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Qualified Health Plan Attachment 7 Response to Comments

The following is the Covered California response to comments received after the January Board meeting release of contract documents for the draft 2022 Qualified Health Plan Model Contract Amendment for the Individual Market.

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

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A7 Item #	A7 Sub-Section #	Comment	Covered CA Response
1	1.01.2	[Organization] supports Covered California's efforts to address health equity with the goal of eliminating disparities via better measurement and quality improvement. Covered California should prioritize data collection and quality improvement metrics that capture the diversity of all populations (including racial, ethnic, sexual, gender, disabled and other underrepresented groups) in clinical practices to fully understand the health status and needs of all individuals as well as to recognize the burdens and disparities they face in obtaining equity-oriented, quality care. We appreciate the continuing requirement to capture 80% of Covered California member race/ethnicity self-identification data. We also support the change to require Healthcare Evidence initiative (HEI) data submissions rather than issuer self-reporting as this will lead to more comprehensive and accurate data collection. In order to fully understand the inequities and disparate outcomes for minoritized and marginalized communities and to guide public policies, equitable allocation of health care resources, and public health interventions, additional data is needed. However, all data collection on race, ethnicity, language ability, sexual orientation, gender, and disability should be culturally sensitive and appropriate and respect individual privacy.	Thank you for your comment. At Covered CA we are committed to protecting individual member privacy as we strive to improve our demographic data collection in a culturally appropriate way.
1	1.01.2	Holding plans to unrealistic goals and tying them to financial penalties appears to be designed to generate a pre-determined outcome. Specifically in Section 1.01.2 – Health plans are concerned that the 80% rate of self-identification may be difficult to achieve since several enrollee responses are being excluded from the calculation in Attachment 14 3.3a. As a result, plans will actually receive a response but if the enrollee does not identify or want to identify with Covered California's list the compliance standard will be much higher than 80%.	A majority of QHP Issuers have reported exceeding the 80% threshold over a number of years since the first required reporting in 2016. Covered CA agrees member self-identification at the point of enrollment is an important opportunity for data collection and will continue to transmit that information to QHP issuers in the 834 file.
1	1.01.2	Reiterating the request to have race and ethnicity data collected at enrollment through Covered CA. This is the most effective method for obtaining the information. The ongoing enrollment and disenrollment throughout the year results in a constant catch-up process to obtain the information. As a carrier, we cannot compel the member to respond. This makes the outreach required burdensome, give the multiple attempts required an the rolling enrollments.	A majority of QHP Issuers have reported exceeding the 80% threshold over a number of years since the first required reporting in 2016. Covered CA agrees member self-identification at the point of enrollment is an important opportunity for data collection and will continue to transmit that information to QHP issuers in the 834 file.

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1	1.01.2	Demographic Data Collection: We strongly support Covered California's Attachment 7 requirement tying 7.5% at risk to health plans who fail to meet an 80% target for self-reported demographic data collection as demonstrated by plans including a valid race and ethnicity attribute in its Healthcare Evidence Initiative (HEI) data submissions. California law already requires health plans to develop a demographic profile of their members which includes "at a minimum, identification of an enrollee's preferred spoken and written language, race and ethnicity." Moreover, Section 4302 of the Patient Protection and Affordable Care Act (ACA), created standards for the collection of disaggregated race and ethnicity date, among other demographic categories. As outlined in the revised Attachment 14, Performance Standard 3.3a, a majority of QHP Issuers have reported exceeding the 80% threshold over a number of years since the first required reporting of this data in 2016. Covered California has promised to continue to transmit self-reported race/ethnicity data from the point of enrollment to its QHP issuers in the 834 file. This data is necessary for plans to meet other, additional requirements pertaining to disparities reduction and Population Health Management. There is no excuse for plans not being able to collect and report this data by 2022 and the contracts should reflect this. As we have previously stated, we additionally urge Covered CA to hold payment at-risk for HEI data submission for other demographic categories including language, LGBTQ+ status and income. • Proposed change: The Contractor shall work with Covered California to assess the feasibility and impact of extending the disparity identification and improvement program for plan year 2023 and beyond. Areas for consideration include: 1) Income 2) Disability status 3) Sexual orientation 4) Gender identity 5) Limited English Proficiency (LEP) 6) Spoken language	Your suggested language was considered in revisions to Section 1.01.1 of Attachment 7.
1	1.02	Identifying Disparities in Care: The Plan support the measure set overlapping with DHCS. Yhe data will have more meaning due to larger denominators.	Thank you for your feedback.
1	1.02	Identifying Disparities in Care: The Plan is interested in the work that will come from the in depth analysis of the Blood pressure and A1C control work from the full hybrid dataset across plans.	Thank you for your interest.

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1	1.02.2	Identifying Disparities in Care: We support Covered California adding additional comprehensive diabetes measures for its disparities reduction initiative and tying plans at 7.5% at risk for not meeting disparities reduction targets for: 1) Comprehensive Diabetes Care (CDC): HbA1c Control 2) Comprehensive Diabetes Care (CDC): Medical attention for nephropathy (NQF #0062) 3) Comprehensive Diabetes Care (CDC): Eye exam (retinal) performed (NQF #0055) 4) Controlling High Blood Pressure (CBP) (NQF #0018) These four measures in tandem, will provide a more complete picture of disparities and related interventions to address them. Covered California previously required plans to report demographic data in order to identify disparities on a total of 14 different measures including measures tied to combatting disparities in asthma and mental health. We understand that Covered California considers this a transitional year as plans switch to the new Healthcare Evidence Initiative (HEI), however we believe it is important to stakeholders, including the health plans and their contracting providers, to be able to look ahead to see what the expectations are and have been in other areas beyond comprehensive diabetes care. We reiterate our request for stronger contract language stating very clearly, Covered California's plans to hold plans accountable for meeting additional disparities reduction metrics beyond 2022. • Proposed change: Covered California will consider adding additional measures to track health disparities in care for plan year 2023 and beyond.	Your suggested language was considered in revisions to Section 1.02.2 of Attachment 7.
1	1.05.2	[Organization] supports the requirement that Contractors must achieve or maintain NCQA Multicultural Health Care Distinction for Measurement Year 2022. As an important component in reducing health disparities, [Organization] recognizes the importance of providing timely and accurate language assistance for patients. Many Qualified Health Plans (QHPs) do not have the ability to provide access to interpretation services on short notice. Patients do not necessarily notify physicians that they need interpretation services prior to their appointment. Physicians are often unable to secure same day interpretation services from the plan. Even when advance notice is given, it is very rare that live, in-person interpretation services are provided by the plan instead of phone services. QHPs should be required to prioritize live, same-day interpretation services in all threshold languages and to cover the cost of these services so that additional financial burdens are not placed on physician practices.	Thank you for sharing your insight on the provider and patient experience as it relates to timely access to preferred language and interpretation services.
1	1.05.2	We appreciate Covered California considering the delay of the requirement for obtaining NCQA Multicultural Health Care Distinction to 2023 instead of 2022.	Thank you for your feedback.
1	1.05.2	We support the requirement that health plans achieve or maintain NCQA's Multicultural Health Care Distinction. We believe this is a worthy, but complementary strategy to Covered California's other new disparities requirements noted above.	Thank you for your comment.

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2	2	Article 2: Population Health Management: We appreciate the inclusion of new contract requirements related to Population Health Management. CPEHN and other consumer advocates participated in a robust workgroup discussion with the Department of Health Care Services on ways to ensure new PHM requirements achieve desired goals and outcomes and would direct staff to consider the most recently updated version of DHCS' Cal-AIM PHM proposal for additional suggestions for contract language, particularly around risk assessment and risk stratification to ensure health plan assessments include an agreed upon standard set of questions and that plans are not engaging in algorithm bias through additional requirements related to health plan assumptions.	Covered California will continue to explore your recommendations to align with DHCS's Cal-AIM PHM proposal as we develop and strengthen this requirement in 2023 and beyond.

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2	2.01.2	[Organization] supports the requirement that all QHPs maintain a population health management program that improves the ability of physicians and other health care providers to identify social factors and needs that impact health. We believe that a more comprehensive strategy that accounts for screenings, health assessments, case management, data collection and monitoring and risk stratification is a fundamental and much-needed improvement to the overall managed care plan responsibility. However, the plans should not develop these population health management programs in isolation. We would recommend that the plans be required to include practicing physicians from the plans' geographic service areas in the development and operationalization of their program. This local input will ensure that plans receive feedback directly from practicing physicians on the most effective ways to improve care coordination, communication and data sharing. One of the challenges in managing high-risk populations is the inability to share appropriate levels of data with providers in a meaningful and timely way. Physicians and patients would greatly benefit from additional information about a patient's social needs, including their access to food, clothing, household goods and transportation. If a health plan is obtaining this information through its patient risk assessment, [Organization] would recommend that a mechanism be developed to appropriately and legally share this patient information with the physicians that are caring for the patients directly. This information should also be available electronically, integrated with the patient's existing health records, and updated in a timely fashion. The data should also be collected in such a way so that it can be easily transmitted in a usable format and incorporated into the risk stratification process. We recommend that initial risk assessment be standardized to the extent that Covered California is able to compare data across plans and develop methods to evaluate the success of their population health management programs. Additionally, to the extent that member-contact screening requirements are passed down to physicians, Covered California should make sure there is adequate reimbursement for such screenings and for any subsequent data collection and submission done by physicians. Screening tools should be separate from screenings used for clinical screenings, cost-effective, and not negatively impact medical care or create additional burden for physicians. Risk Stratification As part of their PHM programs, QHPs will be required to risk stratify the population to determine the level of intervention that members require based on all available data sources, as well as the results of the member-contact screening. [Organization] supports the amendment to specify that data sources and population health categories should be reported as this will support efforts to identify and address bias in the use of these risk stratification algorithms and to avoid introducing or exacerbating health care disparities in connection with the use of these tools, particularly since they will be used for vulnerable populations. While recognizing there is some proprietary intellectual property in the development of risk stratification algorithms, we would also encourage greater transparency about how these tools are being deployed as well as the underlying data being used to generate any outputs. Any algorithms used by plans should be validated nationally and required to use as complete a set of data as possible. The reliance of risk stratification algorithms on inputted data can lead to certain associated risks. These algorithms require access to large quantities of high-quality data during training and validation. Without accurate and meaningful data, algorithms may not be correct or may not be applicable to different populations. The source of the data used during training will impact the algorithm significantly, and models must be tested on a variety of data sets for validation purposes in order to create an algorithm that works accurately across patient populations. Otherwise, an algorithm may be trained and validated, only to produce inaccurate results when used with a population that varies based on race, gender, or socioeconomic background, medical history, hospital setting, or geographic location. Furthermore, the biases of training data can risk exacerbating existing health disparities and structural inequities. If models only reflect the limited populations on which they are trained, they will be less accurate for minority groups, and majority groups will have better access to accurate algorithms and thus superior health care. In addition to training and validating across broad populations, QHPs should work towards increased transparency in order to provide opportunities to disclose and address system bias. Understanding data provenance, including key attributes of the training data population, is necessary to evaluating the accuracy of the risk stratification algorithms and the risks of applying the system to a different population.	Covered California acknowledges the importance of partnering with clinicians in the mission to improve health care delivery. We will continue to explore your recommendations as we develop and strengthen this requirement in 2023 and beyond.

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3	3	General Comment: We believe outreach regarding health and wellness programs is vital and understand the importance of reporting out how the health plans do this. However, it can be challenging when email and cellphone (for texting) isn't required on the application. We kindly ask Covered California to consider making these questions mandatory on the enrollment application.	Thank you for your comment. Covered California will consider your recommendations.
3	3	General Comment: No comments regarding the contract language, but we do have concerns regarding the completeness of data that will be reported. Currently with COVID-19 and the shift from in-person programs to virtual, there is concern that the data to be reported is mainly self-reported and not validated/verified. There is the possibility that the numbers that will be reported out will not be consistent as past years and would like Covered California to be aware of the COVID-19 impacts on these reportings.	Thank you for your comment. Covered California will continue to assess the impact of COVID-19 on issuers.
3	3.02/3.03	Tobacco Cessation Program and Weight Management Program: We appreciate the additional specificity in these two contract areas, including for example, a definition for “unhealthy weight” of BMI>30. We hope this specificity will lead to more targeted interventions to effectively improve health enrollee health outcomes.	Thank you for your comment.
3	3.04	Diabetes Prevention Program (DPP): We appreciate the inclusion of contract language requiring health plans to ensure the DPP must be available both in-person and online and be accessible, especially to eligible Enrollees with limited English proficiency (LEP) and eligible Enrollees with disabilities. For these services to be useful, they must be available and accessible to all plan enrollees. We also support Covered California’s requirements for plans to provide separate reports of the number and percent of eligible enrollees who enroll in the DPP in-person and online, as well as the additional requirement for plans to report on the efficacy of the DPP program as it relates to the number of participants who reach the CDC weight loss goal of 5%. This added specificity will help Covered California and health plans to more effectively evaluate the impact of the program on enrollee health outcomes.	Thank you for your comment.
3	3.04.2	[Health Plan] requests pushing out the DPP in-person requirement to at least year end 2022. Due to the challenges of the pandemic and the uncertainty of when in-person classes will resume, we request allowing DPPs to continue to be accessible online or in-person until then. Currently, there is a limited availability of in-person programs in the state, likely compounded by the COVID-19 pandemic. Additionally, our current vendor does not offer in-person classes. To ensure continuity of care, allowing until the end of 2022 will provide time for adequate transitioning planning and communicating these changes for enrollees currently participating in a DPP program. Additionally, for members without internet or smart phone access, we recommend that the criteria be broadened from “both in-person and online” to "online and/or in-person, distance learning, or a combination of modes” This is aligned with the CDC program categories, which allows for distance learning where participants can call in or video-conference when attending in person is not feasible (https://www.cdc.gov/diabetes/prevention/lcp-details.html). If this change is approved, the criteria would need to be changed for 3.04.3 (3) and (4), to “report program modes separately.”	The contract language will be amended to clarify Covered California's intent to require issuers to offer enrollees a choice of modality for DPP programs (in-person, online, distance learning or a combination) by year end 2022.

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3	3.04.2	Section 3.04.2- Diabetes Prevention Programs are a critical tool for our enrollees to manage their health care condition. Unfortunately, these Diabetes Prevention Programs (DPP) are not always accessible in-person. DPP vendors offering in-person classes are limited. Recommendation: Covered CA keep the existing requirement for the DPP to be accessible either online or in-person, and allow carriers flexibility in meeting consumers participation needs if they are unable to access online or in-person in their area.	The contract language will be amended to clarify Covered California's intent to require issuers to offer enrollees a choice of modality for DPP programs (in-person, online, distance learning or a combination) by year end 2022.
3	3.04.2	QHP's also agree that Diabetes Prevention Programs (DPP) are a critical tool for our enrollees to manage their health care condition. Unfortunately, these DPP are not always accessible in-person. Therefore we continue to recommend that Covered CA keep the existing requirement for the DPP to be accessible either online or in-person. DPP vendors offering in-person classes are limited; moreover, utilization of in-person DPP has been limited.	The contract language will be amended to clarify Covered California's intent to require issuers to offer enrollees a choice of modality for DPP programs (in-person, online, distance learning or a combination) by year end 2022.
4	4.01	Access to Behavioral Health Services: We appreciate that Covered California intends to "evaluate" how insurers track access to behavioral health services and the strategies they implement to improve access to these services for enrollees. Despite California law, which requires commercial health plans and insurers to provide full coverage for the treatment of all mental health conditions and substance use disorders, utilization rates for medically necessary behavioral health services continue to be low. We also appreciate revised language in 4.01.3 requiring insurers to engage with Covered California to review its depression treatment penetration rate and its behavioral health service utilization rate, which will be calculated by Covered California using Health Evidence Initiative (HEI) data to further understand enrollees' access to behavioral health services within the Contractor's network. This language will allow for a more independent evaluation and assessment of whether enrollees have consistent access to medically necessary behavioral health services.	Thank you.
4	4.02.	Offering Telehealth for Behavioral Health Services: Telehealth has proliferated as a result of the COVID-19 pandemic. While there are benefits to telehealth as a modality, particularly for behavioral health, we appreciate Covered California's additional contract language encouraging plans to use network providers to provide telehealth for behavioral health services whenever possible. We also appreciate Covered California's added requirements that health plans "ensure that enrollees can easily find behavioral health telehealth services through a telehealth provider search attribute, inclusion of telehealth service in the provider profile (e.g. Jane Doe, Ph.D. Psychologist telehealth video/phone), or other member portal navigation feature," and the requirement that health plans, "promote the integration and coordination of care between third party behavioral health telehealth vendor services and primary care and other network providers." These additional contract requirements will help to ensure consumers in need of behavioral health services can more easily locate and access these services.	Thank you.

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4	4.02.02	[Organization] supports the change that states: "Covered California encourages the Contractor to use network providers to provide telehealth for behavioral health services whenever possible." However, we request that this language be strengthened by requiring the Contractor to use network providers whenever possible. We also support the requirement to promote integration and coordination of care between third party behavioral health telehealth vendor services and primary care and other network providers. As stated in our previous comments, [Organization] wants to ensure that health plans do not separately contract with third-party telehealth vendors that provide care to enrollees that is not coordinated with the care provided by the plan's contracted providers or the patients' treating providers. Professional services provided via telehealth should be part of the care provided to the patient by their physician, and not an unassociated provider that works through a third-party telehealth vendor. Covered California should ensure that telehealth is merely an alternate site to care delivery and not alternate care that is disassociated with the rest of the enrollees' medical care. This is particularly true for behavioral health services provided through telehealth, which may already be insufficiently integrated with the rest of an enrollee's medical care. While the use of telehealth should be encouraged, such care should be part of the care provided to the patient by their physician, and not an unassociated provider that works through a third-party telehealth vendor. Instead, [Organization] encourages Covered California to ensure that health plans offer their contracted providers a way to provide care via telehealth to their patients in a way that strengthens the patient-physician relationship, ensures continuity of care, and does not result in incomplete or bifurcated medical records based on the modality of care. [Organization] continues to strongly support the requirement that Contractors must offer telehealth for behavioral health services, including audio-only telehealth services. There has been a significant increase in the use of telehealth for behavioral health services since the onset of the pandemic. Audio-only services are an important flexibility that should continue after the pandemic and are particularly important for older adults or other patients with impairments that may limit their ability to use some telehealth technologies.	Covered California agrees that telehealth services provided by contracted network providers is preferred. We also recognize that this is not always feasible for some providers or services and therefore third-party telehealth vendors can play an important role in expanding access. Covered California agrees that ensuring coordinated care between telehealth vendors and a patient's regular clinician is important. In Article 10.01.2, we require issuers to report "How the Contractor facilitates the integration and coordination of care between third party telehealth vendor services and primary care or other contracted providers." This reporting includes telehealth for behavioral health services. We will consider these recommendations for the 2023-2025 Attachment 7 Refresh.
4	4.03.3	We appreciate that plans must still engage with Covered California to review its performance on CMS Quality Rating System required measures for behavioral health including: 1) Antidepressant Medication Management (NQF #0105); 2) Follow-Up After Hospitalization for Mental Illness (7-Day Follow-Up) (NQF #0576); and 3) Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (NQF #0004). These metrics will provide Covered California and consumers with a more accurate assessment of health plan performance in providing accessing to behavioral health services.	Thank you.

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4	4.04.2	We commend Covered California for directly addressing substance and opioid use disorders and incorporating measures to reduce the number of deaths associated with opioid-related overdoses. As we raised in our original comments, while we believe that preventing development of new SUDs and OUDs is an important goal, we are concerned that overemphasizing limits on initial opioid prescriptions for pain may have the unintended effect of creating barriers to medically necessary opioid therapy for pain management, particularly among lower-income individuals. Evidence suggests that the original CDC prescribing guidelines led to prescribers failing to initiate opioid therapy for patients who in actuality needed the medications without an appropriate treatment substitute. In response, the authors of these guidelines subsequently released a letter and commentary clarifying that determining whether a patient should be prescribed opioids for pain and whether to taper down should take place on a case-by-case basis. As such, we recommend amending the current language that broadly calls for "fewer prescriptions, lower doses, and shorter durations" and instead emphasizing a prevention strategy that allows providers to evaluate patients on a case-by-case basis and consider alternative therapies and/or lower doses and shorter durations of opioid medications when appropriate. • Proposed change: Prevent: decrease the number of new starts;: fewer prescriptions, lower doses, shorter durations evaluate enrollees on a case-by-case basis to consider alternative therapies to opioid treatment for pain management, such as physical therapy, over-the-counter medications, among others, and prescribe lower doses and shorter durations of opioid medications when appropriate and safe to do so given the patient's condition.	Covered California has aligned with DHCS and CalPERS to adopt the Smart Care California guidelines. We will adjust the language to note that an enrollee's condition should be considered to ensure they receive appropriate care.
4	4.04.3	Given wide variation in volume of MAT prescribed by X-licensed providers, the X license is a poor proxy for MAT access. We recommend researching more accurate ways of assessing MAT access and introducing a more meaningful requirement. [Health Plan] will share any ideas on alternative metrics that we may develop.	Covered California is removing the requirement for issuers to track active X waiver licensed prescribers based on issuer feedback and the possibility of future adjustments to the X waiver program from HHS. Instead, we propose that issuers must engage with Covered California to review their Medication Assisted Treatment (MAT) prescriptions by clinician and by region using HEI data.
4	4.04.3	Section 4.04.3. – Access to Medication Assisted Therapy (MAT) is an important benefit to Covered California enrollees. However, we have concerns with measuring access to these services by reporting Active X waivers. Health plans do not currently track these waivers so this data source does not exist and we would need to create a process for collecting it. In addition we believe that Active-X waivers are a poor proxy for MAT access. Recommendation: We would like Covered CA to put this requirement on hold until a more meaningful way of assessing MAT access can be identified.	Covered California is removing the requirement for issuers to track active X waiver licensed prescribers based on issuer feedback and the possibility of future adjustments to the X waiver program from HHS. Instead, we propose that issuers must engage with Covered California to review their Medication Assisted Treatment (MAT) prescriptions by clinician and by region using HEI data.

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4	4.04.3	Access to Medication Assisted Therapy (MAT) is an important benefit to Covered California enrollees. However, we have concerns with measuring access to these services by reporting Active-X waivers. Health plans do not currently track these waivers so this data source does not exist and we would need to create a process for collecting it. In addition we believe that Active-X waivers are a poor proxy for MAT access. We would like Covered CA to put this requirement on hold until a more meaningful way of assessing MAT access can be identified.	Covered California is removing the requirement for issuers to track active X waiver licensed prescribers based on issuer feedback and the possibility of future adjustments to the X waiver program from HHS. Instead, we propose that issuers must engage with Covered California to review their Medication Assisted Treatment (MAT) prescriptions by clinician and by region using HEI data.
4	4.04.3	We understand the importance of monitoring access to opioid use disorder treatment, however many plans are not already monitoring X waiver licensed prescribers and this would be challenging to fulfill for some. We kindly request Covered California to remove this requirement from the upcoming contract amendment and/or delay the implementation of this requirement.	Covered California is removing the requirement for issuers to track active X waiver licensed prescribers based on issuer feedback and the possibility of future adjustments to the X waiver program from HHS. Instead, we propose that issuers must engage with Covered California to review their Medication Assisted Treatment (MAT) prescriptions by clinician and by region using HEI data.

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4	4.04.3	We fully support the contractual requirement to measure and report the number of active X waiver licensed prescribers in the plans' networks given the importance of ensuring that more in-network providers are able to prescribe buprenorphine for substance use disorders. However, we recommend that Covered California go even further and require insurers to measure and report the number of enrollees accessing buprenorphine prescriptions on an annual basis. In addition, plans should also be able to report the number of enrollees accessing either methadone or buprenorphine through Narcotic Treatment Programs in order to evaluate trends in substance and opioid use disorder treatment.	Covered California is removing the requirement for issuers to track active X waiver licensed prescribers based on issuer feedback and the possibility of future adjustments to the X waiver program from HHS. Instead, we propose that issuers must engage with Covered California to review their Medication Assisted Treatment (MAT) prescriptions by clinician and by region using HEI data. Covered California intends to track the use of bupenorphine presciptions using the measure, Use of Pharmacotherapy for Opioid Use Disorder (NQF #3400). The measure indicates the percentage of members ages 18–64 with an opioid use disorder who filled a prescription for or were administered or dispensed an FDA-approved medication for the disorder during the measure year. The measure will report any medications used in medication-assisted treatment of opioid dependence and addiction and four separate rates representing the following types of FDA-approved drug products: buprenorphine; oral naltrexone; long-acting, injectable naltrexone; and methadone.
6	6.01	Complex Enrollee Engagement: We appreciate Covered California's emphasis on engaging complex enrollees. We would appreciate more details on how Covered California is defining "Complex Enrollee" for this purpose.	The Complex Enrollee Engagement requirement supplements the Population Health Management Plan submission requirement in Article 2. As part of their Population Health Management Plan, issuers are to stratify their Covered California population into subsets; Complex Enrollees being one of the subsets. At this time, the definition of "Complex Enrollee" is dependent on the stratification an issuer develops.

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6	6.03.2	[Organization] supports the requirements for increased monitoring and enforcement of Admission, Discharge, Transfer (ADT) events by enrollees. QHPs should be required to implement health information technology (HIT) to support population health principles, integrated care and care coordination across the delivery system. We believe the development and funding of this HIT infrastructure is key to the success of Covered California, and would request that Covered California provide more specific information in future stakeholder meetings and written documents as to how it will be built and fund interoperable health information technology and health information exchange infrastructure.	Covered California is excited to hear your support regarding this requirement. At this time, our goal is to align with CMS. CMS has a wide range of resources that provides more information on how the HIT infrastructure should be built out. We will ensure issuers have access to these resources. CMS Resource: https://www.cms.gov/Regulations-and-Guidance/Guidance/Interoperability/index
7	7.02.1	[Organization] supports improving access to complete patient data, including for primary care clinicians. [Organization] recognizes the importance of and fully supports the secure exchange of data among providers to reduce costs, improve quality of care, and reduce administrative burdens. Data should follow the patient and should be available to any appropriate provider at the point of care. Secure and robust data exchange, however, cannot be achieved without sufficient funding for necessary technology infrastructure and training. In addition, [Organization] urges Covered California to ensure that data collection obligations are not passed down to individual providers without the appropriate considerations of cost and administrative burdens. Technologically and financially, physician practices, hospitals, and clinics in California range from large and sophisticated systems to small, strained offices and facilities. Under any statewide policy requiring stakeholders to meaningfully share health information, it is reasonable for certain providers with limited infrastructure and means—such as independent physicians, rural hospitals, and safety-net clinics—to expect public subsidies and incentives to help defray the costs of participation. Moreover, other states' efforts to advance health information sharing through both strong requirements and funding have seen success. Covered California contracts should require health plans to offer financial incentives to help smaller network providers achieve data-sharing and help defray costs for certain onboarding and maintenance activities associated with sharing through HIN/HIEs, such as EHR integration and contract renegotiation fees. Additionally, it is critically important that Contractors use standard processes for encounter data exchange with contracted providers. [Organization] encourages Covered California to ensure that ANSI-accredited standards are adopted to facilitate the exchange, integration, sharing, and retrieval of electronic health information.	We will consider these recommendations for the 2023-2025 Attachment 7 Refresh.

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7	7.02.2	[Organization] appreciates that Covered California is encouraging its Contractors to provide support to primary care practices to improve the quality of care. As part of provider-level coaching or quality improvement efforts, [Organization] urges Covered California to encourage QHPs to provide physicians with financial resources to coordinate care so that these resources can be used for population health management tools, care coordinators, participation in health information exchanges, electronic health record systems, telehealth platforms, tools for quality reporting, practice coaching for front-line staff, targeted care management resources, and any other tools to facilitate coordinating care. In addition, improving interoperability of electronic health records and developing health information exchanges will promote clinical integration without financial consolidation. It is no longer the case that only large, integrated delivery models are able to implement the necessary systems to be successful under the new delivery and payment models. Developments in information technology allow independent practices to work in a coordinated way so to avoid consolidation and to promote competition. [Organization] supports the requirement that annual application for certification include the quality improvement support and technical assistance being provided by the Contractor or other organization to implement or strengthen advanced primary care models.	Thank you for your feedback. We will consider these recommendations for the 2023-2025 Attachment 7 Refresh.
7	7.03	While [Organization] shares Covered California's goals of improving quality, we continue to be concerned that requirements to report additional measures may increase administrative burdens on providers without improving care. If quality measures do not align among all payors, physicians are required to report multiple quality measures in different ways to different entities. This imposes significant burdens on physician practices and impedes comprehensive improvement in overall quality of care. A recent study indicates physicians and their staff can spend upwards of 15 hours per week dealing with various quality measures with different payors. The physician time alone spent dealing with quality programs is estimated to be enough time to care for approximately nine additional patients and the staff time spent is incredibly costly to practices. [Organization] recommends that the quality measures required to be reported not be overly burdensome, focus on patient outcomes rather than process, and is consistent with measures used by payors outside of Covered California. Establishing a physician-approved, standardized, and evidence-based set of core quality measures and reporting requirements that can be automatically extracted from electronic health records would reduce the need for providers and their staff to manually extract and manipulate data measures according to the individual specifications of each entity requiring quality data reporting. This would reduce repetitive procedures; encourage collaboration between providers and data collection entities; and allow for quality data to be compared across providers and plans. Quality measures should also be updated regularly or when new evidence is developed. When new quality measures are adopted others should also be sunset. The quality performance standards tied to value-based payment models must be physician specialty-validated clinical measures; include a sufficient number of patients to produce statistically valid quality information; use an appropriate attribution methodo+F10logy and risk adjustment; and physicians must have the right and ability to appeal inaccurate quality reports and have them corrected. Moreover, in order to maximize improved patient outcomes, there must also be timely notification and feedback provided to physicians regarding the quality measures and results. Risk adjustments need to consider differences in geographic practice costs and patient risk factors, such as socioeconomic and health status, and physicians should only be responsible for costs they can control. [Organization] strongly supports using existing sources of data when evaluating physician practices and that any assessment of the proposed measures be done through existing encounter data. [Organization] also strongly opposes any measures that require increased manual review of medical records by physicians, their staff, or external auditors.	Covered California is collaborating with the California Quality Collaborative, IHA, and other purchasers in the development of the primary care measure set to ensure that it is as aligned as possible with other measure sets currently in use. We agree that the measure set should not be overly burdensome, focus on patient outcomes rather than process, and be consistent with measures used by other purchasers. Covered California looks forward to engaging [Organization] in future conversations regarding the development and implementation of the measure set to assess the prevalence of high-quality, advanced primary care practices.

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7	7.04.03	While [Organization] recognizes the important role of alternative payment models, these models also must be physician-led. To support coordinated care as well as management of preventive services and chronic conditions, payment models must include additional incentive payments to physicians for providing preventive services management, diagnosis coordination and treatment planning, and continued management of chronic conditions. Payments should cover physician administrative costs related to participating in any payment models. Finally, QHPs should be encouraged to reward practices that demonstrate that they are delivering high quality, efficient, and accessible care to patients. For example, the current Comprehensive Primary Care Plus model is an excellent program that makes monthly stratified-risk payments with additional performance payments. Other physician organizations have proposed physician team payments for episodes of care. Covered California may also want to consider the innovative alternative approaches recommended by the CMS Physician-Focused Payment Model Technical Advisory Committee (PTAC), that are based on the direct provider contracting approach. Models should work for specialists, as well as primary care physicians and independent practices. It is also not necessary to require physicians to accept financial risk in all payment models in order to reduce costs. If physicians want to voluntarily accept appropriate financial risk, the levels of mandated downside financial risk should not discourage physician participation and should not unintentionally drive market consolidation.	Thank you for your feedback. Covered California will explore how we can enhance our primary care payment requirements for the 2023-2025 Attachment 7 Refresh.
7	7.04.3	We support Covered California's contract requirements tying a percentage at-risk payment to the number and percent of primary care clinicians paid through the HCP LAN APM categories of population-based payment (Category 4) and alternative payment models built on a fee for service structure such as shared savings (Category 3) each year. Covered California's data shows that the number of Covered California enrollees cared for by Primary Care Medical Home (PCMH) recognized practices increased from 25% to 40% between 2016 and 2018, and from 3% to 11% when [Health Plan] is excluded.1 Given the relatively low percentage of enrollees cared for by PCMHs in non-[Health Plan] plans and the steady progress towards the adoption of PCMHs, we support Covered California in its efforts to encourage payment reforms in this area. We appreciate the additional specificity around Covered California contract expectations with respect to minimum thresholds under HCP LAN APM category 3 or 4. Community health centers, including federally qualified health centers as well as free and low-cost community clinics, are already providing fully integrated services and could potentially help plans meet higher benchmark goals.	Thank you.
8	8	Promotion of Integrated Delivery Systems (IDS) and Accountable Care Organizations (ACOs): We are supportive of Covered California's efforts to encourage a greater proportion of plans to move towards value based payment, including alternative payment models such as ACOs. Given the wide variation in types of ACO payment models, we appreciate the greater specificity in the contract of the arrangements Covered CA hopes to reward.	Thank you.
8	8.01	Suggesting incorporation of language to look beyond the label of ACO/IDS to clarify that plans can work with Covered CA to establish other forms of Integrated Delivery Systems that achieve similar ends by a different path.	Covered California will consider if there is broader language we can use to reflect integrated, coordinated systems of care in 2023 and beyond.

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8	8.01 8.02	Given that Covered California, along with other purchasers, place great importance on the adoption and expansion of integrated, coordinated and accountable systems of care, [Organization] urges Covered California to align the definitions and criteria for IHMs and ACOs among payors and purchasers. These models and organizations take many different forms, which makes it difficult to determine which models and organizations Covered California and other purchasers are trying to be adopt and expand. Moreover, in further promoting ACOs, [Organization] urges Covered California to ensure that ACOs and other coordinated systems are physician-led and encourage an environment of collaboration among physicians. Physician-led ACOs have been found to be more likely to have comprehensive care management programs and advanced IT capabilities, measure and report financial and quality performance at the physician level, and provide meaningful and timely feedback to physicians. Resources, however, must be provided to physicians in independent practices who may want to remain independent but otherwise clinically integrate and collaborate with other physicians for purposes of participating in ACOs or other coordinated systems. This would help prevent these physicians from being driven to join larger practices and align with hospitals that have the resources to take on mounting administrative tasks and to invest in tools that support integrated care and value-based payments. Finally, given that interoperable health information technology and electronic health record systems are key to the success of ACOs, QHPs need to ensure that systems are interoperable to allow physicians to effectively communicate and coordinate care and report on quality. Quality performance standards established by ACOs and other value-based payment models must be physician specialty-validated clinical measures; include a sufficient number of patients to produce statistically valid quality information; use an appropriate attribution methodology and risk adjustment; and physicians must have the right and ability to appeal inaccurate quality reports and have them corrected. Moreover, in order to maximize improved patient outcomes, there must be timely notification and feedback provided to physicians regarding the quality measures and results. Risk adjustments need to take into consideration differences in geographic practice costs and patient risk factors, such as socioeconomic and health status. [Organization] would like to bring to Covered California's attention the potential effect of the Department of Managed Health Care's licensing regulations that clarify which health care entities that assume global risk are required to obtain a Knox-Keene license. The regulations require entities that assume global risk – that is, those entities that accept "a prepaid or periodic charge from or on behalf of enrollees in return for the assumption of both professional and institutional risk" — to obtain a license. [Organization] is concerned that these regulations may have a chilling effect on delivery system and payment innovations that lead to higher quality care and lower costs. The regulations define "prepaid or periodic charge" to include a "percentage of savings or losses in which the entity shares," which have the potential to include parties to a host of value-based contracting arrangements. While the regulations contain provisions allowing the Director to grant exemptions to the licensure requirements, [Organization] is concerned that many practices interested in pursuing value-based contracts geared toward improving healthcare quality and reducing costs will be disincentivized from doing so given this new regulatory burden. There needs to be a balance between oversight of risk-based contracts with the need for innovation in healthcare delivery.	Covered California will continue to look to align the definition of an ACO with other purchasers. We are aiming to better understand the variation in ACO types through the use of the IHA Commercial ACO measure set and developing a registry of characteristics of ACO models so we can compare performance on the measure set against the characteristics of the models. We recognize that physician-led ACOs with two-sided risk contracts are associated with greater savings and improved quality results as noted in the HMA evidence review shared in July 2019.

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9	9	Networks Based on Value: We recognize that Covered California is shifting focus from requiring the exclusion of poor performing hospitals. We ask that plans provide information that can be made public, on why poor performing hospitals continue to be included, such as lack of geographic access or serving specific populations. We appreciate the inclusion of unit price range and trends and ask that this information be made public. We note that the federal No Surprises Act enacted in the last Congress (and signed by the prior President on December 27) prohibits "gag clauses" that shield information about prices and quality from public disclosure. Making public information on unit price ranges and trends is consistent with this.	Covered California will continue to collect the rationale and criteria for inclusion of hospitals with multiple signals of poor performance on cost, safety, and quality and may release this information publicly. Covered California will publicly report on cost reduction measures through AB 929 reporting. We are currently determining what will be reported through AB 929.
9	9.03	[Organization] supports patients having access to networks that are based on high quality and efficient providers. However, Covered California must balance this with timely access to care and accurate quality measurements. When QHPs measure and analyze physician quality, it is important that the data used be accurate and valid. The accuracy of physician quality ratings depends greatly on data collection methods, the source of the data, the metrics and analytic protocols used, the ability of subject physicians to review and correct errors, and the disclosures that accompany any ratings reports. Common sources of error include patient attribution, risk-adjustment including for social determinants of health, measurement gaps, and completeness and quality of the data. Rating physicians without taking into account these factors may lead to a disincentive to care for complex cases and the hardest to treat. [Organization] appreciates that Covered California will work with physicians on provider quality measures. Hearing directly from physicians about past reporting and measurement issues, as well as barriers to effectively using the data, would be beneficial for Covered California and QHPs. Publicly rating or tiering of physicians given the high likelihood of inaccurate and invalid data is problematic and poses risks for both physicians and patients. Until such time that all the problems are corrected and the accuracy and validity of the information is ensured, [Organization] urges Covered California to not proceed with publicly rating or tiering physicians. While we believe that data-driven improvement must be a cornerstone of any physician practice, we do not believe that public reporting based on these data is an appropriate way to accomplish such improvement. Rather, to promote quality care, [Organization] supports Covered California requiring QHPs to report to Covered California how QHPs are engaging with physicians to improve performance using methods such as implementing alternative payment models including population-based payments. Another important issue for Covered California to consider is the administrative burden placed on physicians to correct their data. Our members have estimated they could devote a significant amount of time for this purpose. While making the data available for review is important, the already overwhelming complexities of complying with administrative responsibilities in the average practice must be taken into consideration. Requiring physician practices to allocate even more uncompensated time to correct problems they did not create is unfair. Their time would be better spent providing patient care, especially during the pandemic. We would note that pandemic continues to have a significant financial impact on the viability of physician practices, with a recent [Organization] survey finding that 87% of physician practices are still worried about their financial health. Even with 8 out of 10 practices now utilizing telehealth, patient volume and revenue is still down by one-third, with 25% of practices still experiencing revenue declines of 50% or greater. Accordingly, [Organization] hopes we can work with Covered California and QHPs to explore ways for physicians to review and correct the data that would not create an additional administrative burden on the physician practice.	Covered California recognizes that there is not a good industry standard for measuring the quality of individual physicians. We will continue to collaborate with issuers, providers, and other stakeholders to determine how to assess quality data on the individual physician level.

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10	10.01	[Organization] supports that Covered California has sharpened the reporting requirements for telehealth. In particular, [Organization]appreciates the inclusion of the requirement that Contractors must report on how they are facilitating the integration and coordination of care between third party telehealth vendor services and primary care or other contracted providers. [Organization] strongly supports the use of telehealth to provide patents access to their treating physicians and clinicians. [Organization] wants to ensure that health plans do not separately contract with third-party telehealth vendors that provide care to enrollees that is not coordinated with the care provided by the plan's contracted providers or the patients' treating providers. Professional services provided via telehealth should be part of the care provided to the patient by their physician, and not an unassociated provider that works through a third-party telehealth vendor. Covered California should ensure that telehealth is merely an alternate site to care delivery and not alternate care that is disassociated with the rest of the enrollees' medical care. We also appreciate the expanded definition of telehealth that recognizes the way in which telehealth technologies are currently used in health care and incapsulate all of the asynchronous store-and-forward telehealth modalities now available to patients and providers, such as remote patient monitoring and e-consults, which have even more potential for connecting patients with their providers and improving access to specialists. Remote patient monitoring and chronic disease management, for example, can assist physicians in monitoring conditions like high blood pressure or diabetes and allow physicians to address any issues early on. These tools can also assist patients in gaining more autonomy and permit them to take ownership of their own health and health-related behaviors. E-consult reduces barriers to access by connecting physicians with patients in remote parts of the state and patients who may not be able to travel to an office. Many health systems in California have adopted e-consult as a way to provide services, particularly specialist services, to patients in a timely and cost-reducing manner. Additionally, we strongly support that Contractors be required to facilitate Enrollee access to telehealth services through broadband and internet connected devices, and appreciate the requirement that Contractors report on these measures. We would ask that Contractors not just screen for access to necessary services and technologies but provide funding to ensure all enrollees can use telehealth as needed. Lack of access to broadband has been and remains an issue to telehealth adoption in rural areas. Telehealth platforms must be accessible for a wide variety of users, including those with functional limitations, and should include technologies such as closed captioning for those who are hearing impaired. The expansion of coverage for audio-only visits may provide greater access for older or rural adults who lack internet access or internet-enabled devices. Funding for not only broadband but also devices, particularly targeting those demographics that have been shown to have lower access, could help reduce disparities in this area. Additionally, new telehealth programs and pilots must target vulnerable populations and make sure to include those with limitations that may make it more difficult for them to use technologies. Lastly, we appreciate that Contractor's must provide payment parity for telehealth, including voice-only for comparable in-person services. We would ask that the language in 10.01.2 be modified to state "when clinically appropriate" as it should be determined by a physician what type of care and telehealth modality, if any, is clinically appropriate to treat a patient.	Covered California will consider your recommendation as we continue to develop and strengthen this requirement in 2023 and beyond.

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10	10.01.1	Sites and Expanded Approaches to Care Delivery: 10.01.1 We appreciate Covered California's added emphasis on telehealth contract requirements. While we agree with Covered California that telehealth and other virtual health services offer additional access points to medical care that may reduce barriers such as transportation, childcare, and time off work, we support Covered California's additional language regarding the use of these modalities "when clinically appropriate." We would also note that technological barriers to accessing telehealth exist for many Californians including communities of color and Limited English Proficient (LEP) enrollees as noted in a recent brief published by CPEHN. 2 In some instances, telephonic access is more feasible than video access as a result of barriers to digital technology as well as synchronous video interpreting. These barriers must be acknowledged and addressed for telehealth services to be accessed more equitably.	Covered California will amend the contract to explicitly include telephonic voice-only as a modality option for telehealth.
11	11.03.2	[Health Plan] supports part 4 of the requirement to encourage providers to implement Choosing Wisely guidelines. This is the most current, relevant, widely accepted and evidence based form of shared-decision making. Parts 1-3 of this requirement are no longer the imperative that they may have been years ago because shared decision making is part of the provider standard of contemporary practice. All of our care management programs support shared decision making. Encouraging point of shared decision making in the provider's office should be the focus. Utilization of our purchased shared decision-making tool is extremely low despite strong marketing efforts and incentives for using the program. Vendors offering types of shared-decision making is limited mostly to surgery and the number of vendors is also limited. Shared-decision making takes place at the point of service in the provider's office for many health care needs and conditions. This is not included on the claim, we do not have line-of-sight into this activity and it cannot be quantified by the health plan.	Covered California recognizes that shared decision-making occurs at the point of care and that health plans may not have insight into this process. Sections 1-3 of 11.03.2 will be removed from the contract. We will continue to evaluate how we can measure shared decision-making processes and may look to enhance requirements in 2023.
11	11.04	Plans should be asked to provide their plans for coming into compliance with the federal ONC Information Blocking Regulations set to take effect on April 5, 2021.	Covered California will consider your recommendation as we continue to develop and strengthen this requirement in 2023 and beyond.
11	11.04.2 (1)	Covered CA please confirm the requirements of provider appointment scheduling. Do the services have to be active and available before the 1/1/2022 plan effective date?	Contract compliance with requirements set under 11.04 Enrollee Personalized Health Record Information are expected to be completed by the effective date of January 1, 2022.

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	14	Patient-Centered Social Needs: We appreciate the addition of contract requirements related to social needs screening for food insecurity and housing instability or homelessness. We would suggest that Covered California emphasize screening first for those who are below 150% FPL or as a default, those who are in the Silver 94 plans which comes to about 15% of enrollment. The plans know which consumers are enrolled in Silver 94 so the plans can target the screening to those with incomes below about $18,000 per year or $1,500 per month. These are the consumers who are mostly likely to be at risk for food insecurity or housing instability. We recognize that it may not be timely to include this in the 2022 contract: if so, we would ask that it be included in the 2023 contract provisions. In a future year, this could be expanded to both those in Silver 94 and Silver 87, again because income is the best predictor of food insecurity and housing instability. Were there a way for plans to identify those in Bronze plans at these income levels, we would welcome their inclusion as well.	Covered California intends to prioritize expanded screening for health-related social needs in the 2023 model contract. Your input will be considered in developing contract requirements for 2023 and beyond.
14	14.01	[Organization] supports efforts to promote solutions for people with complex medical and social needs, including well-coordinated and adequately funded case managers. Many social and economic conditions often lead to health disparities, or differences in health outcomes, and vary by socioeconomic status, race/ethnicity, geographic location, educational attainment, sexual orientation, gender, and occupation. Strong evidence has accumulated over the last decade that links unmet social needs with poor health status. When screening and targeting patients with social needs, we would encourage the utilization of existing provider relationships and networks and we strongly support contracted models where QHPs will provide direct funding for physician practices to hire additional case managers who can provide this benefit to patients. If physicians do need to refer patients out for care management, they should be able to refer the patient directly to the plan through a streamlined process that allows the physician to remain informed and involved with the patient's care. Physicians report to [Organization] that oftentimes when managed care plans are given additional requirements for enhanced care management that require high-touch, on the ground and face-to-face contact, either programmatic or data-related, that these requirements tend to be delegated downstream to treating physicians, often without discussion or additional financing to support the new requirements. Providers, both physical and behavioral health, will be key to successfully driving these changes with individual patients. However, in order to successfully address social needs, plans cannot simply add additional unfunded contract requirements to provider contracts and expect this to be absorbed into practice flows; care management must be adequately funded. Additionally, many health care systems have begun to explore ways to integrate data related to social determinants with patients' clinical records. However, many challenges remain before data related to the social determinants of health are readily accessible and actionable. Key challenges are a lack of consensus on standards for capturing or representing social determinants of health in electronic health records. There is no single standard that captures the breadth of information necessary for documenting the determinants in a manner appropriate for clinical care, quality improvement, and research. To address these challenges and effectively use social determinants in health care settings while minimizing additional administrative burden on patients and physicians, we recommend that Covered California implement uniform standards for QHPs for representing data related to social determinants of health, the data be easily extracted, and the collection of the data be incentivized through financial or quality measures.	Covered California acknowledges the importance of partnering with clinicians in the mission to improve health care delivery. We will continue to explore your recommendations as we develop and strengthen this requirement in 2023 and beyond.

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15	15.02	[Organization] recognizes the importance of and fully supports the secure exchange of data among providers to reduce costs, improve quality of care, and reduce administrative burdens. Data should follow the patient and should be available to any appropriate provider at the point of care. Secure and robust data exchange, however, cannot be achieved without sufficient funding for necessary technology infrastructure and training. In addition, [Organization] urges Covered California to ensure that data collection obligations are not passed down to individual providers without the appropriate considerations of cost and administrative burdens. It is critically important that Contractors use standard processes for encounter data exchange with contracted providers, and we appreciate the inclusion of Article 15.02.3 requiring Contractors to use industry standards. Additionally, [Organization] appreciates the new requirements that Contractors report on their own and provider participation in Health Information Exchanges (HIE), and that they agree to engage with Covered California in discussions regarding a transition to a statewide approach to streamline Health Information Exchange participation.	Covered California will consider your recommendation as we continue to develop and strengthen this requirement in 2023 and beyond.
15	15.02.2	We appreciate that Covered California is requiring Contractors to report on participation in Health Information Exchanges (HIEs). The department should add to the list of HIEs in subsection 2) San Mateo County Connected Care. In addition, plans should be required to support other forms of exchange, including national networks (Carequality, Commonwell) and API-based exchange. We appreciate that Covered California has accepted our comment to list all HIEs, but the list should be updated to reflect the most recent addition.	Covered California recognizes that this is not an exhaustive list of HIEs. QHP issuers should describe their participation in a non-listed Health Information Exchange using the "Other Health Information Exchange" option.
15	15.04	We appreciate the new requirement that Contractors must implement and maintain a secure, standards-based Patient Access Application Programming Interface (API) consistent with the CMS Patient Access final rule for Federally Facilitated Marketplaces. However, [Organization] has serious concerns with the Final Rule related to the lack of privacy and security protections for patient data. Therefore, we would ask Covered California to ensure the Contractors sufficiently address the privacy and security of patient data in APIs.	We understand your concerns regarding the privacy and security protections for patient data. Our goal is to align with federal requirements for Federally Facilitated Marketplaces; the privacy and security protections for patient data are important to Covered California. We will consider your recommendation as we continue to develop and strengthen this requirement in 2023 and beyond.
17	17.01	[Organization] supports the requirement that Contractors must be accredited by NCQA by 2024 as this aligns with future CalAIM initiatives from the Department of Health Care Services to improve quality among Medi-Cal Managed Care plans. We believe alignment among regulators and payors will help improve quality without imposing additional administrative burdens on physician practices.	Thank you for your comment. Covered California is excited to hear that [Organization] supports this requirement.

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	Collecting Race and Ethnicity Data	Qualified Health Plans agree with Covered California that improving our health care system and addressing health disparities and equity requires improved data. Unfortunately, we disagree on the best method to collect race and ethnicity data. As we have stated in previous comments regarding Attachment 7, we believe that race and ethnicity data should be collected at time of enrollment - this is the most efficient and consistent way to collect this data. The QHP issuers do not enroll members and therefore do not oversee the completeness of this data field. We recommend that race and ethnicity data should be a mandatory field at the time of enrollment, and Covered CA should add a "decline to state" option and add this field to the 834 files to ensure that the race and ethnicity field is not blank. Unfortunately, the latest version continues to propose a flawed system for collecting important race and ethnicity data, unrealistic goals, and punitive measures against QHP's. We cannot compel our enrollees to answer questions, nor can we force them to choose from a finite list of race and ethnicities if they don't identify with them.	A majority of QHP Issuers have reported exceeding the 80% threshold over a number of years since the first required reporting in 2016. Covered CA agrees member self-identification at the point of enrollment is an important opportunity for data collection and will continue to transmit that information to QHP issuers in the 834 file.
Appendix A		Measurement: We appreciate the Measurement Crosswalk in Appendix A. While we understand certain measures are required for example by CMS as part of the marketplace Quality Rating System, we would appreciate a more robust conversation between Covered California, consumer advocates and plan management more broadly, on its rationale for the inclusion of certain metrics (and not others) as part of Covered California's HEI initiative. While some of these measures appear to make sense to us, others make less sense, and a more detailed conversation could help to pinpoint potential gaps in measurement that would make sense for Covered California to fill.	Covered California anticipates continued stakeholder engagement on measurement for 2023 and beyond on the rationale for the use of certain measures as well as the identification of gaps in measurement that Covered California may be positioned to fill.
Appendix B		Payment: We support the provisions of Appendix B that support the provisions of Attachment 7 that we support. Our other comments on Appendix B are consistent with our comments on Attachment 7.	Thank you.
General Comment		We appreciate many of the new contract requirements in Attachment 7 tied to Attachment 14 performance requirements. We also appreciate the additional detail in Attachment14 and the multi-year plan that Covered California has clearly laid out in each area where payment is at risk. We find it helpful to us as advocates and we hope it is helpful to the health plans and their contracting providers to be able to look ahead to see what the expectations are and have been. The process of achieving the triple aim of improved outcomes, lower costs and increased health equity is a multi-year effort that either progresses year by year or stalls out. We share with Covered California a commitment to continue to make progress towards the Triple Aim of reduced cost, improved quality and progress in addressing health inequities. To that end, we reiterate our request for stronger contract language stating very clearly, Covered California's plans to hold plans accountable for meeting additional disparities reduction metrics beyond 2022. We also provide more detailed comments below.	Your suggested language is under consideration.