Article	Section #	Comment	Covered CA Response
5	5.2.2 a)	As 0.2% was carved out for the premium at risk for performance guarantees the amount at risk for QTI is reduced by that amount. The 2026 at risk amount should be 2.8% rather than 3% and 2027 should be 3.8% rather than 4%.	Per Section 5.2.2, the total amount at risk for PY 2026 is 3%, as it collectively includes both the Attachment 2 performance standards (0.2%) and the Attachment 4 QTI (2.8%).
4	4.3.4 d)	We would like to see a list of these types of providers in order to determine if they could be contracted with and to provide more feedback.	As part of its ECP analytic work, Covered California is preparing and will publicly release for review purposes a list of ECPs based on the proposed definitions and standards.
4	4.3.4 e)	We would like to receive an updated ECP list twice per calendar year to remain up to date.	Preparing the annual ECP list twice per year is not operationally feasible and the production of multiple lists in the same year would complicate compliance activities for both contracted QHP issuers and Covered California with the introduction of a "moving target".
4	4.3.4 b) ii) 1)	Please clarify or further define how the “nature and type… of Contractor’s ECP contracting arrangements” will be measured or reviewed.	Covered California's intention is to identify outlier payment or contracting patterns specific to ECPs. We will look to existing data sources and mechanisms first to establish this review.
4	4.3.6	We recommend removing the new requirements for the implementation of an access-monitoring strategy, assessment and data submission obligation. We are already required to meet the standards set by the DMHC and this may be duplicative. Please also clarify how Covered California would set targets for improvement plans. Please clarify if Covered California intends to launch a secret shopper survey for providers or members. Assuming that the secret shopper survey would be provider focused, this may be duplicative and create survey fatigue. Issuers are already required by the DMHC to administer provider appointment availability surveys. Additionally, there is often network overlap between lines of business and these providers may already be receiving these surveys from DHCS and CalPERS.	The proposed access monitoring strategy will not be removed. Covered California will work closely with regulators and other public purchasers to ensure monitoring and any secret shopper surveys are conducted in alignment with applicable regulations and approaches taken by other purchasers.

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5	5.2.2 a)	We recommend resetting the QTI and Attachment 2 penalties back to a total of 1% (0.8% for QTI and 0.2% for Attachment 2) for the 2026 Contract year penalty amount in order to allow time for QTI measure stratification, measure changes and new benchmark outcomes to be reported and observed before setting penalty increases for future years. We also recommend setting the total maximum penalty at no more than 3% over the 2026-2028 Contract period to allow a steady and reasonable 1% total increase over each calendar year.	The amount at risk for MY2026 will be up to 2.8% of premium, recognizing the importance of reducing disparities and emphasizing that quality cannot exist without equity. It is important to note that when the program was developed, the intent was always to stratify and increase the amount at risk by 1% each year. This current amount reflects a compromise, as an increase to 3.8% in 2026 was initially proposed in the development of the QTI.
5	5.2.2 a) iv)	We do not recommend reducing penalties for new entrants. The QTI program requires significant plan investments, and all participants should have the same set of requirements and metrics.	New entrants have two years per CMS before their QRS scores are reportable and Covered California has aligned with CMS by making new QHP issuers eligible for QTI after an initial two years on the exchange. New QHP issuers will be given a ramp up period with a lower amount at risk just as currently contracted issuers have been provided the same opportunity.
5	5.2.3	It makes sense to maintain alignment with QRS clinical measures once benchmarks are available for 25-2-2. However, new measures should have at least one year of reporting only after a benchmark is established to allow plans to understand the targets that need to be met and set appropriate action plans.	Covered California acknowledges the importance of clarity on the QRS measures' first-year reporting and confirms that 2026 quality results for the 25/2/2 program will be evaluated using MY2026 QRS results against MY2024 static benchmarks, ensuring the use of recent data for accurate performance assessment. Covered California is committed to remaining aligned with the QRS program. Covered California remains committed to providing timely updates and guidance to contracted QHP issuers on QRS reporting requirements and encourages ongoing dialogue with the Equity and Quality Transformation (EQT) team for any concerns or questions.
5	5.2.4	We do not think it is necessary to add the MPL requirement to the 25-2-2 program. The 25th percentile composite rate and the QTI measure percentile goals already provide incentive for QHPs to invest time and funding to make improvements on all QRS measures. Updates on the 25-2-2 measures that are underperforming are already being reported in the SABR meetings. We requests additional information on the expectation around collaborative participation in this section. Quality collaboratives are more relevant to the QTI via PopHI investments, and to other contractual requirements (e.g. hospital quality and patient safety).	Covered California has revised the proposed language to emphasize the potential use of MPL Action Plans to address clinically significant measures persistently scoring below the 25th percentile.

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5	5.2.1 f)	Request to clarify the definition of the term "nondiscriminatory" in this section. (i.e. is it intended to mean equally open to all similarly-situated persons?)	Thank you for your comment. You are correct. Under Section 1557 of the ACA "prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities." All individuals who are eligible and "similarly situated should not be denied access to take part in an incentive program for the reasons listed above.
5	5.2.2 a)	Will Covered California be considering the financial performance of the plan overall to determine whether a fine needs to be issued as to not compound negative financial performance? Also may need exceptions for small plans not offering COCA across broad swaths of the state counties, especially those offering in a few Counties that are known to have high cost providers and healthy members.	Payment obligations for quality and health equity performance are based on the specified accountability programs.
4	4.3.4 b) ii)	We have experienced situations in the past where as a Contractor we have reached out to an ECP on Covered California's list attempting to have them become part of our network but they refuse. We respectfully request that when Covered California considers provider sufficiency that it removes ECPs from the denominator count that Contractor can demonstrate they made a good faith effort to contract with, however, ECP does not want to contract with the Contractor.	This change will not be made. Covered California expects the updated Essential Community Provider definitions to offer more flexibility for QHP issuers to meet those standards.
4	4.3.4 b) ii)	The ECP list has historically included providers that we cannot contract with, for example, free clinics. We respectfully request that when Covered California considers provider sufficiency that it removes ECPs from the denominator count that cannot be contracted with.	This change will not be made. Covered California expects the updated Essential Community Provider definitions to offer more flexibility for QHP issuers to meet those standards.
4	4.3.4 e)	While we recognize that the list may not be a complete list that is published, we request that Covered California clarifies that this is the list that will be used for comparative purposes and remove "non-exhaustive". We also request that Covered California's list will include an NPI for all ECPs included in the denominator.	Covered California is investigating inclusion of NPIs in the ECP list.
5	5.2.2 a)	The Gross Premium at risk is not consistent with Attachment 4. To prevent confusion consider directing to Attachment 4. We request the QTI amount begin at 0.8% for 2026.	The amount at risk for MY2026 will be up to 2.8% of premium, recognizing the importance of reducing disparities and emphasizing that quality cannot exist without equity. It is important to note that when the program was developed, the intent was always to stratify and increase the amount at risk by 1% each year. This current amount reflects a compromise, as we are not increasing it to 3.8% in 2026, which was a possibility.

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5	5.2.4 b)	We recognize the importance of being above the 25th percentile, however, respectfully request that the individual measures which may be subject to the quality improvement plans be reduced.	Covered California has revised the proposed language to emphasize the potential use of MPL Action Plans to address clinically significant measures persistently scoring below the 25th percentile.
5	5.2.4 b)	Please confirm that 25-2-2 does not apply to subpopulations.	Confirmed.
4	4.3.4	4.3.4 Essential Community Providers (updates throughout) **Recommendation:** We are having a difficult time understanding the requirements/process for requesting and complying under the Alternate Standards. Recommend working sessions to develop the process the alternate standard process.	Covered California is happy to host additional ECP sessions.

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5	5.2.2	5.2.2 Payment Obligations for Quality and Health Equity Performance - iv. Contractors newly participating with Covered California **may be subject to reduced payment obligations** during their first years, as specified in Attachment 2 – Performance Standards with Penalties and Attachment 4 – Quality Transformation Initiative. **Recommendation:** We could not find the amount that new entrants would be subject to under Attachment 4, however, we do not believe that new entrants should be advantaged by starting at 1%, when existing QHPs have a higher rate (3% or 4% depending on the year). Given the pivot and inherent uncertainty with the new methodology used for PY2026, recommend that the QTI/Performance Standards 2026 max payment obligation be set at 2% for new and existing QHPs (increasing to 3% for 2027 and 4% for 2028). 5.2.2 ii. text reads "For Measurement Year 2026: no more than 4%" - this should state "For Measurement Year 2027: no more than 4%"	New entrants have two years per CMS before their QRS scores are reportable and Covered California has aligned with CMS by making new QHP issuers eligible for QTI after their initial two years on the exchange. New QHP issuers will be given a ramp up period with a lower amount at risk just as currently contracted issuers have been provided the same opportunity. Thank you for bringing the correction needed to our attention.
5	5.2.3	5.2.3 Removal from the Covered California **Recommendation**: In order to align with DMHC and ensure efficiency Covered California focus should be on the 12 DMHC quality measures not all QRS measures for the 25-2-2 program. Those 12 measures are Colorectal Cancer Screening, Breast Cancer Screening, Hemoglobin A1c Control for Patients with Diabetes, Controlling High Blood Pressure, Asthma Medication Ratio, Depression Screening and Follow-up for Adolescents and Adults, Prenatal and Postpartum Care, Childhood Immunizations Status, Well-Child Visits in the First 30 Months of Life, Child and Adolescent Well-Child Visits, Plan All-Cause Readmissions, and Immunizations for Adolesecents.	Covered California appreciates the suggestion regarding alignment with the Department of Managed Health Care (DMHC) on quality and equity measures. Covered California's commitment to quality improvement is demonstrated through the 25/2/2 program, which uses QRS measures and benchmarks performance at the 25th percentile. This program, already in effect since the 2023 contract, utilizes established QRS measures required for all QHP Issuers.
5	5.2.4	5.2.4 Quality Improvement Plan **Recommendation:** In order to align with DMHC and ensure efficiency Covered California focus should be on the 12 DMHC quality measures not all QRS measures for the 25-2-2 program. Those 12 measures are Colorectal Cancer Screening, Breast Cancer Screening, Hemoglobin A1c Control for Patients with Diabetes, Controlling High Blood Pressure, Asthma Medication Ratio, Depression Screening and Follow-up for Adolescents and Adults, Prenatal and Postpartum Care, Childhood Immunizations Status, Well-Child Visits in the First 30 Months of Life, Child and Adolescent Well-Child Visits, Plan All-Cause Readmissions, and Immunizations for Adolesecents.	Covered California has revised the proposed language to emphasize the potential use of MPL Action Plans to address clinically significant measures persistently scoring below the 25th percentile. There is significant overlap between the QRS Getting Right Care measures and the DMHC quality and equity measures. Covered California will continue to use the QRS Getting the Right Care measures for the 25/2/2 program.

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4	4.3.4 ECP	We appreciate Covered CA reaching out to stakeholders, including consumer advocates, for our thoughts on how to revise Cov. CA's ECP standards so they more meaningfully achieve their stated aim of reaching Cov. CA's most vulnerable enrollees. We do not recall Covered CA staff reaching back out to advocates to share its final direction and would appreciate a briefing before the contract is finalized. We do appreciate the broader definition of ECPs to include FQHCs, CHCs, HCAI's CBO Behavioral health workforce grant program, primary care and behavioral health providers located in quartiles 1 and 2 of the CA Healthy Places Index. We would appreciate more information as to how these new standards align with Covered CA's Equity Practice Transformaton initiative. Additionally, we urge Covered CA to consider including as part of the ECP definition providers in Q3/Q4 that already serve a large proportion of Medi-Cal and vulnerable Covered CA members. We would also appreciate greater details on how Covered CA plans to enforce these standards in order to ensure contractors are contracting with providers in these critical ECPs.	Covered California is happy to host additional ECP sessions and discussion of recommendations.
4	4.3.6	We appreciate the new access monitoring contract requirements that will include analysis of CMS' QRS program, provider directory and HEI as well as potential secret shopper surveys. Measuring and establihsing benchmarks for Covered CA enrollee experience and outcomes, provider availablity and accessibility, and service utilization and quality are critical to ensuring contractors are meeting the needs of the Covered CA enrollees.	Thank you for your support.
4	4.3.4	In regards to the requirement, "Primary care and behavioral health providers located in quartiles 1 and 2 of the California Healthy Places Index." Providers in HPI quartiles 1 and 2 - Interestingly, per the HPI map, although the majority of San Francisco and San Mateo County neighborhoods are largely considered healthy, there are a small concentration of neighborhoods in the less healthy percentiles. How is Covered CA planning to use this tool? Per CMS, none of the zip codes were considered HPSA but were considered less healthy on the HPI map. We would be interested on how HPSA and HPI mapping would be integrated in refining how the ECP requirement should be evaluated.	Covered California's current proposal is to recognize primary care and behavioral health providers practicing in a Healthy Places Index Quartile 1 or 2 geographic location as Essential Community Providers.
4	4.3.6	Regarding the secret shopper surveys, please clarify what criteria is Covered CA planning to evaluate.	This definition refers to the specified provider types practicing in a Healthy Places Index Quartile 1 or 2 geographic location.

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5	5.2.4 b)	We recognize the importance of being above the 25th percentile, however, respectfully request that the individual measures which may be subject to the quality improvement plans be limited.	Covered California has revised the proposed language to emphasize the potential use of MPL Action Plans to address clinically significant measures persistently scoring below the 25th percentile.
4	4.3.4	The general Essential Community Providers (ECP) standard in proposed Section 4.3.4(b) provides that a contractor shall maintain its provider network with a "sufficient number and sufficient geographic distribution of ECPs." Subparagraph (b)(ii)(3) of that section goes on to say that Covered California shall determine whether a contractor provided sufficient geographic distribution of care based on a number of factors including, "the extent to which the providers in the Contractor's network are "accessible" to and provide services that "meet the needs" of the low-income and medically underserved populations. This language establishes a vague standard that can be met by any number of providers or geographic distribution at Covered California' discretion. This is concerning for medical services but is also particularly concerning for mental and behavioral health care given the increased need for mental/behavioral health services since the COVID-19 pandemic, and the persisting shortage of behavioral health providers. There is a pressing need to invest in the state's behavioral health workforce to expand the number of providers in the state. CMA urges Covered California to provide greater clarity and a definition of "sufficient" to ensure QHP ECP provider networks provide reasonable and timely access to covered services for low-income and medically underserved populations.	Covered California's development of updated ECP standards are guided by a commitment to ensuring access for underserved populations. Updated proposals for sufficiency thresholds will be provided in future ECP discussions and final proposed contract language.
1	1.10 Nondiscrimination	We urge Covered CA to ensure revised contract language reflects the April 26, 2024 Section 1557 final rule which recognizes the growing importance of telehealth and patient care decision support tools in the health care marketplace —including artificial intelligence and machine learning— and applies nondiscrimination protections to the use of these technologies and recognizes that protections against discrimination on the basis of sex include sexual orientation and gender identity, consistent with the U.S. Supreme Court's holding in Bostock v. Clayton County.	Covered California explicitly references requirements for patient care decision support tools as amended by the Section 1557 Final Rule cited by commenter in Section 3.05 of Attachment 1. QHP issuers are also required by federal law and existing contractual language at Section 1.10 to comply with nondiscrimination protections in Section 1557 and its implementing regulations. Therefore, no changes will be made.

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4	4.3.4 c)	4.3.4 (c): It's not clear what they are requiring for contractors that qualify under the alternate ECP standard (which SHP has typically qualified for). Can you ask for clarification on the expectations here?	Additional clarification will be provided in future ECP discussions and final proposed contract language. Covered California is not proposing substantive revisions to the alternate standards requirements at this time.