Responses to Comment Cycle 2 - Draft 2025 QHP Issuer Contract Amendment for Individual Market, Attachment 2

Section #	Comment	Covered California Response
1 a.	Please clarify if the language "first contracted with Covered California in Plan Year 2024" is intentional, or if this measure is no longer applicable to carriers contracted as of 2023.	This language has been adjusted to include Contractors contracted as of 2023.
5	We recommend excluding PPO products from the Primary Care Payment requirement. IHA/CQC/PBGH are leading an all payer Commercial PPO Advanced Primary Care pilot that should be completed so that outcomes can be observed in order to set an appropriate measure with targets for PPO products. The current measure targets are not feasible for PPO products with direct network contracting.	While these are long-standing requirements, Covered California is open to learning from the outcomes of the Advanced Primary Care pilot and integrating these insights into our future contract work. PPO products will not be excluded from the Primary Care Payment requirements at this time.
5	Primary Care Payment: The denominator for PCPs should be limited to those PCPs that had at least 10 attributed members during the reporting period. For large PPO networks, there are numerous providers with limited or no IFP primary care patients. This further aligns with how health plans focus targe their contracting deployment strategies, i.e. target providers with the most membership first, as an effort to get as many members and dollars into these payment models.	Covered California will continue to utilize and build upon the published standards and methodology for calculating primary care spend.
6	We respectfully request Covered California add the methodology directly into this Performance Standard as we are experiencing challenges obtaining this methodology directly from IHA.	Covered California is committed to ensuring transparency and accessibility to the methodology and all necessary information for plan compliance.
9	We appreciate Covered California removing PLD submissions from the Performance Standard. Thank you.	Thank you for your comment.
9	Data Submission specific to HEI in Attachment 1, Article 5.02.1 Data Submission in Attachment 1, Article 1.02.1 Monitoring Disparities: Patient Level Data File PLD file was removed but not the reference to Article 1.02.1 monitoring disparities Patient Level Data File, this should also be removed.	The remaining references to Article 1.02.1 will be removed.
9.4	Please remove the new language: "or not representing an individual clinician." Members may be assigned to a PPG clinic as their PCP. In these circumstances, a valid PCP NPI may not represent an individual clinician.	We will remove this language recognizing that some NPIs are at the organizational level.
9.5	Please remove the new language: "or not representing an individual provider." When a service is rendered at in a hospital or a facility, the claim may not include an NPI that represents an individual provider.	We will remove this language recognizing that some NPIs are at the organizational level.

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9.6	Please clarify how member months will be calculated using the Capitation file. This file does not include enrollment start and end dates. The Capitation file may also include retroactive capitation payment adjustments, which may make it difficult to calculate member months. Performance Standard 9.7 already matches the capitation record to the enrollment file, which may be used to identify member months. We recommend removing this additional requirement until a methodology is proposed.	The standard assesses the completeness and consistency of the valuation of the Risk Type field on the enrollment file with the Capitation Type field in the capitation file at a member-level. Detailed specifications and methodology is forthcoming.
9.6	Please remove the additional requirement to populate member cost-share at 98%. This should be included in the data criteria methodology for Performance Standard 9.1 rather than having its own assessment penalty under 9.6.	We will remove this language. Member cost share is included in the data submitted as part of Performance Standard 9.1
9.6	We appreciate the changes Covered California has made to Attachment 2 to accommodate financial validation across different product types (e.g. HMOs versus PPOs).	Thank you for your comment.
9.7	9. Data Submission specific to HEI in Attachment 1, Article 5.02.1 Data Submission in Attachment 1, Article 1.02.1 Monitoring Disparities: Patient Level Data File 7. Medical claim, drug claim, or capitation record submissions that do not match to a current or prior enrollment record more than 1% of the time: 2% penalty Contractor's submission meets or exceeds the 99% matching enrollment threshold: no penalty Retro terminations happen and Carriers are not always able to recoup on payments made to providers for services rendered in good faith while there were active eligibility showing in the Carriers system. When this happens there is not always a matching enrollment record for these services greater than 1%. This issue is out of the Carriers control and we believe the 99% threshold does not allow for these instances and the penalty is unfairly being applied. Additionally since an enrollment "tag" hasn't been applied it is not possible for the HEI vendor to identify if the record is for On Exchange, Off Exchange, Individual or Small Group - so all non tagged records are being included under this measure and should not be a measure included under each contract but only the Individual contract so that penalties aren't duplicated for the same issue. Recommendation: change to 2% to allow for retroactivity that is outside the control of the carrier.	We believe this adjustment is reasonable and will make the change.