

Article-Section No.	Article-Section Title	Comment Date	Comment	Covered California Response
1.01	Expanded Demographic Data Collection:	12/6/21	We support Covered California stratifying data by income for disparities identification and monitoring purposes which we believe is something Covered California should already be able to do. Standards for the collection and reporting of data on sexual orientation and gender identity are close to being finalized. We urge Covered California to affirm its intention to move forward on disparities reduction when this data is available.	Thank you for your comment. We would be happy to review any information you can provide on the referenced sexual orientation and gender identity data standards.
1.01		12/6/21	We appreciate Covered California's response to our comment dated 10/8/21 and look forward to partnering with Covered California in exploring additional sources for member demographic information and opportunities to improve capture of member self-identified race, ethnicity, and language data and continue to transmit that information to QHP issuers in the 834 file.	Thank you for your comment.
1.01		12/6/21	We appreciate Covered California's response to our comment dated 10/8/21 and look forward to partnering with Covered California in bidirectional data updates and exploring best practices for collection and sharing of member self-reported demographic data, including bidirectional data sharing.	Thank you for your comment.
1.01.1		12/6/21	Will Covered CA share standardized categories for collection of expanded Demographic data collection including Disability status, SOGI. Since these are new areas for data collection, having common guidance on data collection will be helpful for Contractors.	Covered California will develop proposals for specific requirements for collection of disability status, sexual orientation and gender identity data in collaboration with stakeholders.

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1.01.2		12/6/21	Is the 80% requirement for spoken and written language data collection combined for both categories? Will there be bidirectional sharing of language data, especially for data captured through self report at Contractor level.	Covered California will be developing the performance scoring methodology for this requirement. As stated in the contract, Covered California anticipates that valid language data captured at Contractor level can be used to meet this threshold, just like we have established for our race/ethnicity data collection contractual requirement.

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1.01.2	Race, Ethnicity and Language Data Collection:	12/6/21	<p>We appreciate the additional requirement that plans collect and report data on enrollee spoken and written language and the percent of at-risk associated with this goal. In recent discussions with Covered California, we learned individuals who leave the field “written and spoken language” blank in CalHEERs are automatically assigned English as their language. This default assignment to English language makes this data unreliable for quality improvement purposes while also potentially leading to poorer quality care for those who should be provided with interpreter services. Again, Covered California must prioritize accurate data, lest greater efforts towards reducing disparities be undermined by lack of basic information. We reiterate our previous comments urging Covered California to utilize the AB 1296 CalHEERs stakeholder process to resolve this data issue as soon as possible. An initial step would be to flag this as a priority issue for Covered California ahead of the upcoming AB 1296 end-of-year meeting. Covered California should also investigate whether those applications leaving this question blank or incorrect spoken or written language information are generated from applications from agents other certified enrollment counselors, or Service Center representatives and re-train as necessary. Finally, enrollee language may be otherwise available to the plan, such as through their own contacts with enrollees or through providers and the plans should be allowed to correct the enrollee spoken and written language in CalHEERs. As mentioned above, we would additionally like to see a percentage of at-risk funds applied to 3. Reducing Health Disparities by language in 2024 and 2025.</p>	<p>Covered California hopes to remove the default English language selection for non-respondents in CalHEERS effective September 2022.</p> <p>In terms of adding a percentage of at-risk funds to 3. Reducing Health Disparities by language in 2024 and 2025, Covered California will assess feasibility of this recommendation and continue to work with stakeholders on our transition to QTI accountability.</p>

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1.01.2		12/6/21	<p>In our comment dated 10/8/21 we stated: "decline to state" is an actual response. A "declined to state" response should be tracked but should be removed from both numerator and denominator. QHPs should not be penalized if an enrollee makes a decision to "decline to state".</p> <p>Covered California responded with:                      At this time, Covered California guidance on race/ethnicity categories aligns with the Office of Management and Budget (OMB) directive. As efforts to further standardize race/ethnicity categories at the federal level take place, we will reassess our approach to improve our application process as necessary. As previously articulated, the 80% threshold acknowledges that not all members choose to share this information.</p> <p>Updated 12/6/21 comment:                      We continue to request Covered California to capture a consumer's active response of "decline to state" and send this information to Contractors. This is different from "null" / "no response". In addition, "decline to state" consumers should be removed from both the numerator and denominator when calculating the 80% expectation. Contractors should not be penalized by consumers that make the active choice to decline to provide this information.</p>	<p>Covered California's position remains consistent with our previous responses. Collection of race, ethnicity, and language data is critical in quality improvement and disparities reduction efforts. We expect Contractors to improve collection of this data to successfully track and implement quality improvement and disparity reduction efforts. Covered California does not plan to include a "decline to state" response option at this time and will continue to consider the issuer's full enrollment as the denominator for this threshold.</p>

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1.01.2		12/6/21	<p>In our comment dated 10/8/21 we stated: The capturing of spoken and written language is critical to meeting the expectations of the agreement (including Attachment 7). We request Covered California take steps towards requiring these fields on the application, as permitted by law. Capturing this information at time of enrollment is most appropriate and alleviates administrative burden on plans to collect this information that Covered California could have access to. In addition, there may be requirements for NCQA MHCD and/or Health Equity regarding the capturing of this enrollment information which is most appropriately collected at time of enrollment by Covered California.</p> <p>Covered California responded: At this time, Covered California guidance on race/ethnicity categories aligns with the Office of Management and Budget (OMB) directive. As efforts to further standardize race/ethnicity categories at the federal level take place, we will reassess our approach to improve our application process as necessary.</p> <p>Updated 12/6/21 comment: The requirements of Attachment 1 are to capture information on at least 80% of enrollees. The application is the most effective place to obtain this information. Capturing this information at time of enrollment is most appropriate and alleviates administrative burden on plans to collect this information that Covered California could have access to. We request Covered California take steps towards requiring fields for race, ethnicity, and language at time of application, as permitted by law.</p>	<p>Covered California is committed to improving collection of race, ethnicity, and language data. As previously stated, these fields will remain optional in the enrollment application at this time.</p>

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1.01.2		12/6/21	We appreciate Covered California's response to our comment dated 10/8/21 and look forward to partnering with Covered California to finalize potential requirement changes in the HEI data format for language fields by April 1, 2022.	Covered California is open to solutions that meet performance standard needs without modifying specifications at this time.
1.02.1	Disparities Measurement: Patient Level Data File	12/6/21	We appreciate the addition of two new metrics: pre-natal and post-natal depression screen and follow-up as a strategy for combatting disparities in maternal health outcomes, particularly for Black women for whom disparities are persistent.	Thank you for your comment.
1.02.2 1)		12/6/21	Comprehensive Diabetes Care: HbA1c Testing (NQF #0057) was removed in HEDIS MY2022 and replaced by a new measure - Hemoglobin A1c Control for Patients With Diabetes (HBD). We recommend aligning with the nationally recognized measure for reporting consistency.	The HbA1c Testing measure continues to be appropriate for diabetes care health disparities assessment, which is a different purpose than general performance accountability. Given the importance of this measure in disparities reduction efforts, Covered California intends to keep this measure as part of our measure set at this time.

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1.02.2 3)		12/6/21	We recommend removing "Avoidable Ambulatory Emergency Room (ER) Visits per 1000)" from the measure set as it is not nationally recognized measure with a standardized methodology. Validating reporting on a new measure requires internal reporting for comparison that is not developed using a methodology that is unknown.	Covered California will remove the measure at this time but pursue identification of a similar valid and reliable measure for avoidable ambulatory emergency room visits.
1.03.1	Disparities Reduction Intervention	12/6/21	We support Covered California's proposed contract revision which eliminates language to the effect that Covered CA and Contractor will establish "mutually agreed upon multi-year disparities targets," and replaces it with "Contractors will meet a multi-year disparities reduction target." The new language reflects Covered California's more proactive stance on quality improvement.	Thank you for your comment.

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2.01.1	Behavioral Health Provider Network	12/6/21	We are not familiar with the Network Management reports Contractors are required to file in accordance with the three-year NCQA accreditation cycle. What do those reports entail and will those reports be made public at no cost?	Covered California will continue to look for opportunities to make information on health plan performance on our contract requirements available, potentially through AB 929 public reporting or other reporting mechanisms.
2.01.2	Offering Telehealth for Behavioral Health:	12/6/21	We are concerned by new contract language authorizing a cost share "equal to or less than the cost share for in-person behavioral health services," as the ability to charge a lower cost-share for telehealth services could disincentivize individuals from seeking medically necessary services delivered in-person.	Covered California is continuing to explore options for standardizing cost shares for telehealth services. We coordinated with DMHC on the proposed telehealth requirements and the cost shares for telehealth services to ensure these requirements follow DMHC guidance.
2.01.3	Promoting Access to Behavioral Health Services:	12/6/21	We appreciate additional requirements related to patient education on the availability of mild-to-moderate mental health services. Plans should also be required to educate providers about these services to ensure they are aware of these services and able to make referrals. We appreciate encouragement for plans/providers to use a common screening tools such as the PHQ-2, 9.	Covered California will add a requirement for QHP issuers to inform providers about behavioral health services and referral options.
2.01.3		12/6/21	<p>We request bullet 1) have the sentence end at "...on key Enrollee pages;" and "such as the home page in its member portal and the provider directory page" be removed.</p> <p>While we agree that that displaying information of coverage is important we are concerned that the location on the home page of its member portal and provider director page may not over the course of the agreement be most appropriate. Current draft language could be interpreted to be prescriptive of where it is placed.</p>	We do not believe current draft language is prescriptive on where a QHP issuer must display coverage of behavioral health services. The member portal and the provider directory page are examples of key Enrollee pages.

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2.02.1		12/6/21	<p>We recommend specifying that the depression screening tool data is collected by primary care providers. The intent of the PHQ-2 and PHQ-9 tools is for them to be used by a primary care provider as a screening. Once the member is seeing a Behavioral Health provider, they do a comprehensive assessment which is not synonymous with screening.</p> <p>In addition, we recommend adding the option to report data collected by a vendor to the requirement. There are behavioral health support tools that use this screening assessment that the member then brings to the provider. Suggested language:</p> <p><i>Contractor must work with its contracted <b>vendors or primary care</b> providers to collect Depression Screening and Follow-Up Plan (NQF #0418) measure results for its Enrollees and report results in the annual application for certification. Contractor must engage with Covered California to review its performance.</i></p>	<p>Covered California will revise the language to "...work with its contracted providers, including primary care providers, to collect..." We understand that depression screening can be completed by several types of providers in addition to primary care providers.</p>

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2.03	Opioids	12/6/21	<p>We appreciate the contract revisions emphasizing a more individualized approach to treatment planning. However, we continue to be concerned about the emphasis on reducing access to prescription opioids in response to the overdose epidemic. As we have said before, strict prescribing limits and unmeasured tapers have the unintended effect of reducing access to medically necessary medications for people experiencing pain. Even when strict limits are not incorporated, the continuous emphasis on such measures has already led and will continue to lead prescribers to limit access to medications to avoid potential liability. As such, we strongly oppose blanket language to “implement quantity limits for new starts,” as these quantity limits are arbitrary and do not take into account individual differences in terms of medical circumstances surrounding the use of opioids and/or individual differences in metabolism. Alternatively, we propose that Covered California require QHPs to take steps to prevent development of opioid use disorders by incorporating the following language: “Ensure prescribers are using appropriate medical standards of care to determine need for and proper dosage of opioids for pain management while avoiding mandatory tapers. When clinically appropriate, support and eliminate barriers such as prior authorization for non-pharmacological approaches to pain management.”</p> <p>With regards to managing the use of opioids, we find the language confusing. How can providers be told to “avoid mandatory tapers,” while also being told “for continuing opioid therapy, tapering down or off opioid therapy; transition to buprenorphine or add non-opioid options.” This language is confusing and seemingly contradictory. Additionally, we would note that chiropractic care if not done properly can increase the need for pain management. We are also concerned with the addition of chiropractic care as a benefit. Because chiropractic care is not an essential health benefit under the Affordable Care Act, we would want to better understand the financial implications of adding this particular benefit and have assurance that this benefit would not be used for anything beyond pain management.</p>	Covered California has revised the language in 2.03.1 to be more clear, remove the statement "implement quantity limits for new starts", emphasize non-pharmacological approaches to pain management, remove the reference to chiropractic care, and emphasize that providers should be following appropriate standards of care.
2.04	Behavioral Health Integration	12/6/21	We appreciate the encouragement to use best practices collaborative care models to support behavioral health integration with primary care.	Thank you.
Article 3	Introduction	12/6/21	<p>We request the last sentence be changed to something similar to the following to better reflect more appropriately a QHPs responsibility since enrollees may refuse to engage with QHPs. In addition, clarifying difference of utilizing services which is very broad from obtaining services of providers.</p> <p>Please consider changing to:                      QHP Issuers are responsible for identifying opportunities, conducting outreach, and attempting to engage for the health of all Enrollees, not just Enrollees who obtain services from providers.</p>	Thank you for your suggestions. Covered California will adjust the contract language to clarify our intent.

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Article 3	Population Health	12/6/21	<p>While we understand the attraction and potential benefits of adopting risk stratification as part of a broader Population Health Management (PHM) strategy, we are troubled by reports of racial bias in many of these types of algorithms. Whereas most health systems choose “cost” as the proxy for “health,” evidence shows that Black patients consistently generate fewer costs than White patients at the same level of health. The reasons are widespread and varying from unequal access to health care and treatment to a well-founded mistrust of health care institutions as a result of historic and systemic racism by health care organizations and institutions including a shameful history of discrimination, experimentation, and exploitation of Black and Indigenous bodies that impacts the quality of care that people of color receive today to documented undertreatment of women and persons of color . This mistreatment also extends to persons with disabilities and LGBTQ+ communities. For example, psychiatry classified homosexuality as a mental disorder until 1973 and continues to pathologize transgender identities today.</p> <p>Unfortunately, while the review of Obermeyer et al. was extremely informative, because most clinical algorithms are treated as “proprietary,” the underlying formulas and identified outcomes are not transparent and therefore subject to objective or academic review. Patients and communities are willing and interested in engaging with health systems on population health management strategies and interventions. But they must have access to the data and underlying assumptions that underpin decisions regarding resource allocation in order to truly assist health and health related organizations in meeting their Triple Aim objectives.</p> <p><b>ARTICLE 3, 12-6-21 COMMENT CONTINUED NEXT ROW</b></p>	<p>Covered California is committed to reducing algorithm bias within Population Health Management. We will continue to explore your recommendations as we develop and strengthen this requirement during the 2024 amendment process and beyond.</p>

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Article 3	Population Health	12/6/21	<p><b>CONTINUED ARTICLE 3, 12-6-21 COMMENT</b></p> <p>Future algorithms should be based on health conditions, risk factors, and disease progressions rather than just utilization and cost which is not an accurate measure of health risk for communities of color and vulnerable communities who are less likely to utilize care. Covered California should provide a standardized, validated tool as a floor for plans, health and health related organizations to use to assess and manage risk, then let organizations add to it. Risk should not change when people move from plan to plan or system to system. Because a lot of these models have racial, age and disability-related bias built in therefore each plan and/or organization should be required to publish their model so it's fully transparent and researchers can understand the models and make improvements. Additionally, plans should be required and incentivized to use broad assessment tools such as PRAPARE and trauma screenings to ensure plans and providers adequately capture the needs of the entire population.</p> <p>While it is not sufficient for population health measures to focus exclusively on "at-risk populations" with high medical needs, it is important to include a focus on these populations. At the same time, the basic preventive care needs of such populations should also not be neglected: it does not do much good to manage the care associated with an organ transplant if someone neglects basic cancer screenings or asthma.</p>	Covered California is committed to reducing algorithm bias within Population Health Management. We will continue to explore your recommendations as we develop and strengthen this requirement during the 2024 amendment process and beyond.
3.02		12/6/21	<p>In our comments dated 10/8/21 we stated "While this states "enrollees", should clarification be made that such promotion cannot be made in sales materials, etc.?"</p> <p>Covered California responded: Covered California would appreciate more information and context for this public comment.</p> <p>Updated 12/6/21 comment: Will Covered California permit QHP Issuers to entice consumers in the sales process about health promotion like stating hypothetically they can earn up to \$ for taking healthy actions? We thought based on conversation with Covered California in July 2021 that such health promotions are only able to be communicated after enrollment. If Covered California will not permit this as part of the sales process we request this be added for clarification.</p>	Additional guidance on consumer incentive programs will be shared outside of Attachment 1 with QHP issuers through Plan Management.
3.02.1		12/6/21	We appreciate Covered California's response to our comment dated 10/8/21 and look forward to partnering with Covered California in exploring the use of HEI data to meet this reporting requirement.	Thank you.

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3.02.2		12/6/21	We appreciate Covered California's response to our comment dated 10/8/21 and look forward to partnering with Covered California in exploring the use of HEI data to meet this reporting requirement.	Thank you.
3.02.2	Diabetes Prevention Program	12/6/21	We support additional contract language requiring an analysis of performance trended over time and a requirement that QHPs report total eligible enrollees identified as high risk for diabetes and total eligible enrollees who should have been identified as high risk for diabetes. We urge Covered California to ensure this analysis is stratified by patient demographic variables including by race, ethnicity and language to ensure the benefit is widely available.	Covered California will continue to explore your recommendations as we develop and strengthen this requirement during our 2024 amendment process and beyond.
3.02.2		12/6/21	We recommend removing part 3 of this requirement to develop a corrective action plan. It is important to collect data to establish a baseline for expected rates among Covered CA QHP issuers before implementing this type of requirement.	Covered California will adjust the contract language to clarify our intent in regards to the corrective action plan. Our intent is to hold plans accountable and understand the processes in place to address a potential gap in DPP utilization.
3.04	Social Health	12/6/21	We appreciate additional language requiring contractors to engage with Covered California to review its performance on screening for and addressing health-related social needs arising from food insecurity and housing instability. We continue to note that caregiving is a health risk—and that Covered California's population (almost entirely adults ages 18-65, with just over half of its enrollment ages 45-64, is the prime age for caregiving responsibilities.	Covered California is committed to expanding social needs screening requirements in future years.
3.04.1		12/6/21	Could Covered CA specify if the social needs screening reporting will be based on attempts or member responses? We currently do offer a screening tool for food insecurity and housing instability. For privacy reasons, the reporting is in aggregate not by member.	The proposed required reporting metrics are based on the number of enrollees who complete the screening.
4.01.1	Encouraging the use of primary care:	12/6/21	We support Covered California's contract revision which gives consumers up to 60 days to choose a primary care physician but still auto-assigning consumers if the consumer does not select a primary care provider in that time period. Additionally, we support the revised contract language which states Covered California will "evaluate the effectiveness of this policy with Contractor and other stakeholders.	Thank you.

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4.01.1		12/6/21	Can the 60 days for Effective Primary Care be 120 days to match Medi-Cal requirements for IHA.	Covered California reviewed the Medi-Cal requirements for an initial health assessment. We believe the purpose of these two policies is different. Covered California is requiring enrollees to be provisionally assigned to a primary care clinician within 60 days of effectuation. We are not requiring primary care clinicians to conduct initial health assessments at this time.
4.01.1		12/6/21	We appreciate Covered California's response to our comment dated 10/8/21 and look forward to partnering with Covered California in exploring opportunities to improve capturing member self-identified race, ethnicity, and language data.	Thank you.
4.01.3	Payment to Support Advanced Primary Care	12/6/21	We appreciate that Contractors must report on its primary care payment models using the Health Care Payment Learning and Action Network Alternative Payment Model (HCP LAN APM) categories and associated subcategories. We request Covered California amend contract language to add, "...associated categories to improve quality and strengthen health equity."	Covered California introduces this requirement by noting that "Covered California and Contractor recognize the importance of adopting and expanding primary care payment models that provide the necessary revenue to fund accessible, data-driven, team-based care with accountability for providing high quality, equitable care, and managing the total cost of care." It is not clear where the requested language should be added to this section.
	Provider value	12/6/21	Advocates appreciate the recognition of the need to comply with applicable network standards, including the impacts on rural areas and other underserved populations.	Thank you.
4.03.3(1)(b)		11/16/2021 REPEAT	The referenced section indicates plans should submit an intervention plan to address low quality providers, which could include removal from the QHP network. This verbiage is problematic as it may lead to plans failing to meet State Regulator network standards.	We will edit the contract language to ensure that Contractors must immediately notify Covered California and state regulators of any removal of a provider from a QHP network. Additionally, any exclusion of a provider group or hospital may be subject to prior regulatory review and could result in required reductions in the Contractor's licensed service area.

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4.03.4	Hospital Value	12/6/21	Hospitals make public their negotiated rates: Advocates very strongly support the inclusion of a contract provision requiring hospitals to make public their negotiated rates, consistent with the newly effective federal rule that also requires this. We ask for a minor edit: it is not either a machine readable file or a price estimator tool. As we recall, both are required in the federal rules. We ask that Covered California require the health plans not only to provide this information to Covered California but to do it with the understanding that the information will be made public and provided to other relevant state agencies. Similarly, when the federal rule on transparency of insurance costs becomes effective, we hope that Covered California will impose similar conditions on health plans.	Thank you for the edits. We will make the correction in Attachment 1.
4.03.4(1)(a)		11/16/2021 REPEAT	The referenced section indicates plans should submit an intervention plan to address low quality hospitals, which could include removal from the QHP network. This verbiage is problematic as it may lead to plans failing to meet State Regulator network standards.	We will edit the contract language to ensure that Contractors must immediately notify Covered California and state regulators of any removal of a hospital from a QHP network. Additionally, any exclusion of a provider group or hospital may be subject to prior regulatory review and could result in required reductions in the Contractor's licensed service area.
4.03.7	Maternity Care	12/6/21	<p>We appreciate the additional attention to depression screening during the entire perinatal period and the additional attention on maternal health disparities. In regards to the additional reporting requirements in the application for certification regarding how a plan engages with hospitals and providers to reduce maternal disparities, we ask that plans' engagement be evaluated on additional actions being taken. Current law requires hospitals, birthing centers, and clinics to conduct implicit bias training for all perinatal providers every two years, thus plans should not be reporting on these requirements as engagement activities. However, additional steps plans are taking to encourage perinatal providers in other settings or at greater frequencies to receive such training would be welcomed. In addition, we urge Covered California to make more explicit requirements about addressing racial disparities in maternity care. For example, we believe data analysis by race and ethnicity should be mandatory for compliance with this section. The only way contractors can truly address racial disparities is if they are reviewing outcomes data by race.</p> <p><b>4.03.7, 12/6/21 COMMENT CONTINUED NEXT ROW:</b></p>	Covered California is committed to reducing maternal health disparities. We will modify the contract language to reflect requirements for implicit bias training for perinatal providers and more clearly specify our intended requirements for measure stratification by race and ethnicity.

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4.03.7	Maternity Care	12/6/21	<p><b>CONTINUED 4.03.7, 12/6/21 COMMENT:</b></p> <p>We also support the encouragement of other services to support birthing people such as community-centered models, in-home lactation support and doula support, though we are not certain why only postpartum services are specified for doulas. While these services are not part of the essential health benefits, we would love to know more about plan's experience in offering such services as the anecdotal information we have has been largely positive in health outcomes and cost. Finally, we urge Covered California to require QHPs to ensure they are effectively communicating to enrollees the availability of the services described in this section since many of these services are novel and enrollees tend to be unaware about supportive services that are culturally and linguistically appropriate. We suggest the following language for "b) Annually report in the application for certification:" on page 36:</p> <p>iv. How it supports its maternity Enrollees, such as access to culturally and linguistically appropriate maternity care, referrals to group prenatal care or community-centered care models for patients, in home lactation and nutrition consultants, doula support for prenatal, labor/delivery, and postpartum care, and related services.</p> <p>v. How it ensures that its maternity enrollees are aware of the supportive services available to them, including the services described in iv. above, and that the enrollees know how to access these services.</p>	<p>Covered California is committed to reducing maternal health disparities. Where appropriate, will update the contract language to reflect your suggested edits.</p>

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4.04.1	Telehealth offerings:	12/6/21	<p>We appreciate the inclusion of additional language requiring Contractors to communicate with enrollees about:</p> <ul style="list-style-type: none"> <li>□ c) Interpreter service availability for telehealth explained on key Enrollee website pages, such as the home page and provider directory page.</li> <li>□ 3) How Contractor facilitates the integration and coordination of care between third party telehealth vendor services and primary care and other network providers, particularly if the telehealth service is for urgent care, chronic disease management, or behavioral health, and;</li> <li>□ 4) How Contractor screens for Enrollee access barriers to telehealth services such as broadband affordability digital literacy, smart-phone ownership and the geographic availability of high-speed internet services.</li> </ul> <p>□ <b>Hospital at Home:</b> Hospital at Home is a new and somewhat experimental approach to care. If it is included, the reporting should also include both what supports are provided in terms of in-person home health nursing as well as telehealth connections. If “hospital-at-home” is limited to merely telehealth rather than including additional supports and services, we have serious concerns about the level of acuity of patients for which this would be appropriate. It should also include an assessment of the burden on family caregivers, including any impairment of the caregiver’s ability to engage in normal activities of daily living, such as work, other family obligations and raising children. Shifting care to the home needs to take into account the impact on family members as well as the patient. Failing to do will worsen disparities for women and people of color while those who are more affluent will simply hire additional help. Tracking of readmissions and other avoidable care should also be included.</p> <p>□ <b>Additional Evaluation Data:</b> We appreciate that Covered California is requiring health plans to report the impact of telehealth on the cost and quality of care provided to enrollees. We urge Covered California to play a more active role in the evaluation of telehealth services for example by not only requiring plans to report on impacts on access, quality and outcomes, but on provider and enrollee experiences including an assessment of telehealth utilization through the lens of health equity by assessing variations and disparities in telehealth utilization and quality of care by race/ethnicity, primary language spoken, sex, and age. The development of Covered California’s research and evaluation plan should be ongoing and involve consumer stakeholders not just Contractors.</p>	<p>Covered California is committed to improving our data collection to reduce health disparities. We appreciate your suggestions about Hospital at Home and will research further on this topic to inform future contract requirements. We will also continue to improve on our HEI data collection in order to provide more robust analysis on telehealth utilization and quality of care.</p>
Article 5	Measurement and Data Sharing	12/6/21	<p>We appreciate additional language stating that “Contractor agrees to work with Covered California to exchange and prioritize feedback on measure development and measure sets. This includes measurement refinements related to the National Committee for Quality Assurance (NCQA) Electronic Clinical Data System, the Quality Rating System, and Healthcare Evidence Initiative measures.”</p>	<p>Thank you.</p>

Article-Section No.	Article-Section Title	Comment Date	Comment	Covered California Response
5.02.1 2)a)		12/6/21	<p>In our comments dated 10/8/21 we stated: Based on verbiage in the 2022 agreement, we request the following modification: "a) Contractor shall work with <del>any</del> the HEI vendor identified in section 6. which Covered California contracts with to assist with its statutory obligations. Covered California represents and warrants that the HEI vendor Covered California contracts with has all appropriate authority to assist Covered California with its health oversight functions."</p> <p>Covered California responded: The language of the HEI section of the QHP contract was the product of many months of legal negotiations between Covered CA and the carriers. This involved highly technical issues pertaining to the requirements of AB929, the HIPAA Privacy Rule, the Covered CA/HEI vendor contract and the terms and conditions of the pending Data Governance Committee Charter and Procedures. We are proposing minimal adjustments to this section at this time.</p> <p>Updated comments 12/6/21: We appreciate the partnership that went into the historical language pertaining to this HEI section. This updated section appears to have deviated from that language. Modifying the language as proposed above in our 10/8/21 comment resolves the concerns that have been surfaced with the introduction of the updated language.</p>	<p>Covered California will be keeping the current language and no significant modifications have been made at this time. We acknowledge that some of the 2023 draft model contract language reflects changes from the 2022 amendment in that some of sentences have been consolidated and rearranged during the reorganization of sub-sections. We may revisit meaningful revisions to the HEI sections in a future contract cycle.</p>
5.02.3	Data Exchange	12/6/21	<p>We appreciate the added requirement that Contractors participate in C-TEN, bi-directionally exchange information and participate in the development of the California Health and Human Services Data Exchange Framework.</p>	<p>Thank you.</p>