**Cover Page**

**Attachment 14 First Round Comments**

The following is the Covered California response to "First Round" comments received for the 2022 Amendment, Attachment 14.

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

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| 1.12 | 1.12 Essential Community Providers (0%):<br>We support the continuance of annual Essential Community Provider (ECP) assessments such as those included in the Attachment 14 draft contract and look forward to participating in discussions with Covered California on an updated methodology for measuring ECP in 2023. We suggest adding contract language to clarify that the ECP assessments must include a comprehensive list of hospitals by name and system, Community Health Centers (CHCs) and Federally Qualified Health Centers (FQHCs) in health plan networks and the populations they serve. We accept lowering the percent at risk to 0% because so many hospitals qualify as "essential community providers" that the term has little meaning with respect to California hospitals. | Covered CA is currently reviewing the ECP requirements and will consider your request as part of that review. |
| 1.13 | 1.13 Hospital Safety (0%): We appreciate the redistribution of risk from hospital safety to other Covered California priorities. While we think hospital safety is an important focus area, we wonder whether there may be other potential focus areas, such as chronic disease management or behavioral health screening that would impact a larger proportion of Covered California beneficiaries. We urge Covered California to continue to participate in cross-agency initiative designed to improve hospital safety: consumers would be appalled to discover how unsafe hospitals continue to be for patients. | Covered California will be working with our stakeholders, consumer advocates, and partner agencies to evaluate how best to improve hospital safety for 2023-2025. |
| 2.1 | 2.1 HEI Data Submissions (10%): We appreciate the added emphasis by Covered California on putting funds at-risk for HEI data submission. We agree that the successful launch of Covered California's HEI is critical for future quality improvement and disparities reduction initiatives. We appreciate the addition of contract language specifying that data submissions must be timely and actionable. | Thank you for your comment. |
| 2.1 | Methodology / Definition for Performance Standard needs to prorate the penalty for each month impacted. So, for example, if there is an issue with taxonomy being invalid in 3 months of the submissions (which would include time to remedy) the Performance Standard would prorated to be ¼ * 3% (to reflect 3/12 months of the annual penalty %).<br><br>The methodology also needs to exclude the any timeframes in which the HEI vendor influences the duration or work, as these can cause a delay for the QHP that it is not able to control. For example, if the HEI vendor needs to do validation testing of a fix before it can go into production, and their testing takes 6 weeks, the QHP should not be assessed a prorated penalty for that timeframe.<br><br>Please clarify what Master Provider Index is - as there is not a specific field in the existing extracts.<br><br>For the last Performance Standard, the PCP NPI ID is not a required field for RX claims. This should be removed from the performance requirement. | Covered CA agrees that data issues can take more than one month to resolve, and continues to work with Carriers and the HEI Vendor to identify and resolve issues as quickly as possible. Penalties will be assessed based on the performance standard failure. More than one multi-month data replacement may incur additional liquidated damages.<br><br>Covered California's HEI Vendor has developed over time and maintains its own provider reference data (i.e., Master Provider Index), including provider name, location, NPI, TIN, etc.<br><br>Thank you for your comment. Covered California will adjust the contract language to:<br>2.1.4. Enrollment or professional medical claim submissions with PCP NPI ID missing or invalid on more than 1% of records: 2% penalty of total performance requirement. Submission meeting or surpassing the 99% populated and valid threshold: no penalty. |

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| 2023 public reporting of performance standards scores annually | Request that prior to any Carrier specific reports and scores of Attachment 14 measures being publicly released, Carriers have the opportunity to review and validate before being made public. This will allow Carriers to correct errors, address items that are considered confidential or proprietary prior to posting, and allow Carriers to prepare for inquiries.<br><br>Request that Covered California will include its results on similar metrics. | Covered California will allow carriers to review and validate reported information prior to publishing for the public. Covered California metrics are currenlty posted online. |
| 3.1 | 3.1: QHP Clinical Quality (33.5%): Thank you for heeding our recommendation to reallocate a greater percentage of risk (35-40%) for clinical quality scores. We remain concerned about the wide variation in quality scores among plans and look forward to seeing the impact of this new performance requirement on clinical results. In reviewing "Covered California Holding Health Plans Accountable for Quality and Delivery System Reform" December 2019, we were dismayed by the failure of most health plans to deliver all sorts of basic care from cancer screenings to flu shots to control of diabetes and hypertension. Even the integrated plans that did well on many of these measures did badly on access to care and care coordination. All in all, it was a record of health plans failing to manage care or even to assure that basic care was delivered to Covered California enrollees.<br>We understand only plans with 1 and 2 stars (ie. those below the 25% percentile or between the 25th and 50% percentile) are at risk in 2022. While we think this is a critical first step, we look forward to working with Covered California to ensure all plans rate well above the 50% percentile which is considered just average compared to national plans. We also encourage Covered California to be mindful of regional variations in plan performance that may be missed by this system. | Thank you for your comment. Covered California will be working with our stakeholders to prioritize areas of quality improvement and measurement for 2023-2025. |
| 3.2 | 3.2 QHP Enrollee Experience (16.5%): We appreciate Covered California's decision to reduce the percentage of at-risk payments for enrollee experience from 25% to 16.5% and shift the other 10% at-risk into clinical effectiveness measures above. Moving forward we urge Covered California to tie at-risk payment to the ability of plans to address and track disparities in CAHPS scores in languages other than English. | Thank you for your comment. Covered California will be working with our stakeholders to prioritize areas of quality improvement and measurement for 2023-2025. |
| 3.3a) | 3.3a) Reducing Health Disparities (7.5%): We support Covered California tying 7.5% of payment at risk for health plans not meeting Covered California's 80% target for self-reported demographic data collection. As we have previously stated, we urge Covered CA to hold payment at-risk for HEI data submission for other demographic categories including language, LGBTQ+ status and income. | Covered CA is reviewing its multi-year disparities reduction contractual approach and continues to explore the feasibility of requiring submission of additional demographic categories beyond race and ethnicity. We plan to expand our internal disparities analyses beyond race and ethnicity. |
| 3.3a) | We appreciate that Attachment 14 lays out a multi-year path. The process of achieving the triple aim of improved outcomes, lower costs and increased health equity is a multi-year effort that either progresses year by year or stalls out. We share with Covered California a commitment to continue to make progress. To that end, we reiterate our request for additional contract language stating very clearly, Covered California's plans to hold plans accountable for meeting additional disparities reduction metrics beyond 2022. | Covered CA is committed to advancing equitable care. Covered California looks forward to working with you to prioritize areas for the 2023-2025 contract. |

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| 3.3a) | Increasing the amount at risk to 7.5 exacerbates our concerns with this measure. If Covered CA continues to be unwilling to add an optional race/ethnicity question to the online application, while enforcing a higher penalty with no available offsetting credit, this measure will actually work against Covered CA's goal of keeping costs low. Not only will most carriers be almost guaranteed to fail to meet this measure on an ongoing basis, incurring a higher penalty, but carriers will also be burdended with the costs of attempting to obtain the information on the back end. Individuals are more likely to provide this information during the enrollment process rather than after enrollment has been completed, even if carriers perform multiple outreaches. | A majority of QHP Issuers have reported exceeding the 80% threshold over a number of years since the first required reporting in 2016. 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. |
| 3.3b) | 3.3b) Disparities Reduction Intervention (7.5%): We support Covered California tying 7.5% of payment at risk for health plans not meeting health disparities goals. We are disappointed to see that plans will only be held accountable for meeting one self-selected disparities reduction metric in 2022. We appreciate Covered California's statement at December's plan management meeting that this is a temporary move as plans work to meet the new data submission requirements as part of Covered California's Health Care Evidence Initiative (HEI). We would like to see contract language that codifies this intention so there can be no doubt. With a fully operational HEI, we expect to see Covered California get back to a full disparities measure set (formerly 14 measures) including newly developed measures using HEI data as has been discussed and we encourage Covered California to communicate that expectation clearly to health plans through contract language and other means. | Thank you for your recommendation. We will consider contract language that can clarify the intention of this requirement. |
| 3.3b) | The changes for this measure in 2022 need additional clarity relating to the goal of investment in best practices and adjustment to the standard to "demonstrate improvement in intervention population rather than reduced disparities gap among race/ethnic/populations" that have been discussed in relation to this measure. | The language will be revised to clarify the requirement and performance levels. |
| 3.3c) | 3.3c) Health Equity Capacity Building (2%): We support requiring NCQA Multicultural Health Care distinction rather than making it voluntary as some commenters have requested. We accept Covered California's delaying the deadline for adoption of this requirement to 2023 and offering a credit for early adoption in 2022. We appreciate Covered California's acknowledgment that this distinction will not be considered a replacement for other disparities reduction requirements. We would strongly oppose substituting NCQA Multicultural Health Care distinction for the disparities requirements in the Covered California contracts: we support requiring both, not replacing a California standard with a national standard developed by a private entity with no public input. | Thank you for your comment. |

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| 3.4 | 3.4 Primary Care (10%): We appreciate Covered California's decision to tie 10% at-risk funds to adoption and progressive expansion of primary care payment models. Covered California's data shows that the number of Covered California enrollees cared for by Primary Care Medical Home (PCMH) recognized practices increased from 25% to 40% between 2016 and 2018, and from 3% to 11% when Kaiser excluded.1 Given the relatively low percentage of enrollees cared for by PCMHs in non-Kaiser plans and the steady progress towards the adoption of PCMHs, we support Covered California in its efforts to encourage payment reforms in this area. We appreciate the additional specificity around Covered California contract expectations with respect to minimum thresholds under HCP LAN APM category 3 or 4. Community health centers, including federally qualified health centers as well as free and low-cost community clinics, are already providing fully integrated services and could potentially help plans meet higher benchmark goals. | Thank you for your comment. |
| 3.4 | This Performance Standard puts an unfair penalty on EPO/PPO network products offering statewide coverage or in geographies in which access standards for HMO network products can not be met. We are unable to move 75% of PPO primary care providers to HCP LAN APM Category 3 or 4 models in the drafted timeframes per Attachment 14. The typical provider contract cycle is multi-year, which also makes these timeframes unrealistic.<br><br>We recommend that the target percentages and penalties be based on annual progress, moving away from HCP LAN APM Category 1, similar to prior years. This can be be achieved via having plan specific annual targets, which Covered Ca has had in prior Attachment 14 PGs. Given the inherent challenges in moving away from FFS, there could be PG credits for achieving Level 4 for the PPO network products. | Covered CA is considering developing different performance levels per product type (HMO and EPO/PPO). Covered CA will maintain the threshold structure of the performance levels. |
| 3.5 | 3.5 Accountable Care Organizations (ACOs) (10%): We are supportive of Covered California's efforts to encourage a greater proportion of plans to move towards value based payment, including alternative payment models. Given the wide variation in types of ACO payment models, we appreciate the greater specificity in the contract of the arrangements Covered CA hopes to reward. Given the mixed record of ACOs in reducing costs while improving quality along with the wide variation in types of ACOs, it is worth considering whether this percentage at-risk is appropriate or whether a lower percentage of 4.5% or 5% might be more appropriate which would free up at-risk funds for chronic conditions, preventive health care, etc. | Covered CA intends to maintain the 10% at risk for performance standard 3.5 ACOs. Covered CA continues to promote the use of ACOs and IDSs as mechanisms to improve quality of care and promote integrated care while also aiming to learn more about ACO best practices in 2022 to inform the 2023 refresh requirements. |
| 3.5 | Attaining membership targets in ACO type models in the EPO/PPO network products is much more challenging than in the HMO based products, and the timeframes and thresholds can not be met. There are certain geographies where launching an ACO involving physicians, hospitals and ancillary providers is not feasible.<br><br>We recommend that the target percentages and penalties be based on annual progress for moving members into different population-based care coordination models (allowing for models other than ACO as defined by Covered California).<br><br>This can be be achieved via having plan specific annual targets, which Covered Ca has had in prior Attachment 14 PGs. | Covered CA is considering developing different performance levels per product type (HMO and EPO/PPO). Covered CA will maintain the threshold structure of the performance levels. |

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| 3.6 | 3.6 Appropriate Use of C-Sections (5%): we wonder how many births Covered California health plans cover given the 5% at-risk? While we think this is an important focus area, we wonder whether there may be other potential focus areas that would impact a larger proportion of Covered California beneficiaries. For example, chronic disease management, behavioral health screening, and an out-patient measure across all categories could potentially be more reflective of the overall needs of Covered California enrollees and working age populations. | For Plan Year 2022, the percentage at-risk for Section 3.8 Appropriate use of C-sections has been increased to 5%.This increase underscores Covered CA's commitment to improving quality, patient safety, and reducing costs.<br>Covered CA will be working with our stakeholders, consumer advocates, and partner agencies to prioritize and improve other areas of patient safety and quality including chronic disease management and behavioral health over the coming years. |
| 3.6 | Continuing our concern regarding the language indicating "all physicians and hospitals are re-contracted with new payment structure…" Most capitated arrangements do not contract directly with physicians, but rather, with Provider Physician Groups. While carriers can encourage this approach with the PPG, we cannot enforce the PPG contracting practices or conditions with their contracted physicians. | The contract language will be updated to state' "all physicians or physician groups and hospitals are re-contracted with new payment structure…" Covered CA's goal is to ensure there is no financial incentive for either physicians, physcian groups, or hospitals to perform C-sections. |
| 4.1-4.7 | Dental Quality Alliance (DQA) Pediatric Measure Set: We appreciate the requirement that dental plans report Dental Quality Alliance measures for the Pediatric Measure Set as part of a pilot period from January 1, 2021 to December 31, 2022. We urge Covered California to require health plans to stratify this data by gender, race, ethnicity and other sociodemographic factors in order to identify health disparities and address them. Additionally, we urge Covered California to consider requiring plans to report on the new patient experience measure currently under development by DQA. | The DQA measures are not reported by demographic data. When Covered CA begins collecting HEI data we will have access to the demographic data from consumers.<br><br>When DQA finalizes the new patient experience measure, we will review and work with plans and stakeholders to consider its inclusion. |
| Covered CA Metrics | We believe that Covered CA should continue to be requred to report these Customer Service Measures to the carriers on the basis that Covered CA under performance can impact carrier volumes, and thus, impact carrier performance. | Covered California will continue to report its Customer Service Measures to the carriers. |