Article	Section #	Comment	Covered CA response	
1	1.01.2	SOGI data is not currently required in the HEI data submissions. Please provide the updated specification and timeline for this change. We recommend requiring SOGI data in the HEI submission by December 2026.	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 file setup available will be shared with Issuers for feedback prior to implementation.	
1	1.02.1	In order to maintain the intention of the original measure selection, we recommend selecting an alternate NCQA CIS Combo measure, such as CIS Combo-7, to continue to maintain focus on improving childhood immunizations while helping to improve rates by removing challenges of the flu vaccine. CIS-7 includes all recommended childhood vaccines minus the flu vaccine, which has been found to be the most challenging for this age range. This will allow for alignment with measures selected by DMHC and CalPERS but will help reduce challenges that make it difficult to improve rates for the Combo-10 measure. Health Net recommends using the CIS-E benchmark (and not CIS) when the switch to the ECDS measure occurs. BPC-E has not officially been approved as a new measure by NCQA yet and may potentially be a new measure next year. We do not recommend transitioning to this measure in the 2026 contract cycle. Blood pressure screenings are not billable services so this will greatly reduce the eligible member data received. The new measure change to hybrid only will automatically make a member non-compliant if no back-end data is received. We recommend waiting to transition to this measure until the CBP and BPC-E rates are more closely aligned. With any new measure introduction, it takes time to adopt to the new specifications and change provider behaviors. NCQA has not communicated plans to retire the CBP measure, so it will still be reportable. DSF-E has reporting challenges that are similar to SNS-E and other measures that use LOINC codes. Smaller providers and groups often do not have the infrastructure to report out on LOINC codes used for this measure, resulting in underreported data. DSF-E has two parts, the screening and the follow-up within 30 days of a positive screen. There are privacy issues that make it challenging to share screening data directly with providers, making it necessary for the member to request the follow-up themselves and setting up their own appointments with a behavioral health provider. Due to limitations with the LOINC codes, and the underreporting of the screening, the denominator for those with a positive screen is very low.	CIS Combo 7 is not currently included in the CMS QRS measure set. Given the significant importance of maintaining alignment across DHCS/Medi-Cal, CalPERS, DMHC, and other statewide initiatives, CIS Combo 10 will remain a scored QTI measure. However, due to smaller denominator sizes for CIS-10 and DSF-E, these measures will be weighted lower than the other three measures, and the CIS-10 Allowance program will continue. To limit the need for multiple data source submissions, alignment with QRS is critical. QHP issuers are encouraged to respond to the CMS Call Letters advocating for the inclusion of CIS-7 in the QRS measure set. Covered California acknowledges your feedback and preference. As CMS has not yet proposed the BPC-E measure, more details on measure specification will come through the CMS Annual Call Letter process. Covered California acknowledges the challenges of the DSF-E measure and will be retaining DSF-E as a scored QTI measure given the importance of identifying and treating depression. However, if DSF-E data is not available to assess performance or establish a benchmark, Covered California may choose not to assess the measure. Covered California will align with QRS scoring for the DSF-E benchmark.	
1	1.02.2	We support the addition of the Follow-up After Hospitalization for Mental Illness measure. We recommend adding the Follow-up After Hospitalization for Substance Use Disorder (FUA) instead of the IET measure. FUA is already a DHCS MCAS measure, and this additional will support alignment for providers and purchasers. FUA focuses on earlier/more immediate interventions that are needed sooner after discharge. Additionally, there are many privacy barriers for reporting SUD interventions for minors, which creates challenges for IET reporting.	The Follow Up After Hospitalization for Substance Use Disorder measure is not currently included in the CMS QRS measure set. To limit the need for multiple data source submissions, alignment with QRS is critical. QHP issuers are encouraged to respond to the CMS Call Letters advocating for the inclusion of measures, such as FUA, that may expand our ability to assess for equitable and evidence-based clinical management of substance use disorders.	

Article	Section #	Comment	Covered CA response	
2	2.01.1 b) iv)	We anticipate BH measures being difficult to stratify by subpopulation due to low denominators. DSF in particular is underreported by providers.	Covered California recognizes that measures with small denominator sizes may be difficult to stratify. However, the DSF-E measure uses an ECDS sample which will enable more robust stratification and assessment of disparities because of the expansion beyond the 411 hybrid sample size. Covered California will align with QRS scoring for the DSF-E benchmark, which will mitigate the impact of individual provider behavior and allow us to assess against the national benchmark. DSF-E is not proposed as a scored stratified measure for 2026-2028.	
2	2.03.3	The Medical Assistance with Smoking and Tobacco Use Cessation (MSC) measure is from the QRS Enrollee Experience survey. We cannot link the data back to individual members, and the response rate is usually below 100 to be able to stratify results. Recommend adding in language that this would be required only with a reportable MSC rate.	Thank you for bringing this to our attention. This section has been revised to clarify requirements.	
3	3.05.1 - 3.05-4	We support sharing best practices for GenAI in healthcare including participating in collaborative discussions with Covered CA and other Issuers. We do not believe that referencing member materials and alerting members of the use of GenAI is necessary given that consumers are growing more and more accustomed to using GenAI in their everyday lives. We do not believe consumers have an expectation that we disclose use of AI in healthcare. We request that Covered CA limit GenAI reporting requirements since this field is evolving rapidly and tracking all the use cases of GenAI can become onerous. GenAI can be very beneficial to help simplify processes and create efficiencies. We do not want additional requirements to create barriers or unnecessary steps that could limit the application or introduce inefficiencies in an environment which is heavily regulated. At a minimum we recommend removing the requirements under 3.05.3 and requirements 1 & 2 under 3.05.4.	Covered California recognizes GenAI as a rapidly evolving field that consumers may increasingly recognize as part of their lives. While consumer familiarity with GenAI is growing, its application in healthcare demands careful consideration due to privacy, accuracy, and potential bias implications. Covered California aims to ensure that GenAI enhances healthcare services without compromising quality or equity. Propsoed contractual reporting requirements are designed to maintain transparency and consumer trust, not to hinder innovation. We acknowledge the challenges of rapid technological advancements and are committed to a collaborative approach in reviewing and adapting these requirements to support beneficial GenAI applications while safeguarding consumer interests.	

Article	Section #	Comment	Covered CA response	
4	4.01.2	We recommend further research on PCP continuity of care trending over time and identify findings that correlate to quality of care before introducing benchmarks and improvement targets into the QHP Contract. This data also needs to account for team-based care where a member sees an available clinician in the PCP office. While PCP assignments are required for PPO plans, members may select those plans so that they do not need to use the PCP as a gatekeeper, and they can see any provider in the network. We cannot require members to see their PCP instead of another provider. Members also have the right to obtain a second opinion from a different provider when considering treatment options. There is also wide variation in utilization of care with some members having one visit in a calendar year and others needing complex care and seeing several providers.	Covered California has reviewed the extensive body of evidence related to Continuity of Care (CoC), with citations presented in the May Contract Workgroup among other sessions, and can share this evidence with stakeholders as needed. This measure is endorsed by the National Quality Forum and its steward is the American Board of Family Medicine. Covered California recognizes the importance of team-based care in the delivery system, and supports patients/members having a usual source of care, even within a care team in accordance with the evidence. The evidence base for the impact of continuity on patient outcomes, ER visits, and cost of care is greatest at the clinician level, and diminishes when measuring continuity at a clinic or provider group level. This measure does not require nor incentivize unnecessary or additional utilization. Only members who have 2 or more visits with any primary care clinician and who are enrolled for the duration of the measurement year will be included in the denominator. Members who do not access primary care services or who receive one visit in a calendar year are not included in this measure. Please refer to detailed specifications for more details.	
4	4.01.3, 4.02.2	Several data elements aligned to HCP-LAN and APM framework are causing significant overlap with OHCA and HCAI. The Office of Health Care Affordability (OHCA) has required managed care plans to submit Total Health Care Expenditures with Non-Claims Payment aggregated based on HCP-LAN and APM Framework. First data submission is on 9/1/2024. The Department of Health Care Access and Information (HCAI) currently has a proposed regulation for Non-Claims Payment (NCP) Data collection under review with the Office of Administrative Law. This regulation would expand the Health Care Payments Data submission to HCAI to include NCP data submitted and aligned to HCP-LAN and APM framework. This will be required for first submission in 9/30/2025. Please refer to https://hcai.ca.gov/wp-content/uploads/2024/04/NCP-Data-Collection-Fact-Sheet-v2.pdf	Covered California considers statewide healthcare objectives in conjunction with our specific contractual obligations. Recognizing our shared goals with OHCA, our direct health plan contracting and unique operational framework necessitate a tailored approach.	
4	4.02.4 1) a)	While health plans can purchase data and consult with Cal Healthcare Compare experts, this is not a collaborative that health plans can participate in.	Recognizing Cal Hospital Compare's multi-stakeholder structure, we encourage direct engagement between health plans and Cal Hospital Compare to explore collaborative opportunities. We are committed to facilitating communication, sharing data outcomes, and aligning quality improvement efforts between all stakeholders to enhance healthcare delivery across California.	
4	4.02.4 2)	We look forward to hearing more about the sessions and activities that will be hosted by Covered California. It would be helpful if Covered California can provide a consolidated list so that we can prepare for our attendance.	Covered California values the eagerness for collaboration but emphasizes that the nature of stakeholder event planning necessitates adaptable scheduling. We are committed to keeping Contractors informed through Carrier calls and emails with advance notice of participation opportunities.	

Article	Section #	Comment	Covered CA response	
4	4.02.6	Please clarify what data would be involved in this reporting. Is this tracking doula care based on claims utilization or reporting the number of contracted doulas in network? Please note that some doula care may be provided by contracted third party organization programs where the doula may not be contracted directly with the health plan. We recommend more research on how doula care will be provided under the requirements of AB 904. There may be variation among health plans, which could complicate reporting.	Covered California acknowledges the concerns regarding variations in contracting and reporting for doulas, midwives, and birthing centers. Doulas, midwives, and birthing centers are a critical access point to ensure comprehensive maternity care services to reducing health disparities. Consistent with current Covered California processes, we will provide a reporting template for feedback from Issuers ahead of finalizing the reporting template for this requirement.	
4	4.03.1	Please clarify what types of services are included in the intended scope for virtual care? Are wellness vendors that provide added-value services like coaching excluded? Please clarify what type of quality monitoring measures would be required for virtual care vendors? Our expectation is that this is referring to key performance indicators (KPIs) rather than HEDIS quality performance.	"Virtual Care" refers to all means to digitally interact with patients, including interactions conducted via telehealth and digital technologies such as app-based care and digital coaching services. Depending on the service provided, quality monitoring measures may vary by virtual care provider, service, or app, and would be dependent on the clinical scope and outcomes expected by the service.	
4	4.03.2	We recommend excluding the requirement for a virtual care improvement plan for outlier utilization findings. The use of virtual care is optional for members, and it is not always preferred. Likewise, not all providers have the capabilities to offer virtual care. We would not require the use of virtual care in order to increase utilization.	Covered California will continue to review and publicly report on virtual care and telehealth utilization trends using HEI data and discuss outlier findings with Issuers. If significant or concerning outliers are identified, Covered California may engage with Issuers on these findings and may require an improvement plan.	
5	5.02.3 4)	We do not have the capability to provide a list of hospitals that have NOT sent an ADT notification to at least one QHIO. This would be difficult and laborsome to identify. We can, however, develop a list of hospitals that HAVE sent an ADT notification to one or more of the QHIOs that we are a part of. But if the hospital sent an ADT notification to a QHIO we are NOT partnered with, we wouldn't know, due to the QHIO to QHIO ADT data exchange not being fully operational (and no concrete future date known).	Covered California appreciates the challenges of reporting information related to QHIOs with which it does not partner. We have included this language to align with DHCS requirements, and are committed to gaining feedback from stakeholders as we develop our reporting templates in order to ensure that we have considered the practical aspects of reporting ADT notifications.	
5	5.02.3 6)	Please revise the language to remove reference to "standard file formats." Please also change the language in part a) to state "Data types to share may include". It would be burdensome to develop a new type of Data Exchange with PCPs, however, we can share data via Cozeva with providers who are participating, and we continue to encourage more providers to participate.	We acknowledge that there may be differences in file formats depending on the vendor/intermediary. We will revise language to suggest data types that may be included in sharing information with PCPs about covered members.	
5	5.02.4	Please note that MediCal is not included in the IHA AMP program data scope. We recommend revising the language to state "for all applicable lines of business"	Thank you for bringing this to our attention. We will make the revision.	
1	1.02.2	Page 14 indicates collaboration across QHP issuers for community based activities, learning sessions, and working groups. Are there any specific activities that are being considered by Covered CA that will be implemented to meet this requirement?	Covered California facilitates several opportunities for collaboration and shared learning across Issuers, including meetings such as Clinical Leaders' Forums and Carrier Calls. In addition to participation in these formal and structured venues, Covered California will work with Issuers to determine additional community-based activities that may be applicable toward this requirement.	

Article	Section #	Comment	Covered CA response	
1	1.01.1	Request to clarify the definition of "Sex characteristics." Is this the same or different from Sexual Orientation and Gender Identity?	Sex characteristics differs from an individual's Sexual Orientation or Gender Identity. Sex characteristics refers to an person's biological aspects or biological sex. Gender Identity refers to an enrollee's gender identity, which may or may not differ from their sex characteristics or biological sex assigned at birth. Sexual Orientation refers to an emotional, romantic, or sexual attraction to other people.	
1	1.02.2	Request to clarify the definition of "non-utilizer rates." Is this specific to preventive services or other services?	The non-utilizer rate is inclusive of all services, and is not limited to primary care and preventive services. Covered California calculates the percentage of members enrolled for 12 months during the plan year who had no claims nor encounters during that year.	
1	1.03 4)	Verbiage on Page 14 states: "Contractor must provide annual staff training focusing on cultural humility, effective collaboration with interpreters, and include the use of National Standards for Culturally and Linguistically Appropriate Services (CLAS)." Request to clarify which issuer staff annual training is required for (i.e. is it inclusive of all staff of the QHP or only staff that engage with enrollees).	Covered California's requirement is that all staff who directly interact with enrollees or are involved in day-to-day operations affecting enrollee services complete this training. We encourage all staff members to participate if possible as we believe broader participation will enhance healthcare service quality and promote a more inclusive organizational culture.	
2	2.02.1	Request to clarify if issuers will be required to submit the Patient Health Questionnaire-2 and 9 for approval, if modified by issuers, since they need to be in a culturally and linguistically appropriate manner.	Issuers are not required to submit the PHQ-2 or PHQ-9 by specific languages. The expectation is for issuers to provide services in a culturally and linguistically appropriate manner.	
3	3.03.1 5) f)	Verbiage on Page 43 states: "Consider receipt of High-Risk Enrollee health information as the Enrollee's request for continuity of care pursuant to Health and Safety Code, § 1373.96, or Insurance Code, § 10133.56." Most of this section talks about "At-risk" enrollees, sub provision "f" references "High risk" enrollees. Please clarify if this sub provision is this meant to apply only "High risk" enrollees or are "At-Risk" enrollees included also. Recommendation to review all verbiage under this section and confirm if all references to "At-risk" vs "High risk" are accurate/applicable as stated or revise as needed for consistency.	Section 3.03 defines both At-Risk and High-Risk Enrollees. High-Risk Enrollees are a subset of At-Risk Enrollees who may experience especially harmful impacts from a care transition. As specified, subdivision (f) applies only to High-Risk enrollees, as defined. Minor edits to terminology have been made to this section to consistently use the defined terms "At-Risk Enrollee" and "High-Risk Enrollee	
3	3.05.3	Request to clarify if a template will be provided to carriers by Covered CA to notify enrollee's if the issuer utilizes GenAI.	Covered California will develop a reporting template based on applicable reporting requirements and will share this with stakeholders for feedback before finalizing as per our usual processes.	

Article	Section #	Comment	Covered CA response	
4	4.02.6 2) a)	Presume that QHPs are not being asked to directly assign members and providers on the basis of race, color or national origin. Language should allow for QHPs to publish/disclose demographic information voluntarily submitted by providers to enrollees so they can select the appropriate provider that meets their needs.	Covered California will revise language to support patient preference for cultural concordance with providers, without mandating provider assignments. Our focus remains on empowering informed choices within the bounds of nondiscrimination laws, like the Affordable Care Act Section 1557 and the Fair Employment and Housing Act. We aim to enhance decision-making through transparent information on maternity care, upholding our commitment to choice, transparency, and nondiscrimination, without requiring specific provider assignments.	
5	5.02.4	Concerns that this section requires reporting for "all lines of business" rather than just the plan's Marketplace LOB as the contract is only applicable to Covered CA enrollees. Recommendation to remove "for all lines of business" requirement.	Covered California will continue to require reporting on "all lines of business" for the 2026-2028 QHP contract, consistent with prior contract years. This reporting is necessary for Covered California to fulfill its healthcare oversight activities and to further its commitment to data-driven healthcare reform. This reporting is vital for maintaining transparency, enabling informed decisions among consumers and stakeholders, and aligning with our efforts to promote affordability, quality, and equity in healthcare.	
1	1.02.1	COL measure (NQF#0034) will be retired from QRS as of MY2024 - Does CoCA wants carriers to continue calculating and reporting this measure directly as a custom measure?	Covered California will not require carriers to continue calculating and reporting the COL measure (NQF#0034) as a custom measure. Covered California will transition to COL-E and follow the published specifications for that measure.	
4	4.02.2	If a small plan only offers COCA in one County that is known for high costs and healthy members, can it be excluded from being required to use capitation with its PCPs or face a penalty?	Covered California recognizes the concerns of QHP issuers regarding capitation goals in areas with unique demographic and cost challenges. We are dedicated to the principles of value-based care and focused on alignment with OHCA benchmarks. In order to support Issuers and facilitate moving toward value-based payment models, we welcome transparent engagement with our Issuers around their specific challenges or barriers.	

Article	Section #	Comment	Covered CA response	
4	4.02.4 3)	Is it not the State's responsibility to ensure the providing hospitals are in regulatory compliance? Also, does this eliminate SIR measurements?	Section 4.02.4.3 of the 2026-2028 QHP Issuer Contract mandates hospitals to comply with the CMS Hospital Price Transparency rule, ensuring the public posting of standard and negotiated charges in a machine-readable format. It also tasks health plans with curating networks that prioritize value, including quality, safety, patient experience, and equity, highlighting their role in selecting and overseeing hospitals that adhere to these standards. We encourage Issuers to monitor SIR measurements to meet hospital safety contractual requirements in alignment with Section 4.02.5.	
1	Preamble	While we recognize the definitions provided, we are concerned that the definition from the Federal Plan for Equitable Long-Term Recovery and Resilience may not be the most appropriate and therefore respectfully request the following change: ~~To achieve health equity requires a comprehensive dismantling of the factors impeding health and wellness. The Federal Plan for Equitable Long-Term Recovery and Resilience outlines the seven vital conditions for Health and Well-Being, which include Basic Needs for Health and Safety, Human Housing, Reliable Transportation, Meaningful Work and Wealth, Thriving Natural World, Belonging and Civic Muscle, and Lifelong Learning.2~~ Addressing health equity and disparities in healthcare is integral to the mission of Covered California. Covered California and Contractor will work in partnership with others to address health equity and disparities in healthcare ~~achieve these vital conditions~~ for Covered California Enrollees.	This language will not be changed.	
1	1.01.1	Please consider removing this section. While this mentions areas of consideration, they are not currently mentioned in the contract as items being collected. If and/or when these or other areas are expanded upon then they can be added as part of data collection.	Covered California is assessing feasibility of implementation, and Issuers are expected to engage with Covered California as we pursue implementation. As per usual processes, Covered California would work with internal teams and stakeholders for their feedback.	
1	1.01.1	If not removed, please advise if sex characteristic and veteran miliary service values will be on the application and be sent to Contractor on the 834 and if they need to be self reported and collected.	Covered California is assessing feasibility of implementation, and Issuers are expected to engage with Covered California as we pursue implementation. As per usual processes, Covered California would work with internal teams and stakeholders for their feedback.	
1	1.01.2 1) b)	Covered California has an established marketplace. The ingestion of 834 data that includes R/E data and a carrier's ability to request information from enrollees should be standard operating procedure, even for new entrants. Covered California's high standards need to apply to new entrants as well. We respectfully request Covered California remove b).	New entrants will be given a ramp up period to enable build and implementation of required data submission elements just as currently contracted issuers have been provided.	

Article	Section #	Comment	Covered CA response	
1	1.01.2 2) b)	Covered California has an established marketplace. The ingestion of 834 data that includes Spoken and Written language data and a carrier's ability to request information from enrollees should be standard operating procedure, even for new entrants. Covered California's high standards need to apply to new entrants as well. We respectfully request Covered California remove b).	New entrants will be given a ramp up period to enable build and implementation of required data submission elements just as currently contracted issuers have been provided.	
1	1.01.2 3) a)	We do not believe SOGI is currently an attribute for the HEI data submissions. We request Contractor, Covered California, and Merative partner together on the HEI data layout to make the additional of SOGI data the least difficult to provide. For example, if it takes less effort to insert the data fields/characters on the far rightin the data layout that would be preferred over shifting all data fields if that required additional effort.	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 file setup available will be shared with Issuers for feedback prior to implementation.	
1	1.01.2 3) a)	We do not believe SOGI is currently an attribute for the HEI data submissions. If modifications of HEI data submissions are necessary, we respectfully request the finalized layout six months ahead of implementation to provide ample development and testing.	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 file setup available will be shared with Issuers for feedback prior to implementation.	
1	1.02.1	Please consider adding statement: "as long as HEDIS measure is not retired."	This change will not be made.	
1	1.02.1	In the introduction paragraph to remain consistent with other areas of the agreement, please consider the following change: …"~~quarterly~~ performance reviews"...	This change will not be made.	
1	1.02.1	We are concerned with development and testing timeframe in the event Covered California changes the PLD layout. We respectfully request Covered California add to the first paragraph that the final layout will be provided 6 months before the due date.	Consistent with our current Covered California process, Patient Level Data (PLD) File submission instructions and data template will continue to be provided several months in advance of the submission deadline, and will be subject to Issuer feedback prior to finalizing.	
1	1.02.1	We are concerned with the volume of data in the PLD and necessary development and testing in order to submit complete and accurate data. We respectfully request the due date be at a minimum one month following receipt of audited results.	We acknowledge the Issuer's feedback regarding the size and complexity of PLD file submissions. Consistent with our current Covered California process, Patient Level Data (PLD) File submission instructions, templates, and timelines will be discussed several months in advance of the submission due date. As the PLD file is a data source needed to calculate QTI payment amounts using our proposed Health Equity Methodology, we will consider Issuers' feedback and balance the need to provide comprehensive and timely estimates of QTI payments. PLD File submission dates directly impact our ability to provide these estimates to Issuers and to plan for Population Health Investments (PopHIs).	
2	2.01.1	There appear to be two 2.01.1 subsections. Please consider updating the section numbers.	We have corrected the formatting in this section.	
2	2.01.1 1) a)	Under the second 2.01.1 subsection, it appears that bullet a) may be continued into b). Please consider removing "b)"	We have corrected the formatting in this section.	
2	2.01.1 1) b) iv)	We respectfully request modifying the paragraph with the following change: …"Representative interventions include, but may not be limited to, include"…	This language change will not be made.	

Article	Section #	Comment	Covered CA response	
2	2.03.3	Our understanding is that Covered California captures information in the application for enrollment process. The fastest way Contractors can begin educating enrollees and impact tobacco use is if Covered California shares this information on the 834. We respectfully request Covered California begin sending this data to Contractor.	Covered California does not capture tobacco use status as part of the enrollment application.	
2	2.03.3	We request the following sentence be added to the second paragraph as second to last sentence: Nothing in the requirement prevents Contractor from implementing Prior Authorizations when clinically appropriate for new drugs that have safety or efficacy concerns.	Covered California acknowledges that Issuers may implement Prior Authorizations when clinically appropriate and Covered California may engage with Issuers around their use and applications of Prior Authorizations as part of its healthcare oversight activities.	
3	3.01.1	On the clean version page 21 has bullet 1) and page 22 starts 3). Please consider updating the bullet numbering.	We have reviewed formatting across the contract.	
3	3.01.1 4) b)	Please consider indenting b) more as it is a subsection of current number 4).	We have reviewed formatting across the contract.	
3	3.05 Preamble	Please consider modifying the language to "data and bias analysis" instead of "bias mitigation".	Covered California is committed to not only to identify and understand biases within data but also to actively engage in strategies and measures that mitigate these biases effectively. "Bias mitigation" encompasses a proactive stance towards not just recognizing biases but also implementing solutions to reduce their impact, ensuring fairness and equity in healthcare operations. Therefore, retaining the term "bias mitigation" reflects our active responsibility towards creating more equitable systems and outcomes.	
3	3.05 3)	We respectfully request this be updated to: Human oversight. Appropriate human oversight should be proportional to the level of risk At this time, there is not specific legislation universally codifying or defining "human in the loop" across all jurisdictions. However, the White House AI Executive Order refers to human oversight.	Covered California recognizes the importance of the request to update the language to emphasize "Human oversight," underlining that it should be proportional to the risk level. While it's true that specific legislation defining "human in the loop" practices varies across jurisdictions, and the White House AI Executive Order does mention human oversight, our approach aims to balance both the adherence to evolving regulatory landscapes and the practical application of human oversight in healthcare operations.	
4	4.01	Since the Covered California contract pertains to Covered California enrollees, we request the following change: "Contractor shall work with Covered California to provide comparison reporting for the requirements specified below ~~for all lines of business~~ to compare performance and inform future Covered California requirements,"	Covered California will continue to require reporting on "all lines of business" for the 2026-2028 QHP contract, consistent with prior contract years. This reporting is necessary for Covered California to fulfill its healthcare oversight activities and to further its commitment to data-driven healthcare reform. This reporting is vital for maintaining transparency, enabling informed decisions among consumers and stakeholders, and aligning with our efforts to promote affordability, quality, and equity in healthcare.	
4	4.01.1 1)	To assist Contractors with the assignment process, we respectfully request Covered California send cultural preference information on the 834. If this is not possible, we request the removal of this expectation.	Covered California does not currently collect cultural preference information as part of enrollment. Covered California expects Issuers to engage with enrolled members to understand their preferences in order to match them with in-network primary care clinician.	

Article	Section #	Comment	Covered CA response	
4	4.01.2 2)	The Continuity of Care Index is different between PPO/EPO and HMO products. As benchmarks are established, we respectfully request that these differences be taken into consideration.	Covered California recognizes the need to assess continuity at the product level, and has found similar rates of continuity using HEI data across HMO, PPO, and EPO plans. We have lowered the threshold in this performance standard such that if less than 60% of members achieve the 0.7 continuity index, Contractor would be expected to engage with Covered California and report their planned improvement activities.	
4	4.01.2 2)	We respectfully request clarity regarding what happens if an enrollee obtains care from a different provider in the same office. Please clarify if this counts as a different primary care provider or counts towards the two or more visits.	The Continuity of Care measure has been studied and validated at the individual PCP level. Evidence to support the impact of continuity of care on healthcare costs and outcomes is strongest at the individual clinician level. There is a limited body of evidence on the impact of continuity at the clinic / provider-organization level, but the evidence that exists reveals a significantly lower level of benefit on outcomes.	
4	4.01.2 2)	While we recognize the importance of primary care and seeing the same provider, however we are concerned this may result in an emphasis in obtaining unnecessary care which may negatively impact enrollees with additional out of pocket expenses for health care services and which may lead to increased health care spend negatively impacting premium rates. We respectfully request Covered California evaluate if such concerns are significant enough to remove this requirement or rephrase it to ensure there are no concerns of potential increased member financial responsibility through out of pocket expenses and potential of increased premium rates.	This measure does not require nor incentivize unnecessary or additional utilization. Only members who have 2 or more visits with any primary care clinician and who are enrolled for the duration of the measurement year will be included in the denominator. Members who do not access primary care services or who receive one visit in a calendar year are not included in this measure. Please refer to detailed specifications for more details. There is a strong evidence base that for those members who have two or more visits with a primary care provider within a year, there are cost-savings impacts of a continuous primary care relationship. The converse has not been found in any published literature.	
4	4.01.3 1)	To remain consistent with OHCA and prevent two different methodologies, we respectfully request the following change: ~~Contractor shall follow methodology provided by Covered California.~~	Covered California values your feedback on aligning OHCA's methodology with our draft 2026-2028 QHP contract. Despite our shared goals with OHCA, our direct health plan contracting, and unique operational framework necessitate a tailored approach. Our efforts aim to balance statewide healthcare objectives with our specific contractual obligations, ensuring access to quality, affordable healthcare centered on primary care.	
4	4.01.3 1)	Please see embedded Primary Care Feedback provided to OHCA to ensure Covered California and OHCA are aligned. See embedded document. Primary Care Feedback Provided to OHCA	Thank you for sharing your feedback on OHCA's benchmark targets and the integration of Alternative Payment Model (APM) adoption goals. Covered California is committed to alignment and support of OHCA's APM adoption targets and approach to enhance investment in primary care and behavioral health.	
4	4.02	We respectfully request the reference to expecting Contractor to address "low value care" be removed. Most Contractors do not practice medicine and there are complexities for providers that may require services which may be considered "low value care."	While health plans do not deliver direct patient care, they possess the capability to assess provider performance utilizing clinical measure scores, patient outcomes, and related data. This data-driven approach can be instrumental in identifying and mitigating low-value care within their networks.	

Article	Section #	Comment	Covered CA response	
4	4.02.2 1) - 2)	Please see embedded Primary Care Feedback provided to OHCA to ensure Covered California and OHCA are aligned. Embedded PDF is under comment 4.01.3 1).	Thank you for sharing your feedback on OHCA's benchmark targets and the integration of Alternative Payment Model (APM) adoption goals. Covered California is committed to alignment and support of OHCA's APM adoption targets and approach to enhance investment in primary care and behavioral health.	
4	4.02.2 1)	To remain consistent with OHCA and to prevent two different methodologies, we respectfully request the following change: ~~Contractor shall follow methodology provided by Covered California using HEI data submitted in accordance with Article 5.02.1.~~ Covered California will review and monitor progress toward OHCA designated benchmarks using HEI data submitted in accordance with Article 5.02.1.	Covered California values your feedback on aligning OHCA's methodology with our draft 2026-2028 QHP contract. Recognizing our shared goals with OHCA, our direct health plan contracting and unique operational framework necessitate a tailored approach. Our efforts aim to balance statewide healthcare initiatives with our specific contractual obligations, ensuring access to quality, affordable healthcare centered on primary care.	
4	4.02.3 1) b)	Requesting copies of medical management policy is not going to demonstrate achieving maximum quality and safety performance. We respectfully request the following change: ~~To demonstrate Contractor is managing provider costs, Covered California may request copies of Contractor's medical management policy.~~	As part of its health oversight activities, Covered California may request submissions of medical management policies to understand Contractor approaches to quality and cost management practices.	
4	4.02.4 5)	Since the Covered California contract pertains to Covered California enrollees, we respectfully request the following change: "5) Contractor shall work with Covered California to provide comparison reporting for the requirements in Article 4.02.4 ~~for all lines of business~~ to compare performance and inform future Covered California requirements in this area."	Covered California will continue to require reporting on "all lines of business" for the 2026-2028 QHP contract, consistent with prior contract years. This reporting is necessary for Covered California to fulfill its healthcare oversight activities and to further its commitment to data-driven healthcare reform. This reporting is vital for maintaining transparency, enabling informed decisions among consumers and stakeholders, and aligning with our efforts to promote affordability, quality, and equity in healthcare.	
4	4.02.6	Our understanding is that Covered California captures information in the application for coverage process. The fastest way Contractors can begin addressing health during pregnancy is if Covered California shares this information on the 834. We respectfully request Covered California begin sending this data to Contractor.	Covered California captures limited information related to pregnancy status as part of the enrollment application, and this information is generally updated by enrollees at only one timepoint per year. Covered California encourages Issuers to work with its members directly to identify pregnancy status as this may change over time.	
4	4.03.1 2) a)	We respectfully request the following change: a) Taxpayer Identification Number (TIN) and National Provider Identifier (NPI) except NPI exempt organizations,	We will maintain the current, specific language in this section.	

Article	Section #	Comment	Covered CA response	
4	4.03.1 2)	We respectfully request the following change to reflect the inventory is limited to in network/contracting providers: 2) An inventory of contracting third party virtual care...	Covered California expects that the information provided is applicable to third party virtual care providers who the Contractor's enrollees may access for care.	
4	4.03.1 2) e)	We respectfully request that URAC telehealth accreditation also be listed as an option to provide status on.	Covered California is currently aligning with NCQA for accreditation purposes and is open to feedback and investigation of additional accreditation bodies for virtual care vendors.	
5	5.02.1 1) c)	We respectfully request clarification whether Covered California analyzes data for purposes of Fraud, Waste, and Abuse.	No, Covered California does not analyze data specifically for purposes of F/W/A.	
5	5.02.4 1)	Since the Covered California contract pertains to Covered California enrollees we respectfully request the following change: 1) Submit ~~all necessary~~ data~~, including supplemental clinical data,~~ for ~~all lines of business~~ Contractor's network to IHA and participate in the IHA Align.	Covered California will continue to require reporting on "all lines of business" for the 2026-2028 QHP contract, consistent with prior contract years. This reporting is necessary for Covered California to fulfill its healthcare oversight activities and to further its commitment to data-driven healthcare reform. This reporting is vital for maintaining transparency, enabling informed decisions among consumers and stakeholders, and aligning with our efforts to promote affordability, quality, and equity in healthcare.	
General Comment	Redline Version Attachment 1	Please consider using a watermark instead of an inserted image stating draft on every page. The draft image made it difficult to read the language behind the image because it was so dark and included a red line. The red line interfered with redlined text. When manually deleting the image we found words/letters that likely were red font weren't even in the document as it appears they were removed if interfering with the red line image making the tracked change review difficult and confusing.	Your feedback will be taken into consideration.	
1	1.01.1	1.01.1 Expanded Demographic Data Collection - Added "Sex Characteristics" **Recommendation:** Please include a defination for "Sex Characteristics"	Sex characteristics differs from an individual's Sexual Orientation or Gender Identity. Sex characteristics refers to an person's biological aspects or biological sex. Gender Identity refers to an enrollee's gender identity, which may or may not differ from their sex characteristics or biological sex assigned at birth.	
1	1.01.2	1.01.2 Race, Ethnicity, Language, Sexual Orientation and Gender Identity Data Collection - SOGI data collection via HEI data files **Recommendation:** HEI Enrollment Extract does not currently allow for submission of SOGI data and will need to be modified to submit this information, carriers will need requirements and implementation timeline as soon as possible to support having this updated prior to the 2026 Plan Year.	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 file setup available will be shared with Issuers for feedback prior to implementation.	

Article	Section #	Comment	Covered CA response	
1	1.02.1	1.02.1 Monitoring Disparities: Patient Level Data File **Questions**: • Please confirm if all of these measures should be found on the IDSS file that will be submitted to the governing agency mid-June? Should all of these measures be included in the IDSS file provided to Covered California • What exactly is needed to be provided by the health plan for items #8 Depression Screening & Follow-Up for Adolescents & Adults (DSF-E) and #9 Depression Screening & Follow-Up for Adolescents & Adults (DSF)? DSF is not currently produced however, DSF-E is. Do we need to submit a PLD for DSF and for DSF-E? • Do we need to provide the member level details for both the non-ECDS and ECDS version of the same measure – example #6 Childhood Immunization Status (Combo 10) (CIS-E) (NQF #0038) and #7 Childhood Immunization Status (Combo 10) (NQF #0038)? • For Social Need Screening, please confirm that it would be for all sub-measures (food screening, food intervention, housing screening, housing intervention, transportation screening, and transportation intervention?	IDSS files differ from Patient Level Data (PLD) files. Covered California requires Contractors to submit a PLD file that includes a unique person identifier as specified by Covered California and valid race and ethnicity attributes for each person in the denominator. Covered Calfornia will provide PLD submission instructions and templates, and measures in PLD files may include both QRS and non-QRS measures. PLD files are used for assessing health disparities across multiple contract provisions and should be submitted in accordance with PLD file specific instructions, templates, and timelines. Thank you for bringing this to our attention. DSF was included in this list in error and will be removed from the PLD measures list. The PLD measures list will include the DSF-E measure, in alignment with the QRS program's transition to ECDS reporting for this measure. Member level details should be provided for all members included in the PLD file submission. PLD file that includes a unique person identifier as specified by Covered California and valid race and ethnicity attributes for each person in the denominator. Covered Calfornia will provide PLD submission instructions and templates, and measures in PLD files may include both QRS and non-QRS measures. For the Social Need Screening and Intervention (SNS-E) measure, Contractor must screen all enrollees at leaset annually for unmet food, housing, and transportation needs using one or more instruments specified in the SNS-E measure specifications. All subrates should be included in the PLD file submission for this measure in alignment with the QRS measure set and specifications.	
5	5.02.3	5.02.3 Data Exchange (6) and (6) a) **Recommendations:** requesting that (6) be updated as follows "Contractor shall make efforts to increase the sharing of information on Covered California enrollees with primary care practices, and report on the progress and approaches with Covered California." Request that section (6) a) be removed in its entirety or if keeping data types to share, add "data types to share may include". Rationale for request is that this is not data typically shared today with PPO primary care practices as many members are not considered attributed to their assigned primary care provider.	Covered California acknowledges that there may be differences in file formats depending on the vendor/itermediary. We will revise language to include suggested data types that may be shared with PCPs about covered members.	
1	1.03	Advocates support these changes that include increased specificity on monitoring and participation in collaborations related to disparities reduction.	Thank you for your comment.	
1	1.04.1	We request clarity on whether Covered California will modify penalties if the intermediary milestones of this revised schedule are met.	This requirement has no financial accountability as part of the proposed 2026-2028 contract.	

Article	Section #	Comment	Covered CA response	
1	1.05.1	Amend to require written notice communicating in English and "at least the top 15 threshold languages spoken by Limited-English-proficient (LEP) individuals in California" (SB 223 – Atkins, 2017) the availability of free language assistance and how individuals can obtain language assistance in English and in threshold languages. Amend: For the purposes of this reporting, health plan threshold languages "additionally include" languages spoken by 1% of individuals served by the organization or by 200 individuals, whichever is less.	Covered California has aligned contract language to NCQA standards as this section is the alternative reporting requirements for non-accredited QHP issuers.	
2	2.01.1	We urge Covered California to more clearly require contractors to outline and explain to enrollees coverge of all medically necessary behavioral health services pursuant to SB 855 and implementing regulations. The DMHC regulations on SB 855 include a non-exhaustive list of behavioral health services that must be covered when medical necessity is met. We believe plans should be required to include this list in their evidences of coverage, provide a refernence to SB 855 and DMHC regulations, and a statement that explains the non-exhaustive nature of the list of services and the fact that SB 855 requires coverage of all medically necessary behavioral health services.	Thank you for your recommendation.	
2	2.02.1	We appreciate that Covered CA is requiring health plans to submit enrollee educational materials regarding scope, availability and access to behavioral health services, inclusive of virtual care. We request that Covered CA add that the educational materials submitted must be culturally and linguistically responsive in a language that members speak and understand.	Covered California will include assessment of cultural and linguistic responsiveness as part of its behavioral health monitoring with its increased fiocus on idnetifying and addressing behavioral health access and utilization disparities.	
2	2.03.1	We continue to caution against the explicit goal of "decreasing the number of new starts" for opioid prescriptions for pain management. Our experience indicates that such instructions leads to inappropriate barriers to accessing medically necessary medications for pain. Other efforts, including availability of non-opioid alternatives, tapering down, and access to treatment including naloxone, are more effective at addressing the rate of overdose deaths without unintentionally harming individuals who truly need opiods for pain.	After conducting an environmental scan of the current available guidelines, Covered California believes that Smart Care California guidelines are the most applicable for our Issuers and enrollees. The draft contract language has been revised to read "Prevent: use opioids sparingly, with lower doses and shorter durations when medically appropriate; support non-pharmacological approaches to pain management such as removing prior authorizations for phyical therapy;".	
2	2.04.1	We seek clarification as to why Covered California proposes to delete the two specific requirements regarding promotion of integrated behavioral health and replace it with a vague and general requirement for the contractor to show "How it is promoting the integration of behavioral health services with primary care, including data exchange between Contractor, its contracted primary care clinicians, and its behavioral health providers."	Covered California recognizes the evidence to support integrated behavioral health. However, these specific reporting requiremetns were we removed due to difficulty in monitoring, measuring, and reporting integrated behavioral health care due to lack of use of Collaborative Care Model codes in claims data, as well as in response to Issuer feedback about the feasibility of reporting at the granular level on specific integration models.	
2	2.05	While we understand the need for additional flexibility for contractors first contracted in 2026, we believe there should be still be a deadline for compliance. We suggest allowing new Contractors and Covered California to mutually agree upon a reasonable alternative deadline not to exceed March 31, 2028.	This language has been revised.	
3	3.03	We urge Covered California to consider explicitly including individuals with behavioral health conditions, particularly those with substance use disorders undergoing medication assisted treatment, as "high-risk enrollees."	Covered California values the suggestion to classify individuals with behavioral health conditions, particularly those with substance use disorders undergoing medication assisted treatment, as "high-risk enrollees" and have made revisions to our language to specify this group of members as considered "high risk."	

Article	Section #	Comment	Covered CA response	
3	3.05	We generally support the proposed generative AI framework which particularly emphasizes bias mitigation, transparency, and other measures to ensure equitable delivery of care. Because generative AI technology is developing rapidly, and new research and best practices are still emerging, the landscape in this area may change significantly through the duration of this contract through 2028. We request language to allow Covered California to flexibly adapt to emerging information to ensure the framework continues to uphold values of anti-bias, equity, transparency, and quality of consumer experience.	Covered California appreciates the support for our GenAI regulatory framework and its focus on equity and transparency. Covered California will consider including flexible language in our contracts to adapt to evolving Gen AI technology ensuring our commitments remain robust.	
4	4.01.1	While assignment of a PCP is a critical first step, we urge for inclusion of contract language to monitor timely access to new patient appointments with PCPs and to ensure enrollees have access to newly assigned or selected PCPs in a timely manner.	We agree that timely access to care is critical to supporting equitable health outcomes. Please refer to proposed Access requirements for our approaches to monitoring and measurement in alignment with other California purchasers.	
4	4.01.1	Given the focus on advanced primary care, we request further specificity to determine the extent to which "advanced" models such as care teams and other coordinated, collaborative approaches are used in the primary care setting.	Covered California has focused its requirements on outcomes in alignment with our guiding principals for this contract's development which include: Our approach will be guided by: Building on strong foundation of 2023-2025 contract development work Prioritizing alignment Emphasizing outcomes Pursuing administrative simplification	
4	4.01.2	If possible, we request inclusion of information on utilization of non-PCP settings such as urgent and walk-in care.	Covered California is aligning with the validated measure specification and evidence-base which excludes Urgent Care as a site of care.	
4	4.02.6	Advocates support the tracking and prioritization of doula and midwife providers, and particularly the emphasis on congruency between provider and enrollee race and ethnicity, to continue increasing equitable access to these services.	Thank you for this comment.	

Article	Section #	Comment	Covered CA response	
4	4.01.2 2) b)	Our organization strongly supports measuring Continuity of Care as a key element of Advanced Primary Care for QHPs, and we applaud Covered California's leadership in this area. As you know, when patients and family caregivers are part of an ongoing, long-term relationship with a physician, their health is better in a wide range of chronic disease areas including diabetes1, asthma2, cancer3, and dementia4. There is substantial evidence that continuous doctor-patient relationships lead to lower costs, including total costs5, emergency department costs6, nursing home costs7, and hospital admissions costs8 as well as utilization9. Long-term relationships can also lead to improved primary care utilization10. The loss of longitudinal relationships in primary care results in $979 million in excess health care expenditures for public and private payers annually11. Continuous relationships are also associated with higher patient satisfaction12. References 1. Lustman, Alex, Doron Comaneshter, and Shlomo Vinker. "Interpersonal continuity of care and type two diabetes." Primary care diabetes 10.3 (2016): 165-170. https://doi.org/10.1016/j.pcd.2015.10.001. 2. Cree, M., et al. "Increased continuity of care associated with decreased hospital care and emergency department visits for patients with asthma." Disease Management 9.1 (2006): 63-71. https://doi.org/10.1089/dis.2006.9.63 3. Almaawiy, Ummukulthum, et al. "Are family physician visits and continuity of care associated with acute care use at end-of-life? A population-based cohort study of homecare cancer patients." Palliative medicine 28.2 (2014): 176-183. https://doi.org/10.1177/0269216313493125 4. Lei, Lianlian, et al. "Can Continuity of Care Reduce Hospitalization Among Community-dwelling Older Adult Veterans Living with Dementia?" Medical Care 58.11 (2020): 988-995. https://www.ingentaconnect.com/content/wk/mcar/2020/00000058/00000011/art00009 5. De Maeseneer, Jan M., et al. "Provider continuity in family medicine: does it make a difference for total health care costs?" The Annals of Family Medicine 1.3 (2003): 144-148. https://doi.org/10.1370/afm.75 6. McBurney PG, Simpson KN, Darden PM. Potential cost savings of decreased emergency department visits through increased continuity in a pediatric medical home. Ambul Pediatr. 2004;4(3):204-208. doi:10.1367/A03-069R. 7. Lei, L., Intrator, O., Conwell, Y., Fortinsky, RH., Cai, S. Continuity of care and health care cost	Thank you for your support and for sharing this valuable information and the extensive evidence supporting Continuity of Care measurement as a key element of Advanced Primary Care. Covered California is committed to advancing primary care quality and is closely following these publications and emerging research to inform our initiatives.	
3	3.05	If CCA plans to set this as a contractual requirement, we would like Covered CA to lead on the GenAI efforts. We would be interested in how other cariers plan to address this requirement first.	Covered California will be taking a collaborative approach to engage carriers and other stakeholders in sharing and establishing best practices regarding uses for GenAI.	
2	2.03.1	Contract language requests alignment with policies and programs that aligns with guidelines from Smart Care California however these guidelines have not been updated since 2019 with the webpage stating the content is archived for historical content only. Request is to re-visit if the recommended guidelines are still applicable today.	After conducting an environmental scan of the current available guidelines, Covered California believes that content within the Smart Care California guidelines are the most applicable for our Issuers and enrollees.	

Article	Section #	Comment	Covered CA response	
1		We request more details on the methodology on which Covered Ca would like us to report on.	We request clarification of this comment. Please email the EQT team at eqt@covered.ca.gov with the specific section for which you'd like methodology.	
1	1.01.2 a)	Does Covered CA define underperforming and low value and variateion providers. Is there a monitoring report template, or is this determined by the Plan	We request clarification of this comment. Please email the EQT team at eqt@covered.ca.gov with the specific section for which you'd like further details.	
1	1.01.1 b)	Does Dovered CA define "equity?"	Please see the preamble section of Attachment 1, Article 1- Equity and Disparities Reduction for how Covered California defines equity.	
1	1.05.1	Covered CA should consider accepting the NCQA HES certificate rather that the actual reports (evidence) submitted to NCQA. These reports are a duplicated and submited to NWA as part of the accreditation and/or renewal process.	Covered California requires that plans provide comprehensive reports to demonstrate strategies and dedication to offering equitable care. Section 1.05 is not intended to verify Contractor's accreditation status, rather to understand how it complies with the specified standards.	
2	2.1.01	Requesting more information on what is in scope under "digital platforms"	Digital platforms are technologies and applications that support healthcare service delivery. They may include applications on tablets or smartphones, monitoring devices, or other digital technologies that provide healthcare on demand.	
2	2.03.3	Is the assumption that carrier's BH vendor would take on the partnership and interventions with Kick It CA?	Covered California is not requiring a specific partnership or intervention vendor. Issuers may choose their own vendor that meets their enrollees' needs.	
4	4.01.3	We request more details on the methodology on which Covered Ca would like us to report on.	The Contractor is required to report annually on total primary care spending by product, using the methodology set by Covered California in alignment with OHCA to monitor progress against OHCA benchmarks. Additionally, the Contractor must analyze the relationship between primary care spending, total healthcare expenditures (TCHE), and overall network performance, focusing on quality and equity. Contractor is already required to collect and submit this data under the current 2023-2025 contract performance standards.	

Article	Section #	Comment	Covered CA response	
4	4.01.2 2)	More information is needed regarding Covered California's methodology for the Continuity of Care Index. The Continuity of Care Index is different between PPO/EPO and HMO products. As benchmarks are established, we urge Covered California to take these differences into consideration and consider a reporting-only period to establish baseline understanding.	Covered California recognizes the need to assess continuity at the product level, and has found similar rates of Continuity using HEI data across HMO, PPO, and EPO plans. We have lowered the threshold in this performance standard such that if less than 60% of members achieve the 0.7 continuity index, Contractor would be expected to engage with Covered California and report their planned improvement activities.	
4	4.02	CAHP requests Covered California remove references expecting Contractor to address "low value care." Most Contractors do not practice medicine, which limits their ability to make changes at the practice level, and there are complexities for providers that may require services which may be considered "low value care."	While health plans do not deliver direct patient care, they possess the capability to assess provider performance utilizing clinical measure scores, patient outcomes, and related data. This data-driven approach can be instrumental in identifying and mitigating low-value care within their networks.	
1	1.02.1	Carriers are concerned with development and testing timeframe in the event Covered California changes the PLD layout. We respectfully request Covered California add to the first paragraph that the final layout will be provided 6 months before the due date.	Consistent with our current Covered California process, Patient Level Data (PLD) File submission instructions and data template will continue to be provided several months in advance of the submission deadline, and will be subject to Issuer feedback prior to finalizing.	
1	1.02.1	Carriers are concerned with the volume of data in the PLD and necessary development and testing in order to submit complete and accurate data. We request the due date be at a minimum one month following receipt of audited results.	We acknowledge the Issuer's feedback regarding the size and complexity of PLD file submissions. Consistent with our current Covered California process, Patient Level Data (PLD) File submission instructions, templates, and timelines will be discussed several months in advance of the submission due date. As the PLD file is a data source needed to calculate QTI payment amounts using our proposed Health Equity Methodology, we will consider Issuers' feedback and balance the need to provide comprehensive and timely estimates of QTI payments. PLD File submission dates directly impact our ability to provide these estimates to Issuers and to plan for Population Health Investments (PopHIs).	
3	3.05 Preamble	Carriers are concerned with the addition of GenAI in attachment 3.05 and request further collatoration in the development of this section.	Covered California Covered California acknowledges carriers' concerns regarding the inclusion of GenAI in attachment 3.05 and is open to further collaboration and providing support. We value your input and are committed to working together to refine these guidelines, ensuring they are practical and beneficial for all parties involved.	
4	4.01.2 2)	While we recognize the importance of primary care and seeing the same provider, carriers are concerned this may result in unnessary premium increases for members and unnecessary care.	The Continuty of Care measure does not require nor incentivize unnecesary or additional utilization. Only members who have 2 or more visits with any primary care clinician and who are enrolled for the duration of the measurement year will be included in the denominator. Members who do not access primary care services or who receive one visit in a calendar year are not included in this measure. Please refer to detailed specifications for more details. There is a strong evidence base that for those members who have two or more visits with a primary care provider within a year, there are cost-savings impacts of a continuous primary care relationship. The converse has not been found in any published literature.	

Article	Section #	Comment	Covered CA response	
4	4.01.3 1)	To remain consistent with OHCA, we request the following change: ~~Contractor shall follow methodology provided by Covered California.~~	Covered California values your feedback on aligning OHCA's methodology with our draft 2026-2028 QHP contract. Recognizing our shared goals with OHCA, our direct health plan contracting and unique operational framework necessitate a tailored approach. Our efforts aim to balance statewide healthcare intiatives with our specific contractual obligations, ensuring access to quality, affordable healthcare centered on primary care.	
4	4.02.2 1)	To remain consistent with OHCA, we request the following change: ~~Contractor shall follow methodology provided by Covered California using HEI data submitted in accordance with Article 5.02.1.~~ Covered California will review and monitor progress toward OHCA designated benchmarks using HEI data submitted in accordance with Article 5.02.1.	Covered California values your feedback on aligning OHCA's methodology with our draft 2026-2028 QHP contract. Recognizing our shared goals with OHCA, our direct health plan contracting and unique operational framework necessitate a tailored approach. Our efforts aim to balance statewide healthcare intiatives with our specific contractual obligations, ensuring access to quality, affordable healthcare centered on primary care.	
4	4.02.2 2)	To remain consistent with OHCA, we request the following change: ~~Contractor shall follow methodology provided by Covered California.~~	Covered California values your feedback on aligning OHCA's methodology with our draft 2026-2028 QHP contract. Recognizing our shared goals with OHCA, our direct health plan contracting and unique operational framework necessitate a tailored approach. Our efforts aim to balance statewide healthcare intiatives with our specific contractual obligations, ensuring access to quality, affordable healthcare centered on primary care.	
5	5.02.4 1)	Since the Covered California contract pertains to Covered California enrollees we request the following change: 1) Submit ~~all necessary~~ data~~, including supplemental clinical data,~~ for ~~all lines of business~~ Contractor's network to IHA and participate in the IHA Align.	Covered California will continue to require reporting on "all lines of business" for the 2026-2028 QHP contract, consistent with prior contract years. This reporting is necessary for Covered California to fulfill its healthcare oversight activities and to further its commitment to data-driven healthcare reform. This reporting is vital for maintaining transparency, enabling informed decisions among consumers and stakeholders, and aligning with our efforts to promote affordability, quality, and equity in healthcare.	

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3	3.05	Our organization is concerned about the proposed contract language around the use of Generative Artificial Intelligence (GenAI) in QHP operations. Artificial intelligence should not be used to deny or modify heath care services. California law makes that clear, stating that no individual, other than a licensed physician or other licensed health care professional who is competent to evaluate the specific clinical issues may deny, or modify requests for authorization of health care services for an enrollee for reasons of medical necessity. (Health & Safety Code § 1367.01(e).) Therefore, while GenAI may be used to authorize health care services, California law prohibits plans from using such technology to "modify or deny" a request for health care services. As such, we have concerns with language in Attachment 1 implying that use of artificial intelligence to deny or modify requests for care is permissible in California. Section 3.05.3, "Enrolled Transparency," requires a contractor to provide written notice to a Covered California Enrollee when the Patient Care Decision Support Tools impacted a decision to "authorize, modify or deny health care service under the benefit provided by the QHP." In addition, Section 3.05.4, "Reporting Requirements for Use of GenAI," requires contractors to provide Covered California with a report on all instances where GenAI impacts a decision to "authorize, modify or deny health care services." Again, under California law, plans may not use AI or any other automation to modify or deny health care decisions, and nothing in Covered California's contract should imply or state otherwise. Additionally, Section 3.05.4(3) requires a contractor to provide a description of the governance structure established to oversee the use of GenAI when its impacts the decision to authorize, modify or deny health care services under the benefits provided by the QHP. This section should be revised to clarify that this governance structure must include physician review, and that any decisions to deny or modify a request for authorization of health care services based on medical necessity are made by a physician or other licensed health care professional competent to evaluate the specific clinical issues.	Covered California values the input on the application of GenAI in QHP operations and the related contract requirements. We are committed to complying with Health & Safety Code § 1367.01(e), which mandates that licensed professionals must make any decisions to deny or modify healthcare services based on medical necessity. We have carefully revised the language in Section 3.05 of Attachment 1 to accurately mirror the legal requirements and limits outlined in Health & Safety Code § 1367.01(e) concerning the use of GenAI in healthcare decision-making. Covered California's requirements will continue to include "Human in the loop" (HITL) oversight to ensure that decisions involving GenAI are always reviewed by licensed healthcare professionals. Our goal is to ensure our requirements both comply with legal standards and safeguard Enrollees' access to equitable and necessary healthcare. Covered California has also introduced a definition for governance structures to clarify the oversight of GenAI implementation in issuer operations, reinforcing our dedication to responsible and lawful GenAI utilization.	

Article	Section #	Comment	Covered CA response	
4	4.02.2	We strongly opposes the language below incorporating the Office of Health Care Affordability's (OHCA) Alternative Payment Model (APM) adoption goal targets as contractual requirements for health plan issuers, and thus their network providers as outlined in Section 4.02.2 (2). Under this section: Contractor must report on its network payment models using the Health Care Payment Learning and Action Network Alternative Payment Model (HCP LAN APM) categories and associated subcategories of fee for service with no link to quality and value (Category 1), fee for service with a link to quality and value (Category 2), alternative payment models built on a fee for service structure such as shared savings (Category 3), and population-based payment (Category 4). Contractor must report the percent of members attributed to each HCP LAN APM Category by Contractor product annually in alignment with OHCA. Contractor shall follow methodology provided by Covered California. Covered California will review and monitor progress towards OHCA designated benchmarks. SB 184 (Stats. 2022, Ch. 47), the law that established the Office of Health Care Affordability makes the adoption of APMs voluntary. (Health & Safety Code § 127504.) Moreover, all the funding that accompanied the passage of the OHCA law intended to help small and medium size physician practices that wished to consider adopting APMs was swept away during the 2024 budget process. Enrollment in Covered California QHPs is a market with significant churn, which, like the Medi-Cal population, makes it much more challenging for providers to achieve the quality metrics associated with successful performance in an APM. Including the OHCA APM adoption goals into the Covered California model contract as a requirement could inadvertently fuel consolidation in the marketplace and create the very "perverse incentives and unintended consequences" that the underlying OHCA APM statute warns against. (Health & Safety Code § 127504(b)(4).) The OHCA discussions surrounding setting aggressive APM adoption goals that far surpass those of other states, have included an acknowledgment that the goals are voluntary, that there won't be any enforcement of these goals, and that we will learn what is actually attainable over time. However, if Covered California adopts these aggressive goals as requirements in its model contract, health plans could be held to these standards in order to stay in Covered California, which would likely result in moving patients away from smaller, less resourced practices and into larger, consolidated systems and potentially dropping some providers from the network. Additionally, the provider networks of Covered California plans have historically been very narrow, and this could exacerbate concerns about timely access to care. We strongly recommend against incorporating OHCA's APM adoption goals into Covered California's issuer contract in a fashion that results in forcing physician practices to adopt APMs or	Covered California is committed to rebalancing healthcare spending, with a particular emphasis on boosting investment in primary care, as aligned with OHCA benchmarks. This strategic focus aims to enhance quality, equity, and affordability of care for Californians. Acknowledging the historical underfunding of primary care, we support setting benchmarks and targets to elevate investment in advanced primary care models. Such models often utilize alternative payment structures, pivotal for meeting OHCA's APM adoption targets and strengthening our primary care foundation. This effort is crucial for improving access to care. We will track and report progress towards OHCA-designated primary care spending benchmarks. In partnership with stakeholders, we are dedicated to expanding APMs and assessing healthcare expenditures in alignment with OHCA and HCP-LAN. This collaboration underscores our transition towards a value-based care system prioritizing quality and improved health outcomes. Our draft 2026-2028 contract reflects our continued commitment to a phased APM implementation that supports all practices and increases investment in primary care and behavioral health. While this approach is in line with OHCA's intent and our shared objective of advancing high-quality, equitable care for our members, the draft contract does not include requirements for contracted QHP issuers to meet the OHCA APM benchmarks, only to report on progress.	
5	5.2.1	Our organization supports health equity and reducing health disparities for patients. And while it is critically important that patients be screened for prenatal and postpartum depression, quality transformation measures, social needs screening and intervention, and the like, it is critical to ensure that contractors do not design their programs in a way that penalizes physicians for patient non-compliance. We recognize the contract language around plan quality improvement and disparities reduction programs is existing language but believe it is important to consider and address this concern to minimize unintended adverse consequences on QHP networks and patient access.	Covered California holds QHP Issuers accountable for high quality and equitable outcomes for enrollees and expects issuers to work with their provider networks to share data and collaborate and ensure high quality outcomes for members. Covered California's requirements are developed in close alignment with California public purchaser partners with the express purpose of minimizing the burden on providers who may be caring for patients across lines of business.	

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5	5.2.3	Our organization supports Covered California's efforts to ensure patients are receiving quality care in Covered California's plan networks, and that contractors' products meet a minimum performance standard. However, it's also imperative that plans be held accountable and are not simply shifting the risk and responsibility for meeting plan clinical performance standards to providers. We are already seeing this with timely access requirements where some plans, through contract language, are requiring individual physicians to meet timely access standards, even though the legal requirement is for plans to offer provider networks sufficient to foster timely access to care for enrollees. In an effort to prevent plan responsibilities being pushed to providers in yet another setting, we recommend revising the model contract to expressly prohibit contractors from penalizing providers based on enrollee health outcomes that are beyond a provider's control.	Covered California holds QHP Issuers accountable for high quality and equitable outcomes for enrollees and should work with their provider networks to share data and collaborate and ensure high quality outcomes for members. Covered California's requirements are developed in alignment with California public purchaser partners with the express purpose of minimizing the burden on providers who may be caring for patients across LOBs.	