

Article	Section #	Comment	Covered CA response
	General: Premium at Risk	Issuer supports retaining Premium at Risk at 1% and objects to increasing it to 2% under the proposed framework. Covered California has not established a sufficient evidentiary basis, validated methodology, or operational infrastructure demonstrating that doubling issuer financial exposure is reasonable, proportionate, or likely to improve performance. Increasing financial risk without valid, stable, transparent, and actionable measures would create unwarranted volatility, reduce premium predictability, and may result in higher premiums without producing measurable improvements in enrollee outcomes. Premium at Risk must remain at 1% unless and until Covered California validates the measures and methodologies, demonstrates that performance expectations are attainable, and limits financial accountability to factors within the Contractor's reasonable control.	The proposed increase from 1% to 2% is not an arbitrary doubling: it reflects our analysis showing that fewer than half of QDP enrollees use any dental services, with utilization particularly low among adult and DHMO enrollees, and indicates the current 1% at-risk mechanism has not generated meaningful performance improvement. The proposal was also shaped by substantial stakeholder feedback gathered across the February–June 2026 QDP Contract Workgroup sessions. The proposed increase is paired with technical and incentives to support improvement without relying solely on penalties. Covered California will continue to share supporting methodology and performance data with issuers before financial accountability is applied, consistent with our commitment on all Attachment 2 measures.
	General: Stand-Alone Dental Plan (SADP)	Issuer objects to applying requirements that presume SADPs have access to the same clinical and medical data available to integrated medical plans. Issuer does not maintain provider electronic health records or routinely receive medical records. Independent dental practices generally submit only the claims and encounter data necessary for benefit administration and required reporting. Measures dependent on medical, clinical, demographic, or other data unavailable to SADPs must remain reporting-only and must not be used to determine Premium at Risk, penalties, corrective action, decertification, or other adverse consequences. Contractor accountability must be limited to data reasonably available to and within the control of the SADP Contractor.	The QDP Attachment 2 oral health measures already reflect this distinction. Where a measure specification includes a combined medical-and-dental numerator, it also includes a dental-services-only numerator built for entities without medical claims access. Covered California scores QDP issuers using that numerator. Medical and dental data are not merged at the member level, so no QDP issuer is held accountable for services documented only in medical records outside its control. Because these standards already rely on dental claims and encounter data within a QDP's control, a blanket reporting-only reclassification is not warranted. Covered California will continue to share measure specifications and data sources before applying financial accountability, consistent with our commitment on all Attachment 2 measures.
	General: HMO Measures	Issuer objects to financial accountability that fails to recognize the DHMO operating model. Because providers receive fixed capitation payments, covered services may generate zero-dollar encounter records rather than traditional paid claims. Accurate utilization measurement therefore depends on independently operated dental practices submitting complete and timely encounter data, including zero-dollar patient visits. It is unreasonable to require issuers to undertake large-scale amendments to all-payer provider agreements or impose Covered California-specific reporting obligations across independent dental practices. Issuer does not maintain provider electronic health records, receive medical records, control practice-level reporting systems, or directly control the completeness and timing of provider encounter submissions. Accordingly, DHMO measures must remain reporting-only unless and until Covered California validates the underlying encounter data, incorporates all valid zero-dollar encounters, discloses identified data deficiencies, and provides issuers with sufficient information and a reasonable opportunity to reconcile and cure reporting gaps. No financial penalty or other adverse consequence should be imposed for data or conduct outside the Contractor's reasonable control.	Covered California is not proposing new all-payer provider agreement amendments or Covered California-specific reporting mandates on independent dental practices; existing HEI submission requirements remain unchanged. We are actively working with QDP Issuers on strategies to improve DHMO encounter-data completeness, including flexible submission methods and provider communication. We do not believe a blanket reporting-only reclassification is warranted. Covered California will continue to share data quality findings, methodology and baseline rates by product before applying financial accountability. QDP issuers contracted with Covered California are responsible for ensuring enrolled members paying monthly premiums are able to utilize care, regardless of the product-type.
	General: Oral Health Standards / Threshold	Issuer objects to applying a uniform 70% performance threshold to each Oral Health Standards measure without a disclosed and validated evidentiary basis. Covered California has not demonstrated that the threshold is statistically reliable, clinically appropriate, attainable for the Covered California population, or suitable across DHMO and DPPO products with different operating and reporting models. Before applying the 70% threshold for financial accountability, Covered California should disclose the supporting methodology, baseline data, statistical validation, product-specific analysis, and applicable external benchmarks. In the absence of this information, the threshold must remain reporting-only and may not be used to impose Premium at Risk, penalties, corrective action, product removal, or other adverse consequences.	The 70% threshold was not introduced arbitrarily. It originated from issuer feedback during the 2027 QDP Amendment process, where an issuer requested a utilization-based threshold above which annual improvement would no longer be tied to financial penalty. Measure performance at or above 70% threshold relieves a product from penalties for failing to show further annual improvement, while still requiring reporting and monitoring. This reduces, rather than increases, financial exposure for higher-performing products. Covered California publishes quality measure performance for all QDP products. Covered California will continue to provide issuers with baseline data by product. Given the multiple years of quality measure performance available, reclassifying these measures as reporting-only is not appropriate.
	General: Oral Health Standards / DQA Measures	Although Covered California applies DQA-based measures, its calculation methodology diverges from DQA because it appears to recognize only adjudicated claims resulting in payment and excludes valid utilization records for covered services with no plan payment. Under the capitated DHMO model, providers receive fixed capitation payments, and many rendered services therefore generate zero-dollar encounter records rather than paid claims. Excluding these encounters understates DHMO utilization and may reduce Issuer's reported performance by as much as 10 percentage points per measure. Issuer recommends that Covered California fully adhere to DQA standards and not impose financial penalties unless and until all valid paid claims and zero-dollar encounters are incorporated, the resulting measure rates are reconciled and validated, and issuers receive a reasonable opportunity to correct data deficiencies before final performance is determined. Adhering to DQA-standard methodology for 2028–2030 would enable Covered California staff, researchers, policymakers, and issuers to compare Covered California population rates with those of other populations.	For the Oral Health Performance Standards, Covered California uses HEI data for each measurement year to generate its oral health measures. The methodology references DQA Measure Technical Specifications and also details how Covered California applies criteria (such as age bands, numerator, and denominator) for Covered California Enrollees based on the Affordable Care Act's definition of required pediatric services. As these performance standards are specific to the Covered California Contract and applicable only to members enrolled on Exchange plans; they do not mirror the DQA specifications exactly as the DQA specifications do not include modifications by line of business. Therefore, the performance standards methodology may vary such as in age bands and population included. And, as Covered California does not collect denied claims, this data is not represented in our oral health measures. Zero-dollar encounter records are included in measure calculation.

	General: Oral Health Standards / Performance Gap Reduction	Issuer requests that Covered California define the Performance Gap methodology through complete formulas and worked examples. The current language does not provide sufficient clarity for issuers to independently reproduce the calculation or reliably determine the performance necessary to avoid a financial penalty. For example, if the 2029 Performance Gap for a specific measure is 20 percentage points (70% threshold – 50% baseline) and the required improvement is at least 10%, would the required reduction be 2 percentage points (20-point gap × 10% reduction), with performance above 52% necessary to avoid a penalty? In this example, would another 2-percentage-point improvement above the prior year's 52% be required in 2030? Please also note that the wording for Measurement Year 2030 under Performance Standard 8 is slightly different, which creates confusion about this calculation. Issuer further requests that any required annual Performance Gap reduction be evidence-based, measure-specific, and reasonably attainable. Required improvement should not exceed the approximately 2.4% average annual improvement rate for preventive care measures identified in AHRQ's National Healthcare Quality and Disparities Report unless Covered California provides measure-specific evidence supporting a higher rate. Unsupported improvement requirements must not be used to impose financial penalties or other adverse consequences.	The gap closure methodology is intended to address varying levels of improvement needed to reach the 70% threshold and to acknowledge that improvement is more difficult to attain at higher performance levels.
	Perf. Standard 4 Pediatric Topical Fluoride for Children	Issuer objects to financial accountability for the Pediatric Topical Fluoride measure until Covered California discloses and validates whether medical and dental data are combined at the member level. Covered California must provide an issuer dashboard showing attribution, measure status, data source, encounter type, stratification, and reconciliation status. The measure must remain reporting-only until results are transparent, reconciled with issuer data, and demonstrated to be within the SADP issuer's reasonable control.	This performance standard is already in place under the current QDP Issuer contract and Covered California shares measure specifications and performance standard methodologies. Covered California has implemented processes to share measure status with all contracted issuers. QDP issuers are not responsible for measures or measure specifications that include medical claims data or other information from an enrollee's medical health record.
	Perf Standard 5 Pediatric Sealant Receipt	Issuer has concerns about the Pediatric Sealant Receipt measure similar to those noted above regarding Pediatric Topical Fluoride for Children. Issuer also requests that any Oral Health Standards measure without a minimum population size be excluded from dental plan financial penalties. Covered California's June 2026 reporting indicated that the denominator for Issuer on the 2025 Pediatric Sealant Receipt measure was fewer than 200 for each of the PPO and DHMO products. This is not an appropriately sized population on which to assess dental plan performance and impose financial penalties.	This performance standard is already in place under the current QDP Issuer contract and Covered California shares measure specifications and performance standard methodologies. The Pediatric Sealant Receipt measure is calculated entirely from dental procedure claims, with no dependence on medical data. Covered California and DQA are aligned in that the measure specifications do not include a minimum population size for this measure. We may evaluate whether an evidence-based minimum is warranted, and welcome further discussion before any change is finalized.
	Perf. Standard 7 & 8 Pediatric and Adult Member Engagement	Issuer requests that Covered California define "any covered dental service," clarify how Standards 7 and 8 avoid duplication with existing utilization measures, account for pediatric, adult, DHMO, and DPPO differences, and reconcile the inconsistent 2030 language under Standard 8. Financial accountability must not apply unless the measures and Performance Gap calculations are validated, reproducible, reasonably attainable, and limited to factors within the Contractor's reasonable control.	Performance Standards 3–6 focus on defined clinical and preventive dental services, including pediatric oral evaluations, fluoride, sealants, and adult preventive-service utilization. In contrast, Standards 7 and 8 measure broader member engagement of pediatric and adult members who receive any covered dental service during the Measurement Year, including diagnostic, preventive, restorative services, or specialty care, without limiting the measure to a specific clinical subset. Although services may overlap across measures, contractors may use the same underlying data and receive credit for each applicable Performance Standard numerator. As with all performance standards, detailed measure specifications will be released before performance is assessed.
	General	Recommendation: We support continued performance oversight. Increasing premium-at-risk from 1% to 2% increases financial risk creates unwarranted volatility, reduced premium predictability, and ultimately will increase premiums.	Covered California recognizes the concern that a higher at-risk amount could create upward pressure on premiums. The proposed increase from 1% to 2% is not an arbitrary doubling: it reflects our analysis showing that fewer than half of QDP enrollees use any dental services, with utilization particularly low among adult and DHMO enrollees, and indicates the current 1% at-risk mechanism has not generated meaningful performance improvement. The proposal was also shaped by substantial stakeholder feedback gathered across the February-June 2026 QDP Contract Workgroup sessions and is not intended to add administrative burden. The proposed increase is paired with technical assistance and incentives to support improvement without relying solely on penalties. Covered California will continue to share supporting methodology and performance data with issuers before financial accountability is applied, consistent with our commitment on all Attachment 2 measures.
	PS 1	Recommendation: We recommend an additional qualifier be added to the DHMO requirement of 350 claims or encounters per 1,000 members, that accounts for efforts made by carriers to work with their capitated DHMO providers to increase submission of zero-dollar encounter records. As a reminder, under a capitated DHMO arrangement, covered services may be delivered without generating traditional paid claims. Instead, these services may be captured through zero-dollar encounter records submitted by independent dental practices. Plans do not maintain provider electronic health records, control practice-level reporting systems, or directly control the completeness and timing of independent provider encounter submissions.	The minimum threshold of 350 claims or encounters per 1,000 members is a reasonable minimum given data completeness across QDPs. Any submitted zero-dollar claims will be counted toward this threshold. QDP issuers are responsible for ensuring members paying monthly premiums are able to access and utilize care as needed and that provider oversight includes adequate data collection.

	PS 7 & 8	Recommendation: We recommend that PS 7 and 8 be removed, as they appear to be duplicative of the pediatric oral exam, adult preventive care utilization measures, the 25-2-2 350 claims or encounters per 1000 utilization requirement, and the HEI measures of 600 claims or encounters per 1000 (DHMO) and 1200 claims per 1000 (DPPO) members - that are also monitoring utilization performance.	Covered California appreciates the recommendation but believes Performance Standards 7 and 8 serve a distinct purpose and should be retained. PS 3–6 focus on defined clinical and preventive dental services, while PS 7 and 8 measure broader member engagement of pediatric and adult members who receive any covered dental service during the Measurement Year, including diagnostic, preventive, restorative services, or specialty care without limiting the measure to a specific clinical subset. Although the underlying HEI data may overlap, contractors may receive credit for each applicable numerator. Additionally, QHP accountability is built on medical-plan measures stewarded under QRS, and the 25/2/2 program uses those QRS results to hold QHP issuers accountable for clinical quality performance, whereas QDP Attachment 2 establishes separate, dental-specific standards assessed by product where applicable.
	Oral Health Performance Standards	Issuer appreciates Covered CA's data submission and oral health standards under the Healthcare Evidence Initiative (HEI). Issuer's only feedback is to provide additional granularity in the methodology document on how certain metrics are calculated. For example, the formula behind the rating for the "denominator" in the methodology document states that it should be equal to "The eligible population (inclusive of enrollees aged 19 and older)." Issuer believes this and other definitions do not always accurately reflect the duration of the member. Issuer proposes two options to adjust for this: (1) Durationally adjusted enrollment (adjust the denominator for the number of months the individual is enrolled); and/or (2) Exclude members with fewer than X months of enrollment. While the second proposed option is likely easier to implement, the first is likely a more accurate reflection of the population.	The Adult Preventive Dental Services denominator already includes a durational safeguard. Per the measure specification, eligible members must have at least 90 days of continuous enrollment in the same Qualified Dental Plan, in addition to being aged 19 and older. This addresses the identified concern by excluding very short enrollment periods.
	General	We respectfully request that Covered California retain the Attachment 2 amount at risk at 1%. Increasing it could raise administrative costs, placing upward pressure on premiums	Covered California recognizes the concern that a higher at-risk amount could place upward pressure on premiums. The proposed increase from 1% to 2% is not an arbitrary doubling: it reflects our analysis showing that fewer than half of QDP enrollees use any dental services, with utilization particularly low among adult and DHMO enrollees, and indicates the current 1% at-risk mechanism has not generated meaningful performance improvement. The proposal was also shaped by substantial stakeholder feedback gathered across the February–June 2026 QDP Contract Workgroup sessions and is not intended to add administrative burden. The proposed increase is paired with technical assistance and incentives to support improvement without relying solely on penalties. Covered California will continue to share supporting methodology and performance data with issuers before financial accountability is applied, consistent with our commitment on all Attachment 2 measures.