Article	Section #	Comment	Covered CA response
3	3.05	We thank Covered California for the significant changes that were made in the Use of Generative Artificial Intelligence (AI) QHP Issues Operations section that address our concerns regarding compliance with Health and Safety Code 1317.01 (e), which states that Generative AI may not be used to deny or modify patient care. The revised language provides clarity and will allow issuers to effectively comply with the law and the provisions of the proposed contract.	Covered California appreciates acknowledgment of our efforts to ensure compliance with Health and Safety Code 1317.01(e) regarding Generative AI use, aiming for clear QHP Issuer guidance and improved patient care.
4	4.02.2	We support Covered California's focus on boosting investment in primary care. Also, we appreciate Covered California's response regarding our concerns with incorporating OHCA's APM adoption goal targets into the contractual requirements for health plan issuers, clarifying that contracted QHP issuers are required to report on their progress towards meeting OHCA APM targets, but are not required to meet the benchmarks. We are comfortable with a reporting requirement for the QHPs. The statute that created OHCA intended participation in APMs to be voluntary, so our concern is if physician practices are pressured to participate in APMs. A shift to adoption of an APM has upfront costs that a physician practice may not be in the position to absorb, and for some physician practices taking on financial risk could jeopardize the continued existence of the practice, with the unintended consequence of reduced access to care for patients. These are among the reasons that the adoption of APMs in the statute is voluntary and QHPs should not be pressuring or requiring physician practices to adopt APMs. In addition, because funding for small and medium size physician practice that wished to consider adopting APMs was swept away in the 2024 budget process, Covered California may wish to consider incentivizing health plan issuers to offer practice transformation grants to smaller practices to assist in moving to value based payment models.	Covered California remains committed to rebalancing healthcare spending, with a strong focus on increasing investment in primary care and behavioral health. This aligns with the benchmarks and targets set by the Office of Health Care Affordability (OHCA) and reflects our dedication to improving the quality, equity, and affordability of care for all Californians. As outlined in the draft 2026–2028 contract, we will collect and track reporting from Qualified Health Plan (QHP) issuers on their progress toward meeting OHCA benchmarks. This reporting is essential for ensuring alignment with state policies and advancing the shared goal of transitioning to value-based care models that improve access, equity, and health outcomes. Our phased approach to Alternative Payment Model (APM) implementation emphasizes transparency and collaboration while recognizing the diverse capacities of physician practices. This strategy supports the gradual and informed adoption of value-based care models that strengthen primary care and behavioral health without compromising access to services or the sustainability of the healthcare system. We appreciate the feedback highlighting the importance of balancing these initiatives with the operational realities of physician practices. Covered California remains focused on developing policies that drive meaningful progress toward a more equitable and effective healthcare system.
4	4.3.4	We would like to reiterate concerns with the vague language contained in Section 4.3.4 Essential Community Providers of the QHP contract. The contract does not reflect any changes to this section and there is no response noted in the comment response document regarding concerns that "sufficient number and sufficient geographic distribution of ECPs" is incredibly subjective and does not provide a lot of direction . Any number of providers or geographic distribution could be deemed sufficient by Covered California. This is concerning for medical services and especially behavioral health services given the increased need for behavioral health services since the COVID-19 pandemic and the persistent shortage of behavioral health providers. Again, we urge Covered California to provide greater clarity and a definition of "sufficient" to ensure QHP ECP provider networks provide reasonable and timely access to covered services for low-income and medically underserved populations.	Covered California is still in the process of evaluating our analytic results and proposing new sufficiency thresholds for Essential Community Providers (ECPs), focusing on both the Primary Care and Behavioral Health categories. Covered California will continue to establish and enforce specific sufficienct thresholds and welcome any feedback on the new proposed sufficiency thresholds.
5	5.2.1	We continue to support Covered California's commitment to advancing equity, quality and value. However, we remain concerned that contractors may design their programs in such a way that physicians may be penalized for patient non-compliance, which will simply disincentivize physicians from participating in these networks. Covered California did not address our concerns in the comment response grid, and we request that Covered California continue to work to minimize the unintended consequences on QHP networks and patient access.	Across contract provisions, Covered California has aligned with the other California public purchasers to minimize provider abrasion and support providers in improving the delivery of high quality care. QHP Issuers are expected to work collaboratively with provider groups to deliver high quality, accessible care.
5	5.2.3	We remain supportive of Covered California's efforts to ensure patients are receiving quality care in Covered California plan networks and that contractors' products meet minimum performance standards. Similar to Contract Article 5, 5.2.1, General Requirements, we remain concerned that risk and responsibility for meeting plan clinical performance standards will be shifted to providers. The response provided did not address our concerns. QHP Issuers are not being held responsible for high quality and equitable outcomes if the plans are simply passing on the responsibility to their network providers in these often narrow networks. As such, we continue to recommend revising the model contract to expressly prohibit contractors from penalizing providers based on enrollee health outcomes that are beyond a provider's control. Thank you again for the opportunity to provide feedback during the second comment period on the proposed 2026-28 QHP Issuer Contract and Attachment and for considering our concerns. We look forward to working with Covered California and other stakeholders on this contract and other issues in the future.	Across contract provisions, Covered California has aligned with the other California public purchasers to minimize provider abrasion and support providers in improving the delivery of high quality care. QHP Issuers are expected to work collaboratively with provider groups to deliver high quality, accessible care. Covered California will maintain active engagement with our contracted QHP issuers to comprehend their strategies for supporting providers in delivering equitable, high-quality care.
2	2.03.3	The QRS QHP Enrollee Survey measure is based on member experience with their doctor or health provider and is not related to the Tobacco Cessation program that is administered by our third-party wellness vendor. We are not able to utilize our claims and encounter data to report on the methods listed in parts a-c, as this reporting would be provided by our third party vendor. We recommend the following language be removed: 1) Analysis of outcomes and results for Covered California Enrollees who use tobacco and enroll in tobacco cessation programs trended over time, inclusive of evidenced-based counseling and appropriate pharmacotherapy~~, in accordance with current QRS measures~~. The analysis ~~shall utilize Contractor's administrative, claims, and encounter data and~~ may include evaluation of the following methods:	Covered California recognizes that some issuers may not have this information through claims data to report this information. If necessary, Contractor should utilize third-party vendor data to complete the analysis of outcomes for enrollees who use tobacco. Covered California believes that leaving language as stated provides Contractors the greatest flexibility to report their data.
3	3.05.2 1)	As AI technology changes quickly, integration can take time. We recommend adding the language in red: "Stay abreast of and take reasonable steps to integrate best practices…"	Thank you for your suggestion. After consideration, this change will not be made.

3	3.05.4 1)	Please clarify if the proposed written notice to a Covered California enrollee under 3.05.4 1) is referring to the required “Disclosure” upon request in SB 1120, or if this is an additional requirement beyond the language in 1367.01 (k) (1) (H):“Disclosures pertaining to the use and oversight of the artificial intelligence, algorithm, or other software tool are contained in the written policies and procedures, as required by subdivision (b).”	Thank you for your comment. The required "Disclosure" notice to a Covered California enrollee under 3.05.4 1) **is** referring to the same disclosure request in SB 1120, therefore this is not an additonal requirement beyond the language in 1367.01 (k) (1) (H).
3	3.05.4 2)	Chatbots have been in use for many years to assist members in finding the information that they need on websites. We respectfully request that the requirement to notify a Covered California enrollee when Gen AI is used in written interactive communications about their benefits be removed.	Thank you for your comment. Covered California recognizes the value and history of Chatbot use. However, our commitment to transparency, especially regarding the use of Generative AI in communications, remains paramount. We aim to ensure enrollees are informed and trust in the accuracy and integrity of their interactions.
4	4.01.2	Please clarify what "2) Member Value and Engagement in Care" is referring to. Will additional bullets be added to this item to provide context?	The draft language was inadvertently omitted from the October 2024 versions of the contracts. The content says: "2. Member Value and Engagement in Care Contractor must ensure active engagement of Enrollees in care to improve health outcomes and member satisfaction. Through proactive engagement and outreach, Contractor enables Enrollees to access preventive services, manage chronic conditions, and avoid unnecessary emergency room care and hospitalizations. Contractor must monitor and increase the portion of Covered California Enrollees with continuous enrollment in Contractor’s QHP throughout the prior Plan Year who have at least one medical or prescription drug claim during the Plan Year. This requirement aims to reduce the number of Enrollees without any healthcare activity and improve utilization of medically necessary care. By tracking claims data and engaging Enrollees through targeted outreach and coordinated care, Contractor can address gaps in care and ensure Enrollees utilize necessary health services, enhancing outcomes and maximizing the value of coverage."
4	4.02.6	Please clarify/define the use of the terms “birthing patients” or “individuals” – does this include pregnancy, child birth, and postpartum care? When "birthing" is used in instances that services or rights to services includes pregnancy, child birth, post-partum care, it can be interpreted as not inclusive of services for pregnancy and post-partum, but only for child birth. We recommend the following instances revert back to the term "maternal" or "maternity": Covered California is committed to addressing health during pregnancy, childbirth, and the postpartum period to provide a comprehensive approach to improving maternal health outcomes. 2) Report how it is engaging with providers and pregnant Enrollees to promote: a) The patients’ right to choose a maternity care provider, who aligns with their needs and reflects may reflect their demographic characteristics, including race, ethnicity, language, socioeconomic status, sexual orientation, and gender identity. 3) Track and report the number in-network doulas, certified nurse midwives, and licensed midwives and include in development and submission of a network expansion strategy for the recruitment of a diverse network of care navigators, for racial and ethnic congruency between provider and members and increased access to maternity care services. 4) Maternal Health disparities exist across the full spectrum of maternal health, from preconception, to pregnancy, and the postpartum period. Disparities in maternal health disproportionately affect Black and Latino populations at higher rates than other racial groups. Reducing and eliminating gaps in maternal health requires a multifaceted approach... c) ...in accessing culturally and linguistically appropriate maternity care, referrals to group prenatal care or community-centered care models for patients, in home lactation and nutrition consultants, doula support for prenatal, labor, delivery, and postpartum care, and related services.	Thank you for your feedback on the terminology in the Comprehensive Maternity section. Covered California is committed to using language that is inclusive, precise, and clearly conveys the full scope of services—encompassing pregnancy, childbirth, and postpartum care. To clarify, the terms 'birthing patients' or 'individuals' are intended to encompass the full spectrum of care related to these phases. This language reflects our commitment to inclusivity, acknowledging the diverse identities of those accessing maternity-related healthcare. We will review and refine the terminology to ensure clarity while upholding our focus on equitable and inclusive care.
5	5.02.4	As requested in the last comment round, please change the language to "all applicable lines of business". The comment responses state that the change will be made, but we did not find it in the redline. Thank you!	Thank you for your comment. "Applicable" was added to the section.
4	4.01.2 3a & b	We strongly support the inclusion of a Continuity of Care baseline threshold as a performance standard	We appreciate your advocacy, voice, and perspective around this measure.
4	4.01 4.02	OHCA Templates on Primary Care and Networks Based on Value - CAHP appreciates Covered California's flexibility on the timeline for submitting these templates, as this is a new requirement for QHPs and carriers want to ensure that the data is accurate and complete. CAHP continues to emphasize the need for alignment and consistency with existing OHCA methodologies and timelines, to avoid unnecessary duplication and confusion. We appreciate ongoing dialogue between Covered California and carriers on these templates, the data that is reported within them, and any anticipated future data collection efforts that Covered California intends to implement concerning OHCA.	Covered California is committed to aligning with OHCA methodologies while tailoring data collection to reflect our provider networks and focus on increasing investment in primary care and behavioral health to support equitable access and improved outcomes for our enrollees. We appreciate stakeholder collaboration to ensure accurate and complete reporting and will continue to provide clarity on templates, methodology, and future data needs.
1	1.01.2	SOGI We kindly continue to ask that you provide us with a copy of the methodology document for our review. To ensure a smooth implementation, we require at least six months from the final version. However, sharing an early draft as soon as possible would be highly beneficial, as it will allow us to assess the potential duration and associated costs of implementing the changes.	Covered California is working with internal teams, including its HEI vendor, to update file specifications accordingly. Covered California is committed to engaging with Issuers and stakeholders for their feedback. The proposed methodology will be shared with Issuers with enough notice prior to implementation.

1	1.02.1	We need the finalization early in 2025. Reverting to a non-ECDS measure involves significant development and lead time to build out retired measures. This switch will also affect the PLD specifications, given that the measures require different data attributes. Therefore, timely finalization is critical for effective planning and implementation.	We are committed to utilizing the ECDS-transitioned measures and ensuring their finalization occurs early in 2025, pending the Final QRS Call Letter. Our goal is to provide ample lead time for implementation. While we are focused on moving forward with ECDS-transitioned measures, we acknowledge that reverting to retired measures would require significant development, lead time, and adjustments to the PLD file specifications. .
1	1.02.2	If Covered California decides to revert to a non-ECDS measure, there will be significant development and lead time required to build out the retired measures. Additionally, this change would impact the PLD specifications, as the measures have different data attributes. Therefore, it's essential to plan accordingly to accommodate these adjustments.	If Covered California decides to revert to a non-ECDS measure, Issuers will be provided appropriate lead time to make the necessary preparations. Covered California will monitor NCQA's developments on the measure.
2	.2.01.5	OHCA is still in the process of establishing its proposed benchmarks for behavioral health investment, including how it will be defining, measuring, and reporting on behavioral health spending. This includes understanding the current spending on mental health and substance use disorders both in-plan and out-of-plan, as well as defining how behavioral health services are integrated into primary care settings. The current estimated timeline for Board adoption of the behavioral health definitions and investment benchmark is May 2025. In late 2025, we anticipate that OHCA will issue its draft Data Submitter Guide (DSG), incorporating the adopted BH reporting requirements. However, we do not expect those regulations to be effective until April 2026. As such, we recommend that Covered California make clear that QHP reporting on BH expenditure not occur until after OHCA has established its BH benchmark and formally adopted the data submission requirements into its current DSG.	No changes will be made in this section. Proposed contract language refers to reporting aligned with OHCA guidelines and progress toward OHCA designated benchmarks.
3	3.05	We propose that utilization review approvals be excluded from the AI requirements. Since cases that cannot be approved by the system are forwarded to the Medical Director for final determination, carving out these approvals will streamline the process and ensure that only the most complex cases require human intervention. This adjustment will enhance efficiency while maintaining high standards of decision-making.	Thank you for your suggestion. After consideration, this change will not be made.
4		If Covered CA aims to align with OHCA's reporting, we strongly request synchronizing with OHCA's reporting timeline, as previously mentioned. Every mandate necessitates administrative resources and funding to fulfill its requirements. Variations in reporting create administrative burdens and increase resource demands. Therefore, we strongly recommend that reporting requirements and file guidelines across regulators for similar purposes (Quality, Equity, and Affordability) be harmonized to reduce these inefficiencies.	Covered California remains committed to aligning with OHCA's spend targets and goals, particularly to increase investment in primary care and behavioral health. These efforts are critical to supporting equity, affordability, and improved health outcomes for our enrollees. While our reporting timelines are distinct and tailored to the unique needs of Covered California's membership and provider networks, we strive to ensure our processes complement OHCA's overarching objectives. We also recognize the importance of minimizing administrative challenges and will continue to provide guidance, resources, and support to assist issuers in meeting these requirements. Through ongoing collaboration, we aim to balance efficiency with our commitment to advancing the specific goals outlined in Covered California's contracts.
4	4.01.1	To streamline the assignment process for Contractors, we respectfully continue to request that Covered California include cultural preference information on the 834 file. Providing cultural preference data will significantly enhance our ability to meet members' needs effectively and ensure a higher quality of care.	Covered California is committed to enhancing the efficiency and effectiveness of our data exchange processes. As part of this ongoing effort, we will investigate the potential for integrating additional data points into our application and 834 transactions in the future. This exploration will necessitate a thorough legal review to ensure compliance with all applicable regulations.
4	4.01.2	We respectfully reiterate our request that if an enrollee receives care from a different provider within the same office, it should count towards the requirement of two or more visits. This adjustment will ensure a more accurate and comprehensive assessment of the care provided to enrollees.	While we acknowledge the potential benefits of clinic-level continuity, recent evidence and the growing body of literature highlight that the most impactful outcomes—such as reduced ED visits and hospitalizations—are achieved through PCP-level continuity. For this reason, maintaining the requirement for visits to be with the same provider is crucial to ensure continuity of care aligns with the strongest evidence base.
4	4.02	To ensure clarity and facilitate effective implementation, we respectfully request detailed guidelines on what constitutes low-value care. Understanding these specifics will better equip us to identify and address this issue within our networks.	Thank you for your feedback and your commitment to addressing low-value care within your networks. Covered California defines low-value care as services or treatments that offer minimal or no clinical benefit, deviate from evidence-based guidelines, or have safer, more cost-effective alternatives. Reducing low-value care is critical to improving the quality, affordability, and equity of healthcare delivery. Covered California will facilitate collaborative forums such as learning sessions, working groups, clinical leader discussions, roundtables, and performance meetings designed to identify opportunities and develop strategies to address low-value care effectively within your networks. We appreciate your engagement and look forward to your participation in these efforts.
4	4.03.1 2) e)	We continue to request the URAC accreditation is acceptable in lieu of NCQA accreditation.	Covered California will make the addition to add URAC accreditation for vendors, while retaining NCQA as an option as well.
5	5.02.1	We again request clarification on whether Covered California is authorized by law to analyze data for the purposes of Fraud, Waste, and Abuse (F/W/A) and to partner with Contractors, at a minimum, to address and prevent Fraud. We strongly believe that Covered California should leverage all the data they receive to identify, prevent, and address Fraud.	Covered California does not analyze Health Evidence Initative (HEI) data specifically for purposes of fraud, waste, and abuse. Covered California may utilize HEI data for health oversight activities and for public reporting under AB929 on quality, cost, and disparities reduction. We welcome specific recommendations for how our health oversight activities might assist contractors in preventing fraud.