Commenter *Names have been randomized*	Commenter Question/Feedback/Request
Purchaser	**Promoting Access to Behavioral Health Services.** Is their language on ensuring the Advisory Board feedback is actually reviewed by health plan leadership and/or Board? Concern is that Advisory Board doesn't have any actual influence on governance.
Purchaser	**Expand Substance Use Disorder Focus.** Is there a measure spec for this? Or just POD spec (which I know doesn't cover the naloxone piece)?
Purchaser	Inpatient Hospitals: Disproportionate Share Hospital (DSH), Children's Hospitals, Rural Referral Centers, Sole Community Hospitals, Free standing Cancer Centers, Critical Access Hospitals. Some of the key categories Purchaser considers for DSH are "Designated Public Hospitals" and "District and Municipal Public Hospitals", which are defined in state statute. Possibly including these would give further clarity on the types of hospitals?
Purchaser	**California Disproportionate Share Hospitals (DSH): MediCal supplemental payment program created to reimburse hospitals for a portion of the uncompensated care costs incurred from providing inpatient hospital services to Medi Cal beneficiaries and uninsured individuals.** From prior slide, consideration of DMPH and DPH framing as well.
Purchaser	Purchaser's only feedback is strong support of your behavioral health changes. We like the 'Back to Basics' approach and are particularly supportive of the focus on reducing disparities and stigma around behavioral health. Additionally, we think requiring submission of more recent provider network data if the data used for accreditation was older than 2 years is very reasonable and we will consider for our next contract update. We did have one question – can you provide examples of the culturally tailored depression screening tools that you are referring to on slide 23?
Issuer F	**Feedback on developing strategies and culturally tailored interventions informed by members of focus populations.** As part of our customized, segmentation and stratification analytic tool and reporting, we include members conditions that are driving their risk scores which includes BH dxs. Also, included in that tool is HE data and SDOH which can be sorted in a number of ways to identify and manage those members with cultural needs more precisely.
Issuer F	Feedback on Issuers submitting selection criteria for behavioral health vendors, including virtual vendors. Issuer F went through a comprehensive RFP process to determine the best BH health plan for us to partner with which included all facets of their programs which were taken into account in making that decision.
Issuer F	Feedback on expanding focus of substance use disorder (SUD) and the addition of HEDIS measure Diagnosed Substance Use Disorder (DSU). Issuer F already focuses on SUD in both our; PHM department as well as our P& T committees as well as being a focus with our BH Plan partner
Issuer F	Feedback on suggested new provider types for Essential Community Providers (ECP) definition: HCAI workforce grant recipients (focus on behavioral health providers) – Issuer F works closely with our BH Plan partner to engage with all BH providers in order to expand access of care to our members as they manage the BH network. Geographic and Medi-Cal specific providers including - Issuer F does not manage MediCal members at this time
Issuer F	Feedback on phased approach to updating ECP standards. Issuer F currently contracts with ECP's and will continue to do so as we sponsor, and I sit on the Board of Advisors which includes all non-profits, as well as ECPs. We also contract with several FQHC's throughout our service area.
Issuer F	Feedback on evaluation approach and measures of success. Issuer F measures success by our HEDIS and CAHPs measure results as well as county and state wide member satisfactions annual scores.

Issuer A	**Add requirements to design and deploy disparities reduction strategies to address disparities identified in collaboration with Covered California, adhering to best practices and the Advancing Health Equity - Road Map to Advance Health Equity** Please clarify if this requirement will be to address disparities identified within our own health plan enrolled population or those identified by Covered California in the marketplace population across all issuers.
Issuer A	**Ensure implementation of culturally tailored depression screening tools and practices.** Depression screening tools are standardized and cannot be customized, unless there is a validated tool that exists for a specific population. We suggest changing this to recommend "Ensure implementation of culturally tailored interventions and practices to address positive depression screening results."
Issuer A	**Implement at least 1 intervention to enhance member experience for historically marginalized group, such as:** How will historically marginalized group be defined and what is the threshold for size requiring intervention within a health plan's enrolled population?
Issuer A	**Feedback on Issuers submitting selection criteria for behavioral health vendors, including virtual behavioral health.** Please provide more information about this recommendation. We do not see details on this requirement in the presentation that was provided.
Issuer A	**Add the following measures to Healthcare Evidence Initiatives Monitoring Disparities measures list in Article 1.02.2 to support ongoing assessment and identification of behavioral health disparities: Initiation and Engagement of Substance Use Disorder (IET), Follow-Up After Hospitalization for Mental Illness (7 Day and 30-Day Follow)** 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 implementing care coordination interventions for SUD interventions (even worse for minors), which creates extra challenges for improving IET performance (a two measurement rate). Please note, that the Antidepression Medication Management measure will be retired after MY 2025. This measure is listed on slide 25.
Issuer A	Add language specifying monitoring of IET measure results using HEI data. - The percentage of members 13 years and older who are diagnosed with substance use disorder:Alcohol disorder, opioid disorder, other unspecified drugs, any substance use disorder. Slide 33 refers to exploring the addition of the DSU HEDIS measure. Issuer A recommends adding DSU instead of IET. The DSU measure is appropriate for monitoring SUD diagnosis. We also recommend the addition of the FUA measure instead of IET, noting our same recommendations stated for section 2.02.2 above.
Issuer A	**Feedback on suggested new provider types for ECP definition:** **HCAI workforce grant recipients (focus on behavioral health providers)** - 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. **Geographic and Medi-Cal specific providers including:** **Certain providers in HPSAs -** No immediate concerns, we would like to see the provider list. **Providers with a minimum percentage of Medi-Cal members** - How will these providers be identified? Is this referring to provider's panel (example, x% of patients are Medi-Cal) ? **Providers in HPI quartiles 1 and 2** - No immediate concerns, we would like to see the provider list.
Issuer A	Additional Comments: - Issuer A would like to receive an updated ECP list twice per calendar year to remain up to date. - Please clarify what type of providers are included in non-340B entities referenced on page 50 of the presentation.

Issuer A	**Feedback on phased approach to updating ECP standards.** When does Phase 1 become effective, is this for the 2026 QHP Contract? We would like to have a year lead time to allow time for provider contracting depending on how substantial the ECP standard requirement changes are.
Issuer A	Feedback on evaluation approach and measures of success: "What percentage of Covered California primary care and behavioral health ECPs also accept Medi-Cal members." - Please clarify if this assessment would be completed by Covered California. This would need to be done comparing NPIs providers who are registered with DHS. Providers registered with DHC may not be contracted with all managed care Medi-Cal plans. What is the measurement of success? Is this measured at the health plan level or across all QHPS. "Covered California should require issuers to report on their ECP contracting arrangements. This could enable Covered California to assess adherence to fair compensation requirements." - Please clarify what type of reporting Covered California is interested in receiving related to ECP contracting; Issuer provider arrangements are pretty steeply regulated by DMHC already and subject to QHP good standing annual certification; provider rates are subject to compliance with myriad managed care rules as part of the larger Issuer-provider arrangement, but they are not subject to review as a specific or standalone dollar figure—i.e. provider rates are not akin to premium rates when it comes to statutory and regulatory review.
Issuer C	**New provider types for ECP definition:** Will the new geographic and Medi-Cal specific provider requirements establish a new threshold? Is it practitioner level or provider/group level as well? How is HPI determined (zip, tract, county, etc.)?
Issuer C	Phase approach to updating ECP Standards: When determining increasing the hospital requirement in high density population areas what is considered a high-density population area? To expand the applicability to non-340B entities, will Covered California establish a list of non-340b entities, so that a denominator can be established? Can NPI number be added to assist with identifying the provider? For adopting category specific, or entity specific, thresholds Issuer C would like more information on how this will be done to review the feasibility. It is a challenge to fit ECP provider category to Issuer provider type/specialty as the crosswalk may be one to many, many to one or many to many. When Covered California scopes out further limiting some, or all, categories to providers with a minimum percentage of Medi-Cal members is it possible to provide: - How the minimum percentage will be determined - will it be based on Medi-Cal members or plan's Medi-Cal members only ? - Is it based on utilization, i.e. historical data - as this may be complicated by providers who may be in/out of network anytime.
Issuer C	**Feedback on evaluation approach and measures of success:** The recommended ECP impact Evaluation Approach on page 6 noted that Covered California should require issuers is to report on their ECP contracting arrangement to assess adherence to fair compensation requirements. We believe this is unnecessary as the relevant data should already be captured via Covered California's Health Evidence Initiative.
Issuer C	Feedback on developing strategies and culturally tailored interventions informed by members of focus populations: Issuer C is aligned with Covered California in developing strategies and culturally tailored interventions informed by members of focus populations and believe this is a prime area where sharing / learning from best practices from other QHPs and stakeholders can be extremely beneficial.

Issuer C	Feedback on Issuers submitting selection criteria for Behavioral Health vendors, including virtual: As described above, there are complex strategies that go into the selection of Behavioral Health vendors and virtual services. We recommend that instead of including contractual requirements to submit this information to Covered California, the "learning and best practice sharing" will be more efficiently achieved via conversations with Issuers.
Issuer C	Feedback on expanding focus of SUD and the addition of HEDIS measure Diagnosed Substance Use Disorder (DSU): Issuer C supports the expanded focus on Substance Use Disorders or the inclusion of the HEDIS DSU measure, combined with additional sessions on this topic to better understand the SUD issues facing both Covered California's and the broader California population. Issuer C is aligned with the work related to the appropriate use of Opioids, however, to do this work equitably we believe there is a need to investigate other SUD issues impacting communities of color as well as looking at the reverse issue of under prescribing of pain medication for communities of color. Our recommendation prior to introducing additional contract requirements is to focus on identifying the issue, how we can define progress towards a common goal, and then ensure progress can be measured across Issuers.
Issuer C	Behavioral Health Provider Network Reports Issuer C supports the submission of more recent provider network data if data used for accreditation was older than 2 years, and supports requirements around training on the topics identified, including cultural humility and effective collaboration with interpreters, annual training on diversity and cultural humility and use of national standards for CLAS. It is important these requirements align with the CalPERS, which will support efficient and effective implementation and monitoring. We feel there is less alignment needed with Medi-Cal / DHCS, given the vastly different delivery models and markets.
Issuer C	**Promoting Access** We question the value of including "samples" of how a QHP promotes Behavioral Health Services across access points and languages as a contractual or recertification requirement. Sample material is only a snapshot of activity, and doesn't reflect if the material was actually opened or drove change. Additionally, as the ecosystem focuses on measuring items such as access to Tele-Behavioral Health services by sub-population, plans will have incentives to improve access to services across all sub-populations. Further, we believe the real focus from this, is to leverage best practices across QHPs, which can be achieved via various collaboration forums.
Issuer C	Monitoring Behavioral Health Utilization Issuer C is aligned with the direction and recommendations for monitoring utilization, and would suggest working together to define the expanded utilization measures to consider data reliability and accessibility, as well as benchmarking considerations.
Issuer C	Monitoring QRS Behavioral Health Measures Issuer C is aligned with the addition of Initiation and Engagement of Substance Use Disorder and Follow-up after Hospitalization for Mental Illness measures.
Issuer C	Monitoring Opioid Use Disorder Treatment Issuer C supports the expanded focus on Substance Use Disorders or the inclusion of additional HEDIS measures. We expect a need to consider other SUD issues and policy considerations (such as around opioid overuse) that could be impacting equitable access. This is a prime area for Covered California to drive collaborations to understand the issues facing both Covered California's population and the broader California population, and exploring community programs' experience meeting the needs of this population.
Issuer E	Feedback on Issuers submitting selection criteria for behavioral health vendors, including virtual vendors. Issuer E has established criteria and protocols for evaluating BH vendors. Plans require continued autonomy in evaluative process to contract with vendors that meet plan criteria including geographic and adequacy requirements.
Issuer E	BH Provider Network Reports. Issuer E anticipates that this change will to lead to more administrative burden and is a duplicative requirement. Provider network data is already submitted each month by Issuers.

Issuer E	Screening for Depression. - For the annual report (NQF 0418), request to clarify if PHQ2/PHQ9 screeners completed by Issuer staff will also be counted in addition to screeners completed by network providers. - Request to clarify if current PHQ2 and PHQ9 assessments all capture race and ethnicity and are reportable. - Request to clarify evaluative method for Issuer implementation.
Issuer E	**Monitoring OUD Treatment** Request to reconsider validity of findings when gathering data for prescribing rates of opioids and naloxone. Naloxone is now available OTC and therefore prescribing rates may not be a true reflection of members who may be in possession of naloxone
Issuer E	Essential Community Providers (ECP) Project. Request to clarify when system requirements will be released for Issuers to update reporting?
Purchaser	Offering Telehealth for BH. Assuming that langauge related to telehealth has clear guardrails such as 1) ensuring members who want in-person can get it and that providers are not pushing it for their own convenience 2) ensuring that telehealth services are offered when clinically effective (which it generally is for BH, especially when a relationship is already established).
Purchaser	Contractor Accountability, Duties and Obligations. As a separate effort: Purchaser love to have an understanding of how you are getting these reports, what your teams are reviewing for and what you consider "unjustified" delegations. We are undertaking a work effort to relook at our reporting templates now to the extent we can align, that would be great.
Issuer I	**Require submission of more recent provider network data if data used for accreditation was older than 2 years.** NCQA health plan accreditation renewal is required every 3 years, the proposed change would cause added administrative burden. We would recommend the reports only be required if the health plan does not have the accreditation.
Issuer I	Add requirements for Issuers to submit screen shots and sample communications demonstrating the promotion of BH services across access points and languages. Issuer I recommend requiring health plans to have the NCQA health equity accreditation in lieu of providing samples.
Issuer I	Add requirements to design and deploy disparities reduction strategies to address disparities identified in collaboration with Covered California, adhering to best practices and the Advancing Health Equity Road Map to Advance Health Equity. Issuer I agrees with reducing disparities while also being mindful of the sizes of various populations among different health plans which might not be comparable.
Issuer I	Ensure implementation of culturally tailored depression screening tools and practices. Issuer I prioritizes culturally competent care and screening methodologies, including in our depression screening tools and practices. We are committed to continuous improvements in this area.
Issuer I	Add the following measures to Healthcare Evidence Initiatives Monitoring Disparities measures list in Article 1.02.2 to support ongoing assessment and identification of behavioral health disparities: - Initiation and Engagement of Substance Use Disorder (IET) - Follow-Up After Hospitalization for Mental Illness (7 Day and 30-Day Follow). Issuer I agrees with the addition of these NCQA HEDIS measures.
Issuer I	Expand utilization measures: - Remove requirement for calculating and tracking depression treatment penetration rate. Issuer I has no concerns.
Issuer I	In alignment with DHCS and CalPERS requirements, implement staff training focused on cultural humility and effective collaboration with interpreters, such as: - Annual training on diversity and cultural humility - Use of National Standards for Culturally and Linguistically Appropriate Services (CLAS) Issuer I agrees with these items and has internal trainings and practices to support these efforts.

Issuer I	Implement at least 1 intervention to enhance member experience for historically marginalized group, such as: - Create culturally appropriate materials for any population that exceeds a specified volume threshold - Adjust website language to reflect threshold groups - Develop a member/community advisory board - Partner with a community-based organization Issuer I has no concerns and has established resources in multiple languages including website accessibility and outreach. Additionally, Issuer I has patient advisory boards and partners with community-based efforts.
Issuer I	Revise to reflect expanded focus on substance use disorders: - Add language specifying monitoring of IET measure results using HEI data - The percentage of members 13 years and older who are diagnosed with substance use disorder: - Alcohol disorder, opioid disorder, other unspecified drugs, any substance use disorder - This data can help establish both a Covered California population baseline SUD rate and support individual plan efforts to meet member needs Issuer I has no concerns.
Issuer I	Remove all requirements except annual report of activities conducted to encourage implementation and expansion of integrated care. Issuer I has no concerns.
Issuer D	NPI Issuer D respectfully request that the ECP list provided by Covered California includes fields that are critical to credentialing. For example, if a TIN is needed the Non-Hospital Provider tab has 3,190 lines however 2,370 don't have a TIN.
Issuer D	**Free clinics** Feedback from our team is that we cannot contract with free clinics. As a result, we request free clinics be excluded from the denominator which we are held to when determining meeting percent of provider participation in a region.
Issuer D	EPCs refuse contracting Issuer D request that if we attempt to contract with an ECP and they refuse and/or don't respond, that they were not included in the denominator. We are concerned that depending on the region those refusers/non-responders could cause us not to meet adequacy requirements.
Issuer H	Feedback on developing strategies and culturally tailored interventions informed by members of focus populations. Inequity in behavioral utilization in Issuer H's population is a well identified phenomenon. We welcome any input on guidelines, processes, initiatives and interventions to aid us.
Issuer H	Feedback on Issuers submitting selection criteria for behavioral health vendors, including virtual behavioral health. Issuer H does not utilize a vendor/vendors for these services.
Issuer H	Feedback on expanding focus of Substance Use Disorder (SUD) and the addition of HEDIS measure Diagnosed Substance Use Disorder (DSU). Issuer H fortunately has an extremely low rate of identifiable POD. We welcome any initiatives directed at detection, diagnosis and treatment of these disorders.
Issuer H	Feedback on phased approach to updating ECP standards. Issuer H agrees that ECP requirements should be clear on what is expected of the Issuer in meeting the intent and purpose of the ECP standards. We also agree that administrative burden should be minimal.
Issuer H	Feedback on evaluation approach and measures of success. Issuer H agree with all approaches of success
Issuer H	On slide 50, Covered CA suggests that pediatric oral service providers to be added to the Non-Hospital tab on the ECP list. If this is the case, is Covered CA planning to make it a contract requirement to have Issuers contract with a certain percentage of pediatric oral service providers on the Non-Hospital tab?

Issuer H	Issuer H appreciate that Covered CA is planning to increase inclusion of FQHCs as a priority in the ECP standards and we look forward to it.