Covered California Qualified Health Plan New Entrant Certification Application for ~~2015~~ Plan Year 2016

Draft for Release

December 22, 2014

Contents

Information submitted in response to this application by the applicant will be held in confidence pursuant to Government Code Section 100508 or 6254(k) under the official information privilege, as applicable, unless the information submitted has already been made public. Throughout this application, any reference to the "Exchange" refers to the California Health Benefit Exchange, also known as Covered California.

1. General Information and Background

1.1 Attestation

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

Issuer Name

NAIC Company Code

NAIC Group Code

Regulator(s)

Federal Employer ID

HIOS/Issuer ID

Corporate Office Address

City

State

ZIP

Primary Contact Name

Contact Title

Contact Phone Number

Contact E-mail

Check applicable categories: ☐Individual ☐SHOP

On behalf of the Applicant stated above, I hereby attest that I meet the requirements in this New Entrant Application and certify that the information provided on this Application and in any attachments hereto are true, complete, and accurate. I understand that Covered California may review the validity of my attestations and

the information provided in response to this application and if Applicant is selected to offer QHPs, may decertify those QHPs 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 New Entrant Application.

Date: _____
Signature: _____
Printed Name: _____
Title: _____

1.2 PURPOSE: The California Health Benefit Exchange (Exchange) is accepting applications from eligible Health Insurance Issuers[1] (Applicants) to submit proposals to offer, market, and sell qualified health plans (QHP) through the Exchange beginning in 2015, for coverage effective January 1, 2015. The Exchange will exercise its statutory authority to selectively contract for health care coverage offered through the Exchange to review submitted applications and reserves the right to select or reject any Applicant or to cancel the Application at any time.

Issuers who have responded to the Notice of Intent to Apply will be issued a web login for on-line access to the final application and instructions for use of the log-in regarding the QHP New Entrant Application.

~~The matter contained in this document is strictly related to the 2015 year Issuer QHP New Entrant applications.~~

1.3 BACKGROUND: Soon after the passage of national health care reform through the Patient Protection and Affordable Care Act of 2010 (ACA), California became the first state to enact legislation to establish a qualified health benefit exchange. (California Government Code § 100500 et seq.; Chapter 655, Statutes of 2010-Perez and Chapter 659, Statutes of 2010-Alquist.) The California state law is referred to as the California Patient Protection and Affordable Care Act (CA-ACA).

Effective January 1, 2014, the California Health Benefit Exchange offers a statewide health insurance exchange to make it easier for individuals and small businesses to compare plans and buy health insurance in the private market. Although the focus of the Exchange is on individuals and small businesses who qualify for tax credits and subsidies under the ACA, the Exchange's goal is to make insurance available to all qualified individuals and to all California businesses with fewer than 50 employees.

The vision of the California Health Benefit Exchange is to improve the health of all Californians by assuring their access to affordable, high quality care coverage. The mission of the California Health Benefit 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 California Health Benefit Exchange is guided by the following values:

- **Consumer-Focused**: At the center of the Exchange's efforts are the people it serves, including patients and their families, and small business owners and their employees. The Exchange will offer a consumer-friendly experience that

[1] The term "Health Issuer" used in this document refers to both health 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 health coverage, while the term "Qualified Health Plan" refers to a specific policy or plan to be sold to a consumer. Qualified Health Plans are also referred to as "products". The term "Applicant" refers to a Health Insurance Issuer who is seeking a Qualified Health Plan contract with the Exchange.

is accessible to all Californians, recognizing the diverse cultural, language, economic, educational and health status needs of those it serves.

- **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.
- **Partnership:** The Exchange welcomes partnerships, and its efforts will be guided by working with consumers, providers, health plans, employers and other purchasers, government partners**,** and other stakeholders.
- **Results:** The impact of the Exchange will be measured by its contributions to expanding coverage and access, improving health care quality, promoting better health and health equity, and lowering costs 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 California Health Benefit 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 will be transformed from one that has focused on risk selection to achieve profitability to one that will reward better care, affordability, and prevention.

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

California has many of the infrastructure elements that allow the Exchange to work with health plans, clinicians, hospitals, consumer groups, purchasers and others as partners to support the changes needed to achieve the triple aim of better care, better health, and lower cost. These include the state's history of multispecialty and organized medical groups, the presence of statewide and regional managed care health maintenance and preferred provider organizations, public reporting of health care information and delivery system performance, and active efforts by public and private sector payers to test new and innovative models of care delivery and payment reform.

The California Health Benefit 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 will operate 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 that will be offered in the Exchange.

The state legislation to establish the California Health Benefit Exchange directed it to "selectively contract with carriers so as to provide health care coverage choices 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.[2]

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

This application has been designed consistent with the policies and strategies of the California Health Benefit Exchange Board which calls for the QHP selection to influence how competitive the market will be, the cost of coverage, and how to add value through health care delivery system improvement.

Important issues include how much to standardize the individual and small group market rating rules and the benefits and member cost-sharing for the Exchange plans, how many and what type of products are offered, what reporting and quality standards the plans must meet, and how to build upon and encourage innovation in both health care delivery and payment mechanisms.

1.4 Application Evaluation and Selection

The evaluation of QHP New Entrant Applications will not be based on a single, strict formula; instead, the evaluation will consider the mix of health plans for each region of California that best meet the Exchange's goals. The Exchange wants to provide an appropriate range of high quality plans to participants at the best available price. 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 in August 2012 which are considered in the review of QHP proposals. These guidelines are:

Promote affordability for the consumer and small employer – 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 in terms of premiums and at the point of care, while fostering competition and stable premiums. The Exchange will seek to offer health plans, plan designs and provider networks that will attract

[2] California Government Code §§100503(c) (AB 1602 §7), and 100505 (AB 1602 §9).

maximum enrollment as part of the Exchange's effort to lower costs by spreading risk as broadly as possible.

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

While premium and out-of-pocket costs for consumers will be a key consideration, contracts will be awarded based on determination of "best value" to the Exchange and its participants. The evaluation of Issuer QHP proposals will focus on quality and service components, including past history of performance, reported quality and satisfaction metrics, quality improvement plans and commitment to serve the Exchange population through cooperation with the Exchange operations, provider network adequacy, cultural and linguistic competency, programs addressing health equity and disparities in care, innovations in delivery system improvements and payment reform. We expect that some necessary regulatory and rate filings may need to be completed after the due date for this QHP New Entrant application. The application responses, in conjunction with the approved filings, will be evaluated by Covered California and used as part of the selection criteria to offer issuers' products on the Exchange for the 2015 plan year.

Encourage Competition Based upon Meaningful QHP Choice and Product Differentiation: Standard and Non-Standard Benefit Plan Designs[3]

The Exchange is committed to fostering competition by offering QHPs with features that present clear choice, product and provider network differentiation. QHP Applicants are required to propose at least one of the Exchange's adopted standardized benefit plan designs (either co-pay or co-insurance plan) in each region for which they submit a proposal. In addition, QHP Applicants may offer the Exchange's standardized Health Savings Account-eligible (HSA) design, and QHP SHOP Applicants may propose an alternative benefit design. The standardized benefit plan designs use cost sharing provisions that are predominantly deductibles with either co-payments ("co-pay plan") or co-insurance ("co-insurance plan") and are intended to be "platform neutral". That is, either of the standardized benefit designs can be applied to a network product design that may be a health maintenance organization (HMO) or exclusive provider organization (EPO) with out-of-network benefits limited to pre-authorized and emergency services, or to Preferred Provider Organization (PPO) or Point of Service (POS) product design that offer out-of-network coverage with significantly higher levels of member cost-sharing. To the extent possible, both HMO and PPO products will be offered. If there are meaningful differences in network design, levels of integration, and other innovative delivery system features, multiple HMO or PPO products will be considered in the same geographic service area. 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

[3] The 2015~~5~~6 Standard Benefit Designs will be finalized ~~promulgated through a future administrative rulemaking~~ after the 2015~~5~~6 federal actuarial value calculator is finalized.

broad overlapping PPO 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 are encouraged to submit QHP proposals in all geographic service areas in which they are licensed, and preference will be given to Issuers that develop QHP proposals that meet quality and service criteria while offering coverage options that provide reasonable access to the geographically underserved areas of the state as well as the more densely populated areas.

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

Central to the Exchange's mission is its 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. Responses that demonstrate an ongoing commitment or have developed the 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 the Applicant having a higher proportion of essential community providers to meet the criteria of sufficient geographic distribution that is reasonably distributed, contracts with Federally Qualified Health Centers, and support or investment 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 and reducing costs. The Exchange wants QHP offerings that incorporate innovations in delivery system improvement, prevention and wellness and/or payment reform that will help foster these broad goals. These may include various models of patient-centered medical homes, targeted quality improvement efforts, participation in community-wide prevention or efforts to increase reporting transparency to provide relevant health care comparisons and to increase member engagement in decisions about their course of care. QHP proposals that incorporate innovative models, particularly those with demonstrated effectiveness and a track record of success, will be preferred.

Encourage Long Term Partnerships with Health issuers

A goal of the Exchange is to reward early participation with contract features that offer a potential for market share and program stability. The Exchange encourages Issuer interest in multi-year contracts (plan year 2015 and 2016) and submitting rates at the most competitive position possible; fosters rate and plan stability and encourages QHP investments in product design, network

development, and quality improvement programs. Application responses that demonstrate an interest and commitment to the long-term success of the Exchange's mission are strongly encouraged, particularly those that include underserved service areas, and that leverage Issuer efforts to provide better care, improve health, and lower cost.

1.5 AVAILABILITY

The QHP Applicant must be available immediately upon contingent certification as a QHP 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 health plan services effective January 1, 2015. Successful Applicants will also be required to adhere to certain provisions through their contracts with the Exchange including but not limited to meeting data interface requirements with the California Healthcare Enrollment, Eligibility, and Retention System (CalHEERS). The Exchange expects to negotiate and sign contracts prior to September 1, 2014. The successful Applicants must be ready and able to accept enrollment as of October 15, 2014.

1.6 APPLICATION PROCESS

The application process shall consist of the following steps:

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

1.7 INTENTION TO SUBMIT A RESPONSE

Applicants interested in responding to this application are required to submit a non-binding Letter of Intent to Apply indicating their interest in applying and their proposed products, service areas and the like and to ensure receipt of additional information. Only those Applicants acknowledging interest in this application by submitting a notification of intention to submit a proposal will continue to receive application-related correspondence throughout the application process. The Exchange intends to select QHPs for the ~~second~~ third year of operation with a strong interest in pursuing multi-year contracts with successful Applicants and may conduct a very limited second or third year solicitation process.

The Applicant's notification letter must identify the contact person for the application process, along with contact information that includes an email address, a telephone number, and a fax number. Receipt of the non-binding letter of intent will be used to issue instructions and login and password information to gain access to the on-line portion(s) of the Applicant submission of response to the Application.

An Issuer's submission of an Intent to Apply will be considered confidential information and not available to the public; the Exchange reserves the right to release aggregate information about Issuers' responses. Final Applicant information is not expected to be released until selected Issuers and QHP proposals are announced in late June 2014. Confidentiality is to be held by the Exchange; 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 and regulators will maintain the confidentiality of rate filings until rates are approved by the regulator and posted publicly on their website.

The Exchange will correspond with only one (1) contact person per Applicant. It shall be 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 shall not be 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:

Taylor Priestley

Taylor.priestley@covered.ca.gov

(916) 228-8397

~~1.9 APPLICATION LIBRARY~~

~~Applicants may access the Application Library at:~~

~~https://www.coveredca.com/hbex/solicitations/Qualified%20Health%20Plan%20New%20Entrant%20Application/~~

~~The Application Library will allow Applicants access to reference documents and information that may be useful for developing the Applicant's response. The Application Library will continue to be updated as further documentation related to the application becomes available. Amendments to this application will not be issued when new information is posted to the Application Library. Applicants are encouraged to continuously monitor the Application Library, but are not required to access or view documents in the Application Library.~~

~~The Exchange makes no warrantees with respect to the contents of the Application Library and requirements specified in this application take precedence over any Application Library contents.~~

1.10 KEY ACTION DATES

Action	Date/Time
Approval ~~Release~~ of Final Application	~~March 10, 2014~~ January 15, 2015
New Entrant Letters of Intent due to Covered California	~~March 17, 2014~~ February 16, 2015
Completed New Entrant Applications Due (include 201~~5~~ Proposed Rates & Networks) subject to Section 6422(d)(3)	~~May 1, 2014~~ May 1, 2015
Negotiations between New Entrants and Covered California	June ~~2014~~ 2015
~~Submission of ECP Networks by Contingently Certified New Entrant QHPs~~	~~June 30, 2014~~
Regulatory Rate Review	July & August ~~2014~~ 2015
Final QHP Recertification/Decertification/New Entrant Certification Decisions	~~August 30, 2014~~ August 31, 2015
New Entrant QHP Contract Execution	September 1, ~~2014~~ 2015

2. LICENSED AND IN GOOD STANDING

2.1 In addition to holding all of the proper and required licenses[4] to operate as a health issuer as defined herein, the Applicant must indicate that it is in good standing with all appropriate local, state, and federal licensing authorities. Good standing means that the Applicant has had no material fines, no material penalties

[4] The Exchange reserves the right to require licenses to be in place at the time of QHP selection in the case of new applicants for licenses. Applicants who are not yet licensed should indicate anticipated date of licensure.

levied or material ongoing disputes with applicable licensing authorities in the last two years (See Appendix A Definition of Good Standing). Covered California, in its sole discretion and in consultation with the appropriate health insurance regulator, determines what constitutes a material violation for this purpose.

Applicant must check the appropriate box. If Applicant selects no, the application will be disqualified from consideration.

- ☐ Yes, issuer is in good standing
- ☐ No

2.2 Does your organization have any ongoing labor disputes, penalties, fines, or corrective action citations for federal or state workplace safety issues? If yes, indicate whether these will be addressed by the date applications are due.

- ☐ Yes (explain)
- ☐ No

2.3 Are you seeking any material modification of an existing license from the California Department of Managed Health Care or certificate of authority from the California Department of Insurance for any commercial individual or small group products proposed to be offered through Covered California?

Applicant must check the appropriate box.

- ☐ Yes
- ☐ No

If yes, Applicant must complete Attachment A Regulatory Filings to indicate type of filing and provide additional information. Updates to Attachment A must be made on a continuous basis as Applicant files amended documents with the regulator.

2.4 Separate from the Applicant's response to this application, Applicant must submit all materials to the California regulatory agency necessary to obtain approval of product/plan and rate filings that are to be submitted in response to this application. Applicant must complete Attachment A Regulatory Filings to indicate product filings related to proposed QHP products that have been submitted for regulatory review and include documentation of the filings as part of the response to this application. If filings are not complete, the Applicant must update the Exchange with such information as it is submitted for regulatory review.

The California Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI) have primary responsibility for regulatory review and issuing preliminary recommendations to the Exchange of certain selection criteria listed below in the definition of good standing in addition to applying the minimum licensure requirements. All licensure, regulatory and product filing requirements of DMHC and CDI shall apply to QHPs offered through the Exchange. Issuers must

adhere to California insurance laws and regulations including, but not limited to, those identified in the roster of Good Standing elements that follow. Applicants must respond to questions raised by the agencies in their review. The agencies will conduct the review of the components outlined in Appendix A Definition of Good Standing.

2.5 Applicant must confirm it will agree to immediately submit to the Exchange the results of final financial, market conduct, or special audits/reviews performed by the Department of Managed Health Care, California Department of Social Services, Department of Covered Services, US Department of Health and Human Services, and/or any other regulatory entity within the State of California that has jurisdiction where Contracted QHP serves enrollees.

- ☐ Yes
- ☐ No

3. APPLICANT HEALTH PLAN PROPOSAL

Applicant must submit a health plan proposal in accordance with submission requirements outlined in this section. Applicant's proposal will be required to include at least one of the standardized plan designs and use the same provider network for each type of standard plan design in a family of plans or insurance policies for specified metal level actuarial values.

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 California Health Benefit 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.

Two-Tier networks are allowed to overlay standard benefit plan designs. A Two-Tiered Network is defined as a benefit design with two in-network benefit levels. Standard plan cost-share is applied to the most cost-effective network with higher cost-share allowed for more expensive in-network choice. Actuarial value is based on likely overall use of tiered networks.

Medications are a point of great concern for consumers. Choosing the best plan may include making decisions based on consumer education needs. Ensuring that one QHP is not disadvantaged over another QHP due to formulary design is a concern for the Exchange.

Plan or Policy Submission Requirements

QHP Applicants must submit ~~-~~one of the 2016~~5~~ Standard Benefit Plan Designs ~~which will be adopted in a future administrative rulemaking~~ and offer all four metal levels and a catastrophic plan in its proposed rating regions.

QHP Applicants may submit proposals for both standard benefit plan designs and the Health Savings Account-eligible standardized design. Health Savings Account-eligible plans may only be proposed at the bronze level in the Individual exchange, and only at the bronze and silver levels in the SHOP.

In addition to the standard benefit design, SHOP Applicants may submit proposals for an alternate benefit design.

3.1 QHP New Entrant Applicant must comply with 2016 ~~2015~~ Standard Benefit Plans Designs ~~which will be adopted in a future administrative rulemaking~~ . Applicant must certify its proposal includes a health product offered at all four metal tiers (bronze, silver, gold and platinum) and catastrophic for each plan it proposes to offer in a rating region. SHOP New Entrant Applicants must certify proposals include a health product offered at all four metal tiers (bronze, silver, gold and platinum). If not, the Applicant's response will be disqualified from consideration. Certification of the actuarial value of each QHP product tier will be performed by the relevant regulatory agency. Complete Attachment B1 Plan Type by Rating Region (Individual) to indicate the rating regions and number and type of plans for which you are proposing a QHP in the Individual Exchange. If applicable, use Attachment B2 Plan Type by Rating Region (SHOP) to submit a SHOP proposal.

☐ Yes, completed Attachment to indicate the rating regions and number and type of plans proposed

☐ No

3.2 The Exchange is encouraging the offering of plan products which include all ten Essential Health Benefits including the pediatric dental Essential Health Benefit. QHP issuer must indicate if it is prepared to adhere to the 2016 ~~2015~~ all ten Essential Health Benefit standard plan design. Failure to offer a product with all ten Essential Health Benefits will not be grounds for rejection of Applicant's application.

3.2.1 Individual Exchange QHPs proposed for 2016 include all ten Essential Health Benefits.

☐ Yes~~, prepared to offer QHP inclusive of embedded pediatric dental Essential Health Benefit~~

☐ No~~, not prepared to offer QHP inclusive of embedded pediatric dental Essential Health Benefit~~

3.2.2 SHOP Exchange QHPs, if applicable, proposed for 2016 include all ten Essential Health Benefits.

☐ Yes

☐ No

3.3 If Applicant answered yes to 3.2, Applicant must describe how it intends to embed pediatric dental Essential Health Benefit as described in 3.2. Provide information describing any intended subcontractor relationship, if applicable, to offer the pediatric dental Essential Health Benefit. Include a description of how QHP issuer will ensure subcontractor adheres to pediatric dental quality measures as determined by Covered California.

3.4 QHP issuer must submit copies of draft disclosure documents including Evidence of Coverage, Summary of Benefits and Coverage and any member disclosure documents that describe proposed 2016 QHP benefits. These draft documents are to be submitted with the response to this application, prior to filing with the applicable regulator.

3.5 QHPs are required to offer products in accordance with Covered California's Standard Benefit Plan Designs, which stipulate four tiers of drug coverage: 1) Generic, 2) Preferred Brand Drugs, 3) Non-preferred Brand Drugs, 4) Specialty Drugs.

3.5.1 Attach a copy of the full formulary(ies), by product, that will be available to Covered California enrollees. Provide the most recent version of your formulary and ensure there is a date on the formulary.

3.5.2 Attach a copy of the tiered formularies that will be available to Covered California enrollees, by product. Provide the most recent version of your formulary and ensure there is a date on the formulary.

If not already tiered according to the 2016 Standard Benefit Plan Designs, provide additional information identifying which medications will be included in each of the four required tiers.

Identify medications by tiers:

- List all Generic Drugs
- List all Preferred Brand Drugs
- List all Non-preferred Brand Drugs
- List all Specialty Drugs

3.5.3 Provide definitions for each of the four tiers (e.g.: describe how Applicant defines a “specialty drug”.)

3.5.4 Describe the criteria for categorizing drugs into the four tiers of drug coverage.

3.6 Preliminary Premium Proposals: Final negotiated and accepted premium proposals shall be in effect for the second full year of operation of the Exchange, effective January 1, 20165, or for the SHOP plan year. Premium proposals are considered preliminary and may be subject to negotiation as part of QHP certification and selection. The final negotiated premium amounts are expected to align with the product rate filings that will be submitted to the regulatory agencies. Premium proposals will be due May 1, 20154. To submit premium proposals for Individual products, QHP applicants will complete and upload through System for Electronic Rate and Form Filing (SERFF) the Unified Rate Review Template (URRT) and the Rates Template located at: http://www.serff.com/plan_management_data_templates.htm . See Section 9 SHOP Supplemental Application for instructions to submit SHOP Premium Proposals. Premium may vary only by geography (rating region), by age band (within 3:1 range requirement), by coverage tier, and by actuarial value metal level.

Applicant shall provide, upon the Exchange’s request, 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 providing adequately supported cost projections. Cost projections include factors impacting rate changes, assumptions, transactions and other information that affects the Exchange specific rate development process. Information pertaining to the key indicators driving the medical factors on trends in medical, pharmacy or other healthcare Provider costs may also be requested to support the assumptions made in forecasting and may be supported by information from the Plan’s actuarial systems pertaining to the Exchange-specific account.

3.7 ~~3.5~~ 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 type of platform and proposed Exchange product, complete and upload through SERFF the Service Area Template located at http://www.serff.com/plan_management_data_templates.htm.

☐ Yes, health plan proposal covers entire geographic service area; ~~attachment~~ template completed

☐ No

3.7.1 For Plan Year 2016, Covered California is encouraging new entrant and recertifying QHP issuers to expand coverage in geographic areas where there are fewer than three plan choices. See Appendix B for zip codes identifying these geographic areas.

☐ Yes, health plan proposal includes zip codes identified in Appendix B.

☐ No, health plan proposal does not include zip codes identified in Appendix B.

3.8 ~~3.6~~ Applicant must confirm if it is interested in a multi-year contract. ~~2015 New Entrant QHPs will be offered in 2015 and 2016 if Applicant's QHPs continue to meet certification criteria.~~

The Exchange seeks to promote multi-year partnerships with QHPs, foster rate stability and encourage QHP investments in product design, network development, and quality improvement programs.

☐ Yes, Applicant is interested in a multi-year contract.

☐ No, Applicant is not interested in a multi-year contract.

4. PROVIDER NETWORK[5]

All requests for provider related data pertain to networks to be available to Covered California enrollees.

4.1 Use Attachment C1 ~~2015~~2016 Enrollment Projections (Individual) and Attachment C2 2016 Enrollment Projections (SHOP) to submit ~~2015~~2016 enrollment projections by product that Applicant proposes for ~~2015~~ 2016. ~~Enrollment projections for both Individual and SHOP Exchange products are reported in this attachment, if applicable.~~ Enrollment projections must be consistent with enrollment projections filed with the regulator.

4.2 Describe your network strategy:

4.2.1 Does Applicant conduct provider negotiations and manage its own network or does applicant lease a network from another organization? If applicant leases a network, describe the terms for the lease agreement: 1) length of the lease agreement (effective date and termination date), 2) ability to direct the addition of new providers, 3) ability to influence provider contract

[5] A Health Care Service Plan as defined in Health and Safety Code 1345(f) may use any delivery platform (e.g. HMO, PPO or EPO).

terms to allow transparency and to implement new programs to enhance care and quality in accordance with the Mission and Vision of Covered California.

4.2.2 Does Applicant allow out of state providers to participate in networks to serve Covered California enrollees? How does Applicant ~~deal with~~ provide access ~~issues~~ for enrollees who live near the state border and may prefer to access care in the bordering state? ~~For example, providers in Reno, Nevada often serve California residents.~~

4.3 Describe provider contracting strategy for your projected 2016 network by product or plan (e.g. HMO, PPO, EPO).

4.3.1 Does Applicant contract providers directly, at the individual practitioner level or at the risk-bearing organization (e.g. medical groups, independent practice associations) level only?

Applicant's Delivery System Platform	**Only Directly Contract with Individual Practitioners (Yes/No)**	**Only Directly Contract with Risk-Bearing Organizations (Yes/No)**	**Directly Contract with both Individual Practitioners and Risk-Bearing Organizations (Yes/No)**
HMO			
PPO			
EPO			

~~4.2~~ 4.4 Provider ~~directory~~ network data for both Individual and SHOP Exchange products for 2016 must be included in this submission for all geographic locations to which applicant is applying for certification as a QHP. Please submit provider data according to the data file layout Attachment D Provider Data File Layout. Be sure that the projected provider network submission for 2016 is consistent with what will be filed to the appropriate regulator for approval if selected to be a QHP. The Exchange requires the information as requested to allow cross network comparisons and evaluations.

~~4.3~~ 4.5 Applicant must certify that for each rating region in which it submits a health plan proposal, the proposed products meet provider network adequacy standards established by the relevant regulatory agency. Provider network adequacy will be evaluated by the governing regulatory agency and verified by Covered California. Additionally, for Plan Year ~~2015~~ 2016, network adequacy standards applicable to dental provider networks will apply to the embedded pediatric dental benefit. ~~See Section 5 for complete Essential Community Provider (ECP) requirements.~~

- ☐ Yes, health plan proposal meets relevant provider network adequacy standards

☐ No

Note that the relevant regulatory agency will assess Applicant's compliance with provider network adequacy standards. See Section 6 for Covered California's complete Essential Community Provider (ECP) Network requirements.

~~4.4~~ 4.6 Using the Healthcare Effectiveness Data and Information Set (HEDIS) technical specifications, identify the number and percentage of contracted primary care physicians, specialists and practitioners who are board-eligible/certified in their respective area of medical specialization in your network for Plan Year 2014 ~~in 2013~~. It is expected that over eighty-five percent of network physicians are board-eligible/certified.

4.6.1 Primary Care Physicians (including Family Practice, General Practice, Pediatrics, Internal Medicine and OB/GYNs)

Number of Board Eligible/Certified in Contracted Network for 2014: ____

Percent Board Eligible/Certified in Contracted Network for 2014: ____

4.6.2 Specialists (including allergists, cardiologists, dermatologists, gastroenterologists, general surgeons, ophthalmologists, orthopedic surgeons, and otolaryngologists and all other medical specialties)

Number of Board Eligible/Certified in Contracted Network for 2014: ____

Percent Board Eligible/Certified in Contracted Network for 2014: ____

~~4.5~~ 4.7 Identify your Centers of Excellence participating facilities that will be available to Covered California enrollees. Specifically indicate the locations of each facility and the type of procedures included, particularly: 1) transplant services (bone marrow, kidney, liver, lung, heart, pancreas), 2) Comprehensive Cancer Care, 3) Bariatric Surgery, 4) Maternity Care.

Type of Procedure	**Facility Name and Locations**	**Available to Covered CA Enrollees? (yes or no)**
1) transplant services (bone marrow, kidney, liver, lung, heart, pancreas),	*Name and location if selection in first column*	
2) Comprehensive Cancer Care,		

3) Bariatric Surgery		
4) Maternity Care		

~~4.6~~ 4.8 Describe any contractual agreements with your participating providers that preclude your organization from making contract terms transparent to plan sponsors and Members.

Applicant must confirm that, if certified as a QHP, to the extent that any Participating Provider's rates are prohibited from disclosure to the Exchange by contract, the Contracted QHP shall identify such Participating Provider. Issuer shall, upon renewal of its Provider contract, but in no event later than July 1, ~~2015~~2016, 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, Contracted QHP agrees to make commercially reasonable efforts to exclude any contract provisions that would prohibit disclosure of such information to the Exchange.

- ☐ Yes, confirmed
- ☐ No, not confirmed

Contract Provisions	Description
What is your organization doing to change the provisions of your contracts 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	

~~4.7~~4.9 Identify the hospitals terminated between January 1, ~~2013~~ 2014 and December 31, ~~2013~~ 2014, including any hospitals that had a break in maintaining a continuous contract during this period. Indicate reason for hospital termination: non-agreement on rates, non-compliance with contract provisions, re-design of network, other (explain).

Total Number of Contracted Hospitals: _____

Total Number of Terminated Hospitals between ~~1/1/13-12/31/13~~ 1/1/2014 – 12/31/2014: _____

Name of Terminated Hospital	Terminated by Issuer or Hospital	Reason for Termination

4.10 Identify the number of participating providers who have terminated from the provider network between 1/1/2014 – 12/31/2014, by rating region.

Covered CA Rating Region #	County	Number of Terminated Providers	Number Terminated by Provider	Number Terminated by Issuer

~~4.8~~4.11 Identify the Independent Practice Associations (IPA), Medical Groups, clinics or health centers terminated between January 1, ~~2013~~ 2014 and December 31, ~~2013~~ 2014, including any IPAs or Medical Groups, Federally Qualified Health Centers 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, other (explain).

Total Number of Contracted IPA/Medical Groups/Clinics (provide information by region, market or city):

Total Number of Terminated IPA/Medical Groups/Clinics ~~between 1/1/13-12/31/13~~1/1/2014 – 12/31/2014:

Name of Terminated IPA/Medical Group/Clinic	Region, Market, or City	Terminated by Issuer or IPA/Medical Group/Clinics	Reason for Termination	Percent of network change/ disruption (# of total entities / # terminated entities)

~~4.9~~ 4.12 Do you perform provider efficiency profiling?

☐ Yes

☐ No

If yes, provide sample calculations showing how an individual Provider is ranked relative to its peers for efficiency profiling, your appeals and correction process. Please include an explanation of how your provider ranking methodology comports with the Patient Charter, which can be accessed at http://healthcaredisclosure.org/docs/files/PatientCharter.pdf ~~.~~

4.13 What non-financial incentives are used to encourage Members to enhance value by use of lower cost and/or higher quality Providers? Non-financial incentives may include, for example: incentive gifts to encourage completion of Health Assessments, making information available in print or online to members to inform care decisions, encouraging use of providers with high profile scores or encouraging member choice of Centers of Excellence programs or other preferred providers for services. (Check all that apply)

☐ Non-financial incentives not used

☐ Information on provider quality and/or costs made available to members through employer, health plan, or other sources

☐ Other (describe)

Is Applicant willing to add a reference to "Choosing Wisely" to its member materials to support member access to information on shared decision options? Choosing Wisely information can be accessed at www.**choosingwisely**.org

☐ Yes

☐ No

4.14 For Plan Year 2016, describe your plans for network development by proposed Covered California product or plan. This description of intended network development should be consistent with the network filings that will be filed with the appropriate regulator.

4.14.1 Do you anticipate making significant changes to your current network(s) that could be described as narrow network or tiered networks?

Anticipate making significant changes ☐ Yes ☐ No

4.14.2 If yes to 4.4.1, describe any plans for network narrowing, by product.

4.14.3 Describe any plans for network tiering, by product, and include description of financial impact to consumer. Discuss how network tiering will be consistent with Covered California's standard benefit designs.

4.14.4 Will Covered California enrollees in Applicant's EPO and PPO networks have access to providers in both the EPO and PPO without restriction or financial penalty?

☐ Yes

☐ No

If yes, provide description of Covered California enrollee access between EPO and PPO networks and indicate the geographic regions ~~which~~that will be impacted.

4.14.5 Describe any plans for network expansion, by product, including the addition of medical systems.

4.14.6 Describe any plans for other network changes that will affect Covered California products or enrollees.

~~4.11 What non-financial incentives are used to encourage Members to enhance value by use of lower cost and/or higher quality Providers? (Check all that apply)~~

~~☐ Non-financial incentives not used~~

~~☐ Information on provider quality and/or costs made available to members through employer, health plan, or other sources~~

~~☐ Other (describe)~~

4.15~~2~~ ~~Applicant must confirm that, if certified, Contracted QHP shall, at a minimum, document its plans to~~ If Applicant is selected as a certified Qualified Health Plan (QHP) applicant must make available to Plan Enrollees information provided for public use, as it becomes available, that reflects the CMS Hospital Compare Program and CMS Physician Quality Reporting System, or Health Resources and Services Administration (HRSA) Uniform Data System as appropriate. ~~Contracted~~ Once certified, QHP shall report how it is or intends to make provider specific cost and quality information available by region, and the processes by which it updates the information.

☐ Yes,- Applicant confirm~~ed~~s it will make information available to enrollees and acknowledges expectation to make specific cost and quality data available.

☐ No, not confirmed

4.163 ~~How have you~~ Covered California has a mission to improve health care quality. Many new models of health care delivery are being developed to improve health care quality. Describe applicant's efforts, if any, to structure~~d~~ provider networks to drive improved quality.

4.16.1 Please describe efforts to improve care for the following three domains: 1) Access for all enrollees, 2) access for enrollees with chronic conditions and 3) implementation of new models for cost-efficiency.

4.16.2 Will these programs be available for Covered California enrollees as of January 2016?

4.16.3 If you have not implemented any such programs, how might you approach this for the Exchange?

4.16.4 Identify the strategies you have implemented or intend to implement to promote access and care coordination:

- ☐ Accountable Care Organizations (ACO)
- ☐ Patient Centered Medical Homes (PCMH)
- ☐ The use of a patient-centered, team-based approach to care delivery and member engagement
- ☐ A focus on additional primary care recruitment, use of Advanced Practice Clinicians (nurse practitioners, physician assistants, certified nurse midwives) and development of new primary care and specialty clinics
- ☐ A focus on expanding primary care access through payment systems and strategies
- ☐ The use of an intensive outpatient care programs (e.g. "Ambulatory ICU") for enrollees with complex chronic conditions
- ☐ The use of qualified health professionals to deliver coordinated patient education and health maintenance support, with a proven approach for improving care for high-risk and vulnerable populations
- ☐ Support of physician and patient engagement in shared decision-making;
- ☐ Providing patient access to their personal health information
- ☐ Promoting team care
- ☐ The use of telemedicine
- ☐ Promoting the use of remote patient monitoring

4.174 Delivery System Reform: In keeping with its mission, vision and values, the Exchange is charged with encouraging delivery system reforms which increase quality and consumer choice, lower cost and improve carehealth. Complete Attachment ED1 Delivery System Reform (Individual) by indicating which delivery system reforms your health plan offers now and will offer in which rating regions to serve Exchange enrollees in 2016. If applicable, complete Attachment ED2 Delivery System Reform (SHOP).

If your plan does not offer any reforms, describe any plans to develop such programs for the Exchange enrollees.

5. ESSENTIAL COMMUNITY PROVIDERS

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

i. Qualified Health Plan Applicants must use Attachment F Essential Community Provider Network Data Submission to indicate list contracts with all providers designated as ECP. ~~and indicate the category of each contracted ECP (e.g. 340B or DSH hospital or Medi-Cal HI-Tech provider or Federally Qualified Health Center, etc.)~~

ii. Applicants must demonstrate sufficient geographic distribution of a mix of essential community providers reasonably distributed throughout the geographic service area; **AND**

iii. Applicants must demonstrate contracts with at least 15% of 340B entities (where available) throughout each ~~county~~ rating region in the proposed geographic service area; **AND**

iv. Applicants must include at least one ECP hospital (including but not limited to 340B hospitals, Disproportionate Share Hospitals, critical access hospitals, academic medical centers, county and children's hospitals) per each county in the proposed geographic service area where available. ~~**AND**~~

Determination that an essential community provider network meets the standard of sufficient geographic distribution with a balance of hospital and non-hospital providers and serves the low-income population within the proposed geographic service area requires the Applicant to apply interactively all four criteria above. The Exchange will evaluate the application of all four criteria to determine whether the Applicant's essential community provider network has achieved the sufficient geographic distribution and balance between hospital and non-hospital requirements. The above are the minimum requirements. For example, in populous

counties, one ECP hospital will not suffice if there are concentrations of low-income population throughout the county that are not served by a sole contracted ECP hospital.

~~ECP networks which include more contracted Federally Qualified Health Centers (FQHC) and Tribal and Urban Indian clinics are preferred and will be considered more favorably. Certified QHPs contracting with Tribal or Urban Indian Clinics must use the Centers for Medicare & Medicaid Services Model QHP Addendum for Indian Health Care Providers. (See Appendix B Model QHP Addendum for Indian Health Care Providers).~~

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

Essential Community Providers are those providers posted in the Covered California Consolidated Essential Community Provider List available at:

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

~~Attachments E1 Contracted Providers By County as of 1-1-14 and Attachment E2 Contracted Facilities by County as of 1-1-14: Complete the attachments by including name(s) of 340B entity contracted and all service sites affiliated with each contracted 340B entity. Only include site locations for a 340B entity if such site is included under the terms of the Issuer-provider contract. Please complete the contracted provider listing data elements using the supplied format in Attachments F1 and F2.~~ The Exchange will calculate the percentage of contracted 340B entities located in each ~~county of~~ rating region of the proposed geographic service area. All 340B entity service sites shall be counted in the denominator, in accordance with the most recent version of Covered California's Consolidated ECP list ~~HRSA 340B provider site listing/link, which can be found at:~~

~~http://www.hrsa.gov/opa/~~

Categories of Essential Community Providers:

Essential Community Providers include the following:

1. The Center for Medicare & Medicaid Services (CMS) non-exhaustive list of available 340B providers in the PHS Act and section 1927(c)(1)(D)(i)(IV) of the Social Security Act.
2. Facilities listed on the California Disproportionate Share Hospital Program, Final DSH Eligibility List FY ~~2012-2013~~ 2013-2014
3. Federally designated 638 Tribal Health Programs and Title V Urban Indian Health Programs

4. Community Clinic or health center licensed as either a “community clinic” or “free clinic”, by the State of California under Health and Safety Code section 1204(a), or is a community clinic or free clinic exempt from licensure under Section 1206
5. Physician Providers with approved applications for the HI-TECH Medi-Cal Electronic Health Record Incentive Program
6. Federally Qualified Health Centers (FQHCs)

~~Covered California will reference Census Tract Level Data on Distribution of California Low-Income Population to identify geographic areas of low-income populations. Appendix C Census Tract Data on California Low Income Population includes data from the Year 2000 United States Census on number of Low-Income Individuals that live in a census tract.~~ 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 ~~county~~ maps to compare contracted providers against the supply of ECPs and ~~against maps which display~~ the distribution of low-income Covered California enrollees.

~~Applicants will be permitted to write-in ECPs not on the CMS-developed non-exhaustive list of available 340B providers.~~

Alternate standard:

QHP issuers that provide a majority of covered professional services through physicians employed by the issuer or through a single contracted medical group may request to be evaluated under the “alternate standard.” The alternate standard requires a QHP issuer to have a sufficient number and geographic distribution of employed providers and hospital facilities, or providers of its contracted integrated medical group and hospital facilities to ensure reasonable and timely access for low-income, medically underserved individuals in the QHP’s service area, in accordance with the Exchange’s network adequacy standards.

To evaluate an Applicant’s request for consideration under the alternate standard, please submit a written description of the following:

1. Percent of services received by Applicant’s members which are rendered by Issuer’s employed providers or single contracted medical group; **AND**
2. Degree of capitation Issuer holds in its contracts with participating providers. What percent of provider services are at risk under capitation; **AND**
3. How Issuer’s network is designed to ensure reasonable and timely access for low-income, medically underserved individuals; **AND**
4. Efforts Issuer will undertake to measure how/if low-income, medically underserved individuals are accessing needed health care services (e.g. maps of low-income members relative to 30-

minute drive time to providers; survey of low-income members experience such as CAHPS “getting needed care” survey)

If existing provider capacity does not meet the above criteria, the Applicant may be required to provide additional contracted or out-of-network care. Applicants are encouraged to consider contracting with identified ECPs in order to provide reasonable and timely access for low-income, medically underserved communities.

6. Operational Readiness and Capacity & Technical Requirements

6.1 Administrative and Account Management Support

6.1.1 Provide a summary of your organization’s capabilities including how long you have been in the business as an Issuer. Are there any recent or anticipated changes in your corporate structure, such as mergers, acquisitions, new venture capital, management team, location of corporate headquarters or tax domicile, stock issue? If yes, Applicant must describe.

6.1.2 Provide a description of any company initiatives, either current or planned, over the next 18 – 24 months which will impact the delivery of services to Exchange members during the contract period. Examples include system changes or migrations, call center opening or closing, or network re-contracting.

6.1.3 Do you routinely subcontract any significant portion of your operations or partner with other companies to provide health plan coverage? If yes, identify which operations are performed by subcontractor or partner.

- Yes
- No

6.1.4 Does your organization provide any administrative services that are not performed within the United States? If yes, describe.

- Yes
- No

6.1.5 Applicant must include an organizational chart of key personnel who will be assigned to Covered California. Provide details of the Key Personnel and representatives of the Account Management Team who will be assigned to Covered California.

	Contact Name	**Title**	**Phone (include extension)**	**Fax**	**E-mail**

President or CEO					
Chief Medical Officer					
Chief Actuary (Lead for Exchange Rate Development)					
Lead Account Manager for Exchange					
Director, Provider Network Management					
Key Contact for CalHEERS technical questions					
Key Contact for Operational Questions					
Other					

6.1.6 Applicant must identify the individual(s) who will have primary responsibility for servicing the Exchange account. Please indicate where these individuals fit into the organizational chart requested above. Please include the following information and repeat as necessary.

- Name
- Title
- Department
- Phone
- Fax
- E-mail

6.2 MEMBER SERVICES

6.2.1 QHP will be required to staff sufficiently to meet contractual member services performance goals. Will you modify your customer service center operating hours,

staffing requirements, and training criteria to meet Exchange requirements? Check all that apply and describe.

___Yes: expected operating hours during Open Enrollment are 8 am to 8 pm

___Yes: staffing requirements - Please provide CSR Ratio to members

___Yes: training criteria

___Yes: languages spoken

___Yes: interface with CalHEERS and Pinnacle HCMS

___No, the organization can handle the increased volume

___No, not willing to modify operations

6.2.2 How do you provide members information regarding how to use their health insurance? Briefly describe your capabilities.

	Yes/ No	Description
Provider referrals		
Member benefit summaries		
Member EOCs		
Member claims status		
Other		

6.2.3 Do you provide secure online tools for members to understand their out-of-pocket costs and possible costs of clinical care choices? If so, describe.

☐ Yes

☐ No

6.2.4 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 regardless of which State Health Insurance Regulator regulates the QHP.

☐ Yes, confirmed

☐ No, not confirmed

6.3 Out-of-Network Benefits

6.3.1 For non-network, non-emergency claims (hospital and professional), describe the terms and manner in which you administer out-of-network benefits. Can you administer a "Usual, Customary, and Reasonable" (UCR) method utilizing the nonprofit FAIR Health (www.fairhealth.org) database to determine reimbursement amounts? What percentile do you target for non-network UCR? Can you administer different percentiles? What percent of your in-network contract rates does your standard non-network UCR method reflect?

Non-Network Claims	Yes/	Describe
Ability to administer FAIR Health UCR method		
Targeted UCR percentile		%
Ability to administer different percentiles		
Amount as a percentage of network contract value		%

6.3.2 Contracted QHPs are required to disclose financial information regarding costs of care to Enrollees. If you intend to offer a PPO product which provides coverage for out-of-network, non-emergent care, describe the steps you will take to disclose to Enrollees the amount Issuer will pay for this care and the amount enrollee will be responsible to pay for such care ~~of additional fees Issuer may impose on this care.~~

6.4 Systems and Data Reporting Management

Issuers must maintain data interfaces with the Exchange and allow the Exchange to monitor issuer operational performance. The Exchange uses the California Healthcare Enrollment, Eligibility and Retention System (CalHEERS) and Pinnacle HCMS for eligibility, enrollment and retention information technology. QHPs must build data interfaces with the CalHEERS and Pinnacle systems and report on transactions.

6.4.1 Technical Interface Capacity

6.4.1.1 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 CalHEERS and Pinnacle HCMS, as early as May ~~2014~~ 2015. Applicant must confirm it will implement systems in order to accept and generate 834, 820, 999 and other standard format electronic files for enrollment and premium remittance in an accurate, consistent and timely fashion and utilize the information for its intended purpose. Covered California requires QHPs to sign an industry-standard agreement which establishes

electronic information exchange standards in order to participate in the required systems testing.

6.4.1.2 Applicant must confirm it will implement systems in order to accept and generate TA1 and 999 acknowledgement files and other standard format electronic files and utilize the information for its intended purpose. Applicant must confirm that it has the capability to accept and complete non-electronic enrollment submissions and changes.

6.4.1.32 Applicant must be able to ~~accurately, appropriately, and timely~~ populate and submit SERFF templates in an accurate, appropriate, and timely fashion at the request of Covered California for:

- Administrative Information
- Rates
- Service Area
- Benefit Plan Designs
- Network

6.4.1.43 Applicant must be able to submit provider data in a format as required by Covered California and at intervals requested by Covered California. ~~for the purposes of populating the centralized provider directory.~~

6.4.1.5 Applicant confirms that it will submit and upload corrections to SERFF within 72 hours of notification by Covered California.

6.4.1.6 Applicant may not make any changes to its SERFF templates once submitted to Covered California without providing prior written notice to Covered California and until Covered California agrees with the proposed changes.

6.4.1.74 Applicant must be able to meet data submission requirements for third party network and clinical analytics vendor, which will require an independent capability for analytics using standard and normalized information sets, standardized risk adjustment, and cross regional and cross issuer analysis.

6.4.1.85 Applicant must provide comments on the requested data formats for interfaces between the Issuer's systems and the Exchange's systems in a timely fashion.

6.4.1.96 Applicant must be ~~available for~~ prepared and able to conduct testing of data interfaces with the Exchange no later than July 1, ~~2014~~2015 and confirms it will plan and implement testing jointly with Covered California in order to meet system release schedules.

6.4.1.107 Will the secure online tools provided by your organization for the Exchange program staff and Members be available 99.5 percent of the time, twenty-four (24) hours a day, seven (7) days a week? If no, describe level of guaranteed availability.

- ☐ Yes
- ☐ No

6.4.1.118 Do you proactively monitor, measure, and maintain the application(s) and associated database(s) to maximize system response time/performance on a regular basis and can your organization report status on a quarterly basis? Describe below.

- ☐ Yes
- ☐ No

6.4.1.129 Do you provide secure online tools for analysis of member utilization and cost trends? Describe below.

- ☐ Yes
- ☐ No

6.4.1.1310 Indicate (1) the types of data and reporting available to the Exchange on health management and chronic conditions, and (2) the sources of data used to generate the types of reports available to the Exchange. The Exchange expects plans to help assess and improve health status of their Exchange members using a variety of sources. Check all that apply.

	Report Features	Sources of Data
Cost	*Multiple-choice* 1: Group-specific results reported 2: Comparison targets/benchmarks of book-of-business 3: Comparison benchmarks of similarly sized groups 4: Report available for additional fee 5: Data/reporting not available	*Multiple-choice* 1: HRAs 2: Medical Claims Data 3: Pharmacy Claims Data 4: Lab Values 5: Other source - please detail below
Utilization	*Same as above*	*Same as above*
Chronic Condition Prevalence	*Same as above*	*Same as above*
Plan Enrollee Use of Preventive Services	*Same as above*	*Same as above*
Participant Population stratified by Risk and/or Risk Factors	*Same as above*	*Same as above*

Disease Management (DM) program enrollment	*Same as above*	*Same as above*
Health status change among DM enrollees	*Same as above*	*Same as above*

6.4.1.1~~1~~41 Performance Measurement capacity: Applicant must designate, as applicable, which of the following performance measures it measures currently, or could measure in the future, for Exchange-specific products. The specific performance metrics noted after the bullet points are performance levels Covered California will require.

Performance Measure	Measure Now Yes/No	Can Measure Exchange-Specific
Operational Standards – Customer Service		
Call Answer Timeliness • 80% of calls answered within 30 seconds		
Processing ID Cards • For the Individual Exchange, 99% sent within 10 business days of receiving complete and accurate enrollment information and binder payment for a specific consumer. For SHOP, 99% sent within 10 business days of receiving complete and accurate enrollment information for a specific consumer. ~~from the Exchange and premium~~		
Number of ID Cards Issued • Number of initial ID cards processed and issued to the consumer.		
Telephone Abandonment Rate • No more than 3% of incoming calls in a calendar month.		
Abandoned Call Volume • Number of calls offered to the service center by the ACD, but terminated by the person originating the call outside of the service level (i.e., 30 seconds)		
Abandonment Rate • The percentage of calls abandoned, calculated by dividing the Abandoned Call Volume by the Inbound Call Volume		
Average Handling Time • The average number of minutes of talk time, hold time, and wrap time necessary to complete the interaction		
Initial Call Resolution for Covered California • 85% of enrollee issues will be resolved within one (1) business day of receipt of the issue		
Grievance Resolution • 95% of enrollee grievances resolved within 30 calendar days of initial receipt.		
Operational Standards		
Enrollment and Payment Transactions • The Exchange will receive the 999 file within ~~one~~ two to three business days of receipt of the 834~~/820~~ file 85% of the time. ~~and within 3 business days of receipt of the 834/820 file 99% of the time within any given month~~		

~~Effectuation and Enrollment Upon Receipt of Payment~~ Reconciliation of Pended Status Enrollee(s) • The Exchange will receive the ~~834~~ effectuation file within ~~one~~ 60 business days from effective date of member 90% of the time. ~~of receipt of the member's initial payment file 85% of the time and within three business days of receipt of the member's initial payment 99% of the time within any given month~~		
~~Member Payment~~ Reconciliation Process • ~~The Exchange will receive the 820 file with one business day of receipt of the member's payment file 95% of the time and within 3 business days of receipt of the member's payment 99% of the time within any given month~~For non-payment the Exchange will receive an 834 cancellation file within 60 days of the member intended effective date 90% of the time.		
~~Enrollment Change Upon Non-Receipt of Member Payment, 30 Day Notice and Termination~~ • ~~The Exchange will receive the 834 file within one business day of receipt of change of the member's status 95% of the time and within 3 business days of receipt of change of the member's status 99% of the time within any given month~~		
Number of Binder Payment Notices Generated – Individual Exchange • Number of initial binder payment notices generated and mailed to the consumer		
Number of Binder Payments Processed – Individual Exchange • Number of binder payments paid-in-full and processed		
Binder Payment Processing Time – Individual Exchange • Time elapsed from the date the binder payment invoice was mailed for a specific consumer(s) through the date the carrier received the binder payment from that consumer(s)		
Member Email or Written Inquiries • Total number of member email or written inquiries received		
Member Email or Written Inquiries • ~~Correspondence~~ 90% ~~response to~~ of email or written inquiries answered within 15 ~~working~~ business days of inquiry. Does not include grievances or appeals.		
Member Call Volume • Track only – no performance requirement or penalty		
Quality Standards		
Quality – Getting the Right Care		
Appropriate Care		
Appropriate Testing for Children With Pharyngitis		
Appropriate Treatment for Children With Upper Respiratory Infection		
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis		
Use of Imaging Studies for Low Back Pain		
All-Cause Readmissions		
Annual Monitoring for Patients with Persistent Medications		
Plan All-Cause Readmission (average adjusted probability of readmission)		
Diabetes Care		
CDC: Medical Attention for Nephropathy		
CDC: Hemoglobin-A1c Testing		

CDC: LDL-C Screening		
CDC: Eye Exam (Retinal) Performed		
CDC: LCL-C Control (<100 mg/DI)		
CDC: HbA1c Control (<8.0%)		
CDC: Blood Pressure Control (140/90 mm Hg)		
CDC: HbA1c Poorly Control (>9.0%)		
Cardiovascular Care		
Controlling High Blood Pressure		
Cholesterol Management for Patients with Cardiovascular Conditions: LDL-C Control (<100 mg/dL)		
Cholesterol Management for Patients With Cardiovascular Conditions (LDL-C Screening Only)		
Persistence of beta blocker treatment after a heart attack		
Behavioral Health Care		
Antidepressant Medication Management (Both Rates)		
Follow-Up After Hospitalization for Mental Illness (7-Day Rate Only)		
Follow-Up for Children Prescribed ADHD Medication (Both Rates)		
Initiation & Engagement of Alcohol & Other Drug Dependence Treatment - Engagement (13-17 Yrs and 18+ Yrs)		
Other Chronic Care		
Medication Management for People With Asthma (50%/75% remained on controller medications)		
Use of Spirometry Testing in the Assessment and Diagnosis of COPD		
Drug Therapy for Rheumatoid Arthritis		
Pharmacotherapy management of COPD Exacerbation (bronchodilator and systemic corticosteroid)		
Doctor and Care Ratings		
Global Rating of Care (CAHPS)		
Global Rating of Personal Doctor (CAHPS)		
Global Rating of Specialist (CAHPS)		
Quality – Access to Care		
Getting Care Quickly Composite (CAHPS)		
Getting Needed Care Composite (CAHPS)		
Child and Adolescent Access to Primary Care Practitioners (12-14, 25mo-6yr, 7-11, 12-19) (HEDIS)		
Adults' Access to Preventive/Ambulatory Health Services (20-44 years and 45-64 years) (HEDIS)		
Quality - Staying Healthy/Prevention		
Adult Staying Health/Prevention		
Checking for Cancer		
Breast Cancer Screening		

Cervical Cancer Screening		
Colorectal Cancer Screening		
Getting Help Staying Healthy		
Chlamydia Screening in Women (Age 21-24)		
Adult BMI Assessment		
Prenatal and Postpartum Care (Both Rates)		
Flu Shots for Adults (Ages 50-64) (CAHPS)		
Medical Assistance with Smoking and Tobacco Use Cessation (Advising Smokers and Tobacco Users to Quit Only) (CAHPS)		
Aspirin Use and Discussion (CAHPS)		
Children and Adolescent Staying Healthy/Prevention		
Weight Assessment & Counseling for Nutrition and Physical Activity for Children and Adolescents		
Well-Child Visits in the 3rd, 4th, 5th, & 6th Years of Life		
Well Child Visits in the First 15 Months of Life		
Adolescent Well-Care Visits		
Immunizations for Adolescents		
Childhood Immunization Status – Combo 3		
Chlamydia Screening in Women (Age 16-20)		
Quality – Plan Service		
Claims Processing Composite (CAHPS)		
Customer Service Composite (CAHPS)		
Plan Information on Costs Composite (CAHPS)		
Global Rating of Plan (CAHPS)		

6.4.1.152 Applicant operates in compliance with applicable federal and state privacy laws and regulations, and maintains appropriate procedures in place to detect and respond to privacy and security incidents.

- ☐ Yes, confirmed
- ☐ No, not confirmed

6.4.1.163 Applicant must confirm it has in place administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Protected Health Information and Personally Identifiable Information that it creates, receives, maintains, or transmits.

- ☐ Yes, confirmed
- ☐ No, not confirmed

6.4.2 Financial Interface Capacity

6.4.2.1 Applicant must confirm it has in place systems to invoice new members effective October 15, 20142015. If such systems are not currently in place, describe plans to implement such systems, including the use of any

~~potential~~ vendors for any functions related to invoicing, if applicable, and an implementation workplan.

- ☐ Yes, confirmed
- ☐ No, not confirmed

6.4.2.2 Applicant must confirm it has in place systems to accept premium payments (including paper checks, cashier's checks, money orders, EFT, web-based payment, and all general purpose pre-paid debit cards and credit card payment) from members effective October 15, 2014. If such systems are not currently in place, describe plans to implement such systems, including the use of~~any potential~~ vendors for any functions related to premium payment, if applicable, and an implementation workplan. QHP must accept premium payment from members no later than October 15, ~~2014~~ 2015. Note: QHP issuer must accept credit cards for binder payments and is encouraged, but not required, to accept credit cards for payment of ongoing invoices.

- ☐ Yes, confirmed
- ☐ No, not confirmed

6.4.2.3 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 binder and ongoing payments for both on-Exchange and off-Exchange lines of business.

6.4.2.4 Applicant must confirm it can provide detailed documentation, including member level detail, to substantiate each per-member per-month (PMPM) payment in a format that is compatible with Covered California's systems. ~~Describe the controls in place to ensure the California Health Benefit Exchange assessment revenue is accurately and timely paid.~~

6.4.2.5 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 issuer in California.

6.5 IMPLEMENTATION PERFORMANCE

6.5.1 Will an implementation manager and support team (not part of the regular account management team) be assigned to lead and coordinate the implementation activities with the Exchange? If yes, specify the name and title(s) of the individual(s).

6.5.2 Should your organization's QHPs be certified by the Exchange, explain how you anticipate accommodating the ~~sizeable~~ additional membership effective January 1, ~~2015~~ 2016(Dd~~d~~iscuss assessment of current resources (human, office space, phone capacity), anticipated hiring needs, staff reorganization, etc.~~)~~:

- Member Services
- Claims
- Account Management
- Clinical staff
- Disease Management staff
- Implementation
- Financial
- Administrative
- Actuarial
- Information Technology
- Other (describe)

6.5.3 Indicate your current or planned procedures for managing the new enrollee transition period. Check all that apply:

- ☐ Request transfer from prior health or dental plan, if applicable, and utilize information to continue plan/benefit accumulators
- ☐ Load claim history from prior health or dental plan, if any
- ☐ Services that have been pre-certified but not completed as of the effective date must also be pre-certified by new plan
- ☐ Will provide pre-enrollment materials to potential Enrollees within standard fees
- ☐ Will make customer service line available to new or potential Enrollees prior to the effective date
- ☐ Provide member communications regarding change in health or dental plans

6.5.4 Describe your network transition of care provisions for patients who are currently receiving care for services at practitioners that are not in your network. Specifically describe plans for transitions of care for the following: 1) pregnant women currently receiving care from a non-network provider, 2) enrollees receiving a course of treatment such as chemotherapy, or scheduled for an invasive procedure. Describe any other transition of care services provided by applicant.

6.5.5 Provide a detailed implementation project plan and schedule targeting a January 1, ~~2015~~ 2016 effective date.

6.6 Fraud, Waste and Abuse Detection

The Exchange is committed to working with its QHPs to establish common efforts to minimize fraud, waste and abuse.

Fraud - An intentional deception or misrepresentation made by a person or entity with the knowledge that the deception could result in some unauthorized benefit to him/herself, itself or some other person or entity. It includes any act that constitutes fraud under applicable federal or state law.

Waste - Waste is the intentional or unintentional, thoughtless or careless 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 also includes incurring unnecessary costs as a result of inefficient or ineffective practices, systems, or controls.

Abuse – Behaviors or practices of providers, physicians, or suppliers of services and equipment that, although normally not considered fraudulent, are inconsistent with accepted sound medical, business, or fiscal practices. The practices may, directly or indirectly, result in unnecessary costs to the program, improper payment, or payment for services that fail to meet professionally recognized standards of care, or which are medically unnecessary. Abuse can also occur with excessive charges, improper billing practices, payment for services that do not meet recognized standards of care and payment for medically unnecessary services. Abuse can occur in financial or non-financial settings.

6.6.1 Describe the processes used in addressing fraud, waste, and abuse for the following:

Process	Description
Determining what is investigated • Specific event triggers • Overall surveillance, audits and ~~scans~~ • Fraud risk assessment	
Method for determining whether fraud, waste, and abuse has occurred	
Follow-up and corrective measures	
Recovery and remittance of funds	

6.6.2 Describe your approach to the following:

Approach	Description
Controls in place to confirm non-contracted Providers who file Claims for amounts above a defined expected threshold of the reasonable and customary amount for that procedure and area.	
Use of the Healthcare Integrity and Protection Data Bank (HIPDB) as part of the credentialing and re-credentialing process for contracted Providers.	
Controls in place to monitor referrals of Plan Members to any health care facility or business entity in which the Provider may have full or partial ownership or own shares.	
Controls in place to confirm enrollment and disenrollment actions are accurately and promptly executed.	
Other	

6.6.3 Provide a brief description of your fraud detection policies (i.e., fraud as it relates to Providers and Plan Members).

Providers	
Plan Members	

6.6.4 Provide a sample copy of your fraud, waste, and abuse report.

- ☐ Sample provided
- ☐ Sample not provided

6.6.5 Indicate how frequently internal audits are performed for each of the following areas.

	Daily	Weekly	Monthly	Quarterly	Other (Specify)
Claims Administration					

	Daily	Weekly	Monthly	Quarterly	Other (Specify)
Customer Service					
Network Contracting					
Eligibility & Enrollment					
Utilization Management					
Billing					

6.6.6 Overall, what percent of Claims are subject to internal audit?

%

6.6.7 Indicate if external audits were conducted for Claims administration for your entire book of business for the last two (2) full calendar years.

	Audit Conducted	Audit Not Conducted
Most recent year		
Prior year		

6.6.8 Indicate the types of Claims and Providers that you typically review for possible fraudulent activity. Check all that apply.

- ☐ Hospitals
- ☐ Physicians
- ☐ Skilled nursing
- ☐ Chiropractic
- ☐ Podiatry
- ☐ Behavioral Health
- ☐ Alternative medical care
- ☐ Durable medical equipment Providers
- ☐ Other service Providers

6.6.9 Describe the different approaches you take to monitor these types of Providers.

6.6.10 Specify your system for flagging unusual patterns of care. Check all that apply:

- ☐ Identified at time of Claim submission
- ☐ Data mining
- ☐ Plan Member referrals
- ☐ Other – Specify

6.6.11What was your organization's recovery success rate and dollars recovered for fraudulent Claims?

	%	$
2012		
2013		

6.6.12 Applicant must confirm that, if certified, Contracted QHP will agree to subject itself to the Exchange for audits and reviews, either by the Exchange or its designee, or the Department of General Services, the Bureau of State Audits or their 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 Advance Premium Tax Credit (APTC) payments and participation fee payments Issuer made to the Exchange. Issuer also agrees to all audits subject to applicable State and Federal law regarding the confidentiality of and release of confidential Protected Health Information of Enrollees.

- ☐ Yes, confirmed
- ☐ No, not confirmed

6.6.13 Describe your revenue recovery process to recoup erroneously paid claims.

6.6.14 Describe how you educate your members to identify and report possible fraud scams. What are your procedures to report fraud scams to law enforcement?

6.6.15 Describe how you safeguard against Social Security and Identity fraud.

6.7 Approaches to Enrollment

Covered California achieves enrollment through a variety of partnerships including Certified Enrollment Entities, Certified Insurance Agents and Certified Plan Based Enrollers.

6.7.1. Describe any experience you may have working with Certified Enrollment Entities or similar entities.

6.7.2 Describe any experience you have working with Certified Insurance Agents or licensed agents.

6.7.2.1 What initiatives is your organization undertaking in order to partner more effectively with the small business community?

6.4.2.2 What initiatives is your organization undertaking in order to partner more effectively with the agent community?

6.7.2.3 What criteria do you use to appoint agents to sell Individual and Small Group products?

6.7.2.4 Does your health plan contract with general agents? If so, please list the general agents with whom you contract and how long you have maintained those relationships.

6.7.2.5 Describe your health plan agent commission schedule for your individual and small group business. Include whether or not the compensation level changes as the business written by the agent matures, and also specify if the agent is compensated at a higher level as he or she attains certain levels/amounts of inforce business. Does the compensation level apply to all plans or benefits or does it vary by plan or benefits?

6.7.2.6 Describe any bonus program your company currently has in place for additional agent compensation. This may include cash bonuses or in-kind compensation programs. Please answer this question relative to general agents as well.

6.7.3 Describe any experience you may have performing plan-based enrollment.

6.8 Marketing and Outreach Activities

The Exchange is committed to working closely with QHPs to maximize enrollment in the Exchange. The Exchange will support enrollment efforts through outreach and education, including statewide advertising efforts aimed at prospective and existing members of the Covered California Health Benefit Exchange. QHP Issuers are required to develop and execute their own marketing plans promoting the enrollment in their respective Exchange plans. Contracted QHPs will adhere to ~~the~~ Covered California Brand Style Guidelines for specific requirements regarding a QHP's use of the Exchange brand name, logo, and taglines. Contracted QHPs will

also adhere to QHP Marketing Guidelines, including requirements for development, submission, and timing of QHP marketing plans and materials.

In the questions that follow, Applicants must provide detailed information pertaining to the Applicant's plans for marketing and advertising for the individual and small group market. Where specific materials are requested, please be sure to label the attachments clearly.

6.8.1 Applicant must provide an organizational chart of ~~your~~ its individual and small group sales and marketing department(s) and identify the individual(s) with primary responsibility for sales and marketing of the Exchange account. Please indicate where these individuals fit into the organizational chart. Please include the following information:

- Name
- Title
- Department
- Phone
- Fax
- E-mail

6.8.2 Applicant must describe its plan to cooperate with Exchange marketing and outreach efforts, including internal and external training, collateral materials and other efforts.

6.8.3 Applicant must confirm that, ~~it will be expected to co-brand the ID card, premium invoices and termination notices.~~ upon certification, it will adhere to Exchange requirements to co-brand ID cards, premium invoices, and termination notices issued to Exchange enrollees. The Exchange retains the right to communicate with Exchange customers and members.

☐ Yes, confirmed

☐ No, not confirmed

6.8.4 Applicant must provide a copy of the most recent Calendar Year or Fiscal Year Marketing Plan for the current lines of business. Applicants serving the Medi-Cal Managed Care population shall report such marketing as "Individual" marketing.

6.8.5 Applicant must indicate estimated total expenditures and allocations for Individual and Small Group related marketing and advertising functions during the most recent Calendar Year/Fiscal Year. Using the table below, Applicant must provide a detailed picture of how this Individual and Small Group funding

commitment was applied. Indicate N/A if the Applicant did not market Individual or Small Group products in the most recent period.

Marketing Results	Total Cost		Total Sales		Cost per Sale	
	Individual	SmallGroup	Individual	Small Group	Individual	Small Group
Television (media investment only)						
Radio (media investment only)						
Out-of-Home (media investment only)						
Newsprint (media investment only)~~t~~						
FSI (Free Standing Inserts) (media investment only)						
Direct Mail (list cost, postage, printing/fulfillment)						
Shared Mail (media investment only)						
Search Engine Marketing (media investment only)~~g~~						
Digital (display, video, mobile, radio) (media investment only)						
Social Media (media investment only)						
Email Marketing (list and deployment costs)						
Lead Purchase						

Broker Seminars			N/A	N/A	N/A	N/A
Direct Sales to Businesses						
Other (specify)						

6.8.6 Applicant must confirm it will adhere to Covered California naming conventions ~~promulgated through a future administrative rulemaking by Covered California for 2015.~~ for on-Exchange plans and off-Exchange mirror products pursuant to Government Code 100503(f).

7. Quality and Delivery System Reform

The Exchange's "Triple Aim" framework seeks to improve the patient care experience including quality and satisfaction, improve the health of the population and reduce the per capita cost of Covered Services. The Quality and Delivery System Reform standards outlined in the QHP Contract outline the ways the Exchange and Contracted QHPs will focus on the promotion of better care and higher value for plan enrollees and other California health care consumers.

7.1 Accreditation

Applicant must be currently accredited by Utilization Review Accreditation Commission (URAC), National Committee on Quality Assurance (NCQA) or Accreditation Association for Ambulatory Health Care (AAAHC). If issuer is not currently accredited, issuer must have an interim survey in place by January 1, ~~2015~~ 2016 in order to offer plans on the Exchange in ~~2015~~ 2016. QHPs must have full accreditation by January 1, ~~2016~~ 2017. Issuer shall authorize the accrediting agency to provide information and data to the Exchange relating to Issuer's accreditation, including, the most recent accreditation survey and other data and information maintained by accrediting agency as required under 45 C.F.R. § 156.275.

7.1.1 Specify the accrediting organization (National Committee on Quality Assurance (NCQA), Utilization Review Accreditation Commission (URAC), Accreditation Association for Ambulatory Health Care (AAAHC)), accreditation status, expiration date of accreditation, next scheduled survey date(s) and proposed timeline if full accreditation has not been achieved or maintained.

NCQA ___

___ Exchange-specific accreditation (if applicable) ___

URAC ___

Exchange-specific accreditation (if applicable) __

AAAHC __

Exchange-specific accreditation (if applicable) __

~~Applicant must provide the following information:~~

~~Applicant's accrediting organization:~~

~~Applicant's current accreditation status:~~

~~Next scheduled survey date(s):~~

~~If full accreditation has not been achieved or maintained, describe proposed timeline to achieve interim survey and full accreditation.~~

7.1.2 For applicants accredited by NCQA, provide the current accreditation status

__ a. Excellent

__ b. Commendable

__ c. Accredited

__ d. Provisional

__ e. Interim

__ f. Denied

7.1.3 Enter the expiration date

__ a. Expires: __/__/__

7.1.4 Next scheduled survey date

__ a. Date: __/__/__

__ b. Next survey date not scheduled

7.1.5 Attach a copy of the NCQA Certificate of Accreditation. If the health plan received a rating of less than "accredited," attach a copy of the corrective action plan (CAP).

7.1.6 For applicants accredited by URAC, provide the current accreditation status.

__ a. Full accreditation

__ b. Provisional accreditation as a start-up

__ c. Conditional accreditation

d. In process

7.1.7 Enter the expiration date

a. Expires __/__/__

7.1.8 Next scheduled survey date

a. Date: __/__/__

b. Next survey date not scheduled

7.1.9 Attach a copy of the URAC Certificate of Accreditation. If the health plan received conditional accreditation, attach a copy of the corrective action plan (CAP).

7.1.10 For applicants accredited by AAAHC, provide the current accreditation status

a. AAAHC Accredited

7.1.11 Enter the expiration date

a. Expires: __/__/__

7.1.12 Next scheduled survey date

a. Date: __/__/__

b. Next survey date not scheduled

7.1.13 Attach a copy of the AAAHC Certificate of Accreditation

7.2 eVALUE8 SUBMISSION

7.2.1 Applicant must complete the eValue8 Request for Information submission as specified in Section 8 of this application.

7.3 QUALITY IMPROVEMENT STRATEGY

As part of a Quality Improvement Strategy, identify the mechanisms the Applicant intends to use to promote improvements in health care quality, better prevention and wellness and making care more affordable. These mechanisms may include plan designs that reduce barriers or provide incentives for preventive or wellness services. The Exchange will give more weight to those responses from Applicants that engage in programs that foster payment and other practices that encourage primary care, care coordination, quality improvement, promoting health equity and reducing costs.

7.3.1 Applicant must describe their past or current initiatives in these areas in the sections that follow and in the eValue8 sections. See Section 9 SHOP Supplemental Application to complete additional detail regarding the availability of financial incentives in SHOP products.

Preventive and Wellness Services	Available in Individual Exchange	Available in SHOP Exchange	SHOP Exchange Financial Incentives
Health Assessment Offered	*Yes/No*	*Yes/No*	*Yes/No*
Plan-Approved Patient-Centered Medical Home Practices	AS ABOVE	AS ABOVE	AS ABOVE
Encourage Participation in Weight-Loss Program (Exercise and/or Diet/Nutrition)	AS ABOVE	AS ABOVE	AS ABOVE
Tobacco Cessation Program	AS ABOVE	AS ABOVE	AS ABOVE
Wellness Goals Other than Weight-Loss and Tobacco Cessation: Stress Management	AS ABOVE	AS ABOVE	AS ABOVE
Wellness Goals Other than Weight-Loss and Tobacco Cessation: Mental Health	AS ABOVE	AS ABOVE	AS ABOVE
OTHER	AS ABOVE	AS ABOVE	AS ABOVE

7.3.2 Describe two Quality Improvement Projects (QIPs) conducted 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 ~~This description shall include but is not limited to,~~ the following information:

QIP Name/Title: Start/End Dates:
Problem Addressed:
Targeted Population:
Study Question:
Study Indicator(s):
Baseline Measurement:
Best Practices Related to Sustained Improvement Achieved (if any):

7.4 Medical Management Services

7.4.1 Do you provide physician report cards? If so, do you use external guidelines to measure physician performance? Describe those procedures and processes. Also describe how the information is shared with consumers.

If you do not provide physician report cards, describe why. Describe if there are plans to implement such report cards or other methods used to evaluate provider quality performance and how that is shared with consumers.

Process	Yes/No	If Yes, description	Description of consumer access to physician performance
Internally Developed Guidelines			
External Guidelines • National Quality Forum • Patient Charter for Physician Performance Measurement			
Other			

7.4.2 Do you provide a Nurse Advice Line? If so, what percentage of eligible members currently accesses the Nurse Advice Line?

- ☐ Yes, provide Nurse Advice Line:
  - ☐ 0-5%
  - ☐ 6-10%
  - ☐ 11-20%
  - ☐ 21-30%
  - ☐ >31%
- ☐ No Nurse Advice Line provided

If you do not provide an advice line, describe how enrollees access assistance after hours related to clinical questions.

If utilization of nurse advice line is below 20%, describe plans to reach consumers and assist them with clinical questions.

7.4.3 Indicate the availability of the following health information resources for ~~to~~ Covered California members. (Check all that apply)

- ☐ 24/7 decision support/health information services

- ☐ Self-care books
- ☐ Preventive care reminders
- ☐ Web-based health information
- ☐ Integration with other health care vendors
- ☐ Integration with a client's internal wellness program
- ☐ Newsletter
- ☐ Other (describe)

7.4.4 Explain how your health plan encourages hospitals and other providers to improve patient safety on an ongoing basis. The focus should be on quality improvement, not claims payment determination. How is information collected and used to improve care and safety for members as well as provide feedback to providers to improve their care?

Describe any oversight your health plan performs targeting the following areas as outlined by the Center for Medicare and Medicaid Services (CMS) Hospital Compare Program:

- Deaths and readmissions,
- Serious complications related to specific conditions,
- Hospital-acquired conditions,
- Health care associated infections.

7.5 Behavioral Health Medical Management

7.5.1 Do you manage Behavioral Health services in-house or do you subcontract? How do you incorporate behavioral health information in identifying members for care management programs or interventions?

7.5.2 Describe how you incorporate Evidence-Based Medicine and monitor outcomes to institute and assess best practices for behavioral health. Include a description of your efforts to assess and modify networks and implement best practices that would meet the specific needs of the Exchange population demographics.

7.5.3 What are your recent actual managed behavioral health network results?

	Actual
Bed days/1,000 members	
Professional encounters/1,000 members	

7.6 HEALTH AND DISEASE MANAGEMENT

All Contracted QHPs are required to demonstrate the capacity and systems to collect, maintain and use individual information about Plan Enrollees' health status and behaviors to promote better health and to better manage Enrollee's health conditions. If a Health Assessment tool is used, Contracted QHP shall use a tool that allows for monitoring of ongoing Enrollee health status. Contracted QHPs will report to the Exchange, at the individual and aggregate levels, changes in Plan Enrollees' health status and outcomes of referral to care management and chronic condition programs based on identification of decline in health status through health assessment process.

7.6.1 Does your health plan use a Health Assessment? ~~If yes, are responses used to identify members for care management programs and is data relayed to providers? Is the data used to assess or stratify risk?~~ Identify which of the following you perform using Health Assessment ("HA") data.

	Yes ~~(describe)~~	No
Populate a personal health record with the information		
Personalize/tailor messages on preventive reminders		
Provide action steps for members to take		
Send a reminder when it is time to take next HA		
Relay data to providers		
Refer to lifestyle management programs (online and telephonic)		
Refer to disease management programs		
Assess/stratify risk using both HA and claims data mining		

7.6.2 Which of the following are communicated to Members? (Check all that apply):

- ☐ Pharmacy compliance reminders
- ☐ Personalized reminders for screenings and immunizations

- Plan monitors whether member has received indicated screenings and immunizations and can provide aggregated reports of the percentage of members that have received these.

- None of the above

7.6.3 Provide or describe three examples of preventive care notifications currently in use by your health plan.

7.7 INTEGRATED HEALTHCARE MODEL

The Exchange is interested in how Applicants plan to address components of an Integrated Healthcare Model:

An integrated model of health care delivery is one in which there is organizational/operational/policy infrastructure addressing patient care across the continuum of care, population management and improvements in care delivery, IT infrastructure to support care delivery, adherence to Evidence Based Medicine (EBM) behaviors from all providers of care, and financial risk sharing incentives for the health plan, hospital, and medical group that drive continuous improvement in cost, quality, and service.

7.7.1 From an organizational/operational/policy perspective, Applicant must indicate if its delivery model addresses the following, providing descriptions where applicable:

Attribute	**Description**
Describe your processes to coordinate care management in the following areas:	
a. Transitional Care	
b. Long Term/Catastrophic	
c. End of Life	

7.7.2 What national sources of Evidence~~d~~ Based Medicine practice guidelines do you use? List all that apply, e.g., Agency for Healthcare Research and Quality, Milliman guidelines.

7.7.3 Describe any requirements you may have for your contracted hospitals to report performance information based on the National Quality Forum consensus measures.
http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=69376

If your plan does not require reporting of such performance information, explain plans to implement such performance monitoring and reporting.

7.7.4 Describe your measurement strategy and any specific ability to track impact on Exchange enrollees for the following areas:

Strategy	Description
Describe your policies in place to address population health management across ~~covered~~ enrolled Members.	
Describe your ability to track Exchange-specific IHM metrics supporting risk-sharing arrangements.	
Describe your processes, if any, to track and monitor clinical and financial performance measurement related to the Integrated Healthcare Association (IHA).	
Describe your ability to track and monitor Exchange-specific data in the following areas:	
a. Member satisfaction	
b. Cost and utilization management (e.g., admission rates, complication rates, readmissions)	
c. Clinical outcome quality	

7.7.5 For your networks, describe your policies to support and give examples of how you support the following:

Attribute	Description
Disease registries	
Ability to identify overuse, under-utilization, and misuse of services	
Access to data by Providers and Members across the continuum of care (e.g., Physicians, Hospitalists, Case Managers, etc.)	
Decision support for Member and Physician interaction in care management	

7.8 INNOVATIONS

7.8.1 Describe your institutional capacity to plan, implement, and evaluate future healthcare quality and cost innovations for Exchange Members. Please include a description of plans for scalability or replicability of successful innovations. Programs that target at-risk enrollees (e.g.: communities at risk for health disparities, enrollees with chronic-conditions, those who live in medically underserved areas) are of special interest to the Exchange.

7.8.2 Covered California seeks to conduct advanced analytics to assess performance of both the Exchange and its contracted health plans. These expectations for Covered California enrollees mean significant clinical and network analytics capacity are needed by each QHP. Describe your infrastructure available or currently in use for clinical and network analytics.

To facilitate analytics and innovations based on data, Contracted QHP will submit claims and encounter data to an Exchange identified third party analytics vendor. Vendor will aggregate data elements related to the following areas:

- Provider network adequacy
- Risk mix and segmentation
- QHP quality
- High severity of illness patient care
- Care management/integration services
- Health disparities reduction
- Hospital quality
- Physician reporting -- patient care interventions
- Care continuity
- Enrollee choice of doctor, practice or medical group -- physician and practice performance ratings
- Enrollee affordability of care
- Payment and benefit design innovation

Applicant agrees to submit claims and encounter data to Exchange identified third party analytics vendor.

☐ Yes

☐ No

8. eVALUE8™ SUBMISSION – eVALUE8 REQUEST FOR INFORMATION

9. SHOP SUPPLEMENTAL APPLICATION

9.1 Applicant must identify the individual(s) who will function as the Exchange's primary contact for SHOP products.

- Name
- Title
- Department
- Phone
- Fax
- E-mail

9.2 In addition to standardized benefit design products, the Applicant may submit ~~one (1)~~ up to two (2) alternate benefit design products for the rating region. Alternate benefit designs are optional. Applicants are not required to offer alternate benefit designs in order to participate in SHOP. Alternate benefit designs must comply with state statutory and regulatory requirements. If two plans are proposed, the plans should be of different metal tiers. ~~The alternate benefit design must be offered at the silver level but is not required to be offered at all metal levels;~~ ~~a~~Any alternate benefit design must represent a product family using the same network across all actuarial values. The alternate benefit design offering should incorporate the standard composite calculation process utilized for all SHOP plans.

Use Attachment G~~F~~ SHOP Alternate Plan Design to submit all cost-sharing and other details for proposed alternate benefit plan designs. The Exchange is not necessarily encouraging alternate benefit plan designs and will carefully scrutinize such proposals.

☐ Yes, completed Attachment G~~F~~ to indicate benefits and cost-sharing for each alternate benefit design proposed

☐ No, not proposing alternate benefit design

If yes, Attachment G SHOP Alternate Plan Design to indicate benefits and member cost sharing design for each alternate benefit plan design you propose. In completing the matrix, Applicant may insert text to:

- Indicate any additional or enhanced benefits relative to EHB
- Confirm all plans include pediatric oral and vision EHB
- If in-network tiers are proposed, describe the structure for hospital or provider tiers.

9.3 Preliminary Premium Proposals: Final negotiated and accepted premium proposals shall be in effect for the 12 month period subsequent to the initial effective dates for all employer groups whose initial effective dates are between January 1, 2016~~5~~ and December 31, 2016~~5~~. Premium proposals are considered preliminary and may be subject to negotiation as part of QHP certification and selection. The final negotiated premium amounts are expected to align with the product rate filings that will be submitted to the regulatory agencies in conjunction. Premium bids are due May 1, 2015~~4~~. To submit premium proposals for SHOP products, QHP applicants will complete and upload through the System for Electronic Rate and Form Filing (SERFF) the Unified

Rate Review Template (URRT) and the Rates Template located at: http://www.serff.com/plan_management_data_templates.htm. Premium may vary only by geography (rating region), by age band (within 3:1 range requirement), by coverage tier, and by actuarial value metal level.

Applicant shall provide, upon the Exchange's request, 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 providing adequately supported cost projections. Cost projections include factors impacting rate changes, assumptions, transactions and other information that affects the Exchange specific rate development process. Information pertaining to the key indicators driving the medical factors on trends in medical, pharmacy or other healthcare Provider costs may also be requested to support the assumptions made in forecasting and may be supported by information from the Plan's actuarial systems pertaining to the Exchange-specific account.

~~9.4 **Agent Relations, Fees and Commissions**~~

~~9.4.1 What initiatives is your organization undertaking in order to partner more effectively with the small business community?~~

~~9.4.2 What initiatives is your organization undertaking in order to partner more effectively with the agent community?~~

~~9.4.3 What criteria do you use to appoint agents to sell Individual and Small Group products?~~

~~9.4.4 Does your health plan contract with general agents? If so, please list the general agents with whom you contract and how long you have maintained those relationships.~~

~~9.4.5 Describe your health plan agent commission schedule for your individual and small group business. Include whether or not the compensation level changes as the business written by the agent matures, and also specify if the agent is compensated at a higher level as he or she attains certain levels/amounts of inforce business. Does the compensation level apply to all plans or benefits or does it vary by plan of benefits?~~

~~9.4.6 Describe any bonus program your company currently has in place for additional agent compensation. This may include cash bonuses or in-kind compensation programs. Please answer this question relative to general agents as well.~~

9.~~4~~5. Quality Improvement

9.~~4~~5.1 Complete the following table to provide additional detail regarding member incentives available in SHOP Exchange.

Preventive and Wellness Services	Available in SHOP Exchange	SHOP Exchange Financial Incentives	SHOP Exchange Financial Incentives
Incentives Contingent	*Yes/No*	*Yes/No*	*Multi, Checkboxes.* 1: Waive/adjust out-of-pocket payments for tests, treatments, Rx contingent upon completion/participation, 2: Part of program with reduced employee premium

			share and increased employer premium share contingent upon completion/participation. Health Plan premium rates remain unchanged, 3: Rewards (cash payments, discounts for consumer goods, etc.) administered independently of medical services and contingent upon completion/participation, 4: Waived or decreased co-payments/deductibles for reaching prevention goals, 5: Incentives to adhere to evidence-based self-management guidelines, 6: Incentives to adhere to recommended care coordination encounters, 7: Not supported
Health Assessment Offered	AS ABOVE	AS ABOVE	
Plan-Approved Patient-Centered Medical Home Practices	AS ABOVE	AS ABOVE	
Encourage Participation in Weight-Loss Program (Exercise and/or Diet/Nutrition)	AS ABOVE	AS ABOVE	
Tobacco Cessation Program	AS ABOVE	AS ABOVE	
Wellness Goals Other than Weight-Loss and Tobacco Cessation: Stress Management	AS ABOVE	AS ABOVE	
Wellness Goals Other than Weight-Loss and Tobacco Cessation: Mental Health	AS ABOVE	AS ABOVE	
OTHER	AS ABOVE	AS ABOVE	