



**Qualified Health Plan Application
Plan Year 2019**

**Individual Marketplace
January 12, 2018**

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19 Covered California Quality Improvement Strategy (QIS)**Error! Bookmark not defined.**

19.2.2 QIS for Reducing Health Disparities and Ensuring Health Equity **Error! Bookmark not defined.**

19.2.3 QIS for Promoting Development and Use of Care Models – Primary Care**Error! Bookmark not defined.**

1 Application Overview

1.1 Purpose

The California Health Benefit Exchange (Exchange) is accepting applications from eligible Health Insurance Issuers¹ (Applicants) to submit proposals to offer, market, and sell qualified health plans (QHPs) through the Exchange beginning in 2018, for coverage effective January 1, 2019. Application for certification for Plan Year 2019 is limited to (1) Medi-Cal Managed Care Plans and (2) plans newly licensed and offered for sale in the individual market after May 2, 2016. QHP Issuers contracted for Plan Year 2018 will complete a simplified certification application since those issuers have a three year contract with the Exchange that imposes ongoing requirements that are similar to the requirements in the certification application and consideration of this contract performance is included in the evaluation process. The Exchange will exercise its statutory authority to selectively contract for health care coverage offered through the Exchange for plan year 2019. The Exchange reserves the right to select or reject any Applicant or to cancel this Application at any time.

1.2 Background

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

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

The Exchange is guided by the following values:

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

¹ The term "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 that has been certified by the Exchange. Qualified Health Plans may also be referred to as "products". The term "Applicant" refers to a Health Insurance Issuer who is seeking to have its products certified as Qualified Health Plans.

Affordability: The Exchange will provide affordable health insurance while assuring quality and access.

Catalyst: The Exchange will be a catalyst for change in California's health care system, using its market role to stimulate new strategies for providing high-quality, affordable health care, promoting prevention and wellness, and reducing health disparities.

Integrity: The Exchange will earn the public's trust through its commitment to accountability, responsiveness, transparency, speed, agility, reliability, and cooperation.

Transparency: The Exchange will be fully transparent in its efforts and will make opportunities available to work with consumers, providers, health plans, employers, purchasers, government partners, and other stakeholders to solicit and incorporate feedback into decisions regarding product portfolio and contract requirements.

Results: The impact of the Exchange will be measured by its contributions to decrease the number of uninsured, have meaningful plan and product choice in all regions for consumers, improve access to quality healthcare, promote better health and health equity, and achieve stability in healthcare premiums for all Californians.

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

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

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

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

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

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

1.3 Application Evaluation and Selection

The evaluation of QHP Certification 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 needs of consumers in that region and the Exchange's goals. The Exchange wants to provide an appropriate range of high quality health plans to participants at the best available price that is balanced with the need for consumer stability and long term affordability. In consideration of the mission and values of the Exchange, the Board of the Exchange articulated guidelines for the selection and oversight of Qualified Health Plans which are used when reviewing the QHP application proposals for 2019. These guidelines are:

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

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

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

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

Encourage Competition Based upon Meaningful QHP Choice and Product Differentiation: Patient-Centered Benefit Plan Designs²

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 adhere to the Exchange's standard benefit plan designs in each region for which they submit a proposal. In addition, QHP Applicants may offer the Exchange's standard Health Savings Account-eligible (HSA) High Deductible Health Plan (HDHP) designs. Applicants may choose to offer either or both of the Gold and Platinum standard benefit plan designs only if there is differentiation between two plans in the same metal tier that is related to either product, network or both. The Exchange is interested in having HMO, EPO and PPO products offered statewide. Within a given product design, the Exchange will look for differences in network providers and the use of innovative delivery models. Under such criteria, the Exchange may choose not to contract with two plans with broad overlapping networks within a rating region unless they offer different innovative delivery system or payment reform features.

Encourage Competition throughout the State

The Exchange must be statewide. Issuers must submit 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.

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

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

Encourage Delivery System Improvement, Effective Prevention Programs and Payment Reform

One of the values of the Exchange is to serve as a catalyst for the improvement of care, prevention and wellness as a way to reduce costs. The Exchange wants QHP offerings that incorporate innovations in delivery system improvement, prevention and

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

wellness, and/or payment reform that will help foster these broad goals. This will include models of patient-centered medical homes, targeted quality improvement efforts, participation in community-wide prevention, or efforts to increase reporting transparency in order to provide relevant health care comparisons and to increase member engagement in decisions about their course of care.

Demonstrate Administrative Capability and Financial Solvency

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

Encourage Robust Customer Service

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

1.4 Availability

The Applicant must be available immediately upon contingent certification of its plans as QHPs 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, 2019. Successful Applicants will also be required to adhere to certain provisions through their contracts with the Exchange, including meeting data interface requirements with the California Healthcare Enrollment, Eligibility, and Retention System (CalHEERS). Successful Applicants must execute the QHP Issuer contract before public announcement of contingent certification. The successful Applicants must be ready and able to accept enrollment as of October 1, 2018.

1.5 Application Process

The application process shall consist of the following steps:

- Release of the Final Application;
- Submission of Applicant responses;
- Evaluation of Applicant responses;

- Discussion and negotiation of final contract terms, conditions and premium rates; and
- Execution of contracts with the selected QHP Issuers.

1.6 Intention to Submit a Response

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

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

New Applicant Entrants

New applicant entrants should meet the following minimum qualifications:

- Currently licensed and in good standing with the applicable Regulator,
- (2) year minimum experience operating as a health issuer, and
- (2) year minimum experience operating in the California marketplace (exchange or other market segments).

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

Application Contact: Jen Jacobs
Jen.Jacobs@Covered.Ca.gov
(916) 228-8273

1.7 Key Action Dates Action

Action	Date/Time
Release of Draft Application for Comment	January 2018
Letters of Intent due to the Exchange	February 16, 2018
Application Opens	March 1, 2018
Completed Applications Due (include 2019 Proposed Rates & Networks)	May 1, 2018
Negotiations between Applicants and the Exchange	June 2018
Final QHP Contingent Certification Decisions	July 2018
QHP Contract Execution	July 2018
Final QHP Certification	October 2018

1.8 Preparation of Application Response

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

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

2 Administration and Attestation

2.1 – 2.4 required for currently contracted QHP Issuers. All questions required for new Applicant entrants.

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

	Response
Issuer Legal Name	10 words.
NAIC Company Code	10 words.
NAIC Group Code	10 words.
Regulator(s)	10 words.
Federal Employer ID	10 words.
HIOS/Issuer ID	10 words.
Corporate Office Address	10 words.
City	10 words.
State	10 words.
Zip Code	10 words.
Primary Contact Name	10 words.
Contact Title	10 words.
Contact Phone Number	10 words.
Contact Email	10 words.
Applicant Eligibility	Single, Pull-down list. 1: Contracted in 2017, 2: Newly licensed since May 2, 3: Medi-Cal Managed Care Plan
On behalf of the Applicant stated above, I hereby attest that I meet the requirements in this Application and certify that the information provided on this Application and in any attachments hereto are true, complete, and accurate. I understand that the Exchange may review the validity of my attestations and the information provided in response to this application and if an Applicant is selected to offer Qualified Health Plans, may decertify those Qualified Health Plans should any material information provided be found to be inaccurate. I confirm that I have the capacity to bind the issuer stated above to the terms of this Application.	
Date	To the day.
Signature	10 words.
Printed Name	10 words.
Title	10 words.

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

10 words.

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

- Chief Executive Officer
- Chief Finance Officer
- Chief Operations Officer
- Contracts
- Plan and Benefit Design
- Network and Quality
- Enrollment and Eligibility
- Legal
- Marketing and Communications
- Information Technology
- Information Security
- Policy

Single, Pull-down list.

Answer and attachment required

1: Attached

2: Not attached

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

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

If yes, Applicant must describe the material changes.

Single, Radio group.

1: Yes, describe: [200 words]

2: No

2.5 Indicate Applicant entity's tax status:

Single, Pull-down list.

1: Not-for-profit

2: For-profit

2.6 In what year was Applicant's entity founded?

10 words.

2.7 Upload Certificate(s) of Insurance to verify that you maintain the following Insurance Requirements:

Commercial General Liability	Limit of not less than \$1,000,000 per occurrence/ \$2,000,000 general aggregate
Comprehensive Business Automobile Liability	Limit of not less than 1,000,000 per accident
Employers Liability Insurance	Limits of not less than \$1,000,000 per accident for bodily injury by accident and \$1,000,000 per employee for bodily injury by disease and \$1,000,000 disease policy limit.
Umbrella Policy	An amount not less than \$10,000,000 per occurrence and in the aggregate
Crime Coverage	At such levels reasonably determined by Contractor to cover occurrences
Professional Liability or Errors and Omissions	Coverage of not less than \$1,000,000 per claim/ \$2,000,000 general aggregate.
Statutory CA's Workers' Compensation Coverage	Provide Proof of Coverage

If your organization does not carry the coverage/limits listed above, please provide an explanation why your organization has elected not to carry each coverage/limit.

Single, Radio group.

1: Yes,

2: No, describe: [200 words]

2.8 Indicate any experience Applicant has participating in exchanges or marketplace environments.

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

3 Licensed and Good Standing

All questions required for new Applicant entrants only.

3.1 Indicate Applicant entity license status below:

Single, Radio group.

1: Applicant currently holds all of the proper and required licenses from the California Department of Managed Health Care to operate as a health issuer as defined herein in the commercial individual market

2: Applicant currently holds all of the proper and required licenses from the California Department of Insurance to operate as a health issuer as defined herein in the commercial individual market

3: Applicant is currently applying for licensure from the California Department of Managed Health Care to operate as a health issuer as defined herein in the commercial individual market. If Yes, enter date application was filed: [To the day]

4: Applicant is currently applying for licensure from the California Department of Insurance to operate as a health issuer as defined herein in the commercial individual market. If yes, enter date application was filed: [To the day]

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

Single, Pull-down list.

1: Confirmed

2: Not confirmed

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

Single, Pull-down list.

1: Confirmed

2: Not confirmed

3: Not applicable

4 Applicant Health Plan Proposal

4.3 – 4.5 required for currently contracted QHP Issuers. All questions required for new Applicant entrants.

Applicant must submit a health plan proposal in accordance with submission requirements outlined in this section. Applicant's proposal must include at least one of the standard plan designs, and use the same provider network for each type of standard plan design in a set of standard 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 Exchange seeks to improve the quality of care while moderating cost, directly for the individuals enrolled in its plans, and indirectly by being a catalyst for delivery system reform in partnership with plans, providers and consumers. With the Affordable Care Act and the range of insurance market reforms that have been implemented, the health insurance marketplace will be transformed from one that has focused on risk selection to achieve profitability to one that will reward better care, affordability and prevention.

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

Plan or Policy Submission Requirements

Applicant must submit a standard set of QHPs including all four metal tiers and a catastrophic plan in its proposed rating regions. The QHPs in the standard set must adhere to the 2019 Standard Benefit Plan Designs and cannot vary by metal tier other than by cost sharing and premium. The same provider network must be available for each QHP in the standard set of QHPs. Applicant's proposal must include coverage of its entire licensed geographic service area.

Applicant may submit proposals including the Health Savings Account-eligible High Deductible Health Plan (HDHP) standard design. Health Savings Account-eligible plans may only be proposed at the bronze level in the individual exchange. Additionally, Applicant may submit proposals to offer additional QHPs for consideration. The additional QHP offerings proposed must be differentiated by product or network and must include all four metal tiers and a catastrophic plan in order to be considered by the Exchange.

The 2014 Payment Parameters rule preamble (78 Fed Reg at 15494) clarifies that an Exchange will be adequately enforcing the requirements of 45 CFR 156.420(b) if a QHP issuer limits the American Indian/Alaska Native (AI/AN) zero cost share plan variation to the lowest level QHP in a set of standard QHPs. (A set of standard QHPs refers to a collection of standard QHPs identical except for differences in cost sharing or premium.) Accordingly, the Exchange requires QHP issuers to offer the lowest cost AI/AN zero cost share plan variation in the standard set of QHPs. This requirement applies to both the standard Bronze plan design and the optional Bronze High Deductible Health Plan (HDHP). If the Bronze

HDHP is offered at a lower premium than the QHP Applicant's standard Bronze plan, the zero cost share A/AN variation of the Bronze HDHP must be offered to consumers instead of the standard Bronze plan variation. The zero cost share A/AN Bronze HDHP variation Evidence of Coverage document should include language to the effect that this plan variation is not eligible for use in conjunction with a Health Savings Account (HSA) or other tax advantages. The QHP issuer may not offer the zero cost share A/AN variation at the higher metal levels within the set of QHPs. However, Issuers offering the additional QHPs, that do not include a Bronze plan, must offer the A/AN zero cost share plan variation at the lowest cost in that additional set of QHPs. This requirement does not apply to the limited cost share A/AN plan variation because the member cost sharing differs depending on the provider sought by the member. Limited cost share A/AN plan variations must be offered for each QHP.

Applicant must cooperate with the Exchange to implement coverage or subsidy programs, including those that complement existing programs that are administered by the Department of Health Care Services (DHCS). These programs include requirements in Welfare and Institutions Code 14102.

4.1 Applicant must certify that its proposal includes a health product offered at all four metal tiers (bronze, silver, gold and platinum) and catastrophic for each individual plan it proposes to offer in a rating region. If not, the Applicant's response will be disqualified.

Single, Pull-down list.

1: Yes, proposal meets requirements

2: No

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

Single, Pull-down list.

1: Confirmed

2: Not confirmed

4.3 Preliminary Premium Proposals.

Final negotiated and accepted premium proposals shall be in effect for coverage effective January 1, 2018. Premium proposals are considered preliminary and may be subject to negotiation as part of QHP certification and selection. The final negotiated premium amounts must align with the product rate filings that will be submitted to the applicable regulatory agency. Premium proposals are due with submission of Applicant's application response. To submit premium proposals for Individual products, QHP applicants must complete and upload through System for Electronic Rate and Form Filing (SERFF) the Unified Rate Review Template (URRT), the Supplemental Rate Review Template (SRRT), Actuarial Memorandum and the Rates Data Template available at: [\[link to 2019 Rates Table Template\]](#). 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, in connection with any negotiation process as reasonably requested by the Exchange, detailed documentation on the Exchange-specific rate development

methodology. Applicant shall provide justification, documentation, and support used to determine rate changes, including adequately supported cost projections. Cost projections include factors impacting rate changes, assumptions, transactions and other information that affects the Exchange-specific rate development process. The Exchange may also request information pertaining to the key indicators driving the medical factors on trends in medical, pharmacy or other healthcare provider costs. This information may be necessary to support the assumptions made in forecasting and may be supported by information from the Applicant's actuarial systems pertaining to the Exchange-specific account.

Single, Pull-down list.

1: Template completed and uploaded

2: Template not completed and uploaded

4.4 Applicant must certify that for each rating region in which it submits a health plan proposal, it is submitting a proposal that covers the entire geographic service area for which it is licensed within that rating region. To indicate which zip codes are within the licensed geographic service area by proposed Exchange product, complete and upload through SERFF the Service Area Template located at: [\[link to 2019 Service Area Template\]](#).

Single, Pull-down list.

1: Yes, health plan proposal covers entire licensed geographic service area; template uploaded,

2: No, health plan proposal does not cover entire licensed geographic service area; template uploaded

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

Single, Pull-down list.

1: Yes, filing service area expansion, exhibit attached

2: Yes, filing service area withdrawal, exhibit attached

3: No, no changes to service area

5 Benefit Design

5.1 – 5.3 and 5.8 required for currently contracted QHP Issuers. All questions required for new Applicant entrants.

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

Single, Pull-down list.

1: Confirmed, template submitted

2: Not confirmed, template not submitted

5.2 Are there operational or administrative barriers to implementing the 2019 Patient-Centered Benefit Plan designs?

Single, Radio group.

1: Yes

2: No

5.3 Applicant must indicate if seeking approval for deviations from the 2019 Patient-Centered Benefit Plan Designs. If yes, Applicant must submit Attachment B Patient-Centered Benefit Design Deviations to describe the proposed deviations and the rationale for the deviation. Alternate benefit design proposals are not permitted in the Individual Marketplace.

Single, Pull-down list.

1: Yes, attachment submitted to request deviation(s)

2: No deviation(s) requested, attachment not submitted

5.4 The Exchange is encouraging the offering of plan products which include all ten Essential Health Benefits, including the pediatric dental Essential Health Benefit. Applicant must indicate if it will adhere to the 2019 standard plan design which includes all ten Essential Health Benefits. Failure to offer a product with all ten Essential Health Benefits will not be grounds for rejection of Applicant's application.

Single, Pull-down list.

1: Yes. Individual Market QHPs proposed for 2019 include all ten Essential Health Benefits.

2: No. Individual Market QHPs proposed for 2019 do not include all ten Essential Health Benefits.

5.5 If Applicant's proposed QHPs will include pediatric dental essential health benefit, Applicant must describe how it intends to embed this benefit. Applicant must describe how it will ensure that the provision of pediatric dental benefits adheres to contractual requirements, including pediatric dental quality measures. Describe any intended subcontractor relationship, if applicable, to offer the pediatric dental Essential Health Benefit.

Single, Radio group.

1: Offer benefit directly under full service license: [100 words]

2: Subcontractor relationship: [100 words],

3: Not Applicable

5.6 Applicant must indicate if proposed QHPs will include coverage of non-emergent out-of-network services.

Single, Radio group.

1: Yes, proposed QHPs will include coverage of non-emergent out-of-network services. If yes, with respect to non-network, non-emergency claims, (hospital and professional), describe the administration of out-of-network benefits including consumer communication, pricing methodology, and claims adjudication: [100 words]

2: No, proposed QHPs will not include coverage of non-emergent out-of-network services

5.7 Complete the following table to report availability of telehealth services to the Exchange enrollees and applicable cost-sharing. Indicate “Not Offered” if telehealth is not offered. If telehealth is offered by contracted medical groups, use the comments section to indicate the percentage of membership with access to those services (i.e. percent of membership attributed to the medical group).

Telehealth Visit or Service Type	Modality	Specify Applicable Cost-Share(s)/Comments
Primary Care Visit	<i>Multi, Checkboxes.</i> 1: Phone, 2: Video, 3: Instant Message/Live Chat, 4: Email, 5: Other, describe in comments, 6: Not Offered	50 words.
Specialist Visit	<i>Multi, Checkboxes.</i> 1: Phone, 2: Video, 3: Instant Message/Live Chat, 4: Email, 5: Other, describe in comments, 6: Not Offered	50 words.
Mental/Behavioral Health Visit	<i>Multi, Checkboxes.</i> 1: Phone, 2: Video, 3: Instant Message/Live Chat, 4: Email, 5: Other, describe in comments, 6: Not Offered	50 words.
Substance Abuse Treatment Visit	<i>Multi, Checkboxes.</i> 1: Phone, 2: Video, 3: Instant Message/Live Chat, 4: Email, 5: Other, describe in comments, 6: Not Offered	50 words.
Other, describe: [20 words]	<i>Multi, Checkboxes.</i> 1: Phone, 2: Video, 3: Instant Message/Live Chat,	50 words.

	4: Email, 5: Other, describe in comments, 6: Not Offered	
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5.8 Applicant must submit, as an attachment, draft Evidence of Coverage or Policy language and draft Schedules of Benefits describing proposed 2019 QHP benefits. This draft language must be submitted with the response to this application, prior to or contemporaneous to filing with the applicable regulator.

Single, Pull-down list.

1: Confirmed, attachment(s) submitted

2: Not confirmed, attachment(s) not submitted

5.9 The Exchange's Patient-Centered Benefit Plan Designs stipulate four tiers of drug coverage:

(1) Tier 1

(2) Tier 2

(3) Tier 3

(4) Tier 4

Applicant must complete and upload through SERFF the Prescription Drug Template available at [\[link to 2019 Prescription Drugs Template\]](#)

Single, Pull-down list.

1: Template completed and uploaded

2: Template not completed and uploaded

5.10 Select all options that apply from the following list to indicate how Applicant's proposed 2019 formulary will comply with California Health and Safety Code § 1342.71 and Insurance Code § 10123.193 requirements prohibiting discrimination in prescription drug benefits. Use the details section for any additional comments.

Multi, Radio group.

1: Does not discourage enrollment of individuals with health conditions and does not reduce the generosity of the benefit for enrollees with a particular condition in a manner that is not based on a clinical indication or reasonable medical management practices

2: Covers single-tablet regimens for HIV/AIDS

3: Caps cost of a 30-day supply to cost share consistent with the Standard Benefit Plan Design

4: Uses tier definitions stipulated in AB 339 and the SBPD

5: Ensure placement of prescription drugs on formulary tiers is based on clinically indicated, reasonable medical management practices

6: Updates formularies with any changes on a monthly basis

7: Includes description of utilization controls, preferred drugs, differences between medical benefit drugs and pharmacy benefit drugs, ways to obtain drugs not listed on the formulary

8: Available on the internet to the general public

9: Other (200 words)

6 Operational Capacity

6.1 Issuer Operations and Account Management Support

6.1.1 – 6.1.2 required for currently contracted QHP Issuers. All questions required for new Applicant entrants.

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

Single, Pull-down list.

Answer and attachment required

1: Attachments completed

2: Attachments not completed

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

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

200 words.

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

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

	1: Yes 2: No	
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6.1.4 Are any of Applicant's operations, such as member services call centers, conducted outside of the United States? If yes, describe: the operations.

Single, Radio group.

1: Yes, describe: [50 words]

2: No

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

Single, Pull-down list.

1: Attached

2: Not attached

6.2 Implementation Performance

All questions required for new Applicant entrants only.

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

Single, Radio group.

1: Yes, describe: [50 words]

2: No,

3: No, Applicant is currently operating in the Exchange

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

Single, Pull-down list.

1: Attached

2: Not attached

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

100 words.

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

Resource	Membership Increase (as % of Current Membership)	Resource Adjustment (specify)	Approach to Monitoring
Members Services	<i>Percent</i>	<i>50 words</i>	<i>50 words</i>

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Claims	<i>Percent</i>	<i>50 words</i>	<i>50 words</i>
Account Management	<i>Percent</i>	<i>50 words</i>	<i>50 words</i>
Clinical staff	<i>Percent</i>	<i>50 words</i>	<i>50 words</i>
Disease Management staff	<i>Percent</i>	<i>50 words</i>	<i>50 words</i>
Implementation	<i>Percent</i>	<i>50 words</i>	<i>50 words</i>
Financial	<i>Percent</i>	<i>50 words</i>	<i>50 words</i>
Administrative	<i>Percent</i>	<i>50 words</i>	<i>50 words</i>
Actuarial	<i>Percent</i>	<i>50 words</i>	<i>50 words</i>
Information Technology	<i>Percent</i>	<i>50 words</i>	<i>50 words</i>
Other (List)	<i>Percent</i>	<i>50 words</i>	<i>50 words</i>

7 Customer Service

All questions required for new Applicant entrants only.

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

Single, Pull-down list.

1: Confirmed

2: Not confirmed

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

Single, Radio group.

1: Confirmed, explain: [100 words]

2: Not confirmed

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

100 words.

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

10 words.

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

Multi, Checkboxes.

1: Instructor-Led Training Sessions

2: Virtual Instructor-Led Training Sessions (live instructor in a virtual environment)

3: Video Training

4: Web-Based training (not Instructor-Led)

5: Self-led Review of Training Resources

6: Other, describe: [50 words]

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

Multi, Checkboxes.

1: Case-Study

2: Roleplaying

3: Shadowing

4: Observation

5: Pre-tests

6: Post-tests

7: Training Evaluations

8: Other, describe: [50 words]

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

50 words.

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

50 words.

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

Multi, Checkboxes.

1: Arabic: [Integer]

2: Armenian: [Integer]

3: Cantonese: [Integer]

4: English: [Integer]

5: Hmong: [Integer]

6: Korean: [Integer]

7: Mandarin: [Integer]

8: Farsi: [Integer]

9: Russian: [Integer]

10: Spanish: [Integer]

11: Tagalog: [Integer]

12: Vietnamese: [Integer]

13: Lao: [Integer]

14: Cambodian: [Integer]

15: Other, specify: [50 words]

7.10 Does Applicant use language line to support consumers that speak languages other than those spoken by Customer Service Representatives? Which language line vendor is contracted for support?

Single, Radio group.

1: Yes, specify vendor: [20 words]

2: No

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

100 words.

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

Multi, Checkboxes.

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

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

50 words.

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

20 words.

8 Financial Requirements

All questions required for new Applicant entrants only.

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

200 words.

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

Multi, Checkboxes.

1: Paper checks

2: Cashier's checks

3: Money orders

4: Electronic Funds Transfer (EFT)

5: Credit cards and debit cards

6: Web-based payment, which may include accepting online credit card payments, and all general purpose pre-paid debit cards and credit card payment

8.3 If such systems are not currently in place, describe plans to implement such systems, including the use of vendors for any functions related to premium payment, if applicable, and an implementation work plan. QHP issuer must be able to accept premium payment from members no later than October 1, 2018. 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.

200 words.

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

200 words.

8.5 Applicant must confirm it can provide detailed documentation, as defined by the Exchange, including member level detail to substantiate each participation fee payment. This documentation is specified in Appendix C PMPM_Member_Level_Detail_Response SAMPLE.

Single, Pull-down list.

1: Yes, confirmed

2: No, not confirmed

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

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Single, Pull-down list.

1: Yes, confirmed

2: No, not confirmed

9 Fraud, Waste and Abuse Detection

9.4.8 and 9.4.17 required for currently contracted QHP Issuers. All questions required for new Applicant entrants.

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

Definitions:

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

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

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

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

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

9.1 Prevention

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

200 words.

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

200 words.

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

200 words.

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

200 words.

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

200 words.

9.1.6 What steps are taken after identification of social security and potential identity theft? Include services offered to impacted members.

200 words.

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

200 words.

9.2 Detection

Describe the following specific control activities to prevent and detect fraud.

9.2.1 What data-analytics activities (for example data matching, data mining) are routinely performed to identify unusual patterns of care? Distinguish between member and provider efforts and state the frequency of the data analytics activities.

200 words.

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

200 words.

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

200 words.

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

200 words.

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

200 words.

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

200 words.

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

200 words.

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

200 words.

9.3 Response

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

200 words.

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

200 words.

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

200 words.

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

200 words.

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

	Total Loss from Fraud Covered California book of business, if applicable	Total Loss from Fraud Total Book of Business	% of Loss Recovered Covered California book of business, if applicable	% of Loss Recovered Total Book of Business	Total Dollars Recovered Covered California book of business, if applicable	Total Dollars Recovered Total Book of Business
Calendar Year 2015	<i>Dollars</i>	<i>Dollars</i>	<i>Percent</i>	<i>Percent</i>	<i>Dollars</i>	<i>Dollars</i>
Calendar Year 2016	<i>Dollars</i>	<i>Dollars</i>	<i>Percent</i>	<i>Percent</i>	<i>Dollars</i>	<i>Dollars</i>
Calendar Year 2017	<i>Dollars</i>	<i>Dollars</i>	<i>Percent</i>	<i>Percent</i>	<i>Dollars</i>	<i>Dollars</i>

9.3.6 If applicable, please explain any trends attributing to the total loss from fraud for Exchange book of business.

200 words.

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

200 words.

9.4 Audits and Reviews

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

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

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

	Response	If other
Audits of Claims Administration and Oversight	<i>Single, Pull-down list.</i> 1: Daily 2: Weekly 3: Monthly 4: Quarterly 5: Other:	10 words

Audits of Network Providers	<i>Single, Pull-down list.</i> 1: Daily 2: Weekly 3: Monthly 4: Quarterly 5: Other:	10 words
Audits of Eligibility and Enrollment Processes and Compliance with Requirements	<i>Single, Pull-down list.</i> 1: Daily 2: Weekly 3: Monthly 4: Quarterly 5: Other:	10 words
Audits of Billing Process	<i>Single, Pull-down list.</i> 1: Daily 2: Weekly 3: Monthly 4: Quarterly 5: Other:	10 words

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

Percent.

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

Multi, Checkboxes.

1: Yes, describe: [200 words]

2: No.

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

Single, Pull-down list.

1: Attached

2: Not attached

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

100 words.

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

200 words.

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

	Response
2017	<i>Single, Pull-down list.</i> 1: Audit Conducted 2: Audit Not Conducted
2016	<i>Single, Pull-down list.</i> 1: Audit Conducted 2: Audit Not Conducted

9.4.9 Describe Applicant's approach to reviewing claims submitted by non-contracted providers, and steps taken when claims received exceed reasonable and customary threshold.

200 words.

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

200 words.

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

200 words.

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

200 words.

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

Multi, Checkboxes.

- 1: Hospitals
- 2: Physicians
- 3: Skilled nursing
- 4: Chiropractic
- 5: Podiatry
- 6: Behavioral Health
- 7: Substance Use Disorder treatment facilities
- 8: Alternative medical care
- 9: Durable medical equipment Providers
- 10: Other service Providers

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

200 words.

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

200 words.

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

200 words.

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

Single, Pull-down list.

1: Yes, confirmed

2: No, not confirmed

10 System for Electronic Rate and Form Filing (SERFF)

All questions required for currently contracted QHP Issuers and new Applicant entrants.

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

- Rates,
- Service Area,
- Benefit Plan Designs,
- Network,
- Prescription Drug.

Single, Pull-down list.

1: Yes, confirmed

2: No, not confirmed

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

Single, Pull-down list.

1: Yes, confirmed

2: No, not confirmed

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

Single, Pull-down list.

1: Yes, confirmed

2: No, not confirmed

11 Electronic Data Interface

11.1 – 11.2 required for currently contracted QHP Issuers. All questions required for new Applicant entrants.

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

Single, Pull-down list.

1: Attached

2: Not attached

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

Single, Pull-down list.

1: Attached

2: Not attached

11.3 Applicant must be prepared and able to engage with the Exchange to develop data interfaces between the Applicant's systems and the Exchange's systems, including the eligibility and enrollment system used by the Exchange, as early as May 2018. Applicant must confirm it will implement system(s) in order to accept and generate 834, 999, TA1, and other standard format electronic files for enrollment and premium remittance in an accurate, consistent and timely fashion and utilize the information received and transmitted for its intended purpose.

- See Appendix L 834 Companion Guide v17.9.20 for detailed 834 transaction specifications.
- Note: The Exchange requires QHP issuers to sign an industry-standard agreement which establishes electronic information exchange standards in order to participate in the required systems testing.

Single, Pull-down list.

1: Yes, confirmed

2: No, not confirmed

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

Single, Radio group.

1: Yes, confirmed, describe: [200 words]

2: No, not confirmed, describe: [200 words]

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

Single, Pull-down list.

1: Yes, confirmed

2: No, not confirmed

11.6 Applicant must be prepared and able to conduct testing of data interfaces with the Exchange no later than June 1, 2018 and confirms it will plan and implement testing jointly

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

Single, Pull-down list.

1: Yes, confirmed

2: No, not confirmed

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

200 words.

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

Single, Radio group.

1: Yes, describe: [100 words]

2: No, describe [100 words]

12 Healthcare Evidence Initiative

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

12.1 required for currently contracted QHP Issuers. All questions required for new Applicant entrants.

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

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

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

Single, Radio group.

1: Confirmed, describe [500 words]

2: Not confirmed, describe [500 words]

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

Claim Type	Response	If No or Yes with deviation, explain.

Professional	<i>Single, Pull-down list.</i> 1: Yes 2: No	50 words Nothing required
Institutional	<i>Single, Pull-down list.</i> 1: Yes 2: No	50 words Nothing required
Pharmacy	<i>Single, Pull-down list.</i> 1: Yes 2: No	50 words Nothing required
Drug (non-Pharmacy)	<i>Single, Pull-down list.</i> 1: Yes 2: No	50 words Nothing required
Dental	<i>Single, Pull-down list.</i> 1: Yes 2: No	50 words Nothing required
Mental Health	<i>Single, Pull-down list.</i> 1: Yes 2: No	50 words Nothing required
Vision	<i>Single, Pull-down list.</i> 1: Yes 2: No	50 words Nothing required

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

Financial Detail to be Provided	Response	If No or Yes with deviation, explain.
Submitted Charges	<i>Single, Pull-down list.</i> 1: Yes 2: No	50 words Nothing required
Discount Amount	<i>Single, Pull-down list.</i> 1: Yes 2: No	50 words Nothing required
Allowable Charges	<i>Single, Pull-down list.</i> 1: Yes 2: No	50 words Nothing required

Copayment	<i>Single, Pull-down list.</i> 1: Yes 2: No	50 words Nothing required
Coinsurance	<i>Single, Pull-down list.</i> 1: Yes 2: No	50 words Nothing required
Deductibles	<i>Single, Pull-down list.</i> 1: Yes 2: No	50 words Nothing required
Coordination of Benefits	<i>Single, Pull-down list.</i> 1: Yes 2: No	50 words Nothing required
Plan Paid Amount (Net Payment)	<i>Single, Pull-down list.</i> 1: Yes 2: No	50 words Nothing required
Capitation Financials (per Provider / Facility) <i>[1] If a portion of Applicant provider payments are capitated. If capitation does not apply, check "No" and state "Not applicable, no provider payments are capitated" in the rightmost column.</i>	<i>Single, Pull-down list.</i> 1: Yes 2: No	50 words Nothing required

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

Detail to be Provided	Response	If No or Yes with deviation, explain.
Covered CA Member ID	<i>Single, Pull-down list.</i> 1: Yes 2: No	50 words Nothing required
Covered CA Subscriber ID	<i>Single, Pull-down list.</i> 1: Yes 2: No	50 words Nothing required

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

PHI Dates to be Provided in Full Year / Month / Day Format	Response	If No or Yes with deviation, explain.
Member Date of Birth	<i>Single, Pull-down list.</i> 1: Yes 2: No	50 words Nothing required
Member Date of Death	<i>Single, Pull-down list.</i> 1: Yes 2: No	50 words Nothing required
Starting Date of Service	<i>Single, Pull-down list.</i> 1: Yes 2: No	50 words Nothing required
Ending Date of Service	<i>Single, Pull-down list.</i> 1: Yes 2: No	50 words Nothing required

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

Provider IDs to be Supplied	Response	If No or Yes with deviation, explain.
TIN	<i>Single, Pull-down list.</i> 1: Yes 2: Yes, unless values represent individual provider Social Security Numbers 3: No	50 words Nothing required
NPI	<i>Single, Pull-down list.</i> 1: Yes 2: Yes, unless values represent individual provider Social Security Numbers 3: No	50 words Nothing required
NCPDP	<i>Single, Pull-down list.</i> 1: Yes 2: Yes, unless values represent individual provider Social Security Numbers 3: No	50 words Nothing required

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

Coding to be Provided	Response	If No or Yes with deviation, explain.
Diagnosis Coding	<i>Single, Pull-down list.</i> 1: Yes 2: No	50 words Nothing required

Procedure Coding (CPT, HCPCS)	<i>Single, Pull-down list.</i> 1: Yes 2: No	50 words Nothing required
Revenue Codes (Facility Only)	<i>Single, Pull-down list.</i> 1: Yes 2: No	50 words Nothing required
Place of Service	<i>Single, Pull-down list.</i> 1: Yes 2: No	50 words Nothing required
NDC Code (Drug Only)	<i>Single, Pull-down list.</i> 1: Yes 2: No	50 words Nothing required

12.8 Can Applicant submit all data directly to the HEI Vendor or is a third party required to submit the data on Applicant's behalf, such as a Pharmacy Benefit Manager (PBM)?

Single, Radio group.

1: Yes, describe: [50 words]

2: No

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

Single, Radio group.

1: Yes, describe: [50 words]

2: No

3: Not Applicable

12.10 Can Applicant submit similar data listed above for other data feeds not yet requested, such as Disease Management or Lab data? If so, please describe.

Single, Radio group.

1: Yes, describe: [50 words]

2: No

13 Privacy and Security Requirements for Personally Identifiable Data

All questions required for new Applicant entrants only.

13.1 HIPAA Privacy Rule

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

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

Single, Pull-down list.

1: Yes, confirmed

2: No, not confirmed

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

Single, Pull-down list.

1: Yes, confirmed

2: No, not confirmed

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

Single, Pull-down list.

1: Yes, confirmed

2: No, not confirmed

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

Single, Pull-down list.

1: Yes, confirmed

2: No, not confirmed

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

Single, Pull-down list.

1: Yes, confirmed

2: No, not confirmed

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

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

Single, Pull-down list.

1: Yes, confirmed

2: No, not confirmed

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

Single, Pull-down list.

1: Yes, confirmed

2: No, not confirmed

13.2 Safeguards

All questions required for new Applicant entrants only.

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

Single, Pull-down list.

1: Yes, confirmed

2: No, not confirmed

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

Single, Pull-down list.

1: Yes, confirmed

2: No, not confirmed

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

Single, Pull-down list.

1: Yes, confirmed

2: No, not confirmed

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

Single, Pull-down list.

1: Yes, confirmed

2: No, not confirmed

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

Single, Pull-down list.

1: Yes, confirmed

2: No, not confirmed

14 Sales Channels

All questions required for new Applicant entrants only.

14.1 Does Applicant have experience working with Insurance Agents?

Single, Radio group.

1: Yes. If yes, 14.2 through 14.4 required

2: No. If no, 14.4 and 14.5 required

14.2 Review Appendix E Covered California Delegation Policy. Describe Applicant's AOR policy and procedures. The policy and procedures must include the following components:

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

500 words.

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

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

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

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

- Name
- Phone Number
- Email Address

50 words.

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

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

QHP Certification Application Plan Year 2019 Individual Marketplace

500 words.

15 Marketing and Outreach Activities

15.4 and 15.5 required for currently contracted QHP Issuers. All questions required for new Applicant entrants.

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

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

Single, Pull-down list.

Attachment required

1: Attached

2: Not attached

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

Single, Pull-down list.

1: Confirmed

2: Not confirmed

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

Single, Pull-down list.

1: Confirmed

2: Not confirmed

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

Single, Pull-down list.

1: Confirmed, attachment complete

2: Attachment not completed

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

(1) Proposed Marketing Plan

Proposed marketing plan must include the following components:

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

(2) Attachment D2 Media Plan Flowchart

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

Single, Pull-down list.

1: Attached

2: Not attached

16 Provider Network

16.1 Network Offerings

All questions required for currently contracted QHP Issuers and new Applicant entrants.

16.1.1 Please indicate the different network products Applicant intends to offer on the Exchange in the individual market for coverage year 2019. If proposing plans with different networks within the same product type, respond for Network 1 under the appropriate product category and respond for Network 2 in the category “Other”.

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

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

Single, Pull-down list.

Attachment required

1: Attached (confirming provider data is for plan year 2018)

2: Not attached

16.1.3 An Applicant must also complete and upload through SERFF the Network ID Template located at [\[link to 2019 Network ID Template\]](#)

Single, Pull-down list.

1: Attached,

2: Not attached

16.2 HMO

16.2.1 Network Strategy

All questions required for new Applicant entrants only.

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

Single, Pull-down list.

1: Applicant contracts and manages network

2: Applicant leases network

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

	Response
Length of the lease agreement	100 words
Start Date	To the day
End Date	To the day
Leasing Organization	100 words

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

Multi, Checkboxes.

1: Transparency

2: Implementation of new programs and initiatives

3: Acquire timely and up-to-date information on providers

4: Ability to obtain data from providers

5: Ability to conduct outreach and education to providers if need arises

6: Ability to add new providers

7: If no, please describe plans to ensure Applicant's ability to control network and meet Exchange requirements: [500 words]

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

	Direct Contract	Capitated	Other (explain in comments)	Comments
Region 1	<i>Percent</i>	<i>Percent</i>	<i>Percent</i>	<i>100 words</i>
Region 2	<i>Percent</i>	<i>Percent</i>	<i>Percent</i>	<i>100 words</i>
Region 3	<i>Percent</i>	<i>Percent</i>	<i>Percent</i>	<i>100 words</i>
Region 4	<i>Percent</i>	<i>Percent</i>	<i>Percent</i>	<i>100 words</i>
Region 5	<i>Percent</i>	<i>Percent</i>	<i>Percent</i>	<i>100 words</i>
Region 6	<i>Percent</i>	<i>Percent</i>	<i>Percent</i>	<i>100 words</i>
Region 7	<i>Percent</i>	<i>Percent</i>	<i>Percent</i>	<i>100 words</i>
Region 8	<i>Percent</i>	<i>Percent</i>	<i>Percent</i>	<i>100 words</i>
Region 9	<i>Percent</i>	<i>Percent</i>	<i>Percent</i>	<i>100 words</i>
Region 10	<i>Percent</i>	<i>Percent</i>	<i>Percent</i>	<i>100 words</i>
Region 11	<i>Percent</i>	<i>Percent</i>	<i>Percent</i>	<i>100 words</i>
Region 12	<i>Percent</i>	<i>Percent</i>	<i>Percent</i>	<i>100 words</i>
Region 13	<i>Percent</i>	<i>Percent</i>	<i>Percent</i>	<i>100 words</i>
Region 14	<i>Percent</i>	<i>Percent</i>	<i>Percent</i>	<i>100 words</i>
Region 15	<i>Percent</i>	<i>Percent</i>	<i>Percent</i>	<i>100 words</i>
Region 16	<i>Percent</i>	<i>Percent</i>	<i>Percent</i>	<i>100 words</i>
Region 17	<i>Percent</i>	<i>Percent</i>	<i>Percent</i>	<i>100 words</i>
Region 18	<i>Percent</i>	<i>Percent</i>	<i>Percent</i>	<i>100 words</i>
Region 19	<i>Percent</i>	<i>Percent</i>	<i>Percent</i>	<i>100 words</i>

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

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

200 words.

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

Single, Radio group.

1: Yes. If yes, does Applicant allow out-of-state (non-emergency) providers to participate in networks to serve Exchange enrollees? [Yes/No]

2: No

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

500 words.

16.2.2 Volume - Outcome Relationship

All questions required for new Applicant entrants only.

Numerous studies have demonstrated a significant correlation between volume of procedures performed by providers and facilities and better outcomes for those procedures. This applies to both common but high risk treatments (such as cancer surgeries and cardiac procedures) as well as complicated, rare and highly specialized procedures (such as transplants). Higher volumes, documented experience and proficiency with all aspects of care underlie successful outcomes, including patient selection, anesthesia and postoperative care.

16.2.2.1 Does Applicant track procedure volume per facility for the above mentioned conditions?

Single, Radio group.

1: Yes

2: No

16.2.2.2 If yes please provide specific details for each category:

- Methodology for categorizing facilities according to volume-outcome relationship (include description of data sources if applicable)
- Volume thresholds (i.e. at what volume per procedure is a facility considered proficient)

500 words.

16.2.2.3 Does Applicant apply this information to enrollee procedure referral (including Exchange enrollees)?

Single, Radio group.

1: Yes

2: No

16.2.2.4 If yes to 16.2.2.3, please provide the following details:

- Methodology for patient identification and selection, such as consideration of patient residence, language proficiency
- Referral procedure for identified patients
- Accommodations for patients not residing in close proximity to a recognized higher volume provider

200 words.

16.2.3 Network Stability

16.2.3.6 – 16.2.3.7 required for currently contracted QHP Issuers. All questions required for new Applicant entrants.

16.2.3.1 Total Number of Contracted Hospitals:

Integer.

16.2.3.2 Identify network hospitals terminated between January 1, 2017 and December 31, 2017, 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, redesign of network, other (explain). Applicants with no prior California presence should use out-of-state experience.

Name of Terminated Hospital	Terminated by:	Reason	Reinstated
<i>10 words.</i>	<i>Single, Pull-down list. 1: Applicant 2: Hospital</i>	<i>20 words.</i>	<i>10 words.</i>
<i>10 words.</i>	<i>Single, Pull-down list. 1: Applicant 2: Hospital</i>	<i>20 words.</i>	<i>10 words.</i>
<i>10 words.</i>	<i>Single, Pull-down list. 1: Applicant 2: Hospital</i>	<i>20 words.</i>	<i>10 words.</i>
<i>10 words.</i>	<i>Single, Pull-down list. 1: Applicant 2: Hospital</i>	<i>20 words.</i>	<i>10 words.</i>
<i>10 words.</i>	<i>Single, Pull-down list. 1: Applicant 2: Hospital</i>	<i>20 words.</i>	<i>10 words.</i>
<i>10 words.</i>	<i>Single, Pull-down list. 1: Applicant</i>	<i>20 words.</i>	<i>10 words.</i>

	2: Hospital		
10 words.	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words.	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words.	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words.	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.

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

	Terminated by Issuer	Terminated by Provider	Reason
Region 1	Integer.	Integer.	20 words.
Region 2	Integer.	Integer.	20 words.
Region 3	Integer.	Integer.	20 words.
Region 4	Integer.	Integer.	20 words.
Region 5	Integer.	Integer.	20 words.
Region 6	Integer.	Integer.	20 words.
Region 7	Integer.	Integer.	20 words.
Region 8	Integer.	Integer.	20 words.
Region 9	Integer.	Integer.	20 words.
Region 10	Integer.	Integer.	20 words.
Region 11	Integer.	Integer.	20 words.

Region 12	<i>Integer.</i>	<i>Integer.</i>	<i>20 words.</i>
Region 13	<i>Integer.</i>	<i>Integer.</i>	<i>20 words.</i>
Region 14	<i>Integer.</i>	<i>Integer.</i>	<i>20 words.</i>
Region 15	<i>Integer.</i>	<i>Integer.</i>	<i>20 words.</i>
Region 16	<i>Integer.</i>	<i>Integer.</i>	<i>20 words.</i>
Region 17	<i>Integer.</i>	<i>Integer.</i>	<i>20 words.</i>
Region 18	<i>Integer.</i>	<i>Integer.</i>	<i>20 words.</i>
Region 19	<i>Integer.</i>	<i>Integer.</i>	<i>20 words.</i>

16.2.3.4 List total Number of Contracted IPA/Medical Groups/Clinics by region:

	Number of Contracted Entities
Region 1	<i>Integer.</i>
Region 2	<i>Integer.</i>
Region 3	<i>Integer.</i>
Region 4	<i>Integer.</i>
Region 5	<i>Integer.</i>
Region 6	<i>Integer.</i>
Region 7	<i>Integer.</i>
Region 8	<i>Integer.</i>
Region 9	<i>Integer.</i>
Region 10	<i>Integer.</i>
Region 11	<i>Integer.</i>

Region 12	<i>Integer.</i>
Region 13	<i>Integer.</i>
Region 14	<i>Integer.</i>
Region 15	<i>Integer.</i>
Region 16	<i>Integer.</i>
Region 17	<i>Integer.</i>
Region 18	<i>Integer.</i>
Region 19	<i>Integer.</i>

16.2.3.5 Identify Independent Practice Associations 6 (IPA), Medical Groups, clinics or health centers terminated between January 1, 2017 and December 31, 2017, 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, and redesign of network or other (explain). Applicants with no prior California presence should use out-of-state experience.

Name of Terminated IPA/Medical Groups/Clinics	Terminated by:	Reason	Reinstated
<i>10 words</i>	<i>Single, Pull-down list. 1: Applicant 2: Hospital</i>	<i>20 words.</i>	<i>10 words.</i>
<i>10 words</i>	<i>Single, Pull-down list. 1: Applicant 2: Hospital</i>	<i>20 words.</i>	<i>10 words.</i>
<i>10 words</i>	<i>Single, Pull-down list. 1: Applicant 2: Hospital</i>	<i>20 words.</i>	<i>10 words.</i>
<i>10 words</i>	<i>Single, Pull-down list. 1: Applicant 2: Hospital</i>	<i>20 words.</i>	<i>10 words.</i>
<i>10 words</i>	<i>Single, Pull-down list. 1: Applicant 2: Hospital</i>	<i>20 words.</i>	<i>10 words.</i>
<i>10 words</i>	<i>Single, Pull-down list. 1: Applicant</i>	<i>20 words.</i>	<i>10 words.</i>

	2: Hospital		
10 words.	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words.	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words.	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words.	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.

16.2.3.7 Describe any plans for network additions, by product, including any new medical groups or hospital systems that Applicant would like to highlight for Exchange attention
100 words.

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

16.3 PPO

16.3.1 Network Strategy

All questions required for new Applicant entrants only.

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

Single, Pull-down list.

1: Applicant contracts and manages network

2: Applicant leases network

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

	Response
Length of the lease agreement	100 words.

Start Date	To the day.
End Date	To the day.
Leasing Organization	100 words.

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

Multi, Checkboxes.

1: Transparency

2: Implementation of new programs and initiatives

3: Acquire timely and up-to-date information on providers

4: Ability to obtain data from providers

5: Ability to conduct outreach and education to providers if need arises

6: Ability to add new providers

7: If no, please describe plans to ensure Applicant's ability to control network and meet Exchange requirements: [500 words]

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

	Direct Contract	Capitated	Other (explain in comments)	Comments
Region 1	Percent.	Percent.	Percent.	100 words.
Region 2	Percent.	Percent.	Percent.	100 words.
Region 3	Percent.	Percent.	Percent.	100 words.
Region 4	Percent.	Percent.	Percent.	100 words.
Region 5	Percent.	Percent.	Percent.	100 words.
Region 6	Percent.	Percent.	Percent.	100 words.
Region 7	Percent.	Percent.	Percent.	100 words.
Region 8	Percent.	Percent.	Percent.	100 words.
Region 9	Percent.	Percent.	Percent.	100 words.

Region 10	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>100 words.</i>
Region 11	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>100 words.</i>
Region 12	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>100 words.</i>
Region 13	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>100 words.</i>
Region 14	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>100 words.</i>
Region 15	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>100 words.</i>
Region 16	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>100 words.</i>
Region 17	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>100 words.</i>
Region 18	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>100 words.</i>
Region 19	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>100 words.</i>

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

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

200 words.

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

Single, Radio group.

1: Yes. If yes, does Applicant allow out of state (non-emergency) providers to participate in networks to serve Exchange enrollees?

2: No

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

500 words.

16.3.2 Volume - Outcome Relationship

All questions required for new Applicant entrants only.

Numerous studies have demonstrated a significant correlation between volume of procedures performed by providers and facilities and better outcomes for those procedures. This applies to both common but high risk treatments (such as cancer surgeries and cardiac procedures) as well as complicated, rare and highly specialized procedures (such as transplants). Higher volumes, documented experience and proficiency with all aspects of care underlie successful outcomes, including patient selection, anesthesia and postoperative care.

16.3.2.1 Does the Applicant track procedure volume per facility for the above mentioned conditions?

Single, Radio group.

1: Yes

2: No

16.3.2.2 If yes, please provide specific details for each category:

- Methodology for categorizing facilities according to volume-outcome relationship (include description of data sources if applicable)
- Volume thresholds (i.e. at what volume per procedure is a facility considered proficient)

500 words.

16.3.2.3 Does Applicant apply this information to enrollee procedure referral (including Exchange enrollees)?

Single, Radio group.

1: Yes

2: No

16.3.2.4 If yes, please provide the following details:

- Methodology for patient identification and selection, such as consideration of patient residence, language proficiency.
- Referral procedure for identified patients
- Accommodations for patients not residing in close proximity to a recognized higher volume provider

200 words.

16.3.3 Network Stability

16.3.3.6 – 16.3.3.7 required for currently contracted QHP Issuers. All questions required for new Applicant entrants.

16.3.3.1 Total Number of Contracted Hospitals:

Integer.

16.3.3.2 Identify network hospitals terminated between January 1, 2017 and December 31, 2017, 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, and redesign of network or other (explain). Applicants with no prior California presence should use out-of-state experience.

Name of Terminated Hospital	Terminated by:	Reason	Reinstated
10 words.	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words.	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words.	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words.	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words.	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words.	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words.	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words.	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words.	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words.	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.

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

	Terminated by Issuer	Terminated by Provider	Reason
Region 1	Integer.	Integer.	20 words.

Region 2	<i>Integer.</i>	<i>Integer.</i>	20 words.
Region 3	<i>Integer.</i>	<i>Integer.</i>	20 words.
Region 4	<i>Integer.</i>	<i>Integer.</i>	20 words.
Region 5	<i>Integer.</i>	<i>Integer.</i>	20 words.
Region 6	<i>Integer.</i>	<i>Integer.</i>	20 words.
Region 7	<i>Integer.</i>	<i>Integer.</i>	20 words.
Region 8	<i>Integer.</i>	<i>Integer.</i>	20 words.
Region 9	<i>Integer.</i>	<i>Integer.</i>	20 words.
Region 10	<i>Integer.</i>	<i>Integer.</i>	20 words.
Region 11	<i>Integer.</i>	<i>Integer.</i>	20 words.
Region 12	<i>Integer.</i>	<i>Integer.</i>	20 words.
Region 13	<i>Integer.</i>	<i>Integer.</i>	20 words.
Region 14	<i>Integer.</i>	<i>Integer.</i>	20 words.
Region 15	<i>Integer.</i>	<i>Integer.</i>	20 words.
Region 16	<i>Integer.</i>	<i>Integer.</i>	20 words.
Region 17	<i>Integer.</i>	<i>Integer.</i>	20 words.
Region 18	<i>Integer.</i>	<i>Integer.</i>	20 words.
Region 19	<i>Integer.</i>	<i>Integer.</i>	20 words.

16.3.3.4 List total Number of Contracted IPA/Medical Groups/Clinics by region:

	Number of Contracted Entities
Region 1	<i>Integer.</i>

Region 2	<i>Integer.</i>
Region 3	<i>Integer.</i>
Region 4	<i>Integer.</i>
Region 5	<i>Integer.</i>
Region 6	<i>Integer.</i>
Region 7	<i>Integer.</i>
Region 8	<i>Integer.</i>
Region 9	<i>Integer.</i>
Region 10	<i>Integer.</i>
Region 11	<i>Integer.</i>
Region 12	<i>Integer.</i>
Region 13	<i>Integer.</i>
Region 14	<i>Integer.</i>
Region 15	<i>Integer.</i>
Region 16	<i>Integer.</i>
Region 17	<i>Integer.</i>
Region 18	<i>Integer.</i>
Region 19	<i>Integer.</i>

16.3.3.5 Identify Independent Practice Associations 6 (IPA), Medical Groups, clinics or health centers terminated between January 1, 2017 and December 31, 2017, 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, and redesign of network or

other (explain). Applicants with no prior California presence should use out-of-state experience.

Name of Terminated IPA/Medical Groups/Clinics	Terminated by:	Reason	Reinstated
10 words	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.

16.3.3.6 Describe any plans for network additions, by product, including any new medical groups or hospital systems that Applicant would like to highlight for Exchange attention.

100 words.

16.3.3.7 Provide information on any known or anticipated potential network disruption that may affect the Applicant's 2019 provider networks. For example: list any pending terminations of general acute care hospitals or medical groups which can include Independent Practice Associations.

100 words.

16.4 EPO

16.4.1 Network Strategy

All questions required for new Applicant entrants only.

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

Single, Pull-down list.

1: Applicant contracts and manages network

2: Applicant leases network

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

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

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

Multi, Checkboxes.

1: Transparency

2: Implementation of new programs and initiatives

3: Acquire timely and up-to-date information on providers

4: Ability to obtain data from providers

5: Ability to conduct outreach and education to providers if need arises

6: Ability to add new providers

7: If no, please describe plans to ensure Applicant's ability to control network and meet Exchange requirements: [500 words]

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

	Direct Contract	Capitated	Other (explain in comments)	Comments
Region 1	Percent.	Percent.	Percent.	100 words.

Region 2	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>100 words.</i>
Region 3	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>100 words.</i>
Region 4	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>100 words.</i>
Region 5	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>100 words.</i>
Region 6	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>100 words.</i>
Region 7	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>100 words.</i>
Region 8	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>100 words.</i>
Region 9	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>100 words.</i>
Region 10	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>100 words.</i>
Region 11	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>100 words.</i>
Region 12	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>100 words.</i>
Region 13	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>100 words.</i>
Region 14	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>100 words.</i>
Region 15	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>100 words.</i>
Region 16	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>100 words.</i>
Region 17	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>100 words.</i>
Region 18	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>100 words.</i>
Region 19	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>100 words.</i>

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

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

200 words.

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

Single, Radio group.

1: Yes. If yes, does Applicant allow out of state (non-emergency) providers to participate in networks to serve Exchange enrollees?

2: No

16.4.1.7 If Applicant answered yes to 16.2.1.6, explain in detail how this coverage is offered.

500 words.

16.4.2 Volume - Outcome Relationship

All questions required for new Applicant entrants only.

Numerous studies have demonstrated a significant correlation between volume of procedures performed by providers and facilities and better outcomes for those procedures. This applies to both common but high risk treatments (such as cancer surgeries and cardiac procedures) as well as complicated, rare and highly specialized procedures (such as transplants). Higher volumes, documented experience and proficiency with all aspects of care underlie successful outcomes, including patient selection, anesthesia and postoperative care.

16.4.2.1 Does the Applicant track procedure volume per facility for the above mentioned conditions?

Single, Radio group.

1: Yes

2: No

16.4.2.2 If yes, please provide specific details for each category:

- Methodology for categorizing facilities according to volume-outcome relationship (include description of data sources if applicable)
- Volume thresholds (i.e. at what volume per procedure is a facility considered proficient)

500 words.

16.4.2.3 Does Applicant apply this information to enrollee procedure referral (including Exchange enrollees)?

Single, Radio group.

1: Yes

2: No

16.4.2.4 If yes, please provide the following details:

- Methodology for patient identification and selection, such as consideration of patient residence, language proficiency.
- Referral procedure for identified patients
- Accommodations for patients not residing in close proximity to a recognized higher volume provider

200 words.

16.4.3 Network Stability

16.4.3.6 – 16.4.3.7 required for currently contracted QHP Issuers. All questions required for new Applicant entrants.

16.4.3.1 Total Number of Contracted Hospitals:

Integer.

16.4.3.2 Identify network hospitals terminated between January 1, 2017 and December 31, 2017, 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, and redesign of network or other (explain). Applicants with no prior California presence should use out-of-state experience.

Name of Terminated Hospital	Terminated by:	Reason	Reinstated
10 words.	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words.	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words.	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words.	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words.	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words.	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words.	Single, Pull-down list.	20 words.	10 words.

	1: Applicant 2: Hospital		
10 words.	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words.	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words.	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.

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

	Terminated by Issuer	Terminated by Provider	Reason
Region 1	Integer.	Integer.	20 words.
Region 2	Integer.	Integer.	20 words.
Region 3	Integer.	Integer.	20 words.
Region 4	Integer.	Integer.	20 words.
Region 5	Integer.	Integer.	20 words.
Region 6	Integer.	Integer.	20 words.
Region 7	Integer.	Integer.	20 words.
Region 8	Integer.	Integer.	20 words.
Region 9	Integer.	Integer.	20 words.
Region 10	Integer.	Integer.	20 words.
Region 11	Integer.	Integer.	20 words.

Region 12	<i>Integer.</i>	<i>Integer.</i>	20 words.
Region 13	<i>Integer.</i>	<i>Integer.</i>	20 words.
Region 14	<i>Integer.</i>	<i>Integer.</i>	20 words.
Region 15	<i>Integer.</i>	<i>Integer.</i>	20 words.
Region 16	<i>Integer.</i>	<i>Integer.</i>	20 words.
Region 17	<i>Integer.</i>	<i>Integer.</i>	20 words.
Region 18	<i>Integer.</i>	<i>Integer.</i>	20 words.
Region 19	<i>Integer.</i>	<i>Integer.</i>	20 words.

16.4.3.4 List total Number of Contracted IPA/Medical Groups/Clinics by region:

	Number of Contracted Entities
Region 1	<i>Integer.</i>
Region 2	<i>Integer.</i>
Region 3	<i>Integer.</i>
Region 4	<i>Integer.</i>
Region 5	<i>Integer.</i>
Region 6	<i>Integer.</i>
Region 7	<i>Integer.</i>
Region 8	<i>Integer.</i>
Region 9	<i>Integer.</i>
Region 10	<i>Integer.</i>
Region 11	<i>Integer.</i>

Region 12	<i>Integer.</i>
Region 13	<i>Integer.</i>
Region 14	<i>Integer.</i>
Region 15	<i>Integer.</i>
Region 16	<i>Integer.</i>
Region 17	<i>Integer.</i>
Region 18	<i>Integer.</i>
Region 19	<i>Integer.</i>

16.4.3.5 Identify Independent Practice Associations 6 (IPA), Medical Groups, clinics or health centers terminated between January 1, 2017 and December 31, 2017, 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, and redesign of network or other (explain). Applicants with no prior California presence should use out-of-state experience.

Name of Terminated IPA/Medical Groups/Clinics	Terminated by:	Reason	Reinstated
<i>10 words.</i>	<i>Single, Pull-down list. 1: Applicant 2: Hospital</i>	<i>20 words.</i>	<i>10 words.</i>
<i>10 words.</i>	<i>Single, Pull-down list. 1: Applicant 2: Hospital</i>	<i>20 words.</i>	<i>10 words.</i>
<i>10 words.</i>	<i>Single, Pull-down list. 1: Applicant 2: Hospital</i>	<i>20 words.</i>	<i>10 words.</i>
<i>10 words.</i>	<i>Single, Pull-down list. 1: Applicant 2: Hospital</i>	<i>20 words.</i>	<i>10 words.</i>
<i>10 words.</i>	<i>Single, Pull-down list. 1: Applicant 2: Hospital</i>	<i>20 words.</i>	<i>10 words.</i>
<i>10 words.</i>	<i>Single, Pull-down list. 1: Applicant</i>	<i>20 words.</i>	<i>10 words.</i>

	2: Hospital		
10 words.	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words.	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words.	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words.	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.

16.4.3.6 Describe any plans for network additions, by product, including any new medical groups or hospital systems that Applicant would like to highlight for Exchange attention.

100 words.

16.4.3.7 Provide information on any known or anticipated potential network disruption that may affect the Applicant's 2019 provider networks. For example: list any pending terminations of general acute care hospitals or medical groups which can include Independent Practice Associations.

100 words.

16.5 Other

All questions required for newly proposed networks – Currently contracted QHP Issuers and new Applicant entrants.

16.5.1 Network Strategy

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

Single, Pull-down list.

1: Applicant contracts and manages network

2: Applicant leases network

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

	Response
Length of the lease agreement	100 words.

Start Date	To the day.
End Date	To the day.
Leasing Organization	100 words.

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

Multi, Checkboxes.

1: Transparency

2: Implementation of new programs and initiatives

3: Acquire timely and up-to-date information on providers

4: Ability to obtain data from providers

5: Ability to conduct outreach and education to providers if need arises

6: Ability to add new providers

7: If no, please describe plans to ensure Applicant's ability to control network and meet Exchange requirements: [500 words]

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

	Direct Contract	Capitated	Other (explain in comments)	Comments
Region 1	Percent.	Percent.	Percent.	100 words.
Region 2	Percent.	Percent.	Percent.	100 words.
Region 3	Percent.	Percent.	Percent.	100 words.
Region 4	Percent.	Percent.	Percent.	100 words.
Region 5	Percent.	Percent.	Percent.	100 words.
Region 6	Percent.	Percent.	Percent.	100 words.
Region 7	Percent.	Percent.	Percent.	100 words.
Region 8	Percent.	Percent.	Percent.	100 words.
Region 9	Percent.	Percent.	Percent.	100 words.
Region 10	Percent.	Percent.	Percent.	100 words.

Region 11	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>100 words.</i>
Region 12	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>100 words.</i>
Region 13	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>100 words.</i>
Region 14	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>100 words.</i>
Region 15	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>100 words.</i>
Region 16	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>100 words.</i>
Region 17	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>100 words.</i>
Region 18	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>100 words.</i>
Region 19	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>100 words.</i>

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

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

200 words.

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

Single, Radio group.

1: Yes. If yes, does Applicant allow out of state (non-emergency) providers to participate in networks to serve Exchange enrollees?

2: No

16.5.1.7 If Applicant answered yes to 16.5.1.6, explain in detail how this coverage is offered.
500 words.

16.5.2 Volume - Outcome Relationship

All questions required for newly proposed networks – Currently contracted QHP Issuers and new Applicant entrants.

16.5.2.1 Numerous studies have demonstrated a significant correlation between volume of procedures performed by providers and facilities and better outcomes for those procedures. This applies to both common but high risk treatments (such as cancer surgeries and cardiac procedures) as well as complicated, rare and highly specialized procedures (such as transplants). Higher volumes, documented experience and proficiency with all aspects of care underlie successful outcomes, including patient selection, anesthesia and postoperative care.

16.5.2.1 Does Applicant track procedure volume per facility for the above mentioned conditions?

Single, Radio group.

1: Yes

2: No

16.5.2.2 If yes, please provide specific details for each category:

- Methodology for categorizing facilities according to volume-outcome relationship (include description of data sources if applicable)
- Volume thresholds (i.e. at what volume per procedure is a facility considered proficient)

500 words.

16.5.2.3 Does Applicant apply this information to enrollee procedure referral (including Exchange enrollees)?

Single, Radio group.

1: Yes

2: No

16.5.2.4 If yes, please provide the following details:

- Methodology for patient identification and selection, such as consideration of patient residence, language proficiency.
- Referral procedure for identified patients
- Accommodations for patients not residing in close proximity to a recognized higher volume provider

200 words.

16.5.3 Network Stability

All questions required for newly proposed networks – Currently contracted QHP Issuers and new Applicant entrants.

16.5.3.1 Total Number of Contracted Hospitals:*Integer.*

16.5.3.2 Identify network hospitals terminated between January 1, 2017 and December 31, 2017, 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, and redesign of network or other (explain). Applicants with no prior California presence should use out-of-state experience.

Name of Terminated Hospital	Terminated by:	Reason	Reinstated
10 words.	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words.	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words.	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words.	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words.	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words.	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words.	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words.	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words.	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words.	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.

16.5.3.3 Identify the number of participating providers who have terminated from the provider network between January 1, 2017 and December 31, 2017, by rating region. Indicate reason.

	Terminated by Issuer	Terminated by Provider	Reason
Region 1	<i>Integer.</i>	<i>Integer.</i>	<i>20 words.</i>
Region 2	<i>Integer.</i>	<i>Integer.</i>	<i>20 words.</i>
Region 3	<i>Integer.</i>	<i>Integer.</i>	<i>20 words.</i>
Region 4	<i>Integer.</i>	<i>Integer.</i>	<i>20 words.</i>
Region 5	<i>Integer.</i>	<i>Integer.</i>	<i>20 words.</i>
Region 6	<i>Integer.</i>	<i>Integer.</i>	<i>20 words.</i>
Region 7	<i>Integer.</i>	<i>Integer.</i>	<i>20 words.</i>
Region 8	<i>Integer.</i>	<i>Integer.</i>	<i>20 words.</i>
Region 9	<i>Integer.</i>	<i>Integer.</i>	<i>20 words.</i>
Region 10	<i>Integer.</i>	<i>Integer.</i>	<i>20 words.</i>
Region 11	<i>Integer.</i>	<i>Integer.</i>	<i>20 words.</i>
Region 12	<i>Integer.</i>	<i>Integer.</i>	<i>20 words.</i>
Region 13	<i>Integer.</i>	<i>Integer.</i>	<i>20 words.</i>
Region 14	<i>Integer.</i>	<i>Integer.</i>	<i>20 words.</i>
Region 15	<i>Integer.</i>	<i>Integer.</i>	<i>20 words.</i>
Region 16	<i>Integer.</i>	<i>Integer.</i>	<i>20 words.</i>
Region 17	<i>Integer.</i>	<i>Integer.</i>	<i>20 words.</i>
Region 18	<i>Integer.</i>	<i>Integer.</i>	<i>20 words.</i>
Region 19	<i>Integer.</i>	<i>Integer.</i>	<i>20 words.</i>

16.5.3.4 List total Number of Contracted IPA/Medical Groups/Clinics by region:

	Number of Contracted Entities
Region 1	<i>Integer.</i>
Region 2	<i>Integer.</i>
Region 3	<i>Integer.</i>
Region 4	<i>Integer.</i>
Region 5	<i>Integer.</i>
Region 6	<i>Integer.</i>
Region 7	<i>Integer.</i>
Region 8	<i>Integer.</i>
Region 9	<i>Integer.</i>
Region 10	<i>Integer.</i>
Region 11	<i>Integer.</i>
Region 12	<i>Integer.</i>
Region 13	<i>Integer.</i>
Region 14	<i>Integer.</i>
Region 15	<i>Integer.</i>
Region 16	<i>Integer.</i>
Region 17	<i>Integer.</i>
Region 18	<i>Integer.</i>
Region 19	<i>Integer.</i>

16.5.3.5 Identify Independent Practice Associations (IPA), Medical Groups, clinics or health centers terminated between January 1, 2017 and December 31, 2017 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, and redesign of network or other (explain). Applicants with no prior California presence should use out-of-state experience.

Name of Terminated IPA/Medical Groups/Clinics	Terminated by:	Reason	Reinstated
10 words.	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words.	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words.	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words.	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words.	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words.	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words.	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words.	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words.	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.
10 words.	Single, Pull-down list. 1: Applicant 2: Hospital	20 words.	10 words.

16.5.3.6 Describe any plans for network additions, by product, including any new medical groups or hospital systems that Applicant would like to highlight for Exchange attention.
100 words.

16.5.3.7 Provide information on any known or anticipated potential network disruption that may affect the Applicant's 2019 provider networks. For example: list any pending terminations of general acute care hospitals or medical groups which can include Independent Practice Associations.

100 words.

17 Essential Community Providers

Required for new Applicant entrants only.

17.1 Applicant must demonstrate that its QHP proposals meet requirements for geographic sufficiency of its Essential Community Provider (ECP) network. The Exchange will use the provider network data submission to assess Applicant's ECP network. All of the below criteria must be met.

1. Applicants must demonstrate sufficient geographic distribution of a mix of essential community providers reasonably distributed throughout the geographic service area;
AND
2. Applicants must demonstrate contracts with at least 15% of 340B entities (where available) throughout each rating region in the proposed geographic service area;
AND
3. 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 they are available.

The Exchange will evaluate the application of all three criteria to determine whether 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 single contracted ECP hospital.

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

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

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

The Exchange will calculate the percentage of contracted 340B entities located in each 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.

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 2013-2014
3. Federally designated 638 Tribal Health Programs and Title V Urban Indian Health Programs
4. Community Clinics or health centers licensed as either “community clinic” or “free clinic”, by the State of California under Health and Safety Code section 1204(a), or operating as 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)

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

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 Applicant’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 Applicant’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, 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.

QHP Certification Application Plan Year 2019 Individual Marketplace

Single, Pull-down list.

- 1: Requesting consideration of alternate standard, explanation attached
- 2: Not requesting consideration under the alternate standard

18 Quality

The Exchange's "Triple Aim" framework seeks to (1) improve the patient care experience including quality and satisfaction, (2) improve the health of the entire California population, and (3) reduce the per capita cost of covered services. The Quality and Delivery System Reform standards outlined in the QHP Issuer Contract describe the ways the Exchange and contracted health plans will focus on the promotion of better care and higher value for plan enrollees and other California health care consumers. This section of the application assesses the Applicant's current and future capacity to work with the Exchange to achieve these aims.

18.1 Accreditation

All questions required for new Applicant entrants only.

Applicant must be accredited by one of the following bodies: (1) Utilization Review Accreditation Commission (URAC); (2) National Committee on Quality Assurance (NCQA); (3) Accreditation Association for Ambulatory Health Care (AAAHC). The following questions will be used to assess the Applicant's current accreditation status of its product(s) as well as any recognition or accreditation of other health programs and activities (e.g. case management, wellness promotion, etc.).

18.1.1 Applicant is responding for the following products for reporting accreditation status.

Multi, Checkboxes.

1: HMO/POS

2: PPO

3: EPO

18.1.2 Please provide the NCQA or URAC accreditation status and expiration date of the accreditation achieved for the HMO product identified in this response. Indicate all that apply.

	Answer	Expiration date MM/DD/YYYY	Programs Reviewed
NCQA HMO	<i>Single, Pull-down list.</i> 1: Excellent 2: Commendable 3: Accredited 4: Provisional 5: Interim 6: In Process 7: Denied 8: Scheduled 9: Expired 10: NCQA not used or product not eligible	<i>To the day.</i> From December 30, 1973 to December 31, 2023.	
NCQA Exchange	<i>Single, Pull-down list.</i> 1: Completed Health Plan Add-On Application 2: Interim 3: First 4: Renewal	<i>To the day.</i> From December 30, 1973 to December 31, 2023.	

	5: NCQA Exchange not used		
NCQA Wellness & Health Promotion Accreditation	<i>Single, Radio group.</i> 1: Accredited and Reporting Measures to NCQA 2: Accredited and NOT reporting measures 3: Did not participate	<i>To the day.</i> From December 30, 1973 to December 31, 2023.	
NCQA Managed Behavioral Health Organization Accreditation	<i>Single, Radio group.</i> 1: Full Accreditation 2: Accredited – 1 Year 3: Provisional Accreditation 4: Denied Accreditation 5: NCQA not used	<i>To the day.</i> From December 30, 1973 to December 31, 2023.	
NCQA Disease Management – Accreditation	<i>Multi, Checkboxes.</i> 1: Patient and practitioner oriented 2: Patient oriented 3: Plan Oriented 4: NCQA not used	<i>To the day.</i> From December 30, 1973 to December 31, 2023.	50 words.
NCQA Disease Management – Certification	<i>Multi, Checkboxes.</i> 1: Program Design 2: Systems 3: Contact 4: NCQA not used	<i>To the day.</i> From December 30, 1973 to December 31, 2023.	50 words.
NCQA Case Management Accreditation	<i>Single, Radio group.</i> 1: Accredited - 3 years 2: Accredited - 2 years 3: No accreditation	<i>To the day.</i> From December 30, 1973 to December 31, 2023.	50 words.
NCQA PHQ Certification	<i>Single, Pull-down list.</i> 1: Certified 2: No PHQ Certification	<i>To the day.</i> From December 30, 1973 to December 31, 2023.	50 words.
NCQA Multicultural Health Care Distinction	<i>Single, Radio group.</i> 1: Distinction 2: No MHC Distinction	<i>To the day.</i> From December 30, 1973 to December 31, 2023.	
URAC Accreditations	<i>Single, Radio group.</i> 1: URAC used 2: URAC not used		
URAC Accreditations - Health Plan	<i>Single, Radio group.</i> 1: URAC Accredited 2: Not URAC Accredited	<i>To the day.</i> From December 30, 1973 to December 31, 2023.	
URAC Accreditation - Comprehensive Wellness	<i>Single, Radio group.</i> 1: URAC Accredited 2: Not URAC Accredited	<i>To the day.</i> From December 30, 1973 to December 31, 2023.	

URAC Accreditations - Disease Management	<i>Single, Radio group.</i> 1: URAC Accredited 2: Not URAC Accredited	<i>To the day.</i> From December 30, 1973 to December 31, 2023.	
URAC Accreditations - Health Utilization Management	<i>Single, Radio group.</i> 1: URAC Accredited 2: Not URAC Accredited	<i>To the day.</i> From December 30, 1973 to December 31, 2023.	
URAC Accreditations - Case Management	<i>Single, Radio group.</i> 1: URAC Accredited 2: Not URAC Accredited	<i>To the day.</i> From December 30, 1973 to December 31, 2023.	
URAC Accreditations - Pharmacy Benefit Management	<i>Single, Radio group.</i> 1: URAC Accredited 2: Not URAC Accredited	<i>To the day.</i> From December 30, 1973 to December 31, 2023.	

18.1.3 If Applicant indicated any accreditations above, provide a copy of the accrediting agency's certificate, and upload as a file titled "Accreditation 1a" and including question number 18.1.3.

Single, Pull-down list.

1: Yes, Accreditation 1a attached

2: Not attached

18.1.4 Please provide the NCQA accreditation status and expiration date of the accreditation achieved for the PPO product identified in this response. Indicate all that apply. For the URAC Accreditation option, please enter each expiration date in the detail box if the Plan has earned multiple URAC accreditations.

Details limited to 50 words.

	Answer	Expiration date MM/DD/YYYY	Programs Reviewed
NCQA PPO	<i>Single, Pull-down list.</i> 1: Excellent 2: Commendable 3: Accredited 4: Provisional 5: Denied 6: In Process 7: Scheduled 8: Expired 9: NCQA not used or product not eligible	<i>To the day.</i> From December 30, 1973 to December 31, 2023.	
NCQA Exchange	<i>Single, Pull-down list.</i> 1: Completed Health Plan Add-On Application 2: Interim 3: First	<i>To the day.</i> From December 30, 1973 to December 31, 2023.	

	4: Renewal 5: NCQA Exchange not used		
NCQA Wellness & Health Promotion Accreditation	<i>Single, Radio group.</i> 1: Accredited and Reporting Measures to NCQA 2: Accredited and NOT reporting measures 3: Did not participate	<i>To the day.</i> From December 30, 1973 to December 31, 2023.	50 words
NCQA Managed Behavioral Healthcare Accreditation	<i>Single, Radio group.</i> 1: Full Accreditation, 2: Accredited – 1 Year 3: Provisional Accreditation 4: Denied Accreditation 5: NCQA not used	<i>To the day.</i> From December 30, 1973 to December 31, 2023.	50 words
NCQA Disease Management – Accreditation	<i>Multi, Checkboxes.</i> 1: Patient and practitioner oriented 2: Patient oriented 3: Plan Oriented 4: NCQA not used	<i>To the day.</i> From December 30, 1973 to December 31, 2023.	50 words
NCQA Disease Management – Certification	<i>Multi, Checkboxes.</i> 1: Program Design 2: Systems 3: Contact 4: NCQA not used	<i>To the day.</i> From December 30, 1973 to December 31, 2023.	50 words
NCQA Case Management Accreditation	<i>Multi, Checkboxes.</i> 1: Accredited - 3 years 2: Accredited - 2 years 3: No accreditation	<i>To the day.</i> From December 30, 1973 to December 31, 2023.	50 words
NCQA PHQ Certification	<i>Single, Pull-down list.</i> 1: Certified 2: No PHQ Certification	<i>To the day.</i> From December 30, 1973 to December 31, 2023.	
NCQA Multicultural Health Care Distinction	<i>Single, Pull-down list.</i> 1: Distinction 2: No MHC Distinction	<i>To the day.</i> From December 30, 1973 to December 31, 2023.	
URAC Accreditations	<i>Single, Radio group.</i> 1: URAC used 2: URAC not used		
URAC Accreditations - Health Plan	<i>Single, Radio group.</i> 1: URAC Accredited 2: Not URAC Accredited	<i>To the day.</i> From December 30, 1973 to December 31, 2023.	
URAC Accreditation - Comprehensive Wellness	<i>Single, Radio group.</i> 1: URAC Accredited 2: Not URAC Accredited	<i>To the day.</i> From December 30, 1973 to December 31, 2023.	

URAC Accreditations - Disease Management	<i>Single, Radio group.</i> 1: URAC Accredited 2: Not URAC Accredited	<i>To the day.</i> From December 30, 1973 to December 31, 2023.	
URAC Accreditations - Health Utilization Management	<i>Single, Radio group.</i> 1: URAC Accredited 2: Not URAC Accredited	<i>To the day.</i> From December 30, 1973 to December 31, 2023.	
URAC Accreditations - Case Management	<i>Single, Radio group.</i> 1: URAC Accredited 2: Not URAC Accredited	<i>To the day.</i> From December 30, 1973 to December 31, 2023.	
URAC Accreditations - Pharmacy Benefit Management	<i>Single, Radio group.</i> 1: URAC Accredited 2: Not URAC Accredited	<i>To the day.</i> From December 30, 1973 to December 31, 2023.	

18.1.5 If Applicant indicated any accreditations above, provide a copy of the accrediting agency's certificate and upload as a file title "Accreditation 1b" and including question number 18.1.5.

Single, Pull-down list.

1: Yes, Accreditation 1b attached.

2: Not attached.

18.1.6 Please provide the NCQA accreditation status and expiration date of the accreditation achieved for the EPO product identified in this response. Indicate all that apply. For the URAC Accreditation option, please enter each expiration date in the detail box if the Plan has earned multiple URAC accreditations.

Details limited to 50 words.

	Answer	Expiration date MM/DD/YYYY	Programs Reviewed
NCQA EPO	<i>Single, Pull-down list.</i> 1: Excellent 2: Commendable 3: Accredited 4: Provisional 5: Interim 6: Denied 7: In Process 8: Scheduled 9: Expired 10: NCQA not used or product not eligible	<i>To the day.</i> From December 30, 1973 to December 31, 2023.	

NCQA Exchange	<i>Single, Pull-down list.</i> 1: Completed Health Plan Add-On Application 2: Interim 3: First 4: Renewal 5: NCQA Exchange not used	<i>To the day.</i> From December 30, 1973 to December 31, 2023.	
NCQA Wellness & Health Promotion Accreditation	<i>Single, Radio group.</i> 1: Accredited and Reporting Measures to NCQA 2: Accredited and NOT reporting measures 3: Did not participate	<i>To the day.</i> From December 30, 1973 to December 31, 2023.	50 words.
NCQA Managed Behavioral Healthcare	<i>Single, Radio group.</i> 1: Full Accreditation, 2: Accredited – 1 Year 3: Provisional Accreditation 4: Denied Accreditation 5: NCQA not used	<i>To the day.</i> From December 30, 1973 to December 31, 2023.	50 words.
NCQA Disease Management – Accreditation	<i>Multi, Checkboxes.</i> 1: Patient and practitioner oriented 2: Patient oriented 3: Plan Oriented 4: NCQA not used	<i>To the day.</i> From December 30, 1973 to December 31, 2023.	50 words.
NCQA Disease Management – Certification	<i>Multi, Checkboxes.</i> 1: Program Design 2: Systems 3: Contact 4: NCQA not used	<i>To the day.</i> From December 30, 1973 to December 31, 2023.	50 words.
NCQA Case Management Accreditation	<i>Multi, Checkboxes.</i> 1: Accredited - 3 years 2: Accredited - 2 years 3: No accreditation	<i>To the day.</i> From December 30, 1973 to December 31, 2023.	50 words.
NCQA PHQ Certification	<i>Single, Pull-down list.</i> 1: Certified 2: No PHQ Certification	<i>To the day.</i> From December 30, 1973 to December 31, 2023.	
NCQA Multicultural Health Care Distinction	<i>Single, Pull-down list.</i> 1: Distinction 2: No MHC Distinction	<i>To the day.</i> From December 30, 1973 to December 31, 2023.	
URAC Accreditations	<i>Single, Radio group.</i> 1: URAC used 2: URAC not used		
URAC Accreditations - Health Plan	<i>Single, Radio group.</i> 1: URAC Accredited 2: Not URAC Accredited	<i>To the day.</i> From December 30, 1973 to December 31, 2023.	

URAC Accreditation - Comprehensive Wellness	<i>Single, Radio group.</i> 1: URAC Accredited 2: Not URAC Accredited	<i>To the day.</i> From December 30, 1973 to December 31, 2023.	
URAC Accreditations - Disease Management	<i>Single, Radio group.</i> 1: URAC Accredited 2: Not URAC Accredited	<i>To the day.</i> From December 30, 1973 to December 31, 2023.	
URAC Accreditations - Health Utilization Management	<i>Single, Radio group.</i> 1: URAC Accredited 2: Not URAC Accredited	<i>To the day.</i> From December 30, 1973 to December 31, 2023.	
URAC Accreditations - Case Management	<i>Single, Radio group.</i> 1: URAC Accredited 2: Not URAC Accredited	<i>To the day.</i> From December 30, 1973 to December 31, 2023.	
URAC Accreditations - Pharmacy Benefit Management	<i>Single, Radio group.</i> 1: URAC Accredited 2: Not URAC Accredited	<i>To the day.</i> From December 30, 1973 to December 31, 2023.	

18.1.7 If Applicant indicated any accreditations above, provide a copy of the accrediting agency's certificate and upload as a file title "Accreditation 1c" and include question number 18.1.7.

Single, Pull-down list.

- 1: Yes, Accreditation 1c attached
2: Not attached.

18.2 Focus on High Cost Providers

Affordability is core to the Exchange's mission to expand the availability of insurance coverage and promote the Triple Aim. The wide variation in unit price and total costs of care charged by providers, with some providers charging far more for care irrespective of quality, is a significant contributor to high cost of medical services. In this section, Applicants will be assessed on the extent to which there are activities in place to assess variation and prevent unduly high prices.

All questions required for currently contracted QHP Issuers and new Applicant entrants.

18.2.1 Describe the Applicant's efforts to understand price variation and strategies to ensure providers and hospitals do not charge unduly high costs. Specifically address the following in the response:

- The factors the Applicant considers in assessing the relative unit prices and total costs of care

- The extent to which the Applicant adjusts or analyzes the reasons for cost factors
- How cost factors are used in the selection of Providers and facilities in networks available to Enrollees
- Whether the Applicant conducts cost analyses of its hospital networks, e.g. identifying specific hospitals with cost deciles and calculating percentage of costs expended in each cost decile
- Comment on potential collaboration opportunities, new statewide or regional initiatives, or other activities that would strengthen this delivery system reform aim to improve affordability.

500 words.

18.3 Demonstrating Action on High Cost Pharmaceuticals

Appropriate treatment with pharmaceuticals is often the best clinical strategy to treating conditions, as well as managing chronic and life threatening conditions. At the same time, the Exchange is concerned with the trend in rising prescription drug costs, including those in specialty pharmacy, and compounding increases in costs of generic drugs, which are a growing driver of total cost of care. In this section, Applicants will be assessed on the extent to which value is considered in the construction of formularies and delivery of pharmacy services.

Question required for new Applicant entrants only.

18.3.1 Describe the Applicant's approach to achieving value in the delivery of pharmacy services and controlling drug costs as a percent of the total cost of care. Specifically address the following in the response:

- How the Applicant considers value in its selection of medications for use in its formulary
- Indicate whether a value assessment methodology, such as the Drug Effectiveness Review Project (DERP) or ICER Value Assessment Framework (ICER-VF), or other independent reports are used by the Applicant, and if so, how they are used to improve the value of pharmacy services.
- How decisions to select drugs and place them on tiers within the formulary are based on total cost of care rather than on drug cost alone
- How the Applicant monitors off-label use of pharmaceuticals and what efforts are undertaken to assure any off-label prescriptions are evidence-based
- How the Applicant provides decision support for prescribers and consumers related to the clinical efficacy and cost impact of treatments and their alternatives
- Comment on potential collaboration opportunities, new statewide or regional initiatives, or other activities that would strengthen this delivery system reform aim to improve affordability and value.

500 words.

18.4 Participation in Collaborative Quality Initiatives

Questions required for new Applicant entrants only.

The Exchange believes that improving health care quality and reducing costs can only be done over the long-term through collaborative efforts that effectively engage and support clinicians and other providers of care. There are many established statewide and national collaborative initiatives for quality improvement that are aligned with priorities established by the Exchange, most notably Smart Care California, which engages participants representing a number of sectors within health care to tackle the issue of overuse and promote best practices. The following questions address the Applicant's current involvement in collaborative efforts. Applicants will be assessed based on the breadth and depth of their involvement.

18.4.1 Describe how Applicant is measuring overuse of C-sections, opioids, and low back pain imaging, and if it is aligning with Smart Care California guidelines to promote best practices of care in these areas.

100 words.

18.4.2 Identify key collaboratives and organizations in which the Applicant is engaged. "Engagement" is defined as active participation through regular meeting attendance, health plan representatives serving as advisory members, submitting data to the collaborative, and/or providing feedback on initiatives and projects.

100 words.

18.5 Data Exchange with Providers

Question required for new Applicant entrants only.

To be successful under Exchange QIS requirements, and in order to improve the quality of care and successfully manage costs, successful Applicants will need to encourage enhanced exchange of clinical data between providers. Participation in Health Information Exchanges (HIE) will enable notification of physicians when their patients are admitted to the hospital and allow contracted plans to track, trend and improve performance on conditions such as hypertension or diabetes control. In this section, Applicants will be assessed on the extent to which clinical data exchange is occurring, plans to improve data exchange, and current participation in regional and statewide initiatives to improve data exchange.

18.5.1 Describe the Applicant's efforts to improve routine exchange of clinical data across specialties and institutional boundaries and between health plans and contracted providers. Specifically address the following:

- The extent to which data, other than claims information, is exchanged between providers and the Applicant and the proportion of providers in the network that currently submit non-claims data (clinical, demographic, etc.) to Applicant or other providers
- Initiatives in place to improve routine exchange of data to improve the quality of care, such as notifying providers of hospital admissions, collecting clinical data to supplement annual HEDIS data collection, and race/ethnicity self-reported identity
- Participation in initiatives to support the aggregation of claims and clinical data

- Comment on potential collaboration opportunities, new statewide or regional initiatives, or other activities that would strengthen this delivery system reform aim to improve quality and manage costs through data exchange.

500 words.

18.6 Data Aggregation Across Health Plans

Question required for new Applicant entrants only.

The Exchange recognizes the importance of aggregating data across purchasers and payers to more accurately understand the performance of providers that have contracts with multiple health plans. Such aggregated data reflecting a larger portion of a provider, group or facility's practice can potentially be used to support performance improvement, contracting and public reporting. In this section, the Applicant will be assessed on the extent to which it is engaging with other payers and stakeholders to support aggregation.

18.6.1 Describe the Applicant's efforts to support aggregation of claims and other information across payers. Specifically address how the Applicant is engaged with the following:

- Integrated Health Association (IHA) for Medical Groups: P4P, Encounter Data Initiative, Provider Directory
- CalHospitalCompare

500 words.

18.7 Mental and Behavioral Health Management

Question required for currently contracted QHP Issuers and new Applicant Entrants.

The Exchange recognizes the critical importance of Mental and Behavioral Health Services as part of the broader set of medical services provided to enrollees. Answers will be evaluated based on the degree of integration and accessibility relative to industry trends and market innovations, as well as the thoroughness of the response.

18.7.1 Describe the Applicant's strategies to improve accessibility of mental and behavioral health services and further integrate mental and behavioral health with medical services. Specifically address the following:

- Efforts to improve the availability of services, such as changes in benefits management, networks, contracting with accountable care organizations, etc.
- Strategies to improve the integration of mental and behavioral health services and medical services, and a description of any recommended models or best practices integrating these services. Indicate whether these efforts are implemented in association with PCMH and IHM models.
- Percent of services provided under an integrated behavioral health-medical model in both its Exchange business (if Applicant had Exchange business in 2017) and total book of business.

- Comment on any highly innovative models in California or nationwide and potential collaborative opportunities to adopt these models on a larger scale.

500 words.

18.8 Health Technology (Telehealth and Remote Monitoring)

The Exchange supports the innovative use of technology to assist in higher quality, accessible, patient-centered care. The following questions address the Applicant's adoption and use of health technology, and answers will be evaluated based on the Applicant's capacity for telehealth and remote monitoring relative to industry trends.

Question required for currently contracted QHP Issuers and new Applicant entrants.

18.8.1 Provide information regarding Applicant's capabilities to support physician-member consultations using technology (e.g., web consultations, telemedicine). In the third and fourth columns, select the books of business and product to which the answer applies to provide meaningful reference points to compare with current or future Exchange business. Applicant will be evaluated based on the availability of telehealth services for all books of business, particularly Exchange membership (if Applicant is not currently contracted with the Exchange, select "1" if the service would be offered to Exchange members, and include a description in the details section).

Note that Applicants selecting "Plan does not offer or allow web or telehealth consultations" will not complete the responses for all rows and columns in this question.

Details limited to 100 words.

Response	Answer	Technology	Details
Applicant ability to support web/telehealth consultations, either through a contractor or provided by the medical group/provider	<i>Multi, Checkboxes.</i> 1: Plan does not offer/allow web or telehealth consultations 2: Web visit using instant messaging 3: Telehealth with interactive face to face dialogue (video) over the Web 4: Telehealth with interactive dialogue over the phone 5: Telehealth via email 6: Other (specify)		20 words.
Indicate availability of web/telehealth consultations, either through a contractor or	<i>Multi, Checkboxes.</i> 1: Exchange 2: All large group 3: Large group buy-		20 words.

provided by a medical group/provider, by book of business	up option only 4: Medicaid 5: Medicare 6: Other		
Indicate availability of web/telehealth consultations, either through a contractor or provided by a medical group/provider, by product type	<i>Multi, Checkboxes.</i> 1: HMO 2: PPO 3: EPO 4: Other		20 words.
Applicant uses a vendor for web/telehealth consultations (indicate vendor and average wait time in the details section)	50 words. N/A OK.	<i>Multi, Checkboxes.</i> N/A OK. 1: Telehealth via web (video) 2: Telehealth via phone 3: Combination of web (video) and phone 4: Instant messaging 5: Email 6: Other (specify)	20 words.
Applicant contracts with medical groups/providers that offer web/telehealth consultations (yes/no with details)	50 words N/A OK	<i>Multi, Checkboxes.</i> N/A OK. 1: Telehealth via web (video) 2: Telehealth via phone 3: Combination of web (video) and phone 4: Instant messaging 5: Email 6: Other (specify)	20 words.
If physicians and/or physician groups/practices are designated in provider directory as having web/telehealth consultation services available, provide percentage of physicians in the network (across all lines of business)	<i>Percent.</i> From 0 to 100.	<i>Multi, Checkboxes.</i> N/A OK. 1: Telehealth via web (video) 2: Telehealth via phone 3: Combination of web (video) and phone 4: Instant messaging 5: Email 6: Other (specify)	20 words.
For physicians that are available to deliver web/telehealth consultations, what is the average wait time? If Applicant can provide average wait time - please describe how that is monitored in detail box at end of question	<i>Single, Radio group.</i> N/A OK. 1: On demand 2: Within 4 hours 3: Within same day 4: Scheduled follow-up within 48 hours 5: Other (describe)	<i>Multi, Checkboxes.</i> N/A OK. 1: Telehealth via web (video) 2: Telehealth via phone 3: Combination of	20 words.

		web (video) and phone 4: Instant messaging 5: Email 6: Other (specify)	
Applicant promotes telehealth (either through vendor or medical group) as an alternative to the ED for urgent health issues (describe specific engagement efforts and any specific contractual requirements related to this topic for vendors or medical groups)	50 words. N/A OK.		20 words.
Member reach of physicians providing web/telehealth consultations (i.e. what % of members are attributed to those physicians offering web/telehealth consultations) (use as denominator total membership across all lines of business). If Applicant has and tracks use by Medi-Cal members as well, number here should include Medi-Cal numbers.)	Percent. From 0 to 100.	Multi, Checkboxes. N/A OK. 1: Telehealth via web (video) 2: Telehealth via phone 3: Combination of web (video) and phone 4: Instant messaging 5: Email 6: Other (specify)	20 words.
What percentage of the current total membership has access to web/telehealth consultations as a covered core benefit (no buy-up required)? (Use as denominator total membership across all lines of business).	Percent. N/A OK. From 0 to 100.	Multi, Checkboxes. N/A OK. 1: Telehealth via web (video) 2: Telehealth via phone 3: Combination of web (video) and phone 4: Instant messaging 5: Email 6: Other (specify)	20 words.
Percentage of unique members with a web/telehealth consultation in 2017	Percent. N/A OK. From 0 to 100.	Multi, Checkboxes. N/A OK. 1: Telehealth via web (video) 2: Telehealth via phone 3: Combination of web (video) and phone 4: Instant messaging 5: Email 6: Other (specify)	20 words.
If Applicant had Exchange business in 2017: Percentage of unique Exchange members with a web/telehealth consultation in 2017	Percent. N/A OK. From 0 to 100.	Multi, Checkboxes. N/A OK. 1: Telehealth via	20 words.

		web (video) 2: Telehealth via phone 3: Combination of web (video) and phone 4: Instant messaging 5: Email 6: Other (specify)	
Applicant reimburses for web/telehealth consultations	<i>Single, Radio group.</i> 1: Yes 2: No	<i>Multi, Checkboxes.</i> N/A OK. 1: Telehealth via web (video) 2: Telehealth via phone 3: Combination of web (video) and phone 4: Instant messaging 5: Email 6: Other (specify)	20 words.
Among members in plans with available web/telehealth consultation, what is the member cost share?	<i>Multi, Checkboxes.</i> 1: No costshare 2: Same cost as a primary care visit 3: Same cost as a specialist visit 4: Telehealth visit cost share (please explain): 5: Other (explain):	<i>Multi, Checkboxes.</i> N/A OK. 1: Telehealth via web (video) 2: Telehealth via phone 3: Combination of web (video) and phone 4: Instant messaging 5: Email 6: Other (specify)	20 words.
Discuss any innovations or pilot programs adopted by the Applicant that are not reflected in this table (such as future plans for new programs, expansion of existing programs, new telehealth features, etc.)	100 words. N/A OK.		

18.9 Health and Wellness

18.9.10 – 18.9.12 required for currently contracted QHP Issuers. All questions required for new Applicant entrants.

The Exchange recognizes that access to care, timely preventive care, coordination of care, and early identification of high risk enrollees are central to the improvement of enrollee health. The following questions address Applicant's ability to track the health and wellness of enrollees and identify enrollees for preventive care and interventions. Answers will be

evaluated based on the degree to which health and wellness data is tracked on membership and used to coordinate care.

18.9.1 Report selected measures below for the two most recently calculated years of HEDIS results for the HMO Applicant (QC 2017 and 2016). ***Colorectal Cancer Screening was eligible for rotation in HEDIS 2015.***

If Applicant did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised: -1 means 'NR', -2 means 'NA', -3 means 'ND', -4 means 'EXC', and -5 means 'NB'.

	HMO QC 2017	QC 2016, or prior year's HMO QC result
Breast Cancer Screening - Total	<i>Percent.</i> From -10 to 100.	<i>Percent.</i> From -10 to 100.
Cervical Cancer Screening	<i>Percent.</i> From -10 to 100.	<i>Percent.</i> From -10 to 100.
Colorectal Cancer Screening	<i>Percent.</i> From -10 to 100.	<i>Percent.</i> From -10 to 100.

18.9.2 Report selected measures below for the two most recently calculated years of HEDIS results for the PPO Applicant (QC 2017 and 2016). ***Colorectal Cancer Screening was eligible for rotation in HEDIS 2015.***

If Applicant did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised: -1 means 'NR', -2 means 'NA', -3 means 'ND', -4 means 'EXC', and -5 means 'NB'.

	PPO QC 2017	PPO QC 2016, or prior year's PPO QC result
Breast Cancer Screening - Total	<i>Percent.</i> From -10 to 100.	<i>Percent.</i> From -10 to 100.

Cervical Cancer Screening	<i>Percent.</i> From -10 to 100.	<i>Percent.</i> From -10 to 100.
Colorectal Cancer Screening	<i>Percent.</i> From -10 to 100.	<i>Percent.</i> From -10 to 100.

18.9.3 Report selected measures below for the two most recently calculated years of HEDIS results for the EPO Applicant (QC 2017 and 2016). ***Colorectal Cancer Screening was eligible for rotation in HEDIS 2015.***

If Applicant did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised: -1 means 'NR', -2 means 'NA', -3 means 'ND', -4 means 'EXC', and -5 means 'NB'.

	EPO QC 2017	EPO QC 2016, or prior year's EPO QC result
Breast Cancer Screening - Total	<i>Percent.</i> From -10 to 100.	<i>Percent.</i> From -10 to 100.
Cervical Cancer Screening	<i>Percent.</i> From -10 to 100.	<i>Percent.</i> From -10 to 100.
Colorectal Cancer Screening	<i>Percent.</i> From -10 to 100.	<i>Percent.</i> From -10 to 100.

18.9.4 Which of the following member interventions were used by Applicant in calendar year 2017 to improve cancer screening rates? Indicate all that apply.

	Educational messages identifying screening options discussing risks and benefits	Member-specific reminders (electronic or written, etc.) sent to members for needed care based on general eligibility (age/gender)	Member-specific reminders for gaps in services based on administrative or clinical information (mail, e-mail/text, automated phone or live outbound telephone calls triggered by the ABSENCE of a service)
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Breast Cancer Screening	<i>Single, Radio group.</i> 1: Yes 2: No	<i>Single, Radio group.</i> 1: Available to > 75% of members 2: Available to < 75% of members 3: Not Available	<i>Single, Radio group.</i> 1: Available to > 75% of members 2: Available to < 75% of members 3: Not Available
Cervical Cancer Screening	<i>Single, Radio group.</i> 1: Yes 2: No	<i>Single, Radio group.</i> 1: Available to > 75% of members 2: Available to < 75% of members 3: Not Available	<i>Single, Radio group.</i> 1: Available to > 75% of members 2: Available to < 75% of members 3: Not Available
Colorectal Cancer Screening	<i>Single, Radio group.</i> 1: Yes 2: No	<i>Single, Radio group.</i> 1: Available to > 75% of members 2: Available to < 75% of members 3: Not Available	<i>Single, Radio group.</i> 1: Available to > 75% of members 2: Available to < 75% of members 3: Not Available

18.9.5 Report selected measures below for the two most recently uploaded years of HEDIS/CAHPS (QC 2017 and QC 2016) results for HMO Applicant.

If Applicant did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised: -1 means 'NR', -2 means 'NA', -3 means 'ND', -4 means 'EXC', and -5 means 'NB'.

Childhood Immunization Status and Immunizations for Adolescents were eligible for rotation in HEDIS 2015.

	QC 2017, or most current year's HMO result	QC 2016, or prior year's HMO QC result
Childhood Immunization Status - Combo 2	<i>Percent.</i> From -10 to 100.	<i>Percent.</i> From -10 to 100.
Immunizations for Adolescents - Combination	<i>Percent.</i> From -10 to 100.	<i>Percent.</i> From -10 to 100.
CAHPS Flu Shots for Adults (50-64) (report rolling average)	<i>Percent.</i> From -10 to 100.	<i>Percent.</i> From -10 to 100.

18.9.6 Report selected measures below for the two most recently uploaded years of HEDIS/CAHPS (QC 2017 and QC 2016) results for PPO Applicant.

If Applicant did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised: -1 means 'NR', -2 means 'NA', -3 means 'ND', -4 means 'EXC', and -5 means 'NB'.

Childhood Immunization Status and Immunizations for Adolescents were eligible for rotation in HEDIS 2015.

	QC 2017, or most current year's PPO result	QC 2016, or prior year's PPO QC result
Childhood Immunization Status - Combo 2	<i>Percent.</i> From -10 to 100.	<i>Percent.</i> From -10 to 100.
Immunizations for Adolescents - Combination	<i>Percent.</i> From -10 to 100.	<i>Percent.</i> From -10 to 100.
CAHPS Flu Shots for Adults (50-64) (report rolling average)	<i>Percent.</i> From -10 to 100.	<i>Percent.</i> From -10 to 100.

18.9.7 Report selected measures below for the two most recently uploaded years of HEDIS/CAHPS (QC 2017 and QC 2016) results for EPO Applicant.

If a plan did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised: -1 means 'NR', -2 means 'NA', -3 means 'ND', -4 means 'EXC', and -5 means 'NB'.

Childhood Immunization Status and Immunizations for Adolescents were eligible for rotation in HEDIS 2015.

	QC 2017, or most current year's EPO result	QC 2016, or prior year's EPO QC result
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Childhood Immunization Status - Combo 2	<i>Percent.</i> From -10 to 100.	<i>Percent.</i> From -10 to 100.
Immunizations for Adolescents - Combination	<i>Percent.</i> From -10 to 100.	<i>Percent.</i> From -10 to 100.
CAHPS Flu Shots for Adults (50-64) (report rolling average)	<i>Percent.</i> From -10 to 100.	<i>Percent.</i> From -10 to 100.

18.9.8 Identify member interventions used in calendar year 2017 to improve immunization rates. Check all that apply.

	Response	Member-specific reminders (electronic or written, etc.) sent to members for needed care based on general eligibility (age/gender)	Member-specific reminders for gaps in services based on administrative or clinical information (mail, email/text, automated phone or live outbound telephone calls triggered by the ABSENCE of a service)
Childhood Immunizations	<i>Multi, Checkboxes.</i> 1: General education (i.e. - member newsletter) 2: Community/employer immunization events 3: None of the above	<i>Single, Radio group.</i> 1: Available to > 75% of members 2: Available to < 75% of members 3: Not available	<i>Single, Radio group.</i> 1: Available to > 75% of members 2: Available to < 75% of members 3: Not available
Immunizations for Adolescents	<i>Multi, Checkboxes.</i> 1: General education (i.e. - member newsletter) 2: Community/employer immunization events 3: None of the above	<i>Single, Radio group.</i> 1: Available to > 75% of members 2: Available to < 75% of members 3: Not available	<i>Single, Radio group.</i> 1: Available to > 75% of members 2: Available to < 75% of members 3: Not available

18.9.9 Indicate whether the Applicant currently participates in the California Immunization Registry (both submitting and receiving data). If yes, include a description of how the

Applicant uses the data obtained in the registry, e.g. supporting outreach to those with gaps in care and/or evaluating effectiveness of provider interventions.

Single, radio group

1: Yes (explain) (50 words)

2: No

Details limited to 100 words.

18.9.10 Indicate the number and percent of tobacco-dependent commercial members identified and participating in cessation activities during 2017.

If Applicant is currently contracted with the Exchange, please provide Exchange counts if available. If Exchange counts are not available, provide state or regional counts.

	Answer
Indicate how Applicant identifies members who use tobacco. Applicant may add up the tobacco users identified in each of the ways identified in this row with the recognition that this may result in some duplication or over counting in response to row below on number of commercial members individually identified as tobacco dependent in 2017.	<i>Multi, Checkboxes.</i> 1: Plan Health Assessment, 2: Employer/Vendor Health Assessment, 3: Member PHR, 4: Claims/Encounter Data, 5: Disease or Care Management, 6: Wellness Vendor, 7: Other (describe in box in cell)
Indicate ability to track identification of tobacco-dependent members. Please select only ONE of response options 1-4 and include response option 5 if applicable	<i>Multi, Checkboxes.</i> 1: Identification tracked statewide & regionally, 2: Identification only tracked statewide, 3: Identification only tracked regionally, 4: Identification not tracked regionally/statewide, 5: Identification can be tracked at Covered California level
Indicate ability to track participation of tobacco-dependent members in cessation activities. Please select only ONE of response options 1-4 and include response option 5 if applicable	<i>Multi, Checkboxes.</i> 1: Participation tracked statewide & regionally, 2: Participation only tracked statewide, 3: Participation only tracked regionally, 4: Participation not tracked regionally/statewide, 5: Participation can be tracked at Covered California level
Number of California members individually identified as tobacco dependent in 2016. (If Applicant has and tracks use by Medi-Cal members as well, number here should include Medi-Cal numbers.)	<i>Decimal.</i> From 0 to 1000000000

% of California members identified as tobacco dependent	<i>Percent</i>
Number of Exchange members individually identified as tobacco dependent in 2017.	<i>Decimal.</i> From 0 to 1000000000
% of Exchange members identified as tobacco dependent	<i>Percent</i>
Number of California members identified as tobacco dependent who participated in a smoking cessation program during 2016. (If Health plan has and tracks use by Medi-Cal members as well, number here should include Medi-Cal numbers.)	<i>Decimal.</i> From 0 to 1000000000
% of California members identified as tobacco dependent participating in smoking cessation program (# program participants divided by # identified smokers)	<i>Percent.</i>
Number of Exchange members identified as tobacco dependent who participated in a smoking cessation program during 2017.	<i>Decimal.</i> From 0 to 1000000000.
% of Exchange members identified as tobacco dependent participating in smoking cessation program (# program participants divided by # identified smokers)	<i>Percent.</i>

18.9.11 Indicate the number of obese members identified and participating in weight management programs during 2017. Do not report general prevalence.

If Applicant is currently contracted with the Exchange, please provide Exchange counts if available. If Exchange counts are not available, provide state/regional counts.

	Answer
Indicate how the Applicant identifies members who are obese. Applicant may add up the obese members identified in each of the ways identified in this row with the recognition that this may result in some duplication or over counting in response to row below on Number of commercial members individually identified as obese in 2017 as of December 2017	<i>Multi, Checkboxes.</i> 1: Plan Health Assessment, 2: Employer/Vendor Health Assessment, 3: Member PHR, 4: Claims/Encounter Data, 5: Disease or Care

	Management, 6: Wellness Vendor, 7: Other (describe in box in cell)
Indicate ability to track identification of obese members. Please select only ONE of response options 1-4 and include response option 5 if applicable	<i>Multi, Checkboxes.</i> 1: Identification tracked statewide & regionally, 2: Identification only tracked statewide, 3: Identification only tracked regionally, 4: Identification not tracked regionally/statewide, 5: Identification can be tracked at Covered California level
Indicate ability to track participation of obese members in weight management programs. Please select only ONE of response options 1-4 and include response option 5 if applicable	<i>Multi, Checkboxes.</i> 1: Participation tracked statewide & regionally, 2: Participation tracked only statewide, 3: Participation only tracked regionally, 4: Participation not tracked regionally/statewide, 5: Participation can be tracked at Covered California level
Number of California members identified as obese in 2017. (If Applicant has and tracks use by Medi-Cal members as well, number here should include Medi-Cal numbers.)	<i>Decimal.</i> From 0 to 1000000000.
% of California members identified as obese	<i>Percent.</i>
Number of Exchange members identified as obese in 2017.	<i>Decimal.</i> From 0 to 1000000000.
% of Exchange members identified as obese	<i>Percent.</i>
Number of California members identified as obese who participated in a weight management program during 2017. (If the Applicant has and tracks use by Medi-Cal members as well, number here should include Medi-Cal numbers.)	<i>Decimal.</i> From 0 to 1000000000.
% of California members identified as obese who are participating in weight management program (# program participants divided by # of identified obese)	<i>Percent.</i>

Number of Exchange members identified as obese who participated in weight management program during 2017.	<i>Decimal.</i> From 0 to 1000000000.
% of Exchange members identified as obese who are participating in weight management program (# program participants divided by # of identified obese)	<i>Percent.</i>

18.9.12 As part of total population management and person-centered care, summarize Applicant activities and ability to:

- Identify members who are non-users (no claims).
- Engage those members in staying/becoming healthy.
- Support Purchasers in communication and engagement.

	Response/Summary	Geography of response
Percent of total commercial membership with no claims in CY 2017	<i>Percent.</i> N/A OK.	<i>Single, Radio group.</i> 1: Regional 2: State
Summary (bullet points) of plan activities to engage members who are non-users	<i>100 words.</i> N/A OK.	
Summary (bullet points) of support provided to Purchasers to engage members who are non-users	<i>100 words.</i> N/A OK.	

18.9.13 Indicate activities and capabilities supporting the Applicant's Health Assessment (HA) programming (formerly known as Health Risk Assessment-HRA or Personal Health Assessment-PHA). Check all that apply.

Multi, Checkboxes.

- 1: HA Accessibility: Both online and in print.
- 2: HA Accessibility: IVR (interactive voice recognition system).
- 3: HA Accessibility: Telephone interview with live person.
- 4: HA Accessibility: Multiple language offerings.
- 5: HA Accessibility: HA offered at initial enrollment.
- 6: HA Accessibility: HA offered on a regular basis to members.

- 7: Addressing At-risk Behaviors: At point of HA response, risk-factor education is provided to member based on member-specific risk, e.g. at point of "smoking-yes" response, tobacco cessation education is provided as pop-up.
- 8: Addressing At-risk Behaviors: Personalized HA report is generated after HA completion that provides member-specific risk modification actions based on responses.
- 9: Addressing At-risk Behaviors: Members are directed to targeted interactive intervention module for behavior change upon HA completion.
- 10: Addressing At-risk Behaviors: Ongoing push messaging for self-care based on member's HA results ("Push messaging" is defined as an information system capability that generates regular e-mail or health information to the member).
- 11: Addressing At-risk Behaviors: Member is automatically enrolled into a disease management or at-risk program based on responses.
- 12: Addressing At-risk Behaviors: Case manager or health coach outreach call triggered based on HA results.
- 13: Addressing At-risk Behaviors: Member can elect to have HA results sent electronically to personal physician.
- 14: Addressing At-risk Behaviors: Member can update responses and track against previous responses.
- 15: Tracking health status: HA responses incorporated into member health record.
- 16: Tracking health status: HA responses tracked over time to observe changes in health status.
- 17: Tracking health status: HA responses used for comparative analysis of health status across geographic regions.
- 18: Tracking health status: HA responses used for comparative analysis of health status across demographics.
- 19: Partnering with Employers: Employer receives trending report comparing current aggregate results to previous aggregate results.
- 20: Partnering with Employers: Health plan can import data from employer-contracted HA vendor.
- 21: Applicant does not offer an HA.

18.9.14 Provide the number of currently enrolled commercial and Exchange members who completed a Health Assessment (HA) in the past year.

	Answer
Geography reported below for HA completion Please select only ONE of response options 1-4 and include response option 5 if applicable	<i>Multi, Checkboxes.</i> 1: Participation tracked statewide & regionally, 2: Participation only tracked statewide, 3: Participation only tracked regionally, 4: Participation not tracked regionally/statewide, 5: Participation can be tracked at Covered California level
Number of members completing Plan-based HA in 2017 (If Applicant has and tracks use by Medi-Cal members as well, number here should include Medi-Cal numbers.)	<i>Decimal.</i> From 0 to 10000000000000000000.
Percent HA completion (Health plan HA completion number divided by total enrollment)	Percent.
Number of completed HAs resulting in referral to health plan case management staff or assigned provider	<i>Decimal.</i>
Percent completed HAs resulting in referral to health plan case management staff or assigned provider (Referral number divided by number of completed HAs)	Percent.

18.9.15 Does Applicant collect information, at both individual and aggregate levels, on changes in Enrollees' health status? Please describe Applicant's process to monitor and track changes in Enrollees' health status, which may include its process for identifying individuals who show a decline in health status, and referral of such Enrollees to care management and chronic condition program(s). Include in the answer how many Exchange enrollees, across all lines of business, have been identified through the process and referred to care management, chronic condition program(s), or other services as a result of a change in health status. If Applicant does not currently have Exchange business, report on all lines of business.

100 words.

18.10 Community Health and Wellness Promotion

All questions required for currently contracted QHP Issuers and new Applicant entrants.

The Exchange recognizes that promoting better health for Enrollees also requires engagement and promotion of community-wide initiatives that foster better health, healthier environments, and the promotion of healthy behaviors across the community. The following question addresses the Applicant's activities to promote better community health, and answers will be evaluated based on the degree to which the Applicant's programs are external-facing (i.e. the activity or program has an expected impact on community health, rather than solely for the Applicant's members).

18.10.1 Provide a description of the external-facing initiatives, programs and projects Applicant supports to promote better community health, and how such programs specifically address health disparities or efforts to improve community health apart from the health delivery system. Examples include California State Innovation Model (CalSIM), Health in All Policies (HIAP), The California Endowment Healthy Communities, and Beach Cities Health District. Please note the definition of external-facing provided in the previous paragraph and include any evaluation results of the activity or program, if available.

500 words.

18.11 At-Risk Enrollees

18.11.7 required for currently contracted QHP Issuers. All questions required for new entrant Applicants.

The Exchange recognizes that identifying and proactively managing at-risk Enrollees, defined as individuals with existing and newly diagnosed chronic conditions, such as diabetes, heart disease, asthma, hypertension or a medically complex condition, serves to better coordinate care, which improves outcomes and lowers costs. The following questions assess Applicant's ability to track and manage these enrollees, and responses will be evaluated on Applicant's use of data and interventions to proactively manage enrollees as well as the thoroughness of the response.

18.11.1 How does Applicant identify at-risk enrollees who would benefit from early, proactive interventions? Describe the categories used, sources of data, and any predictive analytic capabilities.

100 words.

18.11.2 For the Exchange business, please provide (1) the number of members aged 18 and above in first row, (2) the number of members aged 18 and above identified under Applicant's criteria for at-risk enrollees eligible for case management in the second row. If Applicant does not currently have Exchange business, report on all lines of business excluding Medicare.

	Number of members as specified in rows 1, and 2
Number of members aged 18 and above in this state or market	<i>Decimal.</i>
Using Applicant's definition, provide number of members 18 and above who are at-risk enrollees	<i>Decimal.</i>

18.11.3 Describe outreach/interventions used to ensure at risk enrollees get needed care. Please note if any of the strategies below are used:

- Member-specific reminders for due or overdue clinical/diagnostic maintenance services and/or medication events (failure to refill for example)
- Online interactive self-management support. "Online self-management support" is an intervention that includes two-way electronic communication between the Plan and the member
- Self-initiated text/email
- Interactive IVR
- Live outbound telephonic coaching program
- Face to face visits

500 words.

18.11.4 Describe Applicant's process for keeping and updating a medical history of at-risk enrollees in the Applicant's maintained enrollee health profile.

65 words.

18.11.5 Does Applicant share registries of enrollees with their identified risk, as permitted by state and federal law, with appropriate accountable providers, especially the enrollee's PCP. If yes, please describe.

Single, Radio group.

1: Yes, describe: [65 words]

2: No

18.11.6 Describe the mechanisms to evaluate access within the provider network on an ongoing basis, to ensure that an adequate network is in place to support a proactive intervention and care management program for at-risk enrollees.

100 words.

18.11.7 Please describe ability to gather, categorize, and package current information on at risk enrollees in case applicant is requested to transfer to other Covered California health plans to facilitate a smooth transition of care.

100 words.

19 Covered California Quality Improvement Strategy (QIS)

All questions required for currently contracted QHP Issuers and new Applicant entrants.

The Patient Protection and Affordable Care Act (§1311 (g) (1)) requires periodic reporting to the Exchange of activities a contracted health plan has conducted to implement a strategy for quality improvement. This strategy is defined as a multi-year improvement strategy that includes a payment structure that provides increased reimbursement or other incentives for improving health outcomes, preventing readmissions, improving patient safety, wellness and health promotion activities, or reduction of health and health care disparities. Per the final rule issued by the Centers for Medicare and Medicaid Services (CMS) on May 27, 2014, issuers must implement and report on a quality improvement strategy or strategies consistent with the standard of section 1311(g) of the ACA.

Attachment 7 of the Covered California Qualified Health Plan (QHP) Issuer Contract embodies the Exchange's vision for reform and serves as a roadmap to delivery system improvements. Beginning with the 2017 QHP Issuer Contract, QHP issuers have been engaged in supporting existing quality improvement initiatives and programs that are sponsored by other major purchasers including the Department of Health Care Services (DHCS), the California Public Employees' Retirement System (CalPERS), the Pacific Business Group on Health (PBGH), and CMS. These requirements are reflected in the 2017 contract and will be in all successive contracts through 2019. Certification and participation in the Exchange will be conditional on the Issuer developing a multi-year strategy and reporting year-to-year activities and progress on each initiative area.

The Covered California Quality Improvement Strategy (QIS) meets federal requirements for State-based Marketplaces (SBMs) and also serves as the foundational improvement plan and progress report for certification and contractual requirements. All Issuers, both those previously contracted with the Exchange as well as new entrants, are required to complete the QIS as part of the Application process. Reporting is divided into two parts:

- Issuer information
- Implementation plans and progress reports for the Quality Improvement Strategy (QIS) for Covered California Quality and Delivery System Reform:
 - Provider Networks Based on Quality
 - Reducing Health Disparities and Assuring Health Equity
 - Promoting Development and Use of Care Models - Primary Care
 - Promoting Development and Use of Care Models - Integrated Healthcare Models (IHM)
 - Appropriate Use of C-Sections
 - Hospital Patient Safety
 - Patient-Centered Information and Support

Currently Contracted Issuers: The QIS will be evaluated by the Exchange as part of the annual application for recertification and final approval by the Exchange may require follow-up meetings or documentation as necessary. Currently-contracted QHP Issuers applying for

the 2019 Plan Year Issuers may submit an update to the QIS submitted in the Plan Year 2018 Application; however, please note new questions for reporting progress on the initiative area. For Issuers contracted with the Exchange in 2017, Answers to these questions will be used to assess performance guarantees for Plan Year 2019.

19.1 Issuer Information

19.1.1 Complete this section and designate one contact for medical management and one contact for network management.

Type of QIS Submission	<i>Single, Pull-down list.</i> 1: New QIS 2: N/A
QIS Medical Management Contact's Name	20 words.
QIS Medical Management Contact's Title	20 words.
QIS Medical Management Contact's Phone Number	20 words.
QIS Medical Management Contact's Email	20 words.
QIS Network Management Contact's Name	20 words.
QIS Network Management Contact's Title	20 words.
QIS Network Management Contact's Phone Number	20 words.
QIS Network Management Contact's Email	20 words.

19.2 Implementation Plans and Progress Reports for the Quality Improvement Strategy (QIS) for Covered California Quality and Delivery System Reform

19.2.1 QIS for Provider Networks Based on Quality

Federal QIS Topic Area: Activities to improve patient safety and reduce medical errors
2017 QHP Issuer Contract, Section 1.02

Goal for end of 2019: The Issuer should have 1) clear network quality criteria that is used to screen both providers and hospitals for inclusion in network, and 2) possible removal of outliers based on inability to meet quality criteria and/or lack of effort toward improvement.

19.2.1.1: Please describe updates in Applicant's ability to build networks based on quality since the last QIS submission. The narrative should include:

- All quality measures and criteria used to develop 1) provider networks, and 2) hospital networks. Include patient safety and patient-reported experience (noting any measures that are new).

- Please explain the assessment process, source of quality assessment data, specific measures and metrics, and thresholds for inclusion and exclusion in the network.
- If applicable, describe which criteria are prioritized above other criteria to determine the provider network.
- Describe if Centers of Excellence are included in network, and if so the basis for inclusion. Also note if they are promoted among members and if utilization is tracked.
- Progress in 2017 toward the end goal and any further implementation plans for 2018.
- Known or anticipated barriers.

19.2.2 QIS for Reducing Health Disparities and Ensuring Health Equity

Federal QIS Topic Area: Activities to reduce health and health care disparities.
2017 QHP Issuer Contract, Section 3.01 and 3.02

Goal for end of 2019: 1) Reach 80% of Exchange members self-reporting their race/ethnicity, 2) collect, track trend, and demonstrate improvement in reduction of health disparities in management of diabetes, asthma, hypertension, and depression.

19.2.2.1: Provide the percent of Exchange members for whom self-reported data is captured for race/ethnicity in Attachment E QIS Run Charts. If Issuer does not currently have Exchange business, report on all lines of business excluding Medicare. Self-identification may take place through the enrollment application, web site registration, health assessment, reported at provider site, etc. Enter the percentage reported in the Certification Applications for 2017 and 2018 as well.

Single, Pull-down list.

1. Attached
2. Not attached

19.2.2.2: Describe updates on progress made since the last QIS submission, and planned activities to achieve the Applicant's aims. Issuer may submit the progress report or any supporting documentation as an attachment if desired. Please include as applicable:

- Updates in efforts to increase self-reported race/ethnic information including whether there are barriers to self-report.
- Update whether the Rand proxy method using geocoding and surname is used to supplement self-report.
- Updates in ability to compile, track and trend data for understanding disparity gaps in the four key disease areas.

- Planning/implementation of interventions to reduce known disparity gaps.
- Development of market-based incentives to reduce disparities and assure health equity.
- Progress in 2017 toward the end goal and any further implementation plans for 2018.
- Known or anticipated barriers in implementing QIS activities and describe mitigation activities.

2000 words.

19.2.3 QIS for Promoting Development and Use of Care Models – Primary Care

Federal QIS Topic Area: Activities for improving health outcomes

2017 QHP Issuer Contract, Sections 4.01 and 4.02

Goal for end of 2019: 1) Continue to match at least 95% of enrollees with a primary care physician 2) increase proportion of providers paid under a payment strategy that promotes advanced primary care.

19.2.3.1 Report, by product, the percentage of members by product in Applicant's Exchange business who either selected a Personal Care Physician (PCP) or were matched with a Personal Care Physician in 2017 in Attachment E QIS Run Charts. If the Applicant had no Exchange business in 2017, report full book of business excluding Medicare. Enter the percentage reported in the certification Applications for 2017 and 2018 as well. Report data by product (HMO, PPO, EPO).

Single, Pull-down list.

1. Attached
2. Not attached

19.2.3.2 Report the number and percentage of Exchange members who obtain their primary care with a provider or clinic that has received either NCQA PCMH Recognition or The Joint Commission PCMH Certification in Attachment E QIS Run Charts. For currently contracted Applicants, enter the percentage reported in the certification Application for 2018 as well. If Applicant did not have Exchange business during the prior calendar year, please report on the full book of business.

Single, Pull-down list.

1. Attached
2. Not attached

19.2.3.3 Report all types of payment models, including fee for service (FFS) and capitation, used for primary care services and number of providers paid under each model in Attachment E QIS Run Charts. If the Applicant has adopted a model consistent with a Level 3 or 4 alternative payment model (APM) as outlined in the LAN Draft White Paper on Primary Care Payment Models or aligned with CMMI's Comprehensive Primary Care Plus program as part of its strategy to advance primary care in California, please include a description of the model, including any alternative payments such as care management fees and payments based on quality, in the attachment. Applicants may include any newly adopted models that are planned or in progress but not yet implemented among providers (please include timeline for beginning the payment model). Enter the number and percentage of providers paid under each model reported for 2017 and 2018 as well.

References:

HCP LAN Primary Care Payment Models Draft White Paper: <http://hcp-lan.org/workproducts/pcpm-whitepaper-draft.pdf>

CMMI Comprehensive Primary Care Plus:

<https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus>

Single, Pull-down list.

1. Attached
2. Not attached

19.2.3.4: Describe updates on progress made since the last QIS submission in each part of the primary care goals, and planned activities. Applicant may submit the progress report or any supporting documentation as an attachment if desired. Please include in the narrative:

- Updates in year two of the PCP matching initiative, including an implementation status report, feedback on the consumer experience, complaints, positive feedback, unanticipated challenges, and suggestions. (If applicable.)
- If contracted physician organizations have made progress in adopting Level 3 or 4 APMs described in the LAN Draft White Paper (above). Describe the predominant payment structure used among contracted groups and their progress towards implementing APMs. (If applicable.)
- Describe any specific educational support that the Applicant or multi-insurer collaborative is providing to PCMH practices to help support their efforts at transformation.
- How the Applicant is encouraging enrollees to use providers with PCMH recognition?
- Progress in 2017 toward the end goal and any further implementation plans for 2018.
- Known or anticipated barriers in implementing QIS activities and describe mitigation activities.

2000 words.

Attachments:

19.2.4 QIS for Promoting Development and Use of Care Models – Integrated Healthcare Models (IHM)

Federal QIS Topic Area: Activities for improving health outcomes

2017 QHP Applicant Contract, Section 4.03

Goal for end of 2019: Increase proportion of network that meets definition of IHM by providing various types of support to providers to elevate their processes and practice toward this goal. By increasing network, also increase proportion of Covered California enrollees that are receiving care in an IHM.

19.2.4.1 Using the definition for IHMs in Appendix H 2017 QHP Contract Attachment 7, provide details on existing or planned integrated systems of care. State the following:

Attachment(s) Appendix H 2017 QHP Applicant Contract Attachment 7.pdf

	Response
Line of business for which the IHM is or will be available (Exchange, Commercial non-Exchange, Medicare, Medicaid, other)	<i>Multi, Checkboxes.</i> 1: Exchange, 2: Commercial non-Exchange, 3: Medicare, 4: Medicaid, 5: other, 6: N/A
Product for which the IHM is or will be available	<i>Multi, Checkboxes.</i> 1: HMO, 2: EPO, 3: POS, 4: Other, 5: PPO
Location (California Rating Region)	<i>Multi, Checkboxes.</i> 1: Region 1, 2: Region 2, 3: Region 3, 4: Region 4, 5: Region 5, 6: Region 6, 7: Region 7, 8: Region 8, 9: Region 9, 10: Region 10, 11: Region 11, 12: Region 12, 13: Region 13, 14: Region 14, 15: Region 15, 16: Region 16,

	Response
	17: Region 17, 18: Region 18, 19: Region 19, 20: No planned or existing systems in any region
Indicate whether the IHM is founded on an existing provider organization or if it joins multiple providers/groups together under the IHM.	100 words.
Number of California members in the product who are managed under the IHM	Integer.
Percent of California members in the product who are managed under the IHM	Percent.
Number or percent of California members in the product who are managed under the IHM unknown	Yes/No.
Number of Exchange members in the product who are managed under the IHM	Integer.
Percent of Exchange members in the product who are managed under the IHM	Percent.
Number or percent of Exchange members in the product who are managed under the IHM unknown	Yes/No.

Note: Completion of this question may be assisted by referring to a compilation of ACO Best Practices by the Pacific Business Group on Health (PBGH). Covered California will be engaging stakeholders in reviewing, editing and potentially adopting this compilation in 2018. Please refer to Appendix T Draft Summary of ACO Best Practice.

19.2.4.2 Provide as attachments the following documents related to IHMs:

1. (File titled Provider 1a): Plan methodology for documentation on the Triple Aim (quality, enrollee experience, total cost of care), measures in use and weighting of measures or measurement domains, if used for performance payments in IHM. Describe any applicable performance threshold requirements. Indicate the measures that are used for measurement and reporting, and those measures that are used for determination of gainsharing or performance rewards.

2. (File titled Provider 1b): Example of plan report to the IHM on its quality of care and financial performance, including benchmarking relative to performance improvement goals or market norms.

Single, Pull-down list.

Attached

Not attached

19.2.4.3 Describe updates on progress made since the last QIS submission in each part of the primary care goals, and planned activities. Applicant may submit the progress report or any supporting documentation as an attachment if desired. Please include in the narrative:

- Any specific educational support that the Applicant or multi-insurer collaborative is providing to IHMs to help support their efforts at transformation, such as coaching or learning collaboratives.
- Other support (financial, technical, personnel).
- Other activities conducted since the last QIS submission to promote IHMs, or activities that will be conducted.
- Progress 2017 toward the end goal and any further implementation plans for 2018.

2000 words.

19.2.5 QIS for Appropriate Use of C-Sections

Federal QIS Topic Area: Activities for improving health outcomes

2017 QHP Applicant Contract, Section 5.03

Goal for end of 2019: Adjust network hospital payment strategies so that no hospital has a financial incentive to perform a non-medically necessary NTSV C-section by end of 2019.

19.2.5.1 Report number of all network hospitals reporting to the California Maternity Quality Care Collaborative's (CMQCC) Maternal Data Center (MDC) in Attachment E QIS Run Charts. A list of all California hospitals participating in the MDC can be found here:

https://www.cmqcc.org/sites/default/files/CMQCC_County_Participation_List_12.04.17.pdf .

Enter the percentage reported in the certification Applications for 2017 and 2018 as well.

Single, Pull-down list.

1. Attached
2. Not attached

19.2.5.2 Provide a description of all current payment models for maternity services across all lines of business, and specifically address whether payment differs based on vaginal or C-Section delivery. Report models and number of network hospitals paid using each payment strategy in Attachment E QIS Run Charts. Enter the percentages reported in the certification Applications for 2017 and 2018 as well.

Single, Pull-down list.

1. Attached
2. Not attached

19.2.5.3 Describe updates on progress made since the last QIS submission with regards to promoting appropriate use of C-Sections. Applicant may submit the progress report or any supporting documentation as an attachment if desired. Please include in the narrative if applicable:

- Updates to hospital participation in CMQC and/or to hospital engagement in maternity care quality improvement, particularly those with an NTSV rate higher than 23.9
- Hospitals that have newly achieved a NTSV C-section rate of 23.9% or less by year-end 2019, or have achieved improvement in NTSV rates.
- Updates as to how MTSV C-section rate or other maternal safety factors are considered in maternity hospital network.
- Collaborations with other Covered California plans on approaching hospitals to suggest CMQCC involvement and/or alignment on a payment strategy to not incentivize non-medically necessary C-Sections.
- List any known or anticipated barriers in implementing QIS activities and describe mitigation activities.

19.2.6 QIS for Hospital Patient Safety

Federal QIS Topic Area: Activities to improve patient safety and reduce medical errors
2017 QHP Applicant Contract, Section 5.01 and 5.02

Goal for end of 2019: Adjust hospital payment strategy so that 2% of payments are tied to value by the end of 2019. (Note: Trajectory will continue with the goal of 6% of total hospital payments tied to value by the end of 2023.)

19.2.6.1 Report, across all lines of business, the percentage of hospital reimbursement at risk for quality performance and the quality indicators used in Attachment E QIS Run Charts. In the details section of the spreadsheet, describe the model used to put payment at risk, and note if more than one model is used. "Quality performance" includes any number or combination of indicators, including HACs, readmissions, patient satisfaction, etc. In the same sheet, report quality indicators used to assess quality performance. Enter the percentages reported in the certification Applications for 2017 and 2018 as well.

Single, Pull-down list.

1. Attached
2. Not attached

19.2.6.2 Report the number of hospitals contracted under the model described in question 19.2.6.1 with reimbursement at risk for quality performance in Attachment E QIS Run Charts. For currently contracted Applicants, enter the numbers reported in the certification Applications for 2017 and 2018 as well.

Single, Pull-down list.

1. Attached
2. Not attached

19.2.6.3 Describe updates on progress made since the last QIS submission with regards to promoting hospital safety. Applicant may submit the progress report or any supporting documentation as an attachment if desired. Please include in the narrative if applicable:

- Updates to strategy for promoting Hospital Improvement Innovation Networks (HIIN) participation among the non-participating network hospitals, especially those with a standardized infection ratio (SIR) above 1.0 for the five designated Hospital Acquired Conditions (HACs). Please refer to Appendix S1 CAUTI Rates, Appendix S2 CLABSI Rates, Appendix S3 C Diff Rates, Appendix S4 MRSA Rates, and Appendix S5 SSI Colon Rates.
- Updates on efforts to re-contract to tie hospital payment to value to meet 2% by end of 2019.
- Collaborations with other Covered California plans on approaching hospitals to suggest improvement program involvement and/or alignment on a payment strategy to tie hospital payment to value.

2000 words.

19.2.7 QIS for Patient-Centered Information and Support

Federal QIS Topic Area: Activities for improving health outcomes
2017 QHP Applicant Contract, Sections 7.01 and 7.02

Goal by end of 2019: Applicant should be able to supply consumers with 1) provider specific cost shares for common inpatient, outpatient and ambulatory services, 2) costs of prescription drugs, and 3) member specific real-time understanding of accumulations toward deductibles, maximum out of pockets.

19.2.7.1 Fulfilling the QIS Requirement: Please respond to (a) or (b) below as applicable based on anticipated Exchange enrollment.

a) If Applicant has or anticipates having Exchange enrollment of over 100,000 members, describe plans to ensure, by 2019, members will have online access to:
1) Provider specific cost shares for common inpatient, outpatient and ambulatory services, (either as a procedure or as an episode of care). (Waived for Applicants with only HMO products.)

2) Access to costs for prescription drugs and member specific real-time understanding of accumulations toward deductibles, maximum out of pockets.

(Note in response if these requirements have already been fulfilled.)

b) If Applicant has or anticipates having Exchange enrollment of fewer than 100,000 members in Plan Year 2018, describe how Applicant will ensure, by 2019, members have access to:

1) Provider specific cost shares for common inpatient, outpatient and ambulatory services, (either as a procedure or as an episode of care). Information does not need to be provided online. *(Waived for Applicants with only HMO products.)*

2) Access to costs for prescription drugs and member specific real-time understanding of accumulations toward deductibles, maximum out of pockets.

(Note in response if these requirements have already been fulfilled.)

200 words.

19.2.7.2 If Applicant offers online consumer support tools that require login, provide sample login information in lieu of screenshots.

50 words.

19.2.7.2 Please describe any quality related information currently included with cost information. If quality information is not included, please describe feasibility for inclusion by 2019.

200 words.

19.2.7.3 If Applicant already has cost tools available to members, please report number and percent of unique enrollees for the Exchange line of business who used the tool in 2017.

100 words.