Commenter *Names have been randomized*	Commenter Question/Feedback/Request
Issuer B	To address challenges associated with the Childhood Immunization Status (Combo 10) measure, are there recommendations for new measures for its replacement? Issuer B would choose to stay with CIS-10 measure if there is a requirement for a child measure domain. However, we would prefer to switch this measure to PPC as this is a better measure to promote child health early on as well as improving maternal health outcomes. Issuer B has
Issuer B	Input on proposed change to maintain Pharmacotherapy for Opioid Use Disorder (POD) as a reporting-only measure for full contract cycle. Issuer B would prefer that the POD measure is not included as a QTI measure due to the extremely small denominator size of the measure (n=19). We would recommend utilizing the DSF measure for the Behavioral Health domain. However, if POD cannot be removed or replaced, we would agree with keeping it as reporting-only for the next contract cycle to allow time to develop meaningful benchmarks and programming.
Issuer B	Input on the proposed change to keep the amount at risk steady or reset for all QHPs while introducing health equity accountability, followed by a gradual increase in succeeding years. Issuer B supports a gradual increase over the span of 3 years (contract term) instead of 2 to allow more time to adjust. Please define the gradual increase % and method of calculation ahead of time.
Issuer B	**Input on the proposed approach for new entrants, involving a graduated risk introduction, starting them at the lower percentage-at-risk in their first year of QTI eligibility, immediately subject to health equity accountability.** No comment.
Issuer B	**Input on use of QRS 66th percentile as benchmark for all sub-population results.** Our recommendation would be to gradually ease plans into the stratification. Asking for measure overall at 66th with race/ethnicity subgroups at 50th.
Issuer B	Should Covered California set a lower minimum denominator size for measures that achieve the industry standard of 0.7 reliability with a denominator size of less than 100? Issuer B is in agreement with the current recommendation and does not agree with changing this approach.
Issuer B	**Recommendations for oversight approaches to ensure performance gaps do not increase for sub-populations included in All Other Members.** - Create model to report out plan performance on monthly basis to health plans. - Suggestion to reduce penalty if one of the subpopulations in "All Other Members" is performing above 50th or 66th. Continue to monitor all subpopulations for their rate to ensure equity across these diverse groups.
Issuer B	Input regarding the addition of new measures (once benchmarks available) to remain aligned with CMS QRS clinical measures. Issuer B is asking for more details on what these new measures would be.
Issuer B	Feedback on proposed update to benchmark year. Issuer B agrees with updating the benchmark year to no longer reflect MY2018. It would be beneficial to have a benchmark year that is post-pandemic (not MY2020, 2021 or 2022).
Issuer B	Feedback on the proposed Minimum Performance Level (MPL) Action Plan. Issuer B is in alignment with this approach – asking for more details on what action plan summary would look like.
Issuer C	Addressing the challenges associated with the Childhood Immunization Status (Combo 10) measure: Issuer C recommends switching to either the Childhood Immunizations Combo 3 or the Childhood Immunization Combo 7 measures. Combo 3 is more reflective of health plan impact as it removes all vaccines that are typically subject to higher member (parent) hesitation or lack of education in the public/population [HepA, Rotavirus, Flu]. Combo 7 removes the flu vaccine, which is widely misunderstood/unknown by new parents while keeping attention on emerging areas of public health concern.
Issuer C	Keeping Pharmacotherapy for Opioid Use Disorder (POD) as a reporting-only measure : Issuer C recommends and supports switching to either the Use of Opioids at High Dosage measure or the Annual Monitoring for Persons on Long-Term Opioid Therapy and keeping it as reporting only measure. • HDO: Use of Opioids at High Dosage - supports the public health goals of the original measure with less complexity.
Issuer C	**Restarting the money at risk while introducing health equity accountability:** Similar to how Covered California had a 'trial year' with the initial QTI launch, and then started at 0.8% for overall QTI for MY2023, the same approach should apply as QTI shifts towards introducing health equity accountability. There remain challenges with the reliability of race/ethnicity data across the ecosystem, and QHPs are still learning how to effectively and efficiently move the needle at the subpopulation level. Restarting the penalty ladder is unlikely to change the focus, attention, or resources QHPs put into QTI and Health Equity as QHPs will continue to have significant financial incentives for improving performance.

Issuer C	**Equitable treatment for new entrants and those without reportable QTI measurements:** The QTI penalties are allowed to be reflected in premiums beginning in 2025. New entrants who have a different amount at risk, and QHPs without reportable QTI measurements (which won't have that risk) thus have an unlevel playing field that should be mitigated via program design. Allowing a variance among QHPs' QTI risk disadvantages incumbent health plans with reportable scores - which must account for a relatively higher QTI penalty risk. As shown below, assuming both QHPs make the same "PMPM" investment in quality and have the same "QTI percentile," there will be distinct disadvantage in premiums in the three scenarios, given equal quality improvement effort and outcomes. **Existing QHP1 in Regions X:** • $5.00 PMPM on quality improvement for QTI • $0.30 PMPM penalty for MY25 performance with 3% at risk **New QHP2 in Region X:** • $5.00 PMPM on quality improvement for QTI • $0.10 PMPM Penalty for MY25 because 1% at risk **Existing QHP3 in Region X, but too small to report:** • $5.00 PMPM on quality improvement for QTI • $0.00 PMPM penalty for MY25 performance because unable to have a score As such, we recommend that all QHPs have the same percentage-at-risk for performance within each measurement year to ensure appropriate, consistent focus on the measures by all QHPs. To mitigate the above concerns of differences in amount at risk, the program design should waive the QTI penalties for any specific measure for QHPs in that region, if any one QHP is unable to report on a specific QTI measure.
Issuer C	Use of QRS 66th percentile as benchmark for all sub-population results: Issuer C agrees with using the QRS 66th percentile – with caution - as a benchmark for all sub-population results. Given the incremental uncertainty with this change - and corresponding risks – the risks can be mitigated by restarting the QTI penalty back to 1% for the first year, and then increase back up to 4% over the next few years.
Issuer C	**Minimum denominator size for measures that achieve the industry standard of 0.7 reliability:** We do not believe there should be a denominator less than 100 at this point. We are concerned that the high churn rate within the individual market could result in an inefficient use of resources. We recommend that Covered California and QHPs devise strategies for marginalized populations with less than 100 people - working closely with community-based-organization to ensure inequities are addressed with resources needed. We recognize that this may not align with how the QTI incentive is structured, as QHPs with a small enrollment footprint may not have the same relative amount at risk as a larger plan. This will need to be addressed through the overall program design.
Issuer C	Oversight and engagement to ensure performance gaps do not increase for sub-populations included in All Other Members: Issuer C recommends that Covered California set up QHP / Covered California Population Health Working group - allowing for the QHPs to "check in" 2-3 times a year with Covered California and each other. Similar to other ecosystem wide programs, this is an area that will benefit from collaboration and is not an area where competitive "differentiation" is advantageous to a QHP.
Issuer C	Updating to add new measures (once benchmarks available) to remain aligned with CMS QRS clinical measures and updating the benchmark year: Issuer C supports adding the new measures after the benchmarks are available and would suggest including one year as a test / trial period. We also support updating the benchmark year to 2024.

Issuer C	Minimum Performance Level (MPL) Action Plan: Issuer C recommends that the contract identify certain prerequisite activities before requiring a written Minimum Performance Level Action Plan and that plans are only required for specific measurements as identified by Covered California for each QHP. The QHP and Covered California should discuss the specific measures' performance during on-going meetings, such as the Semi-Annual Business Review meetings. These forums will enable discussion on the underlying performance and expectations around improvement efforts. Following these conversations, after two years of performance below the 25th percentile threshold Covered California can identify which, if any, measures require a written MPL Action Plan. We further recommend that these written plans be limited to measures and situations where there is a compelling reason to have written plans. For example, it may be valuable to have multiple QHPs explain the root cause or gap analysis for a particular clinical measure that is poor performing across all plans. This information could then be consolidated to collectively evaluate how to improve results. The rationale for this change is two-fold: • Developing written improvement plans requires QHPs to allocate scarce quality improvement administrative resources. If Covered California can gain sufficient understanding of a QHP's approach from various engagements and meetings, there may be limited incremental improvement to be gained relative to the resources required to document the MPL Action Plans. • The QTI program - by design - focuses on a few measurements at a time to drive meaningful improvements. Often, the most effective levers to improve clinical measurements involve significant investments, including provider or member financial incentives, or targeted outreach. Absent significant investments, some measurements may not move much. If a QHP is not focusing or investing on a particular measure set, there is limited value in documenting an MPL Action Plan that won't move a measure. By having QHP and Covered California ongoing dialog about overall and specific measurement performance, Covered California should continue to have sufficient information to appropriately drive clinical quality improvements across the market and can require written plans on certain measures as appropriate or necessary.
Issuer A	To address challenges associated with the Childhood Immunization Status (Combo 10) measure, are there recommendations for new measures for its replacement? : In order to maintain the intention of the original measure selection, Issuer A recommends selecting an alternate NCQA CIS Combo measure, such as CIS Combo-7, to continue to maintain focus on improving childhood immunizations while helping to improve rates by removing challenges of the flu vaccine. CIS-7 includes all recommended childhood vaccines minus the flu vaccine, which has been found to be the most challenging for this age range. This will allow for alignment with measures selected by DMHC and CalPERS but will help reduce challenges that make it difficult to improve rates for the Combo-10 measure. Issuer A recommends using the CIS-E benchmark (and not CIS) when the switch to the ECDS measure occurs. Issuer A supports keeping CIS in the QTI measure set, as opposed to Well-Child Visits (WCV), to ensure continued alignment among purchaser/regulator priorities and focused provider efforts. CIS in included in the following measure sets: DHCS Medi-Cal Managed Care Accountability Set (MCAS); CalPERS Quality Alignment Measure Set (QAMS); and DMHC Health Equity and Quality Measure Set. WCV is not currently part of the CalPERS QAMS.
Issuer A	Input on proposed change to maintain Pharmacotherapy for Opioid Use Disorder (POD) as a reporting-only measure for full contract cycle: Issuer A agrees with the recommendation to continue POD as a reporting-only measure.
Issuer A	**Input on the proposed change to keep the amount at risk steady or reset for all QHPs while introducing health equity accountability, followed by a gradual increase in succeeding years:** Both the introduction of the measure stratification and the measure changes and new benchmarks could significantly change plan performance. We recommend resetting the QTI penalties back to the 0.8% first year penalty amount and allowing time for observation before setting penalty increases for future years.

Issuer A	**Input on the proposed approach for new entrants, involving a graduated risk introduction, starting them at the lower percentage-at-risk in their first year of QTI eligibility, immediately subject to health equity accountability:** We do not recommend reducing penalties for new entrants. The QTI program requires significant plan investments, and all participants should have the same set of requirements and metrics. In addition to the comments offered above for the requested feedback items, we would also like to provide our comments on the other recommended changes to the QTI measure set. • BPC-E has not officially been approved as a new measure by NCQA yet and may potentially be a new measure next year. We do not recommend transitioning to this measure in the 2026 contract cycle. Blood pressure screenings are not billable services so this will greatly reduce the eligible member data received. The new measure change to hybrid only will automatically make a member non-compliant if no back-end data is received. We recommend waiting to transition to this measure until the CBP and BPC-E rates are more closely aligned. With any new measure introduction, it takes time to adopt to the new specifications and change provider behaviors. NCQA has not communicated plans to retire the CBP measure, so it will still be reportable. • DSF-E has reporting challenges that are similar to SNS-E and other measures that use LOINC codes. Smaller providers and groups often do not have the infrastructure to report out on LOINC codes used for this measure, resulting in understated data. DSF-E has two parts, the screening and the follow-up within 30 days of a positive screen. There are privacy issues that make it challenging to share screening data directly with providers, making it necessary for the member to request the follow-up themselves and setting up their own appointments with a behavioral health provider. Due to limitations with the LOINC codes, and the underreporting of the screening, the denominator for those with a positive screen is very low. We would also like to get clarification on how a benchmark would be set for this measure. Would the benchmark be based on the initial screening or the subsequent follow-up with the small denominator? For the reasons stated above, we recommend keeping this measure as reporting only for the next contract cycle. •In general, new measures should have at least one year of reporting only after a benchmark is established to allow plans to understand the targets that need to be met and set appropriate action plans. • We recommend having the Population Health Investment Advisory Group consider provider grants to help set up the infrastructure for electronic data transfer to be able to improve reporting. This would help most QHPs improve data collection so that we can focus our attention on other initiatives to improve performance.
Issuer A	**Input on use of QRS 66th percentile as benchmark for all sub-population results:** In order to provide feedback on percentile benchmarks, we would like to have more information on how the new proposed measures and the stratified sub-populations are performing in the market across QHPs to set realistic goals. If Covered California can model this data it would be helpful for us to provide additional feedback.
Issuer A	**Should Covered California set a lower minimum denominator size for measures that achieve the industry standard of 0.7 reliability with a denominator size of less than 100?** 100 is an appropriate minimum denominator size.
Issuer A	**Recommendations for oversight approaches to ensure performance gaps do not increase for sub-populations included in All Other Members:** We recommend starting by monitoring the All Other Member sub-population groups to watch for changes and disparities in performance.
Issuer A	**Input regarding the addition of new measures (once benchmarks available) to remain aligned with CMS QRS clinical measures:** It makes sense to maintain alignment with QRS clinical measures once benchmarks are available. However, new measures should have at least one year of reporting only after a benchmark is established to allow plans to understand the targets that need to be met and set appropriate action plans.
Issuer A	**Feedback on proposed update to benchmark year:** Setting a new benchmark year closer to the contract cycle start date is appropriate.
Issuer A	**Feedback on the proposed Minimum Performance Level (MPL) Action Plan:** We do not think it is necessary to add the MPL requirement to the 25-2-2 program. The 25th percentile composite rate and the QTI measure percentile goals already provide incentive for QHPs to invest time and funding to make improvements on all QRS measures. Updates on the 25-2-2 measures that are underperforming are already being reported in the SABR meetings.

Issuer D	To address challenges associated with the Childhood Immunization Status (Combo 10) measure, are there recommendations for new measures for its replacement? Consider replacement of the QTI Combo 10 measure with Combo 7 or Well Child Visit (WCV) or accept pediatrician documentation in the baby's medical record of parental vaccination refusal or alternative vaccine scheduling as "Combo 10 QTI numerator compliance." The small Combo 10 denominators are disproportionally penalized when compared to other QTI metrics. I'd recommend a more stable QTI "numerator noncompliance" penalty. To illustrate, Issuer D has fewer than 375 babies in our MY 2023 HEDIS Combo 10 population while there are over 45,000 adults in our colon cancer screening population. As such, the QTI penalty imposed for every HEDIS gap closed between the 25th percentile and the 66th percentile is over 100x greater for each noncompliant Combo 10 baby compared to colon cancer. Based on our latest projections, most of our penalty exposure is attributed to Combo10 with the disproportionately small numbers of noncompliant babies.
Issuer D	**Input on proposed change to maintain Pharmacotherapy for Opioid Use Disorder (POD) as a reporting-only measure for full contract cycle.** Due to small denominators, I'd recommend keeping this as "reporting only" for the contract duration without associated any associated QTI penalties.
Issuer D	**Input on the proposed change to keep the amount at risk steady or reset for all QHPs while introducing health equity accountability, followed by a gradual increase in succeeding years.** As a physician, I believe any QTI penalties should be required to be spent by the health plan on initiatives specifically designed to improve their HEDIS outcomes and reduce healthcare disparities in their own health plan population. Taking funds away from "underperforming plans" will not achieve your stated goals of improving HEDIS performance or health outcomes due to further depleting funds allocated to quality improvement interventions. Covered CA should require documentation that the entirety of any potential "penalty" to be exclusively spent on patient outreach for the priority HEDIS gap closure activities +/- provider education/interventions on these priority HEDIS measures. Please understand that any health plan financial penalties will ultimately impact overall rates and affordability as plans will have to include these penalties and remediation costs when planning for contract renewals.
Issuer D	**Input on the proposed approach for new entrants, involving a graduated risk introduction, starting them at the lower percentage-at-risk in their first year of QTI eligibility, immediately subject to health equity accountability.** New entrants should be subject to the current penalty percentages (no ramp up period). For example, if the QTI penalty at risk for MY2025 is 2.8% of premium for current Exchange health plan participants, the same rate should apply to new entrants.
Issuer D	**Input on use of QRS 66th percentile as benchmark for all sub-population results. The challenge, as discussed at the IHA meeting is ensuring a statistically significant denominator size for each.** If less than 1000, the sub-population should be rolled into the other sub-populations not meeting the threshold denominator size.
Issuer D	**Should Covered California set a lower minimum denominator size for measures that achieve the industry standard of 0.7 reliability with a denominator size of less than 100?** No, due to regional variation and small denominator volatility, these results will not be actionable.
Issuer D	**Recommendations for oversight approaches to ensure performance gaps do not increase for sub-populations included in All Other Members**. Potentially keep as "reporting only" with clinical actions plans required where a given sub-population falls below a predetermined threshold.
Issuer E	**To address challenges associated with the Childhood Immunization Status (Combo 10) measure, are there recommendations for new measures for its replacement.** **Issuer E recommends that Well Child and Adolescents (WCV) visits should be used as a replacement to Childhood Immunizations (CIS-10).**
Issuer E	Input on proposed change to maintain Pharmacotherapy for Opioid Use Disorder (POD) as a reporting-only measure for full contract cycle. Issuer E agrees that this measure should continue to be reporting-only, as some plans may have very low denominators. The following concerns are raised with the inclusion of this measure: - Narrow Allowable Treatment Gap: The eight-day allowable treatment gap is too narrow. This measure requires Managed Care Plans (MCPs) to identify members using both medical and pharmacy claims data, so there is an anticipated data lag. By the time patients are identified, it may be too late to intervene. We recommend that this time frame be extended to at least a 45-day allowable treatment gap. - Potential Inaccuracies in Measure Calculations: Changes in therapy, including switching, tapering and other medication adjustments are common in Opioid Use Disorder treatment which can cause inaccuracies in measure calculations. - Challenge with Timing of Intake Period: The intake period begins on July 1 of the year prior to the Measurement Year and ends on June 30 of the Measurement Year. Therefore, if this measure is included, MCPs should have started interventions on this measure beginning July 1, 2023 (which has since passed) to impact performance for Measurement Year 2024. In addition, it is often challenging and costly for HEDIS software vendors to generate multiple Measurement Years at a time to identify members for future Measurement Years.
Issuer E	Input on the proposed change to keep the amount at risk steady or reset for all QHPs while introducing health equity accountability, followed by a gradual increase in succeeding years. Issuer E recommends to keep the amount at risk steady.
Issuer E	**Input on the proposed approach for new entrants, involving a graduated risk introduction, starting them at the lower percentage-at-risk in their first year of QTI eligibility, immediately subject to health equity accountability.** Additional feedback: Issuer recommends that Covered CA align with DHCS and begin applying the Healthy Places Index (HPI) when assessing performance. This would score Health Plans with Membership in regions of higher disparity on a consistent and fair basis.

Issuer E	Input on use of QRS 66th percentile as benchmark for all sub-population results. Issuer E recommends that the use of QRS 66th percentile only be applied to the total measure as drilling down to all sub-population results will not allow ample sample size.
Issuer E	**Should Covered California set a lower minimum denominator size for measures that achieve the industry standard of 0.7 reliability with a denominator size of less than 100?** Yes, denominators of less than 100 should be excluded from QTI implications.
Issuer E	**Recommendations for oversight approaches to ensure performance gaps do not increase for sub-populations included in All Other Members.** No comment.
Issuer E	**Input regarding the addition of new measures (once benchmarks available) to remain aligned with CMS QRS clinical measures.** No comment.
Issuer E	**Feedback on proposed update to benchmark year.** No comment.
Issuer E	**Feedback on the proposed Minimum Performance Level (MPL) Action Plan.** No comment.
Issuer F	Slide 6. Issuer F still has concerns about COL-E and the associated benchmarking. Currently, Covered CA is using static benchmarks based on 2019 data (pre pandemic), the downside of having static benchmarks is that it doesn't track with what the overall industry is doing. Slide 12 says the benchmarks will remain fixed "but will allow for mid cycle benchmark re-evaluation". There's a risk that benchmarks may not update mid cycle. The Colorectal Cancer Screening measure is going to have some significant methodological changes in the next three years. Are we able to get confirmation that the benchmarks will be based on the current methodology (without medical records included) and not previous methodology (benchmark where medical records were included)? There has even been talk about using retired methodology even though NCQA will change the measure. This could cost over 100k for this specific measure between software vendor cost, record review costs, and audit costs.
Issuer F	**Slide 13 - Approach for new entrants: percent at risk and health equity accountability.** Consider a decrease in risk while introducing health equity accountability.
Issuer F	Slide 24 - 100 as minimum denominator size. This may be a disadvantage to regional plans. Issuer F most likely will not have many subpopulations that clear the threshold and of those that do, we will likely clear the threshold by a very small margin. This introduces a lot of variability in our results, while larger Issuers will be working with much larger sample sizes. Given the substantial fees at risk here, we don't feel comfortable with the low sample sizes in addition to dropping the threshold to a 0.7 reliability level. Although we understand CCA's stance on the "All Other Members" methodology, we do not agree with this approach.
Issuer G	To address challenges associated with the Childhood Immunization Status (Combo 10) measure, are there recommendations for new measures for its replacement? We recommend replacing Combo 10 with Combo 3. Parents declining the flu shot for their children continues despite provider recommendations and Issuer outreach.
Issuer G	**Input on proposed change to maintain Pharmacotherapy for Opioid Use Disorder (POD) as a reporting-only measure for full contract cycle.** We agree with POD as a reporting only measure for the full contract cycle.
Issuer G	**Input on the proposed change to keep the amount at risk steady or reset for all QHPs while introducing health equity accountability, followed by a gradual increase in succeeding years.** Reset due to the introduction of HE reporting followed by a gradual increase in succeeding years.
Issuer G	**Input on the proposed approach for new entrants, involving a graduated risk introduction, starting them at the lower percentage-at-risk in their first year of QTI eligibility, immediately subject to health equity accountability.** Has no specific feedback.
Issuer G	**Input on use of QRS 66th percentile as benchmark for all sub-population results.** Suggest lowering to the 50th percentile. We believe the baseline is closer to the 25th percentile for this population. Another consideration is not financially penalizing health plans for performance measures with denominators less 100. Targeted cultural/linguistic appropriate efforts may not be fiscally prudent or effective for smaller health plans with small sub-populations. Consider using the same benchmarks as outline by the DMHC Health Equity and Quality Committee.
Issuer G	**Should Covered California set a lower minimum denominator size for measures that achieve the industry standard of 0.7 reliability with a denominator size of less than 100?** A lower denominator size for comparison purposes, yes and not evaluate sub-populations with denominator less than 30. Again, we suggest not financially penalizing health plans for performance measures with less then 100. Targeted cultural/linguistic appropriate efforts may not be fiscally prudent or effective for smaller health plans with small sub-populations.
Issuer G	**Recommendations for oversight approaches to ensure performance gaps do not increase for sub-populations included in All Other Members.** Require reporting stratified for R/E only on those measures required by NCQA. Perhaps consider reporting-only for all sub-populations for those NCQA measures already required to be stratified to keep a visual on those smaller populations. Covered CA could aggregate those small sub-populations and provide performance data for regions and the entire state.

Issuer G	**Input regarding the addition of new measures (once benchmarks available) to remain aligned with CMS QRS clinical measures.** Suggest a set number of measures failing to meet goal consecutively before Monitoring, Remediation and Removal of the health plan occurs.
Issuer G	**Feedback on proposed update to benchmark year.** The benchmark of 25th percentile has been the established rate from previous reporting timeframes. The benchmark year so far has been 2018 and proposal for next benchmark set starting MY2024 with 25th percentile being required rate.
Issuer G	**Feedback on the proposed Minimum Performance Level (MPL) Action Plan.** Using Combo 2 MY2023 (n=42) as an example, it only takes a few children not getting immunized within a small population to make the rate swing wildly. Also for this IMZ class, HPV is what is holding the measure to a low rate along with parents unwilling to immunize their children.
Consumer Advocate Group A	**Slide 7**. We support moving Depression Screening from a reporting only measure to a measure with potential penalties
Consumer Advocate Group A	**Slide 9.** We support Covered CA incorporating a pediatric measure that emphasizes the importance of alignment with other California public purchasers, even though the exchange has a relatively small pediatric population
Consumer Advocate Group A	**Slides 12 and 15.** How will "the amount at risk remain steady or decrease with the introduction of health equity accountability, then incrementally increase" actually work?
Consumer Advocate Group A	**Slide 26.** Consumer Advocate Group A is OK with Covered CA's recommendation to use an "all other members" approach for public reporting and penalties, as long as Covered California and the QHPs are continuing to look at the subpopulation data (e.g. a breakout of the category by size and group) and work on targeted interventions to reduce disparities for those smaller groups. Given the very low numbers for Black beneficiaries in Covered CA for example, we would also want to ensure that Blacks are not being miscategorized as "all other members" to the detriment of reporting and accountability. We are also looking forward to seeing Covered California move towards "all population" data so we can better capture disparities for smaller groups.
Consumer Advocate Group A	**With the MY 2022 data on slide 41,** it looks like: - Anthem HMO, Blue Shield HMO, and Oscar are below the 25th percentile for timeliness of prenatal care - Anthem HMO, Anthem EPO, Blue Shield HMO, HealthNet HMO, HealthNet PPO, LA Care, Oscar, and Sharp are below the 25th percentile for well-child visits in first 15 months - HealthNet PPO and Western are below the 25th percentile for adolescent immunizations - Anthem EPO, Chinese Community, HealthNet PPO, Molina, Oscar, and Valley are below the 25th percentile for breast cancer screening - HealthNet PPO, LA Care, Molina, and Valley are below the 25th percentile for colorectal cancer screening - Blue Shield PPO, Chinese Community, and Molina are below the 25th percentile for controlling blood pressure - Molina is below the 25th percentile for diabetes care HA1c Since these are also DMHC equity and quality measures (which will use the 50th percentile for Medicaid vs. 25th percentile for commercial used here by Covered California), are these health plans at risk for both DMHC and Covered California QTI penalties?
Consumer Advocate Group B	**Consumer Advocate Group B supports a comprehensive approach to behavioral health care that includes substance use and patient-reported outcomes measures:** - Concur with maintaining Pharmacotherapy for Opioid Use Disorder (POD) as a reporting-only measure. - Encourage consideration of Depression Remission or Response for Adolescents and Adults (DRR-E) as a reporting measure. While data collection remains challenging for the Depression Screening and Follow-Up measure (DSF), it is important to signal future expectations for improvement and investment in data capture and reporting infrastructure that supports patient-centered measurement.
Consumer Advocate Group B	Consumer Advocate Group B encourages an inclusive approach that holds plans accountable to Covered California's common metrics that incorporates as many plans as possible. It is reasonable for Covered California set a lower minimum denominator size of less than 100 for measures that achieve the industry standard of 0.7 reliability. Consumer Advocate Group B previously administered a multi-payer claims database that incorporated Medicare fee-for-service data to measure clinical quality performance at the physician and practice level. A multi-stakeholder Steering Committee and technical expert panel deemed that a physician or practice site's measure-specific score reportable if the score had a reliability of at least 0.70 and at least 11 patients for the given measure.
Consumer Advocate Group B	Covered California may consider the recent OMB subpopulation categories for race and ethnicity and review the consistency of the federal aggregation groups with the prevalence of subpopulation groupings in California. To the extent that denominators are smaller and/or reliability falls below 0.70, Covered California may wish to consider expanding the lookback period.
Consumer Advocate Group B	Consumer Advocate Group B supports alignment with the CMS QRS clinical measures but encourages Covered California to maintain a patient-centered and outcomes-focused approach that considers measures that are used in Medi-Cal managed care plans and in commercial populations and which leverages multistakeholder accountability initiatives in California.

Consumer Advocate Group B	**Consumer Advocate Group B encourages Covered California to consider expansion of its activities to improve maternal health care and equity. Significant disparities in C-section rates and maternal mortality persist across racial and ethnic populations. Consumer Advocate Group B recently convened a Comprehensive Maternity Care Workgroup, which has made the following recommendations:** - A set of priority maternal health measures2 that includes prenatal depression screening and follow-up, postpartum depression screening and follow-up, maternity care: postpartum follow-up and care coordination, social need screening and intervention and severe obstetric complications - A set of common purchaser principles. Two specific areas for potential focus include: 1) access to certified midwives and 2) coverage policy for doulas, which could be aligned with Medi-Cal.
Issuer D	To address challenges associated with the Childhood Immunization Status (Combo 10) measure, are there recommendations for new measures for its replacement? We respectfully request that Issuers not to be subject to financial "incentives" for members that are choosing not to comply. As just one example, parents refusing to immunize. We suggest Network Adequacy and BH visits/care as better measures. How do PCPs feel about this measure?
Issuer D	**Input on proposed change to maintain Pharmacotherapy for Opioid Use Disorder (POD) as a reporting-only measure for full contract cycle.** We request Pharmacotherapy for Opioid Use Disorder (POD) remain reporting only. We request Depression Screening and Follow-Up for Adolescents and Adults (DSF-E) also remain reporting only due to the structure and denominator.
Issuer D	**Input on the proposed change to keep the amount at risk steady or reset for all QHPs while introducing health equity accountability, followed by a gradual increase in succeeding years.** We respectfully recommend not increasing QTI further. We are concerned about potential impact to all enrollees through premium rate adjustments that may be necessary with continued increases.
Issuer D	Input on the proposed approach for new entrants, involving a graduated risk introduction, starting them at the lower percentage-at-risk in their first year of QTI eligibility, immediately subject to health equity accountability. We respectfully request that new Issuers have accountability and be monitored immediately with the same penalties at risk. In addition, new Issuers should demonstrate high quality performance and meet the current demands when entering the market with the same exposure. We have concerns about new entrants coming in and disrupting the marketplace, only to leave.
Issuer D	Input on use of QRS 66th percentile as benchmark for all sub-population results. We are currently assessed based on a split of 4 measures x 2 products = 8. For 2026-2028, we understand it would be changed to 5 measures assessed on x 2 products x Race/Ethnicity Depending on population size, this could result in being assessed for anywhere between 40 to 80 splits. For reference see attached spreadsheet. To add to the complexity, as page 23 indicates, there will be a minimum population threshold, so each measure at a product level may have different race and ethnicities in scope. Therefore, we respectfully request to continue to report R/E, and if a Issuer has clear disparities that there are improvement plans the Issuer creates, but Issuers are not assessed at a per subpopulation level.
Issuer D	**Should Covered California set a lower minimum denominator size for measures that achieve the industry standard of 0.7 reliability with a denominator size of less than 100?** No. Reliability is critical to support measurement of year to year improvements. Penalties should not be based on measures with low reliability.
Issuer D	**Recommendations for oversight approaches to ensure performance gaps do not increase for sub-populations included in All Other Members.** Please see response above. We request that measures are split by R/E. Again, the measures would increase 40 to 80 times with small denominator volatility.
Issuer D	**Input regarding the addition of new measures (once benchmarks available) to remain aligned with CMS QRS clinical measures.** We do not have an objection to adding new clinical measures to the 25/2/2 program accountability once benchmarks are available.
Issuer D	**Feedback on proposed update to benchmark year.** We do not have an objection to, at the time of contracting, setting the 25th percentile for the 25/2/2 program accountability to the latest available benchmark.
Issuer D	**Feedback on the proposed Minimum Performance Level (MPL) Action Plan** We oppose an action plan for each measure below 25th percentile for 2 years, rather than just one plan for composite performance, to allow more focus on the whole member and the entire provider relationship.
Issuer D	General With movement of populations between Issuers during Open Enrollment, we respectfully request that Covered California implement improved data sharing to new Issuer to assist with population management of conditions. There is some concern that needs additional research pertaining to members that obtain services during the year, like being compliant with COL, but churn and therefore fall off before the continuous enrollment deadline so they are excluded as compliant members. We would like to look into this further to see if this needs to be taken into consideration prior to any financial "incentive".
Issuer D	**Consultations** We respectfully request that Covered California consider consulting the most important individuals to determine what they think and want who is the Covered California members directly. Please consider surveying the Covered California population directly on both clinical and non-clinical on what they care most about.

Issuer D	**Numbers Reversed** The numbers are reversed for MY22.
Issuer D	**66th percentile** We respectfully request to align with OHCA at 50th percentile.
Purchaser	**To address challenges associated with the Childhood Immunization Status (Combo 10) measure, are there recommendations for new measures for its replacement?** Purchaser feels strongly about retaining the childhood immunization measure and prefers it over alternative measures such as well child visits, given the emphasis on outcomes and CA's poor performance on children's healthcare overall. And while it may be a difficult measure for providers/plans to meet, given the quantity of immunizations and NCQA's lack of catch up schedule accommodation, the measure is hard for all and reflected in the benchmarks. If CCA and Purchaser feel it reasonable, we can discuss the possibility of CIS-7 vs 10. In terms of numerator and denominator sizes, our plans are able to report for the overall population, but stratification will present a challenge.
Purchaser	**Input on proposed change to maintain Pharmacotherapy for Opioid Use Disorder (POD) as a reporting-only measure for full contract cycle.** Support; DSF also remaining report only for now?
Purchaser	**Direct sharing of stratified performance with Contractor for learning and feedback before sharing publicly.** **Payments connected with Health Equity Methodology for some measures no sooner than 2026.** Purchaser supports this approach - refining and testing methodology, sharing results with plans prior to sharing publicly, and payments connected to equity targets no earlier than MY 2026. Purchaser may be a year behind this schedule, as well.
Purchaser	**Input on use of QRS 66th percentile as benchmark for all sub-population results.** Purchaser supports using the 66th percentile as the benchmark for subpopulation results.
Purchaser	**Should Covered California set a lower minimum denominator size for measures that achieve the industry standard of 0.7 reliability with a denominator size of less than 100?** Purchaser would support this. Additionally, NCQA has said that the denominator of 30 rule still holds when comparing to benchmarks (as opposed to comparing subgroups to each other) in terms of statistically stable rates. Using the lowest possible denominator ensures that we can hold plans accountable for improving care for minority populations.
Purchaser	**Recommendations for oversight approaches to ensure performance gaps do not increase for sub-populations included in All Other Members.** Review 'All Other Members' composition results with individual plans to determine if any action should be taken for specific groups in AOM. When reviewing with plans, compare the sub-population rates with the 66th percentile benchmark so that plans are aware of where these subpopulations stand, even if no payment is specifically tied to them. Especially if a subpopulation at some point ends up having a sufficient denominator size of its own.
Purchaser	**Monitoring and remediation required for composite performance only.** **Minimum Performance Level Action Plan required for each clinical measure falling beneath the 25th percentile for 2 consecutive years.** Support; noting that Purchaser requires quality improvement plans for any plan with a core measure below the 25th percentile for one year. Also suggest action/ disparity reduction plan for measures where a subpopulation is lower than the 25th percentile as well.
Issuer H	**Input on use of QRS 66th percentile as benchmark for all sub-population results.** Please provide the 66th percentile, as currently, the CMS proof sheet detailed data only includes 50th and 75th.
Issuer H	**Should Covered California set a lower minimum denominator size for measures that achieve the industry standard of 0.7 reliability with a denominator size of less than 100?** Yes.
Issuer H	**Recommendations for oversight approaches to ensure performance gaps do not increase for sub-populations included in All Other Members.** For underperforming metrics only.
Issuer H	**Input regarding the addition of new measures (once benchmarks available) to remain aligned with CMS QRS clinical measures.** Agreed, aligning regulations with CMS would minimize additional work to small carriers.