Qualified Health Plan Application
Plan Year 2020

Individual Marketplace
March 1, 2019

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1 Application Overview

1.1 Purpose

The California Health Benefit Exchange (Exchange) is accepting applications from eligible Health Insurance Issuers[1] (Applicants) to submit proposals to offer, market, and sell qualified health plans (QHPs) through the Exchange beginning in 2019, for coverage effective January 1, 2020. All Health Insurance Issuers currently licensed at the time of application response submission are eligible to apply for certification of proposed Qualified Health Plans (QHPs) for the 2020 Plan Year. QHP Issuers contracted for Plan Year 2019 will complete a simplified certification application since those issuers already have a contract with the Exchange that imposes ongoing requirements that are similar to or satisfy the requirements in the certification application and consideration of this contract performance is included in the evaluation process. The Exchange will exercise its statutory authority to selectively contract for health care coverage offered through the Exchange for plan year 2020. The Exchange reserves the right to select or reject any Applicant or to cancel this Application at any time.

1.2 Background

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

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

The Exchange is guided by the following values:

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

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

[1] The term "Health Issuer" used in this document refers to both health plans regulated by the California Department of Managed Health Care and insurers regulated by the California Department of Insurance. It also refers to the company issuing health coverage, while the term "Qualified Health Plan" refers to a specific policy or plan to be sold to a consumer that has been certified by the Exchange. Qualified Health Plans may also be referred to as "products". The term "Applicant" refers to a Health Insurance Issuer who is seeking to have its products certified as Qualified Health Plans.

Catalyst: The Exchange will be a catalyst for change in California's health care system, using its market role to stimulate new strategies for providing high-quality, affordable health care, promoting prevention and wellness, and reducing health disparities.
Integrity: The Exchange will earn the public's trust through its commitment to accountability, responsiveness, transparency, speed, agility, reliability, and cooperation.
Transparency: The Exchange will be fully transparent in its efforts and will make opportunities available to work with consumers, providers, health plans, employers, purchasers, government partners, and other stakeholders to solicit and incorporate feedback into decisions regarding product portfolio and contract requirements.
Results: The impact of the Exchange will be measured by its contributions to decrease the number of uninsured, have meaningful plan and product choice in all regions for consumers, improve access to quality healthcare, promote better health and health equity, and achieve stability in healthcare premiums for all Californians.

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

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

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

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

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

This application has been designed consistent with the policies and strategies of the California Health Benefit Exchange Board which calls for the QHP selection to influence

the competitiveness of the market, the cost of coverage, and how value is added through health care delivery system improvement.

1.3 Application Evaluation and Selection

The evaluation of QHP Certification Applications will not be based on a single, strict formula; instead, the evaluation will consider the mix of health plans for each region of California that best meet the needs of consumers in that region and the Exchange's goals. The Exchange wants to provide an appropriate range of high quality health plans to participants at the best available price that is balanced with the need for consumer stability and long-term affordability. In consideration of the mission and values of the Exchange, the Board of the Exchange articulated guidelines for the selection and oversight of Qualified Health Plans which are used when reviewing the Applications for 2020. These guidelines are:

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

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

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

While premium will be a key consideration, contracts will be awarded based on the determination of "best value" to the Exchange and its participants. The evaluation of Issuer QHP proposals will focus on quality and service components, including history of performance, administrative capacity, reported quality and satisfaction metrics, quality improvement plans and commitment to serve the Exchange population. This commitment to serve the Exchange population is evidenced through general cooperation with the Exchange's operations and contractual requirements which include provider network adequacy, cultural and linguistic competency, programs addressing health equity and disparities in care, innovations in delivery system improvements and payment reform. The application responses, in conjunction with the approved filings, will be evaluated by the Exchange and used as part of the selection criteria to offer issuers' products on the Exchange for the 2020 plan year.

Encourage Competition Based upon Meaningful QHP Choice and Product Differentiation: Patient-Centered Benefit Plan Designs[2]

The Exchange is committed to fostering competition by offering QHPs with features that present clear choice, product and provider network differentiation. QHP Applicants are required to adhere to the Exchange's standard benefit plan designs in each region for which they submit a proposal. In addition, QHP Applicants may offer the

[2] The 2020 Patient-Centered Benefit Designs will be finalized when the 2019 federal actuarial calculator is finalized.

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

Encourage Competition throughout the State

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

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

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

Encourage Delivery System Improvement, Effective Prevention Programs and Payment Reform

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

Demonstrate Administrative Capability and Financial Solvency

The Exchange 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 the Exchange, so Applicant's technology and associated resources are heavily scrutinized as this relates to long-term sustainability for consumers. Additionally, in recognition of the significant investment that will continue to be needed in areas of quality reform and improvement programs, the Exchange offered a multi-year contract agreement through the 2017 application. Application responses that demonstrate a commitment to the long-term success of the Exchange's mission are strongly encouraged.

Encourage Robust Customer Service

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

1.4 Availability

Applicant must be available immediately upon contingent certification of its plans as QHPs to start working with the Exchange to establish all operational procedures necessary to integrate and interface with the Exchange information systems and to provide additional information necessary for the Exchange to market, enroll members, and provide health plan services effective January 1, 2020. Successful Applicants will also be required to adhere to certain provisions through their contracts with the Exchange, including meeting data interface requirements with the California Healthcare Enrollment, Eligibility, and Retention System (CalHEERS). Successful Applicants must execute the QHP Issuer contract before public announcement of contingent certification. Failure to execute the QHP Issuer contract may preclude Applicant from offering QHPs through the Exchange. The successful Applicants must be ready and able to accept enrollment as of October 1, 2019.

1.5 Application Process

The application process shall consist of the following steps:

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

1.6 Intention to Submit a Response

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

The Exchange will correspond with only one 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. The Exchange is not responsible for application correspondence not received by Applicant if Applicant fails to notify the Exchange, in writing, of any changes pertaining to the designated contact person.

Application Contact: Meiling Hunter
QHPCertification@covered.ca.gov
(916) 228-8696

1.7 Key Action Dates

Action	Date/Time
Release of Draft Application for Comment	December 2018
Letters of Intent due to the Exchange	February 15, 2019
Application Opens	March 1, 2019
Completed Applications Due (include 2020 Proposed Rates & Networks)	May 1, 2019
Negotiations between Applicants and the Exchange	June 2019
Final QHP Contingent Certification Decisions	July 2019
QHP Contract Execution	September 2019
Final QHP Certification	October 2019

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 may submit questions related to the Application through this mechanism.

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

2 Administration and Attestation

Questions 2.1 and 2.3 are required for currently contracted Applicants. All questions are required for new entrant Applicants.

2.1 Applicant must complete the following:

No space for details provided

	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.*
Corporate Office Address	*10 words.*
City	*10 words.*
State	*10 words.*
Zip Code	*10 words.*
Primary Contact Name	*10 words.*
Contact Title	*10 words.*
Contact Phone Number	*10 words.*
Contact Email	*10 words.*
Applicant Eligibility	*Single, Pull-down list.* 1: Contracted in 2019, 2: New Entrant Applicant

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 the Exchange may review the validity of my attestations and the information provided in response to this application and if an Applicant is selected to offer Qualified Health Plans, may decertify those Qualified Health Plans should any material information provided be found to be inaccurate. I confirm that I have the capacity to bind the issuer stated above to the terms of this Application.	
Date	*To the day.*
Signature	*10 words.*
Printed Name	*10 words.*
Title	*10 words.*

2.2 Applicant must attach a functional organizational chart of key personnel who will be assigned to the Exchange. The chart will identify key individual(s) who will have primary responsibility for servicing the Exchange account and flow of responsibilities. The functional organizational chart should include the following representatives with contact information:

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

No space for details provided.

Single, Pull-down list.
Answer and attachment required
1: Attached,
2: Not attached

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

- Mergers
- Acquisitions
- New venture capital

- Management team
- Location of corporate headquarters or tax domicile
- Stock issue
- Other

If yes, Applicant must describe the material changes.

Single, Radio group.
1: Yes, describe: [200 words],
2: No

2.4 Attach a copy of Applicant's Certificates of Insurance to verify that it maintains the following insurance:

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

If Applicant's organization does not carry the coverages or limits listed above, provide an explanation why Applicant has elected not to carry each coverage or limit.
Answer and attachment required

Single, Radio group.
1: Yes, attached
2: No, attached, describe: [200 words]

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

No space for details provided.

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

Questions required only for new entrant Applicants.

3.1 Indicate Applicant license status below:

Single, Radio group.
1: Applicant currently holds all of the proper and required licenses from the California Department of Managed Health Care to operate as a health issuer as defined herein in the commercial individual market
2: Applicant currently holds all of the proper and required licenses from the California Department of Insurance to operate as a health issuer as defined herein in the commercial individual market
3: Applicant is currently applying for licensure from the California Department of Managed Health Care to operate as a health issuer as defined herein in the commercial individual market. If Yes, enter date application was filed: [To the day]
4: Applicant is currently applying for licensure from the California Department of Insurance to operate as a health issuer as defined herein in the commercial individual market. If yes, enter date application was filed: [To the day]

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

No space for details provided.

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

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

No space for details provided.

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

4 Applicant Health Plan Proposal

Questions 4.3 – 4.6 are required for currently contracted Applicants. Questions 4.1 – 4.5 are required for new entrant Applicants.

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

In addition to being guided by its mission and values, the Exchange's policies are derived from the Federal Affordable Care Act, which calls upon the Exchanges to advance "plan or coverage benefits and health care provider reimbursement structures" that improve health outcomes. The Exchange seeks to improve the quality of care while moderating cost, directly for the individuals enrolled in its plans, and indirectly by being a catalyst for delivery system reform in partnership with plans, providers and consumers. With the Affordable Care Act and the range of insurance market reforms that have been implemented, the health insurance marketplace will be transformed from one that has focused on risk selection to achieve profitability to one that will reward better care, affordability and prevention.

Applicant must submit a standard set of QHPs including all four metal tiers and a catastrophic plan in its proposed rating regions. The QHPs in the standard set must adhere to the 2020 Patient-Centered Benefit Plan Designs. The same provider network type (coinsurance or copay) must be used for each QHP in the standard set of QHPs. Applicant's proposal must include coverage of its entire licensed geographic service area. Applicant may not submit a proposal that includes a tiered hospital, physician, or pharmacy network. Applicants must adhere to the Exchange's standard benefit plan designs and the requirements in this section without deviation unless approved by the Exchange.

Applicant may submit proposals including the Health Savings Account-eligible High Deductible Health Plan (HDHP) standard design. Health Savings Account-eligible plans may only be proposed at the bronze level in the individual exchange in accordance with the Patient-Centered Benefit Plan Designs. Additionally, Applicant may submit proposals to offer additional QHPs for consideration. The additional QHP offerings proposed must be differentiated by product or network.

The 2014 Payment Parameters rule preamble (78 Fed Reg at 15494) clarifies that an Exchange will be adequately enforcing the requirements of 45 CFR 156.420(b) if a QHP issuer limits the American Indian/Alaska Native (AI/AN) zero cost share plan variation to the lowest level QHP in a set of standard QHPs. (A set of standard QHPs refers to a collection of standard QHPs identical except for differences in cost sharing or premium.) Accordingly, the Exchange requires Applicant to offer the lowest cost AI/AN zero-cost share plan variation in the standard set of QHPs. This requirement applies to both the standard Bronze plan design and the optional Bronze High Deductible Health Plan (HDHP). If the Bronze HDHP is offered at a lower premium than Applicant's standard Bronze plan, the zero-cost share AI/AN variation of the Bronze HDHP must be offered to consumers instead of the standard Bronze plan variation. The zero-cost share AI/AN Bronze HDHP variation Evidence of Coverage document should include language to the effect that this plan variation is not eligible for use in conjunction with a Health Savings Account (HSA) or other tax advantages. Applicant may

not offer the zero-cost share AI/AN variation at the higher metal levels within the set of QHPs. However, Applicants offering the additional QHPs, that do not include a Bronze plan, must offer the AI/AN zero-cost share plan variation at the lowest cost in that additional set of QHPs. This requirement does not apply to the limited cost share AI/AN plan variation because the member cost sharing differs depending on the provider sought by the member. Limited cost share AI/AN plan variations must be offered for each QHP.

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

4.1 Applicant must certify that its proposal includes all four metal tiers (bronze, silver, gold, and platinum) and catastrophic for each health product it proposes to offer in a rating region. If not, Applicant must describe how it will meet the requirement to offer a product with all metal levels.

Single, Radio group.
1: Yes, proposal meets requirements
2: No: [500 words]

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

No space for details provided

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

4.3 Preliminary Premium Proposals.

Final negotiated and accepted premium rates shall be in effect for coverage effective January 1, 2020. Premium proposals are considered preliminary and may be subject to negotiation as part of QHP certification and selection process. The final negotiated premium rates must align with the product rate filings that will be submitted to the applicable regulatory agency. Premium proposals must be submitted with the Application. To submit premium proposals for Individual products Applicant must complete and upload through System for Electronic Rate and Form Filing (SERFF) the Unified Rate Review Template (URRT), the Supplemental Rate Review Template (SRRT), Actuarial Memorandum and the Rates Data Template available at: https://www.qhpcertification.cms.gov/s/QHP. Premium may vary only by geography (rating region), by age band (within 3:1 range requirement), by coverage tier, and by actuarial value metal level.

Applicant shall provide, in connection with any negotiation process as reasonably requested by the Exchange, detailed documentation on the Exchange-specific rate development methodology. Applicant shall provide justification, documentation, and support used to determine rate changes, including adequately supported cost projections. Cost projections

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

No space for details provided.

Single, Pull-down list.
1: Template completed and uploaded
2: Template not completed and uploaded

4.4 Applicant must certify that for each rating region in which it submits a health plan proposal, it is submitting a proposal that covers the entire geographic service area for which it is licensed within that rating region. Complete Attachment A (Plan Type by Rating Region (Individual Market)) to indicate the rating regions and number and type of plans for which Applicant is proposing a QHP in the Individual Exchange. To indicate which zip codes are within the licensed geographic service area by proposed Exchange product, complete and upload through SERFF the Service Area Template located at: https://www.qhpcertification.cms.gov/s/QHP

No space for details provided.

Single, Pull-down list.
1: Yes, health plan proposal covers entire licensed geographic service area; template uploaded, and attachment submitted
2: No, health plan proposal does not cover entire licensed geographic service area; template uploaded, and attachment submitted

Attached Document(s): Attachment A – Plan Type by Rating Region – Zip Code Individual QHP.xlsx

4.5 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.

No space for details provided.

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

4.6 Applicant must complete and upload through SERFF the Plan ID Crosswalk located at: link to: https://www.qhpcertification.cms.gov/s/QHP.

No space for details provided.

Single, Pull-down list.
1: Template completed and uploaded,
2: Template not completed and uploaded

5 Benefit Design

Questions 5.1 – 5.12 are required for currently contracted Applicants. All questions are required for new entrant Applicants.

5.1 Applicant must comply with 2020 Patient-Centered Benefit Plan Designs. Applicant must complete and upload through System for Electronic Rate and Form Filing (SERFF) the Plans and Benefits template located at: https://www.qhpcertification.cms.gov/s/QHP.

No space for details provided.

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

5.2 Are there operational or administrative barriers to implementing the 2020 Patient-Centered Benefit Plan Designs? Operational or administrative barriers include infrastructure limitations that preclude administration of a type of member cost-sharing specified in the standard plan design. If yes, Applicant must describe the type of administrative barrier and the solution or proposed workaround, and answer "yes" to Question 5.3 with a completed Attachment B Patient-Centered Benefit Design Deviations.

Attached Document(s): Attachment B Patient-Centered Benefit Design Deviations – Individual QHP.xlsx

Single, Radio group.
1: Yes, describe [100 words]
2: No

5.3 Applicant must indicate if it is requesting approval for cost-sharing deviations from the 2020 Patient-Centered Benefit Plan Designs. If yes, Applicant must submit Attachment B Patient-Centered Benefit Design Deviations to describe the proposed deviations and the rationale for the deviation. Alternate benefit design proposals are not permitted in the Individual Marketplace.

No Space for details provided.

Single, Pull-down list.
1: Yes, attachment submitted to request deviation(s)
2: No deviation(s) requested, attachment not submitted

Attached Document(s): Attachment B Patient-Centered Benefit Design Deviations – Individual QHP.xlsx

5.4 Does Applicant have proposed cost-sharing deviations from the 2020 Patient-Centered Benefit Plan Designs that are condition or place specific? Examples include:

- Waived or reduced cost-sharing for medical or pharmacy benefits to treat a certain disease or condition
- Waived or reduced cost-sharing for medical or pharmacy benefits that are administered in a place other than the typical site of administration, such as via telehealth, in the home, etc.

Single, Radio group.

1: Yes, describe [200 words],

2: No

5.5 The Exchange is encouraging the offering of plan products which include all ten Essential Health Benefits, including the pediatric dental Essential Health Benefit. Applicant must indicate if it will adhere to the 2020 Patient-Centered Benefit Plan Design which includes all ten Essential Health Benefits. Failure to offer a product with all ten Essential Health Benefits will not be grounds for rejection of Applicant's application.

No space for details provided.

Single, Pull-down list.

1: Yes. Individual market QHPs proposed for 2020 include all ten Essential Health Benefits.
2: No. Individual market QHPs proposed for 2020 do not include all ten Essential Health Benefits.

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

- State the name of the contractor
- Does Applicant include performance incentives in its contract with the dental benefits subcontractor?
- Activities conducted for consumer education and communication
- Oversight conducted for dental quality and network management

Single, Radio group.

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

5.7 Describe how Applicant administers mental health and substance use benefits as either administered directly by Applicant or subcontracted to a contractor. If subcontracted, use the details section to specifically address the following:

- State the name of the contractor
- Activities conducted for consumer education and communication related to benefit administration
- Oversight conducted for quality and network management

Single, Radio group.

1: Offer benefit directly under full service license: [200 words]

2: Subcontractor relationship: [200 words]

3: Other: [200 words]

5.8 Describe how Applicant administers child eye care benefits as either administered directly by Applicant or subcontracted to a contractor. If subcontractor, use the details section to specifically address the following:

- State the name of the contractor
- Activities conducted for consumer education and communication related to benefit administration
- Oversight conducted for quality and network management

Single, Radio group.

1: Offer benefit directly under full service license: [200 words]

2: Subcontractor relationship: [200 words]

3: Other: [200 words]

5.9 Applicant must indicate if proposed QHPs will include coverage of non-emergent out-of-network services. If yes, with respect to non-network, non-emergency claims (hospital and professional), describe how non-emergent out-of-network coverage is communicated to enrollees in addition to the details provided in the Evidence of Coverage or Policy document.

Single, Radio group.

1: Yes, describe: [100 words],

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

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

Visit or Service Type	Telehealth Modality	Member Cost-Share	Percent of members with access to service (i.e. percent of membership with access to the plan-provided telehealth or percent attributed to medical group-provided telehealth)	Details (if cost-sharing varies depending on modality, include cost shares here)
Primary Care Visit	*Multi, Checkboxes.* 1: Phone, 2: Video, 3: Instant Message/Live	*Dollars.*	*Percent.*	*50 words.*

	Chat, 4: Email, 5: Other, describe in comments, 6: Not Offered			
Specialist Visit	*Multi, Checkboxes.* 1: Phone, 2: Video, 3: Instant Message/Live Chat, 4: Email, 5: Other, describe in comments, 6: Not Offered	*Dollars.*	*Percent.*	*50 words.*
Mental/Behavioral Health Visit	*Multi, Checkboxes.* 1: Phone, 2: Video, 3: Instant Message/Live Chat, 4: Email, 5: Other, describe in comments, 6: Not Offered	*Dollars.*	*Percent.*	*50 words.*
Family/Marriage counseling	*Multi, Checkboxes.* 1: Phone, 2: Video, 3: Instant Message/Live Chat, 4: Email, 5: Other, describe in comments,	*Dollars.*	*Percent.*	*50 words.*

	6: Not Offered			
Substance Use Disorder Treatment Visit	*Multi, Checkboxes.* 1: Phone, 2: Video, 3: Instant Message/Live Chat, 4: Email, 5: Other, describe in comments, 6: Not Offered	*Dollars.*	*Percent.*	*50 words.*
Other, describe below:	*Multi, Checkboxes.* 1: Phone, 2: Video, 3: Instant Message/Live Chat, 4: Email, 5: Other, describe in comments, 6: Not Offered	*Dollars.*	*Percent.*	*50 words.*

5.11 Applicant must submit the draft Evidence of Coverage (EOC) or Policy language and draft Schedules of Benefits describing proposed 2020 QHP benefits.

Single, Radio group.
1: Confirmed, attachment(s) submitted
2: Not confirmed, attachment(s) not submitted: [100 words]

5.12 The Exchange's Patient-Centered Benefit Plan Designs require four tiers of drug coverage:
(1) Tier 1
(2) Tier 2
(3) Tier 3
(4) Tier 4
Applicant must complete and upload through SERFF the Prescription Drug Template available at: https://www.qhpcertification.cms.gov/s/QHP.

No space for details provided.

Single, Pull-down list.
1: Template completed and uploaded
2: Template not completed and uploaded

5.13 Applicant must select all options that apply from the following list to indicate how Applicant's proposed 2020 formulary will comply with California Health and Safety Code § 1342.71 and Insurance Code § 10123.193 requirements prohibiting discrimination in prescription drug benefits. Use the details section for any additional comments.

Multi, Checkboxes.

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

2: Covers single-tablet regimens for HIV/AIDS

3: Caps cost of a 30-day supply to cost share consistent with the Patient-Centered Benefit Plan Design (PCBPD)

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

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

6: Updates formularies with any changes on a monthly basis

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

8: Available on the internet to the general public,

9: Other: [200 words]

6 Operational Capacity

6.1 Issuer Operations and Account Management Support

Questions 6.1.1 and 6.1.2 are required for currently contracted Applicants. All questions are required for new entrant Applicants.

6.1.1 Applicant must complete Attachments C1- Current and Projected Enrollment and C2- California Off-Exchange Enrollment. 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 Attachments C1 and C2 will require a resubmission of the templates.

No space for details provided.

Single, Pull-down list.
Answer and attachment required
1: Attachments completed
2: Attachments not completed

6.1.2 Applicant must provide a description of any initiatives over the next 24 months which may impact the delivery of services to Exchange enrollees including but not limited to: System changes or migrations, Call center openings, closings, or relocations, Network re-contracting, and vendor changes or other changes during the contract period. Applicant must include a timeline, either current or planned.

200 words.

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

No space for details provided.

	Response	Description	Conducted outside of the United States?
Billing, invoice, and collection activities	*Single, Pull-down list.* 1: Yes 2: No	*50 words*	*Single, Pull-down list.* 1: Yes 2: No
Database and/or enrollment transactions	*Single, Pull-down list.* 1: Yes 2: No	*50 words*	*Single, Pull-down list.* 1: Yes 2: No
Claims processing and invoicing	*Single, Pull-down list.*	*50 words*	*Single, Pull-down*

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

6.1.4 Applicant must provide a summary of its operational capabilities, including how long it has been a licensed health issuer. For example, enrollment system, claims, provider services, sales, etc.

No space for details provided.

100 words.

6.2 Implementation Performance

Questions required only for new entrant Applicants.

6.2.1 Applicant must complete Attachment F Implementation Organizational Chart and include a detailed implementation plan.

Attached Document(s): Attachment F Implementation Organizational Chart.xlsx

Single, Radio group.
1: Yes, attached. Describe: [100 words],
2: No, not attached,
3: No, Applicant is currently operating in the Exchange

6.2.2 Applicant must submit a Renewal and Open Enrollment Readiness Plan. The Plan must include a timeline with dates for communications (regulated and marketing), system and website updates and readiness, and trainings for staff and agents.

No space for details provided.

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

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

200 words.

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

No space for details provided.

Resource	Membership Increase (as % of Current Membership)	Resource Adjustment (specify)	Approach to Monitoring
Members Services	*Percent*	*50 words*	*50 words*
Claims	*Percent*	*50 words*	*50 words*
Account Management	*Percent*	*50 words*	*50 words*
Clinical staff	*Percent*	*50 words*	*50 words*
Disease Management staff	*Percent*	*50 words*	*50 words*
Implementation	*Percent*	*50 words*	*50 words*
Financial	*Percent*	*50 words*	*50 words*
Administrative	*Percent*	*50 words*	*50 words*
Actuarial	*Percent*	*50 words*	*50 words*
Information Technology	*Percent*	*50 words*	*50 words*
Other (List)	*Percent*	*50 words*	*50 words*

7 Customer Service

Questions required only for new entrant Applicants.

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

No space for details provided.

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

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

Single, Radio group.
1: Confirmed, explain: [100 words],
2: Not confirmed

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

100 words.

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

10 words.

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

Multi, Checkboxes.
1: Instructor-Led Training Sessions,
2: Virtual Instructor-Led Training Sessions (live instructor in a virtual environment),
3: Video Training,
4: Web-Based training (not Instructor-Led),
5: Self-led Review of Training Resources,
6: Other, describe: [50 words].

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

Multi, Checkboxes.
1: Case-Study,
2: Roleplaying,
3: Shadowing,
4: Observation,
5: Pre-tests,
6: Post-tests,
7: Training Evaluations,
8: Other, describe: [50 words].

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

50 words.

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

50 words.

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

Multi, Checkboxes.
1: Arabic: [Integer],
2: Armenian: [Integer],
3: Cantonese: [Integer],
4: English: [Integer],
5: Hmong: [Integer],
6: Korean: [Integer],
7: Mandarin: [Integer],
8: Farsi: [Integer],
9: Russian: [Integer],
10: Spanish: [Integer],
11: Tagalog: [Integer],
12: Vietnamese: [Integer],
13: Lao: [Integer],
14: Cambodian: [Integer],
15: Other, specify: [50 words].

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

Single, Radio group.
1: Yes, specify vendor: [20 words],
2: No

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

100 words.

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

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

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

50 words.

7.14 Applicant must identify how many calls per Representative, per week are scored.

20 words.

8 Financial Requirements

Questions required only for new entrant Applicants.

8.1 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.

8.2 Applicant must confirm which systems it has in place to accept payment from members effective October 1, 2019 for the following premium payment types:

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

8.3 If systems to accept payment are not currently in place, describe plans to implement such systems, including the use of vendors for any functions related to premium payment, if applicable, and an implementation work plan. QHP issuer must be able to accept premium payment from members no later than October 1, 2019. Note: QHP issuer must accept electronic payments, such as debit and credit cards for binder payments. Electronic payment is encouraged, but not required, for payment of ongoing invoices.

200 words.

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

200 words.

8.5 Applicant must confirm no fees or charges will be imposed on any member who requests paper premium invoices for any individual products sold by Applicant in California.

No space for details provided.

Single, Pull-down list.
1: Yes, confirmed
2: No, not confirmed

9 Fraud, Waste and Abuse Detection

Questions 9.2.6 and 9.2.11 are required for currently contracted Applicants. All questions are required for new entrant Applicants.

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

Definitions:

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

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

Abuse – Excessive, or improper use of something, or the use of something in a manner contrary to the natural or legal rules for its use; the intentional destruction, diversion, manipulation, misapplication, maltreatment, or misuse of resources; or extravagant or excessive use 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.

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

Internal Audit - Is an independent, objective assurance and consulting activity designed to add value and improve an organization's operations. It 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.

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

9.1 Prevention / Detection / Response

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

200 words.

9.1.2 Applicant must describe anti-fraud strategies and controls including data analytics and fraud risk assessments to circumvent fraud, waste and abuse.

200 words

9.1.3 Applicant must describe how findings/trends are communicated to the Exchange and other federal/state agencies, law enforcement, etc.

200 words.

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

200 words.

9.1.5 Once fraud is detected/or discovered what steps are taken to prevent fraudulent services to be paid. Applicant must describe the process to recoup erroneously paid claims from providers.

200 words.

9.1.6 Applicant must describe specific activities it does to identify any violations in the Special Enrollment Period (SEP) policy. Describe the procedures in place to prevent and detect SEP violations. How are the adverse actions communicated to the Exchange?

200 words.

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

Multi, Checkboxes.
1: Hospitals,

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

9.1.8 Describe the different approaches Applicant takes to monitor the types of providers indicated above in question 9.1.7 for possible fraudulent activity. Applicant must provide an explanation why any provider types not indicated in 9.1.7 are not typically reviewed for possible fraudulent activity.
200 words.

9.1.9 Based on the definition of fraud in the introduction to this section, 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, if applicable	**Total Loss from Fraud** Total Book of Business	**% of Loss Recovered** Covered California book of business, if applicable	**% of Loss Recovered** Total Book of Business	**Total Dollars Recovered** Covered California book of business, if applicable	**Total Dollars Recovered** Total Book of Business
Calendar Year 2016	*Dollars.*	*Dollars.*	*Percent.*	*Percent.*	*Dollars.*	*Dollars.*
Calendar Year 2017	*Dollars.*	*Dollars.*	*Percent.*	*Percent.*	*Dollars.*	*Dollars.*
Calendar Year 2018	*Dollars.*	*Dollars.*	*Percent.*	*Percent.*	*Dollars.*	*Dollars.*

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

200 words.

9.2 Audits and Reviews

9.2.1 Based on the definition of review in the introduction to this section, indicate how frequently reviews are performed for each of the following areas:

No space for details provided.

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

9.2.2 Based on the definition of internal audit in the introduction to this section, does Applicant maintain an independent, internal audit function? If yes, provide a brief description

of Applicant's internal audit function, its reporting structure and 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

9.2.3 If Applicant answered yes to 9.2.2, provide a copy of the organization's internal audit function's annual audit plan applicable to claims administration, eligibility and enrollment, billing, and network providers.

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

9.2.4 If Applicant answered yes to 9.2.2, based on the definition of internal audit in the introduction to this section, indicate how frequently internal auditing is performed for the following areas:

No space for details provided.

	Response	If other
Audits of Claims Administration and Oversight	*Single, Pull-down list.* 1: Quarterly, 2: Semi-annually, 3: Annually, 4: Biennially, 5: Other:	*10 words.*
Audits of Network Providers	*Single, Pull-down list.* 1: Quarterly, 2: Semi-annually, 3: Annually, 4: Biennially, 5: Other:	*10 words.*
Audits of Eligibility and Enrollment Processes and Compliance with Requirements	*Single, Pull-down list.* 1: Quarterly, 2: Semi-annually, 3: Annually, 4: Biennially, 5: Other:	*10 words.*
Audits of Billing Process	*Single, Pull-down list.* 1: Quarterly, 2: Semi-annually, 3: Annually,	*10 words.*

	4: Biennially, 5: Other:	

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

200 words.

9.2.6 Based on the definition of external audit in the introduction to this section, indicate what external audits were conducted over the last three years by State and Federal Regulatory Agencies? For each audit, specify the year of the audit and the name of the agency that conducted the audit.

No space for details provided.

200 words.

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

200 words.

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

200 words.

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

200 words.

9.2.10 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.

9.2.11 Applicant must confirm that, if certified, it will agree to subject itself to the Exchange for audits and reviews, either by the Exchange or its designee, or the California Department of General Services, the California State Auditor or its designee, as they deem necessary to determine the correctness of premium rate setting, the Exchange's payments to agents based on Applicant’s report, questions pertaining to enrollee premium payments and

Advance Premium Tax Credit (APTC) payments and participation fee payments Issuer made to the Exchange. Applicant also agrees to all audits subject to applicable State and Federal laws, and regarding the confidentiality of and release of confidential Protected Health Information (PHI) of enrollees.

No space for details provided.

Single, Pull-down list.
1: Yes, confirmed
2: No, not confirmed

10 System for Electronic Rate and Form Filing (SERFF)

All questions are required for currently contracted Applicants and new entrant Applicants.

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

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

No space for details provided.

Single, Pull-down list.
1: Yes, confirmed
2: No, not confirmed

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

No space for details provided.

Single, Pull-down list.
1: Yes, confirmed
2: No, not confirmed

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

No space for details provided.

Single, Pull-down list.
1: Yes, confirmed
2: No, not confirmed

11 Electronic Data Interface

Questions 11.1 – 11.2 are required for currently contracted Applicants. All questions are required for new entrant Applicants.

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

No space for details provided.

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

11.2 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.

No space for details provided.

1: Attached
2: Not attached

11.3 Applicant must be prepared and able to engage with the Exchange to develop data interfaces between Applicant's systems and the Exchange's systems, including the eligibility and enrollment system used by the Exchange, as early as May 2019. Applicant must confirm it will implement systems to accept and generate 834, 999, TA1, and other standard format electronic files for enrollment and premium remittance in an accurate, consistent and timely fashion and utilize the information received and transmitted for its intended purpose.

- See Appendix L 834 Companion Guide v17.9.20 for detailed 834 transaction specifications.
- Note: The Exchange requires Applicants to sign an industry-standard agreement which establishes electronic information exchange standards to participate in the required systems testing.
- *No space for details provided.*

Single, Pull-down list.
1: Yes, confirmed
2: No, not confirmed

Attached Document(s): Appendix L 834 Companion Guide v17.9.20.pdf

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

Single, Radio group.
1: Yes, confirmed, describe: [200 words],
2: No, not confirmed, describe: [200 words]

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

No space for details provided.

Single, Pull-down list.
1: Yes, confirmed
2: No, not confirmed

11.6 Applicant must be prepared and able to conduct testing of data interfaces with the Exchange no later than June 1, 2019 and confirms it will plan and implement testing jointly with the Exchange to meet system release schedules. Applicant must confirm testing with the Exchange 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.

No space for details provided.

Single, Pull-down list.
1: Yes, confirmed
2: No, not confirmed

11.7 Applicant must describe its ability to produce financial, eligibility, and enrollment data monthly for reconciliation. Standard file requirements and timelines are documented in Appendix D Reconciliation 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.

Attached Document(s): Appendix D Reconciliation Process Guide v3.pdf

11.8 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? Describe below.

Single, Radio group.
1: Yes, describe: [100 words],
2: No, describe [100 words]

12 Healthcare Evidence Initiative

Questions required only for new entrant Applicants.

To fulfill its mission to ensure that consumers have available the plans that offer the optimal combination of choice, value, quality, and service, the Exchange relies on evidence about the enrollee experience with health care. The timely and accurate submission of QHP data is an essential component of assessing the quality and value of the coverage and health care received by Exchange enrollees.

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

Applicant must confirm that, if contracted as a QHP issuer, to the extent that any Participating Provider's rates are prohibited from disclosure to the Exchange by contract, Applicant shall identify such Participating Provider. Applicant shall, upon renewal of its Provider contract, but in no event later than July 1, 2020, make commercially reasonable efforts to obtain agreement by that Participating Provider to amend such provisions, to allow disclosure. In entering into a new contract with a Participating Provider, Applicant agrees to make commercially reasonable efforts to exclude any contract provisions that would prohibit disclosure of such information to the Exchange. (For example: enrollment, medical and prescription claims, and capitation data required by the Exchange's Health Evidence Initiative (HEI) Vendor: allowed amounts, charge and charge submitted amounts, coinsurance, copayment, and deductible amounts, paid and net payment amounts, patient total out-of-pocket amounts, capitation amounts, etc.).

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

Single, Radio group.
1: Confirmed, describe [500 words],
2: Not confirmed, describe [500 words]

12.2 Applicant must provide the Exchange's HEI Vendor with monthly extracts of all requested detail from applicable fee-for-service (FFS) claims or encounter records for the following claim types. If yes with deviation, explain. If unable or unwilling to provide all requested detail, elaborate on problematic claim types, estimating the number and percentage of affected claims and encounters.

No space for details provided.

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

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

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

No space for details provided.

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

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

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

No space for details provided.

Detail to be Provided	Response	If No or Yes with deviation, explain.

Covered CA Member ID	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.* Nothing required
Covered CA Subscriber ID	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.* Nothing required

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

No space for details provided.

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

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

No space for details provided.

Provider IDs to be Supplied	Response	If No or Yes with deviation, explain.

TIN	*Single, Pull-down list.* 1: Yes, 2: Yes, unless values represent individual provider Social Security Numbers, 3: No	*50 words.* Nothing required
NPI	*Single, Pull-down list.* 1: Yes, 2: Yes, unless values represent individual provider Social Security Numbers, 3: No	*50 words.* Nothing required
NCPDP	*Single, Pull-down list.* 1: Yes, 2: Yes, unless values represent individual provider Social Security Numbers, 3: No	*50 words.* Nothing required

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

No space for details provided.

Coding to be Provided	Response	If No or Yes with deviation, explain.
Diagnosis Coding	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.* Nothing required
Procedure Coding (CPT, HCPCS)	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.* Nothing required
Revenue Codes (Facility Only)	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.* Nothing required
Place of Service	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.* Nothing required
NDC Code (Drug Only)	*Single, Pull-down list.*	*50 words.* Nothing required

	1: Yes, 2: No	

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

Single, Radio group.
1: Yes, describe: [50 words],
2: No

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

Single, Radio group.
1: Yes, describe: [50 words],
2: No,
3: Not Applicable

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

Single, Radio group.
1: Yes, describe: [50 words],
2: No

13 Privacy and Security Requirements for Personally Identifiable Data

Questions required only for new entrant Applicants.

13.1 HIPAA Privacy Rule

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

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

No space for details provided.

Single, Pull-down list.
1: Yes, confirmed
2: No, not confirmed

13.1.2 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].

No space for details provided.

Single, Pull-down list.
1: Yes, confirmed
2: No, not confirmed

13.1.3 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)].

No space for details provided.

Single, Pull-down list.
1: Yes, confirmed
2: No, not confirmed

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

No space for details provided.

Single, Pull-down list.
1: Yes, confirmed
2: No, not confirmed

13.1.5 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)].

No space for details provided.

Single, Pull-down list.
1: Yes, confirmed
2: No, not confirmed

13.1.6 Minimum Necessary Disclosure & Use: Unless otherwise exempted by the HIPAA Privacy Rule, Applicant must confirm that 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)].

No space for details provided.

Single, Pull-down list.
1: Yes, confirmed
2: No, not confirmed

13.1.7 Openness and Transparency: Unless otherwise exempted by the HIPAA Privacy Rule, Applicant must confirm that 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)].

No space for details provided.

Single, Pull-down list.
1: Yes, confirmed
2: No, not confirmed

13.2 Safeguards

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

No space for details provided.

Single, Pull-down list.
1: Yes, confirmed
2: No, not confirmed

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

No space for details provided.

Single, Pull-down list.
1: Yes, confirmed
2: No, not confirmed

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

No space for details provided.

Single, Pull-down list.
1: Yes, confirmed
2: No, not confirmed

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

No space for details provided.

Single, Pull-down list.
1: Yes, confirmed
2: No, not confirmed

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

No space for details provided.

Single, Pull-down list.
1: Yes, confirmed
2: No, not confirmed

14 Sales Channels

Question 14.4 is required for currently contracted Applicants. Questions 14.1 is required for new entrant Applicants.

14.1 Does Applicant have experience working with Insurance Agents (also referred to as broker)?

No space for details provided.

Single, Radio group.
1: Yes. If yes, 14.2 required,
2: No. If no, 14.5 and 14.6 required

14.2 Does Applicant have Agent of Record policy?

Single, Pull-down list.

1: Yes. If yes, 14.3 through 14.5 required,
2: No. If no, 14.5 and 14.6 required

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

Individual Market – AOR Policy	**Off-Exchange Business**
What are the requirements Agents must meet to become appointed? Include general agency participation requirement, if any.	*50 words.*
Describe AOR appointment process. Include mandatory requirements for agents to be with a general agency contracted with Applicant.	*50 words.*
Provide the timeline for AOR appointment to be complete.	*50 words.*
Provide AOR Appointment payment timelines. Include any factors that would result in differing timelines.	*50 words.*
Describe AOR Appointment payment dispute processes.	*50 words.*
Describe criteria and requirements that constitute AOR change.	*50 words.*
Provide AOR Change Commission payment timelines. Include any factors that would result in differing timelines.	*50 words.*

Describe AOR Change Commission payment dispute processes.	*50 words.*
Describe how applicable commissions are determined for the new servicing agent in an AOR change.	*50 words.*
Provide the timeline for processing an AOR change. Include how the effective date is determined for the new servicing agent and any factors that would result in a retroactive AOR change.	*50 words.*
Describe procedures used to manage AOR changes when the AOR files are received electronically from an outside source. Include explanation of how changes to assignment of the Federal Employer Identification Number (FEIN) are handled	*50 words.*
Describe AOR reconciliation and error resolution processes, include information on how Applicant resolves commission and AOR discrepancies for Agents.	*50 words.*
Describe requirements for Vested Agents. Include definition of vesting, to whom vesting applies, duration of vesting, how vesting is affected by AOR changes, and vesting rules when an enrollee leaves and then returns for coverage.	*50 words.*
Describe any reasons for which Applicant will not compensate Agents for an enrollment.	*50 words.*
Describe any reasons for which Applicant will not make changes to AOR for an enrollment.	*50 words.*

14.4 Applicant must provide its 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 the Exchange. Successful Applicants may not vary Agent compensation levels by metal tier and must pay the same commission during Open and Special Enrollment for each plan year.

Individual Market - Commission Rate	**On-Exchange Business**	**Off-Exchange Business**
Provide AOR Commission Rate or Schedule for a new enrollment, returning new enrollment, and a renewing	*50 words.*	*50 words.*

enrollment. Include general agency commission, if any.		
Provide AOR Change Commission Rate or Schedule for a new enrollment, returning new enrollment, and a renewing enrollment. Include general agency commission, if any.	*50 words.*	*50 words.*
Does the compensation level change as the business written by the agent matures? (i.e., Downgraded)	*50 words.*	*50 words.*
Specify if the agent is compensated at a different level as he or she attains certain levels or amounts of in-force business.	*50 words.*	*50 words.*
Does the compensation level apply to all plans or does it vary by tier? Include if this differs between AOR Appointment Commission and AOR Change Commission Rates.	*Not Applicable.*	*50 words.*
Does the compensation level vary by product? Include if this differs between AOR Appointment Commission and AOR Change Commission Rates.	*50 words.*	*50 words.*
Does the compensation level vary by subsidized plan and non-subsidized plan? Include if this differs between AOR Appointment Commission and AOR Change Commission Rates.	*50 words.*	*50 words.*
Describe any reasons for which Applicant will not compensate Agents for an enrollment.	*50 words.*	*50 words.*
Describe any reasons for which Applicant will not make changes to AOR for an enrollment.	*Not applicable.*	*50 words.*
Describe process for assigning commission payments to an agent’s Federal Employer Identification Number (FEIN) and how changes to FEIN are capture and updated.	*50 words.*	*50 words.*
Describe any agent commission bonus program(s) in the individual market on or off exchange that is currently available in the 2019 calendar year or will be made available to agents for the 2020 calendar year.	*50 words.*	*50 words.*

Additional Comments	*50 words.*	*50 words.*

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

- Name
- Phone Number
- Email Address

50 words.

14.6 The Exchange recommends that Applicants develop relationships with the agent community. It has been shown that Applicants with relationships to the agent community achieve greater success in the Exchange. Applicant must describe its approach to develop an agent program.

AOR Program Plan	**On-Exchange Business**
What are the requirements Agents must meet to become appointed? Include general agency participation requirement, if any.	*50 words.*
Describe AOR appointment process. Include mandatory requirements for agents to be with a general agency contracted with Applicant.	*50 words.*
Provide the timeline for AOR appointment to be complete.	*50 words.*
Provide AOR Appointment and AOR Change Commission payment timelines. Include any factors that would result in differing timelines.	*50 words.*
Describe AOR Appointment and AOR Change Commission payment dispute processes.	*50 words.*
Describe criteria and requirements that constitute AOR change.	*50 words.*
Describe how applicable commissions are determined for the new servicing agent in an AOR change.	*50 words.*
Provide the timeline for processing an AOR change. Include how the effective date is determined for the new servicing agent and any factors that would result in a retroactive AOR change.	*50 words.*

Describe procedures used to manage AOR changes when the AOR files are received electronically from an outside source. Include explanation of how changes to assignment of the Federal Employer Identification Number (FEIN) are handled.	*50 words.*
Describe AOR reconciliation and error resolution processes, include information on how Applicant resolves commission and AOR discrepancies for Agents.	*50 words.*
Describe requirements for Vested Agents. Include definition of vesting, to whom vesting applies, duration of vesting, how vesting is affected by AOR changes, and vesting rules when an enrollee leaves and then returns for coverage.	*50 words.*
Describe any reasons for which Applicant will not compensate Agents for an enrollment.	*50 words.*
Describe any reasons for which Applicant will not make changes to AOR for an enrollment.	*50 words.*
Provide AOR Appointment Commission Rate or Schedule for a new enrollment, returning new enrollment, and a renewing enrollment. Include general agency commission, if any.	*50 words.*
Provide AOR Change Commission Rate or Schedule for a new enrollment, returning new enrollment, and a renewing enrollment. Include general agency commission, if any.	*50 words.*
Does the compensation level change as the business written by the agent matures? (i.e., Downgraded)	*50 words.*
Specify if the agent is compensated at a different level as he or she attains certain levels or amounts of in-force business.	*50 words.*
Does the compensation level vary by product? Include if this differs between AOR Appointment Commission and AOR Change Commission Rates.	*50 words.*
Does the compensation level vary by agent type? (i.e., general agent, sub agent) Include if this differs between AOR Appointment Commission and AOR Change Commission Rates.	*50 words.*

Does the compensation level vary by subsidized plan and non-subsidized plan? Include if this differs between AOR Appointment Commission and AOR Change Commission Rates.	*50 words.*
Describe any reasons for which Applicant will not compensate Agents for an enrollment.	*50 words.*
Describe any reasons for which Applicant will not make changes to AOR.	*50 words.*
Describe any agent commission bonus program(s) in the individual market on or off exchange that is currently available in the 2019 calendar year or will be made available to agents for the 2020 calendar year.	*50 words.*
Additional Comments	*50 words.*

15 Marketing and Outreach Activities

Questions 15.4 – 15.8 are required for currently contracted Applicants. All questions are required for new entrant Applicants.

15.1 The Exchange expects all successful Applicants to promote enrollment in their QHPs. Applicant must provide an organizational chart of its marketing department(s), including names and titles of the main contacts that will be responsible for marketing their Individual and Family Plans (both, on and off exchange).

No space for details provided.

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

15.2 Applicant must confirm that, upon contingent certification of its QHPs, it will cooperate with the Exchange Marketing Department, and adhere to the Covered California Brand Style Guide, http://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 Exchange 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 the Exchange at least 30 days prior to Open Enrollment.

No space for details provided.

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

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

No space for details provided.

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

15.4 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 0.6% of their individual market gross premium revenue collected (on and off exchange) on marketing

and spend at least 65% of their acquisition marketing funds on DR tactics. Applicants that do not meet this expectation must provide an alternate proposal, including supporting evidence and documentation, and explain how it will better meet Covered California's expectations for enrollee acquisition and retention. Applicant may submit any supporting documentation as an attachment.
Single, Radio group.
1: Alternate proposed marketing investment: [500 words]
2: Not Applicable

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

Proposed Marketing Investment:	*Dollars.*

15.6 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.*

15.7 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.*

15.8 Indicate the percentage of the total proposed marketing spend Applicant projects allocating to Brand Advertising and Direct Response Advertising Tactics. Numerical percentage values must equal 100 when added. Example: 35% brand and 65% Direct Response. 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.*

16 Provider Network

16.1 Network Offerings

All questions are required for currently contracted Applicants and new entrant Applicants

16.1.1 Applicant must indicate the different network products it intends to offer on the Exchange in the individual market for coverage year 2020. 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".

No space for details provided.

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

16.1.2 Provider network data must be included in this submission for all geographic locations to which Applicant is applying for certification as a QHP. Submit provider data according to the data file layout in the Covered California Provider Data Submission Guide, https://hbex.coveredca.com/stakeholders/plan-management/library/Covered-California-Provider-Data-Submission-Guide-V1.9pdf. The provider network submission for 2020 must be consistent with what will be filed to the appropriate regulator for approval if Applicant is selected as a QHP Issuer. The Exchange requires the information, as requested, to allow cross-network comparisons and evaluations.

No space for details provided.

Single, Pull-down list.
Attachment required
1: Attached (confirming provider data is for plan year 2020),
2: Not attached,

3: Not attached, currently contracted Applicant attesting to no material changes to existing 2019 Exchange network for plan year 2020

16.1.3 Applicant must complete and upload through SERFF, the Network ID Template located at: https://www.qhpcertification.cms.gov/s/QHP.

No space for details provided.

Single, Pull-down list.
1: Template Uploaded,
2: Template not Uploaded

16.2 HMO

16.2.1 Network Strategy

All questions are required for Applicants that are new entrants or proposing new networks.

16.2.1.1 Applicant must complete all tabs in Attachment J1 HMO Provider Network Tables, for their HMO Network.
Single, Pull-down list.
1: Attached,
2: Not attached

Attached Document(s): Attachment J1 HMO Provider Network Tables.xlsx

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

No space for details provided.

No space for details provided.

Single, Pull-down list.
1: Applicant contracts and manages network,
2: Applicant leases network

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

No space for details provided.

	Response
Length of the lease agreement	*100 words.*
Start Date	*To the day.*

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

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

Multi, Checkboxes.
1: Transparency,
2: Implementation of new programs and initiatives,
3: Acquire timely and up-to-date information on providers,
4: Ability to obtain data from providers,
5: Ability to conduct outreach and education to providers if need arises,
6: Ability to add new providers,
7: If no, describe plans to ensure Applicant's ability to control network and meet Exchange requirements: [500 words]

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

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

200 words.

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

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

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

500 words.

16.2.2 Volume - Outcome Relationship

All questions required for Applicants that are new entrants or proposing new networks.

Numerous studies have demonstrated a significant correlation between volume of procedures performed by providers and facilities and better outcomes for those procedures. This applies to both common but high-risk treatments (such as cancer surgeries and cardiac procedures)

as well as complicated, rare and highly specialized procedures (such as transplants). Higher volumes, documented experience and proficiency with all aspects of care underlie successful outcomes, including patient selection, anesthesia and postoperative care.

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

No space for details provided.

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

16.2.2.2 If yes, provide specific details for each category:

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

500 words.

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

No space for details provided.

Single, Radio group.
1: Yes
2: No

16.2.2.4 If yes to 16.2.2.3, provide the following details:

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

200 words.

16.2.3 Network Stability

All questions are required for existing Exchange networks and newly-proposed networks.

16.2.3.1 Total Number of Contracted Hospitals:

No space for details provided.
Integer.

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

100 words.

16.3 PPO

16.3.1 Network Strategy

All questions are required for Applicants that are new entrants or proposing new networks.

16.3.1.1 Applicant must complete all tabs in Attachment J2 PPO Provider Network Tables, for their PPO Network.
Single, Pull-down list.
1: Attached
2: Not attached
Attached Document(s): Attachment J2 PPO Provider Network Tables.xlsx

16.3.1.2 Does Applicant conduct provider negotiations and manage its own network or does Applicant lease a network from another organization?
No space for details provided.
Single, Pull-down list.
1: Applicant contracts and manages network,
2: Applicant leases network

16.3.1.3 If Applicant leases network, describe the terms of the lease agreement:
No space for details provided.

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

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

Multi, Checkboxes.
1: Transparency,
2: Implementation of new programs and initiatives,
3: Acquire timely and up-to-date information on providers,
4: Ability to obtain data from providers,
5: Ability to conduct outreach and education to providers if need arises,
6: Ability to add new providers,
7: If no, describe plans to ensure Applicant's ability to control network and meet Exchange requirements: [500 words]

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

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

200 words.

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

No space for details provided.

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

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

500 words.

16.3.2 Volume - Outcome Relationship

All questions required for Applicants that are new entrants or proposing new networks.

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

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

No space for details provided.

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

16.3.2.2 If yes, provide specific details for each category:

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

500 words.

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

No space for details provided.

No space for details provided.

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

16.3.2.4 If yes, provide the following details:

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

200 words.

16.3.3 Network Stability

All questions are required for existing Exchange networks and newly-proposed networks.

16.3.3.1 Total Number of Contracted Hospitals:

No space for details provided.

Integer.

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

100 words.

16.4 EPO

16.4.1 Network Strategy

All questions are required for Applicants that are new entrants or proposing new networks.

16.4.1.1 Applicant must complete all tabs in Attachment J3 EPO Provider Network Tables, for their EPO Network.
Single, Pull-down list.
1: Attached,
2: Not attached

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

No space for details provided.

Single, Pull-down list.
1: Applicant contracts and manages network,
2: Applicant leases network

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

No space for details provided.

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

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

Multi, Checkboxes.
1: Transparency,
2: Implementation of new programs and initiatives,
3: Acquire timely and up-to-date information on providers,
4: Ability to obtain data from providers,

5: Ability to conduct outreach and education to providers if need arises,
6: Ability to add new providers,
7: If no, describe plans to ensure Applicant's ability to control network and meet Exchange requirements: [500 words]

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

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

200 words.

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

No space for details provided.

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

16.4.1.7 If Applicant answered yes to 16.4.1.6, explain in detail how this coverage is offered.

500 words.

16.4.2 Volume - Outcome Relationship

All questions required for Applicants that are new entrants or proposing new networks

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

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

No space for details provided.

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

16.4.2.2 If yes, provide specific details for each category:

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

500 words.

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

No space for details provided.

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

16.4.2.4 If yes, provide the following details:

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

200 words.

16.4.3 Network Stability

All questions required for existing Exchange networks and newly proposed networks.

16.4.3.1 Total Number of Contracted Hospitals:

No space for details provided.

Integer.

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

100 words.

16.5 Other

16.5.1 Network Strategy

All questions are required for Applicants that are new entrants or proposing new networks.

16.5.1.1 Applicant must complete all tabs in Attachment J4 Other Provider Network Tables, for their Other Network.

Single, Pull-down list.
1: Attached
2: Not attached
Attached Document(s): Attachment J4 Other Provider Network Tables.xlsx

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

No space for details provided.

Single, Pull-down list.
1: Applicant contracts and manages network
2: Applicant leases network

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

No space for details provided.

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

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

Multi, Checkboxes.
1: Transparency,
2: Implementation of new programs and initiatives,
3: Acquire timely and up-to-date information on providers,
4: Ability to obtain data from providers,
5: Ability to conduct outreach and education to providers if need arises,
6: Ability to add new providers,
7: If no, describe plans to ensure Applicant's ability to control network and meet Exchange requirements: [500 words]

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

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

200 words.

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

No space for details provided.

Single, Radio group.

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

2: No

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

500 words.

16.5.2 Volume - Outcome Relationship

All questions required for Applicants that are new entrants or proposing new networks

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

16.5.2.1 Does Applicant track volume per facility for the above-mentioned procedures?

No space for details provided.

Single, Radio group.

1: Yes,

2: No

16.5.2.2 If yes, provide specific details for each category:

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

500 words.

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

No space for details provided.

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

16.5.2.4 If yes, provide the following details:

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

200 words.

16.5.3 Network Stability

All questions required for existing Exchange networks and newly proposed networks.

16.5.3.1 Total Number of Contracted Hospitals:
No space for details provided.

Integer.

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

100 words.

17 Essential Community Providers

Question required only for new entrant Applicants.

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

1. Applicants must demonstrate sufficient geographic distribution of a mix of essential community providers reasonably distributed throughout the geographic service area; **AND**
2. Applicants must demonstrate contracts with at least 15% of 340B entities (where available) throughout each rating region in the proposed geographic service area; **AND**
3. Applicants must include at least one ECP hospital (including but not limited to 340B hospitals, Disproportionate Share Hospitals, critical access hospitals, academic medical centers, county and children's hospitals) per each county in the proposed geographic service area - where they are available.

The Exchange will evaluate the application of all three criteria to determine whether Applicant's essential community provider network has achieved the sufficient geographic distribution and balance between hospital and non-hospital requirements. The above are the minimum requirements. For example, in populous counties, one ECP hospital will not suffice if there are concentrations of low-income population throughout the county that are not served by a single contracted ECP hospital.

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

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

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

The Exchange will calculate the percentage of contracted 340B entities located in each rating region of the proposed geographic service area. All 340B entity service sites shall be counted in the denominator, in accordance with the most recent version of Covered California's Consolidated ECP list.

Categories of Essential Community Providers:

Essential Community Providers include the following:

1. The Center for Medicare & Medicaid Services (CMS) non-exhaustive list of available 340B providers in the PHS Act and section 1927(c)(1)(D)(i)(IV) of the Social Security Act.

2. Facilities listed on the California Disproportionate Share Hospital Program, Final DSH Eligibility List FY 2013-2014
3. Federally designated 638 Tribal Health Programs and Title V Urban Indian Health Programs
4. Community Clinics or health centers licensed as either “community clinic” or “free clinic”, by the State of California under Health and Safety Code section 1204(a), or operating as a community clinic or free clinic exempt from licensure under Section 1206
5. Physician Providers with approved applications for the HI-TECH Medi-Cal Electronic Health Record Incentive Program
6. Federally Qualified Health Centers (FQHCs)

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

Alternate standard:

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

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

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

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

No space for details provided.

Single, Pull-down list.

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

18 Quality

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

18.1 Accreditation

Questions required only for new entrant Applicants.

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

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

No space for details provided.

Multi, Checkboxes.
1: HMO/POS
2: PPO
3: EPO

18.1.2 Applicant must provide the NCQA or URAC accreditation status and expiration date of the accreditation achieved for the HMO product identified in this response. Indicate all that apply. If accredited by the Accreditation Association for Ambulatory Health Care (AAAHC), provide accreditation status and expiration date in Details.

Details limited to 50 words.

	Answer	Expiration date MM/DD/YYYY	Programs Reviewed
NCQA HMO	*Single, Pull-down list.* 1: Excellent, 2: Commendable, 3: Accredited, 4: Provisional	*To the day.*	

	5: Interim, 6: In Process, 7: Denied, 8: Scheduled, 9: Expired, 10: NCQA not used or product not eligible		
NCQA Exchange	*Single, Pull-down list.* 1: Completed Health Plan Add-On Application, 2: Interim, 3: First, 4: Renewal, 5: NCQA Exchange not used	*To the day.*	
NCQA Wellness & Health Promotion Accreditation	*Single, Radio group.* 1: Accredited and Reporting Measures to NCQA, 2: Accredited and NOT reporting measures, 3: Did not participate	*To the day.*	
NCQA Managed Behavioral Health Organization Accreditation	*Single, Radio group.* 1: Full Accreditation, 2: Accredited – 1 Year, 3: Provisional Accreditation, 4: Denied Accreditation, 5: NCQA not used	*To the day.*	
NCQA Disease Management – Accreditation	*Multi, Checkboxes.* 1: Patient and practitioner oriented, 2: Patient oriented, 3: Plan Oriented, 4: NCQA not used,	*To the day.*	*50 words.*
NCQA Disease Management – Certification	*Multi, Checkboxes.* 1: Program Design, 2: Systems, 3: Contact, 4: NCQA not used	*To the day.*	*50 words.*
NCQA Case Management Accreditation	*Single, Radio group.* 1: Accredited - 3 years	*To the day.*	*50 words.*

	2: Accredited - 2 years, 3: No accreditation		
NCQA PHQ Certification	*Single, Pull-down list.* 1: Certified, 2: No PHQ Certification	*To the day.*	*50 words.*
NCQA Multicultural Health Care Distinction	*Single, Radio group.* 1: Distinction, 2: No MHC Distinction	*To the day.*	
URAC Accreditations	*Single, Radio group.* 1: URAC used, 2: URAC not used		
URAC Accreditations - Health Plan	*Single, Radio group.* 1: URAC Accredited, 2: Not URAC Accredited	*To the day.*	
URAC Accreditation - Comprehensive Wellness	*Single, Radio group.* 1: URAC Accredited, 2: Not URAC Accredited	*To the day.*	
URAC Accreditations - Disease Management	*Single, Radio group.* 1: URAC Accredited, 2: Not URAC Accredited	*To the day.*	
URAC Accreditations - Health Utilization Management	*Single, Radio group.* 1: URAC Accredited, 2: Not URAC Accredited	*To the day.*	
URAC Accreditations - Case Management	*Single, Radio group.* 1: URAC Accredited, 2: Not URAC Accredited	*To the day.*	
URAC Accreditations - Pharmacy Benefit Management	*Single, Radio group.* 1: URAC Accredited, 2: Not URAC Accredited	*To the day.*	

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

No space for details provided.

Single, Pull-down list.

1: Yes, Accreditation 1a attached
2: Not attached

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

Details limited to 50 words.

	Answer	Expiration date MM/DD/YYYY	Programs Reviewed
NCQA PPO	*Single, Pull-down list.* 1: Excellent, 2: Commendable, 3: Accredited, 4: Provisional, 5: Denied, 6: In Process, 7: Scheduled, 8: Expired, 9: NCQA not used or product not eligible	*To the day.*	
NCQA Exchange	*Single, Pull-down list.* 1: Completed Health Plan Add-On Application, 2: Interim, 3: First, 4: Renewal, 5: NCQA Exchange not used	*To the day.*	
NCQA Wellness & Health Promotion Accreditation	*Single, Radio group.* 1: Accredited and Reporting Measures to NCQA, 2: Accredited and NOT reporting measures, 3: Did not participate	*To the day.*	*50 words.*
NCQA Managed Behavioral Healthcare Accreditation	*Single, Radio group.* 1: Full Accreditation, 2: Accredited – 1 Year, 3: Provisional Accreditation,	*To the day.*	*50 words.*

	4: Denied Accreditation, 5: NCQA not used		
NCQA Disease Management – Accreditation	*Multi, Checkboxes.* 1: Patient and practitioner oriented, 2: Patient oriented, 3: Plan Oriented, 4: NCQA not used	*To the day.*	*50 words.*
NCQA Disease Management – Certification	*Multi, Checkboxes.* 1: Program Design, 2: Systems, 3: Contact, 4: NCQA not used	*To the day.*	*50 words.*
NCQA Case Management Accreditation	*Multi, Checkboxes.* 1: Accredited - 3 years, 2: Accredited - 2 years, 3: No accreditation	*To the day.*	*50 words.*
NCQA PHQ Certification	*Single, Pull-down list.* 1: Certified, 2: No PHQ Certification	*To the day.*	
NCQA Multicultural Health Care Distinction	*Single, Pull-down list.* 1: Distinction, 2: No MHC Distinction	*To the day.*	
URAC Accreditations	*Single, Radio group.* 1: URAC used, 2: URAC not used		
URAC Accreditations - Health Plan	*Single, Radio group.* 1: URAC Accredited, 2: Not URAC Accredited	*To the day.*	
URAC Accreditation - Comprehensive Wellness	*Single, Radio group.* 1: URAC Accredited, 2: Not URAC Accredited	*To the day.*	
URAC Accreditations - Disease Management	*Single, Radio group.* 1: URAC Accredited, 2: Not URAC Accredited	*To the day.*	
URAC Accreditations - Health Utilization Management	*Single, Radio group.* 1: URAC Accredited, 2: Not URAC Accredited	*To the day.*	

URAC Accreditations - Case Management	*Single, Radio group.* 1: URAC Accredited, 2: Not URAC Accredited	*To the day.*	
URAC Accreditations - Pharmacy Benefit Management	*Single, Radio group.* 1: URAC Accredited, 2: Not URAC Accredited	*To the day.*	

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

No space for details provided.

Single, Pull-down list.
1: Yes, Accreditation 1b attached,
2: Not attached

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

Details limited to 50 words.

	Answer	Expiration date MM/DD/YYYY	Programs Reviewed
NCQA EPO	*Single, Pull-down list.* 1: Excellent, 2: Commendable, 3: Accredited, 4: Provisional, 5: Interim, 6: Denied, 7: In Process, 8: Scheduled, 9: Expired, 10: NCQA not used or product not eligible	*To the day.*	
NCQA Exchange	*Single, Pull-down list.* 1: Completed Health Plan Add-On Application, 2: Interim, 3: First,	*To the day.*	

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

URAC Accreditations - Health Plan	*Single, Radio group.* 1: URAC Accredited, 2: Not URAC Accredited	*To the day.*	
URAC Accreditation - Comprehensive Wellness	*Single, Radio group.* 1: URAC Accredited, 2: Not URAC Accredited	*To the day.*	
URAC Accreditations - Disease Management	*Single, Radio group.* 1: URAC Accredited, 2: Not URAC Accredited	*To the day.*	
URAC Accreditations - Health Utilization Management	*Single, Radio group.* 1: URAC Accredited, 2: Not URAC Accredited	*To the day.*	
URAC Accreditations - Case Management	*Single, Radio group.* 1: URAC Accredited, 2: Not URAC Accredited	*To the day.*	
URAC Accreditations - Pharmacy Benefit Management	*Single, Radio group.* 1: URAC Accredited, 2: Not URAC Accredited	*To the day.*	

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

No space for details provided.

Single, Pull-down list.
1: Yes, Accreditation 1c attached
2: Not attached.

18.2 Focus on High Cost Providers

Question required for currently contracted Applicants and new entrant Applicants.

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

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

- The factors Applicant considers in assessing the relative unit prices and total costs of care
- The extent to which Applicant analyzes the reasons for variation in costs of care
- How variation in unit prices or total cost of care is used in the selection of Providers and facilities in networks available to Enrollees, e.g. identifying specific hospitals with cost deciles and calculating percentage of costs expended in each cost decile
- How variation in unit process or total cost of care impact consumer out-of-pocket costs
- The frequency with which these analyses are conducted
- Comment on potential collaboration opportunities, new statewide or regional initiatives, or other activities that would strengthen this delivery system reform aim to improve affordability

500 words.

18.3 Demonstrating Action on High Cost Pharmaceuticals

Question required for currently contracted Applicants and new entrant Applicants.

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

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

- How Applicant considers value in its selection of medications for use in its formulary
- Indicate whether a value assessment methodology, such as the Drug Effectiveness Review Project (DERP) or ICER Value Assessment Framework (ICER-VF), or other independent reports are used by Applicant. If so, list methodologies used as well as how they are used to improve the value of pharmacy services.
- How decisions to select drugs and place them on tiers within the formulary are based on total cost of care rather than on drug cost alone
- Describe Applicant's strategy for specialty pharmacy and biologics management
- How Applicant provides decision support for prescribers and consumers in selecting appropriate, efficacious, high-value treatments and how Applicant alerts prescribers and consumers to more cost-effective alternatives when applicable If Applicant or Applicant's PBM is considering implementing a pharmacy order-entry decision support tool or point of care support tool to promote value-based prescribing, and if so, indicate which tool Applicant is using

- Comment on potential collaboration opportunities, new statewide or regional initiatives, or other activities that would strengthen the Applicant's ability to address high cost pharmaceuticals

1000 words.

18.4 Participation in Collaborative Quality Initiatives

All questions are required only for new entrant Applicants.

The Exchange believes that improving health care quality and reducing costs can only be done over the long-term through collaborative efforts that effectively engage and support clinicians and other providers of care. There are many established statewide and national collaborative initiatives for quality improvement that are aligned with priorities established by the Exchange, most notably Smart Care California, Partnership for Patients, and the California Maternal Quality Care Collaborative (CMQCC). The following questions address Applicant's current involvement in collaborative efforts. Applicants will be assessed based on the breadth and depth of their involvement.

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

18.4.2 Identify key collaboratives and organizations in which Applicant is engaged and briefly explain how the Applicant participates. "Engagement" is defined as active participation through regular meeting attendance, health plan representatives serving as advisory members, providing funding, submitting data to the collaborative, or providing feedback on initiatives and projects.
Multi, Checkboxes.
1: Smart Care California, explain: [100 words] ,
2: Partnership for Patients, explain: [100 words] ,
3: CMQCC, explain: [100 words] ,
4: California Perinatal Quality Collaborative (CPQCC), explain: [100 words] ,
5: California Quality Collaborative (CQC), explain: [100 words] ,
6: Right Care Initiative, explain: [100 words] ,
7: California Accountable Communities for Health, explain: [100 words] ,
8: Other, explain: [100 words]

18.5 Data Exchange with Providers

All questions required for currently contracted Applicants and new entrant Applicants.

To be successful under Exchange Quality Improvement Strategy (QIS) requirements, and to improve the quality of care and successfully manage costs, successful Applicants will need to encourage enhanced exchange of clinical data between providers. Participation in Health Information Exchanges (HIE) will enable notification of physicians when their patients are

admitted to the hospital and allow contracted plans to track, trend and improve performance on conditions such as hypertension or diabetes control. In this section, Applicants will be assessed on the extent to which clinical data exchange is occurring, plans to improve data exchange, and current participation in regional and statewide initiatives to improve data exchange.

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

- The extent to which data, other than claims information, is exchanged between providers and Applicant and the proportion of providers in the network that currently submit non-claims data (clinical, demographic, etc.) to Applicant or other providers
- Initiatives in place to improve routine exchange of data to improve the quality of care, such as notifying providers of hospital admissions, collecting clinical data to supplement annual HEDIS data collection, and race/ethnicity self-reported identity
- Whether Applicant requires contracted providers (hospitals, IPAs, medical groups, individual providers, pharmacies, etc.) to contribute data to HIEs or use HIE services and whether Applicant providers resources or incentives to providers to participate in HIEs
- Comment on potential collaboration opportunities, new statewide or regional initiatives, or other activities that would improve quality and manage costs through data exchange

500 words.

18.5.2 Identify the HIE initiatives and organizations in which Applicant is engaged and briefly explain how the Applicant participates. "Engagement" is defined as submitting data, receiving data, or providing funding.

Describe participation including what data Applicant contributes (eligibility files, medical claims, pharmacy claims, etc.) and how often Applicant contributes data.

Multi, Checkboxes.
1: Central Coast Health Connect (CCHC), explain: [100 words] ,
2: LANES, explain: [100 words] ,
3: Manifest MedEx, explain: [100 words] ,
4: Marin Health Gateway, explain: [100 words] ,
5: OCPRHIO, explain: [100 words] ,
6: SacValley MedShare (merged with Connect Healthcare), explain: [100 words] ,
7: San Diego Health Connect, explain: [100 words] ,
8: Santa Cruz Health Information Exchange, explain: [100 words] ,
9: St. Joseph Health, explain: [100 words] ,
10: Other, explain: [100 words]

18.5.3 What is the core value Applicant is seeking from HIE participation?
Multi, Checkboxes.
1: Improve care coordination
2: Reduce burden of prior authorization and other provider/plan interactions
3: Reduce readmissions

4: Support population health efforts (risk stratification, enrollment in chronic care efforts, etc.)
5: Improve HEDIS, risk adjustment and QRS performance
6: Other: *Details limited to 100 words.*
7: N/A Applicant does not participate in an HIE

18.6 Data Aggregation Across Health Plans

Question required for currently contracted Applicants and new entrant Applicants.

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

18.6.1 Identify the data aggregation initiatives in which the Applicant is engaged to support aggregation of claims or other information across payers.
Multi, Checkboxes.
1: Integrated Health Association (IHA)Align Measure Perform (AMP) Commercial HMO program (formerly known as Value Based P4P),
2: IHA Encounter Data Initiative,
3: IHA Cost and Quality Atlas,
4: IHA Provider Directory Utility,
5: CalHospitalCompare,
6: CMQCC,
7: Other: [100 words]

18.7 Mental and Behavioral Health Management

All questions required for currently contracted Applicants and new entrant Applicants.

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

18.7.1 Describe Applicant's mechanisms to ensure consumers have timely access to and receive appropriate, evidence-based treatment, including a description of methods to monitor mental and behavioral health services' quality, effectiveness, and cultural competency.
500 words.

18.7.2 Specify which measures are tracked (e.g., clinical measures, patient-reported experience, or others) to ensure consumers receive appropriate, evidence-based treatment and provide the outcomes for these measures for 2017 and 2018. Please contact the Exchange if additional rows are needed.

	Measure	Outcome - 2017	Outcome - 2018	Outcome - 2019 (to date)
1	*50 words.* Nothing required	*50 words.* Nothing required	*50 words.* Nothing required	*50 words.* Nothing required
2	*50 words.* Nothing required	*50 words.* Nothing required	*50 words.* Nothing required	*50 words.* Nothing required
3	*50 words.* Nothing required	*50 words.* Nothing required	*50 words.* Nothing required	*50 words.* Nothing required
4	*50 words.* Nothing required	*50 words.* Nothing required	*50 words.* Nothing required	*50 words.* Nothing required
5	*50 words.* Nothing required	*50 words.* Nothing required	*50 words.* Nothing required	*50 words.* Nothing required
6	*50 words.* Nothing required	*50 words.* Nothing required	*50 words.* Nothing required	*50 words.* Nothing required
7	*50 words.* Nothing required	*50 words.* Nothing required	*50 words.* Nothing required	*50 words.* Nothing required
8	*50 words.* Nothing required	*50 words.* Nothing required	*50 words.* Nothing required	*50 words.* Nothing required
9	*50 words.* Nothing required	*50 words.* Nothing required	*50 words.* Nothing required	*50 words.* Nothing required
10	*50 words.* Nothing required	*50 words.* Nothing required	*50 words.* Nothing required	*50 words.* Nothing required
11	*50 words.* Nothing required	*50 words.* Nothing required	*50 words.* Nothing required	*50 words.* Nothing required
12	*50 words.* Nothing required	*50 words.* Nothing required	*50 words.* Nothing required	*50 words.* Nothing required
13	*50 words.* Nothing required	*50 words.* Nothing required	*50 words.* Nothing required	*50 words.* Nothing required
14	*50 words.* Nothing required	*50 words.* Nothing required	*50 words.* Nothing required	*50 words.* Nothing required
15	*50 words.* Nothing required	*50 words.* Nothing required	*50 words.* Nothing required	*50 words.* Nothing required
16	*50 words.* Nothing required	*50 words.* Nothing required	*50 words.* Nothing required	*50 words.* Nothing required
17	*50 words.* Nothing required	*50 words.* Nothing required	*50 words.* Nothing required	*50 words.* Nothing required
18	*50 words.* Nothing required	*50 words.* Nothing required	*50 words.* Nothing required	*50 words.* Nothing required
19	*50 words.* Nothing required	*50 words.* Nothing required	*50 words.* Nothing required	*50 words.* Nothing required

20	*50 words.* Nothing required	*50 words.* Nothing required	*50 words.* Nothing required	*50 words.* Nothing required
21	*50 words.* Nothing required	*50 words.* Nothing required	*50 words.* Nothing required	*50 words.* Nothing required
22	*50 words.* Nothing required	*50 words.* Nothing required	*50 words.* Nothing required	*50 words.* Nothing required
23	*50 words.* Nothing required	*50 words.* Nothing required	*50 words.* Nothing required	*50 words.* Nothing required
24	*50 words.* Nothing required	*50 words.* Nothing required	*50 words.* Nothing required	*50 words.* Nothing required
25	*50 words.* Nothing required	*50 words.* Nothing required	*50 words.* Nothing required	*50 words.* Nothing required

18.7.3 Describe Applicant's strategies to improve accessibility of mental and behavioral health services. Specifically address the following:

- Efforts to improve the availability of services, taking into account provider availability and capacity and unique needs of diverse enrolled populations. Examples of such efforts may include changes in benefits management, networks, providing alternatives to face-to-face visits, etc.
- Assessment of behavioral health providers' or vendor's language capabilities
- Explanation of consumer point of entry to behavioral health services Methods to receive and address consumer concerns

500 words.

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

- Describe Applicant's integrated behavioral health-medical model, if applicable. Indicate whether these efforts are implemented in association with Patient Centered Medical Home (PCMH) and Integrated Healthcare Models (IHM) models
- Percent of services provided under an integrated behavioral health-medical model, as defined and recognized by Applicant, in both its Exchange business (if Applicant had Exchange business in 2018) and total book of business
- How Applicant improves the integration of mental and behavioral health services and medical services, and a description of any recommended models or best practices integrating these services
- Comment on any innovative models in California or nationwide and potential collaborative opportunities to adopt these models on a larger scale

500 words.

18.8 Health Technology (Telehealth and Remote Monitoring)

Questions required for currently contracted Applicants and new entrant Applicants.

The Exchange supports the innovative use of technology to assist in higher quality,

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

18.8.1 Applicant ability to support web/telehealth consultations, either through a contractor or provided by the medical group/provider. Note that Applicants selecting "Plan does not offer or allow web or telehealth consultations" will not be required to complete 18.8.2.

Multi, Checkboxes.
1: Plan does not offer/allow web or telehealth consultations,
2: Web visit using instant messaging,
3: Telehealth with interactive face to face dialogue (video) over the Web,
4: Telehealth with interactive dialogue over the phone,
5: Telehealth via email,
6: Other (specify): [20 words]

18.8.2 Provide information regarding Applicant's capabilities to support provider-member consultations using technology (e.g., web consultations, telemedicine). Applicant will be evaluated based on the availability of telehealth services for all books of business, particularly Exchange membership (if Applicant is not currently contracted with the Exchange, select "1" if the service would be offered to Exchange members, and include a description in the details section).

If no changes from previous Certification Application, CURRENTLY CONTRACTED Applicants will only respond to questions 3, 10-12, and 14-16. All other fields can be answered with an N/A.

All fields required for new entrant Applicants.

Details limited to 100 words.

Response	Response	Technology	Details
1. Indicate availability of web/telehealth consultations, either through a contractor or provided by a medical group/provider, by book of business	*Multi, Checkboxes.* N/A OK. 1: Exchange, 2: All large group, 3: Large group buy-up option only, 4: Medicaid, 5: Medicare, 6: Other		*20 words.* Nothing required
2. Indicate availability of web/telehealth consultations, either through a contractor or	*Multi, Checkboxes.* N/A OK.		*20 words.*

provided by a medical group/provider, by product type	1: HMO, 2: PPO, 3: EPO, 4: Other		Nothing required
3. Indicate availability of web/telehealth consultations in languages other than English. Specify all languages offered in Response box.	*100 words.*		
4. Applicant uses a vendor for web/telehealth consultations (indicate vendor and average wait time in the answer section)	*50 words.* N/A OK.	*Multi, Checkboxes.* N/A OK. 1: Telehealth via web (video), 2: Telehealth via phone, 3: Combination of web (video) and phone, 4: Instant messaging, 5: Email, 6: Other (specify)	*20 words.* Nothing required
5. Applicant contracts with medical groups/providers that offer web/telehealth consultations (yes/no with details)	*50 words.* N/A OK.	*Multi, Checkboxes.* N/A OK. 1: Telehealth via web (video), 2: Telehealth via phone, 3: Combination of web (video) and phone, 4: Instant messaging, 5: Email, 6: Other (specify)	*20 words.* Nothing required
6. If physicians and/or physician groups/practices are designated in provider directory as having web/telehealth consultation services available, provide percentage of physicians in the network (across all lines of business)	*Percent.* N/A OK. From 0 to 100.	*Multi, Checkboxes.* N/A OK. 1: Telehealth via web (video), 2: Telehealth via phone, 3: Combination	*20 words.* Nothing required

		of web (video) and phone, 4: Instant messaging, 5: Email, 6: Other (specify)	
7. For physicians that are available to deliver web/telehealth consultations, what is the average wait time? If Applicant can provide average wait time - describe how that is monitored in detail box at end of question	*Single, Radio group.* N/A OK. 1: On demand, 2: Within 4 hours, 3: Within same day, 4: Scheduled follow-up within 48 hours, 5: Other (describe)	*Multi, Checkboxes.* N/A OK. 1: Telehealth via web (video), 2: Telehealth via phone, 3: Combination of web (video) and phone, 4: Instant messaging, 5: Email, 6: Other (specify)	*20 words.* Nothing required
8. Applicant promotes telehealth (either through vendor or medical group) as an alternative to the ED for urgent health issues (describe specific engagement efforts and any specific contractual requirements related to this topic for vendors or medical groups)	*50 words.* N/A OK.		
9. Member reach of physicians providing web/telehealth consultations (i.e. what % of members are attributed to those physicians offering web/telehealth consultations) (use as denominator total membership across all lines of business). If Applicant has and tracks use by Medi-Cal members as well, number here should include Medi-Cal numbers.)	*Percent.* N/A OK. From 0 to 100.	*Multi, Checkboxes.* N/A OK. 1: Telehealth via web (video), 2: Telehealth via phone, 3: Combination of web (video) and phone, 4: Instant messaging, 5: Email, 6: Other (specify)	*20 words.* Nothing required

10. What percentage of the current total membership has access to web/telehealth consultations as a covered core benefit (no buy-up required)? (Use as denominator total membership across all lines of business).	*Percent.* From 0 to 100.	*Multi, Checkboxes.* 1: Telehealth via web (video), 2: Telehealth via phone, 3: Combination of web (video) and phone, 4: Instant messaging, 5: Email, 6: Other (specify)	*20 words.* Nothing required
11. Percentage of unique members with a web/telehealth consultation in 2018	*Percent.* From 0 to 100.	*Multi, Checkboxes.* 1: Telehealth via web (video), 2: Telehealth via phone, 3: Combination of web (video) and phone, 4: Instant messaging, 5: Email, 6: Other (specify)	*20 words.* Nothing required
12. If Applicant had Exchange business in 2018: Percentage of unique Exchange members with a web/telehealth consultation in 2018	*Percent.* From 0 to 100.	*Multi, Checkboxes.* 1: Telehealth via web (video), 2: Telehealth via phone, 3: Combination of web (video) and phone, 4: Instant messaging, 5: Email, 6: Other (specify)	*20 words.* Nothing required
13. Applicant reimburses for web/telehealth consultations	*Single, Radio group.* N/A OK.	*Multi, Checkboxes.* N/A OK.	*20 words.*

	1: Yes, 2: No	1: Telehealth via web (video), 2: Telehealth via phone, 3: Combination of web (video) and phone, 4: Instant messaging, 5: Email, 6: Other (specify)	Nothing required
14. Among members in plans with available web/telehealth consultation, what is the member cost share?	*Multi, Checkboxes.* 1: No cost share, 2: Same cost as a primary care visit, 3: Same cost as a specialist visit, 4: Telehealth visit cost share (explain):, 5: Other (explain):	*Multi, Checkboxes.* 1: Telehealth via web (video), 2: Telehealth via phone, 3: Combination of web (video) and phone, 4: Instant messaging, 5: Email, 6: Other (specify)	*20 words.* Nothing required
15. Discuss how the Applicant balances encouraging members to use telehealth options while promoting integration and coordination of care	*200 words.*		
16. Discuss any innovations or pilot programs adopted by Applicant that are not reflected in this table (such as plans for new programs, expansion of existing programs, new telehealth features, etc.)	*100 words.*		

18.9 Health and Wellness

All questions are required for currently contracted Applicants and new entrant Applicants.

The Exchange recognizes that access to care, timely preventive care, coordination of care, and early identification of high risk enrollees are central to the improvement of enrollee health. The following questions address Applicant's ability to track the health and wellness of enrollees and identify enrollees for preventive care and interventions. Answers will be evaluated based on the degree to which health and wellness data is tracked on membership and used to coordinate care.

18.9.1 Report selected measures below for the two most recently calculated years of HEDIS results for the HMO Applicant (QC 2018 and 2017).
If Applicant did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised: -1 means 'NR', -2 means 'NA', -3 means 'ND', -4 means 'EXC', and -5 means 'NB'.
No space for details provided.

	HMO QC 2018	QC 2017, or prior year's HMO QC result
Breast Cancer Screening - Total	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Cervical Cancer Screening	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Colorectal Cancer Screening	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.

18.9.2 Report selected measures below for the two most recently calculated years of HEDIS results for the PPO Applicant (QC 2018 and 2017).
If Applicant did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised: -1 means 'NR', -2 means 'NA', -3 means 'ND', -4 means 'EXC', and -5 means 'NB'.
No space for details provided.

	PPO QC 2018	PPO QC 2017, or prior year's PPO QC result
Breast Cancer Screening - Total	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.

Cervical Cancer Screening	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Colorectal Cancer Screening	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.

18.9.3 Report selected measures below for the two most recently calculated years of HEDIS results for the EPO Applicant (QC 2018 and 2017).
If Applicant did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised: -1 means 'NR', -2 means 'NA', -3 means 'ND', -4 means 'EXC', and -5 means 'NB'.
No space for details provided.

	EPO QC 2018	EPO QC 2017, or prior year's EPO QC result
Breast Cancer Screening - Total	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Cervical Cancer Screening	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Colorectal Cancer Screening	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.

18.9.4 Which of the following member interventions were used by Applicant in calendar year 2018 to improve cancer screening rates? Indicate all that apply.
No space for details provided.

	Educational messages identifying screening options discussing risks and benefits	Member-specific reminders (electronic or written, etc.) sent to members for needed care based on general eligibility (age/gender)	Member-specific reminders for gaps in services based on administrative or clinical information (mail, e-mail/text, automated phone or live outbound telephone calls triggered by the ABSENCE of a service)
Breast Cancer Screening	*Single, Radio group.*	*Single, Radio group.* 1: Available to > 75% of members,	*Single, Radio group.* 1: Available to > 75% of members,

	1: Yes, 2: No	2: Available to < 75% of members, 3: Not Available	2: Available to < 75% of members, 3: Not Available
Cervical Cancer Screening	*Single, Radio group.* 1: Yes, 2: No	*Single, Radio group.* 1: Available to > 75% of members, 2: Available to < 75% of members 3: Not Available	*Single, Radio group.* 1: Available to > 75% of members, 2: Available to < 75% of members, 3: Not Available
Colorectal Cancer Screening	*Single, Radio group.* 1: Yes, 2: No	*Single, Radio group.* 1: Available to > 75% of members, 2: Available to < 75% of members, 3: Not Available	*Single, Radio group.* 1: Available to > 75% of members, 2: Available to < 75% of members, 3: Not Available

18.9.5 Report selected measures below for the two most recently uploaded years of HEDIS/CAHPS (QC 2018 and QC 2017) results for HMO Applicant.
If Applicant did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised: -1 means 'NR', -2 means 'NA', -3 means 'ND', -4 means 'EXC', and -5 means 'NB'.
No space for details provided.

	QC 2018, or most current year's HMO result	QC 2017, or prior year's HMO QC result
Childhood Immunization Status - Combo 3	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Immunizations for Adolescents - Combo 2	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
CAHPS Flu Shots for Adults (18-64) (report rolling average)	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.

18.9.6 Report selected measures below for the two most recently uploaded years of HEDIS/CAHPS (QC 2018 and QC 2017) results for PPO Applicant.

If Applicant did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported),

EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised: -1 means 'NR', -2 means 'NA', -3 means 'ND', -4 means 'EXC', and -5 means 'NB'.
No space for details provided.

	QC 2018, or most current year's PPO result	QC 2017, or prior year's PPO QC result
Childhood Immunization Status - Combo 3	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Immunizations for Adolescents – Combo 2	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
CAHPS Flu Shots for Adults (18-64) (report rolling average)	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.

18.9.7 Report selected measures below for the two most recently uploaded years of HEDIS/CAHPS (QC 2018 and QC 2017) results for EPO Applicant.

If Applicant did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised: -1 means 'NR', -2 means 'NA', -3 means 'ND', -4 means 'EXC', and -5 means 'NB'
No space for details provided.

	QC 2018, or most current year's EPO result	QC 2017, or prior year's EPO QC result
Childhood Immunization Status - Combo 3	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Immunizations for Adolescents – Combo 2	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
CAHPS Flu Shots for Adults (18-64) (report rolling average)	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.

18.9.8 Identify member interventions used in calendar year 2018 to improve immunization rates. Check all that apply.
No space for details provided.

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

18.9.9 Indicate whether Applicant currently participates in the California Immunization Registry (both submitting and receiving data). If yes, include a description of how Applicant uses the data obtained in the registry, e.g. supporting outreach to those with gaps in care and/or evaluating effectiveness of provider interventions.
Single, radio group
1: Yes (explain) [*50 words],*
2: No

18.9.10 Indicate the number and percent of tobacco-dependent commercial members identified and participating in cessation activities during 2018.
If Applicant is currently contracted with the Exchange, provide <u>Exchange</u> counts if available. If Exchange counts are not available, provide state or regional counts.

	Answer
Indicate how Applicant identifies members who use tobacco. Applicant may add up the tobacco users identified in each of the ways identified in this row with the recognition that this	*Multi, Checkboxes.* 1: Plan Health Assessment,

may result in some duplication or over counting in response to row below on number of commercial members individually identified as tobacco dependent in 2018.	2: Employer/Vendor Health Assessment, 3: Member PHR, 4: Claims/Encounter Data, 5: Disease or Care Management, 6: Wellness Vendor, 7: Other (describe in box in cell)
Indicate ability to track identification of tobacco-dependent members. Select only ONE of response options 1-4 and include response option 5 if applicable	*Multi, Checkboxes.* 1: Identification tracked statewide & regionally, 2: Identification only tracked statewide, 3: Identification only tracked regionally, 4: Identification not tracked regionally/statewide, 5: Identification can be tracked at Covered California level
Indicate ability to track participation of tobacco-dependent members in cessation activities. Select only ONE of response options 1-4 and include response option 5 if applicable	*Multi, Checkboxes.* 1: Participation tracked statewide & regionally, 2: Participation only tracked statewide, 3: Participation only tracked regionally, 4: Participation not tracked regionally/statewide, 5: Participation can be tracked at Covered California level
Number of California members individually identified as tobacco dependent in 2018. (If Applicant has and tracks use by Medi-Cal members as well, number here should include Medi-Cal numbers.)	*Decimal.*
% of California members identified as tobacco dependent (Calculated as number of California members individually identified as tobacco dependent divided by total California membership)	*Percent*
Number of Exchange members individually identified as tobacco dependent in 2018.	*Decimal.*

% of Exchange members identified as tobacco dependent (Calculated as number of Exchange members individually identified as tobacco dependent divided by total Exchange membership)	*Percent*
Number of California members identified as tobacco dependent who participated in a smoking cessation program during 2018. (If Applicant has and tracks use by Medi-Cal members as well, number here should include Medi-Cal numbers.)	*Decimal.*
Of California members identified as tobacco dependent, what percent are participating in smoking cessation program (Number of program participants divided by number of identified smokers)?	*Percent.*
Number of Exchange members identified as tobacco dependent who participated in a smoking cessation program during 2018.	*Decimal.*
Of Exchange members identified as tobacco dependent, what percent are participating in smoking cessation program (Number of program participants divided by number of identified smokers)?	*Percent.*

18.9.11 Indicate the number of obese members identified and participating in weight management programs during 2018. Do not report general prevalence.
If Applicant is currently contracted with the Exchange, provide <u>Exchange</u> counts if available. If Exchange counts are not available, provide state/regional counts.

	Answer
Indicate how Applicant identifies members who are obese. Applicant may add up the obese members identified in each of the ways identified in this row with the recognition that this may result in some duplication or over counting in response to row below on Number of commercial members individually identified as obese in 2018 as of December 2018	*Multi, Checkboxes.* 1: Plan Health Assessment, 2: Employer/Vendor Health Assessment, 3: Member PHR, 4: Claims/Encounter Data, 5: Disease or Care Management, 6: Wellness Vendor, 7: Other (describe in box in cell)

Indicate ability to track identification of obese members. Select only ONE of response options 1-4 and include response option 5 if applicable	*Multi, Checkboxes.* 1: Identification tracked statewide & regionally, 2: Identification only tracked statewide, 3: Identification only tracked regionally, 4: Identification not tracked regionally/statewide, 5: Identification can be tracked at Covered California level
Indicate ability to track participation of obese members in weight management programs. Select only ONE of response options 1-4 and include response option 5 if applicable	*Multi, Checkboxes.* 1: Participation tracked statewide & regionally, 2: Participation tracked only statewide, 3: Participation only tracked regionally, 4: Participation not tracked regionally/statewide, 5: Participation can be tracked at Covered California level
Number of California members identified as obese in 2018. (If Applicant has and tracks use by Medi-Cal members as well, number here should include Medi-Cal numbers.)	*Decimal.*
% of California members identified as obese (Calculated as number of California members individually identified as obese divided by total California membership)	*Percent.*
Number of Exchange members identified as obese in 2018.	*Decimal.*
% of Exchange members identified as obese (Calculated as number of Exchange members individually identified as obese divided by total Exchange membership)	*Percent.*
Number of California members identified as obese who participated in a weight management program during 2018. (If Applicant has and tracks use by Medi-Cal members as well, number here should include Medi-Cal numbers.)	*Decimal.*
Of California members identified as obese, what percent are participating in a weight management program (Number of program participants divided by number of identified obese)?	*Percent.*

Number of Exchange members identified as obese who participated in weight management program during 2018.	*Decimal.*
Of Exchange members identified as obese, what percent are participating in a weight management program (Number of program participants divided by number of identified obese)?	*Percent.*

18.9.12 As part of total population management and person-centered care, summarize Applicant activities and ability to identify members who are non-users (no claims) and engage those members in staying or becoming healthy.
No space for details provided.

	Response/Summary	Geography of response
Percent of total commercial membership with no claims in CY 2018	*Percent.* N/A OK.	*Single, Radio group.* 1: Regional, 2: State
Summary (bullet points) of plan activities to engage members who are non-users	*100 words.* N/A OK.	

18.9.13 Indicate capabilities supporting Applicant's Health Assessment (HA) programming (formerly known as Health Risk Assessment-HRA or Personal Health Assessment-PHA). Check all that apply.
Multi, Checkboxes.
1: HA Accessibility: Both online and in print,
2: HA Accessibility: IVR (interactive voice recognition system),
3: HA Accessibility: Telephone interview with live person,
4: HA Accessibility: Multiple language offerings,
5: HA Accessibility: HA offered at initial enrollment,
6: HA Accessibility: HA offered on a regular basis to members,
7. Applicant does not offer an HA

18.9.14 Indicate activities supporting Applicant's Health Assessment (HA) programming (formerly known as Health Risk Assessment-HRA or Personal Health Assessment-PHA). Check all that apply.
Not required if answered 7 to 18.9.13.
Multi, Checkboxes.
1. Addressing At-risk Behaviors: At point of HA response, risk-factor education is provided to member based on member-specific risk, e.g. at point of “smoking-yes” response, tobacco cessation education is provided as pop-up.

2: Addressing At-risk Behaviors: Personalized HA report is generated after HA completion that provides member-specific risk modification actions based on responses,
3: Addressing At-risk Behaviors: Members are directed to targeted interactive intervention module for behavior change upon HA completion,
4: Addressing At-risk Behaviors: Ongoing push messaging for self-care based on member's HA results ("Push messaging" is defined as an information system capability that generates regular e-mail or health information to the member),
5: Addressing At-risk Behaviors: Member is automatically enrolled into a disease management or at-risk program based on responses,
6: Addressing At-risk Behaviors: Case manager or health coach outreach call triggered based on HA results,
7: Addressing At-risk Behaviors: Member can elect to have HA results sent electronically to personal physician,
8: Addressing At-risk Behaviors: Member can update responses and track against previous responses,
9: Tracking health status: HA responses incorporated into member health record.
10: Tracking health status: HA responses tracked over time to observe changes in health status,
11: Tracking health status: HA responses used for comparative analysis of health status across geographic regions,
12: Tracking health status: HA responses used for comparative analysis of health status across demographics,
13: Partnering with Employers: Employer receives trending report comparing current aggregate results to previous aggregate results,
14: Partnering with Employers: Health plan can import data from employer-contracted HA vendor

18.9.15 Provide the number of currently enrolled commercial and Exchange members who completed a Health Assessment (HA) in the past year.
No space for details provided.

	Answer
Geography reported below for HA completion Select only ONE of response options 1-4 and include response option 5 if applicable (If option 4 selected, responses to the following question in the table are not required.)	*Multi, Checkboxes.* 1: Participation tracked statewide & regionally, 2: Participation only tracked statewide, 3: Participation only tracked regionally, 4: Participation not tracked regionally/statewide, 5: Participation can be tracked at Covered California level

Number of members completing Plan-based HA in 2018 (If Applicant has and tracks use by Medi-Cal members as well, number here should include Medi-Cal numbers.)	*Decimal.*
Percent HA completion (Health plan HA completion number divided by total enrollment)	Percent.
Number of completed HAs resulting in referral to health plan case management staff or assigned provider	*Decimal.*
Percent completed HAs resulting in referral to health plan case management staff or assigned provider (Referral number divided by number of completed HAs)	Percent.

18.9.16 Does Applicant collect information, at both individual and aggregate levels, on changes in enrollees' health status? Describe Applicant's process to monitor and track changes in enrollees' health status, which may include its process for identifying individuals who show a decline in health status.
200 words.

18.9.17 Does Applicant refer enrollees with a change in health status to care management and chronic condition program(s)? Include in the answer how many Exchange enrollees, across all products, have been identified through the process and referred to care management, chronic condition program(s), or other services due to a change in health status in 2018. If Applicant does not currently have Exchange business, report on all lines of business.
200 words.

18.10 Community Health and Wellness Promotion

Question required for currently contracted Applicants and new entrant Applicants.

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

18.10.1 Provide a description of the external-facing initiatives, programs and projects Applicant supports to promote better community health, and how such programs specifically address health disparities or efforts to improve community health apart from the health delivery system. Examples include the California Reducing Disparities Project (CRDP),

Health in All Policies (HIAP), The California Endowment Healthy Communities, and Beach Cities Health District, among others. Please note the definition of external-facing provided in the previous paragraph and include any evaluation results of the activity or program, if available.
500 words.

18.11 At-Risk Enrollees

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

18.11.1 How does Applicant identify at-risk enrollees who would benefit from early, proactive interventions? Describe applicable diseases for at-risk identification, sources of data, and any predictive analytic capabilities.
100 words.

18.11.2 For the Exchange business, Applicant must provide (1) the number of members aged 18 and above in first row, (2) the number of members aged 18 and above identified under Applicant's criteria for at-risk enrollees eligible for case management in the second row. If Applicant does not currently have Exchange business, report on all lines of business excluding Medicare.
No space for details provided.

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

18.11.3 Describe outreach and interventions used to ensure at-risk enrollees get needed care. Note if any of the strategies below are used and indicate whether the program is specific to at-risk enrollees or a program for all enrollees.

- Member-specific reminders for due or overdue clinical/diagnostic maintenance services and/or medication events (failure to refill for example)

- Online interactive self-management support. "Online self-management support" is an intervention that includes two-way electronic communication between Applicant and the member
- Self-initiated text/email
- Interactive IVR
- Live outbound telephonic coaching program
- Face to face visits

500 words.

18.11.4 Describe Applicant’s process for keeping and updating a medical history of at-risk enrollees in its maintained enrollee health profile.
65 words.

18.11.5 Does Applicant share registries of enrollees with their identified risk, as permitted by state and federal law, with appropriate accountable providers, especially the enrollee’s PCP? If yes, describe.
Single, Radio group.
1: Yes, describe: [65 words],
2: No

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

18.11.7 Describe Applicant’s ability to gather, categorize, and package current information on at-risk enrollees in case Applicant is requested to transfer its enrollees to other Exchange health plans to facilitate a smooth transition of care.
100 words.

19 Covered California Quality Improvement Strategy

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

Attachment 7 of the Covered California Qualified Health Plan (QHP) Issuer Contract embodies the Exchange's vision for reform and serves as a roadmap to delivery system improvements. Beginning with the 2017 QHP Issuer Contract, QHP issuers have been engaged in supporting existing quality improvement initiatives and programs that are sponsored by other major purchasers including the Department of Health Care Services (DHCS), the California Public Employees' Retirement System (CalPERS), the Pacific Business Group on Health (PBGH), and CMS. These requirements are reflected in the 2017 contract and will be in all successive contracts through 2020. QHP certification and participation in the Exchange will be conditional on Applicant developing a multi-year strategy and reporting year-to-year activities and progress on each initiative area.

The Covered California Quality Improvement Strategy (QIS) meets federal requirements for State-based Marketplaces (SBMs) and serves as the foundational improvement plan and progress report for QHP certification and contractual requirements. Applicants currently contracted with the Exchange are required to complete the QIS as part of the Application process. Reporting is divided into two parts:

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

New Entrant Applicants: New entrant Applicants are not required to complete the QIS as part of the 2020 Application but must review Attachment 7 with the understanding that engagement in the QIS and Attachment 7 initiatives will be contractually required and measured in the future if Applicant joins the Exchange.

Currently Contracted Issuers: The QIS will be evaluated by the Exchange as part of the annual application for certification and final approval by the Exchange may require follow-up meetings or documentation as necessary. Currently contracted Applicants should describe updates to the previous QIS submissions. Note new and revised questions throughout this section.

19.1 Applicant Information

Questions 19.1.1 – 19.1.3 are required for new entrant Applicants. Questions 19.1.3 and 19.1.4 are required for currently contracted Applicants.

19.1.1 Confirm Applicant has reviewed Attachment 7 and will comply with contractually required quality improvement initiatives if selected by the Exchange.
No space for details provided.
Single, Pull-down list.
1: Confirmed
2: Not confirmed

19.1.2 Describe any concerns or limitations Applicant may have with the quality improvement initiatives detailed in Attachment 7.
1000 words

19.1.3 Complete this section and designate one contact for medical management and one contact for network management.
No space for details provided.

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

19.1.4 Indicate the health plan product types the Applicant offers for the Exchange. If Applicant offers more than one product type, Applicant will complete Section 19 for each product type.
Multi, Checkboxes.

1. HMO
2. PPO
3. EPO

4. Other

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

19.2.1 QIS for Provider Networks Based on Quality

Federal QIS Topic Area: Activities to improve patient safety and reduce medical errors
2017 QHP Issuer Contract Attachment 7, Section 1.02

QIS Goal: Applicant should have 1) clear network quality criteria that are used to screen providers and hospitals for inclusion in network, and 2) possible removal of outliers based on inability to meet quality criteria or lack of effort toward improvement.

19.2.1.1: Submit as attachments the following documents related to use of quality criteria in network contracting:

(File titled Provider Network): All quality measures and criteria used to develop provider networks. Include patient safety and patient-reported experience (noting any measures that are new). An explanation of the assessment process, including source of quality assessment data, specific measures and metrics, and thresholds for inclusion and exclusion in the network. If applicable, describe which criteria are prioritized above other criteria to determine the provider network.	*Single, Pull-down list.* 1: Attached, 2: Not attached
(File titled Hospital Network): All quality measures and criteria used to develop hospital networks. Include patient safety and patient-reported experience (noting any measures that are new). An explanation of the assessment process, including source of quality assessment data, specific measures and metrics, and thresholds for inclusion and exclusion in the network. If applicable, describe which criteria are prioritized above other criteria to determine the hospital network.	*Single, Pull-down list.* 1: Attached, 2: Not attached

19.2.1.2: Describe updates in Applicant's ability to build networks based on quality since the previous QIS submission. Applicant may submit any supporting documentation as an attachment. Address each of the following in the narrative:

- Progress in 2018 toward the end goal and any further implementation plans for 2019 with milestones for 2019 and 2020 identified.
- Known or anticipated barriers in implementing QIS activities and progress of mitigation activities.

500 words.

19.2.1.3 Describe if Applicant includes Centers of Excellence in network, the basis for inclusion, how they are promoted among members and how utilization is tracked.
Submit an attachment that lists the providers, hospitals and facilities the Applicant uses as Centers of Excellence. For each facility, indicate the condition(s) (cancer, transplants, burns, etc.) for which the facility is used as a Center of Excellence.

Attachment required
Single, Radio group.
1: Yes, COE List attached, describe: [200 words],
2: Not attached

19.2.2 QIS for Reducing Health Disparities and Ensuring Health Equity

Federal QIS Topic Area: Activities to reduce health and health care disparities.

2017 QHP Issuer Contract Attachment 7, Section 3.01 and 3.02

QIS Goal: Applicant will 1) continue to achieve 80% of Exchange members self-reporting their race/ethnicity, 2) collect, track, trend, and reduce health disparities in management of diabetes, asthma, hypertension, and depression.

19.2.2.1 Provide the percent of Exchange members for whom self-reported data is captured for race/ethnicity in Attachment E QIS Run Charts. Self-identification may take place through the enrollment application, web site registration, health assessment, reported at provider site, etc. The percentage should exclude members who have “declined to state” either actively or passively. Enter the percentage reported in the Certification Applications for 2017, 2018 and 2019 as well.

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

19.2.2.2 Describe progress on increasing or maintaining the percent of Exchange members who self-report race/ethnic information. Applicant may submit any supporting documentation as an attachment. Address each of the following in the narrative:

- Updates in efforts to increase self-reported race/ethnic information including whether there are barriers to self-report.
- Update if or how the Rand proxy method using geocoding and surname is used to supplement self-report.
- Any plans to implement or test new programs to increase self-identification.

500 words.

19.2.2.3 Confirm Applicant submitted a quality improvement plan to address health care disparities on March 1, 2019 to the Exchange. Quality Improvement Plan must include the following components:

- Description of the health care disparity
- Rationale for the QI plan
- Targeted population

- Data from at least three years demonstrating the disparity
- Proposed intervention. Include the following:
    - Evidence basis for the intervention
    - Planned resources (staff, infrastructure, IT, etc.)
    - Evaluation methods

Expected year-over-year improvement: Include baseline measurements (MY 2015-2017) and expected performance if the intervention is effective

Single, Pull-down list.
1: Submitted,
2: Not submitted

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

Federal QIS Topic Area: Activities for improving health outcomes

2017 QHP Issuer Contract Attachment 7, Sections 4.01 and 4.02

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

19.2.3.1 Report, by product, the percentage of members in Applicant's Exchange business who either selected a Primary Care Physician (PCP) or were matched with a Primary Care Physician in 2018 in Attachment E QIS Run Charts. If Applicant had no Exchange business in 2018, report full book of business excluding Medicare. Enter the percentage reported in the Certification Applications for 2017, 2018 and 2019 as well. Report data by product (HMO, PPO, EPO).

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

19.2.3.2 Report the number and percentage of Exchange members who obtain their primary care with a provider or clinic that has received PCMH recognition from NCQA, The Joint Commission, or the Accreditation Association for Ambulatory Health Care (AAAHC) in Attachment E QIS Run Charts. For currently contracted Applicants, enter the percentage reported in the Certification Application for 2018 and 2019 as well. If Applicant did not have Exchange business during the prior calendar year, report on the full book of business.

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

19.2.3.3 Report all types of payment methods, including fee for service (FFS) and capitation, used for primary care services and number of providers paid under each model in Attachment E QIS Run Charts. If Applicant has adopted a model consistent with a Level 3 or 4 alternative payment model (APM) as outlined in the Health Care Payment Learning Action & Action Network (HCP LAN) Draft White Paper on Primary Care Payment Models or aligned with

Center for Medicare & Medicaid's (CMMI's) Comprehensive Primary Care Plus program as part of its strategy to advance primary care in California, include a description of the model, including any alternative payments such as care management fees and payments based on quality, in the attachment. Applicants may include any newly adopted models that are planned or in progress but not yet implemented among providers (include timeline for beginning the payment model). Enter the number and percentage of providers paid under each model reported in the Certification Applications for 2017, 2018 and 2019 as well.
References:
HCP LAN Primary Care Payment Models Draft White Paper: http://hcp-lan.org/workproducts/pcpm-whitepaper-draft.pdf
CMMI Comprehensive Primary Care Plus:
https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus

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

19.2.3.4 Describe updates on progress made since the previous QIS submission in each part of the primary care goals, and planned activities. Applicant may submit any supporting documentation as an attachment. Address each of the following in the narrative:

- Updates in year three of the PCP matching initiative, including an implementation status report, feedback on the consumer experience, complaints, positive feedback, unanticipated challenges, and suggestions (if applicable). If contracted physician organizations have made progress in adopting Level 3 or 4 APMs described in the LAN Draft White Paper (above). Describe the predominant payment structure used among contracted groups and their progress towards implementing APMs (if applicable). Describe any support (financial, staffing, educational, etc.) that Applicant or multi-insurer collaborative is providing to primary care providers to support their efforts towards accessible, data-driven, team-based care.
- How Applicant is encouraging enrollees to use PCMH-recognized providers or accessible, data-driven, team-based care providers.
- Progress in 2018 toward the end goal and any further implementation plans for 2019 with milestones for 2019 and 2020 identified

Known or anticipated barriers in implementing QIS activities and progress of mitigation activities

1000 words.

19.2.3.5 What other innovative methods is Applicant considering for increasing support for primary care providers, such as increasing the percent of revenue or premium allocated towards primary care services? Describe.

200 words.

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

Federal QIS Topic Area: Activities for improving health outcomes

2017 QHP Issuer Contract Attachment 7, Section 4.03

QIS Goal: Applicant will increase IHM presence in its Exchange network by providing various types of support to providers to elevate their processes and practice toward this goal. If expanding its network, Applicant will also increase the proportion of Exchange enrollees receiving care in an IHM.

An IHM is defined as a system of population-based care coordinated across the continuum including multi-discipline physician practices, hospitals and ancillary providers that has combined risk sharing arrangements and incentives between Applicant and providers, holding the IHM accountable for nationally recognized evidence-based clinical, financial, and operational performance, as well as incentives for improvements in population outcomes.

19.2.4.1 Using this definition for IHMs, adapted from 2017 QHP Contract Attachment 7 https://hbex.coveredca.com/stakeholders/plan-management/PDFs/Jan-16-2018/Appendix-H-2017-QHP-Issuer-Contract-Attachment-7.pdf, report the number and percentage of Exchange members and total California members who are managed under an IHM in Attachment E QIS Run Charts. For currently contracted Applicants, enter the percentage reported in the Certification Application for 2017, 2018 and 2019 as well. If Applicant did not have Exchange business during the prior calendar year, report on the full book of business.

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

Attached Document(s): Attachment E QIS Run Charts.xlsx

19.2.4.2 Provide as attachments the following documents related to IHMs:

(File titled Provider 1a): Applicant's IHM business model including measures used to track progress and success of IHM providers and the payment model for the IHM.	*Single, Pull-down list.* 1: Attached, 2: Not attached
(File titled Provider 1b): Example of Applicant report to its IHM providers on its quality of care and financial performance, including benchmarking relative to performance improvement goals or market norms.	*Single, Pull-down list.* 1: Attached, 2: Not attached
(File titled Provider 1c): Copy of Applicant's IHA Align Measure Perform (AMP) Commercial ACO report (formerly known as the IHA-PBGH Commercial ACO Measurement & Benchmarking Initiative), if Applicant participates in the	*Single, Pull-down list.* 1: Attached,

program. As noted in Attachment 7, Section 4.03, 4), the Exchange will use the Commercial ACO Measure Set as updated by the IHA as the basis for analysis of variation in performance of different ACO or IHM models, beginning in plan year 2018.	2: Not attached, 3: N/A

19.2.4.3 Describe updates on progress made since the previous QIS submission on each component of the IHM goals, and planned activities. Applicant may submit any supporting documentation as an attachment. Address each of the following in the narrative:

- Progress in 2018 toward the end goal and any further implementation plans for 2019 with milestones for 2019 and 2020 identified.
- How Applicant expects to evolve its model, based on progress or outcomes to date.
- Other activities conducted since the previous QIS submission to promote IHMs, or activities that will be conducted.
- Known or anticipated barriers in implementation of QIS and progress of mitigation activities.

1000 words.

19.2.4.4 Describe how Applicant is providing support for integration and coordination of care through coaching, funding, implementation of information systems, technical assistance, or other means where no provider organization is accepting accountability.

200 words.

19.2.5 QIS for Appropriate Use of Cesarean Sections

Federal QIS Topic Area: Activities for improving health outcomes

2017 QHP Issuer Contract Attachment 7, Section 5.03

QIS Goal: Applicant will: 1) Progressively adopt physician and hospital payment strategies so that revenue for labor and delivery only supports medically necessary care and no financial incentive exists to perform a low-risk Nulliparous Term Singleton Vertex (NTSV) Cesarean Section (C-Section). 2) Promote improvement work through the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center (MDC), so that all maternity hospitals achieve an NTSV C-Section rate of 23.9% or lower or are at least working toward that goal. 3) Include NTSV C-Section rate into contracting criteria so that all hospitals either meet the 23.9% goal, or if not, the plan has rationale for continued inclusion.

19.2.5.1 Report number of all network hospitals reporting to the CMQCC's MDC in Attachment E QIS Run Charts. A list of all California hospitals participating in the MDC can be found here: https://www.cmqcc.org/sites/default/files/CMQCC_County_Participation_List_12.04.17.pdf. Enter the percentage reported in the Certification Applications for 2017, 2018 and 2019 as well.

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

19.2.5.2 Provide a description of all current payment models for maternity services across all lines of business, and specifically address whether payment differs based on vaginal or C-Section delivery. Report models and number of network hospitals paid using each payment strategy in Attachment E QIS Run Charts. Enter the percentages reported in the Certification Applications for 2017, 2018 and 2019 as well.
References: http://www.iha.org/sites/default/files/files/page/c-section_menu_of_payment_and_contracting_options.pdf.

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

19.2.5.3 Describe updates on progress made since the last QIS submission with regards to promoting appropriate use of Cesarean-Sections (C-Sections). Applicant may submit any supporting documentation as an attachment. Address each of the following in the narrative:

- Progress in 2018 toward the end goal and any further implementation plans for 2019 with milestones for 2019 and 2020 identified.
- Updates to hospital participation in CMQCC and hospital engagement in maternity care quality improvement, particularly those with a NTSV rate higher than 23.9%.
- Updates as to how NTSV C-section rate or other maternal safety factors are considered in maternity hospital network.
- How Applicant is using the data from CMQCC to work with hospitals that have a NTSV C-Section rate higher than 23.9%, especially hospitals with a high volume of births.
- Collaborations with other QHP Issuers on approaching hospitals to suggest CMQCC involvement or alignment on a payment strategy to not incentivize NTSV C-Sections and support only medically necessary care.
- List any known or anticipated barriers in implementing QIS activities and progress of mitigation activities.

1000 words.

19.2.6 QIS for Hospital Patient Safety

Federal QIS Topic Area: Activities to improve patient safety and reduce medical errors

2017 QHP Issuer Contract Attachment 7, Section 5.01 and 5.02

QIS Goal: Applicant will: 1) Adopt a hospital payment methodology that places 2% of payment to acute general hospitals either at risk or subject to a bonus payment for quality performance. 2) Promote hospital involvement in improvement programs so that all hospitals achieve infection rates (measured as a standardized infection ratio or SIR) of 1.0 or lower for the five Hospital Acquired Condition (HAC) measures outlined in Attachment 7 or are working to improve. The five HACs are:

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

19.2.6.1 Report, across all lines of business, the percentage of hospital reimbursement at risk for quality performance and the quality indicators used in Attachment E QIS Run Charts. In the details section of the spreadsheet, describe the model used to put payment at risk, and note if more than one model is used. “Quality performance” includes any number or combination of indicators, including HACs, readmissions, patient satisfaction, etc. In the same sheet, report quality indicators used to assess quality performance. Enter the percentages reported in the Certification Applications for 2017, 2018 and 2019 as well.

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

Attached Document(s): Attachment E QIS Run Charts.xlsx

19.2.6.2 Report the number of hospitals contracted under the model described in question 19.2.6.1 with reimbursement at risk for quality performance in Attachment E QIS Run Charts. Enter the numbers reported in the Certification Applications for 2017, 2018 and 2019 as well.

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

Attached Document(s): Attachment E QIS Run Charts.xlsx

19.2.6.3 Describe updates on progress promoting hospital safety since the last previous submission. Applicant may submit any supporting documentation as an attachment.

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

- Information on Partnership for Patients: https://partnershipforpatients.cms.gov/
- Hospital participation in Hospital Improvement Innovation Networks (HIINs): https://partnershipforpatients.cms.gov/about-the-partnership/hospital-engagement-networks/thehospitalengagementnetworks.html
- Hospital HAC rates can be reviewed individually at http://calhospitalcompare.org/.

Address each of the following in the narrative:

- Progress in 2018 toward the end goal and any further implementation plans for 2019 with milestones for 2019 and 2020 identified.
- Updates to strategy for promoting HIIN participation among the non-participating network hospitals, especially those with a standardized infection ratio (SIR) above 1.0 for the five designated Hospital Acquired Conditions (HACs). Refer to Appendix S1 CAUTI Rates, Appendix S2 CLABSI Rates, Appendix S3 CDI Rates, Appendix S4 MRSA Rates, and Appendix S5 SSI Colon Rates.

- Updates on efforts to re-contract hospital payments placing 2% either at risk or subject to a bonus payment for quality performance.
- Collaborations with other QHP Issuers on approaching hospitals to suggest improvement program involvement or alignment on a payment strategy to tie hospital payment to quality.

1000 words.

Attached Document(s): Appendix S5 SSI Colon Rates.pdf, Appendix S4 MRSA Rates.pdf, Appendix S3 CDI Rates.pdf, Appendix S2 CLABSI Rates.pdf, Appendix S1 CAUTI Rates.pdf

19.2.7 QIS for Patient-Centered Information and Support

Federal QIS Topic Area: Activities for improving health outcomes

2017 QHP Issuer Contract Attachment 7, Sections 7.01 and 7.02

QIS Goal: Applicant can supply consumers with 1) provider-specific cost shares for common inpatient, outpatient and ambulatory services, 2) costs of prescription drugs, 3) member specific real-time understanding of accumulations toward deductibles, maximum out of pockets, and 4) quality information on network providers.

19.2.7.1 Fulfilling the QIS Requirement: Respond as applicable based on anticipated Exchange enrollment:

If Applicant has or anticipates having Exchange enrollment more than100,000 members, describe plans to ensure, members will have online access to:

1) Provider specific cost shares for common inpatient, outpatient and ambulatory services, (either as a procedure or as an episode of care). (*Waived for Applicants with only HMO products*.)

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

If Applicant has or anticipates having Exchange enrollment of fewer than 100,000 members, describe how Applicant will ensure, members have access to:

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

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

If confirmed, questions 19.2.7.2 and 19.2.7.3 are not required.

Single, Radio group.
1: Confirm Applicant continues to meet this requirement and there have been no changes since previous Application for Certification.,
2: Not Confirmed, details: [100 words]

19.2.7.2 If Applicant offers online consumer support tools that require login, provide sample login information. If Applicant is unable to provide sample login access, submit screenshots as attachment(s) to this question.

50 words.

19.2.7.3 Describe any quality information currently included with cost information. If quality information is not included, describe feasibility for inclusion by 2020.

200 words.

19.2.7.4 If Applicant has cost tools available to members, report number and percent of unique enrollees for the Exchange line of business who used the tool in 2018.

100 words.

19.2.7.5 Based on the utilization reported in 19.2.7.4, how does Applicant intend to increase or maintain engagement with the tool.

200 words.

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

19.3.1 QIS for Provider Networks Based on Quality

Federal QIS Topic Area: Activities to improve patient safety and reduce medical errors

2017 QHP Issuer Contract Attachment 7, Section 1.02

QIS Goal: Applicant should have 1) clear network quality criteria that are used to screen providers and hospitals for inclusion in network, and 2) possible removal of outliers based on inability to meet quality criteria or lack of effort toward improvement.

19.3.1.1 Submit as attachments the following documents related to use of quality criteria in network contracting:

(File titled Provider Network): All quality measures and criteria used to develop provider networks. Include patient safety and patient-reported experience (noting any measures that are new). An explanation of the assessment process, including source of quality assessment data, specific measures and metrics, and thresholds for inclusion and exclusion in the network. If applicable, describe which criteria are prioritized above other criteria to determine the provider network.	*Single, Pull-down list.* 1: Attached, 2: Not attached

(File titled Hospital Network): All quality measures and criteria used to develop hospital networks. Include patient safety and patient-reported experience (noting any measures that are new). An explanation of the assessment process, including source of quality assessment data, specific measures and metrics, and thresholds for inclusion and exclusion in the network. If applicable, describe which criteria are prioritized above other criteria to determine the hospital network.	*Single, Pull-down list.* 1: Attached, 2: Not attached

19.3.1.2 Describe updates in Applicant's ability to build networks based on quality since the previous QIS submission. Applicant may submit any supporting documentation as an attachment. Address each of the following in the narrative:

- Progress in 2018 toward the end goal and any further implementation plans for 2019 with milestones for 2019 and 2020 identified.
- Known or anticipated barriers in implementing QIS activities and progress of mitigation activities.

500 words.

19.3.1.3 Describe if Applicant includes Centers of Excellence in network, the basis for inclusion, how they are promoted among members and how utilization is tracked.
Submit an attachment that lists the providers, hospitals and facilities the Applicant uses as Centers of Excellence. For each facility, indicate the condition(s) (cancer, transplants, burns, etc.) for which the facility is used as a Center of Excellence.

Attachment required

Single, Radio group.
1: Yes, COE List attached, describe: [200 words] ,
2: Not attached

19.3.2 QIS for Reducing Health Disparities and Ensuring Health Equity

Federal QIS Topic Area: Activities to reduce health and health care disparities.

2017 QHP Issuer Contract Attachment 7, Section 3.01 and 3.02

QIS Goal: Applicant will 1) continue to achieve 80% of Exchange members self-reporting their race/ethnicity, 2) collect, track, trend, and reduce health disparities in management of diabetes, asthma, hypertension, and depression.

19.3.2.1 Provide the percent of Exchange members for whom self-reported data is captured for race/ethnicity in Attachment E QIS Run Charts. Self-identification may take place through the enrollment application, web site registration, health assessment, reported at provider site, etc. The percentage should exclude members who have "declined to state" either actively or passively. Enter the percentage reported in the Certification Applications for 2017, 2018 and 2019 as well.

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

19.3.2.2 Describe progress on increasing or maintaining the percent of Exchange members who self-report race/ethnic information. Applicant may submit any supporting documentation as an attachment. Address each of the following in the narrative:

- Updates in efforts to increase self-reported race/ethnic information including whether there are barriers to self-report.
- Update if or how the Rand proxy method using geocoding and surname is used to supplement self-report.
- Any plans to implement or test new programs to increase self-identification.

500 words.

19.3.2.3 Confirm Applicant submitted a quality improvement plan to address health care disparities on March 1, 2019 to the Exchange. Quality Improvement Plan must include the following components:

- Description of the health care disparity
- Rationale for the QI plan
- Targeted population
- Data from at least three years demonstrating the disparity
- Proposed intervention. Include the following:
    - Evidence basis for the intervention
    - Planned resources (staff, infrastructure, IT, etc.)
    - Evaluation methods

Expected year-over-year improvement: Include baseline measurements (MY 2015-2017) and expected performance if the intervention is effective

Single, Pull-down list.
1: Submitted,
2: Not submitted

19.3.3 QIS for Promoting Development and Use of Care Models - Primary Care

Federal QIS Topic Area: Activities for improving health outcomes

2017 QHP Issuer Contract Attachment 7, Sections 4.01 and 4.02

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

19.3.3.1 Report, by product, the percentage of members in Applicant's Exchange business who either selected a Primary Care Physician (PCP) or were matched with a Primary Care Physician in 2018 in Attachment E QIS Run Charts. If Applicant had no Exchange business in 2018, report full book of business excluding Medicare. Enter the percentage reported in the

Certification Applications for 2017, 2018 and 2019 as well. Report data by product (HMO, PPO, EPO).

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

19.3.3.2 Report the number and percentage of Exchange members who obtain their primary care with a provider or clinic that has received PCMH recognition from NCQA, The Joint Commission, or the Accreditation Association for Ambulatory Health Care (AAAHC) in Attachment E QIS Run Charts. For currently contracted Applicants, enter the percentage reported in the Certification Application for 2018 and 2019 as well. If Applicant did not have Exchange business during the prior calendar year, report on the full book of business.

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

19.3.3.3 Report all types of payment methods, including fee for service (FFS) and capitation, used for primary care services and number of providers paid under each model in Attachment E QIS Run Charts. If Applicant has adopted a model consistent with a Level 3 or 4 alternative payment model (APM) as outlined in the Health Care Payment Learning Action & Action Network (HCP LAN) Draft White Paper on Primary Care Payment Models or aligned with Center for Medicare & Medicaid's (CMMI's) Comprehensive Primary Care Plus program as part of its strategy to advance primary care in California, include a description of the model, including any alternative payments such as care management fees and payments based on quality, in the attachment. Applicants may include any newly adopted models that are planned or in progress but not yet implemented among providers (include timeline for beginning the payment model). Enter the number and percentage of providers paid under each model reported in the Certification Applications for 2017, 2018 and 2019 as well.
References:
HCP LAN Primary Care Payment Models Draft White Paper: http://hcp-lan.org/workproducts/pcpm-whitepaper-draft.pdf
CMMI Comprehensive Primary Care Plus:
https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus

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

19.3.3.4 Describe updates on progress made since the previous QIS submission in each part of the primary care goals, and planned activities. Applicant may submit any supporting documentation as an attachment. Address each of the following in the narrative:

- Updates in year three of the PCP matching initiative, including an implementation status report, feedback on the consumer experience, complaints, positive feedback, unanticipated challenges, and suggestions (if applicable). If contracted physician organizations have made progress in adopting Level 3 or 4 APMs described in the

LAN Draft White Paper (above). Describe the predominant payment structure used among contracted groups and their progress towards implementing APMs (if applicable). Describe any support (financial, staffing, educational, etc.) that Applicant or multi-insurer collaborative is providing to primary care providers to support their efforts towards accessible, data-driven, team-based care.

- How Applicant is encouraging enrollees to use PCMH-recognized providers or accessible, data-driven, team-based care providers.
- Progress in 2018 toward the end goal and any further implementation plans for 2019 with milestones for 2019 and 2020 identified

Known or anticipated barriers in implementing QIS activities and progress of mitigation activities

1000 words.

19.3.3.5 What other innovative methods is Applicant considering for increasing support for primary care providers, such as increasing the percent of revenue or premium allocated towards primary care services? Describe.

200 words.

19.3.4 QIS for Promoting Development and Use of Care Models - Integrated Healthcare Models (IHM)

Federal QIS Topic Area: Activities for improving health outcomes

2017 QHP Issuer Contract Attachment 7, Section 4.03

QIS Goal: Applicant will increase IHM presence in its Exchange network by providing various types of support to providers to elevate their processes and practice toward this goal. If expanding its network, Applicant will also increase the proportion of Exchange enrollees receiving care in an IHM.

An IHM is defined as a system of population-based care coordinated across the continuum including multi-discipline physician practices, hospitals and ancillary providers that has combined risk sharing arrangements and incentives between Applicant and providers, holding the IHM accountable for nationally recognized evidence-based clinical, financial, and operational performance, as well as incentives for improvements in population outcomes.

19.3.4.1 Using this definition for IHMs, adapted from 2017 QHP Contract Attachment 7 https://hbex.coveredca.com/stakeholders/plan-management/PDFs/Jan-16-2018/Appendix-H-2017-QHP-Issuer-Contract-Attachment-7.pdf, report the number and percentage of Exchange members and total California members who are managed under an IHM in Attachment E QIS Run Charts. For currently contracted Applicants, enter the percentage reported in the Certification Application for 2017, 2018 and 2019 as well. If Applicant did not have Exchange business during the prior calendar year, report on the full book of business.

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

19.3.4.2 Provide as attachments the following documents related to IHMs:

(File titled Provider 1a): Applicant's IHM business model including measures used to track progress and success of IHM providers and the payment model for the IHM.	*Single, Pull-down list.* 1: Attached, 2: Not attached
(File titled Provider 1b): Example of Applicant report to its IHM providers on its quality of care and financial performance, including benchmarking relative to performance improvement goals or market norms.	*Single, Pull-down list.* 1: Attached, 2: Not attached
(File titled Provider 1c): Copy of Applicant's IHA Align Measure Perform (AMP) Commercial ACO report (formerly known as the IHA-PBGH Commercial ACO Measurement & Benchmarking Initiative), if Applicant participates in the program. As noted in Attachment 7, Section 4.03, 4), the Exchange will use the Commercial ACO Measure Set as updated by the IHA as the basis for analysis of variation in performance of different ACO or IHM models, beginning in plan year 2018.	*Single, Pull-down list.* 1: Attached, 2: Not attached, 3: N/A

19.3.4.3 Describe updates on progress made since the previous QIS submission on each component of the IHM goals, and planned activities. Applicant may submit any supporting documentation as an attachment. Address each of the following in the narrative:

- Progress in 2018 toward the end goal and any further implementation plans for 2019 with milestones for 2019 and 2020 identified.
- How Applicant expects to evolve its model, based on progress or outcomes to date.
- Other activities conducted since the previous QIS submission to promote IHMs, or activities that will be conducted.
- Known or anticipated barriers in implementation of QIS and progress of mitigation activities.

1000 words.

19.3.4.4 Describe how Applicant is providing support for integration and coordination of care through coaching, funding, implementation of information systems, technical assistance, or other means where no provider organization is accepting accountability.

200 words.

19.3.5 QIS for Appropriate Use of Cesarean Sections

Federal QIS Topic Area: Activities for improving health outcomes

2017 QHP Issuer Contract Attachment 7, Section 5.03

QIS Goal: Applicant will: 1) Progressively adopt physician and hospital payment strategies so that revenue for labor and delivery only supports medically necessary care and no financial incentive exists to perform a low-risk Nulliparous Term Singleton Vertex (NTSV) Cesarean Section (C-Section). 2) Promote improvement work through the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center (MDC), so that all maternity hospitals achieve an NTSV C-Section rate of 23.9% or lower or are at least working toward that goal. 3) Include NTSV C-Section rate into contracting criteria so that all hospitals either meet the 23.9% goal, or if not, the plan has rationale for continued inclusion.

19.3.5.1 Report number of all network hospitals reporting to the CMQCC's MDC in Attachment E QIS Run Charts. A list of all California hospitals participating in the MDC can be found here: https://www.cmqcc.org/sites/default/files/CMQCC_County_Participation_List_12.04.17.pdf. Enter the percentage reported in the Certification Applications for 2017, 2018 and 2019 as well.

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

19.3.5.2 Provide a description of all current payment models for maternity services across all lines of business, and specifically address whether payment differs based on vaginal or C-Section delivery. Report models and number of network hospitals paid using each payment strategy in Attachment E QIS Run Charts. Enter the percentages reported in the Certification Applications for 2017, 2018 and 2019 as well.
References: http://www.iha.org/sites/default/files/files/page/c-section_menu_of_payment_and_contracting_options.pdf.

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

19.3.5.3 Describe updates on progress made since the last QIS submission with regards to promoting appropriate use of Cesarean-Sections (C-Sections). Applicant may submit any supporting documentation as an attachment. Address each of the following in the narrative:

- Progress in 2018 toward the end goal and any further implementation plans for 2019 with milestones for 2019 and 2020 identified.
- Updates to hospital participation in CMQCC and hospital engagement in maternity care quality improvement, particularly those with a NTSV rate higher than 23.9%.
- Updates as to how NTSV C-section rate or other maternal safety factors are considered in maternity hospital network.
- How Applicant is using the data from CMQCC to work with hospitals that have a NTSV C-Section rate higher than 23.9%, especially hospitals with a high volume of births.

- Collaborations with other QHP Issuers on approaching hospitals to suggest CMQCC involvement or alignment on a payment strategy to not incentivize NTSV C-Sections and support only medically necessary care.
- List any known or anticipated barriers in implementing QIS activities and progress of mitigation activities.

1000 words.

19.3.6 QIS for Hospital Patient Safety

Federal QIS Topic Area: Activities to improve patient safety and reduce medical errors

2017 QHP Issuer Contract Attachment 7, Section 5.01 and 5.02

QIS Goal: Applicant will: 1) Adopt a hospital payment methodology that places 2% of payment to acute general hospitals either at risk or subject to a bonus payment for quality performance. 2) Promote hospital involvement in improvement programs so that all hospitals achieve infection rates (measured as a standardized infection ratio or SIR) of 1.0 or lower for the five Hospital Acquired Condition (HAC) measures outlined in Attachment 7 or are working to improve. The five HACs are:

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

19.3.6.1 Report, across all lines of business, the percentage of hospital reimbursement at risk for quality performance and the quality indicators used in Attachment E QIS Run Charts. In the details section of the spreadsheet, describe the model used to put payment at risk, and note if more than one model is used. “Quality performance” includes any number or combination of indicators, including HACs, readmissions, patient satisfaction, etc. In the same sheet, report quality indicators used to assess quality performance. Enter the percentages reported in the Certification Applications for 2017, 2018 and 2019 as well.

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

Attached Document(s): Attachment E QIS Run Charts.xlsx

19.3.6.2 Report the number of hospitals contracted under the model described in question 19.2.6.1 with reimbursement at risk for quality performance in Attachment E QIS Run Charts. Enter the numbers reported in the Certification Applications for 2017, 2018 and 2019 as well.

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

Attached Document(s): Attachment E QIS Run Charts.xlsx

19.3.6.3 Describe updates on progress promoting hospital safety since the last previous submission. Applicant may submit any supporting documentation as an attachment.

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

- Information on Partnership for Patients: https://partnershipforpatients.cms.gov/
- Hospital participation in Hospital Improvement Innovation Networks (HIINs): https://partnershipforpatients.cms.gov/about-the-partnership/hospital-engagement-networks/thehospitalengagementnetworks.html
- Hospital HAC rates can be reviewed individually at http://calhospitalcompare.org/.

Address each of the following in the narrative:

- Progress in 2018 toward the end goal and any further implementation plans for 2019 with milestones for 2019 and 2020 identified.
- Updates to strategy for promoting HIIN participation among the non-participating network hospitals, especially those with a standardized infection ratio (SIR) above 1.0 for the five designated Hospital Acquired Conditions (HACs). Refer to Appendix S1 CAUTI Rates, Appendix S2 CLABSI Rates, Appendix S3 CDI Rates, Appendix S4 MRSA Rates, and Appendix S5 SSI Colon Rates.
- Updates on efforts to re-contract hospital payments placing 2% either at risk or subject to a bonus payment for quality performance.
- Collaborations with other QHP Issuers on approaching hospitals to suggest improvement program involvement or alignment on a payment strategy to tie hospital payment to quality.

1000 words.

Attached Document(s): Appendix S5 SSI Colon Rates.pdf, Appendix S4 MRSA Rates.pdf, Appendix S3 CDI Rates.pdf, Appendix S2 CLABSI Rates.pdf, Appendix S1 CAUTI Rates.pdf

19.3.7 QIS for Patient-Centered Information and Support

Federal QIS Topic Area: Activities for improving health outcomes

2017 QHP Issuer Contract Attachment 7, Sections 7.01 and 7.02

QIS Goal: Applicant can supply consumers with 1) provider-specific cost shares for common inpatient, outpatient and ambulatory services, 2) costs of prescription drugs, 3) member specific real-time understanding of accumulations toward deductibles, maximum out of pockets, and 4) quality information on network providers.

19.3.7.1 Fulfilling the QIS Requirement: Respond as applicable based on anticipated Exchange enrollment:

If Applicant has or anticipates having Exchange enrollment more than100,000 members, describe plans to ensure, members will have online access to:

1) Provider specific cost shares for common inpatient, outpatient and ambulatory services, (either as a procedure or as an episode of care). (*Waived for Applicants with only HMO products*.)

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

If Applicant has or anticipates having Exchange enrollment of fewer than 100,000 members, describe how Applicant will ensure, members have access to:

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

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

If confirmed, questions 19.3.7.2 and 19.3.7.3 are not required.

Single, Radio group.
1: Confirm Applicant continues to meet this requirement and there have been no changes since previous Application for Certification.,
2: Not Confirmed, details: [100 words]

19.3.7.2 If Applicant offers online consumer support tools that require login, provide sample login information. If Applicant is unable to provide sample login access, submit screenshots as attachment(s) to this question.

50 words.

19.3.7.3 Describe any quality information currently included with cost information. If quality information is not included, describe feasibility for inclusion by 2020.

200 words.

19.3.7.4 If Applicant has cost tools available to members, report number and percent of unique enrollees for the Exchange line of business who used the tool in 2018.

100 words.

19.3.7.5 Based on the utilization reported in 19.3.7.4, how does Applicant intend to increase or maintain engagement with the tool.

200 words.

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

19.4.1 QIS for Provider Networks Based on Quality

Federal QIS Topic Area: Activities to improve patient safety and reduce medical errors

2017 QHP Issuer Contract Attachment 7, Section 1.02

QIS Goal: Applicant should have 1) clear network quality criteria that are used to screen providers and hospitals for inclusion in network, and 2) possible removal of outliers based on inability to meet quality criteria or lack of effort toward improvement.

19.4.1.1 Submit as attachments the following documents related to use of quality criteria in network contracting:

(File titled Provider Network): All quality measures and criteria used to develop provider networks. Include patient safety and patient-reported experience (noting any measures that are new). An explanation of the assessment process, including source of quality assessment data, specific measures and metrics, and thresholds for inclusion and exclusion in the network. If applicable, describe which criteria are prioritized above other criteria to determine the provider network.	*Single, Pull-down list.* 1: Attached, 2: Not attached
(File titled Hospital Network): All quality measures and criteria used to develop hospital networks. Include patient safety and patient-reported experience (noting any measures that are new). An explanation of the assessment process, including source of quality assessment data, specific measures and metrics, and thresholds for inclusion and exclusion in the network. If applicable, describe which criteria are prioritized above other criteria to determine the hospital network.	*Single, Pull-down list.* 1: Attached, 2: Not attached

19.4.1.2 Describe updates in Applicant's ability to build networks based on quality since the previous QIS submission. Applicant may submit any supporting documentation as an attachment. Address each of the following in the narrative:

- Progress in 2018 toward the end goal and any further implementation plans for 2019 with milestones for 2019 and 2020 identified.
- Known or anticipated barriers in implementing QIS activities and progress of mitigation activities.

500 words.

19.4.1.3 Describe if Applicant includes Centers of Excellence in network, the basis for inclusion, how they are promoted among members and how utilization is tracked. Submit an attachment that lists the providers, hospitals and facilities the Applicant uses as Centers of Excellence. For each facility, indicate the condition(s) (cancer, transplants, burns, etc.) for which the facility is used as a Center of Excellence.

Attachment required

Single, Radio group.
1: Yes, COE List attached, describe: [200 words] ,
2: Not attached

19.4.2 QIS for Reducing Health Disparities and Ensuring Health Equity

Federal QIS Topic Area: Activities to reduce health and health care disparities.

2017 QHP Issuer Contract Attachment 7, Section 3.01 and 3.02

QIS Goal: Applicant will 1) continue to achieve 80% of Exchange members self-reporting their race/ethnicity, 2) collect, track, trend, and reduce health disparities in management of diabetes, asthma, hypertension, and depression.

19.4.2.1 Provide the percent of Exchange members for whom self-reported data is captured for race/ethnicity in Attachment E QIS Run Charts. Self-identification may take place through the enrollment application, web site registration, health assessment, reported at provider site, etc. The percentage should exclude members who have “declined to state” either actively or passively. Enter the percentage reported in the Certification Applications for 2017, 2018 and 2019 as well.

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

19.4.2.2 Describe progress on increasing or maintaining the percent of Exchange members who self-report race/ethnic information. Applicant may submit any supporting documentation as an attachment. Address each of the following in the narrative:

- Updates in efforts to increase self-reported race/ethnic information including whether there are barriers to self-report.
- Update if or how the Rand proxy method using geocoding and surname is used to supplement self-report.
- Any plans to implement or test new programs to increase self-identification.

500 words.

19.4.2.3 Confirm Applicant submitted a quality improvement plan to address health care disparities on March 1, 2019 to the Exchange. Quality Improvement Plan must include the following components:

- Description of the health care disparity
- Rationale for the QI plan
- Targeted population
- Data from at least three years demonstrating the disparity
- Proposed intervention. Include the following:
    - Evidence basis for the intervention
    - Planned resources (staff, infrastructure, IT, etc.)
    - Evaluation methods

Expected year-over-year improvement: Include baseline measurements (MY 2015-2017) and expected performance if the intervention is effective

Single, Pull-down list.
1: Submitted,
2: Not submitted

19.4.3 QIS for Promoting Development and Use of Care Models - Primary Care

Federal QIS Topic Area: Activities for improving health outcomes

2017 QHP Issuer Contract Attachment 7, Sections 4.01 and 4.02

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

19.4.3.1 Report, by product, the percentage of members in Applicant's Exchange business who either selected a Primary Care Physician (PCP) or were matched with a Primary Care Physician in 2018 in Attachment E QIS Run Charts. If Applicant had no Exchange business in 2018, report full book of business excluding Medicare. Enter the percentage reported in the Certification Applications for 2017, 2018 and 2019 as well. Report data by product (HMO, PPO, EPO).

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

19.4.3.2 Report the number and percentage of Exchange members who obtain their primary care with a provider or clinic that has received PCMH recognition from NCQA, The Joint Commission, or the Accreditation Association for Ambulatory Health Care (AAAHC) in Attachment E QIS Run Charts. For currently contracted Applicants, enter the percentage reported in the Certification Application for 2018 and 2019 as well. If Applicant did not have Exchange business during the prior calendar year, report on the full book of business.

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

19.4.3.3 Report all types of payment methods, including fee for service (FFS) and capitation, used for primary care services and number of providers paid under each model in Attachment E QIS Run Charts. If Applicant has adopted a model consistent with a Level 3 or 4 alternative payment model (APM) as outlined in the Health Care Payment Learning Action & Action Network (HCP LAN) Draft White Paper on Primary Care Payment Models or aligned with Center for Medicare & Medicaid's (CMMI's) Comprehensive Primary Care Plus program as part of its strategy to advance primary care in California, include a description of the model, including any alternative payments such as care management fees and payments based on quality, in the attachment. Applicants may include any newly adopted models that are planned or in progress but not yet implemented among providers (include timeline for beginning the payment model). Enter the number and percentage of providers paid under each model reported in the Certification Applications for 2017, 2018 and 2019 as well.
References:

HCP LAN Primary Care Payment Models Draft White Paper: http://hcp-lan.org/workproducts/pcpm-whitepaper-draft.pdf
CMMI Comprehensive Primary Care Plus: https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus

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

19.4.3.4 Describe updates on progress made since the previous QIS submission in each part of the primary care goals, and planned activities. Applicant may submit any supporting documentation as an attachment. Address each of the following in the narrative:

- Updates in year three of the PCP matching initiative, including an implementation status report, feedback on the consumer experience, complaints, positive feedback, unanticipated challenges, and suggestions (if applicable). If contracted physician organizations have made progress in adopting Level 3 or 4 APMs described in the LAN Draft White Paper (above). Describe the predominant payment structure used among contracted groups and their progress towards implementing APMs (if applicable). Describe any support (financial, staffing, educational, etc.) that Applicant or multi-insurer collaborative is providing to primary care providers to support their efforts towards accessible, data-driven, team-based care.
- How Applicant is encouraging enrollees to use PCMH-recognized providers or accessible, data-driven, team-based care providers.
- Progress in 2018 toward the end goal and any further implementation plans for 2019 with milestones for 2019 and 2020 identified

Known or anticipated barriers in implementing QIS activities and progress of mitigation activities

1000 words.

19.4.3.5 What other innovative methods is Applicant considering for increasing support for primary care providers, such as increasing the percent of revenue or premium allocated towards primary care services? Describe.

200 words.

19.4.4 QIS for Promoting Development and Use of Care Models - Integrated Healthcare Models (IHM)

Federal QIS Topic Area: Activities for improving health outcomes

2017 QHP Issuer Contract Attachment 7, Section 4.03

QIS Goal: Applicant will increase IHM presence in its Exchange network by providing various types of support to providers to elevate their processes and practice toward this goal. If expanding its network, Applicant will also increase the proportion of Exchange enrollees receiving care in an IHM.

An IHM is defined as a system of population-based care coordinated across the continuum including multi-discipline physician practices, hospitals and ancillary providers that has combined risk sharing arrangements and incentives between Applicant and providers, holding the IHM accountable for nationally recognized evidence-based clinical, financial, and operational performance, as well as incentives for improvements in population outcomes.

19.4.4.1 Using this definition for IHMs, adapted from 2017 QHP Contract Attachment 7 https://hbex.coveredca.com/stakeholders/plan-management/PDFs/Jan-16-2018/Appendix-H-2017-QHP-Issuer-Contract-Attachment-7.pdf, report the number and percentage of Exchange members and total California members who are managed under an IHM in Attachment E QIS Run Charts. For currently contracted Applicants, enter the percentage reported in the Certification Application for 2017, 2018 and 2019 as well. If Applicant did not have Exchange business during the prior calendar year, report on the full book of business.

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

19.4.4.2 Provide as attachments the following documents related to IHMs:

(File titled Provider 1a): Applicant's IHM business model including measures used to track progress and success of IHM providers and the payment model for the IHM.	*Single, Pull-down list.* 1: Attached, 2: Not attached
(File titled Provider 1b): Example of Applicant report to its IHM providers on its quality of care and financial performance, including benchmarking relative to performance improvement goals or market norms.	*Single, Pull-down list.* 1: Attached, 2: Not attached
(File titled Provider 1c): Copy of Applicant's IHA Align Measure Perform (AMP) Commercial ACO report (formerly known as the IHA-PBGH Commercial ACO Measurement & Benchmarking Initiative), if Applicant participates in the program. As noted in Attachment 7, Section 4.03, 4), the Exchange will use the Commercial ACO Measure Set as updated by the IHA as the basis for analysis of variation in performance of different ACO or IHM models, beginning in plan year 2018.	*Single, Pull-down list.* 1: Attached, 2: Not attached, 3: N/A

19.4.4.3 Describe updates on progress made since the previous QIS submission on each component of the IHM goals, and planned activities. Applicant may submit any supporting documentation as an attachment. Address each of the following in the narrative:

- Progress in 2018 toward the end goal and any further implementation plans for 2019 with milestones for 2019 and 2020 identified.

- How Applicant expects to evolve its model, based on progress or outcomes to date.
- Other activities conducted since the previous QIS submission to promote IHMs, or activities that will be conducted.
- Known or anticipated barriers in implementation of QIS and progress of mitigation activities.

1000 words.

19.4.4.4 Describe how Applicant is providing support for integration and coordination of care through coaching, funding, implementation of information systems, technical assistance, or other means where no provider organization is accepting accountability.

200 words.

19.4.5 QIS for Appropriate Use of Cesarean Sections

Federal QIS Topic Area: Activities for improving health outcomes

2017 QHP Issuer Contract Attachment 7, Section 5.03

QIS Goal: Applicant will: 1) Progressively adopt physician and hospital payment strategies so that revenue for labor and delivery only supports medically necessary care and no financial incentive exists to perform a low-risk Nulliparous Term Singleton Vertex (NTSV) Cesarean Section (C-Section). 2) Promote improvement work through the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center (MDC), so that all maternity hospitals achieve an NTSV C-Section rate of 23.9% or lower or are at least working toward that goal. 3) Include NTSV C-Section rate into contracting criteria so that all hospitals either meet the 23.9% goal, or if not, the plan has rationale for continued inclusion.

19.4.5.1 Report number of all network hospitals reporting to the CMQCC's MDC in Attachment E QIS Run Charts. A list of all California hospitals participating in the MDC can be found here: https://www.cmqcc.org/sites/default/files/CMQCC_County_Participation_List_12.04.17.pdf. Enter the percentage reported in the Certification Applications for 2017, 2018 and 2019 as well.

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

19.4.5.2 Provide a description of all current payment models for maternity services across all lines of business, and specifically address whether payment differs based on vaginal or C-Section delivery. Report models and number of network hospitals paid using each payment strategy in Attachment E QIS Run Charts. Enter the percentages reported in the Certification Applications for 2017, 2018 and 2019 as well.
References: http://www.iha.org/sites/default/files/files/page/c-section_menu_of_payment_and_contracting_options.pdf.

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

19.4.5.3 Describe updates on progress made since the last QIS submission with regards to promoting appropriate use of Cesarean-Sections (C-Sections). Applicant may submit any supporting documentation as an attachment. Address each of the following in the narrative:

- Progress in 2018 toward the end goal and any further implementation plans for 2019 with milestones for 2019 and 2020 identified.
- Updates to hospital participation in CMQCC and hospital engagement in maternity care quality improvement, particularly those with a NTSV rate higher than 23.9%.
- Updates as to how NTSV C-section rate or other maternal safety factors are considered in maternity hospital network.
- How Applicant is using the data from CMQCC to work with hospitals that have a NTSV C-Section rate higher than 23.9%, especially hospitals with a high volume of births.
- Collaborations with other QHP Issuers on approaching hospitals to suggest CMQCC involvement or alignment on a payment strategy to not incentivize NTSV C-Sections and support only medically necessary care.
- List any known or anticipated barriers in implementing QIS activities and progress of mitigation activities.

1000 words.

19.4.6 QIS for Hospital Patient Safety

Federal QIS Topic Area: Activities to improve patient safety and reduce medical errors
2017 QHP Issuer Contract Attachment 7, Section 5.01 and 5.02

QIS Goal: Applicant will: 1) Adopt a hospital payment methodology that places 2% of payment to acute general hospitals either at risk or subject to a bonus payment for quality performance. 2) Promote hospital involvement in improvement programs so that all hospitals achieve infection rates (measured as a standardized infection ratio or SIR) of 1.0 or lower for the five Hospital Acquired Condition (HAC) measures outlined in Attachment 7 or are working to improve. The five HACs are:

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

19.4.6.1 Report, across all lines of business, the percentage of hospital reimbursement at risk for quality performance and the quality indicators used in Attachment E QIS Run Charts. In the details section of the spreadsheet, describe the model used to put payment at risk, and note if more than one model is used. “Quality performance” includes any number or combination of indicators, including HACs, readmissions, patient satisfaction, etc. In the same sheet, report quality indicators used to assess quality performance. Enter the percentages reported in the Certification Applications for 2017, 2018 and 2019 as well.

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

Attached Document(s): Attachment E QIS Run Charts.xlsx

19.4.6.2 Report the number of hospitals contracted under the model described in question 19.2.6.1 with reimbursement at risk for quality performance in Attachment E QIS Run Charts. Enter the numbers reported in the Certification Applications for 2017, 2018 and 2019 as well.

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

Attached Document(s): Attachment E QIS Run Charts.xlsx

19.4.6.3 Describe updates on progress promoting hospital safety since the last previous submission. Applicant may submit any supporting documentation as an attachment.

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

- Information on Partnership for Patients: https://partnershipforpatients.cms.gov/
- Hospital participation in Hospital Improvement Innovation Networks (HIINs): https://partnershipforpatients.cms.gov/about-the-partnership/hospital-engagement-networks/thehospitalengagementnetworks.html
- Hospital HAC rates can be reviewed individually at http://calhospitalcompare.org/.

Address each of the following in the narrative:

- Progress in 2018 toward the end goal and any further implementation plans for 2019 with milestones for 2019 and 2020 identified.
- Updates to strategy for promoting HIIN participation among the non-participating network hospitals, especially those with a standardized infection ratio (SIR) above 1.0 for the five designated Hospital Acquired Conditions (HACs). Refer to Appendix S1 CAUTI Rates, Appendix S2 CLABSI Rates, Appendix S3 CDI Rates, Appendix S4 MRSA Rates, and Appendix S5 SSI Colon Rates.
- Updates on efforts to re-contract hospital payments placing 2% either at risk or subject to a bonus payment for quality performance.
- Collaborations with other QHP Issuers on approaching hospitals to suggest improvement program involvement or alignment on a payment strategy to tie hospital payment to quality.

1000 words.

Attached Document(s): Appendix S5 SSI Colon Rates.pdf, Appendix S4 MRSA Rates.pdf, Appendix S3 CDI Rates.pdf, Appendix S2 CLABSI Rates.pdf, Appendix S1 CAUTI Rates.pdf

19.4.7 QIS for Patient-Centered Information and Support

Federal QIS Topic Area: Activities for improving health outcomes

2017 QHP Issuer Contract Attachment 7, Sections 7.01 and 7.02

QIS Goal: Applicant can supply consumers with 1) provider-specific cost shares for common inpatient, outpatient and ambulatory services, 2) costs of prescription drugs, 3) member specific real-time understanding of accumulations toward deductibles, maximum out of pockets, and 4) quality information on network providers.

19.4.7.1 Fulfilling the QIS Requirement: Respond as applicable based on anticipated Exchange enrollment:

If Applicant has or anticipates having Exchange enrollment more than100,000 members, describe plans to ensure, members will have online access to:

1) Provider specific cost shares for common inpatient, outpatient and ambulatory services, (either as a procedure or as an episode of care). (*Waived for Applicants with only HMO products*.)

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

If Applicant has or anticipates having Exchange enrollment of fewer than 100,000 members, describe how Applicant will ensure, members have access to:

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

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

If confirmed, questions 19.4.7.2 and 19.4.7.3 are not required.

Single, Radio group.
1: Confirm Applicant continues to meet this requirement and there have been no changes since previous Application for Certification.,
2: Not Confirmed, details: [100 words]

19.4.7.2 If Applicant offers online consumer support tools that require login, provide sample login information. If Applicant is unable to provide sample login access, submit screenshots as attachment(s) to this question.

50 words.

19.4.7.3 Describe any quality information currently included with cost information. If quality information is not included, describe feasibility for inclusion by 2020.

200 words.

19.4.7.4 If Applicant has cost tools available to members, report number and percent of unique enrollees for the Exchange line of business who used the tool in 2018.

100 words.

19.4.7.5 Based on the utilization reported in 19.4.7.4, how does Applicant intend to increase or maintain engagement with the tool.

200 words.

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

19.5.1 QIS for Provider Networks Based on Quality

Federal QIS Topic Area: Activities to improve patient safety and reduce medical errors
2017 QHP Issuer Contract Attachment 7, Section 1.02

QIS Goal: Applicant should have 1) clear network quality criteria that are used to screen providers and hospitals for inclusion in network, and 2) possible removal of outliers based on inability to meet quality criteria or lack of effort toward improvement.

19.5.1.1 Submit as attachments the following documents related to use of quality criteria in network contracting:

(File titled Provider Network): All quality measures and criteria used to develop provider networks. Include patient safety and patient-reported experience (noting any measures that are new). An explanation of the assessment process, including source of quality assessment data, specific measures and metrics, and thresholds for inclusion and exclusion in the network. If applicable, describe which criteria are prioritized above other criteria to determine the provider network.	*Single, Pull-down list.* 1: Attached, 2: Not attached
(File titled Hospital Network): All quality measures and criteria used to develop hospital networks. Include patient safety and patient-reported experience (noting any measures that are new). An explanation of the assessment process, including source of quality assessment data, specific measures and metrics, and thresholds for inclusion and exclusion in the network. If applicable, describe which criteria are prioritized above other criteria to determine the hospital network.	*Single, Pull-down list.* 1: Attached, 2: Not attached

19.5.1.2 Describe updates in Applicant's ability to build networks based on quality since the previous QIS submission. Applicant may submit any supporting documentation as an attachment. Address each of the following in the narrative:

- Progress in 2018 toward the end goal and any further implementation plans for 2019 with milestones for 2019 and 2020 identified.
- Known or anticipated barriers in implementing QIS activities and progress of mitigation activities.

500 words.

19.5.1.3 Describe if Applicant includes Centers of Excellence in network, the basis for inclusion, how they are promoted among members and how utilization is tracked.
Submit an attachment that lists the providers, hospitals and facilities the Applicant uses as Centers of Excellence. For each facility, indicate the condition(s) (cancer, transplants, burns, etc.) for which the facility is used as a Center of Excellence.

Attachment required

Single, Radio group.
1: Yes, COE List attached, describe: [200 words] ,
2: Not attached

19.5.2 QIS for Reducing Health Disparities and Ensuring Health Equity

Federal QIS Topic Area: Activities to reduce health and health care disparities.

2017 QHP Issuer Contract Attachment 7, Section 3.01 and 3.02

QIS Goal: Applicant will 1) continue to achieve 80% of Exchange members self-reporting their race/ethnicity, 2) collect, track, trend, and reduce health disparities in management of diabetes, asthma, hypertension, and depression.

19.5.2.1 Provide the percent of Exchange members for whom self-reported data is captured for race/ethnicity in Attachment E QIS Run Charts. Self-identification may take place through the enrollment application, web site registration, health assessment, reported at provider site, etc. The percentage should exclude members who have “declined to state” either actively or passively. Enter the percentage reported in the Certification Applications for 2017, 2018 and 2019 as well.

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

19.5.2.2 Describe progress on increasing or maintaining the percent of Exchange members who self-report race/ethnic information. Applicant may submit any supporting documentation as an attachment. Address each of the following in the narrative:

- Updates in efforts to increase self-reported race/ethnic information including whether there are barriers to self-report.
- Update if or how the Rand proxy method using geocoding and surname is used to supplement self-report.
- Any plans to implement or test new programs to increase self-identification.

500 words.

19.5.2.3 Confirm Applicant submitted a quality improvement plan to address health care disparities on March 1, 2019 to the Exchange. Quality Improvement Plan must include the following components:

- Description of the health care disparity

- Rationale for the QI plan
- Targeted population
- Data from at least three years demonstrating the disparity
- Proposed intervention. Include the following:
    - Evidence basis for the intervention
    - Planned resources (staff, infrastructure, IT, etc.)
    - Evaluation methods

Expected year-over-year improvement: Include baseline measurements (MY 2015-2017) and expected performance if the intervention is effective

Single, Pull-down list.
1: Submitted,
2: Not submitted

19.5.3 QIS for Promoting Development and Use of Care Models - Primary Care

Federal QIS Topic Area: Activities for improving health outcomes

2017 QHP Issuer Contract Attachment 7, Sections 4.01 and 4.02

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

19.5.3.1 Report, by product, the percentage of members in Applicant's Exchange business who either selected a Primary Care Physician (PCP) or were matched with a Primary Care Physician in 2018 in Attachment E QIS Run Charts. If Applicant had no Exchange business in 2018, report full book of business excluding Medicare. Enter the percentage reported in the Certification Applications for 2017, 2018 and 2019 as well. Report data by product (HMO, PPO, EPO).

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

19.5.3.2 Report the number and percentage of Exchange members who obtain their primary care with a provider or clinic that has received PCMH recognition from NCQA, The Joint Commission, or the Accreditation Association for Ambulatory Health Care (AAAHC) in Attachment E QIS Run Charts. For currently contracted Applicants, enter the percentage reported in the Certification Application for 2018 and 2019 as well. If Applicant did not have Exchange business during the prior calendar year, report on the full book of business.

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

19.5.3.3 Report all types of payment methods, including fee for service (FFS) and capitation, used for primary care services and number of providers paid under each model in Attachment E QIS Run Charts. If Applicant has adopted a model consistent with a Level 3 or 4 alternative

payment model (APM) as outlined in the Health Care Payment Learning Action & Action Network (HCP LAN) Draft White Paper on Primary Care Payment Models or aligned with Center for Medicare & Medicaid's (CMMI's) Comprehensive Primary Care Plus program as part of its strategy to advance primary care in California, include a description of the model, including any alternative payments such as care management fees and payments based on quality, in the attachment. Applicants may include any newly adopted models that are planned or in progress but not yet implemented among providers (include timeline for beginning the payment model). Enter the number and percentage of providers paid under each model reported in the Certification Applications for 2017, 2018 and 2019 as well.
References:
HCP LAN Primary Care Payment Models Draft White Paper: http://hcp-lan.org/workproducts/pcpm-whitepaper-draft.pdf
CMMI Comprehensive Primary Care Plus:
https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus

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

19.5.3.4 Describe updates on progress made since the previous QIS submission in each part of the primary care goals, and planned activities. Applicant may submit any supporting documentation as an attachment. Address each of the following in the narrative:

- Updates in year three of the PCP matching initiative, including an implementation status report, feedback on the consumer experience, complaints, positive feedback, unanticipated challenges, and suggestions (if applicable). If contracted physician organizations have made progress in adopting Level 3 or 4 APMs described in the LAN Draft White Paper (above). Describe the predominant payment structure used among contracted groups and their progress towards implementing APMs (if applicable). Describe any support (financial, staffing, educational, etc.) that Applicant or multi-insurer collaborative is providing to primary care providers to support their efforts towards accessible, data-driven, team-based care.
- How Applicant is encouraging enrollees to use PCMH-recognized providers or accessible, data-driven, team-based care providers.
- Progress in 2018 toward the end goal and any further implementation plans for 2019 with milestones for 2019 and 2020 identified

Known or anticipated barriers in implementing QIS activities and progress of mitigation activities

1000 words.

19.5.3.5 What other innovative methods is Applicant considering for increasing support for primary care providers, such as increasing the percent of revenue or premium allocated towards primary care services? Describe.

200 words.

19.5.4 QIS for Promoting Development and Use of Care Models - Integrated Healthcare Models (IHM)

Federal QIS Topic Area: Activities for improving health outcomes

2017 QHP Issuer Contract Attachment 7, Section 4.03

QIS Goal: Applicant will increase IHM presence in its Exchange network by providing various types of support to providers to elevate their processes and practice toward this goal. If expanding its network, Applicant will also increase the proportion of Exchange enrollees receiving care in an IHM.

An IHM is defined as a system of population-based care coordinated across the continuum including multi-discipline physician practices, hospitals and ancillary providers that has combined risk sharing arrangements and incentives between Applicant and providers, holding the IHM accountable for nationally recognized evidence-based clinical, financial, and operational performance, as well as incentives for improvements in population outcomes.

19.5.4.1 Using this definition for IHMs, adapted from 2017 QHP Contract Attachment 7 https://hbex.coveredca.com/stakeholders/plan-management/PDFs/Jan-16-2018/Appendix-H-2017-QHP-Issuer-Contract-Attachment-7.pdf, report the number and percentage of Exchange members and total California members who are managed under an IHM in Attachment E QIS Run Charts. For currently contracted Applicants, enter the percentage reported in the Certification Application for 2017, 2018 and 2019 as well. If Applicant did not have Exchange business during the prior calendar year, report on the full book of business.

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

19.5.4.2 Provide as attachments the following documents related to IHMs:

(File titled Provider 1a): Applicant's IHM business model including measures used to track progress and success of IHM providers and the payment model for the IHM.	*Single, Pull-down list.* 1: Attached, 2: Not attached
(File titled Provider 1b): Example of Applicant report to its IHM providers on its quality of care and financial performance, including benchmarking relative to performance improvement goals or market norms.	*Single, Pull-down list.* 1: Attached, 2: Not attached
(File titled Provider 1c): Copy of Applicant's IHA Align Measure Perform (AMP) Commercial ACO report (formerly known as the IHA-PBGH Commercial ACO Measurement & Benchmarking Initiative), if Applicant participates in the program.	*Single, Pull-down list.* 1: Attached, 2: Not

As noted in Attachment 7, Section 4.03, 4), the Exchange will use the Commercial ACO Measure Set as updated by the IHA as the basis for analysis of variation in performance of different ACO or IHM models, beginning in plan year 2018.	attached, 3: N/A

19.5.4.3 Describe updates on progress made since the previous QIS submission on each component of the IHM goals, and planned activities. Applicant may submit any supporting documentation as an attachment. Address each of the following in the narrative:

- Progress in 2018 toward the end goal and any further implementation plans for 2019 with milestones for 2019 and 2020 identified.
- How Applicant expects to evolve its model, based on progress or outcomes to date.
- Other activities conducted since the previous QIS submission to promote IHMs, or activities that will be conducted.
- Known or anticipated barriers in implementation of QIS and progress of mitigation activities.

1000 words.

19.5.4.4 Describe how Applicant is providing support for integration and coordination of care through coaching, funding, implementation of information systems, technical assistance, or other means where no provider organization is accepting accountability.

200 words.

19.5.5 QIS for Appropriate Use of Cesarean Sections

Federal QIS Topic Area: Activities for improving health outcomes

2017 QHP Issuer Contract Attachment 7, Section 5.03

QIS Goal: Applicant will: 1) Progressively adopt physician and hospital payment strategies so that revenue for labor and delivery only supports medically necessary care and no financial incentive exists to perform a low-risk Nulliparous Term Singleton Vertex (NTSV) Cesarean Section (C-Section). 2) Promote improvement work through the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center (MDC), so that all maternity hospitals achieve an NTSV C-Section rate of 23.9% or lower or are at least working toward that goal. 3) Include NTSV C-Section rate into contracting criteria so that all hospitals either meet the 23.9% goal, or if not, the plan has rationale for continued inclusion.

19.5.5.1 Report number of all network hospitals reporting to the CMQCC's MDC in Attachment E QIS Run Charts. A list of all California hospitals participating in the MDC can be found here: https://www.cmqcc.org/sites/default/files/CMQCC_County_Participation_List_12.04.17.pdf. Enter the percentage reported in the Certification Applications for 2017, 2018 and 2019 as well.

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

19.5.5.2 Provide a description of all current payment models for maternity services across all lines of business, and specifically address whether payment differs based on vaginal or C-Section delivery. Report models and number of network hospitals paid using each payment strategy in Attachment E QIS Run Charts. Enter the percentages reported in the Certification Applications for 2017, 2018 and 2019 as well.
References: http://www.iha.org/sites/default/files/files/page/c-section_menu_of_payment_and_contracting_options.pdf.

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

19.5.5.3 Describe updates on progress made since the last QIS submission with regards to promoting appropriate use of Cesarean-Sections (C-Sections). Applicant may submit any supporting documentation as an attachment. Address each of the following in the narrative:

- Progress in 2018 toward the end goal and any further implementation plans for 2019 with milestones for 2019 and 2020 identified.
- Updates to hospital participation in CMQCC and hospital engagement in maternity care quality improvement, particularly those with a NTSV rate higher than 23.9%.
- Updates as to how NTSV C-section rate or other maternal safety factors are considered in maternity hospital network.
- How Applicant is using the data from CMQCC to work with hospitals that have a NTSV C-Section rate higher than 23.9%, especially hospitals with a high volume of births.
- Collaborations with other QHP Issuers on approaching hospitals to suggest CMQCC involvement or alignment on a payment strategy to not incentivize NTSV C-Sections and support only medically necessary care.
- List any known or anticipated barriers in implementing QIS activities and progress of mitigation activities.

1000 words.

19.5.6 QIS for Hospital Patient Safety

Federal QIS Topic Area: Activities to improve patient safety and reduce medical errors

2017 QHP Issuer Contract Attachment 7, Section 5.01 and 5.02

QIS Goal: Applicant will: 1) Adopt a hospital payment methodology that places 2% of payment to acute general hospitals either at risk or subject to a bonus payment for quality performance. 2) Promote hospital involvement in improvement programs so that all hospitals achieve infection rates (measured as a standardized infection ratio or SIR) of 1.0 or lower for the five Hospital Acquired Condition (HAC) measures outlined in Attachment 7 or are working to improve. The five HACs are:

- Catheter Associated Urinary Tract Infections (CAUTI)
- Central Line Associated Blood Stream Infections (CLABSI)
- Clostridium Difficile Infection (CDI)

- Methicillin-resistant Staphylococcus Aureus (MRSA)
- Surgical Site Infection of the Colon (SSI Colon)

19.5.6.1 Report, across all lines of business, the percentage of hospital reimbursement at risk for quality performance and the quality indicators used in Attachment E QIS Run Charts. In the details section of the spreadsheet, describe the model used to put payment at risk, and note if more than one model is used. “Quality performance” includes any number or combination of indicators, including HACs, readmissions, patient satisfaction, etc. In the same sheet, report quality indicators used to assess quality performance. Enter the percentages reported in the Certification Applications for 2017, 2018 and 2019 as well.

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

Attached Document(s): Attachment E QIS Run Charts.xlsx

19.5.6.2 Report the number of hospitals contracted under the model described in question 19.2.6.1 with reimbursement at risk for quality performance in Attachment E QIS Run Charts. Enter the numbers reported in the Certification Applications for 2017, 2018 and 2019 as well.

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

Attached Document(s): Attachment E QIS Run Charts.xlsx

19.5.6.3 Describe updates on progress promoting hospital safety since the last previous submission. Applicant may submit any supporting documentation as an attachment.

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

- Information on Partnership for Patients: https://partnershipforpatients.cms.gov/
- Hospital participation in Hospital Improvement Innovation Networks (HIINs): https://partnershipforpatients.cms.gov/about-the-partnership/hospital-engagement-networks/thehospitalengagementnetworks.html
- Hospital HAC rates can be reviewed individually at http://calhospitalcompare.org/.

Address each of the following in the narrative:

- Progress in 2018 toward the end goal and any further implementation plans for 2019 with milestones for 2019 and 2020 identified.
- Updates to strategy for promoting HIIN participation among the non-participating network hospitals, especially those with a standardized infection ratio (SIR) above 1.0 for the five designated Hospital Acquired Conditions (HACs). Refer to Appendix S1 CAUTI Rates, Appendix S2 CLABSI Rates, Appendix S3 CDI Rates, Appendix S4 MRSA Rates, and Appendix S5 SSI Colon Rates.
- Updates on efforts to re-contract hospital payments placing 2% either at risk or subject to a bonus payment for quality performance.
- Collaborations with other QHP Issuers on approaching hospitals to suggest improvement program involvement or alignment on a payment strategy to tie hospital payment to quality.

1000 words.

Attached Document(s): Appendix S5 SSI Colon Rates.pdf, Appendix S4 MRSA Rates.pdf, Appendix S3 CDI Rates.pdf, Appendix S2 CLABSI Rates.pdf, Appendix S1 CAUTI Rates.pdf

19.5.7 QIS for Patient-Centered Information and Support

Federal QIS Topic Area: Activities for improving health outcomes

2017 QHP Issuer Contract Attachment 7, Sections 7.01 and 7.02

QIS Goal: Applicant can supply consumers with 1) provider-specific cost shares for common inpatient, outpatient and ambulatory services, 2) costs of prescription drugs, 3) member specific real-time understanding of accumulations toward deductibles, maximum out of pockets, and 4) quality information on network providers.

19.5.7.1 Fulfilling the QIS Requirement: Respond as applicable based on anticipated Exchange enrollment:

If Applicant has or anticipates having Exchange enrollment more than100,000 members, describe plans to ensure, members will have online access to:

1) Provider specific cost shares for common inpatient, outpatient and ambulatory services, (either as a procedure or as an episode of care). (*Waived for Applicants with only HMO products*.)

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

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

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

If confirmed, questions 19.5.7.2 and 19.5.7.3 are not required.

Single, Radio group.
1: Confirm Applicant continues to meet this requirement and there have been no changes since previous Application for Certification.,
2: Not Confirmed, details: [100 words]

19.5.7.2 If Applicant offers online consumer support tools that require login, provide sample login information. If Applicant is unable to provide sample login access, submit screenshots as attachment(s) to this question.

50 words.

19.5.7.3 Describe any quality information currently included with cost information. If quality information is not included, describe feasibility for inclusion by 2020.

200 words.

19.5.7.4 If Applicant has cost tools available to members, report number and percent of unique enrollees for the Exchange line of business who used the tool in 2018.

100 words.

19.5.7.5 Based on the utilization reported in 19.5.7.4, how does Applicant intend to increase or maintain engagement with the tool.

200 words.