March 26, 2024

Center for Consumer Information and Insurance Oversight
Center for Clinical Standards and Quality
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Subject: Marketplace Quality Initiatives (MQI)-Draft 2024 QRS and QHP Enrollee Survey Call Letter

To Whom It May Concern:

Covered California is pleased to submit the following comments in response to the Centers for Medicare & Medicaid Services (CMS) Draft 2024 Call Letter for the Quality Rating System (QRS) and Qualified Health Plan (QHP) Enrollee Experience Survey.

Since its inception, Covered California has led the way in leveraging the Affordable Care Act (ACA) to not only expand access to health care, but also to improve the quality of care provided to Californians. Our efforts are rooted in a strong commitment to accountability and continuous improvement, ensuring that the health plans we offer meet the highest standards of quality and effectively serve the needs of consumers. We make these comments based upon our experience driving meaningful improvements in health outcomes, enhancing the care experience for Californians, and making strides toward the triple aim of better health, better care, and lower costs.

We appreciate CMS's recognition of the elements key to these continued efforts, and share the below comments related to the specific topics of: (1) Confidential Reporting of Stratified Race and Ethnicity Data; (2) Adding the Social Need Screening Intervention (SNS-E) Measure; (3) Adding the Depression Screening and Follow Up for Adolescents and Adults; (4) Transitioning Colorectal Cancer Screening to Electronic Clinical Data System (ECDS)-Only; (5) Forthcoming Transition to ECDS-Only Reporting; (6) Revising and Adding QHP Enrollee Survey Questions to Support Analysis of Health Equity and Disparities; and (7) Potential Modifications to the Mixed-Mode Administration of the QHP Enrollee Survey.

Confidential Reporting of Stratified Race and Ethnicity Data

Covered California recommends transparent reporting of race and ethnicity stratified performance on quality measures. To identify and address disparities, we encourage CMS to publicly report (either through Public Use File or some other mechanism) stratified performance, in addition to sharing this data directly with exchanges.

Based on our experience working with enrollee demographic data for the last decade and stratifying both operational and quality measures, we recommend modifying the current QRS integrated data systems and services (IDSS) file to add new columns to the race file that list the race-only numerator/denominator counts. This would de-duplicate the Hispanic-Latino counts that currently are embedded in the race counts and base these race category scores only on members who identified racially, rather than members who identify as Hispanic-Latino both ethnically and racially. This change would enable users to align with many existing national standards that give primacy to the ethnic identity for people who identify as Hispanic-Latino and do not commingle ethnicity and race in the race categorizations.

Without this approach, we have found that disparities which affect members who primarily identify as Hispanic-Latino get obscured. While CMS and states would not have to use California's methodology to measure inequities, adding separate columns for race and ethnicity in IDSS would be the most inclusive of all approaches and allow flexibility. For example, analysis of one Qualified Health Plan (QHP) issuer's data from its measurement year 2022 Diabetes Hb1Ac <8% measure significantly differed depending on the methodology used to collect race and ethnicity data:

- Under California's methodology, the data revealed a stark disparity: diabetes control rates were 67% for White enrollees versus 49% for Hispanic-Latino enrollees, reflecting an 18% gap.

- Conversely, employing the NCQA methodology for the same issuer showed diabetes control rates of 51% for White enrollees (including Hispanic-Latinos) and 49% for Hispanic-Latinos alone, indicating a mere 2% disparity.

For this QHP issuer, 43% of Hispanic-Latino members identified as White, but the majority did not. The NCQA and current CMS QRS approach masks a real and meaningful health care disparity in diabetes control for this issuer.

To prevent underreporting and erasure of disparities, we strongly recommend that CMS consider including the additional race-only columns for Hispanic-Latino on the IDSS. Covered California welcomes the opportunity to share more either via the Technical Expert Panel (TEP) or another avenue.

Adding the Social Need Screening Intervention (SNS-E) Measure

Covered California supports the inclusion of measures that advance whole person care and hold QHP issuers accountable for assessing and addressing health related social needs (HRSN). While we endorse the inclusion of the SNS-E measure, we continue to advocate with the measure steward to include the percent of members who screened positive for each specified unmet need to accurately capture gaps.

There is adequate clarity around expectations for social needs screening as well as the associated logical observation identifiers names and codes (LOINC) to support use of this measure, although we know from clinical practice the inconsistency with which these codes are applied and the barriers that health care teams face in documenting in this way. Furthermore, the degree of inconsistency in the structure and format of the data around social needs interventions across electronic health records is a barrier to meaningful measurement and addressing disparities with the ECDS version of this measure.

Of note, unfortunately, we are unable to review or respond to the fast health care interoperability resources (FHIR) value set related to Housing, Food, and Transportation Security Procedures within the Call Letter because the links are not working.

Adding the Depression Screening and Follow up for Adolescents and Adults (DSF-E) Measure

Covered California strongly supports the inclusion of measures to address behavioral health quality and outcomes with an emphasis on evidence-based interventions including timely follow-up. Evidence shows that utilizing this screening and follow-up measure can improve symptoms in adults and adolescents.

Transitioning Colorectal Cancer Screening to ECDS-Only

The three public purchasers in California, Department of Health Care Services/Medi-Cal, Covered California, and the California Public Employees' Retirement System (CalPERS), have aligned on core quality measures, health plan accountability programs, and key pieces of contract language to drive focused impacts in quality improvement throughout California. The four core quality measures for Covered California's 2023-2025 QHP issuer contract are:

- Controlling High Blood Pressure (NQF #0018)
- Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%) (NQF #0575)
- Colorectal Cancer Screening (NQF #0034)
- Childhood Immunization Status (Combo 10) (NQF #0038)

This alignment is critical to scaling change for quality and equity. In fact, due to our focus, the regulators in California, QHP issuers, other collaboratives, and organizations have anchored their programs and provider incentives on these core measures. We continuously receive input from both health plans and providers that simplification and alignment has been enormously helpful in allowing focus and deep investment in interventions which truly impact performance.

As CMS transitions to Electronic Clinical Data System (ECDS) reporting for colorectal cancer screening, Covered California recommends a longer overlap period where traditional (hybrid or administrative) reporting is mandatory alongside ECDS mandatory reporting. This dual reporting will prevent a gap in quality oversight for these critical measures. Dual mandatory reporting until CMS can score and benchmark the newly introduced ECDS measures will allow continued alignment of health plan accountability programs in California that currently rely on traditional CMS measures and continuous quality oversight for all QHP issuers.

Covered California also recommends continued separate reporting on IDSS of age band 45-49 and age band 50-75 for Colorectal Cancer Screening. As the U.S. Preventive Services Task Force adjusted the colorectal cancer screening guidelines in 2021, full adoption has not yet occurred across the delivery system. To fully track where additional quality improvement interventions are needed across the delivery system, we strongly recommend the IDSS layout and technical specifications continue to require reporting of two age stratifications and the total rate.

Forthcoming Transition to ECDS-Only Reporting

As outlined above, during a time in which health plans are energized to make an impact on quality and equity, we recommend allowing for a longer transitional period with mandatory reporting of both traditional (hybrid and administrative) methods and ECDS methods until scoring and benchmarks are available for the ECDS version.

Implementing dual reporting of both traditional and ECDS methods for a transitional period for the forthcoming measures – Childhood Immunization Status (Combo 10), Immunization for Adolescents, and Cervical Cancer Screening, beginning in RY2026/MY2025 – will allow for industry-wide learning, adjustments, and investments by QHP issuers and providers. Critically, this phased approach will safeguard against having a period of time without the ability to assess performance on key quality indicators. Maintaining momentum without any gap in scoring or benchmarking is an essential component of an effective quality program.

Covered California has consistently received feedback from QHP issuers that the stability of the accountability programs allows for incremental but sustained progress. As quality improvement takes years to actualize, Covered California recommends a thoughtful, paced approach to measure changes.

Revising and Adding QHP Enrollee Survey Questions to Support Analysis of Health Equity and Disparities

Covered California strongly endorses the addition of sexual orientation, gender identity, and sex characteristics (SOGISC) questions to advance health equity. However, the framing and confidentiality of these questions must be thoughtfully considered and explained to members ahead of inclusion in the survey to ensure that members are fully aware of their purpose. We strongly encourage this language to be brought to the consumer focus groups referenced in the draft call letter.

Additionally, Covered California strongly supports the inclusion of information on primary language to enable additional stratification of results. Covered California recommends broadening the language availability of the QHP Enrollee Survey to account for the ever-growing diversity not only in California but throughout the U.S., and the demand for enrollee materials offered in multiple languages and dialects. We advise expansion of language preferences beyond English, Spanish, and Cantonese/Mandarin.

Covered California believes in the importance of ensuring providers actively practice with cultural humility and responsiveness, such as embedding enrollees' cultural preferences and needs within their care and providing timely responses and communication to enrollees' regarding their care. To better measure enrollees' experiences and capture dimensions of patient care that directly contribute to health and health care disparities, Covered California suggests adding questions to the QHP Enrollee Survey to capture the following themes:

- Respect for and awareness of enrollees' cultural needs while providing care;
- Receiving timely responses and feedback from provider networks; and
- Ensuring that their health event was addressed in a timely manner.

Critically, with the survey tool approaching over 70 questions, Covered California recommends an assessment of which questions can be eliminated to mediate survey fatigue and diminishing response rates.

Potential Modifications to the Mixed-Mode Administration of the QHP Enrollee Survey

Covered California supports the proposed revised survey protocol to permit sampled enrollees to complete the survey by internet prior to sending mail surveys, an approach that will reduce costs and likely contribute to improved response rates. Covered California further strongly suggests consideration of additional modalities, with an emphasis on online, text-based, or other technology forward modalities to increase response rates. With this type of technology-forward approach, we also encourage oversampling for those who are not English language dominant, and other groups who may be less likely to respond under the current structure.

Finally, while Covered California supports CMS's efforts to enhance the QRS measure set, we strongly suggest that CMS increase and enhance the conversations within the TEP to ensure that stakeholders have sufficient notice and time to prepare for these important and substantial changes.

We appreciate your consideration of our comments. We look forward to continuing our partnership with you to make the ACA work as effectively as possible and build upon its foundation as we work to improve quality of care for all Americans. If you have any questions or would like more information, please feel free to contact me.

Sincerely,

S. Monica Soni, MD
Chief Medical Officer, Chief Deputy Executive Director