COMMENT TEMPLATE - Draft 2023-2025 Attachment 4 - Quality Transformation Initiative Last Update:4/18/2022

Article-Section No.	Article-Section Title	Comment Date	Comment	Response
QTI	General Comment	2/11/22	Thank you for the opportunities to review and provide feedback during the QTI development process. We appreciate the collaboration and the thought that's gone into developing the QTI.	Thank you.
QTI	General Comment	02/11/22	A detailed comment letter has previously been submitted to Covered CA regarding QTI on 1/14/22. The Plan propose a staggered approach requiring health plans to hit a defined rate of improvement from measurement year 2023 to measurement year 2025. This would allow plans over time to increase quality so that the quality improvement targets are more manageable and achievable. CMS uses a similar metric for its Medicare Star Ratings which Covered California could leverage for this purpose. This improvement measure would be based on an evaluation of current year measures as compared to previous year measures for measures where comparisons were not impacted by significant measure specification changes. It would be implemented in the measurement year 2023 to allow health plans credit for showing increases from the previous year.	Covered California has considered your feedback. We will be moving forward with the proposed structure of QTI as an achievement program rather than an improvement program so that we are holding all QHPs to the same standards. Our goal is to incentivize high quality care.
1.01.1	2023-2025 Core Conditions and Measure Set	02/11/22	We applaud Covered California for establishing the Quality Transformation Initiative (QTI) which will tie health plan premium payment directly to its performance on key metrics. While this is an ambitious experiment, we continue to have questions about the narrowness of the areas of focus and adult measures (3) for which Contractors will be held accountable. We look forward to working with Covered California on implementation of the QTI and a robust evaluation of its effectiveness, given its current narrow focus, in transforming the care that consumers get.	Covered California looks forward to engaging with advocates and QHPs on the implementation and evaluation of QTI. We also look forward to expanding the QTI measure set tied to payment to include behavioral health measures in the future as national benchmarks become available.
1.01.1	2023-2025 Core Conditions and Measure Set	02/11/22	We are disappointed to see that measures on mental health a) Depression Screening and Follow-Up for Adolescents and Adults (DSF) b) Pharmacotherapy for Opioid Use Disorder (POD) will not be included in the QTI measure set until after benchmarks have been established. We urge Covered California to prioritize the establishment of mental health benchmarks and a timeline for when these measures can be tied to quality improvement fund payments.	Covered California will prioritize adding behavioral health measures tied to payment to the QTI as soon as possible.

Article-Section No.	Article-Section Title	Comment Date	Comment	Response
1.01.1 1) c)	Core Conditions and Measure Set	2/11/22	We would like Covered CA to send issuers HEI historical claims, particularly for all QTI measures with a look-back period that is longer than 1 year. With regards to the QTI metrics, this would apply to COL and CIS. For example, COL has a long look back period of 10 years, and therefore QHPs will be missing colonoscopy data for members that switched carriers during that time. This would also create alignment with the current DHCS process of sending carriers the historical claims data for new Medi-Cal members whenever they transition between carriers.	Covered California is researching whether this is feasible and whether this will be impactful for QHP issuers. We will follow up with issuers on our findings and next steps.
1.01.1 1) d)	Core Conditions and Measure Set	2/11/22	Childhood Immunization Status (Combo 10) is not currently reported in QRS. We would like to request that the first year be reporting only for Childhood Immunization Status (Combo 10) in order to establish a benchmark. The benchmark for the 2022 QRS will not be released until late the following year, so we will not have the target to work towards until Q2/Q3 2023.	We will not be making any changes to the measure set or measure benchmark years. Even though the benchmark will not be available until 2022, we believe QHP issuers should have a good estimation of how they perform on CIS 10 based on their performance on CIS 3 for QRS and CIS 10 for HEDIS in other markets.
1.01.1 2) a)	Core Conditions and Measure Set	2/11/22	NCQA Depression Screening and Follow-up for Adolescents and Adults (DSF) does not use billable codes, so we do not receive this data via claims. In order to report on NCQA DSF, the data has to be obtained from Electronic Medical Records (EMR). In addition, if providers do not send the data via EMR, the impacted enrollees will be excluded. We recommend removing this requirement from the QTI reporting to allow time for further IT development to obtain a complete data set. As an alternative, the the Depression Screening & Follow Up (NQF#0418) measure does use billable codes and is available in claims data, and was a candidate metric in prior QTI iterations. This measure may yield more comprehensive results for now and allow time for further IT development to support data collection for the NCQA DSF measure. This comment is also applicable to the Patient Level Data (PLD) file requirements in Attachment 1.	Covered California will move forward with requiring the DSF measure as a reporting measure in the QTI measure set in alignment with DHCS and CalPERS. We also support the move towards ECDS measures and CMS is considering moving towards QRS ECDS measures as well.

Article-Section No.	Article-Section Title	Comment Date	Comment	Response
1.01.2	Health Disparities Reduction	2/11/22	Clarify that data requested is the hybrid SAMPLE rate/outcome, not every result of every hybrid measure for every member. Note that for the 2022 contract Attachment 7 - 1.02.2 states the following - The Contractor must also submit HEDIS hybrid measure summary files including numerators and denominators by Race/Ethnicity category for all commercial product types for which it reports these HEDIS measures to the National Committee for Quality Assurance (NCQA) Quality Compass and for each Medi-Cal Managed Care product for which it reports these HEDIS measures to the Department of Health Care Services (DHCS). 2023 Attachment 1 - 1.02.1 replaces the 2022 1.02.2 section and states that contractor must submit the HEDIS hybrid measure patient level data files for CCA enrollees (for the 8 measures listed); a patient level data file that includes a unique person identifier as specified by Covered Ca and valid race and ethnicity attributes for each person in the denominator. Contractor must also submit numerator and denominator totals and rates at the summary level. **Of note: Covered CA should ensure sure all of contract artifacts align, as there is ambiguity and variations between the various artifacts.**	Covered California has revised Attachment 1 and Attachment 4 to clarify the health disparities reduction requirements associated measures.
1.01.2	Health Disparities Reduction	2/11/22	For the submission of patient level data file, the definition of valid needs to account for the known limitations around R/E. We recommend allowing the use of imputed R/E data and to also allow for decline to respond.	Covered California is requiring self-reported R/E data for disparities measures.

Article-Section No.	Article-Section Title	Comment Date	Comment	Response
1.01.2	Health Disparities Reduction Requirements	2/11/22	We strongly support Covered California's requirement for QHPs to stratify the four core measures included in the QTI measure set: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%) (NQF #0575); Controlling High Blood Pressure (NQF #0018); Colorectal Cancer Screening (NQF #0034); and Childhood Immunization Status (Combo 10) (NQF #0038) by race and ethnicity for the purposes of reporting. However we were disappointed to see that Covered California only intends to add health disparities reduction requirements to the QTI measure set after national race and ethnicity stratified population benchmarks have been established. We urge Covered California to include a specific timeline for when health disparities reduction requirements will be added to the QTI measure set as you have in accompanying fact sheets and presentations on this initiative. Amend: ~~After national race and ethnicity stratified population benchmarks have been established, Covered California intends to add health disparities reduction requirements to the QTI measure set.~~ As national benchmarks are established, disparities reduction would be tied to quality improvement fund payments, either as an amendment to the 2025 contract year or commencing 2026 for the next contract cycle.	Thank you for the suggestion. Covered California has made a similar change to the contract language.
1.01.3	Revisions to Measure set	2/11/22	Given the long lead time, and the significant financial implications of the QTI program, we are concerned about the impacts of changes in the measure set. Propose that when QTI measure sets are added or specifications are modified, there is a three (3) year ramp up period.	Covered California will follow established guidelines from NCQA and CMS on changes to measure specifications and whether the measure can be trended or not based on specification changes. If a new measure is introduced, we will follow the measure steward guidelines for reporting and scoring. We will transparently adjust measures including in the QTI measure set through the contract amendment and contract refresh processes.
1.02	Quality Levels	2/11/22	We support Covered California holding plans accountable for meeting national benchmarks. Advocates support using the 75th percentile rather than the 66th percentile as the benchmark. California has been a leader throughout the implementation of the Affordable Care Act. The QHPs offered on Covered California should be above the national average. Consumers expect nothing less. Covered California QHPs should be leading the nation in meeting performance goals. We urge Covered California to amend the contract to reflect this.	We will maintain the structure of the QTI such that scores on quality measures at or above the 66th percentile nationally for marketplace QHPs shall represent levels of performance for which there would be no financial consequences for the current contract period. Covered California will reconsider the benchmark in future contract periods.

Article-Section No.	Article-Section Title	Comment Date	Comment	Response
1.02	Quality Levels	2/11/22	The language in subsection 1) is a bit vague. Recommend revising the language to provide additional clarify on the exact benchmarks We also believe that national percentiles should be rounded to the nearest hundredth, instead of the whole number.	We have revised the language related to benchmarks in Attachment 4 to clarify our intent.
1.02 2) b)	Quality Levels	2/11/22	We would like to request more information on the declining constant linear rate of percentage of penalty owed to understand how this methodology will work and provide further comment. Will there be cut points or will there be a declining percentage at each percentile?	Covered California will be providing detailed modeling and methodology to the QHPs within the next few months to document the methodology and provide QHP issuer product specific examples of payment amounts based on current performance.
1.03	Implementation Timeline	2/11/22	Timeframes: A ninety (90) day review and appeal cycle is too short given the complexity of this program. Recommend six (6) months, which is more typical in industry. We also believe that the 30 calendar day "back and forth" may be too short of windows, and would suggest 60 days.	We have revised the timeline in Attachment 4 to provide more time for the dispute and review process.
1.03	Implementation Timeline	2/11/22	The overall appeal process seems to reflect more of a contracts dispute, vs clinical quality. The review process would benefit from the input of a provider panel (or some other vehicle to bring in outside clinical expertise). For context, discrepancies are typically about how clinical care is coded and interpreted. This is unlikely to easily come to agreement if there is not a panel with care team representatives involved. Given that QTI payments will be used to support Covered California activities, it is important that the resolution of any dispute be facilitated by parties removed from any financial implications.	Covered California will be using HEDIS audited measure results submitted to CMS. We will not be recalculating measure results. We do not believe this level of clinical care review is necessary for the QTI.
1.03)	Implementation Timeline	2/11/22	We would like to request 60 days for the carriers to review the QTI Performance report and either submit a dispute or remit payment. 30 days will not give us sufficient time to review the data as this will likely take place during OEP.	We have revised the timeline in Attachment 4 to provide more time for the dispute and review process.

Article-Section No.	Article-Section Title	Comment Date	Comment	Response
1.04)	Quality Improvement Fund Payments	2/11/22	QTI penalties are scheduled to increase to 3% of premium by 2025. We believe the advantages of a more moderate penalty schedule will allow more carriers to achieve QTI measures versus just price the penalty into premiums. We recommend a slower ramp with the following percentages at risk by year: 0.8% in 2023, 1% in 2024, and 1.5% in 2025. If carriers determine the cost of implementation is too high based on lower potential of success, the penalty increases the risk of higher cost to consumers with no real change in quality outcomes. In addition, as new measures are introduced the penalty weight should be decreased to allow time for ramp up.	Covered California will be keeping the payment structure as proposed. Covered California will follow established guidelines from NCQA and CMS on changes to measure specifications and whether the measure can be trended or not based on specification changes. If a new measure is introduced, we will follow the measure steward guidelines for reporting and scoring. We will transparently adjust measures including in the QTI measure set through the contract amendment and contract refresh processes.
1.05	Quality Improvement Plan	2/11/22	Current language would have Covered California review and approve the Quality Improvement Plan, however there could be differences between the QHP and Covered CA on the strategies or tactics. The QTI and base contract create appropriate incentives for plans to improve quality, and as such, Covered CA's explicit approval shouldn't be necessary. Suggest this section be modified to reflect that Covered California will review and provide input into the plan.	We have revised the language related to the Quality Improvement Plan in the model contract and Attachment 4 to clarify our intent.

Article-Section No.	Article-Section Title	Comment Date	Comment	Response
A4 QTI	Measure Set	1/13/22 - Pre Board email to Cert Mailbox	BBDD15AB.msg er technical question on the QTI measure set: We had understood Covered CA was aligning on the Primary Care work with IHA and CQA to HbA1c >9, yet the current proposal is for HbA1c <8. It would be helpful to understand the rationale for this change, as we are concerned about misalignment with the IHA work.	We are using the HbA1c Good Control (<8%) measure in the QTI measure set because it is a QRS measure and we have national percentile benchmarks from CMS for the measure. We recognize this creates mis-alignment between the proposed QTI measure set and the CQC Advanced Primary Care measure set. We have inquired with CMS whether they will transition to or add the HbA1c Poor Control (>9%) to QRS. We are hoping this does not create much added burden since the good control measure has been in the QRS measure set for some time and we understand that IHA is using both the good control and the poor control measures in the AMP MY2022 measure set. We are now proposing to use the Childhood Immunization Status Combo 10 measure in the QTI measure set and are proposing to use MY2022 as the benchmark year for this measure due to the transition from Combo 3 to Combo 10 in QRS.

Article-Section No.	Article-Section Title	Comment Date	Comment	Response
		1/12/22 - Pre Board email to Cert Mailbox	BBDD15AB.msg eld would like to provide additional input on two of the measurements, to think through how we would handle potential changes. We are not requesting Covered CA change these measures, however we feel that there should be some consideration to how to handle potential changes. **Question 1) Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%) (NQF #0575);** NCQA has announced plans to make small changes in the Diabetes measures for MY2022. This might impact comparability to MY 2021 benchmarks. Our understanding is that this measure will be called "Hemoglobin A1c Control for Patients With Diabetes (HBD)" starting in MY 2022. Definitions will be similar. **Our recommendation to Covered CA:** • Processes and systems should be set up to account for a scenario in which a priority measures is removed from QRS, and the anticipated national benchmarks are suddenly not available. • Plans will need a fair and transparent process to appeal results if we disagree with the way in which Covered CA data teams solve for this problem in the administration of the program as designed/proposed.	Covered California will follow established guidelines from NCQA and CMS on changes to measure specifications and whether the measure can be trended or not based on specification changes. We will transparently adjust measures including in the QTI measure set through the contract amendment and contract refresh processes.

Article-Section No.	Article-Section Title	Comment Date	Comment	Response
		1/12/22 - Pre Board email to Cert Mailbox	BBDD15AB.msg **UED FROM 1-13-22 C0MMENT ABOVE:** **n 2) Childhood Immunization Status (Combo 3) (NQF #0038) (CON'T.)** ▯ As of the October 2021 update, Combo 3 is no longer included in the Quality Rating System. ▯ Our understanding is that, as a result, percentile benchmarks will not be published by CMS on Combo 3 for MY 2021, which is the year that Covered CA is planning to use as a benchmark. ▯ Options: • use MY 2020 or MY 2022 national percentiles as benchmarks for this measure • Covered CA to advocate or work with CMS for percentiles to be calculated and released for measures that are removed but still used by states **Our recommendation to Covered CA:** • Processes and systems should be set up to account for a scenario in which a priority measures is removed from QRS, and the anticipated national benchmarks are suddenly not available. • Plans will need a fair and transparent process to appeal results if we disagree with the way in which Covered CA data teams solve for this problem in the administration of the program as designed/proposed.	Measurement Year 2022 will be the fixed benchmark for CIS 10 throughout the contract period. We believe QHP issuers should have a good estimation of how they perform on CIS 10 based on their performance on CIS 3 for QRS and CIS 10 for HEDIS in other markets even though the benchmark will not be available until 2022. Covered California will follow established guidelines from NCQA and CMS on changes to measure specifications and whether the measure can be trended or not based on specification changes. We will transparently adjust measures including in the QTI measure set through the contract amendment and contract refresh processes.