Cover Page

Attachment 7 First Round Comments

The following is the Covered California response to "First Round" comments received for the 2022 Attachment 7 Amendment.

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

A7 Item #	A7 Sub-Section #	Comment	Final Approved Response	Response Date
General Comment		General Comment - We request that Covered CA allow the plans to review any Quality Rating System (QRS) analyses derived from HEI data prior to submission to CMS and prior to making the information publicly available. We also ask that Covered CA work with the QHP issuers to resolve any variations between the plan's analysis and Covered CA's findings.	Covered California will not be submitting any QRS analyses derived from HEI data to CMS at this time.	1-4-21
General Comment - ACCREDITATION		AAAHC respectfully requests that Covered California consider incorporating language into the contract that would provide issuers with the opportunity to change accreditors if necessary during their contract period, that would allow any accreditation organizations that wish to offer accreditation services to Covered California QHPs the ability to do so as long as the accreditation program meets or exceeds the California requirements, and to provide for alternatives to the three items owned by NCQA listed...1) that issuers achieve or maintain NCQA Multicultural Health Care Distinction by year-end 2022, 2) that issuers submit a copy of NCQA Population Health Management Plan: Standard 1 and Standard 2, and 3) requires that issuers submit specific NCQA HEDIS measures.	Thank you for your feedback. At this time, Covered California intends to move forward with requiring contracted issuers achieve NCQA accreditation.	1-4-21
General Comment		General Comment: Health Net agrees with the Covered CA response from 10/15 response that 2020 and 2021 can be pilot periods for any reporting using HEI data. We also agree about the importance of reviewing the data before it is shared publicly.	Thank you for your feedback.	1-4-21
General Comment		Sutter Health Plan commends Covered California's commitment to improving health care and its delivery within the state by seeking to achieve lower costs, improving quality and health outcomes and promoting health equity. Sutter Health Plan would like to issue comment on the draft 2022 Attachment 7. In the table below, we lay out our observations and suggestions in more detail. In some cases, we present our support with what Covered California has proposed. In others, we spot an area of concern but do not suggest a resolution; instead, provide a suggestion for clarity.	Thank you for your feedback.	1-4-21
General Comment		We appreciate that 2022 is a transitional year for Covered California in terms of revisions to its contract expectations for Qualified Health Plans (QHPs). We also appreciate Covered California's long-term vision to build a foundation through implementation of its new Health Evidence Initiative (HEI) for a more robust, ambitious and evidence-based approach to driving quality improvement and disparities reduction efforts in California. We are concerned however, that the current proposed contract changes appear to be a significant retreat from previous health plan requirements, particularly with regards to disparities reduction requirements. as opposed to a reset as Covered California works with plans to build the data infrastructure needed to significantly improve health care quality and reduce disparities. As a national leader and active purchaser we urge Covered California to communicate its long-term vision for quality improvement and disparities reduction and ensure that vision is better reflected in the 2022 QHP contract language so plans are clear about their contractual obligations in 2022 and beyond. We offer a number of amendments intended to signal the long-term vision so that plan partners and others can prepare for future years, rather than breathing a sigh of relief that Covered California has backed off. The HEI should also give Covered California information on the entire individual and small group markets with more than four million enrollees: many of the data challenges encountered by Covered California should be addressed by the availability of this data set.	Covered CA is committed to advancing equitable care. We look forward to working with you in reflecting this vision in the 2022 amendment.	1-4-21

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Article 1 INDIVIDUALIZED, EQUITABLE CARE		We believe that race and ethnicity data should be collected at time of enrollment - this is the most efficient and consistent way to collect this data.. The QHP issuers do not enroll members and therefore do not oversee the completeness of this data field. We recommend that race and ethnicity data should be a mandatory field at the time of enrollment, and Covered CA should add a "decline to state" option and add this field to the 834 files to ensure that the race and ethnicity field is not blank. The report commissioned by Covered CA and written by Health Management Associates (HMA) states that HMA compared the accreditation requirements for the NCQA Distinction in Multicultural Health Care with the requirements of SB 853. We respectfully request that Covered CA and HMA share this analysis with QHP issuers. The NCQA Distinction in Multicultural Health appears to expect QHPs to follow OMB race and ethnicity code sets. We are asking Covered CA to review existing 834 codes sent to carriers to ensure consistency and to incorporate any necessary changes at least one year before requiring plans to achieve this accreditation.	The HMA NCQA Multicultural Health Care Distinction Crosswalk document has been posted to https://hbex.coveredca.com/stakeholders/plan-management/ Covered CA is working to align race and ethnicity categories definitions across data sources and processes.	1-4-21
	1.01.1 Demographic Data Collection	This 5-year requirement that plans "work with Covered California to assess the feasibility and impact of extending the disparity identification and improvement program over time," has not resulted in the adoption of any additional data categories beyond gender, race and ethnicity. Advocates request Covered California include a timeline for when it will work with plans to expand the disparity identification and improvement program to additional data categories such as income, language, sexual orientation and gender identity.	Thank you for your comment. Covered CA has begun conversations with partner state agencies and departments to assess what is currently collected and identify feasibility.	1-4-21
	1.01	Amendment is stating the health plan must achieve an 80% level of reporting of members' ethnicity. Since this information is self reported from members, it is very challenging for Plans to require and achieve, unless it is mandated on the application.	This will remain an optional field for the Covered CA enrollment application.	1-4-21
	1.01.2 Demographic Data Collection	GENERAL COMMENTS ON RACE & ETHNICITY: The most effective and consistent way for consumers to provide Race and Ethnicity information is at time of enrollment so Covered California can also use this for your purposes as well. We request Covered California pursue requiring this question at time of information with a decline to state option. The MHA report indicated that a comparison of NCQA to SB 853 was performed. We request that analysis be made publicly available. The NCQA Multicultural Health distinction appears to expect plans to follow OMB Race/Ethnicity code sets. We request Covered California review existing 834 codes and sent to carriers to ensure consistency and that if there are any changes needed that they be made at least one year before requiring plans meet this NCQA distinction. The following roll-up of codes may be something to use for consistency across plans: https://www.ncbi.nlm.nih.gov/books/NBK219757/	The HMA NCQA Multicultural Health Care Distinction Crosswalk document has been posted to https://hbex.coveredca.com/stakeholders/plan-management/ Covered CA is working to align race and ethnicity categories definitions across data sources and processes.	1-4-21

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	1.01.2	CMA supports Covered California's efforts to address health equity with the goal of eliminating disparities via better measurement and quality improvement. Covered California should prioritize data collection and quality improvement metrics that capture the diversity of all populations (including racial, ethnic, sexual, gender, disabled and other underrepresented groups) in clinical practices to fully understand the health status and needs of all individuals as well as to recognize the burdens and disparities they face in obtaining equity-oriented, quality care. We appreciate the continuing requirement to capture 80% of Covered California member race/ethnicity self-identification data. We also support the change to require Healthcare Evidence initiative (HEI) data submissions rather than issuer self-reporting as this will lead to more comprehensive and accurate data collection. In order to fully understand the inequities and disparate outcomes for minoritized and marginalized communities and to guide public policies, equitable allocation of health care resources, and public health interventions, additional data is needed. However, all data collection on race, ethnicity, language ability, sexual orientation, gender, and disability be culturally sensitive and appropriate and respect individual privacy.	Thank you for your comment.	1-4-21
	1.01.2 Demographic Data Collection	As noted in our comments above, we believe that Race and Ethnicity should be a mandatory field in the enrollment application. The enrollment application should be updated to include a "decline to state" option, and Covered CA should update the 834 files with a "decline to state" field accordingly. We respectfully request additional information about Covered CA's process for reviewing race and ethnicity data for Off-Exchange enrollment. This data is not collected consistently across all product lines, and as such, more information on this review process would be greatly appreciated.	This will remain an optional field for the Covered CA enrollment application. We plan to discuss the process for reviewing off-Exchange members' race and ethnicity self-identification with all issuers.	1-4-21
	1.01.2	Health Net requests that the reference to Off Exchange race and ethnicity be removed. While we may discuss the HEI data, it is too soon to include this in the Contract due to a lack of standardization for off Exchange data across carriers. Health Net would also like to request that Covered California allow members to "decline to state" if they do not want to provide race and ethnicity information.	The proposed contract requirement for 2022 is engagement with Covered CA staff to review off-Exchange members' race and ethnicity self-identification data. There is no 2022 proposed threshold or Performance Guarantee for these members' data. Collection of accurate demographic data is critical to effective health disparities identification and reduction efforts.	1-4-21
	1.01.2 Demographic Data Collection	We appreciate the revision of 1.1.2. as it applies to the new Healthcare Evidence Initiative (HEI). Advocates suggest the following language be added to 1.1.2: For Measurement Year 2022, the Contractor must achieve eighty percent (80%) self-identification of race and ethnicity data for Covered California Enrollees. The Contractor must demonstrate compliance by including a valid race and ethnicity attribute for at least 80% of Covered California Enrollees in its Healthcare Evidence Initiative (HEI) data submissions. A report on compliance with the data provisions of 1.1.2. may be released to the public by Covered California	Your language addition is under consideration.	1-4-21

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	1.01.2 Demographic Data Collection	We also suggest that 1.1.2 which references specific race/ethnicity data requirements precede 1.1.1 which references extending data requirements beyond race/ethnicity data categories to other data categories.	Your suggested revision is under consideration.	1-4-21
	1.01.2 Demographic Data Collection	•Race and Ethnicity should be a mandatory field in the enrollment application and include an option for "decline to state". Collection at time of enrollment is the most efficient and consistent way for collecting this data •Allow proxy methodology to supplement self-identified data.	This will remain an optional field for the Covered CA enrollment application. The requirement is to achieve 80% member self-identification; while proxy methodology can be used to supplement self-identification data for disparities analyses purposes, it does not meet the requirement's purpose since it cannot be used to assign race or ethnicity at the person level.	1-4-21
	1.01.2 Demographic Data Collection	Sharp Health Plan recommends that enrollees self-identify race/ethnicity during the Covered California enrollment process, for the most reliable collection process, with the data transmitted by Covered California to QHPs on the eligibility file. QHPs can then include that information in the date submitted to the HEI. Given this proposed model, it would not be appropriate to require QHPs to meet a threshold for race and ethnicity data, as the data would be collected by Covered California.	Covered CA agrees member self-identification at the point of enrollment is an important opportunity for data collection and will continue to transmit that information to QHP issuers in the 834 file. The 80% capture rate is a specific threshold for collection of demographic data that supports disparities analysis and represents a requirement for issuers to conduct additional collection attempts if necessary to meet that threshold.	1-4-21
	1.02. Identifying Disparities in Care	Advocates had originally intended for requirements to improve quality and reduce health disparities to be applied across all lines of business of the participating plans. We understand that there has been considerable pushback. However, we remind Covered California that AB 929 gives Covered California authority to obtain information on the individual and small group market both on and off exchange which amounts to over 4 million lives. The disparities goals should be based on the entire individual and small group markets. Including the entire individual and small group markets will also help Covered California deal with the issue of small samples sizes when identifying disparities in chronic diseases. Additionally, in order to deal with the problems of small population sizes for some demographic groups, measurements and results could potentially be averaged over 3-5 years.	Covered CA plans to expand its internal disparities analyses as additional data becomes available through HEI submissions.	1-4-21

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	1.02.1 Identifying Disparities in Care	Please Amend: 1.2.1 as follows: Covered California recognizes that the underlying causes of health disparities are multifactorial and include social and economic factors that impact health. While the healthcare system cannot single handedly eliminate health disparities, there is evidence to show that when disparities are identified and addressed in the context of health care, they can be reduced over time through activities tailored to specific populations and targeting select measures. Therefore, Covered California is requiring the Contractor to regularly collect and report data on its Covered California Enrollees and off-exchange members to identify disparities, measured over time, and determine disparity reduction efforts and targets to be mutually agreed upon by Covered California and the Contractor. Disparity reduction efforts, targets and progress towards meeting goals may be released to the public by Covered California.	Thank you for your recommendation. We will review and consider your proposed amendment.	1-4-21
	1.02.2 1.03.2	(Also recorded in 1.03.2) Sutter Health Plan supports the changes made by Covered California related to collecting HEDIS and demographic data to understand health disparities in its population. As part of an integrated delivery system, Sutter Health Plan understands the importance of capturing this data in order to develop meaningful interventions to improve health outcomes across populations.	Thank you for your comment.	1-4-21
	1.02.2 Identifying Disparities in Care	1.2.2. We understand this is a transitional year for Covered California in terms of its Quality Improvement Strategy. As a national leader we urge Covered California to provide an unequivocal signal to QHPs that it plans to add additional measures tied to mental health and other chronic diseases for plan year 2023 and beyond. Advocates request the following amendment: Covered California will add additional measures with stakeholder input, to track disparities in care and health outcomes in additional areas including mental health and other chronic diseases for plan year 2023 and beyond.	Thank you for your recommendation, we will review and consider your proposed edits.	1-4-21
	1.03.2 1.02.2	(Also recorded in 1.02.2) Sutter Health Plan supports the changes made by Covered California related to collecting HEDIS and demographic data to understand health disparities in its population. As part of an integrated delivery system, Sutter Health Plan understands the importance of capturing this data in order to develop meaningful interventions to improve health outcomes across populations.	Thank you for your comments.	1-4-21
	1.03.2	We are concerned with removing the RAND QDART tool as an additional source of race and ethnicity data. Please clarify if Covered CA intends to administer the QDART methodology for all data through the aggregation of HEI data. Covered CA should also allow QHPs to use a proxy methodology to supplement self-identified data. We recommend additional review of this proposed requirement, as removing the RAND QDART tool could potentially conflict with coding permitted with the NCQA Multicultural Healthcare Distinction.	At this time, Covered CA does not intend to administer the QDART methodology for all data through the aggregation of HEI data. While proxy methodology can be used to supplement self-identification data for disparities analyses purposes, it does not meet the requirement's purpose since it cannot be used to assign race or ethnicity at the person level. We will work with issuers and NCQA to address any potential contradictions in disparities reduction requirements.	1-4-21

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	1.03.2	1.3.2. Advocates request the addition of the following language: The Contractor will reduce an identified disparity based on the mutually agreed-upon health disparities reduction intervention proposal. The Contractor must report progress through submission of the disparities intervention reporting template. Covered California will assess the Contractor's reduction in their intervention disparity based on the submitted HEDIS measures sample per Article 1, Section 1.02. The results of Covered California's assessment may be released to the public by Covered California.	Thank you for your recommendation. We will review and consider your proposed amendment.	1-4-21
	1.03.2	1.3.2.2. We have consistently and strongly opposed plans being allowed to choose which targets they meet. Plans that wish to work on a different disparity metric should be required to demonstrate no disparities in Covered California's selected measures. Advocates request the following amendment: "If the Contractor does not elect either HbA1c Control <8.0% or Controlling High Blood Pressure for its intervention, the Contractor must demonstrate to Covered California that there is no disparity. Additionally, Contractor must submit the patient-level HEDIS measure file for any additional metrics to Covered California for their approved intervention HEDIS measure. The request to use additional metrics and the results may be shared with the public by Covered California."	Thank you for your recommendation. We will review and consider your proposed amendment.	1-4-21
	1.04 Statewide Focus Health Equity Collaborative Efforts	The plans are generally supportive of the requirement to participate in collaboratives that align with the healthcare needs of their members. We are requesting additional information from Covered CA about which collaboratives would be acceptable to fulfill the needs of this measure.	Thank you for your comment, we will further clarify this requirement.	1-4-21
	1.04 Statewide Focus Health Equity Collaborative Efforts	**Statewide Focus Health Equity Collaborative Efforts**: It is unclear from the way the contract language what collaborative efforts Covered California is referencing here.	Thank you for your comment, we will further clarify this requirement.	1-4-21

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	1.05 Culture of Health Equity Capacity Building	**Culture of Health Equity Capacity Building:** We support the requirement that health plans achieve or maintain NCQA Multicultural Health Care Distinction. As we have noted in the past, NCQA distinction is not a substitute for Covered California setting enforceable contract requirements. We also note that NCQA components are not publicly available and not developed with the input of stakeholders outside the health care industry. NCQA distinction should be in addition to, not in place of, California-specific requirements developed in a public process with input from a broad range of stakeholders.	Covered CA does not intend to replace any disparities reduction requirements with the NCQA Multicultural Health Care Distinction.	1-4-21
	1.05.2	Sharp Health Plan does not agree with this requirement, which would require staffing costs and time to be redirected from other member care and quality initiatives. Sharp Health Plan recommends a pilot to evaluate the value of certification in reducing health disparities, before implementing a statewide mandate.	Covered CA intends the requirement to achieve NCQA Distinction in Multicultural Health to complement existing disparities reduction requirements and support the provision of high quality, individualized, equitable care to members.	1-4-21
	1.05.2 Culture of Health Equity Capacity Building	VHP requests that the timeline for achieving the NCQA Multicultural Health Care Distinction be moved to end of 2023 instead of 2022.	Thank you for your comment, we will continue to assess an appropriate timeline to meet this requirement.	1-4-21
	1.05.2 Culture of Health Equity Capacity Building	We do not recommend requiring that plans achieve, or be in the process of achieving, the NCQA Multicultural Health Care Distinction. There are many different approaches that organizations can take to address health disparities. Kaiser Permanente employs multiple strategies to promote equitable care. While obtaining the NCQA Distinction in Multicultural Health Care is one approach, it is not the only avenue. If a QHP does seek and obtain the NCQA Multicultural Health Care Distinction, we recommend having this replace other requirements.	Thank you for your comment. Covered CA does not intend to replace any disparities reduction requirements with the NCQA Multicultural Health Care Distinction.	1-4-21
	1.05.2 Culture of Health Equity Capacity Building	•Carriers can provide a plan for receiving this distinction but should not be required to have it completed by year end 2022 as that timing may not be possible for all Carriers •Covered Ca's Race and Ethnicity codes need to be aligned to NCQA's Distinction in Multicultural Health OMB Race and Ethnicity codes and definitions as they need to have common mapping	Thank you for your comment, we will continue to assess an appropriate timeline to meet this requirement. *Include in response:* Covered CA is working to align race and ethnicity categories definitions across data sources and processes.	1-4-21

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	1.05.2 Culture of Health Equity Capacity Building	CMA supports the requirement that Contractors must achieve or maintain NCQA Multicultural Health Care Distinction for Measurement Year 2022. As an important component in reducing health disparities, CMA recognizes the importance of providing timely and accurate language assistance for patients. Many Qualified Health Plans (QHPs) do not have the ability to provide access to interpretation services on short notice. Patients do not necessarily notify physicians that they need interpretation services prior to their appointment. Physicians are often unable to secure same day interpretation services from the plan. Even when advance notice is given, it is very rare that live, in-person interpretation services are provided by the plan instead of phone services. QHPs should be required to prioritize live, same-day interpretation services in all threshold languages and to cover the cost of these services so that additional financial burdens are not placed on physician practices.	Thank you for your comment. Access to appropriate, equitable care is a priority for Covered CA. Your suggested contract requirements will be taken into consideration.	1-4-21
	1.05.2 Culture of Health Equity Capacity Building	We appreciate the intent behind this new requirement. However, we respectfully ask Covered CA to allow more time to achieve this accreditation and move to at least 2023 or later. In addition, Covered CA will need to align the race and ethnicity codes with NCQA's race and ethnicity codes and definitions, and to have common mapping. We are also asking Covered CA to consider approaches - other than the accreditation requirement - that carriers can implement to achieve the overarching goals of reducing health disparities and health equity.	Thank you for your comment, we will continue to assess an appropriate timeline to meet this requirement. *Include in response:* Covered CA is working to align race and ethnicity categories definitions across data sources and processes.	1-4-21

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Article 2 Population Health Management		**Population Health Management:** We support the requirement for health plans to provide Population Health Management plans based on data driven risk stratification, predictive analytics, and standardized assessment processes. While we understand the attraction and potential benefits of adopting risk stratification as part of a broader Population Health Management (PHM) strategy, we are troubled by reports of racial bias in many of these types of algorithms. Obermeyer et al. for example, recently found evidence of bias in their review of an industry-wide approach to predicting risk used by hospitals, health systems, insurance companies, and government agencies to predict which patients will benefit most from care management programs, and target them accordingly. The problem, they discovered, is "not from the particulars of the algorithm, but from the outcome the algorithm was asked to predict." Whereas most health systems choose "cost" as the proxy for "health," evidence shows that Black patients consistently generate fewer costs than White patients at the same level of health. The reasons are widespread and varying from unequal access to health care and treatment to a well-founded mistrust of health care institutions as a result of historic and systemic racism including a shameful history of discrimination, experimentation, and exploitation of Black and Indigenous bodies that impacts the quality of care that people of color receive today. This mistreatment also extends to persons with disabilities and LGBTQ+ communities. For example, many individuals with disabilities were forced to undergo sterilization and to enter institutions and asylums; psychiatry classified homosexuality as a mental disorder until 1973 and continues to pathologize transgender identities today. We therefore recommend the following: ● Algorithms should be evaluated and certified to not create a disparate racial impact: Covered California should work with health plans and researchers to ensure that algorithms do not create a disparate racial impact. Algorithms should be based on health conditions, risk factors, and disease progressions rather than just utilization and cost which is not an accurate measure of health risk for communities of color and vulnerable communities who are less likely to utilize care per the findings of Obermeyer et al. ● Covered California (potentially in partnership with NCQA) should provide a standardized, validated risk stratification and management tool as a floor for plans, health and health related organizations to use to assess and manage risk, then let organizations add to it. Risk should not change when people move from plan to plan or system to system. ● Entities should be required to publish their models: Because a lot of these models have racial, age and disability-related bias built in, each plan should be required to publish their model so it's fully transparent and researchers can understand the models, critique them and suggest improvements. ● Covered California should require and incentivize the use of broad risk assessment tools such as PRAPARE and trauma screenings to ensure plans and providers adequately capture the needs of all beneficiaries including rising risk populations such as children.	Covered California acknowledges the importance of ensuring reductions in health disparities. We will continue to explore your recommendations as we develop and strengthen this requirement in 2023 and beyond.	1-4-21

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	2.01	Require Qualified Health Plans (QHPs) to include in its population health management plan submission a description of how it is supporting providers transition to advanced primary care models, including Patient-Centered Medical Homes (PCMH), and the proportion of practices with which they contract that are advanced primary care models, including PCMH (Section 2.01).	Covered California will consider your recommendations as we develop and strengthen this requirement.	1-4-21
	2.01	Sutter Health Plan is in support of Covered California's transition from disparate care management programs to the overarching NCQA Population Health Management requirements. Sutter Health Plan supports focusing on the population at large by partnering and engaging members throughout their health care journey.	Thank you for your comment.	1-4-21
	2.01.2	The NCQA reports requested are created for the use of NCQA accreditation and therefore not intended for use beyond accreditation. We do not plan to share these reports for other audiences or uses. Our NCQA accreditation status, which is determined by their assessment of the requested reports, is publicly available.	The intent of this requirement is to reduce burden and duplicative work for issuers by submitting the same reports required for NCQA accreditation. However, Covered California will adjust language to clarify that we will accept a Population Health Management Plan with equivalent components as described in the contract.	1-4-21
	2.01.2	We respectfully request Covered California rephrase the requirement to submit entire information to Covered California. There is information included in the reporting to NCQA that applies to other products that are not subject to Covered California oversight. If QHPs experience such issues that they can collaboratively work with Covered California to provide information needed.	The intent of this requirement is to reduce burden and duplicative work for issuers by submitting the same reports required for NCQA accreditation. However, Covered California will adjust language to clarify that we will accept a Population Health Management Plan with equivalent components as described in the contract.	1-4-21
	2.01.2	As written, this article requires the QHPs to submit the entire data set that would be submitted to NCQA to Covered CA - including data for products that are not subject to Covered CA purview and oversight. CAHP respectfully requests that Covered CA consider rephrasing this requirement to instead request that QHPs share their Population Health Management plans with Covered CA. We believe that this approach will satisfy Covered CA's initiatives regarding population health management.	The intent of this requirement is to reduce burden and duplicative work for issuers by submitting the same reports required for NCQA accreditation. However, Covered California will adjust language to clarify that we will accept a Population Health Management Plan with equivalent components as described in the contract.	1-4-21

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	2.01.2	CMA supports the requirement that all QHPs maintain a population health management program that improves the ability of physicians and other health care providers to identify social factors and needs that impact health. We believe that a more comprehensive strategy that accounts for screenings, health assessments, case management, data collection and monitoring and risk stratification is a fundamental and much-needed improvement to the overall managed care plan responsibility. However, the plans should not develop these population health management programs in isolation. We would recommend that the plans be required to include practicing physicians from the plans' geographic service areas in the development and operationalization of their program. This local input will ensure that plans receive feedback directly from practicing physicians on the most effective ways to improve care coordination, communication and data sharing. One of the challenges in managing high-risk populations is the inability to share appropriate levels of data with providers in a meaningful and timely way. Physicians and patients would greatly benefit from additional information about a patient's social needs, including their access to food, clothing, household goods and transportation. If a health plan is obtaining this information through its patient risk assessment, CMA would recommend that a mechanism be developed to appropriately and legally share this patient information with the physicians that are caring for the patients directly. This information should also be available electronically, integrated with the patient's existing health records, and updated in a timely fashion. The data should also be collected in such a way so that it can be easily transmitted in a usable format and incorporated into the risk stratification process. We recommend that initial risk assessment be standardized to the extent that Covered California is able to compare data across plans and develop methods to evaluate the success of their population health management programs. Additionally, to the extent that member-contact screening requirements are passed down to physicians, Covered California should make sure there is adequate reimbursement for such screenings and for any subsequent data collection and submission done by physicians. Screening tools should be separate from screenings used for clinical screenings, cost-effective, and not negatively impact medical care or create additional burden for physicians. Risk Stratification As part of their PHM programs, QHPs will be required to risk stratify the population to determine the level of intervention that members require based on all available data sources, as well as the results of the member-contact screening. CMA urges the department to ensure that it implements efforts to identify and address bias in the use of these risk stratification algorithms and to avoid introducing or exacerbating health care disparities in connection with the use of these tools, particularly since they will be used for vulnerable populations. While recognizing there is some proprietary intellectual property in the development of risk stratification algorithms, we would also encourage greater transparency about how these tools are being deployed as well as the underlying data being used to generate any outputs. Any algorithms used by plans should be validated nationally and required to use as complete a set of data as possible. The reliance of risk stratification algorithms on inputted data can lead to certain associated risks. These algorithms require access to large quantities of high-quality data during training and validation. Without accurate and meaningful data, algorithms may not be correct or may not be applicable to different populations. The source of the data used during training will impact the algorithm significantly, and models must be tested on a variety of data sets for validation purposes in order to create an algorithm that works accurately across patient populations. Otherwise, an algorithm may be trained and validated, only to produce inaccurate results when used with a population that varies based on race, gender, or socioeconomic background, medical history, hospital setting, or geographic location. Furthermore, the biases of training data can risk exacerbating existing health disparities. If models only reflect the limited populations on which they are trained, they will be less accurate for minority groups, and majority groups will have better access to accurate algorithms and thus superior health care. In addition to training and validating across broad populations, QHPs should work towards increased transparency in order to provide opportunities to disclose and address system bias. Understanding data provenance, including key attributes of the training data population, is necessary to evaluating the accuracy of the risk stratification algorithms and the risks of applying the system to a different population.	Covered California acknowledges the importance of partnering with clinicians in the mission to improve health care delivery. We will continue to explore your recommendations as we develop and strengthen this requirement in 2023 and beyond.	1-4-21

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Article 3: Health Promotion and Prevention		We appreciate the inclusion of several important preventive measures in the draft Attachment 7, and particularly commend the emphasis on tobacco use. However, in order to properly assess the quality of services to address substance use disorders, preventive measures should be in place to screen and provide for early intervention for unhealthy drug use beyond tobacco use. In fact, the U.S. Preventive Services Task Force (USPSTF) recently finalized a recommendation that providers ask "questions about unhealthy drug use in adults age 18 or older…when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred." This recommendation requires that QHPs provide coverage, without cost sharing, for unhealthy drug use screening. As such, Covered California should begin closely monitoring availability of this service among the different plans, and Article 3 should include a requirement that contractors report on the number of enrollees who are accessing screening services for unhealthy drug use and on other actions taken to ensure that primary care providers are in fact complying with this new requirement.	Covered California will consider your recommendation as we continue to develop and strengthen this requirement in 2023 and beyond.	1-4-21
Article 3: Health Promotion and Prevention		Additionally, Covered California must ensure that these wellness programs are accessible for limited English Proficient (LEP) beneficiaries and persons with disabilities. For example, 3.4.2. should be amended to say: The Contractor must provide a Centers for Disease Control and Prevention (CDC)-recognized Diabetes Prevention Lifestyle Change Program, also known as a Diabetes Prevention Program (DPP) to its eligible Enrollees. The DPP must be accessible to all beneficiaries including limited English Proficient (LEP) and persons with disabilities as well accessible both in-person and online."	Covered California will add your suggested language into the 2022 Attachment 7.	1-4-21
	3.02.2	This data is not part of the IHA AMP measure set, and SHP has concerns about the addition of new measures outside of nationally identified measure currently in use as they dilute the impact and focus of providers and medical groups.	The proposed requirement in the 2022 Attachment 7 asks issuers to report on strategies to improve performance on two health promotion measures that are part of the Quality Rating System (QRS): the Medical Assistance with Smoking and Tobacco Use Cessation and the Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC) measures. Our health promotion focus aligns with DHCS priorities per its quality strategy emphasis on smoking cessation and its inclusion of the WCC measure as a Managed Care Plan incentive metric. Though these two measures are not part of the IHA's AMP set, we will be working with IHA and others to advance the use of these and other measures that focus on two of the most important health behaviors.	1-4-21

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	3.03.2	This data is not part of the IHA AMP measure set, and SHP has concerns about the addition of new measures outside of nationally identified measure currently in use as they dilute the impact and focus of providers and medical groups.	The proposed requirement in the 2022 Attachment 7 asks issuers to report on strategies to improve performance on two health promotion measures that are part of the Quality Rating System (QRS): the Medical Assistance with Smoking and Tobacco Use Cessation and the Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC) measures. Our health promotion focus aligns with DHCS priorities per its quality strategy emphasis on smoking cessation and its inclusion of the WCC measure as a Managed Care Plan incentive metric. Though these two measures are not part of the IHA's AMP set, we will be working with IHA and others to advance the use of these and other measures that focus on two of the most important health behaviors.	1-4-21
	3.04.2	CAHP recommends that Covered CA keep the existing requirement for the Diabetes Prevention Program (DPP) to be accessible either online or in-person. DPP vendors offering in-person classes are limited; moreover, utilization for in-person DPP programs have been limited.	Covered California is committed to ensuring that all Enrollees have access to preventative diabetes care and education. Providing both in-person and online DPP services ensures equitable access for these services. This requirement also aligns with CMS' requirements on DPP.	1-4-21
	3.04.2	Health Net does not recommend changing the DPP program from being "accessed either online or in person," to "must be accessible both online and in-person." DPP vendors offering in-person classes are limited, and we have seen limited in-person utilization for Medicare members. Also, the correct DPP website should be: https://nccd.cdc.gov/DDT_DPRP/Programs.aspx	Covered California is committed to ensuring that all Enrollees have access to preventative diabetes care and education. Providing both in-person and online DPP services ensures equitable access for these services. This requirement also aligns with CMS' requirements on DPP.	1-4-21
Article 4 MENTAL HEALTH AND SUBSTANCE USE DISORDER TREATMENT		We urge Covered California to require all measures to be disaggregated by race and ethnicity even those that are not selected for the Disparities Reduction Intervention	Covered California will continually look to expand the measures that can be disaggregated by race and ethnicity.	1-4-21

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	4.01.2	We respectfully request Covered California rephrase the requirement to submit entire information to Covered California. There is information included in the reporting to NCQA that applies to other products that are not subject to Covered California oversight. If QHPs experience such issues that they can collaboratively work with Covered California to provide information needed.	Covered California will update the requirements to allow issuers to submit an alternative report. If an issuer is not accredited with NCQA or will not submit the NCQA accreditation reports, an issuer must submit a separate report for their Covered California population that addresses each of the NCQA Network Management standards for behavioral health.	1-4-21
	4.01.2	The NCQA Network Management Requirements apply to all lines of business, including products that are not subject to Covered CA oversight. We request that Covered CA include such disclaimers in this section and to instead ask issuers to work collaboratively to address any concerns.	Covered California will update the requirements to allow issuers to submit an alternative report. If an issuer is not accredited with NCQA or will not submit the NCQA accreditation reports, an issuer must submit a separate report for their Covered California population that addresses each of the NCQA Network Management standards for behavioral health.	1-4-21
	4.01.2	The NCQA reports requested are created for the use of NCQA accreditation and therefore not intended for use beyond accreditation, and thus it would not be appropriate to share these reports for other audiences or uses. Our NCQA accreditation status, which is determined by their assessment of the requested reports, is publicly available.	Covered California will update the requirements to allow issuers to submit an alternative report. If an issuer is not accredited with NCQA or will not submit the NCQA accreditation reports, an issuer must submit a separate report for their Covered California population that addresses each of the NCQA Network Management standards for behavioral health.	1-4-21
	4.01.3	Please define depression treatment; is it acute or chronic? Will Covered California define specific CPT codes that the health plans will need to use?	The depression treatment penetration rate measure aims to understand the gap between depression prevalence and treatment. Depression prevalence is assessed using the National Survey On Drug Use And Health (NSDUH): Model-Based Prevalence Estimates from major depressive episodes (MDE) in the past year. Covered California will measure this in HEI. Covered California is currently finalizing the specifications for this rate and will engage with issuers to review the specifications.	1-4-21
	4.01.3	"Penetration rate is determined by dividing the number of members who receive a behavioral health service by the expected prevalence rate of behavioral health needs within a state or region, multiplied by 100 to reach a percent" Can Covered CA please define "expected prevalence rate of behavioral health needs within a state or region" - will this rate be provided to health plans be by region or state to ensure consistency across plans?	The depression treatment penetration rate measure aims to understand the gap between depression prevalence and treatment. Depression prevalence is assessed using the National Survey On Drug Use And Health (NSDUH): Model-Based Prevalence Estimates from major depressive episodes (MDE) in the past year. Covered California will measure this in HEI. Covered California is currently finalizing the specifications for this rate and will engage with issuers to review the specifications.	1-4-21

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	4.01.3	Please define "expected prevalence rate of behavioral health needs within a state or region." Please also clarify if the rate will be provided to the plans to ensure consistency across all participating QHPs.	The depression treatment penetration rate measure aims to understand the gap between depression prevalence and treatment. Depression prevalence is assessed using the National Survey On Drug Use And Health (NSDUH): Model-Based Prevalence Estimates from major depressive episodes (MDE) in the past year. Covered CA will measure this in HEI. Covered California is currently finalizing the specifications for this rate and will engage with issuers to review the specifications.	1-4-21
	4.01.3	4.1.3. We agree with the inclusion of all of the current criteria under Article 4, but we believe Covered California should do more to monitor availability of and access to mental health and substance use disorder services as utilization rates across public and commercial insurance continue to be low. We appreciate that the revised contract requires health plans in 4.13. to "engage with Covered California to review its depression treatment penetration rate and its behavioral health service utilization rate using Health Evidence Initiative (HEI) data." Advocates request that Covered California amend the requirement to report utilization rates based on the average number of visits per Covered California member in addition to current reporting methods for utilization. Specifically: 4.1.3. The Contractor must engage with Covered California to review its depression treatment penetration rate and its behavioral health service utilization rate using Health Evidence Initiative (HEI) data to further understand Enrollees' access to behavioral health services within the Contractor's network. Penetration rate is determined by dividing the number of members who receive a behavioral health service by the expected prevalence rate of behavioral health needs within a state or region, multiplied by 100 to reach a percent. Utilization rates will be based on the average number of visits per Covered California member. Covered California may publicly report the results.	Covered California will publicly report on quality measures through AB 929 reporting. We are currently determining what will be reported through AB 929. Through several new measures required in 2022, Covered California is aiming to gain experience with tracking depression treatment measures and other behavioral health measures to determine the most meaningful measures. The depression treatment penetration rate measure aims to understand the gap between depression prevalence and treatment. Depression prevalence is assessed using the National Survey On Drug Use And Health (NSDUH): Model-Based Prevalence Estimates from major depressive episodes (MDE) in the past year. Covered California will measure this in HEI.	1-4-21

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	4.01.3	We also believe Covered California should do more to monitor availability of and access to medication-assisted treatment (MAT) and compliance with both federal and state mental health and substance use disorders parity requirements. Despite enormous gains in recent years, the vast majority of Californians who need access to MAT are still not receiving it partly because some plans continue to impose barriers and conditions to accessing the services, such as prior authorization. The Centers for Medicare and Medicaid Services (CMS) have interpreted provisions of the federal parity law as implying that prior authorization "may be required for some (but not all) MH/SUD benefits, as well as for some (but not all) medical/surgical benefits." For MAT, this means that treatment with at least one medication must be covered without requiring prior authorization. In addition, when its use is permitted, prior authorization requirements for MAT must be no more stringent than prior authorization requirements for medical and surgical benefits. While recently approved state legislation seeks to better enforce these parity requirements, Covered California plays an important role in ensuring compliance among QHPs. For that reason, Attachment 7 should include a requirement for plans to report, on an annual basis, the number of enrollees accessing MAT and levels of retention. In addition, plans should submit evidence demonstrating full compliance with parity requirements and evidence that the plan is taking steps to remove barriers to MAT, particularly where MAT intake remains low. We recommend that this reporting be required for all medications for opioid use disorders, but believe evaluation should focus primarily on buprenorphine treatment and methadone maintenance services.	Covered California is proposing to greatly expand the measures we are using to track opioid use disorder and medication assisted treatment. Within Article 4.04.4, we will track the following opioid use disorder measures using HEI data and engage with issuers to review their performance. 1) Use of Pharmacotherapy for Opioid Use Disorder (NQF #3400); 2) Concurrent Use of Opioids and Benzodiazepines (NQF #3389); 3) Use of Opioids at High Dosage in Persons Without Cancer (NQF #2940); and 4) Concurrent Use of Opioids and Naloxone. Additionally, Covered California is proposing to require issuers to measure and report in the number of active X waiver licensed prescribers in its network and the number of total X waiver licensed prescribers in its network to monitor access to opioid use disorder treatment. An active X waiver licensed prescriber is defined as a provider who has written one or more MAT prescriptions in the past 12 months.	1-4-21
	4.02 Offering Telehealth for Behavioral Health Services	4.2 Offering Telehealth for Behavioral Health Services We appreciate Covered California monitoring and evaluating the use of telehealth for the provision of behavioral health services. Both the treating health professional and the consumer should have the choice of modality (telehealth or in-person). There should also be adequate privacy protections and data/information security to protect patient privacy.	Covered California agrees that providers and consumers should have the choice of telehealth or in-person visits and consumer privacy should be protected.	1-4-21

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	4.02.2	CMA strongly supports the requirement that Contractors must offer telehealth for behavioral health services, including audio-only telehealth services. There has been a significant increase in the use of telehealth for behavioral health services since the onset of the pandemic. Audio-only services are an important flexibility that should continue after the pandemic and are particularly important for older adults or other patients with impairments that may limit their ability to use some telehealth technologies. Additionally, CMA wants to ensure that health plans do not separately contract with third-party telehealth vendors that provide care to enrollees that is not coordinated with the care provided by the plan's contracted providers or the patients' treating providers. Professional services provided via telehealth should be part of the care provided to the patient by their physician, and not an unassociated provider that works through a third-party telehealth vendor. Covered California should ensure that telehealth is merely an alternate site to care delivery and not alternate care that is disassociated with the rest of the enrollees' medical care. This is particularly true for behavioral health services provided through telehealth, which may already be insufficiently integrated with the rest of an enrollee's medical care. While the use of telehealth should be encouraged, such care should be part of the care provided to the patient by their physician, and not an unassociated provider that works through a third-party telehealth vendor. Instead, CMA encourages Covered California to ensure that health plans offer their contracted providers a way to provide care via telehealth to their patients in a way that strengthens the patient-physician relationship, ensures continuity of care, and does not result in incomplete or bifurcated medical records based on the modality of care.	Covered California agrees that telehealth services provided by contracted network providers is preferred. We also recognize that this is not always feasible for some providers or services and therefore third-party telehealth vendors can play an important role in expanding access. We will edit the language in Article 4.02.2 to encourage contracted issuers to use network providers for telehealth services. Covered California agrees that ensuring coordinated care between telehealth vendors and a patient's regular clinicians is important. In Article 10.01.2, we require issuers to report "How the Contractor facilitates the integration and coordination of care between third party telehealth vendor services and primary care or other contracted providers." This reporting includes telehealth for behavioral health services.	1-4-21
	4.03.2	•Remove as this requirement is not a HEDIS measure required for non-Medicare populations and will impose significant burden on providers and plans to collect this data.	Covered California will move forward with requiring submission of the Depression Screening and Follow-Up Plan (NQF #0418) measure results. This measure is being tested in the 2021 IHA ACO Measure Set and is included in the 2021CMS Medicaid Adult Core Measure Set. Other purchasers, like CalPERS, are interested in pursuing this measure. This measure is also included in the CQMC Core Set for Behavioral Health which is supported by CMS and AHIP (https://www.qualityforum.org/CQMC_Core_Sets.aspx). We are looking to build on this requirement in the 2023 contract.	1-4-21

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	4.03.2	This requirement is not a HEDIS measure required for non-Medicare populations and will impose significant burden on providers and plans to collect this data. We respectfully ask Covered CA to remove this requirement.	Covered California will move forward with requiring submission of the Depression Screening and Follow-Up Plan (NQF #0418) measure results. This measure is being tested in the 2021 IHA ACO Measure Set and is included in the 2021CMS Medicaid Adult Core Measure Set. Other purchasers, like CalPERS, are interested in pursuing this measure. This measure is also included in the CQMC Core Set for Behavioral Health which is supported by CMS and AHIP (https://www.qualityforum.org/CQMC_Core_Sets.aspx). We are looking to build on this requirement in the 2023 contract.	1-4-21
	4.03.2	We recommend including only publicly-reported and validated measures (such as HEDIS measures) which have national benchmarks available when reporting measures and commenting on related programs.	Covered California will move forward with requiring submission of the Depression Screening and Follow-Up Plan (NQF #0418) measure results. This measure is being tested in the 2021 IHA ACO Measure Set and is included in the 2021CMS Medicaid Adult Core Measure Set. Other purchasers, like CalPERS, are interested in pursuing this measure. This measure is also included in the CQMC Core Set for Behavioral Health which is supported by CMS and AHIP (https://www.qualityforum.org/CQMC_Core_Sets.aspx). We are looking to build on this requirement in the 2023 contract.	1-4-21
	4.04 Appropriate Use of Opioids	4.4 Appropriate Use of Opioids We commend Covered California for requiring contractors to implement measures to decrease overall adherence to opioids as a tool to reduce overdoses. However, we caution that drastic measures that put patients in need of opioid treatment for pain at risk of not receiving appropriate medications should be avoided. Evidence indicates that strict opioid limits may be counterproductive because they may result in low-income patients losing access to medically necessary medications. While we do not read the Attachment 7 measures as strict limits, we urge Covered California to require Contractors to implement the least restrictive measures and to provide assurance that the adopted measures to decrease unnecessary opioid intake are not resulting in lack of access to appropriate care.	The opioid use disorder measures proposed in Attachment 7 are focused on a spectrum of addressing opioid use disorder from treatment to appropriate prescribing to access to treatment and overdose prevention. This is intended to promote a holistic approach to caring for patients with an opioid use disorder.	1-4-21
	4.04.1	We recommend that Covered CA collaborate with contracted QHP issuers to establish a methodology to assess performance, as there are no industry benchmarks.	Covered California will engage with issuers to establish methodologies, measure specifications and evaluate performance on measures tracked through HEI.	1-4-21

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	4.04.3	We respectfully request the requirement to measure and report the number of active x prescribers be removed since this is not currently tracked	Covered California will move forward with requiring issuers to measure and report the number of active X waiver prescribers. Issuers should be monitoring the number of X waiver licensed prescribers in their networks to ensure adequate access to medication assisted treatment. Issuers can use publicly available data from https://www.samhsa.gov/find-treatment on X waiver prescribers to determine which of their network providers have an X waiver. SAHMHSA provides downloadable CSV or Excel files that issuers can use. At this time, it is not feasible for Covered California to track this information through HEI data.	1-4-21
	4.04.3	Health Net recommends that Covered California perform further research on Active X waivers before adding language into the QHP Contract. Covered California can utilize data from the HEI submissions and SAHMSA to identify Active X waivers.	Covered California will move forward with requiring issuers to measure and report the number of active X waiver prescribers. Issuers should be monitoring the number of X waiver licensed prescribers in their networks to ensure adequate access to medication assisted treatment. Issuers can use publicly available data from https://www.samhsa.gov/find-treatment on X waiver prescribers to determine which of their network providers have an X waiver. SAHMHSA provides downloadable CSV or Excel files that issuers can use. At this time, it is not feasible for Covered California to track this information through HEI data.	1-4-21
	4.04.3	"An active X waiver licensed prescriber is defined as a provider who has written one or more MAT prescriptions in the past 12 months." The definition of active will lead to variations - health plans would only have line of sight to prescriptions written for our membership, processed by our PBM. Molina recommends to clearly define the medications that fall under "MAT Prescriptions" to ensure consistency across plans.	We will edit the language to specify that X waiver licenses are for prescribing buprenorphine and buprenorphine-naloxone. We specify that issuers must track active X waiver prescribers within their network.	1-4-21

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	4.04.3	The number of Active X waiver prescribers is not data that is currently collected nor tracked by the plans and this information and would require the plans to manually look up each prescriber on the U.S. Department of Health and Human Services (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA) website. We believe that this analysis is best done by Covered CA by leveraging the use of HEI pharmacy data submissions. Plans can only evaluate the availability of Active X waiver prescribers based on the MAT prescriptions written for the plan's membership, and these claims are usually processed by a plan's pharmacy benefits manager (PBM). Therefore, the plans do not have the ability to monitor the number of available Active X waiver prescribers that are actually providing MAT vs. "inactive" prescribers. For these reasons, we are asking Covered CA to remove this requirement.	Covered California will move forward with requiring issuers to measure and report the number of active X waiver prescribers. Issuers should be monitoring the number of X waiver licensed prescribers in their networks to ensure adequate access to medication assisted treatment. Issuers can use publicly available data from https://www.samhsa.gov/find-treatment on X waiver prescribers to determine which of their network providers have an X waiver. SAHMHSA provides downloadable CSV or Excel files that issuers can use. At this time, it is not feasible for Covered California to track this information through HEI data.	1-4-21
	4.04.3	•Remove as carriers do not track Active X Waiver Licensed prescribers in their system •Covered Ca could capture this data through the HEI Pharmacy data and outside sources that have identified Active X Waiver Licensed prescribers in California	Covered California will move forward with requiring issuers to measure and report the number of active X waiver prescribers. Issuers should be monitoring the number of X waiver licensed prescribers in their networks to ensure adequate access to medication assisted treatment. Issuers can use publicly available data from https://www.samhsa.gov/find-treatment on X waiver prescribers to determine which of their network providers have an X waiver. At this time, it is not feasible for Covered California to track this information through HEI data.	1-4-21
	4.04.4	We request that Covered CA collaborate with the contracted issuers on how performance may be rated since there are no industry benchmarks.	Covered California will engage with issuers to establish methodologies, measure specifications and evaluate performance on measures tracked through HEI.	1-4-21
	5.01.2	Health Net agrees but would like to add language that if one of these measures is removed from the QRS measure set in 2022, then it will be removed from the contract.	As QRS adjust its measure set, Covered California will reconsider the measures on the list. We will continue to develop and strengthen this requirement in 2023 and beyond.	1-4-21
	5.02.2	Please define "sensitive diagnosis" in subsection B of this article.	Covered California will adjust the contract language to clarify that outreach should be for all At-Risk Enrollees as defined in this section.	1-4-21

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	5.02.2 Supporting At-Risk Enrollees Requiring Transition	Health Net recommends adding clarification to 5.02.2.(1) (a) that outreach to enrollees "that their QHP will be ending" can be conducted by mail. Health Net recommends that the newly assigned QHP be responsible for the outreach to coordinate the transition of care as described in section 5.02.2 (2) (b) and (c)	Covered California does not specify the modality to allow flexibility for issuers to identify the most appropriate method. Covered California has established varying requirements for both current and newly assigned QHPs in the event of service area reduction. We will explore your recommendation as we continue to develop and strengthen this requirement in 2023 and beyond.	1-4-21
	5.02.2	Regarding item b) - Molina recommends to clearly define the following: At-Risk Enrollees with a sensitive diagnosis, i.e. what is considered a sensitive diagnosis	Covered California will adjust the contract language to clarify that outreach should be for all At-Risk Enrollees as defined in this section.	1-4-21
	6.02.2	6.02.2 (4) Health Net recommends that Covered California use the HEI data to identify this information.	At this time, we request the issuers submit this requirement. Covered California will consider your recommendation as we continue to explore the full capabilities of HEI data and develop this requirement in 2023 and beyond.	1-4-21
	6.02.2(4)	The analysis requested in this subsection can be done through HEI data submissions. We recommend that Covered CA use HEI data submissions for this information.	At this time, we request the issuers submit this requirement. Covered California will consider your recommendation as we continue to explore the full capabilities of HEI data and develop this requirement in 2023 and beyond.	1-4-21

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	6.03	Since ADT appears to be a requirement of Medicare, we are concerned in our ability to require this for Covered California enrollees. In addition, since many PCPs are assigned vs member selected and we are concerned with privacy limitations of sending notification to PCPs	Covered California is aware of this requirement for Medicare. At this time, our goal is to align with the federal requirement as we believe this data is critical to ensuring continuity of care. Covered California will align with the specifics of the CMS rule that hospitals must be able to demonstrate that they are sending the notifications "[t]o the extent permissible under applicable federal and state law and regulations, and not inconsistent with the patient's expressed privacy preferences." CMS also states, "Nothing in this proposed rule should be construed to supersede hospitals' compliance with HIPAA or other state or federal laws and regulations related to the privacy of patient information. We note that hospitals would not be required to obtain patient consent for sending a patient event notification for treatment, care coordination, or quality improvement purposes as described in this final policy. However, we also recognize that it is important for hospitals to be able to honor patient preferences to not share their information." Additional FAQs: https://chimecentral.org/wp-content/uploads/2020/04/FAQs-on-ADT-FINAL.pdf	1-4-21
	6.03	This is a Medicare requirement and not a requirement for non-Medicare enrollees and therefore will be challenging to meet for Covered California members. VHP recommends removing this requirement from the contract for this reason.	Covered California is aware of this requirement for Medicare. At this time, our goal is to align with the federal requirement as we believe this data is critical to ensuring continuity of care. The Medicare Conditions of Participation govern the actions of Medicare and Medicaid participating hospitals, rather than their actions for specific patients.	1-4-21

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	6.03	There are HIPAA concerns that would prevent QHPs from being able to comply with this requirement. When a PCP is assigned rather than selected by a member, there is no established relationship between the member and the PCP and therefore, the data cannot be shared with the PCP. The HIPAA concerns with apply to both HMO and PPO products. We believe that this requirement should be modified to reflect the existing constraints, as described above.	Covered California is aware of this requirement for Medicare. At this time, our goal is to align with the federal requirement as we believe this data is critical to ensuring continuity of care. Covered California will align with the specifics of the CMS rule that hospitals must be able to demonstrate that they are sending the notifications "[t]o the extent permissible under applicable federal and state law and regulations, and not inconsistent with the patient's expressed privacy preferences." CMS also states, "Nothing in this proposed rule should be construed to supersede hospitals' compliance with HIPAA or other state or federal laws and regulations related to the privacy of patient information. We note that hospitals would not be required to obtain patient consent for sending a patient event notification for treatment, care coordination, or quality improvement purposes as described in this final policy. However, we also recognize that it is important for hospitals to be able to honor patient preferences to not share their information." Additional FAQs: https://chimecentral.org/wp-content/uploads/2020/04/FAQs-on-ADT-FINAL.pdf	1-4-21
	6.03.2	CMA supports the requirements for increased monitoring and enforcement of Admission, Discharge, Transfer (ADT) events by enrollees. QHPs should be required to implement health information technology (HIT) to support population health principles, integrated care and care coordination across the delivery system. We believe the development and funding of this HIT infrastructure is key to the success of Covered California, and would request that Covered provide more specific information in future stakeholder meetings and written documents as to how it will be built and fund interoperable health information technology and health information exchange infrastructure.	Covered California is excited to hear your support regarding this requirement. At this time, our goal is to align with CMS. CMS has a wide range of resources that provides more information on how the HIT infrastructure should be built out. We will ensure our QHPs have access to these resources.	1-4-21
	6.03.2	Recommend this section be removed. This is a federal requirement; it is unnecessary and burdensome to ask hospitals to also report to health plans whether providers are meeting this federal requirement.	Covered California is aware of this requirement for Medicare. At this time, our goal is to align with the federal requirement as we believe this data is critical to ensuring continuity of care. The Medicare Conditions of Participation govern the actions of Medicare and Medicaid participating hospitals, rather than their actions for specific patients. This requirement does not ask hospitals to report to health plans whether providers are meeting a federal requirement. Rather, it asks health plans to work with hospitals to mirror this requirement for Covered California Enrollees.	1-4-21

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	6.03.2	• Modify - this is not feasible for all Covered CA populations. When a PCP is "auto assigned" rather than selected by a member (especially in the PPO/EPO products) there isn't an established relationship between the assigned PCP and patient. There are limitations on the transfer of this data to the PCP without the patient's express permission •As PCP's would have access to this data thru HIEs, allow QHP's efforts around HIE utilization to apply to this requirement	Our goal is to align with the federal requirement as we believe this data is critical to ensuring continuity of care. Covered California will align with the specifics of the CMS rule that hospitals must be able to demonstrate that they are sending the notifications "[t]o the extent permissible under applicable federal and state law and regulations, and not inconsistent with the patient's expressed privacy preferences." CMS also states, "Nothing in this proposed rule should be construed to supersede hospitals' compliance with HIPAA or other state or federal laws and regulations related to the privacy of patient information. We note that hospitals would not be required to obtain patient consent for sending a patient event notification for treatment, care coordination, or quality improvement purposes as described in this final policy. However, we also recognize that it is important for hospitals to be able to honor patient preferences to not share their information." As for the methodology of transmission of ADT data, we are not limiting the use of HIE to apply for this requirement. Additional FAQs: https://chimecentral.org/wp-content/uploads/2020/04/FAQs-on-ADT-FINAL.pdf	1-4-21
	6.03.2	This is a facility/provider interface that is out of scope for the health plan.	We understand your concern and are aware this is a facility/provider interface. Covered California asks that issuers support their facilities in developing this interface to mirror the ADT data transfer for Covered California Enrollees. We are not asking issuers to develop the interface.	1-4-21

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	6.03.2	6.03.2 (1 &2) – Please further define "hospitals" for this reporting requirement. Is this inclusive of GACH, transplants and psychiatric hospitals? 6.03.2 (3) – Health Net recommends this removing this requirement. The Medicare Condition of Participation is not required for Exchange enrollees. While issuers can report on action taking and implementation of these efforts, we would not be able to remedy non-adherence.	Covered California will adjust language to clarify the facilities need to implement the ADT requirement, the CMS Final Rule states that hospitals, including psychiatric hospitals and critical access hospitals are required to send electronic patient event notifications. Thank you for your comment. We understand your concern and the limitations of QHPs. Covered California will make an amendment change to the language to better reflect our intent.	1-4-21
Article 7: Effective Primary Care		Article 7: Effective Primary Care With regards to the term "advanced primary care," our understanding from prior discussions in Attachment 7 workgroup is that there is no single or agreed-upon definition of "advanced primary care."	Yes, there are numerous definitions of advanced primary care used in the health care industry. Covered California states: "Effective primary care is data driven, team-based and supported by alternative payment models such as population-based payment and shared savings." We recognize advanced primary care definitions from the California Quality Collaborative, the Primary Care Collaborative and the 10 Building Blocks of High-Performing Primary Care.	1-4-21
	7.02	Require QHPs to contract with a minimum proportion of advanced primary care physician practices, including PCMH-accredited practices (Section 7.02).	Covered California has found that the PCMH recognition process does not necessarily lead to improved outcomes through our conversations with issuers and evidence from several studies. PCMH recognition is process-focused and does not include many outcomes-based measures. Therefore, we are proposing to use a measure set to monitor the performance of primary care practices in 2023 and beyond (as noted in Article 7.03). We are also proposing to focus on primary care payment in the 2022 Attachment 14. PCMH recognition can be an important process step towards achieving more effective primary care so we are not discouraging PMCH recognition but Covered California is interested in measuring outcomes of primary care practices as we move forward.	1-4-21

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	7.02	Require QHPs to implement a prospective, risk-adjusted, population-based payment for primary care practices rather than strongly encouraging QHPs to support or provide quality improvement and technical assistance (Section 7.02).	In addition to encouraging issuers support or provide quality improvement and technical assistance, Covered California requires issuers to "must adopt and progressively expand the number and percent of primary care clinicians paid through the HCP LAN categories of population-based payment (Category 4) and alternative payment models built on a fee for service structure such as shared savings (Category 3) each year" as noted in Article 7.04.3.	1-4-21
	7.02.1	CMA supports improving access to complete patient data, including for primary care clinicians. CMA recognizes the importance of and fully supports the secure exchange of data among providers to reduce costs, improve quality of care, and reduce administrative burdens. Data should follow the patient and should be available to any appropriate provider at the point of care. Secure and robust data exchange, however, cannot be achieved without sufficient funding for necessary technology infrastructure and training. In addition, CMA urges Covered California to ensure that data collection obligations are not passed down to individual providers without the appropriate considerations of cost and administrative burdens. Technologically and financially, physician practices, hospitals, and clinics in California range from large and sophisticated systems to small, strained offices and facilities. Under any statewide policy requiring stakeholders to meaningfully share health information, it is reasonable for certain providers with limited infrastructure and means—such as independent physicians, rural hospitals, and safety-net clinics—to expect public subsidies and incentives to help defray the costs of participation. Moreover, other states' efforts to advance health information sharing through both strong requirements and funding have seen success. Covered California contracts should require health plans to offer financial incentives to help smaller network providers achieve data-sharing and help defray costs for certain onboarding and maintenance activities associated with sharing through HIN/HIEs, such as EHR integration and contract renegotiation fees. Additionally, it is critically important that Contractors use standard processes for encounter data exchange with contracted providers. CMA encourages Covered California to ensure that ANSI-accredited standards are adopted to facilitate the exchange, integration, sharing, and retrieval of electronic health information.	Covered California will consider these recommendations in relationship with our Data Sharing and Analytics requirements in Article 15.	1-4-21

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	7.02.2	CMA appreciates that Covered California is encouraging its Contractors to provide support to primary care practices to improve the quality of care. As part of provider-level coaching or quality improvement efforts, CMA urges Covered California to encourage QHPs to provide physicians with financial resources to coordinate care so that these resources can be used for population health management tools, care coordinators, participation in health information exchanges, electronic health record systems, telehealth platforms, tools for quality reporting, practice coaching for front-line staff, targeted care management resources, and any other tools to facilitate coordinating care. In addition, improving interoperability of electronic health records and developing health information exchanges will promote clinical integration without financial consolidation. It is no longer the case that only large, integrated delivery models are able to implement the necessary systems to be successful under the new delivery and payment models. Developments in information technology allow independent practices to work in a coordinated way so to avoid consolidation and to promote competition. CMA supports the requirement that annual application for certification include the quality improvement support and technical assistance being provided by the Contractor or other organization to implement or strengthen advanced primary care models.	Thank you for your feedback. Covered California will consider these recommendations.	1-4-21
	7.03	Clarify that one measure set will be used by all QHPs (Section 7.03).	Yes, one measure set will be used by all contracted issuers.	1-4-21
	7.03	Include CAFP in the development and implementation of the measure set to be piloted by QHPs (Section 7.03).	Covered California looks forward to engaging CAFP in future conversations regarding the development and implementation of the measure set to assess the prevalence of high-quality, advanced primary care practices.	1-4-21

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	7.03	While CMA shares Covered California's goals of improving quality, we are concerned that requirements to report additional measures may increase administrative burdens on providers without improving care. If quality measures do not align among all payors, physicians are required to report multiple quality measures in different ways to different entities. This imposes significant burdens on physician practices and impedes comprehensive improvement in overall quality of care. A recent study indicates physicians and their staff can spend upwards of 15 hours per week dealing with various quality measures with different payors. The physician time alone spent dealing with quality programs is estimated to be enough time to care for approximately nine additional patients and the staff time spent is incredibly costly to practices. CMA recommends that the quality measures required to be reported not be overly burdensome, focus on patient outcomes rather than process, and is consistent with measures used by payors outside of Covered California. Establishing a physician-approved, standardized, and evidence-based set of core quality measures and reporting requirements that can be automatically extracted from electronic health records would reduce the need for providers and their staff to manually extract and manipulate data measures according to the individual specifications of each entity requiring quality data reporting. This would reduce repetitive procedures; encourage collaboration between providers and data collection entities; and allow for quality data to be compared across providers and plans. Quality measures should also be updated regularly or when new evidence is developed. When new quality measures are adopted others should also be sunset. The quality performance standards tied to value-based payment models must be physician specialty-validated clinical measures; include a sufficient number of patients to produce statistically valid quality information; use an appropriate attribution methodology and risk adjustment; and physicians must have the right and ability to appeal inaccurate quality reports and have them corrected. Moreover, in order to maximize improved patient outcomes, there must also be timely notification and feedback provided to physicians regarding the quality measures and results. Risk adjustments need to consider differences in geographic practice costs and patient risk factors, such as socioeconomic and health status, and physicians should only be responsible for costs they can control. CMA strongly supports using existing sources of data when evaluating physician practices and that any assessment of the proposed measures be done through existing encounter data. CMA also strongly opposes any measures that require increased manual review of medical records by physicians, their staff, or external auditors.	Covered California is collaborating with the California Quality Collaborative, IHA, and other purchasers in the development of the primary care measure set to ensure that it is as aligned as possible with other measure sets currently in use. We agree that the measure set should not be overly burdensome, focus on patient outcomes rather than process, and consistent with measures used by other purchasers. Covered California looks forward to engaging CMA in future conversations regarding the development and implementation of the measure set to assess the prevalence of high-quality, advanced primary care practices.	1-4-21
	7.03.2	Contracted medical groups already participate in the IHA AMP program. Sharp Health Plan has concerns that requiring additional measure sets would dilute efforts and contribute to reporting fatigue felt by providers and medical groups.	Covered California is collaborating with the California Quality Collaborative, IHA, and other purchasers in the development of the primary care measure set to ensure that it is as aligned as possible with other measure sets currently in use. We look forward to further engaging providers and medical groups to gather feedback on the primary care measure set.	1-4-21

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	7.04	L.A. Care is supportive of the proposed change from requiring increasing membership assignment to a PCMH and pivoting instead to a measure of available PCPs who are considered as offering advanced primary care. We do want to note that the definition of advanced primary care needs to be clearly defined by Covered CA - are they adopting the CQC's definition?	There are numerous definitions of advanced primary care used in the health care industry. Covered California states: "Effective primary care is data driven, team-based and supported by alternative payment models such as population-based payment and shared savings." We recognize advanced primary care definitions from the California Quality Collaborative, the Primary Care Collaborative and the 10 Building Blocks of High-Performing Primary Care.	1-4-21
	7.04.2 and 7.04.3	For future Covered California requirements, require QHPs to have a minimum number and percent of primary care clinicians paid under an advanced primary care alternative payment model such as the one advanced by AAFP (Sections 7.04.2 and 7.04.3).	Covered California is requiring issuers to adopt and progressively expand the number and percent of primary care clinicians paid through the HCP LAN categories of population-based payment (Category 4) and alternative payment models built on a fee for service structure such as shared savings (Category 3) each year. Issuers are held to an associated performance standard within Attachment 14. We will explore how we can enhance our primary care payment requirements in 2023.	1-4-21
	7.04.2 and 7.04.3	Explore piloting with QHPs payment models such as the American Academy of Family Physicians' Advanced Primary Care Alternative Payment Model (APC-APM) (Sections 7.04.2 and 7.04.3).	Based on our review of the American Academy of Family Physicians' Advanced Primary Care Alternative Payment Model (APC-APM) payment categories, they are similar to the HCP-LAN APM payment categories. Covered California is requiring issuers to adopt and progressively expand the number and percent of primary care clinicians paid through the HCP LAN categories of population-based payment (Category 4) and alternative payment models built on a fee for service structure such as shared savings (Category 3) each year. Issuers are held to an associated performance standard within Attachment 14. We will explore how we can enhance our primary care payment requirements in 2023.	1-4-21

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	7.04.2 and 7.04.4	Clarify that QHPs must report their total primary care spend and issue a report on the QHPs reported primary care spend (Sections 7.04.2 and 7.04.4).	Covered California is requiring issuers to report "The percent of spend within each HCP LAN category compared to its overall primary care spend". We will explore how we can enhance our primary care payment requirements in 2023.	1-4-21
	7.04.3	Provision 7.04.03 requires QHPs to expand the use of payment models, including shared savings and bonus programs. Depending on how those programs are structured by the QHP and provider, the compensation arrangement may require the providers to be licensed under the Knox-Keene Act. These payment models are allowed, but may cause contracting complexities for QHPs that may not have been considered.	Thank you for your feedback. Covered California will work with its contracted issuers to ensure providers are appropriately licensed under the Knox-Keen Act.	1-4-21
	7.04.3	While CMA recognizes the important role of alternative payment models, these models also must be physician-led. To support coordinated care as well as management of preventive services and chronic conditions, payment models must include additional incentive payments to physicians for providing preventive services management, diagnosis coordination and treatment planning, and continued management of chronic conditions. Payments should cover physician administrative costs related to participating in any payment models. Finally, QHPs should be encouraged to reward practices that demonstrate that they are delivering high quality, efficient, and accessible care to patients. For example, the current Comprehensive Primary Care Plus model is an excellent program that makes monthly stratified-risk payments with additional performance payments. Other physician organizations have proposed physician team payments for episodes of care. Covered California may also want to consider the innovative alternative approaches recommended by the CMS Physician-Focused Payment Model Technical Advisory Committee (PTAC), that are based on the direct provider contracting approach. Models should work for specialists, as well as primary care physicians and independent practices. It is also not necessary to require physicians to accept financial risk in all payment models in order to reduce costs. If physicians want to voluntarily accept appropriate financial risk, the levels of mandated downside financial risk should not discourage physician participation and should not unintentionally drive market consolidation.	Thank you for your feedback. Covered California will consider these recommendations and will explore how we can enhance our primary care payment requirements in 2023.	1-4-21
	7.04.3	Please provide an attainment threshold in addition to the requirement to increase the number and percent of PCPs paid through the specified HCP-LAN categories.	Covered California has proposed an attainment threshold for the number and percent of primary care clinicians paid though HCP LAN categories of population-based payment (Category 4) and alternative payment models built on a fee for service structure such as shared savings (Category 3) within the 2022 Attachment 14.	1-4-21

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	7.04.3	Health Net recommends the addition of an attainment threshold in addition to the increasing the number and percent of PCPs paid through the HCP LAN categories.	Covered California has proposed an attainment threshold for the number and percent of primary care clinicians paid though HCP LAN categories of population-based payment (Category 4) and alternative payment models built on a fee for service structure such as shared savings (Category 3) within the 2022 Attachment 14.	1-4-21
	7.04.3	Plans in a delegated model, like L.A. Care. are constrained from successfully meeting the requirement to "expand the number and percent of primary care clinicians paid through the HCP LAN categories of population-base payment." Delegated models have agreements with the Physician Group not the PCPs. L.A. Care does not have a direct line-of-sight to primary care costs as our delegated IPAs/PPGs are responsible for contracting with primary care physicians and the IPAs/PPGs set their cost. The Health Plan cannot control or dictate the payment agreement that the PPG has with its PCPs. We understand the concept of recontracting with the PPGs, but, given that PPG's contract with health plans other than those with Covered CA, there is reluctance to deviate from their payment structure to accommodate one group of plans. We suggest that the incentive requirements be structured differently to align with existing relationships and recognize the challenges of different models.	Covered California recognizes these challenges. To partially address this challenge, we have proposed an attainment threshold for the number and percent of primary care clinicians paid though HCP LAN categories of population-based payment (Category 4) and alternative payment models built on a fee for service structure such as shared savings (Category 3) within the 2022 Attachment 14.	1-4-21
	7.04.3	7.04.03 – Plans in a delegated model are constrained from successfully meeting the requirement to "expand the number and percent of primary care clinicians paid through the HCP LAN categories of population-base payment." Delegated models have agreements with the Physician Group not the PCPs. The Health Plan cannot control or dictate the payment agreement that the PPG has with its PCPs. We understand the concept of recontracting with the PPGs, but, given that PPG's contract with health plans other than those with Covered CA, there is reluctance to deviate from their payment structure to accommodate one group of plans. We suggest that the incentive requirements be structured differently to align with existing relationships and recognize the challenges of different models.	Covered California recognizes these challenges. To partially address this challenge, we have proposed an attainment threshold for the number and percent of primary care clinicians paid though HCP LAN categories of population-based payment (Category 4) and alternative payment models built on a fee for service structure such as shared savings (Category 3) within the 2022 Attachment 14.	1-4-21

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Article 8 PROMOTION OF INTEGRATED DELIVERY SYSTEMS (IDS) AND ACCOUNTABLE CARE ORGANIZATIONS (ACO)		Article 8: ACOs Again, the term “accountable care organizations” seems to cover a broad range of entities with mixed results. As is to be expected with an experimental approach, numerous ACOs have shut down and others have at best mixed results. While we understand the conceptual underpinning, the practical experience has been more mixed.	Covered California recognizes the mixed results of ACOs and is aiming to learn more about the characteristics that determine successful ACOs through the enhanced reporting requirements in the 2022 Attachment 7.	1-4-21
	8.01.2	Include the relationship and intersection of ACOs and advanced primary care as one of the characteristics QHPs must report (Section 8.01.2).	Thank you for your feedback. Covered California will consider this recommendation as it collaborates with issuers and other stakeholders in developing the a registry of characteristics to support the reporting of ACO characteristics.	1-4-21
	8.01.2	Health Net recommends the addition of an attainment threshold in addition to the increasing the number of members cared for within ACO or IDS models.	Covered California has proposed an attainment threshold for the number of enrollees cared for within an ACO or IDS model in the 2022 Attachment 14.	1-4-21
	8.01.2	CAHP has concerns with this requirement and proposed targets (in Attachment 14) as there are limited levers available to QHPs to steer membership into these arrangements. We look forward to having additional discussions to better understand Covered CA’s analysis and methodology for setting these benchmarks.	Covered California has proposed an attainment threshold for the number of enrollees cared for within an ACO or IDS model in the 2022 Attachment 14. These thresholds were set based on historical issuer performance and California and national commercial ACO enrollment. We welcome further discussion about the requirement and the proposed attainment thresholds.	1-4-21
	8.01.2	Because 100% of Sharp Health Plan's enrollees are cared for within an integrated delivery system model, SHP recommends an amendment to confirm that no increase is required beyond a threshold of 95%.	In Attachment 14, Covered California states that "This performance standard is not applicable to issuers with fully integrated systems where 100% of their membership is attributed or assigned to integrated delivery systems (IDS) or ACOs for both the baseline measurement year and the performance measurement year."	1-4-21

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	8.01, 8.02	Given that Covered California, along with other purchasers, place great importance on the adoption and expansion of integrated, coordinated and accountable systems of care, CMA urges Covered California to align the definitions and criteria for IHMs and ACOs among payors and purchasers. These models and organizations take many different forms, which makes it difficult to determine which models and organizations Covered California and other purchasers are trying to be adopt and expand. Moreover, in further promoting ACOs, CMA urges Covered California to ensure that ACOs and other coordinated systems are physician-led and encourage an environment of collaboration among physicians. Physician-led ACOs have been found to be more likely to have comprehensive care management programs and advanced IT capabilities, measure and report financial and quality performance at the physician level, and provide meaningful and timely feedback to physicians. Resources, however, must be provided to physicians in independent practices who may want to remain independent but otherwise clinically integrate and collaborate with other physicians for purposes of participating in ACOs or other coordinated systems. This would help prevent these physicians from being driven to join larger practices and align with hospitals that have the resources to take on mounting administrative tasks and to invest in tools that support integrated care and value-based payments. Finally, given that interoperable health information technology and electronic health record systems are key to the success of ACOs, QHPs need to ensure that systems are interoperable to allow physicians to effectively communicate and coordinate care and report on quality. Quality performance standards established by ACOs and other value-based payment models must be physician specialty-validated clinical measures; include a sufficient number of patients to produce statistically valid quality information; use an appropriate attribution methodology and risk adjustment; and physicians must have the right and ability to appeal inaccurate quality reports and have them corrected. Moreover, in order to maximize improved patient outcomes, there must be timely notification and feedback provided to physicians regarding the quality measures and results. Risk adjustments need to take into consideration differences in geographic practice costs and patient risk factors, such as socioeconomic and health status. CMA would like to bring to Covered California's attention the potential effect of the Department of Managed Health Care's licensing regulations that clarify which health care entities that assume global risk are required to obtain a Knox-Keene license. The regulations require entities that assume global risk – that is, those entities that accept "a prepaid or periodic charge from or on behalf of enrollees in return for the assumption of both professional and institutional risk" — to obtain a license. CMA is concerned that these regulations may have a chilling effect on delivery system and payment innovations that lead to higher quality care and lower costs. The regulations define "prepaid or periodic charge" to include a "percentage of savings or losses in which the entity shares," which have the potential to include parties to a host of value-based contracting arrangements. While the regulations contain provisions allowing the Director to grant exemptions to the licensure requirements, CMA is concerned that many practices interested in pursuing value-based contracts geared toward improving healthcare quality and reducing costs will be disincentivized from doing so given this new regulatory burden. There needs to be a balance between oversight of risk-based contracts with the need for innovation in healthcare delivery.	Covered California will review how we can better align the definition of an ACO with other purchasers. We are aiming to better understand the variation in ACO types through the use of the IHA Commercial ACO measure set and developing a registry of characteristics of ACO models so we can compare performance on the measure set against the characteristics of the models. We recognize that physician-led ACOs with two-sided risk contracts are associated with greater savings and improved quality results as noted in the HMA evidence review shared in July 2019.	1-4-21

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	8.02	VHP requests that this requirement only be applicable to reporting on the Covered California line of business. VHP asks that Covered California define the "percent of spend" in 8.01.2 (3). Can you please clarify what Covered California means by "defining a registry"? Example: is Covered California going to keep records of all the ACOs and what the stakeholders' characteristics are for each ACO?	Covered California is requiring issuers to report to IHA for all lines of business for efficiency and to enable comparisons across lines of business. We can have further conversations with VHP if this is not feasible. Covered California defines percent of spend as the percent of budget or percent of services provided under an ACO or IDS contract. Covered California will collaborate with IHA, issuers and others to develop a list of characteristics of ACO or IDS models. This set of characteristics will make up the registry. Covered California will track the characteristics of each ACO or IDS model that issuers use. Covered California is aiming to better understand the variation in ACO types through the use of the IHA Commercial ACO measure set and developing a registry of characteristics of ACO models so we can compare performance on the measure set against the characteristics of the models.	1-4-21
Article 9 Networks Based on Value		L.A. Care is supportive of the shift away from requiring exclusion of outlier poor performing hospitals from the Network, as an unintended consequence would potentially be a gap in network adequacy / member access as a result of pruning poor performing hospitals from the network.	Thank you for your feedback.	1-4-21
Article 9 Networks Based on Value		Please clarify meaning of "provide the support needed to improve performance" in the following statement: "The Contractor shall hold its contracted hospitals and providers accountable for improving quality and managing or reducing cost and provide the support needed to improve performance across its network."	Covered California encourages issuers to continue to support hospitals participating in quality collaboratives, provide quality improvement or technical assistance to hospitals or provide funding or use alternative payment models to incentivize improvement.	1-4-21

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	9.01 Designing and Managing Networks based on Value	9.01 Designing and Managing Networks based on Value While the contract language talks about "affordable" care and "reasonable prices", nowhere does it make a connection to the consumer who pays a share of the premiums and an ever-increasing share of the out of pocket costs. It is easy to view 70% actuarial value as a static number but as the underlying cost of care for an average population rises, the consumer's 30% of the cost of care costs more because care costs more. If the average cost of care is $6,000 per enrollee rather than $4,000, 30% of the cost has increased by $2,000 or 50% of the original cost. While most Covered California consumers receive premium subsidies based on a share of income, off-exchange consumers do not have a similar protection from increasing premiums. Standard benefit designs and insurance market rules have functionally made off-exchange premiums an extension of on-exchange premiums so the Covered California contract impacts off-exchange premiums as well. For these reasons, we ask that 9.01.3 include the following: Unit price range and trends as well as quality indicators may be released to the public by Covered California to encourage care that is more affordable to consumers in terms of both premiums and out of pocket costs.	Covered California will publicly report on cost reduction measures through AB 929 reporting. We are currently determining what will be reported through AB 929.	1-4-21
	9.01.2	The QHPs are requesting additional information about the data sources Covered CA expects the issuers to use to assess quality data on the individual physician level.	Covered California recognizes that there is not a good industry standard for measuring the quality of individual physicians. We will continue to collaborate with issuers, providers, and other stakeholders to determine how to assess quality data on the individual physician level.	1-4-21
	9.01.2	Health Net would like to request clarification about the data sources Covered CA would like issuers to use to assess quality data on the individual physician level.	Covered California recognizes that there is not a good industry standard for measuring the quality of individual physicians. We will continue to collaborate with issuers, providers, and other stakeholders to determine how to assess quality data on the individual physician level.	1-4-21
	Sections 9.01.2 and 9.03	Review with QHPs the terms of hospital by-laws and plan policies that can and have resulted in constraints on the practice of medicine by qualified family physicians (Sections 9.01.2 and 9.03).	Thank you for your feedback. Covered California will consider this recommendation.	1-4-21

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	9.01.2 and 9.03.2	Do not proceed with publicly rating or tiering physicians until sources of inaccurate and invalid data including patient attribution, risk-adjustment including for social determinants of health, measurement gaps, and completeness and quality of the data are corrected (Sections 9.01.2 and 9.03.2).	Covered California recognizes that there is not a good industry standard for measuring the quality of individual physicians. We will continue to collaborate with issuers, providers, and other stakeholders to determine how to assess quality data on the individual physician level.	1-4-21
	9.01.2 and 9.03.2	Explore ways for physicians to review and correct the data that would not create an additional administrative burden on the physician practice (Sections 9.01.2 and 9.03.2).	Thank you for your feedback. Covered California considers the burden on providers and health plans in developing its contract requirements and will continuously work to reduce burden when possible.	1-4-21
	9.02 Hospital Networks Based on Value	Some participating QHPs are part of a hospital-sponsored organization or are affiliated with hospital systems - these issuers would not have the ability to exclude low performing hospitals. We would appreciate additional language in this section that would exclude health plans owned by hospital systems.	An issuer can report that its rationale for continued inclusion of hospital(s) with multiple signals of poor performance is that the health plan is owned by a hospital system.	1-4-21
	9.02 Hospital Networks Based on Value	9.02.2 Because this section is a retraction from the previous requirement to exclude outlier poor performing hospitals, we ask for additional oversight by Covered California in approving justifications given by plans to include such hospitals as we have difficulty imagining other reasonable justification than meeting the geographic time and distance standards or the need to ensure the availability of specific services: “Rationales for continued inclusion of hospitals may include geographical access needs, specific specialty service needs, or other justification provided by the Contractor and approved by Covered California.	Covered California will continue to collect the rationale and criteria for inclusion of hospitals with multiple signals of poor performance on cost, safety, and quality and may release this information publicly.	1-4-21
	9.02.2	Please clarify the measures and standards that will be used to determine the "lowest decile".	The decile formula is specific to the measure and eligible population. For example, CMQCC and CalHospitalCompare provide the hospital C-section rates for all California hospitals with maternity services. The performance for all eligible hospitals, statewide, is arrayed on 0-100% rate per total deliveries and the lowest decile of that distribution can be computed. We continue to encourage issuers to use the CMQCC and CalHospital Compare data on C-sections and HAI rates to monitor hospital performance.	1-4-21

A7 Item #	A7 Sub-Section #	Comment	Final Approved Response	Response Date
	9.02.2	Please clarify measures/standards used to determine "lowest decile".	The decile formula is specific to the measure and eligible population. For example, CMQCC and CalHospitalCompare provide the hospital C-section rates for all California hospitals with maternity services. The performance for all eligible hospitals, statewide, is arrayed on 0-100% rate per total deliveries and the lowest decile of that distribution can be computed. We continue to encourage issuers to use the CMQCC and CalHospital Compare data on C-sections and HAI rates to monitor hospital performance.	1-4-21
	9.02.3	9.02.3 Advocates ask that a statement similar to the last sentence in 9.02.2 be added to the section on hospital networks based on value: Information on relative unit prices and total cost of care, including distribution by cost deciles or other groupings based on comparison of costs, may be released to the public by Covered California.	Covered California will publicly report on cost reduction measures through AB 929 reporting. We are currently determining what will be reported through AB 929.	1-4-21

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	9.03 Physician Networks Based on Value	CMA supports patients having access to networks that are based on high quality and efficient providers. However, Covered California must balance this with timely access to care and accurate quality measurements. When QHPs measure and analyze physician quality, it is important that the data used be accurate and valid. The accuracy of physician quality ratings depends greatly on data collection methods, the source of the data, the metrics and analytic protocols used, the ability of subject physicians to review and correct errors, and the disclosures that accompany any ratings reports. Common sources of error include patient attribution, risk-adjustment including for social determinants of health, measurement gaps, and completeness and quality of the data. Rating physicians without taking into account these factors may lead to a disincentive to care for complex cases and the hardest to treat. CMA appreciates that Covered California will work with physicians on provider quality measures. Hearing directly from physicians about past reporting and measurement issues, as well as barriers to effectively using the data, would be beneficial for Covered California and QHPs. Publicly rating or tiering of physicians given the high likelihood of inaccurate and invalid data is problematic and poses risks for both physicians and patients. Until such time that all the problems are corrected and the accuracy and validity of the information is ensured, CMA 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, CMA supports Covered California requiring QHPs to report to Covered California how QHPs are engaging with physicians to improve performance using methods such as implementing alternative payment models including population-based payments. Another important issue for Covered California to consider is the administrative burden placed on physicians to correct their data. Our members have estimated they could devote a significant amount of time for this purpose. While making the data available for review is important, the already overwhelming complexities of complying with administrative responsibilities in the average practice must be taken into consideration. Requiring physician practices to allocate even more uncompensated time to correct problems they did not create is unfair. Their time would be better spent providing patient care, especially during the pandemic. We would note that pandemic continues to have a significant financial impact on the viability of physician practices, with a recent CMA survey finding that 87% of physician practices are still worried about their financial health. Even with 8 out of 10 practices now utilizing telehealth, patient volume and revenue is still down by one-third, with 25% of practices still experiencing revenue declines of 50% or greater. Accordingly, CMA hopes we can work with Covered California and QHPs to explore ways for physicians to review and correct the data that would not create an additional administrative burden on the physician practice.	Covered California recognizes that there is not a good industry standard for measuring the quality of individual physicians. We will continue to collaborate with issuers, providers, and other stakeholders to determine how to assess quality data on the individual physician level.	1-4-21

A7 Item #	A7 Sub-Section #	Comment	Final Approved Response	Response Date
	9.03 Physician Networks Based on Value	9.03 Physician Networks Based on Value We believe the last sentence of 9.03.2 is not correctly drafted. It currently reads: "Rationale and criteria for inclusion of the lowest decile of physicians and physicians groups on cost, safety, and quality, may be released to the public by Covered California." Is this provision aimed at high cost/low quality providers? If so, it should be revised to read: "Rationale and criteria for inclusion of the lowest decile of physicians and physicians groups on cost, safety, and quality, but the highest decile on cost may be released to the public by Covered California." Similarly, 5) under 9.03.2 refers to the "lowest decile on quality and cost" but we think the intent is to refer to high cost/low quality. 9.03.3 2) "The Contractor's analysis of variation in unit prices including capitation and whether including high cost physicians or physician groups results in underfunding of other categories of physicians or physician groups such as primary care or behavioral health or contributes to higher premiums and out of pocket costs.	The requirement is aimed at low quality and high cost providers. Covered California will revise the language to make the intent more clear.	1-4-21
	9.03.2 (1)	•IHA AMP Program is currently provided for ACO and HMO Medical Groups and not those PPO non-ACO physician groups. Has IHA agreed to include additional PPO non-ACO physician groups in their program, or would this requirement only be applied to ACO and HMO medical groups.	This requirement would only apply to ACO and HMO medical groups at this time.	1-4-21
	9.03.2	Any analysis of variation in performance of independent, directly contracted physicians will require the physicians to have an adequate number of members to produce statistically meaningful results (i.e. a denominator of at least 30). We recommend that Covered CA specify the measure set (ex. IHA AMP Measure Set) to assess physician group and physician performance so that there is consistency across all carriers and a clearly defined set of expectations.	Covered California does intend that the IHA AMP measure set will be used to monitor the performance of physician groups. We will revise the language to make the intent more clear. We recognize that there is not a good industry standard for measuring the quality of individual physicians. We will continue to collaborate with issuers, providers, and other stakeholders to determine how to assess quality data on the individual physician level.	1-4-21
	9.03.2	Any analysis of variation in performance of independent, direct contracted physicians will require the physician to have an adequate number of members to produce statistically meaningful results (denominator of at least 30). Also, Health Net recommends that Covered CA specify the measure set, preferably the AMP measure set, to assess physician group and physician performance so that there is consistency across insurers and a clearly defined set of expectations.	Covered California does intend that the IHA AMP measure set will be used to monitor the performance of physician groups. We will revise the language to make the intent more clear. We recognize that there is not a good industry standard for measuring the quality of individual physicians. We will continue to collaborate with issuers, providers, and other stakeholders to determine how to assess quality data on the individual physician level.	1-4-21

A7 Item #	A7 Sub-Section #	Comment	Final Approved Response	Response Date
	10.01	CMA supports that Covered California has sharpened the reporting requirements for telehealth. In particular, CMA appreciates the inclusion of the requirement that Contractors must report on how they are facilitating the integration and coordination of care between third party telehealth vendor services and primary care or other contracted providers. CMA strongly supports the use of telehealth to provide patents access to their treating physicians and clinicians. CMA wants to ensure that health plans do not separately contract with third-party telehealth vendors that provide care to enrollees that is not coordinated with the care provided by the plan's contracted providers or the patients' treating providers. Professional services provided via telehealth should be part of the care provided to the patient by their physician, and not an unassociated provider that works through a third-party telehealth vendor. Covered California should ensure that telehealth is merely an alternate site to care delivery and not alternate care that is disassociated with the rest of the enrollees' medical care. We also appreciate the expanded definition of telehealth that recognizes the way in which telehealth technologies are currently used in health care and incapsulate all of the asynchronous store-and-forward telehealth modalities now available to patients and providers, such as remote patient monitoring and e-consults, which have even more potential for connecting patients with their providers and improving access to specialists. Remote patient monitoring and chronic disease management, for example, can assist physicians in monitoring conditions like high blood pressure or diabetes and allow physicians to address any issues early on. These tools can also assist patients in gaining more autonomy and permit them to take ownership of their own health and health-related behaviors. E-consult reduces barriers to access by connecting physicians with patients in remote parts of the state and patients who may not be able to travel to an office. Many health systems in California have adopted e-consult as a way to provide services, particularly specialist services, to patients in a timely and cost-reducing manner. Additionally, we strongly support that Contractors be required to facilitate Enrollee access to telehealth services through broadband and internet connected devices, and appreciate the requirement that Contractors report on these measures. We would ask that Contractors not just screen for access to necessary services and technologies but provide funding to ensure all enrollees can use telehealth as needed. Lack of access to broadband has been and remains an issue to telehealth adoption in rural areas. Telehealth platforms must be accessible for a wide variety of users, including those with functional limitations, and should include technologies such as closed captioning for those who are hearing impaired. The expansion of coverage for audio-only visits may provide greater access for older or rural adults who lack internet access or internet-enabled devices. Funding for not only broadband but also devices, particularly targeting those demographics that have been shown to have lower access, could help reduce disparities in this area. Additionally, new telehealth programs and pilots must target vulnerable populations and make sure to include those with limitations that may make it more difficult for them to use technologies. Lastly, we appreciate that Contractor's must provide payment parity for telehealth, including voice-only for comparable in-person services. We would ask that the language in 10.01.2 be modified to state "when clinically appropriate" as it should be determined by a physician what type of care and telehealth modality, if any, is clinically appropriate to treat a patient.	Covered California will include the suggested language "when clinically appropriate" in the contract.	1-4-21

A7 Item #	A7 Sub-Section #	Comment	Final Approved Response	Response Date
	10.02	Recommend expanding or clarifying the definition of "bonus payment."	Thank you for your comment. "Bonus payment" in this context refers to at-risk payments that a hospital is subject to for their quality performance. Th payment methodology is further outlined in section 10.02.2.	1-4-21
	10.02.2	Provision 10.02.2 may require hospitals contracting with QHPs to be licensed under the Knox-Keene Act, depending on the structure of the compensation arrangement. These payment models comply with the Knox-Keene Act but may cause contracting complexities for QHPs that may not have been considered.	Thank you for your feedback. Covered California will work with its contracted issuers to ensure providers are appropriately licensed under the Knox-Keen Act.	1-4-21
	10.02.2	Plans have existing programs with reimbursement tied to quality. In order to ensure that these existing programs are maintained, we recommend that Covered CA amend the language in this section to require at least a 2% increase in reimbursement by year-end 2022 (rather than the proposed 5% increase). This will minimize disruption of existing efforts. Rather than impose this requirement for all acute care hospitals in a QHP network, we believe that Covered CA should allow exemptions for different models, systems, or regional approaches. We do not believe it is appropriate for Covered CA to impose a performance standard related to this requirement and we are asking Covered CA to consider removing this requirement at this time, until the issuers and Covered CA can have more discussions about this requirement.	Covered California will revert the 5% to 2% in the 2022 Attachment 7 in alignment with the changes in 2022 Attachment 14. The performance standard will be removed for Group 3.9 Hospital Patient Safety for the 2022 contract.	1-4-21
	10.02.2	•Opposed to the increase to 5% in 2022 and that it applies to all acute care hospitals. Concerned that this approach will lead to higher costs for consumers - as providers unwilling to take on more financial risk will shift the costs. This places an additional burden on the PPO/EPO plans that provide coverage in areas with limited provider competition. •Recommend that this requirement allow for exceptions for different models, providers systems or regional approaches; •Performance Standard related to this requirement should be removed, and/or be adjusted based on an allowance for different models, systems or regional approached unique to each QHP	Covered California will revert the 5% to 2% in the 2022 Attachment 7 in alignment with the changes in 2022 Attachment 14. The performance standard will be removed for Group 3.9 Hospital Patient Safety for the 2022 contract.	1-4-21
	10.02.2	Health Net recommends requiring a minimum of 2% of reimbursement by year end 2022. It will be challenging to increase this beyond 2% without adding significant costs and programs have already been established with a 2% reimbursement tied to quality.	Covered California will revert the 5% to 2% in the 2022 Attachment 7 in alignment with the changes in 2022 Attachment 14. The performance standard will be removed for Group 3.9 Hospital Patient Safety for the 2022 contract.	1-4-21

A7 Item #	A7 Sub-Section #	Comment	Final Approved Response	Response Date
	11.03.2	*Choosing Wisely* is one of several decision aids available. Moreover, plans do not have insight into shared decision-making discussions between health care providers and enrollees and cannot track implementation efforts. Therefore, we request that Covered CA remove the references to *Choosing Wisely* in this section and allow the plan's contracted providers to use any decision aids they deem appropriate for their patients.	Covered California continues to support and encourage the incorporation of Choosing Wisely decision aids to promote decisions about appropriate and necessary treatment. We will amend the requirement to state, "Report how contractor is encouraging providers to implement Choosing Wisely guidelines" which eliminates the tracking of implementation, but continues to signal Covered California's support of Choosing Wisely.	1-4-21
	11.03.2	11.03.2 (4) - Heath Net recommends changing the requirement to 'How contractors are encouraging providers to implement Choosing Wisely guidelines' as we do not have a mechanism to track their implementation efforts.	Covered California continues to support and encourage the incorporation of Choosing Wisely decision aids to promote decisions about appropriate and necessary treatment. We will amend the requirement to state, "Report how contractor is encouraging providers to implement Choosing Wisely guidelines" which eliminates the tracking of implementation, but continues to signal Covered California's support of Choosing Wisely.	1-4-21
	11.04	Plans should be asked to provide their plans for coming into compliance with the federal ONC Data Blocking Regulations, as soon as they are finalized.	Covered California will consider your recommendation as we continue to develop and strengthen this requirement in 2023 and beyond.	1-4-21
	12.01	The draft document does not include the appendices referenced in this section. Please share a copy of the appendices with the issuers for review and comment.	The appendices will be included in the draft Attachment 7 released in January 2021.	1-4-21
	12.01 Definitions of Key Drivers	Please provide the appendices referenced in this section,. Health Net will need to review the appendices being able to comment.	The appendices will be included in the draft Attachment 7 released in January 2021.	1-4-21

A7 Item #	A7 Sub-Section #	Comment	Final Approved Response	Response Date
	14.01	CMA supports efforts to promote solutions for people with complex medical and social needs, including well-coordinated and adequately funded case managers. Many social and economic conditions often lead to health disparities, or differences in health outcomes, and vary by socioeconomic status, race/ethnicity, geographic location, educational attainment, sexual orientation, gender, and occupation. Strong evidence has accumulated over the last decade that links unmet social needs with poor health status. When screening and targeting patients with social needs, we would encourage the utilization of existing provider relationships and networks and we strongly support contracted models where QHPs will provide direct funding for physician practices to hire additional case managers who can provide this benefit to patients. If physicians do need to refer patients out for care management, they should be able to refer the patient directly to the plan through a streamlined process that allows the physician to remain informed and involved with the patient's care. Physicians report to CMA that oftentimes when managed care plans are given additional requirements for enhanced care management that require high-touch, on the ground and face-to-face contact, either programmatic or data-related, that these requirements tend to be delegated downstream to treating physicians, often without discussion or additional financing to support the new requirements. Providers, both physical and behavioral health, will be key to successfully driving these changes with individual patients. However, in order to successfully address social needs, plans cannot simply add additional unfunded contract requirements to provider contracts and expect this to be absorbed into practice flows; care management must be adequately funded. Additionally, many health care systems have begun to explore ways to integrate data related to social determinants with patients' clinical records. However, many challenges remain before data related to the social determinants of health are readily accessible and actionable. Key challenges are a lack of consensus on standards for capturing or representing social determinants of health in electronic health records. There is no single standard that captures the breadth of information necessary for documenting the determinants in a manner appropriate for clinical care, quality improvement, and research. To address these challenges and effectively use social determinants in health care settings while minimizing additional administrative burden on patients and physicians, we recommend that Covered California implement uniform standards for QHPs for representing data related to social determinants of health, the data be easily extracted, and the collection of the data be incentivized through financial or quality measures.	Thank you for your recommendation. Covered CA will continue to explore how to best approach new requirements that include provider-level implementation activities.	1-4-21
	14.01	We request that the definition of the ask be more clearly stated and the scope more clearly defined. In particular, we are concerned with the broad nature of "health education or promotion programs" and request that be removed.	Covered CA will clarify the requirement.	1-4-21

A7 Item #	A7 Sub-Section #	Comment	Final Approved Response	Response Date
	14.01	Amendment language implies that all enrollees must be screened, but "at a minimum, members enrolled in Complex Care Management, Case Management and health education/promotion programs must be screened". It would be an unrealistic expectation for health plans to screen all enrollees. Molina recommends that the social needs screening requirements clearly defined and only applied to those members identified as at-risk through defined criteria, i.e. claims/admin data indicating homelessness, etc.	Covered CA will clarify the requirement that, at minimum, all enrollees engaged in the identified plan-based programs be screened for food insecurity and housing instability or homelessness.	1-4-21
	14.01	The intention and scope of this requirement is not clear. As drafted, this amendment implies that the all enrollees enrolled in Complex Care Management or Complex Case Management would be screened for social needs. Furthermore, the as drafted, this section does not include any clearly defined parameters for which a plan would use to identify an at-risk individual. We are asking Covered CA to amend this section to more clearly define the purpose of this new requirement.	Covered CA will clarify the requirement that, at minimum, all enrollees engaged in the identified plan-based programs be screened for food insecurity and housing instability or homelessness. Covered CA does not intend to define criteria or parameters for social needs screening in 2022.	1-4-21
	14.01.2	We propose amending this requirement to exclude health education and promotion programs from the screening requirement, as these programs do not have workflow within the process that would allow for the screening and tracking needed to meet the reporting requirements.	Health promotion and health education programs are included in the proposed social needs screening requirement since food insecurity or housing instability would dramatically interfere with a member's successful participation in these programs and these points of contact represent an important opportunity for the plan or provider to assess social needs. Covered CA will consider this suggested removal for 2022.	1-4-21
	14.01.2	•Remove health education and promotion programs from the screening requirement. These programs are not always integrated with a Case Manager workflow that would allow for appropriate the screening and tracking	Health promotion and health education programs are included in the proposed social needs screening requirement since food insecurity or housing instability would dramatically interfere with a member's successful participation in these programs and these points of contact represent an important opportunity for the plan or provider to assess social needs. Covered CA will consider this suggested removal for 2022.	1-4-21
	14.02	Require that QHPs use a centralized resource and to build on networks and community resources that have already been established to support linkages to appropriate social services (Section 14.02).	Covered CA will revise proposed language to encourage use of existing networks and community resources and established linkages where possible. .	1-4-21

A7 Item #	A7 Sub-Section #	Comment	Final Approved Response	Response Date
Article 15. Data Sharing and Analytics		Article 15. Data Sharing and Analytics We strongly support the requirements to assure effective implementation of the Healthcare Evidence Initiative. The ability of Covered California to collect data on the entire individual and small group markets, both on and off exchange, will strengthen the effect of its efforts to improve quality while reducing disparities and costs.	Covered California is excited to hear your support for the implementation of the HEI initiative.	1-4-21
	15.01.1 Data Submission	Health Net requests to maintain our own section of this contract as agreed to between our Legal teams. We would like to uphold the agreed upon language in the 2021 amendment. If Covered California would like to change the language in this section, please provide an explanation and schedule a meeting with Health Net Legal to discuss.	Covered California is open to discussion and will plan on scheduling a meeting with the legal teams.	1-4-21
	15.01.2	Health Net requests to maintain our own section of this contract as agreed to between our Legal teams. We would like to uphold the agreed upon language in the 2021 amendment. If Covered California would like to change the language in this section, please provide an explanation and schedule a meeting with Health Net Legal to discuss.	Covered California is open to discussion and will plan on scheduling a meeting with the legal teams.	1-4-21
	15.02	CMA recognizes the importance of and fully supports the secure exchange of data among providers to reduce costs, improve quality of care, and reduce administrative burdens. Data should follow the patient and should be available to any appropriate provider at the point of care. Secure and robust data exchange, however, cannot be achieved without sufficient funding for necessary technology infrastructure and training. In addition, CMA urges Covered California to ensure that data collection obligations are not passed down to individual providers without the appropriate considerations of cost and administrative burdens. It is critically important that Contractors use standard processes for encounter data exchange with contracted providers, and we appreciate the inclusion of Article 15.02.3 requiring Contractors to use industry standards. Additionally, CMA appreciates the new requirements that Contractors report on their own and provider participation in Health Information Exchanges (HIE), and that they agree to engage with Covered California in discussions regarding a transition to a statewide approach to streamline Health Information Exchange participation.	Thank you for your comment. Covered California will consider your recommendation as we continue to develop and strengthen this requirement in 2023 and beyond.	1-4-21

A7 Item #	A7 Sub-Section #	Comment	Final Approved Response	Response Date
	15.02 Data Exchange with Providers	15.02 Data Exchange with Providers We support the provisions encouraging plans to participate in statewide or regional initiatives for health information exchanges. As advocates, we have questions about whether the existing health information exchanges contribute to equity in the delivery of care as well as concerns about data security and the privacy of consumer health information. We note that the last sentence requires the plans to engage in discussions regarding possible transition to a statewide approach to Health Information Exchanges: in any such discussion, possible disruptions in care arising from transitions in health information exchanges must be front and center from a consumer perspective. Transitions in data systems may improve the ability to provide care across systems, for example when a consumer goes to an out of network emergency room, but transitions in data systems may also disrupt those systems and thus the care that depends on them.	Thank you for your comment. Covered California will consider your recommendation as we continue to develop and strengthen this requirement in 2023 and beyond.	1-4-21
	15.02.2	We appreciate that Covered California is requiring Contractors to report on participation in Health Information Exchanges (HIEs). The list of HIEs in subsection 2) should be expanded to include all of the Qualified Health Information Organizations (QHIOs) for the California HIE Onboarding Program (Cal-HOP). In addition, plans should be required to support other forms of exchange, including national networks (Carequality, Commonwell) and API-based exchange.	Covered California recognizes that this is not an exhaustive list of HIEs. We will clarify that participation in other qualified HIEs should be described.	1-4-21
	15.02.2	VHP is in favor of engaging with Covered California in discussions regarding a transition to a statewide approach to streamline HIE participation, however we don't believe there is an HIE currently in Santa Clara County that VHP can participate in	Covered California is looking forward to working with VHP to explore options of participation in HIEs.	1-4-21
	15.02.2	Recommend broadening the language to account for other ways of promoting interoperability and exchange of data.	Covered California recognizes that this is not an exhaustive list of HIEs. We will clarify that participation in other qualified HIEs should be described.	1-4-21
	15.02.2	At the end of the section, recommend adding language to include hospitals and health care providers in discussions regarding HIE participation. Recommend the following (additions in **bold**): "The Contractor agrees to engage with Covered California **and hospitals and health care providers** in discussions regarding a transition to a statewide approach to streamline Health Information Exchange participation **or other efforts that could facilitate an improved exchange of data."**	Covered California will continue to develop and strengthen this requirement in 2023 and beyond. We will adjust the contract language to emphasize inclusion of other stakeholders and other efforts.	1-4-21
	15.02.2	•Participation in HIE should be mandatory for all QHPs	Covered California will consider your recommendation as we continue to develop and strengthen this requirement in 2023 and beyond.	1-4-21

A7 Item #	A7 Sub-Section #	Comment	Final Approved Response	Response Date
	15.02.2	I am writing to let you know that I am in agreement with and am appreciative of the Draft Attachment 7 to Covered California 2017 Individual Market QHP Issuer Contract: Quality, Network Management, Delivery System Standards and Improvement Strategy. On page 43, I would like to call your attention to page 43, section 15.02.2 and the fact that SacValley MedShare is not listed in the list of HIE's. We are a regional HIO that has been in business for over 8 years in Northern California, cover 19 counties and over 44,000 square miles. We are also a Qualified HIO under the Cal-HOP program. https://sacvalleyms.org	Covered California recognizes that this is not an exhaustive list of HIEs. We will clarify that participation in other qualified HIEs should be described.	1-4-21
	15.02.2	We applaud your promotion of data sharing in several areas of this document. In particular, we are happy to see data exchange with providers promoted in section 15.02. CAHIE and our members likewise recognize the critical role that sharing health information plays in improving quality of care and successfully managing costs. While many focus use of HIE on providers, we are happy to see you include health plans as well, as health plans represent a critical stakeholder group that is not taking full advantage of data sharing opportunities or levers they have for promoting provider participation. We encourage you to retain language to report on activities, and perhaps more actively promote participation. Section 15.02.2 requires contractors to report on participation in statewide or regional initiatives, including the a listed group of health information exchanges. We would recommend that you ensure the final language clearly differentiates desired participation in community-based HIE from enterprise HIE (a term commonly used in California to identify HIE-like activities of large distributed health systems that are not open to unaffiliated participants) or national networks (that while important don't provide the same level of data sharing that community exchanges do). We include all of the organizations you list among our members and among community HIEs. It may be problematic listing specific organizations in section 15.02.2. There are several active community HIEs that are not on your list, including Redwood MedNet, SacValley MedShare, and San Mateo County Connected Care that are among our members and actively exchange health data in their respective communities. Some community HIEs also have affiliations with others – such as San Joaquin Community HIE, Central Valley HIO, and Inland Empire HIO affiliations with Manifest MedEx – that may confuse providers or plans. An all-inclusive list will be difficult to maintain, and we would recommend that you either add the named organizations and create a process by which other organizations can petition to be included, or remove all named organizations and instead use a definitional approach. We would be happy to work with you on a list or definition that aligns with California's HIE landscape. One operational definition option often used by others (such as DHCS) is to focus on the HIEs that have agreed to participate in the California Trusted Exchange Network that CAHIE operates, as it reflects a commitment by those organizations to share health information statewide across their own organizational boundaries and geographies. You can find a listing of them on our web site at https://www.ca-hie.org/initiatives/cten/.	Covered California recognizes that this is not an exhaustive list of HIEs. We will clarify that participation in other qualified HIEs should be described.	1-4-21

A7 Item #	A7 Sub-Section #	Comment	Final Approved Response	Response Date
	15.02.2(3)(i) and 15.02.03	Please define "professional providers" for the purposes of this reporting requirement, and please clarify if this reporting is requested at the physician group level or the individual physician level. Some providers do not participate in Health Information Exchanges (HIE). Additionally, Manifest MedEx does not appear to report participation at the individual physician level. The QHPs support efforts for Covered CA to require participation in HIE in order to increase provider and hospital participation. For this reason, we encourage Covered CA to make participation in a HIE mandatory.	Covered California will adjust contract language to clarify reporting at individual clinician level. The intent of this requirement is to understand and strengthen network participation in HIEs. As noted in your comment, reporting physician group participation may not accurately depict engagement. We recognize the additional effort by issuers to meet this requirement. Covered California will consider your recommendation as we continue to develop and strengthen this requirement in 2023 and beyond.	1-4-21
	15.02.3	15.02.2 (3)(i) – Please define “professional providers” for this reporting requirement. Is this reporting required at the physician group level or at the individual physician level? Some PPGs may participate in HIE, while an individual physician within that PPG may not. In addition, Manifest MedEx does not appear to report participation at the physician level.	Covered California will adjust contract language to clarify reporting at individual clinician level. The intent of this requirement is to understand and strengthen network participation in HIEs. As noted in your comment, reporting physician group participation may not accurately depict engagement. We recognize the additional effort by issuers to meet this requirement.	1-4-21
	15.02.03	I recommend that a requirement be added for health plans and their contractors (e.g. IPAs, MSOs, and clearinghouses) to utilize the standard EDI 834 transaction for eligibility data transmission. Current lack of standard use of this transaction format throughout the encounter data supply chain causes issues both with the quality of eligibility data due to the need for data transformation downstream, but also can cause delays in the receipt of encounter data by providers when they either need to convert it internally, or have it converted by an intermediary such as an MSO. It is my understanding that some health plans currently only offer transmission of these data as a flat-file (which can be a useful option for provider organizations that cannot conform to this standard today, but which is detrimental when it is the default or only option for communicating eligibility data). This requirement may best fit under section 15.02.03.	Covered California will consider your recommendation as we continue to develop and strengthen this requirement in 2023 and beyond.	1-4-21

A7 Item #	A7 Sub-Section #	Comment	Final Approved Response	Response Date
	15.04	We appreciate the new requirement that Contractors must implement and maintain a secure, standards-based Patient Access Application Programming Interface (API) consistent with the CMS Patient Access final rule for Federally Facilitated Marketplaces. However, CMA has serious concerns with the Final Rule related to the lack of privacy and security protections for patient data. Therefore, we would ask Covered California to ensure the Contractors sufficiently address the privacy and security of patient data in APIs.	We understand your concerns regarding the privacy and security protections for patient data. Our goal is to align with federal requirements for Federally Facilitated Marketplaces; thus, we assure you the privacy and security protections for patient data is one of our biggest priorities. Covered California will consider your recommendation as we continue to develop and strengthen this requirement in 2023 and beyond.	1-4-21
	15.04	Amendment is requiring health plan to set up member/patient application so that members can see their own healthcare data. Expectation is that health plan would make that data available to member within 1 day of receipt of that data. This would be a heavy lift for the health plan to implement. Molina recommends adding more time.	We understand your concerns. At this time, our goal is to minimize burden and align with federal requirement with FFM, Medicare, and Medicaid. Additionally, it is a strong recommendation for state marketplaces. Covered California will consider your recommendation as we continue to develop and strengthen this requirement in 2023 and beyond.	1-4-21
	15.04	This amendment should be updated to include references to the CMS and ONC Interoperability Rules, and to allow additional flexibility for QHPs to comply with the federal requirements.	Covered California will adjust contract language to provide the appropriate resources for issuers.	1-4-21
	15.04	•This amendment should be updated to include references to the CMS and ONC Interoperability Rules, and to allow additional flexibility for QHPs to comply with the federal requirements	Covered California will adjust contract language to provide the appropriate resources for issuers.	1-4-21
	15.04, 15.04.1, 15.04.2	Sutter Health Plan is supportive of Covered California's efforts in making it easier for members to access their health information to help them make better, more informed decisions when navigating their health care needs. In relation to the amendment that requires implementation and compliance with the CMS Patient Access Final Rule - Patient Access API (CMS Interoperability Rules); recognizing that CMS finalized the rule on March 9, 2020 and provided an enforcement safe harbor until July 1, 2021. Sutter Health Plan suggests establishing a deadline for when Covered California participating health plans and insurers are expected to implement and comply with this requirement as there may be health plans and insurers that are not presently subject to the CMS Interoperability Rules.	Contracted issuers should demonstrate implementation and compliance in Plan Year 2022. Covered California will continue to develop and strengthen this requirement in 2023 and beyond.	1-4-21
	17.01	CMA supports the requirement that Contractors must be accredited by NCQA by 2024 as this aligns with future CalAIM initiatives from the Department of Health Care Services to improve quality among Medi-Cal Managed Care plans. We believe alignment among regulators and payors will help improve quality without imposing additional administrative burdens on physician practices.	Covered California is excited to hear the benefits of aligning this deadline with the Department of Health Care Services deadline.	1-4-21