Performance Standard	Section #	Comment	Covered CA Response
8		We advocate for the use of existing measures with established benchmarks to measure the effectiveness of primary care through quality outcomes measures, such as those set by NCQA. Participation in developing and reporting novel metrics requires additional administrative support and oversight on the part of the plan, and effective participation in these collaboratives requires clinician engagement in addition to administrative support. In light of this, the development and measurement of new group specific benchmarks and improvement targets should be 1) developed in collaboration with the plan, and 2) kept to a minimum to allow for continued focus on ongoing quality improvement efforts.	We agree that collaboration with plans is important for any new measure development. The Continuity of Care measure is not a new measure, but rather is validated. Covered California will be using the NQF-endorsed specifications developed by ABFM, ensuring a strong evidence base with minimal administrative burden.
3	3	Please clarify how the denominator will be defined to assess 80% participation. Will QHPs be provided with a calendar of events at the beginning of each year?	The expectation is for Issuers to collaborate with Covered California and other community entities. The goal will be to have a quarterly set of activities that will meet this performance standard available.
4	4	Attachment 1, Article 1.02.1 is related to the submission of PLD files, which was previously removed from Attachment 2. We recommend removing this reference. Please also provide the updated HEI scoring methodology document for review, to align with the consolidated Attachment 2 Performance Standard.	The PLD file, if not submitted timely and completely, may be subject to financial accountability. Because it plays an increasingly critical role in our ability to assess QTI performance and implement our Health Equity methodology, we will establish timeliness, completeness, and reasonableness criteria to assess Issuer submissions. Attachment 2 PS 4 HEI Scoring methodology is under development for 2026-2028. We will share the assessment methodology when it is available for feedback from Issuers.
5 & 6	5 & 6	We recommend the removal of the MY 2027 and 2028 proposed increase over baseline until a baseline can be established in order to identify what is appropriate. Please note, the 2025 Contract requires a 10% increase over the 2024 baseline. Will this requirement be waived? Will these performance standards continue to be evaluated using HEI data?	The MY2027 and 2028 increases will not be removed at this time but may be amended in the future if apporpriate. We do not anticipate waiving the 2025 performance standard.

Performance Standard	Section #	Comment	Covered CA Response
7 & 8	7 & 8	We recommend requiring reporting only on the Utilization and Primary Care Performance Standards in order to further research on utilization and PCP continuity of care trending over time and identify findings that correlate to quality of care. We believe this is needed 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. In order to provide feedback on the reporting requirements, we will need to see the reporting specs including index, measurement definition, and logic.	The methodology for measuring continuity is consistent across product types. Our investigation using HEI data demonstrated only small differences in continuity between HMO and PPO plans, as presented at the May Contract Workgroup meeting. We agree with issuer's recommendation to focus on reporting only for the Utilization and Primary Care Performance Standards. This approach will allow for further research into utilization trends and primary care physician (PCP) continuity over time, helping to identify findings that correlate with the quality of care. Before introducing benchmarks and improvement targets into the QHP Contract, it is essential to analyze this data. EQT will utilize HEI data along with the standard measure specifications to assess and generate plan-level continuity metrics for discussion with the issuers. To provide effective feedback on the reporting requirements, we would need to review the reporting specifications, including index definitions and measurement logic.
1	Reducing Health Disparities: Demographic Data Collection – Enrollee Race and Ethnicity Self-Identification –	Pages 6-8: Our organization Accreditation team suggests a revision to include the following within the statement - **Exception for factors 2 and 3 to read:** Factors 2 and 3 are Not Applicable (N/A) if the organization has direct data on the race/ethnicity of 80% or more of individuals. 80% may be cumulative of each race and ethnicity. The organization is not required to have 80% of each to be eligible for the exception. For example, an organization is eligible for an exception if it has race data on 90% of its population, but only has ethnicity data on 70% of its population. The organization may meet the 80% threshold at any point during the look-book to qualify for this exception.	Thank you for your recommendation.
8		Plans need significant lead time to build and test reporting systems and ensure accurate reporting. Please confirm when Covered CA will be releasing information for QHPs to start building reporting processes.	EQT will use HEI data and the standard measure specifications to measure and produce plan-level continuity for discussion with the Issuers.
Preamble/Introduction	Preamble/Introduction	We respectively request the 2nd to last paragraph add the statement "Reporting that falls on a weekend and/or holiday will be due the first Covered California business day following the weekend/holiday." Historically reporting that falls on weekends or holidays has been due the next business day. We would like that confirmed in the contract please.	If scheduled date falls on a weekend and/or holiday, Covered California will communicate an adjustment of schedule in advance.

Performance Standard	Section #	Comment	Covered CA Response
Preamble/Introduction	Preamble/Introduction	While we recognize the positive intent by Covered California with the language of directing carriers to pay other entities this creates confusion and administrative challenges. We recommend that if Covered California seeks to contract with such entities that Covered California receives all funds directly and pays the entities as their contracted entity/vendor. We respectfully request the following change: ". ~~, or, if directed by Covered California, to an alternative entity that Covered California determines is able to support improvement on Performance Standard and Contractor's quality performance identified on the invoice~~."	The language will remain to allow flexibility in utilization of Performance Standard penalties. Prior to requiring payment to an alternative entity, Covered California will engage directly with issuer to ensure no undue administrative burden or barriers.
Preamble/Introduction	Preamble/Introduction	We respectively request the following change "Contractor shall monitor and track its performance ~~each month~~ against the Performance Standards and, as requested, provide Covered California with a detailed ~~Monthly~~ Performance Report in a mutually-agreeable format." Some Performance Standards may not be as effective in monitoring monthly. This change continues to ensure QHPs are monitoring their own performance.	Issuer will not be asked to submit a monthly report for any Performance Standard where that cadence of reporting is inapplicable.
1	a)	a) states to "See separate methodology document" Please provide a copy of that document for 2026-2028.	Covered California will share the methodology documents once finalized.
1	a)	We respectfully request that Covered California consider "decline to state" or "asked but not answered" as valid and acceptable values.	Covered California will continue to accept "decline to state" or "asked but not answered" as valid responses but will not consider them acceptable for the purposes of assessing comepleteness of member self-identified race and ethnicity information.
1	b)	As our comment states for Attachment 1, we respectfully request the removal of 1.01.2 1.b). If removed, the b) Alternate Standard is no longer necessary.	New entrants will have an alternate standard in their first contracted year, consistent with Covered California practice.
2		a) states to "See separate methodology document" Please provide a copy of that document for 2026-2028.	Covered California will share the methodology documents once finalized.
2	a)	Please clarify what the percent expectation is for this standard. Please advise if this is 80% like Standard 1. a).	Covered California will work with plans to establish improvement targets before setting a universal threshold for this standard.
2	b)	As our comment states for Attachment 1, we respectfully request the removal of 1.01.2 2.b). If removed, the b) Alternate Standard is no longer necessary.	New entrants will have an alternate standard in their first measurement year, consistent with Covered California practice..
3	a)	Please advise how is "engage" to be evaluated.	Issuer will be evaluated based on attendance and must have a representative from the appropriate team attend the meeting based on the subject matter covered during the meeting or event.

Performance Standard	Section #	Comment	Covered CA Response
3	a)	Please advise if Covered California will proactively tell carriers ahead of such activities that they will count towards the 80% to ensure Covered California and Contractors are tracking the same events.	The expectation is for Issuers to collaborate with Covered California and other community entities. No advanced calendar will be provided as events are fluid from both Covered California and Issuers may host its own events.
4	a)	Please clarify a) to read "… Full and Regular submissions of Enrollee data..." This agreement is specific to Covered California and therefore penalties should be limited to Enrollee data and not off-exchange data that needs to be submitted due to AB929.	In order to comply with AB 929, Covered California requires full and regular submission of on and off-exchange data.
5	a)	We respectfully request clarity regarding the 10% increase in 2027 and 15% in 2028. Using 2027 as an example, if baseline is 50% does that mean it is 55% or 60%?	The contractor shall Establish a Baseline and meet or exceed the specified performance standard. If the contractor's baseline rate is 50%, the 2027 performance level would need to be 55% (10% increase) to avoid the penalty.
5 - 6	Pediatric Dental	According to the 2026 the baseline rate will be determined in 2026. According to the 2025 amendment, the baseline rate will be determined in 2024. Please clarify.	These are two distinct contract terms, each of which requires setting a baseline in the first year.
6	a)	We respectfully request clarity regarding the 10% increase in 2027 and 15% in 2028. Using 2027 as an example, if baseline is 50% does that mean it is 55% or 60%?	The contractor shall Establish a Baseline and meet or exceed the specified performance standard. If the contractor's baseline rate is 50%, the 2027 performance level would need to be 55% (10% increase) to avoid the penalty.
7	a)	Standard 7 references 4.01.2 of Attachment 1. There is no corresponding requirement in Attachment 1 Since there is not such requirement in Attachment 1, we request this Performance Standard be removed. We will partner with Covered California to appropriately increase Primary Care visits.	In response to your comment, we have added corresponding language to Attachment 1 to clarify the requirements associated with this Performance Standard.
7	a)	We are concerned with this as a Performance Standard. While Covered California wants to decrease costs to the health care system, consumers may feel the need to have such visits with carriers pushing this since a Performance Standard. This increased utilization will result in higher claims expenses resulting in increased premiums. We request this Performance Standard be removed. We will partner with Covered California to appropriately increase Primary Care visits.	Please note that we are not requiring more primary care visits beyond a member's clinical care needs. Performance Standard 7, overall non-utilization, looks at all claims and encounters, regardless of type, for members with 12+ months of continuous enrollment. It includes any prescription, vaccine, screening, or other services submitted, and is not limited to primary care claims.

Performance Standard	Section #	Comment	Covered CA Response
7	a)	We are concerned with unintended member financial consequences (in addition to higher premium rates). Members that are being pushed for visits may be obtaining care they did not feel they had the need for. The visit they are seen for will likely include costs they were not planning for in the way of copay/coinsurance/deductible. In addition, they may have lab and x-rays they also weren't planning on having an out of pocket for. We request this performance standard be removed.	Please note that we are not requiring more primary care visits beyond a member's clinical care needs. In the context of Performance Standard 7,overall non-utilization: This measure looks at all claims and encounters, regardless of type, for members with 12+ months of continuous enrollment. It includes any prescription, vaccine, screening, or other services submitted, and is not limited to primary care claims.
7	a)	If this Standard is not removed, we request clarity regarding the 5% increase in 2027 and 10% in 2028. Using 2027 as an example, if baseline is 50% does that mean it is 52.5% or 55%?	A 5% increase in 2027 from a baseline of 50% means the target would be 52.5%, reflecting a relative improvement based on the original value, not absolute percentage point increase.
7	a)	If this Standard is not removed, please clarify to state "at least twelve months" and that these are for "claim/encounter".	In the context of Performance Standard 7,overall non-utilization: This measure looks at all claims and encounters (HEI data), regardless of type, for members with 12+ months of continuous enrollment.
7	a)	If this Standard is not removed, if a contract fails to meet the 5% in 2027 or 10% in 2028 but can demonstrate efforts were made to non-compliant members, we request that those efforts be taken into consideration whether Contractor will be subject to the penalty or not. If people only want the coverage for urgent/emergent/catastrophic circumstances and are completely unresponsive by Contractor and/or their providers, we request Contractor not be penalized for that.	Population health and ensuring utilization of preventive care for enrollees is part of the expectation for all issuers on Covered California.
8	a)	Consider whether the second paragraph should be clarified to include establishing a baseline, reviews the Baseline Rate, and (a)…	We have revised the contract language for clarity and lowered the threshold from 70% to specify that if less than 60% of enrollees have a Continuity of Care (CoC) index of 0.7 or higher, contractors will be required to report their planned improvement activities. The data collected during this period will guide future evaluations, with MY2028 being the first year we consider potential improvement targets.

Performance Standard	Section #	Comment	Covered CA Response
8	a) b)	We strongly support the inclusion of Continuity of Care as a performance standard, and we believe the pathway outlined over the three-year measurement window is not only achievable but essential, particularly given the powerful impact continuous patient-physician relationships have on health and cost of care. As we understand it, in the first (2026) Measurement Year, QHPs would simply establish a baseline, and if that baseline is greater than the threshold set by Covered California, there is no penalty. For QHPs who do not meet the baseline threshold, the QHP would report to Covered California on planned improvement activities to avoid any penalty. For Measurement Year 2027, the QHP would implement the planned improvement activities and avoid the penalty, and for the final Measurement Year 2028, the QHP would either meet the threshold or improve their performance by just 10% over Baseline to again avoid a penalty. This approach seems very reasonable, and we believe it will appropriately incentivize QHPs and their primary care providers to prioritize continuous patient-physician relationships. **Continuity of Care Measure Description** ABFM's continuity of care (COC) measure has two dimensions, the first is the patient-level Bice-Boxerman Continuity of Care (BB-COC) index, ranging from 0.0 to 1.0, with larger values indicating greater continuity of care. The ABFM currently utilizes 0.7 as the threshold score for high continuity of care, meaning that each patient with an index of 0.7 (or higher) is counted as part of the measure's numerator. The second dimension is the percentage of patients having a high BB-COC, computed at the measurement unit level, the health plan in this case. We encourage Covered California to clearly specify both the BB-COC index score for what constitutes a high continuity of care at the patient level (the ABFM uses 0.7), as well as the minimum percent of patients with high BB-COC a health plan must have to meet the implementing entity's performance goals. •Index Score. The first dimension is a **patient-level index score** based on the Bice Boxerman Index (BBI) measuring how dispersed a patient's care is across multiple providers. The BBI ranges from 0.0 to 1.0, with higher BBI values indicating higher continuity of care among fewer providers. The ABFM currently utilizes 0.7 as the threshold score for high continuity of care, meaning that each patient with an index of 0.7 (or higher) is counted as part of the measure's	We appreciate your support for the proposed pathway and the importance of continuous patient-physician relationships. We would like to confirm that the contract includes a requirement for QHP issuers to report on their planned improvement activities if they do not meet the baseline threshold.
		· The table shows how both dimensions relate to each other. Using 2021 data from a state all-payer claims database, the percent of patients meeting the BB-COC index of 0.7 (high continuity of care), varied by plan type. Across all plans 57.9% of all patients had a BB-COC of 0.7 or above. Commercial HMO plans had the smallest percentage of patients with high BB-COC (46.3%), compared with Medicare Advantage HMO plans which had the highest percentage (64.0%).	
		Again, we commend Covered California's commitment to quality of care and are happy to provide additional assistance as you implement this important measure.	

Performance Standard	Section #	Comment	Covered CA Response
3	a)	Can Covered CA be more specific regarding the requirements/deliverable/timelines expected with the collaborations	The expectation is for Issuers to collaborate with Covered California and other community entities. The goal will be to have a quarterly set of activities that will meet this performance standard available.
8		**Monitoring Continuity of Care** - We respectfully request Covered California remove this as a Performance Standard. This is newly introduced. Covered California has not yet shared information on where carriers are, and there are many complexities that need to be worked through first. We recommend for the 2026-2028 term this be something we are working towards, and we encourage a reporting-only period while further research is done. At a minimum, we ask that Covered California remove the improvement targets for future years, as it is premature to include those at this juncture. In addition, different products will have different rates. For example, PPO/EPO products will likely have significantly lower rates than HMO products since members can go to any provider they want in the PPO/EPO product. Consumers value this flexibility. We are also concerned that visits to two different primary care clinicians in the same office/group may not be counted as one primary care clinician when the relationship is maintained at the office/group. Additionally, we support any discussions around process that may allow Covered California to use HEI data to conduct further research vs. adding the PG requirement, considering the high volume of report requests that carriers are handling using existing (and often limited) resources.	To clarify, rates of continuity based on current HEI data are similar between HMO and PPO plans. While this measure is NQF-endorsed and part of the PQM measures list, we agree that for MY2026 and MY2027, it will remain in a reporting-focused phase as plans establish their baselines. We will be using the NQF-endorsed specifications, developed and supported by the measure steward (ABFM), which underpins the research and evidence base for this measure. As noted in Attachment 2, if less than 60% of enrollees have a Continuity of Care (CoC) index of 0.7 or higher, contractors will be required to report their planned improvement activities. The data collected during this period will guide future evaluations, with MY2028 being the first year we consider potential improvement targets.
4	a)	Clarify a) to read "… Full and Regular submissions of Covered California Enrollee data..." This contract is specific to Covered California and therefore penalties should be limited to Enrollee data and not off-exchange data that needs to be submitted due to AB929.	In order to comply with AB 929, Covered California requires full and regular submission of on and off-exchange data.
7	a)	Standard 7 references 4.01.2 of Attachment 1. There is no corresponding requirement in Attachment 1. We request this Performance Standard be removed.	In response to your comment, we have added corresponding language to Attachment 1 to clarify the requirements associated with this Performance Standard.
7	a)	We are concerned about unintended member financial consequences, such as higher premium rates. We request this performance standard be removed. Additionally, we support any discussions around process that may allow Covered California to use HEI data to conduct further research vs. adding the PG requirement, considering the high volume of report requests that carriers are handling using existing (and often limited) resources.	Thank you for your concerns. We want to clarify that Covered California is not requiring additional primary care visits. This measure examines all claims and encounters of any type for members with 12 or more months of continuous enrollment. This includes any prescriptions, vaccines, screenings, or services submitted, and is not specific to primary care claims.