



COVERED CALIFORNIA POLICY AND ACTION ITEMS

February 20, 2025 Board Meeting

2026 QUALIFIED HEALTH AND DENTAL PLAN CERTIFICATION APPLICATION

James DeBenedetti
Director
Plan Management Division

CERTIFICATION APPLICATION UPDATES

- ❑ **Qualified Health Plan (QHP)** The QHP Contract period is 2026 - 2028. All Issuers are considered New Entrants and must complete the entire application.
- ❑ **Qualified Dental Plan (QDP)** Contract period is 2024 - 2026. Currently contracted QDPs will have reduced application response requirements. New entrants will complete the entire application.
- ❑ There have been no further substantive updates since the presentation at the January 16, 2025, Board meeting.
- ❑ Plan Year 2026 Certification Health and Dental Applications will be open to all Applicants.
- ❑ The four Certification Applications are posted on the [HBEX Certification page](#).

CERTIFICATION SELECTION CRITERIA

Following a comprehensive stakeholder process and consideration of a set of recommendations by staff, Covered California's Board of Directors articulate guidelines for the selection and oversight of Qualified Health and Dental Plans (QHP and QDP) which are used in selecting Issuers and making certification decisions.

These guidelines are:

- ❑ Promote Affordability and Value for the Consumer – Both in Premiums and at Point of Care
- ❑ Encourage Competition Based upon Quality
- ❑ Encourage Competition Based upon the Populations Served
- ❑ Encourage Competition Based upon Meaningful QHP and QDP Choice and Product Differentiation: Patient-Centered Benefit Plan Designs
- ❑ Encourage Competition throughout the State
- ❑ Encourage Delivery System Improvement, Effective Prevention Programs and Payment Reform
- ❑ Demonstrate Administrative Capability and Financial Solvency
- ❑ Encourage Robust Customer Service

PLAN YEAR 2026 CERTIFICATION MILESTONES

Milestone	Date
Release Draft 2026 QHP & QDP Certification Applications	September 16, 2024
Draft Application Comment Periods End	October 11, 2024
Plan Management Advisory: Benefit Design & Certification Applications Policy Recommendation	January 9, 2025
January Board Meeting: Discussion of Benefit Design & Certification Applications Policy Recommendation	January 16, 2025
Letters of Intent Accepted	February 3-14, 2025
Final AV Calculator Released*	February 2025
Applicant Trainings (electronic submission software, SERFF submission and templates*)	February 2025
February Board Meeting: Anticipated approval of 2026 Patient-Centered Benefit Plan Designs & Certification Applications	February 20, 2025
QHP & QDP Applications Open	March 3, 2025
QHP & QDP Application Responses (Individual and CCSB) Due	April 30, 2025, noon (12:00 pm PT)
Evaluation of QHP Responses & Negotiation Prep	May – June 2025
QHP Negotiations	June 2025
QHP Preliminary Rates Announcement	July 2025
Regulatory Rate Review Begins (QHP Individual Marketplace)	July 2025
Evaluation of QDP Responses & Negotiation Prep	June – July 2025
QDP Negotiations	July 2025
CCSB QHP Rates Due	July 2025
QDP Rates Announcement (no regulatory rate review)	August 2025
Public Posting of Proposed Rates	July 2025
Public Posting of Final Rates	September – October 2025



*Final AV Calculator and final SERFF Templates availability dependent on CMS release
TBD = dependent on CCIIO rate filing timeline requirements

REQUESTED ACTION: PLAN YEAR 2026 CERTIFICATION APPLICATIONS

Staff requests the Board to:

- ❑ Formally adopt the 2026 Certification Criteria and QHP and QDP Applications for the individual and small business health and dental plans.
- ❑ Authorize staff to issue applications for selection of QHPs and QDPs for Plan Year 2026.

PUBLIC COMMENT

CALL: (877) 336-4440

PARTICIPANT CODE: 6981308

- ❑ To request to make a comment, press 10; you will hear a tone indicating you are in the queue for comment. Please wait until the operator has introduced you before you make your comments.
- ❑ If watching via the live webcast, please mute your computer to eliminate audio feedback while calling in. Note, there is a delay in the webcast.
- ❑ The call-in instructions can also be found on page two of the Agenda.

EACH CALLER WILL BE LIMITED TO TWO MINUTES PER AGENDA ITEM

NOTE: Written comments may be submitted to BoardComments@covered.ca.gov.

2026 QUALIFIED HEALTH AND DENTAL PLAN ISSUER MODEL CONTRACTS

James DeBenedetti
Director
Plan Management Division

2026 MODEL CONTRACT UPDATE

- ❑ Proposed changes for the 2026 Qualified Dental Plan Issuer Contract Amendment for the Individual and Small Business markets are minor (primarily for purposes of clarification).
- ❑ Proposed changes presented for discussion at the January 16, 2025, Board meeting, for the Qualified Health Plan Issuer Contracts for the Individual and Small Business markets were significantly updated for the new contract duration of 2026-2028.
- ❑ Updates since the January 16th Board meeting have been made to the draft 2026-2028 Individual Market Attachment 1 Advancing Equity, Quality, and Value, Section 3.05.4 1) Use of Generative Artificial Intelligence in QHP Issuer Operations, Enrollee Transparency.
- ❑ Current draft 2026-2028 QHP Issuer Model Contracts and the draft 2024-2026 QDP Issuer Contract Amendment, are available here:
<https://hbex.coveredca.com/stakeholders/plan-management/contract-listings/2026/>

2026 MODEL CONTRACT CHANGES SUMMARY

- ❑ Section 3.2.1.2 Contractors Activities to Promote Enrollment (QHP Individual and Small Group, QDP):
 - The update to this requirement removes the obligation for QHP and QDP issuers to display a Shop and Compare Tool on their organization's website. QHP and QDP issuers will be required to link to the Covered California website landing page.
- ❑ Section 4.2.6/7 Hearing Aid Coverage for Children Program (QHP Individual and Small Group):
 - QHP Issuers will be required to provide information to Enrollees regarding the availability of the California Department of Healthcare Service's (DHCS) Hearing Aid Coverage for Children Program (HACCP) within its Evidence of Coverage (EOC) document.
- ❑ Section 4.3.2 Network Adequacy (QHP Individual and Small Group, QDP)
 - The update to this requirement includes Covered California in addition to the applicable State Regulators as a responsible entity for review of network adequacy standards, in compliance with federal regulations.

2026 MODEL CONTRACT CHANGES SUMMARY CONTINUED

- ❑ Section 4.6.7 Notices (QHP Individual, QDP)
 - Subsection g) was added in response to concerns raised regarding credits being automatically applied to the monthly premium without notifying consumers that they could request a refund. QHP and QDP issuers within the Individual marketplace will be required to prominently inform consumers of their right to request a refund of any credits on their account on premium invoices, termination notices, and other notices where applicable.
- ❑ Section 6.1.1 Rates and Payments, State Funded Programs (QHP Individual):
 - Covered California amended language in this section to more broadly capture Covered California's responsibility to provide payments for programs required by state law.
- ❑ Article 14 Definitions, Evidence of Coverage (EOC) (QHP Individual and Small Group, QDP)
 - Definition was updated to clarify this document is the State Regulator approved EOC that is issued to a Subscriber or Member. Contract references were updated throughout to align with this definition.

2026-2028 MODEL CONTRACT DRAFTS & RESPONSE TO COMMENTS

2026-2028 Model Contract Drafts and Response to Comment documents are posted on California's Health Benefit Exchange website:

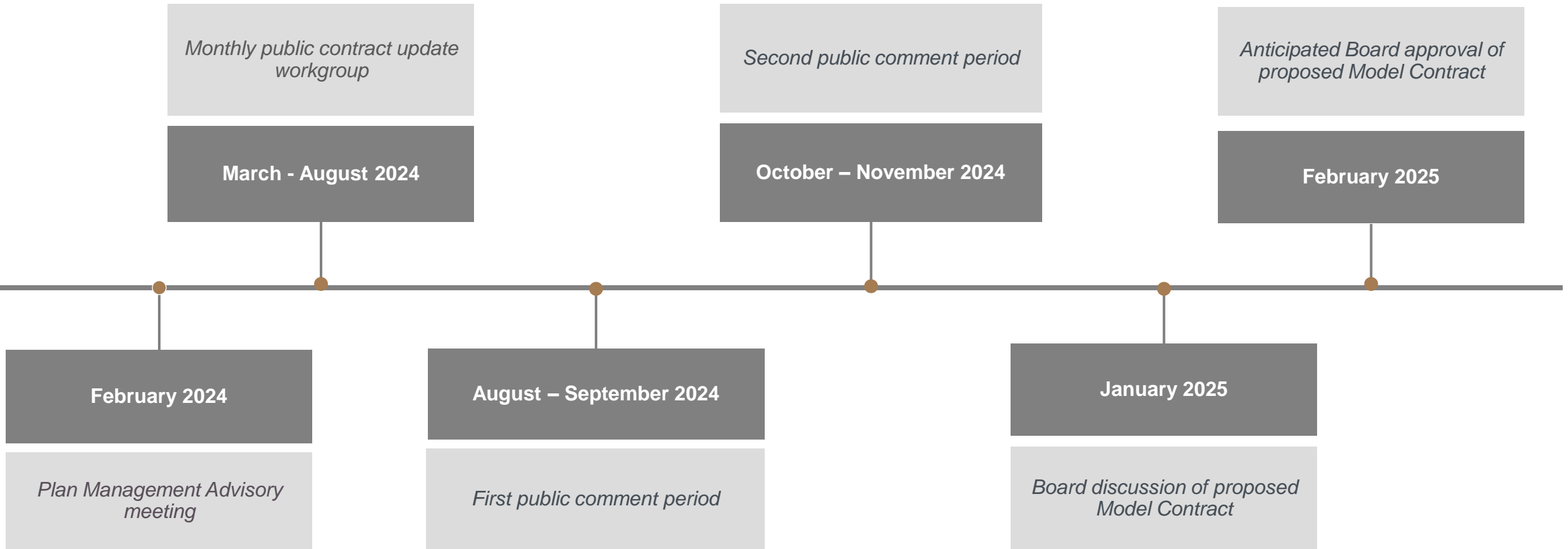
<https://www.hbex.ca.gov/stakeholders/plan-management/contract-listings/2026/>

Any questions please email PMDContractsUnit@covered.ca.gov and EQT@covered.ca.gov

2026-2028 QUALIFIED HEALTH PLAN INDIVIDUAL AND CCSB ISSUER CONTRACT

S. Monica Soni, MD
Chief Medical Officer
Chief Deputy Executive Director
Health Equity and Quality Transformation (EQT)

2026 QHP ISSUER CONTRACT UPDATE TIMELINE



CONTRACT DEVELOPMENT GUIDING PRINCIPLES

Principles

Equity is quality

Center the member

Make it easy to do right

Amplify through alignment

Focused scope for high impact

Framework

Build on the strong foundation of 2023-2025 contract

Prioritize alignment with DHCS, CalPERS, & OHCA

Emphasize outcomes

Pursue administrative simplification

Model Contract

- Essential Community Providers (ECPs)
- Article 5

Attachment 1

- Articles 1-6

Attachment 2

- Performance standards

Attachment 4

- Quality Transformation Initiative

BUILDING ON 2023-2025 WITH BOLD NEW ADDITIONS

Actionable Data

- Selective Contracting for Quality
- Expansion of Demographic Data Collection
- Data Exchange
- Behavioral Health Disparities Reduction
- Quality Transformation Initiative (QTI)

Healthy Workforce

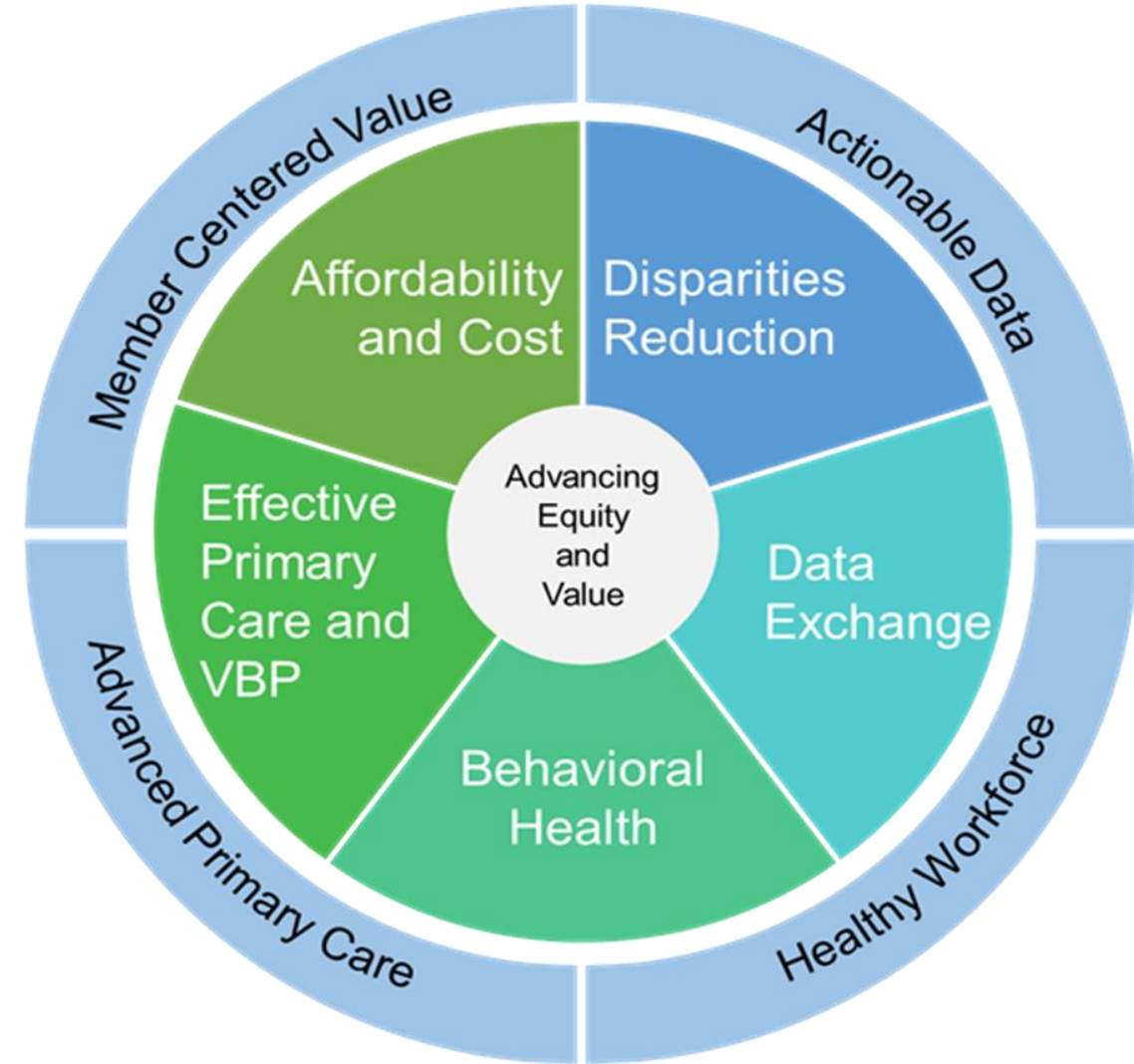
- Essential Community Providers
- Generative Artificial Intelligence
- Primary and Behavioral Health Care Spend Tracking
- Engagement in Collaboratives and with Community

Advanced Primary Care

- Continuity of Care
- Use and Quality of Digital Care
- Behavioral Health Promotion
- Substance Use Disorder Care
- Behavioral Health Vendor Oversight

Member-Centered Value

- Access to Care
- Comprehensive Maternal Healthcare
- Population Health Investments
- Targeted Engagement and Outreach



STAKEHOLDER ENGAGEMENT AND PUBLIC COMMENT

2026 – 2028 Model Contracts

- Contract Workgroup open to all Issuers, Public Purchasers, and Consumer Advocate Groups
- Participants reviewed and offered feedback on the proposed contracts and preliminary contract language
- Two public comment and response periods for Contract feedback

Contract Workgroup

- 9 public meetings from March – August 2024
- 18 unique organizations commented with 341 total comments. Comments were deidentified and are [available online](#)

Public Comment Cycle 1

- Comment Cycle 1 was held between 8/16/2024 – 9/16/2024. Response period to comments 9/16/2024 – 10/17/2024
- 14 unique organizations commented with 236 total comments. Comments and responses are [available online](#)

Public Comment Cycle 2

- Comment Cycle 2 was held between 10/18/2024 – 11/18/2024. Response period to comments 11/18/2024 – 12/20/2024
- 7 unique organizations commented with 50 total comments. Comments and responses are [available online](#)

All 2026 Certification and Contract Documents will be presented in February 2025 for Board approval

ECP STAKEHOLDER ENGAGEMENT AND FEEDBACK

Essential Community Provider Refresh

- Health Management Associates brought on in February as consultants
- ECP Workgroup identified and solicited input from many external stakeholders including State-based Marketplaces, Issuers, Consumer Advocates, and Safety Net and Tribal and Urban Indian Health Care Providers
- General concern with the contracting process & contracting availability was expressed by Issuers and Safety Net providers

ECP Project Public Meetings

- 3 public meetings from June - December 2024
- 6 unique organizations commented with 16 specific ECP comments. Comments were deidentified and are [available online](#)

Public Comment Cycle 1

- Comment Cycle 1 was held between 8/16/2024 – 9/16/2024. Response period to comments 9/16/2024 – 10/17/2024
- 7 unique organizations commented with 14 specific ECP comments. Comments and responses are [available online](#)

Public Comment Cycle 2

- Comment Cycle 2 was held between 10/18/2024 – 11/18/2024. Response period to comments 11/18/2024 – 12/20/2024
- 1 unique organization commented with 1 specific ECP comment. Comments and responses are [available online](#)

Sufficiency Threshold Comment Period

- Comment period specific to proposed sufficiency threshold held between 11/14/24 – 12/6/24
- 6 Issuers and 5 consumer advocacy organizations submitted 32 questions and comments. Comments and responses are [available online](#)

2026 – 2028 QHP ISSUER MODEL CONTRACT DRAFT UPDATES

QHP Issuer Model Contract
Article 4 QHP Issuer Program Requirements
Article 5 Advancing Equity Quality, and Value
Removal From the Exchange (“25/2/2”), Access,
and Essential Community Providers

PROPOSED 2026-28 ECP REQUIREMENTS

Model Contract Article 4 – Essential Community Providers (ECP) Requirements

- ❑ Issuers must meet ECP General Standard by maintaining a network which includes a sufficient geographic distribution of care to provide reasonable and timely access to low-income populations, individuals living in Health Professional Shortage Areas (HPSAs) and medically underserved individuals
- ❑ ECP General Standard Sufficiency Requirements:
 - Issuers must demonstrate sufficient geographic distribution of a mix of essential community providers reasonably distributed throughout the geographic service area
 - Issuers must demonstrate provider contracts with at least 15% of Primary Care ECPs in each rating region in which it offers QHPs
 - Issuers must demonstrate provider agreements with at least 15% of Behavioral Health ECPs in each rating region in which it offers QHPs
 - Issuers must demonstrate agreements with at least one ECP hospital per county requirement or per rating area in counties with multiple rating regions

PROPOSED 2026-28 ECP REQUIREMENTS

Model Contract Article 4 – Essential Community Providers (ECP) Requirements

- ❑ ECP General Standard Sufficiency Requirements (continued):
 - If Issuers are unable to meet the sufficiency requirements stated on the previous slide:
 - ❑ Issuers must demonstrate provider agreements with at least 15% of 340B non-hospital providers in each rating region in which it offers QHPs
 - ❑ Issuers must demonstrate documentation of good faith efforts to achieve the sufficiency requirements stated previously for the first plan year of the contract period
 - ❑ Issuers must demonstrate documentation of improvements in plan years 2027 and 2028 showing material increases in percentage of contracts with Primary Care and Behavioral Health ECPs
- ❑ Issuers in an integrated delivery system may request the ECP alternative standards and must demonstrate compliance by mapping low-income and HPSA member populations and network providers and facilities offering services in all ECP categories

PROPOSED 2026-28 ACCESS REQUIREMENTS

Model Contract Article 4 – Access

- ❑ To assess and monitor Beneficiary Experience and Outcomes, Covered California will track and publicly report CMS QRS Enrollee Experience performance, although removed from Attachment 2 as a performance standard
- ❑ To assess and improve Provider Availability and Accessibility, Covered California will leverage Healthcare Evidence Initiative (HEI) for Network measures agreed upon by California public purchasers and/or regulators, with improvement plans required for underperforming Issuers
 - Provider-to-member ratio: The number of providers per beneficiary
 - Active providers : The percentage of providers serving beneficiaries in the past year
 - Provision of telehealth services: The percentage of providers providing telehealth services
- ❑ To assess and improve Service Utilization and Quality, Covered California may launch a secret shopper survey utilizing questions from DHCS and CalPERS surveys in PY2026 with improvement plans required for underperforming Issuers
 - A repeat survey may be implemented biennially (every other year) if pervasive underperformance

PROPOSED 2026-28 25/2/2 PROGRAM REQUIREMENTS

Model Contract Article 5 – Removal from the Exchange

- Annual assessment of QHP performance on QRS clinical measures
- Monitoring and remediation periods (two years each) for continued QHP clinical composite performance beneath the 25th percentile composite benchmark
- New static benchmark year established, Measurement Year (MY) 2024
- Removal of retired QRS measures from benchmark and composite score calculations
- Clinical measures added to QRS during contract cycle will be included and composite score calculations as benchmarks are published
- Minimum Performance Level (MPL) Action Plan for clinically significant measures falling beneath the 25th percentile for 2 consecutive years.

Attachment 1 Advancing Equity, Quality, and Value

PROPOSED 2026-28 ARTICLE 1 REQUIREMENTS

Article 1: Equity and Disparities Reduction

- ❑ Demographic Data Collection: Issuer must collect member self-identified race, ethnicity, and language data. Issuers must expand data collection to include member-level Sexual Orientation and Gender Identify (SOGI) data and establish baseline performance
- ❑ Disparities Measurement: Patient Level Data (PLD) File: Issuer must submit the following Healthcare Effectiveness Data and Information Set (HEDIS) hybrid measure patient level data files for its enrollees:
 - Prenatal Depression Screen and Follow-up (PND-E)
 - Postpartum Depression Screen and Follow-up (PDS-E)
 - Quality Transformation Initiative (QTI) measures
 - Social Need Screening and Intervention (SNS-E)
- ❑ Disparities Measurement: Healthcare Evidence Initiative: Issuer and Covered California will review performance on specified disparities measures using HEI data
- ❑ Disparities Reduction Intervention: Issuer must meet disparities reduction and health equity requirements throughout Attachment 1 and Attachment 4 Quality Transformation Initiative (QTI)
- ❑ NCQA Health Equity Accreditation: Issuer must achieve and maintain NCQA Health Equity Accreditation within the first year of contracting with Covered California

PROPOSED 2026-28 ARTICLE 2 REQUIREMENTS

Article 2: Behavioral Health

- ❑ Issuers must submit NCQA BH network or equivalent reports with current network data if older than two years, and demonstrate enhanced access to behavioral health services, including telehealth, via website evidence
- ❑ Monitor behavioral and virtual behavioral health quality through utilization analysis and vendor criteria submission, and oversee delegated entities to ensure quality behavioral health care, including submission of a detailed delegation report
- ❑ Provide staff with cultural humility training, deploy culturally specific materials for marginalized groups, and implement and report on disparity reduction in behavioral health utilization using data-driven strategies and community engagement
- ❑ Promote harm reduction for opioid use, support Tobacco Treatment, and track health metrics per Smart Care California guidelines
- ❑ Annually report on behavioral health spending by product according to OHCA guidelines, collaborate with other QHP Issuers, engage in community initiatives, and encourage suggestions for activities that align with Covered California's methodologies
- ❑ Support integration of behavioral health with medical services

PROPOSED 2026-28 ARTICLE 3 REQUIREMENTS

Article 3: Population Health

Population Health Management

- ❑ Issuer must ensure the use of health promotion and prevention services, increase utilization of high value services, risk stratify Enrollees, and develop targeted interventions based on risk
- ❑ Issuer must identify opportunities, conduct outreach, and engage all Covered California Enrollees, not just Covered California Enrollees who obtain services from providers, in population health activities
- ❑ Issuer must submit specific elements of their NCQA Population Health Management plan or provide alternative reporting as outlined in 3.01.1

Health Prevention and Promotion

- ❑ Issuer must identify Enrollees who are eligible for certain high value preventive and wellness benefits, notify Enrollees about the availability of these services, ensure those eligible receive appropriate services and care coordination, and monitor the health status of these Enrollees
- ❑ Issuer must provide a CDC-recognized Diabetes Prevention Program available in different modalities to its eligible Covered California Enrollees

PROPOSED 2026-28 ARTICLE 3 REQUIREMENTS

Article 3: Population Health

Supporting At-Risk Enrollees Requiring Transition

- ❑ Issuer must submit an evaluation and formal transition plan for any service area reduction or any modification to its existing service area
- ❑ Issuer must outreach to all Covered California Enrollees alerting them of the service reduction and options to continue care with other QHP Issuers and conduct outreach to At-Risk Enrollees and get authorization to send health information to receiving QHP Issuers to minimize disruption of continuity of care
- ❑ Issuer receiving At-Risk Enrollees must establish processes to identify At-Risk Enrollees, ensure care transitions account for Enrollees' current health status and provide other vital information that aids in continuity of care

Social Health

- ❑ Issuer must report Enrollee social needs screening process for food, housing and transportation needs, including touch points, who performed the screening, and which methods and instruments were used to conduct screening
- ❑ Issuer must report screening efforts by provider networks, including coordination efforts with providers on screening and linkage to services to connect Covered California Enrollees
- ❑ Issuer must collect and report data for all components of the Social Needs Screening & Intervention (SNS-E) Measure and screen positive rate

PROPOSED 2026-28 ARTICLE 3 REQUIREMENTS

Article 3: Population Health Management

Use of Generative Artificial Intelligence in Qualified Health Plan Issuer Operations

- ❑ Align with federal requirements around Patient Care Decision Support Tools **45 C.F.R § 92.210** inclusive of but not limited to GenAI
- ❑ Incorporate evolving best practices for use of GenAI and healthcare into use cases
- ❑ Ensure transparency with members about the use of generative AI
- ❑ Implement processes to address and mitigate bias
- ❑ Participate in collaborative discussions and shared learnings across Issuers
- ❑ Report on:
 - Processes and approach to mitigate bias
 - GenAI Governance approach
 - GenAI use cases

ARTICLE 3 GEN AI COMMENTS KEY THEMES

- ❑ Multiple Issuers and a trade association expressed concern for the operational and cost implications of notifying enrollees when GenAI or algorithms are used at the time decisions are made available to enrollees
- ❑ One Issuer and a trade association expressed concerns that GenAI contract requirements may extend to medical providers or proprietary utilization management tools used for care decisions
- ❑ One stakeholder group requested clarity on how to apply these requirements in situations such as those mandated by SB 855

PROPOSED 2026-28 ARTICLE 3 CHANGES

Article 3: Population Health: Use of Generative Artificial Intelligence in Qualified Health Plan Issuer Operations

Notable Changes to Draft Attachment 1	Rationale
<p><i>"Provide written notice to a Covered California Enrollee when Contractor knowingly uses artificial intelligence including GenAI, algorithm, or other software for the purpose of utilization review or utilization management functions, based in whole or in part on medical necessity under the benefits provided by the QHP, at the time Contractor communicates the decision to the Enrollee in writing, including electronically. Notice may include information regarding Contractor's use of bias mitigation strategies. This requirement shall not apply to Contractor's medical groups or other delegated entities."</i></p>	<p>The revised language balances ensuring transparency with enrollees about the use of AI within their healthcare decisions and maintaining operational practicality for issuers. It clarifies that issuers can incorporate this requirement into their existing written communication processes and exempts medical groups and delegated entities.</p>

PROPOSED 2026-28 ARTICLE 4 REQUIREMENTS

Article 4: Delivery System and Payment Strategies to Drive Quality

Advanced Primary Care

- Issuer must match enrollees with PCPs and report the number of enrollees who select a PCP or who were assigned a PCP
- Issuer must review and improve primary care selection and healthcare utilization using HEI submitted data
- Issuer must review and improve member continuity of care; measure results to be generated by Covered California using HEI-submitted data
- Issuer must report on total primary care spend in alignment with Office of Health Care Affordability (OHCA)
- Issuer must work with Covered California and other stakeholders to analyze the relationship between primary care spend as a percentage of total healthcare expenditures (THCE) and network performance, including quality, equity, and cost

PROPOSED 2026-28 ARTICLE 4 REQUIREMENTS

Article 4: Delivery System and Payment Strategies to Drive Quality (Continued)

Networks Based on Value:

- ❑ Issuer must report how cost, quality, patient safety, patient experience, and equity are considered in network design and management
- ❑ Issuer must report on Alternative Payment Model (APM) adoption and Total Cost of Healthcare Expenditures in alignment with OHCA
- ❑ Issuers must participate in the IHA Align.Measure.Perform (AMP) program for physician groups and report AMP performance results to Covered California annually or allow IHA to submit results to Covered California

Hospital Quality, Value and Safety

- ❑ Issuer must demonstrate participation in collaborative engagement with Hospitals, Covered California, Issuers and Cal Healthcare Compare (CHC) to analyze performance variation and engage with poor performing hospitals
- ❑ Covered California requires contracted hospitals to comply with public price transparency rules by posting standard charges in a machine-readable format
- ❑ Collaboration is intended to enhance patient safety in hospitals and address the opioid epidemic. Annual reporting will be utilized to evaluate improvements in hospital and facility cost, safety, and quality. Covered California will assess issuers based on their strategic planning and collaborative reporting efforts

PROPOSED 2026-28 ARTICLE 4 REQUIREMENTS

Article 4: Delivery System and Payment Strategies to Drive Quality (Continued)

Comprehensive Maternity Care

- ❑ Issuer must work with Covered California to ensure maternity service providers in network hospitals utilize California Maternity Quality Care Collaborative (CMQCC) resources and enroll in the CMQCC Maternal Data Center
- ❑ Issuer must report on engagement efforts with providers and maternity enrollees to promote individualized provider selection and high-value care delivery, aligned with Cal Healthcare Compare's Maternity Honor Roll Program, alongside facilitating access to necessary social support services
- ❑ Issuer must develop and submit a strategy for expanding the network to include more doulas, nurse midwives, and licensed midwives, aimed at enhancing access to maternity care and ensuring care provider diversity that mirrors member demographics
- ❑ Issuer must collect and analyze data on maternal health disparities, particularly focusing on outcomes stratified by race and ethnicity, and implement targeted interventions to improve care for specific subpopulations, drawing on insights from Cal Healthcare Compare and CMQCC guidelines

PROPOSED 2026-28 ARTICLE 4 REQUIREMENTS

Article 4: Delivery System and Payment Strategies to Drive Quality (Continued)

Use of Virtual Care

- ❑ Issuers must report all virtual care solutions and vendors in place and disclose vendors' NCQA Virtual Care Accreditation status
- ❑ Issuers must collect quality monitoring measures from virtual care vendors and annually report summary findings to Covered California
- ❑ Issuers must provide member support for navigating virtual services, ensuring solutions are culturally and linguistically tailored, and share relevant tools and resources with Covered California
- ❑ Issuers must report on reimbursement policies for both network and third-party providers, ensuring payment parity for virtual services
- ❑ Issuers must collaborate with Covered California to review virtual care service utilization, address disparities using HEI, submit improvement plans for outliers, and participate in best practice collaboratives, including digital literacy support

Participation in Quality Collaboratives

- ❑ Contractors must report participation in quality collaboratives

PROPOSED 2026-28 ARTICLE 5 REQUIREMENTS

Article 5: Measurement and Data Sharing

- ❑ Issuers must submit to Covered California its QRS data and participate in NCQA Quality Compass Reporting for its other lines of business
- ❑ Issuers must submit quality and cost data to HEI in accordance with data submission requirements and in alignment with the HIPAA Privacy Rule and California law, and acknowledge that Covered California will publish this data in accordance with AB-929
- ❑ Issuers must implement and maintain a secure Patient Access API, and report on its use
- ❑ Issuers must execute the Data Sharing Agreement (DSA) as required by Health and Safety Code section 130290 and participate in at least one QHIO
- ❑ Issuers must monitor its network hospital's compliance with ADT event Technical Requirements and report on their adherence
- ❑ Issuers must share information on enrollees with primary care providers for their assigned members

PROPOSED 2026-28 ARTICLE 6 REQUIREMENTS

Article 6: Certification, Accreditation, and Regulation

- ❑ Issuer must achieve and maintain current National Committee for Quality Assurance (NCQA) Health Plan Accreditation by year-end 2026. If Issuer is not currently accredited by NCQA, Issuer must be accredited by Utilization Review Accreditation Commission (URAC) or Accreditation Association for Ambulatory Healthcare (AAAHC) and submit plan to obtain NCQA health plan accreditation
- ❑ Issuer must notify Covered California of scheduled NCQA health plan accreditation review and its results. Issuer must submit a copy of the assessment report within 30 days of its receipt from NCQA
- ❑ Issuers that receive any status other than “Accredited”, lose an accreditation, or fail to maintain a current and up to date accreditation, must:
 - Notify Covered California within ten (10) days of the status change,
 - Implement strategies to achieve the level of “Accredited”
 - Submit a copy of the same Corrective Action Plan (CAP) issued by the NCQA within thirty (30) days, and provide details on all relevant updates
 - Submit a written report to Covered California quarterly regarding the status and progress of Accreditation reinstatement
- ❑ Issuers must submit a copy of any Corrective Action Plan (CAP) issued by the NCQA within thirty (30) days, and provide details on all relevant updates regardless of accreditation status

Attachment 2 Performance Standards with Penalties

PROPOSED 2026-2028 ATTACHMENT 2 REQUIREMENTS

Performance Area	Performance Standards with Penalties	Percent of At-Risk Amount 2026-2028
Health Disparities 20%	1. Reducing Health Disparities: Demographic Data Collection – Enrollee Race and Ethnicity Self-Identification	10%
	2. Reducing Health Disparities: Demographic Data Collection – Enrollee Spoken and Written Language	10%
Engagement in Collaboratives 10%	3. Engagement in Collaboratives and with Community	10%
Data 40%	4. Healthcare Evidence Initiative (HEI) Data Submission	40%
Oral Health 10%	5. Dental Quality Alliance (DQA) Pediatric Measure Set – Pediatric Oral Evaluation, Dental Services (NQF #2517)	5%
	6. Dental Quality Alliance (DQA) Pediatric Measure Set – Pediatric Topical Fluoride for Children, Dental Services (NQF #2528)	5%
Utilization & Primary Care 20%	7. Utilization & Primary Care: Overall Engagement with Members	10%
	8. Utilization & Primary Care: Monitoring Continuity of Care	10%

Attachment 4 Quality Transformation Initiative

PROPOSED 2026-28 ATTACHMENT 4 REQUIREMENTS

- ❑ Proposed QTI Measure Set:
 1. Blood Pressure Control for Patients with Hypertension (BPC-E) *if adopted by CMS QRS by MY2026, otherwise will continue with CBP*
 2. Glycemic Status Assessment for Patients with Diabetes (GSD) >9%
 3. Colorectal Cancer Screening (COL-E)
 4. Childhood Immunization Status (CIS-E)
 5. Depression Screening and Follow-Up for Adolescents and Adults (DSF-E) - *pending CMS QRS benchmarks*
 6. Pharmacotherapy for Opioid Use Disorder (POD) (Reporting Only)
- ❑ Proposed Benchmark: 66th percentile using national Exchange benchmark for CMS QRS measure and held static over contract cycle
- ❑ Proposed Amount at Risk for QTI:
 - Newly contracted QHP issuers to start at 1% of premium at risk in year 1 of QTI eligibility
 - Up to 2.8% of premium at risk for MY2026 for currently contracted QHP issuers
 - Up to 3.8% of premium at risk for MY2027 and MY2028 for currently contracted QHP issuers
 - No more than 1% increase annually

PROPOSED 2026-28 ATTACHMENT 4 REQUIREMENTS

Health Equity Methodology

- ❑ Stratified measure results replace “all-population” measure results for colorectal cancer screening and blood pressure measures
- ❑ Assessment of QTI payments for these measures will be based on performance of stratified eligible subpopulations
- ❑ “Eligible Subpopulation” means the following stratified subpopulations, as defined by the federal Office of Management and Budget (OMB) or Centers for Disease Control (CDC) Race and Ethnicity Code Set, with at least 100 self-reported members in the denominator: American Indian or Alaska Native, Asian, Black or African American, Hispanic or Latino, Native Hawaiian or Other Pacific Islander, and White. Eligible Subpopulation shall also include Multirace, used when an individual reports two or more CDC codes that cross higher OMB concepts
- ❑ “All Other Members” means pooled results from members of the following subpopulations, as defined by OMB or CDC: Other Race, or Unknown, used when an individual has not reported race or ethnicity or where data is missing or inaccurate. All Other Members shall also include pooled results from members of subpopulations that would be Eligible Subpopulations but have fewer than 100 identified enrollees in the denominator

2026-2028 MODEL CONTRACT DRAFTS & RESPONSE TO COMMENT

Any questions please email PMDContractsUnit@covered.ca.gov or EQT@covered.ca.gov

PUBLIC COMMENT

CALL: (877) 336-4440

PARTICIPANT CODE: 6981308

- ❑ To request to make a comment, press 10; you will hear a tone indicating you are in the queue for comment. Please wait until the operator has introduced you before you make your comments.
- ❑ If watching via the live webcast, please mute your computer to eliminate audio feedback while calling in. Note, there is a delay in the webcast.
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EACH CALLER WILL BE LIMITED TO TWO MINUTES PER AGENDA ITEM

NOTE: Written comments may be submitted to BoardComments@covered.ca.gov.

2026 STANDARD BENEFIT DESIGNS

Melanie Droboniku
Plan Management Division

PY2026 BENEFIT DESIGNS

- ❑ At the January Board Meeting, Covered California presented the proposed Standard Benefit Designs for Plan Year 2026 and will request Board action on these designs today

- ❑ Today, Covered California is also bringing forward:
 - The Plan Year 2026 Enhanced Benefit Designs pursuant to the California Enhanced Cost-Sharing Reduction Program
 - The Enhanced Benefit Designs will be brought for action at the April Board Meeting

2026 PATIENT-CENTERED BENEFIT DESIGNS

Benefit	Individual-only Platinum Coinsurance		Individual-only Platinum Copay		Individual-only Gold Coinsurance		Individual-only Gold Copay		Individual-only Silver		Silver 73		CA Enhanced CSR Silver 73		Silver 87		CA Enhanced CSR Silver 87		Silver 94		CA Enhanced CSR Silver 94		Bronze		Bronze HDHP		
	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	
Deductible																											\$7,200
Medical Deductible									\$5,200	\$5,200	\$0	\$1,400	\$0	\$0	\$0	\$0	\$5,800										
Drug Deductible									\$50	\$50	\$0	\$50	\$0	\$0	\$0	\$450											
Coinsurance (Member)		10%		10%		20%		20%		30%		30%		30%		20%		20%		10%		10%		40%		0%	
MOOP		\$5,000		\$5,000		\$9,200		\$9,200		\$9,800		\$8,100		\$6,100		\$3,350		\$3,000		\$1,400		\$1,150		\$9,800		\$7,200	
ED Facility Fee		\$175		\$175		\$350		\$350		\$400		\$400		\$350		\$200		\$150		\$50		\$50	X	40%	X	0%	
Inpatient Facility Fee		10%		\$225		30%		\$375	X	30%	X	30%		30%	X	20%		20%	X	10%		10%	X	40%	X	0%	
Inpatient Physician Fee		10%		---		30%		---		30%		30%		30%		20%		20%		10%		10%	X	40%	X	0%	
Primary Care Visit		\$15		\$15		\$40		\$40		\$50		\$50		\$35		\$15		\$15		\$5		\$5		\$60	X	0%	
Specialist Visit		\$30		\$30		\$70		\$70		\$90		\$90		\$85		\$25		\$25		\$8		\$8	X	\$95	X	0%	
MH/SU Outpatient Services		\$15		\$15		\$40		\$40		\$50		\$50		\$35		\$15		\$15		\$5		\$5		\$60	X	0%	
Imaging (CT/PET Scans, MRIs)		10%		\$75		25%		\$75		\$325		\$325		\$325		\$100		\$100		\$50		\$50	X	40%	X	0%	
Speech Therapy		\$15		\$15		\$40		\$40		\$50		\$50		\$35		\$15		\$15		\$5		\$5		\$60	X	0%	
Occupational and Physical Therapy		\$15		\$15		\$40		\$40		\$50		\$50		\$35		\$15		\$15		\$5		\$5		\$60	X	0%	
Laboratory Services		\$15		\$15		\$40		\$40		\$50		\$50		\$50		\$30		\$20		\$10		\$8		\$50	X	0%	
X-rays and Diagnostic Imaging		\$30		\$30		\$75		\$75		\$95		\$95		\$95		\$50		\$40		\$10		\$8	X	40%	X	0%	
Skilled Nursing Facility		10%		\$125		30%		\$150	X	30%	X	30%		30%	X	20%		20%		10%		10%	X	40%	X	0%	
Outpatient Facility Fee		10%		\$75		30%		\$130		30%		30%		30%		20%		20%		10%		10%	X	40%	X	0%	
Outpatient Physician Fee		10%		\$20		30%		\$60		30%		30%		30%		20%		20%		10%		10%	X	40%	X	0%	
Tier 1 (Generics)		\$9		\$9		\$18		\$18		\$19		\$19		\$15		\$8		\$5		\$3		\$3		\$20	X	0%	
Tier 2 (Preferred Brand)		\$16		\$16		\$60		\$60	X	\$60	X	\$55		\$55	X	\$25		\$25		\$10		\$10	X	40%	X	0%	
Tier 3 (Nonpreferred Brand)		\$25		\$25		\$85		\$85	X	\$90	X	\$85		\$85	X	\$45		\$45		\$15		\$15	X	40%	X	0%	
Tier 4 (Specialty)		10%		10%		20%		20%	X	20%	X	20%		20%	X	15%		15%		10%		10%	X	40%	X	0%	
Tier 4 Maximum Coinsurance		\$250		\$250		\$250		\$250		\$250		\$250		\$250		\$150		\$150		\$150		\$150		\$500*			
Maximum Days for charging IP copay				5		5																					
Begin Specialist deductible after # of copays																								3			
Actuarial Value																											
2026 AV		91.92		91.76		81.39		81.73		71.78†		73.81†		80.37		87.86†		89.60		94.81†		95.39		63.71†		64.76	

KEY	Symbol	Description
	X	Subject to deductible
	*	Drug cap applies to all drug tiers
	+	Additive adjustment (included in AV)
	Orange	Increased member cost from 2025
	Green	Decreased member cost from 2025
	Blue	Enhanced member cost from 2026
	Yellow	Within .5 of upper de minimis
	Light Green	Securely within AV

2026 PATIENT-CENTERED BENEFIT DESIGNS - CCSB

Benefit	CCSB-only Platinum Coinsurance		CCSB-only Platinum Copay		CCSB-only Gold Coinsurance		CCSB-only Gold Copay		CCSB-only Silver Coinsurance		CCSB-only Silver Copay		CCSB-only Silver HDHP	
	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount
Deductible														\$3,200
Medical Deductible					\$350		\$250		\$2,500		\$2,500			
Drug Deductible					\$0		\$0		\$300		\$300			
Coinsurance (Member)		10%		10%		20%		20%		35%		35%		25%
MOOP		\$4,500		\$4,500		\$7,800		\$7,800		\$8,600		\$8,750		\$8,300
ED Facility Fee		\$200		\$150	X	20%	X	\$250	X	35%	X	35%	X	25%
Inpatient Facility Fee		10%		\$250	X	20%	X	\$600	X	35%	X	35%	X	25%
Inpatient Physician Fee		10%		---	X	20%		--	X	35%		35%	X	25%
Primary Care Visit		\$15		\$20		\$25		\$35		\$55		\$55	X	25%
Specialist Visit		\$30		\$30		\$50		\$55		\$90		\$90	X	25%
MH/SU Outpatient Services		\$15		\$20		\$25		\$35		\$55		\$55	X	25%
Imaging (CT/PET Scans, MRIs)		10%		\$100		20%	X	\$250	X	35%	X	\$300	X	25%
Speech Therapy		\$15		\$20		\$25		\$35		\$55		\$55	X	25%
Occupational and Physical Therapy		\$15		\$20		\$25		\$35		\$55		\$55	X	25%
Laboratory Services		\$15		\$20		\$25		\$35		\$55		\$55	X	25%
X-rays and Diagnostic Imaging		\$30		\$30		\$65		\$55		\$90		\$90	X	25%
Skilled Nursing Facility		10%		\$150	X	20%	X	\$300	X	35%	X	35%	X	25%
Outpatient Facility Fee		10%		\$100		20%	X	\$300	X	35%	X	35%	X	25%
Outpatient Physician Fee		10%		\$25		20%		\$35		35%		35%	X	25%
Tier 1 (Generics)		\$10		\$5		\$15		\$15		\$20		\$19	X	25%
Tier 2 (Preferred Brand)		\$25		\$20		\$50		\$40	X	\$75	X	\$85	X	25%
Tier 3 (Nonpreferred Brand)		\$40		\$30		\$80		\$70	X	\$105	X	\$110	X	25%
Tier 4 (Specialty)		10%		10%		20%		20%	X	30%	X	30%	X	25%
Tier 4 Maximum Coinsurance		\$250		\$250		\$250		\$250		\$250		\$250		\$250*
Maximum Days for charging IP copay				5				5						
Begin PCP deductible after # of copays														
Actuarial Value														
2026 AV (Final 2026 AVC)		91.79		91.13		80.25		81.70		71.15†		70.79†		70.61

KEY:		
	X	Subject to deductible
	*	Drug cap applies to all drug tiers
	†	Additive adjustment (included in AV)
		Increased member cost from 2025
		Decreased member cost from 2025
		Within .5 of upper de minimis
		Securely within AV

REQUESTED ACTION: 2026 PATIENT CENTERED BENEFIT DESIGNS

- ❑ There are no additional changes to the Patient Centered Benefit Designs
- ❑ Staff request the Board to formally adopt the baseline Patient Centered Benefit Designs for Plan Year 2026

2026 CALIFORNIA ENHANCED COST-SHARING REDUCTION BENEFIT DESIGNS

2026 ENHANCED BENEFIT DESIGNS

Benefit
Deductible
Medical Deductible
Drug Deductible
Coinsurance (Member)
MOOP
ED Facility Fee
Inpatient Facility Fee
Inpatient Physician Fee
Primary Care Visit
Specialist Visit
MH/SU Outpatient Services
Imaging (CT/PET Scans, MRIs)
Speech Therapy
Occupational and Physical Therapy
Laboratory Services
X-rays and Diagnostic Imaging
Skilled Nursing Facility
Outpatient Facility Fee
Outpatient Physician Fee
Tier 1 (Generics)
Tier 2 (Preferred Brand)
Tier 3 (Nonpreferred Brand)
Tier 4 (Specialty)
Tier 4 Maximum Coinsurance
Actuarial Value
2026 AV (Final 2026 AVC)

Individual-only Silver		Silver 73		CA Enhanced CSR Silver 73	
Ded	Amount	Ded	Amount	Ded	Amount
	\$5,200		\$5,200		\$0
	\$50		\$50		\$0
	30%		30%		30%
	\$9,800		\$8,100		\$6,100
	\$400		\$400		\$350
X	30%	X	30%		30%
	30%		30%		30%
	\$50		\$50		\$35
	\$90		\$90		\$85
	\$50		\$50		\$35
	\$325		\$325		\$325
	\$50		\$50		\$35
	\$50		\$50		\$35
	\$50		\$50		\$50
	\$95		\$95		\$95
X	30%	X	30%		30%
	30%		30%		30%
	30%		30%		30%
	\$19		\$19		\$15
X	\$60	X	\$55		\$55
X	\$90	X	\$85		\$85
X	20%	X	20%		20%
	\$250		\$250		\$250
	71.78†		73.81†		80.37

Silver 87		CA Enhanced CSR Silver 87	
Ded	Amount	Ded	Amount
	\$1,400		\$0
	\$50		\$0
	20%		20%
	\$3,350		\$3,000
	\$200		\$150
X	20%		20%
	20%		20%
	\$15		\$15
	\$25		\$25
	\$15		\$15
	\$15		\$15
	\$15		\$15
	\$30		\$20
	\$50		\$40
X	20%		20%
	20%		20%
	20%		20%
	\$8		\$5
X	\$25		\$25
X	\$45		\$45
X	15%		15%
	\$150		\$150
	87.86†		89.60

Silver 94		CA Enhanced CSR Silver 94	
Ded	Amount	Ded	Amount
	\$0		\$0
	\$0		\$0
	10%		10%
	\$1,400		\$1,150
	\$50		\$50
	10%		10%
	10%		10%
	\$5		\$5
	\$8		\$8
	\$5		\$5
	\$5		\$5
	\$5		\$5
	\$10		\$8
	\$10		\$8
	10%		10%
	10%		10%
	10%		10%
	\$3		\$3
	\$10		\$10
	\$15		\$15
	10%		10%
	\$150		\$150
	94.81		95.39

KEY		
X	Subject to deductible	
*	Drug cap applies to all drug tiers	
†	Additive adjustment (included in AV)	
	Increased member cost from 2025	
	Decreased member cost from 2025	
	Enhanced member cost from 2026	
	Within .5 of upper de minimis	
	Securely within AV	

PY2026 ENHANCED AFFORDABILITY PROGRAM BENEFIT DESIGNS

- ❑ Covered California proposes to hold Enhanced Cost Sharing Reduction Benefit Designs steady from PY2025
- ❑ These designs will be brought before the Board for action at the April Board Meeting

PUBLIC COMMENT

CALL: (877) 336-4440

PARTICIPANT CODE: 6981308

- ❑ To request to make a comment, press 10; you will hear a tone indicating you are in the queue for comment. Please wait until the operator has introduced you before you make your comments.
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NOTE: Written comments may be submitted to BoardComments@covered.ca.gov.

2026 CALIFORNIA ENHANCED COST-SHARING REDUCTION PROGRAM DESIGN

Katie Ravel

Director

Policy, Eligibility, & Research Division

CALIFORNIA ENHANCED COST-SHARING REDUCTION PROGRAM

- ❑ The California Enhanced Cost-Sharing Reduction (CSR) Program began in Plan Year 2024 with a budget of \$82.5 million.
- ❑ In 2024, state funding allowed Covered California to eliminate deductibles for lower income enrollees up to 250% of the federal poverty level (FPL), simplify benefit designs, and reduce out-of-pocket costs.
- ❑ Program budget rose to \$165 million for the Plan Year 2025 affordability program.
- ❑ The 2025 California Enhanced CSR Program expands eligibility to all enrollees regardless of income. The program eliminates deductibles, lowers out-of-pocket costs and allows any enrollee to purchase a Gold-level benefit at a Silver premium.
- ❑ If federal enhanced premium tax credits currently available through the Inflation Reduction Act are extended to 2026, Covered California will use state affordability funding to continue the current California Enhanced CSR Program, contingent upon the enactment of the California Budget Act of 2025.

2026 CALIFORNIA ENHANCED COST-SHARING REDUCTION (CSR) PROGRAM ELIGIBILITY EXPANSION

- ❑ Program eligibility will be maintained for 2026. All enrollees on a subsidized application with income above 200% FPL will be eligible for a California Enhanced Silver 73 plan.
- ❑ American Indian/Alaska Native members with income above 300% will have the California Enhanced Silver 73 design.

Household Income Eligibility by Percentage of FPL	2025 California Enhanced CSR Program Plan
100% up to 150%	Enhanced Silver 94
Above 150% up to 200%	Enhanced Silver 87
Above 200% up to 250%	Enhanced Silver 73
Above 250%	Enhanced Silver 73
American Indian/Alaska Native Above 300%	Enhanced Silver 73

2026 PROGRAM PAYMENT PARAMETERS

- Payment parameters for the 2026 California Enhanced CSR program will be as follows:
 - Covered California will make a per member per month (PMPM) payment to compensate carriers for the difference between the federal cost-sharing reduction benefit and the state benefit.
 - An interim payment of 60 percent of the PMPM rate will be made regularly throughout the year.
 - Carriers will reconcile the interim payments and the actual utilization of medical services following the end of the plan year.
 - 2026 PMPM values appear below and will be adopted through the Program Design Document.

Household Income Eligibility by Percentage of FPL	2026 California Enhanced CSR Plan	2026 Average Statewide Marginal PMPM Payment	2026 Average Statewide Interim PMPM Payment (60%)
100% up to 150%	Silver 94	\$3.69	\$2.21
Above 150% up to 200%	Silver 87	\$2.59	\$1.55
Above 200% up to 250%	Silver 73	\$14.54	\$8.72
Above 250%	Silver 73	\$29.29	\$17.57
American Indian/Alaska Native Above 300%	Silver 73	\$29.29	\$17.57

OVERVIEW OF THE PROGRAM DESIGN PROVISIONS FOR CALIFORNIA ENHANCED CSR PROGRAM

- ❑ The 2026 California Enhanced CSR Program Design Document specifies the following elements for the proposed program:
 1. Establishes income eligibility for the California Enhanced CSR program.
 2. Specifies the qualified health plan (QHP) features of the California Enhanced CSR variants.
 3. Establishes per member per month payment rates, payable to the QHP issuers, for each plan design that will be offered through the California Enhanced CSR program and a QHP issuer payment reconciliation process.
 4. Defines key terms related to the California Enhanced CSR program.
- ❑ Per member per month payment rates have been updated for 2026.
- ❑ Covered California staff will request approval of the Program Design Document at the April Board meeting, contingent upon the enactment of the California Budget Act of 2025.

PUBLIC COMMENT

CALL: (877) 336-4440

PARTICIPANT CODE: 6981308

- ❑ To request to make a comment, press 10; you will hear a tone indicating you are in the queue for comment. Please wait until the operator has introduced you before you make your comments.
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APPENDIX

DRAFT 2026-2028 QHP ISSUER MODEL CONTRACT SPOTLIGHTS

ESSENTIAL COMMUNITY PROVIDERS (ECP)

ESSENTIAL COMMUNITY PROVIDER REFRESH

The ACA requires all State-Based Marketplaces to ensure Qualified Health Plans' low-income and medically underserved populations are served by including Essential Community Providers (ECP).

Covered California creates ECP standards that meet federal requirements and the distinct needs of Californians with a goal to improve:

1. Access to primary care and behavioral health services in low-income communities and Health Professional Shortage Areas
2. Continuity of care across Medi-Cal and Covered California
3. ECP capacity to serve low-income and medically underserved populations
4. Choice of providers serving the diverse needs of members

Covered California has been evaluating and analyzing policies to achieve these goals through updates to the ECP definition, the ECP list, and the required QHP network sufficiency thresholds.

ECP STAKEHOLDER ENGAGEMENT AND FEEDBACK

Essential Community Provider Refresh

- Health Management Associates brought on in February as consultants
- ECP Workgroup identified and solicited input from many external stakeholders including State-based Marketplaces, Issuers, Consumer Advocates, and Safety Net and Tribal and Urban Indian Health Care Providers
- General concern with the contracting process & contracting availability was expressed by Issuers and Safety Net providers

ECP Project Public Meetings

- 3 public meetings from June - December 2024
- 6 unique organizations commented with 16 specific ECP comments. Comments were deidentified and are [available online](#)

Public Comment Cycle 1

- Comment Cycle 1 was held between 8/16/2024 – 9/16/2024. Response period to comments 9/16/2024 – 10/17/2024
- 7 unique organizations commented with 14 specific ECP comments. Comments and responses are [available online](#)

Public Comment Cycle 2

- Comment Cycle 2 was held between 10/18/2024 – 11/18/2024. Response period to comments 11/18/2024 – 12/20/2024
- 1 unique organization commented with 1 specific ECP comment. Comments and responses will be [available online](#)

Sufficiency Threshold Comment Period

- Comment period specific to proposed sufficiency threshold held between 11/14/24 – 12/6/24
- 6 Issuers and 5 consumer advocacy organizations submitted 32 questions and comments. Comments and responses will be [available online](#)

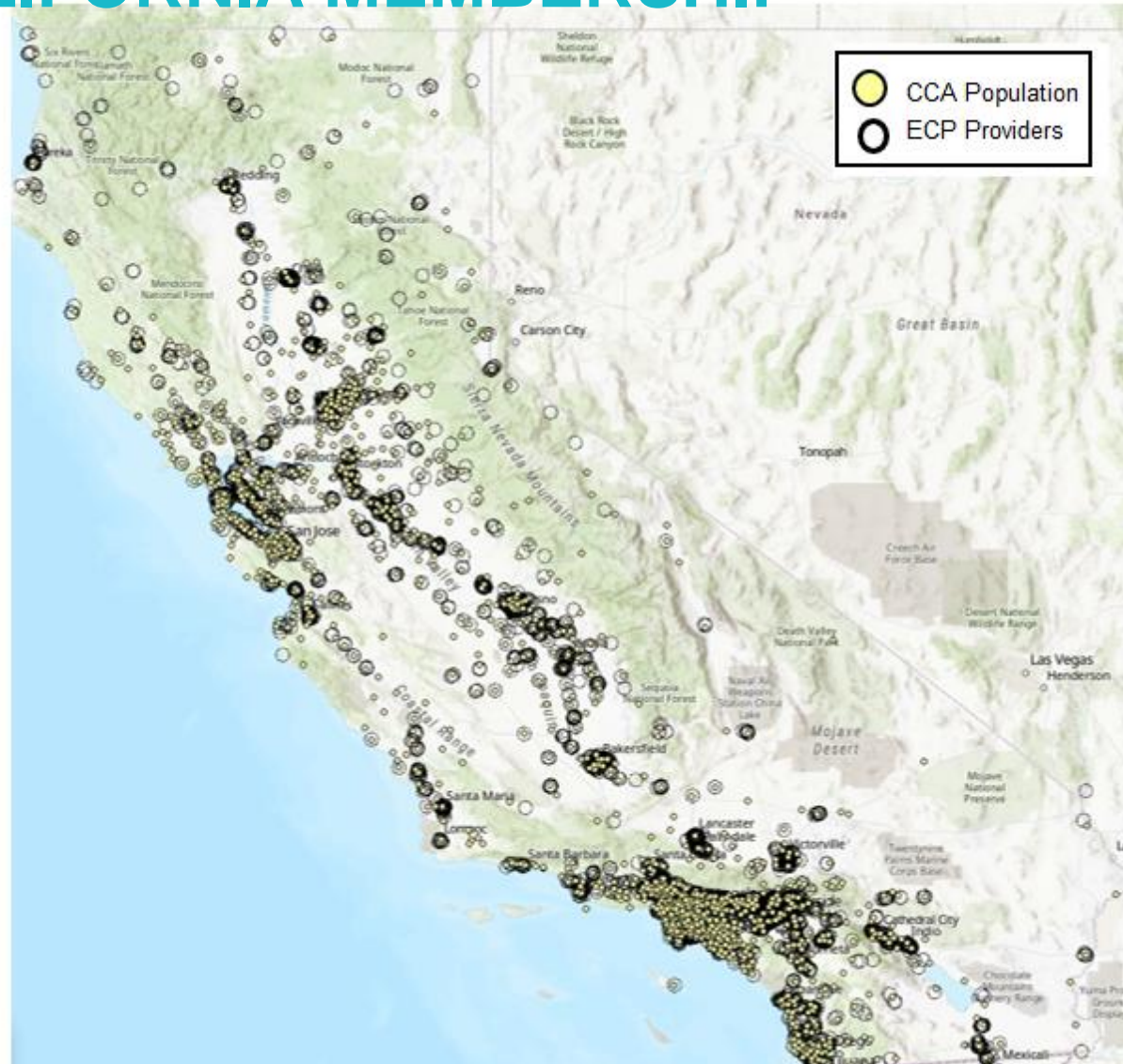
OVERVIEW OF ECP STANDARDS RECOMMENDATIONS

Element	Current Standard	Proposed Standards
Definition and Categories	<p>Federal categories:</p> <ul style="list-style-type: none"> ▪ FQHCs ▪ Ryan White Program Providers ▪ Family Planning Providers ▪ Indian Health Care Providers ▪ Inpatient Hospitals ▪ Other Providers <p>Covered California designated:</p> <ul style="list-style-type: none"> ▪ California Disproportionate Share Hospitals (DSH) ▪ Federally designated 638 Tribal Health Programs ▪ Title V Urban Indian Health Programs ▪ Licensed community clinics ▪ HI-TECH Medi-Cal Electronic Health Record Incentive Program providers 	<p>Federal categories:</p> <ul style="list-style-type: none"> ▪ added Mental Health Facilities ▪ added SUD Treatment Centers ▪ added Critical Access Hospitals ▪ added SHIP Hospitals ▪ added Rural Health Clinics ▪ added certain HPSA providers <p>Covered California designated:</p> <ul style="list-style-type: none"> ▪ added Medi-Cal primary care providers in HPI Quartiles 1 and 2 ▪ added Medi-Cal behavioral health providers in HPI Quartiles 1 and 2 ▪ added HCAI Behavioral Health Workforce grant recipients ▪ added Medi-Cal Pediatric Oral Service Providers ▪ added Dental Hygienists in Alternative Practice ▪ removed H-ITECH providers
General Standard	<p>QHPs must maintain a network ensuring reasonable and timely access to Covered Services for low-income, vulnerable, or medically underserved populations across all geographic regions where their QHPs serve Covered California Enrollees.</p>	<p>Updated Medically Underserved Populations definition: Added individuals living in Health Professional Shortage Areas, Medically Underserved Areas, and belonging to medically Underserved Populations to.</p>
Alternate Standard	<p>QHPs offering an integrated delivery system quality for an alternate standard and demonstrate compliance by mapping low-income member populations and network providers</p>	<p>Retain alternate standard, maintain and refine existing mapping requirements to align with federal priority populations defined as HPSAs and zip codes with at least 30% of the population under 200% FPL; newly require issuers to demonstrate provision of services within each of the ECP categories clarify mapping and reporting requirements</p>

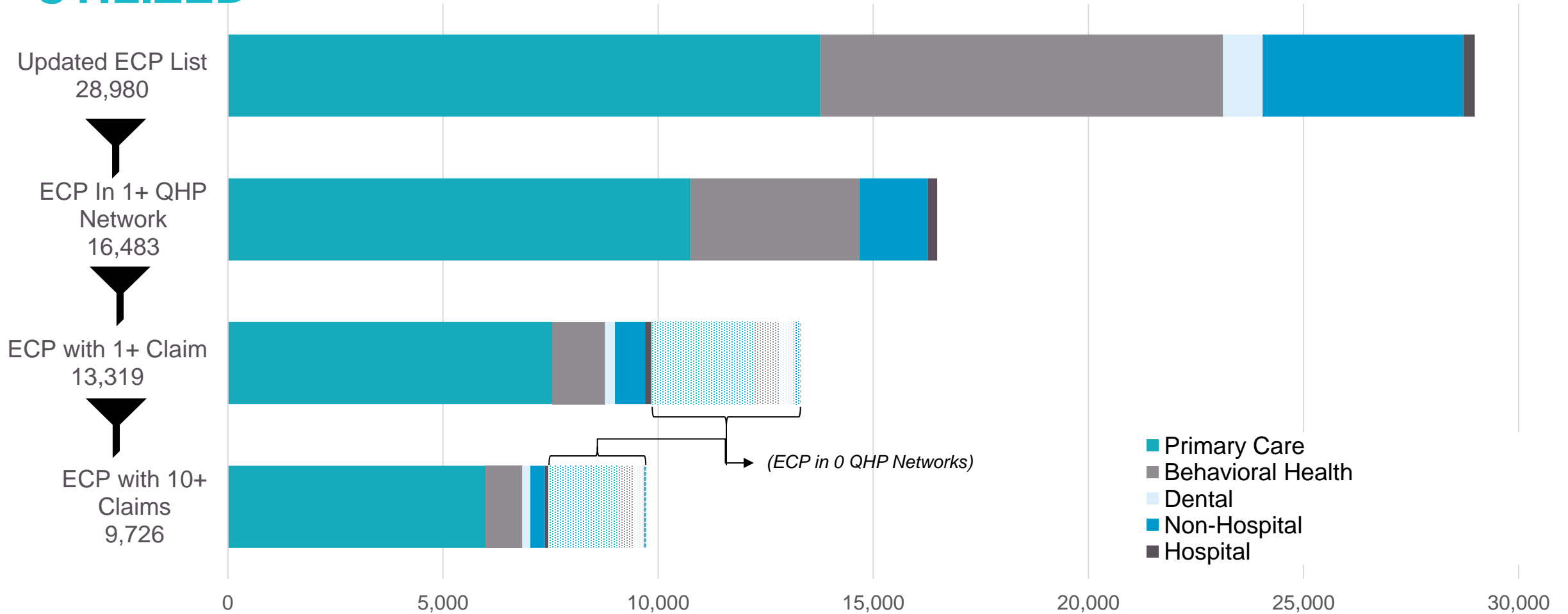
OVERVIEW OF ECP STANDARDS RECOMMENDATIONS

Element	Current Standard	Proposed Standards
Sufficiency Thresholds	<p>Assess sufficiency by region, not service area. Contractor must demonstrate provider contracts with at least:</p> <ul style="list-style-type: none"> ▪ 1 ECP hospital per county ▪ 15% non-hospital 340B Providers in each region QHP is offered 	<p>Continue to assess sufficiency by region, not service area. By 2029, Contractor must demonstrate provider contracts with at least:</p> <ul style="list-style-type: none"> ▪ 1 ECP hospital per county; and 1 per rating region in counties with multiple regions (Los Angeles County) ▪ 15% of Primary Care ECPs in each region of the QHP's service area ▪ 15% of Behavioral Health ECPs in each region of the QHP's service area ▪ If unable to meet new sufficiency requirements, must demonstrate provider agreements with at least 15% of 340B non-hospital entities and & increases in sufficiency in 2027 and 2028.
Impact Evaluation	<p>No current evaluation plan in place.</p>	<p>Networks Analysis: Analyze QHP networks to determine number and percent of ECPs contracted by QHP by region.</p> <p>Utilization Analysis: Analyze ECP utilization to assess how many and which ECPs are treating Covered California enrollees. Conduct utilization analysis by enrollee demographics to assess if meeting goals; ensuring access to primary care and behavioral health services in low-income communities and Health Professional Shortage Areas, supporting continuity of care across Medi-Cal and Covered California, ensuring ECP capacity to serve low-income and medically underserved populations and offering adequate choice of providers serving the diverse needs of members.</p>

GEOGRAPHIC DISTRIBUTION OF PROPOSED ECP ALIGNS WITH COVERED CALIFORNIA MEMBERSHIP



46% OF ECPS ON THE UPDATED LIST ARE CURRENTLY BEING UTILIZED



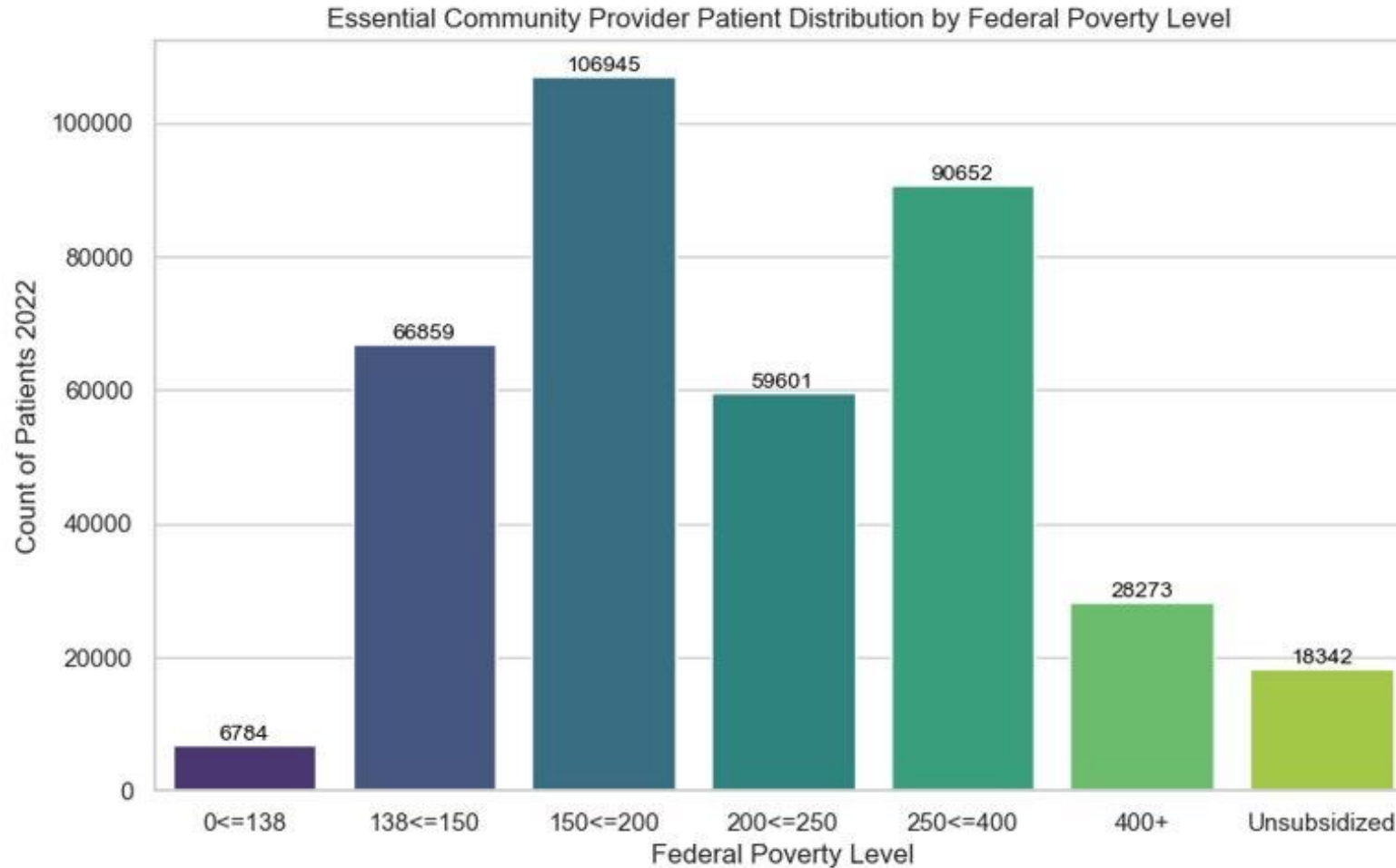
Claims incurred in 2022 plan year. Network participation for claims is based on NPI only. Participation for Non-Hospital and Hospital ECPs is under-represented since facility participation not fully represented by NPI. Some issuers provider network data did not include any dental providers (even though they have dental providers in network). Claims for providers in 0 networks is based on 2022 claims and 2024 QHP networks.

PROPOSED ECP UTILIZATION IS HIGHEST IN THE INLAND EMPIRE AND LOS ANGELES COUNTY

Covered CA Rating Region (Top 10 by ECP Utilization Rate)	Updated ECP Providers with one or more claims	Percentage of All Updated ECP Providers with one or more claims
Region 17: Inland Empire	2,371	17.76%
Region 16: Los Angeles County South & West	2,078	15.56%
Region 15: Los Angeles County North & East	1,803	13.50%
Region 19: San Diego County	1,228	9.20%
Region 10: San Joaquin Valley	938	7.03%
Region 1: Northern Counties	921	6.90%
Region 3: Sacramento Valley	845	6.33%
Region 18: Orange County	588	4.40%
Region 11: Central San Joaquin	457	3.42%
Region 14: Kern County	419	3.14%

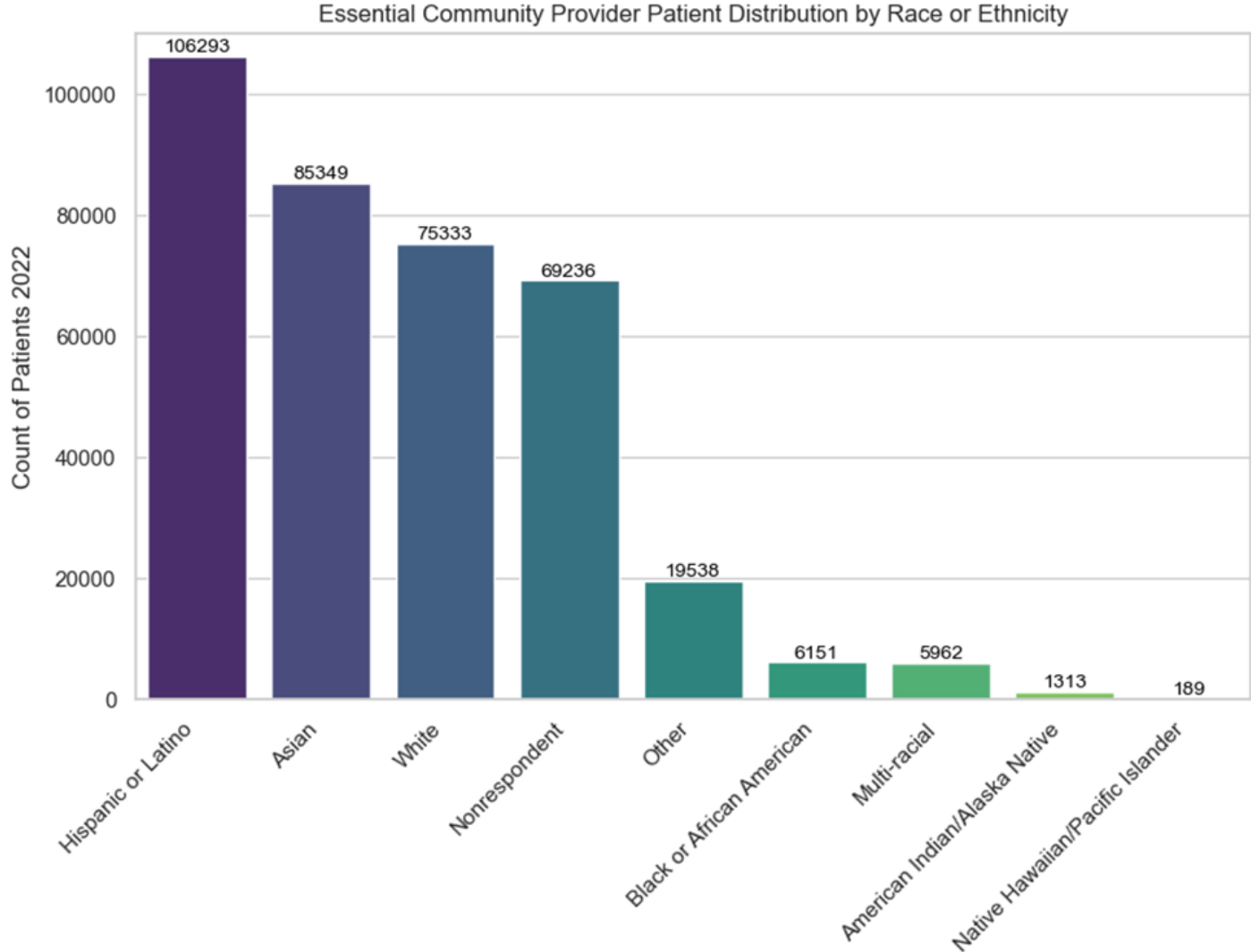
- ❑ 87% of the 13,352 proposed ECPs with claims are located in the 10 regions shown in this table
- ❑ 47% of 13,352 proposed ECPs with claims are located in Inland Empire and Los Angeles Regions (regions 15, 16, & 17)

PATIENT CHARACTERISTICS: 64% OF PATIENTS WHO USED PROPOSED ECPS HAVE INCOMES \leq 250% FPL



- ❑ 64% (240,189/377,456) of patients who used proposed ECPs in 2022 had incomes \leq 250%
 - ❑ 18% have incomes 138-150% FPL
 - ❑ 28% have incomes 150-200% FPL
- ❑ Only 7% of patients who used ECPs had income levels >400% FPL

PATIENT CHARACTERISTICS: ECP UTILIZATION BY RACE/ETHNICITY



- ❑ **29%** (106,293/369,364) of patients who received care from a proposed ECP in 2022 **identify as Hispanic or Latino**
- ❑ **23%** (85,349/369,364) of patients who received care from a proposed ECP **identify as Asian**

CURRENT VS 2026-28 PROPOSED REQUIREMENTS – MODEL CONTRACT

Article 4 – QHP Issuer Program Requirements

2025 Current Requirements	2026-28 Proposed Requirements	Comment Themes	2026-28 Proposed Requirements Comment Based Update
<p>Section 4.3.4 Essential Community Providers Contractor must meet ECP General Standard by maintaining a network that provides reasonable and timely access to covered services for low-income and medically underserved individuals.</p> <p>Contractor must demonstrate provider contracts with at least</p> <ul style="list-style-type: none"> • 15% of 340B non-hospital entities in each rating region • One ECP hospital per county <p>Contractor(s) in an integrated delivery system may request the alternate standard and must demonstrate compliance by mapping low-income member populations and network providers</p>	<p>New ECPs: Primary Care and Behavioral Health providers in HPI Quartiles 1 and 2, HCAI Behavioral Health Workforce grant recipients, Medi-Cal Pediatric Oral Service Providers, Dental Hygienists in Alternative Practice</p> <p>New sufficiency requirements: By 2029, Contractor must demonstrate provider contracts with at least:</p> <ul style="list-style-type: none"> • 15% of Primary Care Providers in HPI Q1 and Q2 in each rating region • 15% of Behavioral Health Providers in HPI Q1 and Q2 in each rating region • One ECP hospital per county, or per rating region in counties with multiple rating regions <p>If unable to meet new sufficiency requirements, must demonstrate provider agreements with at least 15% of 340B non-hospital entities and & increases in sufficiency in 2027 and 2028.</p> <p>Alternate standard: Contractor must map low-income member populations and network providers offering services in all ECP categories.</p>	<p>General support for the ECP update effort and new ECP types.</p> <p>Consumer advocates urged contracting with all FQHCs, rural clinical and tribal health programs (both Indian Health Service and Urban Indian clinics)</p> <p>Several issuers and stakeholders expressed support for the new primary care and BH ECP sufficiency thresholds, while one issuer suggested 10% for primary care ECPs.</p> <p>Several issuers posed clarifying questions regarding data and methods used to develop the proposed ECP list and made suggestions for ease of use of the ECP list</p> <p>Multiple issuers have posed clarifying questions related to the regional denominators for sufficiency calculations and suggested providers that should be excluded from these calculations.</p> <p>One Issuer expressed concern about meeting the sufficiency threshold due to contracting challenges. Several Issuers requested an ECP workshop or working sessions to create space for further discussion</p>	<p>No changes to contract language proposed.</p> <p>Covered California continues to finalize data sources and methodology to produce the new ECP list and will continue to address feedback and incorporate as appropriate.</p>

PROPOSED 2026-28 ECP REQUIREMENTS

Model Contract Article 4 – Essential Community Providers (ECP) Requirements

- ❑ Issuers must meet ECP General Standard by maintaining a network with includes a sufficient geographic distribution of care to provide reasonable and timely access to low-income populations, individuals living in Health Professional Shortage Areas (HPSAs) and medically underserved individuals
- ❑ ECP General Standard Sufficiency Requirements:
 - Issuers must demonstrate sufficient geographic distribution of a mix of essential community providers reasonably distributed throughout the geographic service area
 - By 2029, Issuers must demonstrate providers agreements with at least 15% of Primary Care ECPs¹ and 15% of Behavioral Health Care ECPs² in each rating region in which it offers QHPs
 - If unable to meet new sufficiency requirements, Issuers must demonstrate provider agreements with at least 15% of 340B non-hospital entities and & increases in sufficiency in 2027 and 2028
 - Issues must demonstrate agreements with at least one ECP hospital per county requirement or per rating area in counties with multiple rating regions
- ❑ Issuers in an integrated delivery system may request the ECP alternative standards and must demonstrate compliance by mapping low-income and HPSA member populations and network providers and facilities offering services in all ECP categories

USE OF GENERATIVE ARTIFICIAL INTELLIGENCE IN QHP ISSUER OPERATIONS

WHAT IS GENERATIVE ARTIFICIAL INTELLIGENCE?

Automation

- ❑ Rule-based systems that follow predetermined instructions to provide an output over and over again

Traditional AI

- ❑ Systems that learn from data given to them and make decisions based on that data, can ingest new data when data is added

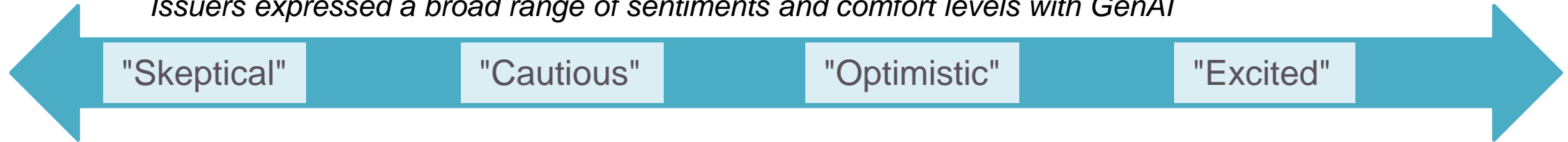
Generative AI

- ❑ Systems that learn from data and inputs and create something new from the information given to them

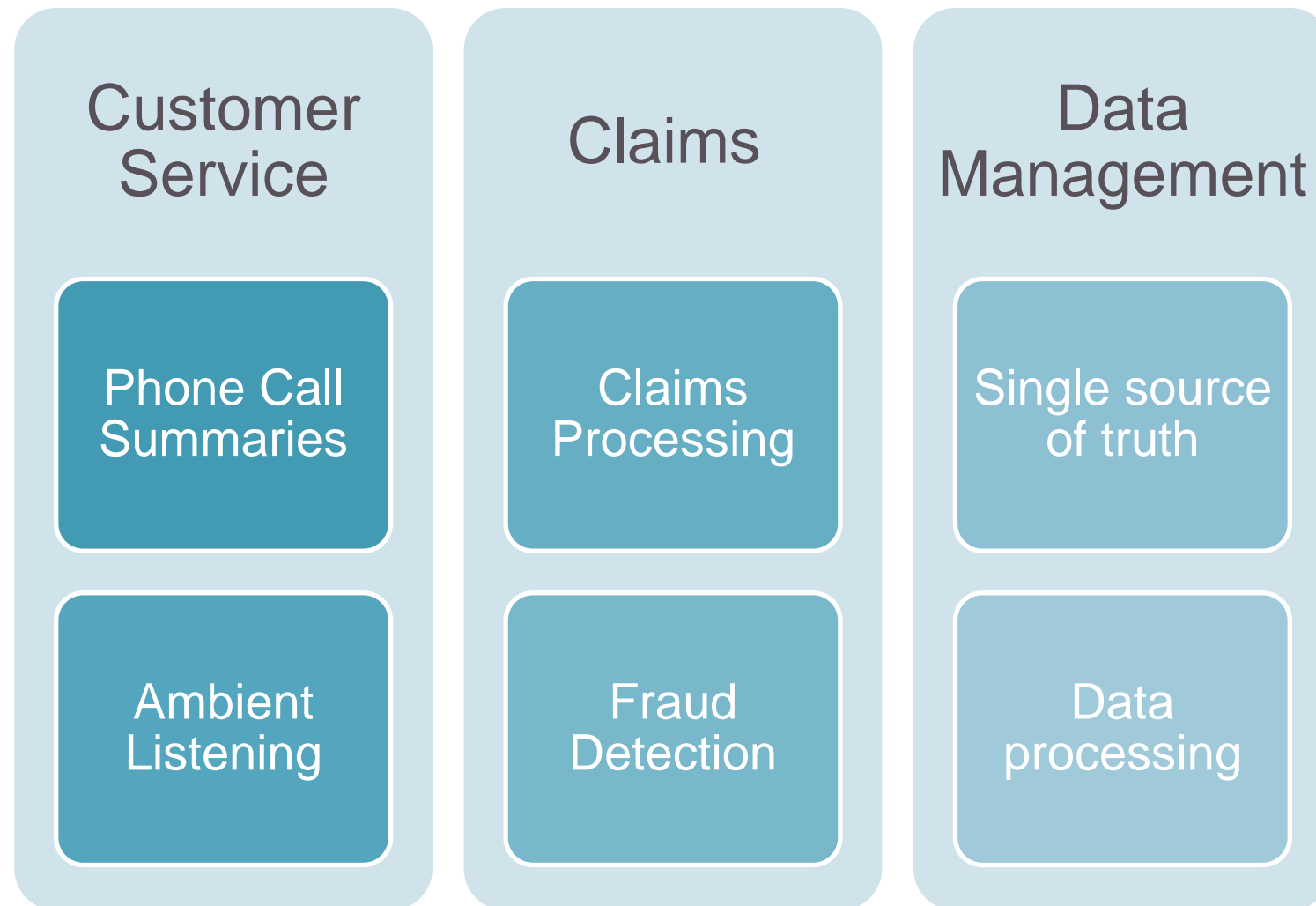
CURRENT PERSPECTIVES ACROSS ISSUERS

Covered California met with each QHP Issuer in Q1 2024 to explore current practices

Issuers expressed a broad range of sentiments and comfort levels with GenAI



ISSUERS' CURRENT STATE USE CASES



CURRENT VS 2026-28 PROPOSED REQUIREMENTS – ATTACHMENT 1

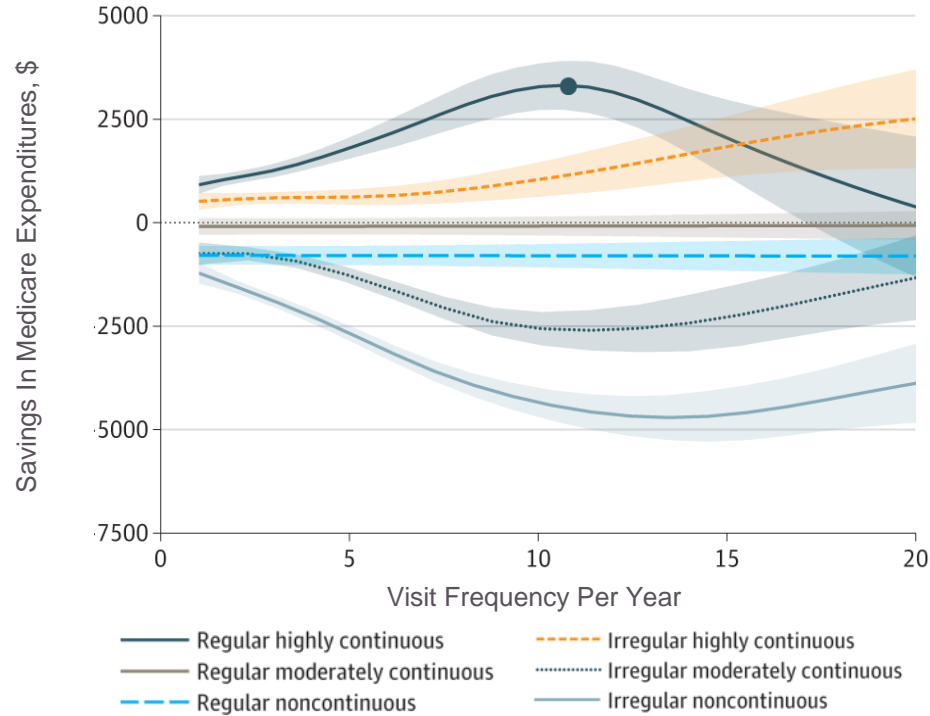
Article 3 – Population Health

2025 Current Requirements	2026-28 Proposed Requirements	Comment Themes	2026-28 Proposed Requirements Comment Based Update
<p>No current requirements</p>	<p>New - 3.05 Use of Generative Artificial Intelligence in QHP Issuer Operations</p> <p>Contractor must:</p> <ul style="list-style-type: none"> Align with federal regulations Patient Care Decision Support Tools 45 C.F.R § 92.210, including GenAI Adopt best practices for GenAI in healthcare Maintain transparency about GenAI use Address and reduce bias Engage in collaborative learning among Issuers Report on bias mitigation, GenAI governance, and use cases 	<ul style="list-style-type: none"> Issuers sought clarity on reporting requirements; one suggested less frequent reporting to ease administrative load An Issuer emphasized the need for autonomy in GenAI governance development Multiple stakeholders advocated for regulatory alignment and industry-wide collaboration while implementing proposed contract requirements An Issuer requested clarification on disclosure requirements for Covered California enrollees pertaining to the use of Gen AI 	<p>Adopted language to align with legal requirements within SB-1120 Health Coverage: Utilization Review</p>

MEASURING ADVANCED PRIMARY CARE

IMPACT OF DISCONTINUOUS PRIMARY CARE

Primary Care Continuity, Frequency, and Regularity Associated With Medicare Savings



- Increasing primary care visit frequency (up to a point) in the setting of a **highly continuous** PCP relationship has a cost-savings effect
- Increasing primary care visit frequency in an irregular, noncontinuous way leads to increased healthcare costs

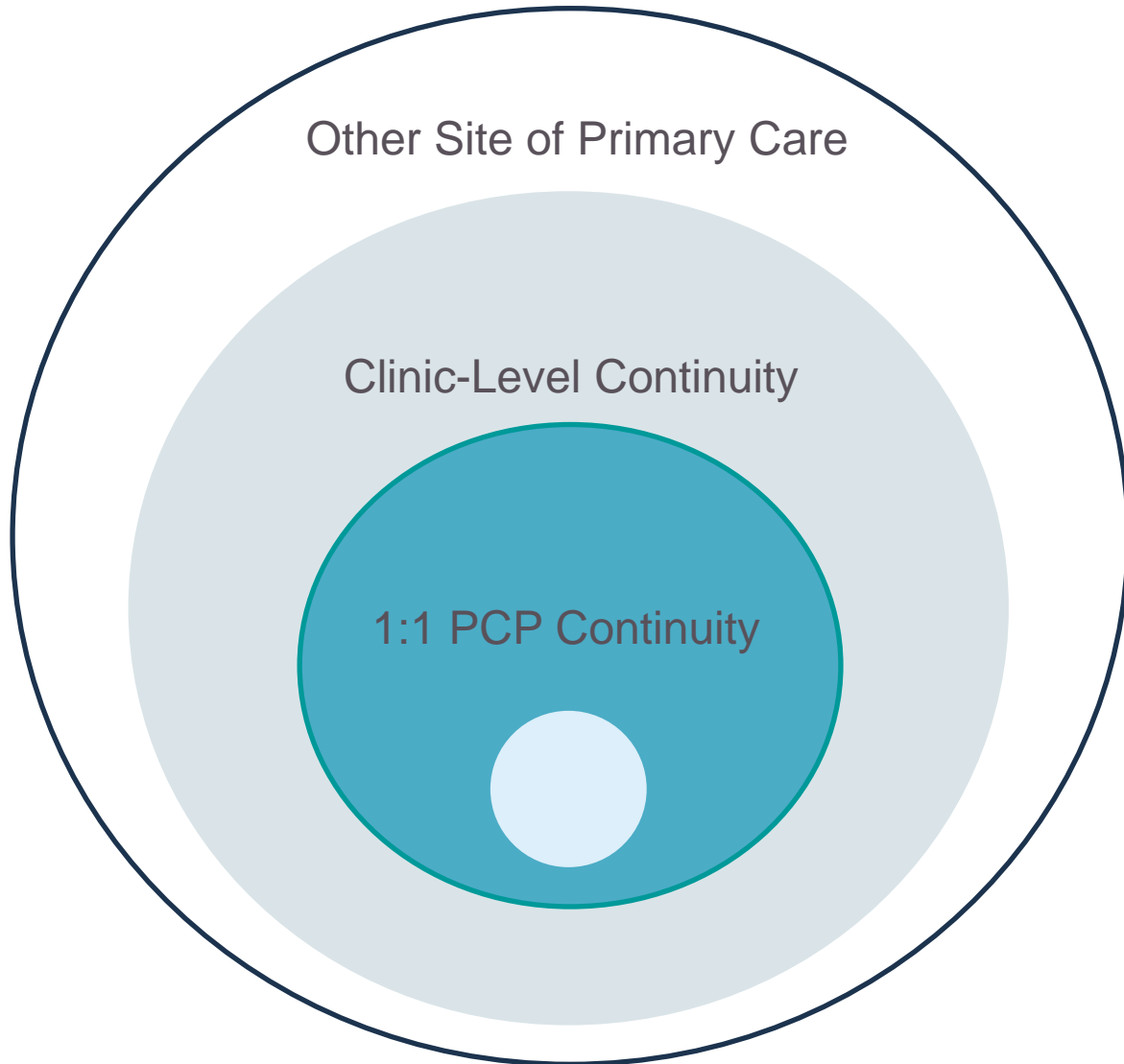
Virtual Visits with Own Family Physician Versus Outside Family Physician and Emergency Dept Use

Table 2. Patient Outcomes in Matched Cohort

Outcome	Patients with virtual encounter, No. (%) (N = 1 885 966)		RD, % (95% CI)	RR (95% CI)
	Physician outside enrolling group (n = 942 983)	Own enrolling physician (n = 942 983)		
ED visit within 7 d				
Any	30 748 (3.3)	18 519 (2.0)	1.3 (1.2-1.3)	1.66 (1.63-1.69)
High acuity	7042 (0.7)	4836 (0.5)	0.2 (0.2-0.3)	1.46 (1.40-1.51)
Low acuity	7759 (0.8)	4084 (0.4)	0.4 (0.4-0.4)	1.90 (1.83-1.97)
ED visit				
Day 1	12 661 (1.3)	6372 (0.7)	0.7 (0.6-0.7)	1.99 (1.93-2.05)
Day 2	6566 (0.7)	3539 (0.4)	0.3 (0.3-0.3)	1.86 (1.78-1.93)
Within 30 d	57 674 (6.1)	41 342 (4.4)	1.7 (1.7-1.8)	1.40 (1.38-1.41)
Mean (SD)	8.9 (9.1)	10.4 (9.2)	NA	HR = 1.41 (1.39-1.43)
ED visit for high-acuity motor vehicle accident day 3-30 ^a	129 (<0.1)	97 (<0.1)	<0.1	1.33 (1.02-1.73)
In-person visit within 7 d				
With any family physician	57 208 (6.1)	45 828 (4.9)	1.2 (1.1-1.3)	1.25 (1.23-1.26)
With same physician	29 043 (3.1)	39 102 (4.1)	1.1 (1.0-1.1)	0.74 (0.73-0.75)
With own enrolling physician	9915 (1.1)	39 102 (4.1)	3.1 (3.1-3.1)	0.25 (0.25-0.26)
With physician in own group	11 532 (1.2)	38 994 (4.1)	2.9 (2.9-3.0)	0.30 (0.29-0.30)
Virtual visit within 7 d				
With any family physician	83 681 (8.9)	44 470 (4.7)	4.2 (4.1-4.2)	1.88 (1.86-1.90)
With same physician	40 100 (4.3)	39 251 (4.2)	0.1 (0.0-0.2)	1.02 (1.01-1.04)
With own enrolling physician	19 658 (2.1)	39 251 (4.2)	2.1 (2.0-2.1)	0.50 (0.49-0.51)
With physician in own group	20 924 (2.2)	38 882 (4.1)	1.9 (1.9-2.0)	0.54 (0.53-0.55)

- Patients who had a virtual encounter with an outside family physician were **66% more likely** to visit an emergency department within 7 days as compared with those who had a virtual visit with their own family physician.

CONTINUITY OF CARE AT THE CLINIC LEVEL



Key Findings:

- ❑ The effect of physician-level continuity was associated with reduced ED visits and hospitalizations
 - Effect was strongest among complex and older patients, but had significant impact on ED use in young and healthy patients
- ❑ Clinic continuity had a similar, but less dramatic effect than physician-level continuity.

CONTINUITY OF CARE MEASURE DESCRIPTION

- ❑ The calculation relies on claims data

Numerator: Number of patients with Continuity index of 0.7 or more

- ❑ Continuity index calculated by looking at % of visits with the same provider
 - Ranges from 0 to 1
 - 0 = all visits with different provider
 - 1 = all visits with the same provider

Denominator: Number of patients with continuous enrollment 12 months with 2 or more visits to any primary care clinician

CONTINUITY OF CARE INDEX

Valid & Evidenced Based

- ❑ Included in CMS' Core Quality Measures Collaborative (CQMC) P4QM Measure Set in 2021
 - Endorsed by NQF, measure steward is the American Board of Family Medicine
- ❑ Validated in 2022 in the [Annals of Family Medicine](#)
- ❑ Strong evidence behind continuity of care measurement:
 - CoC leads to [reduction in ER visits](#), hospitalizations, [healthcare costs](#), and [survival](#)
 - Disruption of continuity via [loss of a PCP increases costs & utilization](#)

Limitations

- ❑ It is provider-centric
 - Does not account for team-based care
 - ✓ No method to account for RN visits, pharmacists, etc.
 - Difficult to reconcile with PCP workforce shortage
- ❑ It is visit-based and does not account for:
 - Work done outside of traditionally scheduled visits or encounters
 - Evolving models of care
 - Use of technology, portals, e-visits not captured in original measure specifications

ANALYSIS: CONTINUITY OF CARE INDEX IN COVERED CALIFORNIA

- **Methods:** We applied the continuity of care index to the Covered California population (2022) with 12+ months of continuous enrollment
 - Evaluated the % of plan-designated PCPs with a continuity index of >0.7 or 70%
 - 70% threshold for continuity is what has been validated in literature and endorsed in NQF and CQCM specifications
 - We rolled up results to the QHP level, and assess what portion of each QHP's designated PCPs had achieved 70% or more continuity
- **Initial Results: Individual QHP results ranged from 41% to 82%**
 - HMOs average continuity is 68%
 - PPOs average continuity is 64%

CURRENT VS 2026-28 PROPOSED REQUIREMENTS – ATTACHMENT 1

Article 4 – Delivery System and Payment Strategies to Drive Quality

2025 Current Requirements	2026-28 Proposed Requirements	Comment Themes	2026-28 Proposed Requirements Comment Based Update
<p>4.01 Advanced Primary Care Commit to promoting advanced primary care models that are patient-centered and data-driven, integrating behavioral health and managing complex conditions, supported by alternative payment methods to enhance access, coordination, and quality of care</p>	<p>PCP Assignment requirement is kept but distinction between assigned and selected has been removed.</p> <p>Added a shift in language to emphasize collaboration with Covered California to improve primary care selection, member value and engagement in care.</p> <p>Introduced and clarified the terminology and reporting requirement on the Continuity of Care, specifying enrollment timelines.</p> <p>Expanded language on payment models to include descriptions of HCP LAN APM categories and primary care clinician compensation.</p> <p>Aligned with OHCA requirements, QHP issuers must report total primary care spend by product, analyze its impact on total healthcare expenditures (TCHE) and network performance of the overall delivery system.</p>	<p>Many issuers recommend further research on the Continuity of Care (CoC) measure and its correlation with quality before setting benchmarks.</p> <p>Concerns were raised about potential for unnecessary visits and increased costs, and the need for a reporting-only phase to establish baseline.</p> <p>Consumer advocates and coalition supported the CoC metric for its positive impact on patient outcomes and cost reduction.</p> <p>Some issuers expressed concerns about duplicative data reporting and recommended aligning with OHCA on primary care spend reporting.</p>	<p>Added language on member value and engagement in care.</p> <p>Revision to related Performance Standard: Utilization and Primary Care: Monitoring Continuity of Care. Lowered the threshold to require improvement efforts if the continuity of care index falls below 0.7 for 60% of enrollees, down from 70% of enrollees.</p>

DATA EXCHANGE

BACKDROP OF CURRENT STATE

- ❑ State has now moved to Data Exchange Framework (DxF) and Qualified Health Information Organization (QHIO) requirement and contract cites California Trusted Exchange Network (CTEN)
 - There is an overlap of CTEN + QHIOs, but they are not fully aligned
- ❑ Difficult to measure / assess volume of these Health Information Exchange activities
- ❑ Other purchasers, namely DHCS, have recently updated their expectations

QHIO VS. CTEN OVERLAP

HIE	QHIO	CTEN
LANES	✓	✓
Manifest MedEx	✓	✓
Orange County Partners in Health HIE	✓	✓
Sac Valley MedShare	✓	✓
San Diego Health Connect	✓	✓
Cozeva	✓	
Health Gorilla	✓	
Long Health, Inc	✓	
Serving Communities HIO	✓	
Alameda County Care Connect		✓
Santa Cruz HIO		✓
San Mateo County Connected Care		✓
OCPRHIO		✓
NCHIN		✓

CURRENT VS 2026-28 PROPOSED REQUIREMENTS – ATTACHMENT 1

Article 5 – Measurement and Data Sharing

2025 Current Requirements	2026-28 Proposed Requirements	Comment Themes	2026-28 Proposed Requirements Comment Based Update
<p>5.01 Measurement and Analytics Emphasizes the importance of measurement in evaluating care quality, equity, and value, utilizing HEDIS and CAHPS measures and developing a Healthcare Evidence Initiative, along with Contractor collaboration</p>	<ul style="list-style-type: none"> - Removed requirement for direct submission of Contractor's CAHPS file to Covered California in addition to submission to CMS + Added statement that Contractor submitted data may be used for financial accountability programs 	<p>Multiple comments on tailoring requirements</p>	<p>No changes</p>
<p>5.02 Data Sharing and Exchange Enhancing healthcare quality and efficiency by promoting the accessibility and sharing of electronic patient data among patients, providers, and payers, thereby supporting better population health management, reducing costs, and empowering patients</p>	<ul style="list-style-type: none"> + Issuers must execute the Data Sharing Agreement (DSA) as required by Health Safety Code section 130290 and participate in at least on QHIO + Issuers must share information on enrollees with primary care providers for their assigned members + Expanded language regarding participation in at least one QHIO should include a statement that QHIOs are expected to share data to “support quality measurement and operational functions” 	<p>Multiple Issuers requested clarity on data sharing protocols</p> <p>One Issuer requested clarity on Fraud/Waste/Abuse data analysis</p> <p>One stakeholder suggested addition of defining language around QHIO requirements</p>	<p>Expanded language around purpose of and expectations of data sharing with QHIOs</p>

COLLABORATION ACROSS QHP ISSUERS AND WITH COMMUNITY

2023-2025 ATTACHMENT 2 REQUIREMENTS

Performance Area	Performance Standards with Penalties	Percent of At-Risk Amount 2023	Percent of At-Risk Amount 2024	Percent of At-Risk Amount 2025
Health Disparities 30%	1. Reducing Health Disparities: Demographic Data Collection – Enrollee Race and Ethnicity Self-Identification	10%	5%	5%
	2. Reducing Health Disparities: Demographic Data Collection – Enrollee Spoken and Written Language	10% (for reporting)	5%	5%
	3. Reducing Health Disparities: Disparities Reduction Intervention	10%	10%	10%
	4. National Committee for Quality Assurance (NCQA) Health Equity Accreditation	0%	10%	10%
Payment 25%	5. Primary Care Payment	10%	10%	10%
	6. Primary Care Spend	10% (for reporting)	5%	5%
	7. Payment to Support Networks Based on Value	10% (for reporting)	10%	10%
Enrollee Experience 20%	8. Quality Rating System (QRS) QHP Enrollee Experience Summary Indicator Rating	20%	20%	20%
Data 20%	9. Healthcare Evidence Initiative (HEI) Data Submission	20%	20%	20%
Oral Health 5%	10. Dental Quality Alliance (DQA) Pediatric Measure Set	0%	5%	5%

2026-2028 ATTACHMENT 2 REQUIREMENTS

Performance Area	Performance Standards with Penalties	Percent of At-Risk Amount 2026-2028
Health Disparities 20%	1. Reducing Health Disparities: Demographic Data Collection – Enrollee Race and Ethnicity Self-Identification	10%
	2. Reducing Health Disparities: Demographic Data Collection – Enrollee Spoken and Written Language	10%
Engagement in Collaboratives 10%	3. Engagement in Collaboratives and with Community	10%
Data 40%	4. Healthcare Evidence Initiative (HEI) Data Submission	40%
Oral Health 10%	5. Dental Quality Alliance (DQA) Pediatric Measure Set – Pediatric Oral Evaluation, Dental Services (NQF #2517)	5%
	6. Dental Quality Alliance (DQA) Pediatric Measure Set – Pediatric Topical Fluoride for Children, Dental Services (NQF #2528)	5%
Utilization & Primary Care 20%	7. Utilization & Primary Care: Overall Engagement with Members	10%
	8. Utilization & Primary Care: Monitoring Continuity of Care	10%

COLLABORATION ACROSS ISSUERS AND WITH COMMUNITY

Covered California is committed to fostering an environment where **collaboration and engagement are at the forefront** of improving health outcomes, enhancing access, and increasing quality for all Californians. We firmly believe in the importance of **facilitating cross-issuer convenings** that are accessible and encourage participation from all Issuers. Furthermore, it is imperative that QHP Issuers actively engage not only with their enrollees but also with **community-based organizations**. This engagement is essential for driving innovation centered around the needs and experiences of our members.

Covered California believes that cross-issuer convenings, which are low barrier to entry and participation, ensuring issuers are engaging with their enrollees as well as community-based organizations is critical to spur **member-centered innovation**.

PERFORMANCE STANDARD 3.3 COLLABORATION ACROSS ISSUERS AND WITH COMMUNITY

Attachment 2 to the 2026-2028 QHP Contract requires Contractor to attend and engage in at least 6 of the 7 equity focused learning sessions, work groups, and community activities – otherwise financial penalties apply.

Performance Standard

Contractor must host or attend QHP Issuer collaboration and community engagement activities approved by Covered California in at least six of the following seven required focus areas during the Plan Year:

1. Disparities Reduction
2. Access to Behavioral Health Services
3. Substance Use Disorders
4. Use of Generative Artificial Intelligence
5. Payments to Support Networks Based on Value
6. Hospital Quality, Value, and Safety
7. Comprehensive Pregnancy and Postpartum Care

Contractor hosted collaborative QHP Issuer and community engagement activities must meet criteria specified by Covered California and must be submitted to and approved by Covered California in advance to count toward this requirement. Additionally, an event that addresses one or more of the focus areas that Covered California's Health Equity and Quality Transformation Division determines meets specified criteria, including, hosted learning sessions, working groups, forums and roundtables, will count toward this requirement.

CURRENT VS 2026-28 PROPOSED REQUIREMENTS – ATTACHMENT 2

New Proposed Performance Standards

2025 Current Requirements	2026-28 Proposed Requirements	Comment Themes	2026-28 Proposed Requirements Comment Based Update
New requirement for 2026-2028	Collaboration Across QHP Issuers and With Community Contractor must annually attend at least 6 of the 7 QHP-led collaborative and community activities specified in Attachment 1. Contractor must submit proposed events for pre-approval and demonstrate participation through documentation.	No comments	No changes

QUALITY TRANSFORMATION INITIATIVE HEALTH EQUITY METHODOLOGY

QUALITY TRANSFORMATION INITIATIVE

Make
Quality
Count

0.8% to 4%
premium
at risk for

Measures
that
Matter

a small set
of clinically
important
measures

Equity
is
Quality

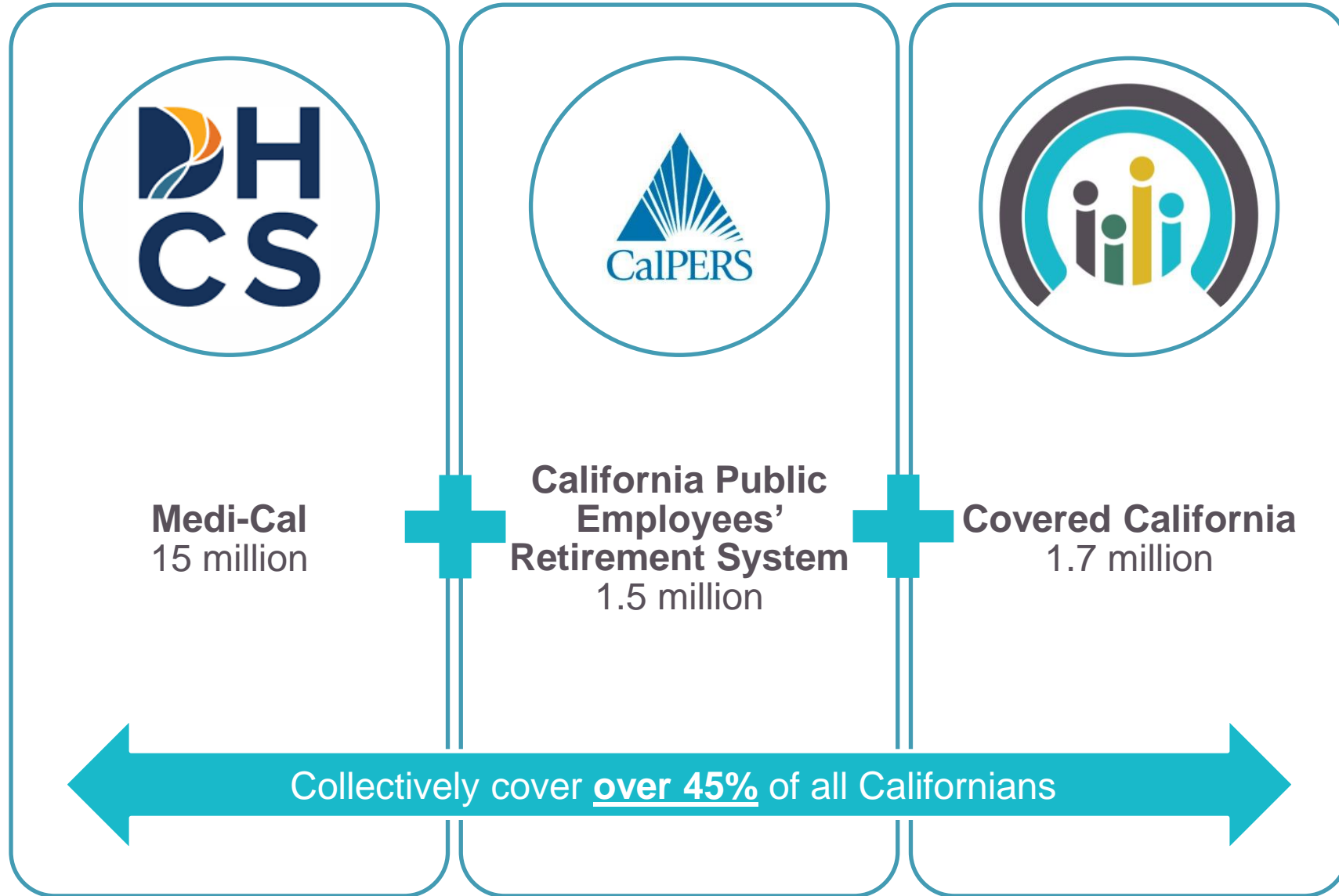
stratified by
race/ethnicity

Amplify
through
Alignment

selected in
concert with
other public
purchasers*

*Public purchasers includes CalPERS and DHCS/Medi-Cal

AN ALIGNED STATE-WIDE APPROACH



EQUITY-CENTERED OUTCOMES MEASURES

Core Measures	Clinical Context
Blood Pressure	Key risk factor for cardiovascular disease (heart attacks and strokes) & the leading cause of death in the United States. BP control rates are ~10% lower for Asian, Black and Hispanic people than White counterparts. Black Americans have 4-5 times greater hypertension-related mortality than White counterparts
Diabetes (A1c control)	~50% Californians have prediabetes or diabetes, which is a leading cause of blindness and amputation and key risk factor for cardiovascular disease. It is 2x more prevalent among Black, AI/AN, and Hispanic people than Whites. Diabetes death was 3x higher among Black and NH/PI than White counterparts
Colorectal Cancer Screening	Cancer is the second leading cause of death after heart disease, and colorectal cancer is the second leading cause of cancer death after lung cancer. Black Americans are 20% more likely to get colorectal cancer and 40% more likely to die from it than others. Screening reduces the risk of developing and dying from CRC cancer by 60-70%
Childhood Immunizations	Childhood immunizations prevent 10.5m diseases annually. Black, Hispanic, AI/AN children have lower vaccine coverage than White children. For every \$1 spent on immunizations, there is as much as \$29 in savings

2026-28 ATTACHMENT 4 REQUIREMENTS

QTI Measure Set:

1. Blood Pressure Control for Patients with Hypertension (BPC-E) *if adopted by CMS QRS, otherwise will continue with CBP*
2. Glycemic Status Assessment for Patients with Diabetes (GSD) >9%
3. Colorectal Cancer Screening (COL-E)
4. Childhood Immunization Status (CIS-E)
5. Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)
6. Pharmacotherapy for Opioid Use Disorder (POD) (Reporting Only)

Proposed Benchmark: 66th percentile using national Exchange benchmark for CMS QRS measure

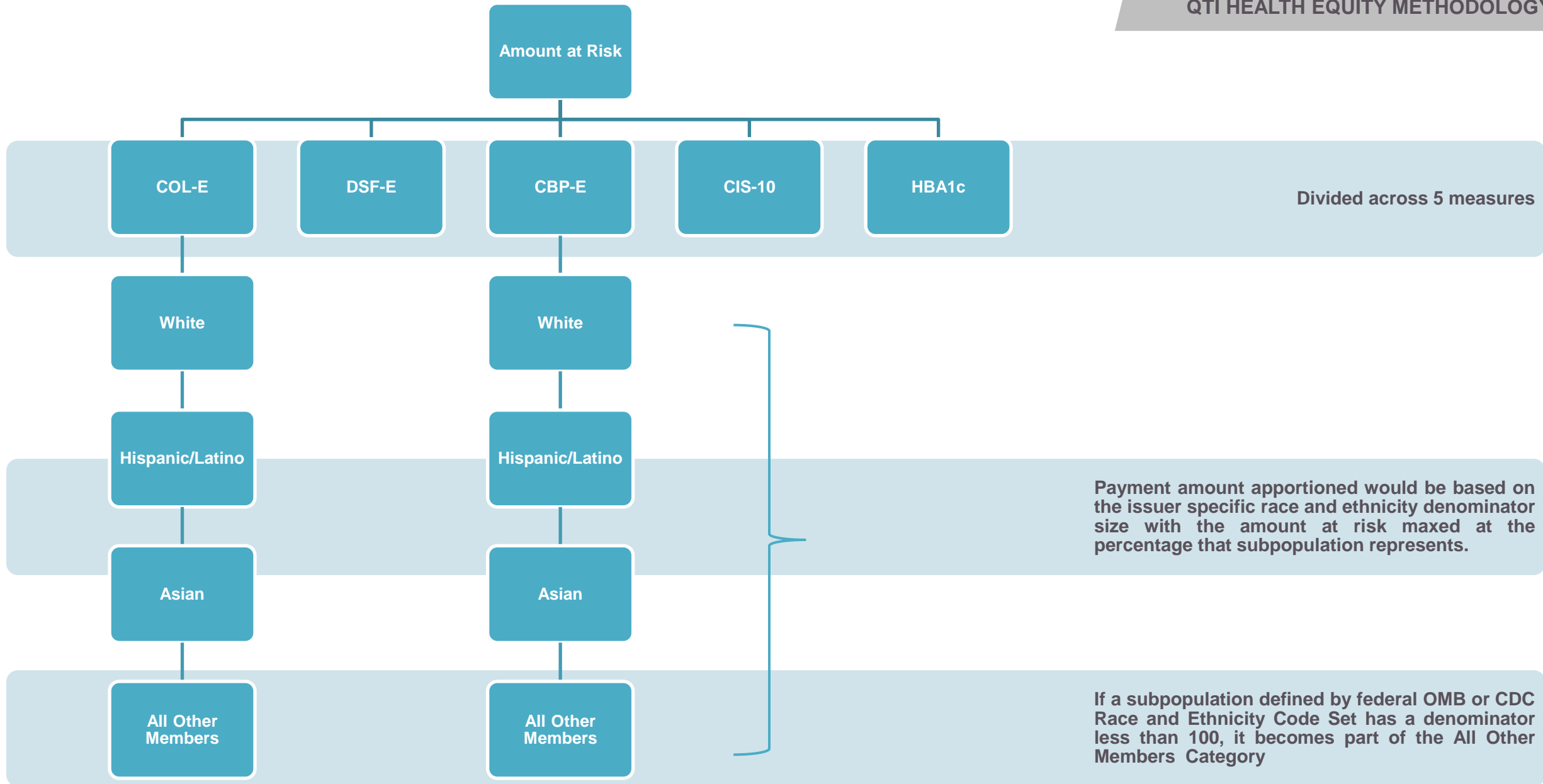
Proposed Amount at Risk for QTI:

- Newly contracted QHP issuers to start at 1% of premium at risk in year 1 of QTI eligibility
- Up to 2.8% of premium at risk for MY2026 for currently contracted QHP issuers
- Up to 3.8% of premium at risk for MY2027 and MY2028 for currently contracted QHP issuers
- No more than 1% increase annually

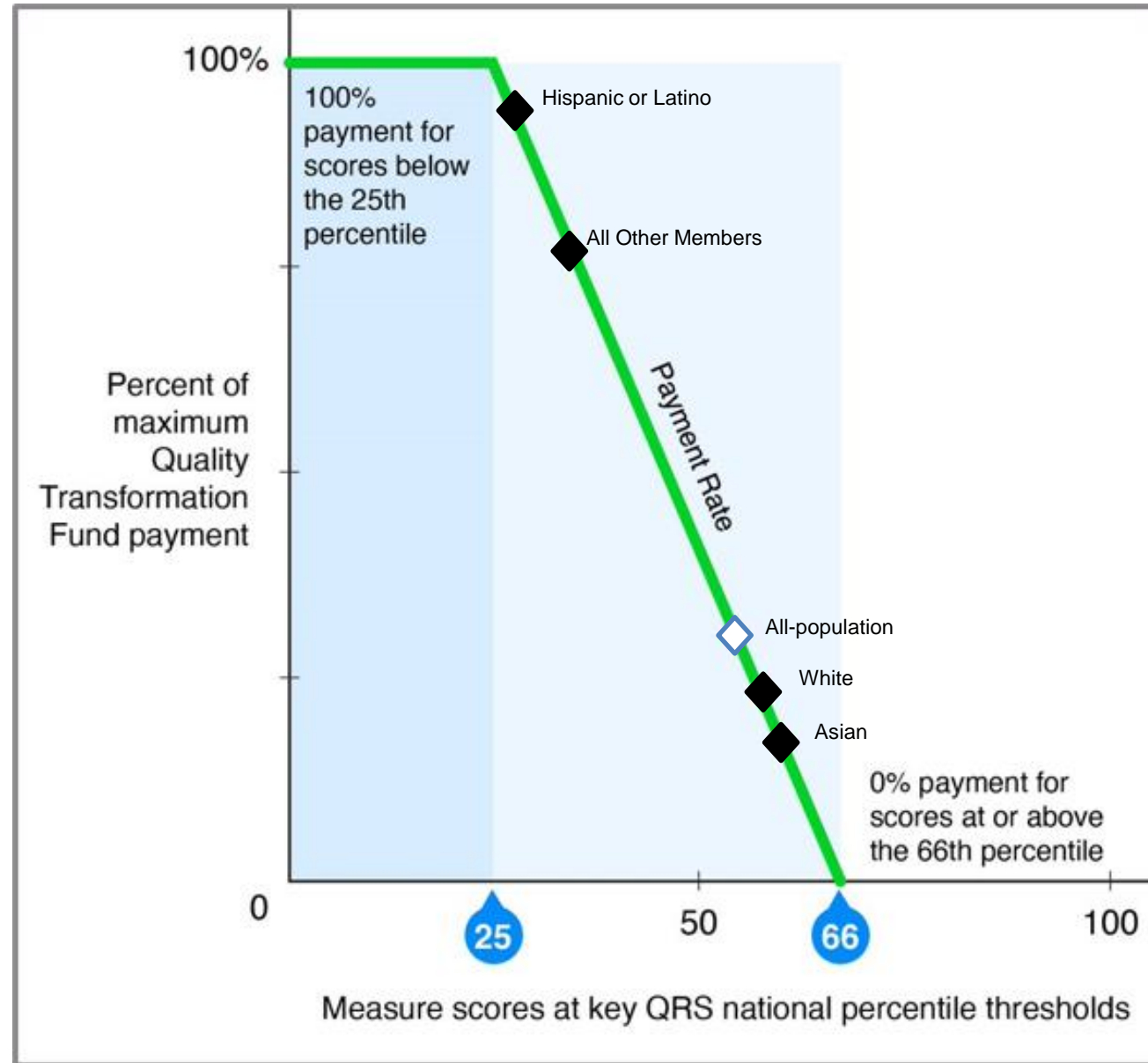
PROPOSED 2026-28 ATTACHMENT 4 REQUIREMENTS

Health Equity Methodology

- ❑ For Measurement Years 2026-2028, the following QTI Scored Measures Shall be Stratified Measures
 - a) Blood Pressure Control for Patients with Hypertension (BPC-E) or, if assessed, Controlling High Blood Pressure (NQF #0018);
 - b) Colorectal Cancer Screening (COL-E) (NQF #0034), or, if assessed, Colorectal Cancer Screening (NQF #0034).
- ❑ Contractor shall be assessed based on QTI Scored Measure performance for all Eligible Subpopulations and the All Other Members Subpopulation, using the benchmarks specified in Section 1.03(Benchmarks and QTI Payments).
- ❑ “Eligible Subpopulation” means the following stratified subpopulations, as defined by the federal Office of Management and Budget (OMB) or Centers for Disease Control (CDC) Race and Ethnicity Code Set, with at least 100 members in the denominator: American Indian or Alaska Native, Asian, Black or African American, Hispanic or Latino, Middle Eastern/North African, Native Hawaiian or Other Pacific Islander, and White. Eligible Subpopulation shall also include Multirace, used when an individual reports two or more CDC codes that cross higher OMB concepts.
- ❑ “All Other Members” means pooled results from members of the following subpopulations, as defined by OMB or CDC: Other Race, or Unknown, used when an individual has not reported race or ethnicity or where data is missing or inaccurate. All Other Members shall also include pooled results from members of subpopulations that would be Eligible Subpopulations but have fewer than 100 identified enrollees in the denominator.
- ❑ Total QTI Payments at risk are divided by each QTI Scored Measure.
- ❑ The QTI Payment at risk for each Stratified Measure is further divided and apportioned based on QHP-Specific subpopulation denominator weights.



SAMPLE PLAN DATA: CONTROLLING BLOOD PRESSURE



CURRENT VS 2026-28 PROPOSED REQUIREMENTS – ATTACHMENT 4

New Quality Transformation Initiative Requirements

2025 Current Requirements	2026-28 Proposed Requirements	Comment Themes	2026-28 Proposed Requirements Comment Based Update
<p>New requirement for 2026-2028</p>	<p>1.02 Race and Ethnicity Stratification and Methodology</p> <p>Contractor must stratify QTI Scored Measure results by Race and Ethnicity using member self-reported data, with subpopulations defined by the OMB or CDC Race and Ethnicity Code Set and requiring at least 100 members in the denominator. Covered California will assess performance based on these stratified results, and All Other Members Subpopulation, which pools members with missing, inaccurate, or smaller subgroup data. Stratified Measures for 2026-2028 include Blood Pressure Control for Patients with Hypertension and Colorectal Cancer Screening, and performance will be evaluated using specified benchmarks. "Stratified Measure", "Eligible Subpopulation", and "All Other Members" are defined.</p>	<p>Several issuers expressed concerns with the proposed financial accountability for stratified performance, citing the differences in plans' member populations and the challenge of meeting quality performance expectations for all racial and ethnic subpopulations as proposed.</p> <p>Inquiries on timeline for implementation with some issuers expressing concern on timing and financial accountability of moving to assessment of stratified performance</p> <p>Requests that future edits to QTI Methodology reconsider weights of smaller subpopulations, include cross-carrier interventions, and impacts to Knox-Keene Act on carriers' ability to report enrollee demographics</p>	<p>No Changes</p>

APPENDIX: DRAFT 2026-2028 QHP ISSUER MODEL CONTRACT DETAILS

CURRENT VS 2026-28 PROPOSED REQUIREMENTS – MODEL CONTRACT

Article 4 – QHP Issuer Program Requirements

2025 Current Requirements	2026-28 Proposed Requirements	Comment Themes	2026-28 Proposed Requirements Comment Based Update
<p>Section 4.3.4 Essential Community Providers Contractor must meet ECP General Standard by maintaining a network that provides reasonable and timely access to covered services for low-income and medically underserved individuals.</p> <p>Contractor must demonstrate provider contracts with at least</p> <ul style="list-style-type: none"> • 15% of 340B non-hospital entities in each rating region • One ECP hospital per county <p>Contractor(s) in an integrated delivery system may request the alternate standard and must demonstrate compliance by mapping low-income member populations and network providers</p>	<p>New ECPs: Primary Care and Behavioral Health providers in HPI Quartiles 1 and 2, HCAI Behavioral Health Workforce grant recipients, Medi-Cal Pediatric Oral Service Providers, Dental Hygienists in Alternative Practice</p> <p>New sufficiency requirements: By 2029, Contractor must demonstrate provider contracts with at least:</p> <ul style="list-style-type: none"> • 15% of Primary Care Providers in HPI Q1 and Q2 in each rating region • 15% of Behavioral Health Providers in HPI Q1 and Q2 in each rating region • One ECP hospital per county, or per rating region in counties with multiple rating regions <p>If unable to meet new sufficiency requirements, must demonstrate provider agreements with at least 15% of 340B non-hospital entities and & increases in sufficiency in 2027 and 2028.</p> <p>Alternate standard: Contractor must map low-income member populations and network providers offering services in all ECP categories.</p>	<p>General support for the ECP update effort and new ECP types.</p> <p>Consumer advocates urged contracting with all FQHCs, rural clinical and tribal health programs (both Indian Health Service and Urban Indian clinics)</p> <p>Several issuers and stakeholders expressed support for the new primary care and BH ECP sufficiency thresholds, while one issuer suggested 10% for primary care ECPs.</p> <p>Several issuers posed clarifying questions regarding data and methods used to develop the proposed ECP list and made suggestions for ease of use of the ECP list</p> <p>Multiple issuers have posed clarifying questions related to the regional denominators for sufficiency calculations and suggested providers that should be excluded from these calculations.</p> <p>One Issuer expressed concern about meeting the sufficiency threshold due to contracting challenges. Several Issuers requested an ECP workshop or working sessions to create space for further discussion</p>	<p>No changes to contract language proposed.</p> <p>Covered California continues to finalize data sources and methodology to produce the new ECP list and will continue to address feedback and incorporate as appropriate.</p>

PROPOSED 2026-28 MODEL CONTRACT LANGUAGE

4.3.4 Essential Community Providers

- a) Contractor must provide reasonable and timely access to Covered Services for Low-income and Medically Underserved populations in each geographic rating region where Contractor's QHPs provide services to Covered California Enrollees, by providing access to Essential Community Providers (ECPs) as specified in this Section. Contractor shall comply with other laws, rules and regulations relating to arrangements with ECPs, as applicable, including those rules set forth at 45 C.F.R. § 156.235. For the purposes of this Section the following definitions shall apply:
- i. "Low-income" populations are individuals and families living at or below 200% of Federal Poverty Level.
 - ii. "Medically Underserved" populations are:
 1. Individuals with HIV/AIDS,
 2. American Indians and Alaska Natives,
 3. Individuals living in Maternity Care Target Areas, as published by the Health Resources and Services Administration (HRSA),
 4. Individuals living in designated Health Professional Shortage Areas, as published by HRSA,
 5. Individuals living in designated Medically Underserved Areas, as published by HRSA, and
 6. Individuals belonging to designated Medically Underserved Populations, as published by HRSA.
- b) General ECP standard. Contractor shall maintain in its provider network a sufficient number and sufficient geographic distribution of ECPs, as specified below. A Contractor that provides a majority of Covered Services through providers employed by the Contractor or through a single contracted medical group, as determined by Covered California, may instead comply with the Alternate ECP standard, specified in (c).
- i. Provider sufficiency. Contractor's provider network must, at a minimum:
 1. Include a mix of ECPs (hospital and non-hospital) reasonably distributed to serve Low-income and Medically Underserved populations.
 2. Include at least one ECP hospital in each county, or, in counties with more than one geographic rating region, one ECP hospital in each geographic rating region, where Contractor's QHPs provide Covered Services to Covered California Enrollees.
 3. Include at least fifteen percent (15%) of ECPs providing primary care services as defined in this Section d) x. in each applicable geographic rating region where Contractor's QHPs provide Covered Services to Covered California Enrollees.
 4. Include at least fifteen percent (15%) of ECPs providing behavioral health services as defined in this Section d) xi. in each applicable geographic rating region where Contractor's QHPs provide Covered Services to Covered California Enrollees.
 5. If Contractor is unable to achieve the sufficiency requirements in this Section b) i. 3. and b) i. 4., include at least fifteen percent (15%) of 340B non-hospital providers in each applicable geographic rating region where Contractor's QHPs provide Covered Services to Covered California Enrollees, and increase Contractor's provider network each Plan Year to achieve the sufficiency requirements in this Section b) i. 3. and b) i. 4. no later than Plan Year 2029. Contractor shall annually provide:

PROPOSED 2026-28 MODEL CONTRACT LANGUAGE

- a. Documentation of Contractor’s good faith efforts to achieve the sufficiency requirements in this Section b) i. 3. and b) i. 4., and
 - b. Documentation each subsequent Plan Year demonstrating increases in Contractor’s percentage of contracts to meet the sufficiency requirements in Section b) i. 3. and b) i. 4.
- ii. Sufficient geographic distribution. Covered California shall determine whether Contractor provides sufficient geographic distribution of care based on a consideration of factors, including:
 1. The nature, type, and distribution of Contractor’s ECP contracting arrangements in each geographic rating region where Contractor’s QHPs provide Covered Services to Covered California Enrollees;
 2. The balance of hospital and non-hospital ECPs in each geographic rating region where Contractor’s QHPs provide Covered Services to Covered California Enrollees; and
 3. The extent to which the providers in Contractor’s network are accessible to and provide services that meet the needs of Low-income and Medically Underserved populations.
- c) Alternate ECP standard. A Contractor that Covered California determines qualifies under the alternate ECP standard, due to its integrated delivery structure, must satisfy the requirement in (a) by providing services to the Low-income and Medically Underserved populations served by the entities listed in each of the ECP categories in (d). It must demonstrate that it does so in each geographic rating region where Contractor’s QHPs provide services to Covered California Enrollees, either through its own system or by offering a contract to at least one ECP outside of its system in each such category.
 - d) ECP categories. ECPs shall include the following categories of entities:
 - i. Entities that participate in the program for limitation on prices of drugs purchased by covered entities under Section 340B of the Public Health Service Act (42 U.S.C. § 256B (“340B Entities”).
 - ii. Entities that participate in the program described in Public Health Service Act § 1927(c)(1)(D)(i)(IV).
 - iii. Entities that participate in California’s Disproportionate Share Hospital (DSH) Program, per the final DSH Eligibility List for the current fiscal year.
 - iv. Federally designated 638 Tribal Health Programs and Title V Urban Indian Health Programs.
 - v. Federally Qualified Health Centers.
 - vi. Community Clinics or health centers either licensed as a “community clinic” or “free clinic”, by the State under Health and Safety Code section 1204, subdivision (a), or exempt from licensure under Health and Safety Code section 1206.
 - vii. State-owned family planning service sites or governmental family planning sites not receiving Federal funding under special programs, including Title X of the PHS Act, unless they have lost their status under that section, or sections 340(B) or 1927 of the PHS Act due to violations of Federal law.
 - viii. Pediatric oral services providers.
 - ix. Recipients of the Department of Health Care Access and Information’s Community-Based Organization (CBO) Behavioral Health Workforce Grant Program.

PROPOSED 2026-28 MODEL CONTRACT LANGUAGE

- x. Medi-Cal primary care providers located in quartiles 1 and 2 of the California Healthy Places Index.
- xi. Medi-Cal behavioral health providers located in quartiles 1 and 2 of the California Healthy Places Index.
- e) Covered California will post a non-exhaustive list of ECPs annually. If Contractor believes an entity it contracts with falls within one or more of the ECP categories, but the entity does not appear on Covered California's published list, Contractor may request approval from Covered California to include the entity as an ECP.
- f) Covered California will annually publish a report on Contractor's efforts to achieve compliance with the requirements in Section 4.3.4. This report will include an assessment of Contractor's ability to meet the provider sufficiency requirements in this Section b) i., and if applicable, Contractor's documented approach to achieving the provider sufficiency requirements for ECPs providing primary care and behavioral health services, submitted in Section b) i. 5.
- g) Reporting requirements for Contractors under the General ECP standard are contained within the required monthly provider data submission pursuant to Section 4.4.4. Contractor must provide a provider data file to Covered California upon request for the purpose of determining compliance with the ECP standard. This file is separate and distinct from the files provided to the Integrated Health Care Association's Symphony Provider Directory as described in Section 4.4.5.
- h) Reporting requirements for Contractors under the Alternate ECP standard are contained within the annual Application for Certification. Contractor must provide access maps to demonstrate the extent to which it provides services to the Low-income and Medically Underserved populations served by the entities listed in each of the ECP categories.
- i) Notice of changes to ECP network. Contractor shall notify Covered California with respect to any change as of and throughout the term of this Agreement to its ECP contracting arrangements, geographic distribution, percentage coverage, ECP classification type (e.g., 340B), and other information relating to ECPs within thirty (30) business days of any change in ECP contracts. Contractor shall notify Covered California of any pending change in its ECP contracting arrangements at least sixty (60) Days prior to any change or immediately upon Contractor's knowledge of the change if knowledge is acquired less than sixty (60) Days prior to the change, and shall cooperate with Covered California in planning for the orderly transfer of plan members.
- j) Indian Health Care Providers. For Contractor's provider contracts entered into on or after January 1, 2015, Contractor shall reference the Centers for Medicare & Medicaid Services "Model QHP Addendum for Indian Health Care Providers" ("Addendum").

Contractor is encouraged to adopt the Addendum whenever it contracts with those Indian health care providers specified in the Addendum. Adoption of the Addendum is not required; it is offered as a resource to assist Contractor in including specified Indian providers in its provider networks.

CURRENT VS 2026-28 PROPOSED REQUIREMENTS – MODEL CONTRACT

Article 4 – QHP Issuer Program Requirements

2025 Current Requirements	2026-28 Proposed Requirements	Comment Themes	2026-28 Proposed Requirements Comment Based Update
<p>New requirement for 2026-2028</p>	<p>Section 4.3.6 Access Monitoring Covered California will track and publicly report CMS QRS Enrollee Experience performance</p> <p>Healthcare Evidence Initiative (HEI) data will be used to assess Provider Availability and Accessibility for Network measures with improvement plans required for underperforming Issuers. Measures include:</p> <ul style="list-style-type: none"> • Provider-to-member ratio: The number of providers per beneficiary • Number of Active providers: The percentage of providers serving beneficiaries in the past year • Provision of telehealth services: The percentage of providers providing telehealth services <p>A secret shopper survey utilizing questions from DHCS and CalPERS surveys may be launched in PY2026 to assess Service Utilization and Quality, which may include improvement plans required for under-performing Issuers. A repeat survey may be implemented biennially (every other year) if pervasive underperformance.</p>	<p>Public purchasers and a Provider Association expressed support for continued alignment on Access measurement and monitoring initiatives</p> <p>Multiple Issuers recommend aligning measures and monitoring approaches with DHCS and DMHC, cautioning against establishing potentially redundant or conflicting requirements. Two Issuers and one stakeholder requested clarity on the secret shopper surveys, expressing concern for survey fatigue, survey criteria, and duplication with other public purchaser efforts.</p> <p>Multiple Issuers requested clarifications, including:</p> <ul style="list-style-type: none"> • How provider utilization rates will indicate patient access issues • If contracted health plans will receive secret shopper survey results as well as if survey results are subject to penalties • How Access monitoring aligns with requirements from DMHC and CMS/NBPP <p>One Issuer requested flexibility for plans to set policies for the provider-to-member ratio when applied to specialty providers (e.g. based on utilization)</p> <p>One Issuer requested significant lead time for HEI data testing and reporting and one Issuer recommended collection of 2 years of baseline data prior to establishing plan-wide benchmarks for active providers</p>	<p>Provider Availability and Accessibility</p> <p>For access and network measures generated from Covered California's Healthcare Evidence Initiative (HEI), two years of data collection will be pursued before setting any benchmarks</p> <p>Service Utilization and Quality</p> <p>Any new survey, including secret shopper effort, will be conducted in alignment with DMHC and other public purchasers</p>

CURRENT VS 2026-28 PROPOSED REQUIREMENTS – MODEL CONTRACT

Article 5 – Advancing Equity, Quality, and Value

2025 Current Requirements	2026-28 Proposed Requirements	Comment Themes	2026-28 Proposed Requirements Comment Based Update
<p>5.2.3 Removal from Exchange Assessment Structure</p> <ul style="list-style-type: none"> Composite scores compared to MY 2018 25th % composite benchmark. 2 years below benchmark = remediation; 4 years = removal from exchange <p>25th Percentile Benchmark</p> <ul style="list-style-type: none"> Average of 2018 QRS measure scores. Excludes NR results and measures without MY 2018 benchmarks <p>Annual Assessment</p> <p>Measure Inclusion/Exclusion</p> <ul style="list-style-type: none"> Follows CMS QRS guidelines; MY 2018 measures only. Retired measures excluded <p>Benchmark Year</p> <ul style="list-style-type: none"> MY 2018 benchmarks used for 2023-2025 contract <p>Scoring Calculation</p> <ul style="list-style-type: none"> Annual updates to composite scores and benchmarking 	<p>2024 Benchmark Year</p> <ul style="list-style-type: none"> Updating 2018 to 2024 as the new static benchmark year which updates and expands measure set used to calculate composite benchmarks and scoring <p>Annual Assessment</p> <ul style="list-style-type: none"> Average of 2024 QRS measure scores <p>Composite Assessment Structure</p> <ul style="list-style-type: none"> Continuing: 2 years below benchmark = remediation; 4 years = removal from exchange <p>Minimum Performance Level (MPL) requirement.</p> <ul style="list-style-type: none"> Measure-specific MPL action plans target consistent underperformance of clinically significant measures beneath the 25th percentile <p>Measure Inclusion/Exclusion</p> <ul style="list-style-type: none"> Adds new CMS measures as benchmarks are published. Limits to MY 2024 and new measures with benchmarks; excludes retired measures 	<p>New Measures and Benchmarks</p> <ul style="list-style-type: none"> Request for details on new measure inclusion and benchmark year selection Support for updated benchmarks and new QRS measures <p>Minimum Performance Level (MPL)</p> <ul style="list-style-type: none"> Clarity requested on MPL action plans Concern about redundancy with composite scores & QTI program. Suggestions to phase in MPL or narrow measures impacted One issuer requested MPL removal from the 2026-2028 contract <p>Timing and Reporting</p> <ul style="list-style-type: none"> Suggestion to wait for one year of QRS reporting before including new measures <p>Shared Goals</p> <ul style="list-style-type: none"> Support for quality improvement and alignment with national standards 	<p>Benchmark Year</p> <ul style="list-style-type: none"> Finalized as Measure year 2024. <p>Measure Inclusion</p> <ul style="list-style-type: none"> Contract terms allow flexibility to include new QRS clinical measures as benchmarks become available <p>Minimum Performance Level (MPL)</p> <ul style="list-style-type: none"> Narrowed the number of clinical measures subject to MPL action plans. Targets consistent underperformance for clinically significant measures beneath the 25th percentile. <p>Composite Scoring</p> <ul style="list-style-type: none"> Maintaining alignment with CMS scoring methodology <p>Timing of New Measures</p> <ul style="list-style-type: none"> Measures must have a QRS benchmark to be included in the composite

CURRENT VS 2026-28 PROPOSED REQUIREMENTS – ATTACHMENT 1

Article 1 – Equity and Disparities Reduction

2025 Current Requirements	2026-28 Proposed Requirements	Comment Themes	2026-28 Proposed Requirements Comment Based Update
<p>1.01 Demographic Data Collection Requires Contractor to collect member self-reported race, ethnicity, and preferred language. Contractor must work with Covered California to expand the disparity identification and improvement requirements in the article.</p>	<p>Requires Contractor to collect member self-reported race, ethnicity, language, and newly sexual orientation and gender identity (SOGI), in order to develop targeted interventions and improve health outcomes for enrollees.</p>	<p>Clarification of timelines for implementation of SOGI requirement.</p>	<p>No changes</p>
<p>1.02 Identifying Disparities in Care Requires Contractor to collect and report member level data for specified HEDIS measures and stratify results by race and ethnicity. Covered California will use HEI data to monitor disparities, and Contractor must review results in collaboration with Covered California.</p>	<p>Continued requirement to report on specified HEDIS hybrid measures via PLD, expanded measures list.</p> <p>HEI-generated stratified measures list expanded to include multiple behavioral health utilization metrics. Continued requirement for Contractor and Covered California to review performances on specified measures using HEI data.</p>	<p>Clarification of PLD file specification, and Some issuers expressed concerns with the number of measures in PLD file.</p> <p>Request for decisions related to implementation of ECDS for PLD file submission of HEDIS measures.</p>	<p>No changes</p>

CURRENT VS 2026-28 PROPOSED REQUIREMENTS – ATTACHMENT 1

Article 1 – Equity and Disparities Reduction

2025 Current Requirements	2026-28 Proposed Requirements	Comment Themes”	2026-28 Proposed Requirements Comment Based Update
<p>1.03 Disparities Reduction Contractor must meet a multi-year disparity reduction target beginning in PY 2023.</p>	<p>Contractor must participate in collaboration across QHP Issuers and with community via learning sessions. Contractor must meet specified disparity identification and reduction requirements with a focus on maternal mental health and behavioral health access, must provide annual CLAS staff training.</p>	<p>Issuer requested guidance on staff training related to the CLAS standards</p>	<p>Revisions to clarify QHP expectations for QHP conducted activities to meet QHP collaboration and community engagement timelines.</p>
<p>1.04 Health Equity Capacity Building Contractor must achieve or maintain NCQA Health Equity Accreditation. If Contractor had a previously MHCD contractor must now transition to NCQA Health Equity Accreditation at the expiration of MHCD.</p>	<p>Continued requirement: Contractor must achieve or maintain NCQA Health Equity Accreditation.</p>	<p>No comments</p>	<p>No changes</p>
<p>Culturally and Linguistically Appropriate Care Contractor must ensure provision of culturally and linguistically appropriate services to Enrollees. Contract must submit specified NCQA HEA standard reports or equivalent reporting if not accredited.</p>	<p>Changed to 1.05 Culturally and Linguistically Appropriate Care Continued requirement: Contractor must submit NCQA Health Equity Accreditation Standards reports or equivalent reporting if not accredited. Covered California to evaluate how Contractor ensures provision of culturally and linguistically appropriate services.</p>	<p>Suggestion of submission of NCQA Health Accreditation Certificate rather than reporting related specified standards</p>	<p>No Changes</p>

CURRENT VS 2026-28 PROPOSED REQUIREMENTS – ATTACHMENT 1

Article 2 – Behavioral Health

2025 Current Requirements	2026-28 Proposed Requirements	Comment Themes	2026-28 Proposed Requirements Comment Based Update
<p>2.01 Access to Behavioral Health Services Enhancing and tracking access to behavioral health services is crucial to ensure that enrollees receive timely and quality care: network oversight, telehealth offerings, promoting access, and monitoring behavioral health service utilization</p>	<ul style="list-style-type: none"> + Specified that telehealth is not a replacement for in-person care; continue to follow network adequacy standards for in-person services + Added screenshots of member materials + Contractor must implement at least 1 new intervention to support underutilizing enrollees to reduce disparities + Addition of behavioral health spend – annual reports in alignment with OHCA 	<p>Consumer advocate groups and Issuers requested clarity on culturally and linguistically appropriate services</p> <p>Overall support for approach focused on access, member engagement in care, and reducing disparities</p>	<p>No changes</p>
<p>2.02 Quality of Behavioral Health Services Monitoring quality is crucial for providing appropriate, evidence-based care to enrollees and supporting quality improvement</p>	<p>No notable changes</p>	<p>No comments</p>	<p>No changes</p>
<p>2.03 Appropriate Use of Opioids Appropriate use of opioids and evidence-based treatment of opioid use disorder, can improve outcomes, reduce inappropriate healthcare utilization, and lower opioid overdose deaths</p>	<p>2.03 Substance Use Disorders</p> <ul style="list-style-type: none"> + Expanded focus including tobacco treatment, and other substances such as alcohol + Tobacco cessation language changed to “tobacco treatment” + Advise quitting, discuss treatment medications and strategies - Medical Assistance with Smoking and Tobacco Use Cessation (NQF #0027) 	<p>Overall support for the expansion of substances, including tobacco</p> <p>One Issuer recommended Follow-Up after SUD admission rather than IET</p>	<p>No changes</p>

CURRENT VS 2026-28 PROPOSED REQUIREMENTS – ATTACHMENT 1

Article 2 – Behavioral Health

2025 Current Requirements	2026-28 Proposed Requirements	Comment Themes	2026-28 Proposed Requirements Comment Based Update
<p>2.04 Integration of Behavioral Health Services with Medical Services Contractor must use alternative payment models for behavioral health integration, report on promotion efforts, and track Collaborative Care Model Utilization</p>	<p>Continued requirement for Contractor to report how they are promoting integration, including data exchange between Contractor, its primary care clinicians and its behavioral health providers</p>	<p>No comments</p>	<p>No changes</p>
<p>2.05 Behavioral Health Subcontractor, Downstream Entity, and Behavioral Health Network Provider Oversight To ensure Enrollees receive high-quality, equitable care for behavioral health: Subcontractors, Downstream Entities, and behavioral health network providers’ delegated functions related to compliance must be reported</p>	<p>No notable changes</p>	<p>No comments</p>	<p>No changes</p>

CURRENT VS 2026-28 PROPOSED REQUIREMENTS – ATTACHMENT 1

Article 3 – Population Health

2025 Current Requirements	2026-28 Proposed Requirements	Comment Themes	2026-28 Proposed Requirements Comment Based Update
<p>3.01 Population Health Management Contractors must implement Population Health Management strategies, including health promotion and Enrollee engagement in health activities, and submit their population health management plans.</p>	<p>No notable changes</p>	<p>No comments</p>	<p>No changes</p>
<p>3.02 Health Promotion and Prevention Contractors must identify Enrollees eligible for preventive and wellness benefits, like the CDC-recognized Diabetes Prevention Program, through proactive outreach and health outcome monitoring, aiming to improve overall population health.</p>	<p>Moved Tobacco Cessation Program requirement to Article 2: Behavioral Health.</p> <p>Removed requirements to report on DPP usage trends among eligible Enrollees compared to expected rates over time and to outline strategies for aligning DPP utilization with long-term improvement goals</p>	<p>Multiple Issuers supported the removal of reporting requirements and reducing administrative burden related to offering health promotion and prevention programs</p>	<p>No changes</p>

CURRENT VS 2026-28 PROPOSED REQUIREMENTS – ATTACHMENT 1

Article 3 – Population Health

2025 Current Requirements	2026-28 Proposed Requirements	Comment Themes	2026-28 Proposed Requirements Comment Based Update
<p>3.03 Supporting At-Risk Enrollees Requiring Transition Contractors must submit detailed transition strategy for changes in service area, ensure all Enrollees are informed of these changes and alternative QHP options, and actively facilitate the transition of At-Risk Enrollees to new QHP Contractors with their consent, guaranteeing continuity of care.</p>	<p>Specified a 60-day outreach period for both "Departing" and "Receiving Contractors" for member communication and care transition, with added details on file transmission processes for Enrollees as specified in federal guidelines (28 CCR 1300.65.1(a)(2)(C), (D).)</p>	<p>Several Issuers advocated use of established guidelines and flexible timing to manage care transition activities for Enrollees in regions experiencing service reductions</p> <p>One Issuer requested clarification on the use of "at-risk" vs "high-risk" in the enrollee transition requirements given the use of "high-risk" in current law</p> <p>Consumer advocates recommended classifying those in medication-assisted treatment for substance disorders as high-risk enrollees</p>	<p>Added clarifying language to "at-risk" and "high-risk" definitions</p> <p>Added Enrollees' undergoing medication assisted treatment for substance use disorders in definition of "At-Risk" Enrollees</p>
<p>3.04 Social Health Contractors must report screening process used to identify Enrollees' unmet social needs (at minimum, food, housing, transportation) including requirements or incentives for provider screenings, linking Enrollees to required services and annually report stratified results for the SNS-E measure</p>	<p>Specified annual report requirement for screening processes and efforts to connect Enrollees to resources.</p>	<p>Issuers sought clarity on SNS-E measure reporting</p> <p>One issuer supported ongoing SNS-E reporting</p> <p>One Issuer raised concerns regarding the coding and data collection challenges for SNS-E, particularly for intervention rates, and advocated total population reporting only rather than stratified reporting</p>	<p>No changes</p>

CURRENT VS 2026-28 PROPOSED REQUIREMENTS – ATTACHMENT 1

Article 3 – Population Health

2025 Current Requirements	2026-28 Proposed Requirements	Comment Themes	2026-28 Proposed Requirements Comment Based Update
<p>No current requirements</p>	<p>New - 3.05 Use of Generative Artificial Intelligence in QHP Issuer Operations</p> <p>Contractor must:</p> <ul style="list-style-type: none"> Align with federal regulations Patient Care Decision Support Tools 45 C.F.R § 92.210, including GenAI Adopt best practices for GenAI in healthcare Maintain transparency about GenAI use. Address and reduce bias Engage in collaborative learning among Issuers Report on bias mitigation, GenAI governance, and use cases 	<ul style="list-style-type: none"> Issuers sought clarity on reporting requirements; one suggested less frequent reporting to ease administrative load An Issuer emphasized the need for autonomy in GenAI governance development Multiple stakeholders advocated for regulatory alignment and industry-wide collaboration while implementing proposed contract requirements An Issuer requested clarification on disclosure requirements for Covered California enrollees pertaining to the use of Gen AI 	<p>Adopted language to align with legal requirements within SB-1120 Health Coverage: Utilization Review</p>

PROPOSED 2026-28 ARTICLE 3 CONTRACT LANGUAGE

3.05 Use of Generative Artificial Intelligence in QHP Issuer Operations

This section acknowledges the transformative potential of Patient Care Decision Support Tools, including Generative Artificial Intelligence (GenAI), to enhance health plan operations and member experiences while promoting health equity. It sets forth a framework for the responsible use of Patient Care Decision Support Tools by QHP Issuers, emphasizing compliance, bias mitigation, transparency, continuous improvement, and collaboration with shared learning.

Definitions:

- 1) Patient Care Decision Support Tools: Patient Care Decision Support Tools has the same meaning as defined in 45 C.F.R. § 92.4. Patient Care Decision Support Tools includes Artificial Intelligence and Generative Artificial Intelligence.
- 2) Artificial Intelligence: Artificial Intelligence has the same meaning as defined in Health and Safety Code, § 1367.01, subdivision (k) and Insurance Code, § 10123.135, subdivision (j). Artificial Intelligence includes Generative Artificial Intelligence.
- 3) Generative Artificial Intelligence (GenAI): Generative Artificial Intelligence is a subset of Artificial Intelligence that includes systems capable of creating content, predictions, or decisions from data inputs. This encompasses machine learning, natural language processing, and neural network technologies.
- 4) Human-in-the-Loop (HITL): A model where human judgment is incorporated into GenAI outputs to guide, review, or alter GenAI-made decisions or predictions.
- 5) Governance Structure: A written framework of systems and processes adopted by an organization to appropriately and ethically manage decision-making regarding use of Patient Care Decision Support Tools in the organization's operations.

CURRENT VS 2026-28 PROPOSED REQUIREMENTS – ATTACHMENT 1

Article 4 – Delivery System and Payment Strategies to Drive Quality

2025 Current Requirements	2026-28 Proposed Requirements	Comment Themes	2026-28 Proposed Requirements Comment Based Update
<p>4.01 Advanced Primary Care Commit to promoting advanced primary care models that are patient-centered and data-driven, integrating behavioral health and managing complex conditions, supported by alternative payment methods to enhance access, coordination, and quality of care</p>	<p>PCP Assignment requirement is kept but distinction between assigned and selected has been removed.</p> <p>Added a shift in language to emphasize collaboration with Covered California to improve primary care selection, member value and engagement in care.</p> <p>Introduced and clarified the terminology and reporting requirement on the Continuity of Care, specifying enrollment timelines.</p> <p>Expanded language on payment models to include descriptions of HCP LAN APM categories and primary care clinician compensation.</p> <p>Aligned with OHCA requirements, QHP issuers must report total primary care spend by product, analyze its impact on total healthcare expenditures (TCHE) and network performance of the overall delivery system.</p>	<p>Many issuers recommend further research on the Continuity of Care (CoC) measure and its correlation with quality before setting benchmarks.</p> <p>Concerns were raised about potential for unnecessary visits and increased costs, and the need for a reporting-only phase to establish baseline.</p> <p>Consumer advocates and coalition supported the CoC metric for its positive impact on patient outcomes and cost reduction.</p> <p>Some issuers expressed concerns about duplicative data reporting and recommended aligning with OHCA on primary care spend reporting.</p>	<p>Added language on member value and engagement in care.</p> <p>Revision to related Performance Standard: Utilization and Primary Care: Monitoring Continuity of Care. Lowered the threshold to require improvement efforts if the continuity of care index falls below 0.7 for 60% of enrollees, down from 70% of enrollees.</p>
<p>4.02 Promotion of Integrated Delivery Systems (IDSs) and Accountable Care Organizations (ACOs)</p>	<p>Retired</p>		

PROPOSED 2026-28 ARTICLE 4 CONTRACT LANGUAGE

4.01.2 Measuring Advanced Primary Care

Advanced primary care is patient-centered, accessible, team-based, data driven, supports the integration of behavioral health services, and provides care management for patients with complex conditions. To support advanced primary care, primary care clinicians should have access to data related to the care their patients receive throughout the delivery system to promote integrated, continuous, and coordinated care.

- 1) Primary Care Clinician Selection
 - a) Covered California will determine if Contractor's Covered California Enrollees utilized their assigned primary care clinician, another plan-identified primary care clinician, sought healthcare services elsewhere, or had no healthcare activity by comparing claims data with the primary care clinician National Provider Identifier (NPI).
 - b) Contractor shall work with Covered California to review and improve primary care clinician selection and healthcare utilization using HEI submitted data in accordance with Article 5.02.1.
- 2) Member Value and Engagement in Care
 - a) Contractor must ensure active engagement of Enrollees in care to improve health outcomes and member satisfaction. Through proactive engagement and outreach, Contractor enables Enrollees to access preventive services, manage chronic conditions, and avoid unnecessary emergency room care and hospitalizations.
 - b) Contractor must monitor and increase the portion of Covered California Enrollees with continuous enrollment in Contractor's QHP throughout the prior Plan Year who have at least one medical or prescription drug claim during the Plan Year. This requirement aims to reduce the number of Enrollees without any healthcare activity and improve utilization of medically necessary care. By tracking claims data and engaging Enrollees through targeted outreach and coordinated care, Contractor can address gaps in care and ensure Enrollees utilize necessary health services, enhancing outcomes and maximizing the value of coverage.
- 3) Continuity of Care
 - a) Covered California will measure continuity of care for Contractor's Covered California Enrollees using the continuity of care index. The continuity of care index assesses the percentage of visits with the same provider, yielding an index ranging from 0 to 1, where 0 indicates all visits with different providers and 1 indicates all visits with the same provider. Using HEI submitted data in accordance with Article 5.02.1, Covered California will measure continuity of care for Covered California Enrollees with continuous enrollment in Contractor's QHP throughout the prior Plan Year and two or more primary care visits with any primary care clinician during the prior Plan Year.
 - b) Contractor shall collaborate with Covered California to establish benchmarks and improvement targets around continuity of care, and work with Covered California to review and improve Enrollee continuity of care.

CURRENT VS 2026-28 PROPOSED REQUIREMENTS – ATTACHMENT 1

Article 4 – Delivery System and Payment Strategies to Drive Quality

2025 Current Requirements	2026-28 Proposed Requirements	Comment Themes	2026-28 Proposed Requirements Comment Based Update
<p>4.03 Networks Based on Value: Design and manage networks based on cost, quality, safety, patient experience, and equity, while reporting selection criteria and collaborating on cost analysis.</p> <ul style="list-style-type: none"> • Payment Models: Support value-based payment models and report spending across APM categories. • Provider Value: Improve provider quality and cost performance, with intervention plans for low-performing providers and reporting on cost factors and distribution. • Hospital Value: Ensure hospitals meet quality and affordability standards, with intervention plans for low-quality hospitals and reporting on cost transparency. • Hospital Payments: Tie hospital payments to quality metrics like mortality, HAIs, and readmissions, and report performance-based payment outcomes. • Hospital Safety: Improve patient safety by addressing HAIs, sepsis management, and opioid use through hospital engagement strategies. • Maternity Care: Reduce unnecessary C-sections and address maternal health disparities through value-based payments, stratified data reporting, and culturally appropriate care initiatives. 	<p>4.02 Networks Based on Value: Added focus on low-value care reduction and affordability barriers.</p> <ul style="list-style-type: none"> • Payments: Align total cost reporting with OHCA benchmarks; track APM member attribution; mandate participation in learning sessions. • Provider Value: Report barriers to affordable care and submit medical management policies upon request. Increased focus on QHP collaboration. • Hospital Quality & Safety: Verify CMS Price Transparency compliance and focus on collaborative improvements. • Hospital Safety: Expand opioid strategies to address substance use disorder and support SUD Honor Roll participation. • Maternity Care: Track and expand doula/midwife access; address maternal health disparities and improve birthing outcomes through targeted interventions and whole-person care. 	<p>Networks Based on Value:</p> <ul style="list-style-type: none"> • Concerns over mandatory OHCA APM goals: timing, redundancy, and administrative burden. • Risks of provider consolidation potentially worsening care access. • Request to remove medical management policy requests and expectations to address "low-value care" as health plans do not practice medicine. <p>Hospital Value and Safety:</p> <ul style="list-style-type: none"> • Request to exclude "all lines of business" from reporting requirements. <p>Comprehensive Maternity Care:</p> <ul style="list-style-type: none"> • Support for equitable access to doulas and midwives from consumer advocates. • Issuers seek clarity on data tracking and raise challenges with third-party network data. 	<p>Networks Based on Value:</p> <ul style="list-style-type: none"> • Added definition of low-value care: services with minimal clinical benefit, deviation from evidence-based guidelines, or safer, cost-effective alternatives. <p>Comprehensive Pregnancy and Postpartum Care:</p> <ul style="list-style-type: none"> • Updated terminology to "Pregnant and Postpartum patients" and to "Pregnancy and Postpartum care" for clarity and inclusivity. • Expanded focus on maternal mental health disparities, including monitoring and reduction through Substance Use Disorder (SUD) and Medication-Assisted Treatment (MAT) programs with coordinated care.

CURRENT VS 2026-28 PROPOSED REQUIREMENTS – ATTACHMENT 1

Article 4 – Delivery System and Payment Strategies to Drive Quality

2025 Current Requirements	2026-28 Proposed Requirements	Comment Themes	2026-28 Proposed Requirements Comment Based Update
<p>4.04 Telehealth Contractors must report on and support the use of telehealth, including types offered, communication and education efforts to enrollees, access barriers, impact on quality while also reviewing utilization with Covered California.</p>	<p>Changed to 4.03 Use of Virtual Care Added requirement to report on virtual behavioral health care vendors Added URAC as an alternative accreditation for digital/telehealth vendors reporting</p>	<p>One Issuer requested adding URAC as an alternative accreditation for virtual care One Issuer requested clarity on the scope of virtual care One Issuer expressed concern about HEI reporting</p>	<p>Added URAC as alternative accreditation for reporting virtual care providers</p>
<p>4.05 Participation in Quality Collaboratives Improving healthcare quality and reducing overuse can only be done through collaboration, data sharing, and effective engagement of hospitals, providers, and other providers of care. Contractors must report participation including financial support for a specified list of collaboratives</p>	<p>Changed to 4.04 Participation in Quality Collaboratives Modified language to focus on collaboration and removed the listing of specific collaboratives</p>	<p>Many Issuers expressed support for reducing required organizations Several Issuers brought up participation costs and time commitments</p>	<p>No changes</p>

CURRENT VS 2026-28 PROPOSED REQUIREMENTS – ATTACHMENT 1

Article 5 – Measurement and Data Sharing

2025 Current Requirements	2026-28 Proposed Requirements	Comment Themes	2026-28 Proposed Requirements Comment Based Update
<p>5.01 Measurement and Analytics Emphasizes the importance of measurement in evaluating care quality, equity, and value, utilizing HEDIS and CAHPS measures and developing a Healthcare Evidence Initiative, along with Contractor collaboration</p>	<ul style="list-style-type: none"> - Removed requirement for direct submission of Contractor's CAHPS file to Covered California in addition to submission to CMS + Added statement that Contractor submitted data may be used for financial accountability programs 	<p>Multiple comments on tailoring requirements</p>	<p>No changes</p>
<p>5.02 Data Sharing and Exchange Contractors must comply with data submission requirements under California law, including providing information on cost, quality, disparities, and HEI Data for audits and evaluations, and engage in interoperability efforts to support enhanced care coordination and patient access to health records, while also participating in health information exchanges and data aggregation initiatives to improve healthcare quality and reduce costs</p>	<ul style="list-style-type: none"> + Issuers must execute the Data Sharing Agreement (DSA) as required by Health Safety Code section 130290 and participate in at least on QHIO + Issuers must share information on enrollees with primary care providers for their assigned members + Expanded language regarding participation in at least one QHIO should include a statement that QHIOs are expected to share data to “support quality measurement and operational functions” 	<p>Multiple Issuers requested clarity on data sharing protocols</p> <p>One Issuer requested clarity on Fraud/Waste/Abuse data analysis</p> <p>One stakeholder suggested addition of defining language around QHIO requirements</p>	<p>Expanded language around purpose and expectations of data sharing with QHIOs</p>

PROPOSED 2026-28 ARTICLE 5 CONTRACT LANGUAGE

5.02.3 Data Exchange

Covered California and Contractor recognize that data sharing between patients, providers, hospitals, and payers is a critical quality of care driver. Efficient data sharing decreases healthcare costs, reduces paperwork, improves outcomes, and gives patients more control over their healthcare. Covered California and Contractor agree these goals are achievable only if providers, hospitals, and payers make patient data available and accessible in accordance with the California Health and Human Services Data Exchange Framework (DxF), Data Sharing Agreement (DSA), and shared Policies and Procedures (P&Ps). Covered California and Contractor recognize that Qualified Health Information Organizations (QHIOs) are DxF designated intermediaries that can assist DxF Participants to meet the requirements of the DSA. Contractor must:

- 1) Execute the DSA as required by Health and Safety Code section 130290.
- 2) Participate in at least one QHIO, that will share data to support quality measurement and operations purposes and report on its use of that QHIO's services and functions to support the following activities:
 - a) Contractor's DSA obligations set forth in the DxF P&Ps, including sharing data that Contractor is required to provide access to or exchange under the Data Elements to Be Exchanged P&P.
 - b) Request, receive, and use information from providers, hospitals, and other DxF Participants as needed by Contractor to support population health management, clinical care, and coordination initiatives for its Covered California Enrollees. These include the Quality Transformation Initiative, Healthcare Evidence Initiative, and Quality Rating System.
 - c) Enhance demographic and social risk factor data capture to improve health equity and access.
 - d) Monitor network hospitals' compliance with the requirement under the Technical Requirements for Exchange P&P.
- 3) Send Notification of Admit, Discharge, and Transfer (ADT) Events when requested by a DxF Participant for Covered California Enrollees. As requested by Covered California, Contractor must report:
 - a) A list of network hospitals by region, including psychiatric hospitals and critical access hospitals, that have not sent requested Notification of ADT Events to at least one QHIO.
 - b) For the above list, a description of whether and how these hospitals are sending Notification of ADT Events using methods that are acceptable to all requesting DxF Participants, as required by the Technical Requirements for Exchange P&P.
- 4) Unless prohibited by law, share information on Covered California Enrollees with primary care practices using standard file formats for assigned and selected members monthly. This benefits the primary care practices by supporting improvement on their quality measure performance, identifying and managing key populations to improve specific outcomes, and supporting partnership between practices and QHP Issuers on high risk and high cost populations.
 - a) Data types to share include: Member enrollment/eligibility file, medical claims, behavioral health claims, pharmacy claims (no cost included in claims file), ADT feeds when available, and member assessment and care management data collected by the plan.

CURRENT VS 2026-28 PROPOSED REQUIREMENTS – ATTACHMENT 1

Article 6 – Certification, Accreditation, and Regulation

2025 Current Requirements	2026-28 Proposed Requirements	Comment Themes	2026-28 Proposed Requirements Comment Based Update
<p>6.01.1 NCQA Health Plan Accreditation Achieve NCQA Health Plan Accreditation by year end 2024 If not currently accredited: Submit a detailed plan on progress towards accreditation for expected approval, while maintaining URAC or AAAHC accreditation. If contracted in Plan Year 2024 or later without NCQA accreditation, achieve it within 12 months of QHP application submission or 90 days before the second Open Enrollment Period</p>	<p>No notable changes</p>	<p>No comments</p>	<p>No changes</p>
<p>6.01.2 Accreditation Review Inform Covered California of dates and outcomes of any accreditation reviews. Within 30 days of receiving an assessment report from any health plan accreditation review, submit a copy of this report to Covered California</p>	<p>No notable changes</p>	<p>No comments</p>	<p>No changes</p>

CURRENT VS 2026-28 PROPOSED REQUIREMENTS – ATTACHMENT 1

2025 Current Requirements	2026-28 Proposed Requirements	Comment Themes	2026-28 Proposed Requirements Comment Based Update
<p>6.01.3 Changes in Accreditation Status Inform Covered California within ten business days of change in accreditation ratings and develop strategies to enhance or reinstate their accreditation level. Report status and progress towards reinstatement</p>	<p>Clarified requirement to submit to Covered California any CAP required by NCQA regardless of accreditation status</p>	<p>One Issuer expressed support for proposed requirement to submit NCQA Corrective Action Plan regardless of status change</p>	<p>No changes</p>
<p>6.01.4 Disciplinary and Enforcement Actions If Contractor loses its accreditation or fails to secure reaccreditation, Covered California has the authority to end the contract, decertify the contractor’s QHPs, or halt enrollments which aligns with federal mandates and 45 C.F.R. § 156.275(a). Contractor must disclose all attempts at health plan certification or accreditation, including failures, and provide comprehensive reports of these efforts</p>	<p>No notable changes</p>	<p>No comments</p>	<p>No changes</p>

CURRENT VS 2026-28 PROPOSED REQUIREMENTS – ATTACHMENT 2

2025 Current Requirements	2026-28 Proposed Requirements	Comment Themes	2026-28 Proposed Requirements Comment Based Update
<p>Reducing Health Disparities: Demographic Data Collection – Enrollee Race and Ethnicity Self-Identification Contractor achieve 80% enrollee self-reported race and ethnicity data by PY 2024, establish a baseline by PY 2023, and ensure 80% HEI data compliance. If contracted in PY 2024, these targets shift to PY 2025 with a baseline in PY 2024. If contracted in PY 2025, establish a baseline and ensure 80% HEI data compliance within the same year</p>	<p>No notable changes</p>	<p>One Issuer suggested consideration of “Decline to state” or “Asked but not answered” as acceptable values</p> <p>One Issuer requested removal of alternative standard for newly contracted QHP Issuers in the first year of operation</p> <p>One issuer expressed concerns regarding (QHPs) facing contractual obligations to collect r/e data amidst potential political challenges, suggesting mandating the collection of this data during the enrollment process and making it a required field in the application form</p>	<p>No changes</p>
<p>Reducing Health Disparities: Demographic Data Collection – Enrollee Spoken and Written Language Contractors starting in PY 2023 submit valid spoken and written language attributes in Healthcare Evidence Initiative (HEI) submissions for 2023 and meet negotiated annual language standards for 2024 and 2025. Those starting in PY 2024 submit language attributes for 2024 and meet 2025 standards. Contractors beginning in PY 2025 submit language attributes in HEI submissions for 2025</p>	<p>No notable changes</p>	<p>One Issuer suggested consideration of “Decline to state” or “Asked but not answered” as acceptable values</p> <p>One Issuer requested removal of alternative standard for newly contracted QHP Issuers in the first year of operation</p>	<p>No changes</p>

CURRENT VS 2026-28 PROPOSED REQUIREMENTS – ATTACHMENT 2

2025 Current Requirements	2026-28 Proposed Requirements	Comment Themes	2026-28 Proposed Requirements Comment Based Update
<p>Reducing Health Disparities: Disparities Reduction Intervention Contractors must meet multi-year disparity reduction target beginning PY 2023 or later if contracted later.</p>	<p>Retired</p>	<p>No comments received</p>	
<p>National Committee for Quality Assurance (NCQA) Health Equity Accreditation Contractor must achieve and maintain NCQA Multicultural Health Care Distinction (MHCD) or Health Equity Accreditation</p>	<p>Retired</p>	<p>No comments received</p>	
<p>Primary Care Payment Contractors must increase the number and percentage of primary care clinicians paid via Health Care Payment Learning and Action Network Alternative Payment Models (HCP LAN APM) Categories 3 and 4, ensuring revenue supports accessible, data-driven, team-based care annually</p>	<p>Retired</p>	<p>QHP issuers supported retirement of Primary Care Payment as a performance standard and alignment with the Office of Health Care and Affordability's (OHCA) methodology for reporting and timelines.</p>	<p>Covered California retained Attachment 1 Article 4 reporting requirement on Primary Care Payment to align with OHCA's methodology.</p>

CURRENT VS 2026-28 PROPOSED REQUIREMENTS – ATTACHMENT 2

2025 Current Requirements	2026-28 Proposed Requirements	Comment Themes	2026-28 Proposed Requirements Comment Based Update
<p>Primary Care Spend Contractor must report total primary care spend and its distribution across HCP LAN APM categories, following Integrated Healthcare Association methodology</p>	<p>Retired Covered California retained Attachment 1 Article 4 reporting requirement on Primary Care Spend to align with OHCA’s methodology.</p>	<p>QHP issuers supported retirement of Primary Care Spend as a performance standard and alignment with OHCA’s methodology for reporting and timeline.</p>	<p>none</p>
<p>Payment to Support Networks Based on Value Contractor must report spending percentages in HCP LAN APM categories: 1) Fee for service without quality/value link, 2) Fee for service with quality/value link, 3) Shared savings models, 4) Population-based payments, compared to overall budget</p>	<p>Retired Covered California retained Attachment 1 Article 4 reporting requirement on Payment to Support Networks Based on Value to align with OHCA’s methodology.</p>	<p>QHP issuers supported retirement of Payment to Support Networks Based on Value as a performance standard and aligned with OHCA’s methodology for reporting and timeline.</p>	<p>none</p>
<p>Quality Rating System (QRS) QHP Enrollee Experience Summary Indicator Rating Contractor must achieve at least a three-star rating in the QRS QHP Enrollee Experience Summary Indicator to avoid penalties. Rating will be based on the QRS performance benchmarks supplied by CMS</p>	<p>Retired Covered California will track and publicly report CMS QRS Enrollee Experience performance as part of new Article 4.3.6 access monitoring activities.</p>	<p>No comments received.</p>	<p>none</p>

CURRENT VS 2026-28 PROPOSED REQUIREMENTS – ATTACHMENT 2

2025 Current Requirements	2026-28 Proposed Requirements	Comment Themes	2026-28 Proposed Requirements Comment Based Update
<p>Healthcare Evidence Initiative (HEI) Data Contractor must complete full and regular data submissions of data according to the agreed upon standards</p>	<ul style="list-style-type: none"> + Incomplete, late, or non-usable submission if HEI data : 40% penalty + Consolidates all HEI data submission expectations under one Performance Standard + Alternate standard: Contractor is held to same requirements and penalty by 2nd Measurement Year 	<p>Two issuers requested clarifying language on who is covered by AB929</p>	<p>No changes</p>
<p>Pediatric Oral Evaluation, Dental Services (OEV-CH-A) (NQF#2517) Contractor must annually provide the necessary HEI Data for this measure to establish a baseline rate and meet improvement targets to be set after baseline has been established</p>	<p>No notable changes</p>	<p>No comments</p>	<p>No changes</p>
<p>Pediatric Topical Fluoride for Children, Dental Services (TFL-CH-A) (NQF #2528) Contractor must annually provide the necessary HEI Data for this measure to establish a baseline rate and meet improvement targets to be set after baseline has been established</p>	<p>Changed to Pediatric Topical Fluoride for Children, Dental Services (TFL-CH-A) (NQF #3700) to capture fluoride treatments applied both in dental and oral health settings</p>	<p>No comments</p>	<p>No changes</p>

CURRENT VS 2026-28 PROPOSED REQUIREMENTS – ATTACHMENT 2

New Proposed Performance Standards

2025 Current Requirements	2026-28 Proposed Requirements	Comment Themes	2026-28 Proposed Requirements Comment Based Update
<p>New requirement for 2026-2028</p>	<p>Collaboration Across QHP Issuers and With Community</p> <p>Contractor must annually attend at least 6 of the 7 QHP-led collaborative and community activities specified in Attachment 1.</p> <p>Contractor must submit proposed events for pre-approval and demonstrate participation through documentation.</p>	<p>No comments</p>	<p>No changes</p>
<p>New requirement for 2026-2028</p>	<p>Utilization and Primary Care: Overall Engagement with Members</p> <p>Contractor must establish a baseline and increase the percentage of continuously enrolled Covered California enrollees with at least one medical or prescription drug claim per Plan Year, meeting or exceeding improvement thresholds.</p>	<p>One issuer expressed concerned over penalties, suggesting adjustments to account for challenges in engaging unresponsive members.</p> <p>One issuer requested removal of this performance standard, citing potential increases in costs and premiums.</p> <p>One issuer requested guidance on increasing performance over the baseline rate and expressed concerns on the new performance standard, preferring to focus on QTI measures.</p>	<p>Added language to clarify timing of performance standard assessment.</p>

PROPOSED 2026-28 ATTACHMENT 2 CONTRACT LANGUAGE

3. Collaboration Across QHP Issuers and With Community – Attachment 1, Articles 1.03, 2.01.3, 2.03.4, 3.05.2, 4.02.2, 4.02.4, 4.02.6

a) Contractor must host or attend QHP Issuer collaboration and community engagement activities approved by Covered California in at least six of the following seven required focus areas during the Plan Year:

1. Disparities Reduction
2. Access to Behavioral Health Services
3. Substance Use Disorders
4. Use of Generative Artificial Intelligence
5. Payments to Support Networks Based on Value
6. Hospital Quality, Value, and Safety
7. Comprehensive Pregnancy and Postpartum Care

Contractor hosted collaborative QHP Issuer and community engagement activities must meet criteria specified by Covered California and must be submitted to and approved by Covered California in advance to count toward this requirement. Additionally, unless otherwise specified in Attachment 1, an event that addresses one or more of the focus areas that Covered California's Health Equity and Quality Transformation Division determines meets specified criteria, including, hosted learning sessions, working groups, forums and roundtables, may count toward this requirement.

Contractor must meet threshold for required activities which will be assessed once in the Assessment Year.

See separate methodology document for activity submission and evaluation process.

Measurement Years 2026, 2027, 2028:

Contractor hosts or attends QHP Issuer collaboration and community engagement activities approved by Covered California in fewer than six of the seven focus areas: **10% penalty**

Contractor hosts or attends QHP Issuer collaboration and community engagement activities

approved by Covered California in at least six of the seven focus areas: **no penalty**

b) **Alternate Standard:** Contractor must host or attend Covered California specified events and collaborative QHP Issuer, community engagements, and qualifying implementation activities to meet Attachment 1 requirements approved by Covered California in at least six out of the following seven required focus areas during the Plan Year:

Contractor hosted collaborative QHP Issuer and community engagement activities must meet criteria specified by Covered California and must be submitted to and approved by Covered California in advance to count toward this requirement. Additionally, unless otherwise specified in Attachment 1, an event that addresses one or more of the focus areas that Covered California's Health Equity and Quality Transformation Division determines meets specified criteria, including, hosted learning sessions, working groups, forums and roundtables, may count toward this requirement.

See separate methodology document for activity submission and evaluation process.

Contractor does not host or attend activities in six out of seven of the focus areas: **10% penalty**

Contractor hosts or attends activities in six out of seven of the focus areas: **no penalty**

Contractor must meet threshold for required activities which will be assessed once in the Assessment Year.

CURRENT VS 2026-28 PROPOSED REQUIREMENTS – ATTACHMENT 2

New Proposed Performance Standards

2025 Current Requirements	2026-28 Proposed Requirements	Comment Themes	2026-28 Proposed Requirements Comment Based Update
<p>New requirement for 2026-2028</p>	<p>Utilization and Primary Care: Monitoring Continuity of Care</p> <p>Contractor must monitor and establish a baseline for the continuity of care index, improve it if less than 60% of Covered California enrollees achieve an index of 0.7, and meet or exceed improvement thresholds during assessment years.</p>	<p>Issuer feedback highlighted the need to leverage existing quality measures to reduce administrative burden, implement a reporting-only phase to establish baseline data, and provide clear guidance on continuity of care calculations, reporting specifications, and timelines.</p> <p>Concerns were raised about setting improvement targets without sufficient research. However, a coalition supported maintaining the index threshold at 0.7 for 70% of enrollees.</p>	<p>The penalty for MY2026 and MY2027 will be connected to QHP issuer participation in review of Covered California generated HEI output and engagement as well as establishment of a benchmark if appropriate. Performance on measure will only be assessed for MY2028 at the earliest.</p> <p>Revision lowered the threshold to require improvement efforts if the continuity of care index falls below 0.7 for 60% of enrollees, down from the initially proposed 70% of enrollees.</p>

CURRENT VS 2026-28 PROPOSED REQUIREMENTS – ATTACHMENT 3

Essential Community Providers

2025 Current Requirements	2026-28 Proposed Requirements	Comment Themes	2026-28 Proposed Requirements Comment Based Update
<p>4.3.4 Essential Community Providers Contractor must meet ECP General Standard by maintaining a network that provides reasonable care and timely access to predominantly low-income and medically underserved individuals.</p> <p>Contractor must demonstrate provider contracts with at least</p> <ul style="list-style-type: none"> • 15% of 340B non-hospital entities in each rating region • One ECP hospital per county <p>Contractor(s) in an integrated delivery system may request the alternate standard and must demonstrate compliance by mapping low-income member populations and network providers</p>	<p>New sufficiency requirements: By 2029, Contractor must demonstrate provider contracts with at least:</p> <ul style="list-style-type: none"> • 15% of Primary Care Providers in HPI Q1 and Q2 in each rating region • 15% of Behavioral Health Providers in HPI Q1 and Q2 in each rating region in each rating region • One ECP hospital per county, or per rating region in counties with multiple rating regions <p>If Contractor is unable to meet new sufficiency requirements, must demonstrate provider agreements with at least 15% of 340B non-hospital entities and & increases in primary care and BH sufficiency in 2027 and 2028.</p> <p>Alternate standard: Contractor must map low-income member populations and network providers offering services in all ECP categories.</p>	<p>No comments received.</p>	<p>No changes to Attachment 3 proposed.</p> <p>Covered California continues to finalize data sources and methodology to produce the new ECP list and will continue to address feedback and incorporate as appropriate.</p>

CURRENT VS 2026-28 PROPOSED REQUIREMENTS – ATTACHMENT 4

Quality Transformation Initiative

2025 Current Requirements	2026-28 Proposed Requirements	Comment Themes	2026-28 Proposed Requirements Comment Based Update
<p>1.01 Core Conditions and Measure Set Focus on four key improvement areas with related QTI Core Measures, subject to QTI Payments, prioritizing quality and equity, aligned with other purchaser measures, and covering both pediatric and adult enrollees</p>	<p>Renamed QTI Scored and Reporting-only Measure Sets</p> <p>The QTI scored measures remain unchanged, and DSF-E has been added as a scored measure. Covered California is committed to transitioning to ECDS reporting in alignment with the planned update by CMS QRS.</p>	<p>Multiple Issuers voiced concerns about the DSF-E measure and that it contains two measures in one.</p> <p>Three Issuers requested a transition from CIS Combo 10 to Combo 7 due to nationwide challenges in administering flu vaccines.</p> <p>Two Issuers raised concerns about transitioning to BPC-E measure, which has not yet been approved by NCQA, and the impact of non-billable blood pressure screenings on data collection.</p>	

CURRENT VS 2026-28 PROPOSED REQUIREMENTS – ATTACHMENT 4

Quality Transformation Initiative

2025 Current Requirements	2026-28 Proposed Requirements	Comment Themes	2026-28 Proposed Requirements Comment Based Update
<p>1.02 Benchmarks and QTI Payments Contractor commits to meet or exceed the 66th national percentile for all QTI Core Measures or contribute QTI Payments based on performance below this benchmark, with payment amounts varying by percentile thresholds, while still engaging in quality improvement activities.</p>	<p>Newly contracted QHP issuers to start at 1% premium at risk in Year 1 of QTI eligibility.</p> <p>The amount at risk for QHP issuers already eligible for QTI will be up to 2.8% percent of premium for MY2026 and then up to 3.8% of premium for MY2027 and MY2028.</p>	<p>Three Issuers requested a one-year reporting-only phase for new measures to establish benchmarks, and two Issuers emphasized the need for earlier QTI benchmarks for ECDS measures (e.g., CBP-E) to reduce burden and support improvement activities.</p> <p>Issuers raised concerns about the costs and administrative burden of custom measures, with one recommending contract language to allow flexibility in adjusting QTI benchmark years during the contract cycle.</p> <p>One Issuer requested reconsideration of the QTI penalty timeline due to OHCA cost-reduction requirements, while two Issuers and one association proposed resetting the QTI percent at risk to 0.8% for the MY2026 contract year, citing concerns about how QTI payments will be applied for the HE methodology.</p> <p>One Issuer suggested removing QTI payment assessments in the first year of ECDS measures due to lack of benchmarks, and another recommended capping the total amount at risk at 3% for 2026-2028.</p>	<p>Revised language describing approach to updating benchmarks if established through use of proof sheets or use of prior version of measure.</p>

CURRENT VS 2026-28 PROPOSED REQUIREMENTS – ATTACHMENT 4

Quality Transformation Initiative

2025 Current Requirements	2026-28 Proposed Requirements	Comment Themes	2026-28 Proposed Requirements Comment Based Update
<p>1.03 QTI Performance Report Covered California will calculate Contractor’s QTI Payments and issue a QTI Performance Report to Contractor on an annual basis, Contractor has the right to dispute within the allotted timeframe</p>	<p>No changes</p>	<p>One issuer proposed adjusting contract language to allow QTI payment obligations to extend into the next calendar year for smoother financial planning.</p>	
<p>1.04 Administration of QTI Payments Covered California shall direct Contractor’s use of QTI Payments and issue PopHI Directive payment instructions</p>	<p>No changes</p>		
<p>1.05 Population Health Investments Covered California will issue directives on using QTI Payments for PopHI programs focused on equity, measurable improvements, evidence-based methods, and advancing equity in underfunded areas</p>	<p>No changes</p>	<p>One issuer requested clarification on the purpose and evaluation process for issuer-operated PopHI, whether issuers must contribute to existing PopHIs and whether the PopHI would serve a broader marketplace population beyond their own enrollees.</p>	

CURRENT VS 2026-28 PROPOSED REQUIREMENTS – ATTACHMENT 4

Quality Transformation Initiative

2025 Current Requirements	2026-28 Proposed Requirements	Comment Themes	2026-28 Proposed Requirements Comment Based Update
<p>1.06 Unspent Funds Unspent QTI Payments shall be used as directed by Covered California</p>	No changes		
<p>1.07 Ongoing Assessment of the Quality Transformation Initiative Payments Evaluate QTI Payments' effectiveness in improving quality, and may revise or create additional programs based on outcomes, feedback, and fund availability</p>	No changes		
<p>1.08 Quality Improvement Plans Contractors scoring below the 25th percentile for a QTI Core Measure must submit a Quality Improvement Plan</p>	Contractors are required to submit a QI Plan if they score below the 25 th national percentile benchmark for any Eligible Subpopulation or the All Other Members Subpopulation under Stratified Measures, in addition to the existing requirement for QTI Scored Measure.		

CURRENT VS 2026-28 PROPOSED REQUIREMENTS – ATTACHMENT 4

New Quality Transformation Initiative Requirements

2025 Current Requirements	2026-28 Proposed Requirements	Comment Themes	2026-28 Proposed Requirements Comment Based Update
<p>New requirement for 2026-2028</p>	<p>1.02 Race and Ethnicity Stratification and Methodology</p> <p>Contractor must stratify QTI Scored Measure results by Race and Ethnicity using member self-reported data, with subpopulations defined by the OMB or CDC Race and Ethnicity Code Set and requiring at least 100 members in the denominator. Covered California will assess performance based on these stratified results and All Other Members Subpopulation, which pools members with missing, inaccurate, or smaller subgroup data. Stratified Measures for 2026-2028 include Blood Pressure Control for Patients with Hypertension and Colorectal Cancer Screening, and performance will be evaluated using specified benchmarks. "Stratified Measure", "Eligible Subpopulation", and "All Other Members" are defined.</p>	<p>Several issuers expressed concerns with the proposed financial accountability for stratified performance, citing the differences in plans' member populations and the challenge of meeting quality performance expectations for all racial and ethnic subpopulations as proposed.</p> <p>Inquiries on timeline for implementation with some issuers expressing concern on timing and financial accountability of moving to assessment of stratified performance</p> <p>Requests that future edits to QTI Methodology reconsider weights of smaller subpopulations, include cross-carrier interventions, and impacts to Knox-Keene Act on carriers' ability to report enrollee demographics</p>	<p>No Changes</p>

CURRENT VS 2026-28 PROPOSED REQUIREMENTS – ATTACHMENT 4

New Quality Transformation Initiative Requirements

2025 Current Requirements	2026-28 Proposed Requirements	Comment Themes	2026-28 Proposed Requirements Comment Based Update
<p>New requirement for 2026-2028</p>	<p>1.04 Preventing Increases in Health Disparities and Requiring Maintained Efforts</p> <p>Contractor shall act in good faith to improve or maintain the health outcomes of all Enrollees to meet or exceed established benchmarks. Covered California will monitor how QHPs are performing with Eligible Subpopulations across all QTI Scored measures.</p> <p>If Covered California has determined that QHP performance is below established benchmarks, or declining, or demonstrates lack of improvement that indicate disinvestment in health interventions with a specific Eligible Subpopulation or all Eligible Subpopulations, it may require Contractor to enter a Quality Improvement Plan, pursuant to section 5.2.4 of agreement. Covered California may also re-weight Contractor’s payment allocations for future Plan Years to increase amounts at risk tied to declining performance or lack of improvement of Eligible Subpopulations.</p>	<p>One issuer requested the removal or further clarification of section 1.04 Preventing Increases in Health Disparities/Requiring Maintained Efforts</p>	<p>Revised language to address perceived ambiguity around “lack of improvement or declining performance for a subpopulation</p>