



COVERED
CALIFORNIA

CERTIFICATION APPLICATION
QUALIFIED DENTAL PLAN
INDIVIDUAL MARKETPLACE
PLAN YEAR 2028

DRAFT – REDLINE

09.14.2026

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1 Application Overview

1.1 Purpose

The California Health Benefit Exchange (Covered California) is accepting applications from eligible Dental Issuers (Applicants or Dental Applicants) to submit proposals to offer, market, and sell Qualified Dental Plans (QDPs) through Covered California, beginning in 2027~~6~~⁷ for coverage effective January 1, 2028~~7~~⁸. All Dental Issuers currently licensed at the time of application response submission are eligible to apply for certification of proposed Qualified Dental Plans (QDPs) for Plan Year 2028~~7~~⁸. Covered California will exercise its statutory authority to selectively contract for health care coverage offered through Covered California for Plan Year 2027~~8~~⁹. 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.

Commitment: Covered California values partners who demonstrate sustained commitment to California consumers and to the strength and stability of the marketplace.

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,

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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 Dental 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, QDPs already operating on the Exchange must maintain performance that meets or exceeds established benchmarks 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 Dental Plans (QDPs) 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 QDP selection to influence the competitiveness of the market, the cost of coverage, and how value is added through health care delivery system improvement.

1.3 Application Evaluation and Selection

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

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

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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 dental 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 dental 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 Applicant QDP 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's 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.

Encourage Competition Based upon the Populations Served

Performing effective outreach, enrollment and retention of the low-income population that will be eligible 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 serviced 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 QDP Choice and Product Differentiation: Patient-Centered Benefit Plan Designs¹

Covered California is committed to fostering competition by offering QDPs with features that present clear choice, product, and provider network differentiation. QDP Applicants are required to adhere to Covered California's standard benefit plan designs in each region for which they submit a proposal. Covered California is interested in having Health Maintenance Organization (HMO), 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 which have broad overlapping networks within a rating region - unless they offer different innovative delivery system or payment reform features.

Encourage Competition throughout the State

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

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

Encourage 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, in order to reduce costs. Covered California encourages QDP offerings that incorporate innovations in delivery system improvement, prevention, and wellness, and/or payment reform that will help foster these broad goals. This will include models of primary care dentists, 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 component for success on 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 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 Applicants to maintain adequate resources to meet consumers' needs. To successfully serve Covered California consumers, Applicants must invest in and sustain adequate staffing, including hiring of bilingual and bicultural staff as appropriate and maintaining internal training as needed. Applicants demonstrating a commitment to dedicated administrative resources for Covered California consumers will receive additional consideration.

Ensure QDPs Offer Stable Products and Provider Networks that Support Consumer Confidence and Peace of Mind

Covered California is committed to offering QDPs that provide consumers with reliable, predictable coverage and continuity of care over time. Covered California will review and consider an Applicant's demonstrated commitment to the market and history of stability across pricing, geographic footprint, product offerings, and provider networks; approach to minimizing disruption resulting from provider, service-area, or product changes; strategies to support continuity of care; and ability to ensure adequate access. Applicants should demonstrate the administrative, operational, and financial capacity to sustain a long-term market presence, deliver consistent service, and fulfill contractual obligations. Together, these commitments strengthen consumer confidence and provide individuals and families with peace of mind when selecting and using their QDP.

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Applicant must be available immediately upon contingent certification of their plans as QDPs 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 dental plan services effective January 1, 2028⁸⁷. 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, Eligibility, Enrollment, and Retention System (CalHEERS). Successful Applicants must execute the QDP Issuer Contract before public announcement of contingent certification. Failure to execute the QDP Issuer Contract may preclude Applicant from offering QDPs through Covered California. The successful Applicants must be ready and able to accept enrollment as of October 1, 2027⁶.

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
- Evaluation of Applicant responses
- Discussion and negotiation of final contract terms, conditions, and premium rates
- Execution of contracts with the selected QDP Issuers

1.6 Intention to Submit a Response

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

Applicant's Letter of Intent must identify the contact person for the application process, including their email address and telephone number. On receipt of the Letter of Intent, Covered California will issue instructions and a password 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 QDPs 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 <https://coveredca.sharepoint.com/sites/Certification-PY28-PY28Applications/Shared Documents/Applications/03 QDP IND/api/doc.php/204051160>
QHPCertification@covered.ca.gov
(916) 954-3138

1.7 Key Action Dates

Action	Date/Time
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Action	Date/Time
Draft Application Released for Comment	September 1 4 ⁵ - 30, 202 6 ⁵
Letters of Intent to Apply Due to Covered California	February 1 2 ³ , 202 7 ⁶
Application Opens	March 1 ² , 202 7 ⁶
Completed Applications Due	April 29 ³⁰ , 202 7 ⁶ , at noon (12:00 pm PT)
SERFF Templates Due	June 202 7 ⁶
Negotiations between Applicants and Covered California	July 202 7 ⁶
Final QDP Contingent Certification Decisions	August 202 7 ⁶
QDP Contract Execution	September 202 7 ⁶
Final QDP Certification	October 202 7 ⁶

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 will need to 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 all new entrant Applicants. All questions should be answered at the Issuer level, not at the 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.
California State 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.

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Number of Years Applicant has been a California licensed Dental 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 that if an Applicant is selected to offer Qualified Dental Plans, may decertify those Qualified Dental Plans should any material information provided be found to be inaccurate. I confirm that I have the capacity to bind the Issuer stated above to the terms of this Application.	
Date	To the day.
Signature	10 words.
Printed Name	10 words.
Title	10 words.
Email Address	10 words.
Phone Number	10 words.

2.2 Applicant must complete the following table for individuals in Applicant's organization that hold these job titles or are responsible for equivalent job duties.

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.

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Dedicated Covered California 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 the following. If Applicant anticipates material changes, Applicant must provide a brief description of those changes.

	Response	Description
Mergers	<i>Single, Pull-down list.</i> 1: Yes, 2: No	200 words.
Acquisitions	<i>Single, Pull-down list.</i> 1: Yes, 2: No	200 words.
New venture capital	<i>Single, Pull-down list.</i> 1: Yes, 2: No	200 words.
Management team	<i>Single, Pull-down list.</i> 1: Yes, 2: No	200 words.
Location of corporate headquarters or tax domicile	<i>Single, Pull-down list.</i> 1: Yes, 2: No	200 words.
Stock issue	<i>Single, Pull-down list.</i> 1: Yes, 2: No	200 words.
Other	<i>Single, Pull-down list.</i> 1: Yes, 2: No	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? If yes, Applicant must indicate the date when the new policy starts.
Commercial General Liability	<i>For comparison.</i> Limit of not less than \$1,000,000 per occurrence/ \$2,000,000 general aggregate.	<i>Compound, Pull-down list.</i> 1: Confirmed, 2: Not confirmed, describe: [50 words]	<i>Compound, Pull-down list.</i> 1: Yes, [50 words], 2: No
Cyber Liability	<i>For comparison.</i> At such levels consistent with industry standards and reasonably determined by Contractor to cover network security, unauthorized access, unauthorized use,	<i>Compound, Pull-down list.</i> 1: Confirmed, 2: Not confirmed, describe: [50 words]	<i>Compound, Pull-down list.</i> 1: Yes, [50 words], 2: No

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	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	<i>For comparison.</i> 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.	<i>Compound, Pull-down list.</i> 1: Confirmed, 2: Not confirmed, describe: [50 words]	<i>Compound, Pull-down list.</i> 1: Yes, [50 words], 2: No
Umbrella Policy	<i>For comparison.</i> An amount not less than \$10,000,000 per occurrence and in the aggregate.	<i>Compound, Pull-down list.</i> 1: Confirmed, 2: Not confirmed, describe: [50 words]	<i>Compound, Pull-down list.</i> 1: Yes, [50 words], 2: No
Statutory CA's Workers' Compensation Coverage	<i>For comparison.</i> Provide Proof of Coverage in full compliance with State law.	<i>Compound, Pull-down list.</i> 1: Confirmed, 2: Not confirmed, describe: [50 words]	<i>Compound, Pull-down list.</i> 1: Yes, [50 words], 2: No

2.5 Applicant must attach a combined copy of current Certificates of Insurance to verify that it maintains the insurance specified in table 2.4. If all applicable Certificates of Insurance are not 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 Applicant must indicate if it has any experience 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 at the product level.

3.1 Applicants are required to retain proper licensure by the applicable regulator to be certified and operate as an Issuer on Covered California. Applicant must indicate license status below.:

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Single, Radio group.

- 1: Applicant currently holds all of the proper and required licenses from the California Department of Managed Health Care to operate as a Dental Issuer as defined herein in the commercial individual market,
- 2: Applicant currently holds all of the proper and required licenses from the California Department of Insurance to operate as a Dental Issuer as defined herein in the commercial individual market,
- 3: Applicant is currently applying for licensure from the California Department of Managed Health Care to operate as a Dental Issuer as defined herein in the commercial individual market. Applicant must provide the Enter date the licensing application was filed and provide the current filing status for licensure at the time the Covered California Application is due: [50 wordsTo the day],
- 4: Applicant is currently applying for licensure from the California Department of Insurance to operate as a Dental Issuer as defined herein in the commercial individual market. Applicant must provide the Enter date the licensing application was filed and provide the current filing status for licensure at the time the Covered California Application is due: [50 wordsTo the day],
- 5: Applicant is not currently licensed in the commercial individual market to operate as a health issuer as defined herein by the California Department of Managed Health Care or the California Department of Insurance, and has not applied for licensure to operate as a health issuer in the commercial individual market with either of these entities.

3.2 Applicant must confirm that it will adhere to requirements, including filing due dates and timely responses to correspondence, set forth by the California Department of Managed Health Care or California Department of Insurance, applicable to its licensure and to its QDP proposals. If Applicant cannot adhere to the requirements, Applicant must explain why.

Single, Pull-down list.

- 1: Confirmed, Applicant will adhere to requirements, filing due dates, and provide timely responses to the applicable regulator
- 2: Not Confirmed, Applicant will not adhere to requirements, filing due dates, and provide timely responses to the applicable regulator, explain [200 words]

3.3 In addition to holding or pursuing all the proper and required licenses to operate as an Issuer on Covered California, Applicant must confirm that it has had no material fines, no material penalties levied or material ongoing disputes, for any licensed entity (health or dental) with applicable licensing authorities in the last two (2) calendar years (See Section 23 - Glossary - Definition of Good Standing). If Applicant has any material disputes, any enforcement actions resulting in monetary penalties equal to or exceeding \$100,000, identified by State and Federal Regulators, with the applicable insurance regulator in the last two (2) calendar years, Applicant must submit notification of these disputes as an attachment, in a combined PDF document. Covered California, in its sole discretion and in consultation with the appropriate dental 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—4.6 are required for currently contracted Applicants.~~ All questions are required for all new entrant Applicants. All questions should be answered at the Issuer level, not at the product level.

4.1 Applicant must describe the systems used to invoice members and record the collection of payments. Description of system must include:

- System Name
- Length of time current system has been in place

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- Review process for system accuracy
- System reporting ability and timeliness
- 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, including a timeframe.

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, such as 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 Applicant must be able to accept premium payment from members no later than October 1st prior to the coverage year. 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 workplan.

Note: QDP 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 Applicant must confirm it will comply with 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 how it will work through (both operationally and systematically) any differences between payment process for the unbanked and usual payment processing procedures and must describe in detail how these types of payments are handled both in and out of their system of record.

Single, Radio group.

- 1: Confirmed, [500 words] ,
- 2: Not confirmed

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 for any member requesting termination of coverage.

Single, Pull-down list.

- 1: Confirmed,
- 2: Not confirmed

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4.6 Applicant must confirm that it accepts premium payments made by or on behalf of an enrollee in connection with health reimbursement arrangements, in compliance with 45 C.F.R. § 156.1240.

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

5.1.1 Applicant must complete Attachment A1 A2_QDP-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_QDP-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 brief description and timeline (over the next 24 months) of any initiatives which may impact the delivery of services to Covered California Enrollees.

	Response	Description and timeline (over the next 24 months)
System changes or migrations	<i>Single, Pull-down list.</i> 1: Yes, 2: No, 3: Not Applicable	200 words.
Call center opening	<i>Single, Pull-down list.</i> 1: Yes, 2: No, 3: Not Applicable	200 words.
Call center closings	<i>Single, Pull-down list.</i> 1: Yes, 2: No, 3: Not Applicable	200 words.
Call center relocations	<i>Single, Pull-down list.</i> 1: Yes, 2: No, 3: Not Applicable	200 words.
Network re-contracting	<i>Single, Pull-down list.</i>	200 words.

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	1: Yes, 2: No, 3: Not Applicable	
Vendor changes	<i>Single, Pull-down list.</i> 1: Yes, 2: No, 3: Not Applicable	200 words.
Other	<i>Single, Pull-down list.</i> 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 dental 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	<i>Single, Pull-down list.</i> 1: Yes, 2: No	<i>Single, Pull-down list.</i> 1: Yes, 2: No	50 words.
Database and/or enrollment transactions	<i>Single, Pull-down list.</i> 1: Yes, 2: No	<i>Single, Pull-down list.</i> 1: Yes, 2: No	50 words.
Claims processing and invoicing	<i>Single, Pull-down list.</i> 1: Yes, 2: No	<i>Single, Pull-down list.</i> 1: Yes, 2: No	50 words.
Membership/customer service	<i>Single, Pull-down list.</i> 1: Yes, 2: No	<i>Single, Pull-down list.</i> 1: Yes, 2: No	50 words.
Welcome package (ID cards, member communications, etc.)	<i>Single, Pull-down list.</i> 1: Yes, 2: No	<i>Single, Pull-down list.</i> 1: Yes, 2: No	50 words.
Other (specify)	<i>Single, Pull-down list.</i> 1: Yes, 2: No	<i>Single, Pull-down list.</i> 1: Yes, 2: No	50 words.

5.2 Implementation Performance

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

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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 describe a detailed implementation plan. If Applicant is currently operating in Covered California, Applicant must explain if there are new systems being implemented. If Applicant is currently operating in Covered California and there are no new updates, Applicant must indicate there are no new updates.

500 words.

5.2.3 Applicant must submit a detailed Renewal and Open Enrollment Readiness Plan. Applicant must include in their plan a timeline with dates for communications (regulated and marketed), system and website updates and readiness, and trainings for staff and agents.

Single, Radio group.

- 1: Attached, [500 words] ,
2: Not attached, [500 words]

5.2.4 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.

5.2.5 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	<i>Percent.</i>	<i>100 words.</i>	<i>100 words.</i>
Claims	<i>Percent.</i>	<i>100 words.</i>	<i>100 words.</i>
Account Management	<i>Percent.</i>	<i>100 words.</i>	<i>100 words.</i>
Clinical staff	<i>Percent.</i>	<i>100 words.</i>	<i>100 words.</i>
Disease Management staff	<i>Percent.</i>	<i>100 words.</i>	<i>100 words.</i>
Implementation	<i>Percent.</i>	<i>100 words.</i>	<i>100 words.</i>
Financial	<i>Percent.</i>	<i>100 words.</i>	<i>100 words.</i>

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Administrative	<i>Percent.</i>	<i>100 words.</i>	<i>100 words.</i>
Actuarial	<i>Percent.</i>	<i>100 words.</i>	<i>100 words.</i>
Information Technology	<i>Percent.</i>	<i>100 words.</i>	<i>100 words.</i>
Other (List)	<i>Percent.</i>	<i>100 words.</i>	<i>100 words.</i>

5.2.6 Applicant must provide a detailed description of~~describe in detail~~ their 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 all new-entrant Applicants. All questions should be answered at the Issuer level, not at the 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 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.	<i>Single, Radio group.</i> 1: Confirmed, 2: Not confirmed
Describe how Applicant will modify customer service center operations to meet Covered California-required operating hours, if hours are not currently matched.	<i>100 words.</i>
Describe how Applicant will modify its current Interactive Voice Response (IVR) system to meet Covered California required operating hours, if applicable.	<i>100 words.</i>

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	<i>Single, Pull-down list.</i> 1: Yes, 2: No	<i>50 words.</i>
Total Calls Answered	<i>Single, Pull-down list.</i> 1: Yes, 2: No	<i>50 words.</i>

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Total Abandon Calls	<i>Single, Pull-down list.</i> 1: Yes, 2: No	50 words.
Average Handle Time	<i>Single, Pull-down list.</i> 1: Yes, 2: No	50 words.
Average Speed to Answer	<i>Single, Pull-down list.</i> 1: Yes, 2: No	50 words.
Abandonment Rate	<i>Single, Pull-down list.</i> 1: Yes, 2: No	50 words.
Adherence Staff	<i>Single, Pull-down list.</i> 1: Yes, 2: No	50 words.
Daily Service Level	<i>Single, Pull-down list.</i> 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, and for providing 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, select 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 Applicant must describe their Customer Service Representative training program.

What is the length of the entire training period for new Customer Service Representatives?	100 words.
What information is covered in the training? (i.e. systems training, health care basics, and customer service skills training.)	100 words.
What is the total time from point of hire to completion of training and release to work independently.	100 words.
How frequently are refresher trainings provided to all Customer Service Representatives?	100 words.

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What trainings are used to focus on skills improvement as well as training resulting from changes to policy and procedures.	100 words.
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6.7 Applicant must indicate languages spoken by Customer Service Representatives, and the number of bilingual Representatives who speak each language. Do not include languages supported only by a language line.

Language	Response	Number of Certified Bilingual Representatives
Arabic	<i>Single, Pull-down list.</i> 1: Yes, 2: No	<i>Integer.</i>
Armenian	<i>Single, Pull-down list.</i> 1: Yes, 2: No	<i>Integer.</i>
Cambodian	<i>Single, Pull-down list.</i> 1: Yes, 2: No	<i>Integer.</i>
Cantonese	<i>Single, Pull-down list.</i> 1: Yes, 2: No	<i>Integer.</i>
English	<i>Single, Pull-down list.</i> 1: Yes, 2: No	<i>Integer.</i>
Farsi	<i>Single, Pull-down list.</i> 1: Yes, 2: No	<i>Integer.</i>
Hmong	<i>Single, Pull-down list.</i> 1: Yes, 2: No	<i>Integer.</i>
Korean	<i>Single, Pull-down list.</i> 1: Yes, 2: No	<i>Integer.</i>
Loa	<i>Single, Pull-down list.</i> 1: Yes, 2: No	<i>Integer.</i>
Mandarin	<i>Single, Pull-down list.</i> 1: Yes, 2: No	<i>Integer.</i>
Russian	<i>Single, Pull-down list.</i> 1: Yes, 2: No	<i>Integer.</i>
Spanish	<i>Single, Pull-down list.</i> 1: Yes, 2: No	<i>Integer.</i>
Tagalog	<i>Single, Pull-down list.</i> 1: Yes, 2: No	<i>Integer.</i>
Vietnamese	<i>Single, Pull-down list.</i> 1: Yes,	<i>Integer.</i>

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	2: No	
Other, specify	20 words. Nothing required	Integer. N/A OK.

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 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, select 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 calls, 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 ~~dentalhealth~~ insurance coverage or access to ~~dentalhealth~~ care services through its QDHPs, 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,

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 for individuals living with disabilities and for individuals who have limited English proficiency.

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200 words.

7 Sales Channels

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

7.1 Covered California expects Applicants to contract with Insurance Agents or General Agencies (also referred to as Insurance Brokers or Producers). If certified, Applicant must confirm it will work with Insurance Agents or General Agencies and will be in compliance with the requirements in the contract with Covered California.

Single, Radio group.

1: Confirmed,

2: Not confirmed

7.2 Applicant must submit its Producer Agreement document as an attachment. If Applicant is a new entrant and does not have a Producer Agreement document, Applicant must explain why.

Single, Radio group.

1: Attached

2: Not attached, [200 words]

7.32 Applicant must submit its Agent of Record (AOR) policy and procedures document. A Producer Guide, broker compensation schedule, or producer agreement does not satisfy this requirement. If Applicant is a new entrant and does not have an Agent of Record (AOR) policy and procedures document attached, Applicant must explain the process in development why. If Applicant is currently contracted and there are no changes, Applicant may indicate “Currently contracted, no changes to current policy and procedures”. Review the Covered California Delegation Policy, https://hbex.coveredca.com/toolkit/PDFs/Delegation_Change_Policy_FINAL.pdf.

Single, Radio group.

1: Attached,

2: Not attached [200 words]

7.43 Applicant must provide a description for the following Agent of Record (AOR) Policy and procedures for the Individual market. If Applicant does not currently work with Insurance Agents or General Agencies (also referred to as Insurance Brokers or Producers), Applicant must explain how Applicant will be ready to contract with Insurance Agents or General Agencies for the certification year. If Applicant is currently contracted and there are no changes, Applicant may indicate “Currently contracted, no changes to current policy and procedures”. “Not Applicable” is not considered an acceptable response. Review the Covered California Agent Delegation Policy, https://hbex.coveredca.com/toolkit/PDFs/Delegation_Change_Policy_FINAL.pdf.

	Individual Market – AOR Appointment Policy	Description
Appointment Process	Describe AOR appointment process for agents to be appointed by the Applicant. This should include the application, and mandatory requirements, exclusions. Also, include the requirements if the agent is to be appointed with a general agency contracted with Applicant.	100 words.
Timeline	Provide the AOR appointment timeline for agents. Include (1) how the	100 words.

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	effective date is determined for the new servicing agent, <u>(2) whether the Applicant accepts retroactive AOR appointment requests, (if not, must explain the policy), and (3) the average processing time from submission to approval any factors that would result in a retroactive AOR change.</u>	
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.
AOR Change	Describe procedures used to manage AOR changes when the change is made via an 834 file.	100 words.
AOR Change	Describe any reasons for which Applicant will not make changes to AOR for an enrollment.	100 words.
Other	Additional comments	100 words.

7.54 Applicant must provide its current plan year and certification year Agent of Record (AOR) Commission Schedule for the individual market in California and describe the payment format and specify the commission basis. ~~If the certification year Agent of Record Commission is not finalized, Applicant must explain in the "Details" box.~~

Applicant must indicate the commission format for each product type using one of the following:

- Flat dollar amount per member per month (\$ PMPM)
- Flat dollar amount per policy per month (\$ per policy/month)
- Percentage of premium (%)
- Tiered structure (by volume, enrollment threshold, or other criteria)

If the commission is tiered, Applicant must describe the full tier schedule, including all volume thresholds and corresponding rates, in the Details row.

If Applicant pays a Field Marketing Organization (FMO) or General Agency (GA) override in addition to base agent commission, Applicant must disclose that amount separately in the Details row.

If the certification year AOR commission is not yet finalized, Applicant must explain why in the Details column and provide the expected date by which the commission schedule will be communicated to agents.

<u>Product</u>	<u>DHMO</u>	<u>DPPO</u>	<u>DEPO</u>
<u>Plan Year 2027 New (\$ or %)</u>	<u>10 words.</u>	<u>10 words.</u>	<u>10 words.</u>
<u>Certification Year 2028 New (\$ or %)</u>	<u>10 words.</u>	<u>10 words.</u>	<u>10 words.</u>
<u>Plan Year 2027 Renewals (\$ or %)</u>	<u>10 words.</u>	<u>10 words.</u>	<u>10 words.</u>
<u>Certification Year 2028 Renewals (\$ or %)</u>	<u>10 words.</u>	<u>10 words.</u>	<u>10 words.</u>
<u>Commission Basis (PMPM / Per Policy /</u>	<u>10 words.</u>	<u>10 words.</u>	<u>10 words.</u>

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<u>% of Premium / Tiered)</u>			
<u>Plan Year 2027 Tiered Structure</u>	<u>Compound, Pull-down list.</u> 1: Yes, [100 words] 2: No	<u>Compound, Pull-down list.</u> 1: Yes, [100 words] 2: No	<u>Compound, Pull-down list.</u> 1: Yes, [100 words] 2: No
<u>Certification Year 2028 Tiered Structure</u>	<u>Compound, Pull-down list.</u> 1: Yes, [100 words] 2: No	<u>Compound, Pull-down list.</u> 1: Yes, [100 words] 2: No	<u>Compound, Pull-down list.</u> 1: Yes, [100 words] 2: No
<u>FMO / GA Override (if applicable)</u>	<u>10 words.</u>	<u>10 words.</u>	<u>10 words.</u>
<u>Details. If commission rate is TBD, provide expected finalization date</u>	<u>100 words.</u>	<u>100 words.</u>	<u>100 words.</u>

Product	Plan Year 2026 New (\$ or %)	Certification Year 2027 New (\$ or %)	Plan Year 2026 Renewals (\$ or %)	Certification Year 2027 Renewals (\$ or %)	Plan Year 2026 Tiered Structure	Certification Year 2027 Tiered Structure	Details
HMO	10 words.	10 words.	10 words.	10 words.	Compound, Pull-down list. 1: Yes, [100 words], 2: No	Compound, Pull-down list. 1: Yes, [100 words], 2: No	100 words.
PPO	10 words.	10 words.	10 words.	10 words.	Compound, Pull-down list. 1: Yes, [100 words], 2: No	Compound, Pull-down list. 1: Yes, [100 words], 2: No	100 words.
EPO	10 words.	10 words.	10 words.	10 words.	Compound, Pull-down list. 1: Yes, [100 words], 2: No	Compound, Pull-down list. 1: Yes, [100 words], 2: No	100 words.

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]~~

7.65 Applicant must confirm if it offers a bonus program. If yes, Applicant must provide: (1) the estimated total annual cost of the bonus program in California for the current benefit year as a % of premium and in dollars, separated by on-exchange and off-exchange where applicable, and (2) a brief

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~~description of the bonus structure (e.g., enrollment-based, retention-based, performance threshold), describe any agent commission bonus program(s) in the individual market on or off exchange that is currently available in the 2026 benefit year or will be made available to agents for the 2027 benefit year.~~

Single, Radio group.

- 1: Confirmed, explain [100 words] ,
2: Not confirmed, explain [100 words]

~~7.76 Applicant must provide the indicate, as a percentage of premium separately for: (a) On-Exchange – base commission only (excluding bonuses), (b) On-Exchange – total including all bonuses and other financial payments, (c) Off-Exchange – base commission only, (d) Off-Exchange – total including all bonuses and other financial payments. If Applicant does not offer Off-Exchange products in California, Applicant must confirm this explicitly, the amount of total commission compensation Applicant expects to pay in calendar year 2026 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.~~

~~100 words.~~

<u>Product</u>	<u>Percent of Premium total commission On Exchange</u>	<u>Percent of Premium total commission Off Exchange</u>	<u>Base Commission</u>	<u>Bonus</u>	<u>Other</u>	<u>Details</u>
<u>DHMO</u>	<u>10 words.</u>	<u>10 words.</u>	<u>10 words.</u>	<u>10 words.</u>	<u>20 words.</u>	<u>100 words.</u>
<u>DPPO</u>	<u>10 words.</u>	<u>10 words.</u>	<u>10 words.</u>	<u>10 words.</u>	<u>20 words.</u>	<u>100 words.</u>
<u>DEPO</u>	<u>10 words.</u>	<u>10 words.</u>	<u>10 words.</u>	<u>10 words.</u>	<u>20 words.</u>	<u>100 words.</u>

~~7.87 Applicant must provide a detailed description of the following commission terms. If Applicant is currently contracted and there are no changes, Applicant may indicate “Currently contracted, no changes to current description on the following commission term”. “Not Applicable” is not considered an acceptable response.~~

	Individual Market - Commission Rate	Description
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.
Payment	Provide the date of payment of commission to an AOR for new member effectuated policies.	100 words.
Payment	Describe any reasons for which Applicant will not compensate agents for an enrollment.	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.
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.

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Reconciliation	Describe AOR commission reconciliation and error resolution processes. Include information on how Applicant resolves commission and AOR discrepancies for agents.	100 words.
Other	Additional Comments.	100 words.

7.98 Applicant must complete the following table of Individual Family Plan Sales Team Organizational Chart.

Key Individual Name	Email Address	Phone Number	Geographic Territory
10 words.	10 words.	10 words.	10 words.
10 words.	10 words.	10 words.	10 words.
10 words.	10 words.	10 words.	10 words.

7.109 Agents have become an integral channel of Applicant's enrollment; Covered California requires Applicants 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 the Applicant's plan product in the Individual and Family Plan market in California. Applicant must provide a description for Agent/Broker Services. If Applicant is currently contracted and there are no changes, Applicant may indicate "Currently contracted, no changes to current service and process". "Not Applicable" is not considered an acceptable response.

Sup-Topic	Agent Services	Description
Support Services	Describe your agent support services for 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.
Support Services	Do you have an agent portal for agents? If yes, describe the portal functionality and capabilities agents have access to.	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.
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.
Sales	<u>Outreach to niche populations:</u> <u>(a) Identify the specific niche or hard-to-reach populations your sales strategy targets.</u> <u>(b) Describe the specific outreach channels and tactics used to reach each population.</u> <u>(c) Identify whether Applicant works with agents, Navigators, CECs, and/or community partners who specialize in serving these populations, and how they are supported. 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</u>	100 words.

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	populations?	
Network Changes	<u>Does the Applicant have an active process for notifying agents of provider network changes? (Yes / No / In Development)</u> <u>If Yes: Describe the frequency, method of notification (email, portal alert, broker newsletter, etc.), and approximate lead time before changes take effect.</u> <u>If No or In Development: Describe the plan and timeline to implement this process. How often are agents updated on provider network changes?</u>	100 words.
Plan-Based Enrollers	Explain how you utilize Plan-Based Enrollers?	100 words.
Off-Exchange Consumers	What is your current number of Off-Exchange IFP members?	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.
Other	Additional comments.	100 words.

8 Marketing and ~~Outreach Activities~~ Enrollment

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

8.1 Covered California expects all successful Applicants to promote enrollment in their QDPs, and support retention, utilization and member engagement. 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 QDPs, it will cooperate with Covered California Marketing Department, and adhere to the Covered California Brand Style Guide, located at

<https://hbex.coveredca.com/toolkit/logos.html>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 thirty (30) days prior to Open Enrollment.

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Single, Pull-down list.

- 1: Confirmed,
- 2: Not confirmed

8.3 Applicant must confirm it will coordinate and cooperate with Covered California Marketing, Public Relations, and Outreach efforts, which may include internal and external trainings, press events, social media efforts, collateral materials, member education and communications, and other efforts. This coordination and cooperation-cooperative obligation includes contractual requirements to submit materials and updates according to deadlines established in the QDP Issuer Model Contract.

Single, Pull-down list.

- 1: Confirmed,
- 2: Not confirmed

8.4 Applicant must confirm it will meet marketing investment plan and reports requirements established in the QDP Issuer Model Contract to indicate their proposed marketing investment to promote enrollment and support retention, utilization and member engagement 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 that this amount 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 "credible marketing." Applicant may submit any supporting documentation as an attachment. If Applicant cannot confirm it will meet marketing investment plan and reports, Applicant must explain why.

Single, Radio group.

- 1: Alternate proposed marketing investment: [500 words],
- 12: Confirmed to meet marketing investment plan and reports requirements spend expectations
- 2: Not confirmed, explain [500 words]

8.5 Applicant must indicate the dollar amount of the total proposed marketing spend Applicant projects allocating to Proposed Marketing Investment in Qualifying Marketing Activities as outlined in the QDP Issuer Model Contract.

Proposed Marketing Investment: Dollars.

~~8.6 Applicant must indicate the percentage of the total Proposed Marketing Investment (using dollar amount entered for question 8.5) Applicant plans to allocate to Acquisition and Retention efforts. Numerical percentage values must equal 100 when added. Example: 70% acquisition and 30% retention.~~

Acquisition efforts:	<u>Percent.</u>
Retention efforts:	<u>Percent.</u>

~~8.7 Applicant must indicate the percentage of the total Proposed Marketing Investment (using dollar amount entered for question 8.5) Applicant plans to allocate to Open and Special Enrollment Periods.~~

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~~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 Applicant must indicate the percentage of the total Proposed Marketing Investment (using dollar amount entered for question 8.5) Applicant plans to allocate 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 Data

9.1 HIPAA Privacy Rule

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

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)].

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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 Applicant 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 Information Security

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

~~Question 9.2.7 and 9.2.8 are required for currently contracted Applicants. All questions are required for new entrant Applicants. All questions should be answered at the Issuer level, not at the product level.~~

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 (NIST), Special Publication 800-53 rev 5, or in the ISO/IEC 27001, that appropriately protects the confidentiality, integrity, and availability of the Protected Health Information (PHI) and Personally Identifiable Information (PII) that it creates, receives, maintains, or transmits.

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Single, Pull-down list.

- 1: Confirmed,
- 2: Not confirmed

9.2.2 Applicant must confirm that all PHI and PII is encrypted - both at rest and in transit - employing the validated Federal Information Processing Standards (FIPS) 140-compliant encryption standards.

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.

Single, Pull-down list.

- 1: Confirmed,
- 2: Not confirmed

9.2.4 Applicant must confirm that it 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

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

Single, Pull-down list.

- 1: Confirmed,
- 2: Not confirmed

9.2.6 Applicant must confirm that when disposing of media containing PHI or, PII, 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

9.2.7 Applicant must provide an overview of the Information Security Program. Applicant may submit an attachment. Applicant must provide all relevant information on how PHI and PII are secured within the organization, including but not limited to the following components:

- Information related to governance and policies,
- Risk assessment,
- Security safeguards (technical, physical, and administrative),
- Monitoring and logging,
- the incident response plan,
- and Regulatory compliance. ~~Applicant may submit an attachment.~~

Single, Radio group.

- 1: Explain [1000 words] ,
- 2: Attached

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9.2.8 In the last twelve (12) months has the Applicant experienced a data breach that compromised PHI or PII? If yes, explain the actions taken in response, and any measures implemented to prevent future occurrences.

Single, Radio group.

1: No, Applicant did not experience a data breach in the last 12 months.

2: Yes, and new preventative measures were implemented, explain: [500 words] ,

3: Yes, and no preventive measures were implemented, explain: [500 words]

10 Fraud, Waste and Abuse Detection

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

~~Questions 10.3 and 10.6—10.8 are required for currently contracted Applicants. All questions are required for new entrant Applicants. All questions should be answered at the Issuer level, not at the product level.~~

Covered California is committed to working with its QDP Issuers to minimize Fraud, Waste, and Abuse, as defined in Section 23 - 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 QDP Issuers to adopt leading practices outlined in the framework to the extent applicable. Fraud prevention is centered on integrity and expected behaviors from employees and others. All 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 Applicant must 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. “Not Applicable” is not considered an acceptable response.

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. “Not Applicable” is not considered an acceptable response.

200 words.

10.3 Applicant must confirm it will report/refer suspected incidents of fraud, waste and abuse to Covered California per the established Carrier Referral Process and to the appropriate state/federal regulator, government agency, and/or law enforcement agency as required by law. If not, Applicant must provide an explanation.

Single, Radio group.

1: Confirmed,

2: Not confirmed, explain: [100 words]

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10.4 Applicant must describe policies and procedures it has in place, including details regarding the withholding and subrogation process for recoupment of payments. Define any acronyms used. “Not Applicable” is not considered an acceptable response.

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. “Not Applicable” is not considered an acceptable response.

200 words.

10.6 Applicant must indicate whether it reviews specified types of providers for possible fraudulent activity related to claims. Applicant must describe the different approaches Applicant takes to monitor the types of providers or provide an explanation why any additional provider types are not being reviewed for fraudulent activity. “Not Applicable” is not considered an acceptable response.

	Response	Description
General Practice Dentist	<i>Single, Radio group.</i> 1: Yes, 2: No	200 words.
Pediatric Dentist	<i>Single, Radio group.</i> 1: Yes, 2: No	200 words.
Endodontist	<i>Single, Radio group.</i> 1: Yes, 2: No	200 words.
Oral and Maxillofacial Surgeon	<i>Single, Radio group.</i> 1: Yes, 2: No	200 words.
Orthodontist	<i>Single, Radio group.</i> 1: Yes, 2: No	200 words.
Periodontist	<i>Single, Radio group.</i> 1: Yes, 2: No	200 words.
Prosthodontist	<i>Single, Radio group.</i> 1: Yes, 2: No	200 words.
Other service Providers, specify	50 words.	500 words.

10.7 Based on the definition of Fraud, as defined in Section 23 - Glossary, what was Applicant's recovery success rate and dollars recovered for fraudulent activities for each year below? Applicant must provide an explanation for loss recovery.

	Total Loss from Fraud Covered California	Total Loss from Fraud Total Book of Business	% of Loss Recovered Covered California	% of Loss Recovered Total Book of Business	Total Dollars Recovered Covered California	Total Dollars Recovered Total Book of Business	Description

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	book of business.	(Includes non-Covered California Business)	book of business.	(Includes non-Covered California Business)	book of business.	(Includes non-Covered California Business)	
Calendar Year 202 4 ³	Dollars.	Dollars.	Percent.	Percent.	Dollars.	Dollars.	<u>200 words.</u>
Calendar Year 202 5 ⁴	Dollars.	Dollars.	Percent.	Percent.	Dollars.	Dollars.	<u>200 words.</u>
Calendar Year 202 6 ⁵	Dollars.	Dollars.	Percent.	Percent.	Dollars.	Dollars.	<u>200 words.</u>

10.8 Applicant must describe any trends that might contribute to the total loss from fraud for Covered California book of business. Define any acronyms used. “Not Applicable” is not considered an acceptable response.

200 words.

10.9 Applicant must describe its 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. “Not Applicable” is not considered an acceptable response.

200 words.

10.10 Applicant must describe its approach to the use of the National Practitioner Data Bank as part of the credentialing and re-credentialing process for contracted providers. Describe any additional steps Applicant takes to verify a provider and facility is a legitimate place of business. Define any acronyms used. “Not Applicable” is not considered an acceptable response.

200 words.

10.11 Applicant must describe the fraud controls it has 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. “Not Applicable” is not considered an acceptable response.

Single, Radio group.

1: Attached, [200 words] ,

2: Not attached, [200 words]

11 Audits

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

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~~Questions 11.2 and 11.4 are required for currently contracted Applicants. All questions are required for new entrant Applicants. All questions should be answered at the Issuer level, not at the product level.~~

~~11.1 Based on the definition of Internal Audit Function in Section 23—Glossary, does Applicant maintain an Internal Audit Function? For example: does the internal audit function report to a board, audit committee, or executive office? Applicant must attach the Internal Audit Charter. If not attached, Applicant must explain why.~~

~~Single, Radio group.~~

~~1: Yes, attached,~~

~~2: No, not attached. describe: [50 words]~~

~~11.2 Applicant must provide a copy of the organization's list of internal audits conducted over the prior year and current year audit plan. If not attached, Applicant must explain why.~~

~~Single, Radio group.~~

~~1: Attached,~~

~~2: Not attached, describe: [50 words]~~

~~11.3 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.~~

~~11.4 Based on the definition of External Audit in Section 23—Glossary, Applicant must indicate what external audits applicable to business done in California were conducted over the last year by third parties? For each audit, specify the name of the agency that conducted the audit.~~

~~200 words.~~

11.15 Applicant must confirm that, if certified, it will agree to subject itself to Covered California for audits and reviews applicable to business done in California, either by Covered California or its designee, or other State or Federal regulatory agencies or their designee. If applicable, audits and reviews shall may 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

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12 Electronic Data Interface (EDI)

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

~~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 at the product level.~~

12.1 Applicant must provide an attachment that includes the following components:

- An overview of its system, data model, vendors,
- Any anticipated changes in key personnel and interface partners. If there are no anticipated changes, Applicant must indicate no changes in the attachment.

Single, Radio group.

1: Attached,

2: Not attached, describe [100 words]

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

Single, Radio group.

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 system(s) and Covered California's systems, including the eligibility and enrollment system used by Covered California. Applicant must confirm it will implement system(s) to accept and generate 834, 999, TA1, and other standard format electronic files for enrollment and premium remittance, and do so in an accurate, consistent, and timely fashion, utilizing the information received and transmitted for its intended purpose.

- See Appendix B_QHP-QDP-IND_EDI 834 Companion Guide CA 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 communicate any testing or production changes to system configuration (URL, certification, bank information) to Covered California in a timely fashion.

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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 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 that 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_Carrier Process 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. Applicant must confirm it can report system status on a quarterly basis.

Single, Radio group.

- 1: Confirmed, 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 at the product level.

13.1 Applicant must confirm to populate and submit all certification year SERFF templates (Rates, Service Area, Plans and Benefits, Network ID, 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 G_QDP-IND-CCSB_Submission Guidelines_Plan Year 2028~~7~~.

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

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13.3 Applicant must confirm, if certified, it will submit complete and accurate SERFF Templates to Covered California. Covered California will participate in two (2) 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 (2) rounds. Changes to any or all of Applicant's SERFF Templates counts as one (1) 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 (2) rounds of validations.

Single, Pull-down list.

- 1: Confirmed,
- 2: Not confirmed

13.4 Applicant must confirm, if certified, it will participate in CalHEERS testing and provide certification of plan data and documents in the CalHEERS pre-production environment. The pre-production 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 (1) 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 it will 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 all Applicants. All questions should be answered at the Issuer level, not at the product level.

~~All questions are required for new entrant Applicants. All questions should be answered at the Issuer level, not at the 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 QDP data is an essential component of assessing the quality and value of the coverage and health care received by Covered California Enrollees. QDP 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

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Manage Documents page as Appendix F_QDP-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 to the resulting QDP 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 Covered California's 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). Responses must address whether and the extent to which Applicant is able to provide data for ALL utilization, including patient encounters with capitated providers who may not need to submit such data to the Applicant for reimbursement. If yes with deviation, explain. If unable to provide all requested detail as outlined in Appendix F_QDP-IND-CCSB_HEI Extract File Specs, provide a plan and timeline to correct problematic detail and estimate the number and percentage of affected claims and encounters.

Claim / Encounter Type	Response	If No or Yes with deviation, explain.
Professional	<i>Single, Pull-down list.</i> 1: Yes, 2: Yes, with deviation, 3: No	<i>50 words.</i>

14.2 State law requires QDP Issuers to submit to Covered California data that represent 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 F_QDP-IND-CCSB_HEI Extract File Specs, provide a plan and timeline to correct problematic data elements and estimate the number and percentage of affected claims and encounters.

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

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	3: No	
Coinsurance	<i>Single, Pull-down list.</i> 1: Yes, 2: Yes, with deviation, 3: No	50 words.
Deductibles	<i>Single, Pull-down list.</i> 1: Yes, 2: Yes, with deviation, 3: No	50 words.
Plan Paid Amount (Net Payment)	<i>Single, Pull-down list.</i> 1: Yes, 2: Yes, with deviation, 3: No	50 words.
Encounter Financials – Covered California requires QDP Issuers to report entire cost of care, including Issuers offering dental HMO or other non-fee-for-service products. This may necessitate QDP Issuers assigning costs or cost equivalents to encounter records submitted to Covered California.	<i>Single, Pull-down list.</i> 1: Yes, 2: Yes, with deviation, 3: No	50 words.
Capitation Financials (per patient / provider / month) <i>Note: If a portion of Applicant provider payments are capitated. If capitation does not apply, select “No” and state “Not applicable, no provider payments are capitated” in the rightmost column.</i>	<i>Single, Pull-down list.</i> 1: Yes, 2: Yes, with deviation, 3: No	50 words.

14.3 Applicant must provide Covered California member IDs and Covered California subscriber IDs, and Social Security Numbers (SSNs) 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	<i>Single, Pull-down list.</i> 1: Yes, 2: Yes, with deviation, 3: No	50 words.
Covered CA Subscriber ID	<i>Single, Pull-down list.</i> 1: Yes, 2: Yes, with deviation, 3: No	50 words.
Member and Subscriber SSN	<i>Single, Pull-down list.</i> 1: Yes,	50 words.

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	2: Yes, with deviation, 3: No	
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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 F_QDP-IND-CCSB_HEI Extract File 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	<i>Single, Pull-down list.</i> 1: Yes, 2: Yes, with deviation, 3: No	50 words.
Starting Date of Service	<i>Single, Pull-down list.</i> 1: Yes, 2: Yes, with deviation, 3: No	50 words.
Ending Date of Service	<i>Single, Pull-down list.</i> 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), and descriptive codes for individual providers. If yes with deviation, explain. If unable to provide all requested detail as outlined in Appendix F_QDP-IND-CCSB_HEI Extract File 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	<i>Single, Pull-down list.</i> 1: Yes, 2: Yes, with deviation, 3: No	50 words.
NPI	<i>Single, Pull-down list.</i> 1: Yes, 2: Yes, with deviation, 3: No	50 words.
American Dental Association (ADA) Dental Provider Taxonomy Code	<i>Single, Pull-down list.</i> 1: Yes, 2: Yes, with deviation, 3: No	50 words.

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14.6 Applicant must provide detailed coding for 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 F_QDP-IND-CCSB_HEI Extract File 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 and Procedure Coding (ICD, CDT, HCPCS)	<i>Single, Pull-down list.</i> 1: Yes, 2: Yes, with deviation, 3: No	50 words.
Place of Service	<i>Single, Pull-down list.</i> 1: Yes, 2: Yes, with deviation, 3: No	50 words.

14.7 Can Applicant or its third-party affiliate submit all data directly to Covered California? Explain “No” responses, “Yes” with deviation, “Yes” responses which rely on a third party to submit data to Covered California on the QDP 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 Dental Plan Proposal

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

Applicant must submit a dental 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 may submit proposals to offer both a Children’s Dental Plan and a Family Dental Plan. Applicant may submit [Dental Preferred Provider Organization \(DPPO\)](#), [Dental Exclusive Provider Organization \(DEPO\)](#), and [Dental Health Maintenance Organization \(DHMO\)](#) product proposals in its proposed rating regions. Applicant’s proposal must include coverage of its entire licensed geographic service area for which it has an adequate network. Applicant may not submit a proposal that includes a tiered 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.

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15.1 Applicant must confirm its dental product proposal includes the pediatric dental Essential Health Benefit, for each individual plan it proposes to offer in a rating region. If not, Applicant's response will be disqualified from consideration.

Single, Pull-down list.

- 1: Confirmed,
- 2: Not confirmed

15.2 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

15.3 Final negotiated and accepted premium rates shall be in effect for coverage effective January 1, 2028~~7~~. Premium proposals must be submitted in accordance with the Certification Application Submission Guidelines instructions and due date(s). Submission instructions for proposals are subject to change and will be communicated to the Applicants. Premium proposals are considered preliminary and may be subject to negotiation as part of QDP certification and selection. The final negotiated premium rates must align with the product rate filings that will be submitted to the applicable regulatory agency. Premium may vary only by geography (rating region), by age, and by actuarial value.

Dental plan premiums for adults 21 and over will be additive and calculated on a per member basis. The same rate must be charged for adults 19 years and older. The single adult rate will be assessed for each adult in the plan. The same rate must be charged for children aged 0 - 18. The single child rate will be multiplied by two for a policy covering two children and by three for policies covering more than two children. Individuals ages 19 and 20 will be assessed the single adult rate and only for purposes of summing total family premium will be considered as children when limiting the total family premium to no more than the three oldest covered children's premiums together with covered adult premiums.

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. 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 products. Applicant must complete and upload through System for Electronic Rate and Form Filing (SERFF) the Rates Template 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

15.4 Applicant must certify that for each rating region in which it submits a dental plan proposal, it is submitting a proposal that covers the entire geographic service area for which it is licensed within that

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rating region. If entire proposed licensed geographic service area is not offer, Applicant must explain why.

Single, Radio group.

1: Yes, dental plan proposal covers entire licensed geographic service area,

2: No, dental plan proposal does not cover entire licensed geographic service area [100 words]

15.5 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 the regulator.

Single, Pull-down list.

1: Yes, filing service area expansion, exhibit attached,

2: Yes, filing service area withdrawal, exhibit attached,

3: No, no changes to service area

15.6 Applicant must indicate the different products it intends to offer on Covered California in the Individual market for the certification year. If Applicant is 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: Existing Covered California Product - Health Maintenance Organization (HMO),

2: Existing Covered California Product - Preferred Provider Organization (PPO),

3: Existing Covered California Product - Exclusive Provider Organization (EPO),

4: Existing Covered California Product - Other Network Type,

5: New Covered California Product - Health Maintenance Organization (HMO),

6: New Covered California Product - Preferred Provider Organization (PPO),

7: New Covered California Product - Exclusive Provider Organization (EPO),

8: New Covered California Product - Other Network Type

16 Benefit Proposal

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

16.1 Applicant must confirm all products offered will comply with the coverage year Patient-Centered Benefit Plan Designs If not, Applicant must explain why.

Single, Radio group.

1: Confirmed,

2: Not confirmed, [200 words]

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

Single, Pull-down list.

1: Confirmed,

2: Not confirmed,

3: Not Applicable, only offering Children's Dental Plan

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16.3 Applicant must confirm the coverage year Schedule of Benefits of Coverage (SBC), Evidence of Coverage (EOC), or Policy language describing proposed health benefits will follow the requirements in Appendix G_QDP-IND-CCSB_Submission Guidelines_Plan Year 2028~~87~~ and must comply with state and federal laws.

Single, Radio group.

1: Confirmed,

2: Not confirmed: [100 words]

16.4 Applicant must confirm all guidelines and due dates will be followed as listed in the Appendix G_QDP-IND-CCSB_Submission Guidelines_Plan Year 2028~~87~~.

Single, Pull-down list.

1: Confirmed,

2: Not confirmed

16.5 Applicant must indicate how it provides plan enrollees with current information about utilization of services and deductible and annual out-of-pocket costs to date.

	Dental Health Maintenance Organization Product	Dental Preferred Provider Organization Product	Dental Exclusive Provider Organization Product	Other Network Product
Status of oral health services received to date provided through member login to the dental plan website	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not confirmed, 3: Not Applicable	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not confirmed, 3: Not Applicable	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not confirmed, 3: Not Applicable	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not confirmed, 3: Not Applicable
Status of oral health services received to date provided by mailed document upon request	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not confirmed, 3: Not Applicable	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not confirmed, 3: Not Applicable	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not confirmed, 3: Not Applicable	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not confirmed, 3: Not Applicable
Status of oral health services received to date available upon member request to customer service	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not confirmed, 3: Not Applicable	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not confirmed, 3: Not Applicable	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not confirmed, 3: Not Applicable	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not confirmed, 3: Not Applicable
Status of deductible and benefit limit provided through member login to the dental plan website	Not Applicable for DHMO	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not confirmed, 3: Not Applicable	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not confirmed, 3: Not Applicable	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not confirmed, 3: Not

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				Applicable
Status of deductible and benefit limit provided by mailed document upon request	Not Applicable for DHMO	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not confirmed, 3: Not Applicable	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not confirmed, 3: Not Applicable	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not confirmed, 3: Not Applicable
Status of deductible and benefit limit available upon member request to customer service	Not Applicable for DHMO	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not confirmed, 3: Not Applicable	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not confirmed, 3: Not Applicable	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not confirmed, 3: Not Applicable
Status of out-of-pocket costs provided through member login to the dental plan website	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not confirmed, 3: Not Applicable	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not confirmed, 3: Not Applicable	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not confirmed, 3: Not Applicable	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not confirmed, 3: Not Applicable
Status of out-of-pocket costs provided by mailed document upon request	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not confirmed, 3: Not Applicable	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not confirmed, 3: Not Applicable	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not confirmed, 3: Not Applicable	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not confirmed, 3: Not Applicable
Status of out-of-pocket costs available upon member request to customer service	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not confirmed, 3: Not Applicable	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not confirmed, 3: Not Applicable	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not confirmed, 3: Not Applicable	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not confirmed, 3: Not Applicable
Other, describe	50 words.	50 words.		50 words.

16.6 Applicant must indicate if proposed QDPs will include coverage of non-emergent out-of-network services. If yes, with respect to non-network, non-emergency claims, describe how Applicant informs consumers about out-of-network benefits and the pricing methodology used for service payment and consumer cost sharing.

Proposed QDP	Response	Details
Dental Health Maintenance Organization (DHMO)	<i>Single, Pull-down list.</i> 1: Yes, 2: No, 3: Not Applicable	100 words.

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Dental Preferred Provider Organization Product (DPPO)	<i>Single, Pull-down list.</i> 1: Yes, 2: No, 3: Not Applicable	100 words.
Dental Exclusive Provider Organization Product (DEPO)	<i>Single, Pull-down list.</i> 1: Yes, 2: No, 3: Not Applicable	100 words.
Other Network Product	<i>Single, Pull-down list.</i> 1: Yes, 2: No, 3: Not Applicable	100 words.

16.7 Applicant must submit the Summary of Dental Benefits and Disclosure Matrix (SDBC) template as submitted to the applicable regulator.

Single, Pull-down list.

- 1: Attached,
- 2: Not attached

17 Network Offerings

17.1 Dental Health Maintenance Organization (DHMO)

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

17.1.1 Applicant must complete Attachment P_QHP-QDP-IND-CCSB_Provider Directory Data Template for provider network data in the network submission that covers all geographic locations to which Applicant is applying for certification as a QHP. Attachment P_QHP-QDP-IND-CCSB_Provider Directory Data Template will follow the data file layout in the Covered California Provider Data Submission Guide with additional required telehealth information. 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 necessary information to allow cross-network comparisons and evaluations. Applicant must indicate if the network it intends to offer on Covered California in the Individual market for the certification year is new, or if it already exists in Covered California, and it must include the network name.

Single, Radio group.

- 1: Attached, Applicant attesting new network (confirming provider data is for the certification year), [10 words] ,
- 2: Attached, Applicant attesting to material changes to existing plan year Covered California network (confirming provider data is for the certification year), [10 words] ,
- 3: Attached, Applicant attesting to no material changes to existing plan year Covered California network for the certification year,
- 4: Not attached, explain [50 words]

17.1.2 Applicant must complete all tabs in Attachment H1_QDP-IND-CCSB_DHMO Provider Network Tables, for their DHMO Network.

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Single, Pull-down list.

- 1: Attached,
- 2: Not attached

17.1.3 Does Applicant conduct provider negotiations and manage its own network, or does Applicant lease a network from another organization? If Applicant leases a network, it must describe the length of the lease agreement, including start and end dates. It must also name the leasing organization, and state whether or not it has the ability to influence provider contract terms.

Single, Radio group.

- 1: Applicant contracts and manages network,
- 2: Applicant leases network, describe [500 words]

17.1.4 Applicant must confirm it will respond to and adhere to the requirements of Health & Safety Code, § 1367.03 or Insurance Code, § 10133.54 and any implementing regulations. The implementing regulations would include regulations relating to consumer access in assessing geographic access to primary, specialty, and hospital care based on enrollee access.

Single, Radio group.

- 1: Confirmed,
- 2: Not Confirmed

17.1.5 Applicant must confirm it tracks ethnic and racial diversity in the population and ensures access to either culturally responsive or concordant providers.

Single, Radio group.

- 1: Confirmed,
- 2: Not Confirmed

17.1.6 Applicants must track ethnic and racial diversity in the population and ensure access to either culturally responsive or concordant providers, including relevant measurement criteria and benchmarks for ensuring adequate access. Applicant must describe in detail the following:

For the population and network providers, how is race/ethnicity information collected?	100 words.
How is practitioner language information collected and shared with enrollees?	100 words.
What tools or services are used to meet the language needs of the population?	100 words.
What percentage of network providers have participated in cultural humility or other related cultural competency training?	100 words.

17.1.7 Applicant must confirm 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 in assessing enrollee wait times for appointments with primary and specialty providers.

Single, Radio group.

- 1: Confirmed,
- 2: Not Confirmed

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17.1.8 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?	<i>Single, Pull-down list.</i> 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. <u>If not, explain why the coverage is not offered.</u>	<i>Compound, Pull-down list.</i> 1: Yes: [200 words], 2: No, <u>[200 words]</u> 3: Not Applicable

17.1.9 Applicant must describe the steps or processes Applicant uses to monitor networks adequacy. Include detail, such as monitoring panel sizes, individual provider terminations or provider group terminations.

200 words.

17.1.10 Applicant must describe in detail how it uses patient safety as a criterion for provider selection for Covered California networks. Include details of Applicant's process for evaluating the provider's administrative measures. This may encompass risk assessment in dental settings, infection control policies and guidelines, and the sources of patient safety assessment data. Additionally, describe the specific measures, metrics, and thresholds used in provider credentialing for inclusion and exclusion.

200 words.

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

Single, Radio group.

- 1: Yes, currently contracted Applicant, explain: [100 words] ,
2: Yes, new entrant Applicant, explain [100 words] ,
3: No, does not use patient reported experience, explain [100 words]

17.1.12 Applicant must describe any plans for network changes, by product, including any new dental provider groups or clinic systems that Applicant would like to highlight for Covered California's attention.

100 words.

17.2 Dental Preferred Provider Organization (DPPO)

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

17.2.1 Applicant must complete Attachment P_QHP-QDP-IND-CCSB_Provider Directory Data Template for provider network data in the network submission that covers all geographic locations to which Applicant is applying for certification as a QHP. Attachment P_QHP-QDP-IND-CCSB_Provider

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Directory Data Template will follow the data file layout in the Covered California Provider Data Submission Guide with additional required telehealth information. 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 necessary information to allow cross-network comparisons and evaluations. Applicant must indicate if the network it intends to offer on Covered California in the Individual market for the certification year is new, or if it already exists in Covered California, and it must include the network name.

Single, Radio group.

- 1: Attached, Applicant attesting to new network (confirming provider data is for the certification year), [10 words] ,
- 2: Attached, Applicant attesting to material changes to existing plan year Covered California network (confirming provider data is for the certification year), [10 words] ,
- 3: Attached, Applicant attesting to no material changes to existing plan year Covered California network for the certification year,
- 4: Not attached, explain [50 words]

17.2.2 Applicant must complete all tabs in Attachment H2_QDP-IND-CCSB_DPPO Provider Network Tables, for their DPPO Network.

Single, Pull-down list.

- 1: Attached,
- 2: Not attached

17.2.3 Does Applicant conduct provider negotiations and manage its own network, or does Applicant lease a network from another organization? If Applicant leases a network, it must describe the length of the lease agreement, including start and end dates. It must also name, the leasing organization, and state whether or not it has the ability to influence provider contract terms.

Single, Radio group.

- 1: Applicant contracts and manages network,
- 2: Applicant leases network, describe [500 words]

17.2.4 Applicant must confirm it will respond to and adhere to the requirements of Health & Safety Code, § 1367.03 or Insurance Code, § 10133.54 and any implementing regulations. The implementing regulations would include regulations relating to consumer access in assessing geographic access to primary, specialty, and hospital care based on enrollee access.

Single, Radio group.

- 1: Confirmed,
- 2: Not Confirmed

17.2.5 Applicant must confirm it tracks ethnic and racial diversity in the population and ensures access to either culturally responsive or concordant providers.

Single, Radio group.

- 1: Confirmed,
- 2: Not Confirmed

17.2.6 Applicants must track ethnic and racial diversity in the population and ensure access to either culturally responsive or concordant providers, including relevant measurement criteria and benchmarks for ensuring adequate access. Applicant must describe in detail the following:

For the population and network providers, how is race/ethnicity information collected.

100
words.

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How is practitioner language information collected and shared with enrollees?	100 words.
What tools or services are used to meet the language needs of the population.	100 words.
What percentage of network providers have participated in cultural humility or other related cultural competency training?	100 words.

17.2.7 Applicant must confirm 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 in assessing enrollee wait times for appointments with primary and specialty providers.

Single, Radio group.

- 1: Confirmed,
- 2: Not Confirmed

17.2.8 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?	<i>Single, Pull-down list.</i> 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. <u>If not, explain why the coverage is not offered.</u>	<i>Compound, Pull-down list.</i> 1: Yes: [200 words], 2: No, <u>[200 words]</u> 3: Not Applicable

17.2.9 Applicant must describe the steps or processes Applicant uses to monitor networks adequacy. Include detail, such as monitoring panel sizes, individual provider terminations or provider group terminations.

200 words.

17.2.10 Applicant must describe how it uses patient safety as a criterion for provider selection for Covered California networks. Include details of Applicant's process for evaluating the provider's administrative measures. This may encompass risk assessment in dental settings, infection control policies and guidelines, and the sources of patient safety assessment data. Additionally, describe the specific measures, metrics, and thresholds used in provider credentialing for inclusion.

200 words.

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

Single, Radio group.

- 1: Yes, currently contracted Applicant, explain: [100 words] ,

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- 2: Yes, new entrant Applicant, explain [100 words] ,
3: No, does not use patient reported experience, explain [100 words]

17.2.12 Applicant must describe any plans for network changes, by product, including any new dental provider groups or clinic systems that Applicant would like to highlight for Covered California's attention.

100 words.

17.3 Dental Exclusive Provider Organization (DEPO)

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

17.3.1 Applicant must complete Attachment P_QHP-QDP-IND-CCSB_Provider Directory Data Template for provider network data in the network submission that covers all geographic locations to which Applicant is applying for certification as a QHP. Attachment P_QHP-QDP-IND-CCSB_Provider Directory Data Template will follow the data file layout in the Covered California Provider Data Submission Guide with additional required telehealth information. 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 necessary information to allow cross-network comparisons and evaluations. Applicant must indicate if the network it intends to offer on Covered California in the Individual market for the certification year is new, or if it already exists in Covered California, and it must include the network name.

Single, Radio group.

- 1: Attached, Applicant attesting to new network (confirming provider data is for the certification year), [10 words] ,
2: Attached, Applicant attesting to material changes to existing plan year Covered California network (confirming provider data is for the certification year), [10 words] ,
3: Attached, Applicant attesting to no material changes to existing plan year Covered California network for the certification year,
4: Not attached, explain [50 words]

17.3.2 Applicant must complete all tabs in Attachment H3_QDP-IND-CCSB_DEPO Provider Network Tables, for their DEPO Network.

Single, Pull-down list.

- 1: Attached,
2: Not attached

17.3.3 Does Applicant conduct provider negotiations and manage its own network, or does Applicant lease a network from another organization? If Applicant leases a network, it must describe the length of the lease agreement, including start and end dates. It must also name the leasing organization, and state whether or not it has the ability to influence provider contract terms.

Single, Radio group.

- 1: Applicant contracts and manages network,
2: Applicant leases network, describe [500 words]

17.3.4 Applicant must confirm it will respond to and adhere to the requirements of Health & Safety Code, § 1367.03 or Insurance Code, § 10133.54 and any implementing regulations. The

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implementing regulations would include regulations relating to consumer access in assessing geographic access to primary, specialty, and hospital care based on enrollee access.

Single, Radio group.

1: Confirmed,

2: Not Confirmed

17.3.5 Applicant must confirm it tracks ethnic and racial diversity in the population and ensures access to either culturally responsive or concordant providers.

Single, Radio group.

1: Confirmed,

2: Not Confirmed

17.3.6 Applicants must track ethnic and racial diversity in the population and ensure access to either culturally responsive or concordant providers, including relevant measurement criteria and benchmarks for ensuring adequate access. Applicant must describe in detail the following: ~~where applicable:~~

For the population and network providers, how is race/ethnicity information collected.	100 words.
How is practitioner language information collected and shared with enrollees?	100 words.
What tools or services are used to meet the language needs of the population.	100 words.
What percentage of network providers have participated in cultural humility or other related cultural competency training?	100 words.

17.3.7 Applicant must confirm 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 in assessing enrollee wait times for appointments with primary and specialty providers.

Single, Radio group.

1: Confirmed,

2: Not Confirmed

17.3.8 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?	<i>Single, Pull-down list.</i> 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. <u>If not, explain why the coverage is not offered.</u>	<i>Compound, Pull-down list.</i> 1: Yes: [200 words], 2: No, <u>[200 words]</u> 3: Not Applicable

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17.3.9 Applicant must describe the steps or processes Applicant uses to monitor networks adequacy. Include detail, such as monitoring panel sizes, individual provider terminations or provider group terminations.

200 words.

17.3.10 Applicant must describe how it uses patient safety as a criterion for provider selection for Covered California networks. Include details of Applicant's process for evaluating the provider's administrative measures. This may encompass risk assessment in dental settings, infection control policies and guidelines, and the sources of patient safety assessment data. Additionally, describe the specific measures, metrics, and thresholds used in provider credentialing for inclusion.

200 words.

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

Single, Radio group.

1: Yes, currently contracted Applicant, explain [100 words] ,

2: Yes, new entrant Applicant, explain [100 words] ,

3: No, does not use patient reported experience, explain [100 words]

17.3.12 Applicant must describe any plans for network changes, by product, including any new dental provider groups or clinic systems that Applicant would like to highlight for Covered California's attention.

100 words.

17.4 Other Network Type

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

17.4.1 Applicant must complete Attachment P_QHP-QDP-IND-CCSB_Provider Directory Data Template for provider network data in the network submission that covers all geographic locations to which Applicant is applying for certification as a QHP. Attachment P_QHP-QDP-IND-CCSB_Provider Directory Data Template will follow the data file layout in the Covered California Provider Data Submission Guide with additional required telehealth information. 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 necessary information to allow cross-network comparisons and evaluations. 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: Attached, Applicant attesting new network (confirming provider data is for the certification year), [10 words] ,

2: Attached, Applicant attesting to material changes to existing plan year Covered California network (confirming provider data is for the certification year), [10 words] ,

3: Attached, Applicant attesting to no material changes to existing plan year Covered California network for the certification year,

4: Not attached, explain [50 words]

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17.4.2 Applicant must complete all tabs in Attachment H4_QDP-IND-CCSB_Dental Other Provider Network Tables, for their Other Network.

Single, Pull-down list.

- 1: Attached,
- 2: Not attached

17.4.3 Does Applicant conduct provider negotiations and manage its own network, or does Applicant lease a network from another organization? If Applicant leases a network, it must describe the length of the lease agreement, including start and end dates. It must also name the leasing organization, and state whether or not it has the ability to influence provider contract terms.

Single, Radio group.

- 1: Applicant contracts and manages network,
- 2: Applicant leases network, describe [500 words]

17.4.4 Applicant must confirm it will respond to and adhere to the requirements of Health & Safety Code, § 1367.03 or Insurance Code, § 10133.54 and any implementing regulations. The implementing regulations would include regulations relating to consumer access in assessing geographic access to primary, specialty, and hospital care based on enrollee access.

Single, Radio group.

- 1: Confirmed,
- 2: Not Confirmed

17.4.5 Applicant must confirm it tracks ethnic and racial diversity in the population and ensures access to either culturally responsive or concordant providers.

Single, Radio group.

- 1: Confirmed,
- 2: Not Confirmed

17.4.6 Applicants must track ethnic and racial diversity in the population and ensure access to either culturally responsive or concordant providers, including relevant measurement criteria and benchmarks for ensuring adequate access. Applicant must describe in detail the following:

For the population and network providers, how is race/ethnicity information collected.	100 words.
How is practitioner language information collected and shared with enrollees?	100 words.
What tools or services are used to meet the language needs of the population.	100 words.
What percentage of network providers have participated in cultural humility or other related cultural competency training?	100 words.

17.4.7 Applicant must confirm 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 in assessing enrollee wait times for appointments with primary and specialty providers.

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Single, Radio group.

- 1: Confirmed,
2: Not Confirmed

17.4.8 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?	<i>Single, Pull-down list.</i> 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. <u>If not, explain why the coverage is not offered.</u>	<i>Compound, Pull-down list.</i> 1: Yes: [200 words], 2: No, <u>[200 words]</u> 3: Not Applicable

17.4.9 Applicant must describe the steps or processes Applicant uses to monitor networks adequacy. Include detail, such as monitoring panel sizes, individual provider terminations or provider group terminations.

200 words.

17.4.10 Applicant must describe how it uses patient safety as a criterion for provider selection for Covered California networks. Include details of Applicant's process for evaluating the provider's administrative measures. This may encompass risk assessment in dental settings, infection control policies and guidelines, and the sources of patient safety assessment data. Additionally, describe the specific measures, metrics, and thresholds used in provider credentialing for inclusion.

200 words.

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

Single, Radio group.

- 1: Yes, currently contracted Applicant, explain: [100 words] ,
2: Yes, new entrant Applicant, explain [100 words] ,
3: No, does not use patient reported experience, explain [100 words]

17.4.12 Applicant must describe any plans for network changes, by product, including any new dental provider groups or clinic systems that Applicant would like to highlight for Covered California's attention.

100 words.

18 Essential Community Providers (ECP)

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

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

- Applicants must ~~complete and submit the use~~ Essential Community Provider Network Data Submission to indicate contracts with all providers designated as ECP.
- Applicants must demonstrate sufficient geographic distribution of a mix of essential community providers reasonably distributed throughout the geographic service area(s).

Covered California will evaluate whether Applicant's ~~ECP~~~~essential community provider~~ network has achieved the sufficient geographic distribution and requirements.

Federal regulations currently require health issuers to adhere to rules regarding payment to non-contracted Federally Qualified Health Centers (FQHC) for services when those services are covered by the QDP's benefit plan. Dental 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 essential community providers.

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

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

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.

Multi, Checkboxes.

- 1: DHMO Network Confirmed,
- 2: DHMO Network Not confirmed,
- 3: DPPO Network Confirmed,
- 4: DPPO Network Not confirmed,
- 5: DEPO Network Confirmed,
- 6: DEPO Network Not confirmed,
- 7: Other Network Confirmed,
- 8: Other Network Not confirmed

19 Equity and Quality Improvement Culture

19.1 Organizational Culture of Health Equity

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

19.1.1 Applicant must indicate if it has taken any of the following actions related to mission, vision, policies, and processes to demonstrate a commitment to creating an organizational culture of health equity.

Multi, Checkboxes.

- 1: Health equity is integrated into organizational systems and culture, including mission, vision, organizational policies, processes, models, and frameworks; or if currently not integrated, Applicant is taking steps to integrate health equity into organizational systems and culture,
- 2: Applicant identifies leaders who are designated and held accountable for disparities reduction, or Applicant is taking steps to identify leaders,
- 3: Applicant invests financially in health equity, or Applicant is taking steps to invest financially in health equity,

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- 4: Applicant openly recognizes disparities, motivation to reduce disparities is encouraged and supported throughout the organization, and staff throughout the organization know their role in the process, or Applicant is taking steps to meet these activities,
- 5: Applicant obtains or has taken steps to obtain provider or medical group buy-in to reduce health disparities,
- 6: Applicant recruits a diverse workforce that reflects plan membership,
- 7: Applicant provides or has taken steps to provide staff training in cultural competence, unconscious bias or implicit bias, cultural humility or racial humility, data analysis training to identify health disparities or other trainings,
- 8: Applicant invests in partnerships with community-based organizations that serve populations identified for disparity reduction staff, and the community,
- 9: Applicant leads or participates in statewide, regional, or cross organizational initiatives or collaborative efforts to promote and advance health equity,
- 10: Not applicable: Health Equity is not incorporated into any part of its organization culture or processes and applicant cannot describe taking steps to include health equity at this time.,
- 11: If there are any activities Applicant performs that have not been listed here but demonstrate a commitment to health equity, list them here: [200 words]

19.2 Culturally and Linguistically Appropriate Care

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

19.2.1 Does Applicant provide training or communication to network providers on patient language needs and the California Language Assistance Program requirements? If yes, describe methods, trainings, or communications to network providers on patient language needs.

200 words.

19.2.2 Applicant must indicate its threshold languages and percentage of enrollees that selected each applicable threshold language in plan year 2025.

*Chinese is the combination of Cantonese, Mandarin, and Other Chinese Language.

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

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

19.2.3 Applicant must indicate in what frequency and format does it communicate to enrollees about availability of language assistance services, such as interpretation and translation.

200 words.

19.2.4 Applicant must indicate what additional strategies does it use to address patient language needs (e.g., matching providers with patients based on language needs).

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200 words.

19.3 Participating in Collaborative Quality Initiatives

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

19.3.1 Applicant must identify any quality improvement collaboratives or organizations in which Applicant participates. Describe Applicant's level or form of engagement, including funding, meeting attendance, advocacy, or other activities.

100 words.

20 DHMO - Advancing Equity, Quality and Value

20.1 Health Equity and Disparity Reductions

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

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

20.1.1 Applicant must 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	Covered California	Medi-Cal	California Commercial Individual and Group (Off-Exchange)	Description If Applicant answered, “data not collected or N/A,” discuss how Applicant intends to collect specified data elements.
Race/Ethnicity	<i>Multi, Checkboxes.</i> 1: Enrollment form, 2: Member services contact, 3: Member portal, 4: Electronic Health Record (EHR), 5: Health Assessments, 6: Other, specify below, 7: Data not collected, 8: N/A	<i>Multi, Checkboxes.</i> 1: Enrollment form, 2: Member services contact, 3: Member portal, 4: Electronic Health Record (EHR), 5: Health Assessments, 6: Other, specify below, 7: Data not collected, 8: N/A	<i>Multi, Checkboxes.</i> 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: N/A	100 words.

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Specify	10 words.	10 words.	10 words.	
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20.1.2 Applicant must 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 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: Race/ethnicity data not used for quality improvement or health equity [100 words]

20.1.3 Applicant must identify the sources of data used to gather member preferred written and spoken language data for each line of business. The response “enrollment form” pertains only to information passed on by the purchaser.

<i>Demographic Data Type</i>	<i>Covered California</i>	<i>Medi-Cal</i>	<i>California Commercial Individual and Group (Off-Exchange)</i>	<i>Description If Applicant answered, “data not collected or N/A,” discuss how Applicant intends to collect specified data elements.</i>
Preferred Language (written or spoken)	Multi, Checkboxes. 1: Enrollment form, 2: Member services contact, 3: Member portal, 4: Electronic Health Record (EHR), 5: Health Assessments, 6: Other, specify below, 7: Data not collected, 8: N/A	Multi, Checkboxes. 1: Enrollment form, 2: Member services contact, 3: Member portal, 4: Electronic Health Record (EHR), 5: Health Assessments, 6: Other, specify below, 7: Data not collected, 8: N/A	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: N/A	100 words.
Specify	10 words.	10 words.	10 words.	

20.1.4 Applicant must indicate how primary written and spoken language data are used to address quality improvement and health equity and disparities. Select all that apply.

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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 provision of 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 (explain): [100 words]

20.1.5 Does Applicant stratify or has Applicant developed plans to stratify clinical or utilization or other measures by race and ethnicity or preferred language for disparities identification and intervention efforts? If so, which measures are stratified by race and ethnicity or preferred language? Specify the applicable lines of business.

200 words.

20.2 Population Health

20.2.1 Risk Stratification

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

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

20.2.1.1 Applicant must describe its activities in the last year conducted to improve collection of oral health status for On- and Off-exchange enrollees. Include types of member outreach and communication strategies to expand or improve capacity to determine enrollee oral health status.

100 words.

20.2.1.2 Does Applicant track changes in oral health status among individual plan enrollees, or have plans to do so? If so, indicate and/or explain any of the following data sources Applicant uses to track changes in oral health status among individual plan enrollees. Select all that apply.

Multi, Checkboxes.

- 1: Oral health risk assessment,
- 2: Claims data,
- 3: Planned activities to build capacity (explain): [100 words] ,
- 4: Systems to track changes in individual enrollee oral health status (explain): [100 words] ,
- 5: Data on oral health status not used,
- 6: Other (explain): [200 words] ,
- 7: Changes in individual enrollee oral health status not tracked.

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20.2.2 Population Health Management

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

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

20.2.2.1 Does Applicant monitor and track trends in oral health outcomes for its member population, identifying patterns and opportunities for improvement, or have plans to do so? If yes, indicate any of the following data sources Applicant uses to track changes in oral health status. Select all that apply.

Multi, Checkboxes.

- 1: Quality Improvement Programs (e.g., tracking progress using benchmarks to improve access to preventive care),
- 2: Claims data and collaborative reporting (establishing partnerships with dental providers to collect clinical outcomes data),
- 3: Planned activities to build capacity (explain): [100 words] ,
- 4: Using Population Health Management Tools or Data sources to track underutilization or changes of oral health status,
- 5: Data Sharing and Interoperability (Ensure interoperability between issuer products, dental providers, and or public health databases to streamline oral health tracking),
- 6: Other (explain): [200 words] ,
- 7: Data on oral health status not tracked

20.2.2.2 How does Applicant identify Covered California Enrollees or other enrollees (1) who are in need of preventive care, disease management, and restorative treatment and (2) who are in need of diagnostic services and treatment plans? Response must include Applicant's definitions or threshold(s).

100 words.

20.2.2.3 How does Applicant identify and address underutilization of diagnostic, preventive, and disease management treatment services? Response must include Applicant's definitions or thresholds for underutilization.

100 words.

20.2.2.4 Applicant must describe if and how it stratifies underutilization data by geography, race and ethnicity, gender, or other factors to identify and address gaps in care. If applicable, specify any additional factors by which underutilization is stratified. Describe steps taken to address identify gaps in care.

200 words.

20.2.2.5 How does Applicant identify and address overutilization? Response must include Applicant's definition or threshold for overutilization.

100 words.

20.3 Health Promotion and Prevention

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

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

20.3.1 Applicant must describe how it conducts outreach to educate enrollees on the availability of and how to access and utilize annual member benefits, including clearly communicating the availability of diagnostic and preventive services without member cost share. Specify if approaches differ by line of business.

100 words.

20.3.2 Applicant must describe how it conducts outreach to educate enrollees on the availability of health risk assessments and how to access and utilize them. Specify if approaches differ by line of business.

100 words.

20.3.3 Applicant must describe how it conducts outreach to educate enrollees on how to access and utilize provider location and matching resources. Specify if approaches differ by line of business.

100 words.

20.3.4 Applicant must describe if and how it determines individual risk and communicates individual risk findings to its Covered California Enrollees.

200 words.

20.3.5 Does Applicant provide any additional or tailored outreach and education to enrollees based on member risk level? Specify if outreach and education approaches vary by line of business and describe any differences.

Single, Radio group.

1: Yes, describe: [200 words] ,

2: No

20.3.6 Tobacco use is preventable and contributes to high morbidity and mortality. Reducing tobacco use will have greater impact on health outcomes in marginalized communities which have disproportionately higher rates of use. Does Applicant work with its contracted dentists to screen enrollees for tobacco use? If yes, describe any referral processes or follow-up actions taken when tobacco use is identified.

Single, Radio group.

1: Yes, describe: [200 words] ,

2: No

20.3.7 Does Applicant ensure contracted dentists have access to an updated list of smoking cessation programs, inclusive of evidenced-based counseling and appropriate pharmacotherapy which patient could discuss with his or her PCP? If so, describe. If not, how does Applicant support dentists in addressing enrollees' positive tobacco use screening results.

Single, Radio group.

1: Yes, describe [50 words] ,

2: No, explain: [50 words]

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20.3.8 Oral health is an important component of prenatal care, as poor oral health during pregnancy can lead to adverse health outcomes for both the mother and baby. How does Applicant work with its contracted dentists to identify pregnant Covered California Enrollees, provide enhanced outreach to support preventive care and treatment for identified oral health conditions, educate members on the importance of preventing and treating periodontitis during pregnancy, and ensure dental providers inform Enrollees about exam findings and recommend discussing them with their obstetrician?

200 words.

20.4 Delivery System and Payment Strategies to Drive Quality

20.4.1 Quality Improvement Program

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

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

20.4.1.1 Consistent with Covered California's mission to promote better care, better health and lower cost as part of a quality improvement strategy, Applicant must confirm it will implement a quality assurance program in accordance with Title 28 of the California Code of Regulations, Section 1300.70, for evaluating the appropriateness and quality of the covered services provided to member.

Single, Pull-down list.

- 1: Confirmed,
- 2: Not confirmed

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

Single, Pull-down list.

- 1: Confirmed,
- 2: Not confirmed

20.4.1.3 Applicant must complete Attachment N_QDP-IND-CCSB_QIP Summary Report to describe a Quality Improvement Program (QIP) conducted by Applicant within the last measurement year. Quality Improvement (QI) is the process of undertaking systematic actions to significantly improve the structures and processes related to the delivery of dental care services, with the ultimate goal of enhancing overall health outcomes. Applicant's QIP will be assessed on the degree to which it achieves optimizing provider network management, improving member access to oral care, ensuring high standards of care by enhancing care coordination, promoting preventive services, and maintaining continuity of care. Include measures, baseline data, and results of the QIP, why the QIP was undertaken and why it ended or has continued, if applicable. Describe the QIP scalability and share best practices if it was successful.

Single, Pull-down list.

- 1: Attachments completed,
- 2: Attachments not completed

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20.4.2 Encouraging Use of Primary Dental Care

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

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

20.4.2.1 Applicant must describe how it promotes continuity of care and the development and use of the dental home model elements by its contracted dentists to advance access, care coordination, and quality.

100 words.

20.4.2.2 If applicable to Applicant's delivery system, Applicant must report the number and percent of enrollees who either selected or were assigned a primary care dentist in 202~~6~~⁵ in Attachment O_QDP-IND-CCSB_Tables.

Single, Pull-down list.

- 1: Attachments completed,
- 2: Attachments not completed

20.4.2.3 Applicant must describe the methodology used in primary dentist selection or auto-assignment, if conducted by Applicant.

100 words.

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

Multi, Checkboxes.

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

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

Multi, Checkboxes.

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

20.4.2.6 If Applicant does not currently identify or encourage use of high-performing dental providers, report how Applicant intends to identify high-performing dental providers.

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Single, Radio group.

- 1: Applicant does not currently identify or encourage use of high-performing dental providers, explain [100 words] ,
- 2: Applicant does identify or encourage use of high-performing dental providers.

20.4.2.7 Applicant must describe the strategies used in outreach and enrollee communication to promote continuity of care and support primary dentist selection or assignment. Include any current or past efforts, and how these strategies are implemented across the member journey (e.g., onboarding, reminders, provider changes). Specify the communication channels used and how effectiveness is assessed, if applicable.

200 words.

20.4.2.8 If selection of or assignment to a primary care dentist is not required due to the Applicant's product type, Applicant must describe how it encourages continuity of care and supports enrollees in finding a dentist to whom they feel comfortable returning for continued care. Responses may include efforts to incorporate gender, language, ethnic or cultural preferences, geographic area, existing family assignment as strategies.

100 words.

20.4.3 Networks Based on Value

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

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

20.4.3.1 Applicant must describe value-based payment models ~~in~~ used in plan year 202~~6~~5, highlighting the rationale for each model and the expected outcomes. Detail how these models aim to enhance quality and efficiency. Indicate the number or percentage of dental providers actively participating in value-based payment arrangements in Attachment O_QDP-IND-CCSB_Tables. This information is crucial for understanding the impact of these models on the broader healthcare landscape and their effectiveness in promoting high-quality, cost-effective care. References: HCP LAN Alternative Payment Model APM Framework: <https://hcp-lan.org/apm-framework/>

Single, Pull-down list.

- 1: Attachments completed,
- 2: Attachments not completed

20.4.4 Teledentistry

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

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

20.4.4.1 Does Applicant offer web-based or teledentistry consultations through any of the following arrangements?

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Multi, Checkboxes.

- 1: Vendor(s) (specify): [50 words] ,
- 2: Contracted dental groups,
- 3: Contracted individual service providers,
- 4: Does not offer or allow web or teledentistry consultations,
- 5: Other (specify): [50 words]

20.4.4.2 Applicant must describe its ability to support web-based or teledentistry services through a vendor.

Multi, Checkboxes.

- 1: Teledentistry with interactive face to face dialogue (video and audio),
- 2: Teledentistry with interactive dialogue over the phone,
- 3: Teledentistry asynchronous via email, text, instant messaging or other,
- 4: Teledentistry asynchronous record collection and sharing of records,
- 5: e-Consult: provider-to-provider,
- 6: Other (specify): [20 words] ,
- 7: Teledentistry is not offered through a vendor,
- 8: Not applicable

20.4.4.3 Applicant must describe its ability to support web-based or teledentistry services through contracted dental groups or individual service providers.

Multi, Checkboxes.

- 1: Teledentistry with interactive face to face dialogue (video and audio),
- 2: Teledentistry with interactive dialogue over the phone,
- 3: Teledentistry asynchronous via email, text, instant messaging or other,
- 4: Teledentistry asynchronous record collection and sharing of records,
- 5: e-Consult: provider-to-provider,
- 6: Other (specify): [20 words] ,
- 7: Teledentistry is not offered through contracted dental groups or individual service providers,
- 8: Not applicable

20.4.4.4 Applicant must report the number and percentage of all California enrollees who utilized teledentistry services via any service provider in 20265.

	Number of Enrollees	Percentage
Covered California DHMO Enrollees	<i>Integer.</i>	<i>Percent.</i>
Covered California DPPO Enrollees	<i>Integer.</i>	<i>Percent.</i>
Covered California DEPO Enrollees	<i>Integer.</i>	<i>Percent.</i>
Medi-Cal	<i>Integer.</i>	<i>Percent.</i>
California Commercial Individual and Group (Off-Exchange) DHMO	<i>Integer.</i>	<i>Percent.</i>
California Commercial Individual and Group (Off-Exchange) DPPO	<i>Integer.</i>	<i>Percent.</i>
California Commercial Individual and Group (Off-Exchange) DEPO	<i>Integer.</i>	<i>Percent.</i>

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20.4.4.5 Applicant must explain how it communicates to and educates enrollees about teledentistry services including: service availability on key Covered California Enrollee website pages, cost-share, availability of interpreter service for teledentistry.

100 words.

20.4.4.6 Applicant must describe if and how it facilitates integration and coordination of care between third party teledentistry vendor services, if applicable.

100 words.

20.4.4.7 Applicant must describe if and how it screens for enrollee access barriers to teledentistry services such as broadband affordability, digital literacy, smartphone ownership, and geographic availability of high-speed internet services.

100 words.

20.4.4.8 Applicant must describe its teledentistry reimbursement policies for network dentists and for third party teledentistry vendors if applicable.

100 words.

20.5 Measurement

20.5.1 Utilization Reporting

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

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

20.5.1.1 Applicant must report utilization of covered dental services for the most recent benefit year for the following utilization measures. Provide current Covered California membership if applicable, and California book of business. Pediatric membership is defined as younger than 19 years of age. For Dental Quality Alliance (DQA) measure specifications, visit

<https://www.ada.org/resources/research/dental-quality-alliance/dqa-dental-quality-measures>.

Pediatric Utilization Measure	Number of Covered California Enrollees, if applicable	Percent of Covered California Enrollees, if applicable	Number of California Commercial Individual and Group (Off-Exchange) Enrollees, if applicable	Percent of California Commercial Individual and Group (Off-Exchange) Enrollees, if applicable	Number of Medi-Cal Enrollees, if applicable	Percent of Medi-Cal Enrollees, if applicable
Oral Evaluation, Dental Services (Pediatric)	Integer.	Percent.	Integer.	Percent.	Integer.	Percent.
Topical Fluoride	Integer.	Percent.	Integer.	Percent.	Integer.	Percent.

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for Children (Pediatric)						
Receipt of Sealants on First Permanent Molar (Pediatric)	<i>Integer.</i>	<i>Percent.</i>	<i>Integer.</i>	<i>Percent.</i>	<i>Integer.</i>	<i>Percent.</i>
Enrollees with one (1) or more fillings in the past year who received a topical fluoride or sealant application	<i>Integer.</i>	<i>Percent.</i>	<i>Integer.</i>	<i>Percent.</i>	<i>Integer.</i>	<i>Percent.</i>
Enrollees who received a pediatric dental treatment service	<i>Integer.</i>	<i>Percent.</i>	<i>Integer.</i>	<i>Percent.</i>	<i>Integer.</i>	<i>Percent.</i>

20.5.1.2 Applicant must report utilization of covered dental services for the most recent benefit year for the following utilization measures. Provide current Covered California membership if applicable, and California book of business. Adult membership is defined as 19 years of age and older. Adult Preventative specifications are outlined in Appendix P_QDP-IND-CCSB_Use of Preventative Dental Adult Services Measure Specification. For all other Dental Quality Alliance (DQA) measure specifications, visit <https://www.ada.org/resources/research/dental-quality-alliance/dqa-dental-quality-measures>.

Adult Utilization Measures	Number of Covered California Enrollees, if applicable	Percent of Covered California Enrollees, if applicable	Number of California Commercial Individual and Group (Off-Exchange) Enrollees, if applicable	Percent of California Commercial Individual and Group (Off-Exchange) Enrollees, if applicable	Number of Medi-Cal Enrollees, if applicable	Percent of Medi-Cal Enrollees, if applicable
Use of Preventive Services: Enrollees who received any preventive/diagnostic dental service (Adult)	<i>Integer.</i>	<i>Percent.</i>	<i>Integer.</i>	<i>Percent.</i>	<i>Integer.</i>	<i>Percent.</i>
Enrolled adults aged 30 years and older with a history of periodontitis who received disease management/recommended restorative treatment as defined by an oral prophylaxis	<i>Integer.</i>	<i>Percent.</i>	<i>Integer.</i>	<i>Percent.</i>	<i>Integer.</i>	<i>Percent.</i>

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OR scaling/root planning OR periodontal maintenance visit at least 2 times within the reporting year						
Enrollees aged 30 years and older with history of periodontitis receiving dental treatment services as defined by comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation within the reporting year.	<i>Integer.</i>	<i>Percent.</i>	<i>Integer.</i>	<i>Percent.</i>	<i>Integer.</i>	<i>Percent.</i>
Enrolled adults aged 18 years and older who are at “elevated” risk (i.e., “moderate” or “high”) who received at least 2 topical fluoride applications within the reporting year	<i>Integer.</i>	<i>Percent.</i>	<i>Integer.</i>	<i>Percent.</i>	<i>Integer.</i>	<i>Percent.</i>
Enrollees with one (1) or more fillings in the past year who received a topical fluoride or sealant application	<i>Integer.</i>	<i>Percent.</i>	<i>Integer.</i>	<i>Percent.</i>	<i>Integer.</i>	<i>Percent.</i>

20.5.1.3 Applicant must provide Cost Reporting as specified in the table. Adult membership is defined as 19 years of age and older.

Cost Measure	Number of Covered California Enrollees, if applicable	Percentage of Covered California Enrollees, if applicable
Pediatric enrollees who reached their annual out-of-pocket maximum.	<i>Integer.</i>	<i>Percent.</i>

20.5.1.4 Applicant must provide the most recent Dental Medical Loss Ratio as specified in the table. Applicant must provide Dental Medical Loss Ratio filed with the applicable regulator and for Covered California business only. Issuers contracted with Covered California must maintain a dental medical loss ratio of at least 50%.

<u>Cost Measure</u>	<u>Dental Medical Loss Ratio Percentage</u>
<u>Dental Medical Loss Ratio filed with applicable Regulator</u>	<u><i>Percent.</i></u>
<u>Dental Medical Loss Ratio for Covered California Business only</u>	<u><i>Percent.</i></u>

20.5.1.54 Applicant must submit copies of the most recent Dental Medical Loss Ratio Reports filed with the applicable regulator. Issuers contracted with Covered California must maintain a dental

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medical loss ratio of at least 50%. Additionally, Applicant must provide Dental Medical Loss Ratio for Covered California business only.

Single, Pull-down list.

1: Attached,

2: Not attached

20.5.2 Enrollee Satisfaction

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

20.5.2.1 Applicant must describe its ability to track and monitor member satisfaction to improve population health management. Include measurement strategy, action taken to respond to member satisfaction survey responses, any specific ability to track impact on Covered California Enrollees, and how Applicant uses this information as part of its population health management strategy.

100 words.

20.6 Data Sharing and Exchange

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

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

20.6.1 Beyond Quality Improvement Projects, Applicant must describe its ability to track and monitor clinical outcome quality measurement. Include measurement and data exchange strategy and any specific ability to track outcomes of Covered California Enrollees.

200 words.

20.6.2 Applicant must indicate its participation in data sharing, plans to develop data exchange capabilities, certified Electronic Health Records implementation, data exchange participation, and other activities building future statewide dental health information exchange infrastructure in support of quality improvement, health equity, and population health. Applicant responses may include provider incentives for these activities.

Multi, Checkboxes.

1: Certified Electronic Health Records implementation, describe: [100 words] ,

2: Participation in Health Information Exchange(s), describe: [100 words] ,

3: Data Sharing Initiatives (excluding Health Information Exchange(s)), describe: [100 words] ,

4: Other, describe: [200 words] ,

5: N/A, describe: [100 words]

21 DPPO - Advancing Equity, Quality and Value

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21.1 Health Equity and Disparity Reductions

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

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

21.1.1 Applicant must 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	Covered California	Medi-Cal	California Commercial Individual and Group (Off-Exchange)	Description If Applicant answered, “data not collected or N/A,” discuss how Applicant intends to collect specified data elements.
Race/Ethnicity	<i>Multi, Checkboxes.</i> 1: Enrollment form, 2: Member services contact, 3: Member portal, 4: Electronic Health Record (EHR), 5: Health Assessments, 6: Other, specify below, 7: Data not collected, 8: N/A	<i>Multi, Checkboxes.</i> 1: Enrollment form, 2: Member services contact, 3: Member portal, 4: Electronic Health Record (EHR), 5: Health Assessments, 6: Other, specify below, 7: Data not collected, 8: N/A	<i>Multi, Checkboxes.</i> 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: N/A	<i>100 words.</i>
Specify	<i>10 words.</i>	<i>10 words.</i>	<i>10 words.</i>	

21.1.2 Applicant must 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 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: Race/ethnicity data not used for quality improvement or health equity [100 words]

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21.1.3 Applicant must identify the sources of data used to gather member preferred written and spoken language data for each line of business. The response “enrollment form” pertains only to information passed on by the purchaser.

<i>Demographic Data Type</i>	<i>Covered California</i>	<i>Medi-Cal</i>	<i>California Commercial Individual and Group (Off-Exchange)</i>	<i>Description If Applicant answered, “data not collected or N/A,” discuss how Applicant intends to collect specified data elements.</i>
Preferred Language (written or spoken)	<i>Multi, Checkboxes.</i> 1: Enrollment form, 2: Member services contact, 3: Member portal, 4: Electronic Health Record (EHR), 5: Health Assessments, 6: Other, specify below, 7: Data not collected, 8: N/A	<i>Multi, Checkboxes.</i> 1: Enrollment form, 2: Member services contact, 3: Member portal, 4: Electronic Health Record (EHR), 5: Health Assessments, 6: Other, specify below, 7: Data not collected, 8: N/A	<i>Multi, Checkboxes.</i> 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: N/A	100 words.
Specify	10 words.	10 words.	10 words.	

21.1.4 Applicant must indicate how primary written and spoken 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 provision of 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 (explain): [100 words]

21.1.5 Does Applicant stratify or has Applicant developed plans to stratify clinical or utilization or other measures by race and ethnicity or preferred language for disparities identification and intervention efforts? If so, which measures are stratified by which race and ethnicity or preferred language? Specify the applicable lines of business.

200 words.

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21.2 Population Health

21.2.1 Risk Stratification

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

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

21.2.1.1 Applicant must describe its activities in the last year for improving collection of oral health status for On- and Off exchange enrollees. Include types of member outreach and communication strategies to expand or improve capacity to determine enrollee oral health status.

100 words.

21.2.1.2 Does Applicant track changes in oral health status among individual plan enrollees, or have plans to do so? If so, indicate and/or explain any of the following data sources Applicant uses to track changes in oral health status among individual plan enrollees. Select all that apply.

Multi, Checkboxes.

- 1: Oral health risk assessment,
- 2: Claims data,
- 3: Planned activities to build capacity (explain): [100 words] ,
- 4: Systems to track changes in individual enrollee oral health status (explain): [100 words] ,
- 5: Data on oral health status not used,
- 6: Other (explain): [200 words] ,
- 7: Changes in individual enrollee oral health status not tracked.

21.2.2 Population Health Management

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

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

21.2.2.1 Does Applicant monitor and track trends in oral health outcomes for its member population, identifying patterns and opportunities for improvement, or have plans to do so? If yes, indicate any of the following data sources Applicant uses to track changes in oral health status. Select all that apply.

Multi, Checkboxes.

- 1: Quality Improvement Programs (e.g., tracking progress using benchmarks to improve access to preventive care),
- 2: Claims data and collaborative reporting (establishing partnerships with dental providers to collect clinical outcomes data),
- 3: Planned activities to build capacity (explain): [100 words] ,
- 4: Using Population Health Management Tools or Data sources to track underutilization or changes of oral health status,
- 5: Data Sharing and Interoperability (Ensure interoperability between issuer products, dental providers, and or public health databases to streamline oral health tracking),
- 6: Other (explain): [200 words] ,
- 7: Data on oral health status not tracked

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21.2.2.2 How does Applicant identify Covered California Enrollees or other enrollees (1) who are in need of preventive care, disease management, and restorative treatment and (2) who are in need of diagnostic services and treatment plans? Response must include Applicant's definitions or threshold(s).

100 words.

21.2.2.3 How does Applicant identify and address underutilization of diagnostic, preventive, and disease management treatment services? Response must include Applicant's definitions or thresholds for underutilization.

100 words.

21.2.2.4 Applicant must describe if and how it stratifies underutilization data by geography, race and ethnicity, gender, or other factors to identify and address gaps in care. If applicable, specify any additional factors by which underutilization is stratified. Describe steps taken to address identify gaps in care.

200 words.

21.2.2.5 How does Applicant identify and address overutilization? Response must include Applicant's definition or threshold for overutilization.

100 words.

21.3 Health Promotion and Prevention

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

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

21.3.1 Applicant must describe how it conducts outreach to educate enrollees on the availability of and how to access and utilize annual member benefits, including clearly communicating the availability of diagnostic and preventive services without member cost share. Specify if approaches differ by line of business.

100 words.

21.3.2 Applicant must describe how it conducts outreach to educate enrollees on the availability of health risk assessments and how to access and utilize them. Specify if approaches differ by line of business.

100 words.

21.3.3 Applicant must describe how it conducts outreach to educate enrollees on how to access and utilize provider location and matching resources. Specify if approaches differ by line of business.

100 words.

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21.3.4 Applicant must describe if and how it determines individual risk and communicates individual risk findings to its Covered California Enrollees.

200 words.

21.3.5 Does Applicant provide any additional or tailored outreach and education to enrollees based on member risk level? Specify if outreach and education approaches vary by line of business and describe any differences.

Single, Radio group.

1: Yes, describe: [200 words] ,

2: No

21.3.6 Tobacco use is preventable and contributes to high morbidity and mortality. Reducing tobacco use will have greater impact on health outcomes in marginalized communities which have disproportionately higher rates of use. Does Applicant work with its contracted dentists to screen enrollees for tobacco use? If yes, describe any referral processes or follow-up actions taken when tobacco use is identified.

Single, Radio group.

1: Yes, describe: [200 words] ,

2: No

21.3.7 Does Applicant ensure contracted dentists have access to an updated list of smoking cessation programs, inclusive of evidenced-based counseling and appropriate pharmacotherapy which patient could discuss with his or her PCP? If so, describe. If not, how does Applicant support dentists in addressing enrollees' positive tobacco use screening results.

Single, Radio group.

1: Yes, describe [50 words] ,

2: No, explain: [50 words]

21.3.8 Oral health is an important component of prenatal care, as poor oral health during pregnancy can lead to adverse health outcomes for both the mother and baby. How does Applicant work with its contracted dentists to identify pregnant Covered California Enrollees, provide enhanced outreach to support preventive care and treatment for identified oral health conditions, educate members on the importance of preventing and treating periodontitis during pregnancy, and ensure dental providers inform Enrollees about exam findings and recommend discussing them with their obstetrician?

200 words.

21.4 Delivery System and Payment Strategies to Drive Quality

21.4.1 Quality Improvement Program

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

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

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21.4.1.1 Consistent with Covered California's mission to promote better care, better health and lower cost as part of a quality improvement strategy, Applicant must confirm it will implement a quality assurance program in accordance with Title 28 of the California Code of Regulations, Section 1300.70, for evaluating the appropriateness and quality of the covered services provided to member.

Single, Pull-down list.

- 1: Confirmed,
- 2: Not confirmed

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

Single, Pull-down list.

- 1: Confirmed,
- 2: Not confirmed

21.4.1.3 Applicant must complete Attachment N_QDP-IND-CCSB_QIP Summary Report to describe a Quality Improvement Program (QIP) conducted by Applicant within the last measurement year. Quality Improvement (QI) is the process of undertaking systematic actions to significantly improve the structures and processes related to the delivery of dental care services, with the ultimate goal of enhancing overall health outcomes. Applicant's QIP will be assessed on the degree to which it achieves optimizing provider network management, improving member access to oral care, ensuring high standards of care by enhancing care coordination, promoting preventive services, and maintaining continuity of care. Include measures, baseline data, and results of the QIP, why the QIP was undertaken and why it ended or has continued, if applicable. Describe the QIP scalability and share best practices if it was successful.

Single, Pull-down list.

- 1: Attachments completed,
- 2: Attachments not completed

21.4.2 Encouraging Use of Primary Dental Care

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

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

21.4.2.1 Applicant must describe how it promotes continuity of care and the development and use of the dental home model elements by its contracted dentists to advance access, care coordination, and quality.

100 words.

21.4.2.2 If applicable to Applicant's delivery system, Applicant must report the number and percent of enrollees who either selected or were assigned a primary care dentist in 202~~65~~⁶⁶ in Attachment O_QDP-IND-CCSB_Tables.

Single, Pull-down list.

- 1: Attachments completed,
- 2: Attachments not completed

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21.4.2.3 Applicant must describe the methodology used in primary dentist selection or auto-assignment, if conducted by Applicant.

100 words.

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

Multi, Checkboxes.

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

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

Multi, Checkboxes.

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

21.4.2.6 If Applicant does not currently identify or encourage use of high-performing dental providers, report how Applicant intends to identify high-performing dental providers.

Single, Radio group.

- 1: Applicant does not currently identify or encourage use of high-performing dental providers, explain [100 words] ,
- 2: Applicant does identify or encourage use of high-performing dental providers.

21.4.2.7 Applicant must describe the strategies used in outreach and enrollee communication to promote continuity of care and support primary dentist selection or assignment. Include any current or past efforts, and how these strategies are implemented across the member journey (e.g., onboarding, reminders, provider changes). Specify the communication channels used and how effectiveness is assessed, if applicable.

200 words.

21.4.2.8 If selection of or assignment to a primary care dentist is not required due to the Applicant's product type, Applicant must describe how it encourages continuity of care and supports enrollees in finding a dentist to whom they feel comfortable returning for continued care. Responses may include efforts to incorporate gender, language, ethnic or cultural preferences, geographic area, existing family assignment as strategies.

100 words.

21.4.3 Networks Based on Value

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

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

21.4.3.1 In the proposed QDP DPPO network, describe degree of variation in provider fee schedules, if any. What factors drive the variation? Describe how Applicant makes the relevant information available to DPPO members.

100 words.

21.4.3.2 Applicant must describe value-based payment models used in plan year 2026⁵, highlighting the rationale behind each model and the expected outcomes. Detail how these models aim to enhance quality and efficiency. Indicate the number or percentage of dental providers actively participating in value-based payment arrangements in Attachment O_QDP-IND-CCSB_Tables. This information is crucial for understanding the impact of these models on the broader healthcare landscape and their effectiveness in promoting high-quality, cost-effective care References: HCP LAN Alternative Payment Model APM Framework: <https://hcp-lan.org/apm-framework/>

Single, Pull-down list.

- 1: Attachments completed,
- 2: Attachments not completed

21.4.4 Teledentistry

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

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

21.4.4.1 Does Applicant offer web-based or teledentistry consultations through any of the following arrangements?

Multi, Checkboxes.

- 1: Vendor(s) (specify): [50 words] ,
- 2: Contracted dental groups,
- 3: Contracted individual service providers,
- 4: Does not offer or allow web or teledentistry consultations,
- 5: Other (specify): [50 words]

21.4.4.2 Applicant must describe its ability to support web-based or teledentistry services through a vendor.

Multi, Checkboxes.

- 1: Teledentistry with interactive face to face dialogue (video and audio),
- 2: Teledentistry with interactive dialogue over the phone,
- 3: Teledentistry asynchronous via email, text, instant messaging or other,
- 4: Teledentistry asynchronous record collection and sharing of records,
- 5: e-Consult: provider-to-provider,
- 6: Other (specify): [20 words] ,
- 7: Teledentistry is not offered through a vendor,
- 8: Not applicable

21.4.4.3 Applicant must describe its ability to support web-based or teledentistry services through contracted dental groups or individual service providers.

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Multi, Checkboxes.

- 1: Teledentistry with interactive face to face dialogue (video and audio),
- 2: Teledentistry with interactive dialogue over the phone,
- 3: Teledentistry asynchronous via email, text, instant messaging or other,
- 4: Teledentistry asynchronous record collection and sharing of records,
- 5: e-Consult: provider-to-provider,
- 6: Other (specify): [20 words] ,
- 7: Teledentistry is not offered through contracted dental groups or individual service providers,
- 8: Not applicable

21.4.4.4 Applicant must report the number and percentage of all California enrollees who utilized teledentistry services via any service provider in 2026⁵.

	Number of Enrollees	Percentage
Covered California DHMO Enrollees	<i>Integer.</i>	<i>Percent.</i>
Covered California DPPO Enrollees	<i>Integer.</i>	<i>Percent.</i>
Covered California DEPO Enrollees	<i>Integer.</i>	<i>Percent.</i>
Medi-Cal	<i>Integer.</i>	<i>Percent.</i>
California Commercial Individual and Group (Off-Exchange) DHMO	<i>Integer.</i>	<i>Percent.</i>
California Commercial Individual and Group (Off-Exchange) DPPO	<i>Integer.</i>	<i>Percent.</i>
California Commercial Individual and Group (Off-Exchange) DEPO	<i>Integer.</i>	<i>Percent.</i>

21.4.4.5 Applicant must explain how it communicates to and educates enrollees about teledentistry services including: service availability on key Covered California Enrollee website pages, cost-share, availability of interpreter service for teledentistry.

100 words.

21.4.4.6 Applicant must describe if and how it facilitates integration and coordination of care between third party teledentistry vendor services, if applicable.

100 words.

21.4.4.7 Applicant must describe if and how it screens for enrollee access barriers to teledentistry services such as broadband affordability, digital literacy, smartphone ownership, and geographic availability of high-speed internet services.

100 words.

21.4.4.8 Applicant must describe how its teledentistry reimbursement policies for network dentists and for third party teledentistry vendors if applicable.

100 words.

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21.5 Measurement

21.5.1 Utilization Reporting

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

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

21.5.1.1 Applicant must report utilization of covered dental services for the most recent benefit year for the following utilization measures. Provide current Covered California membership if applicable, and California book of business. Pediatric membership is defined as younger than 19 years of age. For Dental Quality Alliance (DQA) measure specifications, visit

<https://www.ada.org/resources/research/dental-quality-alliance/dqa-dental-quality-measures>.

Pediatric Utilization Measure	Number of Covered California Enrollees, if applicable	Percent of Covered California Enrollees, if applicable	Number of California Commercial Individual and Group (Off-Exchange) Enrollees, if applicable	Percent of California Commercial Individual and Group (Off-Exchange) Enrollees, if applicable	Number of Medi-Cal Enrollees, if applicable	Percent of Medi-Cal Enrollees, if applicable
Oral Evaluation, Dental Services (Pediatric)	<i>Integer.</i>	<i>Percent.</i>	<i>Integer.</i>	<i>Percent.</i>	<i>Integer.</i>	<i>Percent.</i>
Topical Fluoride for Children (Pediatric)	<i>Integer.</i>	<i>Percent.</i>	<i>Integer.</i>	<i>Percent.</i>	<i>Integer.</i>	<i>Percent.</i>
Receipt of Sealants on First Permanent Molar (Pediatric)	<i>Integer.</i>	<i>Percent.</i>	<i>Integer.</i>	<i>Percent.</i>	<i>Integer.</i>	<i>Percent.</i>
Enrollees with one (1) or more fillings in the past year who received a topical fluoride or sealant application	<i>Integer.</i>	<i>Percent.</i>	<i>Integer.</i>	<i>Percent.</i>	<i>Integer.</i>	<i>Percent.</i>
Enrollees who received a pediatric dental treatment service	<i>Integer.</i>	<i>Percent.</i>	<i>Integer.</i>	<i>Percent.</i>	<i>Integer.</i>	<i>Percent.</i>

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21.5.1.2 Applicant must report utilization of covered dental services for the most recent benefit year for the following utilization measures. Provide current Covered California membership if applicable, and California book of business. Adult membership is defined as 19 years of age and older. Adult Preventative specifications are outlined in Appendix P_QDP-IND-CCSB_Use of Preventative Dental Adult Services Measure Specification. For all other Dental Quality Alliance (DQA) measure specifications, visit <https://www.ada.org/resources/research/dental-quality-alliance/dqa-dental-quality-measures>.

<u>Adult Utilization Measures</u>	<u>Number of Covered California Enrollees, if applicable</u>	<u>Percent of Covered California Enrollees, if applicable</u>	<u>Number of California Commercial Individual and Group (Off-Exchange) Enrollees, if applicable</u>	<u>Percent of California Commercial Individual and Group (Off-Exchange) Enrollees, if applicable</u>	<u>Number of Medi-Cal Enrollees, if applicable</u>	<u>Percent of Medi-Cal Enrollees, if applicable</u>
-	-					
<u>Use of Preventive Services: Enrollees who received any preventive/diagnostic dental service (Adult)</u>	<u>Integer.</u>	<u>Percent.</u>	<u>Integer.</u>	<u>Percent.</u>	<u>Integer.</u>	<u>Percent.</u>
<u>Enrolled adults aged 30 years and older with a history of periodontitis who received disease management/recommended restorative treatment as defined by an oral prophylaxis OR scaling/root planning OR periodontal maintenance visit at least 2 times within the reporting year</u>	<u>Integer.</u>	<u>Percent.</u>	<u>Integer.</u>	<u>Percent.</u>	<u>Integer.</u>	<u>Percent.</u>
<u>Enrollees aged 30 years and older with history of periodontitis receiving dental treatment services as defined by comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation within the reporting year.</u>	<u>Integer.</u>	<u>Percent.</u>	<u>Integer.</u>	<u>Percent.</u>	<u>Integer.</u>	<u>Percent.</u>
<u>Enrolled adults aged 18 years and older who are at “elevated” risk (i.e., “moderate” or “high”) who received at least 2 topical fluoride applications within the reporting year</u>	<u>Integer.</u>	<u>Percent.</u>	<u>Integer.</u>	<u>Percent.</u>	<u>Integer.</u>	<u>Percent.</u>
<u>Enrollees with one (1) or more fillings in the past year who</u>	<u>Integer.</u>	<u>Percent.</u>	<u>Integer.</u>	<u>Percent.</u>	<u>Integer.</u>	<u>Percent.</u>

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<u>received a topical fluoride or sealant application</u>						
Adult Utilization Measures	Number of Covered California Enrollees, if applicable	Percent of Covered California Enrollees, if applicable	Number of California Commercial Individual and Group (Off-Exchange) Enrollees, if applicable	Percent of California Commercial Individual and Group (Off-Exchange) Enrollees, if applicable	Number of Medi-Cal Enrollees, if applicable	Percent of Medi-Cal Enrollees, if applicable
Enrolled adults aged 30 years and older with a history of periodontitis who received disease management/recommended restorative treatment as defined by an oral prophylaxis OR scaling/root planning OR periodontal maintenance visit at least 2 times within the reporting year	Integer.	Percent.	Integer.	Percent.	Integer.	Percent.
Enrollees aged 30 years and older with history of periodontitis receiving dental treatment services as defined by comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation within the reporting year.	Integer.	Percent.	Integer.	Percent.	Integer.	Percent.
Enrollees aged 30 years and older with history of periodontitis receiving dental treatment services as defined by comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation within the reporting year	Integer.	Percent.	Integer.	Percent.	Integer.	Percent.
Enrollees with one (1) or more fillings in the past year who received a topical fluoride or sealant application	Integer.	Percent.	Integer.	Percent.	Integer.	Percent.

21.5.1.3 Applicant must provide Cost Reporting as specified in the table. Adult membership is defined as 19 years of age and older.

Cost Measure	Number of Covered California	Percentage of Covered
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	Enrollees, if applicable	California Enrollees, if applicable
Pediatric enrollees who reached their annual out-of-pocket maximum.	<i>Integer.</i>	<i>Percent.</i>
Pediatric enrollees who reached their deductibles.	<i>Integer.</i>	<i>Percent.</i>
Adult enrollees who reached their annual benefit limit.	<i>Integer.</i>	<i>Percent.</i>
Adult enrollees who reached their deductibles.	<i>Integer.</i>	<i>Percent.</i>

21.5.1.4 Applicant must provide the most recent Dental Medical Loss Ratio as specified in the table. Applicant must provide Dental Medical Loss Ratio filed with the applicable regulator and for Covered California business only. Issuers contracted with Covered California must maintain a dental medical loss ratio of at least 50%.

<u>Cost Measure</u>	<u>Dental Medical Loss Ratio Percentage</u>
<u>Dental Medical Loss Ratio filed with applicable Regulator</u>	<u><i>Percent.</i></u>
<u>Dental Medical Loss Ratio for Covered California Business only</u>	<u><i>Percent.</i></u>

21.5.1.54 Applicant must submit copies of the most recent Dental Medical Loss Ratio Reports filed with the applicable regulator. Issuers contracted with Covered California must maintain a dental medical loss ratio of at least 50%. Additionally, Applicant must provide Dental Medical Loss Ratio for Covered California business only.

Single, Pull-down list.

- 1: Attached,
- 2: Not attached

21.5.2 Enrollee Satisfaction

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

21.5.2.1 Applicant must describe its ability to track and monitor member satisfaction to improve population health management. Include measurement strategy, action taken to respond to member satisfaction survey responses, any specific ability to track impact on Covered California Enrollees, and how Applicant uses this information as part of its population health management strategy.

100 words.

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21.6 Data Sharing and Exchange

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

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

21.6.1 Beyond Quality Improvement Projects, Applicant must describe its ability to track and monitor clinical outcome quality measurement. Include measurement and data exchange strategy and any specific ability to track outcomes of Covered California Enrollees.

200 words.

21.6.2 Applicant must indicate its participation in data sharing, plans to develop data exchange capabilities, certified Electronic Health Records implementation, data exchange participation, and other activities building future statewide dental health information exchange infrastructure in support of quality improvement, health equity, and population health. Applicant responses may include provider incentives for these activities.

Multi, Checkboxes.

1: Certified Electronic Health Records implementation, describe: [100 words] ,

2: Participation in Health Information Exchange(s), describe: [100 words] ,

3: Data Sharing Initiatives (excluding Health Information Exchange(s)), describe: [100 words] ,

4: Other, describe: [200 words] ,

5: N/A, describe: [100 words]

22 DEPO - Advancing Equity, Quality and Value

22.1 Health Equity and Disparity Reductions

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

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

22.1.1 Applicant must 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	Covered California	Medi-Cal	California Commercial Individual and Group (Off-Exchange)	Description If Applicant answered, “data not collected or N/A,” discuss how Applicant intends to collect specified data elements.

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Race/Ethnicity	<i>Multi, Checkboxes.</i> 1: Enrollment form, 2: Member services contact, 3: Member portal, 4: Electronic Health Record (EHR), 5: Health Assessments, 6: Other, specify below, 7: Data not collected, 8: N/A	<i>Multi, Checkboxes.</i> 1: Enrollment form, 2: Member services contact, 3: Member portal, 4: Electronic Health Record (EHR), 5: Health Assessments, 6: Other, specify below, 7: Data not collected, 8: N/A	<i>Multi, Checkboxes.</i> 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: N/A	100 words.
Specify	10 words.	10 words.	10 words.	

22.1.2 Applicant must 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 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: Race/ethnicity data not used for quality improvement or health equity [100 words]

22.1.3 Applicant must identify the sources of data used to gather member preferred written and spoken language data for each line of business. The response “enrollment form” pertains only to information passed on by the purchaser.

<i>Demographic Data Type</i>	<i>Covered California</i>	<i>Medi-Cal</i>	<i>California Commercial Individual and Group (Off-Exchange)</i>	<i>Description If Applicant answered, “data not collected or N/A,” discuss how Applicant intends to collect specified data elements.</i>
Preferred Language (written or spoken)	<i>Multi, Checkboxes.</i> 1: Enrollment form, 2: Member services contact, 3: Member portal, 4: Electronic Health Record (EHR),	<i>Multi, Checkboxes.</i> 1: Enrollment form, 2: Member services contact, 3: Member portal, 4: Electronic Health Record (EHR),	<i>Multi, Checkboxes.</i> 1: Enrollment form, 2: Member services contact, 3: Member portal, 4: Electronic Health Record (EHR), specify estimated percent of enrollees below, 5: Health Assessments,	100 words.

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	5: Health Assessments, 6: Other, specify below, 7: Data not collected, 8: N/A	5: Health Assessments, 6: Other, specify below, 7: Data not collected, 8: N/A	6: Other, specify below, 7: Data not collected, 8: N/A	
Specify	10 words.	10 words.	10 words.	

22.1.4 Applicant must indicate how primary written and spoken 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 provision of 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 (explain): [100 words]

22.1.5 Does Applicant stratify or has Applicant developed plans to stratify clinical or utilization or other measures by race and ethnicity or preferred language for disparities identification and intervention efforts? If so, which measures are stratified by which race and ethnicity or preferred language? Specify the applicable lines of business.

200 words.

22.2 Population Health

22.2.1 Risk Stratification

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

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

22.2.1.1 Applicant must describe its activities in the last year for improving collection of oral health status for On- and Off exchange enrollees. Include types of member outreach and communication strategies to expand or improve capacity to determine enrollee oral health status.

100 words.

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22.2.1.2 Does Applicant track changes in oral health status among individual plan enrollees, or have plans to do so? If so, indicate and/or explain any of the following data sources Applicant uses to track changes in oral health status among individual plan enrollees. Select all that apply.

Multi, Checkboxes.

- 1: Oral health risk assessment,
- 2: Claims data,
- 3: Planned activities to build capacity (explain): [100 words] ,
- 4: Systems to track changes in individual enrollee oral health status (explain): [100 words] ,
- 5: Data on oral health status not used,
- 6: Other (explain): [200 words] ,
- 7: Changes in individual enrollee oral health status not tracked.

22.2.2 Population Health Management

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

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

22.2.2.1 Does Applicant monitor and track trends in oral health outcomes for its member population, identifying patterns and opportunities for improvement? If yes, indicate any of the following data sources Applicant uses to track changes in oral health status. Select all that apply.

Multi, Checkboxes.

- 1: Quality Improvement Programs (e.g., tracking progress using benchmarks to improve access to preventive care),
- 2: Claims data and collaborative reporting (establishing partnerships with dental providers to collect clinical outcomes data),
- 3: Planned activities to build capacity (explain): [100 words] ,
- 4: Using Population Health Management Tools or Data sources to track underutilization or changes of oral health status,
- 5: Data Sharing and Interoperability (Ensure interoperability between issuer products, dental providers, and or public health databases to streamline oral health tracking),
- 6: Other (explain): [200 words] ,
- 7: Data on oral health status not tracked

22.2.2.2 How does Applicant identify Covered California Enrollees or other enrollees (1) who are in need of preventive care, disease management, and restorative treatment and (2) who are in need of diagnostic services and treatment plans? Response must include Applicant's definitions or threshold(s).

100 words.

22.2.2.3 How does Applicant identify and address underutilization of diagnostic, preventive, and disease management treatment services? Response must include Applicant's definitions or thresholds for underutilization.

100 words.

22.2.2.4 Applicant must describe if and how it stratifies under utilization data by geography, race and ethnicity, gender, or other factors to identify and address gaps in care. If applicable, specify any additional factors by which under utilization is stratified. Describe steps taken to address identify gaps in care.

200 words.

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22.2.2.5 How does Applicant identify and address over utilization? Response must include Applicant's definition or threshold for over utilization.

100 words.

22.3 Health Promotion and Prevention

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

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

22.3.1 Applicant must describe how it conducts outreach to educate enrollees on the availability of and how to access and utilize annual member benefits, including clearly communicating the availability of diagnostic and preventive services without member cost share. Specify if approaches differ by line of business.

100 words.

22.3.2 Applicant must describe how it conducts outreach to educate enrollees on the availability of health risk assessments and how to access and utilize them. Specify if approaches differ by line of business.

100 words.

22.3.3 Applicant must describe how it conducts outreach to educate enrollees on how to access and utilize provider location and matching resources. Specify if approaches differ by line of business.

100 words.

22.3.4 Applicant must describe how and if it determines individual risk and communicates individual risk findings to its Covered California Enrollees.

200 words.

22.3.5 Does Applicant provide any additional or tailored outreach and education to enrollees based on member risk level? Specify if outreach and education approaches vary by line of business and describe any differences.

Single, Radio group.

1: Yes, describe: [200 words] ,

2: No

22.3.6 Tobacco use is preventable and contributes to high morbidity and mortality. Reducing tobacco use will have greater impact on health outcomes in marginalized communities which have disproportionately higher rates of use. Does Applicant work with its contracted dentists to screen enrollees for tobacco use? If yes, describe any referral processes or follow-up actions taken when tobacco use is identified.

Single, Radio group.

1: Yes, describe: [200 words] ,

2: No

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22.3.7 Does Applicant ensure contracted dentists have access to an updated list of smoking cessation programs, inclusive of evidenced-based counseling and appropriate pharmacotherapy which patient could discuss with his or her PCP? If so, describe. If not, how does Applicant support dentists in addressing enrollees' positive tobacco use screening results.

Single, Radio group.

1: Yes, describe [50 words] ,

2: No, explain: [50 words]

22.3.8 Oral health is an important component of prenatal care, as poor oral health during pregnancy can lead to adverse health outcomes for both the mother and baby. How does Applicant work with its contracted dentists to identify pregnant Covered California Enrollees, provide enhanced outreach to support preventive care and treatment for identified oral health conditions, educate members on the importance of preventing and treating periodontitis during pregnancy, and ensure dental providers inform Enrollees about exam findings and recommend discussing them with their obstetrician?

200 words.

22.4 Delivery System and Payment Strategies to Drive Quality

22.4.1 Quality Improvement Program

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

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

22.4.1.1 Consistent with Covered California's mission to promote better care, better health and lower cost as part of a quality improvement strategy, Applicant must confirm it will implement a quality assurance program in accordance with Title 28 of the California Code of Regulations, Section 1300.70, for evaluating the appropriateness and quality of the covered services provided to member.

Single, Pull-down list.

1: Confirmed,

2: Not confirmed

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

Single, Pull-down list.

1: Confirmed,

2: Not confirmed

22.4.1.3 Applicant must complete Attachment N_QDP-IND-CCSB_QIP Summary Report to describe a Quality Improvement Program (QIP) conducted by Applicant within the last measurement year. Quality Improvement (QI) is the process of undertaking systematic actions to significantly improve the structures and processes related to the delivery of dental care services, with the ultimate goal of

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enhancing overall health outcomes. Applicant's QIP will be assessed on the degree to which it achieves optimizing provider network management, improving member access to oral care, ensuring high standards of care by enhancing care coordination, promoting preventive services, and maintaining continuity of care. Include measures, baseline data, and results of the QIP, why the QIP was undertaken and why it ended or has continued, if applicable. Describe the QIP scalability and share best practices if it was successful.

Single, Pull-down list.

- 1: Attachments completed,
- 2: Attachments not completed

22.4.2 Encouraging Use of Primary Dental Care

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

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

22.4.2.1 Applicant must describe how it promotes continuity of care and the development and use of the dental home model elements by its contracted dentists to advance access, care coordination, and quality.

100 words.

22.4.2.2 If applicable to Applicant's delivery system, Applicant must report the number and percent of enrollees who either selected or were assigned a primary care dentist in 202~~6~~⁵ in Attachment O_QDP-IND-CCSB_Tables.

Single, Pull-down list.

- 1: Attachments completed,
- 2: Attachments not completed

22.4.2.3 Applicant must describe the methodology used in primary dentist selection or auto-assignment, if conducted by Applicant.

100 words.

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

Multi, Checkboxes.

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

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

Multi, Checkboxes.

- 1: Auto-assign members to high-performing dental providers,
- 2: Identify high-performing providers through the provider directory or other web site location,

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- 3: Customer service referral to dental provider,
- 4: Other (explain): [100 words] ,
- 5: Applicant does not encourage use of high-performing dental providers

22.4.2.6 If Applicant does not currently identify or encourage use of high-performing dental providers, report how Applicant intends to identify high-performing dental providers.

Single, Radio group.

- 1: Applicant does not currently identify or encourage use of high-performing dental providers, explain [100 words] ,
- 2: Applicant does identify or encourage use of high-performing dental providers.

22.4.2.7 Applicant must describe the strategies used in outreach and enrollee communication to promote continuity of care and support primary dentist selection or assignment. Include any current or past efforts, and how these strategies are implemented across the member journey (e.g., onboarding, reminders, provider changes). Specify the communication channels used and how effectiveness is assessed, if applicable.

200 words.

22.4.2.8 If selection of or assignment to a primary care dentist is not required due to the Applicant's product type, Applicant must describe how it encourages continuity of care and supports enrollees in finding a dentist to whom they feel comfortable returning for continued care. Responses may include efforts to incorporate gender, language, ethnic or cultural preferences, geographic area, existing family assignment as strategies.

100 words.

22.4.3 Networks Based on Value

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

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

22.4.3.1 In the proposed QDP DEPO network, describe degree of variation in provider fee schedules, if any. What factors drive the variation? Describe how Applicant makes the relevant information available to DEPO members.

100 words.

22.4.3.2 Applicant must describe value-based payment models used in plan year 2026⁵, highlighting the rationale behind each model and the expected outcomes. Detail how these models aim to enhance quality and efficiency. Indicate the number or percentage of dental providers actively participating in value-based payment arrangements in Attachment O_QDP-IND-CCSB_Tables. This information is crucial for understanding the impact of these models on the broader healthcare landscape and their effectiveness in promoting high-quality, cost-effective care. References: HCP LAN Alternative Payment Model APM Framework: <https://hcp-lan.org/apm-framework/>

Single, Pull-down list.

- 1: Attachments completed,
- 2: Attachments not completed

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22.4.4 Teledentistry

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

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

22.4.4.1 Does Applicant offer web-based or teledentistry consultations through any of the following arrangements?

Multi, Checkboxes.

- 1: Vendor(s) (specify): [50 words] ,
- 2: Contracted dental groups,
- 3: Contracted individual service providers,
- 4: Does not offer or allow web or teledentistry consultations,
- 5: Other (specify): [50 words]

22.4.4.2 Applicant must describe its ability to support web-based or teledentistry services through a vendor.

Multi, Checkboxes.

- 1: Teledentistry with interactive face to face dialogue (video and audio),
- 2: Teledentistry with interactive dialogue over the phone,
- 3: Teledentistry asynchronous via email, text, instant messaging or other,
- 4: Teledentistry asynchronous record collection and sharing of records,
- 5: e-Consult: provider-to-provider,
- 6: Other (specify): [20 words] ,
- 7: Teledentistry is not offered through a vendor,
- 8: Not applicable

22.4.4.3 Applicant must describe its ability to support web-based or teledentistry services through contracted dental groups or individual service providers.

Multi, Checkboxes.

- 1: Teledentistry with interactive face to face dialogue (video and audio),
- 2: Teledentistry with interactive dialogue over the phone,
- 3: Teledentistry asynchronous via email, text, instant messaging or other,
- 4: Teledentistry asynchronous record collection and sharing of records,
- 5: e-Consult: provider-to-provider,
- 6: Other (specify): [20 words] ,
- 7: Teledentistry is not offered through contracted dental groups or individual service providers,
- 8: Not applicable

22.4.4.4 Applicant must report the number and percentage of all California enrollees who utilized teledentistry services via any service provider in 202~~6~~⁵.

	Number of Enrollees	Percentage
Covered California DHMO Enrollees	<i>Integer.</i>	<i>Percent.</i>
Covered California DPPO Enrollees	<i>Integer.</i>	<i>Percent.</i>
Covered California DEPO Enrollees	<i>Integer.</i>	<i>Percent.</i>

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Medi-Cal	<i>Integer.</i>	<i>Percent.</i>
California Commercial Individual and Group (Off-Exchange) DHMO	<i>Integer.</i>	<i>Percent.</i>
California Commercial Individual and Group (Off-Exchange) DPPO	<i>Integer.</i>	<i>Percent.</i>
California Commercial Individual and Group (Off-Exchange) DEPO	<i>Integer.</i>	<i>Percent.</i>

22.4.4.5 Applicant must explain how it communicates to and educates enrollees about teledentistry services including: service availability on key Covered California Enrollee website pages, cost-share, availability of interpreter service for teledentistry.

100 words.

22.4.4.6 Applicant must describe if and how it facilitates integration and coordination of care between third party teledentistry vendor services, if applicable.

100 words.

22.4.4.7 Applicant must describe if and how it screens for enrollee access barriers to teledentistry services such as broadband affordability, digital literacy, smartphone ownership, and geographic availability of high-speed internet services.

100 words.

22.4.4.8 Applicant must describe its teledentistry reimbursement policies for network dentists and for third party teledentistry vendors if applicable.

100 words.

22.5 Measurement

22.5.1 Utilization Reporting

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

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

22.5.1.1 Applicant must report utilization of covered dental services for the most recent benefit year for the following utilization measures. Provide current Covered California membership if applicable, and California book of business. Pediatric membership is defined as younger than 19 years of age. For Dental Quality Alliance (DQA) measure specifications, visit

<https://www.ada.org/resources/research/dental-quality-alliance/dqa-dental-quality-measures>.

Pediatric Utilization Measure	Number of Covered California Enrollees, if	Percent of Covered California Enrollees, if	Number of California Commercial Individual and	Percent of California Commercial Individual and	Number of Medi-Cal Enrollees, if applicable	Percent of Medi-Cal Enrollees, if applicable
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	applicable	applicable	Group (Off-Exchange) Enrollees, if applicable	Group (Off-Exchange) Enrollees, if applicable		
Oral Evaluation, Dental Services (Pediatric)	<i>Integer.</i>	<i>Percent.</i>	<i>Integer.</i>	<i>Percent.</i>	<i>Integer.</i>	<i>Percent.</i>
Topical Fluoride for Children (Pediatric)	<i>Integer.</i>	<i>Percent.</i>	<i>Integer.</i>	<i>Percent.</i>	<i>Integer.</i>	<i>Percent.</i>
Receipt of Sealants on First Permanent Molar (Pediatric)	<i>Integer.</i>	<i>Percent.</i>	<i>Integer.</i>	<i>Percent.</i>	<i>Integer.</i>	<i>Percent.</i>
Enrollees with one (1) or more fillings in the past year who received a topical fluoride or sealant application	<i>Integer.</i>	<i>Percent.</i>	<i>Integer.</i>	<i>Percent.</i>	<i>Integer.</i>	<i>Percent.</i>
Enrollees who received a pediatric dental treatment service	<i>Integer.</i>	<i>Percent.</i>	<i>Integer.</i>	<i>Percent.</i>	<i>Integer.</i>	<i>Percent.</i>

22.5.1.2 Applicant must report utilization of covered dental services for the most recent benefit year for the following utilization measures. Provide current Covered California membership if applicable, and California book of business. Adult membership is defined as 19 years of age and older. Adult Preventative specifications are outlined in Appendix P_QDP-IND-CCSB_Use of Preventative Dental Adult Services Measure Specification. For all other Dental Quality Alliance (DQA) measure specifications, visit <https://www.ada.org/resources/research/dental-quality-alliance/dqa-dental-quality-measures>.

<u>Adult Utilization Measures</u>	<u>Number of Covered California Enrollees, if applicable</u>	<u>Percent of Covered California Enrollees, if applicable</u>	<u>Number of California Commercial Individual and Group (Off-Exchange) Enrollees, if applicable</u>	<u>Percent of California Commercial Individual and Group (Off-Exchange) Enrollees, if applicable</u>	<u>Number of Medi-Cal Enrollees, if applicable</u>	<u>Percent of Medi-Cal Enrollees, if applicable</u>
-	-					
<u>Use of Preventive Services:</u>	<u><i>Integer.</i></u>	<u><i>Percent.</i></u>	<u><i>Integer.</i></u>	<u><i>Percent.</i></u>	<u><i>Integer.</i></u>	<u><i>Percent.</i></u>

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<u>Enrollees who received any preventive/diagnostic dental service (Adult)</u>						
<u>Enrolled adults aged 30 years and older with a history of periodontitis who received disease management/recommended restorative treatment as defined by an oral prophylaxis OR scaling/root planning OR periodontal maintenance visit at least 2 times within the reporting year</u>	<u>Integer.</u>	<u>Percent.</u>	<u>Integer.</u>	<u>Percent.</u>	<u>Integer.</u>	<u>Percent.</u>
<u>Enrollees aged 30 years and older with history of periodontitis receiving dental treatment services as defined by comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation within the reporting year.</u>	<u>Integer.</u>	<u>Percent.</u>	<u>Integer.</u>	<u>Percent.</u>	<u>Integer.</u>	<u>Percent.</u>
<u>Enrolled adults aged 18 years and older who are at “elevated” risk (i.e., “moderate” or “high”) who received at least 2 topical fluoride applications within the reporting year</u>	<u>Integer.</u>	<u>Percent.</u>	<u>Integer.</u>	<u>Percent.</u>	<u>Integer.</u>	<u>Percent.</u>
<u>Enrollees with one (1) or more fillings in the past year who received a topical fluoride or sealant application</u>	<u>Integer.</u>	<u>Percent.</u>	<u>Integer.</u>	<u>Percent.</u>	<u>Integer.</u>	<u>Percent.</u>
-						

<u>Adult Utilization Measures</u>	<u>Number of Covered California Enrollees, if applicable</u>	<u>Percent of Covered California Enrollees, if applicable</u>	<u>Number of California Commercial Individual and Group (Off-Exchange) Enrollees, if applicable</u>	<u>Percent of California Commercial Individual and Group (Off-Exchange) Enrollees, if applicable</u>	<u>Number of Medi-Cal Enrollees, if applicable</u>	<u>Percent of Medi-Cal Enrollees, if applicable</u>
-	-	-	-	-	-	-
<u>Enrolled adults aged 30 years and older with a history of periodontitis who received disease</u>	<u>Integer.</u>	<u>Percent.</u>	<u>Integer.</u>	<u>Percent.</u>	<u>Integer.</u>	<u>Percent.</u>

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management/recommended restorative treatment as defined by an oral prophylaxis OR scaling/root planning OR periodontal maintenance visit at least 2 times within the reporting year						
Enrollees aged 30 years and older with history of periodontitis receiving dental treatment services as defined by comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation within the reporting year.	Integer.	Percent.	Integer.	Percent.	Integer.	Percent.
Enrollees aged 30 years and older with history of periodontitis receiving dental treatment services as defined by comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation within the reporting year	Integer.	Percent.	Integer.	Percent.	Integer.	Percent.
Enrollees with one (1) or more fillings in the past year who received a topical fluoride or sealant application	Integer.	Percent.	Integer.	Percent.	Integer.	Percent.
-						

22.5.1.3 Applicant must provide Cost Reporting as specified in the table. Adult membership is defined as 19 years of age and older.

Cost Measure	Number of Covered California Enrollees, if applicable	Percentage of Covered California Enrollees, if applicable
Pediatric enrollees who reached their annual out-of-pocket maximum.	<i>Integer.</i>	<i>Percent.</i>
Pediatric enrollees who reached their deductibles (if applicable).	<i>Integer.</i>	<i>Percent.</i>
Adult enrollees who reached their annual benefit limit (if applicable).	<i>Integer.</i>	<i>Percent.</i>
Adult enrollees who reached their deductibles (if applicable).	<i>Integer.</i>	<i>Percent.</i>

21.5.1.4 Applicant must provide the most recent Dental Medical Loss Ratio as specified in the table. Applicant must provide Dental Medical Loss Ratio filed with the applicable regulator and for Covered

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California business only. Issuers contracted with Covered California must maintain a dental medical loss ratio of at least 50%.

<u>Cost Measure</u>	<u>Dental Medical Loss Ratio Percentage</u>
<u>Dental Medical Loss Ratio filed with applicable Regulator</u>	<u>Percent.</u>
<u>Dental Medical Loss Ratio for Covered California Business only</u>	<u>Percent.</u>

22.5.1.⁵⁴ Applicant must submit copies of the most recent Dental Medical Loss Ratio Reports filed with the applicable regulator. Issuers contracted with Covered California must maintain a dental medical loss ratio of at least 50%. Additionally, Applicant must provide Dental Medical Loss Ratio for Covered California business only.

Single, Pull-down list.

- 1: Attached,
2: Not attached

22.5.2 Enrollee Satisfaction

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

22.5.2.1 Applicant must describe its ability to track and monitor member satisfaction to improve population health management. Include measurement strategy, action taken to respond to member satisfaction survey responses, any specific ability to track impact on Covered California Enrollees, and how Applicant uses this information as part of its population health management strategy.

100 words.

22.6 Data Sharing and Exchange

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

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

22.6.1 Beyond Quality Improvement Projects, Applicant must describe its ability to track and monitor clinical outcome quality measurement. Include measurement and data exchange strategy and any specific ability to track outcomes of Covered California Enrollees.

200 words.

22.6.2 Applicant must indicate its participation in data sharing, plans to develop data exchange capabilities, certified Electronic Health Records implementation, data exchange participation, and other activities building future statewide dental health information exchange infrastructure in support of quality improvement, health equity, and population health. Applicant responses may include provider incentives for these activities.

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Multi, Checkboxes.

- 1: Certified Electronic Health Records implementation, describe: [100 words] ,
- 2: Participation in Health Information Exchange(s), describe: [100 words] ,
- 3: Data Sharing Initiatives (excluding Health Information Exchange(s)), describe: [100 words] ,
- 4: Other, describe: [200 words] ,
- 5: N/A, describe: [100 words]

23 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 abuse of one's position or authority. Often, the terms fraud and abuse are used interchangeably. 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 Dental Insurance Issuer who is applying to have its plans certified as Qualified Dental 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 "On-Exchange".

Current Year - The calendar year in which the Applicant is completing application for certification of proposed product(s).

Definition of Good Standing- California Department 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⁽¹⁾ 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 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

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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 material² 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 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.

Dental Issuer - A licensed health care service plan or insurer that has been selected and certified by Covered California to offer QDPs through Covered California, as specified in 10 CCR § 6410.

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.~~

Fraud - Consists of an intentional misrepresentation, deceit, or the 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.

Internal Audit Function - A professional individual or group responsible for providing an organization with assurance and advisory services. Internal Auditing is an independent, objective assurance and advisory service designed to add value and improve an organization's operations. It helps an

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.

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organization accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of governance, risk management, and control 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 to promote Enrollee satisfaction. <https://www.lawinsider.com/dictionary/member-portal>..

Waste - Intentional or unintentional, extravagant careless or needless expenditures. The 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.