COVERED CALIFORNIA POLICY AND ACTION ITEMS

January 16, 2025 Board Meeting

2026 QUALIFIED HEALTH PLAN ISSUER CERTIFICATION PROCESS AND CONTRACT DISCUSSION

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) The QDP Contract period is 2024 - 2026.
Currently contracted QDPs will have reduced application response requirements.
New entrants will complete the entire application.

Plan Year 2026 Certification Health and Dental Applications will be open to all Applicants.

PUBLIC COMMENT

- The four draft applications and crosswalks were posted on Monday, 9/16/24 with public comment due back on Friday, 10/11/24.
- The Plan Management and Health Equity and Quality Transformation Divisions received a total of 80 public comments across the four Applications.
- The comments were seeking clarity for instructions, accreditation requirements, and updated contract compliance.
- The Public Comment Summary is available at: https://hbex.coveredca.com/stakeholders/plan-management/qhp-qdp-certification/

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 QHPs and QDPs 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
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

2026 QUALIFIED HEALTH AND DENTAL PLAN ISSUER MODEL CONTRACT DISCUSSION

James DeBenedetti
Director
Plan Management Division

2026 MODEL CONTRACT UPDATE

- The Qualified Health Plan Issuer Contracts for the Individual and Small Business markets were significantly updated for the new contract duration of 2026-2028.
  - The Plan Management Division (PMD) will provide a summary of updates and public comment themes for:
    - 2026-2028 QHP Individual Issuer Model Contract
    - 2026-2028 QHP CCSB Issuer Model Contract
    - 2024-2026 QDP Issuer Model Contract
  - The Health Equity and Quality Transformation Division (EQT) will provide updates and public comment themes for:
    - Model Contract Sections 4.3.4 and 4.3.6
    - Model Contract Article 5
    - Attachments 1, 2, 3, and 4
- Proposed changes for the 2026 Qualified Dental Plan Issuer Contract for the Individual and Small Business markets are minor (primarily for purposes of clarification).
- Responses to comments received on the proposed changes to the 2026 contracts have been posted at: https://hbex.coveredca.com/stakeholders/plan-management/contract-listings/2026/

STAKEHOLDER FEEDBACK – MODEL CONTRACTS

- Requests to define, clarify, and change existing requirements and timelines were received for the following sections:
  - Clarification requests for existing, updated, and new requirements:
    - Article 1 – General Provisions, Nondiscrimination and Fraud, Waste and Abuse; Ethical Conduct
    - Section 6.1.1 Rates and Payments
  - Requests to change or further define requirements for:
    - Section 3.2.1 Enrollment and Marketing Coordination and Cooperation, marketing spend expectation
    - Section 3.2.1.2 Contractors Activities to Promote Enrollment, link to Covered California website landing page
    - Section 3.3 Agents in Covered California for the Individual Market (QHP & QDP)
    - Section 4.2.7 Hearing Aid Coverage for Children Program
    - Section 4.3.2 Network Adequacy Standards (QHP & QDP)
    - Section 4.6.7 Notices, credits on consumer accounts (QHP Ind & QDP)
    - Article 14 Definitions and Contract References, Evidence of Coverage (EOC) and Disclosure Forms
  - Further define timelines for:
    - Section 2.1.1 Covered California Responsibilities, Covered California Weekly Carrier Call
    - Section 4.6.4 Customer Service Call Center, Special Operating Hours
- Appreciation of the addition of Section 4.2.7 Hearing Aid Coverage for Children Program

CURRENT VS 2026-28 PROPOSED REQUIREMENTS

Section 3.2 – Marketing

2025 Current Requirements	2026-28 Proposed Requirements	Comment Themes	2026-28 Proposed Requirements Comment Based Update
QHP Individual 3.2.1 Enrollment and Marketing Coordination and Cooperation Contractor is expected to spend at least 0.4% of projected premium on direct response advertising, outreach and community-based efforts, and non open enrollment “brand” marketing that includes co branding with Covered California. Brand marketing that does not reference Covered California does not count towards this expectation.	Not Applicable	Stakeholders expressed concern that 0.4% is an arbitrary number and that expectations could be more fiscally responsible and drive efficient and appropriate marketing spends.	Proposed requirement will remain the same for 2026, but alternatives will be explored for future years.
QHP Individual and Small Group, QDP 3.2.1.2 Contractors Activities to Promote Enrollment a) Following Covered California making the technology available and within a reasonable time after the receipt of notice from Covered California about the technology, and determination of its compatibility with Contractor’s system, the Contractor shall prominently display the Shop and Compare Tool on its website;	QHP Individual and Small Group, QDP 3.2.1.2 Contractors Activities to Promote Enrollment a) Contractor shall prominently display a link to the Covered California website landing page, https://www.coveredca.com/, on its website in a location that is easily accessible to consumers;	Recommendation for the specific URL link to the Covered California website landing page be removed so health plan issuers can link to current co-branded landing pages.	Proposed requirement will remain the same. The update to this requirement is intended to remove the obligation for QHP issuers to display a Shop and Compare Tool. QHP issuers may choose to link to both locations. At minimum Covered California believes that a link to the Covered California website landing page should be required for consumer accessibility to shopping features that are not available on current co-branded landing pages.

CURRENT VS 2026-28 PROPOSED REQUIREMENTS

Article 4 – QHP Issuer Program Requirements

2025 Current Requirements	2026-28 Proposed Requirements	Comment Themes	2026-28 Proposed Requirements Comment Based Update
Not Applicable	QHP Individual and Small Group 4.2.6/4.2.7 Hearing Aid Coverage for Children Program 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).	Request to consider the timing of the new EHB benchmark plan and the proposed inclusion of this requirement to ensure consistency with state requirements, and to mitigate potential consumer confusion.	Proposed requirement will remain the same at this time. Covered California will closely monitor how changes to California's EHB benchmark plan may impact the necessity of this inclusion.
QHP Individual and Small Group, QDP 4.3.2 Network Adequacy a) Network Standards. Contractor's QHPs shall comply with the network adequacy standards established by the applicable State Regulators responsible for oversight of contractor …	QHP Individual and Small Group, QDP 4.3.2 Network Adequacy a) Network Standards. Contractor's QHPs shall comply with the network adequacy standards established by Covered California and the applicable State Regulators responsible for oversight of contractor …	Requests to remove new additional language and further detail additional requirements. Requests that there will not be additional requirements beyond the state regulators.	Proposed requirement will remain the same at this time. Covered California will continue to work closely with federal and state regulators on network adequacy requirements, including those required by 45 C.F.R. § 155.1050. Covered California will communicate with QHP issuers should there be any efforts to develop additional requirements beyond those imposed by state or federal law.
Not Applicable	Not Applicable	Concerns were raised regarding credits being automatically applied to the monthly premium without offering a refund or notifying consumers that they could request a refund. Request to add information on notices such as statements and invoices.	QHP Individual, QDP 4.6.7 Notices g) Premium invoices, termination notices as required under 45 C.F.R § 156.270, and other notices where applicable must prominently inform consumers of their right to request a refund of any credits on their accounts.

CURRENT VS 2026-28 PROPOSED REQUIREMENTS

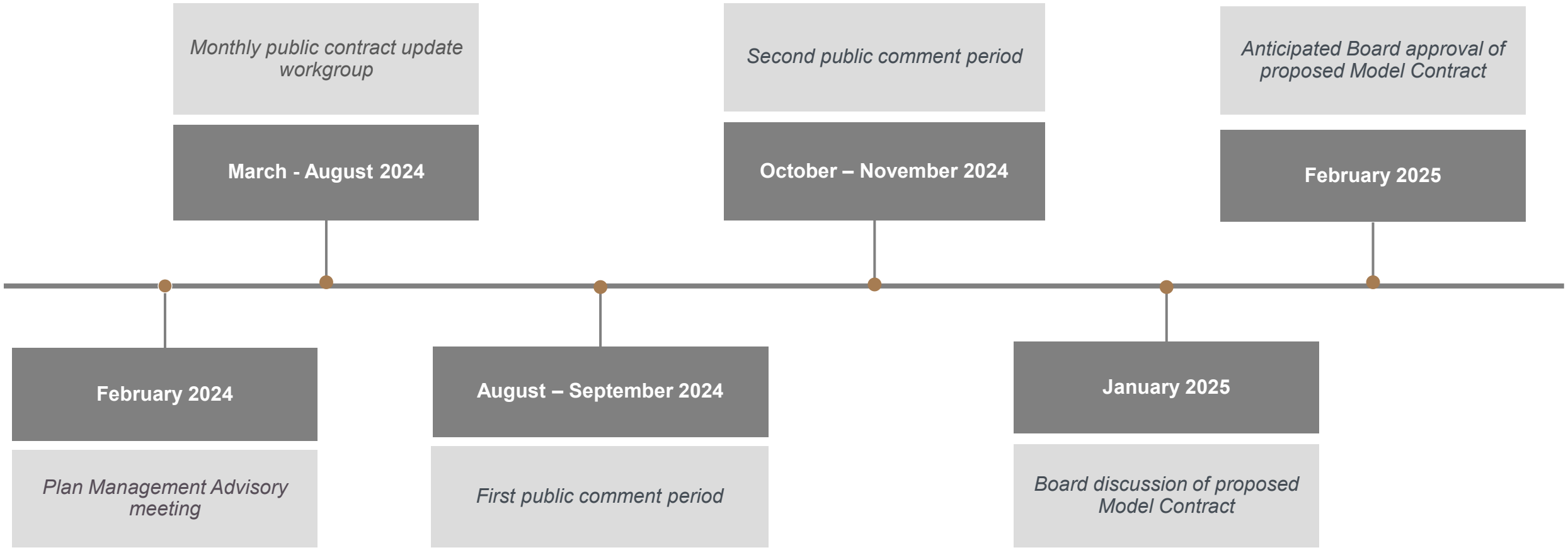
Section 6.1.1 – Rates and Payments & Article 14 Definitions

2025 Current Requirements	2026-28 Proposed Requirements	Comment Themes	2026-28 Proposed Requirements Comment Based Update
QHP Individual 6.1.1 Rates and Payments d) Advanceable Payments. Covered California will administer a State premium assistance program in accordance with Title 25 of the Government Code, commencing at Section 100800 et seq. Covered California shall remit advanceable State premium assistance payments to Contractor in accordance with the State premium assistance program design adopted by the Covered California Board for the applicable plan year. This subsidy payment will be calculated and delivered by Covered California separate from the Participation Fee invoices set forth in Section 6.1.3.	QHP Individual 6.1.1 Rates and Payments d) State Funded Programs. If required by law, Covered California will administer State funded programs. Covered California shall remit advanceable or reconciled State funded payments to Contractor in accordance with program design documents adopted by Covered California for the applicable plan year. Payments will be calculated and delivered by Covered California separate from the Participation Fee invoices set forth in Section 6.1.3.	Confirmation requests that new updated language does not change process details for programs such as California Premium Credit (CAPC) and Cost-Share Reduction (CSR).	Proposed requirement will remain the same at this time. No change to these programs. Covered California amended language in this section to apply to "State Funded Programs" to more broadly capture Covered California's responsibility to provide payments for programs required by state law. Currently this includes both the CAPC and CSR programs.
QHP Individual and Small Group, QDP Article 14 Definitions Evidence of Coverage (EOC) and Disclosure Form – The document which describes the benefits, exclusions, limitations, conditions, and the benefit levels of the applicable Plans.	Updated references to the EOC throughout the contract to match definition title.	Concern with the inclusion of "Disclosure Forms" in the defined and referenced term within Article 14 – Definitions, as this addition to the existing EOC documents would significantly increase the size of the document and contain duplicative information.	QHP Individual and Small Group, QDP Article 14 Definitions Updated definition and contract references: Evidence of Coverage (EOC) – The State-Regulator approved document which describes the benefits, exclusions, limitations, conditions, and the benefit levels of the applicable Plans issued to a Subscriber or Member.

2026-2028 QHP 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	Framework
Equity is quality	Build on the strong foundation of 2023-2025 contract
Center the member	Prioritize alignment with DHCS, CalPERS, & OHCA
Make it easy to do right	Emphasize outcomes
Amplify through alignment	Pursue administrative simplification
Focused scope for high impact	

Model Contract	Attachment 1	Attachment 2	Attachment 4
• Essential Community Providers (ECPs) • Article 5	• Articles 1-6	• Performance standards	• Quality Transformation Initiative

ADVANCING EQUITY, QUALITY AND VALUE CONTRACT UPDATE

Model Contract *with PMD*	Attachment 1	Attachment 2 *with PMD*	Attachment 4
• Essential Community Providers (ECPs) • Article 5	• Articles 1-6	• Performance standards	• Quality Transformation Initiative

CCSB Contract Scope

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

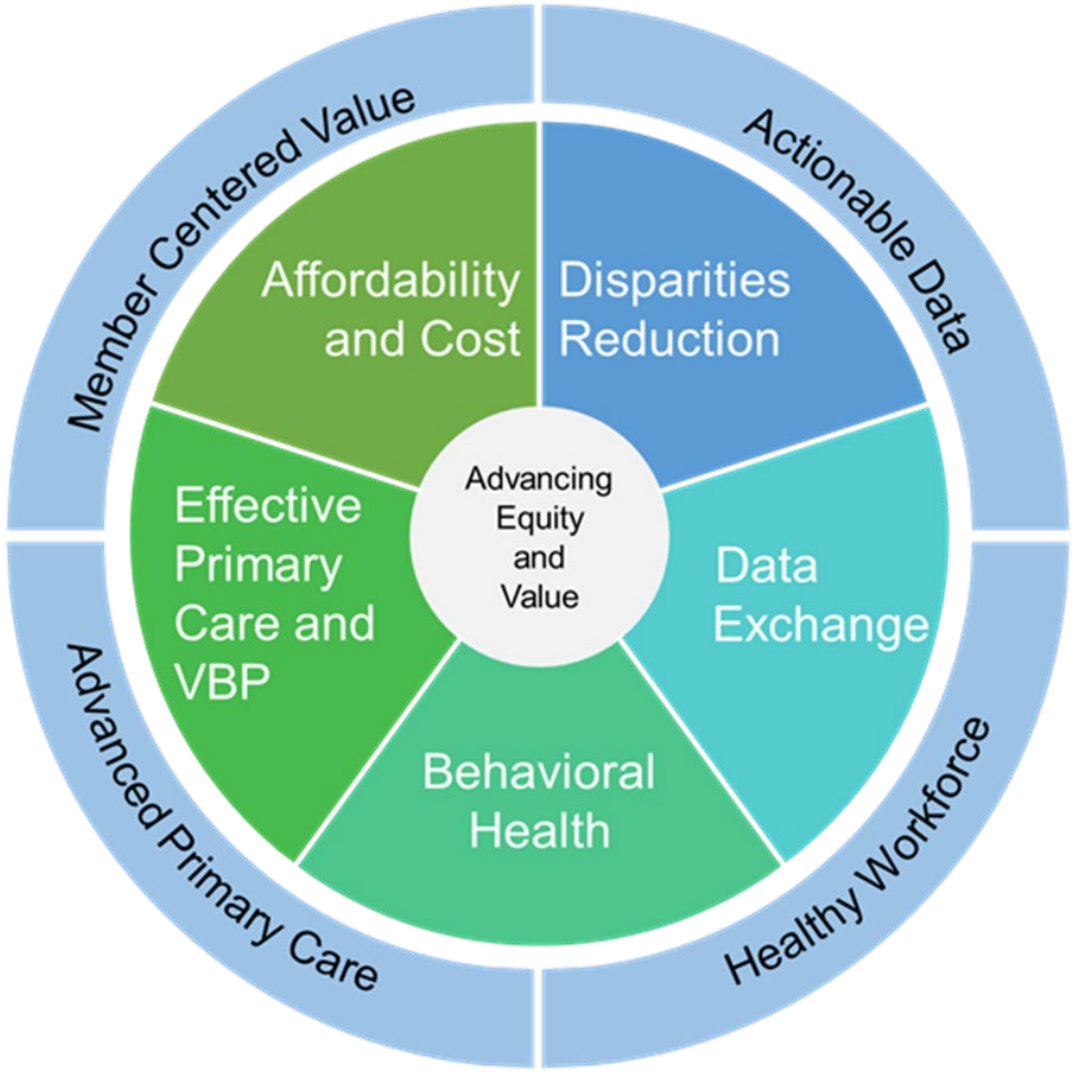
- Essential Community Providers
- Generative Artificial Intelligence
- Primary and Behavioral Health Care Spend Tracking
- Engagement in Collaboratives and with Community

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 will be available online

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

2026-2028: CONTRACT SPOTLIGHTS

Model Contract	Attachment 1	Attachment 2	Attachment 4
• Essential Community Providers (ECPs)	• Use of Generative Artificial Intelligence in QHP Issuer Operations • Measuring Advanced Primary Care • Data Exchange	• Collaboration Across QHP Issuers and With Community	• Quality Transformation Initiative Health Equity Methodology

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

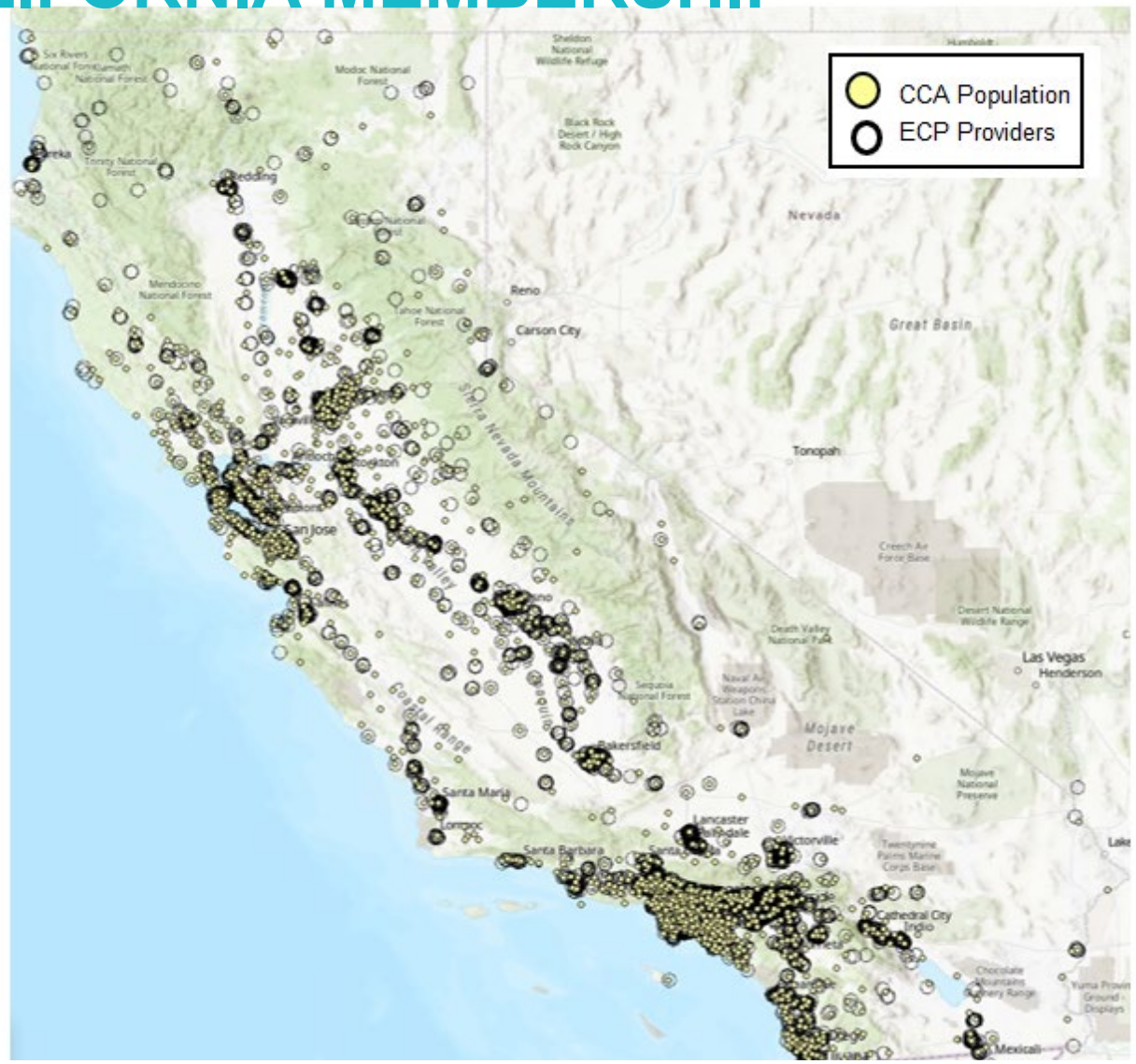
OVERVIEW OF ECP STANDARDS RECOMMENDATIONS

Element	Current Standard	Proposed Standards
Definition and Categories	Federal categories: ▪ FQHCs ▪ Ryan White Program Providers ▪ Family Planning Providers ▪ Indian Health Care Providers ▪ Inpatient Hospitals ▪ Other Providers Covered California designated: ▪ 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	Federal categories: ▪ added Mental Health Facilities ▪ added SUD Treatment Centers ▪ added Critical Access Hospitals ▪ added SHIP Hospitals ▪ added Rural Health Clinics ▪ added certain HPSA providers Covered California designated: ▪ 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	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.	Updated Medically Underserved Populations definition: Added individuals living in Health Professional Shortage Areas, Medically Underserved Areas, and belonging to medically Underserved Populations to.
Alternate Standard	QHPs offering an integrated delivery system quality for an alternate standard and demonstrate compliance by mapping low-income member populations and network providers	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

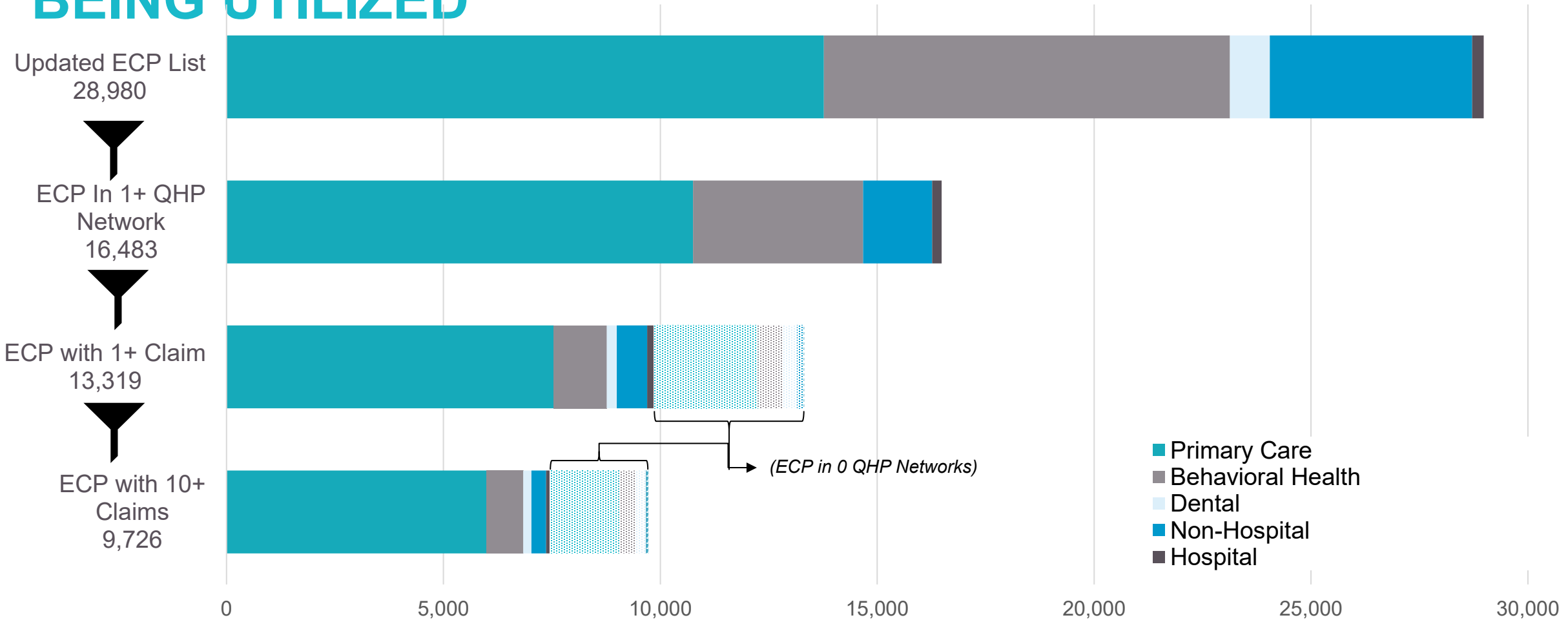
OVERVIEW OF ECP STANDARDS RECOMMENDATIONS

Element	Current Standard	Proposed Standards
Sufficiency Thresholds	Assess sufficiency by region, not service area. Contractor must demonstrate provider contracts with at least: ▪ 1 ECP hospital per county ▪ 15% non-hospital 340B Providers in each region QHP is offered	Continue to assess sufficiency be region, not service area. By 2029, Contractor must demonstrate provider contracts with at least: ▪ 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	No current evaluation plan in place.	Networks Analysis: Analyze QHP networks to determine number and percent of ECPs contracted by QHP by region. 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.

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

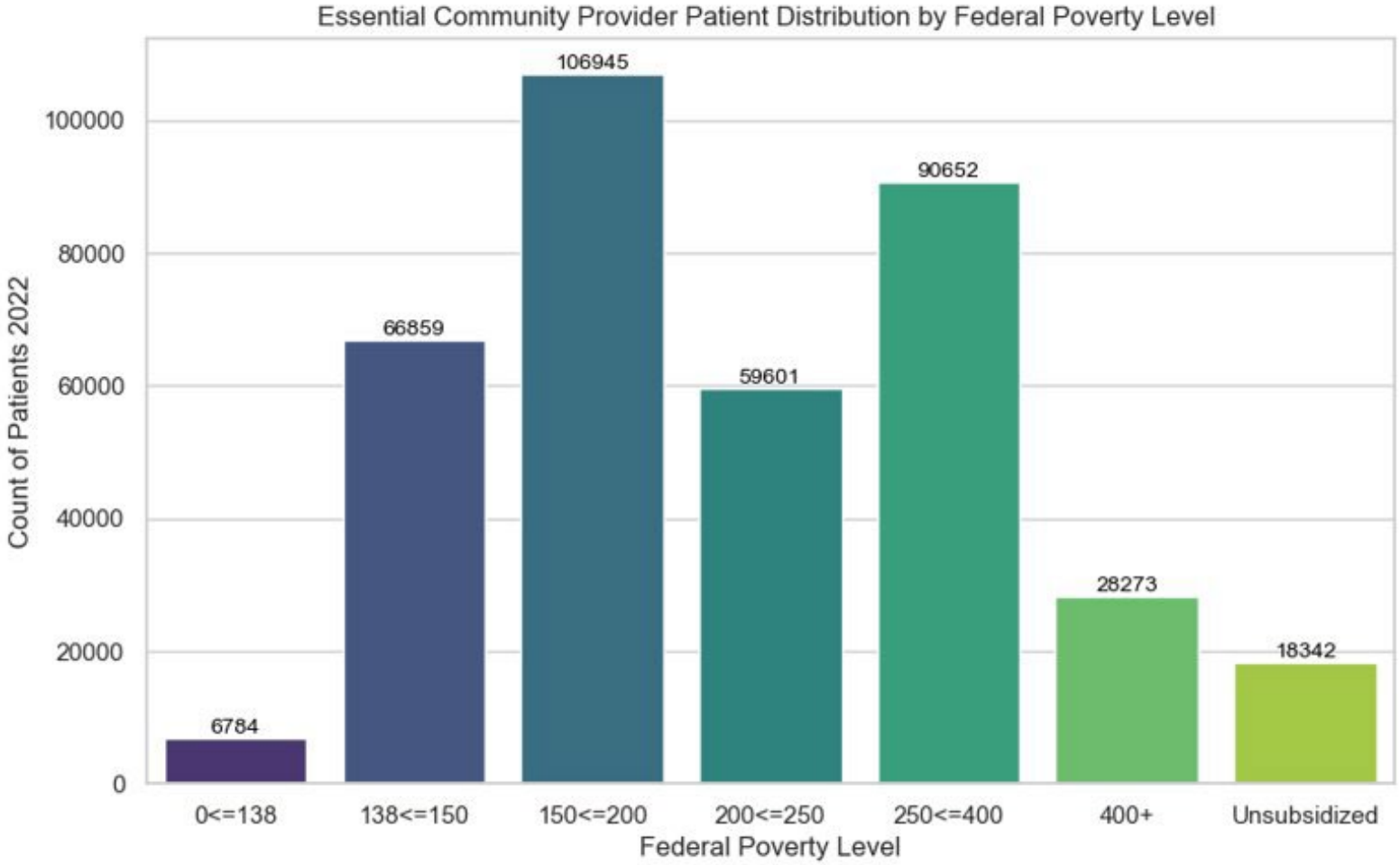
Covered CA Rating Region (Top 10 by ECP Utilization Rate)	Updated ECP Providers with one or more claims	Percentage of All Updated ECP Providers with one or more claims
Region 17: Inland Empire	2,371	17.76%
Region 16: Los Angeles County South & West	2,078	15.56%
Region 15: Los Angeles County North & East	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)

COVERED CALIFORNIA

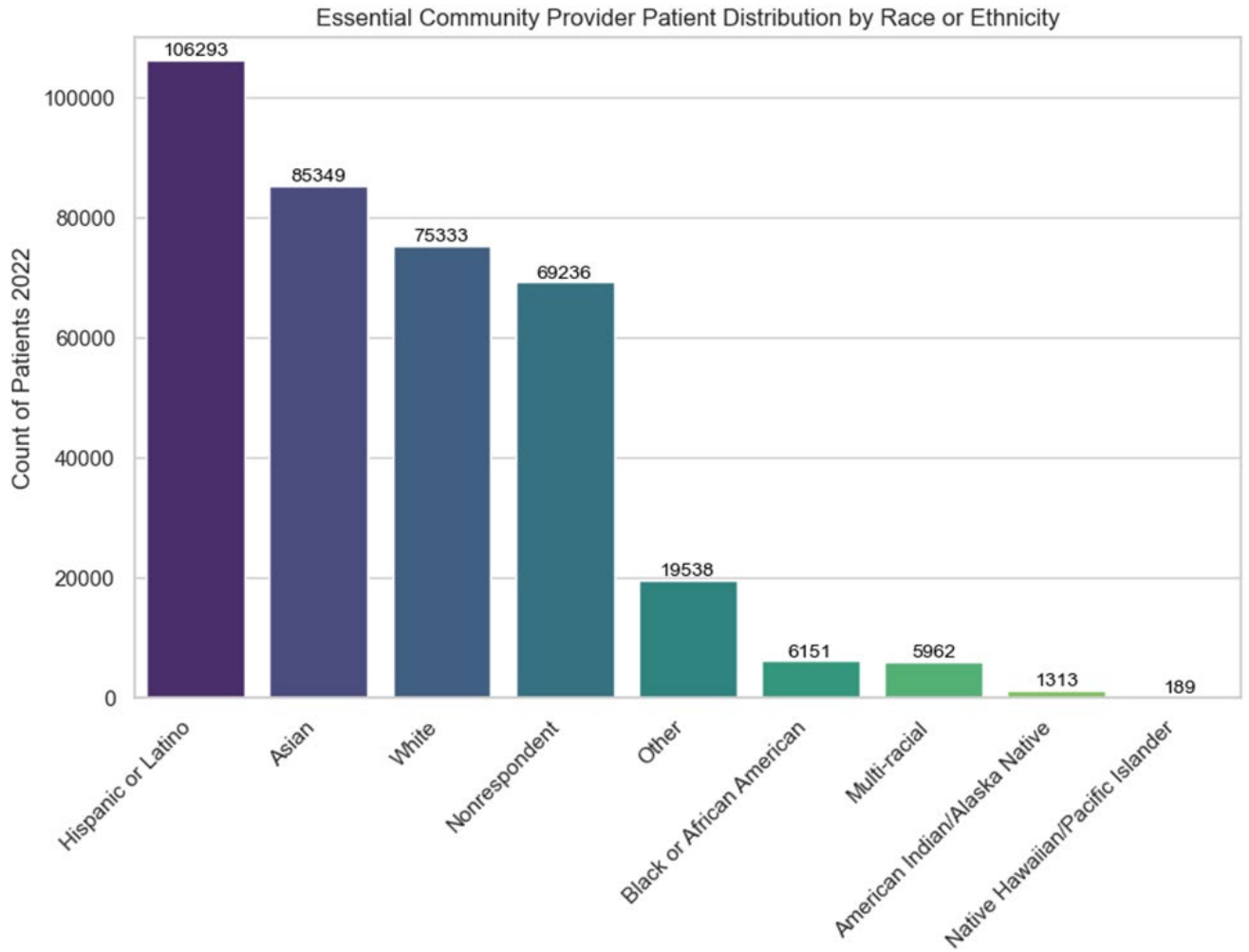
The utilization percent calculated is the number of proposed ECPs with any claims processed in 2022 in one region (numerator) divided by the total 13,352 proposed ECPs with any claims processed in 2022 (denominator)

PATIENT CHARACTERISTICS: 64% OF PATIENTS WHO USED PROPOSED ECPS HAVE INCOMES <=250% FPL



- **64%** (240,189/377,456) **of patients who used proposed ECPs in 2022 had incomes <=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**

Note: 8,092 patients who received care from a proposed ECP in 2022 are missing race and ethnicity information and are not reflected in this analysis

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
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. Contractor must demonstrate provider contracts with at least • 15% of 340B non-hospital entities in each rating region • One ECP hospital per county 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	**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 **New sufficiency requirements:** By 2029, Contractor must demonstrate provider contracts with at least: • 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 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. Alternate standard: Contractor must map low-income member populations and network providers offering services in all ECP categories.	General support for the ECP update effort and new ECP types. Consumer advocates urged contracting with all FQHCs, rural clinical and tribal health programs (both Indian Health Service and Urban Indian clinics) 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. Several issuers posed clarifying questions regarding data and methods used to develop the propped ECP list and made suggestions for ease of use of the ECP list Multiple issuers have posed clarifying questions related to the regional denominators for sufficiency calculations and suggested providers that should be excluded from these calculations. 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	No changes to contract language proposed. 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.

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 ECPs[1] and 15% of Behavioral Health Care ECPs[2] 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

[1]Medi-Cal primary care providers located in quartiles 1 and 2 of the California Healthy Places Index
[2]Medi-Cal behavioral health providers located in quartiles 1 and 2 of the California Healthy Places Index

USE OF GENERATIVE ARTIFICIAL INTELLIGENCE IN QHP ISSUER OPERATIONS

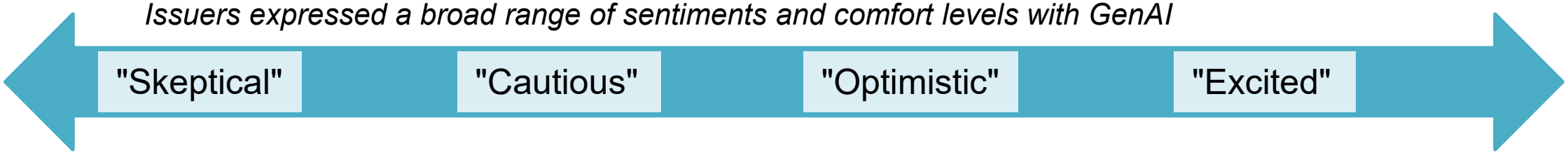
WHAT IS GENERATIVE ARTIFICIAL INTELLIGENCE?

Automation	Traditional AI	Generative AI
❑Rule-based systems that follow predetermined instructions to provide an output over and over again	❑Systems that learn from data given to them and make decisions based on that data, can ingest new data when data is added	❑Systems that learn from data and inputs and create something new from the information given to them

CURRENT PERSPECTIVES ACROSS ISSUERS

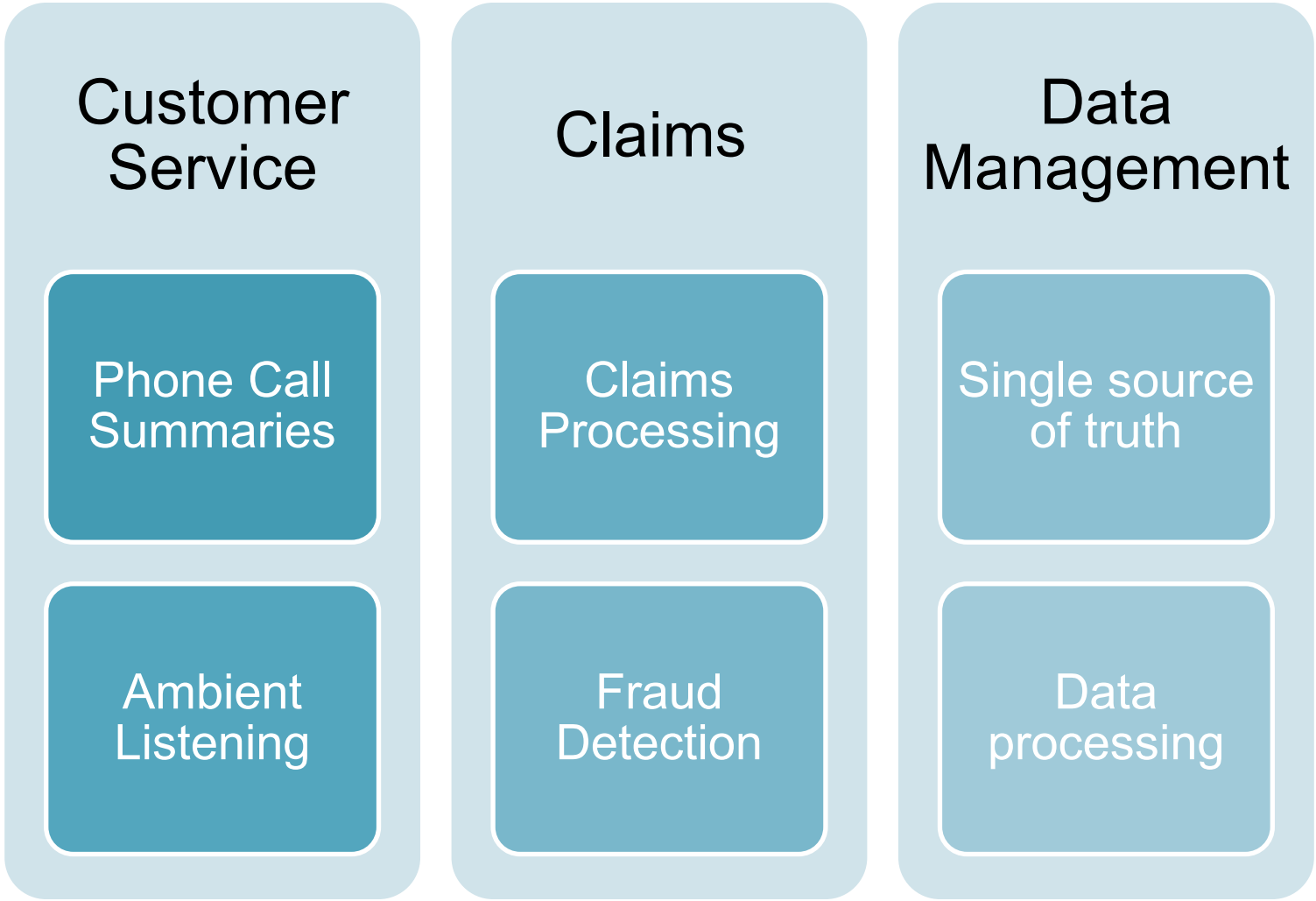
Covered California met with each QHP Issuer in Q1 2024 to explore current practices

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



- Policy and Security Concerns
- Data Management and Data Quality Concerns
- Concerns about Bias and Reliability
- Desire for Guidance and Best Practices
- Interest in Collaboration and Sharing

ISSUERS' CURRENT STATE USE CASES



CURRENT VS 2026-28 PROPOSED REQUIREMENTS – ATTACHMENT 1

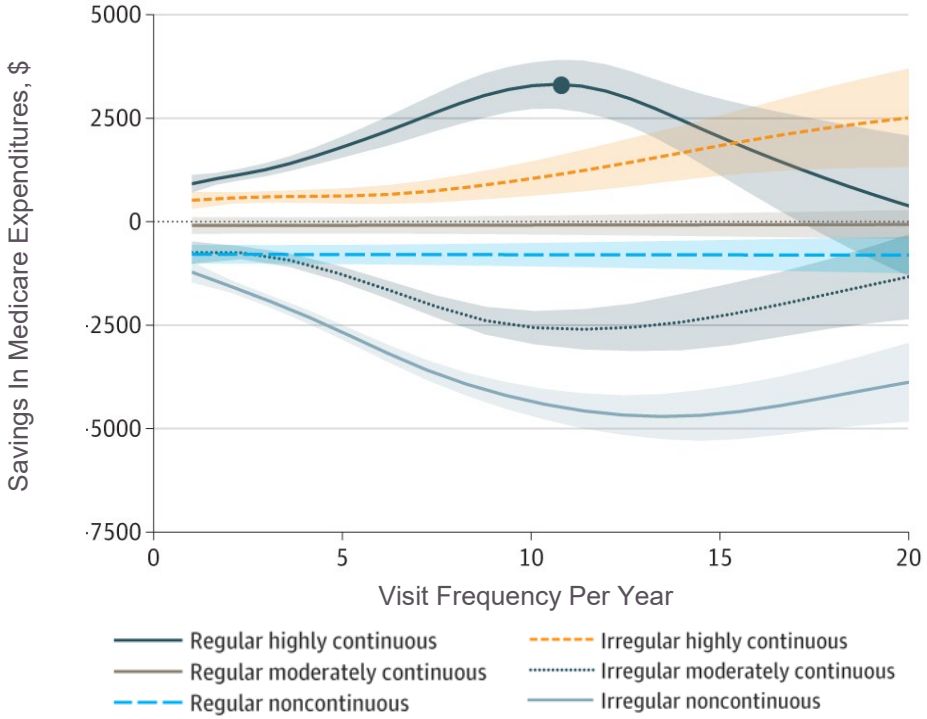
Article 3 – Population Health

2025 Current Requirements	2026-28 Proposed Requirements	Comment Themes	2026-28 Proposed Requirements Comment Based Update
No current requirements	**New - 3.05 Use of Generative Artificial Intelligence in QHP Issuer Operations** Contractor must: 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	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	Adopted language to align with legal requirements within SB-1120 Health Coverage: Utilization Review

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

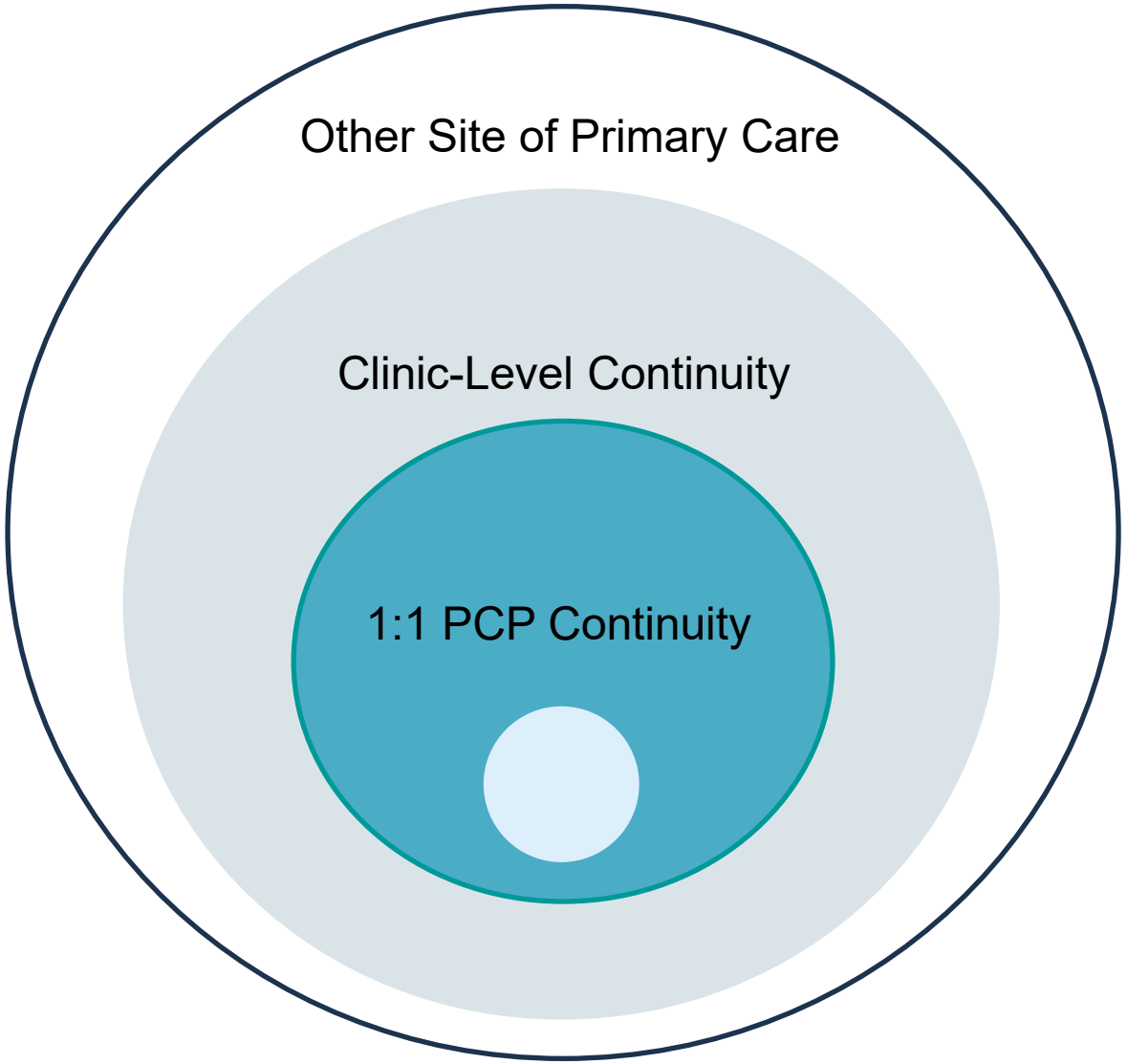
Outcome	Patients with virtual encounter, No. (%) (N = 1 885 966)		RD, % (95% CI)	RR (95% CI)
	Physician outside enrolling group (n = 942 983)	Own enrolling physician (n = 942 983)		
ED visit within 7 d				
Any	30 748 (3.3)	18 519 (2.0)	1.3 (1.2-1.3)	1.66 (1.63-1.69)
High acuity	7042 (0.7)	4836 (0.5)	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.

DOI: 10.1001/jamanetworkopen.2023.29991

DOI: 10.1001/jamanetworkopen.2023.49452

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.

DOI: 10.1370/afm.3107

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
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	PCP Assignment requirement is kept but distinction between assigned and selected has been removed. Added a shift in language to emphasize collaboration with Covered California to improve primary care selection, member value and engagement in care. Introduced and clarified the terminology and reporting requirement on the Continuity of Care, specifying enrollment timelines. Expanded language on payment models to include descriptions of HCP LAN APM categories and primary care clinician compensation. 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.	Many issuers recommend further research on the Continuity of Care (CoC) measure and its correlation with quality before setting benchmarks. Concerns were raised about potential for unnecessary visits and increased costs, and the need for a reporting-only phase to establish baseline. Consumer advocates and coalition supported the CoC metric for its positive impact on patient outcomes and cost reduction. Some issuers expressed concerns about duplicative data reporting and recommended aligning with OHCA on primary care spend reporting.	Added language on member value and engagement in care. 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.

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
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	- 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	Multiple comments on tailoring requirements	No changes
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	+ 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"	Multiple Issuers requested clarity on data sharing protocols One Issuer requested clarity on Fraud/Waste/Abuse data analysis One stakeholder suggested addition of defining language around QHIO requirements	Expanded language around purpose of and expectations of data sharing with QHIOs

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.

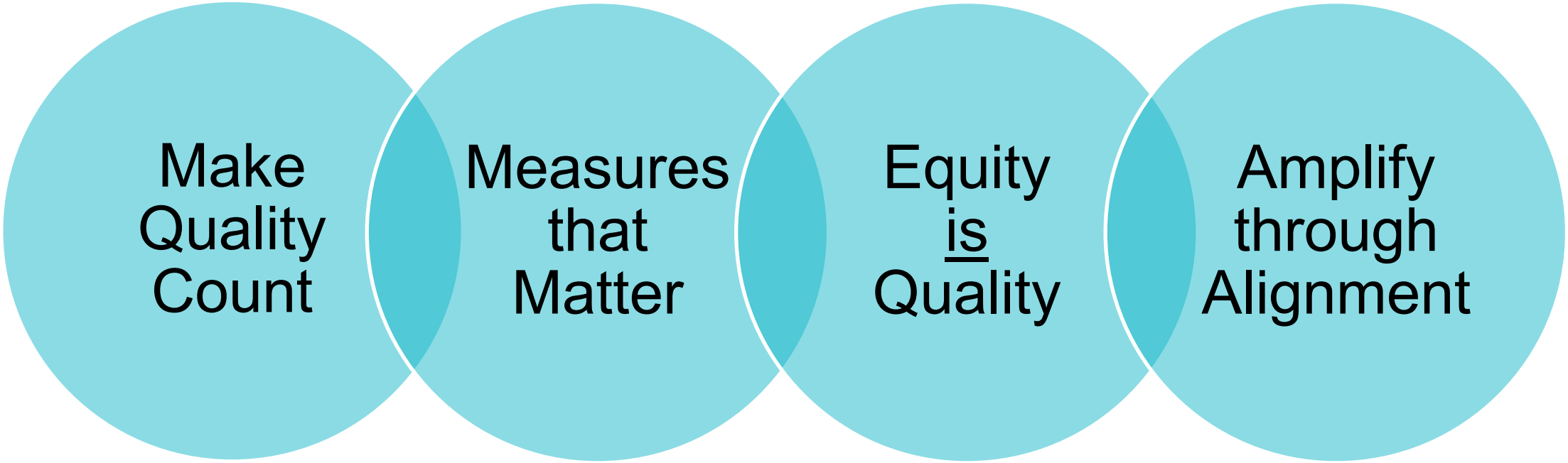
CURRENT VS 2026-28 PROPOSED REQUIREMENTS – ATTACHMENT 2

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



0.8% to 4% premium at risk for

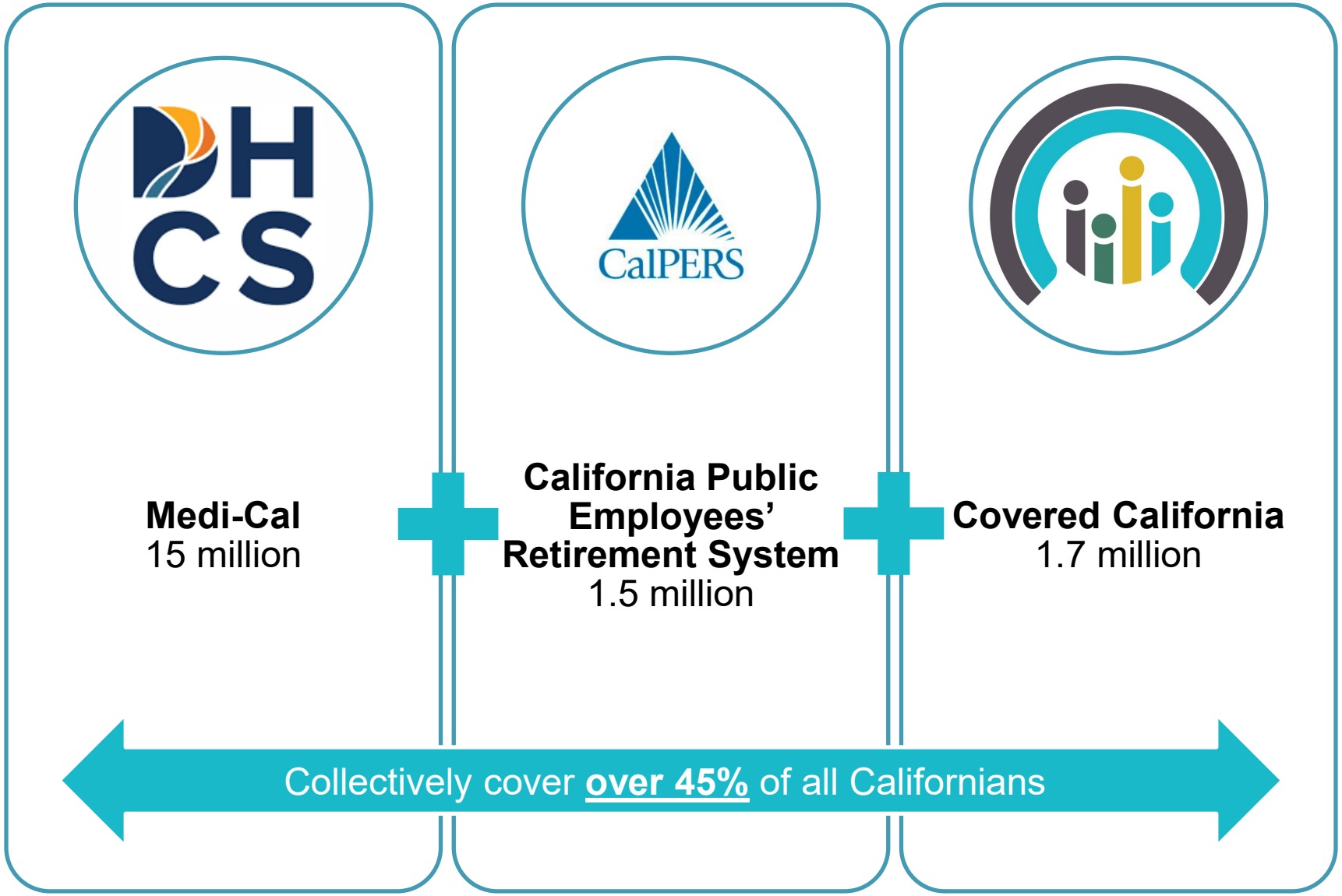
a small set of clinically important measures

stratified by race/ethnicity

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

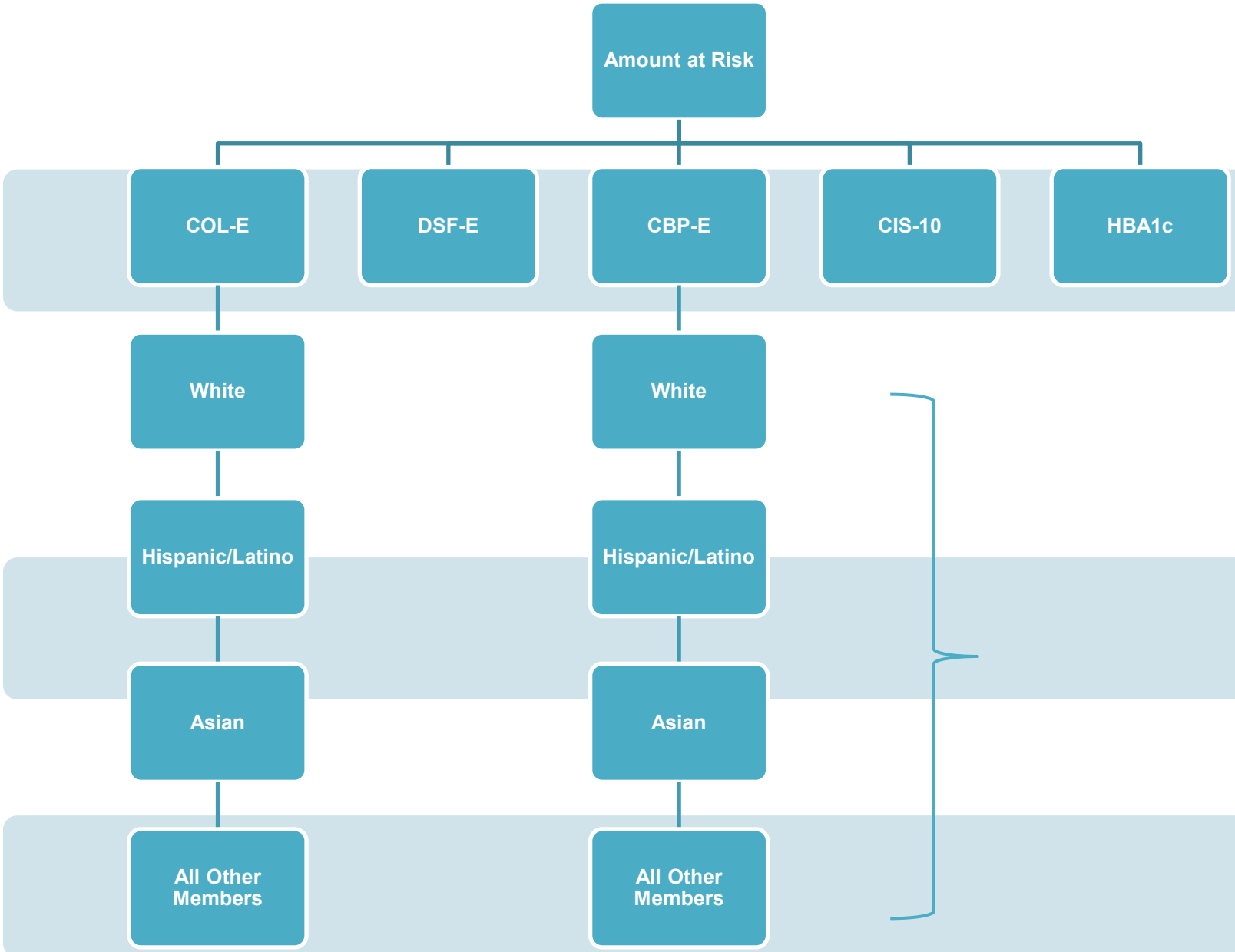
2026-28 ATTACHMENT 4 REQUIREMENTS

- 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.

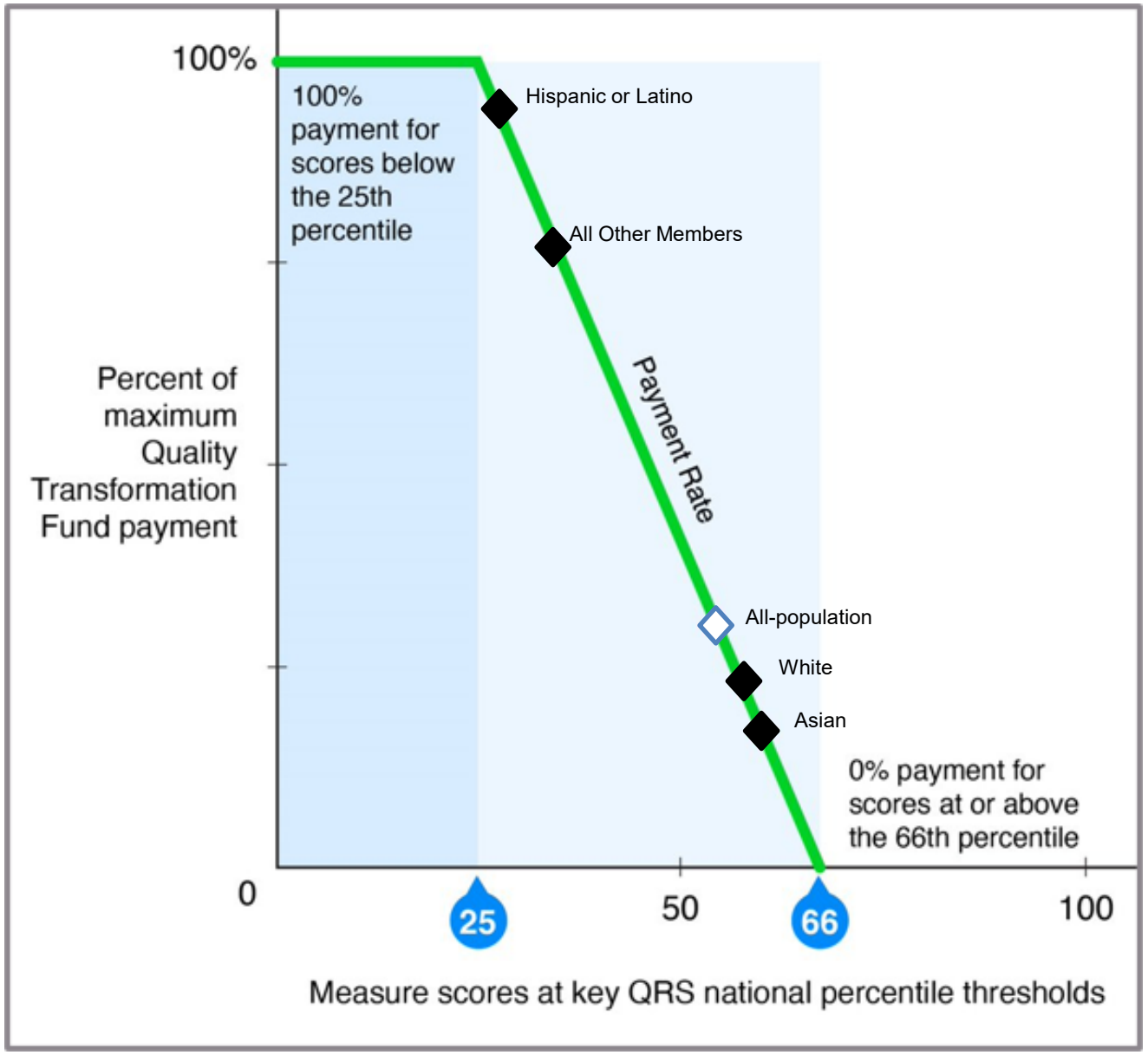


Divided across 5 measures

Payment amount apportioned would be based on the issuer specific race and ethnicity denominator size with the amount at risk maxed at the percentage that subpopulation represents.

If a subpopulation defined by federal OMB or CDC Race and Ethnicity Code Set has a denominator less than 100, it becomes part of the All Other Members Category

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
New requirement for 2026-2028	**1.02 Race and Ethnicity Stratification and Methodology** 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.	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. Inquiries on timeline for implementation with some issuers expressing concern on timing and financial accountability of moving to assessment of stratified performance 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	No Changes

ADVANCING EQUITY, QUALITY AND VALUE CONTRACT UPDATE

Model Contract *with PMD*	Attachment 1	Attachment 2 *with PMD*	Attachment 4
• Essential Community Providers (ECPs) • Article 5	• Articles 1-6	• Performance standards	• Quality Transformation Initiative

CCSB Contract Scope

2026-2028 MODEL CONTRACT DRAFTS & RESPONSE TO COMMENT

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

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

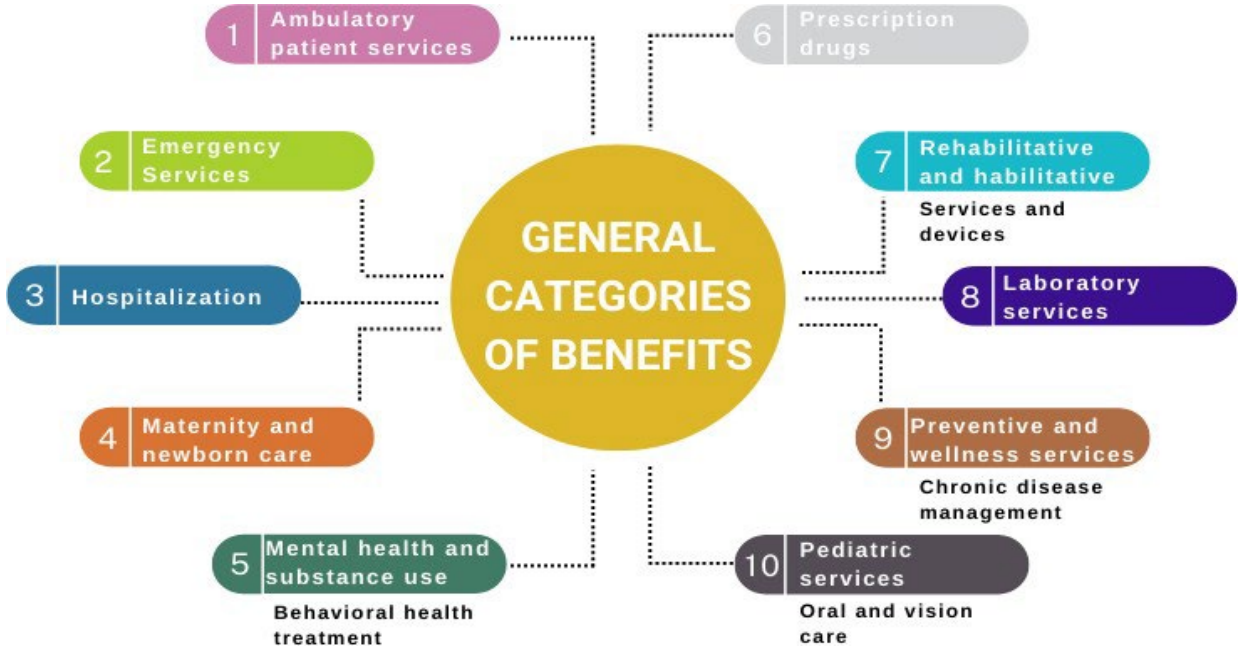
NOTE: Written comments may be submitted to BoardComments@covered.ca.gov.

2026 STANDARD BENEFIT DESIGNS

Melanie Droboniku
Plan Management Division

OVERVIEW OF ESSENTIAL HEALTH BENEFITS

The Patient Protection and Affordable Care Act (PPACA or ACA) requires that all health insurance plans offered in the individual and small-group markets must provide a comprehensive package of items and services, known as essential health benefits (EHBs). These benefits fit into the following 10 categories:



Covered California's covered benefits are based on those identified in our benchmark plan, which was adopted by legislation in 2012. Plans offered on the Exchange must include all the benefits in this plan, and cannot include benefits not included in this plan unless required by Federal legislation, or is otherwise defrayed (i.e. cannot be paid for by premiums). Details of the plan can be found here: https://www.cms.gov/cciio/resources/data-resources/downloads/updated-california-benchmark-summary.pdf

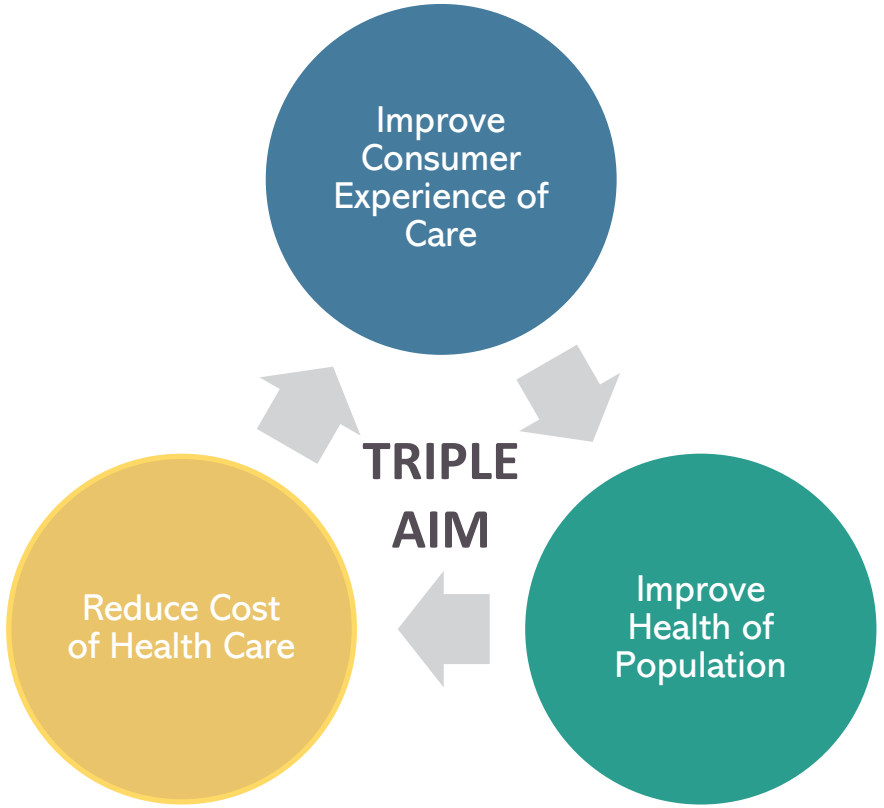
STRATEGY FOR PATIENT-CENTERED BENEFIT PLAN DESIGNS

Organizational Goal

Covered California should have benefit designs that are standardized, promote access to care, and are easy for consumers to understand, i.e., **PATIENT-CENTERED**

Principles

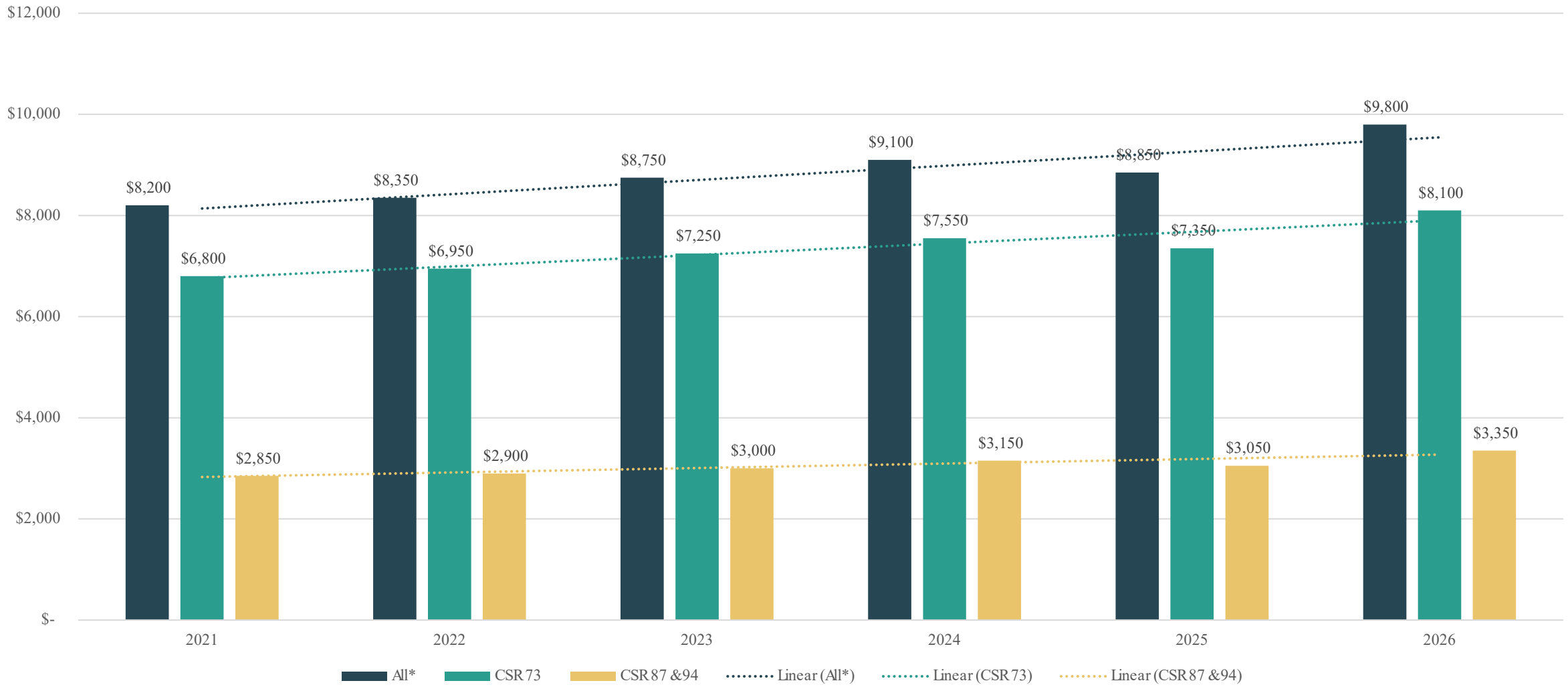
- Multi-year progressive strategy with consideration for market dynamics: changes in benefits should be considered annually based on consumer experience related to access and cost
- Adhere to principles of value-based insurance design by considering value and cost of clinical services
- Set fixed copays as much as possible and utilize coinsurance for services with wide price variation to encourage members to shop for services
- Apply a stair-step approach for setting member cost shares for a service across each metal level, e.g., for Plan Year 2024, a Primary Care visit was $50 in the Silver tier, $35 in Gold, and $15 in Platinum



BENEFIT DESIGN REQUIREMENTS

- The ACA requires individual and small group plans to meet actuarial value (AV) requirements for four levels of coverage:
  - Platinum: 90% AV
  - Gold: 80% AV
  - Silver: 70% AV
  - Bronze: 60% AV
- Additional plan designs with a richer benefit package, known as “Cost Sharing Reduction Plans”, are available to individuals meeting income eligibility requirements
  - Silver 94: 94% AV, 100% - 150% Federal Poverty Level (FPL)
  - Silver 87: 87% AV, 150% - 200% FPL
  - Silver 73: 73% AV, 200% - 250% FPL
- California law authorizes the Covered California Board to standardize products offered through the Exchange. Contracted issuers are required to offer products using Covered California’s Board-approved standard benefit plan designs
- The standard benefit plan design is adjusted annually to meet AV requirements, clarify benefit administration, and incorporate benefit design innovations

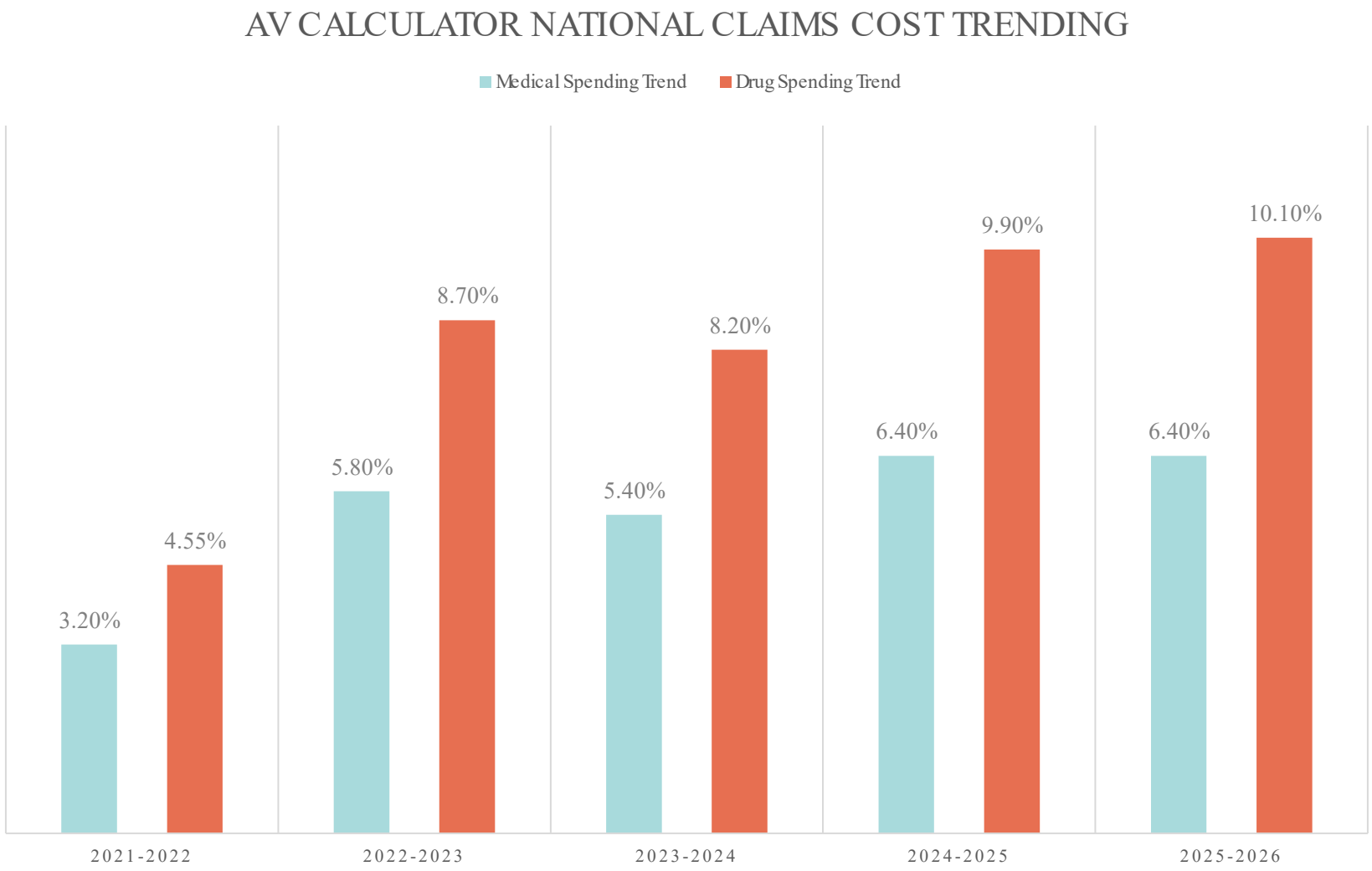
DRAFT NBPP UPDATES AND TRENDS – MAXIMUM OUT OF POCKET



Notes: Non-CSR MOOP is Less Covered California $350 Dental MOOP
Family MOOP is double the individual MOOP

FINAL AV CALCULATOR UPDATES AND TRENDS

- Final AV Calculator released in October rather than as draft
- Medical Trend steady from last year, still higher than previous years
- Drug spending trend higher than all previous years at 10.10%



AV CHANGES FROM 2025 TO 2026 & DE MINIMIS RANGES

	Bronze		Silver				Gold		Platinum	
	HDHP	Standard	Silver	Silver 73	Silver 87	Silver 94	Copay	Coins	Copay	Coins
AV Target	60	60	70	73	87	94	80	80	90	90
Deviation Allowance	+5/-2%	+5/-2%	+2/0%	+1/0%	+1/0%	+1/0%	+/-2%	+/-2%	+/-2%	+/-2%
2025 Final AV	64.88	63.50	71.55	73.74	87.86	94.74	81.64	81.46	91.58	91.90
2025 CA Enhanced CSR AV			**79.22**	**79.22**	**88.86**	**95.07**				
2026 AV	**65.98**	**64.96**	**73.12**	**75.21**	**88.53**	**95.05**	**82.82**	**82.46**	**92.15**	**92.36**

CCSB ONLY	Silver			Gold		Platinum	
	Copay	Coins	HDHP	Copay	Coins	Copay	Coins
AV Target	70	70	70	80	80	90	90
Deviation Allowance	+/-2%	+/-2%	+/-2%	+/-2%	+/-2%	+/-2%	+/-2%
2025 Final AV	68.84	69.24	71.21	80.52	79.08	90.47	91.27
2026 AV	**70.46**	**70.86**	**72.29**	**81.70**	**80.21**	**91.13**	**91.79**

For illustrative purposes only.

*Draft AV does not include 2026 copay accumulation additive adjustment or custom inputs- these are pending and subject to change

Red text: AV is outside de minimis range

Green text: AV is within de minimis range

Yellow text: AV is within de minimis range but is likely too high to accommodate final AV adjustments and buffer for MHPAEA outcomes

Blue text: 2025 CA Enhanced CSR AV

PY2025 CALIFORNIA ENHANCED COST SHARING REDUCTION PROGRAM UPDATE

- $165 million from the HCARF (Health Care Affordability Relief Fund) was allocated to Covered California to support program of financial assistance for coverage year 2025
  - This was an expansion of the $82.5 million program implemented in 2024
- In 2025, we built upon the work of 2024, continuing to:
  - Eliminate deductibles in all Silver CSR plans
  - Revert planned cost-sharing increases for generic drugs and maximum out-of-pocket in the Silver 87 CSR plan
  - Increase the value of the Silver 73 CSR plan to approximate the Gold level of coverage by reducing copays for primary and emergency care to Gold levels, reducing the copay for specialist visits and lowering the maximum out-of-pocket amount
- In 2025, we were able to use the additional funding to remove the income eligibility cap, expanding the CA Enhanced Silver 73 CSR plan design to anyone enrolled in Silver, as well as provide these benefits to the AI/AN population above 300% FPL

PROPOSED PY2026 COST SHARING CHANGES IN CONTEXT

- The proposed PY2026 standard benefit designs presented today represent the impact of the federal updates to the AV calculator and underlying trends
- The Governor's proposed budget again includes $165M to support a program of financial assistance for Covered California members
- These proposed benefit designs do not include the value of the CA enhanced CSR program, and therefore may not represent the ultimate cost-sharing expectations for consumers enrolling in silver plans in PY2026. The PY2026 CA Enhanced CSR program benefit designs will be presented in February.
- With the enhanced federal premium tax credits due to expire at the end of 2025, consumer impact and affordability of coverage and care for Covered California consumers are top of mind

PROPOSED COST SHARE CHANGES

Individual-Only

- **Platinum Coinsurance and Copay Plans:**
  - Increase Maximum Out of Pocket from $4,500 to $5,000
  - Increase Emergency Department Fee from $150 to $175
  - Increase Tier 1 (Generic) copay from $7 to $9

- **Gold Plans:**
  - Increase Maximum Out of Pocket from $8,700 to $9,200
  - Increase Emergency Department fee from $330 to $350
  - Increase Office Visit copays by $5, from $35 to $40, or $65 to $70 for Specialist Visits
  - Increase Tier 1 (Generic) copay from $15 to $18
  - In the Gold Copay plan, increase Inpatient physician fee by $25 from $350 to $375 per day

- **Silver 70 Plan:**
  - Decrease Medical Deductible by $200 from $5,400 to $5,200
  - Increase Maximum Out of Pocket from $8,700 to $9,800
  - Increase Tier 1 (Generic) copay from $18 to $19

- **Silver 73 CSR – Modeled from baseline**
  - Decrease Medical Deductible by $200 from $5,400 to $5,200
  - Decrease Drug Deductible from $350 to $50
  - Increase Maximum Out of Pocket from $7,350 to $8,100
  - Increase Office Visit copays by $15, or $85 to $90 for Specialist Visits
  - Decrease Tier 1 (Generic) copay from $20 to $19

- **Silver 87 CSR – Modeled from baseline**
  - Increase Maximum Out of Pocket from $3,050 to $3,350
  - Decrease Drug Deductible from $350 to $50
  - Increase Laboratory Services from $20 to $30
  - Increase X-rays and Diagnostic Imaging from $40 to $50

- **Silver 94 Plan – Modeled from baseline:**
  - Increase Maximum Out of Pocket from $1,300 to $1,400
  - Increase Laboratory Services and X-rays and Diagnostic Imaging from $8 to $10

PROPOSED COST SHARE CHANGES, CONT

- **Bronze Plan:**
  - Increase Maximum Out of Pocket from $8,850 to $9,800
  - Increase Lab Services from $40 to $50
  - Increase Tier 1 (Generic) drug copay from $19 to $20

- **Bronze HDHP Plan:**
  - Increase Integrated Deductible and Maximum Out of Pocket from $6,650 to $7,200

Covered California for Small Business

- **CCSB-only Silver HDHP**
  - Increase Medical Deductible from $2,850 to $3,200
  - Increase Maximum Out of Pocket from $7,500 to $8,300

PY2026 PATIENT-CENTERED DRAFT BENEFIT DESIGNS

Benefit	Individual-only Platinum Coinsurance		Individual-only Platinum Copay		Individual-only Gold Coinsurance		Individual-only Gold Copay		Individual-only Silver		Silver 73		Silver 87		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
Deductible																				$7,200
Medical Deductible										$5,200		$5,200		$1,400		$0		$5,800		
Drug Deductible										$50		$50		$50		$0		$450		
Coinsurance (Member)		10%		10%		20%		20%		30%		30%		20%		10%		40%		0%
MOOP		$5,000		$5,000		$9,200		$9,200		$9,800		$8,100		$3,350		$1,400		$9,800		$7,200
ED Facility Fee		$175		$175		$350		$350		$400		$400		$200		$50	X	40%	X	0%
Inpatient Facility Fee		10%		$225		30%		$375	X	30%	X	30%	X	20%	X	10%	X	40%	X	0%
Inpatient Physician Fee		10%		---		30%		---		30%		30%		20%		10%	X	40%	X	0%
Primary Care Visit		$15		$15		$40		$40		$50		$50		$15		$5		$60	X	0%
Specialist Visit		$30		$30		$70		$70		$90		$90		$25		$8	X	$95	X	0%
MH/SU Outpatient Services		$15		$15		$40		$40		$50		$50		$15		$5		$60	X	0%
Imaging (CT/PET Scans, MRIs)		10%		$75		25%		$75		$325		$325		$100		$50	X	40%	X	0%
Speech Therapy		$15		$15		$40		$40		$50		$50		$15		$5		$60	X	0%
Occupational and Physical Therapy		$15		$15		$40		$40		$50		$50		$15		$5		$60	X	0%
Laboratory Services		$15		$15		$40		$40		$50		$50		$30		$10		$50	X	0%
X-rays and Diagnostic Imaging		$30		$30		$75		$75		$95		$95		$50		$10	X	40%	X	0%
Skilled Nursing Facility		10%		$125		30%		$150	X	30%	X	30%	X	20%	X	10%	X	40%	X	0%
Outpatient Facility Fee		10%		$75		30%		$130		30%		30%		20%		10%	X	40%	X	0%
Outpatient Physician Fee		10%		$20		30%		$60		30%		30%		20%		10%	X	40%	X	0%
Tier 1 (Generics)		$9		$9		$18		$18		$19		$19		$8		$3		$20	X	0%
Tier 2 (Preferred Brand)		$16		$16		$60		$60	X	$60	X	$55	X	$25		$10	X	40%	X	0%
Tier 3 (Nonpreferred Brand)		$25		$25		$85		$85	X	$90	X	$85	X	$45		$15	X	40%	X	0%
Tier 4 (Specialty)		10%		10%		20%		20%	X	20%	X	20%	X	15%		10%	X	40%	X	0%
Tier 4 Maximum Coinsurance		$250		$250		$250		$250		$250		$250		$150		$150		$500*		
Maximum Days for charging IP copay				5				5												
Begin Specialist deductible after # of copays																		3		
Actuarial Value																				
2026 AV (Final 2026 AVC)		**91.92**		**91.76**		**81.39**		**81.73**		**71.66**		**73.69**		**87.78**		**94.78**		**63.49**		**64.76**
Enrollment as of June 2024		65,830				154,350				331,000		181,380		382,430		199,090		347,200		91,480
Percent of Total enrollment		3.7%				8.7%				18.7%		10.3%		21.6%		11.3%		19.6%		5.2%

KEY		
	X	Subject to deductible
	*	Drug cap applies to all drug tiers
	†	Additive adjustment (included in AV)
		Increased member cost from 2024
		Decreased member cost from 2024
		Does not meet AV
		Within .5 of upper de minimis
		Securely within AV

For illustrative purpose only.

2026 COVERED CALIFORNIA FOR SMALL BUSINESS DESIGNS

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**		**80.21**		**81.70**		**70.86†**		**70.46†**		**70.70**

KEY		
	X	Subject to deductible
	*	Drug cap applies to all drug tiers
	†	Additive adjustment needed (to be included in AV)
		Increased member cost from 2025
		Decreased member cost from 2025
		Does not meet AV
		Within .5 of upper de minimis
		Securely within AV

For illustrative purpose only.

DENTAL UPDATES

PROPOSED PY2025 CDT CODE CHANGES

Revision Code	Nomenclature	Pediatric Copay	Adult Copay
D0801	3D intraoral surface scan – direct	No Charge	No Charge
D2940	placement of interim direct restoration	$25	$20
D6080	implant maintenance procedures when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments	$30	Not Covered
D6081	scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocket depths; includes cleaning of the implant surfaces, without flap entry and closure	$30	Not Covered
D6090	repair of implant/abutment supported prosthesis	$65	Not Covered

Editorial Code	Nomenclature
D5520	replace missing or broken teeth – complete denture – per tooth
D5640	replace missing or broken teeth – partial denture – per tooth
D5650	add tooth to existing partial denture – per tooth

Deleted Code	Nomenclature
D2941	interim therapeutic restoration – primary dentition
D6095	repair implant abutment, by report

NEW DENTAL CODES

New Code	Nomenclature	Suggested Pediatric Copay	Suggested Adult Copay
D2956	removal of an indirect restoration on a natural tooth	Not Covered	Not Covered
D6180	implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed, including cleansing of prosthesis and abutments	$30	Not Covered
D6193	replacement of an implant screw	Not Covered	Not Covered
D7252	partial extraction for immediate implant placement	$80	Not Covered
D7259	nerve dissection	$280	$280
D8091	comprehensive orthodontic treatment with orthognathic surgery	$350	Not Covered
D8671	periodic orthodontic treatment visit associated with orthognathic surgery	$350	Not Covered
D9913	administration of neuromodulators	Not Covered	Not Covered
D9914	administration of dermal fillers	Not Covered	Not Covered
D9959	unspecified sleep apnea services procedure, by report	Not Covered	Not Covered

NEXT STEPS

- Final PY2026 Patient-Centered Benefit Designs will be presented for action in February 2025

- Benefits may require minor changes due to late changes in the final version of the Notice of Benefits and Payment Parameters

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.

APPENDIX

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
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. Contractor must demonstrate provider contracts with at least • 15% of 340B non-hospital entities in each rating region • One ECP hospital per county 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	**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 **New sufficiency requirements:** By 2029, Contractor must demonstrate provider contracts with at least: • 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 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. Alternate standard: Contractor must map low-income member populations and network providers offering services in all ECP categories.	General support for the ECP update effort and new ECP types. Consumer advocates urged contracting with all FQHCs, rural clinical and tribal health programs (both Indian Health Service and Urban Indian clinics) 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. Several issuers posed clarifying questions regarding data and methods used to develop the propped ECP list and made suggestions for ease of use of the ECP list Multiple issuers have posed clarifying questions related to the regional denominators for sufficiency calculations and suggested providers that should be excluded from these calculations. 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	No changes to contract language proposed. 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.

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
New requirement for 2026-2028	**Section 4.3.6 Access Monitoring** Covered California will track and publicly report CMS QRS Enrollee Experience performance 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: • 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 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.	Public purchasers and a Provider Association expressed support for continued alignment on Access measurement and monitoring initiatives 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. Multiple Issuers requested clarifications, including: • 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 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) 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	**Provider Availability and Accessibility** 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 **Service Utilization and Quality** Any new survey, including secret shopper effort, will be conducted in alignment with DMHC and other public purchasers

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
5.2.3 Removal from Exchange **Assessment Structure** • Composite scores compared to MY 2018 25th % composite benchmark. • 2 years below benchmark = remediation; 4 years = removal from exchange **25th Percentile Benchmark** • Average of 2018 QRS measure scores. • Excludes NR results and measures without MY 2018 benchmarks **Annual Assessment** **Measure Inclusion/Exclusion** • Follows CMS QRS guidelines; MY 2018 measures only. • Retired measures excluded **Benchmark Year** • MY 2018 benchmarks used for 2023-2025 contract **Scoring Calculation** • Annual updates to composite scores and benchmarking	**2024 Benchmark Year** • Updating 2018 to 2024 as the new static benchmark year which updates and expands measure set used to calculate composite benchmarks and scoring **Annual Assessment** • Average of 2024 QRS measure scores **Composite Assessment Structure** • Continuing: 2 years below benchmark = remediation; 4 years = removal from exchange **Minimum Performance Level (MPL)** requirement. • Measure-specific MPL action plans target consistent underperformance of clinically significant measures beneath the 25th percentile **Measure Inclusion/Exclusion** • *Adds* new CMS measures as benchmarks are published. • Limits to MY 2024 and new measures with benchmarks; excludes retired measures	**New Measures and Benchmarks** • Request for details on new measure inclusion and benchmark year selection • Support for updated benchmarks and new QRS measures **Minimum Performance Level (MPL)** • 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 **Timing and Reporting** • Suggestion to wait for one year of QRS reporting before including new measures **Shared Goals** • Support for quality improvement and alignment with national standards	**Benchmark Year** • Finalized as Measure year 2024. **Measure Inclusion** • Contract terms allow flexibility to include new QRS clinical measures as benchmarks become available **Minimum Performance Level (MPL)** • Narrowed the number of clinical measures subject to MPL action plans. • Targets consistent underperformance for clinically significant measures beneath the 25th percentile. **Composite Scoring** • Maintaining alignment with CMS scoring methodology **Timing of New Measures** • 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
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.	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.	Clarification of timelines for implementation of SOGI requirement.	No changes
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.	Continued requirement to report on specified HEDIS hybrid measures via PLD, expanded measures list. 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.	Clarification of PLD file specification, and Some issuers expressed concerns with the number of measures in PLD file. Request for decisions related to implementation of ECDS for PLD file submission of HEDIS measures.	No changes

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
1.03 Disparities Reduction Contractor must meet a multi-year disparity reduction target beginning in PY 2023.	Contractor must participate in collaboration across QHP Issuers and with community via learning sessions. Contractor must meet specified disparity identification ad reduction requirements with a focus on maternal mental health and behavioral health access, must provide annual CLAS staff training.	Issuer requested guidance on staff training related to the CLAS standards	Revisions to clarify QHP expectations for QHP conducted activities to meet QHP collaboration and community engagement timelines.
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.	Continued requirement: Contractor must achieve or maintain NCQA Health Equity Accreditation.	No comments	No changes
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.	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.	Suggestion of submission of NCQA Health Accreditation Certificate rather than reporting related specified standards	No Changes

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
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	+ 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	Consumer advocate groups and Issuers requested clarity on culturally and linguistically appropriate services Overall support for approach focused on access, member engagement in care, and reducing disparities	No changes
2.02 Quality of Behavioral Health Services Monitoring quality is crucial for providing appropriate, evidence-based care to enrollees and supporting quality improvement	No notable changes	No comments	No changes
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	**2.03 Substance Use Disorders** + 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)	Overall support for the expansion of substances, including tobacco One Issuer recommended Follow-Up after SUD admission rather than IET	No changes

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
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	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	No comments	No changes
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	No notable changes	No comments	No changes

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
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.	No notable changes	No comments	No changes
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.	Moved Tobacco Cessation Program requirement to Article 2: Behavioral Health. 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	Multiple Issuers supported the removal of reporting requirements and reducing administrative burden related to offering health promotion and prevention programs	No changes

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
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.	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).)	Several Issuers advocated use of established guidelines and flexible timing to manage care transition activities for Enrollees in regions experiencing service reductions 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 Consumer advocates recommended classifying those in medication-assisted treatment for substance disorders as high-risk enrollees	Added clarifying language to “at-risk” and “high-risk definitions Added Enrollees’ undergoing medication assisted treatment for substance use disorders in definition of “At-Risk” Enrollees
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	Specified annual report requirement for screening processes and efforts to connect Enrollees to resources.	Issuers sought clarity on SNS-E measure reporting One issuer supported ongoing SNS-E reporting 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	No changes

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
No current requirements	**New - 3.05 Use of Generative Artificial Intelligence in QHP Issuer Operations** Contractor must: 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	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	Adopted language to align with legal requirements within SB-1120 Health Coverage: Utilization Review

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
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	PCP Assignment requirement is kept but distinction between assigned and selected has been removed. Added a shift in language to emphasize collaboration with Covered California to improve primary care selection, member value and engagement in care. Introduced and clarified the terminology and reporting requirement on the Continuity of Care, specifying enrollment timelines. Expanded language on payment models to include descriptions of HCP LAN APM categories and primary care clinician compensation. 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.	Many issuers recommend further research on the Continuity of Care (CoC) measure and its correlation with quality before setting benchmarks. Concerns were raised about potential for unnecessary visits and increased costs, and the need for a reporting-only phase to establish baseline. Consumer advocates and coalition supported the CoC metric for its positive impact on patient outcomes and cost reduction. Some issuers expressed concerns about duplicative data reporting and recommended aligning with OHCA on primary care spend reporting.	Added language on member value and engagement in care. 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.
4.02 Promotion of Integrated Delivery Systems (IDSs) and Accountable Care Organizations (ACOs)	Retired		

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
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. • **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.	**4.02 Networks Based on Value:** Added focus on **low-value care** reduction and affordability barriers. • **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.	**Networks Based on Value:** • 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. **Hospital Value and Safety:** • Request to exclude "all lines of business" from reporting requirements. **Comprehensive Maternity Care:** • 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.	**Networks Based on Value:** • Added definition of **low-value care**: services with minimal clinical benefit, deviation from evidence-based guidelines, or safer, cost-effective alternatives. **Comprehensive Pregnancy and Postpartum Care:** • 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
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.	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	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	Added URAC as alternative accreditation for reporting virtual care providers
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	Changed to **4.04 Participation in Quality Collaboratives** Modified language to focus on collaboration and removed the listing of specific collaboratives	Many Issuers expressed support for reducing required organizations Several Issuers brought up participation costs and time commitments	No changes

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
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	- 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	Multiple comments on tailoring requirements	No changes
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	+ 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”	Multiple Issuers requested clarity on data sharing protocols One Issuer requested clarity on Fraud/Waste/Abuse data analysis One stakeholder suggested addition of defining language around QHIO requirements	Expanded language around purpose and expectations of data sharing with QHIOs

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
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	No notable changes	No comments	No changes
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	No notable changes	No comments	No changes

CURRENT VS 2026-28 PROPOSED REQUIREMENTS – ATTACHMENT 1

2025 Current Requirements	2026-28 Proposed Requirements	Comment Themes	2026-28 Proposed Requirements Comment Based Update
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	Clarified requirement to submit to Covered California any CAP required by NCQA regardless of accreditation status	One Issuer expressed support for proposed requirement to submit NCQA Corrective Action Plan regardless of status change	No changes
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	No notable changes	No comments	No changes

CURRENT VS 2026-28 PROPOSED REQUIREMENTS – ATTACHMENT 2

2025 Current Requirements	2026-28 Proposed Requirements	Comment Themes	2026-28 Proposed Requirements Comment Based Update
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	No notable changes	One Issuer suggested consideration of "Decline to state" or "Asked but not answered" as acceptable values One Issuer requested removal of alternative standard for newly contracted QHP Issuers in the first year of operation 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	No changes
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	No notable changes	One Issuer suggested consideration of "Decline to state" or "Asked but not answered" as acceptable values One Issuer requested removal of alternative standard for newly contracted QHP Issuers in the first year of operation	No changes

CURRENT VS 2026-28 PROPOSED REQUIREMENTS – ATTACHMENT 2

2025 Current Requirements	2026-28 Proposed Requirements	Comment Themes	2026-28 Proposed Requirements Comment Based Update
Reducing Health Disparities: Disparities Reduction Intervention Contractors must meet multi-year disparity reduction target beginning PY 2023 or later if contracted later.	**Retired**	No comments received	
National Committee for Quality Assurance (NCQA) Health Equity Accreditation Contractor must achieve and maintain NCQA Multicultural Health Care Distinction (MHCD) or Health Equity Accreditation	**Retired**	No comments received	
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	**Retired**	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.	Covered California retained Attachment 1 Article 4 reporting requirement on Primary Care Payment to align with OHCA's methodology.

CURRENT VS 2026-28 PROPOSED REQUIREMENTS – ATTACHMENT 2

2025 Current Requirements	2026-28 Proposed Requirements	Comment Themes	2026-28 Proposed Requirements Comment Based Update
Primary Care Spend Contractor must report total primary care spend and its distribution across HCP LAN APM categories, following Integrated Healthcare Association methodology	**Retired** Covered California retained Attachment 1 Article 4 reporting requirement on Primary Care Spend to align with OHCA's methodology.	QHP issuers supported retirement of Primary Care Spend as a performance standard and alignment with OHCA's methodology for reporting and timeline.	none
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	**Retired** Covered California retained Attachment 1 Article 4 reporting requirement on Payment to Support Networks Based on Value to align with OHCA's methodology.	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.	none
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	**Retired** Covered California will track and publicly report CMS QRS Enrollee Experience performance as part of new Article 4.3.6 access monitoring activities.	No comments received.	none

CURRENT VS 2026-28 PROPOSED REQUIREMENTS – ATTACHMENT 2

2025 Current Requirements	2026-28 Proposed Requirements	Comment Themes	2026-28 Proposed Requirements Comment Based Update
Healthcare Evidence Initiative (HEI) Data Contractor must complete full and regular data submissions of data according to the agreed upon standards	+ 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**	Two issuers requested clarifying language on who is covered by AB929	No changes
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	No notable changes	No comments	No changes
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	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	No comments	No changes

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
New requirement for 2026-2028	**Utilization and Primary Care: Overall Engagement with Members** 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.	One issuer expressed concerned over penalties, suggesting adjustments to account for challenges in engaging unresponsive members. One issuer requested removal of this performance standard, citing potential increases in costs and premiums. 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.	Added language to clarify timing of performance standard assessment.

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
New requirement for 2026-2028	**Utilization and Primary Care: Monitoring Continuity of Care** 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.	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. 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.	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. 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.

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
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. Contractor must demonstrate provider contracts with at least • 15% of 340B non-hospital entities in each rating region • One ECP hospital per county 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	**New sufficiency requirements:** By 2029, Contractor must demonstrate provider contracts with at least: • 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 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. Alternate standard: Contractor must map low-income member populations and network providers offering services in all ECP categories.	No comments received.	No changes to Attachment 3 proposed. 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.

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
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	Renamed QTI Scored and Reporting-only Measure Sets 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.	Multiple Issuers voiced concerns about the DSF-E measure and that it contains two measures in one. Three Issuers requested a transition from CIS Combo 10 to Combo 7 due to nationwide challenges in administering flu vaccines. 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.	

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
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.	Newly contracted QHP issuers to start at 1% premium at risk in Year 1 of QTI eligibility. 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.	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. 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. 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. 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.	Revised language describing approach to updating benchmarks if established through use of proof sheets or use of prior version of measure.

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
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	No changes	One issuer proposed adjusting contract language to allow QTI payment obligations to extend into the next calendar year for smoother financial planning.	
1.04 Administration of QTI Payments Covered California shall direct Contractor's use of QTI Payments and issue PopHI Directive payment instructions	No changes		
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	No changes	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.	

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
1.06 Unspent Funds Unspent QTI Payments shall be used as directed by Covered California	No changes		
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	No changes		
1.08 Quality Improvement Plans Contractors scoring below the 25th percentile for a QTI Core Measure must submit a Quality Improvement Plan	Contractors are required to submit a QI Plan if they score below the 25th 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
New requirement for 2026-2028	**1.02 Race and Ethnicity Stratification and Methodology** 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.	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. Inquiries on timeline for implementation with some issuers expressing concern on timing and financial accountability of moving to assessment of stratified performance 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	No Changes

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
New requirement for 2026-2028	**1.04 Preventing Increases in Health Disparities and Requiring Maintained Efforts** 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. 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.	One issuer requested the removal or further clarification of section 1.04 Preventing Increases in Health Disparities/Requiring Maintained Efforts	Revised language to address perceived ambiguity around "lack of improvement or declining performance for a subpopulation