination transaction to Covered California within ten (10) Days of grace period expiration.</p>
<p>3.2.1 Enrollment and Marketing Coordination and Cooperation - For the 2023 Plan Year, and any year thereafter, Contractor is expected to spend at least 0.4% of premium on direct response advertising...</p>	<p>No change</p>	<ul style="list-style-type: none"> Add "projected" premium since actual premium revenue is not known till the end of plan year. 	<p>Covered California agrees to this update.</p>

SUMMARY OF PROPOSED 2024 QHP ISSUER AMENDMENT REVISIONS

Significant comments for the 2024 QHP Issuer Model Contract Amendment

2023-25 Current Requirements	2024 Proposed Requirements	2024 Comments Summary	2024 Comment Response
	<p>c) Network Disruptions. If Contractor experiences any network hospital with a pending contract termination, including any hospitals that may experience a break in maintaining a continuous contract, Contractor shall provide prior notice to Covered California as defined in 3.3.3 c) i.</p> <p>If Contractor experiences any other provider network disruptions or other similar circumstances that make it necessary for at least 10% of Enrollees residing within any county of an affected region to change Participating Providers...</p>	<p>No comment made.</p>	<p>4.3.3 c) Network Disruptions – addition of "at least" 10% of enrollees for clarity of threshold minimum.</p>
		<p>Several minor comments made during the QDP comment cycle have been determined to apply to the QHP contract as well and will be reflected in the next update. Sections with such updates are listed in "2024 Comment Response" column.</p>	<p>3.1 Transitions of Coverage 3.2.1.2 Contractors Activities to Promote Enrollment 3.2.2.2 c) Marketing Plans 3.2.2.6 Distribution of Enrollment Materials 3.3.3 Agents in Covered California for the Individual Market</p>

2024 QHP ISSUER CONTRACT AMENDMENT – MILESTONES & TIMELINES

EQT	November Plan Management Advisory Group Meeting and Start of 1st External Comment Period Attachment (s) 1, 2, and 4, with 1st Public Posting.	Thu Nov 10 – Fri Dec 9, 2022
PMD	December Plan Management Advisory Group Meeting Review of 1 st Comment - Response	Thu Dec 8, 2022
PMD	Response to Comment and Updated 2024 QHP Issuer Model Contract Amendment Draft Documents 2 nd Public Posting and Start of 2 nd External Comment Period	Mon Dec 12 - Tue Dec 27, 2022
EQT	January Plan Management Advisory Group Meeting and Updated 2024 Attachment(s) 1, 2, and 4, 2 nd Public Posting	Thu Jan 12, 2023
PMD/EQT	2024 QHP Issuer Model Contract Amendment with Attachments 1, 2, and 4 for Board Discussion	Thu Jan 19, 2023
PMD/EQT	Final 2024 QHP Issuer Contract Amendment with Attachments 1, 2, 3 (no changes), and 4 for Board Approval and Public Posting.	Thu Feb 16, 2023

2024-2026 QDP ATTACHMENT 1 PUBLIC COMMENT THEMES

Health Equity and Quality Transformation Division (EQT)

2024-26 QDP ATTACHMENT 1 PUBLIC COMMENT KEY THEMES

Article 1: Equity and Disparities Reduction

Issuers are concerned that the **expectations of contracted health plans cannot be translated** to the dental space without further nuance:

- Plan and provider ecosystem is different
- Children are often covered through QHP, so consider the relationship between QHP and QDP reporting

Issuers requested better collaboration on **sharing data** between Covered California and plans:

- Lack of communication from HEI vendor hinders collaboration
- Requests Covered California transmit enrollee sexual orientation, gender identity and disability status information (though these aren't included in proposed demographic data collection requirements)

Consumer Advocates would like to **expand the scope** of contractual requirements:

- Add preferred language to list of communities at risk for disparities
- Rather than for consideration, disability status, sexual orientation and gender identity data collection should be required for 2024
- Add a requirement for mandatory oral interpretation beyond the threshold languages
- Add a requirement that issuers be generally knowledgeable of disparities and resources for their patients
- Add a requirement for a consumer experience survey

PROPOSED 2024-26 QDP ATTACHMENT 1 CHANGES

Article 1: Equity and Disparities Reduction

Notable Changes to Draft Attachment 1	Rationale
<p>1.01.1 Race, Ethnicity and Language Data Collection Removed proposed member self-reported Race, Ethnicity and Language data collection thresholds</p>	<p>The challenges and costs of implementing the required IT system changes make this unfeasible for QDP issuers at this time, given that other purchasers are not implementing similar requirements.</p> <p>Covered California can perform stratification of measures using demographic data collected at enrollment, permitting QDP issuers to focus on member engagement and utilization. Covered California will work with QDP issuers on a multi-year path toward disparities reduction.</p>

2024-26 QDP ATTACHMENT 1 PUBLIC COMMENT KEY THEMES

Article 2: Population Health

Population Health Management Plan

- **Issuers** requested a **narrowed focus and scope**, such as a target quality improvement project or pilot program, with a staged approach and ability to look at focus populations
- **Consumer Advocates** asked whether Covered California would be **approving issuers' population health management strategies** and recommended doing so
- **Consumer Advocates** recommended a **focus on eliminating bias**

PROPOSED 2024-26 QDP ATTACHMENT 1 CHANGES

Article 2: Population Health

Notable Changes to Draft Attachment 1	Rationale
2.01 Dental Population Health Management Plan Removed multi-year Population Health Management Plan and strategy requirement	Removed requirement to reinforce QDP focus on engagement in care and utilization and data infrastructure development to support future population health management strategy.

2024-26 QDP ATTACHMENT 1 PUBLIC COMMENT KEY THEMES

Article 3: Health Promotion and Prevention

Consumer Advocates recommended adding screening for **undiagnosed diabetes and hypertension** in addition to tobacco cessation and pregnancy

Dental Plan Benefits and Services Communication

Consumer Advocates provided recommendations and questions on the requirements for **dental plan benefits and services communication**:

- How will the plan's outreach activity in section 3.01 be monitored and assessed?
- How will modifications be made for subsequent years?
- Recommendation to include education on patient rights and grievance process
- Recommendation to include tailored outreach to communities experiencing healthcare disparities based on data

Issuers requested the removal of 3.01.5c, the proposed requirement to report the number and percent of Covered California Enrollees who complete recommended preventive services and treatment plans.

2024-26 QDP ATTACHMENT 1 PUBLIC COMMENT KEY THEMES

Cont. Article 3: Health Promotion and Prevention

Tobacco Cessation

Issuers expressed concerns regarding proposed **tobacco cessation** requirements:

- Requested removal of 3.02 (screening for tobacco use, referrals, resource of available cessation programs, and reporting requirements)
- Expressed concern regarding potential for provider administrative burden and re-contracting
- Commented that it is not possible to know which QHPs cover which tobacco cessation resources
- Asked what is meant by "team-based" care

Pregnancy

Issuers had similar concerns regarding the proposed **pregnancy** requirements:

- Requested removal of 3.03 (screening for pregnancy status, enhanced outreach to support preventive care and treatment during pregnancy, and reporting requirements)
- Expressed concern regarding potential for provider administrative burden and re-contracting
- Asked what is meant by "team-based" care

PROPOSED 2024-26 QDP ATTACHMENT 1 CHANGES

Article 3: Health Promotion and Prevention

Notable Changes to Draft Attachment 1	Rationale
<p>3.01 Dental Plan Benefits and Services Communication Removed 3.01.5.c, treatment plan completion reporting requirement</p>	<p>Information is not automated or readily available; preventive and treatment services utilization can be analyzed using QDP HEI data.</p>
<p>3.02 Tobacco Cessation Updated language on smoking cessation program resources.</p>	<p>Clarifying that issuers or providers should refer members reporting tobacco use to their health plan or primary care provider.</p>
<p>3.02.1 Tobacco Cessation & 3.03.1 Pregnancy Clarified screening and reporting requirements for tobacco use and pregnancy status.</p>	<p>To facilitate population oral health management for higher risk groups and adjust proposed requirements based on current practice to avoid increased administrative burden.</p>
<p>3.02.2 Tobacco Cessation & 3.03.2 Pregnancy Removed references to team-based care for tobacco cessation and pregnancy.</p>	<p>Infrastructure not currently available.</p>

2024-26 QDP ATTACHMENT 1 PUBLIC COMMENT KEY THEMES

Article 4: Delivery System and Payment Strategies to Drive Quality

Issuers commented that **Dental Home Model** would be a large and complex administrative lift

- The current contract language does not clearly identify what the plan is required to develop or implement
- Issuers do not see a current need for coordination of care for dental services

Issuers are concerned with administrative costs to implement **DPPO primary dentist assignment or selection**

- DPPO primary dentist assignment or selection is not a proven approach to increase utilization
- Issuers commented that having a primary care dentist is not industry standard practice in DPPOs
- Issuers requested removal of DPPO primary dentist assignment or clarification of requirement to provide selection recommendations to enrollees

Provider Advocates and Issuers mentioned that **HCP LAN Alternate Payment Models (APM) is a new concept** being introduced in the commercial dental market

- Issuers and provider advocates argue this will be a significant shift in the delivery care system of dental benefits which will require substantial investment in systems, resources, and processes
- Some issuers may utilize a leased dental network and do not have control over the contracting of the network providers

2024-26 QDP ATTACHMENT 1 PUBLIC COMMENT KEY THEMES

Article 4: Delivery System and Payment Strategies to Drive Quality (continued)

Issuers argue that providers will be unable to provide the administrative data to enable dental issuers to properly track and report the required **reporting components of teledentistry**

- Per comment received, there are no ADA billing or modifier codes
- Members are unwilling to provide more than necessary data to perform enrollment under a plan

Consumer Advocates recommend requiring QDPs to reimburse teledentistry at the same rate as in-person services to avoid disparities

PROPOSED 2024-26 QDP ATTACHMENT 1 CHANGES

Article 4: Delivery System and Payment Strategies to Drive Quality

Notable Changes to Draft Attachment 1	Rationale
<p>4.01 Promoting the Development and Use of Dental Home Model Reviewed contract language and added clarifying statement on Dental Home Model</p>	<p>Clarified language to address the concerns and confusion over the inclusion of the AAPD definition of the Dental Home Model. There is no requirement except to support the components of the definition.</p>
<p>4.01.1 Encouraging Use of Primary Dental Care Removed primary dentist selection in DPPO plans</p>	<p>Covered California will remove the proposed requirement based on concerns related to cost, administrative burden, and consumer confusion. The proposed requirement will be clarified as DHMO only.</p>
<p>4.02.1 Payment to Support High-Quality, Equitable Dental Care Clarified intent in contract language on HCP LAN APM payment type reporting</p>	<p>Clarified language to emphasize that there is no requirement to adopt or change payment models. The requirement is to report on issuers' dental payment model types. The goal of the reporting is intended to provide information to understand the relationship between payment type, access, and quality of care. Covered California acknowledges DPPO plans' reporting may be limited.</p>
<p>4.03.1 Teledentistry Offerings and Utilization Revised teledentistry reporting requirements</p>	<p>Revised to scale back some of the reporting requirements in teledentistry. Covered California acknowledges there are limitations in collecting information from members about their access barriers.</p>

2024-26 QDP ATTACHMENT 1 PUBLIC COMMENT KEY THEMES

Article 5: Measurement and Data Sharing

No public comments were received for this article

2024-2026 QDP ATTACHMENT 2 PUBLIC COMMENT THEMES

Health Equity and Quality Transformation Division (EQT)

2024-26 QDP ATTACHMENT 2 PUBLIC COMMENT KEY THEMES

Issuers are concerned about requirements surrounding **DHMO encounter data** and request to implement “test and learn” to improve encounter submissions by Provider

An **issuer** is concerned that there is an **unknown gap** between current performance and a future determined target:

- Lack of sizeable denominator
- Underreported claims
- Lack of history will create misrepresented calculations to meet the required utilization

Consumer Advocates suggest to add **additional measures to assess outcomes** and not only utilization

Consumer Advocates suggest to include language requiring Contractor to measure **Enrollee experience** as part of measuring and assessing program quality, similar to Enrollee Satisfaction Survey

An **issuer** expressed concern with setting an 80% requirement for **Race/Ethnicity Data Collection** without knowing the current threshold of collected information (*current QDP enrollee response rates range from 73-85% across QDP issuers as reported by Covered California in April 2022*)

2024-26 QDP ATTACHMENT 2 PUBLIC COMMENT KEY THEMES

Pediatric Measures

Issuers are concerned about **dual enrollment of pediatric members** in QHPs making it difficult for the QDP issuers to report accurately on metrics with no visibility to information or care received outside of their network:

- Request to remove pediatric measures and focus efforts on understanding where pediatric members are receiving dental services from to inform future measurements/performance standards
- Suggestion to use pediatric measures for reporting purposes only and not subject to a percent of premium at risk

Adult Measures

Provider Advocates suggest to clarify the definition of a “**preventive dental service**” to include specific CDT codes for consistency.

PROPOSED 2024-26 QDP ATTACHMENT 2 CHANGES

Notable Changes to Draft Attachment 2	Rationale
<p>Removed Performance Standard 1 Reducing Health Disparities: Demographic Data Collection – Enrollee Race and Ethnicity Self-Identification – Attachment 1, Article 1.01</p>	<p>At this time, we are focused on member engagement and utilization combined with HEI-produced measures.</p>
<p>Removed Performance Standard 2 Reducing Health Disparities: Demographic Data Collection – Enrollee Spoken and Written Language – Attachment 1, Article 1.01</p>	<p>At this time, we are focused on member engagement and utilization combined with HEI-produced measures.</p>
<p>Will define the Adult Preventive Services measure with inclusion of CDT codes in measure specification.</p>	<p>Covered California is reviewing the Medi-Cal specifications for potential alignment on this measure.</p>
<p>Added Proposed Performance Levels: Year 1 – establish baseline data; Year 2 – set performance targets; Year 3 – improvement year Covered California anticipates proposing a 10% improvement over the prior year.</p>	<p>Without external performance benchmarks, Covered California will take a plan-specific relative improvement approach, informed by analysis of baseline data.</p>

ELECTRONIC COMMUNICATIONS

Health Equity and Quality Transformation Division (EQT) & Legal

ELECTRONIC COMMUNICATIONS

Article 3.2: Marketing / Attachment 1

Issuers are concerned that **proposed outreach efforts will lead to higher costs** if dependent on paper mail:

- Request increased information sharing for enrollee electronic contact information (email addresses and phone numbers)
- Request that Covered California collects consent to be contacted electronically on behalf of issuers

ELECTRONIC COMMUNICATIONS

Electronic contact information sharing

- ❑ Currently, Covered California sends issuers information pertaining to an enrollee's preferred contact method
- ❑ System updates will be completed May 1, 2023, that will increase contact information sharing
- ❑ Up to three communication contacts will be transmitted if provided: home phone, cellular phone, work phone, and email address
- ❑ Changes to information will be shared with issuers

To the extent issuers are required to collect enrollee consent to use electronic communication methods, Covered California is unable to collect this consent on behalf of issuers.

- ❑ Covered California's consent complies with MARS-E and the Consumer Privacy Policy
- ❑ Covered California's consent is not tailored toward privacy requirements applicable to issuers

DEMOGRAPHIC DATA IMPROVEMENT PROJECT OVERVIEW & UPDATE

Health Equity and Quality Transformation Division (EQT)

OVERVIEW: BACKGROUND & GOALS

Background

- Covered California would like to more accurately assess health equity for its consumers
- The approach to collecting, storing and processing demographic data varies by the source and use of the data and depends on when during the enrollment cycle the consumer has provided their information and who is collecting the information
- Covered California also requires issuers to collect race/ethnicity data now and will require collection of more data elements in future plan years

Goals

- Continually center health equity best practices of health equity when deciding how and when to ask consumers for sensitive information
- Advance accurate and timely analysis of disparities measurement
- Better understand the Covered California enrollee population

WHEN AND WHERE CAN CONSUMERS SHARE THEIR DEMOGRAPHIC DATA?

- When **applying for coverage** at CoveredCA.com through the application
 - Race, ethnicity and limited sex information are asked in the flow of the application
 - Full sexual orientation and gender identity information are only asked in a supplemental questionnaire that consumers must navigate to after reaching their eligibility determination
- When **reporting a change** to the information they provided on the application
- When enrolling in Medi-Cal **through the county**
- When enrolling through a **certified agent or other assister**
- Through their **health plan** when interacting with customer service
- With their **provider** when receiving care

HOW DO WE ASK FOR DEMOGRAPHIC DATA IN THE APP?

Topic	Question	Answer Options	Where in the Application?	Optional or Mandatory?
Ethnicity (H/S/L indicator)	Is Jane of Hispanic, Latino or Spanish Origin?	Yes; No	In flow	Optional
Ethnicity (if yes)	What is Jane's origin?	Cuban; Guatemalan; Mexican/Mexica/ American/Chicano; Puerto Rican; Salvadorian; Other Hispanic, Latino, or Spanish Origin	In flow	Optional
Race	What is Jane's Race?	American Indian or Alaska Native; Asian Indian; Black or African American; Cambodian; Chinese; Filipino; Guamanian or Chamorro; Hmong; Japanese; Korean; Laotian; Native Hawaiian; Samoan; Vietnamese; White; Other	In flow	Optional
Spoken Language	In what language should we speak to Jane?	(extensive list)	In flow	Optional and defaults to English if no active selection is made (for noticing purposes)
Written Language	In what language should we write to Jane?	(extensive list)	In flow	Optional and defaults to English if no active selection is made (for noticing purposes)

HOW DO WE ASK FOR DEMOGRAPHIC DATA IN THE APP?

Topic	Question	Answer Options	Where in the Application?	Optional or Mandatory?
Sex	What is Jane's sex?	Female; Male; Transgender: Female to Male; Transgender: Male to Female	In flow	Required for every household member consumer adds
Gender	What is your gender? Select that option that best describes your current gender identity	Female; Male; Transgender: Female to Male; Transgender: Male to Female; Non-Binary (neither male nor female); Another gender identity	must be actively navigated to by consumer	Optional
Sex	What sex was listed on your original birth certificate?	Female; Male	must be actively navigated to by consumer	Optional
Sexual Orientation	Do you think of yourself as:	Straight or heterosexual; Gay or lesbian; Bisexual; Queer; Another sexual orientation; Unknown	must be actively navigated to by consumer	Optional
Disability Status	Does Jane have a physical, mental, emotional or developmental disability?	Yes, No	In flow after submission but only if applying for subsidies	Mandatory for subsidized applications, not shown to unsubsidized applications

CONSUMER EXPERIENCE AND DEMO DATA QUESTIONS

- Consumers spend an average of **27 minutes** on **account creation and eligibility determination**
- After eligibility, consumers spend an average of **18 minutes** to **select a plan**, for every **unassisted enrollment**
- Questions in the flow of the application (race, ethnicity, sex at birth, language) see significantly higher response rates *even when they are clearly labeled optional*
- Just **4% of households** that visit the eligibility results summary will make it to the SOGI supplementary questions
- Under the ACA generally, Covered CA cannot require consumers to answer questions that are not related to eligibility for health care
- CMS has allowed race and ethnicity questions to be an exception, and those questions are in the flow of the application, but are clearly noted as optional
- CMS has continued to decline to add the sexual orientation and gender identity questions to the flow of the application. Those questions are effectively hidden from the flow of the application and must be actively navigated to after eligibility.

HEALTH PLAN REQUIREMENTS TO COLLECT AND REPORT DEMOGRAPHIC DATA IN MODEL CONTRACT

Plan Year 2017-2022

- As of 2019, Contractor must meet target of 80% enrollee self-reported race or ethnicity data for Covered California Enrollees.

Plan Year 2023-2025

- Covered California intends to proceed with measures stratification by income for disparities identification and monitoring purposes.
- Contractor must continue to collect self-identified race and ethnicity data for at least 80% of its Covered California Enrollees. New Contractors must meet the 80% threshold by PY2024.
- Contractor must collect data on Covered California Enrollees' preferred spoken and written languages. By year end 2025, Contractor must collect written and spoken language preferences for a minimum of 80% of its Covered California Enrollees. Covered California will negotiate an interim target for 2024 based on 2023 baseline performance.

HOW IS DEMO DATA SHARED BETWEEN COVERED CALIFORNIA AND ISSUERS?

Every enrollment event or change of status through CalHEERS triggers an 834 electronic transaction from Covered California to the enrollee's plan.

Covered California sends all data elements *needed for eligibility* on every 834 transaction (including terminations and cancellations). Currently only those data elements collected in the flow of the application are considered needed for eligibility and included in the 834 transactions.



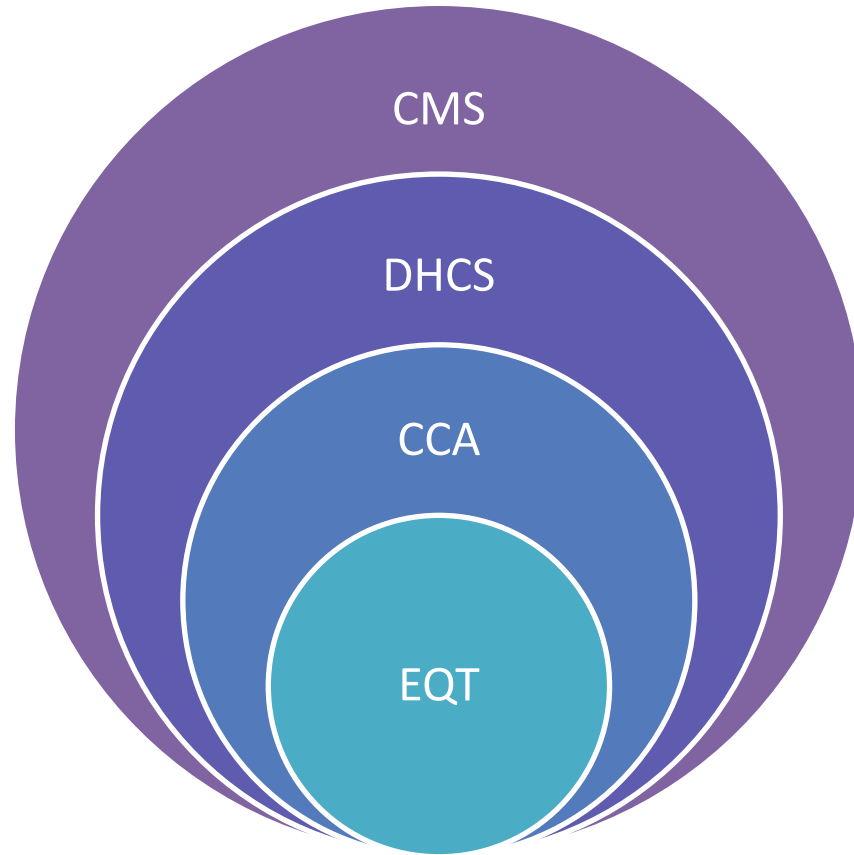
DOMAINS OF CONTROL

Covered CA Domain

- .com web contents
- Marketing materials
- Direct consumer outreach
- Staff training
- Agent/enroller training
- Data analysis

Internal EQT Domain

- HBEX web content
- Policy statements
- Engagement with Issuers
- Model contract language
- Internal training
- Public reporting



Dept Of Healthcare Service (DHCS) Domain

- Changes to the Shared Single Application (SSA) Contents, including language and order of questions

Centers for Medicare & Medicaid Services (CMS) Domain

- Whether we can ask consumers for demographic data elements that are not required for an eligibility determination

CHANGE REQUESTS: RACE, ETHNICITY AND LANGUAGE

Preferred Spoken and Written Language Clarifications (in progress)

- Clarifying preferred spoken and written language response rates
- If an applicant does not answer the preferred spoken and written language questions, business rules will default to English in order to allow automated mandatory notices to be produced
- This change will allow visibility into the default rates in order to assess next best steps

H/S/L Indicator Transmission (enacted Sept 2022)

- The application has a 2-step question soliciting ethnic identity (see page 30 for exact language)
 - The first question asks applicants to indicate whether they identify as Hispanic, Spanish Origin or Latino (H/S/L)
 - Responding YES to the H/S/L indicator causes an additional question to appear where applicants can provide a more specific ethnic identity
- Before the fix, the H/S/L indicator response was not included in 834 transactions, and only ethnicity selections were shared with issuers

CURRENT INITIATIVES: SEXUAL ORIENTATION AND GENDER IDENTITY

Internal Learning

- Building internal capacity in order to map data flow and response rates
- Contractor engagement and internal learning to begin identifying best practices around how to ask and how to support consumer comfort with sharing personal identifying information, including legal options for state-based exchanges

Moving SOGI questions to the flow of the application

- This year Covered California and Dept. of Healthcare Services once again raised the question of moving the SOGI questions to the flow of the application to CMS and is awaiting an official response

Making supplementary questions more accessible

- Covered California is working with CalHEERS to explore how to make it easier to access and update the supplementary questions even if the questions are not in the flow of the application

CURRENT INITIATIVES: DISABILITY STATUS

Internal Learning and Capacity Building Still Needed

- ❑ Current question functions as a flag for Medicaid programs and is shown to subsidized applicants only
- ❑ Not adequate to capture disability status (versus eligibility for Medicaid programs)
- ❑ Business rules do not make any information collected available for 834 transactions
- ❑ Covered California is still learning about current available best practices, while federal regulators and industry partners have not yet aligned on approaches to collecting this information

CERTIFICATION

Plan Management Division

CERTIFICATION APPLICATION UPDATES

- The four draft applications and **PY23** to **PY24** crosswalks were posted on **Tuesday, 11/22** with public comment due tomorrow, **Friday, 12/9**
- The dental applications have been reorganized to mirror the PY23 health applications rewrite
 - Outside of quality, changes in the dental applications mainly consist of moving sections and questions and rewriting for clarity
- The health applications are in a recertification year with changes mainly consisting of adding specificity and removing unneeded questions
- Covered CA will respond to public comments by the January Plan Advisory Group meeting on **Thursday, January 12th**
- The updated PY24 draft certification applications incorporating any changes resulting from public comment will be posted to the Certification HBEX page before the January Board meeting on **Thursday, January 19th**

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

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