**Cover Page**

**Qualified Health Plan (QHP) for Individual Market**
**Attachment 2 – Performance Standards with Penalties**
**Response to Comments**

The following is the Covered California response to comments received in Cycle 1 (October 15, 2021 through November 5, 2021) for the release of contract documents:

- 2023-2025 QHP Attachment X-Performance Standards with Penalties – DRAFT - 10-15-21

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

**Response to Comments - Cycle 1 (October 15, 2021 - November 5, 2021)**
**2023-2025 Qualified Health Plan (QHP) for Individual Market, Attachment 2 - Performance Standards with Penalties**

| A 14 Item # | A14 Sub-Section # | Comment | Covered California Response |
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| 1 | Reducing Health Disparities: Demographic Data Collection – Enrollee Race and Ethnicity Self-Identification | Recommend including provider-reported data that we receive for the member via data exchange. In addition, CALHEERS is the system of record and race and ethnicity data that the carriers collect may be overwritten with the data provided in the 834. | Member self-reported data provided by providers is counted toward the 80% threshold if included in HEI submissions. |
| 1 | Reducing Health Disparities: Demographic Data Collection – Enrollee Race and Ethnicity Self-Identification | The capturing of Race and Ethnicity is critical to meeting certain aspects of contractual requirements such as in Attachment 7 and Attachment 14/X. We request Covered California take steps towards requiring these fields on the application, if permitted by law. Capturing this information at time of enrollment is most appropriate and alleviates administrative burden on plans to collect this information that Covered California could have access to. In addition, there may be requirements for NCQA MHCD and/or Health Equity regarding the capturing of this enrollment information which is most appropriately collected at time of enrollment by Covered California. We also request that Covered California capture at time of application and send to QHPs enrollee ethnic and cultural preferences for primary care clinician assignment. | Covered California agrees the enrollment application is an important opportunity to collect this information but does not intend to pursue mandatory race and ethnicity questions in the enrollment application. We will continue to explore opportunities to improve capture of member self-identified demographic data.<br><br>We will continue to explore your recommendations and continue to explore best practices for collection and sharing of member self-reported demographic data. |
| 1 | Reducing Health Disparities: Demographic Data Collection – Enrollee Race and Ethnicity Self-Identification | Please provide the "list" referenced in "a. See list…" for consideration. | Covered California is working internally to address your comment. |
| 1 | Reducing Health Disparities: Demographic Data Collection – Enrollee Race and Ethnicity Self-Identification | "Decline to state" is an actual response. A "declined to state" response should be tracked but should be removed from both numerator **and** denominator. QHPs should not be penalized if an enrollee makes a decision to "decline to state".<br><br>"Decline to State" should be accepted and applied to the 80% standard to honor enrollee choice about self-reporting race and ethnicity data. "Decline to State" does not appear to be submitted by Covered California on 834. This information should be provided to plans since the consumer actively made that selection. | As previously articulated, the 80% threshold acknowledges that not all members choose to share this information. |

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| 1 | Reducing Health Disparities: Demographic Data Collection – Enrollee Race and Ethnicity Self-Identification | Given the fact that, in addition to this performance standard, the NCQA Health Equity Accreditation is dependent on race and ethnicity information, it is critical that the information is captured as part of the application process. In order to ensure completion, consider removing to designation of optional and provide an option of decline to state. | Covered California agrees the enrollment application is an important opportunity to collect this information but does not intend to pursue mandatory race and ethnicity questions in the enrollment application. We will continue to explore opportunities to improve capture of member self-identified demographic data.<br><br>We will not be pursuing the decline to state response option; as previously articulated, the 80% threshold acknowledges that not all members choose to share this information. |
| 1 | Reducing Health Disparities: Demographic Data Collection – Enrollee Race and Ethnicity Self-Identification | Please clarify what "self-reported racial and ethnic data" refers to. Is this strictly limited to data that the carrier obtains directly from the member or does it include data obtained from the individual's medical record? Does it include the information provided as part of the application process? | Self-reported racial and ethnic data refers to information provided directly by the member. Member self-reported race and ethnicity data may be obtained from the enrollment application, direct contact between plan staff and members, or the member's electronic health record. |
| 1 | Reducing Health Disparities: Demographic Data Collection – Enrollee Race and Ethnicity Self-Identification | Recommendation: We recognize the importance of having self-identified Race & Ethnicity data, and firmly believe the best opportunity to capture this information is during the application/enrollment process. We strictly oppose any penalties for QHPs to achieving above 80% Race & Ethnicity Self Reported Data, as Covered California is the primary and most effective channel for gathering this information.<br><br>Covered California should update the enrollment process to capture DECLINE TO STATE and make the field mandatory in the GI enrollment process, and drive improved data collection via prompts during the enrollment workflow.<br><br>QHP outreach for members to collect this data can be expected to drive lower member satisfaction (particularly if members decline to state, but that information is not shared with QHPs), and will crowd out other pressing member outreach efforts, while increasing administrative costs. | Covered California agrees the enrollment application is an important opportunity to collect this information but does not intend to pursue mandatory race and ethnicity questions in the enrollment application. We will continue to explore opportunities to improve capture of member self-identified demographic data.<br><br>We will not be pursuing the decline to state response option; as previously articulated, the 80% threshold acknowledges that not all members choose to share this information.<br><br>Covered California will continue to work with issuers to reach and maintain the 80% race/ethnicity self-identification threshold during 2023-2025. |

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| 2 | Reducing Health Disparities: Demographic Data Collection – Enrollee Spoken and Written Language | In the past Covered California has requested to have members call the service center when they want to change their language information because Covered California also uses this data. If the carriers collect the data directly, we don't have a way to send it back to update Covered California's system to align our information. In addition, members can only elect to have one written and spoken language. If our data does not align with CALHEERS, it will be overwritten with the data provided in the 834.<br><br>Collection of written and spoken language for 80% of enrollees may be difficult to achieve by 2025 because English speaking enrollees will not feel a need to report this information. This data is often left blank for English speaking members. We suggest setting targets for 2024 and 2025 after 2023 baseline performance and additional research is completed. | Covered California will continue to research existing language data collection processes to identity the appropriate threshold and timeline for this requirement, and adjust the language requirement, as necessary. |
| 2 | Reducing Health Disparities: Demographic Data Collection – Enrollee Spoken and Written Language | The capturing of spoken and written language is critical to meeting certain aspects of contractual requirements such as in Attachment 7 and Attachment 14/X. We request Covered California take steps towards requiring these fields on the application, if permitted by law. Capturing this information at time of enrollment is most appropriate and alleviates administrative burden on plans to collect this information that Covered California could have access to. In addition, there may be requirements for NCQA MHCD and/or Health Equity regarding the capturing of this enrollment information which is most appropriately collected at time of enrollment by Covered California. | Covered California agrees the enrollment application is an important opportunity to collect this information but does not intend to pursue mandatory race and ethnicity questions in the enrollment application. We will continue to explore opportunities to improve capture of member self-identified demographic data.<br>We will continue to explore your recommendations and best practices for collection and sharing of member self-reported demographic data. |
| 2 | Reducing Health Disparities: Demographic Data Collection – Enrollee Spoken and Written Language | It appears that HEI data currently only has two fields for language on the Enrollment file, ME033 and ME034. It does not appear to be clear whether those fields are specifically for spoken, written, or both. We are concerned that Covered California may be modifying the HEI data format. Modifications to such reporting will take development effort and we have not received the specification changes to make such a change. Due to complexities with development, we request the specification changes be provided by April 1, 2022 to meet a January 1, 2023 deliverable. | Covered California is working internally to address your comment. |

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| 2 | Reducing Health Disparities: Demographic Data Collection – Enrollee Spoken and Written Language | Clarify if spoken and written languages must be reported separately in year 1. What is threshold? | Yes, contractor HEI submission must include distinguishable spoken and written language data. Baseline will be established in 2023 to determine a 2024 threshold. |
| 2 | Reducing Health Disparities: Demographic Data Collection – Enrollee Spoken and Written Language | We appreciate the additional requirement that plans collect and report data on enrollee spoken and written language and the percent of at-risk associated with this goal. In recent discussions with Covered California, we learned individuals who leave the field "written and spoken language" blank in CalHEERS are automatically assigned English as their language. This default assignment to English language makes this data unreliable for quality improvement purposes while also potentially leading to poorer quality care for those who should be provided with interpreter services. Again, Covered California must prioritize accurate data, lest greater efforts towards reducing disparities be undermined by lack of basic information. We urge Covered California to utilize the AB 1296 CalHEERS stakeholder process to resolve this data issue as soon as possible. An initial step would be to flag this as a priority issue for Covered California ahead of the upcoming AB 1296 end-of-year meeting. Covered California should also investigate whether those applications leaving this question blank or incorrect spoken or written language information are generated from applications from agents other certified enrollment counselors, or Service Center representatives and re-train as necessary. Finally, enrollee language may be otherwise available to the plan, such as through their own contacts with enrollees or through providers and the plans should be allowed to correct the enrollee spoken and written language in CalHEERS. As mentioned above, we would additionally like to see a percentage of at-risk funds applied to 3. Reducing Health Disparities by language in 2024 and 2025. | Covered California is further researching the default assignment to English language in our enrollment application flow and will address as necessary to improve data quality.<br><br>At this time, we are assessing the appropriate performance threshold and timeline for language data collection and will assess feasibility for disparity reduction in the future. |

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| 2 | Reducing Health Disparities: Demographic Data Collection – Enrollee Spoken and Written Language | Recommendation: Remove the 2023 measurement for valid spoken and written language attributes for enrollees submitted in the HEI Data Submissions, as it is duplicative to the standards for HEI data submissions (incomplete / non-usable HEI data submissions - 9.HEI Data Submissions performance standard).<br><br>There should not be two performance standards related to HEI data submissions or the completeness of that data - as QHPs would be penalized 2x for the same lapse.<br><br>Covered CA also needs to define standards to evaluate if the spoken / written language attributes sent for our enrollees through the HEI data submission was valid.<br><br>Furthermore, this is data captured in the enrollment & application process. Covered California should ensure this is a mandatory field and passed to carriers. | Covered California is working internally to address your comment. |
| 2 | Reducing Health Disparities: Demographic Data Collection – Enrollee Spoken and Written Language | Recommendation: For measurement years 2024 and 2025, we recognize the importance of having self-identified spoken and written language preference data, and firmly believe the best opportunity to capture this information is during the application/enrollment process. We strictly oppose any penalties for QHPs related to the collection of spoken and written language preference data, as Covered California is the primary and most effective channel for gathering this information.<br><br>Covered California should update the enrollment process to capture this information and make the field mandatory in the GI enrollment process, and drive improved data collection via prompts during the enrollment workflow.<br><br>QHP outreach for members to collect this data can be expected to drive lower member satisfaction (particularly if members decline to state, but that information is not shared with QHPs), and will crowd out other pressing member outreach efforts, while increasing administrative costs. | Covered California agrees the enrollment application is an important opportunity to collect this information but does not intend to pursue mandatory questions in the enrollment application. We will continue to explore best practices and opportunities to improve capture of member spoken and written language. |

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| 3 | Reducing Health Disparities: Disparities Reduction Intervention | Please provide a report template and timeline as part of the document to allow carriers to prepare for and manage the submission process. | Covered California will provide a reporting template for use until performance assessment transitions to the PLD file. |
| 4 | National Committee for Quality Assurance (NCQA) Health Equity Accreditation | Please include the performance credit for carriers that have already met this requirement. This will align with the 2022 Contract requirement, incentivizing carriers to meet this requirement early. | The 2022 credit for early achievement was a one-time credit. There are no credit opportunities in 2023-25 Attachment 2. |
| 4 | National Committee for Quality Assurance (NCQA) Health Equity Accreditation | We received verbal confirmation during a recent call with Covered California that for Measurement Years 2024 and 2025 that QHPs that have active/unexpired MHCD will not be subject to penalty. We request this be reflected here as well. Penalty will occur after MHCD expires if QHP does not obtain Health Equity Accreditation. | Confirmed, language will be revised to more clearly specify application of the penalty for issuers transitioning from MHCD to Health Equity Accreditation. |
| 4 | National Committee for Quality Assurance (NCQA) Health Equity Accreditation | We understand Covered California intends to shift 10% of at-risk amounts within the Health Disparities section towards the new requirement that plans meet NCQA Health Equity Accreditation starting in years 2024 and 2025. While we support NCQA Health Equity Accreditation, we caution that the addition of a penalty to an action that is already a requirement for QHP participation could convey the wrong message that QHPs are allowed to fail to meet NCQA Health Equity Accreditation requirements as long as they simply pay a penalty. At a minimum, we urge Covered California to consider re-allocating a portion (5-10%) of at-risk funds from NCQA Accreditation to 3. Reducing Health Disparities. This would allow Covered California to establish its own set of benchmarks should progress towards establishment of national equity benchmarks be slower or less comprehensive than anticipated. Additionally, the imposition of additional at-risk funds for 3. would allow Covered California to expand disparities interventions to address disparities based on language and/or other socio demographic categories. | As Covered California transitions health plan accountability for disparities reduction to the Quality Transformation Initiative, we will continue to look to Attachment 2 performance standards as key complementary standards to advance our health equity goals. Covered California is committed to expanding health disparities reduction efforts and believes penalties for failure to achieve the NCQA Health Equity Accreditation remain important levers to hold health plans accountable. |
| 5 | Primary Care Payment | Recommend adding back in separate targets for PPO primary care clinicians that are contracted under HCP LAN APM Category 3 or Category 4. The measurement year expectations in the draft Attachment X are appropriate for HMO. If separate targets are not established for PPO primary care, please include measurement expectations for improvement and also attainment since these targets are much more aggressive than the PPO targets established for 2022. | Covered California intends to use the same standards for HMOs and EPO/PPOs in 2023-25. Our goal is for all plans to meet similar standards. We have revised the 2023-25 performance levels from 2022 to account for this. |

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| 5 | Primary Care Payment | Please consider modifying this requirement from "contracted" to "assigned as primary care clinicians" throughout this requirement. | Please provide more detail and the rationale for this request. It is unclear how this language change impacts the requirement. |
| 5 | Primary Care Payment | Recommend accommodation for plans operating in areas with limited network options. | Covered California intends to use the same standards for HMOs and EPO/PPOs in 2023-25. Our goal is for all plans to meet similar standards. We have revised the 2023-25 performance levels from 2022 to account for this. |
| 5 | Primary Care Payment | Please consider modifying this requirement from "contracted" to "assigned as primary care clinicians" throughout this requirement. Or create a different measure where "contracted" has a lower threshold and penalty amount and "assigned as primary care clinicians" is more aligned with current expectations for this measure. | Please provide more detail and the rationale for this request. It is unclear how this language change impacts the requirement. |
| 5 | Primary Care Payment | The HCP LAN framework doesn't have a direct fit for our delegated model. We believe the closest fit would be category 4B. | Thank you for this feedback. Covered California will work with issuers to determine how best to report using the HCP LAN framework. |
| 6 | Primary Care Spend | How will total primary care spend be defined by IHA? Will IHA be providing data to the carriers to support this requirement? For Measurement Years 2024 and 2025 future consideration, please include measurement expectations for improvement and also attainment since this is a new requirement. | Covered California will work with IHA to publish the methodology for primary care spend. We are currently working with IHA to analyze primary care spend and will share the results with QHP issuers once it is available. Thank you for the feedback on Measurement Years 2024 and 2025. We will consider this for the 2024 amendment. |
| 6 | Primary Care Spend | The health plan already submits the percent of spend to the Health Care Payment Learning and Action Network (HCP LAN). Will the health plans be required to report out to Covered California as well or is submission to HCP LAN sufficient? | Covered California's expectation is that QHP issuers will report to Covered California using a standard methodology developed in collaboration with IHA. We will work with IHA to publish the methodology for primary care spend. We are currently working with IHA to analyze primary care spend and will share the results with QHP issuers once it is available. We would welcome additional details on what VHP is submitting to HCP LAN on primary care spend. |
| 7 | Payment to Support Networks Based on Value | For Measurement Years 2024 and 2025 future consideration, please include measurement expectations for improvement and also attainment since this is a new requirement. | Thank you for the feedback on Measurement Years 2024 and 2025. Covered California will consider this for the 2024 amendment. |
| 7 | Payment to Support Networks Based on Value | The health plan already reports on its network payment models to Health Care Payment Learning and Action Network (HCP LAN). Will the health plans be required to report out to Covered California as well or is submission to HCP LAN sufficient? | QHP issuers will be required to report to Covered California as well. We are aiming to use the standardized HCP LAN methodology so the reporting should be similar (if not the same) as what VHP is reporting to HCP LAN. Covered California will collaborate with issuers to develop the data collection mechanism and methodology. We will aim to follow standardized methodology that minimizes reporting burden on issuers. |

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| 8 | Quality Rating System (QRS) QHP Enrollee Experience Summary Indicator Rating | The carrier Member Enrollee Experience CAHPS survey includes a very small sample size and does not allow for subsequent questions. We do not believe this is sufficient data to reflect the entire population by product. We recommend removing this performance standard. If the performance standard is not removed, please add a credit for Covered California service center performance. The CAHPS survey responses are impacted by Covered California activities including, but not limited to, the enrollment application and eligibility review and financial assistance calculations. | Covered California intends to maintain the performance standard for QRS QHP Enrollee Experience. If there is evidence that Covered California operations or service center performance impacted the QRS QHP Enrollee Experience scores, we may consider adjusting the penalties for standard 8 of Attachment 2 on a case by case basis at the time of scoring for the measurement year. |
| 8 | Quality Rating System (QRS) QHP Enrollee Experience Summary Indicator Rating | If Covered California experiences a large scale service type disruption/issue during the time period the CAHPS/EES surveys are completed by enrollees, enrollees can penalize QHPs in survey responses. We request if such disruptions/issues occur they are considered.<br><br>If Covered California experiences a large scale service type disruption/issue during the time period the CAHPS/EES surveys are completed by enrollees, enrollees can penalize QHPs in survey responses. We request if such disruptions/issues occur they are considered and penalty is removed. | Covered California intends to maintain the performance standard for QRS QHP Enrollee Experience. If there is evidence that Covered California operations or service center performance impacted the QRS QHP Enrollee Experience scores, we may consider adjusting the penalties for standard 8 of Attachment 2 on a case by case basis at the time of scoring for the measurement year. |
| 8 | Quality Rating System (QRS) QHP Enrollee Experience Summary Indicator Rating | There is consumer exhaustion with surveys as seen with low response rates to CAHPS/EES surveys. We request Covered California consider an alternative to such low response rate surveys as a way to gauge enrollee satisfaction. Especially if Covered California is successful at obtaining consumer experience results at a QHP, product, and geographic variation level. | Covered California looks forward to engaging with issuers, CMS, and others on how to address low response rates to experience surveys. |
| 8 | Quality Rating System (QRS) QHP Enrollee Experience Summary Indicator Rating | Since the measures in this section primarily evaluate member experience with their providers, will there be some sort of accommodation for plans operating in areas with limited network options? | Please provide more detail and the rationale for this request. Our goal is for all plans to meet similar standards. |
| 8 | Quality Rating System (QRS) QHP Enrollee Experience Summary Indicator Rating | Please provide specifics on how Covered California may adjust ratings. | Covered California will work transparently with issuers on any adjustments to QRS ratings as was done for measurement year 2020 due to the impact of COVID-19. |
| 8 | Quality Rating System (QRS) QHP Enrollee Experience Summary Indicator Rating | Recommend 10% penalty for 1-2 Stars. | Covered California has adjusted the proposed performance standard to 20% penalty for a 1-star rating and 10% penalty for a 2-star rating. |

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| 8 | Quality Rating System (QRS) QHP Enrollee Experience Summary Indicator Rating | Suggest varying the penalty based on the number of stars so that a one star plan would receive a higher penalty than a two star plan. This would be similar to the penalty variations based on score that are available for the Primary Care Payment Performance Standard | Covered California has adjusted the proposed performance standard to 20% penalty for a 1-star rating and 10% penalty for a 2-star rating. |
| 8 | Enrollee Experience | We appreciate Covered California staff for walking through the underlying measures and metrics encapsulated in the Quality Rating System (QRS) QHP Enrollee Experience Summary Indicator Rating. We strongly support Covered California's approach of weighting clinical quality scores more heavily (80%) than measures of consumer experience (20%) as part of QTI efforts and hope this allocation of weight continues as the at-risk percentage of the premium increases in future years. While we believe consumer experience is incredibly critical, plans must be held to account for ensuring enrollees receive the basic preventive care they are entitled to which is not the case today. Put another way, the most important consumer experience is being healthier rather than interactions with the health care system. Indeed, people in good or excellent health have fewer interactions with the health care system—and they like it that way. Moving forward, we urge Covered California to require and provide a break-out of consumer experience stratified by plans, geographic regions, disaggregated race and ethnicity, spoken and written language, and other variables. | Covered California will continue to publish QRS Enrollee Experience data by plan. We will explore options for stratifying data by other variables. |
| 9 | 4 | NPI and TIN are not always consistently provided in claims. We agreed with IBM and Covered California that one or the other of these IDs will be sufficient to identify the provider type. Please change from "(NPI) and …(TIN)" to "(NPI) or …(TIN)". | "NPI and TIN" describes the undesirable case. Only when both NPI and TIN are missing or invalid will the enrollment appear in the numerator of the proportion of records violating the standard. Changing to "or" would increase the numerator and make the standard harder for Contractors to achieve. |
| 9 | 5 | Please remove Rx claim and ordering Rx from this requirement. This information is not always included in the claim that we receive from the pharmacy.<br><br>NPI and TIN are not always consistently provided in claims. We agreed with IBM and Covered California that one or the other of these IDs will be sufficient to identify the provider type. Please change from "(NPI) and …(TIN)" to "(NPI) or …(TIN)". | Recommend no change as it is appropriate to require the identity of the prescribing physician.<br><br>For "NPI and TIN" vs. "NPI or TIN", see response above for item 9-4. |

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| 9 | 6 | This calculation must also include the injection fee and tax amount to accurately compare to the allowed amount. In addition, if we are the second payer, amounts from the first payer would need to be included. That information is not currently requirement and is not included in the HEI data submission.<br>*PDF Proposed strikethrough for 9.6 - If we pay secondary to another plan, then we only pay up to the allowed amount for the primary payer. We are not currently sending the primary payer allowed amount. There will be some variances where this is not always the case. Either recommend removing this requirement or specify for primary payer records (primary allowed amount would have to be added to the data to account for this).* | Covered California intends to maintain the performance standard expectations as drafted. After 2022 data is analyzed, Covered California will revisit the expectations. |
| 9 | 8 | HIOS IDs are not assigned to Small Group Off Exchange. Please confirm that this requirement and all other HEI data requirements exclude the Small Group line of business.<br>*PDF Note: Small Group plans do not all have HIOS ID assignments. This requirement should only be applicable to the Individual Market.* | The existing language regarding issuer-specific product ID is sufficient to accommodate any off-Exchange product without a HIOS ID.<br><br>Unless noted otherwise, Small Group Products are included. |
| 9 | 9 | To our knowledge, this analysis of Rx claims submissions against ingredient cost and dispensing fee amounts has not been completed by Covered CA and IBM therefore we are not able to determine if is reasonable at this time. We recommend removing this until further research has been completed.<br>*PDF Proposed strikethrough for 9.9 -This analysis has not been done by the carrier or IBM and we are not able to determine if is reasonable at this time. Recommend removing this.* | Covered California intends to maintain the performance standard expectations as drafted. After 2022 data is analyzed, Covered California will revisit the expectations. |
| 9 | 10 | Please update this requirement to include how “appropriate and accurate proportions” will be defined. | The following has been added to the contract language ", as determined by comparison to Contractor's prior period data submissions, comparison to data aggregated from all data suppliers, and consultation with the Contractor." |
| 9 | Credits | We request credit if Covered California and/or HEI vendor require changes to requirements and/or data submissions due to a technical difficulty of Covered California and/or HEI vendor. | Covered California will not be implementing credits for 2023-25 Attachment 2. |

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| 9 | | Recommend adding additional language to the introductory paragraph of section 9 to allow for data and system coding variances between carriers. The performance standards as listed may make sense for some carriers and not others. We would like to add the following language in red to allow for a mutually-agreed upon alternate standard as necessary:<br><br>Full and regular submission of data according to the standards outlined in Attachment 7, Article 15.01. Contractor must work with Covered California and the HEI vendor to ensure accuracy of data elements on an ongoing basis. Covered California and the Contractor may establish an alternate performance standard if different data variables are necessary to meet the HEI performance standards that have been set by Covered California. | Covered California intends to maintain the performance standard expectations as drafted. After 2022 data is analyzed, Covered California will revisit the expectations. |
| 9 | 9.9 - Rx claim financial validation | For the RX abbreviation, does this mean drug? Is the intent specific to the prescription drug benefit/claims file? | Covered California will replace "Rx" with "drug" for the HEI Data contract language. |
| 10 | DQA Measures | We currently submit the DQA Pediatric Measure set outside the IBM/Watson (HEI) process and do not capture dental claims submitted to dental vendor (Delta Dental). We recommend that this process continue and that if pediatric dental claims are needed for HEI they be submitted directly from the vendors to Covered CA. | Covered California is not opposed to receiving QHP pediatric dental claims from QDP issuers who contract with QHP issuers to provide pediatric dental benefits. |
| 10 | DQA Measures | We would like to request that the DQA measure set be moved to performance standards with no penalties. Analysis and reporting of pediatric dental experience should be completed before introducing a performance standard with penalties. If a performance expectation is set in the future, please include measurement expectations for improvement and also attainment. | Please see revised 2023 penalties. |
| 10 | DQA Measures | We request this penalty be removed at a minimum for 2023 to remain consistent with QDP. Since QDP Attachment 14 does not include such a penalty we request it be removed for QHP. | Please see revised 2023 penalties. |
| 10 | DQA Measures | We look forward to upcoming conversations with Covered California on its goals, objectives and approach to the establishment of a Dental Quality Alliance Pediatric Measure Set, as well as future adult oral health measures. | Thank you for your comment. |

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| General | At-Risk Amount | Our only comment at this point is around the concept of retaining a PS&G program with $s at risk when you are implementing the Quality Improvement Initiative which also has (rather significant) financial penalties/premium at risk. We recommend that either the programs be combined with no more than 4% total at risk, or some of the 4% be carved out of the QTI at risk amount and be applied the performance guarantees. | Covered California has adjusted the percent at risk for performance standards and QTI. We are proposing to adopt 0.2% of premium at risk for performance standards with penalties and 0.8% of premium at risk for QTI for 2023. We are proposing the total percent at risk will continue to increase by 1% each year to 4% and QTI will remain the majority of percent at risk over time. |
| General | At-Risk Amount | We recommend that if CC still wants financial penalties to apply to performance guarantees that the amount at risk not be added to the already very high amount at risk associated with the QTI program, we recommend that instead any premium at risk applied to this area be retasked from that applied to QTI. | Covered California has adjusted the percent at risk for performance standards and QTI. We are proposing to adopt 0.2% of premium at risk for performance standards with penalties and 0.8% of premium at risk for QTI for 2023. We are proposing the total percent at risk will continue to increase by 1% each year to 4% and QTI will remain the majority of percent at risk over time. |
| General | At-Risk Amount | Recommend subtracting the 0.2% of premium at risk from the total QTI penalty (.2% performance standards and 1.8% QTI). Keeping the total penalty amount at risk at 1% of premium will place more emphasis on the importance of QTI measure improvement and will allow carriers to focus resources on this effort. This will also help minimize the impact on premium increases. | Covered California has adjusted the percent at risk for performance standards and QTI. We are proposing to adopt 0.2% of premium at risk for performance standards with penalties and 0.8% of premium at risk for QTI for 2023. We are proposing the total percent at risk will continue to increase by 1% each year to 4% and QTI will remain the majority of percent at risk over time. |
| General | Credits | In order to further align with the goals of Attachment 7, we recommend introducing a performance standard credit to encourage collaboration amongst issuers to address poor performing hospitals on key quality metrics with an intervention plan. Currently a few carriers are using resources to drive an effort that would benefit from collaboration amongst all health plans. | Covered California will not be implementing credits for 2023-25 Attachment 2. |
| General | At-Risk Amount | The draft QTI adds significant penalties on QHPs. We request Attachment 14 penalties be removed and/or that QHPs have the ability to receive credits to offset penalties. | Covered California will not be implementing credits for 2023-25 Attachment 2. |

| A 14 Item # | A14 Sub-Section # | Comment | Covered California Response |
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| General | At-Risk Amount | QHPs rely on accurate and complete information from Covered California. We request that when there are servicing concerns that those are taken into consideration when assessing penalties.<br><br>Examples:<br>a) Attachment 14 will penalize QHPs for failing to meet 80% Race/Ethnicity self-identification. However, the best place to capture this data is at time of application. This is not a required field for applicants to complete. In addition, there is a notable difference in applications completed direct versus completed by an agent. Our understanding is that Covered California is not emphasizing the importance of this information with the agent community. Covered California's expectation of agents to include information on the application is important to meet such expectation of 80%. There are also concerns that the Maintenance 834 transactions may overwrite plan obtained information from consumers based on current contract requirements in updating demographic/enrollment information since Covered California is source of truth.<br><br>b) If Covered California experiences a large scale service type disruption/issue during the time period the CAHPS/EES surveys are completed by enrollees, enrollees can penalize QHPs in survey responses. We request if such disruptions/issues occur they are considered. | Covered California agrees the enrollment application is an important opportunity to collect this information but does not intend to pursue mandatory race and ethnicity questions in the enrollment application. We will continue to explore opportunities to improve capture of member self-identified demographic data.<br><br>If there is evidence that Covered California operations or service center performance impacted the QRS QHP Enrollee Experience scores, we may consider adjusting the penalties for standard 8 of Attachment 2 on a case by case basis at the time of scoring for the measurement year. |
| General | At-Risk Amount | If there need to be penalties in Attachment 14, we request the percent at risk should be escalating over time and not the reverse with year 1 w/o penalty then increase to 2.5% then max 5% by year 3. | Covered California has developed the percent at risk for each performance standard to add up to 100% each year. The variation in percent at risk from 2023 to 2025 is due to the addition of performance standards that are only applicable in later years. |
| General | At-Risk Amount | Recommendation: The total penalty for 2023 between QTI and Attachment 14/X should not exceed 1% of revenue, and these PGs should be phased out over time as QTI is fully implemented.<br><br>We recommend that QTI be .8% which added to Attachment 14/X .2% will equal 1% of revenue at risk between the two. For 2024 QTI would 1.8% + Attachment 14/X .2% for a total of 2% at risk. For 2025 QTI would be 2.8% + Attachment 14/X .2% for a total of 3% at risk. | Covered California has adjusted the percent at risk for performance standards and QTI. We are proposing to adopt 0.2% of premium at risk for performance standards with penalties and 0.8% of premium at risk for QTI for 2023. We are proposing the total percent at risk will continue to increase by 1% each year to 4% and QTI will remain the majority of percent at risk over time. |