
# Qualified Dental Plan Application

## Plan Year 2019

## Individual Marketplace

January 18, 2018

# Contents

# 1 Application Overview

## 1.1 Purpose

The California Health Benefit Exchange (Exchange) is accepting applications from eligible Dental Issuers[1] (Applicants) to submit proposals to offer, market, and sell qualified dental plans (QDPs) through the Exchange beginning in 2018, for coverage effective January 1, 2019. Based on the Covered California Qualified Dental Plan Certification Application for Plan Year 2017, QDP issuers selected for the 2017 Plan Year executed multi-year contracts with the Exchange. As provided in the 2017 Application, application for certification for Plan Years 2018 and 2019 is limited to (1) those QDP issuers contracted for Plan Year 2017 that continue to meet certification standards and performance requirements, and (2) plans newly licensed and offering in the applicable market after May 2, 2016. QDP Issuers contracted for Plan Year 2018 will complete a simplified certification application since those issuers have a three year contract with the Exchange that imposes ongoing requirements that are similar to the requirements in the certification application and consideration of this contract performance is included in the evaluation process. The Exchange will exercise its statutory authority to selectively contract for health care coverage offered through the Exchange for Plan Year 2019. The Exchange reserves the right to select or reject any Applicant or to cancel this Application at any time.

## 1.2 Background

Soon after the passage of national health care reform through the Patient Protection and Affordable Care Act of 2010 (ACA), California enacted legislation to establish a qualified health benefit exchange. (California Government Code § 100500 et seq). The California state law is referred to as the California Patient Protection and Affordable Care Act (CA-ACA).

The Exchange offers a statewide health insurance exchange to make it easier for individuals to compare plans and buy health insurance in the private market. Although the focus of the Exchange is on individuals who qualify for tax credits and subsidies under the ACA, the Exchange's goal is to make insurance available to all qualified individuals. The vision of the Exchange is to improve the health of all Californians by assuring their access to affordable, high quality care coverage. The mission of the Exchange is to increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value.

The Exchange is guided by the following values:

- **Consumer-Focused**: At the center of the Exchange's efforts are the people it serves. The Exchange will offer a consumer-friendly experience that is accessible to all Californians, recognizing the diverse cultural, language, economic, educational and health status needs of those it serves.

[1] The term "Dental Issuer" used in this document refers to both dental plans regulated by the California Department of Managed Health Care and insurers regulated by the California Department of Insurance. It also refers to the company issuing dental coverage, while the term "Qualified Dental Plan" refers to a specific policy or plan to be sold to a consumer that has been certified by Covered California. Qualified Dental Plans are also referred to as "products". The term "Applicant" refers to a Dental Issuer who is seeking to have its products certified as Qualified Dental Plans.

- **Affordability**: The Exchange will provide affordable health insurance while assuring quality and access.
- **Catalyst**: The Exchange will be a catalyst for change in California's health care system, using its market role to stimulate new strategies for providing high-quality, affordable health care, promoting prevention and wellness, and reducing health disparities.
- **Integrity**: The Exchange will earn the public's trust through its commitment to accountability, responsiveness, transparency, speed, agility, reliability, and cooperation.
- **Transparency**: The Exchange will be fully transparent in its efforts and will make opportunities available to work with consumers, providers, health plans, employers, purchasers, government partners, and other stakeholders to solicit and incorporate feedback into decisions regarding product portfolio and contract requirements.
- **Results**: The impact of the Exchange will be measured by its contributions to decrease the number of uninsured, have meaningful plan and product choice in all regions for consumers, improve access to quality healthcare, promote better health and health equity, and achieve stability in healthcare premiums for all Californians.

In addition to being guided by its mission and values, the Exchange's policies are derived from the federal Affordable Care Act which calls upon Exchanges to advance "plan or coverage benefits and health care provider reimbursement structures" that improve health outcomes. The Exchange seeks to improve the quality of care while moderating cost not only for the individuals enrolled in its plans, but also by being a catalyst for delivery system reform in partnership with plans, providers and consumers. With the Affordable Care Act and the range of insurance market reforms that are in the process of being implemented, the health insurance marketplace is transforming from one that has prioritized profitability through a focus on risk selection, to one that rewards better care, affordability, and prevention.

The Exchange needs to address these issues for the millions of Californians who enroll through the Exchange to get coverage, but it is also part of broader efforts to improve care, improve health, and stabilize rising health care costs throughout the state.

The Exchange must operate within the federal standards in law and regulation. Beyond what is framed by the federal standards, California's legislature shapes the standards and defines how the new marketplace for individual and small group health insurance operates in ways specific to their context. Within the requirements of the minimum Federal criteria and standards, the Exchange has the responsibility to "certify" the Qualified Health Plans (QHPs) that will be offered in the Exchange.

The state legislation to establish the Exchange gave authority to the Exchange to selectively contract with issuers so as to provide health care coverage options that offer the optimal combination of choice, value, quality, and service, and to establish and use a competitive process to select the participating health issuers.

These concepts, and the inherent trade-offs among the Exchange values, must be balanced in the evaluation and selection of the Qualified Health Plans that will be offered on the Individual Exchange.

This application has been designed consistent with the policies and strategies of the Exchange Board which calls for the QHP selection to influence the competitiveness of the market, the cost of coverage, and how value is added through health care delivery system improvement.

## 1.3 Application Evaluation and Selection

The evaluation of QDP Certification Applications will not be based on a single, strict formula; instead, the evaluation will consider the mix of health and dental plans for each region of California that best meet the needs of consumers in that region and the Exchange's goals. The Exchange wants to provide an appropriate range of high quality health and dental plans to participants at the best available price that is balanced with the need for consumer stability and long term affordability. In consideration of the mission and values of the Exchange, the Board of the Exchange articulated guidelines for the selection and oversight of Qualified Health Plans which are used when reviewing the QDP application proposals for 2019. These guidelines are:

**Promote affordability for the consumer– both in terms of premium and at point of care**

The Exchange seeks to offer health plans, plan designs and provider networks that are as affordable as possible to consumers both in premiums and cost sharing, while fostering competition and stable premiums. The Exchange will seek to offer health plans, products, and provider networks that will attract maximum enrollment as part of its effort to lower costs by spreading risk as broadly as possible.

**Encourage "Value" Competition Based upon Quality, Service, and Price**

While premium will be a key consideration, contracts will be awarded based on the determination of "best value" to the Exchange and its participants. The evaluation of Issuer QDP proposals will focus on quality and service components, including past history of performance, administrative capacity, reported quality and satisfaction metrics, quality improvement plans and commitment to serve the Exchange population. This commitment to serve the Exchange population is evidenced through general cooperation with the Exchange’s operations and contractual requirements which include provider network adequacy, cultural and linguistic competency, programs addressing health equity and disparities in care, innovations in delivery system improvements and payment reform. The application responses, in conjunction with the approved filings, will be evaluated by the Exchange and used as part of the selection criteria to offer issuers’ products on the Exchange for the 2019 plan year.

### Encourage Competition Based upon Meaningful QDP Choice and Product Differentiation: Patient-Centered Benefit Plan Designs[2]

The Exchange is committed to fostering competition by offering QDPs with features that present clear choice, product and provider network differentiation. QDP Applicants are required to adhere to the Exchange's standard benefit plan designs in each region for which they submit a proposal. The Exchange is interested in having HMO and PPO products offered statewide. Within a given product design, the Exchange will look for differences in network providers and the use of innovative delivery models. Under such criteria, the Exchange may choose not to contract with two plans with broad overlapping networks within a rating region unless they offer different innovative delivery system or payment reform features.

### Encourage Competition throughout the State

The Exchange must be statewide. Issuers must submit QDP proposals in all geographic service areas in which they are licensed and have an adequate network, and preference will be given to Issuers that develop QDP proposals that meet quality and service criteria while offering coverage options that provide reasonable access to the geographically underserved areas of the state.

### Encourage Alignment with Providers and Delivery Systems that Serve the Low Income Population

Performing effective outreach, enrollment and retention of the low income population that will be eligible for premium tax credits and cost sharing subsidies through the Exchange is central to the Exchange's mission. Responses that demonstrate an ongoing commitment to the low income population or demonstrate a capacity to serve the cultural, linguistic and health care needs of the low income and uninsured populations beyond the minimum requirements adopted by the Exchange will receive additional consideration. Examples of demonstrated commitment include: having a higher proportion of essential community providers to meet the criteria of sufficient geographic distribution, having contracts with Federally Qualified Health Centers, and supporting or investing in providers and networks that have historically served these populations in order to improve service delivery and integration.

### Encourage Delivery System Improvement, Effective Prevention Programs and Payment Reform

One of the values of the Exchange is to serve as a catalyst for the improvement of care, prevention and wellness as a way to reduce costs. The Exchange wants QDP offerings that incorporate innovations in delivery system improvement, prevention and wellness, and/or payment reform that will help foster these broad goals. This will include models of patient-centered medical homes, targeted quality improvement efforts, participation in community-wide prevention, or efforts to increase reporting

[2] The 2019 Patient-Centered Benefit Designs will be finalized when the 2019 federal actuarial value calculator is finalized.

transparency in order to provide relevant health care comparisons and to increase member engagement in decisions about their course of care.

**Demonstrate Administrative Capability and Financial Solvency**

The Exchange will review and consider the Applicant's degree of financial risk to avoid potential threats of failure which would have negative implications for continuity of patient care and for the healthcare system as a whole. The Issuer's technology capability is a critical component for success on the Exchange, so Applicant's technology and associated resources are heavily scrutinized as this relates to long term sustainability for consumers. Additionally, in recognition of the significant investment that will continue to be needed in areas of quality reform and improvement programs, the Exchange offered a multi – year contract agreement through the 2017 application. Application responses that demonstrate a commitment to the long-term success of the Exchange's mission are strongly encouraged.

**Encourage Robust Customer Service**

The Exchange is committed to ensuring a positive consumer experience, which requires Issuers to maintain adequate resources to meet consumers' needs. To successfully serve Exchange consumers, Issuers must invest in and sustain adequate staffing, including hiring of bilingual and bicultural staff as appropriate and maintaining internal training as needed. Issuers demonstrating a commitment to dedicated administrative resources for Exchange consumers will receive additional consideration.

## 1.4 Availability

The Applicant must be available immediately upon contingent certification of its plans as QDPs to start working with the Exchange to establish all operational procedures necessary to integrate and interface with the Exchange information systems, and to provide additional information necessary for the Exchange to market, enroll members, and provide dental plan services effective January 1, 2019. Successful Applicants will also be required to adhere to certain provisions through their contracts with the Exchange, including meeting data interface requirements with the California Healthcare Enrollment, Eligibility, and Retention System (CalHEERS). Successful Applicants must execute the QDP Issuer contract before public announcement of contingent certification. The successful Applicants must be ready and able to accept enrollment as of October 1, 2018.

## 1.5 Application Process

The application process shall consist of the following steps:

- Release of the Final Application;
- Submission of Applicant responses;
- Evaluation of Applicant responses;
- Discussion and negotiation of final contract terms, conditions and premium rates; and
- Execution of contracts with the selected QDP Issuers.

## 1.6 Intention to Submit a Response

Applicants interested in responding to this application must submit a non-binding Letter of Intent to Apply, identifying their proposed products and service areas. Only those Applicants who submit the Letter of Intent will continue to receive application-related correspondence throughout the application process. Eligible Applicants who have responded to the Letter of Intent will be issued a web login for on-line access to the final application, and instructions for use of the login for the QDP Certification Application.

The Applicant's Letter of Intent must identify the contact person for the application process, along with contact information that includes an email address and a telephone number. On receipt of the non-binding Letter of Intent, the Exchange will issue instructions and login and password information to gain access to the online portion(s) of the Application. A Letter of Intent will be considered confidential and not available to the public; the Exchange reserves the right to release aggregate information about all Applicants' responses. Final Applicant information is not expected to be released until selected Issuers and QDP proposals are announced. Applicant information will not be released to the public but may be shared with appropriate regulators as part of the cooperative arrangement between the Exchange and the regulators.

The Exchange will correspond with only one (1) contact person per Applicant. It is the Applicant's responsibility to immediately notify the Application Contact identified in this section, in writing, regarding any revision to the contact information. The Exchange is not responsible for application correspondence not received by the Applicant if the Applicant fails to notify the Exchange, in writing, of any changes pertaining to the designated contact person.

Application Contact: Jen Jacobs
Jen.Jacobs@covered.ca.gov
(916) 228-8273

## 1.7 Key Action Dates

| Action | Date/Time |
|---|---|
| Release of Draft Application for Comment | January 2018 |
| Letters of Intent due to the Exchange | February 16, 2018 |
| Application Opens | March 1, 2018 |
| Completed Applications Due (include 2018 Proposed Rates & Networks) | June 1, 2018 |
| Negotiations between Applicants and Covered California | July 2018 |
| Final QDP Contingent Certification Decisions | August 2018 |
| QDP Contract Execution | August 2018 |
| Final QDP Certification | September 2018 |

## 1.8 Preparation of Application Response

Application responses are completed in an electronic proposal software program. Eligible applicants who complete the non-binding Letter of Intent will be provided login and password information to access this portal. Applicants will have access to a Question and Answer function within the portal and may submit questions related to the application through this mechanism.

Applicants must respond to each application question as directed by the response type. Responses should be succinct and address all components of the applicable question. Applicants may not submit documents in place of responding to individual questions in the space provided.

# 2 Administration and Attestation

*2.1 and 2.4 required for currently contracted QDP Issuers. All questions required for new entrant Applicants*

2.1 Attestation

The Exchange intends to make this application available electronically. Applicant must complete the following:

| | |
|---|---|
| Issuer Legal Name | *10 words.* |
| NAIC Company Code | *10 words.* |
| NAIC Group Code | *10 words.* |
| Regulator(s) | *10 words.* |
| Federal Employer ID | *10 words.* |
| HIOS/Issuer ID | *10 words.* |
| Corporate Office Address | *10 words.* |
| City | *10 words.* |
| State | *10 words.* |
| Zip Code | *10 words.* |
| Primary Contact Name | *10 words.* |
| Contact Title | *10 words.* |
| Contact Phone Number | *10 words.* |

| | |
|---|---|
| | |
| Contact Email | *10 words.* |
| Applicant Eligibility | *Single, Pull-down list.*<br>1: Contracted in 2017,<br>2: Newly licensed since May 2 |
| On behalf of the Applicant stated above, I hereby attest that I meet the requirements in this Application and certify that the information provided on this Application and in any attachments hereto are true, complete, and accurate. I understand that the Exchange may review the validity of my attestations and the information provided in response to this application and if any Applicant is selected to offer Qualified Dental Plans, may decertify those Qualified Dental Plans should any material information provided be found to be inaccurate. I confirm that I have the capacity to bind the issuer stated above to the terms of this Application. | |
| Date | *10 words.* |
| Signature | *10 words.* |
| Printed Name | *10 words.* |
| Title | *10 words.* |

2.2 Provide entity name used in consumer-facing materials or communications.
*50 words.*

2.3 Applicant must include an organizational chart of key personnel who will be assigned to the Exchange, identifying the individual(s) who will have primary responsibility for servicing the Exchange account. The Key Personnel and representatives of the Account Management Team who will be assigned to the Exchange must be identified in the following areas:

- Executive
- Finance
- Operations

- Contracts
- Plan and Benefit Design
- Network and Quality
- Enrollment and Eligibility
- Legal
- Marketing and Communications
- Information Technology
- Information Security
- Policy

*Single, Pull-down list.*
1: Attached,
2: Not attached

2.4 Does Applicant anticipate making material changes in corporate structure in the next 24 months, including:

- Mergers
- Acquisitions
- New venture capital
- Management team
- Location of corporate headquarters or tax domicile
- Stock issue
- Other

If yes, Applicant must describe the material changes.

*Single, Radio group.*
1: Yes, describe [200 words],
2: No

2.5 Indicate Applicant entity's tax status:

*Single, Pull-down list.*
1: Not-for-profit,
2: For-profit

2.6 In what year was Applicant's entity founded?

*50 words.*

2.7 Indicate any experience Applicant has participating in exchanges or marketplace environments

| | |
|---|---|
| State-based Marketplace(s), specify state(s) and years of participation | *100 words.* |
| Federally-Facilitated Marketplace, specify state(s) and years of participation | *100 words.* |
| Private Exchange(s), specify exchange(s) and years of participation | *100 words.* |

| | |
|---|---|
| | |

# 3 Licensed and Good Standing

*All questions required for new entrant Applicants only.*

## 3.1 Indicate Applicant entity license status below:

*Single, Radio group.*
1: Applicant currently holds all of the proper and required licenses from the California Department of Managed Health Care to operate as a dental issuer as defined herein in the commercial individual market,
2: Applicant currently holds all of the proper and required licenses from the California Department of Insurance to operate as a dental issuer as defined herein in the commercial individual market,
3: Applicant is currently applying for licensure from the California Department of Managed Health Care to operate as a dental issuer as defined herein in the commercial individual market. If Yes, enter date application was filed: [To the day],
4: Applicant is currently applying for licensure from the California Department of Insurance to operate as a dental issuer as defined herein in the commercial individual market. If yes, enter date application was filed: [To the day]

## 3.2 In addition to holding or pursuing all of the proper and required licenses to operate as a dental issuer as defined herein, Applicant must confirm that it has had no material fines, no material penalties levied or material ongoing disputes with applicable licensing authorities in the last two years (See Appendix A Definition of Good Standing). The Exchange, in its sole discretion and in consultation with the appropriate dental insurance regulator, determines what constitutes a material violation for the purpose of determining Good Standing. Applicant must check the appropriate box. If Applicant does not confirm, the application will be disqualified from consideration.

*Single, Pull-down list.*
1: Confirmed,
2: Not confirmed

## 3.3 If not currently holding a license to operate in California, confirm business entity has had no material fines, no material penalties levied, or material ongoing disputes with applicable licensing authorities in the last two years.

*Single, Pull-down list.*
1: Confirmed,
2: Not confirmed,
3: Not applicable

# 4 Applicant Health Plan Proposal

*4.3 – 4.5 required for currently contracted QDP Issuers. All questions required for new entrant Applicants.*

Applicant must submit a dental plan proposal in accordance with submission requirements outlined in this section. Applicant may submit proposals to offer both a Children's Dental Plan and a Family Dental Plan. Applicant's proposal will be required to include at least one of the standard plan designs.

In addition to being guided by its mission and values, the Exchange's policies are derived from the Federal Affordable Care Act which calls upon the Exchanges to advance "plan or coverage benefits and health care provider reimbursement structures" that improve health outcomes. The Exchange seeks to improve the quality of care while moderating cost not only for the individuals enrolled in its plans, but also by being a catalyst for delivery system reform in partnership with plans, providers and consumers. With the Affordable Care Act and the range of insurance market reforms that have been implemented, the health insurance marketplace will be transformed from one that has focused on risk selection to achieve profitability to one that will reward better care, affordability and prevention.

Tiered networks are not permitted. Applicants must agree to adhere to the Exchange's standard benefit plan designs without deviation unless approved by the Exchange.

Plan or Policy Submission Requirements

Applicant may submit DPPO and DHMO product proposals in its proposed rating regions. Applicant's proposal must include coverage of its entire licensed geographic service area for which it has adequate network.

4.1 Applicant must certify its proposal includes a dental product including the pediatric dental Essential Health Benefit meeting an actuarial value of 85% for each individual plan it proposes to offer in a rating region. If not, the Applicant's response will be disqualified from consideration.

*Single, Pull-down list.*
1: Yes, proposal meets requirements,
2: No

4.2 Applicant must confirm it will adhere to Exchange naming conventions for on-Exchange plans and off-Exchange mirror products pursuant to Government Code 100503(f).

*Single, Pull-down list.*
1: Confirmed,
2: Not confirmed

4.3 Preliminary Premium Proposals: Final negotiated and accepted premium proposals shall be in effect for coverage effective January 1, 2019. Premium proposals are considered preliminary and may be subject to negotiation as part of QDP certification and selection. Premium proposals are due with submission of Applicant's application response. To submit

premium proposals for Individual products, QDP applicants must complete and upload through System for Electronic Rate and Form Filing (SERFF) the Rates Template available at [link to 2019 Rates Table Template]. Premium may vary only by geography (rating region), by age, and by actuarial value.

Dental plan premiums for adults 21 and over will be additive, and calculated on a per member basis. Individuals ages 19 and 20 will be assessed on the one year age band rate for individuals age 15 through 20, and will for purposes of summing total family premium be taken into account as children when limiting the total family premium to no more than the three oldest covered children premiums together with covered adult premiums.

Applicant shall provide, in connection with any negotiation process as reasonably requested by the Exchange, detailed documentation on the Exchange-specific rate development methodology. Applicant shall provide justification, documentation, and support used to determine rate changes, including adequately supported cost projections. Cost projections include factors impacting rate changes, assumptions, transactions and other information that affects the Exchange-specific rate development process. This information may be necessary to support the assumptions made in forecasting and may be supported by information from the Applicant's actuarial systems pertaining to the Exchange-specific account.

*Single, Pull-down list.*
1: Template Uploaded,
2: Template not Uploaded

4.4 Applicant must certify that for each rating region in which it submits a health plan proposal, it is submitting a proposal that covers the entire geographic service area for which it is licensed within that rating region. To indicate which zip codes are within the licensed geographic service area by proposed Exchange product, complete and upload through SERFF the Service Area Template located at [link to 2019 Service Area Template]. *Single, Pull-down list.*
1: Yes, dental plan proposal covers entire licensed geographic service area; template uploaded,
2: No, dental plan proposal does not cover entire licensed geographic service area; template uploaded

4.5 Applicants must indicate if requesting changes to licensed geographic service area with applicable regulator, and if so, submit a copy of the applicable exhibit filed with regulator.

*Single, Pull-down list.*
1: Yes, filing service area expansion, exhibit attached,
2: Yes, filing service area withdrawal, exhibit attached,
3: No, no changes to service area

# 5 Benefit Design

*All questions required for currently contracted QDP Issuers and new entrant Applicants.*

5.1 Applicant must certify its proposed dental products include the pediatric dental Essential Health Benefit meeting an actuarial value of 85% for each individual plan it proposes to offer in a rating region. If not, Applicant's response will be disqualified from consideration.

*Single, Pull-down list.*
1: Yes,
2: No

5.2. If applicable, Applicant must certify its proposed dental products include coverage of Diagnostic, Preventive, Restorative, Periodontics, Endodontics, Prosthodontics and Oral Surgery services for adults age 19 years and older comparable to those benefits found in Applicant's commercially available dental plan products for each individual plan it proposes to offer in a rating region. If not, Applicant's response will be disqualified from consideration.

*Single, Pull-down list.*
1: Yes,
2: No

5.3 Applicant must comply with 2019 Patient-Centered Benefit Plans Designs. Applicant must complete and upload through System for Electronic Rate and Form Filing (SERFF) the Plans and Benefits template located at [link to 2019 Plans and Benefits Template].

*Single, Pull-down list.*
1: Confirmed, template submitted,
2: Not confirmed, template not submitted

5.4 Applicant must submit, as an attachment, draft Evidence of Coverage or Policy language and draft Schedules of Benefits describing proposed 2019 QDP benefits. If the Applicant is applying for recertification, submit a redline version of the EOC and Schedules of Benefits that indicates changes from the previous plan year. This draft language must be submitted with the response to this application, prior to or contemporaneous to filing with the applicable regulator.

*Single, Pull-down list.*
1: Attached,
2: Not attached

5.5 Applicant must indicate how it provides plan enrollees with current information regarding annual out-of-pocket costs and to date. Select all that apply.

*Multi, Checkboxes.*
1: Status of out-of-pocket costs provided through member login to the dental plan website,
2: Status of out-of-pocket costs provided by mailed document upon request,
3: Status of out-of-pocket costs available upon member request to customer service,
4: Other, describe: [20 words],
5: Status of out-of-pocket costs not provided

5.6 Applicant must indicate how it provides plan enrollees with current information regarding total oral health care services received to date. Select all that apply.

*Multi, Checkboxes.*
1: Status of oral health services received to date provided through member login to the dental plan website,
2: Status of oral health services received to date provided by mailed document upon request,
3: Status of oral health services received to date available upon member request to customer service,
4: Other, describe: [20 words],
5: Status of oral health services received to date not provided

## 5.7 If applicable, Applicant must indicate how it provides plan enrollees with current information regarding annual status of deductible and status of benefit limit. Select all that apply.

*Multi, Checkboxes.*
1: Status of deductible and benefit limit provided through member login to the dental plan website,
2: Status of deductible and benefit limit provided by mailed document upon request,
3: Status of deductible and benefit limit available upon member request to customer service,
4: Other, describe: [20 words],
5: Status of deductible and benefit limit not provided,
6: Not Applicable

## 5.8 Applicant must indicate if proposed QDPs will include coverage of non-emergent out-of-network services.

*Single, Radio group.*
1: Yes, proposed QDPs will include coverage of non-emergent out-of-network services. If yes, with respect to non-network, non-emergency claims, describe the administration of out-of-network benefits including consumer communications, pricing methodology, and claims adjudication: [50 words],
2: No, proposed QDPs will not include coverage of non-emergent out-of-network services.

# 6 Operational Capacity

## 6.1 Issuer Operations and Account Management Support

*6.1.1 - 6.1.2 required for currently contracted QDP Issuers. All questions required for new entrant Applicants.*

6.1.1 Complete Attachments C1 Current and Projected Enrollment and C2 California Off-Exchange Enrollment to provide current enrollment and enrollment projections.

*Single, Pull-down list.*
1: Attachments completed,
2: Attachments not completed

6.1.2 Provide a description of any initiatives, including a timeline, either current or planned, over the next 24 months which may impact the delivery of services to Exchange members during the contract period. Examples include:

- System changes or migrations
- Call center opening, closing or relocation
- Network re-contracting
- Other

*100 words.*

6.1.3 Does Applicant routinely subcontract any significant portion of its operations or partner with other companies to provide dental plan coverage? If yes, identify which operations are performed by subcontractor or partner and provide the name of the subcontractor.

| | Response | Description |
|---|---|---|
| Billing, invoice, and collection activities | *Single, Pull-down list.*<br>1: Yes,<br>2: No | *50 words.* |
| Database and/or enrollment transactions | *Single, Pull-down list.*<br>1: Yes,<br>2: No | *50 words.* |
| Claims processing and invoicing | *Single, Pull-down list.*<br>1: Yes,<br>2: No | *50 words.* |
| Membership/customer service | *Single, Pull-down list.*<br>1: Yes,<br>2: No | *50 words.* |
| Welcome package (ID cards, member communications, etc.) | *Single, Pull-down list.*<br>1: Yes,<br>2: No | *50 words.* |

| | | |
|---|---|---|
| Other (specify) | *Single, Pull-down list.*<br>1: Yes,<br>2: No | *50 words.* |

6.1.4 Are any of Applicant's operations, such as member services call centers, conducted outside of the United States? If yes, describe the operations.

*Single, Radio group.*
1: Yes, describe [50 words],
2: No

6.1.5 Provide a summary of Applicant's capabilities, including how long Applicant has been in the business as an issuer.

*100 words.*

## 6.2 Implementation Performance

*All questions required for new entrant Applicants only.*

6.2.1 Please include a detailed implementation plan including proposed organizational chart with Key Staff biographies responsible for overall implementation activities.

*Single, Pull-down list.*

Attachment Required
1: Attached,
2: Not attached

6.2.2 Applicant must submit a Renewal and Open Enrollment Readiness Plan.

*Single, Pull-down list.*
1: Attached,
2: Not attached

6.2.3 Applicant must describe current or planned procedures for managing new enrollees. Please address continuity of care, availability of customer service line prior to coverage effective date, and describe what member communications regarding change in plans are provided to new enrollees.

*100 words.*

6.2.4 Identify the percentage increase of membership that will require adjustment to Applicant's current resources:

| Resource | Membership Increase (as % of Current Membership) | Resource Adjustment (specify) | Approach to Monitoring |
|---|---|---|---|
| Members Services | *Percent.* | *50 words.* | *50 words.* |

| | | | |
|---|---|---|---|
| Claims | *Percent.* | *50 words.* | *50 words.* |
| Account Management | *Percent.* | *50 words.* | *50 words.* |
| Clinical staff | *Percent.* | *50 words.* | *50 words.* |
| Disease Management staff | *Percent.* | *50 words.* | *50 words.* |
| Implementation | *Percent.* | *50 words.* | *50 words.* |
| Financial | *Percent.* | *50 words.* | *50 words.* |
| Administrative | *Percent.* | *50 words.* | *50 words.* |
| Actuarial | *Percent.* | *50 words.* | *50 words.* |
| Information Technology | *Percent.* | *50 words.* | *50 words.* |
| Other (List) | *Percent.* | *50 words.* | *50 words.* |

# 7 Customer Service

*All questions required for new entrant Applicants only.*

7.1 Applicant must confirm it will respond to and adhere to the requirements of California Health and Safety Code Section 1368 relating to consumer grievance procedures.

*Single, Pull-down list.*
1: Confirmed,
2: Not confirmed

7.2 If certified, Applicant will be required to meet contractual member services performance standards. During Open Enrollment, Exchange operating hours are 8 am to 8 pm Monday through Friday (except holidays) and 8 a.m. to 6 p.m. Saturdays. Applicant must confirm it will match Exchange Open Enrollment Customer Service operating hours. Describe how Applicant will modify and monitor your customer service center operations to meet Exchange-required operating hours if applicable.

*Single, Radio group.*
1: Confirmed, explain: [100 words],
2: Not confirmed

7.3 Applicant must list internal daily monitored Service Center Statistics. What is the daily service level goal? For example, 80% of calls answered within 30 seconds.

*50 words.*

7.4 Applicant must provide the ratio of Customer Service Representatives to members for teams that support Exchange business.

*10 words.*

7.5 Indicate which of the following training modalities are used to train new Customer Service Representatives, check all that apply:

*Multi, Checkboxes.*
1: Instructor-Led Training Sessions,
2: Virtual Instructor-Led Training Sessions (live instructor in a virtual environment),
3: Video Training,
4: Web-Based training (not Instructor-Led),
5: Self-led Review of Training Resources,
6: Other, describe: [50 words]

7.6 Indicate which training tools and resources are used during Customer Service Representative training, check all that apply:

*Multi, Checkboxes.*
1: Case-Study,
2: Roleplaying,
3: Shadowing,
4: Observation,
5: Pre-tests,
6: Post-tests,
7: Training Evaluations,
8: Other, describe: [50 words]

7.7 What is the length of the entire training period for new Customer Service Representatives? Include total time from point of hire to completion of training and release to work independently.

*50 words.*

7.8 How frequently are refresher trainings provided to all Customer Service Representatives? Include trainings focused on skills improvement as well as training resulting from changes to policy and procedures.

*50 words.*

7.9 Applicant must indicate languages spoken by Customer Service Representatives, and the number of bilingual Representatives who speak each language. Do not include languages supported only by a language line.

*Multi, Checkboxes.*
1: Arabic: [Integer],
2: Armenian: [Integer],
3: Cantonese: [Integer],
4: English: [Integer],

5: Hmong: [Integer],
6: Korean: [Integer],
7: Mandarin: [Integer],
8: Farsi: [Integer],
9: Russian: [Integer],
10: Spanish: [Integer],
11: Tagalog: [Integer],
12: Vietnamese: [Integer],
13: Lao: [Integer],
14: Cambodian: [Integer],
15: Other, specify: [50 words]

### 7.10 Does Applicant use language line to support consumers that speak languages other than those spoken by Customer Service Representatives?

*Single, Radio group.*
1: Yes, specify vendor: [20 words],
2: No

### 7.11 Applicant must describe any modifications to equipment, technology, consumer self-service tools, staffing ratios, training content and procedures, quality assurance program (or any other items that may impact the customer experience) that may be necessary to provide quality service to Exchange consumers.

*100 words.*

### 7.12 Applicant must indicate what information and tools are utilized to monitor consumer experience, check all that apply:

*Multi, Checkboxes.*
1: Customer Satisfaction Surveys,
2: Monitoring Social Media,
3: Monitoring Call Drivers,
4: Common Problems Tracking,
5: Observation of Representative Calls,
6: Other, describe: [50 words]

### 7.13 List all Customer Service Representative Quality Assurance metrics used for scoring of monitored call.

*50 words.*

### 7.14 How many calls per Representative, per week are scored?

*20 words.*

# 8 Financial Requirements

*All questions required for new entrant Applicants only.*

8.1 Describe systems to invoice members and record the collection of payments. Description must include record retention schedule. If not currently in place, describe plans to implement such systems, including the use of vendors for any functions related to invoicing, if applicable, and an implementation workplan.

*200 words.*

8.2 Applicant must confirm it has in place systems to accept payment from members effective October 1, 2018 the following premium payment types:

*Multi, Checkboxes.*
1: Paper checks,
2: Cashier's checks,
3: Money orders,
4: Electronic Funds Transfer (EFT),
5: Credit cards and debit cards,
6: Web-based payment, which may include accepting online credit card payments, and all general purpose pre-paid debit cards and credit card payment

8.3 If such systems are not currently in place, describe plans to implement such systems, including the use of vendors for any functions related to premium payment, if applicable, and an implementation workplan. QDP issuer must be able to accept premium payment from members no later than October 1, 2018. Note: QDP issuer must accept credit cards for binder payments and is encouraged, but not required, to accept credit cards for payment of ongoing invoices.

*200 words.*

8.4 Describe how Applicant will comply with the federal requirement 45 CFR 156.1240(a)(2) to serve the unbanked, specifying the forms of payment available for this population for both binder and ongoing payments, and for both on-Exchange and off-Exchange lines of business. Applicant must describe any differences between payment process for the unbanked and usual payment processing procedures.

*200 words.*

8.5 Applicant must confirm it can provide detailed documentation, as defined by Covered California, including member level detail to substantiate each participation fee payment. This documentation is specified in Appendix B Issuer Participation Fee Billing Discrepancy Resolution and Appendix C, PMPM_Member_Level_Detail_Response SAMPLE.

*Single, Pull-down list.*
1: Yes, confirmed,
2: No, not confirmed

8.6 Applicant agrees not to impose any fees or charges on any members who request paper invoices for premiums due for any individual products sold by Applicant in California.

*Single, Pull-down list.*
1: Yes, confirmed,
2: No, not confirmed

# 9 Fraud, Waste and Abuse Detection

*9.4.8 and 9.4.17 required for currently contracted QDP Issuers. All questions required for new entrant Applicants.*

The Exchange is committed to working with contracted QDP issuers to establish efforts to minimize fraud, waste and abuse. The framework for managing fraud risks is detailed in Appendix O: U.S. Government Accountability Office circular GAO-15-593SP. The Exchange expects QDP issuers to adopt leading practices outlined in the framework to the extent applicable. Fraud prevention is centered on integrity and expected behaviors from employees and others. All issuer measures to detect, deter, and prevent fraud before it occurs are vital to all issuer and Exchange operations.

**Definitions:**

Fraud – Consists of an intentional misrepresentation, deceit, or concealment of a material fact known to the defendant with the intention on the part of the defendant of thereby depriving a person of property or legal rights or otherwise causing injury. (CA Civil Code §3294 (c)(3), CA Penal Code §§ 470-483.5). Prevention and early detection of fraudulent activities is crucial to ensuring affordable healthcare for all individuals. Examples of fraud include, but are not limited to, false applications to obtain payment, false information to obtain insurance, billing for services that were not rendered.

Waste - Intentional or unintentional, extravagant careless or needless expenditures, consumption, mismanagement, use, or squandering of resources, to the detriment or potential detriment of entities, but without an intent to deceive or misrepresent. Waste includes incurring unnecessary costs as a result of inefficient or ineffective practices, systems, decisions, or controls.

Abuse – Excessive, or improper use of something, or the use of something in a manner contrary to the natural or legal rules for its use; the intentional destruction, diversion, manipulation, misapplication, maltreatment, or misuse of resources; or extravagant or excessive use so as to abuse one's position or authority. Often, the terms fraud and abuse are used simultaneously with the primary distinction is the intent. Inappropriate practices that begin as abuse can quickly evolve into fraud. Abuse can occur in financial or non-financial settings. Examples of abuse include, but not limited to, excessive charges, improper billing practices, payment for services that do not meet recognized standards of care and payment for medically unnecessary services.

Audit – A formal process that includes an independent and objective examination of an organization's programs, operations, and records to evaluate and improve the effectiveness of its policies and procedures. The results, conclusions, and findings of an audit are formally communicated through an audit report delivered to management of the audited entity.

Review – A second inspection and verification of documents for accuracy, validity, and authorization for the purpose of compliance with procedural requirements.

## 9.1 Prevention

9.1.1 Describe the roles and responsibilities of those tasked with carrying out dedicated antifraud and fraud risk management activities throughout the organization. If there is a dedicated unit responsible for fraud risk management describe how this unit interacts with the rest of the organization to mitigate fraud, waste and abuse.
*200 words.*

9.1.2 Describe any specific fraud risk assessments conducted by the Applicant. Describe how the risks identified through the assessment are tracked and corrected.
*200 words.*

9.1.3 Describe specific anti-fraud strategies and the data analytical tools, methods, and sources used to gather information about fraud risks before fraud, waste and abuse occurs.
*200 words.*

9.1.4 Describe how Applicant safeguards against Social Security number and identity theft within its organization.
*200 words.*

9.1.5 Describe the policy set forth in provider contracts that addresses identity verification at the point of service (i.e., verifying identity prior to receiving services)
*200 words.*

9.1.6 What steps are taken after identification of Social Security and potential identity theft? Include services offered to impacted members.
*200 words.*

9.1.7 When applicant has discovered potential identity theft, provide what steps are taken to review utilization of services associated as a result of potential fraud and describe what actions are taken to prevent fraudulent services to be paid.
200 words.

## 9.2 Detection

Describe the following specific control activities to prevent and detect fraud.
9.2.1 What data-analytics activities (for example data matching, data mining) are routinely performed to identify unusual patterns of care? Distinguish between member and provider efforts and state the frequency of the data analytics activities.
*200 words.*

9.2.2 Describe Applicant's internal and external fraud-awareness program that informs and directs individuals to identify red-flags and potential member and provider fraudulent scams.
*200 words.*

9.2.3 Describe how staff, members and providers report suspicious and/or potential fraudulent activities. State the review process, who in the organization is notified and when the Exchange is notified.
*200 words.*

9.2.4 Describe all employee-integrity activities (For example: fraud awareness training, code of conduct, conflict of interest policy).
*200 words.*

9.2.5 Special Enrollment Period (SEP) membership. Describe specific activities the applicant does to prevent and detect potential violations of the SEP policy. For example, describe any data mining reports.
*200 words.*

9.2.6 Describe the plan to respond to identified instances of fraud and ensure the response is prompt and consistently applied. Confirm the policy to notify the Exchange. Describe and distinguish between member and provider activities.
*200 words.*

9.2.7 Describe the controls in place to evaluate that the Exchange enrollment and disenrollment actions (i.e., membership files) are accurately and promptly executed. Specifically address any queries to identify membership red flags.
*200 words.*

9.2.8 Describe Utilization Management (UM) activities or program efforts in place that validate appropriate medical services and treatments to ensure health care service provided for member care is efficient and cost effective.
*200 words.*

## 9.3 Response

9.3.1 Describe the evaluation method for determining whether fraud, waste and abuse has occurred.
*200 words.*

9.3.2 Describe the processes for fraud, waste and abuse investigation follow-up and corrective measures. Address how and when the results of monitoring, evaluation and adverse actions will be or are communicated to the Exchange.

*200 words.*

9.3.3 Describe how the results of investigations and adverse actions are used to enhance fraud prevention and detection.
*200 words.*

9.3.4 Describe Applicant's revenue recovery process to recoup erroneously paid claims from providers.
*200 words.*

9.3.5 Refer to definition of fraud in the introduction to this section. What was Applicant's recovery success rate and dollars recovered for fraudulent activities?

| | **Total Loss from Fraud** Covered California book of business, if applicable | **Total Loss from Fraud** Total Book of Business | **% of Loss Recovered** Covered California book of business, if applicable | **% of Loss Recovered** Total Book of Business | **Total Dollars Recovered** Covered California book of business, if applicable | **Total Dollars Recovered** Total Book of Business |
|---|---|---|---|---|---|---|
| Calendar Year 2014 | *Dollars.* | *Dollars.* | *Percent.* | *Percent.* | *Dollars.* | *Dollars.* |
| Calendar Year 2015 | *Dollars.* | *Dollars.* | *Percent.* | *Percent.* | *Dollars.* | *Dollars.* |
| Calendar Year 2016 | *Dollars.* | *Dollars.* | *Percent.* | *Percent.* | *Dollars.* | *Dollars.* |

9.3.6 If applicable, please explain any trends attributing to the total loss from fraud for Exchange business.
*200 words.*

9.3.7 Describe Applicant's procedures to report potential fraud to law enforcement and the Exchange.

*200 words.*

## 9.4 Audits and Reviews

9.4.1 Refer to definition of review in the introduction to this section. Indicate how frequently reviews are performed for each of the following areas:

| | Response | If other |
|---|---|---|
| Claims Administration Reviews | *Single, Pull-down list.*<br>1: Daily,<br>2: Weekly,<br>3: Monthly,<br>4: Quarterly,<br>5: Other: | *10 words.* |
| Customer Service Reviews | *Single, Pull-down list.*<br>1: Daily,<br>2: Weekly,<br>3: Monthly,<br>4: Quarterly,<br>5: Other: | *10 words.* |
| Eligibility and Enrollment Reviews | *Single, Pull-down list.*<br>1: Daily,<br>2: Weekly,<br>3: Monthly,<br>4: Quarterly,<br>5: Other: | *10 words.* |
| Utilization Management Reviews | *Single, Pull-down list.*<br>1: Daily,<br>2: Weekly,<br>3: Monthly,<br>4: Quarterly,<br>5: Other: | *10 words.* |
| Billing Reviews | *Single, Pull-down list.*<br>1: Daily,<br>2: Weekly,<br>3: Monthly,<br>4: Quarterly,<br>5: Other: | *10 words.* |

9.4.2 Refer to definition of audit in the introduction to this section. Indicate how frequently internal auditing is performed for the following areas:

| | Response | If other |
|---|---|---|
| Audits of Claims Administration and Oversight | *Single, Pull-down list.*<br>1: Quarterly,<br>2: Semi-annually,<br>3: Annually,<br>4: Biennially,<br>5: Other: | *10 words.* |

| | | |
|---|---|---|
| Audits of Network Providers | *Single, Pull-down list.*<br>1: Quarterly,<br>2: Semi-annually,<br>3: Annually,<br>4: Biennially,<br>5: Other: | *10 words.* |
| Audits of Eligibility and Enrollment Processes and Compliance with Requirements | *Single, Pull-down list.*<br>1: Quarterly,<br>2: Semi-annually,<br>3: Annually,<br>4: Biennially,<br>5: Other: | *10 words.* |
| Audits of Billing Processes | *Single, Pull-down list.*<br>1: Quarterly,<br>2: Semi-annually,<br>3: Annually,<br>4: Biennially,<br>5: Other: | *10 words.* |

9.4.3 Refer to definition of audit in the introduction to this section. For the prior fiscal year, what percent of claims were audited?
*Percent.*

9.4.4 Refer to definition of audit in the introduction to this section. Does Applicant maintain an independent, internal audit function? If yes, provide a brief description of Applicant's internal audit function and its reporting structure.

*Multi, Checkboxes.*
1: Yes, describe [200 words],
2: No.

9.4.5 If Applicant answered yes to 9.4.4, provide a copy of Applicant's internal audit function's annual audit plan applicable to claims administration, eligibility and enrollment, billing and network providers.

*Single, Pull-down list.*
1: Attached,
2: Not attached

9.4.6 Refer to definition of audit in the introduction to this section. What oversight authority is there over the internal audit function (for example: does the internal audit function report to a board, audit committee, or executive office)?

*100 words.*

9.4.7 Refer to definition of audit in the introduction to this section. What audit authority does Applicant have over network and non-network providers and contractors (for example: does the organization conduct audits of network and non-network providers and contractors)?

*200 words.*

9.4.8 Indicate if external audits were conducted for claims administration for Applicant's entire book of business for the last two (2) full calendar years.

| | Response |
|---|---|
| 2016 | *Single, Pull-down list.*<br>1: Audit Conducted,<br>2: Audit Not Conducted |
| 2015 | *Single, Pull-down list.*<br>1: Audit Conducted,<br>2: Audit Not Conducted |

9.4.9 Describe Applicant's approach to reviewing claims submitted by non-contracted providers, and steps taken when claims received exceed reasonable and customary threshold. Describe Applicant's approach to defining the expected threshold reasonable and customary amount for a procedure and geographic area for use when reviewing claims submitted by non-contracted providers, and steps taken when claims received exceed this threshold.

*200 words.*

9.4.10 Describe Applicant's approach to use of the National Practitioner Data Bank as part of the credentialing and re-credentialing process for contracted providers.

*200 words.*

9.4.11 Describe any additional steps the Applicant takes to verify a physician and facility is a legitimate place of business.

*200 words.*

9.4.12 Describe Applicant's controls in place to monitor referrals of enrollees to any health care facility or business entity in which the provider may have full or partial ownership or own shares. Attach a copy of the applicable conflict of interest statement.

*200 words.*

9.4.13 Indicate the types of claims and providers that Applicant typically reviews for possible fraudulent activity. Check all that apply.

*Multi, Checkboxes.*
1: General Practice Dentist,
2: Pediatric Dentist,
3: Endodontist,
4: Oral and Maxillofacial Surgeon,
5: Orthodontist,
6: Periodontist,
7: Prosthodontist,
8: Other service Providers

9.4.14 Describe the different approaches Applicant takes to monitor these types of providers. Provide an explanation why any provider types not indicated by Applicant in 9.4.12 are not typically reviewed for possible fraudulent activity.

*200 words.*

9.4.15 Describe in detail Applicant's policy to validate provider information during initial contracting.

*200 words.*

9.4.1.16 Describe the Applicant's policy to validate information when a provider reports a change (including demographic information, address, and network or panel status).

*200 words.*

9.4.17 Applicant must confirm that, if certified, it will agree to subject itself to the Exchange for audits and reviews, either by the Exchange or its designee, or the California Department of General Services, the California State Auditor or its designee, as they deem necessary to determine the correctness of premium rate setting, the Exchange's payments to agents based on the Issuer's report, questions pertaining to enrollee premium payments and participation fee payments Issuer made to the Exchange. Applicant also agrees to all audits subject to applicable State and Federal law regarding the confidentiality of and release of confidential Protected Health Information (PHI) of Enrollees.

*Single, Pull-down list.*
1: Yes, confirmed,
2: No, not confirmed

# 10 System for Electronic Rate and Form Filing (SERFF)

*All questions required for currently contracted QDP Issuers and new entrant Applicants.*

10.1 Applicant must be able to populate and submit SERFF templates in an accurate, appropriate, and timely fashion at Exchange request for:

- Rates,
- Service Area,
- Benefit Plan Designs,
- Network

*Single, Pull-down list.*
1: Yes, confirmed,
2: No, not confirmed

10.2 Applicant confirms that it will submit and upload corrections to SERFF within three (3) business days of notification by the Exchange, adjusted for any SERFF downtime. Applicant must adhere to amendment language specifications when any item is corrected in SERFF.

*Single, Pull-down list.*
1: Yes, confirmed,
2: No, not confirmed

10.3 Applicant may not make any changes to its SERFF templates once submitted to the Exchange without providing prior written notice to the Exchange - and only if the Exchange agrees in writing with the proposed changes.

*Single, Pull-down list.*
1: Yes, confirmed,
2: No, not confirmed

# 11 Electronic Data Interface

*11.1 - 11.2 required for currently contracted QDP Issuers. All questions required for new entrant Applicants.*

11.1 Applicant must provide an overview of its system, data model, vendors, anticipated changes in key personnel and interface partners.

*Single, Pull-down list.*
1: Attached,
2: Not attached

11.2 Applicant must submit a copy of its system lifecycle and release schedule.

*Single, Pull-down list.*
1: Attached,
2: Not attached

11.3 Applicant must be prepared and able to engage with the Exchange to develop data interfaces between the Issuer's systems and the Exchange's systems, including the eligibility and enrollment system used by the Exchange, as early as May 2017. Applicant must confirm it will implement system(s) in order to accept and generate 834, 999, TA1, and other standard format electronic files for enrollment and premium remittance in an accurate, consistent and timely fashion and utilize the information received and transmitted for its intended purpose.

- See Appendix L 834 Companion Guide v16.9.40 for detailed 834 transaction specifications.
- Note: The Exchange requires QDP Issuers to sign an industry-standard agreement which establishes electronic information exchange standards in order to participate in the required systems testing.

*Single, Pull-down list.*
1: Yes, confirmed,
2: No, not confirmed

11.4 Applicant must describe its ability and experience processing and resolving errors identified by a TA1 file or a 999 file as appropriate and in a timely fashion. Applicant must confirm that it has the capability to accept and complete non-electronic enrollment submissions and changes.

*Single, Radio group.*
1: Yes, confirmed, describe: [200 words],
2: No, not confirmed, describe: [200 words]

11.5 Applicant must communicate any testing or production changes to system configuration (URL, certification, bank information) to the Exchange in a timely fashion.

*Single, Pull-down list.*
1: Yes, confirmed,
2: No, not confirmed

11.6 Applicant must be prepared and able to conduct testing of data interfaces with the Exchange no later than June 1, 2017 and confirms it will plan and implement testing jointly

with Covered California in order to meet system release schedules. Applicant must confirm testing with the Exchange will be under industry security standard: firewall, certification, and fingerprint. Applicant must confirm it will make dedicated, qualified resources available to participate in the connectivity and testing effort.

*Single, Pull-down list.*
1: Yes, confirmed,
2: No, not confirmed

11.7 Applicant must describe its ability to produce financial, eligibility, and enrollment data on a monthly basis for the purpose of reconciliation. Standard file requirements and timelines are documented in Appendix D Reconciliation Process Guide. Applicant must provide description of its ability to make system updates to reconcilable enrollment fields on a timely basis and provide verification of completion.

*200 words.*

11.8 Does Applicant proactively monitor, measure, and maintain the application(s) and associated database(s) to maximize system response time and performance on a regular basis and can the Applicant's organization report status on a quarterly basis? Describe below.

*Single, Radio group.*
1: Yes, describe [100 words],
2: No

# 12 Healthcare Evidence Initiative

In order to fulfill its mission to ensure that consumers have available the plans that offer the optimal combination of choice, value, quality, and service, the Exchange relies on evidence about the enrollee experience with health care. QDP data submission requirements are an essential component of assessing the quality and value of the coverage and health care received by Exchange enrollees. The capabilities described in this section are requirements of QDP data submission obligations.

*12.1 required for currently contracted QDP Issuers. All questions required for new entrant Applicants.*

12.1 Applicant must describe any contractual agreements with participating providers that preclude Applicant's organization from making contract terms transparent to plan sponsors and members.

Applicant must confirm that, if contracted as a QDP issuer, to the extent that any Participating Provider's rates are prohibited from disclosure to the Exchange by contract, Applicant shall identify such Participating Provider. Applicant shall, upon renewal of its Provider contract, but in no event later than July 1, 2018, make commercially reasonable efforts to obtain agreement by that Participating Provider to amend such provisions, to allow disclosure. In entering into a new contract with a Participating Provider, Applicant agrees to make commercially reasonable efforts to exclude any contract provisions that would prohibit disclosure of such information to the Exchange (for example, enrollment, medical and Rx claims, and capitation data required by the Exchange's HEI Vendor: allowed amounts; charge and charge submitted amounts; coinsurance, copayment, and deductible amounts; paid and net payment amounts; patient total out-of-pocket amounts; capitation amounts; etc.).

- What specific steps is Applicant taking to change these contract provisions going forward to make this information accessible?
- List provider groups or facilities for which current contract terms preclude provision of information to plan sponsors.
- List provider groups or facilities for which current contract terms preclude provision of information to members.

*Single, Pull-down list.*
1: Confirmed, describe [500 words],
2: Not confirmed, describe [500 words]

12.2 Will Applicant provide the Exchange's Healthcare Evidence Initiative (HEI) Vendor with monthly extracts of all requested detail from applicable fee-for-service (FFS) claims or encounter records for the following claim types? If not, or if yes with deviation, explain. If unable or unwilling to provide all requested detail, elaborate on problematic claim types, estimating the number and percentage of affected claims and encounters.

| Claim Type | Response | If No or Yes with deviation, explain. |
|---|---|---|
| Professional | *Single, Pull-down list.*<br>1: Yes,<br>2: No | *50 words.* |

| | | |
|---|---|---|
| Institutional | *Single, Pull-down list.*<br>1: Yes,<br>2: No | *50 words.* |
| Pharmacy, if applicable | *Single, Pull-down list.*<br>1: Yes,<br>2: No | *50 words.* |
| Drug (non-Pharmacy), if applicable | *Single, Pull-down list.*<br>1: Yes,<br>2: No | *50 words.* |

12.3 The Exchange is interested in QDP issuer data that represents the cost of care. Can Applicant provide monthly extracts of complete financial detail for all applicable claims and encounters? If not, or if yes with deviation, explain. If unable or unwilling to provide all requested financial detail, elaborate on problematic data elements, estimating the number and percentage of affected claims and encounters.

| Financial Detail to be Provided | Response | If No or Yes with deviation, explain. |
|---|---|---|
| Submitted Charges | *Single, Pull-down list.*<br>1: Yes,<br>2: No | *50 words.* |
| Discount Amount | *Single, Pull-down list.*<br>1: Yes,<br>2: No | *50 words.* |
| Allowable Charges | *Single, Pull-down list.*<br>1: Yes,<br>2: No | *50 words.* |
| Copayment | *Single, Pull-down list.*<br>1: Yes,<br>2: No | *50 words.* |
| Coinsurance | *Single, Pull-down list.*<br>1: Yes,<br>2: No | *50 words.* |
| Deductibles | *Single, Pull-down list.*<br>1: Yes,<br>2: No | *50 words.* |
| Coordination of Benefits | *Single, Pull-down list.*<br>1: Yes,<br>2: No | *50 words.* |
| Plan Paid Amount (Net Payment) | *Single, Pull-down list.*<br>1: Yes,<br>2: No | *50 words.* |

| | | |
|---|---|---|
| Capitation Financials (per Provider / Facility)<br>***[1]*** *If a portion of Applicant provider payments are capitated. If capitation does not apply, check "No" and state "Not applicable, no provider payments are capitated" in the rightmost column.* | *Single, Pull-down list.*<br>1: Yes,<br>2: No | *50 words.* |

12.4 Can Applicant provide member and subscriber IDs assigned by the Exchange on all records submitted? In the absence of other Personally Identifiable Information (PII), these elements are critical for the HEI Vendor to generate unique encrypted member identifiers linking eligibility to claims and encounter data, enabling the HEI Vendor to follow the health care experience of each de-identified member, even if he or she moves from one plan to another. If not, or if yes with deviation, explain. If unable or unwilling to provide all requested detail, elaborate on problematic data elements, estimating the number and percentage of affected enrollments, claims, and encounters.

| Detail to be Provided | Response | If No or Yes with deviation, explain. |
|---|---|---|
| Covered CA Member ID | *Single, Pull-down list.*<br>1: Yes,<br>2: No | *50 words.* |
| Covered CA Subscriber ID | *Single, Pull-down list.*<br>1: Yes,<br>2: No | *50 words.* |

12.5 Can Applicant supply Protected Health Information (PHI) dates, such as starting date of service, in full year / month / day format to the HEI Vendor for data aggregation? If not, or if yes with deviation, explain. If unable or unwilling to provide all requested detail, elaborate on problematic PHI dates, estimating the number and percentage of affected enrollments, claims, and encounters.

| PHI Dates to be Provided in Full Year / Month / Day Format | Response | If No or Yes with deviation, explain. |
|---|---|---|
| Member Date of Birth | *Single, Pull-down list.*<br>1: Yes,<br>2: No | *50 words.* |
| Starting Date of Service | *Single, Pull-down list.*<br>1: Yes,<br>2: No | *50 words.* |
| Ending Date of Service | *Single, Pull-down list.*<br>1: Yes,<br>2: No | *50 words.* |

12.6 Can Applicant supply all applicable Provider Tax ID Numbers (TINs) and National Provider Identifiers (NPIs) for individual providers? If not, or if yes with deviation, explain. If unable or unwilling to provide all requested detail, elaborate on problematic Provider IDs, estimating the number and percentage of affected providers, claims, and encounters.

| Provider IDs to be Supplied | Response | If No or Yes with deviation, explain. |
|---|---|---|
| TIN | *Single, Pull-down list.*<br>1: Yes,<br>2: Yes, unless values represent individual provider Social Security Numbers,<br>3: No | *50 words.* |
| NPI | *Single, Pull-down list.*<br>1: Yes,<br>2: Yes, unless values represent individual provider Social Security Numbers,<br>3: No | *50 words.* |

12.7 Can Applicant provide detailed coding for procedures, etc. on all claims for all data sources? If not, or if yes with deviation, explain. If unable or unwilling to provide all requested coding detail, elaborate on problematic coding, estimating the number and percentage of affected claims and encounters.

| Coding to be Provided | Response | If No or Yes with deviation, explain. |
|---|---|---|
| Procedure Coding (CDT, HCPCS) | *Single, Pull-down list.*<br>1: Yes,<br>2: No | *50 words.* |
| Revenue Codes (Facility Only) | *Single, Pull-down list.*<br>1: Yes,<br>2: No | *50 words.* |
| Place of Service | *Single, Pull-down list.*<br>1: Yes,<br>2: No | *50 words.* |

12.8 Can Applicant submit all data directly to the HEI Vendor or is a third party required to submit the data on Applicant's behalf?

*Single, Radio group.*
1: Yes, describe [50 words],
2: No

12.9 If data must be submitted by a third party, can Applicant guarantee that the same information above will also be submitted by the third party?

*Single, Radio group.*
1: Yes, describe: [50 words],
2: No,
3: Not Applicable

# 13 Privacy and Security Requirements for Personally Identifiable Data

*All questions required for new entrant Applicants only.*

## 13.1 HIPAA Privacy Rule

Applicant must confirm that it complies with the following privacy-related requirements set forth within Subpart E of the Health Insurance Portability and Accountability Act [45 CFR §164.500 et. seq.]:

13.1.1 Individual access: Unless otherwise exempted by the HIPAA Privacy Rule, Applicant must confirm that it provides consumers with the opportunity to access, inspect and obtain a copy of any PHI contained within their Designated Record Set [45 CFR §§164.501, 524].

*Single, Pull-down list.*
1: Yes, confirmed,
2: No, not confirmed

13.1.2 Amendment: Applicant must confirm that it provides consumers with the right to amend inaccurate or incomplete PHI contained within their Designated Record Set [45 CFR §§164.501, 526].

*Single, Pull-down list.*
1: Yes, confirmed,
2: No, not confirmed

13.1.3 Restriction Requests: Applicant must confirm that it provides consumers with the opportunity to request restrictions upon Applicant's use or disclosure of their PHI [45 CFR §164.522(a)].

*Single, Pull-down list.*
1: Yes, confirmed,
2: No, not confirmed

13.1.4 Accounting of Disclosures: Unless otherwise exempted by the HIPAA Privacy Rule, Applicant must confirm that it provides consumers with an accounting of any disclosures made by Applicant of the consumer's PHI upon the consumer's request [45 CFR §164.528].

*Single, Pull-down list.*
1: Yes, confirmed,
2: No, not confirmed

13.1.5 Confidential Communication Requests: Applicant must confirm that Applicant permits consumers to request an alternative means or location for receiving their PHI than what Applicant would typically employ [45 CFR §164.522(b)].

*Single, Pull-down list.*
1: Yes, confirmed,
2: No, not confirmed

13.1.6 Minimum Necessary Disclosure & Use: Unless otherwise exempted by the HIPAA Privacy Rule, Applicant must confirm that Applicant discloses or uses only the minimum

necessary PHI needed to accomplish the purpose for which the disclosure or use is being made [45 CFR §§164.502(b) & 514(d)].

*Single, Pull-down list.*
1: Yes, confirmed,
2: No, not confirmed

13.1.7 Openness and Transparency: Unless otherwise exempted by the HIPAA Privacy Rule, Applicant must confirm that Applicant currently maintains a HIPAA-compliant Notice of Privacy Practices to ensure that consumers are aware of their privacy-related rights and Applicant's privacy-related obligations related to the consumer's PHI [45 CFR §§164.520(a)&(b)].

*Single, Pull-down list.*
1: Yes, confirmed,
2: No, not confirmed

## 13.2 Safeguards

*All questions required for new entrant Applicants only.*

13.2.1 Applicant must confirm that it has policy, standards, processes, and procedures in place and that its information system is configured with administrative, physical and technical security controls that meet or exceed those standards in the National Institute of Standards and Technology, Special Publication (NIST) 800-53 that appropriately protect the confidentiality, integrity, and availability of the Protected Health Information (PHI) and Personally Identifiable Information (PII) that it creates, receives, maintains, or transmits.

*Single, Pull-down list.*
1: Yes, confirmed,
2: No, not confirmed

13.2.2 Applicant must confirm that all Protected Health Information (PHI) and Personally Identifiable Information (PII) is encrypted – both at rest and in transit – employing the validated Federal Information Processing Standards (FIPS) Publication 140-2 Cryptographic Modules.

*Single, Pull-down list.*
1: Yes, confirmed,
2: No, not confirmed

13.2.3 Applicant must confirm that it operates in compliance with applicable federal and state security and privacy laws and regulations, and has an incident response policy, process, and procedures in place and can verify that the process is tested at least annually.

*Single, Pull-down list.*
1: Yes, confirmed,
2: No, not confirmed

13.2.4 Applicant must confirm that there is a contingency plan in place that addresses system restoration without deterioration of the security measures originally planned and implemented, and that the plan is tested at least annually.

*Single, Pull-down list.*
1: Yes, confirmed,
2: No, not confirmed

13.2.5 Applicant must confirm that when disposal of PHI, PII or the decommissioning of media occurs they adhere to the guidelines for media sanitization as described in the NIST Special Publication 800-88.

*Single, Pull-down list.*
1: Yes, confirmed,
2: No, not confirmed

# 14 Sales Channels

*All questions required for new entrant Applicants only.*

14.1 Does Applicant have experience working with Insurance Agents?

*Single, Radio group.*
1: Yes. If yes, 14.2 through 14.4 required,
2: No. If no, 14.4 and 14.5 required

14.2 Review Appendix E Covered California Delegation Policy. Describe Applicant's delegation or Agent of Record (AOR) policy and procedures. The policy and procedures must include the following components:

- Appointing Agents, including requirements a broker must meet to be appointed, appointment process, and timeline for appointment to be complete.
- Agent of Record (AOR) changes, including incoming broker commission schedule. Include requirements for an AOR change to be processed, how applicable commissions are determined for the Agent taking over the case, rules regarding when the AOR change is effective, policy - if any - on retroactive AOR changes, and AOR processing timelines. Additionally, describe procedures used to manage changes when the AOR files are received on an 834 or other electronic file.
- Vested Agents, including definition of vesting, to whom vesting applies, duration of vesting, how vesting is affected by AOR changes, vesting rules when a case leaves and then returns for coverage.

*500 words.*

14.3 Applicant must provide its commission schedule for individual business in California. Note: successful Applicants will be required to use a standardized Agent compensation program with levels and terms that result in the same aggregate compensation amounts to Agents, whether products are sold within or outside of the Exchange. Successful Applicants may not vary Agent compensation levels by metal tier, and must pay the same commission during Open and Special Enrollment for each plan year.

| **Individual Market - Commission Rate** | **On-Exchange Business** | **Direct Business** |
|---|---|---|
| Provide Commission Rate or Schedule | *10 words.* | *10 words.* |
| Does the compensation level change as the business written by the agent matures?<br>(i.e., Downgraded) | *50 words.* | *50 words.* |
| Specify if the agent is compensated at a different level as he or she attains certain levels or amounts of enforce business. | *50 words.* | *50 words.* |

| | | |
|---|---|---|
| Does the compensation level apply to all plans or does it vary by plan? | *Not Applicable* | *50 words.* |
| Does the compensation level vary by product? | *50 words.* | *50 words.* |
| Describe any business for which Applicant will not compensate Agents. | *50 words.* | *50 words.* |
| Describe any business for which Applicant will not make changes to Agent of Record. | *Not applicable* | *50 words.* |
| Additional Comments | *50 words.* | *50 words.* |

14.4 Applicant must provide a copy of the sales team organizational chart. If applicable, Applicant must identify primary point of contact for broker or agent services and include the following contact information:

- Name
- Phone Number
- Email Address

*50 words.*

14.5 The Exchange recommends that Applicants develop relationships with the agent community. It has been shown that Applicants with relationships to the agent community achieve greater success in the Exchange. If Applicant does not currently work with Insurance Agents, describe Applicant's approach to develop an agent program. Include plan to develop agent appointment process. Plan should include the following components:

- Appointing Agents, including requirements a broker must meet to be appointed, appointment process, and timeline for appointment to be complete.
- Agent of Record (AOR) changes, including requirements for an AOR change to be processed, how applicable commissions are determined for the Agent taking over the case, rules regarding when the AOR change is effective, policy - if any - on retroactive AOR changes, and AOR processing timelines. Additionally, please describe procedures used to manage changes when the Agent of Record files are received on an 834 or other electronic file.
- Vested Agents, including definition of vesting, who vesting applies to, duration of vesting, how vesting is affected by AOR changes, vesting rules when a case leaves and then returns for coverage.
- Applicant must provide a primary point of contact for development of broker or agent program and include the following contact information:
    - Name
    - Phone Number
    - Email Address

# QDP Certification Application Plan Year 2018 Individual Marketplace

*500 words.*

# 15 Marketing and Outreach Activities

*15.4 and 15.5 required for currently contracted QDP Issuers. All questions required for new entrant Applicants.*

15.1 The Exchange expects all successful Applicants to promote enrollment in their certified QDPs, including investment of resources and coordination of staff with the Exchange's Marketing Department, which includes social media and member communications efforts. Applicant must provide an organizational chart of its marketing department(s), including names and titles of the main contacts with the following primary responsibility related to the Exchange account:

- Marketing (designate who will submit cobranded documents to the Exchange)
- Social Media Efforts
- Member Retention/Member Communication Efforts

*Single, Pull-down list.*
Attachment required
1: Attached,
2: Not attached

15.2 Applicant must confirm that, upon contingent certification of its QDPs, it will cooperate with the Exchange Marketing Department, and adhere to the Appendix G Covered California Brand Style Guide (and Marketing Guidelines, if applicable) when co-branded materials are issued to Exchange enrollees. If Applicant is certified, co-branded items must be submitted using the Member Communications Calendar prior to use and in a timely manner; ID cards are to be submitted to the Exchange at least 30 days prior to Open Enrollment. The Exchange retains the right to communicate directly with Exchange consumers and members.

*Single, Pull-down list.*
1: Confirmed,
2: Not confirmed

15.3 Applicant must confirm it will cooperate with Exchange Marketing, Public Relations, and Outreach efforts, which may include: internal and external trainings, press events, collateral materials, and other efforts. This cooperative obligation includes contractual requirements to submit materials and updates according to deadlines established in the QDP Issuer Model Contract.

*Single, Pull-down list.*
1: Confirmed,
2: Not confirmed

15.4 Applicant must complete and submit Attachment D1 Member Communication Calendar, including proposed Exchange member communications. Documents and materials may be draft placeholders. Upon contingent certification, when co-branded materials are issued to Exchange enrollees, the Member Communication Calendar and accompanying documents must be submitted to the Exchange prior to use and in a timely manner.

*Single, Pull-down list.*
1: Confirmed, attachment complete,
2: Attachment not completed

15.5 Applicant must submit the following documents for the Individual Market line of business:

(1) Proposed Marketing Plan

Proposed marketing plan must include the following components:

- Regions to be supported with marketing efforts,
- Proposed marketing investment,
- Enrollment goals,
- Strategy and tactics,
- Target audience parameters (age range, household income, ethnicity, gender, marital status),
- Timing,
- Proportion of marketing expenditure for on-Exchange QDPs in relation to off-Exchange plan marketing expenditure,

(2) Attachment D2 Media Plan Flowchart

(3)Attachment D3 Estimated Media Spend by Designated Market Area (DMA).

*Single, Pull-down list.*
1: Marketing Plan, Attachment D2 and Attachment D3 Attached,
2: Not attached

# 16 Provider Network

## 16.1 Network Offerings

*All questions required for currently contracted QDP Issuers and new entrant Applicants.*

16.1.1 Please indicate the different network products Applicant intends to offer on the Exchange in the individual market for coverage year 2018.

| | Offered | New or Existing Network? | Network Name(s) |
|---|---|---|---|
| HMO | *Single, Pull-down list.*<br>1: Yes,<br>2: No | *Single, Pull-down list.*<br>1: New Network,<br>2: New to Exchange,<br>3: Existing Exchange | *10 words.* |
| PPO | *Single, Pull-down list.*<br>1: Yes,<br>2: No | *Single, Pull-down list.*<br>1: New Network,<br>2: New to Exchange,<br>3: Existing Exchange | *10 words.* |

16.1.2 Provider network data must be included in this submission for all geographic locations to which Applicant is applying for certification as a QDP. Submit provider data according to the data file layout in Appendix I Covered California Provider Data Submission Guide. The provider network submission for 2019 must be consistent with what will be filed to the appropriate regulator for approval if Applicant is selected as a QDP Issuer. The Exchange requires the information, as requested, to allow cross-network comparisons and evaluations.

*Single, Pull-down list.*
1: Attached (confirming provider data is for plan year 2018),
2: Not attached

16.1.3 Applicant must also complete and upload through SERFF the Network ID Template located at [link to 2019 Network ID Template].

*Single, Pull-down list.*
1: Template Uploaded,
2: Template not Uploaded

# 16.2 HMO

## 16.2.1 Network Strategy

*All questions required for new entrant Applicants only.*

16.2.1.1 Does Applicant conduct provider negotiations and manage its own network or does Applicant lease a network from another organization?

*Single, Pull-down list.*
1: Applicant contracts and manages network,
2: Applicant leases network

16.2.1.2 If Applicant leases network, describe the terms of the lease agreement:

| | Response |
|---|---|
| Length of the lease agreement | *100 words.* |
| Start Date | *To the day.* |
| End Date | *To the day.* |
| Leasing Organization | *100 words.* |

16.2.1.3 If Applicant leases network, does Applicant have the ability to influence provider contract terms for (select all that apply):

*Multi, Checkboxes.*
1: Transparency,
2: Implementation of new programs and initiatives,
3: Acquire timely and up-to-date information on providers,
4: Ability to obtain data from providers,
5: Ability to conduct outreach and education to providers if need arises,
6: Ability to add new providers,
7: If no, please describe plans to ensure Applicant's ability to control network and meet Exchange requirements: [500 words]

16.2.1.4 By rating region covered, please provide the percentages of providers in capitated vs non- capitated arrangements:

| | Direct Contract | Capitated | Other (explain in comments) | Comments |
|---|---|---|---|---|
| Region 1 | *Percent.* | *Percent.* | *Percent.* | *100 words.* |
| Region 2 | *Percent.* | *Percent.* | *Percent.* | *100 words.* |
| Region 3 | *Percent.* | *Percent.* | *Percent.* | *100 words.* |
| Region 4 | *Percent.* | *Percent.* | *Percent.* | *100 words.* |
| Region 5 | *Percent.* | *Percent.* | *Percent.* | *100 words.* |

| | | | | |
|---|---|---|---|---|
| Region 6 | *Percent.* | *Percent.* | *Percent.* | *100 words.* |
| Region 7 | *Percent.* | *Percent.* | *Percent.* | *100 words.* |
| Region 8 | *Percent.* | *Percent.* | *Percent.* | *100 words.* |
| Region 9 | *Percent.* | *Percent.* | *Percent.* | *100 words.* |
| Region 10 | *Percent.* | *Percent.* | *Percent.* | *100 words.* |
| Region 11 | *Percent.* | *Percent.* | *Percent.* | *100 words.* |
| Region 12 | *Percent.* | *Percent.* | *Percent.* | *100 words.* |
| Region 13 | *Percent.* | *Percent.* | *Percent.* | *100 words.* |
| Region 14 | *Percent.* | *Percent.* | *Percent.* | *100 words.* |
| Region 15 | *Percent.* | *Percent.* | *Percent.* | *100 words.* |
| Region 16 | *Percent.* | *Percent.* | *Percent.* | *100 words.* |
| Region 17 | *Percent.* | *Percent.* | *Percent.* | *100 words.* |
| Region 18 | *Percent.* | *Percent.* | *Percent.* | *100 words.* |
| Region 19 | *Percent.* | *Percent.* | *Percent.* | *100 words.* |

16.2.1.5 Describe in detail how Applicant ensures access to care for all enrollees. This should include:

- If Applicant assesses geographic access to primary and specialist care based on enrollee residence, describe tools and brief methodology

- If Applicant tracks ethnic and racial diversity in the population and ensure access to appropriate culturally competent providers, describe tools and brief methodology

*(200 words)*

16.2.1.6 Many California residents live in counties bordering other states where the out of state services are closer than in-state services. Does Applicant offer coverage in a county or region bordering another state?

*Single, Radio group.*
1: Yes. If yes, does Applicant allow out of state (non-emergency) providers to participate in networks to serve Exchange enrollees?,
2: No

16.2.1.7 If Applicant answered yes to 16.2.1.6, explain in detail how this coverage is offered.
*500 words.*

## 16.2.2 Network Quality

*All questions required for all networks.*

16.2.2.1 Does Applicant currently use patient safety as a criterion for provider selection for Exchange networks? If yes, describe in detail, including the assessment process, the source of the patient safety assessment data, specific measures and metrics, thresholds for inclusion and exclusion.

*Single, Radio group.*
1: Yes, please explain: [100 words],
2: No

16.2.2.2 Does Applicant currently use cost efficiency as a criterion for provider selection for Exchange networks? If yes, describe in detail, including the assessment process, the source of the assessment data, specific measures and metrics, thresholds for inclusion and exclusion.

*Single, Radio group.*
1: Yes, please explain: [100 words],
2: No

16.2.2.3 Does Applicant currently use patient reported experience as a criterion for provider selection for Covered California networks? If yes, describe in detail, including the assessment process, the source of the patient reported experience assessment data, specific measures and metrics, thresholds for inclusion and exclusion.

*Single, Radio group.*
1: Yes, please explain: [100 words],
2: No

16.2.2.4 To what extent does Applicant encourage use of high quality network dental providers?

*Multi, Checkboxes.*
1: Auto-assign members to high-performing dental providers,
2: Identify high-performing providers through the provider directory or other web site location,
3: Customer service referral to dental provider,
4: Other (please explain): [100 words],
5: Applicant does not encourage use of high-performing dental providers

16.2.2.5 If Applicant encourages use of high-performing dental providers, what criteria does Applicant use to identify high-performing providers?

*Multi, Checkboxes.*
1: Dental quality measures,
2: Health improvement initiatives,
3: Preventive services rendered,
4: Patient satisfaction,
5: Low occurrence of complaints and grievances,
6: Other (please explain): [100 words],
7: Applicant does not encourage use of high-performing dental providers

16.2.2.6 If Applicant does not currently identify or encourages use of high-performing dental providers, please report how the Applicant intends to identify high-performing dental providers.

*200 words.*

## 16.2.3 Network Stability

*16.2.3.4 – 16.2.3.5 required for currently contracted QDP Issuers. All questions required for new entrant Applicants.*

16.2.3.1 Identify the number of participating providers who have terminated from the provider network between January 1, 2017 and December 31, 2017, by rating region. Indicate reason for termination: non-agreement on rates, non-compliance with contract provisions, re-design of network or other (explain).

| | Terminated by Issuer | Terminated by Provider | Reason | Reinstated |
|---|---|---|---|---|
| Region 1 | *Integer.* | *Integer.* | *20 words.* | *10 words.* |
| Region 2 | *Integer.* | *Integer.* | *20 words.* | *10 words.* |
| Region 3 | *Integer.* | *Integer.* | *20 words.* | *10 words.* |
| Region 4 | *Integer.* | *Integer.* | *20 words.* | *10 words.* |
| Region 5 | *Integer.* | *Integer.* | *20 words.* | *10 words.* |
| Region 6 | *Integer.* | *Integer.* | *20 words.* | *10 words.* |
| Region 7 | *Integer.* | *Integer.* | *20 words.* | *10 words.* |
| Region 8 | *Integer.* | *Integer.* | *20 words.* | *10 words.* |
| Region 9 | *Integer.* | *Integer.* | *20 words.* | *10 words.* |

| | | | | |
|---|---|---|---|---|
| Region 10 | *Integer.* | *Integer.* | *20 words.* | *10 words.* |
| Region 11 | *Integer.* | *Integer.* | *20 words.* | *10 words.* |
| Region 12 | *Integer.* | *Integer.* | *20 words.* | *10 words.* |
| Region 13 | *Integer.* | *Integer.* | *20 words.* | *10 words.* |
| Region 14 | *Integer.* | *Integer.* | *20 words.* | *10 words.* |
| Region 15 | *Integer.* | *Integer.* | *20 words.* | *10 words.* |
| Region 16 | *Integer.* | *Integer.* | *20 words.* | *10 words.* |
| Region 17 | *Integer.* | *Integer.* | *20 words.* | *10 words.* |
| Region 18 | *Integer.* | *Integer.* | *20 words.* | *10 words.* |
| Region 19 | *Integer.* | *Integer.* | *20 words.* | *10 words.* |

16.2.3.2 List total Number of Contracted Dental Groups/Clinics (provide information by product by region):

| | Number of Contracted Entities |
|---|---|
| Region 1 | *Integer.* |
| Region 2 | *Integer.* |
| Region 3 | *Integer.* |
| Region 4 | *Integer.* |
| Region 5 | *Integer.* |
| Region 6 | *Integer.* |
| Region 7 | *Integer.* |
| Region 8 | *Integer.* |

| | |
|---|---|
| Region 9 | *Integer.* |
| Region 10 | *Integer.* |
| Region 11 | *Integer.* |
| Region 12 | *Integer.* |
| Region 13 | *Integer.* |
| Region 14 | *Integer.* |
| Region 15 | *Integer.* |
| Region 16 | *Integer.* |
| Region 17 | *Integer.* |
| Region 18 | *Integer.* |
| Region 19 | *Integer.* |

16.2.3.3 Identify groups, clinics or health centers terminated between January 1, 2017 and December 31, 2017, including any Dental Groups, Federally Qualified Health Centers (FQHC) or community clinics that had a break in maintaining a continuous contract during this period. Indicate reason for termination: non-agreement on rates, non-compliance with contract provisions, re-design of network or other (explain).

| Name of Terminated Group/Clinic/Center | Terminated by: | Reason | Reinstated |
|---|---|---|---|
| *10 words.* | *Single, Pull-down list.*<br>*1: Applicant*<br>*2: Provider* | *20 words.* | *10 words.* |
| *10 words.* | *Single, Pull-down list.*<br>*1: Applicant*<br>*2: Provider* | *20 words.* | *10 words.* |
| *10 words.* | *Single, Pull-down list.*<br>*1: Applicant*<br>*2: Provider* | *20 words.* | *10 words.* |
| *10 words.* | *Single, Pull-down list.*<br>*1: Applicant*<br>*2: Provider* | *20 words.* | *10 words.* |
| *10 words.* | *Single, Pull-down list.* | *20 words.* | *10 words.* |

| | | | |
|---|---|---|---|
| | *1: Applicant*<br>*2: Provider* | | |
| *10 words.* | *Single, Pull-down list.*<br>*1: Applicant*<br>*2: Provider* | *20 words.* | *10 words.* |
| *10 words.* | *Single, Pull-down list.*<br>*1: Applicant*<br>*2: Provider* | *20 words.* | *10 words.* |
| *10 words.* | *Single, Pull-down list.*<br>*1: Applicant*<br>*2: Provider* | *20 words.* | *10 words.* |
| *10 words.* | *Single, Pull-down list.*<br>*1: Applicant*<br>*2: Provider* | *20 words.* | *10 words.* |
| *10 words.* | *Single, Pull-down list.*<br>*1: Applicant*<br>*2: Provider* | *20 words.* | *10 words.* |

16.2.3.4 Describe any plans for network additions, by product, including any new dental provider groups or clinic systems that Applicant would like to highlight for Exchange attention.
*100 words.*

16.2.3.5 Provide information on any known or anticipated potential network disruption that may affect the Applicant's 2019 provider networks. For example: list any pending terminations of dental groups which can include Independent Practice Associations.
*100 words.*

# 16.3 PPO

## 16.3.1 Network Strategy

*All questions required for new entrant Applicants only.*

16.3.1.1 Does Applicant conduct provider negotiations and manage its own network or does Applicant lease a network from another organization?

*Single, Pull-down list.*
1: Applicant contracts and manages network,
2: Applicant leases network

16.3.1.2 If Applicant leases network, describe the terms of the lease agreement:

| | Response |
|---|---|

| | |
|---|---|
| Length of the lease agreement | *100 words.* |
| Start Date | *To the day.* |
| End Date | *To the day.* |
| Leasing Organization | *100 words.* |

16.3.1.3 If Applicant leases network, does Applicant have the ability to influence provider contract terms for (select all that apply):

*Multi, Checkboxes.*
1: Transparency,
2: Implementation of new programs and initiatives,
3: Acquire timely and up-to-date information on providers,
4: Ability to obtain data from providers,
5: Ability to conduct outreach and education to providers if need arises,
6: Ability to add new providers,
7: If no, please describe plans to ensure Applicant's ability to control network and meet Exchange requirements: [500 words]

16.3.1.4 By rating region covered, please provide the percentages of providers in capitated vs non- capitated arrangements:

| | Direct Contract | Capitated | Other (explain in comments) | Comments |
|---|---|---|---|---|
| Region 1 | *Percent.* | *Percent.* | *Percent.* | *100 words.* |
| Region 2 | *Percent.* | *Percent.* | *Percent.* | *100 words.* |
| Region 3 | *Percent.* | *Percent.* | *Percent.* | *100 words.* |
| Region 4 | *Percent.* | *Percent.* | *Percent.* | *100 words.* |
| Region 5 | *Percent.* | *Percent.* | *Percent.* | *100 words.* |
| Region 6 | *Percent.* | *Percent.* | *Percent.* | *100 words.* |

| | | | | |
|---|---|---|---|---|
| Region 7 | *Percent.* | *Percent.* | *Percent.* | *100 words.* |
| Region 8 | *Percent.* | *Percent.* | *Percent.* | *100 words.* |
| Region 9 | *Percent.* | *Percent.* | *Percent.* | *100 words.* |
| Region 10 | *Percent.* | *Percent.* | *Percent.* | *100 words.* |
| Region 11 | *Percent.* | *Percent.* | *Percent.* | *100 words.* |
| Region 12 | *Percent.* | *Percent.* | *Percent.* | *100 words.* |
| Region 13 | *Percent.* | *Percent.* | *Percent.* | *100 words.* |
| Region 14 | *Percent.* | *Percent.* | *Percent.* | *100 words.* |
| Region 15 | *Percent.* | *Percent.* | *Percent.* | *100 words.* |
| Region 16 | *Percent.* | *Percent.* | *Percent.* | *100 words.* |
| Region 17 | *Percent.* | *Percent.* | *Percent.* | *100 words.* |
| Region 18 | *Percent.* | *Percent.* | *Percent.* | *100 words.* |
| Region 19 | *Percent.* | *Percent.* | *Percent.* | *100 words.* |

16.3.1.5 Describe in detail how Applicant ensures access to care for all enrollees. This should include:

- If Applicant assesses geographic access to primary and specialist care based on enrollee residence, describe tools and brief methodology
- If Applicant tracks ethnic and racial diversity in the population and ensure access to appropriate culturally competent providers, describe tools and brief methodology

*200 words*

16.3.1.6 Many California residents live in counties bordering other states where the out of state services are closer than in-state services. Does Applicant offer coverage in a county or region bordering another state?

*Single, Radio group.*
1: Yes. If yes, does Applicant allow out of state (non-emergency) providers to participate in networks to serve Exchange enrollees?,
2: No

16.3.1.7 If Applicant answered yes to 16.3.1.6, explain in detail how this coverage is offered.
*500 words.*

## 16.3.2 Network Quality

*All questions required for all networks*

16.3.2.1 Does Applicant currently use patient safety as a criterion for provider selection for Exchange networks? If yes, describe in detail, including the assessment process, the source of the patient safety assessment data, specific measures and metrics, thresholds for inclusion and exclusion.

*Single, Radio group.*
1: Yes, please explain: [100 words],
2: No

16.3.2.2 Does Applicant currently use cost efficiency as a criterion for provider selection for Exchange networks? If yes, describe in detail, including the assessment process, the source of the assessment data, specific measures and metrics, thresholds for inclusion and exclusion.

*Single, Radio group.*
1: Yes, please explain: [100 words],
2: No

16.3.2.3 Does Applicant currently use patient reported experience as a criterion for provider selection for Covered California networks? If yes, describe in detail, including the assessment process, the source of the patient reported experience assessment data, specific measures and metrics, thresholds for inclusion and exclusion.

*Single, Radio group.*
1: Yes, please explain: [100 words],
2: No

16.3.2.4 To what extent does Applicant encourage use of high quality network dental providers?

*Multi, Checkboxes.*
1: Auto-assign members to high-performing dental providers,
2: Identify high-performing providers through the provider directory or other web site location,
3: Customer service referral to dental provider,
4: Other (please explain): [100 words],
5: Applicant does not encourage use of high-performing dental providers

16.3.2.5 If Applicant encourages use of high-performing dental providers, what criteria does Applicant use to identify high-performing providers?

*Multi, Checkboxes.*
1: Dental quality measures,
2: Health improvement initiatives,
3: Preventive services rendered,
4: Patient satisfaction,
5: Low occurrence of complaints and grievances,
6: Other (please explain): [100 words],
7: Applicant does not encourage use of high-performing dental providers

16.3.2.6 If Applicant does not currently identify or encourage use of high-performing dental providers, please report how the Applicant intends to identify high-performing dental providers.
*200 words.*

## 16.3.3 Network Stability

*16.3.3.4 – 16.3.3.5 required for currently contracted QDP Issuers. All questions required for new entrant Applicants.*

16.3.3.1 Identify the number of participating providers who have terminated from the provider network between January 1, 2017 and December 31, 2017, by rating region. Indicate reason for termination: non-agreement on rates, non-compliance with contract provisions, re-design of network or other (explain).

| | Terminated by Issuer | Terminated by Provider | Reason | Reinstated |
|---|---|---|---|---|
| Region 1 | *Integer.* | *Integer.* | *20 words.* | *10 words.* |
| Region 2 | *Integer.* | *Integer.* | *20 words.* | *10 words.* |
| Region 3 | *Integer.* | *Integer.* | *20 words.* | *10 words.* |
| Region 4 | *Integer.* | *Integer.* | *20 words.* | *10 words.* |
| Region 5 | *Integer.* | *Integer.* | *20 words.* | *10 words.* |
| Region 6 | *Integer.* | *Integer.* | *20 words.* | *10 words.* |
| Region 7 | *Integer.* | *Integer.* | *20 words.* | *10 words.* |
| Region 8 | *Integer.* | *Integer.* | *20 words.* | *10 words.* |
| Region 9 | *Integer.* | *Integer.* | *20 words.* | *10 words.* |
| Region 10 | *Integer.* | *Integer.* | *20 words.* | *10 words.* |

| | | | | |
|---|---|---|---|---|
| Region 11 | *Integer.* | *Integer.* | *20 words.* | *10 words.* |
| Region 12 | *Integer.* | *Integer.* | *20 words.* | *10 words.* |
| Region 13 | *Integer.* | *Integer.* | *20 words.* | *10 words.* |
| Region 14 | *Integer.* | *Integer.* | *20 words.* | *10 words.* |
| Region 15 | *Integer.* | *Integer.* | *20 words.* | *10 words.* |
| Region 16 | *Integer.* | *Integer.* | *20 words.* | *10 words.* |
| Region 17 | *Integer.* | *Integer.* | *20 words.* | *10 words.* |
| Region 18 | *Integer.* | *Integer.* | *20 words.* | *10 words.* |
| Region 19 | *Integer.* | *Integer.* | *20 words.* | *10 words.* |

16.3.3.2 List total Number of Contracted Dental Groups/Clinics (provide information by product by region):

| | Number of Contracted Entities |
|---|---|
| Region 1 | *Integer.* |
| Region 2 | *Integer.* |
| Region 3 | *Integer.* |
| Region 4 | *Integer.* |
| Region 5 | *Integer.* |
| Region 6 | *Integer.* |
| Region 7 | *Integer.* |
| Region 8 | *Integer.* |
| Region 9 | *Integer.* |

| | |
|---|---|
| Region 10 | *Integer.* |
| Region 11 | *Integer.* |
| Region 12 | *Integer.* |
| Region 13 | *Integer.* |
| Region 14 | *Integer.* |
| Region 15 | *Integer.* |
| Region 16 | *Integer.* |
| Region 17 | *Integer.* |
| Region 18 | *Integer.* |
| Region 19 | *Integer.* |

16.3.3.3 Identify groups, clinics or health centers terminated between January 1, 2017 and December 31, 2017, including any Dental Groups, Federally Qualified Health Centers (FQHC) or community clinics that had a break in maintaining a continuous contract during this period. Indicate reason for termination: non-agreement on rates, non-compliance with contract provisions, re-design of network or other (explain).

| Name of Terminated Group/Clinic/Center | Terminated by: | Reason | Reinstated |
|---|---|---|---|
| *10 words.* | *Single, Pull-down list.*<br>*1: Applicant*<br>*2: Provider* | *20 words.* | *10 words.* |
| *10 words.* | *Single, Pull-down list.*<br>*1: Applicant*<br>*2: Provider* | *20 words.* | *10 words.* |
| *10 words.* | *Single, Pull-down list.*<br>*1: Applicant*<br>*2: Provider* | *20 words.* | *10 words.* |
| *10 words.* | *Single, Pull-down list.*<br>*1: Applicant*<br>*2: Provider* | *20 words.* | *10 words.* |
| *10 words.* | *Single, Pull-down list.*<br>*1: Applicant*<br>*2: Provider* | *20 words.* | *10 words.* |

| | | | |
|---|---|---|---|
| *10 words.* | *Single, Pull-down list.*<br>*1: Applicant*<br>*2: Provider* | *20 words.* | *10 words.* |
| *10 words.* | *Single, Pull-down list.*<br>*1: Applicant*<br>*2: Provider* | *20 words.* | *10 words.* |
| *10 words.* | *Single, Pull-down list.*<br>*1: Applicant*<br>*2: Provider* | *20 words.* | *10 words.* |
| *10 words.* | *Single, Pull-down list.*<br>*1: Applicant*<br>*2: Provider* | *20 words.* | *10 words.* |
| *10 words.* | *Single, Pull-down list.*<br>*1: Applicant*<br>*2: Provider* | *20 words.* | *10 words.* |

16.3.3.4 Describe any plans for network additions, by product, including any new dental provider groups or clinic systems that Applicant would like to highlight for Exchange attention.
*100 words.*

16.3.3.5 Provide information on any known or anticipated potential network disruption that may affect the Applicant's 2019 provider networks. For example: list any pending terminations of dental groups which can include Independent Practice Associations.
*100 words.*

# 17 Essential Community Providers

*Required for new entrant Applicants only.*

17.1 Applicant must demonstrate that its QDP proposals meet requirements for geographic sufficiency of its Essential Community Provider (ECP) network. All of the below criteria must be met.

1. Applicants must use Essential Community Provider Network Data Submission to indicate contracts with all providers designated as ECP.
2. Applicants must demonstrate sufficient geographic distribution of a mix of essential community providers reasonably distributed throughout the geographic service area.

The Exchange will evaluate whether the Applicant’s essential community provider network has achieved the sufficient geographic distribution and requirements.

Federal regulations currently require health issuers to adhere to rules regarding payment to non-contracted FQHCs for services when those services are covered by the QDP’s benefit plan. Certified QDPs will be required in their contract with the Exchange to operate in compliance with all federal regulations issued pursuant to the Affordable Care Act, including those applicable to essential community providers.

Essential Community Providers include dental providers included in the Covered California Consolidated Essential Community Provider List available at:

http://hbex.coveredca.com/stakeholders/plan-management/

Low-income is defined as a family at or below 200% of Federal Poverty Level. The ECP data supplied by Applicant will allow the Exchange to plot contracted ECPs on maps to compare contracted providers against the supply of ECPs and the distribution of low-income Covered California enrollees.

# 18 Quality

## 18.1 Quality Improvement Strategy

*18.1.1 and 18.1.2 required for currently contracted QDP Issuers. All questions required for new entrant Applicants.*

18.1.1 Consistent with the Exchange's mission to promote better care, better health and lower cost as part of a Quality Improvement Strategy, Applicants must confirm it will implement a quality assurance program in accordance with Title 2, CCR, Section 1300.70, for evaluating the appropriateness and quality of the covered services provided to member.

*Single, Pull-down list.*
1: Confirmed,
2: Not confirmed

18.1.2 Applicant must confirm it will maintain a system of accountability for quality improvement in accordance with all applicable statutes and regulations, monitoring, evaluating and taking effective action to address any needed improvements, as identified by the Exchange, in the quality of care delivered to members.

*Single, Pull-down list.*
1: Confirmed,
2: Not confirmed

18.1.3 QIP #1: Describe a Quality Improvement Project (QIP) conducted by Applicant within the last five (5) years. Include information about results of the QIP, why the QIP was undertaken and why it ended or has continued, if applicable. Describe the QIP scalability, if it was successful. Also include the following information:

- Start/End Dates:
- QIP Name/Title:
- Problem Addressed:
- Rationale (why selected):
- Targeted Population:
- Study Indicator(s):
- Baseline Measurement:
- Results:
- What best practices have been implemented to sustain Improvement (if any):

*500 words.*

18.1.4 QIP #2: Describe a second Quality Improvement Project (QIP) conducted by Applicant within the last five (5) years. Include information about results of the QIP, why the QIP was undertaken and why it ended or has continued, if applicable. Describe the QIP scalability, if it was successful. Also include the following information:

- Start/End Dates:
- QIP Name/Title:
- Problem Addressed:

- Rationale (why selected):
- Targeted Population:
- Study Indicator(s):
- Baseline Measurement:
- Results:
- What best practices have been implemented to sustain Improvement (if any):

*500 words.*

## 18.2 Care Management

*All questions required for currently contracted QDP Issuers and new entrant Applicants.*

18.2.1 Applicant must confirm it will make available to Exchange enrollees the following programs and services

| | |
|---|---|
| Care Reminders | *Single, Pull-down list.*<br>1: Confirmed,<br>2: Not confirmed |
| Risk Assessments | *Single, Pull-down list.*<br>1: Confirmed,<br>2: Not confirmed |
| Disease Management Programs | *Single, Pull-down list.*<br>1: Confirmed,<br>2: Not confirmed |

18.2.2 Which of the following activities are used by the Applicant to encourage use of diagnostic and preventive services?

*Multi, Checkboxes.*
1: Mailed printed materials about preventive services with $0 cost-share to members (oral exam, cleaning, X-rays),
2: Emails sent to membership about preventive services with $0 cost-share to members (oral exam, cleaning, X-rays),
3: Automated outbound telephone reminders about preventive services with $0 cost-share to members (oral exam, cleaning, X-rays),
4: Other (please explain): [ 100 words ],
5: No current activities used to encourage use of preventive services

18.2.3 Discuss any planned activities to encourage use of diagnostic and preventive services.

*100 words.*

18.2.4 If Applicant indicated that any of the activities in 18.2.2 are used to encourage use of diagnostic and preventive services, please upload as an attachment screenshots and/or materials demonstrating these activities.

*200 words.*

18.2.5 Which of the following activities are used by the Applicant to communicate oral health and wellness (i.e. self-care for maintaining good oral health)?

*Multi, Checkboxes.*
1: Mailed printed materials about oral health self-care,
2: Emails sent to membership about oral health self-care,
3: Other (please explain): [100 words],
4: No current activities used to encourage oral health self-care

18.2.6 Discuss any planned activities to communicate oral health and wellness information to Enrollees.

*100 words.*

18.2.7 If Applicant indicated that any of the activities in 18.2.5 are used to communicate oral health and wellness, please upload as an attachment screenshots and/or materials demonstrating these activities.

*200 words.*

18.2.8 Indicate the availability of the following demand management activities and health information resources for Exchange members. (Check all that apply)

*Multi, Checkboxes.*
1: Teledentistry,
2: Decision support,
3: Self-care books,
4: Electronic Preventive care reminders,
5: Web-based health information,
6: Web-based self-care resources,
7: Integration with other health care vendors,
8: Other (describe): [200 words]

## 18.3 Health Status and Risk Assessment

*All questions required for currently contracted Applicants and new entrant Applicants.*

18.3.1 Indicate features of the oral health risk assessment to determine enrollee oral health status. Select all that apply.

*Multi, Checkboxes.*
1: Oral health risk assessment offered online or in print,
2: Oral health risk assessment offered through telephone interview with a live person,
3: Oral health risk assessment offered in multiple languages,
4: Upon completion of oral health risk assessment, risk-factor education is provided to member based on member-specific risk, e.g. if member reports tobacco use, education is provided on gum disease risk,
5: Personalized oral health risk assessment report is generated with risk modification actions,
6: Member is directed to interactive intervention module for behavior change upon risk assessment completion,
7: Email on self-care generated based on enrollee responses,
8: Email or phone call reminders to schedule preventive or diagnostic visits generated based on enrollee responses,
9: Oral health risk assessment not offered

18.3.2 Does Applicant collect information on enrollee oral health status using any of the following sources of data? Select all that apply.

*Multi, Checkboxes.*
1: Oral health risk assessment,
2: Claims data,
3: Other (please explain): [100 words],
4: Data on oral health status not collected

18.3.3 Discuss any planned activities to build capacity or systems to determine enrollee oral health status.

*100 words.*

18.3.4 Does Applicant use any of the following sources of data to track changes in oral health status among Plan Enrollees? Select all that apply.

*Multi, Checkboxes.*
1: Oral health risk assessment,
2: Claims data,
3: Other (please explain): [200 words],
4: Data on oral health status not used

18.3.5 Discuss any planned activities to build capacity or systems to track changes in enrollee oral health status.

*200 words.*

18.3.6 How does Applicant currently identify at-risk enrollees, which may include members with existing or newly diagnosed needs for dental treatment or members with co-morbid conditions?

*Single, Radio group.*
1: Claims data,
2: Website registration prompts self-report of existing/newly diagnosed need for dental treatment and/or co-morbid conditions,
3: Oral health risk assessment,
4: Other (please explain): [200 words],
5: Plan does not currently identify at-risk enrollees

18.3.7 Discuss any planned activities to identify at-risk enrollees.

*100 words.*

18.3.8 Please report the number of enrollees who have been identified as “at-risk.”

| | Exchange Enrollees, if applicable | Book of Business |
|---|---|---|
| Number of enrollees who have been identified as “at-risk” | *Integer.* | *Integer.* |

| | | |
|---|---|---|
| Number of enrollees | *Integer.* | *Integer.* |

## 18.4 Enrollee Population Management

*All questions required for currently contracted QDP Issuers and new entrant Applicants.*

18.4.1 Describe practices in place to address population health management across enrolled members. Include measurement strategy and any specific ability to track impact on Exchange enrollees.

*100 words.*

18.4.2 Describe ability to track and monitor member satisfaction. Include measurement strategy and any specific ability to track impact on Exchange enrollees.

*100 words.*

18.4.3 Describe ability to track and monitor cost and utilization management. Include measurement strategy and any specific ability to track impact on Exchange enrollees.

*100 words.*

18.4.4 Describe ability to track and monitor clinical outcome quality. Include measurement strategy and any specific ability to track impact on Exchange enrollees.

*100 words.*

## 18.5 Innovations

*All questions required for new entrant Applicants only.*

18.5.1 Describe institutional capacity to plan, implement, evaluate, and replicate future healthcare quality and cost innovations for Exchange Members. Of special interest to Exchange are programs with focus on at-risk enrollees (e.g.: communities at risk for health disparities, enrollees with chronic-conditions and those who live in medically underserved areas).

*200 words.*

## 18.6 Reducing Health Disparities and Ensuring Health Equity

*All questions required for currently contracted QDP Issuers and new entrant Applicants.*

18.6.1 Identify the sources of data used to gather members' race/ethnicity, primary language, and disability status. The response “enrollment form” pertains only to information reported directly by members or passed on by CalHEERS. Report on Exchange membership if applicable.

| Data Element | Data Collection Method (Select all that apply) | Other please explain | Percent of membership for whom data is captured |
|---|---|---|---|
| Race/ethnicity | *Multi, Checkboxes.*<br>1: Enrollment form,<br>2: Oral health risk assessment,<br>3: Information requested upon website registration,<br>4: Inquiry upon call to customer service,<br>5: Indirect method such as surname or zip code analysis,<br>6: Other (please explain),<br>7: Data not collected | *50 words.* | *Percent.*<br>N/A OK. |
| Primary language | *Multi, Checkboxes.*<br>1: Enrollment form,<br>2: Oral health risk assessment,<br>3: Information requested upon website registration,<br>4: Inquiry upon call to customer service,<br>5: Indirect method such as surname or zip code analysis,<br>6: Other (Please explain),<br>7: Data not collected | *50 words.* | *Percent.*<br>N/A OK. |
| Disability | *Multi, Checkboxes.*<br>1: Enrollment form,<br>2: Oral health risk assessment,<br>3: Information requested upon website registration,<br>4: Inquiry upon call to customer service,<br>5: Indirect method such as surname or zip code analysis,<br>6: Other (Please explain),<br>7: Data not collected | *50 words.* | *Percent.*<br>N/A OK. |

18.6.2 If Applicant answered “data not collected” to 18.6.1, please discuss how Applicant intends to collect data elements to support improving health equity.

*200 words.*

18.6.3 Indicate how race/ethnicity data are used to address quality improvement and health equity. Select all that apply.

*Multi, Checkboxes.*
1: Assess adequacy of language assistance to meet members' needs,
2: Calculate dental quality performance measures by race/ethnicity, language, or disability status,
3: Calculate member experience measures by race/ethnicity, language, or disability status,
4: Identify areas for quality improvement,
5: Identify areas for health education/promotion,
6: Share provider race/ethnicity/language data with member to enable selection of concordant dentists,
7: Share with dental network to assist them in providing language assistance and culturally competent care,
8: Set benchmarks or target goals for reducing measured disparities in preventive or diagnostic care,
9: Analyze disenrollment patterns,
10: Develop outreach programs that are culturally sensitive (please explain): [100 words],
11: Other (please explain): [100 words],
12: Race/ethnicity data not used for quality improvement or health equity,

### 18.6.4 Indicate how primary language data are used to address quality improvement and health equity. Select all that apply.

*Multi, Checkboxes.*
1: Assess adequacy of language assistance to meet members' needs,
2: Calculate dental quality performance measures by race/ethnicity, language, or disability status,
3: Calculate member experience measures by race/ethnicity, language, or disability status,
4: Identify areas for quality improvement,
5: Identify areas for health education/promotion,
6: Share provider race/ethnicity/language data with member to enable selection of concordant dentists,
7: Share with dental network to assist them in providing language assistance and culturally competent care,
8: Set benchmarks or target goals for reducing measured disparities in preventive or diagnostic care,
9: Analyze disenrollment patterns,
10: Develop outreach programs that are culturally sensitive (please explain): [100 words],
11: Other (please explain): [100 words],
12: Language data not used for quality improvement or health equity,

### 18.6.5 Indicate how disability status data are used to address quality improvement and health equity. Select all that apply.

*Multi, Checkboxes.*
1: Assess adequacy of language assistance to meet members' needs,
2: Calculate dental quality performance measures by race/ethnicity, language, or disability status,
3: Calculate member experience measures by race/ethnicity, language, or disability status,
4: Identify areas for quality improvement,
5: Identify areas for health education/promotion,
6: Share provider race/ethnicity/language data with member to enable selection of concordant dentists,
7: Share with dental network to assist them in providing language assistance and culturally competent care,
8: Set benchmarks or target goals for reducing measured disparities in preventive or diagnostic care,
9: Analyze disenrollment patterns,
10: Develop outreach programs that are culturally sensitive (please explain): [100 words],
11: Other (please explain): [100 words],
12: Disability data not used for quality improvement or health equity

## 18.7 Promotion, Development, and Use of Care Models

*All questions required for new entrant Applicants.*

18.7.1 If applicable to Applicant's delivery system, please report the number of enrollees who have been encouraged to select or assigned a primary care dentist.

| | Exchange Enrollees, if applicable | Book of Business |
|---|---|---|
| Number of enrollees who have been encouraged to select or assigned a primary care dentist | *Integer.* | *Integer.* |
| Number of enrollees | *Integer.* | *Integer.* |

18.7.2 If selection of or assignment to a primary care dentist is not required, describe how Applicant encourages member's use of dental home.

*100 words.*

18.7.3 If selection of or assignment to a primary care dentist is not required, describe how Applicant encourages contracted providers to retain patients for continued care.

*100 words.*

## 18.8 Provider Cost and Quality

*All questions required for currently contracted and new entrant Applicants only.*

18.8.1 Indicate how the Applicant provides members with cost information for network providers. Select all that apply.

*Multi, Checkboxes.*
1: Web site includes a cost calculator tool for dental services (e.g. crowns, casts, endodontics, periodontics, etc.),
2: Web site provides information on average regional charges for dental services (e.g. crowns, casts, endodontics, periodontics, etc.),
3: Cost information on provider-specific contracted rates available upon request through Web site or customer service line,
4: Members directed to network providers to request cost information,
5: Other (please explain): [100 words],
6: Cost information not provided to membership

18.8.2 If the plan does not currently provide members with cost information, please report how the Applicant intends to make provider-specific cost information available to members.

*100 words.*

## 18.9 Community Health and Wellness Promotion

*All questions required for currently contracted QDP Issuers and new entrant Applicants*

18.9.1 Applicant must indicate the type of initiatives, programs, and projects the Applicant supports and describe how such activities specifically promote community health and/or

address health disparities. Select all that apply and provide a narrative report in the “details” describing the activity.

| Type of Activity | Response | Details |
|---|---|---|
| Internal facing, member-related efforts to promote oral health (e.g. oral health education programs) | *Single, Pull-down list.* 1: Yes, 2: No | *100 words.* |
| External facing, high-level community facing activities (e.g. health fairs, attendance at community coalitions, participation in health collaboratives) | *Single, Pull-down list.* 1: Yes, 2: No | *100 words.* |
| Engaged with non-profit health systems or local health agencies to conduct community risk assessments to identify high priority needs and health disparities related to oral health | *Single, Pull-down list.* 1: Yes, 2: No | *100 words.* |
| Community oral health effort built on evidence-based program and policy interventions, and planned evaluation included in the initiative | *Single, Pull-down list.* 1: Yes, 2: No | *100 words.* |
| Funded community health programs based on needs assessment or other activity | *Single, Pull-down list.* 1: Yes, 2: No | *100 words.* |
| Plan is currently planning a community oral health promotion activity | *Single, Pull-down list.* 1: Yes, 2: No | *100 words.* |
| Plan does not conduct any community oral health initiatives | *Single, Pull-down list.* 1: Yes, 2: No | *100 words.* |

## 18.10 Utilization

*All questions required for currently contracted QDP Issuers and new entrant Applicants*

18.10.1 Applicant must provide dental utilization for the most recent benefit year for the following utilization measures. Provide current Covered California membership if applicable, and California book of business. Pediatric membership is defined as younger than 19 years of age. Adult membership is defined as 19 years of age and older.

| Pediatric Utilization | Exchange enrollees, if applicable | California Book of Business |
|---|---|---|
| Percentage of membership that received any covered dental service | *Percent.* | *Percent.* |

| | | |
|---|---|---|
| Percentage of membership that received a preventive/diagnostic dental service | *Percent.* | *Percent.* |
| Percentage of members receiving dental treatment services (excluding preventive and diagnostic services) | *Percent.* | *Percent.* |
| Percentage of members who received a treatment for caries or a caries-preventive procedure | *Percent.* | *Percent.* |
| Percentage of members with one (1) or more fillings in the past year who received a topical fluoride or sealant application | *Percent.* | *Percent.* |
| Percentage of pediatric membership identified as moderate or high caries risk | *Percent.* | *Percent.* |
| Percentage of pediatric membership who reached their annual out-of-pocket maximum. | | |
| Adult Utilization | *Percent.* | *Percent.* |
| Percentage of membership that received any covered dental service | *Percent.* | *Percent.* |
| Percentage of membership that received a preventive/diagnostic dental service | *Percent.* | *Percent.* |
| Percentage of members receiving dental treatment services (excluding preventive and diagnostic services) | *Percent.* | *Percent.* |
| Percentage of members who received a treatment for caries or a caries-preventive procedure | *Percent.* | *Percent.* |
| Percentage of members with one (1) or more fillings in the past year who received a topical fluoride or sealant application | *Percent.* | *Percent.* |
| Percentage of membership identified as high risk | *Percent.* | *Percent.* |
| Percentage of members whom reached the plan's maximum annual benefit, if applicable | *Percent.* | *Percent.* |

18.10.2 Applicant must submit copies of the most recent Dental Medical Loss Ratio Reports filed with the applicable regulator.

*Single, Pull-down list.*
1: Attached,
2: Not attached