2026-2028 QHP Issuer Contract Update: Preview of First Public Comment Draft

August 1, 2024

AGENDA

Time	Topic	Presenter(s)
9:00-9:05	Welcome and Introductions	Charles Raya
9:05-9:15	Model Contract Articles 4 and 5: Removal from the Exchange (“25/2/2”), Access, Essential Community Providers (ECP)	EQT
9:15-9:50	Attachment 1 Advancing Equity, Quality and Value	EQT
9:50-10:00	Attachment 2 Performance Standards with Penalties	EQT
10:00-10:20	Attachment 4 Quality Transformation Initiative	EQT
10:20-10:30	Wrap Up & Next Steps	Charles Raya

QHP Issuer Model Contract
Article 4 QHP Issuer Program Requirements
Article 5 Advancing Equity Quality, and Value
Removal From the Exchange (“25/2/2”), Access, and Essential Community Providers

EQT Team

COVERED CALIFORNIA

PROPOSED 2026-28 25/2/2 PROGRAM REQUIREMENTS

Model Contract Article 5 – Removal from the Exchange

- Annual assessment of QHP performance on QRS clinical measures
- Monitoring and remediation periods (up to two years each) for continued QHP clinical composite performance beneath the 25th percentile composite benchmark
- New static benchmark year established, likely Measurement Year (MY) 2025
- Removal of retired QRS measures from benchmark and composite score calculations
- Clinical measures added to QRS during contract cycle will be included and composite score calculations as benchmarks are published
- Minimum Performance Level (MPL) Action Plan required for each clinical measure falling beneath the 25th percentile for 2 consecutive years.

2026-28 25/2/2 PROGRAM PUBLIC COMMENT KEY THEMES

Issuer Model Contract- Removal from the Exchange

- Multiple Issuers requested more details about inclusion of new measures and static benchmark year selection
- Multiple Issuers expressed support for updated benchmark year and inclusion of new QRS clinical measures in benchmark and composite scoring
- Multiple Issuers requested more details on the proposed requirement for Minimum Performance Level (MPL) action plans for individual measure scores beneath the 25th percentile for two consecutive years
- While one Issuer expressed support for proposed MPL action plan requirement, multiple Issuers expressed concerns regarding redundancy between individual measure expectations and composite performance assessments, advocating that the composite score sufficiently highlights performance gaps
- One Issuer suggested use of phased requirements prior to requiring MPL Action Plans for individual measure scores
- Advocates and Issuers expressed a shared desire for healthcare quality improvement and alignment with national standards as a commitment to patient centered care

2026-28 25/2/2 PROGRAM

Issuer Model Contract- Removal from the Exchange

Notable changes to Issuer Model Contract 25/2/2	Rationale
MY2025 Static Benchmark Year No changes proposed	
New Clinical Measures Added as benchmarks are published No changes proposed	
Minimum Performance Level (MPL) Action Plan for measures below the 25th percentile No changes proposed	

PROPOSED 2026-28 ACCESS REQUIREMENTS

Model Contract Article 5 – Access

- To assess and monitor Beneficiary Experience and Outcomes, Covered California will track and publicly report CMS QRS Enrollee Experience performance, although removed from Attachment 2 as a performance standard
- To assess and improve Provider Availability and Accessibility, Covered California will leverage Healthcare Evidence Initiative (HEI) for Network measures agreed upon by California public purchasers and/or regulator, with improvement plans required for underperforming Issuers
  - Provider-to-member ratio: The number of providers per beneficiary
  - Active providers : The percentage of providers serving beneficiaries in the past year
  - Provision of telehealth services: The percentage of providers providing telehealth services
- To assess and improve Service Utilization and Quality, Covered California may launch a secret shopper survey utilizing questions from DHCS and CalPERS surveys in PY2026 with improvement plans required for underperforming Issuers
  - A repeat survey may be implemented biennially (every other year) if pervasive underperformance

2026-28 ACCESS PUBLIC COMMENT KEY THEMES

Model Contract Article 5 – Access

- Public purchasers and a Provider Association expressed support for continued alignment on Access measurement and monitoring initiatives
- Multiple Issuers recommend aligning measures and monitoring approaches with DHCS and DMHC, cautioning against establishing potentially redundant or conflicting requirements
- Multiple Issuers requested clarifications, including:
  - How provider utilization rates will indicate patient access issues
  - If contracted health plans will receive secret shopper survey results as well as if penalties are at risk for survey results
  - How Access monitoring aligns with requirements from DMHC and CMS/NBPP
- One Issuer requested flexibility for plans to set policies for the provider-to-member ratio when applied to specialty providers (e.g. based on utilization)
- One Issuer requested significant lead time for HEI data testing and reporting
- One Issuer recommended collection of 2 years of baseline data prior to establishing plan-wide benchmarks for active providers

PROPOSED 2026-28 ACCESS CHANGES

Model Contract Article 5 – Access

Notable Changes to Draft	Rationale
Beneficiary Experience and Outcomes No changes	
Provider Availability and Accessibility For access and network measures generated from Covered California's Healthcare Evidence Initiative (HEI), two years of data collection will be pursued before setting any benchmarks	Learning and exploration mindset critical for any new measures
Service Utilization and Quality Any new survey, including secret shopper effort, will be done in alignment with DMHC and other public purchasers	Desire to limit administrative burden and create across-state alignment on access monitoring strategy

PROPOSED 2026-28 ECP REQUIREMENTS

Model Contract Article 4 – Essential Community Providers (ECP) Requirements

- Issuers must meet ECP General Standard by maintaining a network with includes a sufficient geographic distribution of care to provide reasonable and timely access to low-income populations, individuals living in Health Professional Shortage Areas (HPSAs) and medically underserved individuals

- ECP General Standard Sufficiency Requirements:
  - Issuers must demonstrate sufficient geographic distribution of a mix of essential community providers reasonably distributed throughout the geographic service area
  - Issuers must demonstrate providers agreements with at least 15% of 340B non-hospital providers in each rating region in which it offers QHPs
  - Issues must demonstrate agreements with at least one ECP hospital per county requirement or per rating area in counties with multiple rating regions

- Issuers in an integrated delivery system may request the ECP alternative standards and must demonstrate compliance by mapping low-income and HPSA member populations and network providers and facilities offering services in all ECP categories

2026-28 ECP PUBLIC COMMENT KEY THEMES

Model Contract Article 4 – Essential Community Providers Requirements

- Multiple commenters requested further clarity to hospitals types to better outline the ‘Hospital’ categories under ECP
- Multiple Issuers expressed general support of the addition of HCAI workforce grant recipients as ECPs, with multiple Issuers requesting to review the HCAI workforce grant recipients
- One Issuer expressed support for certain providers in HPSAs as ECPs
- Multiple Issuers request additional details on the process to identify:
  - Providers with a minimum percentage of Medi-Cal members
  - Providers located in Healthy Places Index (HPI) Quartiles 1 and 2
  - Geographic areas and hospital contracting requirements
- One Issuer requested at least one year to comply with new ECP requirements once finalized and an updated ECP list twice per year instead of annually

PROPOSED 2026-28 ECP CHANGES

Model Contract Article 4 – Essential Community Providers Requirements

Notable Changes to Draft 4.3.4 Essential Community Providers	Rationale
Changes and Additions to ECP Categories No changes proposed	
Sufficiency Standards No changes proposed	
ECP General Standards No changes proposed	
ECP Alternative Standards No changes proposed	

Attachment 1 Advancing Equity, Quality, and Value

EQT Team

PROPOSED 2026-28 ATTACHMENT 1 REQUIREMENTS

Article 1: Equity and Disparities Reduction

- Demographic Data Collection: Issuer must collect member self-identified race, ethnicity, and language data. Issuers must expand data collection to include member-level Sexual Orientation and Gender Identify (SOGI) data to establish baseline performance.
- Disparities Measurement: Patient Level Data (PLD) File: Issuer must submit the following Healthcare Effectiveness Data and Information Set (HEDIS) hybrid measure patient level data files for its enrollees:
  - Prenatal Depression Screen and Follow-up (PND-E)
  - Postpartum Depression Screen and Follow-up (PDS-E)
  - Quality Transformation Initiative (QTI) measures
  - Social Need Screening and Intervention (SNS-E)
- Disparities Measurement: Healthcare Evidence Initiative: Issuer and Covered California will review performance on specified disparities measures using HEI data.
- Disparities Reduction Intervention: Issuer must meet disparities reduction and health equity requirements throughout Attachment 1 and Attachment 4 Quality Transformation Initiative (QTI).
- NCQA Health Equity Accreditation: Issuer must achieve and maintain NCQA Health Equity Accreditation within the first year of contracting with Covered California

2026-28 ATTACHMENT 1 PUBLIC COMMENT KEY THEMES

Article 1: Equity and Disparities Reduction

- Multiple Issuers and Public Purchasers expressed support for collection of SOGI data
- One Issuer expressed support for updated PLD File measures
- Multiple Issuers requested additional details and clarifications of PLD File requirements and HEI measures
- Multiple Issuers expressed concerns with potential administrative workload pertaining to updated reporting templates and expanded measures for HEI and PLD data.
- One Issuer expressed concerns with expectations that Enrollee sub-population measure results meet the 66th percentile threshold as part of QTI health equity accountability
- One Issuer expressed support for NCQA Health Equity Accreditation requirement

PROPOSED 2026-28 ARTICLE 1 CHANGES

Article 1: Equity and Disparities Reduction

Notable Changes to Draft Attachment 1	Rationale
Expanded Demographic Data Collection No proposed changes	
Disparities Monitoring: Patient Level Data No proposed changes	
Disparities Monitoring: Health Evidence Initiative Data No proposed changes	
NCQA Health Equity Accreditation No proposed changes	

PROPOSED 2026-28 ARTICLE 2 REQUIREMENTS

Article 2: Behavioral Health

- Issuer must submit specified NCQA Health Plan Accreditation Network Management reports, or a comparable report, and include timely provider network data if data used for accreditation was older than two years
- Issuer must promote access to behavioral health services and offer telehealth for behavioral health services, submitting screenshots of homepage and other relevant pages to demonstrate the promotion of behavioral health services across access points and languages
- Issuer must address disparities in behavioral health utilization by deploying disparities reduction strategies based on stratified utilization data and informed by engagement with impacted member populations
- Issuer must monitor behavioral health and virtual behavioral health care quality through monitoring of behavioral health utilization and submission of selection criteria for behavioral health care vendors
- Issuer must provide staff cultural humility training and deploy culturally tailored materials and strategies for historically marginalized groups
- Issuer must promote the appropriate use of opioids using a harm reduction framework and individualized approach to treatment planning aligned with Smart Care California guidelines; develop and maintain programming focused on Tobacco Cessation; and monitor Initiation, Engagement, Treatment (IET) and Follow-Up after Hospitalization (FUH) measure rates

PROPOSED 2026-28 ARTICLE 2 REQUIREMENTS

Article 2: Behavioral Health

- Issuer must report how it is promoting integration of behavioral health services with medical services
- Issuer must oversee delegated entities to ensure enrollees' access to quality behavioral health care, including monitoring and evaluating behavioral health quality. Issuers must submit a delegation report describing entities, types, purpose and description.

2026-28 ARTICLE 2 PUBLIC COMMENT KEY THEMES

Article 2: Behavioral Health

- Many Issuers and public purchasers expressed strong support for reducing disparities and stigma in behavioral health, including the implementation of culturally tailored interventions to address disparities, along with the adoption of a 'Back to Basics' approach.
- Multiple Issuers requested clarification of proposed requirement to submit more current provider network data with NCQA Network Management reports, and some Issuers expressed concern about potential added administrative burden and duplication of data submissions
- Multiple Issuers expressed concerns with anticipated complexity and administrative burden of complying with proposed vendor selection criteria reporting requirements
- Multiple Issuers requested clarification of expectations for use of culturally tailored depression screening tools and practices
- Many Issuers and public purchasers expressed agreement with expanded SUD focus and proposed monitoring of stratified results for Initiation and Engagement of Substance Use Disorder (IET) and Follow-Up After Hospitalization for Mental Illness (7-Day and 30-Day Follow-Up) measures
- One Issuer recommended monitoring of Follow-up After Hospitalization for Substance Use Disorder (FUA) measure instead of IET for alignment with DHCS and due to challenges improving IET rates

PROPOSED 2026-28 ARTICLE 2 CHANGES

Article 2: Behavioral Health

Notable Changes to Draft Attachment 1	Rationale
Promoting Access to Behavioral Health Services Revised requirement to use the Advancing Health Equity Roadmap to Advance Health Equity	While Issuers are encouraged to use the Road Map to Reduce Health Equity, contract language will not require use of this tool in design and implementation of interventions that best address identified disparities
Substance Use Disorders Expansion of Substance Use Disorder to include Tobacco Cessation	Moved from Article 3 Population Health

PROPOSED 2026-28 ARTICLE 3 REQUIREMENTS

Article 3: Population Health

Population Health Management

- Issuer must ensure the use of health promotion and prevention services, increase utilization of high value services, risk stratify Enrollees, and develop targeted interventions based on risk
- Issuer must identify opportunities, conduct outreach, and engage all Covered California Enrollees, not just Covered California Enrollees who obtain services from providers, in population health activities
- Issuer must submit specific elements of their NCQA Population Health Management plan or provide alternative reporting as outlined in 3.01.1

Health Prevention and Promotion

- Issuer must identify Enrollees who are eligible for certain high value preventive and wellness benefits, notify Enrollees about the availability of these services, ensure those eligible receive appropriate services and care coordination, and monitor the health status of these Enrollees
- Issuer must provide a CDC-recognized Diabetes Prevention Program available in different modalities to its eligible Covered California Enrollees

PROPOSED 2026-28 ARTICLE 3 REQUIREMENTS

Article 3: Population Health

Supporting At-Risk Enrollees Requiring Transition

- Issuer must submit an evaluation and formal transition plan for any service area reduction or any modification to its existing service area
- Issuer must outreach to all Covered California Enrollees alerting them of the service reduction and options to continue care with other QHP Issuers and conduct outreach to At-Risk Enrollees and get authorization to send health information to receiving QHP Issuers to minimize disruption of continuity of care
- Issuer receiving At-Risk Enrollees must establish processes to identify At-Risk Enrollees, ensure care transitions account for Enrollees' current health status and provide other vital information that aids in continuity of care

Social Health

- Issuer must report Enrollee social needs screening process for food, housing and transportation needs, including touch points, who performed the screening, and which methods and instruments were used to conduct screening
- Issuer must report screening efforts by provider networks, including coordination efforts with providers on screening and linkage to services to connect Covered California Enrollees
- Issuer must collect and report data for all components of the Social Needs Screening & Intervention (SNS-E) Measure and screen positive rate

PROPOSED 2026-28 ARTICLE 3 REQUIREMENTS

Article 3: Population Health Management

Use of Generative Artificial Intelligence in Qualified Health Plan Issuer Operations

- Align with federal requirements around Patient Care Decision Support Tools **45 C.F.R § 92.210** inclusive of but not limited to GenAI
- Incorporate evolving best practices for use of GenAI and healthcare into use cases
- Ensure transparency with members about the use of generative AI
- Implement processes to address and mitigate bias
- Participate in collaborative discussions and shared learnings across Issuers
- Report on:
  - Processes and approach to mitigate bias
  - GenAI Governance approach
  - GenAI use cases

2026-28 ARTICLE 3 PUBLIC COMMENT KEY THEMES

Article 3: Population Health

Health Promotion and Prevention

- Multiple Issuers support the removal of reporting requirements and reducing administrative burden related to offering health promotion and prevention programs

Supporting At-Risk Enrollees Requiring Transition

- Several Issuers advocated use of established guidelines and flexible timing to manage care transition activities for Enrollees in regions experiencing service reductions

Social Health

- Several Issuers requested clarification of SNS-E measure reporting method
- One Issuer expressed support for continued SNS-E measure and screening process reporting
- One Issuer raised concerns regarding the coding and data collection challenges for SNS-E, particularly for intervention rates, and advocated total population reporting only rather than stratified reporting

2026-28 ARTICLE 3 PUBLIC COMMENT KEY THEMES

Article 3: Population Health Management

Use of Generative Artificial Intelligence in Qualified Health Plan Issuer Operations

- Multiple Issuers requested more detail on proposed reporting requirements and one Issuer recommended reduced proposed annual reporting due to concerns with administrative burden
- Several Issuers commented that plans are in various stages of development and implementation of GenAI use cases
- One Issuer commented that plans require autonomy in developing governance approaches
- Multiple Issuers urged alignment with regulatory requirements and broader industry efforts and collaboration across issuers in implementing proposed contract requirements

PROPOSED 2026-28 ARTICLE 3 CHANGES

Article 3: Population Health: Health Promotion and Prevention

Notable Changes to Draft Attachment 1	Rationale
Tobacco Cessation Program Tobacco Cessation Program requirements moved to Article 2 Behavioral Health	Tobacco cessation requirements included in expansion of Substance Use Disorder provisions in Behavioral Health article
Diabetes Prevention Programs No changes proposed	

PROPOSED 2026-28 ARTICLE 3 CHANGES

Article 3: Population Health: Supporting At-Risk Enrollees Requiring Transition

Notable Changes to Draft Attachment 1	Rationale
Submission of Transition Plan Added clarifying language about processes to complete file transmissions for Enrollees and adherence to timeline as specified in federal guidelines (28 CCR 1300.65.1(a)(2)(C), (D).)	This language clarifies requirements and timing for file transmissions.

PROPOSED 2026-28 ARTICLE 3 CHANGES

Article 3: Population Health: Social Health

Notable Changes to Draft Attachment 1	Rationale
Screening for and Addressing Social Needs No changes proposed	

PROPOSED 2026-28 ARTICLE 3 CHANGES

Article 3: Population Health: Use of Generative Artificial Intelligence in Qualified Health Plan Issuer Operations

Notable Changes to Draft Attachment 1	Rationale
Addition of language around Patient Care Decision Support Tools in accordance with 45 C.F.R § 92.210	▪ Aligning the contract to the 1557 Rule's new definition and requirements for Patient Care Decision Support Tools, which are appropriate for Covered California programs' use of technology. The interplay between HTI-1 and 1557 is discussed in the preamble to the Rule. ▪ Regulations are inclusive of, but not limited to, GenAI
Narrow focus of use case reporting requirements to center on instances where GenAI impacts a decision to authorize, modify, or deny health care services	▪ Aligns with UM statute ▪ Shifts focus to transparency on clinical use cases with most direct impact on health care access and outcomes

PROPOSED 2026-28 ARTICLE 4 REQUIREMENTS

Article 4: Delivery System and Payment Strategies to Drive Quality

Advanced Primary Care

- Issuer must match enrollees with PCPs and report the number of enrollees who select a PCP or who were assigned a PCP
- Issuer must review and improve primary care selection and healthcare utilization using HEI submitted data
- Issuer must review and improve member continuity of care; measure results to be generated by Covered California using HEI-submitted data
- Issuer must report on total primary care spend in alignment with Office of Health Care Affordability (OHCA)
- Issuer must work with Covered California and other stakeholders to analyze the relationship between primary care spend as a percentage of total healthcare expenditures (TCHE) and network performance, including quality, equity, and cost

PROPOSED 2026-28 ARTICLE 4 REQUIREMENTS

Article 4: Delivery System and Payment Strategies to Drive Quality (Continued)

Networks Based on Value:

- Issuer must report how cost, quality, patient safety, patient experience, and equity are considered in network design and management
- Issuer must report on Alternative Payment Model (APM) adoption and Total Cost of Healthcare Expenditures in alignment with OHCA
- Issuers must participate in the IHA Align.Measure.Perform (AMP) program for physician groups and report AMP performance results to Covered California annually or allow IHA to submit results to Covered California

Hospital Value and Safety

- Issuer must demonstrate participation in collaborative engagement with Covered California, Issuers and Cal Healthcare Compare (CHC) to analyze performance variation and engage with poor performing hospitals

Comprehensive Maternity Care

- Issuer must report stratified performance on maternal health and maternal mental health measures
- Issuers must participate or ensure network hospital participation in data aggregation, data transparency, and performance accountability partnerships such as CHC and the California Maternal Quality Care (CMQCC) Maternal Data Center

PROPOSED 2026-28 ARTICLE 4 REQUIREMENTS

Article 4: Delivery System and Payment Strategies to Drive Quality (Continued)

Use of Virtual Care

- Issuers must report all virtual care solutions and vendors in place and disclose vendors' NCQA Virtual Care Accreditation status
- Issuers must collect quality monitoring measures from virtual care vendors and annually report summary findings to Covered California
- Issuers must provide member support for navigating virtual services, ensuring solutions are culturally and linguistically tailored, and share relevant tools and resources with Covered California
- Issuers must report on reimbursement policies for both network and third-party providers, ensuring payment parity for virtual services
- Issuers must collaborate with Covered California to review virtual care service utilization, address disparities using HEI, submit improvement plans for outliers, and participate in best practice collaboratives, including digital literacy support

Participation in Quality Collaboratives

- Contractors must report participation in quality collaboratives

2026-28 ARTICLE 4 PUBLIC COMMENT KEY THEMES

Article 4: Delivery System and Payment Strategies to Drive Quality

Advanced Primary Care

- Several Issuers support continuing the requirement to report on the proportion of enrollees who select or are assigned a PCP though several Issuers recommend removing this requirement due to administrative complexity or assertions that this distinction is not relevant to assessing primary care
- Issuers universally support retiring the related HEI Performance Standard 9.4 from Attachment 2
- Some issuers and one advocate support proposed continuity of care assessment for advanced primary care measurement though multiple Issuers expressed concerns about the timing of benchmarks and a need for further research or testing for continuity measures.
- Diverse stakeholders are broadly optimistic about aligning spending and investment targets with OHCA and adopting its reporting methodologies and benchmarks.
- All commenters support the removal of prior performance standards 5 Primary Care Payment & 6 Primary Care Spend.
- Some Issuers expressed concerns regarding the measurement of alternative payment models and called for adjustments to accurately track and enhance primary care investment.

2026-28 ARTICLE 4 PUBLIC COMMENT KEY THEMES

Article 4: Delivery System and Payment Strategies to Drive Quality

Networks Based on Value

- Issuers unanimously approve of removing IDS & ACO reporting requirements while advocates suggest reconsideration and further work to enhance the approach to tracking and measuring
- Collective support for retirement of Attachment 2 Performance Standard 7
- Most issuers expressed support for alignment with OHCA for network spend reporting and promoting Alternative Payment Models (APM) but are concerned about efficiency of standardized reporting across plans and products. Multiple Issuers also requested more information on detailed requirements and benchmarks.

Hospital Value and Safety

- Some issuers praised the shift from individual hospital interventions toward collaborative convening for poor performing hospitals while a few Issuers suggest that internal efforts are more effective.
- Issuers unanimously approve of retiring reporting requirements for hospital payments based on quality and value while advocates suggest reconsideration and further work to enhance the approach to tracking and measuring.

Comprehensive Maternity Care

- Some Issuers expressed support for participation with Cal Healthcare Compare but seek more detail regarding participation and cost, while some Issuers recommended not requiring this participation.
- Advocates and several Issuers applaud alignment with DHCS initiatives and doula tracking. Multiple Issuers expressed concerns with operationalizing proposed requirements, emphasizing the need for further clarification of reporting requirements.

2026-28 ARTICLE 4 PUBLIC COMMENT KEY THEMES

Article 4: Delivery System and Payment Strategies to Drive Quality

Use of Virtual Care

- One issuer expressed concern about reporting and NCQA Accreditation.
- One issuer expressed concern about effort involved in creation of HEI reports.

Participation in Quality Collaboratives

- Responding Issuers agree with reducing the list of required collaboratives, identifying a variety of collaboratives as highest value. Some recommendations to provide a menu of choices and have a threshold level of participation required.
- One quality collaborative recommended use of criteria to define a quality collaborative and issuer participation.
- Several Issuers expressed continued concerns with cost of participating in collaboratives, both financial and time required, and requested inclusion of low- and no-cost collaboratives to select.
- Mixed feedback on inclusion of proposed related performance standard and use of penalties to subsidize membership.

PROPOSED 2026-28 VIRTUAL CARE CHANGES

Article 4: Delivery System and Payment Strategies to Drive Quality

Notable Changes to Draft Attachment 1	Rationale
Advanced Primary Care Continuity of care measure will not have a benchmark set until at least two years of reporting	While the continuity of care measure is a validated measure (NQF # 3617) and is predictive of reduced mortality, reduced acute care utilization and lower cost, Covered California appreciates that a learning environment is needed before attaching penalties.
Use of Virtual Care No changes made	
Participation in Quality Collaboratives Covered California will not mandate specific quality collaboratives but will require reporting on participation in quality collaboratives.	Covered California appreciates that issuers may have specific strategic initiatives and partnerships that advance their internal goals and are less applicable to all issuers. Covered California continues to encourage participation in quality collaboratives and will participate as a purchaser in efforts that have broader impacts for the health, access or affordability of care for all Californians. Covered California will continue to require participation in the data aggregation, data transparency and performance accountability organizations that have other requirements throughout the contract.

2026-28 NETWORKS BASED ON VALUE

Article 4: Delivery System and Payment Strategies to Drive Quality

Notable Changes to Draft Attachment 1	Rationale
Networks Based on Value No changes made	
Hospital Value and Safety No changes made	
Comprehensive Maternity Care No changes made	

PROPOSED 2026-28 ARTICLE 5 REQUIREMENTS

Article 5: Measurement and Data Sharing

- Issuers must submit to Covered California its QRS data and participate in NCQA Quality Compass Reporting for its other lines of business
- Issuers must submit quality and cost data to HEI in accordance with data submission requirements and in alignment with the HIPAA Privacy Rule and California law, and acknowledge that Covered California will publish this data in accordance with AB-929
- Issuers must implement and maintain a secure Patient Access API, and report on its use
- Issuers must execute the Data Sharing Agreement (DSA) as required by Health and Safety Code section 130290 and participate in at least one QHIO
- Issuers must monitor its network hospital's compliance with ADT event Technical Requirements and report on their adherence
- Issuers must share information on enrollees with primary care providers for their assigned members

2026-28 ARTICLE 5 PUBLIC COMMENT KEY THEMES

Article 5: Measurement and Data Sharing

- Issuer and public purchaser expressed support for alignment of Data Exchange Framework and Medi-Cal expectations
- Unanimous agreement among commenters supporting proposed changes

PROPOSED 2026-28 ARTICLE 5 CHANGES

Article 5: Measurement and Data Sharing

Notable Changes to Draft Attachment 1	Rationale
Change approach from "Encourage and measure" use cases related to quality and contract provisions (QTI, QRS programs, etc.) to "encourage" use cases that support quality improvement and contract provisions	Given feasibility of measuring direct impact of data exchange on quality performance, as well as ensuring close alignment with DHCS language, we have adjusted the approach to encourage data exchange to support quality use cases

PROPOSED 2026-28 ARTICLE 6 REQUIREMENTS

Article 6: Certification, Accreditation, and Regulation

- Issuer must achieve and maintain current National Committee for Quality Assurance (NCQA) Health Plan Accreditation by year-end 2026. If Issuer is not currently accredited by NCQA, Issuer must be accredited by Utilization Review Accreditation Commission (URAC) or Accreditation Association for Ambulatory Healthcare (AAAHC) and submit plan to obtain NCQA health plan accreditation
- Issuer must notify Covered California of scheduled NCQA health plan accreditation review and its results. Issuer must submit a copy of the assessment report within 30 days of its receipt from NCQA
- Issuers that receive any status other than “Accredited”, lose an accreditation, or fail to maintain a current and up to date accreditation, must:
  - Notify Covered California within ten (10) days of the status change,
  - Implement strategies to achieve the level of “Accredited”
  - Submit a copy of the same Corrective Action Plan (CAP) issued by the NCQA within thirty (30) days, and provide details on all relevant updates
  - Submit a written report to Covered California quarterly regarding the status and progress of Accreditation reinstatement
- Issuers must submit a copy of any Corrective Action Plan (CAP) issued by the NCQA within thirty (30) days, and provide details on all relevant updates regardless of accreditation status

2026-28 ARTICLE 6 PUBLIC COMMENT KEY THEMES

Article 6: Certification, Accreditation, and Regulation

- One Issuer expressed support for proposed requirement to submit NCQA Corrective Action Plan regardless of status change

PROPOSED 2026-28 ARTICLE 6 CHANGES

Article 6: Certification, Accreditation, and Regulation

Notable Changes to Draft Attachment 1	Rationale
Changes in Accreditation Status Clarify requirement to submit to Covered California any CAP required by NCQA regardless of accreditation status	To ensure transparency and accountability related to achieving and maintaining NCQA Health Plan Accreditation

Attachment 2 Performance Standards with Penalties

EQT

PROPOSED 2026-2028 ATTACHMENT 2 REQUIREMENTS

Performance Area	Performance Standards with Penalties	Percent of At-Risk Amount 2026-2028
Health Disparities 20%	1. Reducing Health Disparities: Demographic Data Collection – Enrollee Race and Ethnicity Self-Identification	10%
	2. Reducing Health Disparities: Demographic Data Collection – Enrollee Spoken and Written Language	10%
Engagement in Collaboratives 10%	3. Engagement in Collaboratives and with Community	10%
Data 40%	4. Healthcare Evidence Initiative (HEI) Data Submission	40%
Oral Health 10%	5. Dental Quality Alliance (DQA) Pediatric Measure Set – Pediatric Oral Evaluation, Dental Services (NQF #2517)	5%
	6. Dental Quality Alliance (DQA) Pediatric Measure Set – Pediatric Topical Fluoride for Children, Dental Services (NQF #2528)	5%
Utilization & Primary Care 20%	7. Utilization & Primary Care: Overall Engagement with Members	10%
	8. Utilization & Primary Care: Monitoring Continuity of Care	10%

2026-28 ATTACHMENT 2 PUBLIC COMMENT KEY THEMES

- Multiple Issuers agreed with removal of performance standards on primary care payment, primary care spend, networks based on value, and QRS enrollee experience summary indicator.
- One Issuer requested clarification on Health Equity Accreditation accountability if removed from Performance Standards.
- Multiple Issuers requested more details on Engagement in Collaboratives assessment criteria including if Covered California would specify which collaboratives are required or if there would be a menu of options to chose from with a minimum threshold
- Broad support for simplification of Performance Standard 9 – HEI data submission, but advocacy for longer timelines given data replacement and build complexities. One issuer expressed concern about the proposed 40% weighting for this performance standard.
- Multiple Issuers cautioned on setting benchmarks for continuity of care given newly being assessed.

PROPOSED 2026-28 ATTACHMENT 2 CHANGES

Notable Changes to Draft Attachment 2	Rationale
Performance Standard 3 - updated to Collaboration Across Issuers and with Community Covered California will assess attendance and engagement in scheduled learning sessions, cross-issuer collectives, community engagement events, clinical leaders' forum, CMO roundtables, and carrier calls. Proposed performance threshold is >/= 80% participation and engagement annually.	Covered California believes that cross-issuer convenings, which are low barrier to entry and participation, are critical to improve health outcomes, access and affordability for all Californians. Additionally, ensuring issuers are engaging with their enrollees as well as community-based organizations is critical to spur member-centered innovation.
Performance Standard 8 - Utilization & Primary Care: Monitoring Continuity of Care For continuity of care measure, penalty for MY2026 and MY2027 will be connected to QHP issuer participation in review of Covered California generated HEI output and engagement as well as establishment of a benchmark if appropriate. Performance on measure will only be assessed for MY2028 at the earliest.	While the continuity of care measure is a validated measure (NQF # 3617) and is predictive of reduced mortality, reduced acute care utilization and lower cost, Covered California appreciates that a learning environment is needed before attaching penalties for performance.

Attachment 4 Quality Transformation Initiative

EQT

PROPOSED 2026-28 ATTACHMENT 4 REQUIREMENTS

- Proposed QTI Measure Set:
  1. Blood Pressure Control for Patients with Hypertension (BPC-E) *if adopted by CMS QRS by MY2026, otherwise will continue with CBP*
  2. Glycemic Status Assessment for Patients with Diabetes (GSD) >9%
  3. Colorectal Cancer Screening (COL-E)
  4. Childhood Immunization Status (CIS-E)
  5. Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)
  6. Pharmacotherapy for Opioid Use Disorder (POD) (Reporting Only)
- Proposed Benchmark: 66th percentile using national Exchange benchmark for CMS QRS measure and held static over contract cycle.
- Proposed Amount at Risk for QTI:
  - Newly contracted QHP issuers to start at 1% of premium at risk in year 1 of QTI eligibility
  - Up to 2.8% of premium at risk for MY2026 for currently contracted QHP issuers
  - Up to 3.8% of premium at risk for MY2027 and MY2028 for currently contracted QHP issuers
  - No more than 1% increase annually

2026-28 ATTACHMENT 4 PUBLIC COMMENT KEY THEMES

QTI Measure Set & Benchmarks

- Mixed response to continuing with CIS-10
  - One Issuer and one Consumer Advocate support retaining CIS-10
  - Majority of responding Issuers support switching to either Combo 3 or Combo 7
  - Few responding Issuers support switching to Well Child Visits
- Issuers universally and one public purchaser support maintaining Pharmacotherapy for Opioid Use Disorder (POD) as reporting only
  - One Issuer also recommended measure change to Use of Opioids at High Dosage or Annual Monitoring for Persons on Long-Term Opioid Therapy
  - One responding purchaser also supported keeping POD as reporting only
- Half of responding QHP issuers supported no ramp up period for QTI amount at risk for new entrants to the Exchange
  - Few responding issuers had no comment
  - One Issuer supported a ramp up period for new entrants
- Half of responding QHP issuers requested a reset percentage at risk back to 0.8% with new contract cycle

PROPOSED 2026-28 ATTACHMENT 4 CHANGES

QTI Measure Set and Benchmarks

Notable Updates to Draft Attachment 4	Rationale
QTI Scored Measures: ▪ No changes to the core measures, but the 5 measures will not be equally weighted with 75% of the amount at risk divided across diabetes control, blood pressure control and colorectal cancer screening	▪ Given the mixed feedback on measure substitution and the significant importance of remaining alignment across DHCS/Medi-Cal, CalPERS, DMHC and other state-wide initiatives, CIS-10 will remain a measure. However, given the smaller denominator sizes for CIS-10 and DSF-E they will be weighted lower than the remaining 3 measures.
Amount at Risk for Newly Contracted QHP Issuers: ▪ Newly contracted QHP issuers to start at 1% premium at risk in year 1 of QTI eligibility	▪ To support new QHP issuers during their first year of QTI eligibility and mitigate the steep onboarding challenges. ▪ This adjustment acknowledges that long-standing issuers had years to prepare for QTI before it was fully implemented.
Amount at Risk for Currently Contracted QHP Issuers: ▪ Amount at risk for QHP issuers already eligible for QTI will be up to 2.8 percent of premium for MY2026 and then up to 3.8% of premium for MY2027 and 2028 ▪ Variable weighting by measure with lower weight for measures with small denominator sizes and high variability in performance (i.e., CIS-E and DSF-E)	▪ The maximum amount at risk for MY2026 will be 2.8% of premium recognizing the importance of disparities reduction and the fact that there can be no quality without equity. Additionally, Covered California intends to continue the CIS-10 allowance initiative which generated substantial savings for issuers. At Covered California's discretion, however, a lower amount than 2.8% may be deployed pending additional insights from the transition to ECDS measures and the inclusion of DSF-E. ▪ Given the decision to continue with CIS-10, but the small denominator sizes for CIS-10 and DSF-E, the 5 QTI measures will not be equally weighted

PROPOSED 2026-28 ATTACHMENT 4 REQUIREMENTS

Health Equity Methodology

- Stratified measure results replace “all-population” measure results for colorectal cancer screening and blood pressure measures
- Assessment of QTI payments for these measures will be based on performance of stratified eligible subpopulations
- “Eligible Subpopulation” means the following stratified subpopulations, as defined by the federal Office of Management and Budget (OMB) or Centers for Disease Control (CDC) Race and Ethnicity Code Set, with at least 100 self-reported members in the denominator: American Indian or Alaska Native, Asian, Black or African American, Hispanic or Latino, Native Hawaiian or Other Pacific Islander, and White. Eligible Subpopulation shall also include Multirace, used when an individual reports two or more CDC codes that cross higher OMB concepts
- “All Other Members” means pooled results from members of the following subpopulations, as defined by OMB or CDC: Other Race, or Unknown, used when an individual has not reported race or ethnicity or where data is missing or inaccurate. All Other Members shall also include pooled results from members of subpopulations that would be Eligible Subpopulations but have fewer than 100 identified enrollees in the denominator.

PROPOSED 2026-28 ATTACHMENT 4 CHANGES

Health Equity Methodology

Notable Changes to Draft Attachment 4	Rationale
Race and Ethnicity Stratification Methodology ▪ No changes	Additional reliability testing will occur over 2024 to assess composition of “All other members” with move to ECDS measures

Wrap-up and Next Steps

Please submit feedback on today's topics, questions, and suggestions for future meetings to EQT@covered.ca.gov
Thank you!