Cover Page

Qualified Health Plan Attachment 1 Response to Comments

The following is the Covered California response to comments received in Round 1 release of contract documents for the Draft 2023_QHP_IND_Attachment_7_09.10.21.

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

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Article	Section #	Comment Date	Comment	Covered California Response
4	4.03.3(1)(b)	10/4/21	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 DMHC network standards.	Covered California recognizes that removal of low quality provider groups from the QHP issuer network must be balanced with network adequacy standards. We will add language to reflect this.
4	4.03.4(1)(a)	10/4/21	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 DMHC network standards.	We will add language in the contract to clarify that removal of a hospital from the QHP network must be balanced with DMHC network adequacy standards including geographical access needs and specific specialty service needs.
4	4.03.5(2)	10/4/21	The referenced section requires plans to adopt a payment methodology that would put hospitals at risk. Requiring hospitals to take on risk may implicate California Code of Regulations, title 28, section 1300.49, in that hospitals would need to be appropriately licensed to take on risk.	We will edit the language in the contract to "hospital payment methodology for each general acute care hospital in its QHP networks that ties payment for to quality performance." Covered California recognizes that hospitals need to be appropriately licensed to take on risk.
Intro		10/7/21	CoveredCA has the opportunity to promote the utilization of Comprehensive Medication Management (CMM) as a means to significantly improve quality, equity, delivery system transformation and value to enrollees of contracted health plans. CMM programs in California such as the California Right Medications Collaborative (CRMC) are currently providing the quality, equity and value to their subscribers that Covered California seeks. CMM is evidence-based, team-based, patient-centric and evaluated on its success in producing positive patient outcomes - value. By incentivizing Contractors to incorporate bona fide CMM programs with their QHPs, enrollees and CoveredCA will benefit from a proven process that translates CoveredCA goals into high-impact results.	Covered California appreciates the information and feedback on Comprehensive Medication Management (CMM). We need additional time to research CMM and determine how we might be able to integrate CMM requirements into Attachment 1 requirements. We will continue to explore CMM to inform future contract requirements.

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Article	Section #	Comment Date	Comment	Covered California Response
1	02.2	10/7/21	1.02.2 Disparities Measurement: Healthcare Evidence Initiative A CMM business model utilizing local pharmacies which are demographically and geographically linked to local communities promotes health equity by: -Providing Culturally and Linguistically Aligned Services (CLAS)- pharmacists or pharmacy technicians are often culturally and linguistically aligned with the local population served -Offering medication management services in the neighborhoods where patients live (Medicaid patients visit their local pharmacies 2-3 times a month, over 90% of the population lives within 5 miles of a pharmacy, within 2 miles in urban areas) - Expanding the role of pharmacists in the community, whom patients trust 1) Comprehensive Diabetes Care (CDC): Hemoglobin A1c (HbA1c) Testing (NQF #0057): Patients with uncontrolled diabetes and related conditions are one of the most common populations managed through Comprehensive Medication Management programs. For example, the California Right Meds Collaborative has health plan partners, including LA Care Health Plan, who are targeting patients with uncontrolled A1C for enrollment. Control of A1C, blood pressure, and statin utilization are components of of the value-based payment model and are driven towards target through a rigorous CQI process. As a result, aligned NQF measures are positively impacted. 2) Ambulatory Emergency Room (ER) Visits© per 1,000: Health plans participating in existing Comprehensive Medication Management programs usually prioritize high utilizers of acute care services to receive Comprehensive Medication Management. Comprehensive Medication Management has proven to markedly reduce acute care utilization (and consequently total cost of care) for patients who are moderate-high utilizers at baseline. 3) Avoidable Ambulatory Emergency Room (ER) Visits© per 1,000: As above 5) Breast Cancer Screening (BCS) (NQF #2372): Some systems (e.g., Kaiser) use pharmacy touchpoints as an opportunity to facilitate appointments for recommended screenings. This can be facilitated through CMM partnerships involving community pharmacy, facilitated through a data exchange platform partner (see below)	Covered California appreciates the information and feedback on Comprehensive Medication Management (CMM). We need additional time to research CMM and determine how we might be able to integrate CMM requirements into Attachment 1 requirements. We will continue to explore CMM to inform future contract requirements.

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Article	Section #	Comment Date	Comment	Covered California Response
2	01.1	10/7/21	2.01.1 Behavioral Health Provider Network The California Right Meds Collaborative has launched a parallel collaborative, the Psychiatry for Population Health Pharmacists Collaborative, to provide pharmacists with core skills for managing psychiatric medications for mild to mild-moderate conditions, and recognize when patients need more advanced care requiring referral to a psychiatrist, psychologist, social worker, etc.	Thank you. Covered California will research the Psychiatry for Population Health Pharmacists Collaborative further.
2	01.2	10/7/21	2.01.2 Promoting Access to Behavioral Health Services As mentioned previously, the Psychiatry for Population Health Pharmacists Collaborative facilitates identification of patients who need behavioral health services through training and preparation, and ensures participating pharmacies have systems in place to facilitate connecting patients to the appropriate behavioral health services or experts.	Thank you. Covered California will research the Psychiatry for Population Health Pharmacists Collaborative further.
2	01.3	10/7/21	2.01.3 Offering Telehealth for Behavioral Health The California Right Meds Collaborative offers Comprehensive Medication Management either in-person or through video or phone telehealth. All participating health plans have approved Comprehensive Medication Management delivery through telehealth, and thanks to a process developed by the USC School of Pharmacy's Center for Medicare and Medicaid Innovation Healthcare Innovation Award [1], all participating pharmacies are trained on a best practice model for telehealth delivery specific to underserved populations. [1] https://innovation.cms.gov/innovation-models/participant/health-care-innovation-awards/university-of-southern-california	Covered California will continue to explore your recommendations as we develop and strengthen this requirement.
2	02.1	10/7/21	2.02.1 Screening for Depression PHQ-2/-9 testing is administered to all patients who receive Comprehensive Medication Management.	Thank you.

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Article	Section #	Comment Date	Comment	Covered California Response
2	03	10/7/21	2.03 Appropriate Use of Opioids (Narrative #5) Despite a decades-long rise in overdose deaths, access to MAT—the most effective tool in combating substance abuse disorders—substantially lags demand. According to a 2018 US Surgeon General report, "Medication-assisted treatment (MAT) combined with psychosocial therapies and community-based recovery supports is the gold standard for treating opioid addiction. [2] The Covid pandemic exacerbated are already staggering problem, inciting even higher level of addiction and overdose deaths.[3] San Francisco, for example, had twice as many overdose deaths as Covid deaths in 2020.[4] Unfortunately, access to appropriate MAT is far too limited to meet the current need. A nationwide 2018 study found that only 41 percent of facilities providing substance abuse treatment offered any FDA-approved MAT and fewer than three percent offered all three types of FDA-approved MAT.[5] Similarly, alcohol consumption is the third leading cause of preventable deaths in the US [6], yet AUD often goes untreated. In fact, as of 2018, it is estimated that over 14 million adults had AUD, yet only 641,000—or 4 percent—received treatment [7]. Combining appropriate behavioral telehealth screening with MAT treatment in pharmacies would close significant gaps in California's ability to treat AUD. This year, in an effort to address the deadly scourge of addiction and lack of access to appropriate care, the California Legislature passed AB 1533 (Committee on Business and Professions) with unanimous bipartisan support. AB 1533 would, among other provisions, authorize a pharmacist to provide MAT pursuant to a state protocol, to the extent authorized by federal law. By expanding the ability of pharmacists to provide MAT, AB 1533 will provide a significant lifeline to Californians facing addiction, particularly in underserved rural areas and urban treatment deserts—two areas hit especially hard by the addiction pandemics. It is imperative that Covered California require contractors to educate patients and pharmacists about AB 1533's expansion of MAT access and develop strategies to integrate behavioral telehealth services (see: section 2.01.3) and MAT treatment in pharmacies to close gaps in care. The combination of these two critical components of addiction treatment would significantly reduce the rise in AUD and OUD in California. CMM services delivered through community pharmacies are already a key part of the opioid stewardship process, e.g., monitor appropriate utilization and dosing, facilitate	Covered CA will explore collaborating with QHP issuers to educate patients and pharmacists about AB 1533 expansion of MAT access through technical assistance or other means.

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Article	Section #	Comment Date	Comment	Covered California Response
2	04.1	10/7/21	2.04.1 Promotion of Integrated Behavioral Health As mentioned previously, the California Right Meds Collaborative has a data exchange partner who is able to provide its pharmacy network with point-of-care PDC results and can provide 2-way data exchange and communication between pharmacies and any partnering entity. While this does not meet the requirements for this section, it at least ensures that complete prescribing information is aggregated for Comprehensive Medication Management, providing the opportunity to intervene where necessary to optimize efficacy and safety.	Covered California will continue to explore your recommendations as we develop and strengthen this requirement.
3	0	10/7/21	Article 3 - Population Health When engaging in Comprehensive Medication Management, health plans risk stratify members and usually prioritize high cost / high utilization patients for enrollment. In addition, community pharmacies in California are involved in health promotion and prevention services (AB1114).	Covered California will continue to explore your recommendations as we develop and strengthen this requirement.
3	01	10/7/21	3.01 Population Health Management Population Health Management shifts the focus from a disease-centered approach to the needs of Enrollees and provides focus for improving health outcomes through care coordination and patient engagement. CMM is a whole person care approach encompassing social and health factors. It starts with patient engagement through education and motivational interviewing, leading to patient activation and better self-management. Pharmacists in CMM programs that target the underserved often state they feel like a social worker or care coordinator.	Covered California will continue to explore your recommendations as we develop and strengthen this requirement.

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Article	Section #	Comment Date	Comment	Covered California Response
3	01.1	10/7/21	3.01.1 Population Health Management Plan Submission Outcomes from the California Right Meds Collaborative and the USC School of Pharmacy Center for Medicare and Medicaid Innovation Healthcare Innovation Award demonstrate that CMM significantly improves all four Quadruple Aim components: Cost of care, healthcare quality, provider and member satisfaction. In addition, patient safety improves through identification and management of adverse drug events and potential adverse drug events. Access to physicians improves since time-consuming patients who primarily need medication management are seeing the pharmacist more often than the physician [8]. Alternatively, if Contractor is not yet NCQA accredited or is unable to provide components of its NCQA Population Health Management plan, Contractor must submit a separate Population Health Management plan for its Covered California population that addresses each of the following components: a) i. This aligns with the California Right Meds Collaborative. Health plans choose the high risk / high cost / emerging high risk or cost population to target for CMM service enrollment. ii. This process has been implemented by health plans when soliciting patient enrollment in the California Right Meds Collaborative. iv. Data exchange platform companies are available to partner with CMM programs to help facilitate this. b) i. As above, the CA Right Meds Collaborative's data platform partner brings all of these data points together including social determinants, which are processed through a machine learning platform to generate AI recommendations iii. As noted, a key to the success of California Right Meds Collaborative CMM is a very aggressive CQI program that utilizes real-time process and outcome indicators to ensure patients are safely and efficiently reaching treatment goals [8] https://www.careinnovations.org/wp-content/uploads/2017/10/USC.CEPC_.pharm_webinar_FinalV.pdf	Covered California will continue to explore your recommendations as we develop and strengthen this requirement.

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Article	Section #	Comment Date	Comment	Covered California Response
3	02	10/7/21	3.02 Health Promotion and Prevention As mentioned previously, AB 1114 supports a wide array of high-value preventative health services provided by community pharmacies including immunizations, smoking cessation, naloxone distribution, PrEP and PEP, etc. Thus CMM provided by community pharmacies provides an ideal venue for management of uncontrolled chronic disease as well as health promotion and prevention.	Covered California will continue to explore your recommendations as we develop and strengthen this requirement.

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Article	Section #	Comment Date	Comment	Covered California Response
3	02.2	10/7/21	3.02.2 Diabetes Prevention Programs (Narrative #2) Less than half of Medi-Cal patients with diabetes have A1c under control and over one-third have an A1c of >9%. And while two-thirds of Medi-Cal patients with hypertension have blood pressure under control, the first 5 lines of medications for treating hypertension are generic, inexpensive, and widely available.[9] Patients in the U.S. with diabetes use an average of 5.9 concurrent prescription medications. A t least 2 or 3 medications are required to control blood pressure for the majority of patients.[10,11] Yet medications for these and other chronic conditions are often highly underutilized, as illustrated by the rise in monotherapy for hypertension in recent years. [12] Research shows that evidence-based preventative services such as the Diabetes Prevention Program (DPP) can improve health and lower healthcare spending in the long run. However, patient copays and coinsurance can act as a barrier to accessing these preventative services. We therefore urge Covered California to require contractors to provide DPP to eligible Enrollees at no copay or coinsurance, culturally and linguistically appropriate as allowed by the Affordable Care Act for preventative services. Furthermore, Comprehensive Medication Management ensures that patients with any chronic condition, including diabetes and hypertension, are successfully controlled by 1) ensuring that evidence-based optimal treatment options are selected; 2) dosing is appropriate to ensure efficacy while avoiding adverse events; 3) patient safety is maintained by avoiding harmful drug-drug and drug-disease interactions; 4) patients are able to use medication-related devices; 5) treatment is affordable; and 6) the patient is adherent and engaged in his/her own care. An abundance of evidence confirms the effectiveness of Comprehensive Medication Management in diabetes, hypertension, and other disease states.[13] A 5-month interim evaluation from launch of the California Right Meds Collaborative Comprehensive Medication Management program demonstrated remarkable results for patients with diabetes and related conditions: 2.6-point reduction in A1c, 23mmHg reduction in systolic blood pressure, and doubling in statin utilization from 42% to 84% (data on file).	Covered California will continue to explore your recommendations as we develop and strengthen this requirement.

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3	03	10/7/21	3.03 Supporting At-Risk Enrollees Requiring Transition Medication misadventures are a key driver of avoidable hospital readmissions and ED visits (therapeutic duplications, drug interactions, improper dosing, etc., leading to adverse drug events or inadequate disease control). High-risk patients need, at minimum, a comprehensive medication review by a pharmacist at transition points and, if needed, more extensive follow-up and management through CMM. Even patients on maintenance prescription drugs are at risk, because oftentimes patients are not treated with adequate intensity to reach treatment goals and remain on fixed medication therapies. And while there may be specific targeted drugs used as enrollment proxies due to high risk / high cost / problem prone status, CMM evaluates all medications (including supplements, herbals, etc.) and all indications to ensure the entire medication regimen is safe and optimal.	Covered California will continue to explore your recommendations as we develop and strengthen this requirement.
3	04.1	10/7/21	3.04.1 Screening for and Addressing Social Needs This process occurs for all patients receiving CMM through the California Right Meds Collaborative, and is tracked / facilitated through the smart data exchange platform. Teams are trained to not just point patients to resources, but facilitate the connection as well. And since participating pharmacies are embedded in the community, pharmacies are well familiar with local resources.	Covered California appreciates the information and feedback on Comprehensive Medication Management (CMM). We need additional time to research CMM and determine how we might be able to integrate CMM requirements into Attachment 1 requirements. We will continue to explore CMM to inform future contract requirements.

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Article	Section #	Comment Date	Comment	Covered California Response
4		10/7/21	Article 4 - Delivery System and Payment Strategies to Drive Quality As previously addressed CMM is Quadruple-aim aligned, improves medication safety, and improves physician / health system access. CMM delivers high value by ensuring patients meet their chronic disease treatment goals. The California Right Meds Collaborative partners with health plans to support Comprehensive Medication Management through value-based payments. Health plan participants include two large Medi-Cal managed care plans, LA Care Health Plan and Inland Empire Health Plan, and Blue Shield of California will join in January 2022. The value-based payments limit risk to health plans and require participating pharmacies to deliver the results in order to be fully compensated. A critical success factor is an effective continuous quality improvement (CQI) process, which is imbedded in the California Right Meds Collaborative. Temporal process and outcome measures are tracked continuously and available at any time to participating pharmacies through a dashboard and reviewed with all pharmacies on at least a monthly basis through deidentified report cards. Trends and challenges are identified, and CRMC pharmacies and health plans work with participating pharmacists in aggregate to develop solutions for common success barriers which may include enhanced support for social determinants, patient incentives, improving engagement with providers, etc. When needed, individual 1-on-1 consultation between a CRMC Comprehensive Medication Management expert and pharmacist is available.	Covered California will continue to explore your recommendations as we develop and strengthen this requirement.
4	01	10/7/21	4.01 Effective Primary Care CMM provided through the California Right Meds Collaborative is grounded in health plan partnerships that pay for CMM through value-based payments. Pharmacists receive a limited number of modest fee-for-service payments plus a larger bonus payment when established treatment goals are met. Goals include attainment of NQF / HEDIS targets and other validated measures of disease control, and/or avoidance of acute care utilization over a given time period.	Covered California will continue to explore your recommendations as we develop and strengthen this requirement.

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4	01.1	10/7/21	4.01.1 Encouraging Use of Primary Care Community pharmacies offer CLAS. If not the pharmacist, then the technician or clerk is almost always ethnically aligned with the community served. In addition, pharmacists often assist with care coordination and ensure patients follow-up with their primary care clinician, closing the loop of care.	Covered California will continue to explore your recommendations as we develop and strengthen this requirement.
4	01.2	10/7/21	4.01.2 Measuring Advanced Primary Care The California Right Meds Collaborative's data platform aggregation partner provides the tools needed to conduct a rigorous CQI process and data sharing (2-way) between pharmacies and health plans, health systems, etc.	Covered California will continue to explore your recommendations as we develop and strengthen this requirement.
4	01.3	10/7/21	4.01.3 Payment to Support Advanced Primary Care The California Right Meds Collaborative is grounded in a value-based payment model, ensuring that only successful care is fully compensated.	Covered California will continue to explore your recommendations as we develop and strengthen this requirement.
4	02	10/7/21	4.02 Promotion of Integrated Delivery Systems (IDSs) and Accountable Care Organizations (ACOs) Where quality tied to financial risk is at stake (e.g., performance payments, shared savings, shared or full risk, etc.), Comprehensive Medication Management is a high-value solution for maximizing ROI by ensuring optimal use of medications and driving patients towards chronic disease targets.	Covered California will continue to explore your recommendations as we develop and strengthen this requirement.
4	03	10/7/21	4.03 Networks Based on Value CMM delivered through the California Right Meds Collaborative is subjected to a thorough vetting process for pharmacy participation eligibility and, through a rigorous CQI program, ensures that pharmacies either perform well or are removed from the network if not progressing (uncommon since vetting process is rigorous). California Right Meds Collaborative also improves clinic / FQHC P4P measures, adding direct financial value to physician partnerships.	Covered California will continue to explore your recommendations as we develop and strengthen this requirement.
4	03.1	10/7/21	4.03.1 Designing and Managing Networks Based on Value These are measured, tracked and reported by high-quality Comprehensive Medication Management programs.	Covered California will continue to explore your recommendations as we develop and strengthen this requirement.

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Article	Section #	Comment Date	Comment	Covered California Response
4	03.2	10/7/21	4.03.2 Payment to Support Networks Based on Value (Narrative #6) As mentioned previously, CMM provided through the California Right Meds Collaborative is grounded in health plan partnerships that pay for CMM through value-based payments. Pharmacists receive a limited number of modest fee-for-service payments plus a larger bonus payment when established treatment goals are met. Goals include attainment of NQF / HEDIS targets and other validated measures of disease control, and/or avoidance of acute care utilization over a given time period.	Covered California will continue to explore your recommendations as we develop and strengthen this requirement.
4	03.3	10/7/21	4.03.3 Provider Value 1) The rigorous CQI process utilized in the California Right Meds Collaborative incorporates temporal process measures and national quality of care benchmarks into real-time dashboards, which are analyzed and acted upon when indicated to ensure efficient and optimal results from Comprehensive Medication Management. a) The majority of AMP measures are directly or indirectly dependent on medication therapy optimization, which is achieved through Comprehensive Medication Management. b) Since Comprehensive Medication Management delivered through the Calif Right Meds Collaborative is supported by health plan value-based payments, only successful outcomes are fully compensated. The rigorous CQI process utilized by the Calif Right Meds Collaborative ensures that targeted treatment goals are efficiently attained while excluding persistently poor performing pharmacists from the network.	Covered California will continue to explore your recommendations as we develop and strengthen this requirement.

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Article	Section #	Comment Date	Comment	Covered California Response
4	04	10/7/21	4.04 Telehealth (Narrative #4) Comprehensive Medication Management has been successfully delivered via telehealth, serving as a critical means of improving access and communication with patients. Well before the pandemic, various models of Comprehensive Medication Management have been successfully delivered via telehealth. In Minnesota, a fully remote pharmacist-provided telehealth hypertension medication management program achieved 10mmHg greater reduction in systolic blood pressure compared to usual care at 6 and 12 months.[14] At 5-year follow-up, patients in the pharmacist medication management group experienced 50% less major adverse cardiovascular events compared to usual care, yielding a return on investment of 126% and a net per patient costs savings of $1,900. The Covid pandemic then brought to light many of the most glaring disparities in our health care system. Fortunately, it has also shown opportunities for addressing those disparities—particularly, the proper utilization of telehealth. The commentors fervently believe that providers and plans must meet patients where they are, both physically and emotionally, by providing maximum patient choice to receive health services in the manner and modality that they choose. The impact on diabetes and related measures shared previously from the California Right Meds Collaborative were generated through fully remote Comprehensive Medication Management, since the collaborative launched in the peak of the pandemic. The methodology used to deliver remote Comprehensive Medication Management services was from a Centers for Medicare and Medicaid Innovation (CMMI) Healthcare Innovation Award program conducted by the University of Southern California School of Pharmacy for Medi-Cal and uninsured patients in Los Angeles and Orange Counties. In this CMMI program, the impact of Comprehensive Medication Management on patients with chronic diseases in terms of healthcare quality measures, patient safety, cost, and patient and provider satisfaction was the same whether provided in-person or via telehealth. [14] Hypertension. 2020;76:1097-1103. DOI: 10.1161/HYPERTENSIONAHA.120.15492.)	Covered California appreciates the information and feedback on Comprehensive Medication Management (CMM). We need additional time to research CMM and determine how we might be able to integrate CMM requirements into Attachment 1 requirements. We will continue to explore CMM to inform future contract requirements.

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4	05	10/7/21	4.05 Participation in Quality Collaboratives Add California Right Meds Collaborative (www.calrightmeds.org)	We will add the California Right Meds Collaborative to the list of quality collaboratives.

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5	02.2	10/7/21	5.02.2 Interoperability and Patient Access (Narrative #3) Implement and Maintain Application Programming Interfaces (APIs) Building on the CMS Interoperability and Patient Access final rule (CMS-9115-F)[16], this proposed rule would place new requirements on Medicaid and CHIP managed care plans, state Medicaid and CHIP fee-for-service programs, and Qualified Health Plans (QHP) issuers on the Federally facilitated Exchanges (FFEs) to improve the electronic exchange of health care data, and streamline processes related to prior authorization. The rule would require increased patient electronic access to their health care information and would improve the electronic exchange of health information among payers, providers, and patients. Together, these policies would play a key role in reducing overall payer and provider burden and improving patient access to health information. This rule includes five sets of proposals and five requests for information. [17] The CMS rule did not go far or deep enough to help solve for the gap in information sharing and data fluidity across the entire ecosystem. While very helpful in helping patients understand what they paid or their insurer paid on their behalf, the CMS rule did not account for the need of patients and their care team to have in workflow, real-time patient specific, eligibility, benefit, coverage and cost information. This information assists in making fully informed decisions about care, prospectively and should be available and shared with the Patient and Provider at Time of Care by utilizing American National Standards Institute (ANSI) accredited standards-based data exchange including the use of standards-based APIs that harmonize data between the medical and pharmacy benefit industry, including but not limited to the National Council for Prescription Drug Programs (NCPDP) standards, Health Level 7 (HL7) standards, etc.[18,19] This harmonization and interoperability will bring together Cost Benefit Transparency (CBT) for both medical and pharmacy.[20] Tethering CBT data with utilization management rules and requirements will providers and patients the information they need to make fully informed care decisions and better understand costs and benefits at the time of care. Lack of interoperability between electronic systems and cost are some of the reasons manual methods persist, decades after most industries have moved on from the fax machine. Patients and their healthcare providers will have the opportunity to be more informed, which can lead to better care and improved patient	Covered California recognizes that alignment with federal policies is important. We are holistically looking at multiple data exchange channels and discussing what Covered California's role is in advancing one or more data exchange channels that would better position collective efforts to address the challenges described.

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Article	Section #	Comment Date	Comment	Covered California Response
	2.04.1 Promotion of Integrated Behavioral Health	10/08/21	CAFP supports Covered California's efforts to promote integrated behavioral health services with medical services, particularly primary care services. CAFP suggests strengthening these efforts beyond reporting to requiring QHPs to reimburse for integrated behavioral health services, including financial support to employ a behavioral health team in a medical setting. Financial supports are the needed catalyst to redesign the delivery system in a holistic team-based and patient-centered manner, using an integrated approach that is able to meet the full spectrum of a patient's physical and behavioral health care needs.	Covered California believes QHP issuers should pay primary care providers through population-based payment and other alternative payment models to support behavioral health integration with primary care. We will add language to signal this intent in Article 2.04. We have also launched a behavioral health consulting project with DHCS and CalPERS to further explore what behavioral health requirements, including any related to payment, we should expand or add to Attachment 1 in the 2024 contract amendment.
	3.04.1 Screening for and Addressing Social Needs	10/08/21	CAFP supports Covered California's efforts to promote the screening for food insecurity and housing instability or homelessness. Many social and economic conditions are significant drivers of health outcomes and often lead to health disparities. Screening for these social and economic conditions, particularly for food insecurity and housing instability or homelessness, is an important first step in improving health outcomes and reducing health disparities. Accordingly, CAFP supports the requirement in section 3.04.1 of Attachment 7 that QHPs screen all Enrollees for a minimum of two standard social needs: food insecurity and housing instability or homelessness. The screening requirement in this section also states that, "[s]creening in coordination with providers in the network is highly encouraged." If the QHPs pass on the screening requirement to the providers in their network, CAFP urges Covered California to require QHPs to provide coverage for these screenings similarly to coverage provided for adverse childhood experiences screenings. Moreover, CAFP urges Covered California to require health plans to obtain feedback from family physicians on the screening tool that is used.	Covered California acknowledges the importance of partnering with physicians in the mission to improve health care delivery. We will continue to explore your recommendations as we develop and strengthen this requirement.

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	4.01.2 Measuring Advanced Primary Care	10/08/21	Given the American Academy of Family Physicians (AAFP) and CAFP's extensive experience and leadership role in value-based payment models and quality measurements within those models, CAFP respectfully requests that we be included in the development and implementation of the measure set that includes quality and cost-driving utilization measures for advanced primary care. One measure of concern is using total cost of care as a primary care measure, because primary care practices would be held accountable for utilization of services outside of their control. Practices can only be held accountable for total cost of care of attributed patients when all participants in the health care system (e.g., hospitals, sub-specialists, etc.) are operating under aligned value-based incentives. There is a particular concern with the appropriateness of this measure for small and rural practices. Small and rural practices may have less resources to influence utilization for their patients. Small referral networks also exacerbate this issue, particularly for rural practices, as physicians may not have the option of referring to a specialist that controls cost and utilization. Moreover, the primary care physician will not know the utilization rates of other specialists, i.e., whether certain specialists perform unnecessary or duplicative services. If all participants in the health care system are operating under aligned value-based incentives, total cost of care should be used as a long-term measure. Adequate time before measurement needs to be allowed, because investments in primary care cannot	Covered California will continue to engage CAFP in the development and implementation of the advanced primary care measure set with CQC and IHA. We will also collaborate with QHP issuers, providers, and other stakeholders to implement the measure set in a manner that creates the least burden possible and builds on existing measurement work. We look forward to our continued collaboration.

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	4.01.3 Payment to Support Advanced Primary Care	10/08/21	CAFP supports requiring QHPs to report on its primary care payment models. Realizing a vision for advanced primary care will require expanding upon and adopting new primary care payment models. In order to move towards alternative payment models, it is important to first understand the baseline of how QHPs are currently paying its contracted primary care physicians. We will likely find that the predominant payment scheme is fee-for-service payments, which is not structured to support or sustain a comprehensive primary care system. Advanced primary care alternative payment models aim to improve patient outcomes and experience, reduce health care spending, and improve physician satisfaction. AAFP has produced an Advanced Primary Care Alternative Payment Model (APC-APM), currently piloted by the Centers of Medicare and Medicaid Services (CMS). The APC-APM would create a new payment structure for participating primary care practices consisting of a combination of four mechanisms: (1) A prospective, risk-adjusted, primary care global payment for direct patient care; (2) Fee-for-service limited to services not included in the primary care global fee; (3) A prospective, risk-adjusted, population-based payment; and (4) Performance-based incentive payments that hold physicians appropriately accountable for quality and costs. CAFP urges Covered California to explore piloting this payment model with QHPs. CAFP supports Covered California requiring QHPs to adopt and progressively expand the percent of primary care clinicians paid through population-based payment and alternative payment models built on a fee-for-service structure such as shared savings. However, CAFP urges Covered California to strengthen this requirement by requiring QHPs to have a minimum percent of primary care clinicians paid under an advanced primary care alternative payment model such as the one advanced by AAFP. Advanced primary care alternative payment models have proven results. In 2010, CAFP joined the self-insured Fresno Unified School District/Joint Health Management Board in supporting the creation of a local PCMH. The 2014 final report includes infographics about cost savings and quality gains. A video about the project also describes the success of the model. CAFP further supports Covered California requiring QHPs to report on total primary care spend. CAFP strongly urges Covered California to strengthen the requirement on	We believe the Advanced Primary Care Alternative Payment Model (APC-APM) aligns well with our requirements for QHP issuers to increase the number of primary care clinicians paid through population-based payment and alternative payment models built on a fee-for-service structure such as shared savings. We will note that a combination of HCP LAN categories may be the most effective to support providers and improve quality. Covered California defines specific thresholds for the percent of primary care providers paid through HCP LAN Categories 3 or 4 in Attachment 2. We set specific thresholds in 2022 and plan to continue with similar standards in 2023 and beyond. Covered California is continuing to evaluate the research on primary care spend and is currently studying primary care spend in California in partnership with IHA and CHCF. We will consider setting a floor or target for primary care spend in 2024 or 2025 after a baseline has been established.

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Article	Section #	Comment Date	Comment	Covered California Response
	4.02.1 Enrollment in IDSs and ACOs	10/08/21	CAFP supports the promotion of ACOs, particularly those in which primary care is a focus. A Patient-Centered Primary Care Collaborative Study found that advanced primary care, and the PCMH in particular, contribute to an ACO's success. The study's analysis of NCQA and Medicare data demonstrated that the PCMH does have a positive impact on an ACO's cost and quality outcomes. This is because the systems that employ advanced primary care are naturally set up for some of the care delivery changes sought by ACOs. As Covered California seeks to understand the characteristics of ACOs that contribute to success, it is important to also take into account the synergy between ACOs and advanced primary care. Accordingly, CAFP	Covered California will incorporate the availability or performance of advanced primary care practices in the characteristics for ACO reporting in the Certification Application.

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Article	Section #	Comment Date	Comment	Covered California Response
	4.03.1 Designing and Managing Networks Based on Value and 4.03.3 Provider Value	10/08/21	CAFP 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 appropriate measures are used (see discussion under 4.01.2 above) and the data is 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. CAFP urges Covered California and QHPs to 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, CAFP 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, CAFP 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. Physician practices should not have to allocate even more uncompensated time to	Covered California recognizes that removal of low quality provider groups from the QHP issuer network must be balanced with network adequacy standards. We will add language to reflect this. We also recognize that physician group quality ratings should use standardized, appropriate measures with valid, accurate data sources. We are focusing on the use of the IHA AMP program to monitor the performance of QHP issuer contracted provider groups and using the CQC advanced primary care measure set for primary care practices for these reasons. Based on the challenges and concerns CAFP has expressed, we are focusing on the quality and value of primary care provider practices and provider organizations rather than individual physicians. Covered California will continue to be transparent in the development of our contract requirements and collaborate with CAFP and other physicians and physician organizations.

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Article	Section #	Comment Date	Comment	Covered California Response
	4.04.1 Telehealth Offerings	10/08/21	CAFP supports Covered California requiring QHPs to report on how it facilitates the integration and coordination of care between third party telehealth vendor services and primary care and other network providers, as well as to provide a description of its telehealth reimbursement policies for network providers and for third party telehealth vendors. CAFP wants to ensure that QHPs do not separately contract with third-party telehealth vendors that provide care to enrollees that is not coordinated with the care provided by the patients' treating primary care physician. 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.	Thank you for the comment. We will incorporate language to encourage QHP issuers to promote telehealth services provided by network providers to support care coordination.
	5.02.3 Data Exchange	10/08/21	CAFP recognizes the importance of the secure exchange of data with providers. Data being available to providers at the point of care will result in lower costs, improved quality of care, and reduced administrative burdens. Secure and robust data exchange, however, cannot be achieved without sufficient funding for necessary technology infrastructure and training. CAFP urges Covered California to ensure that if data exchange obligations are passed down to providers, they are provided with the financial	Covered California will continue to explore your recommendations as we develop and strengthen our data exchange requirements. QHP issuers should pay primary care providers through population-based payment and other alternative payment models to support data exchange.
4	4.03.7 Maternity Care	10/08/21	Recommendation to add "Health plan networks are required to provide members with access to freestanding birth centers (FBCs) as well as to services provided by Certified Nurse Midwives (CNMs) and Licensed Midwives (LMs), in accordance with the All Plan Letter 18-022."	We are committed to improving maternal health and reducing disparities and will consider your comment as we move forward with the 2023-25 Attachment 1 development.
4	4.03.3b Provider Value	10/08/21	Recommendation to require submission of quantitative data about the technical assistance provided, potentially including the type of TA, $ invested in TA, and recipients.	Covered California currently requires QHP issuers to report the amount of financial support to quality improvement collaboratives through the Certification Application. We will review the Certification Application to ensure we are collecting this information and clarify this in Article 4.05.
4	4.05.b	10/08/21	Remove CalHIVE Network (a PBGH/California Quality Collaborative program), as it ends in 2022.	We will remove CalHIVE Network from the contract.

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Article	Section #	Comment Date	Comment	Covered California Response
1		10/08/21	Include requirements to collect and report demographic data for billable providers and analyze concordance with patient populations for addressing equity. Reporting should include race/ethnicity/language composition among providers by major specialty areas, including but not limited to primary care and behavioral health.	While Covered California acknowledges the important role of providers in delivery of culturally and linguistically appropriate care, we want to be mindful of collection of provider demographic data and make sure it is used appropriately. Currently, provider language is a required data field under our model contract provider directory data requirement. We will continue to explore your recommendations.
4	4.03.3	10/08/21	Include a parallel statement to 4.03.4.2 to encourage collaboration among QHP issuers to invest in shared delivery system providers. Recommendation to add 'Covered California encourages collaboration among QHP Issuers in order to achieve maximum quality and safety performance in provider networks. To this end, Covered CA will provide technical assistance to foster this collaborative efforts.'	We will include a similar statement to encourage collaboration among QHP issuers and support from Covered California for both monitoring provider and hospital value.
4	4.05	10/08/21	Change to 'Covered California requires participation in specific quality improvement collaboratives and data sharing initiatives.' Health plans are decreasing their investments in technical assistance and improvement collaboratives, with an accelerated decline during the pandemic. We recommend a parallel requirement to joining IHA should be included for the sponsorship of improvement collaboratives working in the shared delivery system, particularly for support of small and independent practices which do not rise to priority for health plan delivered technical assistance due to small patient volume. However, when aggregated these practices make up a large amount of patients and tend to be lower-performing given the historical lack of attention and resources received for quality improvement support.	We strongly encourage our QHP issuers to participate in quality improvement collaboratives. Currently, nine of our 11 QHP issuers participate with the California Quality Collaborative and are committed to investments in provider group quality improvement initiatives. We will continue to explore possible requirements for sponsorship of collaboratives.
1	1.02.2	10/8/21	Consider inclusion of measures that identify known disparities in care or variability in risk factors, such as asthma medication ratio, or stratified reporting key indicators such as C-section rates and prevalence of low-birth weight.	Covered California will continue to engage with stakeholders to consider additional measures to track health disparities in future years.

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Article	Section #	Comment Date	Comment	Covered California Response
2	2.01.1	10/8/21	Consider requirement for QHP response to National Alliance of Healthcare Purchaser Coalitions behavioral health program assessment, including assessment of payment parity consistent with federal requirements, approach to measurement-based behavioral health care, and network adequacy.	Covered California has launched a behavioral health consulting project with DHCS and CalPERS to further explore what behavioral health requirements we should expand or add to Attachment 1. We will incorporate this recommendation into the project to inform our 2024 contract amendment.
2	2.01.3	10/8/21	Consider inclusion of disclosure of payment parity policy related to telehealth, and specifically telehealth for primary care and behavioral health with assessment of adherence to policies.	Covered California has launched a behavioral health consulting project with DHCS and CalPERS to further explore what behavioral health requirements we should expand or add to Attachment 1. We will incorporate this recommendation into that project to inform our 2024 contract amendment.
3	3.04.1	10/8/21	Address use of standardized tools for assessment and QHP strategy to assess outcomes.	Covered California acknowledges the importance of standardized screening and assessment tools. We will continue to explore your recommendations as we develop and strengthen this requirement.
4	4.03.4	10/8/21	QHPs should report the portion of their contracted hospitals that are fully compliant, partially compliant, or not compliant with the federal Hospital Cost Transparency requirements.	We are committed to improving cost and affordability of health care services for all Californians. Where it is appropriate, we will align with the federal cost transparency requirements.
4	4.03.4/4b	10/8/21	Add language: Such metrics should be commonly in use in hospitals and endorsed by the National Quality Forum "or in current use by the CMS Value Purchasing programs for Inpatient, Outpatient and Ambulatory Surgery" as CMS has proactively implemented select measures to advance quality accountability strategies.	We will update the contract language to reflect your suggested edits.
4	4.03.6	10/8/21	Include outpatient hospital and ambulatory surgery quality and safety consistent with Leapfrog and CMS-reported data.	We will consider your feedback as we move forward in the development of the 2023-25 Attachment 1.
		10/8/21	Demonstration of reporting transparency in alignment and adherence to the requirements of the federal Transparency in Coverage rules and Prescription Drug Cost Transparency requirements.	We are committed to improving cost and affordability of health care services for all Californians. Where it is appropriate, we will align with the federal cost transparency requirements.

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Article	Section #	Comment Date	Comment	Covered California Response
1	Disparities	10/8	We appreciate that Covered California is requiring health plans to stratify all performance measures by race, ethnicity, and language, and to identify and set specific disparities reduction thresholds on key disparities related measures such as Comprehensive Diabetes Care (CDC): Hemoglobin (HbA1c) Testing (NQF #0057) and Avoidable Ambulatory Emergency Room (ER) Visits© per 1,000. We urge Covered California to: • Utilize both exchange and off-exchange data whenever available. • As noted above, require plans wherever possible to improve sample sizes, whether by oversampling, inclusion of multi-year data, or utilizing other best practices to deal with small numbers, particularly for smaller populations such as Cambodians, Filipinos and Koreans, Native Hawaiian and Pacific Islander, and American Indian or Alaska Native. • Move up timelines for 80% self-reported data on language to 2023 rather than 2025. • We are perplexed as to why Covered CA is allowing QHPs to simply "assess the feasibility and impact of extending the disparity identification and improvement requirements for 2023 and beyond." o Covered California already has data on income that it should be able to assess for this purpose. o On disability status, we would look forward to working to identify claims data that would provide information on disability status. o Additionally, since Covered California currently includes optional questions on sexual orientation and gender identity (SOGI) and collects such data, it would be useful to share this information with the public, including current SOGI responses and the percentage response rate. Moreover, when CMS finalizes the standardized application questions on SOGI, if they become required fields on the application, it will provide more accurate data and can be compared to Covered California's current data at some point in the next few years. o We would like to see much stronger language on expansion of Covered California's data categories to include these other sociodemographic categories. Plans should also be required to share best practices and a plan of action for implementing these new sociodemographic data standards in 2023-25 plan years. • We object to the proposal that "disparity reduction efforts and targets be mutually	Covered California is proposing significant updates to the PY2023 QHP Certification Application related to collection of expanded demographic data, including disability status and sexual orientation gender identity (SOGI). We continue our internal research to assess data capture and availability of disability status and SOGI. We will continue to research best practices on expansion of demographic data collection and update this requirement as necessary. Covered California will continue to research existing language data collection processes to identity the appropriate threshold and timeline for this requirement, and adjust the language requirement, as necessary. See Article 1.03 Disparities Reduction Intervention for contract language revision.

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Article	Section #	Comment Date	Comment	Covered California Response
2	Behavioral Health	10/8	We appreciate that Covered California is prioritizing improvements in behavioral health. We urge Covered California to: • Ensure all of the information Covered California collects on behavioral health provider networks is shared publicly. • Take action against plans who consistently fail to have adequate behavioral health networks, timely access, and language access including dropping them from the offered products. We recognize that the Department of Managed Health Care and the Department of Insurance are the regulators: however, at a minimum, Covered California should refer plans to the regulators for their oversight and action. • Given persistent challenges in ensuring accuracy of provider directories, particularly for behavioral health providers, subsection 2.01.2 should be clarified to include penalties if information to enrollees is not accurate and up to date.	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. One key objective of the behavioral health joint consultant project is to learn more about network adequacy and ways we can assess networks and implement strategies to improve access. We will look to implement requirements informed by this project in the 2024 amendment. We are also assessing our certification requirements and may develop stronger certification requirements in future years to ensure health plan networks include a robust behavioral health network. For provider directories, Covered California works with the health plans and a third-party, LexisNexis, to ensure the accuracy and completeness of the provider data that health plans submit to us. We evaluate the accuracy of health plan provider data each month and have standards for completeness and accuracy in the QHP model contract.

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Article	Section #	Comment Date	Comment	Covered California Response
2	2.01.3	10/8	We appreciate the inclusion of telehealth measures in Attachment 7, particularly as it relates to the provision of behavioral health services. We are concerned, however, about the impact of allowing QHPs to offer telehealth services at a lower cost share level than in-person services as this could potentially steer consumers towards telehealth services when in-person services may be a better standard of care, while at the same time, leading to providers refusing to accept plans or offer telehealth services entirely. To the extent possible, cost share for telehealth services should be equal, not less, than cost share for similar, in-person services. In addition, we are worried that "encourage[ing] Contractor to use network providers to provide telehealth for behavioral health service" may be interpreted as allowing QHPs to circumvent network adequacy requirements through telehealth availability. We believe the use of telehealth should not derail network adequacy and other managed care protections. As such, while we appreciate the intention behind this statement, Covered California should clarify that QHPs should continue to comply with network adequacy standards based on provision of in-person services and that telehealth services should complement, but not supplant, in-person services.	Covered California is continuing to explore options for standardizing cost shares for telehealth services. We are in communication with DMHC about our proposed telehealth requirements and the cost shares for telehealth services to ensure these requirements meet regulations and follow DMHC guidance. We will clarify that health plans must continue to comply with network adequacy standards while offering telehealth for behavioral health services.

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Article	Section #	Comment Date	Comment	Covered California Response
2	2.03.01	10/8	We are concerned that Covered California's focus on appropriate use of opioids is unfairly weighted towards reducing access to pain medications without emphasizing plan requirements to provide access to alternative treatments. We urge Covered California to ensure the 2023-2025 contract: • Hold plans accountable for ensuring access to non-opioid treatments (e.g., physical therapy) when those non-pharmacological options are more appropriate as a front line treatment. As part of this, we wonder whether it would make sense for the provisions of the Smart Care guidelines to be reflected in Attachment 7 so that Covered California may more readily enforce these as contract provisions. • Consider including non-medication-based treatments given the efficacy of concurrent pharmacological and non-pharmacological (e.g., both medications and talk therapy/counseling) treatment for opioid use disorder (OUD). As drafted, the contract heavily emphasizes reduction of opioid prescriptions as prevention, and medication as primary treatment. If Covered California encourages the use of non-Rx treatment for OUD, how will the measures reflect that? How can behavioral health utilization be monitored through the claims database? We continue to be concerned that Covered California has mostly focused Attachment 7's behavioral health measures on the appropriate use of opioids instead of access to OUD screening and treatment. We understand that unnecessarily prescribing opioids for pain treatment can lead to OUDs, but simply cutting opioid treatment initiation is not a panacea to reduce overdoses in the State and, in some situations, improper tapering of opioid treatment can be harmful to patients' needs. As the authors of the CDC Guideline for Prescribing Opioids for Chronic Pain have acknowledged, misapplication of opioid prescribing guidelines and strict limits have unfortunately led some providers, with encouragement from insurers, to abruptly cut off patients from opioid treatment or even refuse to prescribe opioids in the first place regardless of medical necessity. While we appreciate that the section on "Guidelines for Appropriate Use of Opioids" asks QHPs to identify patients on risky opioid regimes without the use of mandatory tapers, we believe more is needed to refocus the requirements on evidence-based strategies where we know significant gaps remain.	We have made adjustments to the requirements within Article 2.03 Appropriate Use of Opioids based on this feedback to emphasize a harm reduction framework and an individualized approach to treatment. One key objective of the behavioral health joint consultant project is to learn more about best practices for screening and treatment of behavioral health conditions. We will further revise our behavioral health requirements informed by this project in the 2024 amendment. Covered California can monitor the use of non-Rx treatment through the Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) measure (although this is not specific to opioid use disorder). The IET measure is a QRS measure. We also plan to monitor behavioral health utilization through the claims database. We may be able to track treatment visits for opioid use disorder (we are still researching this).

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Article	Section #	Comment Date	Comment	Covered California Response
2	2.03.02	10/8	We appreciate Covered California's willingness to evaluate plans' activities to monitor access to OUD treatment, particularly around medication-assisted treatment (MAT). We recognize that MAT is the gold standard of care and that gaps in accessing treatment with medications such as methadone, buprenorphine, and the overdose-reversal naloxone, are key drivers of the overdose epidemic. However, we believe QHPs can provide more information about how they are increasing access to such services. Covered California should: • Require QHPs to inform to what extent they are removing prior authorization, step therapy, and concurrent behavioral therapy requirements and how removal of those barriers is impacting MAT intake among their enrollees. • Require QHPs to provide data regarding access to other OUD treatment and services that support medication treatment disaggregated by race, ethnicity and other demographic variables. These services could include: counseling, case management, recovery services, medication management and monitoring, among others. We believe	We have made adjustments to the requirements within Article 2.03 Appropriate Use of Opioids based on this feedback to emphasize a harm reduction framework and an individualized approach to treatment. One key objective of the behavioral health joint consultant project is to learn more about best practices for screening and treatment of behavioral health conditions. We will further revise our behavioral health requirements informed by this project in the 2024 amendment.

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Article	Section #	Comment Date	Comment	Covered California Response
3	3.01.1	10/8	The contract provision requires the plan to submit a Population Health Management plan and requires the plan to clearly identify any information it deems confidential, trade secret, or proprietary information. Since health plans routinely deem as confidential, information that is already public, the Department of Managed Health Care has issued an All Plan Letter clarifying what information is "confidential, trade secret or proprietary". We commend it to you for consideration. We ask that the Population Health Management plan submitted by each QHP be made public along with the underlying assumptions plans are using to assess health risks. Researchers and community advocates have raised concerns about data analytics tools used to assess health risks that may include racial and ethnic biases that might unintentionally perpetuate health inequities. Whereas most health systems choose "cost" (aka "utilization") as the proxy for "health," evidence shows that Black patients consistently generate fewer costs than White patients at the same level of health. Using medical claims data to predict need for care management and other supports may exclude patients of color, persons with disabilities, and LGBTQ+ patients who historically have less access to both primary and specialty care due to discrimination, poverty, and other structural barriers. If these barriers to access have resulted in lower utilization among patients of color - despite equivalent diagnoses and needs for services - some risk algorithms may inadvertently perpetuate disparities by coding those patients of color as less in need of care management and other supports. We urge Covered California to require QHPs to: • Incorporate other data such as health conditions, risk factors, and disease progressions, in order to avoid exacerbating underlying biases in utilization data that may drive health disparities. • Analyze the results of its stratification/segmentation algorithm to identify and correct any biases the algorithm may introduce based on race, ethnicity, language, LGBTQ+ status, functional status, or other sources of health disparities. • Submit to Covered California its list of stratification/segmentation data sources, the risk stratification/segmentation algorithm (or the name of the tool if it is proprietary), and also the method of bias analysis to promote transparency and best practices.	As part of the Population Health Management (PHM) standards for NCQA Health Plan Accreditation, QHP issuers are required to collect, integrate and assess various data sources as part of their risk stratification and segmentation efforts, and evaluate their PHM strategy to gain insights into areas needing improvement. Additionally, we are in the process of incorporating questions regarding 'prevention of algorithmic bias in healthcare' into the Certification Application. Elements of the Population Health article are subject to public reporting, where it is appropriate, as part of future AB929 reporting.

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Article	Section #	Comment Date	Comment	Covered California Response
3	3.04.01	10/8	We support screening for food insecurity and housing instability. Lack of food or housing negatively impacts health. Preventing homelessness is easier than addressing it once it has already occurred. Food insecurity worsens chronic conditions and makes disease management more challenging. We would also ask that for future years, screening for caregiving responsibilities be added. There is now ample literature demonstrating that caregiving responsibilities for aging parents or disabled family members impairs or risks the health and wellbeing of caregivers. The callous indifference of most of the health care system to the burdens of	We will consider your recommendations for additional health-related social needs screening in future contractual requirements.
4	4.01	10/8	We are concerned by contract language that suggests Covered California will "evaluate the effectiveness of this policy based on criteria mutually agreed-upon between Covered California and Contractor." We have the same comments and questions on this provision as on the same language under disparities.	We will revised the language to better demonstrate our intent. Covered California will share the proposed methodology for analyzing the effectiveness of PCP matching and solicit input through our usual processes (Plan Management advisory, ad hoc meetings, etc.). The intention behind this language is to ensure that we develop methodology that Covered California and the health plans can implement.
4	4.01.2	10/8	The proposed requirements on health plans to encourage Advanced Primary Care models still seems very weak. We urge Covered California to require specific benchmarking and goals for percentage of payments being APMs/VBPs as other states have done? Oregon for example has set a 2024 goal of 70% of CCO payments to providers being VBPs/LAN Category 2C.	Covered California has defined the overall requirements for APMs for primary care payment in Attachment 1. We define requirements for the percent of primary care providers paid through HCP LAN Categories 3 or 4 in Attachment 2. We set specific thresholds in 2022 and plan to continue with similar standards in 2023 and beyond.
4	4.01.3	10/8	Looking only at the five largest physician groups for a health plan may or may not make sense. Some large physician groups are composed entirely of specialists. Statewide health plans such as Anthem and Blue Shield may contract with a large number of physician groups so that five groups might constitute a small subset of the contracting physician groups. Conversely a regional plan like Chinese Community or an integrated system like Kaiser might contract with fewer. We suggest revising this concept to align with a more realistic expectation.	We are aiming to better understand how physician organizations pay their primary care providers through this requirement as we do not have very good insight into this. We recognize this is just a sample of the physician organizations that some plans contract with. We hope to learn from this reporting requirement to inform more specific future requirements.

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Article	Section #	Comment Date	Comment	Covered California Response
4	4.03.04	10/8	We appreciate Covered California's efforts to dissuade plans from contracting with low-quality hospitals while at the same time recognize it may not be avoidable in every instance. However, with regards to the intervention plan that is required when contracting with hospitals on the lowest decile of state or national benchmarks for quality and safety, the interventions seem focused largely on the payment rate for the hospital and not directly on informing consumers of the quality and safety issues or helping consumers find higher quality care. Consumers should be permitted to go out-of-network or have transportation assistance to get to a higher quality hospital if the only alternative is a hospital that falls in the lowest 10% of all hospitals. In 3), the contract requires QHP to assess "relative unit prices and total cost of care." • What about the new federal regulations on transparency of negotiated rates? Will Covered California look at how QHPs (fail to) negotiate effectively on costs? • And for Kaiser, and perhaps other integrated delivery systems, the "unit price" must be considered in the context of the "integrated care management fee" which amounts to 23% or more of premiums for Kaiser—and which when factored in to "unit price" or "negotiated rate" makes Kaiser costs comparable to Sutter.	We are committed to improving cost and affordability of health care services for all Californians. Where it is appropriate, we will align with the federal cost transparency requirements.
4	4.03.05	10/8	The proposed metrics that are applied for performance based payments "such as" mortality, hospital-associated infections, sepsis management, readmissions "or" satisfaction as measured through HCAHPS raise two questions: • Under existing California law, all or almost all of these metrics are already public information. Will these metrics be made public through Covered California? • Why "such as" and "or"? That means it could be one or none of these metrics.	We expect QHP issuers to report all the metrics they use to determine performance based payments to hospitals. However, we are not mandating the specific metrics that a QHP uses in their performance based payment methodology. The language in the contract "such as" provides examples of the metrics that a QHP can use in determining their performance based payment methodology. These metrics will be considered for public reporting as applicable under AB 929.

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Article	Section #	Comment Date	Comment	Covered California Response
4	4.04	10/8	1) These contract requirements seem skewed towards adoption of telehealth without proper balancing with consumer rights. Will Covered California also require plans to share how they plan to notify beneficiaries of their right to in-person services if preferred or audio-only services if patients lack video technology? 2) How will Covered California ensure plans are making telehealth services accessible to patients with low digital literacy and/or limited English proficiency (LEP) in need of interpreter services? We would strongly recommend including a requirement that consumers are notified of the availability of interpretive services along with telehealth services: CPEHN and ARI have found that lack of language access has been one of the major problems for LEP patients in the transition to telehealth, as well as a continuing problem with access to health care services generally.	We are requiring health plans to report "How Contractor screens for Enrollee access to telehealth services such as broadband affordability and lower-cost alternative modalities, digital literacy, availability of smartphones or other devices for internet connectivity, and the geographic availability of high-speed internet services." We will add a reporting requirement for how Contractors notify consumers about the availability of interpreter services for telehealth services.
5		10/8	The draft contract requires QHPs to participate in a Health Information Exchange (HIE) such as C-TEN. Given the broader statewide discussions with CHHS, we urge Covered California to: • Take a more aggressive approach to requiring QHP participation in the new state health information exchange network and eventual community information exchanges for social needs. • More actively encourage QHPs to incentivize adoption of the 2015 ONC EHR standards, with comprehensive demographic data • Require QHPs to make patient-facing APIs available so that patients can access their	Covered California is actively participating in the taskforce dedicated to developing the data exchange framework for the new state health information exchange. Once this framework is developed our intent is to align with DMHC, DOI, and other state departments in requirements to participate. Community health information exchanges is an active area of exploration. We would welcome further input. We require QHP issuers to make patient-facing APIs available as described in Article 5.02.2.
5	5.02.1 5) c)	10/8	HEI Records that reveal contracted rates are not subject to public disclosure: • This is verbatim from AB929 that created the HEI; however, it is superseded by the new federal rule requiring public disclosure of contracted rates for hospitals Therefore, why isn't Covered California requiring the plans to submit those rates, either here under the HEI or in the earlier section on "hospital value"?	Thank you for your comment. After internal discussion, we are leaving this language as drafted because it is intended to be broader than the federal price transparency laws. We reference the federal price transparency laws in Article 4.

COMMENT TEMPLATE - Draft 2023 - 2025 Attachment for Quality, Equity, And Delivery System Transformation Requirements and Improvement Strategy

Article	Section #	Comment Date	Comment	Covered California Response
1	1.01	10/8/21	The capturing of Race and Ethnicity, Written and Spoken language, Gender identity, Sexual orientation, Disability status 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. We also request that Covered California capture at time of application and send to QHPs enrollee ethnic and cultural preferences for primary care clinician assignment.	Covered California will continue to explore 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. We will also work with QHP issuers to continue to explore additional sources for member demographic information.
1	1.01	10/8/21	Will Covered California be collecting "complete member demographic data" and providing this to QHPs? Collecting information at time of enrollment is most appropriate.	Covered California will continue to explore 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. We will also work with QHP issuers to continue to explore additional sources for member demographic information.
1	1.01	10/8/21	To prevent data accuracy concerns, we request bidirectional data updates between QHPs and Covered California.	Covered California shares the goal of bidirectional data updates and will continue to explore best practices for collection and sharing of member self-reported demographic data, including bidirectional data sharing. Covered California looks forward to working with all carriers to identify systems challenges that will need to be addressed across all carriers in order to improve our data capture and quality.
1	1.01.2	10/8/21	"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".	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.

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Article	Section #	Comment Date	Comment	Covered California Response
1	1.01.2	10/8/21	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.	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.
1	1.01.2	10/8/21	It appears that HEI data currently only has two fields for language on the Enrollment file, ME033 and ME034. It does not appear to be clear whether those fields are specifically for spoken, written, or both. We are concerned that Covered California may be modifying the HEI data format. Modifications to such reporting will take development effort and we have not received the specification changes to make such a change. Due to complexities with development, we request the specification changes be provided by April 1, 2022 to meet a January 1, 2023 deliverable.	Covered California will further research this issue and provide guidance as necessary.
1	1.02.1	10/8/21	How does Covered California use "for each Medi-Cal Managed Care product" data? This is an administrative burden as we have found in the past certain HEDIS measures have not been pulled by the Medi-Cal team. We request only Covered California / Marketplace data be provided.	Covered California will limit stratified measures submission to the Covered California line of business. We will work with public purchaser partners to assess disparities across enrolled populations.
1	1.02.1	10/8/21	We request the Patient Level Data File format be "mutually agreed to."	Covered California will continue to work collaborative with issuers on implementation of the Patient Level Data File requirement as we have done in the past.
1	1.02.1	10/8/21	We request the Patient Level Data File format be finalized six months before the submission is due and that the format remains the same over the contract period. Changes to file format creates administrative burden.	Covered California will continue to work collaborative with issuers on implementation of the Patient Level Data File requirement as we have done in the past.
1	1.02.2	10/8/21	Is the Patient Level Data File only for measures in 1.02.1 or also for 1.02.2?	The Patient Level Data File submission requirement only applies to measures in Article 1.02.1.

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Article	Section #	Comment Date	Comment	Covered California Response
1	1.02.2	10/8/21	Anthem has not received a response to concerns raised during the AB929 comment period. Concerns regarding measures as raised during that comment period are embedded to the LEFT.	Covered California is in the process of reviewing issuer AB 929 comments.
1	1.04.1	10/8/21	We received verbal confirmation during a recent call with Covered California that for Measurement Years 2024 and 2025 that QHPs that have active/unexpired MHCD can use that to meet the Health Equity Accreditation achievement until MHCD expires. We request that be further clarified here.	As stated in the contract, the NCQA MHCD or Health Equity Accreditation may be used to meet this requirement, contract language will be updated to more explicitly state Health Equity Accreditation will not be required prior to MHCD expiration.
2	2.02.1	10/8/21	Please consider whether the "and" should be replaced with "and/or".	The measure specifications for Depression Screening and Follow-Up Plan (NQF #0418) refer to Patient Health Questionnaire (PHQ-9) as one of the standardized tools that can be used for this measure. Covered California included the reference to PHQ-2 to recognize that many providers screen patients with the PHQ-2 first when using this tool.
2	2.04.1	10/8/21	2) We request this reporting be limited to Covered California enrollees.	Covered California continues to require reporting for both Covered California enrollees and an issuer's larger book of business in order to conduct comparison reporting.
3	Introduction	10/8/21	We request clarification what the last sentence is intended to mean "QHP Issuers are financially responsible for addressing population health."	We revised the contract language to clarify our intent, which is to highlight that QHP issuers are responsible for addressing the health of all their enrollees, not just enrollees who utilize services.
3	3.02	10/8/21	While this states "enrollees", should clarification be made that such promotion cannot be made in sales materials, etc.?	Covered California would appreciate more information and context for this public comment.
3	3.02.1	10/8/21	Can Covered California receive similar data from the HEI claims submissions? If Covered California can obtain there then it would be a consistent process to obtain the information. If this cannot be performed through HEI data, please consider providing QHPs consistent requirements for the data pull for the Certification Application.	Covered California will consider your recommendation as we continue to explore the full capabilities of HEI data to develop and strengthen this requirement.

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Article	Section #	Comment Date	Comment	Covered California Response
3	3.02.2	10/8/21	It appears that the 834 has in the 2200 Disability Information that is not currently populated. Will Covered California begin sharing this information with QHPs?	We are doing internal research to assess data capture and availability on disability status. We anticipate data sources outside the enrollment application will be better suited to identification of disability status.
4	4.01	10/8/21	How will Covered California use "all lines of business" reporting? We request this be limited to Covered California enrollees.	Covered California continues to require reporting for both Covered California enrollees and an issuer's larger book of business for certain requirements in order to conduct comparison reporting.
4	4.01.1	10/8/21	It appears the Glossary has been removed. Please consider adding clinician types/specialties Covered California accepts for Primary Care Clinician assignment/selection.	Covered California defers to QHP issuers on how they define primary care clinicians for primary care assignment or selection.
4	4.01.1	10/8/21	The capturing of Race and Ethnicity, Written and Spoken language, Gender identity, Sexual orientation, Disability status is critical to meeting certain aspects of other contractual requirements such as in the Agreement and Attachment 14/X. We request Covered California take steps towards requiring these fields on the application, if 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. We also request that Covered California capture at time of application and sending to QHPs enrollee ethnic and cultural preferences for primary care clinician assignment.	Covered California agrees the enrollment application is an important opportunity to collect this information but does not intend to pursue mandatory race and ethnicity questions in the enrollment application. We will continue to explore opportunities to improve capture of member self-identified demographic data. We will continue to explore your recommendations.
2	2.01.1	10/8/21	We can provide information that is provided to NCQA, however, some of the information may not be limited to Covered California as it may be enterprise data across all our states. We will provide same information that we provide NCQA.	Thank you. Covered California recognizes that health plans will submit the same information that is submitted to NCQA.

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Article	Section #	Comment Date	Comment	Covered California Response
2	2.01.1	10/8/21	We request clarification of how the reports are used as there may be other report sources that may better serve Covered California requests.	Covered California intends to use these reports to have additional insight into how issuers track access to behavioral health services and the strategies used to improve access. The intent of this requirement is to reduce burden and duplicative work for issuers by submitting the same reports required for NCQA accreditation.
5	5.01.2 1)	10/8/21	Since Covered California is commercial business we request this not apply to Medi-Cal lines of business.	Covered California is leaving this mention of Medi-Cal in this section. We may revisit this around 2026 which is the deadline for the DHCS NCQA Accreditation requirement for Medi-Cal managed care plans.
5.02	5.02.1 2)a)	10/8/21	Based on verbiage in the 2022 agreement, we request the following modification: "a) Contractor shall work with ~~any~~ 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.	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.
5.02	a) i.	10/8/21	We request "an" be changed to "the" since section 6. specifies the HEI vendor.	Thank you for your comment. We will revise the language.
Glossary		10/8/21	Previous versions of Attachment 7 have included a Glossary. Will Covered California be including a Glossary in this version of Attachment 7?	Covered California will consider adding the glossary back to Attachment 1. If so, we will publish this with the next draft of Attachment 1.
4	6-Primary Care Spend	10/6/2021	Requesting that the reports submitted automatically be treated as confidential	Covered California may publish information on health plan performance on our contract requirements in accordance with AB 929 public reporting requirements.

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Article	Section #	Comment Date	Comment	Covered California Response
1	1.01.2	10/8/21	We recognize the importance of having self-identified Race, Ethnicity and Language Preference data, and firmly believe the best opportunity to capture this information is during the application/enrollment process. Covered California should update the enrollment process to capture DECLINE TO STATE and make these fields mandatory in the GI enrollment process, and drive improved data collection via prompts during the enrollment workflow. QHP outreach for members to collect this data can be expected to drive lower member satisfaction (particularly if members decline to state, but that information is not shared with QHPs), and will crowd out other pressing member outreach efforts, while increasing administrative costs. Additional when the language updates being made for release 22.02 were reviewed CalHEERS indicated that they default if a language preference was not provided was English, if Covered Ca is sending a value either the default or actual self identified preference wouldn't the 80% threshold listed in 1.01.2 by year end 2025 all ready be	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. Covered California agrees the enrollment application is an important opportunity to collect this information but does not intend to pursue mandatory race and ethnicity questions in the enrollment application. We will continue to explore opportunities to improve capture of member self-identified demographic data. Covered California will continue to research existing language data collection processes (including the default to English if a language preference is not provided) to identity the appropriate threshold and timeline for this requirement, and adjust the language requirement, as necessary.
1	1.01.1	10/4/21	While these areas for expanded disparity identification are important, this is data that Covered California does not currently share with the carriers. There may be legal limitations with sharing this data that should be researched before including this as a Contract consideration. We recommending removing 1.01.1 for now.	Covered California will continue to research feasibility of expansion of demographic data collection and update this requirement as necessary.
1	1.01.2	10/4/21	Race and Ethnicity Data: Health Net recommends including provider-reported data that we receive for the member via data exchange. In addition, CALHEERS is the system of record and race and ethnicity data that the carriers collect may be overwritten with the data provided in the 834. Language: In the past Covered California has requested to have members call the service center when they want to change their language information because Covered California also uses this data. If the carriers collect the data directly, we don't have a way to send it back to update Covered California's system to align our information. In addition, members can only elect to have one written and spoken language. If our data does not align with CALHEERS, it will be overwritten with the data provided in the 834. Collection of written and spoken language for 80% of enrollees may be difficult to	Covered California shares the goal of bidirectional data updates and will continue to explore best practices for collection and sharing of member self-reported demographic data, including bidirectional data sharing. Covered California looks forward to working with all carriers to identify systems challenges that will need to be addressed across all carriers in order to improve our data capture and quality.

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Article	Section #	Comment Date	Comment	Covered California Response
1	1.02.2	10/4/21	Health Net recommends using nationally recognized measures that can be validated by the carrier. Please refer to Health Net's comments "AB 929 Crosswalk to HEDIS_MCAS_HIE Specifications_08-23-2021". We recommend a complete review and consideration of carrier feedback on the AB 929 reporting before finalizing this	Covered California is in the process of reviewing issuer AB 929 comments. We will continue to engage with stakeholders to consider additional measures to track health disparities.
1	1.03.1	10/4/21	This Contract section should reference the PLD measures established in the Quality Transformation Initiative 1.02.1 instead of 1.02.2.	See Article 1.03 Disparities Reduction Intervention for contract language revision.
2	2.04.1	10/4/21	We recommend removing parts 2 and 3 of this requirement until Collaborative Care Models can be further defined with additional guidance including a way to identify these providers and applicable claims codes. We do not currently have a way to clearly identify these practices and we do not reimburse providers for Collaborative Care Model services due to unknown financial impacts. Currently Integration of Behavioral Health takes place at the health plan level through Case Management using an Integrated Care Management model	Covered California will define the Collaborative Care Model in this article by referring to the AIMS Center at the University of Washington (https://aims.uw.edu/collaborative-care). Covered California has provided the Collaborative Care Model claims codes in the Certification Application to support reporting on this requirement. We believe that behavioral health integration is most effective through integration at the delivery system, especially between primary care and behavioral health providers. Case management is important but it is not sufficient.
3	3.02.2 3)	10/4/21	Please clarify or define the "expected rates" to be used when assessing the DPP outcomes and triggering a corrective action plan.	The CDC Diabetes Prevention Impact Toolkit is a potential tool QHP issuers can use to determine "expected rates" for the Diabetes Prevention Program. The tool can determine projected health effects of the National DPP lifestyle change program on their population at risk for diabetes, such as projected participation rates. Here are two potential gaps where Covered California believes is appropriate for triggering a corrective action plan: 1) a gap between the percent of enrollees identified as high risk and percent of enrollees who should have been identified as high risk (using the CDC tool); and 2) a gap between 1) and the percent of enrollees who actually use the DPP service.

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Article	Section #	Comment Date	Comment	Covered California Response
3	3.04.1	10/4/21	Please add back in the criteria for a minimum of screening enrollees participating in plan-based programs. Screening all enrollees for sensitive information would be very challenging and impractical.	Food insecurity in California has dramatically increased across the state during the COVID-19 pandemic. 25% of Californian households are currently food insecure, a rate 2.5 times higher than pre Covid-19 levels. We know that food insecurity as well as other social and economic determinants of health, put individuals at a higher risk of contracting COVID-19. Health-related social needs impact all members, not only those involved in plan-based programs. The intention of screening all Enrollees is to identify and address these needs in a timely manner before unmet needs lead to adverse health outcomes. We do not intend to reduce the screening requirements.
4	4.01.1 2)	10/4/21	PCP Auto-assignment is a standard business practice resulting in 100% member assignment to PCP. Is this reporting still necessary in the annual certification?	Yes, Covered California will continue to require reporting on PCP assignment.
4	4.01.3 1) c)	10/4/21	Carriers do not have information on how physician groups pay their primary care providers if they are not paid by the plan. This is not information that they are required to share with us. We recommend "and how its primary care clinicians are paid"	Covered California is aiming to better understand how physician organizations pay their primary care providers as we do not have very good insight into this. We hope to learn from this reporting requirement to inform more specific future requirements on primary care payment reform.
4	4.03.4 c) & d)	10/4/21	Please define "hospital price transparency data". Is this referring to CMS hospital price transparency rule?	Language will be edited to clarify that this requirement refers to the CMS hospital price transparency requirements.
4	4.03.5 2)	10/4/21	We recommend removing this requirement. HCAHPS results are not plan or member specific and cannot be used to identify unintended consequences from at-risk payments.	There is value in reviewing HCAHPS results for hospitals. We will edit the contract language to provide more clarity of our expectations.
4	4.03.6 5)	10/4/21	Health Net recommends relocating this requirement under 2.03. It may be clearer to keep all opioid safety requirements in the same Contract section.	Article 4.03.6.5 refers to hospital opioid safety and will thus remain in the hospital safety section.
4	4.03.6 5) a)	10/4/21	Please clarify how carriers might influence opioid use for inpatient hospital care.	We expect QHP issuers to work with Cal Hospital Compare or other quality collaboratives to identify hospitals with poor quality performance in opioid use. QHP issuers shall engage with poor performing hospitals to improve opioid use through such interventions as corrective action plans, quarterly performance reviews, and technical support and trainings.

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Article	Section #	Comment Date	Comment	Covered California Response
4	4.03.7 2) b) iii)	10/4/21	Please remove hospitals from this requirement. We not have hospital data to support this effort. In addition, the measures under 4.03.7 b) i) are provider based measures.	We are committed to reducing maternal health disparities both in the hospital and outpatient setting. We will update the contract language to clarify our expectations on this requirement.
5	5.02.1 2) a)	10/4/21	Please replace this section with the language from the 2022 Contract. This is necessary to address that the HEI vendor is contracted to assist with health oversight functions and activities and has legal authority to collect, store and process HEI data. "Covered California represents and warrants that any HEI Vendor which, in its sole discretion, Covered California should contract with to assist with its health oversight functions and activities shall have any and all legal authority to provide any such assistance, including but not limited to the authority to collect, store, and process HEI Data subject to this	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.
5	5.02.3	10/4/21	Please clarify the intent for carriers to participate and exchange data on CTEN. What is the expectation for how a participates with CAHIE CTEN? Health Net recommends waiting for the results of AB 133 CAHIE recommendations before determining how payers are required to participate in CTEN.	We will revise this language to clarify that it should be the HIE(s), not the QHP issuer, that is participating in CTEN. These HIE(s) would be the ones that that a QHP issuer participates in.
1	1.02.2	10/6/21	Use of HEI data will likely result in material differences on some HEDIS measures from what we produce ourselves. Covered CA should expect to have to work with us to produce accurate results using data from our electronic health record or other sources.	Covered California will engage with issuers to ensure disparities measure performance through HEI data submission is accurate.
4	4.01.1 (2)	10/6/21	We do not currently have the capability to report PCP self selection vs assignment. We are working to understand what it would take to develop this capability, but it appears that it may be very difficult and expensive to do so. We may need to discuss with Covered CA the value of this reporting vs the cost.	If QHP issuers cannot report PCP assignment vs. selection, the issuer can report 100% assignment at this time.
1	1.02.1	10/6/21	Their first year doing this required plans to go back multiple years to gather data and we faced some challenges that continued to be discussed with Covered CA. Suggest they will make the timeframe for collection to just the single measurement year	PY 2023 requires submission of a single measurement year for the Patient Level Data File.
2	2.01	10/6/21	Covered CA can help these efforts by sharing care coordination data with health plans similar to what DHCS does. This is even more important for marketplace because members move around between plans and it would help to have historical data on the members as this happens.	Covered California would appreciate additional information on the care coordination data that DHCS shares with contracted plans. We will follow up to learn more.

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Article	Section #	Comment Date	Comment	Covered California Response
2	2.01.3	10/6/21	I suggest that Covered CA/ QRS tech specs follow NCQA tech specs in using the telehealth value sets (Online Assessments/Telephone Visits)	Thank you for this feedback. Covered California will review the NCQA telehealth value sets and follow up with more guidance for QHP issuers.
2	2.04.1	10/6/21	See my comment above for care coordination data sharing with plans.	Covered California would appreciate additional information on the care coordination data that DHCS shares with contracted plans. We will follow up to learn more.
4	4.01.1	10/6/21	Suggest for Covered CA to use NCQA AAP measure for this, if AAP is not already part of QRS/Covered CA reporting.	Thank you. Covered California will consider the use of the Adults' Access to Preventive/Ambulatory Health Services (AAP) measure as we expand our use of HIE data.
4	4.03.7	10/6/21	"(1) Prenatal and Postpartum Care (PCC) (NQF #1517)" should be PPC, not PCC	Thank you for the edit. We will update the language.
4	4.04	10/6/21	See my comments above about telehealth	Covered California will review the NCQA telehealth value sets and follow up with more guidance for QHP issuers.
5		10/6/21	See my comments above for care coordination data sharing.	Thank you for your comment.
5	5.02.2	10/6/21	Perhaps Covered CA can include some ECDS measures as that will encourage interoperability	Thank you for your comment. Covered California will explore ECDS measures as we move forward with the 2023-25 Attachment 1 development.
1	1.02.2	10/1/2021	Consider aligning measures with NCQA Medi-Cal accreditation measures to ensure alignment with most health plans. For example, A1C testing is high performing and NCQA uses A1c Control as part of its accreditation set. and the utilization measure listed maybe run differently from plan to plan due to lack of standardization.	Covered California will continue to engage with stakeholders to consider additional measures to track health disparities.
1		10/6/21	Request to clarify what process will be used to reconcile difference in measure performance? Will Covered CA allow for submission of supplemental data in addition to the HEI file transmission to help reconcile? Attachment 7 is not clear on how plans would be able to reconcile rates against the HEI data.	Covered California will engage with issuers to ensure disparities measure performance through HEI data submission is accurate.
1	1.01	10/6/21	Recommendation for Covered CA to work with various stakeholders to determine how this type of data can be collected feasibly by health plans and upon enrollment to Covered CA. A consistent strategy for all plans to collect this information voluntarily by enrollees would be welcomed in order to make significant progress.	Covered California will continue to research best practices on expansion of demographic data collection to disability status and sexual orientation gender identity (SOGI) and update this requirement as necessary.

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Article	Section #	Comment Date	Comment	Covered California Response
1	1.01.2	10/6/21	Due to the voluntary nature of this data collection, request for Covered CA to work with health plans to determine how to best collect this information upon enrollment to Covered CA. Request for carriers to report this information during MY 2023 without any specific assigned percentages. A disparities improvement workgroup could then be established to determine how to best improve the reported percentages.	Covered California will continue to research existing language data collection processes to identity the appropriate threshold and timeline for this requirement.
1	1.02.1	10/6/21	Recommendation for Covered CA to implement this strategy for data collection according to NCQA's final data collection timeline.	Covered California is tracking NCQA's measure stratification approach and aligning where it makes sense for our California members.
2	2.01.1	10/6/21	For NCQA-accredited health plan, recommendation for Covered CA give credit to health plans that meet this requirement for NCQA instead of submitting duplicative reports to Covered CA. Request to consider this approach to reduce potential duplication and additional review by another organization.	Covered California intends to use these reports to have additional insight into how issuers track access to behavioral health services and the strategies used to improve access. The intent of this requirement is to reduce burden and duplicative work for issuers by submitting the same reports required for NCQA accreditation.
2	2.01.3	10/6/21	Telehealth offers enhanced alternatives for health plan enrollees to receive behavioral health services. Request that Covered CA support the work from plans to also use telehealth services to meet quality measure requirements, aligning with HEDIS allowances.	Covered California will research this further and follow up with more guidance for QHP issuers.
2	2.02.1	10/6/21	The Depression Screening measure is difficult to implement and report from network providers as the measure is collected through an assessment. Request for Covered CA to alternatively allow plans to report on a measure that will allow for data collection to be more feasible, like the Antidepressant Medication Management HEDIS measure.	Covered California intends to move towards more outcomes-focused measures to monitor the quality of behavioral health services. The use of the Depression Screening measure is aligned with the CQC Advanced Primary Care measure set as well. We will collaborate with issuers to support the implementation of this measure.
2	2.03.3	10/6/21	Recommendation for Covered CA to allow plans to submit the opioid management measures using HEDIS, in order to have more valid and reliable comparisons across CA and the country.	Covered California will use HEI data to monitor the opioid use disorder measures mentioned in 2.03.3.

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Article	Section #	Comment Date	Comment	Covered California Response
3	3.01.1	10/6/21	Request for Covered CA to consider allowing NCQA-accredited plans to receive automatic credit to meet these requirements without submitting additional documents and reports to Covered CA. For plans that fully meet the NCQA requirements, automatic credit should be given to these plans without mandating that these plans submit additional documentation to Covered CA.	The intent of this requirement is to assist in developing and strengthening our Population Health Management (PHM) requirements. We are requesting the same PHM reports for NCQA Health Plan Accreditation, which will reduce administrative burden and duplicative work for QHP issuers. Additionally, we included an option to submit equivalent reports for QHP issuers who prefer to do so.
3	3.04.1	10/6/21	Recommendation that health plans that pursue and received Health Equity Plus distinction from NCQA receive credit for this process and potential reduction in submission requirements be considered.	The NCQA MHCD or Health Equity Accreditation may be used to meet this requirement. Credits are not longer available for PY2023.
4	4.03.5	10/6/21	Request that Covered CA allow health plans to work with hospitals that already conduct H-CAHPS surveys to review their results and design improvement strategies without having health plans to conduct an additional survey for the hospital.	We will update the contract to provide more clarity on our expectations from this requirement.
4	4.03.7(2)(b)(i)	10/6/21	Recommendation to allow health plans to select the measures that are the most valid and reliable. Recommendation that Covered CA focus on the Prenatal and Postpartum Care HEDIS measures and not the more subjective depression screening measure.	We are committed to improving maternal health which includes maternal mental health. Depression screening tools such as PQH-9 and Edinburgh Postnatal Depression Scale are evidence based tools commonly used in the clinical setting to screen for pre and post natal depression. These reporting requirements will inform future contract requirements. We will edit the contract language to provide more clarity on our expectations for maternal health.
1+8:8F102:62:192:2:8+2:6	1.02.2	10/8/21	Sharp has concerns about #3) Avoidable Ambulatory Emergency Room Visits. There is no validated measure from any recognized agency to define these type of visits.	Covered California will continue to engage with stakeholders to consider the most effective measures to identify and track health disparities.

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Article	Section #	Comment Date	Comment	Covered California Response
2	2.01.1	10/8/21	"Contractor must annually submit to Covered California its National Committee for Quality Assurance (NCQA) Health Plan Accreditation Network Management reports as follows" . NCQA health plan accreditation operates on a three year cycle. Is the expectation that the plan update this annually outside of the accreditation cycle or submit the same report every year during the three year cycle?	After the initial Network Management report submissions, QHP issuers will only be required to submit their reports to Covered California once every three years. If any significant changes are made to the reports within the three-year cycle, QHP issuers will be required to resubmit their reports.
2	2.02.1 & 2.02.2	10/8/21	Two concerns here; 1) groups do not systematically use the PHQ tool, some medical groups use the tool in different populations, 2) is it medically appropriate to test everyone with the PHQ tool?	Covered California recognizes that not all providers may use the PHQ tool. Our goal is to encourage the use of the PHQ tool so we can move towards implementing additional measures such as the Depression Remission or Response for Adolescents and Adults (DRR) measure in the future. The measure specifications for Depression Screening and Follow-Up Plan (NQF #0418) refer to Patient Health Questionnaire (PHQ-9) as one of the standardized tools that can be used for this measure.
3	3.01.1	10/8/21	The same issue as 2.01.1, NCQA is a three year cycle. Will we submit the same report three times or update the report outside of the accreditation cycle?	After the initial Population Health Management (PHM) plan submission, QHP issuers will only be required to submit their PHM plan to Covered California once every three years. If any significant changes are made to the PHM plan within the three-year cycle, QHP issuers will be required to resubmit their PHM plan.
3	3.02.1	10/8/21	The population for this is quite low which may not provide the appropriate/accurate results.	Covered California is committed to reducing tobacco use as part of our health promotion and prevention mission. We will continue to develop and strengthen this requirement.
3	3.04.1	10/8/21	The language says we must screen all enrollees. Our concerns, 1) is it appropriate to screen all enrollees?	Health-related social needs impact all members, not only those involved in plan-based programs. The intention of screening all Enrollees is to identify and address these needs in a timely manner before unmet needs lead to adverse health outcomes.

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Article	Section #	Comment Date	Comment	Covered California Response
4	4.02.2	10/8/21	Contractor must annually report its performance on the IHA Commercial ACO **and** HMO Measure Set for all lines of business to Covered California or allow IHA to submit results to Covered California on Contractor's behalf. This reads like we need to submit both Commercial ACO and HMO. This should read IHA Commercial ACO **or** HMO Measure Set.	The contract requirement states "Contractor must submit data to IHA for use in the IHA Commercial ACO Measure Set and Commercial HMO Measure Set, as applicable for its delivery system model." This is necessary because some issuers have more than one product and may participate in both measure sets. Issuers will only be required to report on the IHA program that it participates in for its products.
4	4.03.7	10/8/21	b) Annually report in the application for certification: i. Its strategies to improve its rates on the following HEDIS measures, which may include evidence-based interventions or participation in quality collaboratives: (1) Prenatal and Postpartum Care (PCC) (NQF #1517) (2) Prenatal Depression Screen and Follow-up (PND-E) (3) Postnatal Depression Screen and Follow-up (PDS-E) ii. How it identifies maternal health disparities among its maternity Enrollees. Concerns with set up for this.	We are committed to improving maternal health which includes maternal mental health. Depression screening tools such as PQH-9 and Edinburgh Postnatal Depression Scale are evidence based tools commonly used in the clinical setting to screen for pre and post natal depression. These reporting requirements will inform future contract requirements. We will edit the contract language to provide more clarity on our expectations for maternal health.
2	2.02.1	10-8-21	PHQ-2 and PHQ-9 are administered by the providers, not the health plan. The health plan suggests that the language in the contract be changed from "Contractor" to "providers".	Covered California will adjust the requirement to indicate that issuers must collaborate with contracted providers to collect Depression Screening and Follow-Up Plan (NQF #0418) measure results.
3	3.02.2	10-8-21	What is the source and expected rate for the Diabetes Prevention Program?	The CDC Diabetes Prevention Impact Toolkit is a potential tool QHP issuers can use to determine "expected rates" for the Diabetes Prevention Program. The tool can determine projected health effects of the National DPP lifestyle change program on their population at risk for diabetes, such as projected participation rates.
4	4.01.3	10-8-21	Regarding reporting out HCP LAN APM categories: The health plan already submits directly to the Health Care Payment Learning and Action Network (HCP LAN). Will the health plans be required to report out to Covered California as well or is submission to HCP LAN sufficient?	Issuers will be required to submit payment data for the HCP LAN categories to Covered California. This ensures we have standardized reporting across all issuers.