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| 1 | 1.01 1) a) | **For the change from CBP-> BPC-E:** We would prefer the BPC-E <140/90 mm HG rate, and not <130/80 mm HG | Covered California acknowledges your feedback and preference. As CMS has not yet proposed the BPC-E measure, more details on measure specification will come through the CMS Annual Call Letter process. | |
| 1 | 1.01 1) d) | There are concerns about CIS Combo 10 and recommend transition to CIS Combo 7. This is due to nation-wide challenges with flu vaccinations in this population. | CIS Combo 7 is not currently included in the CMS QRS measure set. Given the significant importance of maintaining alignment across DHCS/Medi-Cal, CalPERS, DMHC, and other statewide initiatives, CIS Combo 10 will remain a scored QTI measure. However, due to smaller denominator sizes for CIS-10 and DSF-E, these measures will be weighted lower than the other three measures, and the CIS-10 Allowance program will continue. To limit the need for multiple data source submissions, alignment with QRS is critical. QHP issuers are encouraged to respond to the CMS Call Letters advocating for the inclusion of CIS-7 in the QRS measure set. | |
| 1 | 1.02 | We would encourage CovCA to use breakouts by race and ethnicity as prescribed by HEDIS NCQA, rather than consolidating multiple race and ethnicity categories into "other".<br>a. Our performance improvement work on AA HTN wouldn't be reflected if proposed subpopulation stratification was applied; in this proposed stratification the African American population would be consolidated into the "other" category.<br>b. There may be variation across plans that are unexpected and inappropriately weighted in this model. Specifically, our organization race and ethnicity subpopulations might not be comparable across other plans' subpopulations due to denominator size<br>c. Health plans are already calculating this data with the NCQA HEDIS race and ethnicity categories. Requiring separate analysis with non-standard race/ethnicity groups increases the reporting/data burden for health plans. | Covered California uses stratification guidelines consistent with OMB standards and CDC race and ethnicity codes, which are consistent with NCQA stratification. Any subpopulation recognized by OMB and meeting the minimum denominator size will be an Eligible Subpopulation for which Contractor would be subject to QTI scoring. The proposed contract requirements do not require Contractors to construct the All Other Members category as this grouping is used only for scoring and payment assessment purposes. Creation of this group for scoring purposes is supported by statistical analysis and prevents small subpopulations from exclusion from Contractor accountability. As proposed in the draft contract, Covered California will continue to monitor stratified rates for all subpopulations regardless of size and expects Contractors to monitor measure rates for these subpopulations and implement culturally tailored interventions. | |

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| 1 | 1.01.1 | CIS-E<br>In order to maintain the intention of the original measure selection, we recommend 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. We recommend using the CIS-E benchmark (and not CIS) when the switch to the ECDS measure occurs.<br><br>We agree with continuing the CIS-10 allowance for flu if the measure remains as CIS-10. If so, we recommend adding this language into the contract. | CIS Combo 7 is not currently included in the CMS QRS measure set. Given the significant importance of maintaining alignment across DHCS/Medi-Cal, CalPERS, DMHC, and other statewide initiatives, CIS Combo 10 will remain a scored QTI measure. However, due to smaller denominator sizes for CIS-10 and DSF-E, these measures will be weighted lower than the other three measures, and the CIS-10 Allowance program will continue. To limit the need for multiple data source submissions, alignment with QRS is critical. QHP issuers are encouraged to respond to the CMS Call Letters advocating for the inclusion of CIS-7 in the QRS measure set. | |
| 1 | 1.01.1 | BPC-E<br>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 supplemental EMR data (i.e. back-end data) is received. We recommend waiting to transition to this measure until the CBP and BPC-E rates are more closely aligned, and NCQA has officially retired CBP. 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. | Covered California acknowledges your feedback and preference. As CMS has not yet proposed the BPC-E measure, more details on measure specification will come through the CMS Annual Call Letter process. QTI payment for CBP measure will be maintained in QTI if CBP is not transitioned to BPC-E. | |
| 1 | 1.01.1 | DSF-E<br>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 underreported 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.<br><br>DSF-E should remain a reporting only measure until we have at least 2 years of benchmarks from NCQA in Quality Compass. 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? | Covered California acknowledges the challenges of the DSF-E measure and will be retaining DSF-E as a scored QTI measure given the importance of identifying and treating depression. However, if DSF-E data is not available to assess performance or establish a benchmark, Covered California may choose not to assess the measure. Covered California will align with QRS scoring for the DSF-E benchmark. | |

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| 1 | 1.01.2 | If Covered California elects to include additional reporting only measures in the future, they should be from the QRS catalog of available measures to ensure certified software vendors can produce certified rates for plans. Reporting on custom measures comes with a programming cost and we will need at least 3 months lead time to program.<br><br>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. | Covered California remains committed to use of static benchmarks in the new contract and will not introduce new measures, only the ECDS counterparts of the current QTI measures. Most measures will retain their specifications, with adjustments made solely for the transition to ECDS. The QTI relies on reportable QRS measure scores published through the CMS Marketplace Quality Module within CMS's Health Insurance and Oversight System. Additionally, no new custom measures will be introduced but Covered California may use historic measures, which have already been programmed. As a result, there should be minimal to no new costs associated with this transition. | |
| 1 | 1.03 1) | 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.<br><br>Additionally, setting the benchmark as Measurement Year 2025 means that the QTI benchmarks will not be released until September/October 2026, which will be well into the 2026 QTI year. We recommend changing the benchmark to MY 2024 for contract years 2026-2027 to allow plans to set appropriate targets prior to the start of this new cycle. | After advocacy, Covered California received confirmation from CMS that national benchmarks will be provided for all QRS measures required for QRS data collection, including those in the first year of data collection. This will allow issuers the opportunity to assess plan performance as early as possible before financial accountability begins for MY2026. While MY2024 can't be used for benchmarks due to the transition of several measures to ECDS on different timelines, it is still important to note since some data and benchmarks will be available for some measures by MY2024. This early data will provide valuable insights for issuers to understand performance trends and prepare for the upcoming accountability and contract period. | |
| 1 | 1.03 2) | During the Plan Management meeting on August 8th, the proposed health equity methodology applied to colorectal cancer screening and blood pressure measures (see first bullet point on page 92 of the Plan Advisory Group Master Deck - August 2024): “Stratified measure results replace “all population” measure results for colorectal cancer screening and blood<br>pressure measures." Our ogranization supports assessing payments for COL and CBP (as long as the measure does not transition to BPC-E) for QTI payments. | Covered California appreciates your feedback and acknowledges challenges with the transition to the BPC-E measure. | |
| 1 | 1.03 3) | We recommend payments be apportioned for subpopulations only for select QTI measures: COL, and CBP (if the measure does not transition to BPC-E). | The percent at risk is divided across the QTI Measures (final weighting still to be determined). As discussed in the 2026 contract workgroup, both the CBP/BCP-E and COL/COL-E measures will be assessed at the stratified level, with the remaining measures assessed at the all-population level. | |

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| 1 | 1.03 4) | Both the introduction of the measure stratification and the measure changes and new benchmarks could significantly change plan performance. We recommend resetting the QTI and Attachment 2 penalties back to a total of 1% (0.8% for QTI and 0.2% for Attachment 2) for the 2026 Contract year penalty amount in order to allow time for QTI measure stratification, measure changes and new benchmark outcomes to be reported and observed before setting penalty increases for future years. We also recommend setting the total maximum penalty at no more than 3% over the 2026-2028 Contract period to allow a steady and reasonable 1% total increase over each calendar year. | The amount at risk for MY2026 will be up to 2.8% of premium, recognizing the importance of reducing disparities and emphasizing that quality cannot exist without equity. It is important to note that when the program was developed, the intent was always to stratify and increase the amount at risk by 1% each year. This current amount reflects a compromise, as an increase to 3.8% in 2026 was initially proposed in the development of the QTI. Additionally, Covered California will continue the CIS-10 allowance initiative, which has generated substantial savings for issuers while recognizing delivery of clinically appropriate care for pediatric members. | |
| 1 | 1.03 4) | Per the Plan Management meeting on August 8th (see page 91 of the Plan Advisory Group Master Deck - August 2024), CIS and DSF would be weighted 25% and the remaining measures would be weighted 75%. We support adding this weighting back in, due to the small denominator for CIS and the underreporting issue with DSF. If CIS and DSF are weighted 25%, please clarify whether each measure will be weighted 12.5% or if a different weighting will be implemented.<br><br>Please also clarify the proposed methodology to divide each measure amount at risk based on QHP-specific subpopulation denominator weights. | Covered California is still finalizing proposed weighting of scored QTI measures. For stratified measures, the amount at risk would be apportioned at the race/ethnicity group level meaning that the at-risk amount for the stratified measure would be subdivided by each eligible subpopulation. The payment amount would be determined based on QHP specific subpopulation denominator size. For example, if a subpopulation represents 30% of the total measure sample denominator, the amount at risk for that group is maxed at 30% of that total pool for that measure. | |
| 1 | 1.10 | We request that any Quality Improvement Plans at the subpopulation level be deferred until MY 2027 results at the earliest, given the methodological changes for 2026. | The QTI Health Equity methodology will apply only to the blood pressure and colorectal cancer screening measures during the 2026-2028 contract cycle. By MY2026, plans will have gained valuable experience from submitting quality improvement plans and disparity intervention plans during the previous contract period, which will better inform their approach to subpopulation-level quality improvement plans. | |

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| Intro | | Recommend changing requirement of "2 years of QRS reportable scores" to "2 years of HEDIS reporting". There is no difference in the annual HEDIS submission process. By design, multi-year measures would have lower denominators to account for the new population. New "QHPs" would be able to leverage QTI fines to support their own growth without facing consequences. This does not align with verbiage under Section 1.03 (4) which indicates that "Newly Contracted QHP issuers will start with a reduce risk percentage in Year 1 of QTI eligibility". | Per Attachment 4, the assessment under the QTI relies on reportable QRS measure scores published through the CMS Marketplace Quality Module within CMS's Health Insurance and Oversight System. Additionally, 45 C.F.R. § 156.1120(a)(1) mandates that a QHP issuer must submit data to HHS and Exchanges to support the calculation of quality ratings for each QHP offered in an Exchange for at least one year. As Covered California is a state-based marketplace, we are required to utilize CMS QRS scores. Additionally, commercial performance and benchmarks are not the same as marketplace data, which is why Covered California cannot use HEDIS commercial performance. New entrants have two years per CMS before QHP QRS scores are reportable and Covered California has aligned with CMS by making new QHP issuers eligible for QTI after the initial two years on the exchange. New QHP issuers will be given a ramp up period with a lower amount at risk just as currently contracted issuers have been provided the same opportunity. | |
| 1 | 1.01.1 2) | Request to provide detailed guidance including technical specifications for any QTI measure substitutions. | Covered California acknowledges the request for detailed guidance on QTI measure substitutions and understands the importance of maintaining consistency in measure selection. While we have ensured stability in the QTI measure set, we must also accommodate the transition to ECDS measures. To streamline the process and minimize the need for multiple data source submissions, alignment with QRS is essential.<br>We will not introduce any new QTI measures, only the ECDS counterparts of the current QTI measures. Most measures will retain their specifications, with adjustments made solely for the transition to ECDS. The QTI will continue to rely on reportable QRS measure scores as published through the CMS Marketplace Quality Module within CMS's Health Insurance and Oversight System. Additionally, no new custom measures will be introduced but Covered California may use historic measures, which have already been programmed. As a result, there should be minimal to no new costs associated with this transition. | |

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| 1 | 1.01.1 3) | Request for commitment to measure selection provided in this contract due to the administrative burdened required of providers to accommodate changes of EMR systems and member engagement. Recommendation for the term "periodically" to be updated to "annually, per NCQA HEDIS submission guidelines". | Covered California understands the importance of stability for providers, particularly in light of the administrative burden associated with changes to EMR systems and member engagement. While we strive to maintain consistency in benchmarks throughout the contract period, we are reliant on QRS measures, which may evolve over time. Additionally, as ECDS measures transition on varying timelines, there will inevitably be some movement in measure reporting. | |
| 1 | 1.02 1), 1.03, 1.03.2, 1.04 | The use of multiple race/ethnicity reporting models (OMB and CDC) is challenging and poses significant administrative burden on issuers. Request for Covered Ca to pick one model due to concerns with the use of CDC codes and mapping to OMB categories. Further, subpopulations should not be assessed as tied to financial sanctions. Recommendation to keep QTI payment penalties tied to total scores for each measure rather than subpopulation/stratified results. Tying payments to race/ethnicity stratifications could inadvertently lead to the treatment of similarly situated individuals differently in which QHPs potentially target activities to improving HEDIS rates for certain subpopulations and take focus way from other subpopulations. | The use of OMB categories and the CDC race and ethnicity code set is already in place in the current contract and current data collection and sharing practices. Covered California is not proposing any changes to current stratification approaches. Covered California is committed to implementation of financial accountability for stratified performance beginning in 2026. Stratification enables unmasking real differences in performance by race and ethnicity and allows for tailored interventions for populations to prevent any group from being left behind. Proposed contract language includes several provisions to ensure thorough monitoring and potential consequences in the event of stagnant or worsening disparities among subpopulations. | |
| 1 | 1.03 | Concerns with the new contract verbiage allowing for frequent benchmark updates/changes as it takes multiple years to truly create change. Request to match the 2023 - 2025 contract process which did not change benchmarks. | Covered California understands the importance of stability for providers and will strive to maintain consistency in benchmarks throughout the contract period. However, we are reliant on QRS measures which may evolve over time and given that ECDS measures will transition on varying timelines, there will inevitably be some movement in measure reporting. Covered California remains committed to minimizing disruption while aligning with necessary transitions. | |
| 1 | 1.03.4 | Newly contracted QHP issuers should have the same standards as all QHP participants. By default of NCQA HEDIS metrics, new QHPs will have smaller denominators allowing time to accommodate building the infrastructure. | New entrants have two years per CMS before QHP QRS scores are reportable and Covered California has aligned with CMS by making new QHP issuers eligible for QTI after the initial two years on the exchange. New QHP issuers will be given a ramp up period with a lower amount at risk just as currently contracted issuers have been provided the same opportunity. | |
| 1 | 1.07 | Recommendation for contract language to reflect PopHIs that more specifically support improvement on QHP performance measures. QHP flexibility to focus PopHI investments on activities that improve measures that QHPs are being assessed on. | QTI is a health plan accountability program designed to improve QHP performance in the core measures. The Population Health Investments (PopHIs) are anchored by the guiding principles for the use of funds centered on improving health outcomes for Covered California enrollees: Equity First, Direct, Evidence-based, and Additive. | |

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| 1 | 1.10 | Recommendation that the Quality Improvement Plan be kept to the overall measure performance. Assigning work to each measure subpopulation is a significant administrative burden. | The QTI Health Equity methodology will apply only to the blood pressure and colorectal cancer screening measures during the 2026-2028 contract cycle. Subpopulation-specific improvement plans would be required in situations of worsening or stagnant disparities, reflecting a need for timely focused intervention, not administrative burden. | |
| 1 | 1.01.1 2) | COL measure (NQF#0034 )will be retired from QRS as of MY2024 - Does CoCA wants carriers to continue calculating and reporting this measure directly as a custom measure? | No, Covered California will not require carriers to continue calculating and reporting the COL measure (NQF#0034) as a custom measure. Instead, it will transition to COL-E and follow the published specifications for that measure. | |
| 1 | 1.02 1) | Will this data be collected via PLD report? | Yes, as directed by Covered California, the current contract requirement will continue. Contractors must submit Healthcare Effectiveness Data Information Set (HEDIS) measure patient level data files for its Covered California Enrollees. Covered California may require submission of all or some of the HEDIS measures. Please see section 1.02.1 Monitoring Disparities: Patient Level Data File section for more information. | |
| 1 | 1.03 | What if the benchmark is met for the measure as a whole, but the sub-population is small den and doesn't surplass the benchmark.<br>What is the minimum den size for sub-populations? | Any Eligible Subpopulation with a score beneath the 66th percentile will result in assessment of the appropriate payment amount regardless of the overall measure score. If a subpopulation is smaller than the minimum denominator size of 100, it will be included in the All Other Members category. This category was established for subpopulations that would be part of an eligible subpopulation but have fewer than 100 identified enrollees in the denominator. | |
| Preamble | Preamble | We request the maximum amount at risk for QTI be 0.8% for 2026. If accepted, we request in the second paragraph "as high as 4%" be updated. | The amount at risk for MY2026 will be up to 2.8% of premium, recognizing the importance of reducing disparities and emphasizing that quality cannot exist without equity. It is important to note that when the program was developed, the intent was always to stratify and increase the amount at risk by 1% each year. This current amount reflects a compromise, as we are not increasing it to 3.8% in 2026, which was a possibility. Additionally, Covered California will continue the CIS-10 allowance initiative, which has generated substantial savings for issuers. | |

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| 1 | 1.01 1) | As Covered California is aware, there are concerns with keeping Combo 10. We request this be changed to Combo 7. | CIS Combo 7 is not currently included in the CMS QRS measure set. Given the significant importance of maintaining alignment across DHCS/Medi-Cal, CalPERS, DMHC, and other statewide initiatives, CIS Combo 10 will remain a scored QTI measure. However, due to smaller denominator sizes for CIS-10 and DSF-E, these measures will be weighted lower than the other three measures, and the CIS-10 Allowance program will continue. To limit the need for multiple data source submissions, alignment with QRS is critical. QHP issuers are encouraged to respond to the CMS Call Letters advocating for the inclusion of CIS-7 in the QRS measure set. | |
| 1 | 1.01 1) | Our understanding is that ECDS and Depression will have two indicators but will not have % sub-measures. Please clarify how the % sub-measures will be done. | Covered California will align with QRS scoring for the DSF-E benchmark. | |
| 1 | 1.01 1) | Please advise how the DSF-e will be scored for QTI in MY2026:<br>A. The two indicators averaged then compared to 66th percentile for the average of the two indicators, or<br>B. Each indicator is compared to the 66th percentile for the respective indicator?<br>The two indicators are Depression Screening, and Follow-Up on Positive Screen. | Covered California will align with QRS scoring for the DSF-E benchmark. | |
| 1 | 1.02 1) | We are committed to addressing health disparities and recognize stratifying the subpopulations as stated in this section. We are, however, concerned with the assessment being made at a subpopulation level. For a QHP issuer that offers only 1 product, this appears to be 10 levels of stratification per measure multiplied by the 5 measures. So a total of 50 splits of data for the assessment. While there is likely an initial stratification of 9, there is a roll-up for all that don't hit 100 enrollees to be calculated as All Other. That's just if a carrier offers one product.<br>We respectfully request Covered California analyze at a subpopulation level but only assess the QTI at the Enrollee population of measure and not subpopulation. | Covered California is committed to implementation of financial accountability for stratified performance beginning in 2026. Stratification enables unmasking real differences in performance by race and ethnicity and allows for tailored interventions for populations to prevent any group from being left behind. | |
| 1 | 1.02 1) | Assessing the QTI at a subpopulation level negaive impacts carriers offering plans across multiple rating regions. Where a Contractor that operates in one rating region may only have 20 enrollees of a subpopulation and therefore it is not counted at a subpopulation level, a carrier offering products across multiple regions can have even fewer than the 20 across rating regions but still add up to 100 enrollees across the state.<br>We respectfully request Covered California analyze at a subpopulation level but only assess the QTI at the Enrollee population of measure and not subpopulation. | Covered California is committed to implementation of financial accountability for stratified performance beginning in 2026. If a subpopulation is smaller than the minimum denominator size of 100, it will be included in the All Other Members category. This category was established for subpopulations that would be part of an eligible subpopulation but have fewer than 100 identified enrollees in the denominator. | |

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| 1 | 1.02 1) | We are concerned with the definition of Eligible Subpopulation and request the following change. The concern is that Covered California does not pass Middle Eastern/North African to Contractors on the 834. We believe a more appropriate definition for purposes of the stratification analysis is not to call out the specific race and ethnicities. Instead, if they meet 100 members then they are included in analysis. We respectfully request the following change:<br>"Eligible Subpopulation" means the following stratified subpopulations, as defined by the federal Office of Management and Budget (OMB) or Centers for Disease Control (CDC) Race and Ethnicity Code Set, with at least 100 members in the denominator: ~~American Indian or Alaska Native, Asian, Black or African American, Hispanic or Latino, Middle Eastern/North African, Native Hawaiian or Other Pacific Islander, and White.~~ Eligible Subpopulation for analysis shall also include Multirace, used when an individual reports two or more CDC codes that cross higher OMB concepts. | Covered California's policy and practice are consistent with that of OMB. Covered California is not revising the definition of Eligible Subpopulation. | |
| 1 | 1.02 1) | Please clarify if enrollees that affirmatively decline to state will be included in a subpopulation and if so, which subpopulation they will fall into. | If an enrollee chooses to decline to state, they would be included in the All Other Members Category along with other members whose race or ethnicity is unknown. | |
| 1 | 1.02 1) | Please clarify if enrollees that only respond "not Hispanic or Latino" will be classified as "All Other Members Subpopulation." | If an enrollee responds as not belonging to the Hispanic or Latino Category but identifies as belonging to an "Eligible Subpopulation" as defined in the contract, then the enrollee would be placed in one of those groups. | |
| 1 | 1.02 | We respectfully request more details on the subpopulation stratification process. | An "Eligible Subpopulation" is a group that belongs to a population defined by the federal Office of Management and Budget (OMB) or the Centers for Disease Control's (CDC) Race and Ethnicity Code Set, which map directly to the OMB categories, with at least 100 members in the denominator:<br>• American Indian or Alaska Native<br>• Asian<br>• Black or African American<br>• Hispanic or Latino<br>• Middle Eastern/North African<br>• Native Hawaiian or Other Pacific Islander<br>• White<br>• Multirace, used when an individual reports two or more CDC codes that cross higher OMB concepts.<br>Subpopulations that do not meet the minimum denominator size of 100 will be grouped under the "All Other Members" category. For QTI scoring, Covered California will construct the Eligible Subpopulations and All Other Members groups for each stratified measure. | |

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| 1 | 1.02 | Please clarify if the directions on the Race and Ethnicity Hierarchy will vary by measure, contractor, or product. | No, they will not. |
| 1 | 1.03 1) | We are concerned with using Measurement Year 2025 as the benchmark for 2026 as QRS national percentiles will not be issued for Measurement Year 2025 until September/October 2026 which is very late in the 2026 Measurement Year. We respectfully request that Measurement Year 2024 be used for 2026. | After advocacy, Covered California received confirmation from CMS that national benchmarks will be provided for all QRS measures required for QRS data collection, including those in the first year of data collection. This will allow issuers the opportunity to assess plan performance as early as possible before financial accountability begins for MY2026. While MY2024 can't be used for benchmarks due to the transition of several measures to ECDS on different timelines, it is still important to note since some data and benchmarks will be available for some measures by MY2024. This early data will provide valuable insights for issuers to understand performance trends and prepare for the upcoming accountability and contract period. |
| 1 | 1.03 1) | To maintain stability, we respectfully recommend national benchmarks be used and Covered California not deviate. | Covered California will use the CMS provided national benchmarks for all QRS measures required for QRS data collection, including those in the first year of data collection. MY2025 will serve as the 'reporting only' year, with new contract provisions taking effect for QTI accountability in MY2026. |
| 1 | 1.03 2) | We request clarity in 2) beginning "… if any Covered California may…" | Thank you, we will clarify the sentence to read, "For each year of the Agreement, Covered California will compare Contractor's QTI Scored Measure, including scores for each Eligible Subpopulation and the All Other Members Subpopulation for Stratified Measures, for each product, against the benchmark to determine Contractor's QTI Payments, ~~if any~~. Covered California may direct Contractor to submit QTI Core Measures using alternative measure specifications, either to Covered California or to another entity, and score them using verified data sources or may use data submitted pursuant to Section 5.01.1 of Attachment 1 of this Agreement to appropriately adjust Contractor's reportable QTI Core Measure score." |
| 1 | 1.03 2) - 4) | We are committed to addressing health disparities and recognize stratifying the subpopulations as stated in this section. We are concerned with the assessment being made at a subpopulation level. For a QHP issuer that offers only 1 product, this appears to be 10 levels of stratification per measure multiplied by the 5 measures. So a total of 50 splits of data for the assessment. While there is likely an initial stratification of 9, there is a roll-up for all that don't hit 100 enrollees to be calculated as All Other. That's just if a carrier offers one product.<br>We request Covered California assess the QTI at the Enrollee population of measure and not subpopulation | Covered California is committed to implementation of financial accountability for stratified performance beginning in 2026. Stratification enables unmasking real differences in performance by race and ethnicity and allows for tailored interventions for populations to prevent any group from being left behind. |

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| 1 | 1.03 3) | In Section 1.01 we request Combo 10 be replaced with Combo 7. If this cannot occur, we request Combo 10 not be weighted as heavily as the other measures due to known issues with this measure. | CIS Combo 7 is not currently included in the CMS QRS measure set. Given the significant importance of maintaining alignment across DHCS/Medi-Cal, CalPERS, DMHC, and other statewide initiatives, CIS Combo 10 will remain a scored QTI measure. However, due to smaller denominator sizes for CIS-10 and DSF-E, these measures will be weighted lower than the other three measures, and the CIS-10 Allowance program will continue. To limit the need for multiple data source submissions, alignment with QRS is critical. QHP issuers are encouraged to respond to the CMS Call Letters advocating for the inclusion of CIS-7 in the QRS measure set. | |
| 1 | 1.03 3) | We understand that Covered California may be applying different weight per measure. We request Covered California clarify what the weights will be per measure.<br>Per August workgroup, QTI Scored Measures, the 5 measures will not be equally weighted with 75% of the amount at risk divided across diabetes control, blood pressure control and colorectal cancer screening<br>We respectfully request Covered California update Attachment 4. | Covered California is still finalizing proposed weighting of scored QTI measures. | |
| 1 | 1.03 4) | The Gross Premium at risk is not consistent with the Model Contract. We request the QTI amount begin at 0.8% for 2026. | The amount at risk for MY2026 will be up to 2.8% of premium, recognizing the importance of reducing disparities and emphasizing that quality cannot exist without equity. It is important to note that when the program was developed, the intent was always to stratify and increase the amount at risk by 1% each year. This current amount reflects a compromise, as an increase to 3.8% in 2026 was initially proposed in the development of the QTI. Additionally, Covered California will continue the CIS-10 allowance initiative, which has generated substantial savings for issuers while recognizing delivery of clinically appropriate care for pediatric members. | |
| 1 | 1.03 5) | To ensure consistency in assessing Contractors to possibly waive or reduce QTI penalties, please provide clarity what is considered "significant improvement". | Significant improvement will be evaluated based on several factors, including overall performance trends, performance relative to national and state benchmarks, and commensurate improvement across multiple lines of business. Additionally, we will consider improvements in addressing disparities, sensitivity to the current state of the measure, and the Contractor's ability to show consistent progress in closing gaps in care. | |
| 1 | 1.03 5) | We fear there will be increased challenges in reaching consumers in the future due to matters such as "do not contact lists" and consumers that opt-out for such outreach. We respectfully request Covered California also take into consideration efforts Contractors make to reach non-compliant enrollees that fail/refuse to engage and remove those non-compliant enrollees from the denominator. | All measure-eligible enrollees will remain in the denominator for performance assessment purposes, consistent with HEDIS and QRS scoring. While Covered California recognizes the challenges in reaching and effectively engaging consumers, the QTI is intended to improve health outcomes which requires maintaining accountability for all enrollees, including those who do not readily engage in healthcare. | |
| 1 | 1.04 | Consider changing "members" in first sentence to "Enrollees." | Covered California will consider the suggestion. | |

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| 1 | 1.04 | We appreciate and agree with Covered California's concern about declines or worsening scores. We are however concerned with the last sentence and respectfully request that it be removed. QTI calculations are complex and the possibility that "Covered California may re-weight" payment allocations causes increased confusion. We believe the Quality Improvement Plan in Section 5.2.4 of the Agreement should address this and therefore prevent such concern. | Section 1.04 includes a number of potential consequences for stagnant or worsening disparities. As written, potential re-weighting of payment allocations would occur after persistent declines or widening disparities. | |
| 1 | 1.04 | We respectfully request that performance be weighed when there are two years of continuous decline/worsening gaps. Otherwise, a single year's trend may be a HEDIS hybrid sampling problem. | Covered California does not intend to enact re-weighting of payment allocations after a single year of declines or widening disparities and this intent is reflected in the proposed contract language. | |
| 1 | 1.01.1 | 1.01.1 2026 - 2028 QTI Scored Measure Set<br><br>**Recommendation:** As it relates to the addition of the "E" measures, Covered California should align with the HEDIS roadmap and schedule for adoption of the "E" measures, and not require the submission until that time. | Per Attachment 4, the assessment under the QTI relies on reportable QRS measure scores published through the CMS Marketplace Quality Module within CMS's Health Insurance and Oversight System. Additionally, 45 C.F.R. § 156.1120(a)(1) mandates that a QHP issuer must submit data to HHS and Exchanges to support the calculation of quality ratings for each QHP offered in an Exchange for at least one year. As Covered California is a state-based marketplace, we are required to utilize CMS QRS scores. | |
| 1 | 1.02 | 1.02 Race and Ethnicity Stratification Methodology - Eligible sub-populations includes "Middle Eastern/North African"<br><br>**Recommendation:** Remove Middle Eastern/North African as a sub-population as it not an official OMB category at this time. Request that contract language clarify Covered California's intention is to align to OMB and DMHC, and these may change to align with both. | Covered California's proposed 2026 stratification approach is consistent with OMB's revised Statistical Policy Directive No 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity. | |
| 1 | 1.01.2 | We continue to support adding utilization of Pharmacotherapy for Opioid Use Disorders as a QTI-scored measure and hope to see it included soon. | Covered California's appreciates your support and intends to include this measure as a scored measure in future years. | |
| 1 | 1.02 | The category of "all other members" is broad. We request date in this category to be further broken down into the "other/unknown race" when possible, and if sample size is sufficient in the subcategories for the minimal statistical reliability needed for implementing penalties for non-compliance. | The purpose of the All Other Members category is to properly capture members of populations that don't reach the denominator of 100 for health plan accountability. Although these members are grouped for purposes of financial accountability, Covered California remains committed to transparent and disaggregated public reporting and will work with Issuers to ensure appropriately culturally tailored interventions for these groups still occur. | |
| 1 | 1.03 | We request more information on how the benchmarks that go 'up to' 2.8% and 3.8% are determined | The percent at risk threshold is continuously being assessed, and is based on a combination of plan performance data and ongoing discussions with internal stakeholders. | |

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| 1 | 1.10 | We appreciate Covered CA requiring QIPs that reflect measures for Eligible subpopulations and all other members subpopulations for stratified measures. | Thank you for your comment. | |
| 1 | 1.02 | If plans meet the 66th percentile for overall population and all eligible subpopulations but ONE will there be a penalty assigned. Does that penalty go down based on the number of subpopulations meet the 66th? | Contractors will be assessed on QTI scored measure performance for all Eligible Subpopulations and the All Other Members subpopulation. The payment allocation will vary according to subpopulation denominator size. If any eligible subpopulation does not meet the 66th percentile, Contractor will be assessed and payment will be apportioned based on the QHP specific race/ethnicity denominator size. For example, if a subpopulation represents 30% of the measure denominator, the amount at risk for that group is maxed at 30% of the amount at risk for that measure. The payment model for stratified performance accounts for stratified group performance that meets or exceeds the 66th percentile. | |
| 1 | 1.02 | How will CIS-10 be handled since the denominator is barely over 100? | CIS-10 is not a proposed stratified measure for 2026-2028 so will be scored at the all-population level. | |
| 1 | 1.01 | Can Covered CA be more specific abut what this QIP would look like/require? | While it will be similar to the MY2023-2025 QI plan, it will include a focus on subpopulation-level metrics when applicable. | |
| 1 | 1.02 1) - 3) | QHP issuers are committed to addressing health disparities and recognize stratifying the subpopulations as stated in this section. However, we are concerned with the assessment being made at a subpopulation level. For example, for a QHP issuer that offers only one product, this appears to be 10 levels of stratification per measure multiplied by the 5 measures, which equates to a total of 50 splits of data for the assessment. While there is likely an initial stratification of 9, there is a roll-up for all that don't hit 100 enrollees to be calculated as All Other. That is just if a carrier offers one product. There is a 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 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 information the path forward.<br><br>Additionally, considering the above concerns about variability across carriers and regions, we recommend Covered California consider alternative methodologies, such as assessing the QTI at the Enrollee population of measure and not subpopulation. | Covered California is committed to implementation of financial accountability for stratified performance beginning in 2026. Stratification enables unmasking real differences in performance by race and ethnicity and allows for tailored interventions for populations to prevent any group from being left behind. | |

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| 1 | 1.03 3) - 4) | If Covered California proceeds with stratification as identified in section 1.02, additional clarity is needed on the penalty weight distribution methodology for subpopulations. Considering the uncertainty and unique concerns with this new style of reporting, we also request Covered California reduce the penalty for the first year of stratification by subpopulation and consider a gradual increase to no more than 3% total at risk for QTI and Attachment 2 by the end of the contract period. | Covered California is finalizing the weighting. The percent at risk is based on a plan's QTI Performance, which is based on the gross premium for the plan year. The amount at risk would be apportioned at the race/ethnicity group level. The total amount at risk for MY2026 will be up to 2.8% of premium, recognizing the importance of reducing disparities and emphasizing that quality cannot exist without equity. It is important to note that when the program was developed, the intent was always to stratify and increase the amount at risk by 1% each year. Covered California will continually assess this approach in subsequent years to ensure it continues to align with Covered California goals. | |
| 1 | 1.04 | We appreciate and agree with Covered California's concern about declining or worsening scores. However, QTI calculations are complex and the possibility that "Covered California may re-weight" payment allocations may cause increased confusion. We recommend removing the last sentence, as this concern is already addressed in section 5.2.4 of the contract (Quality Improvement Plan). | Section 1.04 includes a number of potential consequences for stagnant or worsening disparities. As written, potential re-weighting of payment allocations would occur after persistent declines or widening disparities. | |
| 1 | 1.03 4) | We request the amount at risk of assessment restart to 0.8% for 2026. | The amount at risk for MY2026 will be up to 2.8% of premium, recognizing the importance of reducing disparities and emphasizing that quality cannot exist without equity. It is important to note that when the program was developed, the intent was always to stratify and increase the amount at risk by 1% each year. This current amount reflects a compromise, as an increase to 3.8% in 2026 was initially proposed in the development of the QTI. Additionally, Covered California will continue the CIS-10 allowance initiative, which has generated substantial savings for issuers while recognizing delivery of clinically appropriate care for pediatric members. | |
| 1 | 1.03 1) | We are concerned with using Measurement Year 2025 as the benchmark for 2026 as QRS national percentiles will not be issued for Measurement Year 2025 until September/October 2026, which is very late in the 2026 Measurement Year. We request that Measurement Year 2024 be used for 2026. | After advocacy, Covered California received confirmation from CMS that national benchmarks will be provided for all QRS measures required for QRS data collection, including those in the first year of data collection. This will allow issuers the opportunity to assess plan performance as early as possible before financial accountability begins for MY2026. While MY2024 can't be used for benchmarks due to the transition of several measures to ECDS on different timelines, it is still important to note since some data and benchmarks will be available for some measures by MY2024. This early data will provide valuable insights for issuers to understand performance trends and prepare for the upcoming accountability and contract period. | |
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