Attachment 14. Performance Standards

During the term of this Agreement, Contractor shall meet or exceed the Performance Standards identified in this Attachment. For those Performance Standards with Penalties, Contractor shall be responsible for payment of penalties for Contractor's failure to meet the Performance Standards in accordance with the terms set forth in Section 6.1 of the Agreement and this Attachment 14. Contractor shall submit the data required by the Performance Standards by the date specified by Covered California. Some of the data required applies to a window of time. Some of the data represents a point in time. This measurement timing is described in more detail in the sections within this Attachment.

Contractor shall monitor and track its performance each month against the Performance Standards and provide Covered California with a detailed Monthly Performance Report in a mutually-agreeable format. Contractor must report on Covered California business only and report Contractor's Enrollees in Covered California for the Individual Exchange separate from Contractor's Enrollees in Covered California for Small Business. Except as otherwise specified below in the Performance Standards Table, the reporting period for each Performance Standard shall be one calendar month. All references to days shall be calendar days and references to time of day shall be to Pacific Standard Time.

If Contractor fails to meet any Performance Standard in any calendar month (whether or not the failure is excused), Covered California may request and Contractor shall (a) investigate and report on the root cause of the problem; (b) develop a corrective action plan (where applicable); (c) to the extent within Contractor's control, remedy the cause of the performance failure and resume meeting the affected Performance Standards; (d) implement and notify Covered California of measures taken by Contractor to prevent recurrences, if the performance failure is otherwise likely to recur; and (e) make written recommendations to Covered California for improvements in Contractor's procedures.

As specified below, certain Performance Standards are subject to penalties. The total amount at risk is equal to ten percent (10%) of the total Participation Fee paid by Contractor in accordance with the terms set forth in Section 5.1.3 of the Agreement for the Individual Market (At-Risk Amount). Penalties will be determined on an annual basis at the end of each calendar year, based on Contractor's final year-end data for each Performance Standard. The amount of penalty will be reduced by any credit Contractor receives. Where applicable, performance is assessed for each product (HMO, PPO, EPO) the Contractor offers. Penalties are weighted by enrollment in the product for Contractor's with multiple products. Covered California has specified below when the At-Risk Amount or the performance requirements differ by product. In no event shall the total credits to Contractor exceed the total amount of the performance penalty owed to Covered California by Contractor.

Covered California will provide the Contractor an Initial Contractor Performance Standard Evaluation Report, covering preliminary year end data available, which Covered California will send to Contractor for review no later than February 28th of the following calendar year.

When the results of the Performance Standards are calculated, Covered California will provide Contractor with a Final Contractor Performance Standard Evaluation Report, along with an invoice, within 60 calendar days of receipt of the Performance Standards data requirements. Contractor shall remit payment to Covered California within 30 calendar days of receiving the Final Contractor Performance Measurement Evaluation Report and invoice.

If Contractor does not agree with either the Initial or Final Performance Standard Evaluation Report, Contractor may dispute the Report in writing within thirty (30) calendar days of receipt of that Report. The written notification of dispute shall provide a detailed explanation of the basis for the dispute. Covered California shall review and provide a written response to Contractor's dispute within thirty (30) calendar days of receipt of Contractor's notification of dispute. If the Contractor still disputes the findings of Covered California, Contractor may pursue additional remedies in accordance with Section 12.1 of the Agreement.

Contractor shall not be responsible for any failure to meet a Performance Standard if and to the extent that the failure is excused pursuant to Section 12.7 of the Agreement (Force Majeure), or the parties agree that the lack of compliance is due to Covered California's failure to properly or timely perform (or cause to be properly or timely performed) any responsibility, duty, or other obligation under this Agreement, provided that Contractor timely notifies Covered California of the problem and uses commercially reasonable efforts to perform and meet the Performance Standards notwithstanding Covered California's failure to perform or delay in performing.

If Contractor wishes to avail itself of one of these exceptions, Contractor must notify Covered California in its response to the performance report identifying the failure to meet such Performance Standard. This response must include: (a) the identity of the Performance Standard that is subject to the exception, and (b) the circumstances that gave rise to the exception in sufficient detail to permit Covered California to evaluate whether Contractor's claim of exception is valid. Notwithstanding anything to the contrary herein, in no event shall any failure to meet a Customer Satisfaction Performance Standard fall within an exception.

The Parties may adjust, suspend, or add Performance Standards from time to time, upon written agreement of the parties, without an amendment to this contract.

Performance Standards and Expectations				
Covered California will create an Annual Report of Performance Standards and Expectations, displaying Contractor's final Plan Year 2022 performance in Performance Standards and Expectations, Standards 1.1 - 1.11, to be posted publicly on Covered California's website. Covered California will continue public reporting of its service level performance metrics.				
Performance Standard		**Performance Requirements**	**Contractor Must Submit Data by the 10th of the following month**	**Measurement Period**
1.1	**Abandonment Rate**	Expectation: No more than 3% of incoming calls abandoned in a calendar month. Divide number of abandoned calls by the number of calls offered to a phone representative.	X	January 1, 2022-December 31, 2022
1.2	**Service Level**	Expectation: 80% of calls answered in 30 seconds or less.	X	January 1, 2022-December 31, 2022
1.3	**Grievance Resolution**	Expectation: 95% of Covered California enrollee grievances resolved within 30 days of initial receipt.	X	January 1, 2022-December 31, 2022
1.4	**Covered California member Email or Written Inquiries Answered and Completed**	Expectation: 90% of Covered California member email or written inquiries not relating to Urgent Access to Care issues answered and completed within 15 business days of the inquiry.	X	January 1, 2022-December 31, 2022
1.5	**ID Card Processing Time**	Expectation: 99% of ID cards issued within 10 business days of receiving complete and accurate enrollment information and binder payment for a specific consumer(s).	X	January 1, 2022-December 31, 2022

Performance Standards and Expectations				
Performance Standard		**Performance Requirements**	**Contractor Must Submit Data by the 10th of the following month**	**Measurement Period**
1.6	**Implementation of Appeals Decisions**	Expectation: 90% of Administrative Law Judge decisions will be implemented within ten (10) days of Contractor's receipt of all necessary data elements from Covered California required to implement the appeals decision.	X	January 1, 2022- December 31, 2022
1.7	**834 Processing**	Expectation: Covered California will receive a TA1 or 999 file, or both as appropriate within three business days of receipt of the 834 transaction 95% of the time.		Plan Year 2022, 834 transactions will begin with renewals. October 1, 2021 – December 31, 2022
1.8	**834 Generation – Effectuation and Cancellation Transactions**	Expectation: Covered California will successfully receive and process effectuation, and cancellation 834 transactions within 60 days from either the coverage effective date or transaction timestamp, whichever is later 95% of the time.		Plan Year 2022 834 transactions will begin with renewals. October 1, 2021 – December 31, 2022
1.9	**834 Generation – Termination Transactions**	Expectation: Covered California will receive termination 834 transactions within ten days of the grace period expiration 95% of the time.		Plan Year 2022 834 transactions will begin with renewals. October 1, 2021 – December 31, 2022

Performance Standards and Expectations				
Performance Standard		**Performance Requirements**	**Contractor Must Submit Data by the 10th of the following month**	**Measurement Period**
1.10	**Reconciliation Process**	Expectation: Covered California shall receive a comparison reconciliation extract in accordance with the file validations and resolution timelines, as mutually agreed upon in the Reconciliation Process Guide (Extranet, Data Home, Contractor's folder) 90% of the time for accuracy and timeliness.		January 1, 2022-December 31, 2022
1.11	**Provider Directory Data Submission**	Expectation: Full and regular submission of provider data according to the standards outlined in the Performance Standard contract specific to contract Section 3.4.4. Submissions occur every month pursuant to the submission schedule (Extranet, Plan Home, Resources, Provider Directory Resources, Covered California Provider Data Submission Schedule_Current Year).		January 1, 2022-December 31, 2022

Performance Standards and Expectations				
Performance Standard		**Performance Requirements**	**Contractor Must Submit Data by the 10th of the following month**	**Measurement Period**
1.12	**Essential Community Providers – Article 3, Section 3.3.3**	Expectation: 1. Contractor to demonstrate provider agreements with at least 15% of 340B non-hospital providers in each applicable rating region. 2. Contractor to demonstrate provider agreements that reflect a mix of essential community providers (hospital and non-hospital) reasonably distributed to serve the low-income, vulnerable, or medically underserved populations. Or meet Alternate Standard Contractor requirements. Refer to Article 3, Section 3.3.3.		January 1, 2022-December 31, 2022
1.13	**Hospital Safety – Attachment 7, Article 10, Section 10.02**	Contractor shall adopt a payment strategy that places hospital payments in Covered California networks either at risk or subject to a bonus payment for quality performance Contractor may structure this strategy according to its own priorities, with the exception that if the Contractor uses readmissions measure, it shall not be the only measure. Contractor shall report on its strategy and progress on adoption of the payment strategy annually. Expectation: At least 2% of payments to hospitals in Covered California network(s) are at-risk for quality performance by year-end 2022.		January 1, 2022-December 31, 2022

Performance Standards with Penalties		
Health Evidence Initiative (HEI) Data		
Definitions for Performance Standard 2.1 Incomplete: A file or part of a file is missing, or critical data elements are not provided. Irregular: Unexpected file or data element formatting, or record volumes or data element counts / sums deviate significantly from historical submission patterns for the data supplier. Late: Data is submitted on a date later than the supplier's agreed-upon submission date (i.e., between the 5th and 15th of the month) plus five business days. Non-Usable: HEI Vendor cannot successfully include submitted data in its database build, or HEI Vendor's or Covered CA's analysts determine that critical components of the submitted data cannot be used or relied upon in subsequent analytic work.		
Performance Standard		**Performance Requirements**
2.1	**HEI Data Submission specific to Attachment 7, Section 15.01 Data Submission.** 10% of At-Risk Amount.	Expectation: Full and regular submission of data according to the standards outlined in the Attachment 7 citations. The Contractor must work with Covered California and HEI vendor to ensure accuracy of data variables on an ongoing basis. Performance Levels: 1. Incomplete, irregular, late or non-useable submission of HEI data: 3% penalty of total performance requirement. Failure to submit required financials (e.g., allowed, copay, coinsurance, and deductible amounts) or dental claims covered under medical benefits constitutes incomplete submission. Full and regular submission according to the formats specified and useable by Covered California within 5 business days of each monthly reporting cycle: no penalty. 2. Inpatient facility medical claim submissions for which the HEI Vendor cannot identify / match at least 95% of admissions to its Master Provider Index: 3% penalty of total performance requirement. Submission meeting or surpassing the 95% identification / matching threshold: no penalty.

		3. Professional medical and Rx claim submissions with provider taxonomy or type missing or invalid on more than 1% of records: 2% penalty of total performance requirement. Submission meeting or surpassing the 99% populated and valid threshold: no penalty. 4. Enrollment or professional medical claim submissions with PCP NPI ID missing or invalid on more than 1% of records: 2% penalty of total performance requirement. Submission meeting or surpassing the 99% populated and valid threshold: no penalty.

Performance Standards with Penalties Quality, Network Management and Delivery System Standards	
The Parties may adjust, suspend, or add Performance Standards from time to time, upon written agreement of the parties, without an amendment to this contract. 90% of At-Risk Amount for Measurement Year 2022.	
Covered California and Contractor shall work together to periodically review and adjust the specific measures consistent with any applicable Federal regulations.	
Performance Standards 3.1 and 3.2	
QHP Issuers are required by CMS annually to collect and submit third-party validated QRS measure data, for the previous measurement year that will be used by CMS to calculate QHP scores and ratings. These measures will be determined by CMS. Covered California will publicly report the QRS scores and ratings that are produced by CMS and reserves the right to produce additional QRS scores from the CMS data for public release. QRS scores are based on surveys of both individual market and Covered California for Small Business Enrollees for those products offered in both marketplaces. Performance penalties will be calculated using the PMPM for individual market only. The Contractor will still be subject to an assessment of penalty or no penalty for Measurement Year 2021 (Plan Year 2023 QRS) if Covered California issues a rating score and CMS does not issue a rating score (as was done for Measurement Year 2019 (Plan Year 2021 QRS). However, if neither Covered California or CMS issues a rating score, then the Contractor will not be subject to an assessment of penalty or no penalty.	
Performance Standard	**Performance Requirements**

3.1	**Quality Rating System (QRS) – QHP Clinical Quality Management Summary Indicator Rating** 33.5% of At-Risk Amount	Expectation: QHP Clinical Quality Management Summary Indicator Rating (product type reporting): Performance Level: The rating score will be based on the QRS performance benchmarks supplied by CMS or adjusted, as appropriate, by Covered California. 1-2 Stars: **33.5% performance penalty**. 3-5 Stars: **no penalty**.
3.2	**Quality Rating System (QRS) QHP Enrollee Experience Summary Indicator Rating** 16.5% of At-Risk Amount	Expectation: QHP Enrollee Experience Summary Indicator Rating (product type reporting): Performance Level: The rating score will be based on the QRS performance benchmarks supplied by CMS or adjusted, as appropriate, by Covered California. 1-2 Stars: **16.5% performance penalty.** 3-5 Stars: **no penalty.**

Performance Standards with Penalties

Quality, Network Management and Delivery System Standards

Definitions for Performance Standards: 3.3 – 3.6
Measurement Year: The calendar year that activity being assessed is performed
Reporting Year: The calendar year that performance data is reported to Covered California
Assessment Year: The calendar year that performance data is evaluated, and Measurement Year performance level is determined

Performance Standard 3.3a)

3.3a) Reducing Health Disparities – Attachment 7, Article 1, Sections 1.01 and 1.02 – 7.5% of At-Risk Amount

Contractor will meet the target of eighty percent (80%) enrollee self-reported race or ethnicity data for Covered California Enrollees by year-end 2022. Contractor must demonstrate compliance by including valid race and ethnicity attributes for at least 80% of Covered California Enrollees in its Healthcare Evidence Initiative (HEI) data submissions.

Please note the following specifications:
a. See list of acceptable standard values in separate methodology document.
b. "Other", "mixed", "multi-racial", etc. values do apply toward meeting the 80% race and ethnicity thresholds.
c. "Null", "blank", "missing", "unknown", "not reported", "decline to state", etc. values DO NOT apply toward meeting the 80% race and ethnicity thresholds.

Performance Requirements 3.3a)

Measurement Year 2017	Measurement Year 2018	Measurement Year 2019	Measurement Year 2020	Measurement Year 2021	Measurement Year 2022
No Assessment for Measurement Year 2017.	Expectation: Meet 2018 intermediate milestone for self-reported racial or ethnic identify by the end of 2018. Performance Levels: Contractor achieves no improvement in self-reported identity from baseline: **2% penalty** Contractor shows improvement in self-reported identity, but	Expectation: Meet target of 80% self-reported racial or ethnic identify by the end of 2019. Performance Levels: Contractor achieves no improvement in self-reported identity from 2018 and does not meet 80% target: **2% penalty**	Expectation: Meet or continue to meet target of 80% self-reported racial or ethnic identity for Measurement Year 2020. Performance Levels: Contractor does not meet 80% target for self-reported identity: **2% penalty** Contractor achieves 80% target for self-	Expectation: Meet or continue to meet target of 80% self-reported racial or ethnic identity for Measurement Year 2021. Performance Levels: Contractor does not meet 80% target for self-reported	Expectation: Meet the target of 80% self-reported race or ethnic identity for Measurement Year 2022. Performance Levels: Contractor does not meet 80% target for self-reported identity for Covered California Enrollees: **7.5% penalty** Contractor meets 80% target for self-reported

	does not meet incremental target by end of 2018: **No penalty** Contractor achieves incremental target for self-reported identity by end of 2018: **2% credit**	Contractor achieves improvement in self-reported identity, but does not meet 80% target: **No penalty** Contractor achieves 80% target for self-reported identity by end of 2019: **2% credit**	reported identity: **2% credit**	identity: **2% penalty** Contractor achieves 80% target for self-reported identity: **2% credit**	identity for Covered California Enrollees: **no penalty**

Performance Standards with Penalties

Quality, Network Management and Delivery System Standards

Performance Standard 3.3b)

3.3b) Disparities Reduction Intervention – Attachment 7, Article 1, Sections 1.03 - 7.5% of At-Risk Amount

Contractor will demonstrate meaningful improvement for the selected disparity measure for the intervention population based on the mutually agreed upon intervention proposal and target improvement rate. Contractor must report progress, including analysis of outcomes and potential to scale or replicate intervention, through submission of an acceptable and approved disparities intervention progress report.

Performance Requirements 3.3b)

Measurement Year 2017	Measurement Year 2018	Measurement Year 2019	Measurement Year 2020	Measurement Year 2021	Measurement Year 2022
No Assessment for Measurement Year 2017	No Assessment for Measurement Year 2018	No Assessment for Measurement Year 2019	Performance Levels: Contractor does not select at least one disparity measure for reduction or does not meet mutually agreed upon milestone(s) selected for the 2020 disparity reduction target: **3% penalty** Contractor meets mutually agreed upon milestone(s) selected for the 2020 disparity target: **3% credit**	Performance Levels: Contractor does not meet mutually agreed upon milestone(s) selected for the 2021 disparity reduction target: **3% penalty** Contractor meets mutually agreed upon milestone(s) selected for the 2021 disparity target: **3% credit**	Performance Levels: Contractor submits progress reports AND Contractor does not meet target improvement rate in intervention population for identified disparity measure: **7.5% penalty** Contractor meets target improvement rate in intervention population for identified disparity measure: **no penalty**

Performance Standards 3.3c)

3.3c) Health Equity Capacity Building - Attachment 7, Article 1, Section 1.05 – 2% Credit

Contractor must achieve and maintain NCQA Multicultural Health Care Distinction (MHCD).

Performance Requirements 3.3c)

3.3c) Performance Level

Contractor demonstrates *early* compliance of NCQA Multicultural Health Care Distinction (MHCD) attainment (by December 30, 2022): **2% credit**

Performance Standards with Penalties

Quality, Network Management and Delivery System Standards

Performance Standard 3.4

3.4 Primary Care – Attachment 7, Article 7, Section 7.04
HMO Products: 10% of At-Risk Amount
PPO and EPO Products: 20% of At-Risk Amount

Contractor describes a payment strategy for adoption and progressive expansion of primary care payment models that provide the revenue necessary for Primary Care Providers (PCPs) to adopt accessible, data-driven, team-based care. The Contractor must progressively expand the number and percent of primary care clinicians paid through the HCP LAN APM categories of population-based payment (Category 4) and alternative payment models built on fee for service structure such as shared savings (Category 3) and meet a minimum threshold by end of Plan Year 2022.

Data from Measurement Year 2020 providing the percent of PCPs paid under the new payment strategy will be compared to Measurement Year 2019 data. Data from Measurement Year 2021 providing the percent of PCPs paid under the new payment strategy will be compared to Measurement Year 2020 data.

Performance requirements differ by product.

Performance Requirements 3.4

Measurement Year 2017	Measurement Year 2018	Measurement Year 2019	Measurement Year 2020	Measurement Year 2021	Measurement Year 2022
Expectation: Describe payment strategy and begin re-contracting by end of Plan Year 2017 Performance Levels: Contractor does not provide description of payment strategy or reports no PCPs contracted based on new payment strategy: **3% penalty**	Expectation: Describe payment strategy and begin re-contracting by end of Plan Year 2018. Performance Levels: Contractor does not provide description of payment strategy or reports no PCPs contracted based on new payment strategy**: 3% penalty** Contractor provides description of payment	Expectation: Describe payment strategy and begin re-contracting by end of Plan Year 2019. Performance Levels: Contractor does not provide description of payment strategy or reports no PCPs contracted based on new payment strategy: **3% penalty** Contractor provides description of payment	Expectation: Describe payment strategy and make further progress in re-contracting by end of Plan Year 2020. Performance Levels: Contractor reports no increase in the percentage of PCPs contracted under new payment strategy compared to Measurement Year 2019: **3% penalty**	Expectation: Describe payment strategy and make further progress in re-contracting by end of Plan Year 2021. Performance Levels: Contractor reports no increase in the percentage of PCPs contracted under new payment strategy compared to	Expectation: Contractor meets a minimum threshold of PCPs paid under HCP LAN APM Category 3 or Category 4 by end of Plan Year 2022. Performance Levels: HMO Products: Contractor demonstrates that 0 to <80% of PCPs are contracted under HCP

Contractor provides description of payment strategy and reports more than 0% but less than 10% of PCPs contracted under new payment strategy: **No penalty** Contractor provides description of payment strategy and reports 10% or more of PCPs contracted under new payment strategy: **3% credit**	strategy and reports more than 0% but less than 10% of PCPs contracted under new payment strategy: **No penalty** Contractor provides description of payment strategy and reports 10% or more of PCPs contracted under new payment strategy: **3% credit**	strategy and reports more than 0% but less than 10% of PCPs contracted under new payment strategy: **No penalty** Contractor provides description of payment strategy and reports 10% or more of PCPs contracted under new payment strategy: **3% credit**	Contractor reports an increase of more than 0% but less than 10% in the percentage of PCPs contracted under new payment strategy compared to Measurement Year 2019: **No penalty** Contractor reports an increase of 10% or more in the percentage of PCPs contracted under new payment strategy compared to Measurement Year 2019: **3% credit**	Measurement Year 2020: **3% penalty** Contractor reports an increase of more than 0% but less than 10% in the percentage of PCPs contracted under new payment strategy compared to Measurement Year 2020: **No penalty** Contractor reports an increase of 10% or more in the percentage of PCPs contracted under new payment strategy compared to Measurement Year 2020: **3% credit**	LAN APM Category 3 or Category 4: **10% penalty** Contractor demonstrates that between 80% and <90% of PCPs are contracted under HCP LAN APM Category 3 or Category 4: **5% penalty** Contractor demonstrates that between 90% and <95% of PCPs are contracted under HCP LAN APM Category 3 or Category 4: **2.5% penalty** Contractor demonstrates that ≥95% of PCPs are contracted under HCP LAN APM Category 3 or Category 4: **No penalty** <u>PPO and EPO Products:</u> Contractor demonstrates that 0 to <20% of PCPs are contracted under HCP LAN APM Category 3 or Category 4: **20% penalty**

					Contractor demonstrates that between 20% and <30% of PCPs are contracted under HCP LAN APM Category 3 or Category 4: **15% penalty** Contractor demonstrates that between 30% and <40% of PCPs are contracted under HCP LAN APM Category 3 or Category 4: **10% penalty** Contractor demonstrates that ≥40% of PCPs are contracted under HCP LAN APM Category 3 or Category 4: **No penalty**

Performance Standards with Penalties

Quality, Network Management and Delivery System Standards

Performance Standard 3.5

3.5 Accountable Care Organizations (ACOs) – Attachment 7, Article 8, Section 8.01

HMO Products: 10% of At-Risk Amount
PPO and EPO Products: 0% of At-Risk Amount

Contractor increases Covered California enrollment in ACOs (previously referred to as integrated healthcare models) and meets a minimum threshold for ACO enrollment by end of Plan Year 2022. An ACO is defined as a system of population-based care coordinated across the continuum including multidisciplinary physicians and physician groups, hospitals, and ancillary providers with combined risk sharing arrangements and incentives between the Contractor and providers.

Baseline identified from data reported in Measurement Year 2017 and 2018. Data from Measurement Year 2019 providing the percentage of Covered California membership in ACOs will be compared to baseline reported. Data from Measurement Year 2020 will be compared to Measurement Year 2019 data. Data from Measurement Year 2021 will be compared to Measurement Year 2020 data.

Performance requirements differ by product.

Performance Requirements 3.5

Measurement Year 2017	Measurement Year 2018	Measurement Year 2019	Measurement Year 2020	Measurement Year 2021	Measurement Year 2022
No Assessment for Plan Year 2017	No Assessment for Plan Year 2018	Expectation: Contractor increases the percentage of enrollment in IHMs by the end of 2019. Performance Levels: Contractor reports no increase in the percentage of membership attributed or assigned to IHMs: **5% penalty** Contractor reports an increase of more than	Expectation: Contractor increases the percentage of enrollment in ACOs by the end of 2020. Performance Levels: Contractor reports no increase in the percentage of membership attributed or assigned to ACOs compared to Measurement Year 2019: **5% penalty**	Expectation: Contractor increases the percentage of enrollment in ACOs by the end of 2021. Performance Levels: Contractor reports no increase in the percentage of membership attributed or assigned to ACOs compared to Measurement Year 2020: **5% penalty**	Expectation: Contractor meets a minimum threshold of enrollment in ACOs by the end of Plan Year 2022. Performance Levels: HMO Products: Contractor reports 0 to <60% of membership is attributed or assigned to ACOs: **10% penalty** Contractor reports 60 to <70% of membership is

		0% but less than 10% in membership attributed or assigned to IHMs: **No penalty** Contractor reports an increase of 10% or more in membership	Contractor reports an increase of more than 0% but less than 10% in membership attributed or assigned to ACOs compared to Measurement Year 2019: **No penalty**	Contractor reports an increase of more than 0% but less than 10% in membership attributed or assigned to ACOs compared to Measurement Year 2020: **No penalty**	attributed or assigned to ACOs: **5% penalty** Contractor reports 70 to <80% of membership is attributed or assigned to ACOs: **2.5% Penalty** Contractor reports ≥80% of membership is attributed or assigned to ACOs: **No penalty** <u>PPO and EPO Products</u>: Not applicable.

Performance Standards with Penalties

Quality, Network Management and Delivery System Standards

Performance Standard 3.6

3.6 Appropriate Use of C-Sections – Attachment 7, Article 10, Section 10.04 – 5% of At-Risk Amount

Contractor shall adopt a payment methodology progressively to include all contracted physicians and hospitals serving Enrollees, such that by year end 2022, payment is structured to support only medically necessary care and there is no financial incentive to perform C-sections. Smart Care California has outlined three payment strategies to align payment with medically necessary use of C-sections:

i. Adopt a blended case rate payment for both physicians and hospitals;
ii. Include a NTSV C-section metric in existing hospital and physician quality incentive programs; and
iii. Adopt population-based payment models, such as maternity episode payment models.

Contractor shall report on its strategy and progress on adoption of the payment strategy annually.

Performance Requirements 3.6

Measurement Year 2017	Measurement Year 2018	Measurement Year 2019	Measurement Year 2020	Measurement Year 2021	Measurement Year 2022
No Assessment for Plan Year 2017	No Assessment for Plan Year 2018	Expectation: All physicians and hospitals are re-contracted with new payment structure by the end of 2019. Performance Levels: Contractor is unable to demonstrate that >33% of physicians and >33% hospitals have been re-contracted to not incentivize NTSV C-section: **4.5% penalty** Contractor demonstrates that 33% to 66% of physicians and hospitals have	Expectation: All physicians and hospitals are re-contracted with new payment structure by the end of 2020. Performance Levels: Contractor is unable to demonstrate that >50% of physicians and >50% hospitals have been re-contracted to not incentivize NTSV C-section: **4.5% penalty** Contractor demonstrates that ≥50% to <80% of physicians and ≥50% to	Expectation: All physicians and hospitals are re-contracted with new payment structure by the end of 2021. Performance Levels: Contractor is unable to demonstrate that >50% of physicians and >50% of hospitals have been re-contracted to not incentivize NTSV C-section: **4.5% penalty** Contractor demonstrates that ≥50% to <80% of physicians and ≥50% to <80% of hospitals have been re-contracted to not	Expectation: All physicians and hospitals are re-contracted with new payment structure by the end of 2022. Performance Levels: Contractor demonstrates that 0 to <25% of physicians and 0 to <25% of hospitals have been re-contracted to not incentivize NTSV C-section: **5% penalty** Contractor demonstrates that between 25% and <50% of physicians and between 25% and <50% of hospitals have been re-contracted to not

		been re-contracted to not incentivize NTSV C-section: **No penalty** Contractor demonstrates that >66% of physicians and hospitals have been re-contracted to not incentivize NTSV C-section: **4.5% credit**	<80% of hospitals have been re-contracted to not incentivize NTSV C-sections: **No penalty** Contractor demonstrates that ≥80% of physicians and hospitals have been re-contracted to not incentivize NTSV C-sections: **4.5% credit**	incentivize NTSV C-sections: **No penalty** Contractor demonstrates that ≥80% of physicians and hospitals have been re-contracted to not incentivize NTSV C-sections: **4.5% credit**	incentivize NTSV C-section: **3% penalty** Contractor demonstrates that between 50% and <75% of physicians and between 50% and <75% of hospitals have been re-contracted to not incentivize NTSV C-section: **1.5% penalty** Contractor demonstrates that ≥75% of physicians and ≥75% hospitals have been re-contracted to not incentivize NTSV C-sections: **No penalty**

Performance Standards with Penalties

Dental Quality Alliance (DQA) Pediatric Measure Set

Pilot Period: January 1, 2021 – December 31, 2022

Contractor must annually report on the following Performance Standards for embedded pediatric dental for each plan year. Contractor must submit this report by April 30th of the following calendar year.

Measure		Description	Numerator	Denominator	QDP Performance Rate	Expectation
4.1	**Utilization of Services**	Percentage of all enrolled children aged 0 - 1 who received at least one dental service within the reporting year.	Unduplicated number of enrolled children aged 0 – 1 who received at least one dental service.	Unduplicated number of all enrolled children aged .0 - 1	NUM/DEN	10%
4.2	**Utilization of Services**	Percentage of all enrolled children aged 2 – under age 19 who received at least one dental service within the reporting year.	Unduplicated number of enrolled children aged 2 – under 19 who received at least one dental service.	Unduplicated number of all enrolled children aged 2 – under age 19.	NUM/DEN	50%
4.3	**Oral Evaluation**	Percentage of enrolled children under age 19 who received a comprehensive or periodic oral evaluation within the reporting year.	Unduplicated number of enrolled children under age 19 who received a comprehensive or periodic oral evaluation as a dental service.	Unduplicated number of enrolled children under age19.	NUM/DEN	50%
4.4 a	**Sealants in 10 year olds**	Percentage of enrolled children, who have ever received sealants on a permanent first molar tooth: (1) at least one sealant sealed by 10th birthdate.	Unduplicated number of enrolled children who ever received sealants on a permanent first molar tooth: (1) at least one sealant.	Unduplicated number of enrolled children with their 10th birthdate in measurement year.	NUM1/DEN	20%

Performance Standards with Penalties

Dental Quality Alliance (DQA) Pediatric Measure Set

Pilot Period: January 1, 2021 – December 31, 2022

Contractor must annually report on the following Performance Standards for embedded pediatric dental for each plan year. Contractor must submit this report by April 30th of the following calendar year.

Measure		Description	Numerator	Denominator	QDP Performance Rate	Expectation
4.4 b	**Sealants in 10 year olds**	Percentage of enrolled children, who have ever received sealants on a permanent first molar tooth: (2) all four molars sealed by 10th birthdate.	Unduplicated number of enrolled children who ever received sealants on a permanent first molar tooth: (2) all four molars sealed.	Unduplicated number of enrolled children with their 10th birthdate in measurement year. Exclude children who received treatment (restorations, extractions, endodontic, prosthodontic, and other dental treatments) on all four first permanent molars in the 48 months prior to the 10th birthdate.	NUM2/DEN (after exclusions)	20%
4.5 a	**Sealants in 15 year olds**	Percentage of enrolled children, who have ever received sealants on a permanent second molar tooth: (1) at least one sealant sealed by the 15th birthdate.	Unduplicated number of enrolled children who ever received sealants on a permanent second molar tooth: (1) at least one sealant.	Unduplicated number of enrolled children with their 15th birthdate in measurement year.	NUM1/DEN	20%

Performance Standards with Penalties

Dental Quality Alliance (DQA) Pediatric Measure Set

Pilot Period: January 1, 2021 – December 31, 2022

Contractor must annually report on the following Performance Standards for embedded pediatric dental for each plan year. Contractor must submit this report by April 30th of the following calendar year.

Measure		Description	Numerator	Denominator	QDP Performance Rate	Expectation
4.5 b	**Sealants in 15 year olds**	Percentage of enrolled children, who have ever received sealants on a permanent second molar tooth: (2) all four molars sealed by the 15th birthdate.	Unduplicated number of enrolled children who ever received sealants on a permanent second molar tooth: (2) all four molars sealed.	Unduplicated number of enrolled children with their 15th birthdate in measurement year. Exclude children who received treatment (restorations, extractions, endodontic, prosthodontic, and other dental treatments) on all four second permanent molars in the 48 months prior to the 15th birthdate.	NUM2/DEN (after exclusions)	20%
4.6	**Topical Fluoride for Children at Elevated Caries Risk**	Percentage of enrolled children aged 1-18 years who are at "elevated" risk (i.e. "moderate" or "high") who received at least 2 topical fluoride applications within the reporting year.	Unduplicated number of enrolled children aged 1-18 years who are at "elevated" risk (i.e. "moderate" or "high") who received at least 2 topical fluoride applications as a dental service.	Unduplicated number of enrolled children aged 1-18 years at "elevated" risk (i.e. "moderate" or "high").	NUM/DEN	50%

Performance Standards with Penalties

Dental Quality Alliance (DQA) Pediatric Measure Set

Pilot Period: January 1, 2021 – December 31, 2022

Contractor must annually report on the following Performance Standards for embedded pediatric dental for each plan year. Contractor must submit this report by April 30th of the following calendar year.

Measure		Description	Numerator	Denominator	QDP Performance Rate	Expectation
4.7	**Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children**	Number of emergency department (ED) visits for caries-related reasons per 100,000 member months for all enrolled children.	Number of ED visits with caries-related diagnosis code among all enrolled children.	All member months for enrollees 0 through 18 years during the reporting year.	(NUM/DEN) x 100,000	Monitoring until claims data is received
4.8	**Follow-Up After ED Visit by Children for Dental Caries**	The percentage of caries-related emergency department visits among children 0 through 18 years in the reporting year for which the member visited a dentist within 7 days of the ED visit.	Number of caries-related ED visits in the reporting year for which the member visited a dentist within 7 days (NUM) of the ED visit.	Number of caries-related ED visits in the reporting year.	NUM/DEN	Monitoring until claims data is received

Performance Standards with Penalties

Dental Quality Alliance (DQA) Pediatric Measure Set

Pilot Period: January 1, 2021 – December 31, 2022

Contractor must annually report on the following Performance Standards for embedded pediatric dental for each plan year. Contractor must submit this report by April 30th of the following calendar year.

Measure		Description	Numerator	Denominator	QDP Performance Rate	Expectation
4.9	**Follow-Up After ED Visit by Children for Dental Caries**	The percentage of caries-related emergency department visits among children 0 through 18 years in the reporting year for which the member visited a dentist within 30 days of the ED visit.	Number of caries-related ED visits in the reporting year for which the member visited a dentist within 30 days (NUM) of the ED visit.	Number of caries-related ED visits in the reporting year.	NUM/DEN	Monitoring until claims data is received