Article	Section #	Comment	Covered CA response
8		Please provide direction to inform how carriers are expected to increase this performance metric over the Baseline Rate. While we understand the importance of continuity of care and the research behind this new performance standard, this is dependent on the provider's office capabilities and resources.We ask that Covered CA reconsider introducing a new a new performance standard with a penalty at risk. Our preference is to remain focused on driving improvements on the QTI measures. Adding additional performance standards will shift resources away from QTI and reduce our ability to remain highly focused on achieving aggressive targets.	Thank you for your comment, and we value your partnership. We remain committed to fostering collaboration and are happy to convene with QHP issuers to discuss and share strategies for improving performance on this metric. We would also expect issuers to work with provider organizations and provider groups, considering how they invest in primary care systems that prioritize and value continuity.
8	a & b	We strongly supports the inclusion of a Continuity of Care baseline threshold as a performance standard. We urge CoveredCA to keep the continuity of care (CoC) index threshold of at least 0.7 for at least 70% of enrollees and not lower the bar to 0.7 for 60% of enrollees. The stated reason at the Plan Management meeting for CoveredCA's change is the new proposed threshold will be more achievable. Of course, a lower standard will be more achievable. One of the Cycle One responders noted that across all plans, 57.9% of all patients have already met the 0.7 level. To improve by another 2.1% seems a very light and weak lift. The higher standard will gain better and more substantive results and outcomes for patients. Continuity of care is extremely important for the chronic care community because higher threshold levels mean more improved patient outcomes, enhanced patient satisfaction, cost effectiveness and better coordination of the care team. An abundance of studies and the Knox-Keene Act, as amended, recognizes the importance of continuity of care. We are glad that CoveredCA recognizes its importance too. But we urge CoveredCA to achieve the higher threshold. We also recognize that achieving a high standard of CoC takes hard work by providers, patients and issuers. During the next 3 contract years, we and our patients and providers are willing to work with issuers and CoveredCA to reach the threshold of 0.7 for at least 70% of enrollees as quickly as possible to create a seamless and efficient healthcare experience for patients. Together, we all can make that happen during these next contract years.	The inclusion of the continuity of care measure in the 2026–2028 contract garnered significant attention and feedback during the first round of comments, leading to our adjustment from 70% to 60%, as noted in your comment. We appreciate your feedback and support for this measure.
7, 8	a & b	Reconsider Introducing New Performance Standards with Penalties – Specifically, CAHP and the QHP carriers strongly recommend Covered California remove the Continuity of Care Index and Primary Care Utilization standards in Attachment 2. Due to several factors, such as the amount at risk for QTI and the introduction of OHCA spending targets, carriers are concerned that they will be unable to allocate resources to significantly impact these new performance standards. Additionally, while we recognize the importance of the CoC Index, this change needs to take place in the provider's office and QHP issuers will have limited ability to influence this measure. If Covered California elects to continue studying these items, we strongly recommend moving them to the Performance 3 penalties for reporting-only with no penalty at risk while further research is conducted. Furthermore, if Covered California keeps these performance standards, we also request the following: • A better understanding of the process leading up to the adjustment in performance level from 70% to 60% of membership. • Assurance that the Contractor will not be penalized if enrollees only want coverage for urgent/emergent/catastrophic circumstances and are otherwise unresponsive to the Contractor and/or their providers. • An opportunity to review the reporting specifications, including index definitions and measurement logic. • A clear acknowledgement of different expectations between EPO/PPO and HMO, considering differences in rates.	Thank you for your feedback on the Continuity of Care (CoC) Index and Primary Care Utilization standards. While we understand resource concerns related to QTI and OHCA spending, these measures are critical to improving outcomes and long-term cost-effectiveness. - The inclusion of the continuity of care measure in the 2026–2028 contract garnered significant attention and feedback during the first round of comments, leading to our adjustment from 70% to 60%. The adjustment from 70% to 60% reflects stakeholder input to balance ambition with feasibility. - We acknowledge the challenges of engaging members who primarily seek urgent or emergency services. Members utilizing urgent or emergency services will still be counted as having received services and will not be categorized as "non-utilizers." - We will work closely with stakeholders to provide detailed reporting specifications, including index definitions and measurement logic. This will ensure a shared understanding and allow for feedback prior to final implementation. - Preliminary analysis shows minimal CoC differences between plan types, supporting equitable expectations across EPO, PPO, and HMO models.
8		Sufficeint time is necessary to evaluate new reporting specification and test. Request reports to evaluate baseline data in HEI meetings. Will Covered Ca be providing interim reports during HEI meetings to evaluate Baseline data callculation?	We acknowledge the need for sufficient time to evaluate the new reporting specifications and baseline data. To support this effort, Covered California will provide a recalculated Continuity of Care (CoC) analysis using Measurement Year (MY) 2023 data. This will help evaluate baseline data.
1		Years ago, under a different presidential emphasis on immigration, there were challenges in obtaining Race and Ethnicity (R/E) data. We are concerned that QHPs may be held accountable if similar challenges resurface during this contract period. We respectfully request that Covered California take this into consideration.	Covered California's threshold requirement has always taken into account the voluntary response rate, which has been consistent over time. We will continue to monitor this closely and remain committed to activities the support informed disclosure of demographic data by our members. Thank you for sharing this concern.
1		To help us improve health equity, we propose that Race and Ethnicity (R/E) data be collected at the time of enrollment and that it be a mandatory field on the application with an option to decline to state. Making R/E data collection a requirement, while allowing the option to decline to state, will significantly enhance our ability to address health disparities and ensure equitable care for all enrollees.	Covered California recognizes the efficiency of collecting applicant data during the application process and we infer from our consistently high voluntary response rates our members feel comfortable disclosing this information as part of that process. However, the application process is not intended to be the only avenue for QHP issuers to gather information about their enrollees.

7		We have a concern that if a contractor fails to meet the 5% target in 2027 or the 10% target in 2028 but can demonstrate substantial efforts were made to engage non-compliant members, those efforts should be taken into consideration when determining whether the contractor will be subject to penalties. Contractors should not be penalized if individuals only seek coverage for urgent, emergent, or catastrophic circumstances and remain completely unresponsive to outreach by the contractor and/or their providers. Covered California's response: Population health and ensuring utilization of preventive care for enrollees are part of the expectations for all issuers on Covered California. Follow-up: We continue to be concerned on this response. While we understand and appreciate the focus on population health and preventive care, it is crucial to recognize the challenges associated with engaging members who are unresponsive to outreach efforts. We request a more nuanced approach that considers documented engagement efforts and the realities of member behavior when assessing penalties.	We appreciate your feedback and recognize the challenges associated with engaging members who may be unresponsive to outreach efforts. The targets for 2027 and 2028 are designed to measure relative improvement from each contractor's established baseline, focusing on driving incremental progress over time rather than achieving a universal benchmark. For Measurement Year (MY) 2026, contractors are required to report baseline data, and no penalties will be applied. Please note that members who only seek urgent care services will count toward the overall utilization metric. Only members with zero utilization—meaning no flu shot, urgent care, medication use, telemedicine, or primary care visits—and who have been enrolled for 12+ months, will be categorized as non-utilizers.
7		We continue to be concerned with this as a Performance Standard. While Covered California aims to decrease costs to the healthcare system, consumers may feel pressured to have more visits, especially with carriers pushing this Performance Standard. Although Covered California is not requiring more primary care visits beyond a member's clinical care needs, increased utilization under Performance Standard 7 will result in higher claims expenses, ultimately leading to increased premiums. We request that this Performance Standard be removed. We are committed to partnering with Covered California to appropriately increase primary care visits without imposing unnecessary burdens on members or carriers.	Increased utilization under Performance Standard 7 encompasses various forms of preventive and primary care engagement, not solely primary care visits. This approach supports improved health outcomes without imposing unnecessary burdens on members or carriers. Covered California remains committed to collaborating with partners to achieve these goals effectively.
7 & 8		We continue to have concerns with these requirements, including the difficulties in enforcing them. Additionally, we are concerned about the potential for carriers to increase premiums or drop out of the exchange due to penalties. These points highlight significant challenges and potential negative consequences of the current approach. We urge a reconsideration of how accountability is managed to ensure that both members and carriers can contribute effectively to the goals of population health without placing an undue burden on either party.	There is a robust evidence basis for reductions in total healthcare costs as a result of primary care utilization in the setting of a highly continuous relationship. Covered California has presented this evidence base as part of our contract development and stakeholder engagement processes. In response to Issuer feedback, we have lowered the 70% threshold to 60% to support feasibility of implementing this Performance Standard. Covered California expects Issuers to work with provider groups and ensure that primary care investment is done in a way that supports high quality and relationship-based primary care.