Commenter *Names have been randomized*	Commenter Question/Feedback/Request
Issuer E	Collaboration and Issuer discussion required in advance of implementing contract requirements
Issuer E	Issuer E is in varying stages of AI evaluation
Issuer E	Adequate time is required to evaluate effectiveness of AI solutions prior to implementation
Issuer E	Administrative Services /Vendor Agreements are required to be filed with DMHC
Issuer E	Clear criteria required to understand applicable member disclosure activities
Issuer E	Technical specifications are required to evaluate new proposed reporting requirements and assess development lead times
Issuer E	Plans require autonomy regarding governance approach
Issuer E	HEDIS data intervention work already includes vendor activity
Issuer E	Significant plan resources to build/support process & standardized reporting
Issuer E	NCQA virtual provider vendor certification is not widespread and in some instances accreditation programs do not exist for all vendor types
Issuer E	Issuer E does not support mandating NCQA accreditation as a condition for virtual vendor participation
Issuer E	All HEI data reporting requirements need significant lead time to build and test prior to implementation
Issuer E	Collaborative evaluation and review necessary prior to improvement plans issued
Issuer E	Recommend aligning access monitoring methodology with the DHCS and DMHC existing processes for monitoring health plans and at an annual basis for monitoring access with health plans
Issuer E	Recommendation to align vendors to reduce provider abrasion
Issuer E	Recommend aligning with annual DHCS network certification methodology for calculating provider to member ratios with health plan data for PCPs
Issuer E	Recommend aligning with DMHC access and availability regulations
Issuer E	Flexibility for plans to set policies for specialty provider types of member ratios based on utilization as they do not have member assignment as PCPs.
Issuer E	All HEI data reporting requirements need significant lead time to build and test prior to implementation
Issuer E	Recommend 2-year baseline of data collected prior to setting plan wide benchmarks for active providers
Issuer E	Recommend methodology for annual review and alignment with DHCS and DMHC for telehealth services monitoring
Issuer E	Performance Standard 9-HEI Data Submission: - Support collaborative approach - After step 2, request for timelines to account for testing periods needed prior to going to production and data being re-assessed. - There needs to be an appropriate life cycle timeline for working with the technical teams to allow sufficient time for a testing phase prior to being re-assessed.
Issuer E	New Standard: Engagement in Collaboratives and with Community: - Further definition of performance standard and measurement is needed to assess and provide comment
Issuer E	New Standard: Primary Care and Utilization: Overall Member Engagement: - Request flexibility to establish non utilization benchmarks in collaboration with Covered CA - All HEI data reporting requirements need significant lead time to build and test prior to implementation - HEI data use and evaluative process overview is requested

Issuer E	New Standard: Primary Care Utilization: Measuring Continuity of Care: - Define COC assessment required to evaluate proposal - Align COC requirements with DMHC standards - COC is member driven - Request flexibility to establish primary care utilization regarding measurement of primary care in collaboration with Covered CA - All HEI data reporting requirements need significant lead time to build and test prior to implementation - HEI data use and evaluative process overview is requested
Purchaser	Purchaser very much appreciates CCA for taking the lead on contract language around AI; what you shared looks like a very reasonable first step to us and we are considering similar language for our next contract update for 2026. We particularly like the language around addressing and mitigating bias.
Purchaser	Regarding virtual health, is CCA considering encouraging, or eventually requiring, the health plans to achieve NCQA virtual care accreditation? Purchaser notices that you are encouraging plans to report on virtual care accreditation status for health plan vendors, but there is no mention of the plans themselves. I think NCQA's pilot includes health plans as well as other entities. Purchaser is looking at this as a possibility eventually, but have not included any language yet.
Purchaser	Purchaser supports keeping REaL data collection as a performance standard with penalties. Just flagging that there are potential updates to the race/ethnicity categories.
Purchaser	Finally, regarding access, Purchaser doesn't have any particular feedback at this time other than we are looking forward to continued discussions around aligning our measurement and monitoring of access concerns.
Association A	Association A aligns with CCA's aim to enhance healthcare accessibility and quality for all Californians, acknowledging the particular challenges faced by disadvantaged communities. While supporting initiatives to improve access and equity, Association A expresses uncertainty about the effectiveness of using data from the Healthcare Evidence Initiative (HEI) claims provider directory to address these issues, questioning how provider utilization rates would indicate patient access problems. Association A urges CCA to further refine these approaches.
Association A	Attachment 2 Feedback: - Association A opposes making OHCA's voluntary APM adoption goals mandatory for health plan issuers and providers, arguing it contradicts the statute's intent. - The push for mandatory APM standards could limit access, as not all practices can meet these models, especially given the fluctuating enrollment in Covered California. - Enforcing APM goals could drive consolidation, pushing patients from small practices to larger systems and risking provider exclusion from networks. - Acknowledging the aggressive nature of these goals, Association A notes there's no plan for enforcement, suggesting a learning approach over time. - Association A warns that including these goals in contracts could narrow provider networks further, impacting patient access to care. - Strongly advising against contractual obligations for APM goals, Association A highlights the statute's intention for these to remain non-mandatory.
Issuer B	Is Covered Ca proposing that health plans would be required to incorporate the use of Generative AI? If so, how would we be expected to use it. Issuer B currently only has plans to use Generative AI for customer service applications but not for care decision making.
Issuer B	Please clarify what the quality measures are and what the reporting expectations are
Issuer B	Will the health plans receive results of the secret shopper survey? Are penalties at risk for results of this survey?
Issuer B	Given that Issuers will not be held to financial risk for HEA accreditation. Will it still be part of contract requirements but with no financial accountability?
Issuer B	Will Covered CA assign the collaboratives in which Issuers are required to participate, or will Issuers be required to identify collaborative in which to participate?
Issuer B	The jump to 40% of amount of penalty at risk for HEI seem like a large jump and seems to imbalance the Performance Standards.

Issuer F	**Ensure transparency with members:** Align with federal AI transparency regulations—since federal HTI 1 addresses it from the perspective of requiring HIT/EHR developers to create technical framework to disclose, we can more easily adhere to Covered CA's transparency requirements on slide 7 if they align with the requirements on our vendors. Also—transparency via patient/member disclosures by health systems has been proposed but not yet mandated in CA or federally.
Issuer F	Implement processes to address and mitigate bias in GenAI: Align with HTI, this should not befall health systems—this should be directed to the health IT developers/vendors. Additionally, bias identification and mitigation is to be determined. Issuer F is very engaged through participation on CHAI workgroups, but the industry has not yet identified what gold standard is. Aligning with HTI would alleviate confusing constraints and burden on health systems.
Issuer F	Slide 7 & 8: Support: Collaborative pieces of slides 7 & 8; would be good to get Issuer F involved on state-side discussions with government entities on AI matters in addition to CHAI/VALID/etc from broad national perspective. Particularly in collaborate sessions with CCA (slide 7).
Issuer C	**Use of Virtual Care - Vendors & Point Solutions:** Recommend removing some of the annual reporting requirements. We are concerned about the administrative burden placed on health plans by reporting each year on each vendors' specific quality monitoring measures. Reporting should be limited to listing all virtual vendors and status of each vendor's NCQA Virtual Care Accreditation. Existing contract requirements support Covered California's request for specific questions on a QHP vendor, which would include Telehealth or Virtual Care vendors.
Issuer C	**Use of Virtual Care - Virtual Modalities used by Healthcare Teams:** Recommend removing the requirement to submit improvement plans for Virtual Care disparities. We support the collaboration and joint evaluation of virtual care patterns, as this is a rapidly evolving and expanding modality. However, we have concerns about a requirement to develop and execute improvement plans to reduce disparities. As the QTI program evolves towards disparities in the existing QTI measure sets, adding additional "areas" to develop disparity plans is likely to redirect resources away from QTI focus.
Issuer C	**Access Monitoring:** Encourage more dialog to understand how Covered California's expansion of network and access monitoring aligns with requirements and monitoring from other regulatory departments, particularly DMHC, as it appears to be redundant and could potentially creating challenges aligning between Covered California, DMHC and CMS/NBPP.
Issuer C	Feedback on New Section on Use of Generative AI: Recommend removing reporting requirements: Issuer C appreciates the opportunity to align and share learnings/ best practices in this emerging field. As demonstrated in other subjects, we encourage collaborative discussions and shared learning sessions among the QHPs and Covered California. However, requiring annual reporting on all clinical use cases will be administrative burdensome and costly, and provide limited value for Covered California, relative to other industry wide or emerging regulatory vehicles likely to emerge. Instead, we recommend the contract require QHPs to engage with Covered California to share overall practices and direction in these areas and remove any specific reporting requirement.
Issuer C	Issuer C is aligned with keeping the following performance measures without revisions: - Performance Standard 1 Reducing Health Disparities: Race and Ethnicity Self Identification - Performance Standard 2 Reducing Health Disparities: Spoken and Written Language - Performance Standard 10 Pediatric Oral Evaluation, Dental Services - Performance Standard 11 Pediatric Topical Fluoride for Children, Dental Services
Issuer C	Issuer C is aligned with the retirement of the following measures: - Performance Standard 3 Reducing Health Disparities: Disparities Reduction Intervention - Performance Standard 4 NCQA Health Equity Accreditation - Performance Standard 5 Primary Care Payment - Performance Standard 6 Primary Care Spend - Performance Standard 7 Payment to Support Networks Based on Value - Performance Standard 8 Quality Rating System (QRS) QHP Enrollee Experience Summary Indicator