Commenter *Names have been randomized*	Commenter Question/Feedback/Request
Issuer A	Input on retaining the reporting requirement for the proportion of enrollees who select versus are assigned a primary care clinician and retirement from HEI Performance Standard 9 (HEI Submission) in Attachment 2. Issuer A recommends discontinuing the PCP assignment reporting in the annual QHP Application. All reported years from 2016-current include 100% PCP assignment due to the utilization of auto-assignment if a member does not make a selection, as this is a long-standing QHP Contract requirement. The current QHP run chart reporting does not require plans to distinguish PCP selection from auto-assignment. We support the retirement of the standards in Attachment 2, 9. 4 PCP NPI, as this data is already required to be submitted in the HEI data specs and reporting methodology.
Issuer A	Input on deploying a continuity of care assessment and other novel analytics via HEI to measure advanced primary care and establishing benchmarks and improvement targets as new Performance Standards in Attachment 2. Issuer A recommends further research on PCP continuity of care trending over time and identify findings that correlate to quality of care 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.
Issuer A	**Input on aligning with OHCA methodology for required reporting on adoption of HCP LAN Alternative Payment Models using percent of members as well as primary care spend methodology, and retirement from Performance Standard 5 (Primary Care Payment) and 6 (Primary Care Spend) in Attachment 2.** We support the change to remove the Performance Standards 5 and 6 and focus on OCHA reporting methodology alignment. Please clarify if the Covered California will require reporting only using the OCHA methodology and that benchmarks, improvement targets and goals will be managed by OCHA.
Issuer A	**Input on removal of IDS and ACO enrollment and descriptive reporting requirements.** This aligns with changes Covered California has already made to remove ACO and IDS assignment from Attachment 2. It makes sense to retire this reporting.
Issuer A	**Input on aligning with OHCA in reporting adoption of HCP LAN Alternative Payment Models using percent of members and retirement of Attachment 2 Performance Standard 7 (Payment to Support Networks Based on Value).** We support the change to remove the Performance Standard 7 and focus on OCHA reporting methodology alignment. Please clarify if the Covered California will require reporting only using the OCHA methodology and that benchmarks, improvement targets and goals will be managed by OCHA.
Issuer A	Input on retirement of individual hospital intervention plans and shift to collaborative engagement with poor performing hospitals. Issuer A agrees that collaborative engagement with poor performing hospitals should be the focus and we look forward to continuing this work. Slide 33 presented states that “Covered California seeks to foster collaboration among network hospitals…” Please clarify that the collaboration is among the health plans with shared network hospitals. We do not expect the poor performing hospitals to collaborate among themselves. Slide 33 also states that “Covered California seeks to…provide technical assistance…” While health plans can connect hospitals to resources to give them technical assistance, we do not have the resources to provide direct technical assistance.

Issuer A	Input on retirement of Hospital Payments to Promote Quality and Value section. Issuer A supports this change.
Issuer A	**Input on requiring Cal Healthcare Compare participation for patient safety oversight and maternity quality improvement.** While health plans can purchase data and consult with Cal Healthcare Compare experts, this is not a collaborative that health plans can participate in. Please provide clarity on the specifics of this requirement.
Issuer A	**Input on tracking volume of in-network doulas.** Please clarify what data would be involved in this reporting. Is this tracking doula care based on claims utilization or reporting the number of contracted doulas in network? Please note that some doula care may be provided by contracted third party organization programs where the doula may not be contracted directly with the health plan. We recommend more research on how doula care will be provided under the requirements of AB 904. There may be variation among health plans, which could complicate reporting.
Issuer A	In response to feedback on administrative burden, provide input on reducing the number of required collaboratives and initiatives. Issuer A supports this change.
Issuer A	In response to feedback on financial burden, provide input on proposal to utilize Attachment 2 penalties in part or whole to support cost of required quality collaborative memberships and participation. Due to the complexities involved, we do not currently recommend this approach. We would like for this proposed methodology to be further defined in order for us to provide input. For example, would the Attachment 2 penalties be retained by the Issuer and used directly to pay towards their own collaborative participation? Or will funds be retained by Covered California and be distributed equally to Issuers to pay for collaboratives? Would funds be retained by Covered California to pay for select Issuers to pay for collaboratives?
Issuer A	**Input on highest value collaboratives to have required participation.** Of the collaboratives listed on slide 45, IHA provides the highest value, although they are also the most costly. Leapfrog is also important to our work. Please note that while plans can engage with Cal Hospital Compare and CMQCC, these are not collaboratives that health plans can participate in directly.
Issuer C	Encouraging Use of Primary Care: Issuer C historically has auto assigned the Primary Care Physician (PCP) when enrolling members for both our HMO and PPO products. Members are notified of the PCP assignment and how to update to the PCP of their choice. In May 2024, we launched the capability for new members to select a PCP at the time of enrollment. Issuer C does not have the system capability to report whether the initial PCP was auto assigned or selected by the consumer, as proposed by Covered California. We are hesitant to understand the development expenses related to this report, as its unclear what additional, actionable insights this report would provide, as we are already working on efforts to encourage more members to select a PCP during the enrollment process. Issuer C recommends that this reporting be removed from the 2026 – 2026 contract requirements. Issuer C is aligned with the removal of Attachment 2 Performance Standard 9 (Healthcare Evidence Initiative (HEI) Data Submission) related to submission of a valid NPI/TIN for the assigned PCP in the membership extract.
Issuer C	Measuring Advanced Primary Care: Issuer C is aligned with deploying continuity of care assessments and other novel analytics via HEI data submissions; however, this isn't currently in the Advanced Primary Care measure set, and we believe it is too early to consider benchmarks or performance improvement targets with financial risk for the 2026 – 2028 contracting period. Issuer C recommends continuing to monitor this measure, providing additional understanding of how the Continuity Index of 0.7 (70%) was established and working with the Advanced Primary Care workgroup on any changes to how Advanced Primary Care is being measured.

Issuer C	Payment to Support Advanced Primary Care:Issuer C strongly supports the Office of Health Care Affordability (OHCA) and using OHCA's primary care spend methodology. We support OHCA's proposal for a relative payer investment benchmark of 0.5 to 1.0 percentage point increases year-over-year, and a total spending benchmark of 15% by 2034. We agree with the notion that increasing primary care investment will help to bend the cost curve over the long-term. Additionally, the incremental payer benchmark of 0.5 to 1.0 percentage point increases will ensure that overall system spending does not increase as investment shifts from higher-acuity care to primary care practice settings. As such, we are aligned with the retirement of Attachment 2 Performance Standards 5 and 6. With regard to the OHCA approach to alternative payment model (APM) standards and benchmark, while we support the goals of adopting HCP-LAN Categories 3 and 4, we have concerns with the measurement approach to adoption, and to the PPO benchmark. We continue to recommend that OHCA align with HCP-LAN utilizing total percentage of spending as the unit of measurement, not the number of members in an APM arrangement. Measuring total spending on APM aligns more closely to the goal of ensuring our health care dollars are spent on the promotion of high-quality payment arrangements versus the per-member measurement, which may obscure total spending on APMs. Additionally, with regard to PPO measurement, we continue to recommend that if members continue to be the unit of measurement, that PPO measurement only include members that seek care in a given year. In PPO arrangements, members are not attributed to particular providers. PPO member spending can only be attributed if they seek care and a claim is produced.
Issuer C	Promotion of Integrated Delivery Systems (IDS) and Accountable Care Organizations (ACO) Issuer C is aligned with the removal of the IDS and ACO enrollment and descriptive reporting requirements from the 2026 – 2028 contract. The Integrated Healthcare Association stood up programs for 2-3 years specific to Accountable Care Organizations and, after a pilot, test and implementation, discontinued their statewide California programs. It is our understanding that IHA was unable to continue its efforts with ACOs because each health plan defines an Accountable Care Organization in its own unique way. This lowers statistical comparability, alignment for the purpose of quality measurement and incentives, and assessment of impact. Currently, each health plan designs an ACO based on the cost, utilization and quality outcomes it needs to achieve. Until there is a universally applicable definition of what "counts" as Accountable Care, and all health plans are held to this standard, descriptive reporting may lead to erroneous conclusions.
Issuer C	Networks Based on Value Issuer strongly supports the Office of Health Care Affordability (OHCA) and aligning with OHCA in reporting adoption of HCP LAN Alternative Payment Models. Issuer C does have some concerns with OHCA's percent of membership methodology but does align with the percent of spend methodology. We are not sure it is efficient to do both reporting and causes additional burden on administrative costs. Issuer C is aligned with the retirement of Attachment 2 Performance Standard 7 (Payment to Support Networks Based on Value) reporting on total network spend and percent of spend within each HCP LAN category. Issuer C is aligned with retiring the individual hospital intervention plans and agrees with the shift to collaborative engagement with poor performing hospitals. Issuer C is aligned with the retirement of section 4.03.5 Hospital Payments to Promote Quality and Value. Issuer participates with Cal Hospital Compare, CMQCC and CQC, and does see value in having other Issuers participate in these programs for patient safety oversight and maternity quality improvement. Issuer is aligned with the maternity health equity focus through DHCS improvement initiatives and does offer doula services to our members. We do not have any issues with tracking volume of in-network doulas if that information would be helpful to Covered California.

Issuer C	Participation in Quality Collaboratives Issuer C is aligned with the reduction of the number of collaboratives that Issuers are required to participate in. We have concerns with an expectation in which some Qualified Health Plans (QHPs) subsidize the costs for other QHPs to participate in a required or recommended quality collaborative. To mitigate concerns that certain QHPs may not receive significant value by their participation, we recommend that Covered California, and potentially CAHP, work with the collaboratives on different pricing models that demonstrates greater value to encourage plan participation. Additionally, plans can still "align" work to the collaboratives even if not participating directly. Issuer C recommends the following collaboratives be mandatory for all QHPs: •Symphony as the single provider data utility - while this effort has continued to face challenges in its execution, the problems it is working to solve are still relevant. •Integrated Healthcare Association (IHA) - continues to have the greatest momentum related to industry wide payment/quality efforts. •California Quality Collaborative (CQC) - significant traction on industry wide payment/quality as the collaboratives with the highest value for required participation. Mandating participation in these collaboratives helps to ensure that QHPs remain active partners in helping to achieve statewide public health objectives. The collaboration between QHPs, IHA, and CQC has helped to drive alignment and standardization on issues where there might otherwise be a dearth of leadership to accomplish that goal. For example, the California Advanced Primary Care measure set now used by Covered California is a product of this collaboration. The forthcoming multi-payer Advanced Primary Care payment demonstration, where four QHPs will collectively pilot value-based payment for shared primary care practices, is also a product of this collaboration. This opportunity would not have come to fruition without mandatory participation by QHPs in this initiative. Continuing to mandate participation with IHA and CQC will further advance goals set by the state as well as Covered California around primary care, behavioral health, and multi-payer alignment.
Consumer Advocate Group C	Consumer Advocate Group C advocates for retaining the reporting requirement for the proportion of enrollees who select verse are assigned a primary care provider, as there continues to be efforts needed to shift the paradigm toward a more patientcentered approach that engages patients in care through the informed selection of their PCP.
Consumer Advocate Group C	Consumer Advocate Group C supports deployment of a continuity of care assessment and other analytics to measure advanced primary care. Consumer Advocate Group C encourages Covered California to modify its plan by conducting a testing period before establishing benchmarks and improvement targets to assess feasibility of new and emerging measures that have not yet been tested at scale. From our research through literature review and key information interviews in developing the Advanced Primary Care Measure Set, emerging measures have shown promise in small tests, but have not yet been tested at scale to evaluate feasibility in diverse and large settings and communities for applicability in California, and more clarity is needed to develop the delivery system infrastructure to support sustainable long-term measurement collection. Consumer Advocate Group C also advocates that the testing include assessment of applicability of measurement at the practice level in order to support more granular data that can be utilized to target and inform improvement efforts.
Consumer Advocate Group C	Consumer Advocate Group C supports alignment with OHCA methodology for required reporting.
Consumer Advocate Group C	Support retaining reporting requirement for PCP selection vs assignment.
Consumer Advocate Group C	Consumer Advocate Group C supports removal of enrollment and descriptive reporting in exchange for the inclusion of and alignment with OHCA methodology for required reporting on HCP LAN Alternative Payment Models.
Consumer Advocate Group C	Consumer Advocate Group C supports defining quality participation as a requirement. Given that collaboratives may focus on different care settings or improvement areas, Consumer Advocate Group C advocates that Covered California further define if required participation is participation in all of the collaboratives listed or a minimum threshold of participation in a portion but not all listed collaboratives.

Consumer Advocate Group C	Consumer Advocate Group C supports reducing the number of required collaboratives and initiatives. The current list is a broad aggregation of organizations addressing quality improvement, but with inconsistent definition of impactful improvement through collaboration across health plans and provider organizations. Consumer Advocate Group C encourages Covered California to define quality collaboratives for the purpose of evaluating and specifying inclusion in its requirements. A smaller list with defined criteria will enable Covered California to more realistically implement consistent participation by all health plans. A narrow list of collaboratives with common definitions will also enable more purposeful collaboration and partnership among the listed collaboratives. o Definitional criteria for use may include: • Equitable and transparent membership model • Governance structure, with priority for multi-stakeholder membership • Regular cadence of formal member meetings for collaboration which include a role for Covered California • Defined goals and measurements for collective impact • Annual workplan of initiatives, programs and activities to support achievement of collective goals • Demonstrated engagement by health plans through formal coordination, collaboration, and integrated programs and funding that moves partnership beyond communication and cooperation in simple learning networks, as defined in the image below • Demonstrated impact in improving key metrics from Covered California contracts • Qualitative impact and value reported by participants, including health plan, providers and partners • Partnership with other key partners to more effectively implement improvement activities, such as participation in and/or collaboration with quality data aggregation and transparency organizations (e.g. Integrated Healthcare Association, Cal Healthcare Compare)
Consumer Advocate Group C	Consumer Advocate Group C also advocates that Covered California require a defined role for itself in participating in the collaboratives alongside its healthcare delivery partners.
Consumer Advocate Group C	Consumer Advocate Group C encourages Covered California to address financial burden for small plans through 2 parallel paths: o Consumer Advocate Group C supports utilization of Attachment 2 penalties to support cost of collaborative participation in an equitable way among health plans. In combination with participation requirements, more sustainable funding for collaboratives, in absence of California state regulated financial support as other states provide, will enable collaboratives to focus more precious resources on improvement work instead of the annual effort to renew funding from health plans. This would also enable Covered California to more directly influence the strategies and priorities toward alignment with its goals. o Consumer Advocate Group C advocates for Covered California to require collaboratives in consideration to share membership information and impact assessment on a regular cadence. Information may include: • membership and participation requirements, including costs; • models for equitable inclusion of and engagement by small and local plans • QHP participation and engagement in the collaborative and its initiatives • Annual workplans and/or impact reports
Consumer Advocate Group C	Consumer Advocate Group C recommends that data aggregation, transparency and performance accountability organizations (e.g. Integrated Healthcare Association, Cal Healthcare Compare, HPD, Leapfrog) be removed from the list of quality improvement collaboratives, as these organizations already have or could have participation requirements listed in other sections of the Covered California contract. For those organizations such as CMQCC that provide both data aggregation and quality improvement activities, requirement in the different programs/functions should be separate.

Consumer Advocate Group C	While the data critically enables improvement activities, the data and performance accountability organizations do not directly implement improvement activities. Impactful quality improvement collaboratives will be partnering with these organizations and this partnership should be a requirement of listed quality improvement collaboratives. o Additionally, the listed data organizations should be required to share Covered California data with listed quality improvement organizations for, ideally no-cost, but minimal cost. Currently, the data aggregation organizations charge quality improvement collaboratives substantial financial amounts to analyze data from Covered California plans, practices and patients. The quality improvement organizations cannot directly access data from some of these data organizations for their own analysis and are forced into paying for expensive analysis work. Much of health plan membership and grant funding to quality improvement collaboratives is re-directed to the data organizations to access critical information to target, implement and monitor impact of improvement collaborative programs. Consumer Advocate Group C, like many quality collaboratives in California, have had to create redundant but cheaper data infrastructure to avoid high costs from the data organizations, which adds additional reporting burden to health plans and providers to participate in quality improvement collaboratives and to demonstrate value and impact to participants.
Issuer G	Input on retaining the reporting requirement for the proportion of enrollees who select versus are assigned a primary care clinician and retirement from HEI Performance Standard 9 (HEI Submission) in Attachment 2 Issuer G is in agreement with Covered CA's approach. (It worth highlighting that the member experience is enhanced when they have the opportunity to make their PCP selection on the enrollment application and that selection is communicated to the Issuers on the enrollment file.)
Issuer G	Input on deploying a continuity of care assessment and other novel analytics via HEI to measure advanced primary care and establishing benchmarks and improvement targets as new Performance Standards in Attachment 2 Issuer G is open to Covered CA's proposed suggestion on what kind of reports are feasible. We would look to Covered CA to provide support and guidance on APM risk modeling, adoption, benchmark setting and meeting performance standards as well as to focus on the limitations of continuity of care measures and address risk.
Issuer G	Input on aligning with OHCA methodology for required reporting on adoption of HCP LAN Alternative Payment Models using percent of members as well as primary care spend methodology, and retirement from Performance Standard 5 (Primary Care Payment) and 6 (Primary Care Spend) in Attachment 2 Issuer G is in agreement with this approach and would seek involvement and input into OHCA workgroups on APM.
Issuer G	Input on removal of IDS and ACO enrollment and descriptive reporting – Issuer G agrees.
Issuer G	Input on aligning with OHCA in reporting adoption of HCP LAN Alternative Payment Models using percent of members and retirement of Attachment 2 Performance Standard 7 (Payment to Support Networks Based on Value). – Issuer G agrees.
Issuer G	Input on retirement of individual hospital intervention plans and shift to collaborative engagement with poor performing hospitals. – Issuer G agrees.
Issuer G	Input on retirement of Hospital Payments to Promote Quality and Value section. - Issuer G agrees.
Issuer G	Input on requiring Cal Healthcare Compare participation for patient safety oversight and maternity quality improvement. Issuer G strongly recommends not requiring contractual participation with Cal Hospital Compare. Their data is 2-years old, and their costs have gone up exponential with no increase in value. We can access Cal Healthcare Compare data available publicly to track hospital performance.
Issuer G	Input on tracking volume of in-network doulas. Issuer G will need to develop a process for tracking the volume of in-network doulas, but we agree with this approach.

Issuer G	In response to feedback on administrative burden, provide input on reducing the number of required collaboratives and initiatives. Issuer G agrees with reducing administrative burden. For example, provide a list of collaboratives recommended and allowing plans to choose which collaboratives to participate in.
Issuer G	In response to feedback on financial burden, provide input on proposal to utilize Attachment 2 penalties in part or whole to support cost of required quality collaborative memberships and participation. Issuer G agrees with using penalties to help plans offset cost of collaboratives.
Issuer G	Input on highest value collaboratives to have required participation. – Issuer G agrees.
Issuer E	**Input on retaining the reporting requirement for the proportion of enrollees who select versus are assigned a primary care clinician and retirement from HEI Performance Standard 9 (HEI Submission) in Attachment 2.** Support retaining the reporting requirement for the proportion of enrollees who select versus are assigned a primary care clinician and retirement from HEI Performance Standard 9 (HEI Submission) in Attachment 2.
Issuer E	**Input on deploying a continuity of care assessment and other novel analytics via HEI to measure advanced primary care and establishing benchmarks and improvement targets as new Performance Standards in Attachment 2.** o Measure does not align with DHCS or DMHC o Creates additional quality measure for providers to track and report o Complex to administer o Measure does not account for alternative models of care such as referrals to community-based services, housing etc. o Clarification requested if measure is similar to risk adjustment capture and measurement
Issuer E	**Input on aligning with OHCA methodology for required reporting on adoption of HCP LAN Alternative Payment Models using percent of members as well as primary care spend methodology, and retirement from Performance Standard 5 (Primary Care Payment) and 6 (Primary Care Spend) in Attachment 2.** Support alignment with OHCA methodology for required reporting
Issuer E	**Input on removal of IDS and ACO enrollment and descriptive reporting.** Support removal of IDS and ACO enrollment and descriptive reporting
Issuer E	**Input on aligning with OHCA in reporting adoption of HCP LAN Alternative Payment Models using percent of members and retirement of Attachment 2 Performance Standard 7 (Payment to Support Networks Based on Value).** Support aligning with OHCA in reporting adoption of HCP LAN Alternative Payment Models using percent of members and retirement of Attachment 2 Performance Standard 7
Issuer E	**Input on retirement of individual hospital intervention plans and shift to collaborative engagement with poor performing hospitals.** Support retirement of individual hospital intervention plans. Support shift to industry collaborative engagement based on clarifications noted below and shift to industry collaboration. Open questions: Clarification requested regarding collaborative, lead organization structure, oversight, and metrics /measurement criteria
Issuer E	**Input on retirement of Hospital Payments to Promote Quality and Value section.** Support retirement of Hospital Payments to Promote Quality and Value section
Issuer E	**Input on requiring Cal Healthcare Compare participation for patient safety oversight and maternity quality improvement.** Support Cal Health compare
Issuer E	**Input on tracking volume of in-network doulas.** Support alignment of activities with DHCS
Issuer E	**In response to feedback on administrative burden, provide input on reducing the number of required collaboratives and initiatives.** Support reducing number of required collaboratives. Recommend 2-3

Issuer E	**In response to feedback on financial burden, provide input on proposal to utilize Attachment 2 penalties in part or whole to support cost of required quality collaborative memberships and participation.** Clarification regarding evaluation process
Issuer E	**Input on highest value collaboratives to have required participation.** Support highest value collaboratives-Symphony, Cal Hospital Compare, Healthcare Payer Data System (HPD), California Quality Collaborative (CQC)
Issuer H	Input on retaining the reporting requirement for the proportion of enrollees who select versus are assigned a primary care clinician and retirement from HEI Performance Standard 9 (HEI Submission) in Attachment 2. Issuer H agrees on retirement of HEI Performance Standard 9 in Attachment 2. However, Issuer H would like Covered CA to state detailed definitions of what is defined as a selected PCP vs. assigned PCP in the contracts so we can have better alignment with Covered CA's standards.
Issuer H	**Input on deploying a continuity of care assessment and other novel analytics via HEI to measure advanced primary care and establishing benchmarks and improvement targets as new Performance Standards in Attachment 2.** No comment but we would like to be able to review what novel analytics would be new before the targets are set.
Issuer H	**Input on aligning with OHCA methodology for required reporting on adoption of HCP LAN Alternative Payment Models using percent of members as well as primary care spend methodology, and retirement from Performance Standard 5 (Primary Care Payment) and 6 (Primary Care Spend) in Attachment 2.** What is the OHCA methodology that Covered CA will be utilizing?
Issuer H	**Input on removal of IDS and ACO enrollment and descriptive reporting.** No comment
Issuer H	**Input on aligning with OHCA in reporting adoption of HCP LAN Alternative Payment Models using percent of members and retirement of Attachment 2 Performance Standard 7 (Payment to Support Networks Based on Value).** What is the OHCA methodology that Covered CA will be utilizing?
Issuer H	**Input on retirement of individual hospital intervention plans and shift to collaborative engagement with poor performing hospitals.** Will be more targeted to poor performing hospitals. Lower administrative burden on health plans.
Issuer H	**Input on retirement of Hospital Payments to Promote Quality and Value section.** Same as above.
Issuer H	**Input on requiring Cal Healthcare Compare participation for patient safety oversight and maternity quality improvement.** Important initiatives that will hopefully produce some good data.
Issuer H	**Input on tracking volume of in-network doulas.** Unknown impact and uncertain as to what insights this will produce.
Issuer H	In response to feedback on administrative burden, provide input on reducing the number of required collaboratives and initiatives. Yes, reducing required collaboratives and initiatives will reduce administration burden, Issuer H.
Issuer H	In response to feedback on financial burden, provide input on proposal to utilize Attachment 2 penalties in part or whole to support cost of required quality collaborative memberships and participation. Issuer H agrees with this approach.
Issuer H	Input on highest value collaboratives to have required participation. Although Issuer H is willing to participate in high value collaboratives, Issuer H may have financial constraints. By using penalties to support the cost of membership and participation, it will definitely help us in supporting our initiatives.

Issuer I	Input on retaining the reporting requirement for the proportion of enrollees who select versus are assigned a primary care clinician and retirement from HEI Performance Standard 9 (HEI Submission) in Attachment 2. Issuer I does not support retaining the reporting requirement for the proportion of enrollees who select versus are assigned a primary care clinician. We prioritize the relationship between patients and their PCPs and understand the importance of members having a PCP that meets their needs. We offer multiple points of outreach to our new members to facilitate their selection of a primary care physician. Outreach efforts include welcome calls, written materials, and online tools to encourage and support member selection of a PCP, as well as additional outreach when a new member has not selected a PCP. Members who are assigned a PCP may elect to remain with that clinician, making the distinction potentially inaccurate. We advocate for altering the reporting requirement to the proportion of enrollees who select OR are assigned a primary care clinician. Segregating the two counts places an administrative burden on the plan, and does not add value to reporting regarding patient linkage with a primary care provider. We are happy to discuss further if helpful. We do support retirement from HEI Standard 9 (HEI Submission).
Issuer I	**Input on deploying a continuity of care assessment and other novel analytics via HEI to measure advanced primary care and establishing benchmarks and improvement targets as new Performance Standards in Attachment 2.** 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.
Issuer I	Input on aligning with OHCA methodology for required reporting on adoption of HCP LAN Alternative Payment Models using percent of members as well as primary care spend methodology, and retirement from Performance Standard 5 (Primary Care Payment) and 6 (Primary Care Spend) in Attachment 2. We are generally supportive of alignment with OHCA. However, it is critical that the methodology to calculate primary care spend from claims for Issuer I allow for allocation of a proportion of the Integrated Care Management (ICM) Fee.
Issuer I	**Input on removal of IDS and ACO enrollment and descriptive reporting requirements.** NO CONCERNS/QUESTIONS
Issuer I	**Input on aligning with OHCA in reporting adoption of HCP LAN Alternative Payment Models using percent of members and retirement of Attachment 2 Performance Standard 7 (Payment to Support Networks Based on Value).** NO CONCERNS/QUESTIONS
Issuer I	Hospital Value: Update CMS Price Transparency Language; shift from individual hospital intervention plans to demonstrating collaborative engagement with poor performing hospitals. In California, Issuer I owns and operates our hospitals, and we utilize a collaborative approach to quality improvement efforts to engage all of our Hospitals when multiple facilities are not meeting identified targets. We strongly recommend that plans and hospitals retain the ability to opt into externally administered collaboratives, while retaining the option to develop plan or facility specific intervention plans when an internal effort would be the more effective approach to resolving to the issue(s). We recommend that Covered California accept participation in relevant industry collaboratives in lieu of individual/plan specific intervention plans when a plan/hospital elects to participate in a qualifying initiative, while not requiring collaborative engagement.
Issuer I	**Hospital Payments to Promote Quality and Value: Retirement of this section.** We support retirement of this section, which is not relevant to our model of care.

Issuer I	**Hospital Patient Safety: Require Cal Healthcare Compare participation for patient safety oversight.** We support a general requirement for participation in Cal Healthcare Compare, without requirements for engagement in specified collaboratives or initiatives.
Issuer I	**Input on retirement of individual hospital intervention plans and shift to collaborative engagement with poor performing hospitals.** We do not favor a wholesale shift from individual intervention plans to a collaborative approach. At present we participate voluntarily in a variety of quality collaboratives sponsored by the California Maternal Quality Care Collaborative (CMQCC) and anticipate continuing to do so. In California, we utilize a collaborative approach to quality improvement efforts to engage our Hospitals when multiple facilities are not meeting identified targets. We strongly recommend that plans and hospitals retain the ability to opt into externally administered collaboratives, while retaining the option to develop plan or facility specific intervention plans when an internal effort would be the more effective approach to resolving to the issue(s). We recommend that Covered California accept participation in relevant industry collaboratives in lieu of individual/plan specific intervention plans when a plan/hospital elects to participate in a qualifying initiative, while not requiring collaborative engagement.
Issuer I	**Input on retirement of Hospital Payments to Promote Quality and Value section.** We support retirement of this section, which is not relevant to our model of care.
Issuer I	**Input on requiring Cal Healthcare Compare participation for patient safety oversight and maternity quality improvement.** We support a general requirement for participation in Cal Healthcare Compare and the California Maternal Quality Care Collaborative, without requirements for engagement in specified collaboratives and initiatives.
Issuer I	**Input on tracking volume of in-network doulas.** Information regarding in-network doulas is available via the provider directory. We do not support a requirement to report volume of in-network doulas as these figures are variable due to ongoing contracting efforts.
Issuer I	**In response to feedback on administrative burden, provide input on reducing the number of required collaboratives and initiatives.** Participation in quality collaboratives and initiatives requires additional administrative support and oversight. In addition, effective participation in these collaboratives requires clinician engagement, detracting from time allocated to direct patient care. We recommend keeping the number of required collaboratives and initiatives to a minimum, allowing plans to determine which areas of clinical quality require the greatest allocation of resources, and to remain flexible and timely in responding to improvement opportunities as the arise.
Issuer I	**In response to feedback on financial burden, provide input on proposal to utilize Attachment 2 penalties in part or whole to support cost of required quality collaborative memberships and participation.** The impact to plans of participation in collaboratives is not limited to a financial burden. Participation in quality collaboratives and initiatives requires additional administrative support and oversight. In addition, effective participation in these collaboratives requires clinician engagement, detracting from time allocated to direct patient care.
Issuer I	**Input on highest value collaboratives to have required participation.** We value participation in collaboratives that utilize established clinical measures that have been provided to effectively assess quality care and outcomes, with associated industry benchmarks (e.g., NCQA HEDIS, CMQCC). We recommend keeping the number of required collaboratives and initiatives to a minimum, allowing plans to determine which areas of clinical quality require the greatest allocation of resources, and to remain flexible and timely in responding to improvement opportunities as the arise.

Consumer Advocate Group B	Shift to Collaborative Engagement Consumer Advocate Group B supports multistakeholder approach to support alignment of measures and quality improvement efforts. California's commercially insured population, including self-funded large purchasers, is broadly distributed among national, statewide and regional Issuers. Coordination of efforts is critical to achieving better quality outcomes and results in more efficient use of resources that ultimately improves affordability as well.
Consumer Advocate Group B	Hospital Payments to Promote Quality and Value Consumer Advocate Group B encourages Covered California to consider modifying its data request specifications for plans to report information on alternative payment models rather than eliminating reporting altogether. In the past, Consumer Advocate Group B supported Covered California's efforts to field the eValue8 Request for Information which had specific cost categories in which plans reported expenditures for capitation, bundled payment, etc. Consumer Advocate Group B would welcome the opportunity to work with Covered California to redesign the data reporting requirements.
Consumer Advocate Group B	Cal Healthcare Compare Participation • Consumer Advocate Group B encourages Covered California to require network hospitals to participate in Cal Healthcare Compare for patient safety oversight and maternity quality improvement. Additionally, Consumer Advocate Group B encourages that Covered California require hospitals to complete the Leapfrog patient safety survey (including outpatient surgery centers) as well as report data to the California Maternal Data Center. • As a performance accountability initiative, inclusion of Leapfrog reporting in this section is more aligned with Cal Healthcare Compare participation, rather than including Leapfrog as a quality collaborative. Covered California can also seek expanded public reporting of maternal hospital quality to improve the information that is available to consumers. • Consumer Advocate Group B supports Covered California's comprehensive approach to addressing Maternity Care in Section 4.03.07 and its promotion of blended case rate payments to aid in the reduction of avoidable C-sections. Consumer Advocate Group B supports the existing measures addressing prenatal and postnatal depression screening and follow-up. Consumer Advocate Group B encourages Covered California to adopt a broader measure set recommended by its Comprehensive Maternity Care Workgroup. The measure set includes: Nulliparous, Term, Singleton, Vertex C-section; Prenatal depression screening and follow-up & Postpartum depression screening and follow-up; Maternity Care: Postpartum Follow-up and Care Coordination; Social need screening and intervention; Patient experience – Consumer Assessment of Healthcare Providers & Systems (CAHPS) and Hospital Consumer Assessment of Healthcare Providers & Systems (HCAHPS) for maternity population; Severe obstetric complications. • Consumer Advocate Group B encourages Covered California to support strategies to improve access to certified midwives, including: Availability in absolute numbers and as a percentage of the plans' OB-GYNs under contract; Information in provider directories for members; Reporting on payment policies. • Additional purchaser requirements are summarized in the recently published Comprehensive Maternity Care (CMC) Common Purchasing Agreement 1.0, including: Targeted strategies to improve birth equity; Actions to address maternal health care access, specifically in rural markets and other identified "maternity deserts" where providers are scarce (in addition to providers able to
Consumer Advocate Group B	Tracking Volume of In-network Doulas Consumer Advocate Group B supports the expansion of maternity health equity focus. Many Consumer Advocate Group B members have expanded benefit coverage for doulas. Covered California can support workforce development, expansion of doula access and align with DHCS on scope of services definitions.
Issuer B	Input on retaining the reporting requirement for the proportion of enrollees who select versus are assigned a primary care clinician and retirement from HEI Performance Standard 9 (HEI Submission) in Attachment 2. Issuer B Care supports retaining the reporting requirement and the retirement of HEI Performance Standard 9 (HEI Submission) in Attachment 2.

Issuer B	Input on deploying a continuity of care assessment and other novel analytics via HEI to measure advanced primary care and establishing benchmarks and improvement targets as new Performance Standards in Attachment 2. Issuer B strongly recommends against implementing the continuity of care measure at this time. We agree with the challenges and limitations outlined by Covered CA on slide 16. Additionally, provider assignment disruption due to other factors such as members moving in/out of plan options with different provider networks and member satisfaction with providers, choose to change provider due to not happy with initial provider visit. We recommend health plans continue to remain focus on getting members in for their initial visits and annual wellness visits as basis for quality of care.
Issuer B	Input on aligning with OHCA methodology for required reporting on adoption of HCP LAN Alternative Payment Models using percent of members as well as primary care spend methodology, and retirement from Performance Standard 5 (Primary Care Payment) and 6 (Primary Care Spend) in Attachment 2. Issuer B supports proposal to move from FFS to APM models and increasing the amount spent on primary care year over year. Also supports the retirement of Attachment 2 Performance Standards 5 and 6 in favor of OHCA methodology.
Issuer B	Input on removal of IDS and ACO enrollment and descriptive reporting. Issuer B supports the recommendation to remove this reporting requirement.
Issuer B	Input on aligning with OHCA in reporting adoption of HCP LAN Alternative Payment Models using percent of members and retirement of Attachment 2 Performance Standard 7 (Payment to Support Networks Based on Value). Issuer B support the plan to increase the percent of members impacted by APM. Also supports the retirement of Attachment 2 Performance Standard 7 in favor of OHCA methodology.
Issuer B	Input on retirement of individual hospital intervention plans and shift to collaborative engagement with poor performing hospitals. Issuer B supports the recommendation to retire this plan in favor of collaborative engagement
Issuer B	Input on retirement of Hospital Payments to Promote Quality and Value section. Issuer B supports the recommendation to retire this section
Issuer B	Input on requiring Cal Healthcare Compare participation for patient safety oversight and maternity quality improvement. Issuer B supports this recommendation
Issuer B	Input on tracking volume of in-network doulas. Issuer B recommends Covered CA align their approach and coverage for Douals with the DHCS Doula Benefit. This will positively impact the expansion of the Doula network. We also propose for Covered CA to consider including Douals as an essential health benefit with same reimbursement rates as Medi-Cal. DHCS recently revised the Doula reimbursement to ensure that Doulas make a living wage. Having the same rates across all products/LOBs ensures that the Doulas can service the members without any rate differentiations, that can otherwise lead to interruptions in healthcare delivery.
Issuer B	In response to feedback on administrative burden, provide input on reducing the number of required collaboratives and initiatives. Issuer B supports the proposal to remove the number of required collaboratives. We would also like to see options of low and no-cost collaborative be added.
Issuer B	In response to feedback on financial burden, provide input on proposal to utilize Attachment 2 penalties in part or whole to support cost of required quality collaborative memberships and participation. Issuer B supports the proposed use of Attachment 2 penalties funds to support collaboratives participation dues and fees.
Issuer B	Input on highest value collaboratives to have required participation. Issuer B recommends at minimum, the following organizations be considered as high-value collaboratives; 1. CMQCC 2. CHC 3. Symphony 4. IHA

Stakeholder A	**Measuring the performance of primary care practices within Contractor's network is important to ensure Enrollees receive high-quality care, to inform quality improvement and technical assistance efforts, and to support the adoption of alternative payment models. To measure the performance of primary care practices, Contractor must:** 1- Implement a measure set that includes quality and cost-driving utilization measures for advanced primary care (APC) to assess the prevalence of high-quality, advanced primary care practices within Contractor's network. Contractor will collaborate with Covered California, the Integrated Healthcare Association (IHA), California Quality Collaborative (CQC), and other stakeholders to implement the measure set. 2- Submit data to IHA all necessary data, including supplemental clinical data, for all lines of business to implement the APC measure set. Contractor must report its performance on the APC measure set sourced from IHA to Covered California or allow IHA to submit results to Covered California on Contractor's behalf.
Stakeholder A	**Measuring the performance of IDSs and ACOs is important to ensure Enrollees receive high-quality, equitable, and affordable care, to inform improvement efforts, and to establish best practices. To measure the performance of IDSs and ACOs, Contractor must:** 1- Submit data to IHA all necessary data, including supplemental clinical data, for all lines of business for and participate in the IHA Align. Measure. Perform. (AMP) Program , as applicable for its delivery system model Atlas program. Contractor must report its performance, sourced from IHA, on the IHA AMP Atlas measure set for all applicable lines of business to Covered California or allow IHA to submit results to Covered California on Contractor's behalf. 2- Engage and work with Covered California to evaluate its performance using the results of the IHA AMP Atlas Program and the characteristics of different IDS and ACO systems to establish best practices to inform future requirements
Stakeholder A	**Contractor shall contract with providers, including physicians and physician groups, that demonstrate they provide quality care and promote the safety of Enrollees at a reasonable price. Contractor shall improve quality and cost performance across its contracted providers.** 1- Covered California will work with the Integrated Healthcare Association (IHA), California providers, and QHP Issuers to profile and analyze variation in performance on provider quality measures. This profile and analysis will be based on national and state benchmarks, variation in provider performance, best existing science of quality improvement, and informed by effective engagement of stakeholders. To meet this expectation, Contractor must: a- Submit all necessary data, including supplemental clinical data, for all lines of business to IHA and fully participate in the IHA Align. Measure. Perform (AMP) program for physician groupsprovider organizations and for primary care practices and report AMP performance results sourced from IHA for each contracted physician groupprovider organization and each primary care practice that participates in its QHPs to Covered California or allow IHA to submit results to Covered California on Contractor's behalf. Contractor shall use AMP performance results to profile and analyze variation in performance on quality measures and total cost of care.
Issuer D	**Input on retaining the reporting requirement for the proportion of enrollees who select versus are assigned a primary care clinician and retirement from HEI Performance Standard 9 (HEI Submission) in Attachment 2 – Remove 9.4** Comment: HEI data doesn't appear to have this. Would that be a change and if so, would it be going forward?
Issuer D	Input on deploying a continuity of care assessment and other novel analytics via HEI to measure advanced primary care and establishing benchmarks and improvement targets as new Performance Standards in Attachment 2 The proposed change to Attachment 2 for Measuring Continuity of Care causes us concern and we would like to understand how this assessment will work, especially if enrollees change Issuers resulting in doctor changes in a new network.
Issuer D	Input on aligning with OHCA methodology for required reporting on adoption of HCP LAN Alternative Payment Models using percent of members as well as primary care spend methodology, and retirement from Performance Standard 5 (Primary Care Payment) and 6 (Primary Care Spend) in Attachment 2 – OCHA reporting methodology & retire PG 5 & 6 Issuer D agrees with OHCA alignment.

Issuer D	**Input on removal of IDS and ACO enrollment and descriptive reporting requirements** No comment
Issuer D	**Input on aligning with OHCA in reporting adoption of HCP LAN Alternative Payment Models using percent of members and retirement of Attachment 2 Performance Standard 7 (Payment to Support Networks Based on Value)** No comment
Issuer C	Performance Standard 9 HEI Data Submission: Issuer C is aligned with the proposed recommendations for consolidating all components of the current Performance Standard 9 into one standard, and assessing performance using a comprehensive methodology document that outlines all timely and complete data expectations. However, we believe that any new or modified requirements for these data extracts should not be considered performance issues with required Corrective Action Plans. New or modified requirements, changes to the layout of the extract or the way data is being sent must have a negotiated implementation plan with the Issuer, including whether data replacement should be supplied.
Issuer C	Performance Standard New: Engagement in Collaboratives and with Community - Issuer C is aligned with engaging in learning collaboratives such as CalHealthcare Compare and IHA, as we currently support these collaboratives, and many others. We believe it is critical to understand what additional collaboratives, and the level of participation Covered Ca is requiring to understand if this should have a performance penalty associated with it. - As Issuer C communicated on 5/23, we are aligned with the reduction of the number of collaboratives that Issuers are required to participate in. We have concerns with an expectation in which some Qualified Health Plans (QHPs) subsidize the costs for other QHPs to participate in a required or recommended quality collaborative. Additionally, plans can still “align” work to the collaboratives even if not participating directly.
Issuer C	Issuer C recommends the following collaboratives be mandatory for all QHPs: - Symphony as the single provider data utility - while this effort has continued to face challenges in its execution, the problems it is working to solve are still relevant. - Integrated Healthcare Association (IHA) - continues to have the greatest momentum related to industry wide payment/quality efforts - California Quality Collaborative (CQC) - significant traction on industry wide payment/quality as the collaboratives with the highest value for required participation.
Issuer C	Mandating participation in these collaboratives helps to ensure that QHPs remain active partners in helping to achieve statewide public health objectives. The collaboration between QHPs, IHA, and CQC has helped to drive alignment and standardization on issues where there might otherwise be a dearth of leadership to accomplish that goal. For example, the California Advanced Primary Care measure set now used by Covered California is a product of this collaboration. The forthcoming multi-payer Advanced Primary Care payment demonstration, where four QHPs will collectively pilot value-based payment for shared primary care practices, is also a product of this collaboration. This opportunity would not have come to fruition without mandatory participation by QHPs in this initiative. Continuing to mandate participation with IHA and CQC will further advance goals set by the state as well as Covered California around primary care, behavioral health, and multi-payer alignment.
Issuer C	Performance Standard New: Primary Care Utilization - Overall Member Engagement - Issuer C is aligned with the proposed recommendations on tracking primary care and utilization.
Issuer C	Performance Standard New: Primary Care Utilization - Measuring Continuity of Care - Issuer C is aligned with deploying continuity of care assessments and other novel analytics via HEI data submissions; however, we are concerned that this isn’t currently in the Advanced Primary Care measure set, and we believe it is too early to consider benchmarks or performance improvement targets with financial risk for the 2026 – 2028 contracting period. Issuer C recommends continuing to monitor this measure, providing additional understanding of how the Continuity Index of 0.7 (70%) was established and working with the Advanced Primary Care workgroup on any changes to how Advanced Primary Care is being measured."