Article	Section #	Comment	Covered CA response
1	1.02.2	In the event that the three reference measures are used (NQF #0018, NQF #0034 and NQF#0038), what benchmark year will be used for performance asssessment?	In the event that three referenced measures (NQF #0018 (Controlling Blood Pressure), NQF#0034 (Colorectal Cancer Screening), and NQF#0038 (Childhood Immunization Status/Combo 10)), Covered California would use the most recent scored measurement year for each measure before they transitioned to ECDS.
1	1.07.1	Please clarify the purpose of the allowance for an Issuer to operate its own PoPHI. How will Covered California evaluate a new PoPHI recommendation, and would the issuer also need to contribute funds to the existing PoPHI? Will the issuer operated PoPHI continue to support a marketplace population outside of their own enrollment?	Covered California has introduced this language to encourage Issuers to continue to develop new, innovative ideas to advance population health as well as to allow for future close alignment with the DHCS community reinvestments. Regarding a new PopHI recommendation, Covered California will continue to leverage the guiding principles outlined in the contract as well as the decision framework used to determine the current PopHIs. We would anticipate significant Covered California enrollee input as well as continued broad stakeholder engagement.
1	1.03 4)	In light of OHCA requirements to reduce costs, we ask Covered CA to reconsider the QTI penalty timeline and maximum.	Covered California is closely tracking the OHCA requirements and timeline. When QTI was developed, the intent was to increase the amount at risk by 1% each year to 4% for MY2026. However, Covered California has adjusted the amount at risk for MY2026 to a maximum of 2.8% of premium recognizing the learning curve related to transitioning to ECDS as well as other requirements from sister state departments.
1	1.03	We recommend adding language that will allow for Covered California to remain flexible and change the selected measurement year for the QTI benchmark over the Contract Cycle. As we may see some measures decline over time, for example, as we have seen with CIS-Combo 10, it may be necessary to select a different measurement year that better suits the current environment an circumstances that may not be expected beyond 2025.	The current language does accomodate adjustments to the benchmark if indicated based on a measure transition or updated scoring from QRS. However, based on years of feedback from Issuers as well as providers, Covered California remains committed to maintaining static benchmarks as best able for the QTI throughout the Contract Cycle. While we recognize that some measures may fluctuate over time, the intent is to ensure consistency and accountability in tracking progress. Committing to a measurement year early allows QHP issuers with the necessary lead time to adjust and prepare as well as demonstrate year over year improvement.
	Overall	If there is any future evolution of the QTI program Health Equity component, we would like to recommend that Covered Ca consider the DHCS All Plan Letter for COVID vaccinations and their methodology of weighting the gap between the lowest performing stratified subpopulation group and the highest performing stratified subpopulation group and set the performance penalties based on the issuers ability to close the gap between these subpopulations. To ensure smaller subpopulations don't get lost under the "Other" population subgroup we would like to recommend Covered Ca consider a cross-carrier intervention in partnership with tribal partners and community organizations, focused on these small subpopulations to address the collective responsibility to promote equity in the most marginalized communities. We would also encourage Covered Ca to consider the impact that the Knox Keene and other anti-discrimination statutes have on the ability for carriers to build programs based on racial or ethnic demographics. We are working alongside community partners and national experts while informing statewide and industry efforts to shed light on the roadblocks and how to overcome them and appreciate Covered Ca's continued leadership in helping overcome them as well.	Covered California is aware that this a multi-year commitment by QHPs to multiple racial and ethnic subpopulation to make meaningful strides in to address inequities. The health equity methodology acknowledges and incentivizes quality improvement and was developed in alignment and collaboration with DMHC, DHCS, and CalPERS. It is our hope and expectation that all plans will continue to invest in addressing identified disparities and commit to supporting all subpopulations in reaching the 66th percentile.
	1.05 or 1.06	1.06 Administration of QTI Payments or 1.05 QTI Peformance Report **Recommendation:** Per existing timeframes for the calculation of Contractors QTI payments, the payment obligation will fall towards the very end of a calendar year and even early into the following year. To support Contractors' financial management and planning processes, we propose contract language be modified to enable a Contractor to fulfill its payment obligation early in the next calendar year with Covered California's approval, if the 60 days notification should fall before december 31.	The deadline for QTI payments was moved to accommodate the timing concerns raised, which is reflected in the PopHI Directives. This adjustment was made to allow for better financial planning and management. We believe this provides sufficient flexibility for Contractors without requiring additional modifications to the contract language.

1	1.02 1) - 6)	Risks of Variability Related to QTI Methodology – QHP issuers remain committed to addressing health disparities and recognize stratifying the subpopulations as stated in Attachment 4. However, carriers continue to express concerns regarding Covered California's new proposed QTI methodology plans to hold QHPs financially accountable based on the individual race/ethnicity for a given HEDIS measure rather than overall performance for the measure. In our previous comments, CAHP emphasized the high potential for variability among carriers with this requirement, as the mix of subpopulations could be very different from carrier to carrier (and by rating region), which in turn means a high potential for variability in how penalties are assessed. We are concerned about the fairness of application and assessment, and we also have concerns about member impact. A successful Quality strategy that creates lasting change is a multi-year approach with realistic goals that requires teamwork and investment from every department within the plan. Requiring all race/ethnicities to reach the same benchmark, within the same time frame, from differing starting points creates a risk for unintentional consequences that may only further drive health disparities among Covered California members. We continue to respectfully request Covered California allow for the first year to be reporting-only, so carriers can establish a baseline understanding of the subpopulation data being reported among products and geographies. We believe this step is necessary to better inform the path forward.	Thank you for your feedback.Covered California is aware that this a multi-year commitment by QHPs to multiple racial and ethnic subpopulation to make meaningful strides in to address inequities. The proposed methodology has been consistent since it was released in 2023 and will not take effect until 2026 with the intention of giving plans enough time to prepare and address known disparities. The health equity methodology acknowledges and incentivizes quality improvement and was developed in alignment and collaboration with DMHC, DHCS, and CalPERS. It is our hope and expectation that all plans will continue to invest in addressing identified disparities and commit to supporting all subpopulations in reaching the 66th percentile.
1	1.01	We understand Covered CA is proposing to use CBP-E metric with the new QTI contract requirements and establish benchmarks. This "CBP-E" measure is in discussion by NCQA and we understand it will not be a reportable measure until 2026 measurement year. Based on timing, benchmarks at the earliest would be established October of 2027 and retroactively applied to 2026. It is imperative benchmarks are defined prior to 2026 for plans to support improvement activities and quality goals for CBP-E measure. We request Covered CA define the 2026-2028 QTI benchmarks prior to contract go-live on 1/1/2026.	We recognize the importance of having these benchmarks in place early to support improvement activities and quality goals for the CBP-E measure. We will continue to track CMS QRS updates in order to achieve this goal.
1	1.01	Utilizing a retired HEDIS measure due to the absence of an available benchmark creates an administrative burden for plans to contract with a vendor to support multiple years of the measure concurrently. We respectfully request that no QTI penalty be assessed, given the lack of benchmarks for the first year of "E" measures.	We understand the challenges using retired measures may present for plans. To help mitigate these concerns, Covered California will communicate early and ahead of time to allow QHP issuers to plan accordingly. Additionally, we continue to work closely with NCQA and CMS QRS to align our programs.
1	1.03	We respectfully request the removal of this section due to its vague language. Additionally, we request that any substantial changes to QTI measures include adequate time and opportunity for public comment. This will ensure transparency and allow stakeholders to provide valuable input before any significant adjustments are made.	The section in question addresses several scenarios for benchmarking, which were added to account for inevitable changes in measure specifications. This addition is crucial for establishing clear performance expectations and providing a comprehensive framework for assessing QTI, as measures develop and change over the course of contract years. Covered California does not agree that the language is vague. It specifies how performance will be assessed if QRS scores are not calculated and published by CMS for 2025, to allow Contractors to plan accordingly. Regarding QTI measures, we are committed to ensuring transparency and providing adequate time for public comment when substantial changes are made.
1	1.04	We respectfully request the removal of this section due to its vague language and because subpopulations will be compared to the 66th percentile. If this clause is not removed, further clarification is needed. We respectfully request that specific definitions for "decline" and "stagnation" be provided, as well as a detailed outline of how carriers will be notified of any additional remediation steps. This will ensure transparency and help carriers effectively meet expectations.	Updates have been made to the contract language to enhance its clarity.