CERTIFICATION APPLICATION
QUALIFIED DENTAL PLAN
INDIVIDUAL MARKETPLACE
PLAN YEAR 2025

FINAL – 01.11.2024

Certification Application Qualified Dental Plan Individual Marketplace Plan Year 2025 - FINAL

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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 2024, for coverage effective January 1, 2025. 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 2025. Covered California will exercise its statutory authority to selectively contract for health care coverage offered through Covered California for Plan Year 2025. Covered California reserves the right to select or reject any Applicant or to cancel this Application at any time.

1.2 **Background**

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

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

Covered California is guided by the following values:

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

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

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

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

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

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

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

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

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

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 Issuer 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 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 Designs[1]

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 with broad overlapping networks within a rating region unless they offer different innovative delivery system or payment reform features.

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

Encourage Competition throughout the State

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

Encourage Delivery System Improvement, Effective Prevention Programs and Payment Reform

One of the values of Covered California is to serve as a catalyst for the improvement of care, prevention, and wellness to reduce costs. Covered California encourages 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 a commitment to the long-term success of Covered California's mission are strongly encouraged.

Encourage Robust Customer Service

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

1.4 **Availability**

Applicant must be available immediately upon contingent certification of its plans as 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, 2025. Successful Applicants will also be required to adhere to certain provisions through their contracts with Covered California, including meeting data interface requirements with the California Healthcare Enrollment, Eligibility, and Retention System (CalHEERS). Successful Applicants must execute the 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, 2024.

1.5 **Application Process**

The application process shall consist of the following steps:

- Completion of Letter of Intent to Apply
- Release of the Final Application
- Submission of Applicant responses, including network data
- 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 web login and instructions for online access to the final Application.

Applicant's Letter of Intent must identify the contact person for the application process that includes an email address and a 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
QHPCertification@covered.ca.gov
(916) 954-3138

1.7 **Key Action Dates**

Action	Date/Time
Release of Draft Application for Comment	October 2023
Letter of Intent to Apply Due to Covered California	February 15, 2024
Application Opens	March 1, 2024
Completed Applications Due	May 1, 2024
Proposed Rates and Networks Due	June 2024
Negotiations between Applicants and Covered California	July 2024
Final QDP Contingent Certification Decisions	August 2024
QDP Contract Execution	September 2024

Action	Date/Time
Final QDP Certification	October 2024

1.8 **Preparation of Application Response**

Application responses are completed in an electronic proposal software program. Applicants will have access to a Question-and-Answer function within the portal and 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 new entrant Applicants. All questions should be answered at the Issuer level, not product level.

2.1 Applicant must complete the following:

	Response
Issuer Legal Name	*10 words.*
Entity name used in consumer-facing materials or communications	*10 words.*
NAIC Company Code	*10 words.*
NAIC Group Code	*10 words.*
Regulator(s)	*10 words.*
Federal Employer ID	*10 words.*
HIOS/Issuer ID	*10 words.*
Applicant tax status	*Single, Pull-down list.* 1: Not-for-profit, 2: For-profit
Year Applicant was founded	*10 words.*
Number of Years Applicant has been a licensed 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 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	*10 words.*
Signature	*10 words.*
Printed Name	*10 words.*
Title	*10 words.*

2.2 Applicant must complete the following table.

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

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

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

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

Coverage	Amount	Applicant must confirm if the coverage amount meets requirement.	Does the current policy expire before the end of the current Plan Year?	Indicate the date when the current policy expires and the start and end date (or term) of the renewed policy.
Commercial General Liability	Limit of not less than $1,000,000 per occurrence/ $2,000,000 general aggregate.	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed, describe: [50 words]	*Single, Pull-down list.* 1: Yes, 2: No	*200 words.*

Cyber Liability	At such levels consistent with industry standards and reasonably determined by Contractor to cover network security, unauthorized access, unauthorized use, 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.	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed, describe: [50 words]	*Single, Pull-down list.* 1: Yes, 2: No	*200 words.*
Employers Liability Insurance	Limits of not less than $1,000,000 per accident for bodily injury by accident and $1,000,000 per employee for bodily injury by disease and $1,000,000 disease policy limit.	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed, describe: [50 words]	*Single, Pull-down list.* 1: Yes, 2: No	*200 words.*
Umbrella Policy	An amount not less than $10,000,000 per occurrence and in the aggregate.	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed, describe: [50 words]	*Single, Pull-down list.* 1: Yes, 2: No	*200 words.*
Statutory CA's Workers' Compensation Coverage	Provide Proof of Coverage in full compliance with State law.	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed, describe: [50 words]	*Single, Pull-down list.* 1: Yes, 2: No	*200 words.*

2.5 Applicant must attach a copy of current Certificates of Insurance to verify that it maintains the insurance specified in the table in question 2.4. If not all applicable Certificates of Insurance are attached, Applicant must explain why.
Single, Radio group.
1: Attached, explain if not all certificates are attached. [200 words]
2: Not attached, explain [200 words]

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

State-based Marketplace(s), specify state(s) and years of participation	*100 words.*

Federally Facilitated Marketplace, specify state(s) and years of participation	*100 words.*
Private exchange(s), specify exchange(s) and years of participation	*100 words.*

3 Licensed and Good Standing

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

3.1 Indicate Applicant license status below:
Single, Radio group.
1: Applicant currently holds all of the proper and required licenses from the California Department of Managed Health Care to operate as a 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. Enter date application was filed: [To the day],
4: Applicant is currently applying for licensure from the California Department of Insurance to operate as a Dental Issuer as defined herein in the commercial individual market. Enter date application was filed: [To the day]

3.2 In addition to holding or pursuing all the proper and required licenses to operate as a Dental Issuer, Applicant must confirm that it has had no material fines, no material penalties levied or material ongoing disputes with applicable licensing authorities in the last two years (See Section 22 - Glossary - Definition of Good Standing). If Applicant has any material disputes with the applicable health insurance regulator in the last two years, Applicant must submit notification of these disputes as an attachment. 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, Pull-down list.
1: Confirmed, no material disputes in the last two years,
2: Not confirmed, notification of material disputes attached

4 Financial Requirements

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

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

200 words.

4.2 Applicant must confirm which systems it has in place to accept payment from members effective no later than the beginning of October prior to the coverage year for the following premium payment types (electronic payments, 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 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. QDP Issuer must be able to accept premium payment from members no later than October prior to the coverage year.
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 Describe how Applicant will comply (both operationally and systematically) with the federal requirement 45 CFR 156.1240(a)(2) to serve the unbanked, specifying the forms of payment available for this population for both binder and ongoing payments, and for both on-Exchange and off-Exchange lines of business. Applicant must describe any differences between payment process for the unbanked and usual payment processing procedures. Applicant must describe in detail how these types of payments are handled both in and out of their system of record.
200 words.

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

5 Operational Capacity

5.1 Issuer Operations and Account Management Support

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

5.1.1 Applicant must complete Attachment A1 A2_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 description of any initiatives, including a timeline, over the next 24 months which may impact the delivery of services to Covered California enrollees.

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

5.1.3 Does Applicant routinely subcontract any significant portion of its operations or partner with other companies to provide 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	*Single, Pull-down list.* 1: Yes, 2: No	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Database and/or enrollment transactions	*Single, Pull-down list.* 1: Yes, 2: No	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*

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

5.2 Implementation Performance

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

5.2.1 Applicant must complete Attachment B_QHP-QDP-IND-CCSB_Implementation Organizational Chart and include a detailed implementation plan.

Single, Radio group.
1: Attached,
2: Not attached, [50 words]

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

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

200 words.

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

Resource	Membership Increase (as % of Current Membership)	Resource Adjustment (specify)	Approach to Monitoring

Members Services	*Percent.*	*100 words.*	*100 words.*
Claims	*Percent.*	*100 words.*	*100 words.*
Account Management	*Percent.*	*100 words.*	*100 words.*
Clinical staff	*Percent.*	*100 words.*	*100 words.*
Disease Management staff	*Percent.*	*100 words.*	*100 words.*
Implementation	*Percent.*	*100 words.*	*100 words.*
Financial	*Percent.*	*100 words.*	*100 words.*
Administrative	*Percent.*	*100 words.*	*100 words.*
Actuarial	*Percent.*	*100 words.*	*100 words.*
Information Technology	*Percent.*	*100 words.*	*100 words.*
Other (List)	*Percent.*	*100 words.*	*100 words.*

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

200 words.

6 Customer Service

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

6.1 Applicant must confirm it will respond to and adhere to the requirements of California Health and Safety Code Section 1368 relating to consumer grievance procedures and maintain an internal review process to resolve a consumer's written or oral expression of dissatisfaction.

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

6.2 If certified, Applicant will be required to meet certain member services performance standards. During Open Enrollment, Covered California operating hours are 8 AM to 6 PM Monday through Friday (except holidays). Applicant must confirm it will match Covered California Open Enrollment Customer Service operating hours. Describe how Applicant will modify customer service center operations to meet Covered California-required operating hours if applicable. Describe how Applicant

will modify its current Interactive Voice Response (IVR) system to meet Covered California required operating hours.
Single, Radio group.
1: Confirmed, explain: [100 words],
2: Not confirmed

6.3 Applicant must list internal daily monitored Service Center Statistics.

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

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

100 words.

6.5 Applicant must indicate which of the following training modalities training tools, and resources are used to train new Customer Service Representatives, check all that apply:
Multi, Checkboxes.
1: Instructor-Led Training Sessions,
2: Virtual Instructor-Led Training Sessions (live instructor in a virtual environment),
3: Video Training,
4: Web-Based training (not Instructor-Led),
5: Self-led Review of Training Resources,
6: Case-Study,
7: Roleplaying,
8: Shadowing,
9: Observation,
10: Pre-tests,
11: Post-tests,

12: Training Evaluations,
13: Other, describe: [50 words]

6.6 What is the length of the entire training period for new Customer Service Representatives? Include a minimum of system trainings, health care basics, and customer service skills training. Include total time from point of hire to completion of training and release to work independently. How frequently are refresher trainings provided to all Customer Service Representatives? Include trainings focused on skills improvement as well as training resulting from changes to policy and procedures.
100 words.

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

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

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

6.8 Does Applicant use language line to support consumers that speak languages other than those spoken by Customer Service Representatives? Which language line vendor is contracted for support?
Single, Radio group.
1: Yes, specify vendor: [20 words],
2: No

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

100 words.

6.10 Applicant must indicate what information and tools are utilized to monitor consumer experience, check all that apply:
Multi, Checkboxes.
1: Customer Satisfaction Surveys,
2: Monitoring Social Media,
3: Monitoring Call Drivers,
4: Common Problems Tracking,
5: Observation of Representative Calls,
6: Other, describe: [50 words],
7: Applicant does not monitor consumer experience

6.11 Applicant must list all Customer Service Representative Quality Assurance metrics used for scoring of monitored 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 health insurance coverage or access to health care services through its QHPs, as defined by 45 CFR § 156.250, it will do so in accordance with the accessibility standards described in 45 CFR § 155.205(c).
Single, Radio group.
1: Confirmed, explain: [100 words],
2: Not confirmed

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

7 Sales Channels

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

7.1 Does Applicant currently work with Insurance Agents or General Agencies (also referred to as Insurance Brokers or Producers)?

Single, Radio group.
1: Yes,
2: No

7.2 Applicant must describe Agent of Record (AOR) policy and procedures for the individual market and submit its AOR policy document as an attachment. Review the Covered California Delegation Policy, https://hbex.coveredca.com/toolkit/PDFs/Delegation_Change_Policy_FINAL.pdf.

Single, Pull-down list.
1: Attached, [200 words]
2: Not attached [200 words
3: Not attached, Applicant is currently operating in Covered California and attesting to no changes

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

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

Other	Additional comments	*100 words.*	*100 words.*

7.4 Applicant must describe below and is required to provide as an attachment, its current Agent of Record (AOR) Commission Schedule for the individual market in California.
Note: Successful Applicants will be required to use a standardized Agent commission program with levels and terms that result in the same aggregate compensation amounts to Agents, whether products are sold within or outside of Covered California. Successful Applicants may not vary Agent compensation levels by metal tier and must pay the same commission during Open and Special Enrollment for each plan year.
Single, Radio group.
1: Attached: [200 words],
2: Not attached: [200 words]

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

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

Other	Additional Comments	*100 words.*	*100 words.*

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

- Name
- Office Address
- Phone Number
- Email Address Geographic Territory Assigned (statewide, county, etc.)
  The identified point of contact must appear in the attached Organizational Chart.

50 words.

7.7 Agents have become an integral channel of 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. “Not Applicable” is not considered a response.

Sup-Topic	Agent Services	On-Exchange Business	Off-Exchange Business
Support Services	Describe your agent support services to your appointed agents/brokers. Include different ways on how an appointed agent/broker can reach out to Applicant for questions and support with their appointment, commissions, client cases, plan information, etc.	*100 words.*	*100 words.*
Support Services	Do you have an agent portal for agents? If yes, describe the portal functionality and capabilities of agents have access to.	*100 words.*	*100 words.*
Support Services	Describe sales and marketing tools or trainings you have available for Agents to reach consumers for your enrollment support. Include the sales collateral (hard copy) and online sales tool resources. Include how you disburse these.	*100 words.*	*100 words.*
Communication	Describe your overall communication strategy to agents to share messages, updates, important announcements, and dates impacting the agents' work and their client cases. Include the different types of communication method (email, text, portal, etc.)	*100 words.*	*100 words.*
Sales	Does your sales strategy include niche populations? Why or why not? Explain how you outreach to them? Are you working with Agents that can directly assist consumers in the niche populations?	*100 words.*	*100 words.*
Network Changes	How often are Agents updated on provider network changes?	*100 words.*	*100 words.*

Plan-Based Enrollers	Explain how you utilize Plan-Based Enrollers?	*100 words.*	*100 words.*
Off-Exchange Consumers	What is your current number of off-exchange IFP members?	*100 words.*	*100 words.*
Off-Exchange Consumers	Do you evaluate off-exchange members to determine if they qualify for ACA Advanced Premium Tax Credit (APTC)? If an off-exchange member is eligible for APTC, what is your commitment with direct outreach to make them aware of their potential cost-savings?	*100 words.*	*100 words.*
Other	Additional comments	*100 words.*	*100 words.*

8 Marketing and Outreach Activities

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

8.1 Covered California expects all successful Applicants to promote enrollment in their QDPs, 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/PDFs/Brand_Style_Guide_022819_for-external-partners.pdf, (and Marketing Guidelines, if applicable) when co-branded materials are issued to Covered California enrollees. If Applicant is certified, co-branded items must be submitted in a timely manner, but no later than 10 business days before the material is used; ID cards must be submitted to Covered California at least 30 days prior to Open Enrollment.

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

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

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

8.4 Applicant must indicate their proposed marketing investment to promote enrollment in Individual and Family Plans (on and off exchange). In addition, Applicant must provide projected marketing spend allocation for acquisition versus retention efforts, open enrollment versus special enrollment periods, and brand versus direct response (DR). Upon contingent certification, the expectation for all Applicants is to invest at least 0.4% of their individual market gross premium revenue collected (on

and off exchange) on marketing during Open Enrollment and 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.
Single, Radio group.
1: Alternate proposed marketing investment: [500 words],
2: Confirmed to meet marketing spend expectations

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

Proposed Marketing Investment:	*Dollars.*

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

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

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

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

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

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

9 Privacy and Security Requirements for Personally Identifiable Data

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

9.1 HIPAA Privacy Rule

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

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

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

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

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

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

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

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

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

9.1.5 Confidential Communication Requests: Applicant must confirm that 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 Safeguards

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

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

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

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

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

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

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

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

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

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

9.2.6 Applicant must describe how they safeguard against Social Security number and identity theft within its organization.

200 words.

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

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

10 Fraud, Waste and Abuse Detection

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

Covered California is committed to working with its QDP Issuers to minimize Fraud, Waste, and Abuse, as defined in Section 22 - Glossary. The framework for managing fraud risks is detailed in Appendix A_QHP-QDP-IND-CCSB_GAO-15-593SP (located on the Manage Documents page). Covered California expects 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 Describe the roles and responsibilities of those tasked with carrying out dedicated anti-fraud and fraud risk management activities throughout the organization. If there is a dedicated unit responsible for fraud risk management describe how this unit interacts with the rest of the organization to mitigate fraud, waste, and abuse. Define any acronyms used.

200 words.

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

200 words.

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

200 words.

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

200 words.

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

200 words.

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

Multi, Checkboxes.

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

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

100 words.

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

100 words.

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

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

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

200 words.

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

200 words.

10.12 Describe Applicant's approach to the use of the National Practitioner Data Bank as part of the credentialing and re-credentialing process for contracted providers and any additional steps Applicant takes to verify a provider and facility is a legitimate place of business. Define any acronyms used.

200 words.

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

200 words.

11 Audits

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

11.1 Based on the definition of Internal Audit Function in Section 22 - Glossary, does Applicant maintain an Internal Audit Function? If yes, provide a brief description of Applicant's Internal Audit function's responsibilities and its reporting structure, including what oversight authority is there over the Internal Audit Function. For example: does the Internal Audit Function report to a board, audit committee, or executive office?
Single, Radio group.
1: Yes, describe: [200 words],
2: No, describe: [200 words]

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

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

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

11.4 What audit authority does Applicant have over network and non-network providers and contractors? For example: does Applicant conduct audits of network and non-network providers and contractors?

200 words.

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

200 words.

11.6 Applicant must confirm that, if certified, it will agree to subject itself to Covered California for audits and reviews 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 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; and
6. Applicant's internal controls to perform specified duties.
7. Applicant also agrees to all audits subject to applicable State and Federal laws regarding the confidentiality of and release of confidential Protected Health Information (PHI) of Covered California enrollees.

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

12 Electronic Data Interface (EDI)

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

12.1 Applicant must provide an overview of its system, data model, vendors, and anticipated changes in key personnel and interface partners. Include a summary of dependent sub-systems, interface messaging, interaction of vendors, development lifecycle, testing, and integration with CalHEERS.

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

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

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

12.3 Applicant must be prepared and able to engage with Covered California to develop data interfaces between Applicant's 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 in an accurate, consistent, and timely fashion and utilize the information received and transmitted for its intended purpose.

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

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

12.6 Applicant must be prepared and able to conduct testing of data interfaces with Covered California no later than June of the current year and confirms it will plan and implement testing jointly with Covered California to meet system release schedules. Applicant must confirm testing with Covered California will utilize industry security standards: firewall, certification, and fingerprint. Applicant must confirm it will make dedicated, qualified resources available to participate in the connectivity and testing effort.

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

12.7 Applicant must describe its ability to produce financial, eligibility, and enrollment data monthly for reconciliation. Standard file requirements and timelines are documented in Appendix C_QHP-QDP-IND_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 and can Applicant's organization 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 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 2025.

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

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

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

13.3 Applicant must confirm, if certified, it will submit complete and accurate SERFF Templates to Covered California. Covered California will participate in two rounds of validation with the Applicant. Applicant agrees to pay liquidated damages in the amount of $5,000 for each additional round of validation beyond the first two rounds. Changes to any or all of Applicant's SERFF Templates counts as one round of validation. If instructions provided by Covered California include inaccurate information which necessitates an additional round of validation, or an additional round of validation is necessary due to required changes by Covered California or Applicant's State Regulators, those rounds of validation will not be counted in the two rounds of validations.

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

13.4 Applicant must confirm, if certified, it will 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 upload, for purposes of this paragraph, includes all plan data and documents that must be resubmitted to correct Applicant's errors including Summary of Benefits and Coverage, Evidence of Coverage documents. Liquidated damages will not apply to additional uploads resulting from errors in the instructions provided by Covered California, or changes required by Covered California or Applicant's regulator.

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

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

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

14 Healthcare Evidence Initiative (HEI)

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

To fulfill its mission to ensure that consumers have available the plans that offer the optimal combination of choice, value, quality, and service, Covered California relies on evidence about the enrollee experience with health care. The timely and accurate submission of 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 Manage Documents page as Appendix F_QDP-IND-CCSB_HEI Extract File Specs. The data elements required to be submitted pursuant to this application, and 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 claim or encounter types and, estimate the number and percentage of affected claims and encounters.

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

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

14.3 Applicant must provide Covered California member IDs 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	*Single, Pull-down list.* 1: Yes, 2: Yes, with deviation, 3: No	*50 words.*
Covered CA Subscriber ID	*Single, Pull-down list.* 1: Yes, 2: Yes, with deviation, 3: No	*50 words.*
Member and Subscriber SSN	*Single, Pull-down list.* 1: Yes, 2: Yes, with deviation, 3: No	*50 words.*

14.4 Applicant must supply dates, such as starting date of service, in full year / month / day format to Covered California for data aggregation. If yes with deviation, explain. If unable to provide all requested detail as outlined in Appendix 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	*Single, Pull-down list.* 1: Yes, 2: Yes, with deviation, 3: No	*50 words.*
Starting Date of Service	*Single, Pull-down list.* 1: Yes, 2: Yes, with deviation, 3: No	*50 words.*
Ending Date of Service	*Single, Pull-down list.* 1: Yes, 2: Yes, with deviation, 3: No	*50 words.*

14.5 Applicant must supply all applicable Provider Tax ID Numbers (TINs), National Provider Identifiers (NPIs), 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	*Single, Pull-down list.* 1: Yes, 2: Yes, with deviation, 3: No	*50 words.*

NPI	*Single, Pull-down list.* 1: Yes, 2: Yes, with deviation, 3: No	*50 words.*
American Dental Association (ADA) Dental Provider Taxonomy Code	*Single, Pull-down list.* 1: Yes, 2: Yes, with deviation, 3: No	*50 words.*
CMS Provider Type and Specialty Codes	*Single, Pull-down list.* 1: Yes, 2: Yes, with deviation, 3: No	*50 words.*

14.6 Applicant must provide detailed coding for 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)	*Single, Pull-down list.* 1: Yes, 2: Yes, with deviation, 3: No	*50 words.*
Place of Service	*Single, Pull-down list.* 1: Yes, 2: Yes, with deviation, 3: No	*50 words.*

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

15.1 Applicant must confirm that its proposal includes a dental product including 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 where applicable, pursuant to Government Code 100503(f).

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

15.3 Preliminary Premium Proposals: Final negotiated and accepted premium rates shall be in effect for coverage effective January 1 of the certification year. Premium proposals are considered preliminary and may be subject to negotiation as part of QDP certification and selection. Premium proposals must be submitted with the Application. To submit premium proposals for Individual 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. 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.

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 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 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 proposing plans with different networks within the same product type, respond for Network 1 under the appropriate product category and respond for Network 2 in the category “Other”.
Multi, Checkboxes.
1: Health Maintenance Organization
2: Preferred Provider Organization
3: Other Network Type

16 Benefit Proposal

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

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 2025 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 2025.
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	Other Network Product
Status of oral health services received to date provided through member login to the dental plan website	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed, 3: Not Applicable	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed, 3: Not Applicable	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed, 3: Not Applicable
Status of oral health services received to date provided by mailed document upon request	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed, 3: Not Applicable	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed, 3: Not Applicable	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed, 3: Not Applicable
Status of oral health services received to date available upon member request to customer service	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed, 3: Not Applicable	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed, 3: Not Applicable	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed, 3: Not Applicable
Status of deductible and benefit limit provided through member login to the dental plan website	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed, 3: Not Applicable	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed, 3: Not Applicable	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed, 3: Not Applicable
Status of deductible and benefit limit provided by mailed document upon request	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed, 3: Not Applicable	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed, 3: Not Applicable	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed, 3: Not Applicable
Status of deductible and benefit limit available upon member request to customer service	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed, 3: Not Applicable	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed, 3: Not Applicable	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed, 3: Not Applicable
Status of out-of-pocket costs provided through member	*Single, Pull-down list.* 1: Confirmed,	*Single, Pull-down list.* 1: Confirmed,	*Single, Pull-down list.*

login to the dental plan website	2: Not confirmed, 3: Not Applicable	2: Not confirmed, 3: Not Applicable	1: Confirmed, 2: Not confirmed, 3: Not Applicable
Status of out-of-pocket costs provided by mailed document upon request	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed, 3: Not Applicable	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed, 3: Not Applicable	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed, 3: Not Applicable
Status of out-of-pocket costs available upon member request to customer service	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed, 3: Not Applicable	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed, 3: Not Applicable	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed, 3: Not Applicable
Status of oral health services received to date not provided	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed, 3: Not Applicable	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed, 3: Not Applicable	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed, 3: Not Applicable
Status of deductible and benefit limit not provided	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed, 3: Not Applicable	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed, 3: Not Applicable	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed, 3: Not Applicable
Status of out-of-pocket costs not provided	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed, 3: Not Applicable	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed, 3: Not Applicable	*Single, Pull-down list.* 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.

Single, Radio group.

1: Yes, proposed DPPO 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: [50 words],
2: Yes, proposed DPPO 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 DHMO QDPs do not cover non-emergent out-of-network services: [50 words],
3: No, proposed DPPO QDPs will not include coverage of non-emergent out-of-network services,
4: No, offering a DHMO QDPs

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 Issuer level.

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

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

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

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

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

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

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

Single, Pull-down list.
1: Applicant contracts and manages network,
2: Applicant leases network, describe [500 words]

17.1.5 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 geographic access to primary, specialty, and hospital care based on enrollee access.

Single, Pull-down list.
1: Confirmed [200 words],
2: Not Confirmed [200 words]

17.1.6 Applicant must confirm it tracks ethnic and racial diversity in the population and ensuring access to appropriate culturally competent providers and must briefly describe its methodology, data and tools used to track ethnic and racial diversity in the population and ensuring access to appropriate culturally concordant providers, including relevant measurement criteria and benchmarks for ensuring adequate access.

Single, Pull-down list.
1: Confirmed, describe [200 words],
2: Not Confirmed, describe [200 words]

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, Pull-down list.
1: Confirmed [200 words],
2: Not Confirmed [200 words]

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

17.1.9 Describe the steps or process 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 Describe in detail, how Applicant use patient safety as a criterion for provider selection for Covered California networks including the assessment process, the source of the patient safety assessment data, specific measures and metrics, thresholds for inclusion and exclusion.

100 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, explain: [100 words]
2: No

17.1.12 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

17.1.13 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

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

17.1.15 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 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 Issuer level.

17.2.1 Applicant must indicate if the network it intends to offer on Covered California in the Individual market for the certification year is new or existing to Covered California and include the network name.
Single, Pull-down list.
1: New Network to Covered California, including an existing network with material changes [10 words],
2: Existing Network to Covered California with no material changes to current network [10 words]

17.2.2 Provider network data must be included in this submission for all geographic locations to which Applicant is applying for certification as a QDP. Submit provider data according to the data file layout in the Covered California Provider Data Submission Guide. The provider network submission for the certification year must be consistent with what will be filed to the appropriate regulator for approval if Applicant is selected as a QDP Issuer. Covered California requires the information, as requested, to allow cross-network comparisons and evaluations.
Single, Pull-down list.
1: Attached, Applicant attesting to material changes to existing network or new network (confirming provider data is for the certification year),
2: Not attached, Applicant attesting to no material changes to existing plan year Covered California network for the certification year.

17.2.3 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

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

Single, Pull-down list.
1: Applicant contracts and manages network,
2: Applicant leases network, describe [500 words]

17.2.5 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 geographic access to primary, specialty, and hospital care based on enrollee access.

Single, Pull-down list.
1: Confirmed [200 words],
2: Not Confirmed [200 words]

17.2.6 Applicant must confirm it tracks ethnic and racial diversity in the population and ensuring access to appropriate culturally competent providers. and must briefly describe its methodology, data and tools used to track ethnic and racial diversity in the population and ensuring access to appropriate culturally concordant providers, including relevant measurement criteria and benchmarks for ensuring adequate access.

Single, Pull-down list.
1: Confirmed, describe [200 words],
2: Not Confirmed, describe [200 words]

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, Pull-down list.
1: Confirmed [200 words],
2: Not Confirmed [200 words]

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

17.2.9 Describe the steps or process 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 Describe in detail, how Applicant uses patient safety as a criterion for provider selection for Covered California networks including the assessment process, the source of the patient safety assessment data, specific measures and metrics, thresholds for inclusion and exclusion.

100 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, explain: [100 words],
2: No

17.2.12 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

17.2.13 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

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

200 words.

17.2.15 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 attention.

100 words.

17.3 Other Network Type

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

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

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

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

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

17.3.3 Applicant must complete all tabs in Attachment H3_QDP-IND-CCSB_Dental Other Provider Network Tables, for their Other Network.

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

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

Single, Pull-down list.
1: Applicant contracts and manages network,
2: Applicant leases network, describe [500 words]

17.3.5 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 geographic access to primary, specialty, and hospital care based on enrollee access.

Single, Pull-down list.
1: Confirmed [200 words],
2: Not Confirmed [200 words]

17.3.6 Applicant must confirm it tracks ethnic and racial diversity in the population and ensuring access to appropriate culturally competent providers. and must briefly describe its methodology, data and tools used to track ethnic and racial diversity in the population and ensuring access to appropriate culturally concordant providers, including relevant measurement criteria and benchmarks for ensuring adequate access.

Single, Pull-down list.
1: Confirmed, describe [200 words],
2: Not Confirmed, describe [200 words]

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, Pull-down list.
1: Confirmed [200 words],
2: Not Confirmed [200 words]

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

17.3.9 Describe the steps or process 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 Describe in detail how Applicant uses patient safety as a criterion for provider selection for Covered California networks, including the assessment process, the source of the patient safety assessment data, specific measures and metrics, thresholds for inclusion and exclusion.

100 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, explain: [100 words],
2: No

17.3.12 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

17.3.13 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

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

200 words.

17.3.15 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 attention.

100 words.

18 Essential Community Providers (ECP)

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

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.

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

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

Federal regulations currently require health issuers to adhere to rules regarding payment to non-contracted FQHCs for services when those services are covered by the QDP's benefit plan. 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.

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

19 Equity and Quality Improvement Culture

19.1 Organizational Culture of Health Equity

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

19.1.1 Has Applicant 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,
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 (300 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 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?

200 words.

19.2.2 Applicant must indicate its threshold languages and percentage of enrollees that selected each applicable threshold language in plan year 2023.

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

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

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

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

200 words.

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

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 product level.

19.3.1 Identify any quality improvement collaboratives and 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 Issuer level.

20.1.1 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	*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.*	

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

Demographic Data Type	*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.*
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 Indicate how primary language data are used to address quality improvement and health equity and disparities. Select all that apply.

Multi, Checkboxes.
1: Assess adequacy of language assistance to meet members' needs,
2: Calculate quality performance measures by language,
3: Calculate member experience measures by language,
4: Identify areas for quality improvement,

5: Identify areas for health education/promotion,
6: Share provider language data with member to support provider selection,
7: With appropriate protections, share with provider network to support 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 Identify the sources of data used to gather member sexual orientation for each line of business. The response "enrollment form" pertains only to information passed on by the purchaser. If member sexual orientation is collected from members, provide response options offered to members in the Description column.

Demographic Data Type	*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.*
Sexual Orientation	*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.*	

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

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

Demographic Data Type	*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.*
Gender Identity	*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.*	

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

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

Demographic Data Type	*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.
Disability Status	*Multi, Checkboxes.* 1: enrollment form, 2: member services contact, 3: member portal, 4: Electronic Health Record (EHR), 5: Health Assessments, 6: claims data, 7: other, specify below, 8: data not collected, 9: N/A	*Multi, Checkboxes.* 1: enrollment form, 2: member services contact, 3: member portal, 4: Electronic Health Record (EHR), 5: Health Assessments, 6: claims data, 7: other, specify below, 8: data not collected, 9: 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: claims data, 7: other, specify below, 8: data not collected, 9: N/A	*100 words.*
Specify	*10 words.*	*10 words.*	*10 words.*	

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

20.1.11 Does Applicant stratify or has Applicant developed plans to stratify clinical or utilization or other measures by demographic factors for disparities identification and intervention efforts? If so, which measures are stratified by which demographic factors? Specify the applicable lines of business.
200 words.

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 Issuer level.

20.2.1.1 Does Applicant risk stratify its population?
Single, Radio group.

1: Yes, describe risk stratification process and methodology, including how risk tiers are defined: [200 words],
2: No

20.2.1.2 If Applicant performs risk stratification, report the percent of population that falls into each risk tier by book of business.

Risk Tier	Risk Tier Label or Definition	Covered California Enrollees, if applicable	Medi-Cal	California Commercial Individual and Group (Off-Exchange)
1	*10 words.*	*Percent.*	*Percent.*	*Percent.*
2	*10 words.*	*Percent.*	*Percent.*	*Percent.*
3	*10 words.*	*Percent.*	*Percent.*	*Percent.*
4	*10 words.*	*Percent.*	*Percent.*	*Percent.*
5	*10 words.*	*Percent.*	*Percent.*	*Percent.*

20.2.1.3 If Applicant does not use risk stratification, how does Applicant determine enrollee oral health status and identify at-risk enrollees? At-risk enrollees may include members with existing or newly diagnosed needs for dental treatment or members with co-morbid conditions.
Multi, Checkboxes.
1: Claims data,
2: Website registration prompts self-report of existing/newly diagnosed need for dental treatment and/or co-morbid conditions,
3: Oral health risk assessment,
4: Other (explain): [200 words],
5: Plan does not currently identify at-risk enrollees

20.2.1.4 If Applicant determines enrollee oral health status, report the number of enrollees who have been identified as “at-risk”.

	Covered California Enrollees, if applicable	MediCal	California Commercial Individual and Group (Off-Exchange)
Number of enrollees who have been identified as “at-risk”	*Integer.*	*Integer.*	*Integer.*
Number of enrollees	*Integer.*	*Integer.*	*Integer.*

20.2.1.5 Describe any efforts undertaken in the last year for on- and off-exchange enrollees to improve collection of enrollee oral health status, including member outreach or communication strategies to expand or improve capacity to determine enrollee oral health status.

100 words.

20.2.1.6 Does Applicant track changes in oral health status among individual plan enrollees? If so, indicate 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: Other (explain): [200 words],
4: Describe any planned activities to build capacity or systems to track changes in individual enrollee oral health status

(explain): [200 words],
5: Data on oral health status not used,
6: Changes in individual enrollee oral health status not tracked.

20.3 Health Promotion and Prevention

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

20.3.1 Describe how Applicant 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 Describe how Applicant 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 Describe how Applicant 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 Describe if and how Applicant 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?
Single, Radio group.
1: Yes, describe any referral processes or follow-up actions taken when tobacco use is identified: [100 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]

20.3.8 Report the unique number and percent of Covered California Enrollees who use tobacco (screened positive) in the last 12 months.

	Covered California Enrollees, if applicable
Number of enrollees who use tobacco (screened positive) in the last 12 months	*Integer.*
Percentage of enrollees who use tobacco (screened positive) in the last 12 months	*Percent.*

20.3.9 Oral health may be considered an important part of prenatal care, given that poor oral health during pregnancy can lead to poor health outcomes for the mother and baby. How does Applicant work with its contracted dentists to offer enhanced outreach to support preventive care during pregnancy and provide treatment of identified oral health conditions?

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 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 Complete Attachment N_QDP-IND-CCSB_QIP Summary Report to describe a Quality Improvement Project (QIP) conducted by Applicant within the last five (5) years. Quality Improvement is defined as systematic actions taken to measurably improve oral health care, structure, processes, or outcomes. Include information about 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

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 Issuer level.

20.4.2.1 Describe how Applicant promotes 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 2022 in Attachment O_QDP-IND-CCSB_Tables.

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

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

100 words.

20.4.2.4 Describe the outreach and Enrollee communication conducted to support primary dentist selection or assignment activities.

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 Issuer level.

20.4.3.1 Using the Alternative Payment Model APM Framework, Applicant must report all types of payment models used for dental services and the number of providers paid under each model in plan year 2022 in Attachment O_QDP-IND-CCSB_Tables.
References:
HCP LAN Alternative Payment Model APM Framework: https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf

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 Issuer level.

20.4.4.1 Covered California supports the innovative use of technology to assist in higher quality, accessible, patient-centered care. Does Applicant offer web or teledentistry, either through a contractor or provided by the medical group/provider?
Single, Dropdown.
1: Applicant does not offer or allow web or teledentistry consultations,
2: Applicant offers or allows web or teledentistry consultations

20.4.4.2 Describe the Applicant's ability to support web or teledentistry, either through a contractor or provided by the medical group/provider.
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]

20.4.4.3 Report the number and percentage of all California enrollees who utilized teledentistry in 2022.

	Number of Enrollees	**Percentage**
Covered California DHMO Enrollees	*Integer.*	*Percent.*
Covered California DPPO Enrollees	*Integer.*	*Percent.*
Medi-Cal	*Integer.*	*Percent.*
California Commercial Individual and Group (Off-Exchange) DHMO	*Integer.*	*Percent.*
California Commercial Individual and Group (Off-exchange) DPPO	*Integer.*	*Percent.*

20.4.4.4 Explain how Applicant 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.

20.4.4.5 Describe if and how Applicant facilitates integration and coordination of care between third party teledentistry vendor services, if applicable.
100 words.

20.4.4.6 Describe if and how Applicant 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.

20.4.4.7 Describe Applicant's teledentistry reimbursement policies for network dentists and for third party teledentistry vendors if applicable.

100 words.

20.5 Measurement and Data Sharing

20.5.1 Utilization Reporting

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

20.5.1.1 How does Applicant identify Covered California Enrollees or other enrollees (1) who are in need of preventive, diagnostic, and treatment services appropriate for each enrollee and (2) who complete preventive and diagnostic services and treatment plans? Response must include Applicant's definitions or threshold(s).

100 words.

20.5.1.2 How does Applicant identify and address under-utilization of preventive, diagnostic, and treatment services? Response must include Applicant's definitions or thresholds for under-utilization.

100 words.

20.5.1.3 Describe if and how Applicant 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.

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

100 words.

20.5.1.5 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.

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
Enrollees that received any covered dental	*Integer.*	*Percent.*	*Integer.*	*Percent.*	*Integer.*	*Percent.*

service						
Enrollees that received a preventive/diagnostic dental service	*Integer.*	*Percent.*	*Integer.*	*Percent.*	*Integer.*	*Percent.*
Oral Evaluation, Dental Services (Pediatric)	*Integer.*	*Percent.*	*Integer.*	*Percent.*	*Integer.*	*Percent.*
Topical Fluoride for Children (Pediatric)	*Integer.*	*Percent.*	*Integer.*	*Percent.*	*Integer.*	*Percent.*
Receipt of Sealants on First Permanent Molar (Pediatric)	*Integer.*	*Percent.*	*Integer.*	*Percent.*	*Integer.*	*Percent.*
Enrollees needing dental treatment services (excluding preventive and diagnostic services)	*Integer.*	*Percent.*	*Integer.*	*Percent.*	*Integer.*	*Percent.*
Enrollees receiving dental treatment services (excluding preventive and diagnostic services)	*Integer.*	*Percent.*	*Integer.*	*Percent.*	*Integer.*	*Percent.*
Enrollees who received a treatment for caries or a caries-preventive procedure	*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.*

20.5.1.6 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 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

Enrollees that received any covered dental service	*Integer.*	*Percent.*	*Integer.*	*Percent.*	*Integer.*	*Percent.*
Use of Preventive Services: Enrollees who received any preventive dental service (Adult)	*Integer.*	*Percent.*	*Integer.*	*Percent.*	*Integer.*	*Percent.*
Enrollees needing dental treatment services (excluding preventive and diagnostic services)	*Integer.*	*Percent.*	*Integer.*	*Percent.*	*Integer.*	*Percent.*
Enrollees receiving dental treatment services (excluding preventive and diagnostic services)	*Integer.*	*Percent.*	*Integer.*	*Percent.*	*Integer.*	*Percent.*
Enrollees who received a treatment for caries or a caries-preventive procedure	*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.*

20.5.1.7 Cost Reporting

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.	*Integer.*	*Percent.*
Pediatric enrollees who reached their deductibles (DPPO plans only).	*Integer.*	*Percent.*
Adult enrollees who reached their annual benefit limit (DPPO plans only).	*Integer.*	*Percent.*
Adult enrollees who reached their deductibles (DPPO plans only).	*Integer.*	*Percent.*

20.5.1.8 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%.

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 Issuer level.

20.5.2.1 Describe 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.

20.5.3 Data Sharing and Exchange

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

20.5.3.1 Beyond Quality Improvement Projects, describe 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.

20.5.3.2 Indicate Applicant 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

21.1 Health Equity and Disparity Reductions

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

21.1.1 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	*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.*	

21.1.2 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]

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

Demographic Data Type	*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.*
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.*	

21.1.4 Indicate how primary language data are used to address quality improvement and health equity and disparities. Select all that apply.
Multi, Checkboxes.
1: Assess adequacy of language assistance to meet members' needs,
2: Calculate quality performance measures by language,
3: Calculate member experience measures by language,
4: Identify areas for quality improvement,
5: Identify areas for health education/promotion,
6: Share provider language data with member to support provider selection,
7: With appropriate protections, share with provider network to support 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 Identify the sources of data used to gather member sexual orientation for each line of business. The response "enrollment form" pertains only to information passed on by the purchaser. If member sexual orientation is collected from members, provide response options offered to members in the Description column.

Demographic Data Type	*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.*
Sexual Orientation	*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.*	

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

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

Demographic Data Type	*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.
Gender Identity	*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.*	

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

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

Demographic Data Type	*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.*
Disability Status	*Multi, Checkboxes.* 1: enrollment form, 2: member services contact, 3: member portal, 4: Electronic Health Record (EHR), 5: Health Assessments,	*Multi, Checkboxes.* 1: enrollment form, 2: member services contact, 3: member portal, 4: Electronic Health Record (EHR), 5: Health Assessments,	*Multi, Checkboxes.* 1: enrollment form, 2: member services contact, 3: member portal, 4: Electronic Health Record (EHR), specify estimated percent of enrollees below, 5: Health Assessments, 6: claims data, 7: other, specify below,	*100 words.*

	6: claims data, 7: other, specify below, 8: data not collected, 9: N/A	6: claims data, 7: other, specify below, 8: data not collected, 9: N/A	8: data not collected, 9: N/A	
Specify	*10 words.*	*10 words.*	*10 words.*	

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

21.1.11 Does Applicant stratify or has Applicant developed plans to stratify clinical or utilization or other measures by demographic factors for disparities identification and intervention efforts? If so, which measures are stratified by which demographic factors? Specify the applicable lines of business.
200 words.

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 Issuer level.

21.2.1.1 Does Applicant risk stratify its population?
Single, Radio group.
1: Yes, describe risk stratification process and methodology, including how risk tiers are defined: [200 words],
2: No

21.2.1.2 If Applicant performs risk stratification, report the percent of population that falls into each risk tier by book of business.

Risk Tier	Risk Tier Label or Definition	Covered California Enrollees, if applicable	Medi-Cal	California Commercial Individual and Group (Off-Exchange)
1	*10 words.*	*Percent.*	*Percent.*	*Percent.*
2	*10 words.*	*Percent.*	*Percent.*	*Percent.*

3	*10 words.*	*Percent.*	*Percent.*	*Percent.*
4	*10 words.*	*Percent.*	*Percent.*	*Percent.*
5	*10 words.*	*Percent.*	*Percent.*	*Percent.*

21.2.1.3 If Applicant does not use risk stratification, how does Applicant determine enrollee oral health status and identify at-risk enrollees? At-risk enrollees may include members with existing or newly diagnosed needs for dental treatment or members with co-morbid conditions.
Multi, Checkboxes.
1: Claims data,
2: Website registration prompts self-report of existing/newly diagnosed need for dental treatment and/or co-morbid conditions,
3: Oral health risk assessment,
4: Other (explain): [200 words],
5: Plan does not currently identify at-risk enrollees

21.2.1.4 If Applicant determines enrollee oral health status, report the number of enrollees who have been identified as “at-risk”.

	Covered California Enrollees, if applicable	MediCal	California Commercial Individual and Group (Off-Exchange)
Number of enrollees who have been identified as “at-risk”	*Integer.*	*Integer.*	*Integer.*
Number of enrollees	*Integer.*	*Integer.*	*Integer.*

21.2.1.5 Describe any efforts undertaken in the last year for on- and off-exchange enrollees to improve collection of enrollee oral health status, including member outreach or communication strategies to expand or improve capacity to determine enrollee oral health status.
100 words.

21.2.1.6 Does Applicant track changes in oral health status among individual plan enrollees? If so, indicate 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: Other (explain): [200 words],
4: Describe any planned activities to build capacity or systems to track changes in individual enrollee oral health status (explain): [200 words],
5: Data on oral health status not used,
6: Changes in individual enrollee oral health status not tracked.

21.3 Health Promotion and Prevention

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

21.3.1 Describe how Applicant 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 Describe how Applicant 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 Describe how Applicant 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.

21.3.4 Describe if and how Applicant 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?
Single, Radio group.
1: Yes, describe any referral processes or follow-up actions taken when tobacco use is identified: [100 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 supports 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 Report the unique number and percent of Covered California Enrollees who use tobacco (screened positive) in the last 12 months.

	Covered California Enrollees, if applicable
Number of enrollees who use tobacco (screened positive) in the last 12 months	*Integer.*
Percentage of enrollees who use tobacco (screened positive) in the last 12 months	*Percent.*

21.3.9 Oral health may be considered an important part of prenatal care, given that poor oral health during pregnancy can lead to poor health outcomes for the mother and baby. How does Applicant work with its contracted dentists to offer enhanced outreach to support preventive care during pregnancy and provide treatment of identified oral health conditions?

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 Issuer level.

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 Complete Attachment N_QDP-IND-CCSB_QIP Summary Report to describe a Quality Improvement Project (QIP) conducted by Applicant within the last five (5) years. Quality Improvement is defined as systematic actions taken to measurably improve oral health care, structure, processes, or outcomes. Include information about 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 Issuer level.

21.4.2.1 Describe how Applicant promotes 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 2022 in Attachment O_QDP-IND-CCSB_Tables.

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

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

100 words.

21.4.2.4 Describe the outreach and Enrollee communication conducted to support primary dentist selection or assignment activities.

100 words.

21.4.2.5 If selection of or assignment to a primary care dentist is not required due to the Applicant's product type, describe how Applicant encourages 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 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 Using the Alternative Payment Model APM Framework, Applicant must report all types of payment models used for dental services and the number of providers paid under each model in plan year 2022 in Attachment O_QDP-IND-CCSB_Tables.
References:
HCP LAN Alternative Payment Model APM Framework: https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf

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 Issuer level.

21.4.4.1 Covered California supports the innovative use of technology to assist in higher quality, accessible, patient-centered care. Does Applicant offer web or teledentistry, either through a contractor or provided by the medical group/provider.
Single, Dropdown.
1: Applicant does not offer or allow web or teledentistry consultations,
2: Applicant offers or allows web or teledentistry consultations

21.4.4.2 Describe the Applicant's ability to support web or teledentistry, either through a contractor or provided by the medical group/provider.
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]

21.4.4.3 Report the number and percentage of all California enrollees who utilized teledentistry in 2022.

	Number of Enrollees	**Percentage**
Covered California DHMO Enrollees	*Integer.*	*Percent.*
Covered California DPPO Enrollees	*Integer.*	*Percent.*
Medi-Cal	*Integer.*	*Percent.*
California Commercial Individual and Group (Off-Exchange) DHMO	*Integer.*	*Percent.*
California Commercial Individual and Group (Off-exchange) DPPO	*Integer.*	*Percent.*

21.4.4.4 Explain how Applicant 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.

21.4.4.5 Describe if and how Applicant facilitates integration and coordination of care between third party teledentistry vendor services, if applicable.
100 words.

21.4.4.6 Describe if and how Applicant 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.

21.4.4.7 Describe Applicant's teledentistry reimbursement policies for network dentists and for third party teledentistry vendors if applicable.

100 words.

21.5 Measurement and Data Sharing

21.5.1 Utilization Reporting

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

21.5.1.1 How does Applicant identify Covered California Enrollees or other enrollees (1) who are in need of preventive, diagnostic, and treatment services appropriate for each enrollee and (2) who complete preventive and diagnostic services and treatment plans? Response must include Applicant's definitions or threshold(s).

100 words.

21.5.1.2 How does Applicant identify and address under-utilization of preventive, diagnostic, and treatment services? Response must include Applicant's definitions or thresholds for under-utilization.

100 words.

21.5.1.3 Describe if and how Applicant 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.

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

100 words.

21.5.1.5 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.

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
Enrollees that received any covered dental service	*Integer.*	*Percent.*	*Integer.*	*Percent.*	*Integer.*	*Percent.*

Enrollees that received a preventive/diagnostic dental service	*Integer.*	*Percent.*	*Integer.*	*Percent.*	*Integer.*	*Percent.*
Oral Evaluation, Dental Services (Pediatric)	*Integer.*	*Percent.*	*Integer.*	*Percent.*	*Integer.*	*Percent.*
Topical Fluoride for Children (Pediatric)	*Integer.*	*Percent.*	*Integer.*	*Percent.*	*Integer.*	*Percent.*
Receipt of Sealants on First Permanent Molar (Pediatric)	*Integer.*	*Percent.*	*Integer.*	*Percent.*	*Integer.*	*Percent.*
Enrollees needing dental treatment services (excluding preventive and diagnostic services)	*Integer.*	*Percent.*	*Integer.*	*Percent.*	*Integer.*	*Percent.*
Enrollees receiving dental treatment services (excluding preventive and diagnostic services)	*Integer.*	*Percent.*	*Integer.*	*Percent.*	*Integer.*	*Percent.*
Enrollees who received a treatment for caries or a caries-preventive procedure	*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.*

21.5.1.6 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 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
Enrollees that received any covered dental	*Integer.*	*Percent.*	*Integer.*	*Percent.*	*Integer.*	*Percent.*

service						
Use of Preventive Services: Enrollees who received any preventive dental service (Adult)	*Integer.*	*Percent.*	*Integer.*	*Percent.*	*Integer.*	*Percent.*
Enrollees needing dental treatment services (excluding preventive and diagnostic services)	*Integer.*	*Percent.*	*Integer.*	*Percent.*	*Integer.*	*Percent.*
Enrollees receiving dental treatment services (excluding preventive and diagnostic services)	*Integer.*	*Percent.*	*Integer.*	*Percent.*	*Integer.*	*Percent.*
Enrollees who received a treatment for caries or a caries-preventive procedure	*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.*

21.5.1.7 Cost Reporting

Cost Measure	Number of Covered California enrollees, if	Percentage of Covered California enrollees, if

	applicable	applicable
Pediatric enrollees who reached their annual out-of-pocket maximum.	*Integer.*	*Percent.*
Pediatric enrollees who reached their deductibles (DPPO plans only).	*Integer.*	*Percent.*
Adult enrollees who reached their annual benefit limit (DPPO plans only).	*Integer.*	*Percent.*
Adult enrollees who reached their deductibles (DPPO plans only).	*Integer.*	*Percent.*

21.5.1.8 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%.

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 Issuer level.

21.5.2.1 Describe 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.

21.5.3 Data Sharing and Exchange

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

21.5.3.1 Beyond Quality Improvement Projects, describe 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.

21.5.3.2 Indicate Applicant 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 Glossary

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

Applicant - A 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 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[2] statutory or regulatory violations, including penalties levied, in the past two years in relation to any of the following, where applicable: Financial solvency and reserves reviewed; Benefit Design; State mandates (to cover and to offer) - Essential health benefits (State required), Basic health care services, Copayments, deductibles, out-of-pocket maximums, Actuarial value confirmation (using certification year Federal Actuarial Value Calculator); Network adequacy and accessibility standards are met - provider contracts; Language access; uniform disclosure (summary of benefits and coverage); Claims payment and policies and practices; Enrollee/Member grievances/complaints and appeals policies and practices; Independent medical review; Marketing and advertising; Guaranteed issue individual and small group; Rating Factors; Medical Loss Ratio; Premium rate review - Geographic rating regions and rate development justification is consistent with ACA requirements.

Definition of Good Standing - Department of Managed Health Care- Verification that Issuer holds a state health care service plan license or insurance certificate of authority: Approved for lines of business sought in the Exchange (e.g., commercial, small group, individual; Approved to operate in what geographic service areas and most recent financial exam and medical survey report reviewed.

Affirmation of no material[2] statutory or regulatory violations, including penalties levied, in the past two years in relation to any of the following, where applicable: Financial solvency and reserves reviewed; Administration and organizational capacity acceptable; Benefit Design; State mandates (to cover and to offer) - Essential health benefits (State required), Basic health care services, Copayments, deductibles, out-of-pocket maximums, Actuarial value confirmation (using 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 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 - An internal audit function is accountable to an organization's senior management and those charged with governance of the audited entity. An internal auditing activity is an independent, objective assurance and consulting activity designed to add value and improve an organization's operations. Internal Auditing helps an organization accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control, and governance processes.

Member Portal - Covered California uses this term consistent with the Law Insider dictionary definition: Member Portal means information secured behind an authentication wall which will require a unique username and password combination, and which will grant the User access to customized

information pertaining only to the User and those Beneficiaries (where applicable) linked to the User. https://www.lawinsider.com/dictionary/member-portal.

Member Services - Covered California uses this term consistent with the Law Insider dictionary definition: Member Services means a method of assisting Enrollees in understanding CONTRACTOR policies and procedures, facilitating referrals to participating specialists, and assisting in the resolution of problems and member complaints. The purpose of Member Services is to improve access to services and promote Enrollee satisfaction. https://www.lawinsider.com/dictionary/member-services.

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

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.