QDP Model Contract Attachment 1 for Individual and Small Business Market First Round Comments

The following is the Covered California response to “First Round” comments received for the 2024-2026 QDP Individual Issuer Contract Attachment 1.

All documents will be posted to the Plan Management HBEX webpage: https://hbex.coveredca.com/stakeholders/plan-management/.

Article-Section No.	Article-Section Title	Comment	Covered California Response
1	General Comment	We appreciate Covered California's unwavering support of consumer access and quality of oral healthcare. We share in the desire to improve oral health outcomes, but also the desire to do so in a measured and cost-effective manner to preserve consumer access to affordable dental care. Our comments touch on several aspects of administrative and technical investment to ensure contract compliance. The challenge to dental plans is the ability to recoup those dollars through increased premiums on relatively nominal levels of enrollment. Administrative and technical debt could easily exceed several million dollars in staffing, recruitment, administrative platforms, provider reimbursement, increased benefit utilization, and member services annually that can only be recouped through premiums increases. Increases that are likely to make consumer affordability unattainable resulting in significant decreases in dental plan enrollment, exacerbating administrative and technical debt concerns. To illustrate – assume an average dental plan enrollment of 50K enrolled members and a desire to increase quality through preventive utilization. Carriers are likely to employ a multi-touch outreach including automated member calls, digital outreach (e.g., email, mobile app), plus mailings. These items would be repeated several times with automated calls costing up to $1/call and mailings as much as $2/mailer after supplies, postage, vendor, and related fulfillment costs on a small population. If we assume $3 per campaign and 3 outreaches across 50K members the cost to a dental plan would equate to nearly $500K. If you assume an average $2-4 or $3 at the midpoint in terms of operating gain by a dental plan, this single activity to ensure compliance under the contract, comprises 25% of existing plan operating margin. Given this is a relatively small aspect of the proposed contract, this illustrates the significant financial burden on plans to comply and their ability to participate in the exchange with a predictable return on investment.	Covered California takes very seriously the imperative to keep QDPs affordable for enrollees and appreciates QDP issuer feedback to understand potential cost implications of proposed contractual requirements.
1	General Comment	We are concerned with the timing of the final Attachment 1 requirements and the timing to rate submissions. We need direction timely to understand which elements of the current Attachment 1 proposal will be staying for 2024 as we develop rates.	Covered California is committed to providing a clear understanding of which elements will remain in Attachment 1 for 2024 ahead of the January Covered California board meeting discussion.

Article-Section No.	Article-Section Title	Comment	Covered California Response
1	Introduction	We agree with the need to address health care disparities. We are concerned with the dental ecosystem with providers that the expectations for health disparities in healthcare may need adjustment for dental care and disparities in dental care.	Thank you for you comment emphasizing this key industry characteristic. In recognition of the differences between the dental and health ecosystems, Covered California's current requirements emphasize the importance of data and many requirements will be phased in over time. Additionally, we will focus QDP contract requirements on member engagement and utilization, with proposed removal of demographic data threshold requirements for this contract cycle, as Covered California can generate stratified measures using HEI and enrollment data, sharing these results with QDP issuers and preparing for future work to intervene and reduce disparities.
1 - Equity and Disparities Reduction Paragraph 1	Article 1 - Equity and Disparities Reduction	We appreciate highlighting the list of identities that health disparities affect. We recommend the following edit: "Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; **preferred language;** religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."	Covered California will take this suggestion into consideration and ensure any potential changes to definitions are aligned wth QHP issuer contract language.
1 1.01.2	Article 1 - Equity and Disparities Reduction	Rather than areas for *consideration* , disability status, sexual orientation, and gender identity data collection should also be *required* for 2024 and beyond along with income stratification.	At this time Covered California intends to keep QDP contractual requirements aligned with QHP contractual requirements.
1 1.01.2	Identifying Disparities in Care	In addition to the data collection already required, Contractor should also work with Covered CA to assess consumer experience through an Enrollee Satisfaction Survey, as is done for QHPs, and address disparities.	Covered California will take this suggestion into consideration. At this time we are not aware of an industry-standard dental plan enrollee satisfaction survey and look forward to hearing more about whether non-standardized options may be valuable.

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1 1.01.2	Expanded Demographic Data Collection	We agree to work with Covered California, however, Covered California must communicate information on income, disability status, sexual orientation, and gender identity that Covered California receives at time of application to us. Several of these fields Covered California receives today from consumers but Covered California for some reason does not pass to carriers. For example, 2100A Member Income and 2200 Disability Information are loops/segments that Covered California does not transmit to carriers according to the most recent EDI 834 Companion Guide. In addition, DMG03 Gender Code is limited to Female and Male. We respectfully request Covered California provide this information to carriers.	Covered California recognizes the importance of developing demographic data sharing capacity and its central role in performing eligibility and enrollment functions. Sharing additional demographic data with contracted plans is a priority we are pursuing though disability status, sexual orientation and gender identity present unique challenges to collecting and sharing.
1 1.02.1	Monitoring Disparities	We are concerned by the fact that two of the monitoring disparities categories focus on children, most of whom are covered by QHPs. That means that the results of this evaluation will not be truly reflective of how QDPs are doing with regards to reduction of disparities for the vast majority of their enrollees.	We are open to expanding the measures stratified by demographic factors for disparities identification and reduction and welcome suggestions for additional adult measures.
1 1.02.1	Monitoring Disparities	Since many children are covered through QHP pediatric dental benefits consider recognizing the relationship between QHP and QDP reporting.	Covered California remains committed to addressing concerns related to application of contract requirements to dually-enrolled pediatric QDP members.
1 1.03.1	Disparities Reduction	There have seen very little reporting to us as a carrier from Covered California's HEI vendor. We must receive consistent and timely reporting that is of value from Covered California's HEI vendor for us to monitor and improve.	Covered California is committed to supporting effective implementation of QDP HEI data submission and establishment of satisfactory communication practices and processes.
1 1.03.1 (2)	Disparities Reduction	Covered California must timely notify carrier of group collaborative learning and engagement sessions stated in 2). We respectfully request Covered California provide carriers 30-day advance notice so appropriate staff are able to participate in such sessions hosted by Covered California.	Covered Calfiornia appreciates the request and can commit to providing carriers at least 30-day notice for learning and engagement sessions.

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1 1.03.1 (2)	Disparities Reduction	We respectfully request the group collaborative learning and engagement sessions stated in 2) be focused heavily on disparities and equity in dental care.	Covered Calfornia agrees and intends to develop disparities reduction learning and engagement sessions specific to dental plan enrollee populations and the dental plan role in disparities reduction.
1 1.03.1 2)	Disparities Reduction	"Contractor must participate in group collaborative efforts and group and individual health equity and disparities reduction learning and engagement sessions hosted by Covered California focused on data collection and measurement for disparities identification. **Contractor staff should be knowledgeable on region-specific challenges along with health disparities and inequities based on race, ethnicity, culture, language, age, geography, gender identity, and sexual orientation. Contractor staff should also be able to identify and leverage resources available in an Enrollee's community so that they can be accessed to provide assistance to the Enrollee.**"	Covered California will take this suggested language into consideration when revising the proposed contract language.
1 1.04	Cultural and Linguistic Competence	Please include: "Oral interpretation should be available in any language, even beyond the required threshold languages, and oral interpretation should be provided in a timely manner so as to not delay Enrollee care."	Covered California will not be amending the contract at this time because oral interpretation beyond the threshold languages is already required. Specifically, federal law (Section 1557) requires issuers to take reasonable steps to “ensure meaningful access” to health programs or activities by limited English proficient individuals, including access to language assistance services (not limited to threshold language requirements). (45 C.F.R. 92.101.) State law also specifies that these services must be provided in a timely manner (meaning “in a manner appropriate for the situation in which language assistance is needed. Interpretation services are not timely if delay results in the effective denial of the service, benefit, or right at issue”). (Cal. Code Regs., tit. 28, sec. 1300.67.04, subd. (c)(2)(G).)

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2 2.01	Dental Population Health Management Plan	The Dental Population Health Management initiative is broad reaching and less targeted than manageable at the premium level for most of the DHMO SADPs. Narrowing the focus of the PHM plan to specific identifiable demographic categories would be a better use of the time and resources available to the SADPs and allow for measurable outcomes. A targeted Quality Improvement Project spanning a three year period and addressing a specific segment of the population would be appropriate in this instance. The SADP can work with Covered CA to identify a specific segment of the Covered CA membership (for example, Hispanic women between 20-40 in targeted geographic regions, or Caucasian men ages 55-64 in rural zip codes) for an improvement project. The first year would involve collecting data around utilization and using claims history, published studies, and information from organization such as the DQA and the ADA to identify the specific population needs and barriers toward achieving those goals. The SADPs would then tailor an outreach program to the intended audience. Rather than a scattershot approach attempting to address the entire Covered CA population, this would allow the SADP to create targeted educational materials, train bilingual outreach staff in the population needs, design phone outreach programs, and demographic specific health risk screeners, etc. Year two would be initiating the outreach program and collecting data. At the end of year two, the data would be analyzed for statistically significant improvement in utilization of the targeted population compared to year one, and therefore efficacy of the initiative. If significant change is not realized, the SADP would then modify the program and continue data collection for year three. At the end of year three, the improvement in utilization must be statistically significant as a result of the outreach program or the SADP would be out of compliance with the contract. I suggest these improvement plans be published by Covered CA at the end of year three, or at least provided to all other SADPs. This would allow the SADPs to learn what types of initiatives are the most effective and utilize those in future endeavors. Attempting to address the full population of Covered CA members would be a significant administrative burden to the SADP to implement, likely have poor results, and would lead to higher premiums but no improvement in outcomes.	Covered California will remove the population health management plan and strategy requirement to reinforce QDP focus on engagement in care and utilization. Covered California will consider reporting requirement to understand strategies used by the plans to reach and engage members in care.
2 2.01.1	Dental Population Health Management Plan	Will Covered CA approve/request modifications to the Contractor's Dental Population Health Management Strategy, if necessary? Contractor's strategy plan should require approval by Covered CA, and take into account Covered CA guidance on eliminating bias.	Covered California will remove the population health management plan and strategy requirement to reinforce QDP focus on engagement in care and utilization. Covered California will consider reporting requirements to understand strategies used by the plans to reach and engage members in care and agrees on the importance of addressing bias.

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3 - Health Promotion and Prevention	Article 3 - Health Promotion and Prevention	We appreciate the requirements in Article 3 related to tobacco cessation and pregnancy. Another section should be included for diabetes and hypertension. Patients should be screened for undiagnosed diabetes and hypertension, and if found to be at risk, should be referred to their primary care physician for a diagnosis and additional care. This would strengthen oral health integration with primary care and could help reduce health disparities.	Covered California will take these recommendations into consideration for subsequent years, as systems for data sharing and coordination of care between dental and health providers continue to develop.
3 3.01	Dental Plan Benefits and Services Communication	How will Contractor outreach activity outlined in "3.01 Dental Plan Benefits and Services Communication" be monitored/assessed each year, and how will modifications be made for subsequent years, as needed?	Compliance with the 3.01 requirements will be assessed annually. Covered California will review QDP issuers' reports and engage with issuers to revise the approach and tactics as needed. Modifications for subsequent years will be based on findings from previous years and reflected in updated contract language.
3 3.01 2)	Dental Plan Benefits and Services Communication	Contractor should also conduct outreach to all Covered California Enrollees providing education on their rights as patients and how to file a grievance	Covered California will take this recommendation into consideration.
3 3.01 4)	Dental Plan Benefits and Services Communication	In addition to tailored outreach based on member risk, Contractor should perform tailored outreach to communities that have been identified through data to be experiencing healthcare disparities and inequities	Covered California agrees with prioritizing populations experiencing health and healthcare disparities for outreach and engagement. Based on the current state of demographic and clinical data collected and exchanged by dental plans, Covered California has proposed in Article 1 requirements to address disparities reduction and the phased progression to set those targets and activities.
3 3.01 (5)	Dental Plan Benefits and Services Communication	We respectfully request removal of 5) c) as there currently is not a process in place within the dental industry to communicate treatment plans and patient specific recommended preventive services (outside of the regular frequency limits) from the provider to the dental plan.	Covered California will remove 3.01.5.c.

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3 3.02	Tobacco Cessation	We respectfully request removal of 3.02 Tobacco Cessation. Not all QDP members have their medical coverage with the same QHP. As a result, if a consumer is covered with carrier A for QDP, carrier A may not be able to appropriately communicate programs that are appropriate for the consumer since the consumer's QHP coverage is through carrier B. Please consider requiring possibly in Article 3 of the Model Contract that Covered California will educate applicants for QDP coverage of the benefits of addressing health disparities by having their medical and dental coverage with the same carrier. In previous discussions, Covered CA stated they were not going to require Dental providers/PCPs to refer to/coordinate with smoking cessation program based on the realities and limitations of this type of care management in a dental office setting.	Covered California would like to promote the role of dental providers and QDP issuers in screening for tobacco use and connecting a patient to resources for cessation, regardless of who the Enrollee's QHP issuer might be. We will propose revised language to clarify the expectation that dental providers will refer patients who report tobacco use to their QHP issuer and/or PCP to identify the best options for them. Given the role that tobacco plays in cancer development, including oral cancers, it is a natural fit for oral health care providers to be part of the safety net that identifies at risk individuals to promote cessation.
3 3.02	Tobacco Cessation	Tobacco Cessation - While tobacco use and pregnancy status is a required part of a dental health history form, tobacco use and pregnancy status is not currently reported to plans by providers. The vast majority of practice management systems used in dental offices do not have a mechanism to identify and/or pull reporting on these conditions, so this would have to be an entirely manual process, which is a burden to providers and their staff. The bottom line is we cannot expect network providers to do this, and we have concerns that this could be an additional cause of network erosion as yet another contractual provision a network dentist would have in addition to those that already exist. Without direct reporting, dental plans would have to poll enrollees when they sign up for coverage, and while we are willing to “test and learn”, we have reservations that the majority of enrollees will inform a dental plan, especially of their tobacco status.	Covered Califorania will propose revised language to clarify the expectation that dental providers identify tobacco and pregnancy status of its members as is done in current practice and facilitate patient care in partnership with QDP issuers by referring patients with the pertinent information to their QHP, PCP and/or obstetrician to identify best management options.
3 3.02 1)	Tobacco Cessation	Suggestion for more inclusive language: "Contractor shall ensure contracted dentists have access to an updated list of smoking cessation programs, inclusive of evidenced-based counseling and appropriate pharmacotherapy which patient could discuss with ~~**his or her**~~ **their** PCP."	Thank you for your recommendationm. This modification has been made.
3 3.02 2)	Tobacco Cessation	How will Contract strategies to improve tobacco use prevention be monitored/assessed, and how will modifications be made for subsequent years, as needed?	Compliance will be assessed as part of the annual review process. Modifications will be based on findings from previous years and reflected in updated contract language.

Article-Section No.	Article-Section Title	Comment	Covered California Response
3 3.03	Pregnancy	Pregnancy- while tobacco use and pregnancy status is a required part of a dental health history form, tobacco use and pregnancy status is not currently reported to plans by providers. The vast majority of practice mangagement systems used in dental offices do not have a mechanism to identify and/or pull reporting on these conditions, so this would have to be an entirely manual process, which is a burden to providers and their staff. Our recommendation is that it is appropriate to requrie a MEDICAL plan to require a "clearance form" for pregnant patients to be filled out by a dentist and returned to the treating obstetrician demonstrating that there are no concerning oral conditions in need of treatment and that the pregnant woman has completed her necessary oral hygeine cleaning based on risk status.	Covered California will propose revised language to clarify the expectation that dental providers identify pregnancy status of its members as is done in current practice and facilitate patient care in partnership with QDP issuers by referring patients to their QHP issuer and/or obstetrician with the pertinent information to identify the best management for them. References to team based care will be removed and reporting requriements revised .
3.03 (1)	Pregnancy	Article 1: *"Covered CA would like contract dentists to particiapte in team-based care coordination efforts with obstetricians for shared patients."* Please explain how Plans are going to have team-based care? Will dental plans be contracting with obygns?	Covered California will remove references to team based care.
3 3.04.(2)	Covered California Enrollee Cost Transparency	Please consider adding statement that for 2) that a QDP may satisfy this requirement by providing cost transparency tool(s) electronically/digitally to consumers.	Covered California will make this change.

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4 (02)	Networks Based on Value	We disagree with this overall statement as this is an inaccurate depiction of the cost of dental services. While there is variation in costs of dental services, the variation in dental costs is not as significant as in medical care. Additionally, while the cost of medical care has skyrocketed over the last two decades, dental care has not risen in cost as drastically. In fact, contracted dental plan rates have remained mostly stable over the past decade and in many cases, dental plans have reduced or cut contracted rates. Dental plans cover a much smaller percentage of the cost of care, when compared to medical plans, which under ACA are required to cap a patient's annual maximum and are unable to implement lifetime caps on coverage. Dental benefits usually cover less than 50% of the cost of care, with an annual maximum that stays stagnant. This leaves patients often on the hook for a large percentage of their dental coverage. Dental plans keep premiums to beneficiaries relatively constant, while dental benefits to beneficiaries continue to shrink. The cost of care increases as does the costs of goods and services, yet providers are faced with stagnant or reduced rates. Dental plans over time have shifted the cost of care to providers and beneficiaries. There are many factors in the high cost of dental services which begin with dental plans. We suggest the following edits to the section - "Affordability is core to Covered California's mission to expand the availability of insurance coverage. ~~The wide variation in unit price and total costs of care, with some dentists charging far more for care irrespective of quality, is a key contributor to the high cost of dental services.~~ Contractor shall be held ~~hold its contracted dentists~~ accountable for improving quality and managing or reducing cost and provide support to improve performance among their contracted dentists.	Covered California will take the recommended clarifying language into consideration and revise the contract language pertaining to networks based on value.
4 (02.1)	Payment to Support High-Quality, Equitable Dental Care	We support moving to a more quality and outcome driven reimbursement mechanism. However, given the various categories within HCP LAN APM we raise concern with a risk-based or capitated model, as we have yet to see this work successfully for dental providers. There has incredible success with increased utilization in the Medi-Cal Dental Program with the previous Dental Transformation Initiative and now CalAIM. CalAIM offers pay-for-performance payments within the FFS system designed to increase the use of preventive services and establishing/maintain continuity of care. The APM framework rests on various principles, one of them being that reformed payment mechanisms will only be successful as the delivery system capabilities and innovations they support. We question whether QDP delivery system has the capability to be successful in this measure.	Covered California will revise the contract language to reiterate there is no requirement to adopt or change payment models except to report on payment types. The proposed reporting requirements are intended to provide information to understand the relationship between payment type and access and quality of care.

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4 4.01	Promoting the Development and Use of Dental Home Model	Unlike medical networks where increasing preventive utilization and quality metrics generally result in significant medical cost of care and outcome driven savings, the same is not true of dental plans as they are limited benefit plans with only nominal cost of care and outcome driven savings vs. standard utilization trend which is generally 70% diagnostic and preventive care. As providers face a burgeoning administrative landscape and are currently reviewing and consolidating their participating networks nationally, it is unlikely a broad-based network of providers will support this model state-wide or even county-wide (rating regions) which may preclude a solution the meets ACA standards and requirements alongside DMHC in terms of ongoing regulation of dental plans in regards to Provider Access standards. This solution will likely require a pilot initiative/plan and/or a waiver from CMS/DMHC to offer during the next contract cycle to ensure dental plan compliance.	Covered California will be adding clarifying contract language to reiterate that the inclusion of the AAPD definition of Dental Home Model is merely to encourage supporting the components of the definition. There is no requirement to report nor adopt the model.

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4 4.01.1	Encouraging Use of Primary Dental Care	While we appreciate and agree with the benefits of a primary dentist, we are concerned with the administrative costs to implement PCP selection and/or auto assignment for PPO. When this was implemented for QHP years ago, we believe implementation costs were approximately $3 million. The premium cost of QDP coverage cannot effectively support such a project implementation cost in QDP. Section 4.02 states" Affordability is core to Covered California's mission to expand the availability of insurance coverage." Requiring PCP selection and/or auto assignment for QDP PPO will raise rates. We respectfully request you remove this as a requirement for PPO in section 4.01.1 and consider changing to a preference. In addition, assignment of PCP including DPPO will not be beneficial to dental members since DPPO members may go to any provider. Coordination of care for dentistry is completely different than medical. Expense to the plan and will increase premium rates. Covered CA mentioned they would consider alternatives during workgroup meetings. Furthermore, suggesting or assigning a provider based on gender typically is not as important to dental patients as it is for medical. Particularly since doing so will complicate/conflict with trying to be consistent with existing family member assignment, which is typically of greater concern to most couples/families. Please rephrase this to carrier partner with Covered California and other stakeholders to identify opportunities for consumers to see their dentist and maintain a relationship with that dentist.	Covered California will be removing the proposed requirements related to primary dentist selection in DPPO plans based on concerns related to cost, administrative burden, and consumer confusion. The proposed requirement will be clarified as DHMO only.
4 4.01.1 3) c) d)	Encouraging Use of Primary Dental Care	The number and percentage of Covered California Enrollees who have selected a primary dentist and who have been assigned a primary dentist should be disaggregated by different demographics such as race/ethnicity, language, geographic region, etc.	Thank you for the feedback. Covered California will move forward with the current proposed requirement. We may consider disaggregated reporting requirements in the future, which will be dependent on more robust demographic data.

Article-Section No.	Article-Section Title	Comment	Covered California Response
4 4.02.1	Payment to Support High-Quality, Equitable Dental Care	We request clarification on the adoption of dental payment models. We would want to evaluate these items and agree to support efforts as long as they are financial and resource feasible and have a timeline that we can accommodate.	Covered California will revise the contract language to reiterate there is no requirement to adopt or change payment models except to report on payment types. The proposed reporting requirements are intended to provide information to understand the relationship between payment type and access and quality of care.
4 4.03.1	Teledentistry Offerings and Utilization	We respectfully request removal of 4.03 . Several of the teledentistry items that QDP carriers are being asked to track are rather difficult to monitor. Some of our providers focus specifically on teledentistry solutions to supplement services offered by our general dentists (for example when the member has an emergency but cannot reach their normal dentist or does not have a relationship with a dentist). However, it is much more difficult to track when traditional providers are submitting claims for services that they perform using teledentistry modalities as the provider would bill PPO plan or track encounters based on the service performed, and would not bill for the technology used to facilitate that service. In addition, AB1982 should cover this reporting.	Covered California will evaluate opportunities to reduce the scope of proposed teledentistry reporting requirements. Covered California acknowledges there are limitations in collecting information from members about their access barriers.
4 4.03.1	Teledentistry Offerings and Utilization	We urge Covered California to not only require QDPs to inform how reimbursement differs between telehealth and in-person services, but also to require QDPs to reimburse telehealth at the same rate to avoid disparities.	Covered California will not propose requirements related to teledentistry reimbursement at this time. The intent of the reporting requirement is to better understand the current state to propose future requirements related to teledentistry offerings and utilization.
4 4.04	Participation in Collaborative Quality Initiatives	Please identify what statewide and national collaborative initiatives are aligned with Covered California for dental to both educate carriers and ensure carriers are participating with those collaboratives, as appropriate.	Thank you for the feedback. Covered California acknowledges there are fewer opportunities for dental plans to participate in dental or oral health collaboratives. One example would be participating in the annual measures review facilitated by the Dental Quality Alliance (DQA).