Issue #	Application/Section	Issue Area	Consolidated Comment	Comment From	Covered California Response
1	Individual Health - Benefit Design	Clarification	Clarification requested on the difference between Alternate Benefit Design and Cost-Sharing Deviations.	Carriers	Cost-Sharing Deviations described in the Application would not be considered an alternative benefit design and would be reviewed and approved/denied on a case-by-case basis. Applicants should use "Attachment B Patient-Centered Benefit Design Deviations" to identify all deviations and use the notes section to provide a justification. The justification should identify a rationale for the deviation based on delivery system design, operational limitation, etc.
2	Individual Health - Financial Requirements	8.2	Covered CA should not add the requirement to accept cash payment. Requiring a cash option will only serve to raise costs while not providing a meaningful service option to the unbanked. We recommend removing cash payment as a requirement in the application.	Carriers and CAHP	Covered CA modified the question to ask Applicants to detail which methods of payment the Applicant accepts.
3	Individual Health - Electronic Data Interface	11.2	Request to remove the question which asks about Applicants systems lifecycle and release schedule. It's unclear how CalHEERS will use this information (e.g. monthly releases). The information is likely to be of very limited value (e.g. full of internal system names which won't be useful to an to an outside party). There hasn't been a specific need for this information having worked through numerous releases with Covered CA.	Carrier	System lifecycles and release schedules may change year to year and help to provide a level of awareness that promotes productive Applicant engagement with the Covered CA Reconciliation Team. This question will remain in place for both new entrant Applicants and currently contracted Applicants.
4	Small Business Health - Electronic Data Interface	11.2	Given the lack of integration needed by CCSB and the history of not needing the similar technical requirements as IFP, we are questioning why this continues to be a question for existing Applicants.	Carrier	Due to ongoing eligibility reconciliation development this question will remain in place for both new entrant Applicants and currently contracted Applicants.

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5	Individual Health - Marketing and Outreach	15.4	Request to remove the requirement that 0.6% of premium revenue be spent on marketing. This percentage will result in a significant investment for larger Applicants and there are a variety of tested marketing strategies in place without a specific spending requirement. The QHPs request marketing spend continue to be at the QHPs' discretion.	Carriers and CAHP	Covered CA will have discussions with individual Carriers.
6	Small Business Health - Marketing and Outreach	15.4	Applicant is unable to provide a marketing budget in May - when the application is due. Typically the marketing plans and budgets budgets are developed well after rates, products, etc announced to understand the market dynamics and expected shifts in membership, etc. Additionally, we are unsure how this information is used during the recertificaiton process. There are other opportunities to engage with CCSB Marketing teams on strategies and tactics.	Carrier	Applicant to provide proposed marketing plan with any details available.
7	Individual Health - Network	16.1.2	Recommend to remove the requirement to provide a network file with the application if there are no material changes to the network being made. CC should be relying on the existing network files they get from the Applicants.	Carrier	Covered CA will revise the requirement for currently contracted Applicants to forgo this requirement if they attest they have no material changes to their network.
8	Individual & Small Business Health - Quality	18.2.1	Why change to the word "costs" to "price"? Prices, especially list prices, don't capture or fully reflect the true costs to the system and to consumers.	Health Access	This question is focused on Applicant Issuer's approach to understanding price variation in contracting with providers and facilities.
9	Individual & Small Business Health - Quality	18.3 Demonstrating Action on High Cost Pharmaceuticals	18.3.1 - Regarding the question on “If Applicant or Applicant’s PBM is considering implementing a pharmacy order-entry decision support tool to promote value-based prescribing, and if so, indicate which tool Applicant is using” Blue Shield believes CCA is inquiring about point of care decision support tools to promote value based prescribing as opposed to pharmacy order entry tool. Our suggested edit to the question is in red, “If Applicant or Applicant’s PBM is considering implementing **a point of care support tool** to promote value-based prescribing, and if so, indicate which tool Applicant is using”	Carrier	This question will be revised.

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10	Individual & Small Business Health - Quality	18.3.1	Strike out of bullet #5 - Will the change in question produce the actual data results that the previous question intended to generate? Or will an answer about strategy generalize too much what the QHPs are doing and not come up with actual useful answers?	Health Access	The Exchange removed bullet #5 of 18.3.1 because state law has requirements for off-label use of pharmaceuticals. Applicant responses to this question in the past have provided no further insight beyond state requirements.
11	Individual & Small Business Health - Quality	18.6.1	Why is it necessary to know what other data initiatives applicant's are involved in? Is CoveredCA intending to use the applicants' submitted data in other initiative? If so, how?	Health Access	The Exchange seeks to understand issuer's current involvement and commitment to data exchange.
12	Individual & Small Business Health - Quality	18.7.1	Request an additional requirement that plans provide data on utilization of these services by race, ethnicity, language and other sociodemographic factors. We would also be interested to know how plans assess the language capacity of behavioral health staff and whether or what types of incentives or bonuses they currently provide to bilingual staff.	CPEHN, Health Access, NHeLP	Covered CA will consider a requirement that Applicants provide data on utilization of mental and behavioral health services by race, ethnicity, language and other sociodemographic factors for future contract and certification application requirements. Covered CA will add a bullet on assessing the language capacity of behavioral health staff to 18.7.2.
13	Individual & Small Business Health - Quality	18.9	Consider improving alignment with DHCS' Quality Strategy by requiring plans to report on the proportion of smokers who report being counseled to quit or who report a provider discussed tobacco cessation medications in the prior six months (CAHPS): https://www.dhcs.ca.gov/formsandpubs/Documents/ManagedCareQSR062918.pdf	CPEHN	Will consider for future contract and certification application requirements.
14	Quality Individual & Small Business Health - Quality	18.9.11	Are QHPs required to provide data on member utilization of Diabetes Prevention Program (DPP)?	CPEHN	Will consider for future contract and certification application requirements.
15	Individual & Small Business Health - Quality Improvement Strategies	19.2.2	It sounds like from the way this question is asked, that all current Covered CA plans have reached their goal of achieving 80% of Exchange members self-reporting their race/ethnicity? How would this section apply to new applicants? For current applicants, can we add additional self-reporting requirements for other sociodemographic factors (e.g. language, SOGI)?	CPEHN, Health Access, NHeLP	Question has been revised to reflect 2020 expectation based on 2019 year-end contract requirements. Section 19.2 does not apply to New Entrant Applicants, though Attachment 7 would be included in the executed contract for any newly selected issuers. Additional self-identification capture requirements will be considered for 2021 contract and certification application requirements.

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16	Individual & Small Business Health - Quality Improvement Strategies	19.2.2	We are concerned about the deletion of bullets regarding plan progress in identifying and reducing health disparities. Are these questions addressed and answered in each QHP's quality improvement plan? How will plan progress be assessed in this area for new applicants? Please explain. On a related note, how is the exchange using these QIPs to apply contract penalties or credits?	CPEHN, Health Access	Question 19.2.2.3 will be revised to include quality improvement plan specifications. Contracted Issuers are subject to contractual performance penalties or credits based on outcome of disparities quality improvement plan once implemented.