CERTIFICATION APPLICATION
QUALIFIED HEALTH PLAN
INDIVIDUAL MARKETPLACE
PLAN YEAR 2025

FINAL – 01.11.2024

Certification Application Qualified Health Plan Individual Market Plan Year 2025 FINAL

Table of Contents

1 Application Overview 5
2 Administration and Attestation 11
3 Licensed and Good Standing 15
4 Financial Requirements 15
5 Operational Capacity 16
5.1 Issuer Operations and Account Management Support 16
5.2 Implementation Performance 18
6 Customer Service 19
7 Sales Channels 23
8 Marketing and Outreach Activities 27
9 Privacy and Security Requirements for Personally Identifiable Information 28
9.1 HIPAA Privacy Rule 28
9.2 Safeguards 30
10 Fraud, Waste, and Abuse Detection 31
11 Audits 33
12 Electronic Data Interface (EDI) 34
13 System for Electronic Rate and Form Filing (SERFF) 36
14 Healthcare Evidence Initiative (HEI) 37
15 Essential Community Providers (ECP) 43
16 Health Equity and Quality Transformation 45
16.1 Accreditation 45
16.2 Health Equity and Disparities Reduction 47
16.2.1 Organizational Commitment to Cultivating a Culture of Health Equity 47
16.2.2 Linking Quality and Equity 49
16.2.3 Culturally and Linguistically Appropriate Care 54
16.3 Behavioral Health 56
16.4 Health Promotion and Prevention 65
16.5 Population Health Management 68
16.5.1 Health Assessment 68
16.5.2 Supporting At-Risk Enrollees 69
16.5.3 Health-Related Social Needs 70

16.5.4 Prevention of Algorithmic Bias in Healthcare 72
16.6 Affordability and Cost 73
16.6.1 Demonstrating Action on High-Cost Pharmaceuticals 73
16.6.2 Patient-Centered Information and Support 74
16.7 Participating in Quality Improvement Collaboratives 75
16.8 Data Sharing and Exchange 78
17 Health Plan Proposal 81
18 Health Maintenance Organization (HMO) 83
18.1 Benefit Design 83
18.2 Benefit Administration 85
18.3 Provider Network 91
18.4 Delivery System and Payment Strategies to Drive Quality 92
18.4.1 Provider Networks Based on Value 93
18.4.2 Advanced Primary Care 95
18.4.3 Integrated Delivery Systems and Accountable Care Organizations 96
18.4.4 Appropriate Use of Cesarean Sections 100
18.4.5 Hospital Quality, Value, and Patient Safety 105
19 Preferred Provider Organization (PPO) 107
19.1 Benefit Design 107
19.2 Benefit Administration 108
19.3 Provider Network 114
19.4 Delivery System and Payment Strategies to Drive Quality 116
19.4.1 Provider Networks Based on Value 116
19.4.2 Advanced Primary Care 118
19.4.3 Integrated Delivery Systems and Accountable Care Organizations 119
19.4.4 Appropriate Use of Cesarean Sections 122
19.4.5 Hospital Quality, Value, and Patient Safety 127
20 Exclusive Provider Organization (EPO) 129
20.1 Benefit Design 129
20.2 Benefit Administration 130
20.3 Provider Network 136
20.4 Delivery System and Payment Strategies to Drive Quality 138

20.4.1 Provider Networks Based on Value 139
20.4.2 Advanced Primary Care 140
20.4.3 Integrated Delivery Systems and Accountable Care Organizations 142
20.4.4 Appropriate Use of Cesarean Sections 145
20.4.5 Hospital Quality, Value, and Patient Safety 149
21 Other Network Type 152
21.1 Benefit Design 152
21.2 Benefit Administration 153
21.3 Provider Network 159
21.4 Delivery System and Payment Strategies to Drive Quality 161
21.4.1 Provider Networks Based on Value 162
21.4.2 Advanced Primary Care 163
21.4.3 Integrated Delivery Systems and Accountable Care Organizations 165
21.4.4 Appropriate Use of Cesarean Sections 168
21.4.5 Hospital Quality, Value, and Patient Safety 173
22 Glossary 175

1 Application Overview

1.1 **Purpose**

The California Health Benefit Exchange (Covered California) is accepting applications from eligible Health Insurance Issuers (Applicants or Health Issuer) to submit proposals to offer, market, and sell Qualified Health Plans (QHPs) through Covered California beginning in 2024, for coverage effective January 1, 2025. All Health Insurance Issuers currently licensed at the time of application response submission are eligible to apply for certification of proposed Qualified Health Plans (QHPs) for Plan Year 2025. Covered California will exercise its statutory authority to selectively contract for health care coverage offered through Covered California for Plan Year 2025. Covered California 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).

Covered California 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 Covered California is on individuals who qualify for tax credits and subsidies under the ACA, Covered California's goal is to make insurance available to all qualified individuals. The vision of Covered California is to improve the health of all Californians by assuring their access to affordable, high quality care coverage. The mission of Covered California 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.

Covered California is guided by the following values:

Consumer-Focused: At the center of Covered California's efforts are the people it serves. Covered California 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.

Affordability: Covered California will provide affordable health insurance while assuring quality and access.

Catalyst: Covered California 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: Covered California will earn the public's trust through its commitment to accountability, responsiveness, transparency, speed, agility, reliability, and cooperation.

Transparency: Covered California 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 Covered California 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, Covered California's policies are derived from the federal ACA which calls upon Exchanges to advance “plan or coverage benefits and health care provider reimbursement structures" that improve health outcomes. Covered California 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.

Covered California needs to address these issues for the millions of Californians who enroll through Covered California 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.

Covered California 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, Covered California has the responsibility to "certify" the Qualified Health Plans that will be offered in Covered California.

The state legislation to establish Covered California gave authority to Covered California to selectively contract with Issuers 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. To this end, Covered California only certifies those Applicants who demonstrate a clear value proposition to its consumers, both in terms of quality and price; in addition, QHPs already operating on the Exchange must maintain quality scores that meet or exceed established benchmarks and reduce health disparities, or risk being removed from the Exchange.

These concepts, and the inherent trade-offs among Covered California values, must be balanced in the evaluation and selection of the Qualified Health Plans (QHPs) 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 meets the needs of consumers in that region and Covered California's goals. Covered California 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 Covered California, the Board of Covered California articulated guidelines for the selection and oversight of Qualified Health Plans which are used when reviewing the Applications. These guidelines are:

Promote Affordability and Value for the Consumer - Both in Premiums and at Point of Care

While premiums will be a key consideration, contracts will be awarded based on the determination of "best value" to Covered California and its participants. Covered California 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. Covered California 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 Competition Based upon Quality

The evaluation of Issuer QHP proposals will focus on quality and service components, including history of performance, administrative capacity, reported quality and satisfaction metrics, quality improvement plans and commitment to serve Covered California population. The application responses, in conjunction with the approved filings, will be evaluated by Covered California and used as part of the selection criteria to offer Issuers' products on Covered California for the certification year. In addition, supplemental contracted provider network data will be used to predict the likely quality of new entrant QHPs to ensure that new entrants are held to the same quality standards as existing QHPs. Proposed provider networks will be evaluated using provider-organization quality data, hospital quality data, and health plan quality results including NCQA commercial and Medicaid HEDIS measure results and QRS Marketplace measure results from other states.

Encourage Competition Based upon the Populations Served

Performing effective outreach, enrollment and retention of the low-income population that will be eligible for premium tax credits and cost sharing subsidies through Covered California is central to Covered California'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 Covered California 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 to improve service delivery and integration. This commitment to serve Covered California's population is evidenced through general cooperation with Covered California's operations and

contractual requirements which include provider network adequacy, quality improvement, cultural and linguistic competency, programs addressing health equity and disparities in care, innovations in delivery system improvements, and payment reform.

Encourage Competition Based upon Meaningful QHP Choice and Product Differentiation: Patient-Centered Benefit Plan Designs[1]

Covered California 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 Covered California's standard benefit plan designs in each region for which they submit a proposal. In addition, QHP Applicants may offer Covered California's standard Health Savings Account-eligible (HSA) High Deductible Health Plan (HDHP) designs. Applicants may choose to offer either or both Gold and Platinum standard benefit plan designs if there is differentiation between two plans in the same metal tier that is related to either product, network or both or an additional benefit explained. Covered California is interested in having Health Maintenance Organization (HMO), Exclusive Provider Organization (EPO), Preferred Provider Organization (PPO), and other products offered statewide. Within a given product design, Covered California will look for differences in network providers and the use of innovative delivery models. Under such criteria, Covered California 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

Issuers must submit QHP proposals in all geographic service areas in which they are licensed and have an adequate network, and preference will be given to Issuers that develop 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 Delivery System Improvement, Effective Prevention Programs and Payment Reform

One of the values of Covered California is to serve as a catalyst for the improvement of care, prevention, and wellness to reduce costs. Covered California encourages QHP offerings that incorporate innovations in delivery system improvement, prevention, and wellness and/or payment reform that will help foster these broad goals. This will include models of patient-centered medical homes, targeted quality improvement efforts, participation in community-wide prevention, or efforts to increase reporting transparency to provide relevant health care comparisons and to increase member engagement in decisions about their course of care.

Demonstrate Administrative Capability and Financial Solvency

Covered California will review and consider 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. Applicant's technology capability is a critical

[1] The certification year Patient-Centered Benefit Plan Designs will be finalized when the certification year federal actuarial calculator is finalized.

component for success for Covered California, so Applicant's technology and associated resources are heavily scrutinized as this relates to long-term sustainability for consumers. Application responses that demonstrate a commitment to the long-term success of Covered California's mission are strongly encouraged.

Encourage Robust Customer Service

Covered California is committed to ensuring a positive consumer experience, which requires Issuers to maintain adequate resources to meet consumers' needs. To successfully serve Covered California 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 Covered California consumers will receive additional consideration.

1.4 **Availability**

Applicant must be available immediately upon contingent certification of its plans as QHPs to start working with Covered California to establish all operational procedures necessary to integrate and interface with Covered California information systems and to provide additional information necessary for Covered California to market, enroll members, and provide health plan services effective January 1, 2025. Successful Applicants will also be required to adhere to certain provisions through their contracts with Covered California, 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. Failure to execute the QHP Issuer Contract may preclude Applicant from offering QHPs through Covered California. The successful Applicants must be ready and able to accept enrollment as of October 1, 2024.

1.5 **Application Process**

The application process shall consist of the following steps:

- Completion of Letter of Intent to Apply
- Release of the Final Application
- Submission of Applicant responses, including network and quality data
- Evaluation of Applicant responses
- Discussion and negotiation of final contract terms, conditions, and premium rates
- 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 and instructions for online access to the final Application.

Applicant's Letter of Intent must identify the contact person for the application process, that includes an email address and telephone number. On receipt of the Letter of Intent, Covered

California will issue instructions to gain access to the online Application. A Letter of Intent will be considered confidential and not available to the public. However, Covered California reserves the right to release aggregate information about all Applicants' responses. Final Applicant information is not expected to be released until the selected Issuers and QHPs 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 Covered California and the regulators.

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

Application Contact: Libby Bennett
QHPCertification@covered.ca.gov
(916) 954-3138

1.7 **Key Action Dates**

Action	Date/Time
Release of Draft Application for Public Comment	October 2023
Letter of Intent to Apply due to Covered California	February 15, 2024
Application Opens	March 1, 2024
Completed Applications Due (include the certification year proposed Rates & Networks)	May 1, 2024
Negotiations between Applicants and Covered California	June 2024
Final QHP Contingent Certification Decisions	July 2024
QHP Contract Execution	September 2024
Final QHP Certification	October 2024

1.8 **Preparation of Application Response**

Application responses are completed in an electronic proposal software program. Applicants will have access to a Question-and-Answer function within the portal and must 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 question. Applicants may not submit documents in place of responding to individual questions in the space provided.

2 Administration and Attestation

Questions 2.1 – 2.3 are required for currently contracted Applicants. All questions are required for new entrant Applicants. All questions should be answered at the Issuer level, not product level.

2.1 Applicant must complete the following:

	Response
Issuer Legal Name	*10 words.*
Entity name used in consumer-facing materials or communications	*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.*
Applicant tax status	*Single, Pull-down list.* 1: Not-for-profit, 2: For-profit
Year Applicant was founded	*10 words.*
Number of Years Applicant has been a licensed Health Issuer	*10 words.*
Applicant's Covered California Operation Status	*Single, Pull-down list.* 1: Currently operating in Covered California, 2: Not currently operating in Covered California
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.*
On behalf of 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 Covered California 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	*10 words.*
Signature	*10 words.*
Printed Name	*10 words.*
Title	*10 words.*

2.2 Applicant must complete the following table.

Key Individual	Name	Email Address	Phone Number
Chief Executive Officer	*10 Words.*	*10 Words.*	*10 Words.*
Chief Finance Officer	*10 Words.*	*10 Words.*	*10 Words.*
Chief Operations Officer	*10 Words.*	*10 Words.*	*10 Words.*
Chief Medical Officer	*10 Words.*	*10 Words.*	*10 Words.*
Dedicated Liaison	*10 Words.*	*10 Words.*	*10 Words.*

2.3 Does Applicant anticipate making material changes in corporate structure in the next 24 months, including but not limited to:

	Response	*Description*
Mergers	*Single, Pull-down list.* 1: Yes, 2: No, 3: Not Applicable	*200 words.*

Acquisitions	*Single, Pull-down list.* 1: Yes, 2: No, 3: Not Applicable	*200 words.*
New venture capital	*Single, Pull-down list.* 1: Yes, 2: No, 3: Not Applicable	*200 words.*
Management team	*Single, Pull-down list.* 1: Yes, 2: No, 3: Not Applicable	*200 words.*
Location of corporate headquarters or tax domicile	*Single, Pull-down list.* 1: Yes, 2: No, 3: Not Applicable	*200 words.*
Stock issue	*Single, Pull-down list.* 1: Yes, 2: No, 3: Not Applicable	*200 words.*
Other	*Single, Pull-down list.* 1: Yes, 2: No, 3: Not Applicable	*500 words.*

2.4 Applicant must complete the following table of current Certificates of Insurances specified below.

Coverage	Amount	Applicant must confirm if the coverage amount meets requirement.	Does the current policy expire before the end of the current Plan Year?	Indicate the date when the current policy expires and the start and end date (or term) of the renewed policy.
Commercial General Liability	Limit of not less than $1,000,000 per occurrence/ $2,000,000 general aggregate.	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed, describe: [50 words]	*Single, Pull-down list.* 1: Yes, 2: No,	*200 words.*
Cyber Liability	At such levels consistent with industry standards and reasonably determined by Contractor to cover network security, unauthorized access, unauthorized use,	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed, describe: [50 words]	*Single, Pull-down list.* 1: Yes, 2: No,	*200 words.*

	receipt or transmission of a malicious code, denial of service attack, unauthorized disclosure or misappropriation of private information and privacy liability Protected Health Information and Personally-Identifiable Information			
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.	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed, describe: [50 words]	*Single, Pull-down list.* 1: Yes, 2: No,	*200 words.*
Umbrella Policy	An amount not less than $10,000,000 per occurrence and in the aggregate.	*Single, Pull-down list.* 1: Confirmed, 2: No, not confirmed, describe: [50 words]	*Single, Pull-down list.* 1: Yes, 2: No,	*200 words.*
Statutory CA's Workers' Compensation Coverage	Provide Proof of Coverage in full compliance with State law.	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed, describe: [50 words]	*Single, Pull-down list.* 1: Yes, 2: No,	*200 words.*

2.5 Applicant must attach a copy of current Certificates of Insurance to verify that it maintains the insurance specified in the table in question 2.4. If not all applicable Certificates of Insurance are attached, Applicant must explain why.

Single, Radio group.
1: Attached, explain if not all certificates are attached. [200 words]
2: Not attached, explain [200 words]

2.6 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 are required for all Applicants. All questions should be answered at the Issuer level, not product level.

3.1 Indicate Applicant 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. 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. Enter date application was filed: [To the day]

3.2 In addition to holding or pursuing all the proper and required licenses to operate as a Health Issuer, 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 Section 22 Glossary - Definition of Good Standing). If Applicant has any material disputes with the applicable health insurance regulator in the last two years, Applicant must provide notification of disputes. Covered California, in its sole discretion and in consultation with the appropriate health insurance regulator, determines what constitutes a material violation for determining Good Standing.
Single, Radio group.
1: Confirmed, no material disputes in the last two years,
2: Not confirmed, notification of material disputes attached: [200 words]

4 Financial Requirements

Questions 4.4-4.5 are required for currently contracted Applicants. All questions are required for new entrant Applicants. All questions should be answered at the Issuer level, not product level.

4.1 Describe Applicant's systems used 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.

4.2 Applicant must confirm which systems it has in place to accept payment from members effective no later than the beginning of October prior to the coverage year for the following premium payment types (electronic payments, debit, and credit cards for binder payments are required.):
Multi, Checkboxes.

1: Paper checks,
2: Cashier's checks,
3: Money orders,
4: Electronic Funds Transfer (EFT),
5: Credit cards,
6: Debit cards,
7: Web-based payment, which may include accepting online credit card payments, and all general purpose pre-paid debit cards and credit card payment,
8: Cash,
9: Other, list additional forms of payment accepted not listed above: [100 words]

4.3 If systems to accept payment 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 the beginning of October prior to the coverage year. Note: QHP Issuer must accept electronic payments, such as debit and credit cards for binder payments. Electronic payment is encouraged, but not required, for payment of ongoing invoices. *200 words.*

4.4 Describe how Applicant will comply (both operationally and systematically) 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. Applicant must describe in detail how these types of payments are handled both in and out of their system of record.
200 words.

4.5 Applicant must confirm no fees, no charges, and no administrative fees will be imposed on any member who requests paper premium invoices for any individual products or services sold by Applicant in California or on any member requesting termination of coverage.
Single, Pull-down list.
1: Confirmed,
2: Not confirmed

5 Operational Capacity

5.1 Issuer Operations and Account Management Support

Questions 5.1.1 and 5.1.2 are required for currently contracted Applicants. All questions required for new entrant Applicants. All questions should be answered at the Issuer level, not product level.

5.1.1 Applicant must complete Attachment A1 A2_QHP-IND-CCSB_Current and Projected Enrollment for California On and Off-Exchange. Applicant must complete all data points for their lines of business (including Employer-Based coverage, Individual Market, and Government Payers) to provide current enrollment and enrollment projections. Failure to complete

Attachment A1 A2_QHP-IND-CCSB_Current and Projected Enrollment will require a resubmission of the templates.

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

5.1.2 Applicant must provide a description of any initiatives, including a timeline, over the next 24 months which may impact the delivery of services to Covered California enrollees.

	Response	Description (including a timeline)
System changes or migrations	*Single, Pull-down list.* 1: Yes, 2: No, 3: Not Applicable	*200 words.*
Call center opening	*Single, Pull-down list.* 1: Yes, 2: No, 3: Not Applicable	*200 words.*
Call center closings	*Single, Pull-down list.* 1: Yes, 2: No, 3: Not Applicable	*200 words.*
Call center relocations	*Single, Pull-down list.* 1: Yes, 2: No, 3: Not Applicable	*200 words.*
Network re-contracting	*Single, Pull-down list.* 1: Yes, 2: No, 3: Not Applicable	*200 words.*
Vendor changes	*Single, Pull-down list.* 1: Yes, 2: No, 3: Not Applicable	*200 words.*
Other	*Single, Pull-down list.* 1: Yes, 2: No, 3: Not Applicable	*200 words.*

5.1.3 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	Conducted outside of the United States?	Description
Billing, invoice, and collection activities	*Single, Pull-down list.* 1: Yes, 2: No	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*

Database and/or enrollment transactions	*Single, Pull-down list.* 1: Yes, 2: No	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Claims processing and invoicing	*Single, Pull-down list.* 1: Yes, 2: No	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Membership/customer service	*Single, Pull-down list.* 1: Yes, 2: No	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Welcome package (ID cards, member communications, etc.)	*Single, Pull-down list.* 1: Yes, 2: No	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Other (specify)	*Single, Pull-down list.* 1: Yes, 2: No	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*

5.2 Implementation Performance

All questions are required for new entrant Applicants. All questions should be answered at the Issuer level, not product level.

5.2.1 Applicant must complete Attachment B_QHP-QDP-IND-CCSB_Implementation Organizational Chart.
Single, Radio group.
1: Attached.,
2: Not attached

5.2.2 Applicant must submit an Open Enrollment Readiness plan. Applicant must include in their plan a timeline (dates) for communications (regulated and marketed), system and website updates and readiness, and trainings for staff and agents. box.
Single, Radio group.
1: Attached [200 words],
2: Not attached, [200 words]

5.2.3 Applicant must describe current or planned procedures for managing new Covered California enrollees. Applicant must address availability of customer service prior to coverage effective date and new member orientation services and materials.
200 words.

5.2.4 Applicant must identify the percentage increase of membership that will require adjustment to Applicant's current resources, describe what resource adjustments will be made for the increased membership and how it will be monitored.

Resource	Membership Increase (as % of Current Membership)	Resource Adjustment (specify)	Approach to Monitoring
Members Services	*Percent.*	*100 words.*	*100 words.*
Claims	*Percent.*	*100 words.*	*100 words.*
Account Management	*Percent.*	*100 words.*	*100 words.*
Clinical staff	*Percent.*	*100 words.*	*100 words.*
Disease Management staff	*Percent.*	*100 words.*	*100 words.*
Implementation	*Percent.*	*100 words.*	*100 words.*
Financial	*Percent.*	*100 words.*	*100 words.*
Administrative	*Percent.*	*100 words.*	*100 words.*
Actuarial	*Percent.*	*100 words.*	*100 words.*
Information Technology	*Percent.*	*100 words.*	*100 words.*
Other (List)	*Percent.*	*100 words.*	*100 words.*

5.2.5 Applicant must describe in detail its policy to validate provider information during initial contracting and when a provider reports a change (including demographic information, address, and network or panel status).
200 words.

6 Customer Service

All questions are required for new entrant Applicants. All questions should be answered at the Issuer level, not product level.

6.1 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 and maintain an internal review process to resolve a consumer's written or oral expression of dissatisfaction.
Single, Pull-down list.
1: Confirmed,
2: Not confirmed

6.2 If certified, Applicant will be required to meet certain member services performance standards. During Open Enrollment, Covered California operating hours are 8 AM to 6 PM Monday through Friday (except holidays). Applicant must confirm it will match Covered California Open Enrollment Customer Service operating hours. Describe how Applicant will modify customer service center operations to meet Covered California-required operating hours if applicable. Describe how Applicant will modify its current Interactive Voice Response (IVR) system to meet Covered California required operating hours.
Single, Radio group.
1: Confirmed, explain: [100 words],
2: Not confirmed

6.3 Applicant must list internal daily monitored Service Center Statistics.

Daily Service Center Statistic	Monitored	Daily Service Level Goal (i.e., 80% of calls answered within 30 seconds)
Total Inbound Calls	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Total Calls Answered	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Total Abandon Calls	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Average Handle Time	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Average Speed to Answer	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Abandonment Rate	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Adherence Staff	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Daily Service Level	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*

6.4 Applicant must describe the process for staffing the Service Center for teams that support Covered California business for service center goals and metrics.
100 words.

6.5 Applicant must indicate which of the following training modalities, training tools, and resources 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: Case-Study,
7: Roleplaying,
8: Shadowing,
9: Observation,
10: Pre-tests,
11: Post-tests,
12: Training Evaluations,
13: Other, describe: [50 words]

6.6 What is the length of the entire training period for new Customer Service Representatives? Include a minimum of systems training, health care basics, and customer service skills training. Include total time from point of hire to completion of training and release to work independently. 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.
100 words.

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

Language	Response	Number of Certified Bilingual Representatives
Arabic	*Single, Pull-down list.* 1: Yes, 2: No	*Integer.*
Armenian	*Single, Pull-down list.* 1: Yes, 2: No	*Integer.*
Cambodian	*Single, Pull-down list.* 1: Yes, 2: No	*Integer.*
Cantonese	*Single, Pull-down list.* 1: Yes, 2: No	*Integer.*
English	*Single, Pull-down list.* 1: Yes, 2: No	*Integer.*
Farsi	*Single, Pull-down list.* 1: Yes, 2: No	*Integer.*
Hmong	*Single, Pull-down list.* 1: Yes, 2: No	*Integer.*

Korean	*Single, Pull-down list.* 1: Yes, 2: No	*Integer.*
Loa	*Single, Pull-down list.* 1: Yes, 2: No	*Integer.*
Mandarin	*Single, Pull-down list.* 1: Yes, 2: No	*Integer.*
Russian	*Single, Pull-down list.* 1: Yes, 2: No	*Integer.*
Spanish	*Single, Pull-down list.* 1: Yes, 2: No	*Integer.*
Tagalog	*Single, Pull-down list.* 1: Yes, 2: No	*Integer.*
Vietnamese	*Single, Pull-down list.* 1: Yes, 2: No	*Integer.*
Other, specify	*20 words.*	*Integer.*

6.8 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

6.9 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 Covered California consumers.
100 words.

6.10 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: Applicant does not monitor consumer experience

6.11 Applicant must list all Customer Service Representative Quality Assurance metrics used for scoring of monitored call, include how many calls per Representative, per week are scored. Score card metrics must include:

- Caller Connection
- Communication
- Issue identification and Resolution
- Call Management
- System Issues

200 words.

6.12 Applicant must confirm that to the extent it provides information that is critical for obtaining health insurance coverage or access to health care services through its QHPs, as defined by 45 CFR § 156.250, it will do so in accordance with the accessibility standards described in 45 CFR § 155.205(c).
Single, Radio group.
1: Confirmed, explain: [100 words],
2: Not confirmed

6.13 Applicant must briefly describe its process for providing information to consumers and enrollees in plain language and in a manner that is accessible and timely to individuals living with disabilities and to individuals who are limited English proficient.
200 words.

7 Sales Channels

All questions are required for all Applicants. All questions should be answered at the Issuer level, not product level.

7.1 Does Applicant currently work with Insurance Agents or General Agencies (also referred to as Insurance Brokers or Producers)?
Single, Radio group.
1: Yes,
2: No

7.2 Applicant must describe Agent of Record (AOR) policy and procedures for the individual market and must submit its AOR policy document as an attachment. Review the Covered California Agent Delegation Policy,
https://hbex.coveredca.com/toolkit/PDFs/Delegation_Change_Policy_FINAL.pdf.
Single, Radio group.
1: Attached, [200 words],
2: Not attached, [200 words]
3: Not attached, Applicant is currently operating in Covered California and attesting to no changes

7.3 Applicant must provide a description for the following Agent of Record (AOR) Policy. “Not Applicable” is not considered a response.

	Individual Market – AOR Appointment Policy	On-Exchange Business	Off-Exchange Business
Appointment Process	Describe AOR appointment process including the application, mandatory requirements, exclusions, for agents to be appointed with Applicant. Also, include the requirements if the agent is to be appointed with a general agency contracted with Applicant.	*100 words.*	*100 words.*
Timeline	Provide the AOR appointment timeline for agents. Include how the effective date is determined for the new servicing agent and any factors that would result in a retroactive AOR change.	*100 words.*	*100 words.*
AOR Change	Describe the procedure for AOR changes requested by consumers outside of the 834-file process. For example, if the consumer contacts the Applicant directly, what is the Applicant's process?	*100 words.*	*100 words.*
AOR Change	Describe procedures used to manage AOR changes when the change is made via an 834-file.	*100 words.*	*100 words.*
AOR Change	Describe any reasons for which Applicant will not make changes to AOR for an enrollment.	*100 words.*	*100 words.*
Other	Additional comments	*100 words.*	*100 words.*

7.4 Applicant must describe and submit its current Agent of Record (AOR) Commission Schedule for the individual market in California.
Note: Successful Applicants will be required to use a standardized Agent commission program with levels and terms that result in the same aggregate compensation amounts to Agents, whether products are sold within or outside of Covered California. 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.
Single, Radio group.
1: Attached, [200 words],
2: Not attached, [200 words]

7.5 Applicant must provide a description of the Commission Rate. “Not Applicable” is not considered a response.

	Individual Market - Commission Rate	On-Exchange Business	Off-Exchange Business
Payment	Provide the policy on how commissions are paid to AOR for Individual and Family Plans (IFP) plans. What are the exclusions, if any?	*100 words.*	*100 words.*
Payment	Provide the date of payment of commission to an AOR for new member effectuated policies.	*100 words.*	*100 words.*

Payment	Describe any reasons for which Applicant will not compensate Agents for an enrollment.	*100 words.*	*100 words.*
Retention Incentives	Describe any retention incentives for the AOR if the agent retains a specified number of members' policies during renewal or over a period of time.	*100 words.*	*100 words.*
Plan Product Payment	Does the compensation level vary by the Applicant's plan product (HMO, EPO, PPO, etc.)? If yes, explain.	*100 words.*	*100 words.*
Tax ID Changes	Describe the process agents must follow in order to change their payee tax ID with the Applicant in order to continue to receive commission payments.	*100 words.*	*100 words.*
Bonus	Describe any agent commission bonus program(s) in the individual market on or off exchange that is currently available in the 2024 benefit year or will be made available to agents for the 2025 benefit year.	*100 words.*	*100 words.*
Payment Percentage Average	Applicant must indicate as a percentage of premium the amount of total commission compensation Applicant expects to pay in calendar year 2024 to external distribution partners, including licensed insurance agents for the individual line of business on and off the marketplace. Include base commissions, bonuses, and any other financial payment. Answer required.	*100 words.*	*100 words.*
Reconciliation	Describe AOR commission reconciliation and error resolution processes, include information on how Applicant resolves commission and AOR discrepancies for agents.	*100 words.*	*100 words.*
Other	Additional Comments	*100 words.*	*100 words.*

7.6 Applicant is required to provide a copy of Applicant's Individual and Family Plans Sales Team Organizational Chart as an attachment titled “Carrier Name Sales Team Org Chart”. In addition to the attachment, Applicant must identify a primary point of contact for Covered California's Outreach & Sales department in the response and include the following contact information:

- Name
- Office Address
- Phone Number
- Email Address
- Geographic Territory Assigned (statewide, county, etc.)

The identified point of contact must appear in the attached Organizational Chart.

50 words.

7.7 Agents have become an integral channel of the Applicant's enrollment: Covered California requires Applicant to have an agent services support team to provide communication and sales strategy that assists in facilitating the ease of business. Therefore, part of the strategy requires Applicant to provide support services to the agents who enroll consumers in Applicant's plan

product in the Individual and Family Plan market in California. Applicant must provide a description for Agent Services. “Not Applicable” is not considered a response.

Sup-Topic	Agent Services	On-Exchange Business	Off-Exchange Business
Support Services	Describe your agent support services to your appointed agents/brokers. Include different ways on how an appointed agent/broker can reach out to Applicant for questions and support with their appointment, commissions, client cases, plan information, etc.	*100 words.*	*100 words.*
Support Services	Do you have an agent portal for agents? If yes, describe the portal functionality and capabilities of agents have access to.	*100 words.*	*100 words.*
Support Services	Describe sales and marketing tools or trainings you have available for Agents to reach consumers for your enrollment support. Include the sales collateral (hard copy) and online sales tool resources. Include how you disburse these.	*100 words.*	*100 words.*
Communication	Describe your overall communication strategy to agents to share messages, updates, important announcements, and dates impacting the agents' work and their client cases. Include the different types of communication method (email, text, portal, etc.)	*100 words.*	*100 words.*
Sales	Does your sales strategy include niche populations? Why or why not? Explain how you outreach to them? Are you working with Agents that can directly assist consumers in the niche populations?	*100 words.*	*100 words.*
Network Changes	How often are Agents updated on provider network changes?	*100 words.*	*100 words.*
Plan-Based Enrollers	Explain how you utilize Plan-Based Enrollers?	*100 words.*	*100 words.*
Off-Exchange Consumers	What is your current number of off-exchange IFP members?	*100 words.*	*100 words.*
Off-Exchange Consumers	Do you evaluate off-exchange members to determine if they qualify for ACA Advanced Premium Tax Credit (APTC)? If an off-exchange member is eligible for APTC, what is your commitment with direct outreach to make them aware of their potential cost-savings?	*100 words.*	*100 words.*
Other	Additional comments	*100 words.*	*100 words.*

8 Marketing and Outreach Activities

Questions 8.4 – 8.8 are required for currently contracted Applicants. All questions are required for new entrant Applicants. All questions should be answered at the Issuer level, not product level.

8.1 Covered California expects all successful Applicants to promote enrollment in their QHPs. Applicant must provide an organizational chart of its marketing department(s), including names and titles of the main marketing contacts that will be responsible for marketing their Individual and Family Plans (both on and off exchange).
Single, Pull-down list.
1: Attached,
2: Not attached

8.2 Applicant must confirm that, upon contingent certification of its QHPs, it will cooperate with Covered California Marketing Department, and adhere to the Covered California Brand Style Guide https://hbex.coveredca.com/toolkit/PDFs/Brand_Style_Guide_022819_for-external-partners.pdf, (and Marketing Guidelines, if applicable) when co-branded materials are issued to Covered California enrollees. If Applicant is certified, co-branded items must be submitted in a timely manner, but no later than 10 business days before the material is used; ID cards must be submitted to Covered California at least 30 days prior to Open Enrollment.
Single, Pull-down list.
1: Confirmed,
2: Not confirmed

8.3 Applicant must confirm it will cooperate with Covered California 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

8.4 Applicant must indicate their proposed marketing investment to promote enrollment in Individual and Family Plans (on and off exchange). In addition, Applicant must provide projected marketing spend allocation for acquisition versus retention efforts, open enrollment versus special enrollment periods, and brand versus direct response (DR).
Upon contingent certification, the expectation for all Applicants is to invest at least 0.4% of their individual market gross premium revenue collected (on and off exchange) on marketing during open enrollment and this amount will be spent on direct response advertising, outreach and community efforts, and non-open enrollment brand marketing that includes co-branding of Covered California. Brand marketing that does not reference Covered California will not be reflected in determining the “creditable marketing”. Applicant may submit any supporting documentation as an attachment.
Single, Radio group.
1: Alternate proposed marketing investment: [500 words],
2: Confirmed to meet marketing spend expectations

8.5 Indicate the dollar amount of the total proposed marketing spend Applicant projects allocating to Proposed Marketing Investment.

Proposed Marketing Investment:	*Dollars.*

8.6 Indicate the percentage of the total proposed marketing spend Applicant projects allocating to Acquisition and Retention efforts. Numerical percentage values must equal 100 when added. Example: 70% acquisition and 30% retention.

Acquisition efforts:	*Percent.*
Retention efforts:	*Percent.*

8.7 Indicate the percentage of the total proposed marketing spend Applicant projects allocating to Open and Special Enrollment Periods. Numerical percentage values must equal 100 when added. Example: 70% Open Enrollment and 30% Special Enrollment.

Open Enrollment Period:	*Percent.*
Special Enrollment Period:	*Percent.*

8.8 Indicate the percentage of the total proposed marketing spend Applicant projects allocating to Brand Advertising and Direct Response Advertising Tactics during the Open Enrollment period only. Numerical percentage values must equal 100 when added. Example: 35% brand and 65% Direct Response during Open Enrollment. To determine if spend is Brand vs. DR, classify advertising materials as "Brand" if they're focused on establishing a distinct and impacting message about your brand's benefits; and classify them as "DR" if there is a call to action to generate immediate sales or drive traffic.

Brand Advertising Tactics:	*Percent.*
Direct Response Advertising Tactics:	*Percent.*

9 Privacy and Security Requirements for Personally Identifiable Information

Question 9.2.7 is required for currently contracted Applicants. All questions (except 9.2.7) are required for new entrant Applicants. All questions should be answered at the Issuer level, not product level.

9.1 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.]:

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

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

9.1.2 Amendment: Applicant must confirm that it provides enrollees 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: Confirmed,
2: Not confirmed

9.1.3 Restriction Requests: Applicant must confirm that it provides enrollees 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: Confirmed,
2: Not confirmed

9.1.4 Accounting of Disclosures: Unless otherwise exempted by the HIPAA Privacy Rule, Applicant must confirm that it provides enrollees with an accounting of any disclosures made by Applicant of the enrollee's PHI upon the enrollee's request [45 CFR §164.528].
Single, Pull-down list.
1: Confirmed,
2: Not confirmed

9.1.5 Confidential Communication Requests: Applicant must confirm that it permits enrollees 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: Confirmed,
2: Not confirmed

9.1.6 Minimum Necessary Disclosure & Use: Unless otherwise exempted by the HIPAA Privacy Rule, Applicant must confirm that it 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: Confirmed,
2: Not confirmed

9.1.7 Openness and Transparency: Unless otherwise exempted by the HIPAA Privacy Rule, Applicant must confirm that it currently maintains a HIPAA-compliant Notice of Privacy Practices to ensure that enrollees are aware of their privacy-related rights and Applicant's privacy-related obligations related to the enrollee's PHI [45 CFR §§164.520(a)&(b)].
Single, Pull-down list.
1: Confirmed,
2: Not confirmed

9.2 Safeguards

9.2.1 Applicant must confirm that it has policy, standards, processes, and procedures in place and that its information system is configured with administrative, physical and technical security controls that meet or exceed those standards in the National Institute of Standards and Technology, Special Publication (NIST) 800-53 that appropriately protect the confidentiality, integrity, and availability of the Protected Health Information (PHI) and Personally Identifiable Information (PII) that it creates, receives, maintains, or transmits.
Single, Pull-down list.
1: Confirmed,
2: Not confirmed

9.2.2 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: Confirmed,
2: Not confirmed

9.2.3 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: Confirmed,
2: Not confirmed

9.2.4 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: Confirmed,
2: Not confirmed

9.2.5 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: Confirmed,
2: Not confirmed

9.2.6 Applicant must describe how they safeguard against Social Security Number (SSN) and identity theft within its organization.

200 words.

9.2.7 In the last 12 months, has Applicant changed the way how they safeguard against Social Security Number (SSN) and identity theft within its organization?

Single, Radio group.
1: Yes, explain: [200 words],
2: No changes have been made to current process.

10 Fraud, Waste, and Abuse Detection

Questions 10.1 – 10.4, 10.6 – 10.13 are required for currently contracted Applicants. All questions are required for new entrant Applicants. All questions should be answered at the Issuer level, not product level.

Covered California is committed to working with its QHP Issuers to minimize Fraud, Waste, and Abuse as defined in Section 22 - Glossary. The framework for managing fraud risks is detailed in Appendix A_QHP-QDP-IND-CCSB_GAO-15-593SP (located on the Manage Documents page). Covered California 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 measures to detect, deter, and prevent fraud before it occurs are vital to all issuer and Covered California operations. This Certification ensures that Applicant has policies, procedures, and systems in place to prevent, detect, and respond to fraud, waste, and abuse.

10.1 Describe the roles and responsibilities of those tasked with carrying out dedicated anti-fraud 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. Define any acronyms used.

200 words.

10.2 Applicant must describe anti-fraud strategies and controls including data analytics and fraud risk assessments to circumvent fraud, waste, and abuse. Define any acronyms used.

200 words.

10.3 Applicant must describe how findings/trends are communicated to Covered California and other federal/state agencies, law enforcement, etc. Define any acronyms used.
200 words.

10.4 Applicant must describe policies and procedures it has in place, including details regarding withholding and subrogation process for recoupment of payments. Define any acronyms used.

200 words.

10.5 Applicant must describe in detail specific activities it does to identify any violations in the Special Enrollment Period (SEP) policy, the procedures in place to prevent and detect SEP violations, and how the adverse actions are communicated to Covered California? Define any acronyms used.

200 words.

10.6 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: Pharmacy,
11: Other service Providers

10.7 Describe the different approaches Applicant takes to monitor the types of providers indicated above in question 10.6 for possible fraudulent activity. Define any acronyms used.

100 words.

10.8 Applicant must provide an explanation why any additional provider types, not indicated in 10.6, are not being reviewed for fraudulent activity. Define any acronyms used.

100 words.

10.9 Based on the definition of Fraud as defined in Section 22 - Glossary, what was Applicant's recovery success rate and dollars recovered for fraudulent activities for each year below?

	Total Loss from Fraud Covered California book of business.	**Total Loss from Fraud** Total Book of Business (includes non-Covered California business)	**% of Loss Recovered** Covered California book of business.	**% of Loss Recovered** Total Book of Business (includes non-Covered California business)	**Total Dollars Recovered** Covered California book of business.	**Total Dollars Recovered** Total Book of Business (includes non-Covered California business)
Calendar Year 2021	*Dollars.*	*Dollars.*	*Percent.*	*Percent.*	*Dollars.*	*Dollars.*
Calendar Year 2022	*Dollars.*	*Dollars.*	*Percent.*	*Percent.*	*Dollars.*	*Dollars.*
Calendar Year 2023	*Dollars.*	*Dollars.*	*Percent.*	*Percent.*	*Dollars.*	*Dollars.*

10.10 Applicant must describe any trends attributing to the total loss from fraud for Covered California book of business. Define any acronyms used.

200 words.

10.11 Describe Applicant's approach to reviewing claims submitted by non-contracted providers, and steps taken when claims received exceed the reasonable and customary threshold. Define any acronyms used.

200 words.

10.12 Describe Applicant's approach to the use of the National Practitioner Data Bank as part of the credentialing and re-credentialing process for contracted providers and any additional steps

Applicant takes to verify a physician and facility is a legitimate place of business. Define any acronyms used.
200 words.

10.13 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. Define any acronyms used.
200 words.

11 Audits

Questions 11.1 – 11.5 are required for currently contracted Applicants. All questions are required for new entrant Applicants. All questions should be answered at the Issuer level, not product level.

11.1 Based on the definition of Internal Audit Function as defined in Section 22 - Glossary, does Applicant maintain an Internal Audit Function? If yes, provide a brief description of Applicant's internal audit function's responsibilities and its reporting structure, including 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?
Single, Radio group.
1: Yes, describe: [200 words],
2: No, describe: [200 words]

11.2 If Applicant answered yes to 11.1, provide a copy of the organization's list of internal audits conducted over the last three years and current year audit plan.
Single, Pull-down list.
1: Attached,
2: Not attached, describe [50 words
3: Not Applicable

11.3 If Applicant answered yes to 11.1, indicate how frequently internal auditing is performed for the following types of audits:

	Response	If other
Financial Audits (e.g., financial condition, results, use of resources, etc.).	*Single, Pull-down list.* 1: Quarterly, 2: Semi-annually, 3: Annually, 4: Biennially, 5: Other, 6: Not Applicable	*10 words.*
Performance Audits (e.g., operations, system, risk management, internal control, governance processes, etc.).	*Single, Pull-down list.* 1: Quarterly, 2: Semi-annually, 3: Annually, 4: Biennially,	*10 words.*

	5: Other, 6: Not Applicable	
Compliance Audits (e.g., regulatory, security controls, etc.).	*Single, Pull-down list.* 1: Quarterly, 2: Semi-annually, 3: Annually, 4: Biennially, 5: Other, 6: Not Applicable	*10 words.*

11.4 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.

11.5 Based on the definition of External Audit as defined in Section 22 - Glossary, indicate what External Audits, particular to business done in California, were conducted over the last three years by third parties? For each audit, specify the year of the audit and the name of the agency that conducted the audit.

200 words.

11.6 Applicant must confirm that, if certified, it will agree to subject itself to Covered California for audits and reviews, either by Covered California or its designee, or other State or Federal regulatory agencies or their designee. If applicable, audits and reviews shall include, but are not limited to:

1. Evaluation of the correctness of premium rate setting
2. Payments to Agents
3. Questions pertaining to Covered California enrollee premium payments and advance premium tax credit payments or state premium assistance payments
4. Participation fee payments made to Covered California
5. Applicant's compliance with the provisions set forth in a contract with Covered California
6. Applicant's internal controls to perform specified duties
7. Applicant also agrees to all audits subject to applicable State and Federal laws regarding the confidentiality of and release of confidential Protected Health Information (PHI) of Covered California enrollees.

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

12 Electronic Data Interface (EDI)

Questions 12.1 – 12.2 are required for currently contracted Applicants. All questions are required for new entrant Applicants. All questions should be answered at the Issuer level, not product level.

12.1 Applicant must provide an overview of its system, data model, vendors, and anticipated changes in key personnel and interface partners. Include a summary of dependent sub-

systems, interface messaging, interaction of vendors; development lifecycle, testing, and integration with CalHEERS.

Single, Pull-down list.
1: Attached,
2: Not attached, describe [100 words]

12.2 Applicant must submit a copy of its system lifecycle and release schedule. Include details on dependencies, internal and external development team, integration with CalHEERS, interface messaging and testing program.

Single, Pull-down list.
1: Attached,
2: Not attached, describe [100 words]

12.3 Applicant must be prepared and able to engage with Covered California to develop data interfaces between Applicant's systems and Covered California's systems, including the eligibility and enrollment system used by Covered California. Applicant must confirm it will implement systems 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 B_QHP-QDP-IND_EDI 834 Companion Guide for detailed 834 transaction specifications.
- Note: Covered California requires Applicants to sign an industry-standard agreement which establishes electronic information Covered California standards to participate in the required systems testing.

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

12.4 Applicant must confirm and 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. Include a statement of capabilities to perform corrective actions.

Single, Radio group.
1: Confirmed, describe: [200 words],
2: Not confirmed, describe: [200 words]

12.5 Applicant must confirm to communicate any testing or production changes to system configuration (URL, certification, bank information) to Covered California in a timely fashion.

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

12.6 Applicant must be prepared and able to conduct testing of data interfaces with Covered California no later than the beginning of June of the current year and confirms it will plan and implement testing jointly with Covered California to meet system release schedules. Applicant must confirm testing with Covered California will utilize industry security standards: 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: Confirmed,
2: Not confirmed

12.7 Applicant must describe its ability to produce financial, eligibility, and enrollment data monthly for reconciliation. Standard file requirements and timelines are documented in Appendix C_QHP-QDP-IND_CarrierProcess Guide. Applicant must provide a description of its ability to make system updates to reconcilable enrollment fields on a timely basis and provide verification of completion.
200 words.

12.8 Applicant must confirm and describe how they proactively monitor, measure, and maintain its application(s) and associated database(s) to maximize system response time and performance on a regular basis and can Applicant's organization report system status on a quarterly basis?
Single, Radio group.
1: Confirm, describe: [100 words],
2: Not confirmed, describe [100 words]

13 System for Electronic Rate and Form Filing (SERFF)

All questions are required for all Applicants. All questions should be answered at the Issuer level, not product level.

13.1 Applicant must confirm to populate and submit all certification year SERFF templates (Rates, Service Area, Plans and Benefits, Network ID, Prescription Drug, Plan ID Crosswalk, Supporting Documentation, and Supplemental URL Submissions) in an accurate, appropriate, and timely fashion listed in Section 1.7 - Key Dates and Appendix D_QHP-IND_Submission Guidelines_Plan Year 2025.

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

13.2 Applicant must confirm that it will submit and upload corrections to SERFF within five (5) business days of notification by Covered California, adjusted for any SERFF downtime. Applicant must adhere to amendment language specifications when any item is corrected in SERFF.

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

13.3 Applicant must confirm, if certified, it will submit complete and accurate SERFF Templates to Covered California. Covered California will participate in two rounds of validation with the Applicant. Applicant agrees to pay liquidated damages in the amount of $5,000 for each additional round of validation beyond the first two rounds. Changes to any or all of Applicant's SERFF Templates counts as one round of validation. If instructions provided by Covered California include inaccurate information which necessitates an additional round of validation, or an additional round of validation is necessary due to required changes by Covered California or

Applicant's State Regulators, those rounds of validation will not be counted in the two rounds of validations.

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

13.4 Applicant must confirm, if certified, it will in CalHEERS testing and provide certification of plan data and documents in the CalHEERS pre-production environment. The preproduction environment is the test environment where the parties can validate templates and documents prior to the Renewal and Open Enrollment Periods. Following Applicant's certification of the QHPs in the pre-production environment, any subsequent upload required to correct Applicant's errors in the production environment will result in liquidated damages in the amount of $25,000. One upload, for purposes of this paragraph, includes all plan data and documents that must be resubmitted to correct Applicant's errors including Summary of Benefits and Coverage, Evidence of Coverage documents. Liquidated damages will not apply to additional uploads resulting from errors in the instructions provided by Covered California, or changes required by Covered California or Applicant's regulator.

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

13.5 Applicant must confirm to not make any changes to its SERFF templates once submitted to Covered California without providing prior written notice to Covered California and only if Covered California agrees in writing with the proposed changes.

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

14 Healthcare Evidence Initiative (HEI)

All questions are required for new entrant Applicants. All questions should be answered at the Issuer level, not product level.

To fulfill its mission to ensure that consumers have available the plans that offer the optimal combination of choice, value, quality, and service, Covered California relies on evidence about the enrollee experience with health care. The timely and accurate submission of QHP data is an essential component of assessing the quality and value of the coverage and health care received by Covered California enrollees. QHP Issuers are required by state law to submit data described by this section. The file layout which details current expectations of requested data is available for review on the Manage Documents page as Appendix H_QHP-IND-CCSB_HEI Extract File Specs. Covered California will consider modifications to the layout when appropriate.

The data elements required to be submitted pursuant to this application, and the resulting QHP Issuer contract, will include the personal information of enrollees and Applicant’s proprietary rate information. Covered California will, and is required by law, to protect and maintain the confidentiality of this information, which shall at all times be subject to the same stringent 350-

plus security and privacy-related requirements as other personal information within Covered California's custody or control.

14.1 Applicant must provide Covered California, through its HEI Vendor, with monthly extracts of all requested detail from applicable claims or encounter records for the following types (both on-Exchange and non-grandfathered off-Exchange). If yes with deviation, explain. If unable to provide all requested detail as outlined in Appendix H_QHP-IND-CCSB_HEI Extract File Specs, provide a plan and timeline to correct problematic claim or encounter types and estimate the number and percentage of affected claims and encounters.

Claim / Encounter Type and Applicable Extract Specifications	Response	If No or Yes with deviation, explain.
Professional (using medical claim / encounter specifications)	*Single, Pull-down list.* 1: Yes, 2: Yes, with deviation, 3: No	*50 words.*
Institutional (using medical claim / encounter specifications)	*Single, Pull-down list.* 1: Yes, 2: Yes, with deviation, 3: No	*50 words.*
Pharmacy (using drug claim specifications)	*Single, Pull-down list.* 1: Yes, 2: Yes, with deviation, 3: No	*50 words.*
Drug (non-Pharmacy) (using medical claim / encounter specifications, i.e., for injections, infusions, specialty drugs, and other drugs administered in a medical setting)	*Single, Pull-down list.* 1: Yes, 2: Yes, with deviation, 3: No	*50 words.*
Embedded Pediatric Dental covered under Medical Benefits (using medical claim / encounter specifications)	*Single, Pull-down list.* 1: Yes, 2: Yes, with deviation, 3: No	*50 words.*
Mental Health (using medical claim / encounter specifications)	*Single, Pull-down list.* 1: Yes, 2: Yes, with deviation, 3: No	*50 words.*

Embedded Pediatric Vision covered under Medical Benefits (using medical claim / encounter specifications)	*Single, Pull-down list.* 1: Yes, 2: Yes, with deviation, 3: No	*50 words.*

14.2 State law requires QHP Issuers to submit data to Covered California that represents the cost of care. Applicant must provide monthly extracts of complete financial detail for all applicable claims and encounters (both on-Exchange and non-grandfathered off-Exchange). If yes with deviation, explain. If unable to provide all requested financial detail as outlined in Appendix H_QHP-IND-CCSB_HEI File Extract Specs, provide a plan and timeline to correct problematic data elements and estimate the number and percentage of affected claims and encounters. If applicable, address situations in which the QHP Issuer does not currently provide financial details for all or some medical encounters in a capitated arrangement. For example, can or will the Applicant provide a market price or fee-for-service equivalent price so that Covered California's analyses will closely approximate total cost of care?

Financial Detail to be Provided	Response	If No or Yes with deviation, explain.
Submitted Charges	*Single, Pull-down list.* 1: Yes, 2: Yes, with deviation, 3: No	*50 words.*
Allowable Charges	*Single, Pull-down list.* 1: Yes, 2: Yes, with deviation, 3: No	*50 words.*
Copayment	*Single, Pull-down list.* 1: Yes, 2: Yes, with deviation, 3: No	*50 words.*
Coinsurance	*Single, Pull-down list.* 1: Yes, 2: Yes, with deviation, 3: No	*50 words.*
Deductibles	*Single, Pull-down list.* 1: Yes, 2: Yes, with	*50 words.*

	deviation, 3: No	
Plan Paid Amount (Net Payment)	*Single, Pull-down list.* 1: Yes, 2: Yes, with deviation, 3: No	*50 words.*
Capitation Financials (per Provider / Facility) ***Note:*** *If a portion of Applicant provider payments are capitated. If capitation does not apply, check "No" and state "Not applicable, no provider payments are capitated" in the rightmost column.*	*Single, Pull-down list.* 1: Yes, 2: Yes, with deviation, 3: No	*50 words.*

14.3 Applicant must provide Covered California member IDs, Covered California subscriber IDs, and Social Security Numbers (SSNs) when possible, on all applicable records submitted (on-Exchange and non-grandfathered off-Exchange). In the absence of other Personally Identifiable Information (PII), these elements are critical for Covered California to generate unique encrypted member identifiers linking eligibility to claims and encounter data, enabling Covered California to follow the health care experience of each de-identified member, even if he or she moves from one plan to another or between on- and off-Exchange.

Detail to be Provided	Response	If No or Yes with deviation, explain.
Covered CA Member ID	*Single, Pull-down list.* 1: Yes, 2: Yes, with deviation, 3: No	*50 words.*
Covered CA Subscriber ID	*Single, Pull-down list.* 1: Yes, 2: Yes, with deviation, 3: No	*50 words.*
Member and Subscriber SSN	*Single, Pull-down list.* 1: Yes, 2: Yes, with deviation, 3: No	*200 words.*

14.4 Applicant must supply dates, such as starting date of service, in full year / month / day format to Covered California for data aggregation. If yes with deviation, explain. If unable to provide all requested detail as outlined in Appendix H_QHP-IND-CCSB_HEI File Extract Specs, provide a plan and timeline to correct problematic dates and estimate 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 / Patient Date of Birth	*Single, Pull-down list.* 1: Yes,	*50 words.*

	2: Yes, with deviation, 3: No	
Member / Patient Date of Death	*Single, Pull-down list.* 1: Yes, 2: Yes, with deviation, 3: No	*50 words.*
Starting Date of Service	*Single, Pull-down list.* 1: Yes, 2: Yes, with deviation, 3: No	*50 words.*
Ending Date of Service	*Single, Pull-down list.* 1: Yes, 2: Yes, with deviation, 3: No	*50 words.*

14.5 Applicant must supply all applicable Provider Tax ID Numbers (TINs), National Provider Identifiers (NPIs), National Council for Prescription Drug Programs (NCPDP) Provider IDs (pharmacy only), and descriptive codes for individual providers. If yes with deviation, explain. If unable to provide all requested detail as outlined in Appendix H_QHP-IND-CCSB_HEI File Extract Specs, provide a plan and timeline to correct problematic Provider IDs and descriptive codes and estimate the number and percentage of affected providers, claims, and encounters.

Provider IDs and Descriptive Codes to be Supplied	Response	If No or Yes with deviation, explain.
TIN	*Single, Pull-down list.* 1: Yes, 2: Yes, with deviation, 3: No	*50 words.*
NPI	*Single, Pull-down list.* 1: Yes, 2: Yes, with deviation, 3: No	*50 words.*
NCPDP	*Single, Pull-down list.* 1: Yes, 2: Yes, with deviation, 3: No	*50 words.*
American Medical Association (AMA) Health Care Provider Taxonomy Code	*Single, Pull-down list.* 1: Yes, 2: Yes, with	*50 words.*

	deviation, 3: No	
CMS Provider Type and Specialty Codes	*Single, Pull-down list.* 1: Yes, 2: Yes, with deviation, 3: No	*50 words.*

14.6 Applicant must provide detailed coding for diagnosis, procedures, etc. on all claims for all data sources. If yes with deviation, explain. If unable to provide all requested coding detail as outlined in Appendix H_QHP-IND-CCSB_HEI File Extract Specs, provide a plan and timeline to correct problematic coding and estimate the number and percentage of affected claims and encounters.

Coding to be Provided	*Response*	If No or Yes with deviation, explain.
Diagnosis Coding	*Single, Pull-down list.* 1: Yes, 2: Yes, with deviation, 3: No	*50 words.*
Procedure Coding (CPT, HCPCS)	*Single, Pull-down list.* 1: Yes, 2: Yes, with deviation, 3: No	*50 words.*
Revenue Codes (Facility Only)	*Single, Pull-down list.* 1: Yes, 2: Yes, with deviation, 3: No	*50 words.*
Place of Service	*Single, Pull-down list.* 1: Yes, 2: Yes, with deviation, 3: No	*50 words.*
NDC Code (Drug Only)	*Single, Pull-down list.* 1: Yes, 2: Yes, with deviation, 3: No	*50 words.*

14.7 Can Applicant or its third-party affiliate (e.g., Pharmacy Benefit Manager) submit all data directly to Covered California? Explain “No” responses, “Yes” responses with deviation, and “Yes” responses which rely on a third party to submit data to Covered California on the QHP Issuer's behalf.
Single, Radio group.
1: Yes,
2: Yes, with deviations or any third-party involvement: [50 words],
3: No, explain: [50 words]

15 Essential Community Providers (ECP)

All questions are required for new entrant Applicants. All questions should be answered at the Issuer level, not product level.

15.1 Applicant must demonstrate that its QHP proposals meet requirements for geographic sufficiency of its Essential Community Provider (ECP) network. Covered California will use the provider network data submission to assess Applicant's ECP network. All the criteria below 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.
4. Covered California 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. Health Issuers will be required, in their contract with Covered California, to operate in compliance with all federal regulations issued pursuant to the Affordable Care Act, including those applicable to ECPs.

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/ecp-list/

Covered California 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
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 Applicant will allow Covered California 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:

Applicants 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 Applicant 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 Covered California's network adequacy standards.

To evaluate an Applicant's request for consideration under the alternate standard, 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 Applicant 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 Applicant 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).

Applicant to produce access map to demonstrate location of low income, medically underserved population(s) in Applicants proposed service area and their access to health care services. Low income, vulnerable, or medically underserved individuals shall be defined as those individuals who fall below two hundred percent (200%) of the FPL. Maps shall demonstrate the extent to which provider sites are accessible to and have services that meet the needs of specific underserved populations, including:

1. Individuals with HIV/AIDS
2. American Indians and Alaska Natives

3. Low income and underserved individuals seeking women's health and reproductive health services
4. Other specific populations served by Essential Community Providers in the service area such as STD Clinics, Tuberculosis Clinics, Hemophilia Treatment Centers, Black Lung Clinics, and other entities that serve predominantly low income, medically underserved individuals.

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 to provide reasonable and timely access for low-income, medically underserved communities.
Single, Pull-down list.
1: Requesting consideration of alternate standard, explanation attached,
2: Not requesting consideration under the alternate standard

16 Health Equity and Quality Transformation

Attachment 1 of the Covered California Qualified Health Plan (QHP) Issuer Contract delineates Covered California's vision for reform and serves as a roadmap for 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 Purchaser Business Group on Health (PBGH), and CMS. These requirements are reflected in the 2017-2022 QHP Issuer contract and have been revised and enhanced in the 2023-2025 QHP Issuer contract. QHP certification and participation in Covered California will be conditional on Applicant developing a multi-year strategy, and reporting year-to-year activities and progress on each of the initiative areas below.

16.1 Certification Requirements

All questions are required for all Applicants. All questions should be answered at the Issuer level, not product level. Questions 16.1.1-16.1.4 will be used to assess Applicant's current accreditation status as well as any recognition or accreditation of other health programs and activities (e.g., case management, wellness promotion, etc.).

Contracted QHP Issuers must be accredited by the National Committee on Quality Assurance (NCQA). Covered California strongly recommends that new entrant Applicants not accredited by NCQA begin the pre-NCQA accreditation process immediately to become accredited by NCQA. Currently contracted Applicants not yet NCQA-accredited must submit a workplan demonstrating progress to meeting the year-end 2024 NCQA Health Plan Accreditation contractual requirement.

16.1.1 Applicant must provide proof of accreditation by uploading a copy of the accrediting agency's certificate, naming the file as: "[NCQA, URAC, or AAAHC] Accreditation," and entering the expiration date of the accreditation achieved.

For NCQA Health Plan Accreditation, the Exchange line of business is separate from the Commercial line of business. The NCQA Health Plan Accreditation certificate must indicate the Exchange line of business, the product (HMO, EPO, or PPO), and the expiration date.

Plan Year 2025 new entrant applicants, and Contracted QHP Issuers that first contracted with Covered California in Plan Year 2024, without NCQA accreditation must achieve NCQA Health Plan Accreditation within 12 months of submitting the initial application for QHP Certification or no later than 90 days before the second Open Enrollment Period that the new entrant's product is offered.

Indicate all that apply.
Multi, Checkboxes.
1: NCQA Health Plan Accreditation: [To the day], Certificate attached,
2: Utilization Review Accreditation Commission (URAC) Marketplace Health Plan Accreditation: [To the day], Certificate attached,
3: Accreditation Association for Ambulatory Health Care (AAAHC): [To the day], Certificate attached,
4: Not accredited

16.1.2 If Applicant reported a provisional, interim, in process, or scheduled status for any accreditation or current Utilization Review Accreditation Commission (URAC) or Accreditation Association for Ambulatory Health Care (AAAHC) accreditation in 16.1.1, Applicant must submit a workplan to achieve NCQA Health Plan Accreditation by year-end 2024. This workplan may include any pre-accreditation or other improvement steps recommended by the accrediting agency and be coordinated with the NCQA pre-accreditation process. The workplan must be uploaded as a file with the file name “Accreditation Workplan.”

Plan Year 2025 new entrant applicants, and Contracted QHP Issuers that first contracted with Covered California in Plan Year 2024 with a provisional, interim, in process, or scheduled status for NCQA Health Plan Accreditation, must receive NCQA Health Plan Accreditation within 12 months of submitting the initial application for QHP Certification or no later than 90 days before the second Open Enrollment Period that the new entrant's product is offered.

Plan Year 2025 currently contracted applicants with a provisional, interim, in process, or scheduled status for NCQA Health Plan Accreditation must receive NCQA Health Plan Accreditation no later than year-end 2024.
Multi, Checkboxes.
1: Yes, Accreditation Workplan attached,
2: Date of scheduled survey for NCQA Health Plan Accreditation: [To the day],
3: Not attached,
4: Not applicable

16.1.3 If Applicant reported a denied or expired status for any accreditation, Applicant must submit a corrective action plan to remedy any deficiencies and demonstrate incorporation in workplan to achieve and maintain NCQA Health Plan Accreditation. This corrective action plan must include any improvement steps recommended by the accrediting agency and be coordinated with the NCQA pre-accreditation process, if applicable.

Plan Year 2025 new entrant applicants with a recently denied or expired status for NCQA Health Plan Accreditation must receive NCQA Health Plan Accreditation within 12 months of submitting the initial application for QHP Certification or no later than 90 days before the second Open Enrollment Period that the new entrant's product is offered.

Plan Year 2025 currently contracted applicants with a recently denied or expired status for NCQA Health Plan Accreditation must receive NCQA Health Plan Accreditation no later than year-end 2024.

The corrective action plan should be uploaded as a file with the file name “Accreditation Corrective Action Plan.”
Single, Radio group.
1: Yes, Accreditation Corrective Action Plan attached.,
2: Date of scheduled survey for NCQA Health Plan Accreditation: [To the day],
3: Not attached,
4: Not applicable

16.1.4 Other NCQA Programs - Applicant must provide expiration date(s) of any NCQA Program(s) achieved for the QHP(s) proposed for Plan Year 2025. Indicate all that apply.
Multi, Checkboxes.
1: Case Management: [To the day],
2: Credentialing: [To the day],
3: Credentials Verification Organization (CVO): [To the day],
4: Health Information Products: [To the day],
5: Long-Term Services and Supports (LTSS): [To the day],
6: Managed Behavioral Health Organization (MBHO): [To the day],,
7: Physician and Hospital Quality: [To the day],
8: Population Health Program Accreditation: [To the day],
9: Provider Network: [To the day],
10: Specialty Pharmacy Accreditation: [To the day],
11: Utilization Management: [To the day],
12: Wellness and Health Promotion: [To the day],
13: N/A

16.1.5 Applicant must confirm its compliance with all contractual requirements found in Attachment 1 - Advancing Equity, Quality, and Value, and Attachment 2 – Performance Standards with Penalties of the Covered California 2023-2025 Individual Market QHP Issuer Contract.
Single, Radio group.
1: Confirmed, Contracted Applicant compliant with specified contractual requirements
2: Confirmed, New Entrant Applicant agrees to meet all specified contractual requirements if certified
3: Not Confirmed

16.2 Health Equity and Disparities Reduction

16.2.1 Organizational Commitment to Cultivating a Culture of Health Equity

All questions are required for new entrant Applicants. All questions should be answered at the Issuer level, not product level.

16.2.1.1 Applicant may submit to Covered California its National Committee for Quality Assurance (NCQA) Health Equity Accreditation standard HE 1: Organizational Readiness reports in lieu of responding to section 16.2.1.

If Applicant has not yet achieved the NCQA Health Equity Accreditation or does not provide HE 1: Organizational Readiness components of its NCQA Health Equity Accreditation reports, Applicant must respond to all questions in this section.

Single, Radio group.
1: Yes, NCQA Health Equity Accreditation standard HE 1 attached,
2: No, Applicant has not yet achieved the NCQA Health Equity Accreditation,
3: No, Applicant cannot provide HE 1

16.2.1.2 Applicant demonstrates commitment to creating an organizational culture of health equity by taking the following actions related to mission, vision, policies, and processes:

Multi, Checkboxes.
1: Applicant includes health equity in organizational mission and vision, or if currently not included in organization's mission and vision, Applicant is taking steps to incorporate health equity; describe, including specific examples: [100 words],
2: Health equity is integrated into organizational systems and culture, including organizational policies, processes, models, and frameworks; describe, including specific examples: [100 words],
3: Not applicable, health equity not integrated in organizational culture.

16.2.1.3 Applicant demonstrates commitment to a culture of health equity in its organizational leadership:

Multi, Checkboxes.
1: Applicant identifies leaders who are designated and held accountable for disparities reduction, describe, including titles and descriptions of roles and responsibilities: [100 words],
2: Applicant identifies and develops equity champions in the organization, describe, including specific examples:: [100 words],
3: Applicant obtains executive leadership buy-in to reduce health disparities, describe, including specific examples:: [100 words],
4: Applicant invests financially in health equity, describe, including specific examples: [100 words]

16.2.1.4 Applicant demonstrates commitment to a culture of health equity in forming and engaging its teams.

Multi, Checkboxes.
1: Disparities are openly recognized, everyone within the organization is motivated to reduce them, and everyone knows their role in the process, describe: [100 words],
2: Applicant obtains provider or medical group buy-in to reduce health disparities, describe: [100 words],
3: Applicant recruits a diverse workforce that reflects plan membership, describe: [100 words],
4: Applicant provides staff training in unconscious bias or implicit bias, cultural humility or racial humility, data analysis training to identify health disparities or other trainings, describe: [100 words],
5: Applicant provides provider training in unconscious bias or implicit bias, cultural humility or racial humility, trauma-informed care or other trainings, describe: [100 words]

16.2.1.5 Applicant demonstrates commitment to a culture of health equity in its community partnerships.

Multi, Checkboxes.
1: Applicant invests in partnerships with community-based organizations that serve populations identified for disparity reduction, describe: [100 words],
2: Applicant demonstrates commitment to culturally and linguistically appropriate care to patients, staff, and the community, describe: [100 words],
3: Applicant conducts external-facing initiatives, programs and projects to promote better community health, specifically addressing health disparities or improvement of community health apart from the health delivery system. Include any evaluation results of the activity or program, if available, describe: [100 words], Applicant may submit any supporting documentation as an attachment.,
4: Applicant leads or participates in statewide, regional, or cross organizational initiatives or collaborative efforts to promote and advance health equity. Include any evaluation results of the activity or program, if available, describe: [100 words]

16.2.2 Linking Quality and Equity

All questions are required for new entrant Applicants. All questions should be answered at the Issuer level, not product level.

16.2.2.1 How does applicant incorporate health equity into quality improvement work across lines of business? If health equity is currently not part of Applicant's quality improvement program, how does Applicant plan to incorporate health equity into quality improvement work across lines of business?

Responses must address:
Multi, Checkboxes.
1: Staffing, describe: [100 words],
2: Budget, describe: [100 words],
3: Initiatives, describe: [100 words],
4: Data infrastructure, describe: [100 words],

16.2.2.2 Identify the sources of data used to gather member race and ethnicity data for each line of business. The response "enrollment form" pertains only to information passed on by the purchaser.

Demographic Data Type	*CalPERS*	*Medi-Cal*	*California Commercial Individual and Group (Off-Exchange)*	*Description If Applicant answered, "data not collected," discuss how Applicant intends to collect specified data elements.*
Race/Ethnicity	*Multi, Checkboxes.* 1: enrollment form, 2: member services contact, 3: member portal, 4: EHR, 5: Health Assessments, 6: other, specify below, 7: data not collected 8: line of business not offered	*Multi, Checkboxes.* 1: enrollment form, 2: member services contact, 3: member portal, 4: EHR, 5: Health Assessments, 6: other, specify below, 7: data not collected 8: line of business not offered	*Multi, Checkboxes.* 1: enrollment form, 2: member services contact, 3: member portal, 4: Electronic Health Record (EHR), specify estimated percent of enrollees below, 5: Health Assessments, 6: other, specify below, 7: data not collected 8: line of business not offered	*100 words.*
Specify	*10 words.*	*10 words.*	*10 words.*	

16.2.2.3 Indicate whether a methodology is used to estimate race and ethnicity for membership who have not self-identified and use the text box to describe how the data is used in quality improvement efforts. Note that this method should not be used to calculate Applicant's race and ethnicity member self-report rate. Select one from the options below.
Single, Radio group.

1: Applicant uses the RAND proxy methodology, describe: [100 words],
2: Applicant uses another methodology to estimate race and ethnicity, describe: [100 words],
3: Applicant does not use a methodology to estimate race and ethnicity, describe: [100 words]

16.2.2.4 Indicate how race and ethnicity data are used to address quality improvement and health equity and disparities. Select all that apply.
Multi, Checkboxes.
1: Assess adequacy of network to meet members' needs
2: Calculate quality performance measures by race/ethnicity,
3: Calculate member experience measures by race/ethnicity,
4: Identify areas for quality improvement,
5: Identify areas for health education/promotion,
6: Share provider race/ethnicity data with member to support provider selection,
7: With appropriate protections, share with provider network to support in provision culturally sensitive care,
8: Set benchmarks or target goals for reducing measured disparities in preventive or diagnostic care,
9: Analyze disenrollment patterns,
10: Resource allocation decisions,
11: Develop outreach programs that are culturally sensitive (explain): [100 words],
12: Other (explain): [100 words],
13: Race/ethnicity data not used for quality improvement or health equity

16.2.2.5 Identify the sources of data used to gather member preferred language data for each line of business. The response “enrollment form” pertains only to information passed on by the purchaser.

Demographic Data Type	*CalPERS*	*Medi-Cal*	*California Commercial Individual and Group (Off-Exchange)*	*Description If Applicant answered “data not collected,” discuss how Applicant intends to collect specified data elements.*
Preferred Language (written or spoken)	*Multi, Checkboxes.* 1: enrollment form, 2: member services contact, 3: member portal, 4: EHR, 5: Health Assessments, 6: other, specify below, 7: data not collected 8: line of business not offered	*Multi, Checkboxes.* 1: enrollment form, 2: member services contact, 3: member portal, 4: EHR, 5: Health Assessments, 6: other, specify below, 7: data not collected 8: line of business not offered	*Multi, Checkboxes.* 1: enrollment form, 2: member services contact, 3: member portal, 4: Electronic Health Record (EHR), specify estimated percent of enrollees below, 5: Health Assessments, 6: other, specify below, 7: data not collected 8: line of business not offered	*100 words.*
Specify	*10 words.*	*10 words.*	*10 words.*	

16.2.2.6 Indicate how primary language data are used to address quality improvement and health equity and disparities. Select all that apply.
Multi, Checkboxes.
1: Assess adequacy of language assistance to meet members' needs,
2: Calculate quality performance measures by language,
3: Calculate member experience measures by language,
4: Identify areas for quality improvement,
5: Identify areas for health education/promotion,
6: Share provider language data with member to support provider selection,
7: With appropriate protections, share with provider network to support in provisioning language assistance and culturally sensitive care,
8: Set benchmarks or target goals for reducing measured disparities in preventive or diagnostic care,
9: Analyze disenrollment patterns,
10: Resource allocation decisions,
11: Develop outreach programs that are culturally sensitive (explain): [100 words],
12: Other (explain): [100 words],
13: Language data not used for quality improvement or health equity

16.2.2.7 Identify the sources of data used to gather member sexual orientation for each line of business. The response “enrollment form” pertains only to information passed on by the purchaser. If member sexual orientation is collected from members, provide response options offered to members in the Description column.

Demographic Data Type	*CalPERS*	*Medi-Cal*	*California Commercial Individual and Group (Off-Exchange)*	*Description If Applicant answered “data not collected,” discuss how Applicant intends to collect specified data elements.*
Sexual Orientation	*Multi, Checkboxes.* 1: enrollment form, 2: member services contact, 3: member portal, 4: EHR, 5: Health Assessments, 6: other, specify below, 7: data not collected 8: line of business not offered	*Multi, Checkboxes.* 1: enrollment form, 2: member services contact, 3: member portal, 4: EHR, 5: Health Assessments, 6: other, specify below, 7: data not collected 8: line of business not offered	*Multi, Checkboxes.* 1: enrollment form, 2: member services contact, 3: member portal, 4: Electronic Health Record (EHR), specify estimated percent of enrollees below, 5: Health Assessments, 6: other, specify below, 7: data not collected 8: line of business not offered	*100 words.*
Specify	*10 words.*	*10 words.*	*10 words.*	

16.2.2.8 Indicate how member sexual orientation data are used to address quality improvement and health equity and disparities. Select all that apply.
Multi, Checkboxes.
1: Assess adequacy of network to meet members' needs

2: Calculate quality performance measures by sexual orientation,
3: Calculate member experience measures by sexual orientation,
4: Identify areas for quality improvement,
5: Identify areas for health education/promotion,
6: Share provider LGBTQ+ specialty care data with member to support provider selection,
7: With appropriate protections, share with provider network to support provision of culturally sensitive,
8: Set benchmarks or target goals for reducing measured disparities in preventive or diagnostic care,
9: Analyze disenrollment patterns,
10: Resource allocation decisions,
11: Develop outreach programs that are culturally sensitive (explain): [100 words],
12: Other (explain): [100 words],
13: Sexual orientation data not used for quality improvement or health equity

16.2.2.9 Identify the sources of data used to gather member gender identity for each line of business. The response "enrollment form" pertains only to information passed on by the purchaser. If member gender identity is collected from members, provide response options offered to members in the Description column.

Demographic Data Type	*CalPERS*	*Medi-Cal*	*California Commercial Individual and Group (Off-Exchange)*	*Description If Applicant answered, "data not collected," discuss how Applicant intends to collect specified data elements.*
Gender Identity	*Multi, Checkboxes.* 1: enrollment form, 2: member services contact, 3: member portal, 4: EHR, 5: Health Assessments, 6: other, specify below, 7: data not collected 8: line of business not offered	*Multi, Checkboxes.* 1: enrollment form, 2: member services contact, 3: member portal, 4: EHR, 5: Health Assessments, 6: other, specify below, 7: data not collected 8: line of business not offered	*Multi, Checkboxes.* 1: enrollment form, 2: member services contact, 3: member portal, 4: Electronic Health Record (EHR), specify estimated percent of enrollees below, 5: Health Assessments, 6: other, specify below, 7: data not collected 8: line of business not offered	*100 words.*
Specify	*10 words.*	*10 words.*	*10 words.*	

16.2.2.10 Indicate how member gender identity data are used to address quality improvement and health equity and disparities. Select all that apply.
Multi, Checkboxes.
1: Assess adequacy of network to meet members' needs,
2: Calculate quality performance measures by gender identity,
3: Calculate member experience measures by gender identity,
4: Identify areas for quality improvement,
5: Identify areas for health education/promotion,
6: Share provider gender identity data with member to support provider selection,
7: With appropriate protections, share with provider network to support in provision of culturally sensitive care,

8: Set benchmarks or target goals for reducing measured disparities in preventive or diagnostic care,
9: Analyze disenrollment patterns,
10: Resource allocation decisions,
11: Develop outreach programs that are culturally sensitive (explain): [100 words],
12: Other (explain): [100 words],
13: Gender identity data not used for quality improvement or health equity

16.2.2.11 Identify the sources of data used to gather member disability status for each line of business. The response "enrollment form" pertains only to information passed on by the purchaser. Describe any use of standard screening questions or survey tools used in the Description column.

Demographic Data Type	*CalPERS*	*Medi-Cal*	*California Commercial Individual and Group (Off-Exchange)*	*Description If Applicant answered "data not collected," discuss how Applicant intends to collect specified data elements.*
Disability Status	*Multi, Checkboxes.* 1: enrollment form, 2: member services contact, 3: member portal, 4: EHR, 5: Health Assessments, 6: claims data, 7: other, specify below, 8: data not collected 9: line of business not offered	*Multi, Checkboxes.* 1: enrollment form, 2: member services contact, 3: member portal, 4: EHR, 5: Health Assessments, 6: claims data, 7: other, specify below, 8: data not collected 9: line of business not offered	*Multi, Checkboxes.* 1: enrollment form, 2: member services contact, 3: member portal, 4: Electronic Health Record (EHR), specify estimated percent of enrollees below, 5: Health Assessments, 6: claims data, 7: other, specify below, 8: data not collected 9: line of business not offered	*100 words.*
Specify	*10 words.*	*10 words.*	*10 words.*	

16.2.2.12 Indicate how member disability status data are used to address quality improvement and health equity and disparities. Select all that apply.
Multi, Checkboxes.
1: Assess adequacy of network and accessibility services to meet members' needs,
2: Calculate quality performance measures by disability status,
3: Calculate member experience measures by disability status,
4: Identify areas for quality improvement,
5: Identify areas for health education/promotion,
6: With appropriate protections, share with provider network to support in provision in culturally sensitive care,
7: Set benchmarks or target goals for reducing measured disparities in preventive or diagnostic care,
8: Analyze disenrollment patterns,
9: Develop outreach programs that are culturally sensitive (explain): [100 words],
10: Resource allocation decisions,

11: Other (explain): [100 words],
12: Disability data not used for quality improvement or health equity

16.2.2.13 Does Applicant stratify clinical measures by demographic factors for disparities identification and intervention efforts? If so, which measures are stratified by which demographic factors? Specify the applicable lines of business.
200 words.

16.2.2.14 Does Applicant stratify maternal health measures by demographic factors for disparities identification and intervention efforts? If so, which measures are stratified by which demographic factors? Specify the applicable lines of business.
200 words.

16.2.3 Culturally and Linguistically Appropriate Care

All questions are required for all Applicants. All questions should be answered at the Issuer level, not product level.

16.2.3.1 What training or communication on patient language needs and the California Language Assistance Program requirements does Applicant share with network providers?
200 words.

16.2.3.2 Applicant must indicate its threshold languages and percentage of enrollees that selected each applicable threshold language in plan year 2022.
* Chinese is the combination of Cantonese, Mandarin, and Other Chinese Language.

Threshold language	Response	Percent
Arabic	*Single, Pull-down list.* 1: Yes, 2: No	*Percent.*
Armenian	*Single, Pull-down list.* 1: Yes, 2: No	*Percent.*
Cambodian	*Single, Pull-down list.* 1: Yes, 2: No	*Percent.*
Chinese*	*Single, Pull-down list.* 1: Yes, 2: No	*Percent.*
English	*Single, Pull-down list.* 1: Yes, 2: No	*Percent.*
Farsi	*Single, Pull-down list.* 1: Yes, 2: No	*Percent.*

Hindi	*Single, Pull-down list.* 1: Yes, 2: No	*Percent.*
Hmong	*Single, Pull-down list.* 1: Yes, 2: No	*Percent.*
Japanese	*Single, Pull-down list.* 1: Yes, 2: No	*Percent.*
Korean	*Single, Pull-down list.* 1: Yes, 2: No	*Percent.*
Laotian	*Single, Pull-down list.* 1: Yes, 2: No	*Percent.*
Mien	*Single, Pull-down list.* 1: Yes, 2: No	*Percent.*
Punjabi	*Single, Pull-down list.* 1: Yes, 2: No	*Percent.*
Russian	*Single, Pull-down list.* 1: Yes, 2: No	*Percent.*
Spanish	*Single, Pull-down list.* 1: Yes, 2: No	*Percent.*
Tagalog	*Single, Pull-down list.* 1: Yes, 2: No	*Percent.*
Thai	*Single, Pull-down list.* 1: Yes, 2: No	*Percent.*
Ukrainian	*Single, Pull-down list.* 1: Yes, 2: No	*Percent.*
Vietnamese	*Single, Pull-down list.* 1: Yes, 2: No	*Percent.*
Other, specify	*Single, Pull-down list.* 1: Yes, 2: No	*100 words.*

16.2.3.3 In what frequency and format does Applicant communicate to enrollees about availability of language assistance services, such as interpretation and translation?
200 words.

16.2.3.4 What additional strategies does Applicant use to address patient language needs (e.g., matching providers with patients based on language needs)?

200 words.

16.3 Behavioral Health

All questions required for new entrant Applicants. All questions should be answered at the Issuer level, not product level.

16.3.1 Indicate which of the following mechanisms Applicant will use to ensure Covered California Enrollees have timely access to and receive appropriate, evidence-based behavioral health services. Provide one example of each selected mechanism in use.
Note: Applicant may include behavioral health provider network reports from its accrediting organization (NCQA, URAC, AAAHC) as a supplemental attachment.
Multi, Checkboxes.
1: Efforts to improve the accessibility and timeliness of behavioral health services considering provider availability, capacity, and the unique needs of diverse enrolled populations, describe: [50 words]
2: Changes in benefits management, describe: [50 words]
3: Changes to provider networks, describe: [50 words]
4: Changes to telehealth service offerings, describe: [50 words]
5: Assessment of behavioral health providers' or vendor's language capabilities, describe: [50 words]
6: Efforts to improve Enrollee education including explanation of point of entry to behavioral health services, describe: [50 words]
7: Methods to receive and address Covered California Enrollee concerns, describe: [50 words]
8: Other (explain): [100 words]

16.3.2 Indicate which of the following methods Applicant uses to monitor the quality, effectiveness, and cultural humility of its behavioral health services. Provide one example of each selected activity.
Multi, Checkboxes.
1: Promoting cultural concordance between enrollees and providers, describe: [50 words],
2: Monitoring quality measures (HEDIS, PQA, QRS, etc.), describe: [50 words]
3: Monitoring patient-reported experience measures (CAHPS, CG-CAHPS, etc.), describe: [50 words]
4: Monitoring utilization measures, describe: [50 words]
5: Other processes or mechanisms to monitor screening and treatment rates and outcomes not addressed above, describe: [50 words],
6: Efforts to support diversification of behavioral health workforce and provider network, describe: [50 words]
7: Development of programs for specific cultural settings or populations, describe: [50 words]
8: Other (explain): [100 words]

16.3.3 Applicant must indicate the number of behavioral health measures tracked (e.g., clinical measures, patient-reported experience, or others) to ensure enrollees receive appropriate, evidence-based treatment.

Single, Pull-down list.
1: No measures are tracked,
2: 1,
3: 2,
4: 3,
5: 4,
6: 5,

7: 6,
8: 7,
9: 8,
10: 9,
11: 10,
12: 11,
13: 12,
14: 13,
15: 14,
16: 15,
17: 16,
18: 17,
19: 18,
20: 19,
21: 20,
22: 21,
23: 22,
24: 23,
25: 24,
26: 25

16.3.4 Applicant must specify which measures are tracked (e.g., HEDIS clinical measures, CAHPS patient-reported experience, patient-reported outcome measures, or others) to ensure enrollees receive appropriate, evidence-based behavioral health treatment and provide the results for these measures for measurement years. Indicate whether the measure is used to monitor subcontractor performance in Details. Applicant must provide measure results for its commercial lines of business. If Applicant does not have a commercial line of business, Applicant must provide measure results for its Medi-Cal, California dual Medicaid-Medicare, California Medicare or other state-based exchange line of business. Indicate the line of business in the Details.

	Measure				*Results - Measurement Year 2023*	Details
1	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*100 words.*
2	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*100 words.*
3	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*100 words.*
4	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*100 words.*
5	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*100 words.*
6	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*100 words.*
7	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*100 words.*
8	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*100 words.*
9	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*100 words.*
10	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*100 words.*
11	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*100 words.*
12	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*100 words.*
13	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*100 words.*
14	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*100 words.*

15	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*100 words.*
16	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*100 words.*
17	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*100 words.*
18	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*100 words.*
19	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*100 words.*
20	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*100 words.*
21	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*100 words.*
22	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*100 words.*
23	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*100 words.*
24	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*100 words.*
25	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*100 words.*

16.3.5 Describe Applicant's efforts to implement and increase the use of patient-reported outcome measures, such as those based on the use of standardized screening and follow-up tools for depression, anxiety, and substance use disorders by primary care and behavioral health providers.
200 words.

16.3.6 In the following table, Applicant must identify which Smart Care California opioid guidelines the Applicant has implemented and describe how Applicant is implementing each selected guideline in Details.

	Guideline	*Implementation*	*Details*
1	Offer or support provider education on pain management based on prescribing guidelines (CDC or medical board).	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*
2	Offer or support specific programs that help providers safely manage patients on high opioid doses or combinations (opioids and benzodiazepines), avoiding mandatory tapers to arbitrary dose targets.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*
3	Analyze data to identify outlier prescribers and flag for education, coaching, and/or fraud investigation.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*
4	Ensure access to in-network pain specialists aligned with CDC guidelines for peer consultation or secondary case review.	*Single, Pull-down list.*	*50 words.*

		1: In place, 2: Implementation in progress, 3: Have not implemented	
5	Create dashboards to measure comparative opioid prescribing rates and work with outlier prescribers; avoid using incentive programs that could encourage involuntary tapers or refusal to treat new opioid-dependent patients.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*
6	Participate in local opioid safety coalitions to support community prescribing guidelines and integration of addiction treatment into health care settings.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*
7	Work with inpatient and outpatient provider network to change preset opioid prescribing order sets, focusing on acute pain management.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*
8	Remove prior authorization requirement for first course of physical therapy for back pain and ensure timely access to care.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*
9	Offers chiropractic services as needed based on Enrollee treatment plan.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*
10	Offers acupuncture services as needed based on Enrollee treatment plan.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*
11	Offers health education or mindfulness.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress,	*50 words.*

		3: Have not implemented	
12	Train case managers on common issues in chronic pain and addiction.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*
13	Increase access to behavioral health services for patients with chronic pain.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*
14	Identify members losing prescribers (e.g., prescribers no longer providing opioid management) and coordinate referrals to pain management or addiction treatment where needed. Develop polices to prevent “opioid refugees.”	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*
15	Review dose limit policies to ensure they do not encourage involuntary tapers and ensure prompt clinical review of exception requests to ensure harm does not exceed benefit for individual patients.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*
16	Implement quantity limits for new starts.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*
17	Set up policies to decrease new starts for concurrent opioid and benzodiazepine use.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*
18	Remove prior authorization requirements for common nonopioid pain medications (e.g., antidepressants, neuroleptics with indications for pain).	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*

19	Implement pharmacy and/or prescriber lock program for patients using multiple prescribers and provide case management to ensure appropriate care and referral to services.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*
20	Provide member education on opioid risks and nonopioid pain management strategies.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*
21	Evaluate network adequacy for specialty addiction treatment and develop action plan to meet demand.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*
22	Evaluate network adequacy for primary care addiction treatment (buprenorphine and naltrexone) and develop action plan to meet demand.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*
23	Contract with medication-assisted treatment (MAT) telehealth providers.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*
24	Offer or support provider education on buprenorphine prescribing (e.g., waiver training).	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*
25	Offer financial incentives or alternative payment models to encourage primary care providers to treat addiction with buprenorphine.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*
26	Work with emergency departments (EDs) to treat addiction with buprenorphine and refer for ongoing management in ED, and to dispense naloxone to high-risk patients.	*Single, Pull-down list.* 1: In place,	*50 words.*

		2: Implementation in progress, 3: Have not implemented	
27	Place navigators or recovery coaches in EDs to help facilitate entry into addiction treatment.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*
28	Work with hospitalists to start buprenorphine or methadone treatment with patients hospitalized with addiction-related diagnoses (e.g., endocarditis or osteomyelitis).	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*
29	(Work with correctional settings to offer all addiction treatments and care coordination of medical and behavioral needs on re-entry.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*
30	Ensure adequate access to buprenorphine and methadone for pregnant women.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*
31	Work with hospitals to ensure evidence-based treatment of neonatal abstinence syndrome, minimizing medication and NICU use and promoting family unification.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*
32	Incentivize behavioral health integration through pay-for-performance or direct grants; avoid incentive programs that could encourage dismissing patients from opioid treatment or refusing entry for new pain management patients.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*
33	Offer or support provider education on co-prescribing naloxone.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress,	*50 words.*

		3: Have not implemented	
34	Work with local opioid safety coalitions to build new MAT access points.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*
35	Train case managers to guide members to addiction treatment.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*
36	Identify members on high-dose or risky regimens and refer to case management.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*
37	Notify outpatient prescribers about hospital and ED admission for overdose events.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*
38	Remove authorization requirements for initiating and maintaining buprenorphine for addiction, including eliminating requirements for detox in lieu of maintenance.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*
39	Remove authorization requirements for initiating and maintaining buprenorphine for pain.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*
40	Work with pharmacy network to support stocking and furnishing naloxone.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*

41	Remove authorization requirements for naloxone.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*
42	Provide member education on naloxone.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*
43	Ensure that members at high risk of addiction or opioid overuse receive outreach from peers, recovery support, or case manager.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*

16.3.7 What percentage of adult enrollees who are receiving specialty mental health or substance use disorder (SUD) services had a primary care visit in measurement year 2023? Include numerator and denominator counts in the table below.

Total number of adult enrollees receiving specialty mental health or SUD services	Total number of adult enrollees receiving specialty mental health or SUD services who had a primary care visit in measurement year 2023	Percentage of adult enrollees receiving specialty mental health or SUD services who had a primary care visit in measurement year 2023
Integer	*Integer*	*Percentage*

16.3.8 What is the emergency department visit rate for adult enrollees receiving specialty mental health or substance use disorder services in the past year? Include numerator and denominator counts in the table below.

Total number of Adult Enrollees receiving specialty mental health or SUD services	Total number of Adult Enrollees receiving specialty mental health or SUD services who had an emergency department visit in the past year	Percentage of Adult Enrollees receiving specialty mental health or SUD services who had an emergency department visit in the past year
Integer	*Integer*	*Percentage*

16.4 Health Promotion and Prevention

All questions are required for new entrant Applicants. All questions should be answered at the Issuer level, not product level.

16.4.1 Identify enrollee interventions used in 2023 to improve immunization rates. Check all that apply.

	Response	*Details*
Childhood Immunizations	*Multi, Checkboxes.* 1: Enrollee reminders (electronic or written, etc.) sent to enrollees for needed care based on general eligibility (age/gender), 2: Enrollee-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), 3: Enrollee incentives, describe: [50 words] 4: Provider incentives, describe: [50 words] 5: Other, describe, 6: None of the above	*50 words.*
Immunizations for Adolescents	*Multi, Checkboxes.* 1: Enrollee reminders (electronic or written, etc.) sent to enrollees for needed care based on general eligibility (age/gender), 2: Enrollee-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), 3: Enrollee incentives, describe: [50 words] 4: Provider incentives, describe: [50 words] 5: Other, describe, 6: None of the above	*50 words.*
Immunizations for Adults	*Multi, Checkboxes.* 1: Enrollee reminders (electronic or written, etc.) sent to enrollees for needed care based on general eligibility (age/gender), 2: Enrollee-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), 3: Enrollee incentives, describe: [50 words] 4: Provider incentives, describe: [50 words] 5: Other, describe, 6: None of the above	*50 words.*

16.4.2 Indicate whether Applicant currently participates in the California Immunization Registry (CAIR) (both submitting and receiving data). If yes, include a description of how Applicant uses the data obtained in the registry, e.g., supporting outreach to those with gaps in care or evaluating the effectiveness of provider interventions.
Single, Radio group.
1: Applicant participates in CAIR, describe: [50 words],
2: Applicant does not participate in CAIR.

16.4.3 Indicate how Applicant identifies tobacco-dependent enrollees and the tobacco cessation interventions available to enrollees.

	Response	Details
1. Indicate how Applicant identifies tobacco-dependent Enrollees.	*Multi, Checkboxes.* 1: Plan Health Assessment,	*50 words.*

	2: Employer/Purchaser Health Assessment, 3: Plan Personal Health Record, 4: Claims/Encounter Data, 5: Disease or Care Management, 6: Wellness Vendor, 7: Other, describe, 8: None	
2. Indicate the tobacco cessation interventions Applicant provides directly to enrollees.	*Multi, Checkboxes.* 1: Nicotine Replacement Therapy, 2: Smoking cessation class or program, 3: Smoking cessation counseling via PCP/health coach, 4: Medication assisted cessation, 5: Enrollee incentives, describe, 6: Other, describe, 7: None	*50 words.*
3. Confirm Applicant will provide coverage of tobacco cessation as required under Essential Health Benefits (EHB) and describe any additional tobacco cessation interventions Applicant will offer for enrollees.	*Multi, Checkboxes.* 1: Applicant provides coverage only for tobacco cessation as required under EHB, 2: Applicant provides coverage for tobacco cessation as required under EHB and offers the following additional interventions, describe, 3: Applicant does not provide coverage for tobacco cessation	*50 words.*

16.4.4 All contracted QHP Issuers must provide the Centers for Disease Control and Prevention (CDC) National Diabetes Prevention Program (DPP), to its eligible Covered California Enrollees. The DPP must be available both in-person and online to ensure Covered California Enrollees have equitable access to these services in the event of service area challenges such as rural location or limited program availability and to allow Covered California Enrollees a choice of modality (in-person, online, distance learning, or a combination of modes). The DPP must be accessible to eligible Covered California Enrollees with limited English proficiency (LEP) and eligible Covered California Enrollees with disabilities. The DPP is covered as a diabetes education benefit with zero cost sharing pursuant to the Patient-Centered Benefit Plan Designs. Contractor's DPP must have pending or full recognition by the CDC for all components, including the Lifestyle Change Program. A list of recognized programs in California can be found at: https://dprp.cdc.gov/Registry.
Note: Provide California commercial individual and group (off-exchange) Enrollee counts and details on interventions or planned activities.

	Response	*Details*
1. Indicate how Applicant identifies or will identify eligible Enrollees for the Diabetes Prevention Program.	*Multi, Checkboxes.* 1: Plan Health Assessment, 2: Employer/Purchaser Health Assessment, 3: Plan Personal Health Record, 4: Claims/Encounter Data, 5: Disease or Care Management, 6: Wellness Vendor,	*50 words.*

	7: Other, describe, 8: None	
2. Indicate how Applicant conducts or will conduct Enrollee outreach for the Diabetes Prevention Program.	*Multi, Checkboxes.* 1: Marketing campaigns (letter, email, text, phone, newsletter, mailer, social media), 2: Open Enrollment materials (welcome kits), 3: Disease or Care Management, 4: Member Portal, 5: Outreach events, 6: Other, describe, 7: None	*50 words.*
3. Indicate how Applicant advertises or will advertise the Diabetes Prevention Program.	*Single, Radio group.* 1: Internal staff, 2: Wellness vendor or contracted group, 3: Both	
3. Describe how Applicant monitors and evaluates or will monitor and evaluate the effectiveness of the Diabetes Prevention Program.	*50 words.*	
California Commercial Individual and Group (Off-Exchange) Enrollees		
4. As of December 2023, the number of California commercial individual and group (off-exchange) Enrollees eligible for Diabetes Prevention Program.	*Integer.*	
5. As of December 2023, the percent of California commercial individual and group (off-exchange) Enrollees eligible for Diabetes Prevention Program. *(Calculated as number of California commercial individual and group (off-exchange) Enrollees eligible for Diabetes Prevention Program divided by total number of California commercial individual and group (off-exchange) Enrollees ages 18 years and older)*	*Percent.*	
6. As of December 2023, the number of eligible California commercial individual and group (off-exchange) Enrollees who enrolled in an in-person Diabetes Prevention Program.	*Integer.*	
7. As of December 2023, the number of eligible California commercial individual and group (off-exchange) Enrollees who enrolled in and reached a modest reduction in hemoglobin A1C (HbA1C) of 0.2% using an in-person Diabetes Prevention Program (use cumulative total of Enrollees).	*Integer.*	
8. As of December 2023, the number of eligible California commercial individual and group (off-exchange) Enrollees who enrolled in an on-line or virtual Diabetes Prevention Program.	*Integer.*	

9. As of December 2023, the number of eligible California commercial individual and group (off-exchange) Enrollees who enrolled in and reached a modest reduction in hemoglobin A1C (HbA1C) of 0.2% using an on-line or virtual Diabetes Prevention Program (use cumulative total of Enrollees).	*Integer.*	

16.4.5 Describe the strategies Applicant is implementing to ensure its enrollee population is up to date with USPSTF recommendations for clinical preventive health screenings and include a full list of those clinical preventive screenings offered.
100 words.

16.4.6 Describe how Applicant identifies and addresses gaps, such as through enrollee reminders and use of incentives, in preventive care.
100 words.

16.5 Population Health Management

All questions are required for new entrant Applicants. All questions should be answered at the Issuer level, not product level.

16.5.1 Health Assessment

16.5.1.1 Indicate Applicant's capabilities supporting 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 enrollees,
7: Applicant does not offer an HA

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

	Response
Addressing At-Risk Behaviors	*Multi, Checkboxes.* 1: At point of HA response, risk-factor education is provided to enrollee based on enrollee-specific risk, e.g., at point of “smoking-yes” response, tobacco cessation education is provided as pop-up, 2: Personalized HA report is generated after HA completion that provides enrollee-specific risk modification actions based on responses, 3: Enrollees are directed to targeted interactive intervention module for behavior change upon HA completion, 4: Ongoing push messaging for self-care based on enrollee’s HA results ("Push messaging" is defined as an information system capability that generates regular e-mail or health

	information to the enrollee), 5: Enrollee is automatically enrolled into a disease management or at-risk program based on responses, 6: Care manager or health coach outreach call triggered based on HA results, 7: Enrollee can elect to have HA results sent electronically to personal physician, 8: Enrollee can update responses and track against previous responses
Tracking Health Status	*Multi, Checkboxes.* 1: HA responses incorporated into enrollee health record, 2: HA responses tracked over time to observe changes in health status, 3: HA responses used for comparative analysis of health status across geographic regions, 4: HA responses used for comparative analysis of health status across demographics

16.5.1.3 As part of total population management and person-centered care, describe capability to identify enrollees who are utilizing few or no services each year and engage those members in services as needed. Include description of outreach efforts used to engage these enrollees in care.

	California commercial	Medi-Cal	California dual Medicaid-Medicare
Percent of membership with no claims in Measurement Year 2023	*Percent.*	*Percent.*	*Percent.*
Description of plan activities to engage members who are non-utilizing	*100 words.*	*100 words.*	*100 words.*

16.5.2 Supporting At-Risk Enrollees

16.5.2.1 How does Applicant incorporate risk-stratified care management (RSCM) (the process of assigning a health risk status to a patient and using the patient's risk status to direct and improve care) to identify at-risk enrollees who would benefit from early, pro-active interventions? Describe applicable risk factors and diseases considered for at-risk identification, sources of data or methods used, and any predictive analytic capabilities.
100 words.

16.5.2.2 Indicate whether Applicant offers care management programs through a contracted vendor or internal staff and describe each care management program.
Single, Radio group.
1: Applicant offers programs through internal staff, describe each program: [100 words],
2: Applicant offers programs through contracted vendor, describe each program: [100 words],
3: Applicant offers programs through internal staff and contracted vendor, describe each program: [100 words]

16.5.2.3 Describe outreach and interventions used to ensure at-risk enrollees received needed care for measurement year 2023.

	Response	Details

Outreach and interventions	*Multi, Checkboxes.* 1: Live outbound telephonic coaching program, 2: Face to face visits, 3: Enrollee-specific reminders for due or overdue clinical/diagnostic maintenance services or medication events (failure to refill for example, 4: Online interactive self-management support: "Online interactive self-management support" is an intervention that includes two-way electronic communication between Applicant and the Enrollee, 5: Self-initiated text or email, 6: Interactive IVR, 7: Other, describe, 8: No outreach or interventions were used	*50 words.*

16.5.3 Health-Related Social Needs

Given the strong evidence of the role of social factors like food insecurity, marginal housing, and lack of transportation on health outcomes, addressing health-related social needs ("social needs") is an important step in advancing Covered California's goal to ensure everyone receives the best possible care. Covered California acknowledges the importance of understanding patient health-related social needs – an individual's socioeconomic barriers to health – to move closer to equitable care and seeks to encourage the use of social needs informed and targeted care. As social needs are disproportionately borne by disadvantaged populations, identifying, and addressing these barriers at the individual patient level is a critical first step in improving health outcomes, and reducing health disparities. Identification and information sharing of available community resources is critical to meeting identified member social needs.

16.5.3.1 Through what channels does Applicant screen Enrollees for health-related social needs? If screening varies by line of business, specify the line of business.
Multi, Checkboxes.
1: Include social needs screening in member portal, list: [50 words],
2: Include social needs screening in health assessments, list: [50 words],
3: Conduct social needs screening in select health plan programs, describe Enrollee eligibility for these programs: [50 words],
4: Require or incentivize network providers to screen, describe: [50 words],
5: Other, describe: [50 words],
6: No Enrollee health-related social needs screening performed or incentivized

16.5.3.2 Identify all health assessment or screening tools in use. If screening varies by line of business, specify the line of business in Other.
Multi, Checkboxes.
1: Accountable Health Communities Health-Related Social Needs Screening Tool,
2: HealthBegins,
3: Health Leads,
4: Income, Housing, Education, Legal Status, Literacy, Personal Safety (IHELLP) Questionnaire,
5: Medicare Total Health Assessment,
6: National Academy of Medicine Domains,
7: PRAPARE,
8: WellRx,
9: Your Current Life Situation,

10: Other, describe: [100 words],
11: Not applicable, no Enrollee health-related social needs screening performed or incentivized

16.5.3.3 Which Applicant staff or vendor representatives conduct or administer the health assessment or screening tool? Include description of any variation by program or internal workstream. If screening varies by line of business, specify any differences by line of business in response. Indicate “not applicable” if social needs screening not performed or incentivized.
50 words.

16.5.3.4 What training is provided to Applicant staff or network providers who conduct the health assessment or social needs screening? If screening varies by line of business, specify any differences by line of business in response.
Multi, Radio group.
1: Training specific to the assessment of screening instrument is provided, describe: [50 words],
2: Internally developed training is provided, describe: [50 words],
3: No training provided

16.5.3.5 Does Applicant require or incentivize contracted providers to use a health assessment or screening tool to identify Enrollee's social needs? If applicable, describe. If screening varies by line of business, specify any differences by line of business in response.
Single, Radio group.
1: Yes, require screening, describe: [100 words],
2: Yes, incentivize screening, describe: [100 words],
3: No screening requirements or incentives for contracted providers

16.5.3.6 Does Applicant incentivize provider use of z codes or Longitudinal Observation Identifier Names and Codes (LOINC) terminology for identified social needs?
Multi, Checkboxes.
1: Yes, Applicant incentivizes provider use of z codes, describe: [50 words],
2: Yes, Applicant incentivizes provider use of LOINC codes, describe: [50 words],
3: No, Applicant does not incentivize provider use of z codes
4: No, Applicant does not incentivize provider use of LOINC codes

16.5.3.7 How are social needs data collected from the health assessment or screening tool used? If screening varies by line of business, specify any differences by line of business.
Multi, Checkboxes.
1: Data linked to Enrollee’s demographic data, describe: [50 words],
2: Data linked to Enrollee’s health status, describe: [50 words],
3: Health plan representative refers Enrollees to the appropriate social service, describe: [50 words],
4: Vendor representative or platform refers Enrollees to the appropriate social service, describe: [50 words],
5: Provider or provider team member refers Enrollee to appropriate social service, describe: [50 words],
6: Data not linked to Enrollee’s demographic data or health status,
7: No referral made

16.5.3.8 Does Applicant maintain a community resource directory or contract with vendor(s) to provide enrollee referrals that address social needs? If yes, indicate all that apply. If screening varies by line of business, specify any differences by line of business in Other.
Multi, Checkboxes.
1: 211,
2: Aunt Bertha,
3: Healthify,
4: One Degree,
5: UniteUs,

6: Other, specify: [20 words],
7: No, Applicant does not maintain a community resource directory or contract with vendor to provide enrollee referrals

16.5.3.9 Does Applicant operate a closed-loop referral tracking system to address Enrollee's identified social needs? A closed loop referral tracking is the process of tracking the outcomes of a referral, including whether the Enrollee received help through the referral and whether the needs that triggered the referral were addressed. If screening varies by line of business, specify any differences by line of business.
Single, Radio group.
1: Applicant operates a closed-loop referral system to address Enrollee social needs, describe: [50 words],
2: Applicant does not operate a closed-loop referral system to address Enrollee social needs

16.5.4 Prevention of Algorithmic Bias in Healthcare

The potential for bias in algorithms used in decisions to allocate health care resources is increasingly documented. For example, algorithms using cost and utilization data to assess risk and allocate health care services or other resources will exacerbate existing disparities in access to health care by prioritizing those patient populations utilizing services for receipt of additional support. Processes and systems to identify and address these biases are critical to an equitable population health management strategy and preventing exacerbation of existing health disparities.

Covered California recommends referring to the Chicago Booth Center for Applied Artificial Intelligence Algorithmic Bias Playbook for an explanation of algorithmic bias and steps health care services entities can take to identify and address bias in algorithms in use and implement best practices for use of algorithms. The questions in this section 16.5.4 refer to the Playbook's four step process to address potential bias in algorithms.

References:

Algorithmic Bias Playbook Chicago Booth The Center for Applied Artificial Intelligence

https://www.chicagobooth.edu/research/center-for-applied-artificial-intelligence/research/algorithmic-bias/playbook

16.5.4.1 Does Applicant regularly inventory clinical algorithms in use by plan program staff, vendors, or contracted providers?
Single, Radio group.
1: Yes, describe: [100 words],
2: No

16.5.4.2 Does Applicant screen or assess clinical algorithms for bias?
Single, Radio group.
1: Yes, describe: [100 words],
2: No

16.5.4.3 If identified, has Applicant taken steps to improve or suspend the use of biased algorithms?
Single, Radio group.

1: Yes, describe: [100 words],
2: No
3: Not applicable, Applicant does not assess clinical algorithms for bias

16.5.4.4 Has Applicant implemented business processes to prevent future algorithmic bias?
Single, Radio group.
1: Yes, describe: [100 words],
2: No

16.6 Affordability and Cost

16.6.1 Demonstrating Action on High-Cost Pharmaceuticals

All questions are required for new entrant Applicants. All questions should be answered at the Issuer level, not product level.

Appropriate treatment with pharmaceuticals is often the best clinical strategy for treating conditions, including managing chronic and life-threatening conditions. At the same time, Covered California 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, including cost and clinical outcomes, is considered in the construction of formularies and delivery of pharmacy services.

16.6.1.1 Indicate which of the following sources Applicant uses to improve the value of pharmacy services. Choose all that apply.
Multi, Checkboxes.

1: ASCO Value of Cancer Treatment Options (ASCO- VF),
2: DrugAbacus (MSKCC) (DAbacus),
3: Drug Effectiveness Review Project (DERP),
4: The ICER Value Assessment Framework (ICER-VF),
5: CN Evidence Blocks (NCCN-EB),
6: United Kingdom’s National Institute for Health and Care Excellence (NICE),
7: Other (explain): [50 words]

16.6.1.2 Describe how Applicant considers value (maximizing outcomes achieved per dollar spent) and cost-effectiveness (relative value of different treatments) in its formulary design.
100 words.

16.6.1.3 Describe Applicant's specialty pharmacy and biologics management strategy.
100 words.

16.6.1.4 Does Applicant promote and use biosimilar drugs?
Single, Radio group.
1: Yes, describe: [50 words],
2: No

16.6.1.5 Does Applicant provide decision support for prescribers and Enrollees in selecting appropriate, efficacious, high-value treatments and more cost effective alternatives when applicable?
Single, Radio group.
1: Yes, describe: [50 words],
2: No

16.6.2 Patient-Centered Information and Support

All questions are required for new entrant Applicants. All questions should be answered at the Issuer level, not product level.

Enrollees are empowered to engage in their medical decision-making process when they have access to timely health information. Covered California is committed to ensuring that Enrollees have access to 1) provider-specific cost shares for common inpatient, outpatient, and ambulatory services, 2) costs of prescription drugs, 3) member specific real-time understanding of accumulations toward deductibles and out of pocket limits, 4) quality information on network providers, and 5) decision-making tools to inform decisions on appropriate care.

16.6.2.1 Does Applicant provide a cost tool for Enrollees?
Multi, Checkboxes.
1: Web based cost tool,
2: App based cost tool,
3: None,
4: Other; explain [50 words]

16.6.2.2 Does Applicant provide cost estimator tools for common inpatient, outpatient, and ambulatory service to Enrollees?
Single, Radio group.
1: Yes, describe: [50 words],
2: No

16.6.2.3 Indicate the quality information available that enables Enrollees when searching for providers based on quality performance in selecting a primary care clinician or elective specialty and hospital providers. Indicate the quality information displayed in Applicant's provider search tools in the table below.

Tool	*Quality Information Available*	*Details*
Provider Search	*Multi, Checkboxes.* 1: Rankings and ratings, 2: Patient Experience (CAHPS), 3: Awards and recognitions, 4: Accreditations, 5: Certifications, 6: Other, explain in details	*50 words.*

16.6.2.4 Indicate the quality information available in Applicant's provider cost estimator in the table below.

Tool	*Quality Information Available*	*Details*

Provider Cost Estimator	*Multi, Checkboxes.* 1: Rankings and ratings, 2: Patient Experience (CAHPS), 3: Awards and recognitions, 4: Accreditations, 5: Certifications, 6: Other, explain in details	*50 words*

16.6.2.5 Indicate the quality information available in Applicant's other member cost tools in the table below.

Tool	*Quality Information Available*	*Details*
Other:	*Multi, Checkboxes.* 1: Rankings and ratings, 2: Patient Experience (CAHPS), 3: Awards and recognitions, 4: Accreditations, 5: Certifications, 6: Other, explain in details	*50 words.*

16.6.2.6 Describe how Applicant tracks utilization and effectiveness of the cost tools offered to Enrollees.
100 words.

16.6.2.7 Does Applicant provide a mechanism for Enrollees to check prescription drug cost shares?
Single, Radio group.
1: Yes, describe: [50 words],
2: No

16.6.2.8 Does Applicant provide a mechanism for Enrollees to compare provider and facility cost variation?
Single, Radio group.
1: Yes, describe: [50 words],
2: No

16.7 Participating in Quality Improvement Collaboratives

All questions are required for new entrant Applicants. All questions should be answered at the Issuer level, not product level.

16.7.1 Identify key quality improvement collaboratives and organizations in which Applicant is engaged in the following table.

Quality Collaborative	*Participation*	*How does Applicant engage with the collaborative?*	*Details*

American Joint Replacement Registry (AJRR) for California	*Single, Pull-down list.* 1: Participates, 2: Does not participate	*Multi, Checkboxes.* 1: Attends meetings, 2: Health plan representative serves as advisory member, 3: Submits data to collaborative, 4: Provides feedback on initiatives and projects, 5: Provides funding; explain the amount and nature of financial support	*50 words.*
Cal Health Care Compare	*Single, Pull-down list.* 1: Participates, 2: Does not participate	*Multi, Checkboxes.* 1: Attends meetings, 2: Health plan representative serves as advisory member, 3: Submits data to collaborative, 4: Provides feedback on initiatives and projects, 5: Provides funding; explain the amount and nature of financial support	*50 words.*
California Maternal Quality Care Collaborative (CMQCC)	*Single, Pull-down list.* 1: Participates, 2: Does not participate	*Multi, Checkboxes.* 1: Attends meetings, 2: Health plan representative serves as advisory member, 3: Submits data to collaborative, 4: Provides feedback on initiatives and projects, 5: Provides funding; explain the amount and nature of financial support	*50 words.*
Collaborative Healthcare Patient Safety Organization (CHPSO)	*Single, Pull-down list.* 1: Participates, 2: Does not participate	*Multi, Checkboxes.* 1: Attends meetings, 2: Health plan representative serves as advisory member, 3: Submits data to collaborative, 4: Provides feedback on initiatives and projects, 5: Provides funding; explain the amount and nature of financial support	*50 words.*
California Improvement Network (CIN) This list for CIN partners can be found at: https://www.chcf.org/program/california-improvement-network/partners/	*Single, Pull-down list.* 1: Participates, 2: Does not participate	*Multi, Checkboxes.* 1: Attends meetings, 2: Health plan representative serves as advisory member, 3: Submits data to collaborative, 4: Provides feedback on	*50 words.*

		initiatives and projects, 5: Provides funding; explain the amount and nature of financial support	
California Right Meds Collaborative	*Single, Pull-down list.* 1: Participates, 2: Does not participate	*Multi, Checkboxes.* 1: Attends meetings, 2: Health plan representative serves as advisory member, 3: Submits data to collaborative, 4: Provides feedback on initiatives and projects, 5: Provides funding; explain the amount and nature of financial support	*50 words.*
Leapfrog	*Single, Pull-down list.* 1: Participates, 2: Does not participate	*Multi, Checkboxes.* 1: Attends meetings, 2: Health plan representative serves as advisory member, 3: Submits data to collaborative, 4: Provides feedback on initiatives and projects, 5: Provides funding; explain the amount and nature of financial support	*50 words.*
Symphony Provider Directory	*Single, Pull-down list.* 1: Participates, 2: Does not participate	*Multi, Checkboxes.* 1: Attends meetings, 2: Health plan representative serves as advisory member, 3: Submits data to collaborative, 4: Provides feedback on initiatives and projects, 5: Provides funding; explain the amount and nature of financial support	*50 words.*
Health Care Payments Data (HPD) System	*Single, Pull-down list.* 1: Participates, 2: Does not participate	*Multi, Checkboxes.* 1: Attends meetings, 2: Health plan representative serves as advisory member, 3: Submits data to collaborative, 4: Provides feedback on initiatives and projects, 5: Provides funding; explain the amount and nature of financial support	*50 words.*
Other similar collaboratives or initiatives, explain in details section			*50 words.*

16.8 Data Sharing and Exchange

All questions are required for new entrant Applicants. All questions should be answered at the Issuer level, not product level.

To improve the quality of care and successfully manage costs, successful Applicants will be required to participate in a Health Information Exchange (HIE) by December 31, 2025 with a goal of enhancing exchange of data along the patient, provider, hospital, and payer continuum. Covered California 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. Contracted QHP Issuers must participate in the Integrated Healthcare Association's (IHA) Align.Measure.Perform (AMP) Programs to aggregate data by December 31, 2025. In this section, Applicants will be assessed on the extent to which clinical data exchange is occurring, plans to improve data exchange, and the extent to which they are engaging with other payers and stakeholders to support data aggregation.

16.8.1 Describe Applicant's efforts to improve the routine exchange of timely information and clinical data with providers to support the delivery of high-quality care, including participation in a Health Information Exchange (HIE). Applicant must address each of the following:

- Initiatives to improve the routine exchange of data to improve the quality of care, such as collecting clinical data to supplement annual HEDIS data collection and self-reported race and ethnicity identity.
- Any real-time or near real-time actionable data, such as pertaining to Emergency Department visits, the Applicant shares with providers.
- Whether Applicant provides resources or incentives to providers to participate in HIEs.
- Describe any data exchange initiatives that enhance health equity with an emphasis on supporting enhanced demographic and social risk factor data capture and facilitation of the exchange of community health resources and information.

200 words.

16.8.2 Identify the HIE initiatives and statewide or regional initiatives in which Applicant is engaged and explain how Applicant participates.

California HIEs *Indicates HIE(s) that have membership in the California Trusted Exchange Network (CTEN)	*Applicant HIE participation*	*Details*
Manifest MedEx * (formerly CalIndex)	*Multi, Checkboxes.* 1: Applicant receipt of information from HIE(s), 2: Applicant dissemination of information to an HIE(s), 3: Other, explain in details, 4: Applicant does not participate	*100 words.*

Los Angeles Network for Enhanced Services* (LANES)	*Multi, Checkboxes.* 1: Applicant receipt of information from HIE(s), 2: Applicant dissemination of information to an HIE(s), 3: Other, explain in details, 4: Applicant does not participate	*100 words.*
Orange County Partnership Regional Health Information Organization* (OCPRHIO)	*Multi, Checkboxes.* 1: Applicant receipt of information from HIE(s), 2: Applicant dissemination of information to an HIE(s), 3: Other, explain in details, 4: Applicant does not participate	*100 words.*
San Diego Health Connect*	*Multi, Checkboxes.* 1: Applicant receipt of information from HIE(s), 2: Applicant dissemination of information to an HIE(s), 3: Other, explain in details, 4: Applicant does not participate	*100 words.*
Santa Cruz Health Information Organization (HIO) *	*Multi, Checkboxes.* 1: Applicant receipt of information from HIE(s), 2: Applicant dissemination of information to an HIE(s), 3: Other, explain in details, 4: Applicant does not participate	*100 words.*
Other	*Multi, Checkboxes.* 1: Applicant receipt of information from HIE(s), 2: Applicant dissemination of information to an HIE(s), 3: Other, explain in details, 4: Applicant does not participate in any HIE., 5: N/A	*100 words.*

16.8.3 Provide information regarding the extent of Applicant's participation in HIEs.

	Response
Number of individual contracted clinicians that participate in HIEs	*Integer.*
Percent of individual contracted clinicians that participate in HIEs (Calculated as number of individual clinicians that participate in HIEs divided by total number of individual clinicians contracted with Applicant)	*Percent.*
Number of contracted hospitals that participate in HIEs	*Integer.*
Percent of contracted hospitals that participate in HIEs (Calculated as number of hospitals that participate in HIEs divided by total number of hospitals contracted with Applicant)	*Percent.*
Describe Contractor’s activities to promote HIE participation by hospitals and individual clinicians.	*75 words.*

16.8.4 Report the number and percent of Applicant's Enrollees accessing their Patient Access Application Programming Interface (API).

	Response
Number of Enrollees accessing their Patient Access API	*Integer.*
Percent of Enrollees accessing their Patient Access API	*Percent.*

16.8.5 Identify the data aggregation initiatives in which Applicant is engaged in to support aggregation of claims or other information across payers and describe its participation.
Multi, Checkboxes.
1: Integrated Health Association (IHA) Align Measure Perform (AMP) Commercial HMO and Commercial ACO program,
2: IHA Encounter Data Initiative,
3: IHA Cost and Quality Atlas,
4: IHA Provider Directory Utility (Symphony),
5: Cal Hospital Compare,
6: California Maternity Quality Care Collaborative (CMQCC),
7: Other, including any description of participation: [100 words],
8: Does not participate in any data aggregation initiatives.

16.8.6 If Applicant does not currently participate in IHA Align. Measure. Perform (AMP) programs, describe the status of Applicant's progress towards participating in such programs.
Single, Radio group.
1: N/A, Applicant currently participates in IHA AMP programs,
2: Does not currently participate in IHA AMP programs, [100 words]

16.8.7 Provide details on the status of electronic information exchange to notify primary care providers of Admission, Discharge, Transfer (ADT) events for Covered California Enrollees.

	Response
Applicant has a process to support and monitor its contracted hospitals in their implementation of ADT data exchange with primary care providers for its Covered California Enrollees.	*Single, Radio group.* 1: Yes, 2: No
Describe actions taken by Applicant to support and monitor its contracted hospitals in their implementation of ADT data exchange with primary care providers for its Covered California Enrollees.	*75 words.*
Number of hospitals that have implemented ADT notification for Covered California Enrollees.	*Integer.*
Percent of hospitals that have implemented ADT notification for Covered California Enrollees (Calculated as number of hospitals that have implemented ADT notification for Covered California Enrollees divided by total number of hospitals contracted with Applicant).	*Percent.*
Describe mechanisms in place to assist those hospitals not yet exchanging ADT data to primary care providers for Covered California Enrollees.	*75 words.*

17 Health Plan Proposal

All questions are required for all Applicants. All questions should be answered at the Issuer level, not product level.

Applicant must submit a health plan proposal in accordance with all requirements outlined in this section.

In addition to being guided by its mission and values, Covered California'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. Covered California 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.

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 certification plan year Patient-Centered Benefit Plan Designs. The same provider network type must be used for each QHP in the standard set of QHPs. Applicant's proposal must include coverage of its entire licensed geographic service area. Applicant may not submit a proposal that includes a tiered hospital, physician, or pharmacy network. Applicants must adhere to Covered California's standard benefit plan designs and the requirements in this section without deviation unless approved by Covered California.

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 in accordance with the Patient-Centered Benefit Plan Designs. Additionally, Applicant may submit proposals to offer additional QHPs for consideration. The additional QHP offerings proposed must be differentiated by product or network.

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, Covered California requires Applicant 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 Applicant's standard Bronze Plan, the zero-cost share AI/AN variation of the Bronze HDHP must be offered to consumers instead of the standard Bronze Plan variation. The zero-cost share AI/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. Applicant may not offer the zero-cost share AI/AN variation at the higher metal levels within the set of QHPs. However, Applicants offering

the additional QHPs, that do not include a Bronze Plan, must offer the AI/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 AI/AN plan variation because the member cost sharing differs depending on the provider sought by the member. Limited cost share AI/AN plan variations must be offered for each QHP.

Applicant must cooperate with Covered California 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.

17.1 Applicant must certify that its proposal includes all four metal tiers (bronze, silver, gold, and platinum) and catastrophic for each health product it proposes to offer in a rating region. If not, Applicant must describe how it will meet the requirement to offer a product with all metal levels.
Single, Radio group.
1: Yes, proposal meets requirements,
2: No: [500 words]

17.2 Applicant must confirm that it will adhere to Covered California 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

17.3 Preliminary Premium Proposals.

Final negotiated and accepted premium rates shall be in effect for coverage effective January 1, 2025. Premium proposals are considered preliminary and may be subject to negotiation as part of QHP certification and selection process. The final negotiated premium rates must align with the product rate filings that will be submitted to the applicable regulatory agency. Premium proposals must be submitted with the Application. Premiums may vary by geographic area, family size, and age as permitted by State law, including the requirements of State Regulators regarding rate setting and rate variation set forth at Health and Safety Code §§ 1357.512 and 1399.855, Insurance Code §§ 10753.14 and 10965.9, 10 CCR § 2222.12 and, as applicable, other laws, rules, and regulations, including, 45 C.F.R. § 156.255(b).

Applicant shall provide, in connection with any negotiation process as reasonably requested by Covered California, detailed documentation on Covered California-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 Covered California-specific rate development process. Covered California 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 Applicant's actuarial systems pertaining to Covered California-specific account. Applicant must confirm it will submit complete premium proposals for Individual products; the Unified Rate Review Template (URRT), the Supplemental Rate Review Template (SRRT), Actuarial

Memorandum and the Rates Data Template through System for Electronic Rate and Form Filing (SERFF) available at: https://www.qhpcertification.cms.gov/s/QHP.

Single, Pull-down list.
1: Confirmed templates will be completed and uploaded by the due date,
2: Not Confirmed templates will not be completed and uploaded by the due date

17.4 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. If entire proposed licensed geographic service area is not offered, Applicant must explain why.
Single, Radio group.
1: Yes, health plan proposal covers entire licensed geographic service area;
2: No, health plan proposal does not cover entire licensed geographic service area; [100 words]

17.5 Applicant must indicate if it is requesting changes to its licensed geographic service area with the regulator, and if so, submit a copy of the applicable exhibit filed with regulator.
Single, Radio group.
1: Yes, filing service area expansion, exhibit attached, [50 words],
2: Yes, filing service area withdrawal, exhibit attached, [50 words],
3: No, no changes to service area

17.6 Applicant must indicate the different products it intends to offer on Covered California in the individual market for the certification year. 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”.

Multi, Checkboxes.
1: Health Maintenance Organization (HMO)
2: Preferred Provider Organization (PPO)
3: Exclusive Provider Organization (EPO)
4: Other Network Type

17.7 Applicant must complete all tabs in Attachment L_QHP-IND-CCSB_Contracted Provider Organizations to indicate the contracted provider organizations (POs) in-network for each of the prospective QHP's proposed products (HMO, PPO, EPO, Other). Attachment L includes the Integrated Healthcare Association's (IHA) list of POs, with their associated unique IDs, as well as their county and region locations.

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

18 Health Maintenance Organization (HMO)

18.1 Benefit Design

All questions are required for all Applicants. All questions should be answered at the product level, not Issuer level.

18.1.1 Applicant must confirm all products offered will comply with the coverage year Patient-Centered Benefit Plan Designs (PCBPD). If not, Applicant must explain why.
Single, Radio group.
1: Confirmed,
2: Not confirmed, [200 words]

18.1.2 Applicant must confirm all guidelines and due dates will be followed as listed in the Appendix D_QHP-IND_Submission Guidelines_Plan Year 2025.
Single, Pull-down list.
1: Confirmed,
2: Not confirmed

18.1.3 Applicant must indicate if it is requesting approval for any cost-sharing deviations from the coverage year Patient-Centered Benefit Plan Designs. If yes, Applicant must submit Attachment C_QHP-IND_Patient-Centered Benefit Plan Design Deviations. In addition, Applicant must submit the same cost-sharing deviations to Applicant's applicable regulator for approval.
Note: Alternate benefit design proposals are not permitted in the Individual Marketplace. Covered California's decision whether to approve or deny QHP specific proposed deviations are on a case-by-case basis and are not considered an alternate benefit design.
Single, Pull-down list.
1: Yes, deviations requested, attached.
2: No, no deviations requested

18.1.4 Covered California encourages Applicant to offer 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 coverage year Patient-Centered Benefit Plan Design which includes all ten Essential Health Benefits. Failure to offer a product without pediatric dental will not be grounds for rejection of Applicant's application.
Single, Pull-down list.
1: Yes. Individual market QHPs proposed for coverage year include all ten Essential Health Benefits.,
2: No. Individual market QHPs proposed for coverage year do not include all ten Essential Health Benefits.

18.1.5 Applicant must indicate if proposed QHPs will include coverage of non-emergent out-of-network services. If yes, with respect to non-network, non-emergency claims, describe how non-emergent out-of-network coverage is communicated to enrollees in addition to the details provided in the Evidence of Coverage or Policy document. If no, describe how the lack of coverage for non-emergent out-of-network services coverage is communicated to enrollees, such as the Evidence of Coverage or Policy document.
Single, Radio group.
1: Yes, describe: [100 words],
2: No, describe: [100 words]

18.1.6 Applicant must confirm the coverage year Schedule of Benefits and Coverage (SBC), Evidence of Coverage (EOC) or Policy language describing proposed health Benefits will follow the requirements in the Appendix D_QHP-IND_Submission Guidelines_Plan Year 2025 and must comply with state and federal laws.
Single, Radio group.
1: Confirmed,
2: Not confirmed:

18.2 Benefit Administration

All questions are required for all Applicants. All questions should be answered at the product level, not Issuer level.

18.2.1 If Applicant's proposed QHPs will include the pediatric dental essential health benefit, Applicant must describe how it intends to embed this benefit. In the description of the option selected, Applicant must describe how it will ensure that the provision of pediatric dental benefits adheres to contractual requirements, including pediatric dental quality measures. Specifically address the following for the pediatric dental Essential Health Benefit:

- Activities conducted for consumer education and communication.
- Oversight conducted for dental quality and network management.
- If the benefit is subcontracted, state the name of the contractor, and describe any performance incentives included in the pediatric dental benefits subcontractor contract including metrics used for performance assessment.

Single, Radio group.
1: Offer benefit directly under full-service license: [100 words],
2: Subcontractor relationship: [100 words],
3: Not Applicable

18.2.2 Describe how Applicant administers child eye care benefits. Use the details section to specifically address the following:

- Activities conducted for consumer education and communication related to child eye care benefits.
- Oversight conducted for quality and network management.

If the benefit is subcontracted, state the name of the contractor, and describe any performance incentives included in the child eye care benefits subcontractor contract including metrics used for performance assessment.
Single, Radio group.
1: Offer benefit directly under full-service license: [200 words],
2: Subcontractor relationship: [200 words],
3: Other: [200 words]

18.2.3 Indicate how Applicant administers mental health and substance use disorder (MHSUD) benefits as either administered directly by Applicant or subcontracted to a contractor.
Single, Radio group.
1: Applicant offers benefit directly under full-service license,
2: Applicant offers benefit through subcontractor, state the name of the contractor: [50 words],
3: Other, describe: [50 words]

18.2.4 Describe activities Applicant conducts to educate and communicate to consumers about mental health and substance use disorder (MHSUD) benefits and how to access MHSUD services.

200 words.

18.2.5 Specify how Applicant monitors the following components of network management, access, and quality of care for its mental health and substance use disorder (MHSUD) provider network, either directly by Applicant or by a subcontractor.

Network Management, Access, and Quality Monitoring Components	*Monitoring Completed by Applicant or Subcontractor*		
Provider Network Development	*Single, Pull-down list.* 1: Applicant, 2: Subcontractor, 3: Both		
Network Adequacy	*Single, Pull-down list.* 1: Applicant, 2: Subcontractor, 3: Both		
Appointment Wait Times	*Single, Pull-down list.* 1: Applicant, 2: Subcontractor, 3: Both		
Clinical Quality Performance	*Single, Pull-down list.* 1: Applicant, 2: Subcontractor, 3: Both		
Patient Experience	*Single, Pull-down list.* 1: Applicant, 2: Subcontractor, 3: Both		
Cultural and Linguistic Concordance	*Single, Pull-down list.* 1: Applicant, 2: Subcontractor, 3: Both		
Referral Process between Physical Health and Behavioral Health Providers	*Single, Pull-down list.* 1: Applicant, 2: Subcontractor, 3: Both		
Care Coordination	*Single, Pull-down list.* 1: Applicant, 2: Subcontractor, 3: Both		
Telehealth	*Single, Pull-down list.* 1: Applicant, 2: Subcontractor, 3: Both		

18.2.6 Describe the oversight and accountability process for and any performance incentives associated with behavioral health provider network development.
100 words.

18.2.7 Describe the oversight and accountability process for and any performance incentives associated with behavioral health network adequacy.
100 words.

18.2.8 Describe the oversight and accountability process for and any performance incentives associated with behavioral health appointment wait times.
100 words.

18.2.9 Describe the oversight and accountability process for and any performance incentives associated with behavioral health clinical quality.
100 words.

18.2.10 Describe the oversight and accountability process for and any performance incentives associated with behavioral health patient experience.
100 words.

18.2.11 Describe the oversight and accountability process for and any performance incentives associated with behavioral health cultural and linguistic concordance.
100 words.

18.2.12 Describe the oversight and accountability process for and any performance incentives associated with the referral process between physical health and behavioral health Providers.
100 words.

18.2.13 Describe the oversight and accountability process for and any performance incentives associated with behavioral health care coordination.
100 words.

18.2.14 Describe the oversight and accountability process for and any performance incentives associated with behavioral health telehealth.
100 words.

18.2.15 Covered California supports the innovative use of technology to assist in higher quality, accessible, patient-centered care. Describe Applicant's ability to support telehealth consultations, either through a contractor or provided by the medical group or provider.
Multi, Checkboxes.
1: Plan does not offer or allow telehealth consultations,
2: Telehealth with interactive face to face dialogue (video and audio),
3: Telehealth with interactive dialogue over the phone,
4: Telehealth asynchronous store and forward,
5: Telehealth mobile health tools (reminders, alerts, monitoring) via text, instant messaging or other,
6: Remote patient monitoring,
7: e-Consult: provider-to-provider,
8: Other (specify): [20 words]

18.2.16 Do cost shares for telehealth services differ from the standard benefit design for that product?
Single, Radio group.
1: No, (no attachment),
2: Yes, Attachment D required

18.2.17 Provide information in the following chart to describe providers and telehealth vendors' telehealth capabilities to support provider-member consultations using technology. If Applicant

is not currently contracted with Covered California, provide a description of telehealth capabilities, and indicate whether those services will be offered to Covered California members.

	Network Provider Capability	Percent Network Provider with capability	Telehealth Vendor Capability	Details
1. Interactive face to face dialogue (video and audio) (Use as denominator total providers across all lines of business).	*Single, 1: network provider capability 2: capability not available with network provider*	*Percent.*	*Single, 1: network provider capability 2: capability not available with network provider*	*20 words.*
2. Interactive dialogue (audio only) (Use as denominator total providers across all lines of business).	*Single, 1: network provider capability 2: capability not available with network provider*	*Percent.*	*Single, 1: network provider capability 2: capability not available with network provider*	*20 words.*
3. Telehealth for behavioral health services with interactive face to face dialogue (video and audio). (Use as denominator total providers across all lines of business).	*Single, 1: network provider capability 2: capability not available with network provider*	*Percent.*	*Single, 1: network provider capability 2: capability not available with network provider*	*20 words.*
4. Telehealth for behavioral health services with interactive dialogue (audio only). (Use as denominator total providers across all lines of business).	*Single, 1: network provider capability 2: capability not available with network provider*	*Percent.*	*Single, 1: network provider capability 2: capability not available with network provider*	*20 words.*
5. Mobile health tools, such as reminders, alerts, monitoring via text, instant messaging, or other (Use as denominator total providers across all lines of business).	*Single, 1: network provider capability 2: capability not available with network provider*	*Percent.*	*Single, 1: network provider capability 2: capability not available with network provider*	*20 words.*
6. Remote patient monitoring (Use as denominator total provider across all lines	*Single, 1: network provider capability*	*Percent.*	*Single, 1: network provider capability*	*20 words.*

of business).	*2: capability not available with network provider*		*2: capability not available with network provider*	

18.2.18 Applicant must complete the following table.

	Network Provider	Details
1. Report the percent of providers with access to e-Consult: provider-to-provider (Use as denominator total providers across all lines of business).	*Percent.*	*20 words.*
2. Provide percentage of network physicians and/or physician groups and practices that are designated as having telehealth consultation services available (across all lines of business).	*Percent.*	*20 words.*
3. Report the percent of providers identified as available for store-and-forward asynchronous telehealth services (use as denominator total providers across all lines of business).	*Percent.*	*20 words.*
4. For physicians that are available to deliver telehealth consultations, what is the average wait time? If Applicant can provide average wait time, describe how that is monitored in the Details section.	*Compound, Pull-down list.* 1: On demand, 2: Within 4 hours, 3: Within same day, 4: Scheduled follow-up within 48 hours, 5: Other (describe): [100 words], 6: N/A	

18.2.19 Confirm Applicant reimburses providers for telehealth consultations conducted.

Single, Radio group.
1: Confirmed
2: Not confirmed

18.2.20 Describe the availability of web or telehealth consultations in languages other than English. Include details on how members are notified about the availability of interpreter services for telehealth. Specify all languages offered in response and distinguish between use of interpreter service and availability of in-language consultations in languages other than English..

200 words.

18.2.21 Describe how Applicant promotes telehealth (either through vendor or medical group) as an alternative to the Emergency Department for urgent health issues (describe specific engagement efforts and any specific contractual requirements related to this topic for vendors or medical groups).

200 words.

18.2.22 Describe how Applicant promotes integration and coordination of care between telehealth providers and in-person providers (primary care providers, specialists, etc.).

200 words.

18.2.23 Covered California requires contracted QHP Issuers to offer telehealth for behavioral health services. In the following table, indicate whether Applicant offers telehealth for behavioral health services by selecting which services are offered. Indicate how Applicant educates Covered California Enrollees on how to access services and how the information is displayed to Covered California Enrollees through Applicant's member portal and provider directory. If Applicant is not currently contracted with Covered California, provide a description of its telehealth capabilities, and indicate whether those services will be offered to Covered California Enrollees.

	Telehealth Offered	*Education Efforts*	*Details*
Applicant offers telehealth for behavioral health services	*Multi, Checkboxes.* 1: Telehealth for emergency behavioral health offered, 2: Telehealth for outpatient behavioral health (not integrated) offered, 3. Telehealth for inpatient behavioral health offered, 4. Telehealth for integrated primary care and behavioral health offered, 5. Remote monitoring (e.g., mobile health applications, self-management tools) offered, describe: [100 words] 6. Other, describe: [100 words] 7: No, Applicant does not offer telehealth for behavioral health services	*Multi, Checkboxes.* 1: Member welcome packets, 2: Educational emails, 3: Educational mailings, 4: Website notices or information, 5: Member portal notices or information, 6: Information available through provider directory, 7: Member app notices or information, 8: Information available through call center, 9: Other, describe	*100 words.*

18.2.24 Does Applicant use a behavioral health telehealth vendor?
Single, Radio group.
1: Yes, specify vendor: [20 words],
2: No

18.2.25 Report utilization of telehealth for behavioral health services in 2023.

Plan Year 2023 Utilization	Percent
Members who utilized a single telehealth for behavioral health service with a network provider or telehealth vendor.	*Percent.*
Members who utilized multiple telehealth for behavioral health services with a network provider or telehealth vendor	*Percent.*

18.2.26 Specific to behavioral health providers, describe how Applicant promotes integration and coordination of care between in-person providers and behavioral health telehealth providers.

200 words.

18.2.27 Describe the referral process and access timeline for members who need higher levels of behavioral health care in addition to or following a behavioral health telehealth visit.

200 words.

18.3 Provider Network

All questions are required for all Applicants. All questions should be answered at the product level, not Issuer level.

18.3.1 Applicant must indicate if the network it intends to offer on Covered California in the Individual market for the certification year is new or existing to Covered California and include the network name.

Single, Radio group.
1: New Network to Covered California, including an existing network with material changes [*10 words*],
2: Existing Network to Covered California with no material changes to current network [*10 words*]

18.3.2 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 the Covered California Provider Data Submission Guide. The provider network submission for the certification year must be consistent with what will be filed to the appropriate regulator for approval if Applicant is selected as a QHP Issuer. Covered California requires the information, as requested, to allow cross-network comparisons and evaluations.

Single, Pull-down list.
1: Attached, Applicant attesting to material changes to existing network or new network (confirming provider data is for the certification year),
2: Not attached, Applicant attesting to no material changes to existing plan year Covered California network for the certification year

18.3.3 Applicant must complete all tabs in Attachment E1_QHP-IND-CCSB_HMO Provider Network Tables, for their HMO Network.

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

18.3.4 Does Applicant conduct provider negotiations and manage its own network or does Applicant lease a network from another organization? If Applicant leases a network, Applicant must describe the length of the lease agreement, including start and end dates, along with the leasing organization and if the Applicant has the ability to influence provider contract terms.

Single, Radio group.
1: Applicant contracts and manages network,
2: Applicant leases network, describe [500 words]

18.3.5 Applicant must confirm that it will respond to and adhere to the requirements of Health & Safety Code, § 1367.03 or Insurance Code, § 10133.54 and any implementing regulations relating to consumer access to primary, specialty, behavioral health and hospital care based on enrollee access.

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

18.3.6 Applicant must confirm it tracks ethnic and racial diversity in the population and ensuring access to appropriate culturally competent providers, and must briefly describe its methodology, data and tools used to track ethnic and racial diversity in the population and ensuring access to appropriate culturally concordant providers, including relevant measurement criteria and benchmarks for ensuring adequate access.
Single, Radio group.
1: Confirmed, describe [200 words],
2: Not Confirmed, describe [200 words]

18.3.7 Applicant must confirm that it will respond to and adhere to the requirements of Health & Safety Code, § 1367.03 or Insurance Code, § 10133.54 for assessing enrollee wait times for appointments with primary, specialty, and behavioral health providers.
Single, Pull-down list.
1: Confirmed,
2: Not Confirmed

18.3.8 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, Pull-down list.* 1: Yes, 2: No, 3: Not Applicable
Does applicant allow out-of-state (non-emergency) providers to participate in networks to serve Covered California enrollees? If yes, explain in detail how this coverage is offered.	*Compound, Pull-down list.* 1: Yes: [200 words], 2: No, 3: Not Applicable

18.3.9 Describe any plans for network changes, by product, including any new medical groups or hospital systems that Applicant would like to highlight for Covered California attention.
100 words.

18.4 Delivery System and Payment Strategies to Drive Quality

Attachment 1 of the Covered California Qualified Health Plan (QHP) Issuer Contract embodies Covered California's vision for delivery system reform and serves as a roadmap to delivery system improvements. A number of the delivery system and payment strategy requirements in Attachment 1 meet the federal Quality Improvement Strategy (QIS) requirements.

The Patient Protection and Affordable Care Act (§1311(g)(1)) requires periodic reporting to Covered California of activities a QHP Issuer 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, reducing hospital readmissions, improving patient safety, and reducing medical errors, implementing wellness and health promotion activities, and reducing health and

health care disparities. QHP Issuers must implement and report on a quality improvement strategy or strategies consistent with the standard of section 1311(g) of the ACA.

Applicants that are currently operating in Covered California are required to complete QIS workplans as part of the Application process. The following strategies meet the QIS requirements and Applicants must submit QIS workplans:

- Advanced Primary Care
- Appropriate Use of Cesarean Sections
- Hospital Quality, Value, and Patient Safety

QHP certification is conditioned on Applicant developing a multi-year QIS and reporting year-to-year activities and progress on each initiative area.

Applicants that are not currently operating in Covered California are not required to complete the QIS workplan updates as part of the Application for 2025 but must review Attachment 1 with the understanding that engagement in the QIS and Attachment 1 initiatives will be contractually required and measured in the future if Applicant contracts with Covered California.

18.4.1 Provider Networks Based on Value

All questions are required for new entrant Applicants. All questions should be answered at the product level, not Issuer level.

Applicant shall curate and manage its network(s) to address variation in quality and cost performance across network hospitals and providers, with a focus on improving the performance of hospitals and providers. Applicant shall measure, analyze, and reduce variation to achieve consistent high performance for all network hospitals and providers. Applicant shall hold its contracted hospitals and providers accountable for improving quality and managing cost and provide support to its contracted hospitals and providers to improve performance. The following questions address Applicant's ability to track and address variation in quality and cost performance across network hospitals and providers.

18.4.1.1 In the following table, Applicant must identify key quality and cost sources and measures that the Applicant uses to evaluate providers and hospitals for determining initial and ongoing network inclusion, and briefly explain how each measure is used, including if and how the measure is used for performance payment. Applicant must also describe any additional criteria used to determine network inclusion.

	Data Source	*Purpose*	*Provide examples if response #4 selected for Purpose*	*Provide details if Other selected in Data Source or Purpose*
Hospital Quality	*Multi, Checkboxes.* 1: Cal Hospital Compare data, 2: California Maternal Quality Collaborative data, 3: Leapfrog Group data,	*Multi, Checkboxes.* 1: Used for initial contracting assessment, 2: Used for re-contracting assessment, 3: Has been used for incentive or Pay for Performance payments, 4: Has been used for	*100 words.*	*100 words.*

	4: CMS Hospital Quality Reporting, 5: Program or another CMS program, 6: Designated Center of Excellence (COE), 7: Other, explain	termination or exclusion (give examples), 5: Other, explain		
Hospital Cost	*Multi, Checkboxes.* 1: Percent of Medicare rates, 2: Diagnosis-Related Group (DRG) costs, 3: Comparison to other hospital costs in geographic area, 4: Comparison to other hospital costs by decile or other method, 5: CMS Hospital Price Transparency data, 6: Other, explain	*Multi, Checkboxes.* 1: Used for initial contracting assessment, 2: Used for re-contracting assessment, 3: Has been used for incentive or Pay for Performance payments, 4: Has been used for termination or exclusion (give examples), 5: Other, explain	*100 words.*	*100 words.*
Additional Criteria	*100 words.*	*100 words.*	*100 words.*	*100 words.*

18.4.1.2 In the following table, Applicant must identify key quality and cost sources and measures that the Applicant uses to evaluate providers for determining initial and ongoing network inclusion, and briefly explain how each measure is used, including if and how the measure is used for performance payment. Applicant must also describe any additional criteria used to determine network inclusion.

	Data Source	*Purpose*	*Provide examples if response #4 selected for Purpose*	*Provide details if Other selected in Data Source or Purpose*
Provider Quality	*Multi, Checkboxes.* 1: Integrated Healthcare Association data, 2: Office of Patient Advocate data, 3: Other, explain	*Multi, Checkboxes.* 1: Used for initial contracting assessment, 2: Used for re-contracting assessment, 3: Has been used for incentive or Pay for Performance payments, 4: Has been used for termination or exclusion (give examples), 5: Other, explain	*100 words.*	*100 words.*
Provider Cost	*Multi, Checkboxes.* 1: Total Cost of Care data, 2: Comparison to other physician or physician	*Multi, Checkboxes.* 1: Used for initial contracting assessment, 2: Used for re-	*100 words.*	*100 words.*

	groups in geographic area, 3: Other, explain	contracting assessment, 3: Has been used for incentive or Pay for Performance payments, 4: Has been used for termination or exclusion (give examples), 5: Other, explain		
Additional Criteria	*100 words.* Nothing required	*100 words.* Nothing required	*100 words.*	*100 words.*

18.4.2 Advanced Primary Care

All questions required for currently contracted Applicants. Questions 18.4.2.1 and 18.4.2.2 are required for new entrant Applicants. All questions should be answered at the product level, not Issuer level.

Covered California recognizes that providing high-quality, equitable, and affordable care requires a foundation of effective and patient-centered primary care. Advanced primary care is patient-centered, accessible, team-based, data driven, supports the integration of behavioral health services, and provides care management for patients with complex conditions. Advanced primary care is supported by alternative payment models such as population-based payments and shared savings arrangements. Applicant shall actively promote the development and use of advanced primary care models that promote access, care coordination, and quality while managing the total cost of care. The following questions address Applicant's ability to match at least 95% of enrollees with a primary care clinician and increase the proportion of providers paid under a payment strategy that promotes advanced primary care.

This strategy meets the QIS requirements.

18.4.2.1 Report the percentage of Covered California Enrollees who either selected or were matched with a primary care clinician in 2023 in Attachment J_QHP-IND_Run Charts. If Applicant had no Covered California business in 2023, report full 2023 book of business excluding Medicare. Applicants currently contracted with Covered California must enter the number and percentage of providers paid under each model reported in the Certification Application for 2022, 2023 and 2024 as well. Report data by product (HMO, PPO, EPO, Other).

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

Attached Document(s): Attachment J - QHP IND Run Charts.xlsx

18.4.2.2 Report all types of payment methods used for primary care services and number of providers paid under each model in 2023 in Attachment J_QHP-IND_Run Charts using the alternative payment models (APM) outlined in the Health Care Payment Learning Action & Action Network (HCP LAN) Alternative Payment Model APM Framework. If Applicant had no Covered California business in 2023, report full 2023 book of business excluding Medicare. Applicants currently contracted with Covered California must enter the number and percentage of providers paid under each model reported in the Certification Applications for 2021, 2022, 2023 and 2024 as well. Report data by product (HMO, PPO, EPO, Other).

References:
HCP LAN Alternative Payment Model APM Framework: http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf

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

18.4.2.3 Complete Attachment K1_QHP-IND-CCSB_QIS 1 Work Plan - Advanced Primary Care to describe updates on progress made since the previous QIS submission in each part of the primary care goals, and planned activities. Address each of the following in the work plan narrative:

- Updates on the PCP matching initiative, including a status report, feedback on the enrollee experience, challenges, and suggestions (if applicable)
- Progress implementing alternative payment models for primary care to align with Category 3 or 4 APMs described in the APM Framework including: activities conducted, data collected and analyzed, and results
- Describe any support or technical assistance (financial, staffing, educational, etc.) that Applicant or multi-insurer collaborative is providing to primary care providers to support their efforts towards accessible, data-driven, team-based care
- Implementation of advanced primary care initiatives and quality improvement activities to improve health outcomes on any of the QTI measures:
- Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%) (NQF #0575)
- Controlling High Blood Pressure (NQF #0018)
- Colorectal Cancer Screening (NQF #0034)
- Childhood Immunization Status (Combo 10) (NQF #0038)
- Further implementation plans for 2024 including milestones and targets for 2024 and 2025
- Known or anticipated barriers in implementing QIS activities and progress of mitigation activities

Single, Pull-down list.
1: Attached,
2: Not attached, [50 words]

18.4.3 Integrated Delivery Systems and Accountable Care Organizations

Question 18.4.3.1 is required for currently contracted Applicants. All questions are required for new entrant Applicants. All questions should be answered at the product level, not Issuer level.

Evidence suggests the adoption and expansion of integrated, coordinated, and accountable systems of care such as Integrated Delivery Systems (IDSs) or Accountable Care Organization (ACOs) can lead to improved quality and reduced costs. An IDS is defined as an organized healthcare delivery system in which payers, hospitals, and providers coordinate to provide patient care, integrate care across settings, and share responsibility for patient outcomes and resource use. IDS partners are generally managed by the same organization. An ACO is defined as a system of population-based care coordinated across the continuum including

multidisciplinary physicians and physician groups, hospitals, and ancillary providers with combined risk sharing arrangements and shared incentives between providers or between payers and providers. Ideally ACO partners are held accountable for nationally recognized clinical, financial, and operational performance. As providers accept more accountability under this provision, Applicant shall ensure that providers have the capacity to manage the risk. There are many variations of ACO implementation with evidence suggesting that there are key characteristics of an ACO model that influence its success. The following questions address Applicant's ability to increase enrollment in IDS or ACO models in its Covered California network and solicit information about the structure of Applicant's IDS and ACO models.

18.4.3.1 Using the definition for IDS or ACO above, report the number and percentage of Covered California Enrollees and total California Enrollees who are managed under an IDS or ACO in 2023 in Attachment J_QHP-IND-CCSB_Run Charts. Applicants currently contracted with Covered California must enter the percentage reported in the Certification Applications for 2022, 2023 and 2024 as well. If Applicant had no Covered California business in 2023, report full 2023 book of business excluding Medicare. Report data by product (HMO, PPO, EPO, Other).

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

18.4.3.2 Applicant must identify key components of the Applicant's IDS or ACO model and must briefly explain how each component is implemented.

	Response	*Details*
Regulated ACO or IDS entity status: Insurer	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Regulated ACO or IDS entity status: Provider with Knox Keene license	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Participation: 2-way (health plan/provider organization)	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Participation: 3-way (health plan/provider organization/hospital)	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Participation: 4-way (health plan/provider organization/purchaser)	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Participation: Includes advanced primary care providers or patient-centered medical homes	*Single, Pull-down list.*	*50 words.*

	1: Yes, 2: No	
Participation: Other	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Base payment: Global capitation	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Base payment: Professional capitation only	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Base payment: Separate professional capitation and hospital capitation	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Base payment: Fee for service	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Base payment: Other	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Performance payment: Two-sided shared savings (upside/downside risk)	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Performance payment: One-sided shared savings (upside risk)	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Performance payment: Pay for performance quality bonus	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Performance payment: Other	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Leadership: Physician-led	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Leadership: Hospital-led	*Single, Pull-down list.*	*50 words.*

	1: Yes, 2: No	
Leadership: Plan-led	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Leadership: Other	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Leadership: Jointly led by physician and hospitals	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Member assignment: Attribution algorithm	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Member assignment: Patient selection	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Member assignment: Health plan assignment	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Member assignment: Other	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Timing: Retrospective	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Timing: Prospective	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Timing: Other	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*

18.4.3.3 Applicant must provide, as attachments, documents related to IDSs or ACOs or confirm Applicant will submit the documents as they become available.

	Response

(File titled Provider 1a): Applicant's quality and cost measures used to track progress and success of IDS or ACO providers.	*Single, Pull-down list.* 1: Attached, 2: Not attached
(File titled Provider 1b): Example of Applicant report to its IDS or ACO providers on its quality of care and financial performance, including benchmarking relative to performance improvement goals or market norms.	*Single, Pull-down list.* 1: Attached, 2: Not attached
(File titled Provider 1c): Confirm Applicant will submit a copy of Applicant's 2023 IHA Align Measure Perform (AMP) Commercial ACO report when it becomes available, if Applicant participates in the program.	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed, 3: N/A

18.4.4 Appropriate Use of Cesarean Sections

All questions are required for currently contracted Applicants. Questions 18.4.4.1 – 18.4.4.6 are required for new entrant Applicants. All questions should be answered at the product level, not Issuer level.

According to the World Health Organization, maternal health refers an individual's health during pregnancy, childbirth, and the postpartum period. Covered California is committed to addressing all three phases to provide a comprehensive approach to maternal health. Cesarean sections (C-sections) can be lifesaving, but significant numbers of low-risk, first-time pregnancies are undergoing this invasive surgery when it is not medically necessary. Reducing the rate of unnecessary C-sections improves health outcomes and patient safety.

Applicant must: 1) Progressively adopt physician and hospital payment strategies so that revenue for labor and delivery only supports medically necessary care and no financial incentive exists to perform a low-risk Nulliparous Term Singleton Vertex (NTSV) Cesarean Section (C-Section). 2) Promote improvement work through the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center (MDC), so that all maternity hospitals achieve an NTSV C-Section rate of 23.9% or lower or are at least working toward that goal. 3) Consider a hospital's NTSV C-section rate, improvement trajectory, and willingness to engage in coaching as part of its maternity hospital contracting decisions and terms. Covered California does not expect Contractor to base poor performance, and potential network removal decisions, on one measure alone.

Smart Care California has outlined three payment strategies to align payment with medically necessary use of C-sections:

- Adopt a blended case rate payment for both physicians and hospitals;
- Include a NTSV C-section metric in existing hospital and physician quality incentive programs; and
- Adopt population-based payment models, such as maternity episode payment models or inclusion in Integrated Delivery System, ACO, or similar financial accountability arrangement.

The following questions address Applicant's ability to meet the requirements for the appropriate use of cesarean sections.

Applicants that are not currently operating in Covered California are expected to adopt a payment methodology structured to support only medically necessary care with no financial incentive to perform C-sections for all contracted physicians and hospitals serving enrollees. This strategy meets the QIS requirements.

18.4.4.1 Describe how Applicant is measuring overuse of Cesarean Sections.
100 words.

18.4.4.2 Describe how Applicant is implementing Smart Care California guidelines (https://www.iha.org/wp-content/uploads/2020/12/c-section_menu_of_payment_and_contracting_options.pdf) to promote best practices to reduce unnecessary Cesarean Sections.

	Guideline	*Implementation*	*Description*
1	Adopt a blended case rate payment for both physicians and hospitals.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*
2	Include a NTSV C-section metric in existing hospital and physician quality incentive programs.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*
3	Adopt population-based payment models, such as ACO-like arrangements.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*
4	Pay less for C-sections without medical indication and for scheduled non-medically necessary repeat C-sections.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*
5	Require or incent hospital participation in CMQCC's Maternal Data Center (MDC).	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*

6	Implement network quality improvement requirements with a deadline.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*

18.4.4.3 Report number of all network hospitals reporting to the California Maternity Quality Care Collaborative (CMQCC) Maternal Data Center (MDC) in 2023 in Attachment J_QHP-IND_Run Charts. A list of all California hospitals participating in the MDC can be found here: https://www.cmqcc.org/about-cmqcc/member-hospitals. Applicants currently contracted with Covered California must enter the percentage reported in the Certification Applications for 2022, 2023, and 2024 as well. If Applicant had no Covered California business in 2023, report full 2023 book of business excluding Medicare.

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

18.4.4.4 Contracted QHP Issuers must adopt value-based payment strategies structured to support only medically necessary care with no financial incentive to perform non-medically necessary NTSV C-sections for all contracted physicians and hospitals by year end 2023 or in the first year of the QHP certification if after 2023. These value-based payment strategies include: 1) Blended case rate payment for both physicians and hospitals; 2) Including a NTSV C-section metric in existing hospital and physician quality incentive programs; and 3) Population-based payment models, such as maternity episode payment models.

Report models and number of network hospitals paid using each payment strategy in 2023 in Attachment J_QHP-IND Run Charts. 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 non-medically necessary C-Section delivery.

Applicants currently contracted with Covered California must enter the percentages reported in the Certification Applications for 2020, 2021, 2022, 2023, and 2024 as well. If Applicant had no Covered California business in 2023, report full 2023 book of business excluding Medicare.
Single, Pull-down list.
1: Attached,
2: Not attached

18.4.4.5 Applicant must confirm that all network physicians are paid on a case rate for deliveries and that payment is the same for both vaginal and non-medically necessary C-section delivery. Confirm that all network physicians are paid on a case rate for deliveries and that payment is the same for both vaginal and C-section delivery.

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

18.4.4.6 If Applicant selected not confirmed in question 18.4.4.5, that all network physicians are paid on a case rate for deliveries and that payment is the same for both vaginal and non-medically necessary C-section delivery, Applicant must complete the following table.

Payment Strategy	**Description**	**Percent of Physicians Paid Under Strategy**	**Numerator**	**Denominator**
Strategy 1: Blended Case Rate	*50 words.*	*Percent.*	*Integer.*	*Integer.*
Strategy 2: Provide quality bonuses for physicians that attain NTSV C-section rate goal or make improvements in reducing NTSV C-sections	*50 words.*	*Percent.*	*Integer.*	*Integer.*
Strategy 3: Population-based payment models	*50 words.*	*Percent.*	*Integer.*	*Integer.*
Strategy 4: Other (explain)	*50 words.*	*Percent.*	*Integer.*	*Integer.*
Strategy 5: Other (explain)	*50 words.*	*Percent.*	*Integer.*	*Integer.*
Strategy 6: Other (explain)	*50 words.*	*Percent.*	*Integer.*	*Integer.*

18.4.4.7 Maternal health disparities exist across the full spectrum of maternal health, from preconception, to pregnancy, and the postpartum period. Disparities in maternal health disproportionately affect Black and Latino populations at higher rates than other racial groups. Reducing and eliminating gaps in maternal health requires a multifaceted approach. Indicate and describe in the following table any of the activities undertaken by Applicant to identify and reduce maternal health disparities.

Activities to Identify and Reduce Maternal Health Disparities	*Response*	*Details*
1. Engages with contracted providers to improve performance on maternal health measures, specify measures and if engagement includes performance reviews, evidence-based interventions, or participation in quality collaboratives	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
2. Identifies maternal health disparities among its maternity Enrollees	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
3. Engages with hospitals and providers to address maternal health disparities. Specify if engagement includes quarterly performance reviews, data analysis on race and ethnicity of its maternity Enrollees and outcomes, or implementation of corrective action plans	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
4. Ensures that its network perinatal providers, staff, and facilities are complying with the California Dignity in Pregnancy and Childbirth Act, which mandates	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*

implicit bias training to reduce the effects of implicit bias in pregnancy, childbirth, and postnatal care		
5. Supports its maternity Enrollees, such as access to culturally and linguistically appropriate maternity care, referrals to group prenatal care or community-centered care models for patients, in home lactation and nutrition consultants, doula support for prenatal, labor, delivery, and postpartum care, and related services	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
6. Ensures that its maternity Enrollees are aware of the supportive services available to them, including the services described in (5) above, and that Enrollees know how to access these services	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
7. Works to promote and encourage all in-network hospitals that provide maternity services to use the resources provided by California Maternity Quality Care Collaborative (CMQCC) and the California Department of Public Health's Maternal, Child and Adolescent Health (MCAH) Division to address maternal health disparities	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*

18.4.4.8 Complete Attachment K2_QHP-IND-CCSB_QIS 2 Work Plan – Appropriate Use of C-Sections to describe updates on progress made since the last QIS submission with regards to promoting appropriate use of Cesarean-Sections (C-Sections). Address each of the following in the work plan narrative:

- Description of how Applicant engages with its network hospitals to reduce NTSV (non-medically necessary) C-Section rates to 23.9% or less
- Description of its value-based payment strategies structured to support only medically necessary care with no financial incentive to perform C-sections for all contracted physicians and hospitals by year end 2023
- Description of how NTSV (non-medically necessary) C-section rates are included in network hospital and provider contracting criteria
- Description of how Applicant promotes and encourages all in-network hospitals that provide maternity services to use the resources provided by CMQCC and enroll in the CMQCC MDC
- Updates to hospital participation in CMQCC and hospital engagement in maternity care quality improvement, particularly those with a NTSV rate higher than 23.9%
- Further implementation plans for 2024 including milestones and targets for 2024 and 2025
- List any known or anticipated barriers in implementing QIS activities and progress of mitigation activities

Note: Refer to Appendix M for hospital C-section rates.
Single, Radio group.
1: Attached,
2: Not attached

18.4.5 Hospital Quality, Value, and Patient Safety

All questions required for currently contracted Applicants. Questions 18.4.5.1-18.4.5.3 are required for new entrant Applicants. All questions should be answered at the product level, not Issuer level.

Applicant must: 1) Adopt a hospital payment strategy that ties hospital payments to quality, value, and safety. 2) Promote hospital involvement in improvement programs so that all hospitals achieve infection rates (measured as a standardized infection ratio or SIR) of 1.0 or lower for the five Hospital Associated Infection (HAI) measures listed below or are working to improve. 3) Promote hospital involvement in improvement programs so that all hospitals comply with Sepsis Management according to CMS guidelines.

The five HAIs and Sepsis Management are:

- Catheter Associated Urinary Tract Infections (CAUTI)
- Central Line Associated Blood Stream Infections (CLABSI)
- Clostridioides Difficile Infection (CDI)
- Methicillin-resistant Staphylococcus Aureus (MRSA)
- Surgical Site Infection of the Colon (SSI Colon)
- Sepsis Management (SEP-1)

The following questions address Applicant's ability to meet the requirements for hospital patient safety.

This strategy meets the QIS requirements.

18.4.5.1 Applicant shall adopt a hospital payment methodology for each general acute care hospital in its networks that ties payment to quality, value and safety. Report, across all lines of business, the percentage of hospital reimbursements tied to quality, value and safety and the metrics applied for performance-based payments in Attachment J_QHP-IND Run Charts. In the details section of the spreadsheet, describe the performance-based payment strategy structure used to put payments at risk, and note if more than one structure is used. "Quality performance" includes any number or combination of metrics, including HAIs, readmissions, patient satisfaction, etc. In the same sheet, report metrics used to assess quality performance. Currently contracted Applicants must enter the percentages reported in the Certification Application for 2022, 2023, and 2024 as well. If Applicant had no Covered California business in 2023, report full 2023 book of business excluding Medicare.

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

18.4.5.2 Report the number and percent of hospitals contracted under the model described in question 18.4.5.1 with reimbursement at risk for quality performance in 2023 in Attachment J_QHP-IND_Run Charts. Currently contracted Applicants must enter the numbers reported in the Certification Applications for 2022, 2023, and 2024 as well. If Applicant had no Covered California business in 2023, report full 2023 book of business excluding Medicare.

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

18.4.5.3 Covered California is committed to addressing the opioid epidemic and continues to pursue improvement in the appropriate use of opioids in both the outpatient and hospital settings. In the following table, describe Applicant's strategies to improve the appropriate use of opioids in its network hospitals and how Applicant encourages all network hospitals to utilize the Opioid Management Hospital Self-Assessment, which outlines key milestones to achieving opioid safety, and to participate in the Opioid Care Honor Roll program from Cal Hospital Compare. The self-assessment can be accessed from: https://calhospitalcompare.org/wp-content/uploads/2022/08/Opioid-Mgmt-Hospital-Self-Assessment_2023-1.pdf.

	Response
Describe Applicant's strategies to improve the appropriate use of opioids in its network hospitals.	*200 words.*
Describe how Applicant encourages all network hospitals to utilize the Opioid Management Hospital Self-Assessment.	*200 words.*
Describe how Applicant encourages all network hospitals to participate in the Opioid Care Honor Roll program from Cal Hospital Compare.	*200 words.*

18.4.5.4 Complete Attachment K3_QHP-IND-CCSB_QIS 3 Work Plan–Hospital Quality, Value, Patient Safety to describe progress promoting hospital safety since the last submission. Address each of the following in the work plan narrative:

- How Applicant is engaging with its network hospitals to reduce the five specified HAIs to achieve a Standardized Infection Ratio (SIR) of 1.0 or lower for each of the specified HAIs
- How Applicant aims to improve adherence to the Sepsis Management (SEP-1) guidelines
- How Applicant is leveraging the poor performing hospitals list provided by Cal Hospital Compare to collaborate with other QHP Issuers who contract with the same poor performing hospitals
- Progress in adopting a payment strategy that ties hospital payment to quality, value, and safety
- Collaborations with other QHP Issuers on approaching hospitals to suggest quality improvement program participation or alignment on a payment strategy to tie hospital payment to quality
- Further implementation plans for 2024 including milestones and targets for 2024 and 2025
- List any known or anticipated barriers in implementing QIS activities and progress of mitigation activities

Note: In addition to hospital HAI rates in Appendix M, refer to the following publicly available references, which describe free coaching programs available to hospitals:

Information on Partnership for Patients: https://partnershipforpatients.cms.gov/

Hospital participation in Hospital Improvement Innovation Networks (HIINs): https://partnershipforpatients.cms.gov/about-the-partnership/hospital-engagement-networks/thehospitalengagementnetworks.html

Hospital HAI rates can be reviewed individually at http://calhospitalcompare.org/.

Single, Radio group.

1: Attached,

2: Not attached

19 Preferred Provider Organization (PPO)

19.1 Benefit Design

All questions are required for all Applicants. All questions should be answered at the product level, not Issuer level.

19.1.1 Applicant must confirm all products offered will comply with the coverage year Patient-Centered Benefit Plan Designs (PCBPD). If not, Applicant must explain why.
Single, Radio group.
1: Confirmed,
2: Not confirmed, [200 words]

19.1.2 Applicant must confirm all guidelines and due dates will be followed as listed in the Covered California Submission Guidelines Health Individual – Plan Year 2025.
Single, Pull-down list.
1: Confirmed,
2: Not confirmed

19.1.3 Applicant must indicate if it is requesting approval for any cost-sharing deviations from the coverage year Patient-Centered Benefit Plan Designs. If yes, Applicant must submit Attachment C_QHP-IND-CCSB_Patient-Centered Benefit Plan Design Deviations. In addition, Applicant must submit the same cost-sharing deviations to Applicant's applicable regulator for approval.
Note: Alternate benefit design proposals are not permitted in the Individual Marketplace. Covered California's decision whether to approve or deny QHP specific proposed deviations are on a case-by-case basis and are not considered an alternate benefit design.
Single, Pull-down list.
1: Yes, deviations requested, attached.,
2: No, no deviations requested

19.1.4 Covered California encourages Applicant to offer 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 coverage year Patient-Centered Benefit Plan Design which includes all ten Essential Health Benefits. Failure to offer a product without pediatric dental will not be grounds for rejection of Applicant's application.
Single, Pull-down list.
1: Yes. Individual market QHPs proposed for coverage year include all ten Essential Health Benefits.,
2: No. Individual market QHPs proposed for coverage year do not include all ten Essential Health Benefits.

19.1.5 Applicant must indicate if proposed QHPs will include coverage of non-emergent out-of-network services. If yes, with respect to non-network, non-emergency claims, describe how non-emergent out-of-network coverage is communicated to enrollees in addition to the details provided in the Evidence of Coverage or Policy document. If no, describe how the lack of coverage for non-emergent out-of-network services coverage is communicated to enrollees,

such as the Evidence of Coverage or Policy document.
Single, Radio group.
1: Yes, describe: [100 words],
2: No, describe: [100 words]

19.1.6 Applicant must confirm the coverage year Schedule of Benefits and Coverage (SBC), Evidence of Coverage (EOC) or Policy language describing proposed health Benefits will follow the requirements in the Covered California Submission Guidelines Health Individual – Plan Year 2025 and must comply with state and federal laws.

Single, Radio group.
1: Confirmed,
2: Not confirmed:

19.2 Benefit Administration

All questions are required for all Applicants. All questions should be answered at the product level, not Issuer level.

19.2.1 If Applicant's proposed QHPs will include the pediatric dental essential health benefit, Applicant must describe how it intends to embed this benefit. In the description of the option selected, Applicant must describe how it will ensure that the provision of pediatric dental benefits adheres to contractual requirements, including pediatric dental quality measures. Specifically address the following for the pediatric dental Essential Health Benefit:

- Activities conducted for consumer education and communication.
- Oversight conducted for dental quality and network management.
- If the benefit is subcontracted, state the name of the contractor, and describe any performance incentives included in the pediatric dental benefits subcontractor contract including metrics used for performance assessment.

Single, Radio group.
1: Offer benefit directly under full-service license: [100 words],
2: Subcontractor relationship: [100 words],
3: Not Applicable

19.2.2 Describe how Applicant administers child eye care benefits. Use the details section to specifically address the following:

- Activities conducted for consumer education and communication related to child eye care benefits.
- Oversight conducted for quality and network management.

Single, Radio group.
1: Offer benefit directly under full-service license: [200 words],
2: Subcontractor relationship: [200 words],
3: Other: [200 words]

19.2.3 Indicate how Applicant administers mental health and substance use disorder (MHSUD) benefits as either administered directly by Applicant or subcontracted to a contractor.
Single, Radio group.
1: Applicant offers benefit directly under full-service license,

2: Applicant offers benefit through subcontractor, state the name of the contractor: [50 words],
3: Other, describe: [50 words]

19.2.4 Describe activities Applicant conducts to educate and communicate to consumers about mental health and substance use disorder (MHSUD) benefits and how to access MHSUD services.

200 words.

19.2.5 Specify how Applicant monitors the following components of network management, access, and quality of care for its mental health and substance use disorder (MHSUD) provider network, either directly by Applicant or by a subcontractor.

Network Management, Access, and Quality Monitoring Components	*Monitoring Completed by Applicant or Subcontractor*		
Provider Network Development	*Single, Pull-down list.* 1: Applicant, 2: Subcontractor, 3: Both		
Network Adequacy	*Single, Pull-down list.* 1: Applicant, 2: Subcontractor, 3: Both		
Appointment Wait Times	*Single, Pull-down list.* 1: Applicant, 2: Subcontractor, 3: Both		
Clinical Quality Performance	*Single, Pull-down list.* 1: Applicant, 2: Subcontractor, 3: Both		
Patient Experience	*Single, Pull-down list.* 1: Applicant, 2: Subcontractor, 3: Both		
Cultural and Linguistic Concordance	*Single, Pull-down list.* 1: Applicant, 2: Subcontractor, 3: Both		
Referral Process between Physical Health and Behavioral Health Providers	*Single, Pull-down list.* 1: Applicant, 2: Subcontractor, 3: Both		
Care Coordination	*Single, Pull-down list.* 1: Applicant, 2: Subcontractor, 3: Both		
Telehealth	*Single, Pull-down list.* 1: Applicant, 2: Subcontractor, 3: Both		

19.2.6 Describe the oversight and accountability process for and any performance incentives associated with behavioral health provider network development.
100 words.

19.2.7 Describe the oversight and accountability process for and any performance incentives associated with behavioral health network adequacy.
100 words.

19.2.8 Describe the oversight and accountability process for and any performance incentives associated with behavioral health appointment wait times.
100 words.

19.2.9 Describe the oversight and accountability process for and any performance incentives associated with behavioral health clinical quality.
100 words.

19.2.10 Describe the oversight and accountability process for and any performance incentives associated with behavioral health patient experience.
100 words.

19.2.11 Describe the oversight and accountability process for and any performance incentives associated with behavioral health cultural and linguistic concordance.
100 words.

19.2.12 Describe the oversight and accountability process for and any performance incentives associated with the referral process between physical health and behavioral health Providers.
100 words.

19.2.13 Describe the oversight and accountability process for and any performance incentives associated with behavioral health care coordination.
100 words.

19.2.14 Describe the oversight and accountability process for and any performance incentives associated with behavioral health telehealth.
100 words.

19.2.15 Covered California supports the innovative use of technology to assist in higher quality, accessible, patient-centered care. Describe Applicant's ability to support telehealth consultations, either through a contractor or provided by the medical group or provider.
Multi, Checkboxes.
1: Plan does not offer or allow telehealth consultations,
2: Telehealth with interactive face to face dialogue (video and audio),
3: Telehealth with interactive dialogue over the phone,
4: Telehealth asynchronous store and forward,
5: Telehealth mobile health tools (reminders, alerts, monitoring) via text, instant messaging or other,
6: Remote patient monitoring,
7: e-Consult: provider-to-provider,
8: Other (specify): [20 words]

19.2.16 Do cost shares for telehealth services differ from the standard benefit design for that product?

Single, Radio group.
1: No, (no attachment),
2: Yes, Attachment D required

19.2.17 Provide information in the following chart to describe providers and telehealth vendors' telehealth capabilities to support provider-member consultations using technology. If Applicant is not currently contracted with Covered California, provide a description of telehealth capabilities, and indicate whether those services will be offered to Covered California members.

	Network Provider Capability	Percent Network Provider with capability	Telehealth Vendor Capability	Details
1. Interactive face to face dialogue (video and audio) (Use as denominator total providers across all lines of business).	*Single, 1: network provider capability 2: capability not available with network provider*	*Percent.*	*Single, 1: network provider capability 2: capability not available with network provider*	*20 words.*
2. Interactive dialogue (audio only) (Use as denominator total providers across all lines of business).	*Single, 1: network provider capability 2: capability not available with network provider*	*Percent.*	*Single, 1: network provider capability 2: capability not available with network provider*	*20 words.*
3. Telehealth for behavioral health services with interactive face to face dialogue (video and audio) (Use as denominator total providers across all lines of business).	*Single, 1: network provider capability 2: capability not available with network provider*	*Percent.*	*Single, 1: network provider capability 2: capability not available with network provider*	*20 words.*
4. Telehealth for behavioral health services with interactive dialogue (audio only). (Use as denominator total providers across all lines of business).	*Single, 1: network provider capability 2: capability not available with network provider*	*Percent.*	*Single, 1: network provider capability 2: capability not available with network provider*	*20 words.*
5. Mobile health tools, such as reminders, alerts, monitoring via text, instant	*Single, 1: network provider capability*	*Percent.*	*Single, 1: network provider capability*	*20 words.*

messaging, or other (Use as providers total membership across all lines of business).	*2: capability not available with network provider*		*2: capability not available with network provider*	
6. Remote patient monitoring(Use as provider total membership across all lines of business).	*Single,* *1: network provider capability* *2: capability not available with network provider*	*Percent.*	*Single,* *1: network provider capability* *2: capability not available with network provider*	*20 words.*

19.2.18 Applicant must complete the following table.

	Network Provider	Details
1. Report the percent of providers with access to e-Consult: provider-to-provider (Use as denominator total providers across all lines of business).	*Percent.*	*20 words.*
2. Provide percentage of network physicians and/or physician groups and practices that are designated as having telehealth consultation services available (across all lines of business).	*Percent.*	*20 words.*
3. Report the percent of providers identified as available for store-and-forward asynchronous telehealth services (use as denominator total providers across all lines of business).	*Percent.*	*20 words.*
4. For physicians that are available to deliver telehealth consultations, what is the average wait time? If Applicant can provide average wait time, describe how that is monitored in the Details section.	*Compound, Pull-down list.* 1: On demand, 2: Within 4 hours, 3: Within same day, 4: Scheduled follow-up within 48 hours, 5: Other (describe): [100 words], 6: N/A	

19.2.19 Confirm Applicant providers for telehealth consultations conducted.

Single, Radio group.
1: Confirmed,
2: Not confirmed

19.2.20 Describe the availability of web or telehealth consultations in languages other than English. Include details on how members are notified about the availability of interpreter services for telehealth. Specify all languages offered in response and distinguish between use of interpreter service and availability of in-language consultations in languages other than English.

200 words.

19.2.21 Describe how Applicant promotes telehealth (either through vendor or medical group) as an alternative to the Emergency Department for urgent health issues (describe specific engagement efforts and any specific contractual requirements related to this topic for vendors or medical groups).

200 words.

19.2.22 Describe how Applicant promotes integration and coordination of care between telehealth providers and in-person providers (primary care providers, specialists, etc.).

200 words.

19.2.23 Covered California requires contracted QHP Issuers to offer telehealth for behavioral health services. In the following table, indicate whether Applicant offers telehealth for behavioral health services by selecting which services are offered. Indicate how Applicant educates Covered California Enrollees on how to access services and how the information is displayed to Covered California Enrollees through Applicant's member portal and provider directory. If Applicant is not currently contracted with Covered California, provide a description of its telehealth capabilities, and indicate whether those services will be offered to Covered California Enrollees.

	Telehealth Offered	*Education Efforts*	*Details*
Applicant offers telehealth for behavioral health services	*Multi, Checkboxes.* 1: Telehealth for emergency behavioral health offered, 2: Telehealth for outpatient behavioral health (not integrated) offered, 3. Telehealth for inpatient behavioral health offered, 4. Telehealth for integrated primary care and behavioral health offered, 5. Remote monitoring (e.g., mobile health applications, self-management tools) offered, describe: [100 words] 6. Other, describe: [100 words] 7: No, Applicant does not offer telehealth for behavioral health services	*Multi, Checkboxes.* 1: Member welcome packets, 2: Educational emails, 3: Educational mailings, 4: Website notices or information, 5: Member portal notices or information, 6: Information available through provider directory, 7: Member app notices or information, 8: Information available through call center, 9: Other, describe	*100 words.*

19.2.24 Does Applicant use a behavioral health telehealth vendor:
Single, Radio group.
1: Yes, specify vendor: [20 words],
2: No

19.2.25 Report utilization of telehealth for behavioral health services in 2023.

Plan Year 2023 Utilization	Percent
Members who utilized a single telehealth for behavioral health service with a network provider or telehealth vendor.	*Percent.*
Members who utilized multiple telehealth for behavioral health services with a network provider or telehealth vendor	*Percent.*

19.2.26 Specific to behavioral health providers, describe how Applicant promotes integration and coordination of care between in-person providers and behavioral health telehealth providers.

200 words.

19.2.27 Describe the referral process and access timeline for members who need higher levels of behavioral health care in addition to or following a behavioral health telehealth visit.

200 words.

19.3 Provider Network

All questions are required for all Applicants. All questions should be answered at the product level, not Issuer level.

19.3.1 Applicant must indicate if the network it intends to offer on Covered California in the Individual market for the certification year is new or existing to Covered California and include the network name.

Single, Radio group.
1: New Network to Covered California, including an existing network with material changes [*10 words*],
2: Existing Network to Covered California with no material changes to current network [*10 words*]

19.3.2 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 the Covered California Provider Data Submission Guide. The provider network submission for the certification year must be consistent with what will be filed to the appropriate regulator for approval if Applicant is selected as a QHP Issuer. Covered California requires the information, as requested, to allow cross-network comparisons and evaluations.

Single, Pull-down list.
1: Attached, Applicant attesting to material changes to existing network or new network (confirming provider data is for the certification year),
2: Not attached, Applicant attesting to no material changes to existing plan year Covered California network for the certification year

19.3.3 Applicant must complete all tabs in Attachment E2_QHP-IND-CCSB_PPO Provider Network Tables v1.xlsx, for their PPO Network.

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

19.3.4 Does Applicant conduct provider negotiations and manage its own network or does Applicant lease a network from another organization? If Applicant leases a network, Applicant must describe the length of the lease agreement, including start and end dates, along with the leasing organization and if the Applicant has the ability to influence provider contract terms.

Single, Radio group.
1: Applicant contracts and manages network,
2: Applicant leases network, describe [500 words]

19.3.5 Applicant must confirm that it will respond to and adhere to the requirements of Health & Safety Code, § 1367.03 or Insurance Code, § 10133.54 and any implementing regulations relating to consumer access to primary, specialty, behavioral health and hospital care based on enrollee access.

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

19.3.6 Applicant must confirm it tracks ethnic and racial diversity in the population and ensuring access to appropriate culturally competent providers, and must briefly describe its methodology, data and tools used to track ethnic and racial diversity in the population and ensuring access to appropriate culturally concordant providers, including relevant measurement criteria and benchmarks for ensuring adequate access.
Single, Radio group.
1: Confirmed, describe [200 words],
2: Not Confirmed, describe [200 words]

19.3.7 Applicant must confirm that it will respond to and adhere to the requirements of Health & Safety Code, § 1367.03 or Insurance Code, § 10133.54 for assessing enrollee wait times for appointments with primary, specialty, and behavioral health providers.
Single, Pull-down list.
1: Confirmed,
2: Not Confirmed

19.3.8 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, Pull-down list.* 1: Yes, 2: No, 3: Not Applicable
Does applicant allow out-of-state (non-emergency) providers to participate in networks to serve Covered California enrollees? If yes, explain in detail how this coverage is offered.	*Compound, Pull-down list.* 1: Yes: [200 words], 2: No, 3: Not Applicable

19.3.9 Describe any plans for network changes, by product, including any new medical groups or hospital systems that Applicant would like to highlight for Covered California attention.

100 words.

19.4 Delivery System and Payment Strategies to Drive Quality

Attachment 1 of the Covered California Qualified Health Plan (QHP) Issuer Contract embodies Covered California's vision for delivery system reform and serves as a roadmap to delivery system improvements. A number of the delivery system and payment strategy requirements in Attachment 1 meet the federal Quality Improvement Strategy (QIS) requirements.

The Patient Protection and Affordable Care Act (§1311(g)(1)) requires periodic reporting to Covered California of activities a QHP Issuer 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, reducing hospital readmissions, improving patient safety, and reducing medical errors, implementing wellness and health promotion activities, and reducing health and health care disparities. QHP Issuers must implement and report on a quality improvement strategy or strategies consistent with the standard of section 1311(g) of the ACA.

Applicants that are currently operating in Covered California are required to complete QIS workplans as part of the Application process. The following strategies meet the QIS requirements and Applicants must submit QIS workplans:

- Advanced Primary Care
- Appropriate Use of Cesarean Sections
- Hospital Quality, Value, and Patient Safety

QHP certification is conditioned on Applicant developing a multi-year QIS and reporting year-to-year activities and progress on each initiative area.

Applicants that are not currently operating in Covered California are not required to complete the QIS workplan updates as part of the Application for 2025 but must review Attachment 1 with the understanding that engagement in the QIS and Attachment 1 initiatives will be contractually required and measured in the future if Applicant contracts with Covered California.

19.4.1 Provider Networks Based on Value

All questions are required for new entrant Applicants. All questions should be answered at the product level, not Issuer level.

Applicant shall curate and manage its network(s) to address variation in quality and cost performance across network hospitals and providers, with a focus on improving the performance of hospitals and providers. Applicant shall measure, analyze, and reduce variation to achieve consistent high performance for all network hospitals and providers. Applicant shall hold its contracted hospitals and providers accountable for improving quality and managing cost and provide support to its contracted hospitals and providers to improve performance. The following questions address Applicant's ability to track and address variation in quality and cost performance across network hospitals and providers.

19.4.1.1 In the following table, Applicant must identify key quality and cost sources and measures that the Applicant uses to evaluate providers and hospitals for determining initial and ongoing network inclusion, and briefly explain how each measure is used, including if and how the measure is used for performance payment. Applicant must also describe any additional criteria used to determine network inclusion.

	Data Source	*Purpose*	*Provide examples if response #4 selected for Purpose*	*Provide details if Other selected in Data Source or Purpose*
Hospital Quality	*Multi, Checkboxes.* 1: Cal Hospital Compare data, 2: California Maternal Quality Collaborative data, 3: Leapfrog Group data, 4: CMS Hospital Quality Reporting, 5: Program or another CMS program, 6: Designated Center of Excellence (COE), 7: Other, explain	*Multi, Checkboxes.* 1: Used for initial contracting assessment, 2: Used for re-contracting assessment, 3: Has been used for incentive or Pay for Performance payments, 4: Has been used for termination or exclusion (give examples), 5: Other, explain	*100 words.*	*100 words.*
Hospital Cost	*Multi, Checkboxes.* 1: Percent of Medicare rates, 2: Diagnosis-Related Group (DRG) costs, 3: Comparison to other hospital costs in geographic area, 4: Comparison to other hospital costs by decile or other method, 5: CMS Hospital Price Transparency data, 6: Other, explain	*Multi, Checkboxes.* 1: Used for initial contracting assessment, 2: Used for re-contracting assessment, 3: Has been used for incentive or Pay for Performance payments, 4: Has been used for termination or exclusion (give examples), 5: Other, explain	*100 words.*	*100 words.*
Additional Criteria	*100 words.*	*100 words.*	*100 words.*	*100 words.*

19.4.1.2 In the following table, Applicant must identify key quality and cost sources and measures that the Applicant uses to evaluate providers for determining initial and ongoing network inclusion, and briefly explain how each measure is used, including if and how the measure is used for performance payment. Applicant must also describe any additional criteria used to determine network inclusion.

	Data Source	*Purpose*	*Provide examples if response #4 selected for Purpose*	*Provide details if Other selected in Data Source or Purpose*
Provider Quality	*Multi, Checkboxes.* 1: Integrated Healthcare Association data, 2: Office of Patient Advocate data, 3: Other, explain	*Multi, Checkboxes.* 1: Used for initial contracting assessment, 2: Used for re-contracting assessment, 3: Has been used for incentive or Pay for	*100 words.*	*100 words.*

		Performance payments, 4: Has been used for termination or exclusion (give examples), 5: Other, explain		
Provider Cost	*Multi, Checkboxes.* 1: Total Cost of Care data, 2: Comparison to other physician or physician groups in geographic area, 3: Other, explain	*Multi, Checkboxes.* 1: Used for initial contracting assessment, 2: Used for re-contracting assessment, 3: Has been used for incentive or Pay for Performance payments, 4: Has been used for termination or exclusion (give examples), 5: Other, explain	*100 words.*	*100 words.*
Additional Criteria	*100 words.* Nothing required	*100 words.* Nothing required	*100 words.*	*100 words.*

19.4.2 Advanced Primary Care

All questions required for currently contracted Applicants. Questions 19.4.2.1 and 19.4.2.2 are required for new entrant Applicants. All questions should be answered at the product level, not Issuer level.

Covered California recognizes that providing high-quality, equitable, and affordable care requires a foundation of effective and patient-centered primary care. Advanced primary care is patient-centered, accessible, team-based, data driven, supports the integration of behavioral health services, and provides care management for patients with complex conditions. Advanced primary care is supported by alternative payment models such as population-based payments and shared savings arrangements. Applicant shall actively promote the development and use of advanced primary care models that promote access, care coordination, and quality while managing the total cost of care. The following questions address Applicant's ability to match at least 95% of enrollees with a primary care clinician and increase the proportion of providers paid under a payment strategy that promotes advanced primary care.

This strategy meets the QIS requirements.

19.4.2.1 Report the percentage of Covered California Enrollees who either selected or were matched with a primary care clinician in 2023 in Attachment J_QHP-IND Run Charts. If Applicant had no Covered California business in 2023, report full 2023 book of business excluding Medicare. Applicants currently contracted with Covered California must enter the number and percentage of providers paid under each model reported in the Certification Applications for 2022, 2023 and 2024 as well. Report data by product (HMO, PPO, EPO, Other).

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

19.4.2.2 Report all types of payment methods used for primary care services and number of providers paid under each model in 2023 in Attachment J_QHP-IND_Run Charts using the alternative payment models (APM) outlined in the Health Care Payment Learning Action & Action Network (HCP LAN) Alternative Payment Model APM Framework. If Applicant had no Covered California business in 2023, report full 2023 book of business excluding Medicare. Applicants currently contracted with Covered California must enter the number and percentage of providers paid under each model reported in the Certification Applications for 2022, 2023 and 2024 as well. Report data by product (HMO, PPO, EPO, Other).

References:

HCP LAN Alternative Payment Model APM Framework: http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf

Single, Pull-down list.

1: Attached,
2: Not attached

19.4.2.3 Complete Attachment K1_QHP-IND-CCSB_QIS 1 Work Plan – Advanced Primary Care to describe updates on progress made since the previous QIS submission in each part of the primary care goals, and planned activities. Address each of the following in the work plan narrative:

- Updates on the PCP matching initiative, including a status report, feedback on the enrollee experience, challenges, and suggestions (if applicable)
- Progress implementing alternative payment models for primary care to align with Category 3 or 4 APMs described in the APM Framework including: activities conducted, data collected and analyzed, and results
- Describe any support or technical assistance (financial, staffing, educational, etc.) that Applicant or multi-insurer collaborative is providing to primary care providers to support their efforts towards accessible, data-driven, team-based care
- Implementation of advanced primary care initiatives and quality improvement activities to improve health outcomes on any of the QTI measures:
- Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%) (NQF #0575)
- Controlling High Blood Pressure (NQF #0018)
- Colorectal Cancer Screening (NQF #0034)
- Childhood Immunization Status (Combo 10) (NQF #0038)
- Further implementation plans for 2024 including milestones and targets for 2024 and 2025
- Known or anticipated barriers in implementing QIS activities and progress of mitigation activities

Single, Pull-down list.

1: Attached,
2: Not attached

19.4.3 Integrated Delivery Systems and Accountable Care Organizations

Question 19.4.3.1 is required for currently contracted Applicants. All questions are required for new entrant Applicants. All questions should be answered at the product level, not Issuer level.

Evidence suggests the adoption and expansion of integrated, coordinated, and accountable systems of care such as Integrated Delivery Systems (IDSs) or Accountable Care Organization (ACOs) can lead to improved quality and reduced costs. An IDS is defined as an organized healthcare delivery system in which payers, hospitals, and providers coordinate to provide patient care, integrate care across settings, and share responsibility for patient outcomes and resource use. IDS partners are generally managed by the same organization. An ACO is defined as a system of population-based care coordinated across the continuum including multidisciplinary physicians and physician groups, hospitals, and ancillary providers with combined risk sharing arrangements and shared incentives between providers or between payers and providers. Ideally ACO partners are held accountable for nationally recognized clinical, financial, and operational performance. As providers accept more accountability under this provision, Applicant shall ensure that providers have the capacity to manage the risk. There are many variations of ACO implementation with evidence suggesting that there are key characteristics of an ACO model that influence its success. The following questions address Applicant's ability to increase enrollment in IDS or ACO models in its Covered California network and solicit information about the structure of Applicant's IDS and ACO models.

19.4.3.1 Using the definition for IDS or ACO above, report the number and percentage of Covered California Enrollees and total California Enrollees who are managed under an IDS or ACO in 2023 in Attachment J – QHP-IND Run Charts. Applicants currently contracted with Covered California must enter the percentage reported in the Certification Application for 2022, 2023 and 2024 as well. If Applicant had no Covered California business in 2023, report full 2023 book of business excluding Medicare. Report data by product (HMO, PPO, EPO, Other).

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

19.4.3.2 Applicant must identify key components of the Applicant's IDS or ACO model and must briefly explain how each component is implemented.

	Response	*Details*
Regulated ACO or IDS entity status: Insurer	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Regulated ACO or IDS entity status: Provider with Knox Keene license	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Participation: 2-way (health plan/provider organization)	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Participation: 3-way (health plan/provider organization/hospital)	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Participation: 4-way (health plan/provider organization/purchaser)	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*

Participation: Includes advanced primary care providers or patient-centered medical homes	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Participation: Other	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Base payment: Global capitation	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Base payment: Professional capitation only	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Base payment: Separate professional capitation and hospital capitation	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Base payment: Fee for service	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Base payment: Other	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Performance payment: Two-sided shared savings (upside/downside risk)	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Performance payment: One-sided shared savings (upside risk)	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Performance payment: Pay for performance quality bonus	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Performance payment: Other	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Leadership: Physician-led	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Leadership: Hospital-led	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Leadership: Plan-led	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Leadership: Other	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Leadership: Jointly led by physician and hospitals	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*

Member assignment: Attribution algorithm	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Member assignment: Patient selection	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Member assignment: Health plan assignment	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Member assignment: Other	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Timing: Retrospective	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Timing: Prospective	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Timing: Other	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*

19.4.3.3 Applicant must provide, as attachments, documents related to IDSs or ACOs or confirm Applicant will submit the documents as they become available.

	Response
(File titled Provider 1a): Applicant's quality and cost measures used to track progress and success of IDS or ACO providers.	*Single, Pull-down list.* 1: Attached, 2: Not attached
(File titled Provider 1b): Example of Applicant report to its IDS or ACO providers on its quality of care and financial performance, including benchmarking relative to performance improvement goals or market norms.	*Single, Pull-down list.* 1: Attached, 2: Not attached
(File titled Provider 1c): Confirm Applicant will submit a copy of Applicant's 2023 IHA Align Measure Perform (AMP) Commercial ACO report when it becomes available, if Applicant participates in the program.	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed, 3: N/A

19.4.4 Appropriate Use of Cesarean Sections

All questions are required for currently contracted Applicants. Questions 19.4.4.1 – 19.4.4.6 are required for new entrant Applicants. All questions should be answered at the product level, not Issuer level.

According to the World Health Organization, maternal health refers an individual's health during pregnancy, childbirth, and the postpartum period. Covered California is committed to addressing all three phases to provide a comprehensive approach to maternal health. Cesarean sections (C-sections) can be lifesaving, but significant numbers of low-risk, first-time pregnancies are undergoing this invasive surgery when it is not medically necessary. Reducing the rate of unnecessary C-sections improves health outcomes and patient safety.

Applicant must: 1) Progressively adopt physician and hospital payment strategies so that revenue for labor and delivery only supports medically necessary care and no financial incentive exists to perform a low-risk Nulliparous Term Singleton Vertex (NTSV) Cesarean Section (C-Section). 2) Promote improvement work through the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center (MDC), so that all maternity hospitals achieve an NTSV C-Section rate of 23.9% or lower or are at least working toward that goal. 3) Consider a hospital's NTSV C-section rate, improvement trajectory, and willingness to engage in coaching as part of its maternity hospital contracting decisions and terms. Covered California does not expect Contractor to base poor performance, and potential network removal decisions, on one measure alone.

Smart Care California has outlined three payment strategies to align payment with medically necessary use of C-sections:

- Adopt a blended case rate payment for both physicians and hospitals;
- Include a NTSV C-section metric in existing hospital and physician quality incentive programs; and
- Adopt population-based payment models, such as maternity episode payment models or inclusion in Integrated Delivery System, ACO, or similar financial accountability arrangement.

The following questions address Applicant's ability to meet the requirements for the appropriate use of cesarean sections.

Applicants that are not currently operating in Covered California are expected to adopt a payment methodology structured to support only medically necessary care with no financial incentive to perform C-sections for all contracted physicians and hospitals serving enrollees.

This strategy meets the QIS requirements.

19.4.4.1 Describe how Applicant is measuring overuse of Cesarean Sections.

100 words.

19.4.4.2 Describe how Applicant is implementing Smart Care California guidelines (https://www.iha.org/wp-content/uploads/2020/12/c-section_menu_of_payment_and_contracting_options.pdf) to promote best practices to reduce unnecessary Cesarean Sections.

	Guideline	*Implementation*	*Description*
1	Adopt a blended case rate payment for both physicians and hospitals.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*

2	Include a NTSV C-section metric in existing hospital and physician quality incentive programs.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*
3	Adopt population-based payment models, such as ACO-like arrangements.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*
4	Pay less for C-sections without medical indication and for scheduled non-medically necessary repeat C-sections.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*
5	Require or incent hospital participation in CMQCC's Maternal Data Center (MDC).	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*
6	Implement network quality improvement requirements with a deadline.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*

19.4.4.3 Report number of all network hospitals reporting to the California Maternity Quality Care Collaborative (CMQCC) Maternal Data Center (MDC) in 2023 in Attachment J – QHP IND Run Charts. A list of all California hospitals participating in the MDC can be found here: https://www.cmqcc.org/about-cmqcc/member-hospitals. Applicants currently contracted with Covered California must enter the percentage reported in the Certification Applications for 2022, 2023, and 2023 as well. If Applicant had no Covered California business in 2023, report full 2023 book of business excluding Medicare.

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

19.4.4.4 Contracted QHP Issuer must adopt value-based payment strategies structured to support only medically necessary care with no financial incentive to perform non-medically necessary NTSV C-sections for all contracted physicians and hospitals by year end 2023 or in the first year of QHP certification if after 2023. These value-based payment strategies include:

1) Blended case rate payment for both physicians and hospitals; 2) Including a NTSV C-section metric in existing hospital and physician quality incentive programs; and 3) Population-based payment models, such as maternity episode payment models.

Report models and number of network hospitals paid using each payment strategy in 2023 in Attachment J – QHP IND Run Charts. 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 non-medically necessary C-Section delivery.

Applicants currently contracted with Covered California must enter the percentages reported in the Certification Applications for 2022, 2023, and 2024 as well. If Applicant had no Covered California business in 2023, report full 2023 book of business excluding Medicare.

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

19.4.4.5 Applicant must confirm that all network physicians are pain on a case rate for deliveries and that payment is the same for both vaginal and non-medically necessary C-section delivery. Confirm that all network physicians are paid on a case rate for deliveries and that payment is the same for both vaginal and C-section delivery.

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

19.4.4.6 If Applicant selected not confirmed in question 19.4.4.5, that all network physicians are paid on a case rate for deliveries and that payment is the same for both vaginal and non-medically necessary C-section delivery, Applicant must complete the following table.

Payment Strategy	Description	Percent of Physicians Paid Under Strategy	Numerator	Denominator
Strategy 1: Blended Case Rate	*50 words.*	*Percent.*	*Integer.*	*Integer.*
Strategy 2: Provide quality bonuses for physicians that attain NTSV C-section rate goal or make improvements in reducing NTSV C-sections	*50 words.*	*Percent.*	*Integer.*	*Integer.*
Strategy 3: Population-based payment models	*50 words.*	*Percent.*	*Integer.*	*Integer.*
Strategy 4: Other (explain)	*50 words.*	*Percent.*	*Integer.*	*Integer.*
Strategy 5: Other (explain)	*50 words.*	*Percent.*	*Integer.*	*Integer.*
Strategy 6: Other (explain)	*50 words.*	*Percent.*	*Integer.*	*Integer.*

19.4.4.7 Maternal health disparities exist across the full spectrum of maternal health, from preconception, to pregnancy, and the postpartum period. Disparities in maternal health disproportionately affect Black and Latino populations at higher rates than other racial groups. Reducing and eliminating gaps in maternal health requires a multifaceted approach. Indicate

and describe in the following table any of the activities undertaken by Applicant to identify and reduce maternal health disparities.

Activities to Identify and Reduce Maternal Health Disparities	*Response*	*Details*
1. Engages with contracted providers to improve performance on maternal health measures, specify measures and if engagement includes performance reviews, evidence-based interventions, or participation in quality collaboratives	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
2. Identifies maternal health disparities among its maternity Enrollees	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
3. Engages with hospitals and providers to address maternal health disparities. Specify if engagement includes quarterly performance reviews, data analysis on race and ethnicity of its maternity Enrollees and outcomes, or implementation of corrective action plans	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
4. Ensures that its network perinatal providers, staff, and facilities are complying with the California Dignity in Pregnancy and Childbirth Act, which mandates implicit bias training to reduce the effects of implicit bias in pregnancy, childbirth, and postnatal care	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
5. Supports its maternity Enrollees, such as access to culturally and linguistically appropriate maternity care, referrals to group prenatal care or community-centered care models for patients, in home lactation and nutrition consultants, doula support for prenatal, labor, delivery, and postpartum care, and related services	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
6. Ensures that its maternity Enrollees are aware of the supportive services available to them, including the services described in (5) above, and that Enrollees know how to access these services	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
7. Works to promote and encourage all in-network hospitals that provide maternity services to use the resources provided by California Maternity Quality Care Collaborative (CMQCC) and the California Department of Public Health's Maternal, Child and Adolescent Health (MCAH) Division to address maternal health disparities	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*

19.4.4.8 Complete Attachment K2 – QHP-IND-CCSB_QIS 2 Work Plan – Appropriate Use of C-Sections to describe updates on progress made since the last QIS submission with regards to promoting appropriate use of Cesarean-Sections (C-Sections). Address each of the following in the work plan narrative:

- Description of how Applicant engages with its network hospitals to reduce NTSV (non-medically necessary) C-Section rates to 23.9% or less

- Description of its value-based payment strategies structured to support only medically necessary care with no financial incentive to perform C-sections for all contracted physicians and hospitals by year end 2023
- Description of how NTSV (non-medically necessary) C-section rates are included in network hospital and provider contracting criteria
- Description of how Applicant promotes and encourages all in-network hospitals that provide maternity services to use the resources provided by CMQCC and enroll in the CMQCC MDC
- Updates to hospital participation in CMQCC and hospital engagement in maternity care quality improvement, particularly those with a NTSV rate higher than 23.9%
- Further implementation plans for 2024 including milestones and targets for 2024 and 2025
- List any known or anticipated barriers in implementing QIS activities and progress of mitigation activities

Note: Refer to Appendix M for hospital C-section rates.
Single, Radio group.
1: Attached,
2: Not attached

19.4.5 Hospital Quality, Value, and Patient Safety

All questions required for currently contracted Applicants. Questions 19.4.5.1-19.4.5.3 are required for new entrant Applicants. All questions should be answered at the product level, not Issuer level.

Applicant must: 1) Adopt a hospital payment strategy that ties hospital payments to value, and safety. 2) Promote hospital involvement in improvement programs so that all hospitals achieve infection rates (measured as a standardized infection ratio or SIR) of 1.0 or lower for the five Hospital Associated Infection (HAI) measures listed below or are working to improve. 3) Promote hospital involvement in improvement programs so that all hospitals comply with Sepsis Management according to CMS guidelines.

The five HAIs and Sepsis Management are:

- Catheter Associated Urinary Tract Infections (CAUTI)
- Central Line Associated Blood Stream Infections (CLABSI)
- Clostridioides Difficile Infection (CDI)
- Methicillin-resistant Staphylococcus Aureus (MRSA)
- Surgical Site Infection of the Colon (SSI Colon)
- Sepsis Management (SEP-1)

The following questions address Applicant's ability to meet the requirements for hospital patient safety.

This strategy meets the QIS requirements.

19.4.5.1 Applicant shall adopt a hospital payment methodology for each general acute care hospital in its networks that ties payment to quality value, and safety. Report, across all lines of business, the percentage of hospital reimbursements tied to quality, value and safety and the

metrics applied for performance-based payments in Attachment J – QHP-IND Run Charts. In the details section of the spreadsheet, describe the performance-based payment strategy structure used to put payments at risk, and note if more than one structure is used. "Quality performance" includes any number or combination of metrics, including HAIs, readmissions, patient satisfaction, etc. In the same sheet, report metrics used to assess quality performance. Currently contracted Applicants must enter the percentages reported in the Certification Applications for 2022, 2023, and 2024. If Applicant had no Covered California business in 2023, report full 2023 book of business excluding Medicare.

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

19.4.5.2 Report the number and percent of hospitals contracted under the model described in question 18.4.5.1 with reimbursement at risk for quality performance in 2023 in Attachment J – QHP-IND Run Charts. Currently contracted Applicants must enter the numbers reported in the Certification Applications for 2024. If Applicant had no Covered California business in 2023, report full 2023 book of business excluding Medicare.

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

19.4.5.3 Covered California is committed to addressing the opioid epidemic and continues to pursue improvement in the appropriate use of opioids in both the outpatient and hospital settings. In the following table, describe Applicant's strategies to improve the appropriate use of opioids in its network hospitals and how Applicant encourages all network hospitals to utilize the Opioid Management Hospital Self-Assessment, which outlines key milestones to achieving opioid safety, and to participate in the Opioid Care Honor Roll program from Cal Hospital Compare. The self-assessment can be accessed from: https://calhospitalcompare.org/wp-content/uploads/2022/08/Opioid-Mgmt-Hospital-Self-Assessment_2023-1.pdf.

	Response
Describe Applicant's strategies to improve the appropriate use of opioids in its network hospitals.	*200 words.*
Describe how Applicant encourages all network hospitals to utilize the Opioid Management Hospital Self-Assessment.	*200 words.*
Describe how Applicant encourages all network hospitals to participate in the Opioid Care Honor Roll program from Cal Hospital Compare.	*200 words.*

19.4.5.4 Complete Attachment K3 – QHP QIS 3 Work Plan – Hospital Quality, Value, Patient Safety to describe progress promoting hospital safety since the last submission. Address each of the following in the work plan narrative:

- How Applicant is engaging with its network hospitals to reduce the five specified HAIs to achieve a Standardized Infection Ratio (SIR) of 1.0 or lower for each of the specified HAIs
- How Applicant aims to improve adherence to the Sepsis Management (SEP-1) guidelines

- How Applicant is leveraging the poor performing hospitals list provided by Cal Hospital Compare to collaborate with other QHP Issuers who contract with the same poor performing hospitals
- Progress in adopting a payment strategy that ties hospital payment to quality, value, and safety
- Collaborations with other QHP Issuers on approaching hospitals to suggest quality improvement program participation or alignment on a payment strategy to tie hospital payment to quality
- Further implementation plans for 2024 including milestones and targets for 2024 and 2025
- List any known or anticipated barriers in implementing QIS activities and progress of mitigation activities

Note: In addition to hospital HAI rates in Appendix M, refer to the following publicly available references, which describe free coaching programs available to hospitals:

Information on Partnership for Patients: https://partnershipforpatients.cms.gov/

Hospital participation in Hospital Improvement Innovation Networks (HIINs): https://partnershipforpatients.cms.gov/about-the-partnership/hospital-engagement-networks/thehospitalengagementnetworks.html

Hospital HAI rates can be reviewed individually at http://calhospitalcompare.org/.

Single, Radio group.
1: Attached,
2: Not attached

20 Exclusive Provider Organization (EPO)

20.1 Benefit Design

All questions are required for all Applicants. All questions should be answered at the product level, not Issuer level.

20.1.1 Applicant must confirm all products offered will comply with the coverage year Patient-Centered Benefit Plan Designs (PCBPD). If not, Applicant must explain why.
Single, Radio group.
1: Confirmed,
2: Not confirmed, [200 words]

20.1.2 Applicant must confirm all guidelines and due dates will be followed as listed in the Covered California Submission Guidelines Health Individual – Plan Year 2024.

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

20.1.3 Applicant must indicate if it is requesting approval for any cost-sharing deviations from the coverage year Patient-Centered Benefit Plan Designs. If yes, Applicant must submit Attachment C_QHP-IND_Patient-Centered Benefit Plan Design Deviations. In addition, Applicant must submit the same cost-sharing deviations to Applicant's applicable regulator for approval.
Note: Alternate benefit design proposals are not permitted in the Individual Marketplace. Covered California's decision whether to approve or deny QHP specific proposed deviations are on a case-by-case basis and are not considered an alternate benefit design.

Single, Pull-down list.
1: Yes, deviations requested, attached.,
2: No, no deviations requested

20.1.4 Covered California encourages Applicant to offer 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 coverage year Patient-Centered Benefit Plan Design which includes all ten Essential Health Benefits. Failure to offer a product without pediatric dental will not be grounds for rejection of Applicant's application.

Single, Pull-down list.
1: Yes. Individual market QHPs proposed for coverage year include all ten Essential Health Benefits.,
2: No. Individual market QHPs proposed for coverage year do not include all ten Essential Health Benefits.

20.1.5 Applicant must indicate if proposed QHPs will include coverage of non-emergent out-of-network services. If yes, with respect to non-network, non-emergency claims, describe how non-emergent out-of-network coverage is communicated to enrollees in addition to the details provided in the Evidence of Coverage or Policy document. If no, describe how the lack of coverage for non-emergent out-of-network services coverage is communicated to enrollees, such as the Evidence of Coverage or Policy document.
Single, Radio group.
1: Yes, describe: [100 words],
2: No, describe: [100 words]

20.1.6 Applicant must confirm the coverage year Schedule of Benefits and Coverage (SBC), Evidence of Coverage (EOC) or Policy language describing proposed health Benefits will follow the requirements in the Covered California Submission Guidelines Health Individual – Plan Year 2025 and must comply with state and federal laws.

Single, Radio group.
1: Confirmed,
2: Not confirmed:

20.2 Benefit Administration

All questions are required for all Applicants. All questions should be answered at the product level, not Issuer level.

20.2.1 If Applicant's proposed QHPs will include the pediatric dental essential health benefit, Applicant must describe how it intends to embed this benefit. In the description of the option selected, Applicant must describe how it will ensure that the provision of pediatric dental

benefits adheres to contractual requirements, including pediatric dental quality measures. Specifically address the following for the pediatric dental Essential Health Benefit:

- Activities conducted for consumer education and communication.
- Oversight conducted for dental quality and network management.
- If the benefit is subcontracted, state the name of the contractor, and describe any performance incentives included in the pediatric dental benefits subcontractor contract including metrics used for performance assessment.

Single, Radio group.
1: Offer benefit directly under full-service license: [100 words],
2: Subcontractor relationship: [100 words],
3: Not Applicable

20.2.2 Describe how Applicant administers child eye care benefits. Use the details section to specifically address the following:

- Activities conducted for consumer education and communication related to child eye care benefits.
- Oversight conducted for quality and network management.

Single, Radio group.
1: Offer benefit directly under full-service license: [200 words],
2: Subcontractor relationship: [200 words],
3: Other: [200 words]

20.2.3 Indicate how Applicant administers mental health and substance use disorder (MHSUD) benefits as either administered directly by Applicant or subcontracted to a contractor.
Single, Radio group.
1: Applicant offers benefit directly under full-service license,
2: Applicant offers benefit through subcontractor, state the name of the contractor: [50 words],
3: Other, describe: [50 words]

20.2.4 Describe activities Applicant conducts to educate and communicate to consumers about mental health and substance use disorder (MHSUD) benefits and how to access MHSUD services.
200 words.

20.2.5 Specify how Applicant monitors the following components of network management, access, and quality of care for its mental health and substance use disorder (MHSUD) provider network, either directly by Applicant or by a subcontractor.

Network Management, Access, and Quality Monitoring Components	*Monitoring Completed by Applicant or Subcontractor*		
Provider Network Development	*Single, Pull-down list.* 1: Applicant, 2: Subcontractor, 3: Both		.
Network Adequacy	*Single, Pull-down list.* 1: Applicant, 2: Subcontractor, 3: Both		
Appointment Wait Times	*Single, Pull-down list.* 1: Applicant,		

	2: Subcontractor, 3: Both		
Clinical Quality Performance	*Single, Pull-down list.* 1: Applicant, 2: Subcontractor, 3: Both		
Patient Experience	*Single, Pull-down list.* 1: Applicant, 2: Subcontractor, 3: Both		
Cultural and Linguistic Concordance	*Single, Pull-down list.* 1: Applicant, 2: Subcontractor, 3: Both		
Referral Process between Physical Health and Behavioral Health Providers	*Single, Pull-down list.* 1: Applicant, 2: Subcontractor, 3: Both		
Care Coordination	*Single, Pull-down list.* 1: Applicant, 2: Subcontractor, 3: Both		
Telehealth	*Single, Pull-down list.* 1: Applicant, 2: Subcontractor, 3: Both		

20.2.6 Describe the oversight and accountability process for and any performance incentives associated with behavioral health provider network development.
100 words.

20.2.7 Describe the oversight and accountability process for and any performance incentives associated with behavioral health network adequacy.
100 words.

20.2.8 Describe the oversight and accountability process for and any performance incentives associated with behavioral health appointment wait times.
100 words.

20.2.9 Describe the oversight and accountability process for and any performance incentives associated with behavioral health clinical quality.
100 words.

20.2.10 Describe the oversight and accountability process for and any performance incentives associated with behavioral health patient experience.
100 words.

20.2.11 Describe the oversight and accountability process for and any performance incentives associated with behavioral health cultural and linguistic concordance.
100 words.

20.2.12 Describe the oversight and accountability process for and any performance incentives associated with the referral process between physical health and behavioral health Providers.
100 words.

20.2.13 Describe the oversight and accountability process for and any performance incentives associated with behavioral health care coordination.
100 words.

20.2.14 Describe the oversight and accountability process for and any performance incentives associated with behavioral health telehealth.
100 words.

20.2.15 Covered California supports the innovative use of technology to assist in higher quality, accessible, patient-centered care. Describe Applicant's ability to support telehealth consultations, either through a contractor or provided by the medical group or provider.
Multi, Checkboxes.
1: Plan does not offer or allow telehealth consultations,
2: Telehealth with interactive face to face dialogue (video and audio),
3: Telehealth with interactive dialogue over the phone,
4: Telehealth asynchronous store and forward,
5: Telehealth mobile health tools (reminders, alerts, monitoring) via text, instant messaging or other,
6: Remote patient monitoring,
7: e-Consult: provider-to-provider,
8: Other (specify): [20 words]

20.2.16 Do cost shares for telehealth services differ from the standard benefit design for that product?
Single, Radio group.
1: No, (no attachment),
2: Yes, Attachment D required

20.2.17 Provide information in the following chart to describe 'providers and telehealth vendors' telehealth 'capabilities to support provider-member consultations using technology. If Applicant is not currently contracted with Covered California, provide a description of telehealth capabilities, and indicate whether those services will be offered to Covered California members.

	Network Provider Capability	Percent Network Provider with capability	Telehealth Vendor Capability	Details
1. Interactive face to face dialogue (video and audio) (Use as denominator total providers across all lines of business).	*Single,* *1: network provider capability* *2: capability not available with network provider*	*Percent.*	*Single,* *1: network provider capability* *2: capability not available with network provider*	*20 words.*

2. Interactive dialogue (audio only) (Use as denominator total providers across all lines of business).	*Single, 1: network provider capability 2: capability not available with network provider*	*Percent.*	*Single, 1: network provider capability 2: capability not available with network provider*	*20 words.*
3. Telehealth for behavioral health services with interactive face to face dialogue (video and audio) (Use as denominator total providers across all lines of business).	*Single, 1: network provider capability 2: capability not available with network provider*	*Percent.*	*Single, 1: network provider capability 2: capability not available with network provider*	*20 words.*
4. Telehealth for behavioral health services with interactive dialogue (audio only) (Use as denominator total providers across all lines of business).	*Single, 1: network provider capability 2: capability not available with network provider*	*Percent.*	*Single, 1: network provider capability 2: capability not available with network provider*	*20 words.*
5. Mobile health tools, such as reminders, alerts, monitoring via text, instant messaging, or other (Use as denominator total providers across all lines of business).	*Single, 1: network provider capability 2: capability not available with network provider*	*Percent.*	*Single, 1: network provider capability 2: capability not available with network provider*	*20 words.*
6. Remote patient monitoring (Use as denominator total provider across all lines of business).	*Single, 1: network provider capability 2: capability not available with network provider*	*Percent.*	*Single, 1: network provider capability 2: capability not available with network provider*	*20 words.*

20.2.18 Applicant must complete the following table.

	Network Provider	Details
1. Report the percent of providers with access to e-Consult: provider-to-provider (Use as denominator total providers across all lines of business).	*Percent.*	*20 words.*
2. Provide percentage of network physicians and/or physician groups and practices that are designated as having	*Percent.*	*20 words.*

telehealth consultation services available (across all lines of business).		
3. Report the percent of providers identified as available for store-and-forward asynchronous telehealth services (use as denominator total providers across all lines of business).	*Percent.*	*20 words.*
4. For physicians that are available to deliver telehealth consultations, what is the average wait time? If Applicant can provide average wait time, describe how that is monitored in the Details section.	*Compound, Pull-down list.* 1: On demand, 2: Within 4 hours, 3: Within same day, 4: Scheduled follow-up within 48 hours, 5: Other (describe): [100 words], 6: N/A	

20.2.19 Confirm Applicant reimburses providers for telehealth consultations conducted.

Single, Radio group.
1: Confirmed,
2: Not confirmed

20.2.20 Describe the availability of web or telehealth consultations in languages other than English. Include details on how members are notified about the availability of interpreter services for telehealth. Specify all languages offered in response and distinguish between use of interpreter service and availability of in-language consultations in languages other than English.

200 words.

20.2.21 Describe how Applicant promotes telehealth (either through vendor or medical group) as an alternative to the Emergency Department for urgent health issues (describe specific engagement efforts and any specific contractual requirements related to this topic for vendors or medical groups).

200 words.

20.2.22 Describe how Applicant promotes integration and coordination of care between telehealth providers and in-person providers (primary care providers, specialists, etc.).

200 words.

20.2.23 Covered California requires contracted QHP Issuers to offer telehealth for behavioral health services. In the following table, indicate whether Applicant offers telehealth for behavioral health services by selecting which services are offered. Indicate how Applicant educates Covered California Enrollees on how to access services and how the information is displayed to Covered California Enrollees through Applicant's member portal and provider directory. If Applicant is not currently contracted with Covered California, provide a description of its telehealth capabilities, and indicate whether those services will be offered to Covered California Enrollees.

	Telehealth Offered	*Education Efforts*	*Details*

Applicant offers telehealth for behavioral health services	*Multi, Checkboxes.* 1: Telehealth for emergency behavioral health offered, 2: Telehealth for outpatient behavioral health (not integrated) offered, 3. Telehealth for inpatient behavioral health offered, 4. Telehealth for integrated primary care and behavioral health offered, 5. Remote monitoring (e.g., mobile health applications, self-management tools) offered, describe: [100 words] 6. Other, describe: [100 words] 7: No, Applicant does not offer telehealth for behavioral health services	*Multi, Checkboxes.* 1: Member welcome packets, 2: Educational emails, 3: Educational mailings, 4: Website notices or information, 5: Member portal notices or information, 6: Information available through provider directory, 7: Member app notices or information, 8: Information available through call center, 9: Other, describe	*100 words.*

20.2.24 Does Applicant use a behavioral health telehealth vendor:
Single, Radio group.
1: Yes, specify vendor: [20 words],
2: No

20.2.25 Report utilization of telehealth for behavioral health services in 2023.

Plan Year 2023 Utilization	Percent
Members who utilized a single telehealth for behavioral health service with a network provider or telehealth vendor.	*Percent.*
Members who utilized multiple telehealth for behavioral health services with a network provider or telehealth vendor	*Percent.*

20.2.26 Specific to behavioral health providers, describe how Applicant promotes integration and coordination of care between in-person providers and behavioral health telehealth providers.
200 words.

20.2.27 Describe the referral process and access timeline for members who need higher levels of behavioral health care in addition to or following a behavioral health telehealth visit.
200 words.

20.3 Provider Network

All questions are required for all Applicants. All questions should be answered at the product level, not Issuer level.

20.3.1 Applicant must indicate if the network it intends to offer on Covered California in the Individual market for the certification year is new or existing to Covered California and include the network name.

Single, Radio group.
1: New Network to Covered California, including an existing network with material changes [*10 words*],
2: Existing Network to Covered California with no material changes to current network [*10 words*]

20.3.2 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 the Covered California Provider Data Submission Guide. The provider network submission for the certification year must be consistent with what will be filed to the appropriate regulator for approval if Applicant is selected as a QHP Issuer. Covered California requires the information, as requested, to allow cross-network comparisons and evaluations.

Single, Pull-down list.
1: Attached, Applicant attesting to material changes to existing network or new network (confirming provider data is for the certification year),
2: Not attached, Applicant attesting to no material changes to existing plan year Covered California network for the certification year

20.3.3 Applicant must complete all tabs in Attachment E3 – EPO Provider Network Tables, for their EPO Network.

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

20.3.4 Does Applicant conduct provider negotiations and manage its own network or does Applicant lease a network from another organization? If Applicant leases a network, Applicant must describe the length of the lease agreement, including start and end dates, along with the leasing organization and if the Applicant has the ability to influence provider contract terms.

Single, Radio group.
1: Applicant contracts and manages network,
2: Applicant leases network, describe [500 words]

20.3.5 Applicant must confirm that it will respond to and adhere to the requirements of Health & Safety Code, § 1367.03 or Insurance Code, § 10133.54 and any implementing regulations relating to consumer access to primary, specialty, behavioral health and hospital care based on enrollee access.

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

20.3.6 Applicant must confirm it tracks ethnic and racial diversity in the population and ensuring access to appropriate culturally competent providers, and must briefly describe its methodology, data and tools used to track ethnic and racial diversity in the population and ensuring access to appropriate culturally concordant providers, including relevant measurement criteria and benchmarks for ensuring adequate access.
Single, Radio group.
1: Confirmed, describe [200 words],
2: Not Confirmed, describe [200 words]

20.3.7 Applicant must confirm that it will respond to and adhere to the requirements of Health & Safety Code, § 1367.03 or Insurance Code, § 10133.54 for assessing enrollee wait times for appointments with primary, specialty, and behavioral health providers.
Single, Pull-down list.
1: Confirmed,
2: Not Confirmed

20.3.8 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, Pull-down list.* 1: Yes, 2: No, 3: Not Applicable
Does applicant allow out-of-state (non-emergency) providers to participate in networks to serve Covered California enrollees? If yes, explain in detail how this coverage is offered.	*Compound, Pull-down list.* 1: Yes: [200 words], 2: No, 3: Not Applicable

20.3.9 Describe any plans for network changes, by product, including any new medical groups or hospital systems that Applicant would like to highlight for Covered California attention.
100 words.

20.4 Delivery System and Payment Strategies to Drive Quality

Attachment 1 of the Covered California Qualified Health Plan (QHP) Issuer Contract embodies Covered California's vision for delivery system reform and serves as a roadmap to delivery system improvements. A number of the delivery system and payment strategy requirements in Attachment 1 meet the federal Quality Improvement Strategy (QIS) requirements.

The Patient Protection and Affordable Care Act (§1311(g)(1)) requires periodic reporting to Covered California of activities a QHP Issuer 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, reducing hospital readmissions, improving patient safety, and reducing medical errors, implementing wellness and health promotion activities, and reducing health and health care disparities. QHP Issuers must implement and report on a quality improvement strategy or strategies consistent with the standard of section 1311(g) of the ACA.

Applicants that are currently operating in Covered California are required to complete QIS workplans as part of the Application process. The following strategies meet the QIS requirements and Applicants must submit QIS workplans:

- Advanced Primary Care
- Appropriate Use of Cesarean Sections
- Hospital Quality, Value, and Patient Safety

QHP certification is conditioned on Applicant developing a multi-year QIS and reporting year-to-year activities and progress on each initiative area.

Applicants that are not currently operating in Covered California are not required to complete the QIS workplan updates as part of the Application for 2025 but must review Attachment 1 with the understanding that engagement in the QIS and Attachment 1 initiatives will be contractually required and measured in the future if Applicant contracts with Covered California.

20.4.1 Provider Networks Based on Value

All questions are required for new entrant Applicants. All questions should be answered at the product level, not Issuer level.

Applicant shall curate and manage its network(s) to address variation in quality and cost performance across network hospitals and providers, with a focus on improving the performance of hospitals and providers. Applicant shall measure, analyze, and reduce variation to achieve consistent high performance for all network hospitals and providers. Applicant shall hold its contracted hospitals and providers accountable for improving quality and managing cost and provide support to its contracted hospitals and providers to improve performance. The following questions address Applicant's ability to track and address variation in quality and cost performance across network hospitals and providers.

20.4.1.1 In the following table, Applicant must identify key quality and cost sources and measures that the Applicant uses to evaluate providers and hospitals for determining initial and ongoing network inclusion, and briefly explain how each measure is used, including if and how the measure is used for performance payment. Applicant must also describe any additional criteria used to determine network inclusion.

	Data Source	*Purpose*	*Provide examples if response #4 selected for Purpose*	*Provide details if Other selected in Data Source or Purpose*
Hospital Quality	*Multi, Checkboxes.* 1: Cal Hospital Compare data, 2: California Maternal Quality Collaborative data, 3: Leapfrog Group data, 4: CMS Hospital Quality Reporting, 5: Program or another CMS program, 6: Designated Center of Excellence (COE), 7: Other, explain	*Multi, Checkboxes.* 1: Used for initial contracting assessment, 2: Used for re-contracting assessment, 3: Has been used for incentive or Pay for Performance payments, 4: Has been used for termination or exclusion (give examples), 5: Other, explain	*100 words.*	*100 words.*
Hospital Cost	*Multi, Checkboxes.* 1: Percent of Medicare rates, 2: Diagnosis-Related Group (DRG) costs, 3: Comparison to other	*Multi, Checkboxes.* 1: Used for initial contracting assessment, 2: Used for re-contracting assessment, 3: Has been used for	*100 words.*	*100 words.*

	hospital costs in geographic area, 4: Comparison to other hospital costs by decile or other method, 5: CMS Hospital Price Transparency data, 6: Other, explain	incentive or Pay for Performance payments, 4: Has been used for termination or exclusion (give examples), 5: Other, explain		
Additional Criteria	*100 words.*	*100 words.*	*100 words.*	*100 words.*

20.4.1.2 In the following table, Applicant must identify key quality and cost sources and measures that the Applicant uses to evaluate providers for determining initial and ongoing network inclusion, and briefly explain how each measure is used, including if and how the measure is used for performance payment. Applicant must also describe any additional criteria used to determine network inclusion.

	Data Source	*Purpose*	*Provide examples if response #4 selected for Purpose*	*Provide details if Other selected in Data Source or Purpose*
Provider Quality	*Multi, Checkboxes.* 1: Integrated Healthcare Association data, 2: Office of Patient Advocate data, 3: Other, explain	*Multi, Checkboxes.* 1: Used for initial contracting assessment, 2: Used for re-contracting assessment, 3: Has been used for incentive or Pay for Performance payments, 4: Has been used for termination or exclusion (give examples), 5: Other, explain	*100 words.*	*100 words.*
Provider Cost	*Multi, Checkboxes.* 1: Total Cost of Care data, 2: Comparison to other physician or physician groups in geographic area, 3: Other, explain	*Multi, Checkboxes.* 1: Used for initial contracting assessment, 2: Used for re-contracting assessment, 3: Has been used for incentive or Pay for Performance payments, 4: Has been used for termination or exclusion (give examples), 5: Other, explain	*100 words.*	*100 words.*
Additional Criteria	*100 words.* Nothing required	*100 words.* Nothing required	*100 words.*	*100 words.*

20.4.2 Advanced Primary Care

All questions required for currently contracted Applicants. Questions 20.4.2.1 and 20.4.2.2 are required for new entrant Applicants. All questions should be answered at the product level, not Issuer level.

Covered California recognizes that providing high-quality, equitable, and affordable care requires a foundation of effective and patient-centered primary care. Advanced primary care is patient-centered, accessible, team-based, data driven, supports the integration of behavioral health services, and provides care management for patients with complex conditions. Advanced primary care is supported by alternative payment models such as population-based payments and shared savings arrangements. Applicant shall actively promote the development and use of advanced primary care models that promote access, care coordination, and quality while managing the total cost of care. The following questions address Applicant's ability to match at least 95% of enrollees with a primary care clinician and increase the proportion of providers paid under a payment strategy that promotes advanced primary care.

This strategy meets the QIS requirements.

20.4.2.1 Report the percentage of Covered California Enrollees who either selected or were matched with a primary care clinician in 2023 in Attachment J_QHP-IND_Run Charts. If Applicant had no Covered California business in 2023, report full 2023 book of business excluding Medicare. Applicants currently contracted with Covered California must enter the number and percentage of providers paid under each model reported in the Certification Applications for 2022, 2023 and 2024 as well. Report data by product (HMO, PPO, EPO, Other).

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

20.4.2.2 Report all types of payment methods used for primary care services and number of providers paid under each model in 2023 in Attachment J_QHP-IND_Run Charts using the alternative payment models (APM) outlined in the Health Care Payment Learning Action & Action Network (HCP LAN) Alternative Payment Model APM Framework. If Applicant had no Covered California business in 2023, report full 2023 book of business excluding Medicare. Applicants currently contracted with Covered California must enter the number and percentage of providers paid under each model reported in the Certification Applications for 2022, 2023 and 2024 as well. Report data by product (HMO, PPO, EPO, Other).

References:
HCP LAN Alternative Payment Model APM Framework: http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf

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

20.4.2.3 Complete Attachment K1_QHP-IND-CCSB_ QIS 1 Work Plan-Advanced Primary Care to describe updates on progress made since the previous QIS submission in each part of the primary care goals, and planned activities. Address each of the following in the work plan narrative:

- Updates on the PCP matching initiative, including a status report, feedback on the enrollee experience, challenges, and suggestions (if applicable)
- Progress implementing alternative payment models for primary care to align with Category 3 or 4 APMs described in the APM Framework including: activities conducted, data collected and analyzed, and results

- Describe any support or technical assistance (financial, staffing, educational, etc.) that Applicant or multi-insurer collaborative is providing to primary care providers to support their efforts towards accessible, data-driven, team-based care
- Implementation of advanced primary care initiatives and quality improvement activities to improve health outcomes on any of the QTI measures:
- Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%) (NQF #0575)
- Controlling High Blood Pressure (NQF #0018)
- Colorectal Cancer Screening (NQF #0034)
- Childhood Immunization Status (Combo 10) (NQF #0038)
- Further implementation plans for 2024 including milestones and targets for 2024 and 2025
- Known or anticipated barriers in implementing QIS activities and progress of mitigation activities

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

20.4.3 Integrated Delivery Systems and Accountable Care Organizations

Question 20.4.3.1 is required for currently contracted Applicants. All questions are required for new entrant Applicants. All questions should be answered at the product level, not Issuer level.

Evidence suggests the adoption and expansion of integrated, coordinated, and accountable systems of care such as Integrated Delivery Systems (IDSs) or Accountable Care Organization (ACOs) can lead to improved quality and reduced costs. An IDS is defined as an organized healthcare delivery system in which payers, hospitals, and providers coordinate to provide patient care, integrate care across settings, and share responsibility for patient outcomes and resource use. IDS partners are generally managed by the same organization. An ACO is defined as a system of population-based care coordinated across the continuum including multidisciplinary physicians and physician groups, hospitals, and ancillary providers with combined risk sharing arrangements and shared incentives between providers or between payers and providers. Ideally ACO partners are held accountable for nationally recognized clinical, financial, and operational performance. As providers accept more accountability under this provision, Applicant shall ensure that providers have the capacity to manage the risk. There are many variations of ACO implementation with evidence suggesting that there are key characteristics of an ACO model that influence its success. The following questions address Applicant's ability to increase enrollment in IDS or ACO models in its Covered California network and solicit information about the structure of Applicant's IDS and ACO models.

20.4.3.1 Using the definition for IDS or ACO above, report the number and percentage of Covered California Enrollees and total California Enrollees who are managed under an IDS or ACO in 2023 in Attachment J_QHP-IND_Run Charts. Applicants currently contracted with Covered California must enter the percentage reported in the Certification Application for 2022, 2023 and 2024 as well. If Applicant had no Covered California business in 2023, report full 2023 book of business excluding Medicare. Report data by product (HMO, PPO, EPO, Other).

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

20.4.3.2 Applicant must identify key components of the Applicant's IDS or ACO model and must briefly explain how each component is implemented.

	Response	*Details*
Regulated ACO or IDS entity status: Insurer	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Regulated ACO or IDS entity status: Provider with Knox Keene license	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Participation: 2-way (health plan/provider organization)	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Participation: 3-way (health plan/provider organization/hospital)	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Participation: 4-way (health plan/provider organization/purchaser)	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Participation: Includes advanced primary care providers or patient-centered medical homes	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Participation: Other	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Base payment: Global capitation	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Base payment: Professional capitation only	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Base payment: Separate professional capitation and hospital capitation	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Base payment: Fee for service	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Base payment: Other	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Performance payment: Two-sided shared savings (upside/downside risk)	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*

Performance payment: One-sided shared savings (upside risk)	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Performance payment: Pay for performance quality bonus	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Performance payment: Other	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Leadership: Physician-led	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Leadership: Hospital-led	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Leadership: Plan-led	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Leadership: Other	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Leadership: Jointly led by physician and hospitals	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Member assignment: Attribution algorithm	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Member assignment: Patient selection	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Member assignment: Health plan assignment	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Member assignment: Other	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Timing: Retrospective	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Timing: Prospective	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Timing: Other	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*

20.4.3.3 Applicant must provide, as attachments, documents related to IDSs or ACOs or confirm Applicant will submit the documents as they become available.

	Response
(File titled Provider 1a): Applicant's quality and cost measures used to track progress and success of IDS or ACO providers.	*Single, Pull-down list.* 1: Attached, 2: Not attached
(File titled Provider 1b): Example of Applicant report to its IDS or ACO providers on its quality of care and financial performance, including benchmarking relative to performance improvement goals or market norms.	*Single, Pull-down list.* 1: Attached, 2: Not attached
(File titled Provider 1c): Confirm Applicant will submit a copy of Applicant's 2023 IHA Align Measure Perform (AMP) Commercial ACO report when it becomes available, if Applicant participates in the program.	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed, 3: N/A

20.4.4 Appropriate Use of Cesarean Sections

All questions are required for currently contracted Applicants. Questions 20.4.4.1 – 20.4.4.6 are required for new entrant Applicants. All questions should be answered at the product level, not Issuer level.

According to the World Health Organization, maternal health refers an individual's health during pregnancy, childbirth, and the postpartum period. Covered California is committed to addressing all three phases to provide a comprehensive approach to maternal health. Cesarean sections (C-sections) can be lifesaving, but significant numbers of low-risk, first-time pregnancies are undergoing this invasive surgery when it is not medically necessary. Reducing the rate of unnecessary C-sections improves health outcomes and patient safety.

Applicant must: 1) Progressively adopt physician and hospital payment strategies so that revenue for labor and delivery only supports medically necessary care and no financial incentive exists to perform a low-risk Nulliparous Term Singleton Vertex (NTSV) Cesarean Section (C-Section). 2) Promote improvement work through the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center (MDC), so that all maternity hospitals achieve an NTSV C-Section rate of 23.9% or lower or are at least working toward that goal. 3) Consider a hospital's NTSV C-section rate, improvement trajectory, and willingness to engage in coaching as part of its maternity hospital contracting decisions and terms. Covered California does not expect Contractor to base poor performance, and potential network removal decisions, on one measure alone.

Smart Care California has outlined three payment strategies to align payment with medically necessary use of C-sections:

- Adopt a blended case rate payment for both physicians and hospitals;
- Include a NTSV C-section metric in existing hospital and physician quality incentive programs; and
- Adopt population-based payment models, such as maternity episode payment models or inclusion in Integrated Delivery System, ACO, or similar financial accountability arrangement.

The following questions address Applicant's ability to meet the requirements for the appropriate use of cesarean sections.

Applicants that are not currently operating in Covered California are expected to adopt a payment methodology structured to support only medically necessary care with no financial incentive to perform C-sections for all contracted physicians and hospitals serving enrollees.

This strategy meets the QIS requirements.

20.4.4.1 Describe how Applicant is measuring overuse of Cesarean Sections.

100 words.

20.4.4.2 Describe how Applicant is implementing Smart Care California guidelines (https://www.iha.org/wp-content/uploads/2020/12/c-section_menu_of_payment_and_contracting_options.pdf) to promote best practices to reduce unnecessary Cesarean Sections.

	Guideline	*Implementation*	*Description*
1	Adopt a blended case rate payment for both physicians and hospitals.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*
2	Include a NTSV C-section metric in existing hospital and physician quality incentive programs.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*
3	Adopt population-based payment models, such as ACO-like arrangements.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*
4	Pay less for C-sections without medical indication and for scheduled non-medically necessary repeat C-sections.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*
5	Require or incent hospital participation in CMQCC's Maternal Data Center (MDC).	*Single, Pull-down list.* 1: In place, 2: Implementation in progress,	*50 words.*

		3: Have not implemented	
6	Implement network quality improvement requirements with a deadline.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*

20.4.4.3 Report number of all network hospitals reporting to the California Maternity Quality Care Collaborative (CMQCC) Maternal Data Center (MDC) in 2023 in Attachment J_QHP-IND_Run Charts. A list of all California hospitals participating in the MDC can be found here: https://www.cmqcc.org/about-cmqcc/member-hospitals. Applicants currently contracted with Covered California must enter the percentage reported in the Certification Applications for 2022, 2023, and 2024 as well. If Applicant had no Covered California business in 2022, report full 2022 book of business excluding Medicare.

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

20.4.4.4 Contracted QHP Issuer must adopt value-based payment strategies structured to support only medically necessary care with no financial incentive to perform non-medically necessary NTSV C-sections for all contracted physicians and hospitals by year end 2023 or in the first year of QHP certification if after 2023. These value-based payment strategies include: 1) Blended case rate payment for both physicians and hospitals; 2) Including a NTSV C-section metric in existing hospital and physician quality incentive programs; and 3) Population-based payment models, such as maternity episode payment models.

Report models and number of network hospitals paid using each payment strategy in 2023 in Attachment J_QHP-IND_Run Charts. 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 non-medically necessary C-Section delivery.

Applicants currently contracted with Covered California must enter the percentages reported in the Certification Applications for 2022, 2023, and 2024 as well. If Applicant had no Covered California business in 2023, report full 2023 book of business excluding Medicare.

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

20.4.4.5 Applicant must confirm that all network physicians are pain on a case rate for deliveries and that payment is the same for both vaginal and non-medically necessary C-section delivery. Confirm that all network physicians are paid on a case rate for deliveries and that payment is the same for both vaginal and C-section delivery.

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

20.4.4.6 If Applicant selected not confirmed in question 20.4.4.5, that all network physicians are paid on a case rate for deliveries and that payment is the same for both vaginal and non-medically necessary C-section delivery, Applicant must complete the following table.

Payment Strategy	**Description**	**Percent of Physicians Paid Under Strategy**	**Numerator**	**Denominator**
Strategy 1: Blended Case Rate	*50 words.*	*Percent.*	*Integer.*	*Integer.*
Strategy 2: Provide quality bonuses for physicians that attain NTSV C-section rate goal or make improvements in reducing NTSV C-sections	*50 words.*	*Percent.*	*Integer.*	*Integer.*
Strategy 3: Population-based payment models	*50 words.*	*Percent.*	*Integer.*	*Integer.*
Strategy 4: Other (explain)	*50 words.*	*Percent.*	*Integer.*	*Integer.*
Strategy 5: Other (explain)	*50 words.*	*Percent.*	*Integer.*	*Integer.*
Strategy 6: Other (explain)	*50 words.*	*Percent.*	*Integer.*	*Integer.*

20.4.4.7 Maternal health disparities exist across the full spectrum of maternal health, from preconception, to pregnancy, and the postpartum period. Disparities in maternal health disproportionately affect Black and Latino populations at higher rates than other racial groups. Reducing and eliminating gaps in maternal health requires a multifaceted approach. Indicate and describe in the following table any of the activities undertaken by Applicant to identify and reduce maternal health disparities.

Activities to Identify and Reduce Maternal Health Disparities	*Response*	*Details*
1. Engages with contracted providers to improve performance on maternal health measures, specify measures and if engagement includes performance reviews, evidence-based interventions, or participation in quality collaboratives	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
2. Identifies maternal health disparities among its maternity Enrollees	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
3. Engages with hospitals and providers to address maternal health disparities. Specify if engagement includes quarterly performance reviews, data analysis on race and ethnicity of its maternity Enrollees and outcomes, or implementation of corrective action plans	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
4. Ensures that its network perinatal providers, staff, and facilities are complying with the California Dignity in Pregnancy and Childbirth Act, which mandates implicit bias training to reduce the effects of implicit bias in pregnancy, childbirth, and postnatal care	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
5. Supports its maternity Enrollees, such as access to culturally and linguistically appropriate maternity care, referrals to group	*Single, Pull-down list.*	*50 words.*

prenatal care or community-centered care models for patients, in home lactation and nutrition consultants, doula support for prenatal, labor, delivery, and postpartum care, and related services	1: Yes, 2: No	
6. Ensures that its maternity Enrollees are aware of the supportive services available to them, including the services described in (5) above, and that Enrollees know how to access these services	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
7. Works to promote and encourage all in-network hospitals that provide maternity services to use the resources provided by California Maternity Quality Care Collaborative (CMQCC) and the California Department of Public Health's Maternal, Child and Adolescent Health (MCAH) Division to address maternal health disparities	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*

20.4.4.8 Complete Attachment K2_QHP-IND-CCSB_QIS 2 Work Plan–Appropriate Use of C-Sections to describe updates on progress made since the last QIS submission with regards to promoting appropriate use of Cesarean-Sections (C-Sections). Address each of the following in the work plan narrative:

- Description of how Applicant engages with its network hospitals to reduce NTSV (non-medically necessary) C-Section rates to 23.9% or less
- Description of its value-based payment strategies structured to support only medically necessary care with no financial incentive to perform C-sections for all contracted physicians and hospitals by year end 2023
- Description of how NTSV (non-medically necessary) C-section rates are included in network hospital and provider contracting criteria
- Description of how Applicant promotes and encourages all in-network hospitals that provide maternity services to use the resources provided by CMQCC and enroll in the CMQCC MDC
- Updates to hospital participation in CMQCC and hospital engagement in maternity care quality improvement, particularly those with a NTSV rate higher than 23.9%
- Further implementation plans for 2024 including milestones and targets for 2024 and 2025
- List any known or anticipated barriers in implementing QIS activities and progress of mitigation activities

Note: Refer to Appendix M for hospital C-section rates.
Single, Radio group.
1: Attached,
2: Not attached

20.4.5 Hospital Quality, Value, and Patient Safety

All questions required for currently contracted Applicants. Questions 20.4.5.1-20.4.5.3 are required for new entrant Applicants.

Applicant must: 1) Adopt a hospital payment strategy that ties Hospital payments to quality, to value, and safety. 2) Promote hospital involvement in improvement programs so that all hospitals achieve infection rates (measured as a standardized infection ratio or SIR) of 1.0 or lower for the five Hospital Associated Infection (HAI) measures listed below or are working to improve. 3) Promote hospital involvement in improvement programs so that all hospitals comply with Sepsis Management according to CMS guidelines.

The five HAIs and Sepsis Management are:

- Catheter Associated Urinary Tract Infections (CAUTI)
- Central Line Associated Blood Stream Infections (CLABSI)
- Clostridioides Difficile Infection (CDI)
- Methicillin-resistant Staphylococcus Aureus (MRSA)
- Surgical Site Infection of the Colon (SSI Colon)
- Sepsis Management (SEP-1)

The following questions address Applicant's ability to meet the requirements for hospital patient safety.

This strategy meets the QIS requirements.

20.4.5.1 Applicant shall adopt a hospital payment methodology for each general acute care hospital in its networks that ties payment to quality, value, and safety. Report, across all lines of business, the percentage of hospital reimbursements tied to quality, value and safety and the metrics applied for performance-based payments in Attachment J_QHP-IND_Run Charts. In the details section of the spreadsheet, describe the performance-based payment strategy structure used to put payments at risk, and note if more than one structure is used. "Quality performance" includes any number or combination of metrics, including HAIs, readmissions, patient satisfaction, etc. In the same sheet, report metrics used to assess quality performance. Currently contracted Applicants must enter the percentages reported in the Certification Applications for 2022, 2023, and 2024 as well. If Applicant had no Covered California business in 2023, report full 2023 book of business excluding Medicare.

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

20.4.5.2 Report the number and percent of hospitals contracted under the model described in question 18.4.5.1 with reimbursement at risk for quality performance in 2023 in Attachment J_QHP-IND_Run Charts. Currently contracted Applicants must enter the numbers reported in the Certification Applications for 2022, 2023, and 2024 as well. If Applicant had no Covered California business in 2023, report full 2023 book of business excluding Medicare.

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

20.4.5.3 Covered California is committed to addressing the opioid epidemic and continues to pursue improvement in the appropriate use of opioids in both the outpatient and hospital settings. In the following table, describe Applicant's strategies to improve the appropriate use of opioids in its network hospitals and how Applicant encourages all network hospitals to utilize the Opioid Management Hospital Self-Assessment, which outlines key milestones to achieving opioid safety, and to participate in the Opioid Care Honor Roll program from Cal Hospital

Compare. The self-assessment can be accessed from: https://calhospitalcompare.org/wp-content/uploads/2022/08/Opioid-Mgmt-Hospital-Self-Assessment_2023-1.pdf.

	Response
Describe Applicant's strategies to improve the appropriate use of opioids in its network hospitals.	*200 words.*
Describe how Applicant encourages all network hospitals to utilize the Opioid Management Hospital Self-Assessment.	*200 words.*
Describe how Applicant encourages all network hospitals to participate in the Opioid Care Honor Roll program from Cal Hospital Compare.	*200 words.*

20.4.5.4 Complete Attachment K3_QHP-IND-CCSB_QIS 3 Work Plan–Hospital Quality, Value, Patient Safety to describe progress promoting hospital safety since the last submission. Address each of the following in the work plan narrative:

- How Applicant is engaging with its network hospitals to reduce the five specified HAIs to achieve a Standardized Infection Ratio (SIR) of 1.0 or lower for each of the specified HAIs
- How Applicant aims to improve adherence to the Sepsis Management (SEP-1) guidelines
- How Applicant is leveraging the poor performing hospitals list provided by Cal Hospital Compare to collaborate with other QHP Issuers who contract with the same poor performing hospitals
- Progress in adopting a payment strategy that ties hospital payment to quality, value, and safety
- Collaborations with other QHP Issuers on approaching hospitals to suggest quality improvement program participation or alignment on a payment strategy to tie hospital payment to quality
- Further implementation plans for 2024 including milestones and targets for 2024 and 2025
- List any known or anticipated barriers in implementing QIS activities and progress of mitigation activities

Note: In addition to hospital HAI rates in Appendix M, refer to the following publicly available references, which describe free coaching programs available to hospitals:

Information on Partnership for Patients: https://partnershipforpatients.cms.gov/

Hospital participation in Hospital Improvement Innovation Networks (HIINs): https://partnershipforpatients.cms.gov/about-the-partnership/hospital-engagement-networks/thehospitalengagementnetworks.html

Hospital HAI rates can be reviewed individually at http://calhospitalcompare.org/.

Single, Radio group.

1: Attached,
2: Not attached

21 Other Network Type

21.1 Benefit Design

All questions are required for all Applicants. All questions should be answered at the product level, not Issuer level.

21.1.1 Applicant must confirm all products offered will comply with the coverage year Patient-Centered Benefit Plan Designs (PCBPD). If not, Applicant must explain why.
Single, Radio group.
1: Confirmed,
2: Not confirmed, [200 words]

21.1.2 Applicant must confirm all guidelines and due dates will be followed as listed in the Covered California Submission Guidelines Health Individual – Plan Year 2024.
Single, Pull-down list.
1: Confirmed,
2: Not confirmed

21.1.3 Applicant must indicate if it is requesting approval for any cost-sharing deviations from the coverage year Patient-Centered Benefit Plan Designs. If yes, Applicant must submit Attachment C_QHP-IND_Patient-Centered Benefit Plan Design Deviations. In addition, Applicant must submit the same cost-sharing deviations to Applicant's applicable regulator for approval.
Note: Alternate benefit design proposals are not permitted in the Individual Marketplace. Covered California's decision whether to approve or deny QHP specific proposed deviations are on a case-by-case basis and are not considered an alternate benefit design.
Single, Pull-down list.
1: Yes, deviations requested, attached.,
2: No, no deviations requested

21.1.4 Covered California encourages Applicant to offer 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 coverage year Patient-Centered Benefit Plan Design which includes all ten Essential Health Benefits. Failure to offer a product without pediatric dental will not be grounds for rejection of Applicant's application.
Single, Pull-down list.
1: Yes. Individual market QHPs proposed for coverage year include all ten Essential Health Benefits.,
2: No. Individual market QHPs proposed for coverage year do not include all ten Essential Health Benefits.

21.1.5 Applicant must indicate if proposed QHPs will include coverage of non-emergent out-of-network services. If yes, with respect to non-network, non-emergency claims, describe how non-emergent out-of-network coverage is communicated to enrollees in addition to the details provided in the Evidence of Coverage or Policy document. If no, describe how the lack of coverage for non-emergent out-of-network services coverage is communicated to enrollees, such as the Evidence of Coverage or Policy document.
Single, Radio group.

1: Yes, describe: [100 words],
2: No, describe: [100 words]

21.1.6 Applicant must confirm the coverage year Schedule of Benefits and Coverage (SBC), Evidence of Coverage (EOC) or Policy language describing proposed health Benefits will follow the requirements in the Covered California Submission Guidelines Health Individual – Plan Year 2025 and must comply with state and federal laws.

Single, Radio group.
1: Confirmed,
2: Not confirmed:

21.2 Benefit Administration

All questions are required for all Applicants. All questions should be answered at the product level, not Issuer level.

21.2.1 If Applicant's proposed QHPs will include the pediatric dental essential health benefit, Applicant must describe how it intends to embed this benefit. In the description of the option selected, Applicant must describe how it will ensure that the provision of pediatric dental benefits adheres to contractual requirements, including pediatric dental quality measures. Specifically address the following for the pediatric dental Essential Health Benefit:

- Activities conducted for consumer education and communication.
- Oversight conducted for dental quality and network management.
- If the benefit is subcontracted, state the name of the contractor, and describe any performance incentives included in the pediatric dental benefits subcontractor contract including metrics used for performance assessment.

Single, Radio group.
1: Offer benefit directly under full-service license: [100 words],
2: Subcontractor relationship: [100 words],
3: Not Applicable

21.2.2 Describe how Applicant administers child eye care benefits. Use the details section to specifically address the following:

- Activities conducted for consumer education and communication related to child eye care benefits.
- Oversight conducted for quality and network management.

Single, Radio group.
1: Offer benefit directly under full-service license: [200 words],
2: Subcontractor relationship: [200 words],
3: Other: [200 words]

21.2.3 Indicate how Applicant administers mental health and substance use disorder (MHSUD) benefits as either administered directly by Applicant or subcontracted to a contractor.
Single, Radio group.
1: Applicant offers benefit directly under full-service license,
2: Applicant offers benefit through subcontractor, state the name of the contractor: [50 words] ,
3: Other, describe: [50 words]

21.2.4 Describe activities Applicant conducts to educate and communicate to consumers about mental health and substance use disorder (MHSUD) benefits and how to access MHSUD services.

200 words.

21.2.5 Specify how Applicant monitors the following components of network management, access, and quality of care for its mental health and substance use disorder (MHSUD) provider network, either directly by Applicant or by a subcontractor.

Network Management, Access, and Quality Monitoring Components	*Monitoring Completed by Applicant or Subcontractor*	
Provider Network Development	*Single, Pull-down list.* 1: Applicant, 2: Subcontractor, 3: Both	
Network Adequacy	*Single, Pull-down list.* 1: Applicant, 2: Subcontractor, 3: Both	
Appointment Wait Times	*Single, Pull-down list.* 1: Applicant, 2: Subcontractor, 3: Both	
Clinical Quality Performance	*Single, Pull-down list.* 1: Applicant, 2: Subcontractor, 3: Both	
Patient Experience	*Single, Pull-down list.* 1: Applicant, 2: Subcontractor, 3: Both	
Cultural and Linguistic Concordance	*Single, Pull-down list.* 1: Applicant, 2: Subcontractor, 3: Both	.
Referral Process between Physical Health and Behavioral Health Providers	*Single, Pull-down list.* 1: Applicant, 2: Subcontractor, 3: Both	
Care Coordination	*Single, Pull-down list.* 1: Applicant, 2: Subcontractor, 3: Both	
Telehealth	*Single, Pull-down list.* 1: Applicant, 2: Subcontractor, 3: Both	

21.2.6 Describe the oversight and accountability process for and any performance incentives associated with behavioral health provider network development.

100 words.

21.2.7 Describe the oversight and accountability process for and any performance incentives associated with behavioral health network adequacy.
100 words.

21.2.8 Describe the oversight and accountability process for and any performance incentives associated with behavioral health appointment wait times.
100 words.

21.2.9 Describe the oversight and accountability process for and any performance incentives associated with behavioral health clinical quality.
100 words.

21.2.10 Describe the oversight and accountability process for and any performance incentives associated with behavioral health patient experience.
100 words.

21.2.11 Describe the oversight and accountability process for and any performance incentives associated with behavioral health cultural and linguistic concordance.
100 words.

21.2.12 Describe the oversight and accountability process for and any performance incentives associated with the referral process between physical health and behavioral health Providers.
100 words.

21.2.13 Describe the oversight and accountability process for and any performance incentives associated with behavioral health care coordination.
100 words.

21.2.14 Describe the oversight and accountability process for and any performance incentives associated with behavioral health telehealth.
100 words.

21.2.15 Covered California supports the innovative use of technology to assist in higher quality, accessible, patient-centered care. Describe Applicant's ability to support telehealth consultations, either through a contractor or provided by the medical group or provider.
Multi, Checkboxes.
1: Plan does not offer or allow telehealth consultations,
2: Telehealth with interactive face to face dialogue (video and audio),
3: Telehealth with interactive dialogue over the phone,
4: Telehealth asynchronous store and forward,
5: Telehealth mobile health tools (reminders, alerts, monitoring) via text, instant messaging or other,
6: Remote patient monitoring,
7: e-Consult: provider-to-provider,
8: Other (specify): [20 words]

21.2.16 Do cost shares for telehealth services differ from the standard benefit design for that product?

Single, Radio group.
1: No, (no attachment),
2: Yes, Attachment D required

21.2.17 Provide information in the following chart to describe providers and telehealth vendors' telehealth capabilities to support provider-member consultations using technology. If Applicant is not currently contracted with Covered California, provide a description of telehealth capabilities, and indicate whether those services will be offered to Covered California members.

	Network Provider Capability	Percent Network Provider with capability	Telehealth Vendor Capability	Details
1. Interactive face to face dialogue (video and audio) (Use as denominator total provider across all lines of business).	*Single, 1: network provider capability 2: capability not available with network provider*	*Percent.*	*Single, 1: network provider capability 2: capability not available with network provider*	*20 words*
2. Interactive dialogue (audio only) (Use as denominator total provider across all lines of business).	*Single, 1: network provider capability 2: capability not available with network provider*	*Percent.*	*Single, 1: network provider capability 2: capability not available with network provider*	*20 words*
3.Ttelehealth for behavioral health services with interactive face to face dialogue (video and audio) (Use as denominator total providers across all lines of business).	*Single, 1: network provider capability 2: capability not available with network provider*	*Percent.*	*Single, 1: network provider capability 2: capability not available with network provider*	*20 words*
4. Telehealth for behavioral health services with interactive dialogue (audio only) (Use as denominator total providers across all lines of business).	*Single, 1: network provider capability*	*Percent.*	*Single, 1: network provider capability*	*20 words*

	2: capability not available with network provider		*2: capability not available with network provider*	
5. Mobile health tools, such as reminders, alerts, monitoring via text, instant messaging, or other (Use as denominator total provider across all lines of business).	*Single, 1: network provider capability 2: capability not available with network provider*	*Percent.*	*Single, 1: network provider capability 2: capability not available with network provider*	*20 words*
6. Remote patient monitoring (Use as denominator total provider across all lines of business).	*Single, 1: network provider capability 2: capability not available with network provider*	*Percent.*	*Single, 1: network provider capability 2: capability not available with network provider*	*20 words*

21.2.18 Applicant must complete the following table.

	Network Provider	Details
1. Report the percent of providers with access to e-Consult: provider-to-provider (Use as denominator total providers across all lines of business).	*Percent.*	*20 words*
2. Provide percentage of network physicians and/or physician groups and practices that are designated as having telehealth consultation services available (across all lines of business).	*Percent.*	*20 words*
3. Report the percent of providers identified as available for store-and-forward asynchronous telehealth services (use as denominator total providers across all lines of business).	*Percent.*	*20 words*
4. For physicians that are available to deliver telehealth consultations, what is the average wait time? If Applicant can provide average wait time, describe how that is monitored in the Details section.	*Compound, Pull-down list.* 1: On demand, 2: Within 4 hours, 3: Within same day, 4: Scheduled	

	follow-up within 48 hours, 5: Other (describe): [100 words], 6: N/A	

21.2.19 Confirm Applicant reimburses providers for telehealth consultations conducted.

Single, Radio group.
1: Confirmed,
2: Not confirmed

21.2.20 Describe the availability of web or telehealth consultations in languages other than English. Include details on how members are notified about the availability of interpreter services for telehealth. Specify all languages offered in response and distinguish between use of interpreter service and availability of in-language consultations in languages other than English..

200 words.

21.2.21 Describe how Applicant promotes telehealth (either through vendor or medical group) as an alternative to the Emergency Department for urgent health issues (describe specific engagement efforts and any specific contractual requirements related to this topic for vendors or medical groups).

200 words.

21.2.22 Describe how Applicant promotes integration and coordination of care between telehealth providers and in-person providers (primary care providers, specialists, etc.).

200 words.

21.2.23 Covered California requires contracted QHP Issuers to offer telehealth for behavioral health services. In the following table, indicate whether Applicant offers telehealth for behavioral health services by selecting which services are offered. Indicate how Applicant educates Covered California Enrollees on how to access services and how the information is displayed to Covered California Enrollees through Applicant's member portal and provider directory. If Applicant is not currently contracted with Covered California, provide a description of its telehealth capabilities, and indicate whether those services will be offered to Covered California Enrollees.

	Telehealth Offered	*Education Efforts*	*Details*
Applicant offers telehealth for behavioral health services	*Multi, Checkboxes.* 1: Yes, Applicant offers telehealth for behavioral health services, 2: Telehealth for emergency behavioral health offered, 3: Telehealth for outpatient behavioral health (not integrated) offered, 4. Telehealth for inpatient behavioral health offered, 5. Telehealth for integrated primary care and behavioral health offered,	*Multi, Checkboxes.* 1: Member welcome packets, 2: Educational emails, 3: Educational mailings, 4: Website notices or information, 5: Member portal notices or information, 6: Information available through provider directory, 7: Member app notices	*100 words.*

	5. Remote monitoring (e.g., mobile health applications, self-management tools) offered, describe: [100 words] 6. Other, describe: [100 words] 7: No, Applicant does not offer telehealth for behavioral health services	or information, 8: Information available through call center, 9: Other, describe	

21.2.24 Does Applicant use a behavioral health telehealth vendor:
Single, Radio group.
1: Yes, specify vendor: [20 words],
2: No

21.2.25 Report utilization of telehealth for behavioral health services in 2023.

Plan Year 2023 Utilization	Percent
Members who utilized a single telehealth for behavioral health service with a network provider or telehealth vendor.	*Percent.*
Members who utilized multiple telehealth for behavioral health services with a network provider or telehealth vendor	*Percent.*

21.2.26 Specific to behavioral health providers, describe how Applicant promotes integration and coordination of care between in-person providers and behavioral health telehealth providers.
200 words.

21.2.27 Describe the referral process and access timeline for members who need higher levels of behavioral health care in addition to or following a behavioral health telehealth visit.
200 words.

21.3 Provider Network

All questions are required for all Applicants. All questions should be answered at the product level, not Issuer level.

21.3.1 Applicant must indicate if the network it intends to offer on Covered California in the Individual market for the certification year is new or existing to Covered California and include the network name.
Single, Pull-down list.
1: New Network to Covered California, including an existing network with material changes [*10 words*],
2: Existing Network to Covered California no material changes to current network [*10 words*]

21.3.2 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 the Covered California Provider Data Submission Guide. The provider network submission for the certification year must be consistent with what will be filed to the appropriate

regulator for approval if Applicant is selected as a QHP Issuer. Covered California requires the information, as requested, to allow cross-network comparisons and evaluations.

Single, Pull-down list.
1: Attached, Applicant attesting to material changes to existing network or new network (confirming provider data is for the certification year),
2: Not attached, Applicant attesting to no material changes to existing plan year Covered California network for the certification year

21.3.3 Applicant must complete all tabs in Attachment E4_QHP-IND_Other Provider Network Tables, for their Other Network.

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

21.3.4 Does Applicant conduct provider negotiations and manage its own network or does Applicant lease a network from another organization? If Applicant leases a network, Applicant must describe the length of the lease agreement, including start and end dates, along with the leasing organization and if the Applicant has the ability to influence provider contract terms.

Single, Pull-down list.
1: Applicant contracts and manages network,
2: Applicant leases network, describe [500 words]

21.3.5 Applicant must confirm that it will respond to and adhere to the requirements of Health & Safety Code, § 1367.03 or Insurance Code, § 10133.54 and any implementing regulations relating to consumer access to primary, specialty, behavioral health and hospital care based on enrollee access.

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

21.3.6 Applicant must confirm it tracks ethnic and racial diversity in the population and ensuring access to appropriate culturally competent providers, and must briefly describe its methodology, data and tools used to track ethnic and racial diversity in the population and ensuring access to appropriate culturally concordant providers, including relevant measurement criteria and benchmarks for ensuring adequate access.
Single, Pull-down list.
1: Confirmed, describe [200 words],
2: Not Confirmed, describe [200 words]
.

21.3.7 Applicant must confirm that it will respond to and adhere to the requirements of Health & Safety Code, § 1367.03 or Insurance Code, § 10133.54 for assessing enrollee wait times for appointments with primary, specialty, and behavioral health providers.
Single, Pull-down list.
1: Confirmed,
2: Not Confirmed

21.3.8 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, Pull-down list.* 1: Yes, 2: No, 3: Not Applicable
Does applicant allow out-of-state (non-emergency) providers to participate in networks to serve Covered California enrollees? If yes, explain in detail how this coverage is offered.	*Compound, Pull-down list.* 1: Yes: [200 words], 2: No, 3: Not Applicable

21.3.9 Describe any plans for network changes, by product, including any new medical groups or hospital systems that Applicant would like to highlight for Covered California attention.

100 words.

21.4 Delivery System and Payment Strategies to Drive Quality

Attachment 1 of the Covered California Qualified Health Plan (QHP) Issuer Contract embodies Covered California's vision for delivery system reform and serves as a roadmap to delivery system improvements. A number of the delivery system and payment strategy requirements in Attachment 1 meet the federal Quality Improvement Strategy (QIS) requirements.

The Patient Protection and Affordable Care Act (§1311(g)(1)) requires periodic reporting to Covered California of activities a QHP Issuer 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, reducing hospital readmissions, improving patient safety, and reducing medical errors, implementing wellness and health promotion activities, and reducing health and health care disparities. QHP Issuers must implement and report on a quality improvement strategy or strategies consistent with the standard of section 1311(g) of the ACA.

Applicants that are currently operating in Covered California are required to complete QIS workplans as part of the Application process. The following strategies meet the QIS requirements and Applicants must submit QIS workplans:

- Advanced Primary Care
- Appropriate Use of Cesarean Sections
- Hospital Quality, Value, and Patient Safety

QHP certification is conditioned on Applicant developing a multi-year QIS and reporting year-to-year activities and progress on each initiative area.

Applicants that are not currently operating in Covered California are not required to complete the QIS workplan updates as part of the Application for 2025 but must review Attachment 1 with the understanding that engagement in the QIS and Attachment 1 initiatives will be contractually required and measured in the future if Applicant contracts with Covered California.

21.4.1 Provider Networks Based on Value

All questions are required for new entrant Applicants. All questions should be answered at the product level, not Issuer level.

Applicant shall curate and manage its network(s) to address variation in quality and cost performance across network hospitals and providers, with a focus on improving the performance of hospitals and providers. Applicant shall measure, analyze, and reduce variation to achieve consistent high performance for all network hospitals and providers. Applicant shall hold its contracted hospitals and providers accountable for improving quality and managing cost and provide support to its contracted hospitals and providers to improve performance. The following questions address Applicant's ability to track and address variation in quality and cost performance across network hospitals and providers.

21.4.1.1 In the following table, Applicant must identify key quality and cost sources and measures that the Applicant uses to evaluate providers and hospitals for determining initial and ongoing network inclusion, and briefly explain how each measure is used, including if and how the measure is used for performance payment. Applicant must also describe any additional criteria used to determine network inclusion.

	Data Source	*Purpose*	*Provide examples if response #4 selected for Purpose*	*Provide details if Other selected in Data Source or Purpose*
Hospital Quality	*Multi, Checkboxes.* 1: Cal Hospital Compare data, 2: California Maternal Quality Collaborative data, 3: Leapfrog Group data, 4: CMS Hospital Quality Reporting, 5: Program or another CMS program, 6: Designated Center of Excellence (COE), 7: Other, explain	*Multi, Checkboxes.* 1: Used for initial contracting assessment, 2: Used for re-contracting assessment, 3: Has been used for incentive or Pay for Performance payments, 4: Has been used for termination or exclusion (give examples), 5: Other, explain	*100 words.*	*100 words.*
Hospital Cost	*Multi, Checkboxes.* 1: Percent of Medicare rates, 2: Diagnosis-Related Group (DRG) costs, 3: Comparison to other hospital costs in geographic area, 4: Comparison to other hospital costs by decile or other method, 5: CMS Hospital Price Transparency data, 6: Other, explain	*Multi, Checkboxes.* 1: Used for initial contracting assessment, 2: Used for re-contracting assessment, 3: Has been used for incentive or Pay for Performance payments, 4: Has been used for termination or exclusion (give examples), 5: Other, explain	*100 words.*	*100 words.*
Additional Criteria	*100 words.*	*100 words.*	*100 words.*	*100 words.*

21.4.1.2 In the following table, Applicant must identify key quality and cost sources and measures that the Applicant uses to evaluate providers for determining initial and ongoing network inclusion, and briefly explain how each measure is used, including if and how the measure is used for performance payment. Applicant must also describe any additional criteria used to determine network inclusion.

	Data Source	*Purpose*	*Provide examples if response #4 selected for Purpose*	*Provide details if Other selected in Data Source or Purpose*
Provider Quality	*Multi, Checkboxes.* 1: Integrated Healthcare Association data, 2: Office of Patient Advocate data, 3: Other, explain	*Multi, Checkboxes.* 1: Used for initial contracting assessment, 2: Used for re-contracting assessment, 3: Has been used for incentive or Pay for Performance payments, 4: Has been used for termination or exclusion (give examples), 5: Other, explain	*100 words.*	*100 words.*
Provider Cost	*Multi, Checkboxes.* 1: Total Cost of Care data, 2: Comparison to other physician or physician groups in geographic area, 3: Other, explain	*Multi, Checkboxes.* 1: Used for initial contracting assessment, 2: Used for re-contracting assessment, 3: Has been used for incentive or Pay for Performance payments, 4: Has been used for termination or exclusion (give examples), 5: Other, explain	*100 words.*	*100 words.*
Additional Criteria	*100 words.* Nothing required	*100 words.* Nothing required	*100 words.*	*100 words.*

21.4.2 Advanced Primary Care

All questions required for currently contracted Applicants. Questions 21.4.2.1 and 21.4.2.2 are required for new entrant Applicants. All questions should be answered at the product level, not Issuer level.

Covered California recognizes that providing high-quality, equitable, and affordable care requires a foundation of effective and patient-centered primary care. Advanced primary care is patient-centered, accessible, team-based, data driven, supports the integration of behavioral health services, and provides care management for patients with complex conditions. Advanced primary care is supported by alternative payment models such as population-based payments and shared savings arrangements. Applicant shall actively promote the development and use of advanced primary care models that promote access, care coordination, and quality while

managing the total cost of care. The following questions address Applicant's ability to match at least 95% of enrollees with a primary care clinician and increase the proportion of providers paid under a payment strategy that promotes advanced primary care.

This strategy meets the QIS requirements.

21.4.2.1 Report the percentage of Covered California Enrollees who either selected or were matched with a primary care clinician in 2023 in Attachment J_QHP-IND_Run Charts. If Applicant had no Covered California business in 2023, report full 2023 book of business excluding Medicare. Applicants currently contracted with Covered California must enter the number and percentage of providers paid under each model reported in the Certification Applications for 2022, 2023 and 2024 as well. Report data by product (HMO, PPO, EPO, Other).

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

21.4.2.2 Report all types of payment methods used for primary care services and number of providers paid under each model in 2023 in Attachment J_QHP-IND_Run Charts using the alternative payment models (APM) outlined in the Health Care Payment Learning Action & Action Network (HCP LAN) Alternative Payment Model APM Framework. If Applicant had no Covered California business in 2022, report full 2023 book of business excluding Medicare. Applicants currently contracted with Covered California must enter the number and percentage of providers paid under each model reported in the Certification Applications for 2022, 2023 and 2024 as well. Report data by product (HMO, PPO, EPO, Other).

References:
HCP LAN Alternative Payment Model APM Framework: http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf

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

21.4.2.3 Complete Attachment K1_QHP-IND-CCSB_QIS 1 Work Plan–Advanced Primary Care to describe updates on progress made since the previous QIS submission in each part of the primary care goals, and planned activities. Address each of the following in the work plan narrative:

- Updates on the PCP matching initiative, including a status report, feedback on the enrollee experience, challenges, and suggestions (if applicable)
- Progress implementing alternative payment models for primary care to align with Category 3 or 4 APMs described in the APM Framework including: activities conducted, data collected and analyzed, and results
- Describe any support or technical assistance (financial, staffing, educational, etc.) that Applicant or multi-insurer collaborative is providing to primary care providers to support their efforts towards accessible, data-driven, team-based care
- Implementation of advanced primary care initiatives and quality improvement activities to improve health outcomes on any of the QTI measures:
- Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%) (NQF #0575)
- Controlling High Blood Pressure (NQF #0018)

- Colorectal Cancer Screening (NQF #0034)
- Childhood Immunization Status (Combo 10) (NQF #0038)
- Further implementation plans for 2024 including milestones and targets for 2024 and 2025
- Known or anticipated barriers in implementing QIS activities and progress of mitigation activities

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

21.4.3 Integrated Delivery Systems and Accountable Care Organizations

Question 21.4.3.1 is required for currently contracted Applicants. All questions are required for new entrant Applicants. All questions should be answered at the product level, not Issuer level.

Evidence suggests the adoption and expansion of integrated, coordinated, and accountable systems of care such as Integrated Delivery Systems (IDSs) or Accountable Care Organization (ACOs) can lead to improved quality and reduced costs. An IDS is defined as an organized healthcare delivery system in which payers, hospitals, and providers coordinate to provide patient care, integrate care across settings, and share responsibility for patient outcomes and resource use. IDS partners are generally managed by the same organization. An ACO is defined as a system of population-based care coordinated across the continuum including multidisciplinary physicians and physician groups, hospitals, and ancillary providers with combined risk sharing arrangements and shared incentives between providers or between payers and providers. Ideally ACO partners are held accountable for nationally recognized clinical, financial, and operational performance. As providers accept more accountability under this provision, Applicant shall ensure that providers have the capacity to manage the risk. There are many variations of ACO implementation with evidence suggesting that there are key characteristics of an ACO model that influence its success. The following questions address Applicant’s ability to increase enrollment in IDS or ACO models in its Covered California network and solicit information about the structure of Applicant’s IDS and ACO models.

21.4.3.1 Using the definition for IDS or ACO above, report the number and percentage of Covered California Enrollees and total California Enrollees who are managed under an IDS or ACO in 2023 in Attachment J_QHP-IND_Run Charts. Applicants currently contracted with Covered California must enter the percentage reported in the Certification Application for 2022, 2023 and 2024 as well. If Applicant had no Covered California business in 2023, report full 2023 book of business excluding Medicare. Report data by product (HMO, PPO, EPO, Other).

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

21.4.3.2 Applicant must identify key components of the Applicant's IDS or ACO model and must briefly explain how each component is implemented.

	Response	*Details*

Regulated ACO or IDS entity status: Insurer	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Regulated ACO or IDS entity status: Provider with Knox Keene license	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Participation: 2-way (health plan/provider organization)	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Participation: 3-way (health plan/provider organization/hospital)	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Participation: 4-way (health plan/provider organization/purchaser)	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Participation: Includes advanced primary care providers or patient-centered medical homes	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Participation: Other	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Base payment: Global capitation	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Base payment: Professional capitation only	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Base payment: Separate professional capitation and hospital capitation	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Base payment: Fee for service	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Base payment: Other	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*

Performance payment: Two-sided shared savings (upside/downside risk)	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Performance payment: One-sided shared savings (upside risk)	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Performance payment: Pay for performance quality bonus	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Performance payment: Other	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Leadership: Physician-led	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Leadership: Hospital-led	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Leadership: Plan-led	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Leadership: Other	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Leadership: Jointly led by physician and hospitals	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Member assignment: Attribution algorithm	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Member assignment: Patient selection	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Member assignment: Health plan assignment	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*

Member assignment: Other	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Timing: Retrospective	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Timing: Prospective	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Timing: Other	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*

21.4.3.3 Applicant must provide, as attachments, documents related to IDSs or ACOs or confirm Applicant will submit the documents as they become available.

	Response
(File titled Provider 1a): Applicant's quality and cost measures used to track progress and success of IDS or ACO providers.	*Single, Pull-down list.* 1: Attached, 2: Not attached
(File titled Provider 1b): Example of Applicant report to its IDS or ACO providers on its quality of care and financial performance, including benchmarking relative to performance improvement goals or market norms.	(*Single, Pull-down list.* 1: Attached, 2: Not attached
(File titled Provider 1c): Confirm Applicant will submit a copy of Applicant's 2023 IHA Align Measure Perform (AMP) Commercial ACO report when it becomes available, if Applicant participates in the program.	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed, 3: N/A

21.4.4 Appropriate Use of Cesarean Sections

All questions are required for currently contracted Applicants. Questions 21.4.4.1 - 21.4.4.6 are required for new entrant Applicants. All questions should be answered at the product level, not Issuer level.

According to the World Health Organization, maternal health refers an individual's health during pregnancy, childbirth, and the postpartum period. Covered California is committed to addressing all three phases to provide a comprehensive approach to maternal health. Cesarean sections (C-sections) can be lifesaving, but significant numbers of low-risk, first-time pregnancies are

undergoing this invasive surgery when it is not medically necessary. Reducing the rate of unnecessary C-sections improves health outcomes and patient safety.

Applicant must: 1) Progressively adopt physician and hospital payment strategies so that revenue for labor and delivery only supports medically necessary care and no financial incentive exists to perform a low-risk Nulliparous Term Singleton Vertex (NTSV) Cesarean Section (C-Section). 2) Promote improvement work through the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center (MDC), so that all maternity hospitals achieve an NTSV C-Section rate of 23.9% or lower or are at least working toward that goal. 3) Consider a hospital's NTSV C-section rate, improvement trajectory, and willingness to engage in coaching as part of its maternity hospital contracting decisions and terms. Covered California does not expect Contractor to base poor performance, and potential network removal decisions, on one measure alone.

Smart Care California has outlined three payment strategies to align payment with medically necessary use of C-sections:

- Adopt a blended case rate payment for both physicians and hospitals;
- Include a NTSV C-section metric in existing hospital and physician quality incentive programs; and
- Adopt population-based payment models, such as maternity episode payment models or inclusion in Integrated Delivery System, ACO, or similar financial accountability arrangement.

The following questions address Applicant's ability to meet the requirements for the appropriate use of cesarean sections.

Applicants that are not currently operating in Covered California are expected to adopt a payment methodology structured to support only medically necessary care with no financial incentive to perform C-sections for all contracted physicians and hospitals serving enrollees.

This strategy meets the QIS requirements.

21.4.4.1 Describe how Applicant is measuring overuse of Cesarean Sections.

100 words.

21.4.4.2 Describe how Applicant is implementing Smart Care California guidelines (https://www.iha.org/wp-content/uploads/2020/12/c-section_menu_of_payment_and_contracting_options.pdf) to promote best practices to reduce unnecessary Cesarean Sections.

	Guideline	*Implementation*	*Description*
1	Adopt a blended case rate payment for both physicians and hospitals.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*
2	Include a NTSV C-section metric in existing hospital and physician quality incentive programs.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress,	*50 words.*

		3: Have not implemented	
3	Adopt population-based payment models, such as ACO-like arrangements.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*
4	Pay less for C-sections without medical indication and for scheduled non-medically necessary repeat C-sections.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*
5	Require or incent hospital participation in CMQCC's Maternal Data Center (MDC).	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*
6	Implement network quality improvement requirements with a deadline.	*Single, Pull-down list.* 1: In place, 2: Implementation in progress, 3: Have not implemented	*50 words.*

21.4.4.3 Report number of all network hospitals reporting to the California Maternity Quality Care Collaborative (CMQCC) Maternal Data Center (MDC) in 2023 in Attachment J_QHP-IND_Run Charts. A list of all California hospitals participating in the MDC can be found here: https://www.cmqcc.org/about-cmqcc/member-hospitals. Applicants currently contracted with Covered California must enter the percentage reported in the Certification Applications for 2022, 2023, and 2024 as well. If Applicant had no Covered California business in 2023, report full 2023 book of business excluding Medicare.

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

21.4.4.4 Contracted QHP Issuer must adopt value-based payment strategies structured to support only medically necessary care with no financial incentive to perform non-medically necessary NTSV C-sections for all contracted physicians and hospitals by year end 2023 or in the first year of QHP certification if after 2023. These value-based payment strategies include: 1) Blended case rate payment for both physicians and hospitals; 2) Including a NTSV C-section metric in existing hospital and physician quality incentive programs; and 3) Population-based payment models, such as maternity episode payment models.

Report models and number of network hospitals paid using each payment strategy in 2023 in Attachment J_QHP-IND_Run Charts. 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 non-medically necessary C-Section delivery.

Applicants currently contracted with Covered California must enter the percentages reported in the Certification Applications for 2022, 2023, and 2024 as well. If Applicant had no Covered California business in 2023, report full 2023 book of business excluding Medicare.

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

21.4.4.5 Applicant must confirm that all network physicians are pain on a case rate for deliveries and that payment is the same for both vaginal and non-medically necessary C-section delivery. Confirm that all network physicians are paid on a case rate for deliveries and that payment is the same for both vaginal and C-section delivery.

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

21.4.4.6 If Applicant selected not confirmed in question 21.4.4.5, that all network physicians are paid on a case rate for deliveries and that payment is the same for both vaginal and non-medically necessary C-section delivery, Applicant must complete the following table.

Payment Strategy	**Description**	**Percent of Physicians Paid Under Strategy**	**Numerator**	**Denominator**
Strategy 1: Blended Case Rate	*50 words.*	*Percent.*	*Integer.*	*Integer.*
Strategy 2: Provide quality bonuses for physicians that attain NTSV C-section rate goal or make improvements in reducing NTSV C-sections	*50 words.*	*Percent.*	*Integer.*	*Integer.*
Strategy 3: Population-based payment models	*50 words.*	*Percent.*	*Integer.*	*Integer.*
Strategy 4: Other (explain)	*50 words.*	*Percent.*	*Integer.*	*Integer.*
Strategy 5: Other (explain)	*50 words.*	*Percent.*	*Integer.*	*Integer.*
Strategy 6: Other (explain)	*50 words.*	*Percent.*	*Integer.*	*Integer.*

21.4.4.7 Maternal health disparities exist across the full spectrum of maternal health, from preconception, to pregnancy, and the postpartum period. Disparities in maternal health disproportionately affect Black and Latino populations at higher rates than other racial groups. Reducing and eliminating gaps in maternal health requires a multifaceted approach. Indicate and describe in the following table any of the activities undertaken by Applicant to identify and reduce maternal health disparities.

Activities to Identify and Reduce Maternal Health Disparities	*Response*	*Details*

1. Engages with contracted providers to improve performance on maternal health measures, specify measures and if engagement includes performance reviews, evidence-based interventions, or participation in quality collaboratives	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
2. Identifies maternal health disparities among its maternity Enrollees	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
3. Engages with hospitals and providers to address maternal health disparities. Specify if engagement includes quarterly performance reviews, data analysis on race and ethnicity of its maternity Enrollees and outcomes, or implementation of corrective action plans	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
4. Ensures that its network perinatal providers, staff, and facilities are complying with the California Dignity in Pregnancy and Childbirth Act, which mandates implicit bias training to reduce the effects of implicit bias in pregnancy, childbirth, and postnatal care	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
5. Supports its maternity Enrollees, such as access to culturally and linguistically appropriate maternity care, referrals to group prenatal care or community-centered care models for patients, in home lactation and nutrition consultants, doula support for prenatal, labor, delivery, and postpartum care, and related services	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
6. Ensures that its maternity Enrollees are aware of the supportive services available to them, including the services described in (5) above, and that Enrollees know how to access these services	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
7. Works to promote and encourage all in-network hospitals that provide maternity services to use the resources provided by California Maternity Quality Care Collaborative (CMQCC) and the California Department of Public Health's Maternal, Child and Adolescent Health (MCAH) Division to address maternal health disparities	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*

21.4.4.8 Complete Attachment K2_QHP-IND-CCSB_QIS 2 Work Plan - Appropriate Use of C-Sections to describe updates on progress made since the last QIS submission with regards to promoting appropriate use of Cesarean-Sections (C-Sections). Address each of the following in the work plan narrative:

- Description of how Applicant engages with its network hospitals to reduce NTSV (non-medically necessary) C-Section rates to 23.9% or less
- Description of its value-based payment strategies structured to support only medically necessary care with no financial incentive to perform C-sections for all contracted physicians and hospitals by year end 2023
- Description of how NTSV (non-medically necessary) C-section rates are included in network hospital and provider contracting criteria
- Description of how Applicant promotes and encourages all in-network hospitals that provide maternity services to use the resources provided by CMQCC and enroll in the CMQCC MDC

- Updates to hospital participation in CMQCC and hospital engagement in maternity care quality improvement, particularly those with a NTSV rate higher than 23.9%
- Further implementation plans for 2024 including milestones and targets for 2024 and 2025
- List any known or anticipated barriers in implementing QIS activities and progress of mitigation activities

Note: Refer to Appendix M for hospital C-section rates.
Single, Radio group.
1: Attached,
2: Not attached

21.4.5 Hospital Quality, Value, and Patient Safety

All questions required for currently contracted Applicants. Questions 21.4.5.1-21.4.5.3 are required for new entrant Applicants. All questions should be answered at the product level, not Issuer level.

Applicant must: 1) Adopt a hospital payment strategy that ties hospital payment to quality, value, and safety. 2) Promote hospital involvement in improvement programs so that all hospitals achieve infection rates (measured as a standardized infection ratio or SIR) of 1.0 or lower for the five Hospital Associated Infection (HAI) measures listed below or are working to improve. 3) Promote hospital involvement in improvement programs so that all hospitals comply with Sepsis Management according to CMS guidelines.

The five HAIs and Sepsis Management are:

- Catheter Associated Urinary Tract Infections (CAUTI)
- Central Line Associated Blood Stream Infections (CLABSI)
- Clostridioides Difficile Infection (CDI)
- Methicillin-resistant Staphylococcus Aureus (MRSA)
- Surgical Site Infection of the Colon (SSI Colon)
- Sepsis Management (SEP-1)

The following questions address Applicant's ability to meet the requirements for hospital patient safety.

This strategy meets the QIS requirements.

21.4.5.1 Applicant shall adopt a hospital payment methodology for each general acute care hospital in its networks that ties payment to quality, value and safety. Report, across all lines of business, the percentage of hospital reimbursements tied to quality and safety and the metrics applied for performance-based payments in Attachment J_QHP-IND_Run Charts. In the details section of the spreadsheet, describe the performance-based payment strategy structure used to put payments at risk, and note if more than one structure is used. "Quality performance" includes any number or combination of metrics, including HAIs, readmissions, patient satisfaction, etc. In the same sheet, report metrics used to assess quality performance. Currently contracted Applicants must enter the percentages reported in the Certification Applications for 2022, 2023, and 2024 as well. If Applicant had no Covered California business in 2022, report full 2022 book of business excluding Medicare.

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

21.4.5.2 Report the number and percent of hospitals contracted under the model described in question 18.4.5.1 with reimbursement at risk for quality performance in 2022 in Attachment J_QHP-IND_Run Charts. Currently contracted Applicants must enter the numbers reported in the Certification Application for 2022, 2023 and 2024 as well. If Applicant had no Covered California business in 2023, report full 2023 book of business excluding Medicare.

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

21.4.5.3 Covered California is committed to addressing the opioid epidemic and continues to pursue improvement in the appropriate use of opioids in both the outpatient and hospital settings. In the following table, describe Applicant's strategies to improve the appropriate use of opioids in its network hospitals and how Applicant encourages all network hospitals to utilize the Opioid Management Hospital Self-Assessment, which outlines key milestones to achieving opioid safety, and to participate in the Opioid Care Honor Roll program from Cal Hospital Compare. The self-assessment can be accessed from: https://calhospitalcompare.org/wp-content/uploads/2022/08/Opioid-Mgmt-Hospital-Self-Assessment_2023-1.pdf.

	Response
Describe Applicant's strategies to improve the appropriate use of opioids in its network hospitals.	*200 words.*
Describe how Applicant encourages all network hospitals to utilize the Opioid Management Hospital Self-Assessment.	*200 words.*
Describe how Applicant encourages all network hospitals to participate in the Opioid Care Honor Roll program from Cal Hospital Compare.	*200 words.*

21.4.5.4 Complete Attachment K3_QHP-IND-CCSB_QIS 3 Work Plan-Hospital Quality, Value, Patient Safety to describe progress promoting hospital safety since the last submission. Address each of the following in the work plan narrative:

- How Applicant is engaging with its network hospitals to reduce the five specified HAIs to achieve a Standardized Infection Ratio (SIR) of 1.0 or lower for each of the specified HAIs
- How Applicant aims to improve adherence to the Sepsis Management (SEP-1) guidelines
- How Applicant is leveraging the poor performing hospitals list provided by Cal Hospital Compare to collaborate with other QHP Issuers who contract with the same poor performing hospitals
- Progress in adopting a payment strategy that ties hospital payment to quality, value, and safety
- Collaborations with other QHP Issuers on approaching hospitals to suggest quality improvement program participation or alignment on a payment strategy to tie hospital payment to quality
- Further implementation plans for 2023 including milestones and targets for 2023 and 2024

- List any known or anticipated barriers in implementing QIS activities and progress of mitigation activities

Note: In addition to hospital HAI rates in Appendix M, refer to the following publicly available references, which describe free coaching programs available to hospitals:

Information on Partnership for Patients: https://partnershipforpatients.cms.gov/

Hospital participation in Hospital Improvement Innovation Networks (HIINs): https://partnershipforpatients.cms.gov/about-the-partnership/hospital-engagement-networks/thehospitalengagementnetworks.html

Hospital HAI rates can be reviewed individually at http://calhospitalcompare.org/.

Single, Radio group.
1: Attached,
2: Not attached

22 Glossary

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 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.

Applicant - A Health Insurance Issuer who is applying to have its plans certified as Qualified Health Plans.

California Commercial - Includes individual and group lines of business.

Certification Year - The year for which Applicant is applying for proposed product(s) to be certified.

Coverage Year - The year the benefits will cover an enrollee.

Covered California Enrollee - Refers to every individual enrolled in Covered California for the purpose of receiving health benefits. Also referred to as “On-Exchange”.

Current Year - The calendar year Applicant is completing application for certification of proposed product(s).

Definition of Good Standing - Department of Insurance - Verification that issuer holds a state health care service plan license or insurance certificate of authority: Approved for lines of business sought in the Exchange (e.g., commercial, small group, individual; Approved to operate in what geographic service areas and most recent market conduct exam reviewed.

Affirmation of no material[2] statutory or regulatory violations, including penalties levied, in the past two years in relation to any of the following, where applicable: Financial solvency and reserves reviewed; Benefit Design; State mandates (to cover and to offer) - Essential health benefits (State required), Basic health care services, Copayments, deductibles, out-of-pocket maximums, Actuarial value confirmation (using the certification year Federal Actuarial Value Calculator); Network adequacy and accessibility standards are met - provider contracts; Language access; uniform disclosure (summary of benefits and coverage); Claims payment and policies and practices; Enrollee/Member grievances/complaints and appeals policies and practices; Independent medical review; Marketing and advertising; Guaranteed issue individual and small group; Rating Factors; Medical Loss Ratio; Premium rate review - Geographic rating regions and rate development justification is consistent with ACA requirements.

Definition of Good Standing - Department of Managed Health Care -

Verification that issuer holds a state health care service plan license or insurance certificate of authority: Approved for lines of business sought in the Exchange (e.g., commercial, small group, individual; Approved to operate in what geographic service areas and most recent financial exam and medical survey report reviewed.

Affirmation of no material[2] statutory or regulatory violations, including penalties levied, in the past two years in relation to any of the following, where applicable: Financial solvency and reserves reviewed; Administration and organizational capacity acceptable; Benefit Design; State mandates (to cover and to offer) - Essential health benefits (State required), Basic health care services, Copayments, deductibles, out-of-pocket maximums, Actuarial value confirmation (using the certification year Federal Actuarial Value Calculator); Network adequacy and accessibility standards are met - provider contracts; Language access; uniform disclosure (summary of benefits and coverage); Claims payment and policies and practices; Enrollee/Member grievances/complaints and appeals policies and practices; Independent medical review; Marketing and advertising; Guaranteed issue individual and small group; Rating Factors; Medical Loss Ratio; Premium rate review - Geographic rating regions and rate development justification is consistent with ACA requirements.

Enrollee - Refers to every individual enrolled for the purpose of receiving health benefits, including Covered California Enrollees and Off-Exchange membership.

External Audit - A formal audit process that includes an independent and objective examination of an organization's programs, operations, and records performed by a third party (e.g., independent audit or consulting firm, state and federal oversight agencies, etc.) to evaluate and improve the effectiveness of its policies and procedures. The results, conclusions, and findings of an audit in California or any other state(s) where Applicant provides services are formally communicated through an audit report delivered to management of the audited entity.

2 Covered California, in its sole discretion and in consultation with the appropriate health insurance regulator, determines what constitutes a material violation for this purpose.

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.

Healthcare Consumer or Consumer - Covered California uses this term consistent with the Health Consumers NSW definition: A 'consumer' tends to choose and get involved in decision making whereas traditionally a 'patient' tends to be a person who receives care without necessarily taking part in decision making. https://www.hcnsw.org.au/consumers-toolkit/who-is-a-health-consumer-and-other-definitions/.

Health Issuer - A licensed health care service plan or insurer that has been selected and certified by Covered California to offer QHPs through Covered California, as specified in 10 CCR § 6410.

Internal Audit Function - An internal audit function is accountable to an organization's senior management and those charged with governance of the audited entity. An internal auditing activity is an independent, objective assurance and consulting activity designed to add value and improve an organization's operations. Internal Auditing helps an organization accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control, and governance processes.

Member Portal - Covered California uses this term consistent with the Law Insider dictionary definition: Member Portal means information secured behind an authentication wall which will require a unique username and password combination, and which will grant the User access to customized information pertaining only to the User and those Beneficiaries (where applicable) linked to the User. https://www.lawinsider.com/dictionary/member-portal.

Member Services - Covered California uses this term consistent with the Law Insider dictionary definition: Member Services means a method of assisting Enrollees in understanding CONTRACTOR policies and procedures, facilitating referrals to participating specialists, and assisting in the resolution of problems and member complaints. The purpose of Member Services is to improve access to services and promote Enrollee satisfaction. https://www.lawinsider.com/dictionary/member-services.

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 because of inefficient or ineffective practices, systems, decisions, or controls.