CERTIFICATION APPLICATION
QUALIFIED HEALTH PLAN
INDIVIDUAL MARKETPLACE
PLAN YEAR 2023
DRAFT

Certification Application Qualified Health Plan Individual Market Plan Year 2023

Table of Contents

1 Application Overview

1.1 Purpose

The California Health Benefit Exchange (Covered California) is accepting applications from eligible Health Insurance Issuers (Applicants or Health Issuer) to submit proposals to offer, market, and sell Qualified Health Plans (QHPs) through Covered California beginning in 2022, for coverage effective January 1, 2023. All Health Insurance Issuers currently licensed at the time of application response submission are eligible to apply for certification of proposed Qualified Health Plans (QHPs) for Plan Year 2023. Covered California will exercise its statutory authority to selectively contract for health care coverage offered through Covered California for Plan Year 2023. Covered California reserves the right to select or reject any Applicant or to cancel this Application at any time.

1.2 Background

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

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

Covered California is guided by the following values:

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

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

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

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

Transparency: Covered California will be fully transparent in its efforts and will make opportunities available to work with consumers, providers, health plans, employers,

purchasers, government partners, and other stakeholders to solicit and incorporate feedback into decisions regarding product portfolio and contract requirements.

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

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

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

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

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

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

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

1.3 Application Evaluation and Selection

The evaluation of QHP Certification Applications will not be based on a single, strict formula; instead, the evaluation will consider the mix of health plans for each region of California that best meet the needs of consumers in that region and Covered California's goals. Covered California wants to provide an appropriate range of high-quality health plans to participants at the best

available price that is balanced with the need for consumer stability and long-term affordability. In consideration of the mission and values of Covered California, the Board of Covered California articulated guidelines for the selection and oversight of Qualified Health Plans which are used when reviewing the Applications. These guidelines are:

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

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

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

While premiums will be a key consideration, contracts will be awarded based on the determination of "best value" to Covered California 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 Covered California population. This commitment to serve Covered California population is evidenced through general cooperation with Covered California'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 Covered California and used as part of the selection criteria to offer Issuers' products on Covered California for the certification year.

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

Covered California is committed to fostering competition by offering QHPs with features that present clear choice, product, and provider network differentiation. QHP Applicants are required to adhere to Covered California's standard benefit plan designs in each region for which they submit a proposal. In addition, QHP Applicants may offer Covered California's standard Health Savings Account-eligible (HSA) High Deductible Health Plan (HDHP) designs. Applicants may choose to offer either or both Gold and Platinum standard benefit plan designs if there is differentiation between two plans in the same metal tier that is related to either product, network or both or an additional benefit explained. Covered California is interested in having Health Maintenance Organization (HMO), Exclusive Provider Organization (EPO), Preferred Provider Organization (PPO), and other products offered statewide. Within a given product design, Covered California will look for differences in network providers and the use of innovative delivery models. Under such criteria, Covered California may choose not to contract with two plans with broad overlapping networks within a rating region unless they offer different innovative delivery system or payment reform features.

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

Encourage Competition throughout the State

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

Encourage 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 Covered California is central to Covered California's mission. Responses that demonstrate an ongoing commitment to the low-income population or demonstrate a capacity to serve the cultural, linguistic and health care needs of the low-income and uninsured populations beyond the minimum requirements adopted by Covered California will receive additional consideration. Examples of demonstrated commitment include having a higher proportion of essential community providers to meet the criteria of sufficient geographic distribution, having contracts with Federally Qualified Health Centers, and supporting or investing in providers and networks that have historically served these populations to improve service delivery and integration.

Encourage Delivery System Improvement, Effective Prevention Programs and Payment Reform

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

Demonstrate Administrative Capability and Financial Solvency

Covered California will review and consider Applicant's degree of financial risk to avoid potential threats of failure which would have negative implications for continuity of patient care and for the healthcare system. Applicant's technology capability is a critical component for success for Covered California, so Applicant's technology and associated resources are heavily scrutinized as this relates to long-term sustainability for consumers. Application responses that demonstrate a commitment to the long-term success of Covered California's mission are strongly encouraged.

Encourage Robust Customer Service

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

administrative resources for Covered California consumers will receive additional consideration.

1.4 Availability

Applicant must be available immediately upon contingent certification of its plans as QHPs to start working with Covered California to establish all operational procedures necessary to integrate and interface with Covered California information systems and to provide additional information necessary for Covered California to market, enroll members, and provide health plan services effective January 1, 2023. Successful Applicants will also be required to adhere to certain provisions through their contracts with Covered California, including meeting data interface requirements with the California Healthcare Enrollment, Eligibility, and Retention System (CalHEERS). Successful Applicants must execute the QHP Issuer Contract before public announcement of contingent certification. Failure to execute the QHP Issuer Contract may preclude Applicant from offering QHPs through Covered California. The successful Applicants must be ready and able to accept enrollment as of October 1, 2022.

1.5 Application Process

The application process shall consist of the following steps:

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

1.6 Intention to Submit a Response

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

Applicant's Letter of Intent must identify the contact person for the application process, that includes an email address and telephone number. On receipt of the Letter of Intent, Covered California will issue instructions to gain access to the online Application. A Letter of Intent will be considered confidential and not available to the public. However, Covered California reserves the right to release aggregate information about all Applicants' responses. Final Applicant information is not expected to be released until the selected Issuers and QHPs are announced. Applicant information will not be released to the public but may be shared with appropriate regulators as part of the cooperative arrangement between Covered California and the regulators.

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

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

1.7 Key Action Dates

Action	Date/Time
Release of Draft Application for Public Comment	December 2021
Letters of Intent to Apply due to Covered California	February 11, 2022
Application Opens	March 1, 2022
Completed Applications Due (include the certification year proposed Rates & Networks)	April 29, 2022
Negotiations between Applicants and Covered California	June 2022
Final QHP Contingent Certification Decisions	July 2022
QHP Contract Execution	September 2022
Final QHP Certification	October 2022

1.8 Preparation of Application Response

Application responses are completed in an electronic proposal software program. Applicants will have access to a Question and Answer function within the portal and must submit questions related to the Application through this mechanism.

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

2 Administration and Attestation

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

2.1 Applicant must complete the following:

	Response
Issuer Legal Name	*10 words.*
Entity name used in consumer-facing materials or communications	*10 words.*
NAIC Company Code	*10 words.*
NAIC Group Code	*10 words.*
Regulator(s)	*10 words.*
Federal Employer ID	*10 words.*
HIOS/Issuer ID	*10 words.*
Applicant tax status	*Single, Pull-down list.* *1: Not-for-profit,* *2: For-profit*

Year Applicant was founded	*10 words.*
Years Applicant has been a licensed health issuer	*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.*
On behalf of Applicant stated above, I hereby attest that I meet the requirements in this Application and certify that the information provided on this Application and in any attachments hereto are true, complete, and accurate. I understand that Covered California may review the validity of my attestations and the information provided in response to this application and if an Applicant is selected to offer Qualified Health Plans, may decertify those Qualified Health Plans should any material information provided be found to be inaccurate. I confirm that I have the capacity to bind the issuer stated above to the terms of this Application.	
Date	*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 Covered California. The chart will identify key individual(s) who will have primary responsibility for servicing Covered California 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 Management
- Quality and Medical Management
- Enrollment and Eligibility
- Legal
- Marketing and Communications
- Information Technology
- Information Security
- Policy
- Dedicated Liaison
- Health Equity and Disparities Reduction

Single, Pull-down list.
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:

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

2.4 Applicant must attach a copy of Certificates of Insurance to verify that it maintains the following insurance:

Coverage	Amount
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 consistent with industry standards and 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 in full compliance with State law

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.

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.

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

3 Licensed and Good Standing

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

3.1 Indicate Applicant license status below:

Single, Radio group.
1: Applicant currently holds all of the proper and required licenses from the California Department of Managed Health Care to operate as a health issuer as defined herein in the commercial individual market,
2: Applicant currently holds all of the proper and required licenses from the California Department of Insurance to operate as a health issuer as defined herein in the commercial individual market,
3: Applicant is currently applying for licensure from the California Department of Managed Health Care to operate as a health issuer as defined herein in the commercial individual market. 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 Section 22 Glossary - Definition of Good Standing). If Applicant has any material disputes with the applicable health insurance regulator in the last two years, Applicant must provide notification of disputes. Covered California, in its sole discretion and in consultation with the appropriate health insurance regulator, determines what constitutes a material violation for determining Good Standing.

Single, Pull-down list.
1: Confirmed, no material disputes in the last two years
2: Not confirmed, notification of material disputes attached: [200 words]

4 Financial Requirements

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

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

200 words.

4.2 Applicant must confirm which systems it has in place to accept payment from members effective October 1 of the current year for the following premium payment types (electronic payments, debit, and credit cards for binder payments, are required):

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

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

Note: QHP issuer must accept electronic payments, such as debit and credit cards for binder payments. Electronic payment is encouraged, but not required, for payment of ongoing invoices.

200 words.

4.4 Describe how Applicant will comply (both operationally and systematically) with the federal requirement 45 CFR 156.1240(a)(2) to serve the unbanked, specifying the forms of payment available for this population for both binder and ongoing payments, and for both on-Exchange and off-Exchange lines of business. Applicant must describe any differences between payment process for the unbanked and usual payment processing procedures. Applicant must describe in detail how these types of payments are handled both in and out of their system of record.

200 words.

4.5 Applicant must confirm no fees, no charges, and no administrative fees will be imposed on any member who requests paper premium invoices for any individual products sold by Applicant in California or on any member requesting termination of coverage.

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

5 Operational Capacity

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

5.1 Issuer Operations and Account Management Support

5.1.1 Applicant must complete Attachment A1 A2 – QHP Current and Projected Enrollment for California On and Off-Exchange. Applicant must complete all data points for their lines of business (including Employer-Based coverage, Individual Market, and Government Payers) to provide current enrollment and enrollment projections. Failure to complete Attachment A1 A2 – QHP Current and Projected Enrollment will require a resubmission of the templates.

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

Attached Document(s): Attachment A1 A2 – QHP Current and Projected Enrollment

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

	Response	Description
System changes or migrations	*Single, Pull-down list.* *1: Yes* *2: No* *3: Not Applicable*	*200 words.*
Call center opening	*Single, Pull-down list.* *1: Yes* *2: No* *3: Not Applicable*	*200 words.*
Call center closings	*Single, Pull-down list.* *1: Yes* *2: No*	*200 words.*

	3: Not Applicable	
Call center relocations	*Single, Pull-down list.* *1: Yes* *2: No* *3: Not Applicable*	*200 words.*
Network re-contracting	*Single, Pull-down list.* *1: Yes* *2: No* *3: Not Applicable*	*200 words.*
Vendor changes	*Single, Pull-down list.* *1: Yes* *2: No* *3: Not Applicable*	*200 words.*
Other	*Single, Pull-down list.* *1: Yes* *2: No* *3: Not Applicable*	*200 words.*

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

	Response	Conducted outside of the United States?	Description
Billing, invoice, and collection activities	*Single, Pull-down list.* *1: Yes* *2: No*	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*
Database and/or enrollment transactions	*Single, Pull-down list.* *1: Yes* *2: No*	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*
Claims processing and invoicing	*Single, Pull-down list.* *1: Yes* *2: No*	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*
Membership/customer service	*Single, Pull-down list.* *1: Yes* *2: No*	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*
Welcome package (ID cards, member communications, etc.)	*Single, Pull-down list.* *1: Yes* *2: No*	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*
Other (specify)	*Single, Pull-down list.* *1: Yes* *2: No*	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*

5.1.4 Applicant must provide a summary of its operational capabilities. For example, enrollment system, claims, provider services, sales, etc.

100 words.

5.1.5 Indicate how frequently reviews are performed for each of the following areas:

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.*

5.2 Implementation Performance

5.2.1 Applicant must complete Attachment B - Implementation Organizational Chart and include a detailed implementation plan.

Attached Document(s): Attachment B - Implementation Organizational Chart

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

5.2.2 Applicant must submit an Open Enrollment Readiness plan. Applicant must include in their plan a timeline (dates) for communications (regulated and marketed), system and website updates and readiness, and trainings for staff and agents. If Applicant held a contract with Covered California in the past, attachment is not required but Applicant must explain in the word box.

Single, Pull-down list.
1: Yes, Attached, [200 words]
2: No, Not attached, [200 words]

5.2.3 Applicant must describe current or planned procedures for managing new Covered California enrollees. Address availability of customer service prior to coverage effective date and new member orientation services and materials. If Applicant held a contract with Covered California in the past, attachment is not required but Applicant must explain in the word box.
200 words.

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

Resource	Membership Increase (as % of Current Membership)	Resource Adjustment (specify)	Approach to Monitoring
Members Services	*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.*

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

200 words.

6 Customer Service

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

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

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

6.2 If certified, Applicant will be required to meet certain member services performance standards. Applicant must confirm during Open Enrollment Period, call center hours shall be, unless otherwise agreed by Covered California, Monday through Friday eight o'clock (8:00) a.m. to eight o'clock (8:00) p.m., and Saturday eight o'clock (8:00) a.m. to six o'clock (6:00) p.m. (Pacific Standard Time), except on holidays observed by Covered California. During non-Open Enrollment Periods, call center hours Monday through Friday eight o'clock (8:00) a.m. to six o'clock (6:00) p.m., and Saturday eight o'clock (8:00) a.m. to five o'clock (5:00) p.m. (Pacific Standard Time), however, may adjust hours as required by customer demand with prior agreement of Covered California. Describe how Applicant will modify customer service center operations and current Interactive Voice Response (IVR) system to meet Covered California required operating hours.

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

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

100 words.

6.4 Applicant must provide the ratio of Customer Service Representatives to members for teams that support Covered California business.

100 words.

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

Multi, Checkboxes.
1: Instructor-Led Training Sessions
2: Virtual Instructor-Led Training Sessions (live instructor in a virtual environment)
3: Video Training
4: Web-Based training (not Instructor-Led)
5: Self-led Review of Training Resources
6: Case-Study
7: Roleplaying
8: Shadowing
9: Observation
10: Pre-tests

11: Post-tests
12: Training Evaluations
13: Other, describe: [50 words]

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

100 words.

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

Language	Response
Arabic	*Single, Pull-down list.* *1: Yes* *2: No*
Armenian	*Single, Pull-down list.* *1: Yes* *2: No*
Cambodian	*Single, Pull-down list.* *1: Yes* *2: No*
Cantonese	*Single, Pull-down list.* *1: Yes* *2: No*
English	*Single, Pull-down list.* *1: Yes* *2: No*
Farsi	*Single, Pull-down list.* *1: Yes* *2: No*
Hmong	*Single, Pull-down list.* *1: Yes* *2: No*
Korean	*Single, Pull-down list.* *1: Yes* *2: No*
Loa	*Single, Pull-down list.* *1: Yes* *2: No*
Mandarin	*Single, Pull-down list.* *1: Yes* *2: No*
Russian	*Single, Pull-down list.* *1: Yes* *2: No*
Spanish	*Single, Pull-down list.* *1: Yes* *2: No*
Tagalog	*Single, Pull-down list.* *1: Yes* *2: No*

Vietnamese	*Single, Pull-down list.* *1: Yes* *2: No*
Other, specify	*25 words*

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

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

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

100 words.

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

Multi, Checkboxes.
1: Customer Satisfaction Surveys
2: Monitoring Social Media
3: Monitoring Call Drivers
4: Common Problems Tracking
5: Observation of Representative Calls
6: Other, describe: [50 words]
7: Applicant does not monitor consumer experience

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

50 words.

7 Sales Channels

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

7.1 Does Applicant have experience working with Insurance Agents (also referred to as Insurance Brokers or Producers)?

Single, Radio group.
1: Yes
2: No

7.2 Applicant must describe Agent of Record (AOR) policy and procedures for the individual market and must submit its AOR policy document as an attachment. Review the Covered California Agent Delegation Policy,

https://hbex.coveredca.com/toolkit/PDFs/Delegation_Change_Policy_FINAL.pdf.

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

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

	Individual Market – AOR Appointment Policy	On-Exchange Business	Off-Exchange Business
Appointment Process	Describe AOR appointment process including the application, mandatory requirements, exclusions, for agents to be appointed with Applicant. Also, include the requirements if the agent is to be appointed with a general agency contracted with Applicant.	*100 words.*	*100 words.*
Timeline	Provide the AOR appointment timeline for agents. Include how the effective date is determined for the new servicing agent and any factors that would result in a retroactive AOR change.	*100 words.*	*100 words.*
AOR Change	Provide the policy on AOR changes not requested by the agent, including the criteria and requirements that constitute AOR change.	*100 words.*	*100 words.*
AOR Change	Describe procedures used to manage AOR changes when the agent files are received electronically from an outside source. Include explanation of how changes to assignment of the Federal Employer Identification Number (FEIN) are handled.	*100 words.*	*100 words.*
AOR Change	Describe any reasons for which Applicant will not make changes to AOR for an enrollment.	*100 words.*	*100 words.*
Other	Additional comments	*100 words.*	*100 words.*

7.4 Applicant must describe and submit its current Agent of Record (AOR) Commission Schedule for the individual market in California. Note: successful Applicants will be required to use a standardized Agent commission program with levels and terms that result in the same aggregate compensation amounts to Agents, whether products are sold within or outside of Covered California. Successful Applicants may not vary Agent compensation levels by metal tier and must pay the same commission during Open and Special Enrollment for each plan year.

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

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

	Individual Market - Commission Rate	On-Exchange Business	Off-Exchange Business

Payment	Provide the policy on how commissions are paid to AOR for Individual and Family Plans (IFP) plans. What are the exclusions, if any?	*100 words.*	*100 words.*
Payment	Provide the date of payment of commission to an AOR for new member effectuated policies.	*100 words.*	*100 words.*
Payment	Describe any reasons for which Applicant will not compensate Agents for an enrollment.	*100 words.*	*100 words.*
Rate Schedule	Provide AOR Commission Rate or Schedule for a new enrollment, returning new enrollment, and a renewing enrollment. Include general agency commission, if any. In addition, Applicant is required to submit their Agent of Record (AOR) Commission Schedule as an attachment.	*100 words.*	*100 words.*
Retention Incentives	Describe any retention incentives for the AOR if the agent retains a specified number of members' policies during renewal or over a period of time.	*100 words.*	*100 words.*
Plan Product Payment	Does the compensation level vary by the Applicant's plan product (HMO, EPO, PPO, etc.)? If yes, please explain.	*100 words.*	*100 words.*
FEIN	Describe the payment process when Applicant pays an AOR commission based on the agent's Federal Employer Identification Number (FEIN) and how changes to FEIN are captured and updated. Include the change process from an agent's request to change the payment from FEIN to SSN.	*100 words.*	*100 words.*
SSN	Describe the payment process when Applicant pays an AOR commission based on the agent's Social Security Number (SSN) and how changes to SSN are captured	*100 words.*	*100 words.*

	and updated. Include the change process from an agent's request to change the payment from SSN to FEIN.		
Bonus	Describe any agent commission bonus program(s) in the individual market on or off exchange that is currently available in the 2022 benefit year or will be made available to agents for the 2023 benefit year.	*100 words.*	*100 words.*
Payment Percentage Average	Provide an estimated percentage of total premium that will be paid in total commissions inclusive of base commissions and bonuses for the 2023 benefit year. E.g. commissions account for X% of premium. Answer required.	*100 words.*	*100 words.*
Reconciliation	Describe AOR commission reconciliation and error resolution processes, include information on how Applicant resolves commission and AOR discrepancies for agents.	*100 words.*	*100 words.*
Other	Additional Comments	*100 words.*	*100 words.*

7.6 Applicant is required to provide a copy of Applicant's Individual and Family Plans Sales Team Organizational Chart as an attachment. Applicant must identify a primary point of contact for Covered California's Outreach & Sales department and include the following contact information:

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

50 words.

7.7 Agents have become an integral channel of the Applicant's enrollment: Covered California requires Applicant to have an agent services support team to provide communication and sales strategy that assists in facilitating the ease of business. Therefore, part of the strategy requires Applicant to provide support services to the agents who enroll consumers in Applicant's plan product in the Individual and Family Plan market in California. Applicant must provide a description for Agent Services. "Not Applicable" is not considered a response.

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

8 Marketing and Outreach Activities

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

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

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

8.2 Applicant must confirm that, upon contingent certification of its QHPs, it will cooperate with Covered California Marketing Department, and adhere to the Covered California Brand Style Guide https://hbex.coveredca.com/toolkit/PDFs/Brand_Style_Guide_022819_for-external-partners.pdf, (and Marketing Guidelines, if applicable) when co-branded materials are issued to Covered California enrollees. If Applicant is certified, co-branded items must be submitted in a timely manner, but no later than 10 business days before the material is used; ID cards must be submitted to Covered California at least 30 days prior to Open Enrollment.

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

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

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

8.4 Applicant must indicate their proposed marketing investment to promote enrollment in Individual and Family Plans (on and off exchange). In addition, Applicant must provide projected marketing spend allocation for acquisition versus retention efforts, open enrollment versus special enrollment periods, and brand versus direct response (DR).

Upon contingent certification, the expectation for all Applicants is to invest at least 0.6% of their individual market gross premium revenue collected (on and off exchange) on marketing during open enrollment 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 Covered California enrollee acquisition and retention. Applicant may submit any supporting documentation as an attachment.

Single, Radio group.
1: Alternate proposed marketing investment: [500 words]
2: Confirmed to meet marketing spend expectations

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

Proposed Marketing Investment:	*Dollars.*

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

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

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

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

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

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

9 Privacy and Security Requirements for Personally Identifiable Data

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

9.1 HIPAA Privacy Rule

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

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

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

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

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

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

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

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

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

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

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

9.1.6 Minimum Necessary Disclosure & Use: Unless otherwise exempted by the HIPAA Privacy Rule, Applicant must confirm that it discloses or uses only the minimum necessary PHI needed to accomplish the purpose for which the disclosure or use is being made [45 CFR §§164.502(b) & 514(d)].

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

9.1.7 Openness and Transparency: Unless otherwise exempted by the HIPAA Privacy Rule, Applicant must confirm that it currently maintains a HIPAA-compliant Notice of Privacy Practices

to ensure that enrollees are aware of their privacy-related rights and Applicant's privacy-related obligations related to the enrollee's PHI [45 CFR §§164.520(a)&(b)].

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

9.2 Safeguards

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

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

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

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

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

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

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

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

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

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

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

200 words.

10 Fraud, Waste and Abuse Detection

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

Covered California is committed to working with its QHP Issuers to minimize Fraud, Waste, and Abuse as defined in Section 22 - Glossary. The framework for managing fraud risks is detailed in Appendix A - U.S. Government Accountability Office circular GAO-15-593SP (located on the Manage Documents page). Covered California expects QHP Issuers to adopt leading practices outlined in the framework to the extent applicable. Fraud prevention is centered on integrity and expected behaviors from employees and others. All measures to detect, deter, and prevent fraud before it occurs are vital to all issuer and Covered California operations. This Certification ensures that Applicant has policies, procedures, and systems in place to prevent, detect, and respond to fraud, waste, and abuse.

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

200 words.

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

200 words.

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

200 words.

10.4 Applicant must describe policies and procedures it has in place, including details regarding withholding or recoupment of payments once fraud is detected or discovered.

200 words.

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

200 words.

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

Multi, Checkboxes.
1: Hospitals,
2: Physicians,
3: Skilled nursing,
4: Chiropractic,
5: Podiatry,
6: Behavioral Health,
7: Substance Use Disorder treatment facilities,
8: Alternative medical care,

9: Durable medical equipment Providers,
10: Pharmacy,
11: Other service Providers

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

100 words.

10.8 If applicable, Applicant must provide an explanation why any provider types not indicated in 10.7 are not typically reviewed for possible fraudulent activity.

100 words.

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

	Total Loss from Fraud Covered California book of business, if applicable.	**Total Loss from Fraud** Total Book of Business (includes non-Covered California business)	**% of Loss Recovered** Covered California book of business, if applicable.	**% of Loss Recovered** Total Book of Business (includes non-Covered California business)	**Total Dollars Recovered** Covered California book of business, if applicable.	**Total Dollars Recovered** Total Book of Business (includes non-Covered California business)
Calendar Year 2018	*Dollars.*	*Dollars.*	*Percent.*	*Percent.*	*Dollars.*	*Dollars.*
Calendar Year 2019	*Dollars.*	*Dollars.*	*Percent.*	*Percent.*	*Dollars.*	*Dollars.*
Calendar Year 2020	*Dollars.*	*Dollars.*	*Percent.*	*Percent.*	*Dollars.*	*Dollars.*

10.10 If applicable, explain any trends attributing to the total loss from fraud for Covered California book of business.

200 words.

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

200 words.

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

200 words.

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

200 words.

11 Audits

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

11.1 Based on the definition of Internal Audit Function as defined in Section 22 - Glossary, does Applicant maintain an Internal Audit Function? If yes, provide a brief description of Applicant's internal audit function's responsibilities and its reporting structure, including what oversight authority is there over the internal audit function? For example: does the internal audit function report to a board, audit committee, or executive office? Applicant must provide the Internal Audit Charter.

Single, Radio group.
1: Yes, describe: [200 words], Attached
2: No, describe: [200 words], Not attached

11.2 If Applicant answered yes to 11.1, provide a copy of the organization's list of internal audits conducted over the last three years and current year audit plan.

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

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

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

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

200 words.

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

200 words.

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

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

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

12 Electronic Data Interface (EDI)

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

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

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

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

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

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

- See Appendix B – EDI 834 Companion Guide for detailed 834 transaction specifications.
- Note: Covered California requires Applicants to sign an industry-standard agreement which establishes electronic information Covered California standards to participate in the required systems testing.

Single, Pull-down list.
1: Yes, confirmed
2: No, not confirmed
3: No, Applicant is currently operating in Covered California

12.4 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]

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

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

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

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

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

12.8 Applicant must confirm and describe how they proactively monitor, measure, and maintain its application(s) and associated database(s) to maximize system response time and performance on a regular basis and can Applicant's organization report system status on a quarterly basis? Describe below.

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

13 System for Electronic Rate and Form Filing (SERFF)

All questions are required for all Applicants. All questions should be answered at the Issuer and product level.

13.1 Applicant must populate and submit all certification year SERFF templates (Rates, Service Area, Plans and Benefits, Network ID, Prescription Drug, Plan ID Crosswalk, Supporting Documentation, and Supplemental URL Submissions) in an accurate, appropriate, and timely fashion listed in Section 1.7 - Key Dates and Appendix D - Covered California PY 2023 Individual Health Submission Guidelines.

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

Attached Document(s): Appendix D - Covered California PY 2023 Individual Health Submission Guidelines

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

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

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

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

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

errors in the instructions provided by Covered California, or changes required by Covered California or Applicant's regulator.
Single, Pull-down list.
1: Yes, confirmed
2: No, not confirmed

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

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

14 Healthcare Evidence Initiative (HEI)

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

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

The data elements required to be submitted pursuant to this application, and the resulting QHP Issuer contract, will include the personal information of enrollees and Applicant's proprietary rate information. Covered California will, and is required by law, to protect and maintain the confidentiality of this information, which shall at all times be subject to the same stringent 350-plus security and privacy-related requirements as other personal information within Covered California's custody or control.

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

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

Pharmacy	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*
Drug (non-Pharmacy)	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*
Dental	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*
Mental Health	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*
Vision	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*

14.2 State law requires QHP Issuers to submit data to Covered California that represents the cost of care. Applicant must provide monthly extracts of complete financial detail for all applicable claims and encounters (both on-Exchange and non-grandfathered off-Exchange). If yes with deviation, explain. If unable to provide all requested financial detail as outlined in Appendix H-HEI File Specifications, provide a plan and timeline to correct problematic data elements and estimate the number and percentage of affected claims and encounters.

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

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

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

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

14.4 Applicant must supply dates, such as starting date of service, in full year / month / day format to Covered California for data aggregation. If yes with deviation, explain. If unable to provide all requested detail as outlined in Appendix H- HEI File Specifications, provide a plan and timeline to correct problematic dates and estimate the number and percentage of affected enrollments, claims, and encounters.

PHI Dates to be Provided in Full Year / Month / Day Format	Response	If No or Yes with deviation, explain.
Member / Patient Date of Birth	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*
Member / Patient Date of Death	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*
Starting Date of Service	*Single, Pull-down list.*	*50 words.*

	1: Yes *2: No*	
Ending Date of Service	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*

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

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

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

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

Place of Service	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*
NDC Code (Drug Only)	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*

14.7 Can Applicant submit all data directly to Covered California 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

14.8 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

14.9 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

15 Essential Community Providers

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

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

1. Applicants must demonstrate sufficient geographic distribution of a mix of essential community providers reasonably distributed throughout the geographic service area; **AND**
2. Applicants must demonstrate contracts with at least 15% of 340B entities (where available) throughout each rating region in the proposed geographic service area; **AND**
3. Applicants must include at least one ECP hospital (including but not limited to 340B hospitals, Disproportionate Share Hospitals, critical access hospitals, academic medical centers, county, and children's hospitals) per each county in the proposed geographic service area - where they are available.
4. Covered California will evaluate the application of all three criteria to determine whether Applicant's essential community provider network has achieved the sufficient geographic distribution and balance between hospital and non-hospital requirements. The above are the minimum requirements. For example, in populous counties, one ECP hospital will not suffice if there are concentrations of low-income population throughout the county that are not served by a single contracted ECP hospital.

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

Essential Community Providers include those providers posted in the Covered California Consolidated Essential Community Provider List available at:
http://hbex.coveredca.com/stakeholders/plan-management/ecp-list/

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

Categories of Essential Community Providers:

Essential Community Providers include the following:

1. The Center for Medicare & Medicaid Services (CMS) non-exhaustive list of available 340B providers in the PHS Act and section 1927(c)(1)(D)(i)(IV) of the Social Security Act.
2. Facilities listed on the California Disproportionate Share Hospital Program, Final DSH Eligibility List
3. Federally designated 638 Tribal Health Programs and Title V Urban Indian Health Programs
4. Community Clinics or health centers licensed as either "community clinic" or "free clinic", by the State of California under Health and Safety Code section 1204(a), or operating as a community clinic or free clinic exempt from licensure under Section 1206
5. Physician Providers with approved applications for the HI-TECH Medi-Cal Electronic Health Record Incentive Program
6. Federally Qualified Health Centers (FQHCs)

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

Alternate standard:

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

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

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

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

Single, Pull-down list.
1: Requesting consideration of alternate standard, explanation attached,
2: Not requesting consideration under the alternate standard

16 Health Equity and Quality Transformation

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

Attachment 1 of the Covered California Qualified Health Plan (QHP) Issuer Contract embodies Covered California'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 2017-2022 QHP Issuer contract and have been revised and enhanced in the 2023-2025 QHP Issuer contract. QHP certification and participation in Covered California will be conditional on Applicant developing a multi-year strategy and reporting year-to-year activities and progress on each initiative area.

16.1 Accreditation

Applicant must be accredited by National Committee on Quality Assurance (NCQA) or have a current accreditation by one of the following bodies: (1) Utilization Review Accreditation Commission (URAC); (2) Accreditation Association for Ambulatory Health Care (AAAHC). Applicant is required to achieve NCQA Accreditation by year end 2024. Covered California strongly recommends that Applicant begin the pre-NCQA accreditation process to become accredited by NCQA by year end 2024 or earlier as required if the Applicant is currently accredited by a different accrediting body. 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.).

16.1.1 Applicant must provide proof of accreditation and expiration date of the accreditation achieved for the Applicant identified in this response. Indicate all that apply. If accredited by the Utilization Review Accreditation Commission (URAC) (Health Plan with Health Insurance Marketplace Accreditation) or the Accreditation Association for Ambulatory Health Care (AAAHC), provide accreditation status and expiration date.

	Answer	Expiration date MM/DD/YYYY	Details
NCQA Accreditation-Health Plan	*Multi, Checkboxes.* *1: Population Health Program Accreditation,* *2: Case Management,* *3: Utilization Management,* *4: Credentialing,* *5: Credentials Verification Organization (CVO),* *6: Long-Term Services and Supports (LTSS),* *7: Provider Network,* *8: Managed Behavioral Healthcare Organization (MCHO),* *9: Wellness and Health Promotion,* *10: Multicultural Health Care,* *11: Disease Management,* *12: Health Information Products,* *13: Physician and Hospital Quality,* *14: N/A*	*To the day.*	*50 words.*
URAC Accreditation	*Multi, Checkboxes.* *1: Health Plan Accreditation,* *2: Health Plan with Health Insurance Marketplace Accreditation,* *3: N/A*	*To the day.*	*50 words.*
AAAHC Accreditation	*Multi, Checkboxes.* *1: Health Plan Accreditation,* *2: N/A*	*To the day.*	*50 words.*

16.1.2 Applicant must provide a copy of the accrediting agency's certificate, and upload as a file titled “[NCQA, URAC, or AAAHC] “Accreditation”.

Single, Radio group.
1: Yes, Accreditation attached,
2: Not attached

16.1.3 If Applicant reported any provisional, interim, in process, or scheduled, status for any accreditation, Applicant must submit a workplan to achieve Health Plan accreditation within 12 months of accrediting entity's notification. This workplan should include any pre-accreditation or other improvement steps recommended by the accrediting agency. The workplan should be uploaded as a file with the file name “Accreditation Workplan.”

Single, Pull-down list.
1: Yes, Accreditation Workplan attached,

2: Not attached,
3: Not applicable

16.1.4 If Applicant reported any denied or expired status for any accreditation, Applicant must submit a corrective action plan to achieve Health Plan accreditation within 12 months of accrediting entity's notification. This corrective action plan should include any improvement steps recommended by the accrediting agency. The corrective action plan should be uploaded as a file with the file name "Accreditation Corrective Action Plan."

Single, Pull-down list.
1: Yes, Accreditation Corrective Action Plan attached,
2: Not attached,
3: Not applicable

NCQA Health Equity Accreditation

16.1.5 The National Committee for Quality Assurance (NCQA) has updated its health equity accreditation standards, as a result, the Distinction in Multicultural Health Care will sunset in 2022 and the updated standards will become the NCQA Health Equity Accreditation, effective 2022. Successful applicants must demonstrate achievement of the NCQA Health Equity Accreditation by year-end 2023. Applicant must submit evidence of Accreditation achievement or if applicable, workplan to achieve the NCQA Health Equity Accreditation by year-end 2023 as an attachment. Applicants with current NCQA Multicultural Health Care Distinction may meet this requirement with submission of evidence of the Distinction and submission of a workplan to transition to Health Equity Accreditation at the expiration of the Distinction's term.

Single select, radio group.
1: Applicant has current NCQA Health Equity Accreditation: upload NCQA Health Equity Accreditation certificate; attached.
2: Applicant has current NCQA Multicultural Health Care Distinction, please provide expiration date: [20 words]. Upload NCQA Multicultural Health Care Distinction certificate and workplan and timeline to transition to NCQA Health Equity Accreditation; attached.
3: On track to achieve NCQA Health Equity Accreditation by year-end 2023: upload workplan and timeline; attached.
4: Will not achieve NCQA Health Equity Accreditation by year-end 203. Please explain: [200 words]; attached.

16.2 Health Equity and Disparities Reduction

The Institute of Medicine defines health care equity as "providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status." Healthy People 2020 defines disparities as "a particular type of health difference that is closely linked with social, economic and/or environmental disadvantage." Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.

Addressing health equity and disparities in healthcare is integral to the mission of
Covered California. In order to achieve impactful and meaningful change, Covered California recognizes that addressing health disparities requires alignment, commitment, focus, and accountability. Responses will be evaluated based on Applicant's demonstrated organizational commitment to health equity and disparities reduction.

16.2.1 Organizational Commitment to Cultivating a Culture of Health Equity

16.2.1.1. Applicant demonstrates commitment to creating an organizational culture of health equity by taking the following actions related to mission, vision, policies, and processes:
Multi, Checkboxes
1. Applicant includes health equity in organizational mission and vision, or if currently not included in organization's mission and vision, explains what steps are being taken to incorporate health equity, describe: [100 words]
2. Health equity is integrated into organizational systems and culture, including organizational policies, processes, models, and frameworks; describe: [100 words]
3. Not applicable, health equity not integrated in organizational culture.

16.2.1.2. Applicant demonstrates commitment to a culture of health equity in its organizational leadership:
Multi, checkboxes
1. Applicant identifies leaders who are designated and held accountable for disparities reduction, describe: [100 words]
2. Applicant identifies and develops equity champions in the organization, describe: [100 words]
3. Applicant obtains executive leadership buy-in to reduce health disparities, describe: [100 words]
4. Applicant invests financially in health equity, describe: [100 words]

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

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

16.2.2 Linking Quality and Equity

16.2.2.1. How does Applicant affirm its commitment to health equity as an essential part of quality improvement? If health equity is currently not part of Applicant's quality improvement program, how does Applicant plan to incorporate health equity into quality improvement work across lines of business? Responses should explicitly address:

- staffing

- budget
- initiatives
- data infrastructure

200 words.

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

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

16.2.2.3. Provide the percent of Covered California members for whom self-reported data is captured for race or ethnicity in Attachment J - QHP IND Run Charts. Self-reported data capture may take place through the enrollment application, web site registration, health assessment, reported at provider site, etc. The percentage should exclude members whose race or ethnicity is unknown, missing, or who have "declined to state" either actively or passively. Currently contracted applicants must enter the percentage reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, 2021, and 2022.
Single, Pull-down list.
1: Attached,
2: Not attached

16.2.2.4. Describe progress increasing or maintaining the percent of Covered California members who self-report race and ethnicity 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 or ethnicity information including whether there are barriers to self-report;
- Any plans to implement or test new programs to increase self-identification. If applicable, include any experience or lessons learned regarding race and ethnicity self-identification capture resulting from increased telehealth utilization and related member interaction.

200 words.

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

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

16.2.2.6. Indicate how race and ethnicity data are used to address quality improvement and health equity. Select all that apply.
Multi, Checkboxes.
1: Calculate quality performance measures by race/ethnicity
2: Calculate member experience measures by race/ethnicity
3: Identify areas for quality improvement
4: Identify areas for health education/promotion
5: Share provider race/ethnicity data with member to enable selection of concordant providers
6: Share with provider network to assist them in providing culturally competent care
7: Set benchmarks or target goals for reducing measured disparities in preventive or diagnostic care
8: Analyze disenrollment patterns
9: Resource allocation decisions
10.Develop outreach programs that are culturally sensitive (please explain): [100 words]
11: Other (please explain): [100 words]
12: Race/ethnicity data not used for quality improvement or health equity

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

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

16.2.2.8. Indicate how primary language data are used to address quality improvement and health equity. Select all that apply.

Multi, Checkboxes.
1: Assess adequacy of language assistance to meet members' needs
2: Calculate quality performance measures by language
3: Calculate member experience measures by language
4: Identify areas for quality improvement
5: Identify areas for health education/promotion
6: Share provider language data with member to enable selection of concordant dentists
7: Share with provider network to assist them in providing language assistance and culturally competent care
8: Set benchmarks or target goals for reducing measured disparities in preventive or diagnostic care
9: Analyze disenrollment patterns
10: Resource allocation decisions
11: Develop outreach programs that are culturally sensitive (please explain): [100 words]
12: Other (please explain): [100 words]
13: Language data not used for quality improvement or health equity

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

Demographic Data Type	*Covered California*	*Medi-Cal*	*California Commercial*	*Description* *If Applicant answered "data not collected," discuss how Applicant intends to collect specified data elements.*
Sexual Orientation	*Multi, Checkboxes.* *1. enrollment form* *2. member services contact* *3. member portal* *4. EHR* *5. Health Assessments* *6. other, specify: [10 words]* *7. data not collected*	*Multi, Checkboxes.* *1. enrollment form* *2. member services contact* *3. member portal* *4. EHR* *5. Health Assessments* *6. other, specify: [10 words]* *7. data not collected*	*Multi, Checkboxes.* *1. enrollment form* *2. member services contact* *3. member portal* *4. Electronic Health Record (EHR), specify estimated percent of enrollees: [percent]* *5. Health Assessments* *6. other, specify: [10 words]* *7. data not collected*	*100 words.*

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

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

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

16.2.2.12. Indicate how member gender identity data are used to address quality improvement and health equity. Select all that apply.

Multi, Checkboxes.

1: Calculate quality performance measures by gender identity
2: Calculate member experience measures by gender identity
3: Identify areas for quality improvement
4: Identify areas for health education/promotion
5: Share provider gender identity data with member to enable selection of concordant providers
6: With appropriate protections, share with provider network to assist them in providing culturally competent care
7: Set benchmarks or target goals for reducing measured disparities in preventive or diagnostic care
8: Analyze disenrollment patterns
9: Resource allocation decisions
10.Develop outreach programs that are culturally sensitive (please explain): [100 words]
11: Other (please explain): [100 words]
12: Gender identity data not used for quality improvement or health equity

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

Demographic Data Type	*Covered California*	*Medi-Cal*	*California Commercial*	*Description* *If Applicant answered "data not collected," discuss how Applicant intends to collect specified data elements.*

Disability Status	*Multi, Checkboxes.* *1. enrollment form* *2. member services contact* *3. member portal* *4. EHR* *5. Health Assessments* *6. claims data* *7. other, specify: [10 words]* *8. data not collected*	*Multi, Checkboxes.* *1. enrollment form* *2. member services contact* *3. member portal* *4. EHR* *5. Health Assessments* *6. claims data* *7. other, specify: [10 words]* *8. data not collected*	*Multi, Checkboxes.* *1. enrollment form* *2. member services contact* *3. member portal* *4. Electronic Health Record (EHR), specify estimated percent of enrollees: [percent]* *5. Health Assessments* *6. claims data* *7. other, specify: [10 words]* *8. data not collected*	*100 -words.*

16.2.2.14. Indicate how member disability status data are used to address quality improvement and health equity. Select all that apply.
Multi, Checkboxes.
1: Calculate quality performance measures by disability status
2: Calculate member experience measures by disability status
3: Identify areas for quality improvement,
4: Identify areas for health education/promotion,
5: Share with provider network to assist them in providing culturally competent care
6: Set benchmarks or target goals for reducing measured disparities in preventive or diagnostic care
7: Analyze disenrollment patterns
8: Develop outreach programs that are culturally sensitive (please explain): [100 words]
9. Resource allocation decisions
10: Other (please explain): [100 words]
11: Disability data not used for quality improvement or health equity

16.2.2.15 Does Applicant stratify clinical measures by demographic factors for disparities identification and intervention efforts? If so, which measures are stratified by demographic factors?
200 words.

16.2.2.16 Does Applicant stratify maternal health measures by demographic factors for disparities identification and intervention efforts? If so, which measures are stratified?
200 words.

16.2.3 Culturally and Linguistic Appropriate Care

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

16.2.3.2 Applicant must indicate its threshold languages and percentage of enrollees that selected each applicable threshold language in plan year 2021.

Threshold language	*Response*	*Percent*
Arabic	*Single, Pull-down list.*	*Percent.*

	1: Yes *2: No*	
Armenian	*Single, Pull-down list.* *1: Yes* *2: No*	*Percent.*
Cambodian	*Single, Pull-down list.* *1: Yes* *2: No*	*Percent.*
Cantonese	*Single, Pull-down list.* *1: Yes* *2: No*	*Percent.*
English	*Single, Pull-down list.* *1: Yes* *2: No*	*Percent.*
Farsi	*Single, Pull-down list.* *1: Yes* *2: No*	*Percent.*
Hmong	*Single, Pull-down list.* *1: Yes* *2: No*	*Percent.*
Korean	*Single, Pull-down list.* *1: Yes* *2: No*	*Percent.*
Lao	*Single, Pull-down list.* *1: Yes* *2: No*	*Percent.*
Mandarin	*Single, Pull-down list.* *1: Yes* *2: No*	*Percent.*
Russian	*Single, Pull-down list.* *1: Yes* *2: No*	*Percent.*
Spanish	*Single, Pull-down list.* *1: Yes* *2: No*	*Percent.*
Tagalog	*Single, Pull-down list.* *1: Yes* *2: No*	*Percent.*
Vietnamese	*Single, Pull-down list.* *1: Yes* *2: No*	*Percent.*
Other, specify	*Single, Pull-down list.* *1: Yes* *2: No*	*100 words.*

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

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

16.3 Behavioral Health

Mental health and substance use disorder services – collectively referred to as behavioral health services – includes identification, engagement, and treatment of those with mental health conditions and substance use disorders. Covered California recognizes the critical importance of behavioral health services as part of the broader set of healthcare services provided to enrollees in improving health outcomes and reducing costs. Responses 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. Responses prepared by behavioral health vendors or subcontractors must be reviewed by the Applicant and integrated by Applicant with overall submission for this section, 16.3 Behavioral Health.

16.3.1 Describe how Applicant administers mental health and substance use disorder (MHSUD) benefits as either administered directly by Applicant or subcontracted to a contractor.

		Activities conducted for consumer education and communication	*Oversight conducted for quality and network management*	*If the benefit is subcontracted, state the name of the contractor and whether the contract with the MHSUD benefits subcontractor includes performance incentives*
Offer benefit directly under full-service license:	*Single, Pull-down list.* *1: Yes* *2: No* *3: Not Applicable*	*100 words.*	*100 words.*	*100 words.*
Subcontractor relationship:	*Single, Pull-down list.* *1: Yes* *2: No* *3: Not Applicable*	*100 words.*	*100 words.*	*100 words.*
Other:	*Single, Pull-down list.* *1: Yes, 10 words* *2: No* *3: Not Applicable*	*100 words.*	*100 words.*	*100 words.*

16.3.2 Describe Applicant's mechanisms to ensure Covered California Enrollees have timely access to and receive appropriate, evidence-based behavioral health services including:

- Efforts to improve the availability of services, considering provider availability, capacity, and the unique needs of diverse enrolled populations. Responses should address changes in benefits management, networks, providing alternatives to face-to-face visits, and any other initiatives

- Assessment of behavioral health providers' or vendor's language capabilities
- Explanation of Covered California Enrollees' point of entry to behavioral health services
- Methods to receive and address Covered California Enrollee concerns

Note: Applicant must address all elements of the question. Applicant may include behavioral health provider network reports from its accrediting organization (NCQA, URAC, AAAHC) as a supplemental attachment.

200 words.

16.3.3 Describe the methods Applicant uses to monitor the quality, effectiveness, and cultural competency of its behavioral health services.

200 words.

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

Single, Pull-down list.
1: No measures are tracked,
2: 1,
3: 2,
4: 3,
5: 4,
6: 5,
7: 6,
8: 7,
9: 8,
10: 9,
11: 10,
12: 11,
13: 12,
14: 13,
15: 14,
16: 15,
17: 16,
18: 17,
19: 18,
20: 19,
21: 20,
22: 21,
23: 22,
24: 23,
25: 24,
26: 25

16.3.5 Applicant must specify which measures are tracked (e.g., HEDIS clinical measures, CAHPS patient-reported experience, or others) to ensure Covered California Enrollees receive appropriate, evidence-based behavioral health treatment and provide the results for these measures for measurement years 2018, 2019, 2020, and 2021. QHP Issuers will be required to collect and report on Depression Screening and Follow-Up Plan (NQF #0418) measure results in 2022. If Applicant tracks the Depression Screening and Follow-Up Plan (NQF #0418) measure, include the results for this measure.

	Measure	*Results - 2018*	*Results - 2019*	*Results - 2020*	*Results - 2021*
1	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*50 words.*

2	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*50 words.*
3	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*50 words.*
4	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*50 words.*
5	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*50 words.*
6	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*50 words.*
7	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*50 words.*
8	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*50 words.*
9	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*50 words.*
10	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*50 words.*
11	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*50 words.*
12	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*50 words.*
13	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*50 words.*
14	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*50 words.*
15	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*50 words.*
16	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*50 words.*
17	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*50 words.*
18	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*50 words.*
19	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*50 words.*
20	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*50 words.*
21	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*50 words.*
22	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*50 words.*
23	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*50 words.*
24	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*50 words.*
25	*50 words.*	*50 words.*	*50 words.*	*50 words.*	*50 words.*

16.3.6 Describe Applicants efforts to implement and increase the use of patient-reported outcome measures, such as those based on the use of standardized screening and follow-up tools for depression, anxiety, and substance use disorders.

References:

Current Best Evidence and Performance Measures for Improving Quality of Care and Delivery System Reform: Expert Reviews by HMA and PwC:
https://hbex.coveredca.com/stakeholders/plan-management/library/coveredca_current_best_evidence_and_performance_measures_07-19.pdf

See pages 69-76.

200 words.

16.3.7 Describe how Applicant is implementing the Smart Care California guidelines for appropriate use of opioids (https://www.iha.org/wp-content/uploads/2021/02/Curbing-Opioid-Epidemic-Checklist-Health-Plans-Purchasers.pdf).

100 words.

16.3.8 Describe Applicant's integrated behavioral health-medical models and specify whether Applicant uses standardized models such as the Collaborative Care Model, co-located care, or Primary Care Behavioral Health. Indicate whether these efforts are implemented in association with advanced primary care models or Integrated Delivery Systems (IDSs) or Accountable Care Organizations (ACOs).

200 words.

References:

Current Best Evidence and Performance Measures for Improving Quality of Care and Delivery System Reform: Expert Reviews by HMA and PwC: https://hbex.coveredca.com/stakeholders/plan-management/library/coveredca_current_best_evidence_and_performance_measures_07-19.pdf, See pages 78-81.

16.3.9 Applicant must report the number and percent of enrollees cared for under an integrated behavioral health-medical model, as defined by Applicant in 16.3.7, in both its Covered California business (if Applicant had Covered California business in 2020 and 2021) and total book of business in California. Describe how these numbers are determined in the details.

	Covered California Enrollees cared for under an integrated behavioral health-medical model	*Total Covered California Enrollment*	*Percent of Covered California Enrollment cared for under an integrated behavioral health-medical model*	*Total California book of business cared for under an integrated behavioral health-medical model*	*Total California Enrollment*	*Percent of California Enrollment cared for under an integrated behavioral health-medical model*	*Details*
2020	*Integer.*	*Integer.*	*Percentage.*	*Integer.*	*Integer.*	*Percentage.*	*100 words.*
2021	*Integer.*	*Integer.*	*Percentage.*	*Integer.*	*Integer.*	*Percentage.*	*100 words.*

16.3.10 Describe Applicant's strategies to strengthen the integration of behavioral health with medical services, especially primary care services including:

- How Applicant is improving the integration of behavioral health services and medical services with its contracted network providers, including if the Applicant supports providers through payment models, technical assistance, or other mechanisms

- Whether Applicant reimburses for the Collaborative Care Model claims codes (G0444, 99420 with relevant diagnosis, Standard CPT codes: 99484, 99492, 99493, 99494)
- If Applicant does not reimburse for the Collaborative Care Model claims codes, describe the barriers to reimbursing for these codes and efforts to address those barriers
- Comment on any innovative models in California or nationwide and potential collaborative opportunities to adopt these models on a larger scale

Note: Applicant must address all elements of the question.

References:

Current Best Evidence and Performance Measures for Improving Quality of Care and Delivery System Reform: Expert Reviews by HMA and PwC: https://hbex.coveredca.com/stakeholders/plan-management/library/coveredca_current_best_evidence_and_performance_measures_07-19.pdf, See pages 78-81.

200 words.

16.3.11 Covered California encourages Applicant to offer telehealth for behavioral health services. Indicate whether Applicant offers telehealth for behavioral health services and if yes, describe how Applicant educates Covered California Enrollees on how to access services and how the information is displayed to Covered California Enrollees through Applicant's member portal and provider directory.

Single, Pull-down list.
1: Yes, Applicant offers telehealth for behavioral health services, [100 words.]
2: No, Applicant does not offer telehealth for behavioral health services

16.4 Health Promotion and Prevention

Health promotion and prevention are key components of high-value health care. Covered California 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. Responses will be evaluated based on the degree to which health and wellness data is tracked on membership and used to coordinate care.

16.4.1 Identify enrollee interventions used in measurement year 2021 to improve immunization rates. Check all that apply and provide a description of selected activities in Details fields.

	Response	*Details*
Childhood Immunizations	*Multi, Checkboxes.* *1: Enrollee reminders (electronic or written, etc.) sent to enrollees for needed care based on general eligibility (age/gender),* *2: Enrollee-specific reminders for gaps in services based on administrative or clinical information (mail, email/text, automated phone or live outbound telephone calls triggered by the ABSENCE of a service),* *3: Enrollee incentives,* *4: None of the above,* *5: Other, explain in Details*	*100 words.*

Immunizations for Adolescents	*Multi, Checkboxes.* *1: Enrollee reminders (electronic or written, etc.) sent to enrollees for needed care based on general eligibility (age/gender),* *2: Enrollee-specific reminders for gaps in services based on administrative or clinical information (mail, email/text, automated phone or live outbound telephone calls triggered by the ABSENCE of a service),* *3: Enrollee incentives,* *4: None of the above,* *5: Other, explain in Details*	*100 words.*
Immunizations for Adults	*Multi, Checkboxes.* *1: Enrollee reminders (electronic or written, etc.) sent to enrollees for needed care based on general eligibility (age/gender),* *2: Enrollee-specific reminders for gaps in services based on administrative or clinical information (mail, email/text, automated phone or live outbound telephone calls triggered by the ABSENCE of a service),* *3: Enrollee incentives,* *4: None of the above,* *5: Other, explain in Details*	*100 words.*

16.4.2 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 or evaluating the effectiveness of provider interventions.

Single, Radio group.
1: Yes (explain) [50 words],
2: No

16.4.3 Indicate the number and percent of tobacco-dependent commercial enrollees identified and participating in cessation activities during measurement year 2021. Do not report general prevalence. *If new entrant Applicants are currently operating in Covered California, provide non-Covered California enrollee counts and Covered California enrollee counts. If Covered California counts are not available or new entrant Applicants are not currently operating in Covered California, provide state or regional counts and indicate what population is being reported on.*

	Response	*Details*
1. Indicate how Applicant identifies enrollees who use tobacco.	*Multi, Checkboxes.* *1: Plan Health Assessment,* *2: Employer/Purchaser Health Assessment,* *3: Plan PHR* *4: Claims/Encounter Data,* *5: Disease or Care Management,* *6: Wellness Vendor,* *7: Other, explain in Details*	*100 words.*
2. Indicate the tobacco cessation interventions Applicant provides directly to enrollees.	*Multi, Checkboxes.* *1: Nicotine Replacement Therapy,* *2: Smoking cessation class or program,* *3: Smoking cessation counseling via PCP/health*	*100 words.*

	coach, 4: Medication assisted cessation, 5. Enrollee incentives 6: None, 7: Other, explain in Details	
3. Indicate the tobacco cessation interventions Applicant covers for enrollees.	*Multi, Checkboxes.* 1: Nicotine Replacement Therapy, 2: Smoking cessation class or program, 3: Smoking cessation counseling via PCP/health coach, 4: Medication assisted cessation, 5. Enrollee incentives 6: None, 7: Other, explain in Details	*100 words.*
California Commercial Enrollees		
4. Number of California commercial enrollees individually identified as tobacco dependent in 2021. *(If Applicant has and tracks use by Medi-Cal enrollees as well, number here should include Medi-Cal numbers)*	*Decimal.*	
5. Percent of California commercial enrollees identified as tobacco dependent *(Calculated as number of California commercial enrollees identified as tobacco dependent divided by total California commercial enrollees)*	*Percent.*	
6. Number of California commercial enrollees identified as tobacco dependent who participated in a smoking cessation program during 2021. *(If Applicant has and tracks use by Medi-Cal enrollees as well, number here should include Medi-Cal numbers)*	*Decimal.*	
7. Percent of California commercial enrollees who participated in a smoking cessation program during 2021 *(Calculated as number of California commercial enrollees who enrolled in a smoking cessation program divided by number of eligible California commercial enrollees)*	*Percent.*	
Covered California Enrollees		
8. Number of Covered California enrollees who have been identified as tobacco dependent in 2021.	*Decimal.*	

9. Percent of Covered California enrollees who have been identified as tobacco dependent in 2021. *(Calculated as number of Covered California enrollees identified as tobacco dependent divided by total Covered California enrollees)*	*Percent.*	
10. Number of Covered California enrollees identified as tobacco dependent who participated in a smoking cessation program during 2021.	*Decimal.*	
11. Percent of Covered California enrollees identified as tobacco dependent who participated in a smoking cessation program during 2021. *(Calculated as number of Covered California enrollees identified as tobacco dependent who enrolled in a smoking cessation program divided by number of eligible Covered California enrollees)*	*Percent.*	

16.4.4 Describe the strategies Applicant is implementing to decrease the rate of Covered California enrollees with tobacco and smoking dependency. Applicant must include its strategies to improve tobacco use prevention and its strategies to reduce rates on the Medical Assistance with Smoking and Tobacco Use Cessation measure.
500 words.

16.4.5 All Applicants must provide a Centers for Disease Control and Prevention (CDC)-recognized Diabetes Prevention Lifestyle Change Program, also known as a Diabetes Prevention Program (DPP), to its eligible enrollees. The DPP must be accessible both in-person and online. The DPP shall be available to all enrollees in the geographic service area and covered under the $0 preventive services benefit or diabetes education benefit in the Patient-Centered Benefit Plan Designs. Contractor's DPP must have pending or full recognition by the CDC as a Lifestyle Change Program. A list of recognized programs in California can be found at: https://dprp.cdc.gov/Registry.

> *Note: If new entrant Applicants are currently operating in Covered California, provide non-Covered California commercial enrollee counts and Covered California enrollee counts for measurement year 2021. If Covered California counts are not available or new entrant Applicants are not currently operating in Covered California, provide details on interventions or planned activities, state or regional counts, and indicate what population is being reported on.*

	Response	*Details*
1. Indicate how Applicant identifies eligible enrollees for the Diabetes Prevention Program.	*Multi, Checkboxes.* *1: Plan Health Assessment,* *2: Employer/Purchaser Health Assessment,* *3: Plan PHR,*	*100 words.*

	4: Claims/Encounter Data, *5: Disease or Care Management,* *6: Wellness Vendor,* *7: Other, describe in Details*	
2. Describe how Applicant informs its enrollees about the Diabetes Prevention Program and indicate if Applicant advertises the Diabetes Prevention Program directly or through contracted groups.	*100 words.*	
3. Describe how Applicant monitors and evaluates the effectiveness of the Diabetes Prevention Program.	*100 words.*	
California Commercial Enrollees		
4. Number of total commercial enrollees eligible for Diabetes Prevention Program.	*Decimal.*	
5. Percent of total commercial enrollees eligible for Diabetes Prevention Program. *(Calculated as number of total commercial enrollees eligible for Diabetes Prevention Program divided by total commercial enrollees ages 18 years and older)*	*Percent.*	
6. Number of total eligible enrollees who enrolled in an in-person Diabetes Prevention Program.	*Decimal.*	
7. Number of total eligible enrollees who reached a modest reduction in hemoglobin A1C (HbA1C) of 0.2% using an in-person Diabetes Prevention Program (use cumulative total of enrollees).	*Decimal.*	
8. Number of total eligible enrollees who enrolled in an on-line/virtual Diabetes Prevention Program.	*Decimal.*	
9. Number of total eligible enrollees who reached a modest reduction in hemoglobin A1C (HbA1C) of 0.2% using an on-line/virtual Diabetes Prevention Program (use cumulative total of enrollees).	*Decimal.*	
Covered California Enrollees		
10. Number of total Covered California enrollees eligible for Diabetes Prevention Program.	*Decimal.*	
11. Percent of total Covered California enrollees eligible for Diabetes Prevention Program.	*Percent.*	

(Calculated as number of total Covered California enrollees eligible for Diabetes Prevention Program divided by total Covered California enrollees ages 18 years and older)		
12. Number of total eligible Covered California enrollees who enrolled in an in-person Diabetes Prevention Program.	*Decimal.*	
13. Number of total eligible Covered California enrollees who reached a modest reduction in hemoglobin A1C (HbA1C) of 0.2% using an in-person Diabetes Prevention Program (use cumulative total of enrollees).	*Decimal.*	
14. Number of total eligible Covered California enrollees who enrolled in an on-line/virtual Diabetes Prevention Program.	*Decimal.*	
15. Number of total eligible Covered California enrollees who reached a modest reduction in hemoglobin A1C (HbA1C) of 0.2% using an on-line/virtual Diabetes Prevention Program (use cumulative total of enrollees).	*Decimal.*	

16.5 Population Health Management

Covered California recognizes that effective population health management, including 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) results in improved outcomes and lowers costs. The following questions assess Applicant's ability to identify, stratify, track, and manage enrollees. Responses will be evaluated on Applicant's use of data and interventions to proactively manage enrollees as well as the thoroughness of the response.

16.5.1 Population Health Management in Health Care Services

As part of total population management and person-centered care, summarize Applicant activities and ability to identify enrollees who are non-users (no claims) and assess those enrollees' health statuses and risks and engage those enrollees in services as needed.

	Response
Number of total Covered California enrollees with no claims in calendar year 2021	*Decimal.*
Percent of total Covered California enrollees with no claims in CY 2021	*Percent.*

Summary (bullet points) of plan activities to engage enrollees who are non-users	*100 words.*

16.5.2 Health Assessment

16.5.2.1 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 enrollees,
7: Applicant does not offer an HA

16.5.2.2 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.

Multi, Checkboxes.

1: Addressing At-risk Behaviors: At point of HA response, risk-factor education is provided to enrollee based on enrollee-specific risk, e.g. at point of "smoking-yes" response, tobacco cessation education is provided as pop-up,
2: Addressing At-risk Behaviors: Personalized HA report is generated after HA completion that provides enrollee-specific risk modification actions based on responses,
3: Addressing At-risk Behaviors: Enrollees 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 enrollee's HA results ("Push messaging" is defined as an information system capability that generates regular e-mail or health information to the enrollee),
5: Addressing At-risk Behaviors: Enrollee 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: Enrollee can elect to have HA results sent electronically to personal physician,
8: Addressing At-risk Behaviors: Enrollee can update responses and track against previous responses,
9: Tracking health status: HA responses incorporated into enrollee 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

16.5.2.3 Provide the number of currently enrolled non-Covered California commercial, Medi-Cal, and Covered California enrollees who completed a Health Assessment (HA) in measurement year 2021 and explain how HA results lead to referrals for Applicant's case management or assigned provider.

	Response
1. Indicate how Applicant tracks HA participation Select only ONE of response options 1-4 and include response option 5 if applicable *(If option 4 is selected, responses to the following questions 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*
2. Number of enrollees completing plan-based HA in 2021 *(If Applicant has and tracks use by Medi-Cal enrollees as well, number here should include Medi-Cal numbers)*	*Decimal.*
3. Percent of enrollees completing plan-based HA completion in 2021 *(Calculated as number of enrollees who have completed plan-based HA divided by total enrollment)*	*Percent.*
4. Number of completed HAs resulting in referral to health plan case management staff or assigned provider	*Decimal.*
5. Percent of completed HAs resulting in referral to health plan case management staff or assigned provider *(Calculated as number of completed HAs resulting in referral divided by number of completed HAs)*	*Percent.*
6. Explain how HA results lead to referrals for Applicant's case management or assigned provider	*50 words.*

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

200 words.

16.5.3 Supporting At-Risk Enrollees

16.5.3.1 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, and indicate what chronic disease management programs Applicants have and whether they are provided through a contracted vendor or internal staff.

> *Note: NCQA-accredited Applicants may submit reports, as an attachment, demonstrating compliance with Population Health Management Standards 1 and 2 in lieu of a response.*

100 words.

16.5.3.2 For Covered California business in measurement year 2021, Applicant must provide (1) the number of enrollees aged 18 and above, (2) the number of enrollees aged 18 and above identified under Applicant's criteria for at-risk enrollees eligible for case management in the second row. *If new entrant Applicants are not currently operating in Covered California, report on all lines of business excluding Medicare.*

Note: NCQA-accredited Applicants may submit reports, as an attachment, demonstrating compliance with Population Health Management Standards 1 and 2 in lieu of a response.

	Response
1. Number of Covered California enrollees aged 18 and above	*Decimal.*
2. Using Applicant's criteria, provide number of Covered California enrollees aged 18 and above who are at-risk enrollees eligible for case management	*Decimal.*

16.5.3.3 Building on the National Committee for Quality Assurance (NCQA) Population Health Management plans submission requirement, Applicant must describe outreach and interventions used to ensure at-risk enrollees received needed care for plan year 2021.

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

500 words.

16.5.3.4 Provide the following information regarding Applicant's outreach efforts for at-risk enrollees in plan year 2021.

	Response
1. Number of at-risk enrollees engaged in appropriate care management	*Decimal.*
2. Percent of at-risk enrollees engaged in appropriate care management *(Calculated as number of at-risk enrollees enrolled in a care management program or receiving care from specialty provider divided by total number of at-risk enrollees)*	*Percent.*

16.5.3.5 Does Applicant share registries (disease-specific or gaps in care) of enrollees, as permitted by state and federal law, with clinically appropriate accountable providers, including the enrollee's primary care clinician? If yes, describe the methods used to share registries of enrollees and how care management is integrated with the delivery system.

Note: NCQA-accredited Applicants may submit reports, as an attachment, demonstrating compliance with Population Health Management Standards 1 and 2 in lieu of a response.

Single, Radio group.
1: Yes, describe: [65 words],
2: No

16.5.3.6 In the event of a service area reduction, describe Applicant's current or planned process for identifying an at-risk enrollee and how Applicant facilitates a smooth transfer of care and health information when an at-risk enrollee transfers to another Covered California QHP Issuer.

100 words.

16.5.4 Health – Related Social Needs

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

Responses will be evaluated on extent of Applicant's health-related social needs enrollee screening and referral programs.

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

16.5.4.2 Identify all health assessment or screening tools in use:
Multi, checkboxes
1. *Accountable Health Communities Health-Related Social Needs Screening Tool*
2. *HealthBegins*
3. *Health Leads*
4. *Income, Housing, Education, Legal Status, Literacy, Personal Safety (IHELLP) Questionnaire*
5. *Medicare Total Health Assessment*
6. *National Academy of Medicine Domains*
7. *PRAPARE*
8. *WellRx*
9. *Your Current Life Situation*
10. *Other, describe: [100 words]*

16.5.4.3 Which Applicant staff or vendor representatives conduct or administer the health assessment or screening tool? Include description of any variation by program or internal workstream.
50 words.

16.5.4.4 What training is provided to staff who conduct the health assessment or social needs screening?
Single, checkbox
1. Training specific to the assessment of screening instrument is provided, describe: [50 words]
2. Internally developed training is provided, describe: [50 words]
2. No training provided

16.5.4.5 Does Applicant require or incentivize contracted providers to use a health assessment or screening tool to identify Enrollee's social needs? If applicable, describe.
Single, checkbox
1. Yes, require screening, describe: [100 words]
2. Yes, incentivize screening, describe: [100 words]
3. No screening requirements or incentives for contracted providers

16.5.4.6 Does Applicant incentivize provider use of z codes for identified social needs?
Single, checkbox
1. Yes, Applicant incentivizes provider use of z codes, describe: [50 words]
2. No, Applicant does not incentivize provider use of z codes

16.5.4.7 How are social needs data collected from the health assessment or screening tool used?
Multi, checkboxes
1. Data linked to Enrollee's demographic data, describe: [50 words]
2. Data linked to Enrollee's health status, describe: [50 words]
3. Health plan representative refers Enrollees to the appropriate social service
4. Vendor representative or platform refers Enrollees to the appropriate social service
5. Provider or provider team member refers Enrollee to appropriate social service
6. Data not linked to Enrollee's demographic data or health status
7. No referral made

16.5.4.8 Does Applicant maintain a community resource directory or contract with vendor(s) to provide enrollee referrals that address social needs? Indicate all that apply:
Multi, checkboxes,
1. 211
2. Aunt Bertha
3. Healthify
4. One Degree
5. UniteUs
6. Other, specify: [20 words]

16.5.4.9 Does Applicant operate a closed-loop referral tracking system to address Enrollee's identified social needs? A closed loop referral tracking is the process of tracking the outcomes of a referral, including whether the Enrollee received help through the referral and whether the needs that triggered the referral were addressed.
Single, checkbox
1. Applicant operates a closed-loop referral system to address Enrollee social needs, describe: [50 words]
2. Applicant does not operate a closed-loop referral system to address Enrollee social needs

16.5.4.10 Describe any current or past interventions to address social needs or social determinants of health initiated or led by Applicant. The World Health Organization defines social determinants of health as "the non-medical factors that influence health outcomes. …the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life." Include the social need or social determinant selected, relevant partners, the intervention goal(s), and impact of the intervention.
200 words.

16.5.4.11 Describe Applicant's participation in current or past interventions to address social needs or social determinants of health initiated or led by other organizations. Include the social need or social determinant selected, lead organization, relevant partners, the intervention goal(s), and impact of the intervention.
200 words.

16.5.5 Prevention of Algorithmic Bias in Healthcare

The potential for bias in algorithms used in decisions to allocate health care resources is increasingly recognized. Processes and systems to identify and address these biases are critical to an equitable population health management strategy and preventing exacerbation of existing health disparities.

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

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

16.5.5.3 Has Applicant taken steps to improve or suspend the use of biased algorithms?
Single, Radio group.
1: Yes, explain: [100 words]
2: No

16.5.5.4 Has Applicant implemented business processes to prevent future algorithmic bias?

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

16.6 Complex Care

Covered California recognizes the importance of effectively managing complex conditions for individuals that require multiple high-cost specialty treatments or end of life care. Numerous studies have demonstrated a significant correlation between volume of procedures performed by

providers and facilities and better outcomes for those procedures, referred to throughout this section as the “volume-outcome relationship”. 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.

16.6.1 Describe the mechanisms used to ensure enrollees can access providers with documented special experience and proficiency, based on volume and outcome data, that treat conditions requiring highly specialized management (e.g., transplant patients, burn patients, rare cancers, rare genetic conditions).

200 words.

16.6.2 Does Applicant track procedure volume per facility for high-risk treatments (such as certain cancer surgeries and cardiac procedures) and highly specialized procedures (such as solid organ and bone marrow transplants)?

	Response
Applicant tracks procedure volume per facility for high-risk treatments (such as certain cancer surgeries and cardiac procedures) and highly specialized procedures (such as solid organ and bone marrow transplants)	*Single, Radio group.* *1: Yes, complete table* *2: No*
	Response
1. Briefly describe the high-risk treatments and highly specialized procedures and the methodology used for categorizing facilities according to the volume-outcome relationship	*300 words.*
2. List data sources used	*100 words.*
3. Provide volume thresholds (i.e., at what volume per procedure is a facility considered proficient)	*200 words.*

16.6.3 Does Applicant apply the information described in 16.6.2 to the referral process for enrollees (including Covered California enrollees) for high-risk treatments and highly specialized procedures?

	Response
Applicant applies the information described in 16.6.2 to the referral process for enrollees (including Covered California enrollees) for high-risk treatments and highly specialized procedures	*Single, Radio group.* *1: Yes, complete table* *2: No*
	Response
1. Describe methodology for patient identification and selection, such as consideration of patient residence and language proficiency	*200 words.*
2. Describe the referral procedure for identified patients	*200 words.*

3. Describe accommodations provided for patients not residing in close proximity to a recognized higher volume provider	*200 words.*

16.6.4 Provide the following information and attachments regarding Applicant's use of Centers of Excellence, if used.

	Response
1a. Applicant uses Centers of Excellence	*Single, Radio group.* 1: Yes, 2: No
1b. If Centers of Excellence are used, attach a list of affiliated facilities with the conditions treated at each facility	*200 words.*
2. For Centers of Excellence for the three (3) top conditions based on volume and cost for Covered California (total joint replacement, spine conditions, and bariatric treatments), describe the criteria for the inclusion of these Centers of Excellences and the methods used to promote enrollee use	*200 words.*
3. For each condition with an associated Center of Excellence, provide the number and percent of enrollees in the plan population with the condition in the attached list *(Calculated as number of enrollees with each condition divided by total number of Enrollees)*	*200 words.*
4. For each condition with an associated Center of Excellence, provide the number and percent of enrollees treated at a Center of Excellence in the attached list *(Calculated as number of enrollees with each condition treated at a Center of Excellence divided by total number of enrollees with each condition)*	*200 words.*

16.7 Affordability and Cost

Affordability is core to Covered California'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, the lack of transparency with pharmaceutical drug pricing, and the limited access to cost information for consumers, are all significant contributors to high cost of medical services. This section will focus on the affordability and cost of pharmaceutical drugs and how consumers are informed of their cost shares. The Applicant's capability to manage the wide variation in unit price and total costs of care charged by providers and hospital is assessed in Provider Networks Based on Value.

16.7.1 Demonstrating Action on High Cost Pharmaceuticals

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

16.7.1.1 Indicate which of the following sources Applicant uses to improve the value of pharmacy services. Choose all that apply.

Multi, Checkboxes.

1. ACC/AHA Cost/Value Methodology in Clinical Practice Guidelines
2. ASCO Value of Cancer Treatment Options (ASCO- VF)
3. DrugAbacus (MSKCC) (DAbacus)
4. Drug Effectiveness Review Project (DERP)
5. The ICER Value Assessment Framework (ICER-VF)
6. CN Evidence Blocks (NCCN-EB)
7. Premera Value-Based Drug Formulary (Premera VBF)
8. United Kingdom's National Institute for Health and Care Excellence (NICE)
9. Other (explain)*100 words.*

16.7.1.2 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. Applicant must answer each of the questions in the table below.

	Response
Describe how Applicant considers value in its formulary design.	*200 words.*
Describe Applicant's strategy for specialty pharmacy and biologics management, including the promotion and use of biosimilar drugs.	*200 words.*
Describe how Applicant provides decision support for prescribers and enrollees in selecting appropriate, efficacious, high-value treatments and how Applicant alerts prescribers and Enrollees to more cost-effective alternatives when applicable.	*200 words.*

If Applicant or Applicant's PBM is considering implementing a pharmacy order-entry decision support tool or point of care support tool for prescribers to promote value-based prescribing, then indicate which tool Applicant is using or considering.	*200 words.*
Describe any potential or current collaboration opportunities, new statewide or regional initiatives, or other activities that would strengthen Applicant's ability to address high cost pharmaceuticals.	*200 words.*

16.7.2 Patient-Centered Information and Support

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

16.7.2.1 Describe any quality information currently included with cost information that enables enrollees to compare providers based on quality performance in selecting a primary care clinician or elective specialty and hospital providers.

200 words.

16.7.2.2 Applicant must complete the following table describing how it informs enrollees of provider-specific cost shares and its cost tools available for enrollees.

	Response	*Details*
Indicate and describe the type of cost tools available to members in details section	*Multi, checkboxes* *1: Web based cost tool* *2: App based cost tool* *3: None* *4: Other; explain*	*100 words.*
Report the number of enrollees for Covered California lines of business who used the tool in 2021.	*Integer.* *Note: If not applicable, please explain.*	*100 words.*

Report the percent of enrollees for Covered California line of business who used the tool in 2021 (Calculated as number of Covered California enrollees individually who utilized the tool divided by total Covered California membership)	*Percent.*	
Report the number of total enrollees across all lines of business, including Medicare, who used the tool in 2021	*Integer.* *Note: If not applicable, please explain*	*100 words.*
Report the percent of total enrollees across all lines of business, including Medicare, who used the tool in 2021 (Calculated as number of California enrollees individually who utilized the tool divided by total California membership)	*Percent.*	
Describe how Applicant tracks utilization and effectiveness of the cost tools		*200 words.*
Describe how cost shares for common inpatient, outpatient, and ambulatory service are made available to consumer		*200 words.*
Describe how prescription drug cost shares are made available to consumer		*200 words.*
Describe how member specific accumulations towards annual deductibles and maximum out of pockets are communicated		*200 words.*
Describe Applicant's efforts to make variation in provider or facility cost transparent to enrollees		*200 words.*
Describe the strategies Applicant currently utilizes or intends to implement to increase enrollee engagement with the cost tools		*200 words.*
Describe Applicant's efforts to make variation in provider or facility cost transparent to enrollees		*200 words.*

16.8 Participation in Quality Improvement Collaboratives

Covered California believes that improving health care quality can only be done over the long-

term through collaborative efforts that effectively engage and support clinicians, hospitals, health systems, and other providers of care. There are several established statewide and national collaborative initiatives for quality improvement that are aligned with priorities established by Covered California. The following question addresses Applicant's current involvement in quality collaborative efforts. Applicants will be assessed based on the breadth and depth of their involvement in such efforts.

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

Quality Collaborative	*Response*	*Response*	*Details*
American Joint Replacement Registry (AJRR) for California	*Single, Checkboxes.* *1: Participates* *2: Does not participate*	How does Applicant engage with collaborative? *Multi, Checkboxes.* *1. Attends meetings* *2. Health plan representative serves as advisory member* *3. Submits data to collaborative* *4. Provides feedback on initiatives and projects* *5. Provides funding; explain the amount and nature of financial support*	*200 words.*
Cal Hospital Compare	*Single, Checkboxes.* *1: Participates* *2: Does not participate*	How does Applicant engage with collaborative? *Multi, Checkboxes.* *1. Attends meetings* *2. Health plan representative serves as advisory member* *3. Submits data to collaborative* *4. Provides feedback on initiatives and projects* *5. Provides funding; explain the amount and nature of financial support*	*200 words.*
California Maternal Quality Care Collaborative (CMQCC)	*Single, Checkboxes.* *1: Participates* *2: Does not participate*	How does Applicant engage with collaborative? *Multi, Checkboxes.* *1. Attends meetings* *2. Health plan representative serves as advisory member*	*200 words.*

		3. Submits data to collaborative *4. Provides feedback on initiatives and projects* *5. Provides funding; explain the amount and nature of financial support*	
Collaborative Healthcare Patient Safety Organization (CHPSO)	*Single, Checkboxes.* *1: Participates* *2: Does not participate*	How does Applicant engage with collaborative? *Multi, Checkboxes.* *1. Attends meetings* *2. Health plan representative serves as advisory member* *3. Submits data to collaborative* *4. Provides feedback on initiatives and projects* *5. Provides funding; explain the amount and nature of financial support*	*200 words.*
California Improvement Network (CIN) This list for CIN partners can be found at: https://www.chcf.org/program/california-improvement-network/partners/	*Single, Checkboxes.* *1: Participates* *2: Does not participate*	How does Applicant engage with collaborative? *Multi, Checkboxes.* *1. Attends meetings* *2. Health plan representative serves as advisory member* *3. Submits data to collaborative* *4. Provides feedback on initiatives and projects* *5. Provides funding; explain the amount and nature of financial support* 1.	*200 words.*
California Right Meds Collaborative	*Single, Checkboxes.* *1: Participates* *2: Does not participate*	How does Applicant engage with collaborative? *Multi, Checkboxes.* *1. Attends meetings* *2. Health plan representative serves as advisory member* *3. Submits data to collaborative* *4. Provides feedback on initiatives and projects*	*200 words.*

		5. Provides funding; explain the amount and nature of financial support 1.	
Leapfrog	*Single, Checkboxes.* *1: Participates* *2: Does not participate*	How does Applicant engage with collaborative? *Multi, Checkboxes.* *1. Attends meetings* *2. Health plan representative serves as advisory member* *3. Submits data to collaborative* *4. Provides feedback on initiatives and projects* *5. Provides funding; explain the amount and nature of financial support*	*200 words.*
Symphony Provider Directory	*Single, Checkboxes.* *1: Participates* *2: Does not participate*	How does Applicant engage with collaborative? *Multi, Checkboxes.* *1. Attends meetings* *2. Health plan representative serves as advisory member* *3. Submits data to collaborative* *4. Provides feedback on initiatives and projects* *5. Provides funding; explain the amount and nature of financial support*	*200 words.*
Health Care Payments Data (HPD) System	*Single, Checkboxes.* *1: Participates* *2: Does not participate*	How does Applicant engage with collaborative? *Multi, Checkboxes.* *1. Attends meetings* *2. Health plan representative serves as advisory member* *3. Submits data to collaborative* *4. Provides feedback on initiatives and projects* *5. Provides funding; explain the amount and nature of financial support*	*200 words.*

Other similar collaboratives or initiative, explain in details section			*200 words.*

16.9 Data Sharing and Exchange

To improve the quality of care and successfully manage costs, successful Applicants are required to participate in a Health Information Exchange (HIE) by January 1, 2024 and encourage enhanced exchange of data along the patient, provider, hospital, and payer continuum. Covered California also 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. Applicants must participate in the Integrated Healthcare Association's (IHA) Align.Measure.Perform (AMP) Programs to aggregate data by January 1, 2023. In this section, Applicants will be assessed on the extent to which clinical data exchange is occurring, plans to improve data exchange, and the extent to which it is engaging with other payers and stakeholders to support data aggregation.

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

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

250 words.

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

	Response	*Response-* Applicant's HIE(s) that have membership in the California Trusted Exchange Network (CTEN)	*Response*	*Details*
HIE Participation – Applicant's Participation in	*Multi, Checkboxes.* *1: Manifest MedEx (formerly CalIndex),* *2: Los Angeles Network*	*Multi, Checkboxes.* *1: Manifest MedEx*	*Multi, Checkboxes.* *1: Applicant receipt of information from HIE(s)* *2: Applicant dissemination of*	*100 words.*

an HIE(s)	*for Enhanced Services (LANES),* *3: Orange County Partnership Regional Health Information Organization (OCPRHIO),* *4: San Diego Health Connect,* *5: Santa Cruz Health Information Exchange,* *6: Other, explain in Details section*	*(formerly CalIndex),* *2: Los Angeles Network for Enhanced Services (LANES),* *3: Orange County Partnership Regional Health Information Organization (OCPRHIO),* *4: San Diego Health Connect,* *5: Santa Cruz Health Information Exchange,*	*information to an HIE(s)* *3: Other, explain in Details section*	
HIE Participation – Indicate the core value of HIE participation for the Applicant.			*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: [100 words] ,* *7: No significant value* *8: N/A Applicant does not participate in an HIE*	*50 words.*

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

	Response
Number of individual contracted clinicians that participate in HIEs	*Decimal.*
Percent of individual contracted clinicians that participate in HIEs (Calculated as number of individual clinicians that participate in HIEs divided by total number of individual clinicians contracted with Applicant)	*Percent.*
Number of contracted hospitals that participate in HIEs	*Decimal.*
Percent of contracted hospitals that participate in HIEs (Calculated as number of hospitals that participate in HIEs divided by total number of hospitals contracted with Applicant)	*Percent.*
Describe Contractor’s activities to promote HIE participation by hospitals and individual clinicians.	*100 words.*

16.9.4 Report the number and percent of Applicant’s patients accessing their Patient Access Application Programming Interface (API).

	Response
Number of patients accessing their Patient Access API	*Decimal.*

Percent of patients accessing their Patient Access API	*Decimal.*

16.9.5 Identify the data aggregation initiatives in which Applicant is engaged to support aggregation of claims or other information across payers and describe its participation.

Multi, Checkboxes.
1: Integrated Health Association (IHA) Align Measure Perform (AMP) Commercial HMO and Commercial ACO program,
2: IHA Encounter Data Initiative,
3: IHA Cost and Quality Atlas,
4: IHA Provider Directory Utility (Symphony),
5: Cal Hospital Compare,
6: California Maternity Quality Care Collaborative (CMQCC),
7: Other, including any description of participation: [100 words]

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

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

	Response
Applicant has a process to support and monitor its contracted hospitals in their implementation of ADT data exchange with primary care providers for its Covered California enrollees.	*Single, Radio group.* *1: Yes,* *2: No*
Describe actions taken by Applicant to support and monitor its contracted hospitals in their implementation of ADT data exchange with primary care providers for its Covered California enrollees.	*200 words.*
Number of hospitals that have implemented ADT notification for Covered California enrollees.	*Decimal.*
Percent of hospitals that have implemented ADT notification for Covered California enrollees (Calculated as number of hospitals that have implemented ADT notification for Enrollees divided by total number of hospitals contracted with Applicant)	*Percent.*
Describe mechanisms in place to assist those hospitals not yet exchanging ADT data to primary care providers for Covered California enrollees.	*100 words.*

17 Health Plan Proposal

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

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

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

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

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

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

Applicant must cooperate with Covered California to implement coverage or subsidy programs, including those that complement existing programs that are administered by the Department of

Health Care Services (DHCS). These programs include requirements in Welfare and Institutions Code 14102.

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

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

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

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

17.3 Preliminary Premium Proposals.

Final negotiated and accepted premium rates shall be in effect for coverage effective January 1, 2023. Premium proposals are considered preliminary and may be subject to negotiation as part of QHP certification and selection process. The final negotiated premium rates must align with the product rate filings that will be submitted to the applicable regulatory agency. Premium proposals must be submitted with the Application. Premiums may vary by geographic area, family size, and age as permitted by State law, including the requirements of State Regulators regarding rate setting and rate variation set forth at Health and Safety Code §§ 1357.512 and 1399.855, Insurance Code §§ 10753.14 and 10965.9, 10 CCR § 2222.12 and, as applicable, other laws, rules and regulations, including, 45 C.F.R. § 156.255(b).

Applicant shall provide, in connection with any negotiation process as reasonably requested by Covered California, detailed documentation on Covered California-specific rate development methodology. Applicant shall provide justification, documentation, and support used to determine rate changes, including adequately supported cost projections. Cost projections include factors impacting rate changes, assumptions, transactions, and other information that affects Covered California-specific rate development process. Covered California may also request information pertaining to the key indicators driving the medical factors on trends in medical, pharmacy or other healthcare provider costs. This information may be necessary to support the assumptions made in forecasting and may be supported by information from Applicant's actuarial systems pertaining to Covered California-specific account. Applicant must confirm it will submit complete premium proposals for Individual products; the Unified Rate Review Template (URRT), the Supplemental Rate Review Template (SRRT), Actuarial Memorandum and the Rates Data Template through System for Electronic Rate and Form Filing (SERFF) available at:
https://www.qhpcertification.cms.gov/s/QHP.

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

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

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

Single, Pull-down list.
1: Yes, health plan proposal covers entire licensed geographic service area;
2: No, health plan proposal does not cover entire licensed geographic service area; template completed [100 words]

17.5 Applicant must indicate if it is requesting changes to its licensed geographic service area with the regulator, and if so, submit a copy of the applicable exhibit filed with regulator.

Single, Pull-down list.
1: Yes, filing service area expansion, exhibit attached, [50 words]
2: Yes, filing service area withdrawal, exhibit attached, [50 words]
3: No, no changes to service area

17.6 Applicant must indicate the different network products it intends to offer on Covered California in the individual market for the certification year. If proposing plans with different networks within the same product type, respond for Network 1 under the appropriate product category and respond for Network 2 in the category “Other”.

	Offered	Network Name(s)
HMO	*Single, Pull-down list.* *1: Yes* *2: No*	*10 words.*
PPO	*Single, Pull-down list.* *1: Yes* *2: No*	*10 words.*
EPO	*Single, Pull-down list.* *1: Yes* *2: No*	*10 words.*
Other	*Single, Pull-down list.* *1: Yes* *2: No*	*10 words.*

18 Health Maintenance Organization (HMO)

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

18.1 Benefit Design

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

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

18.1.2 Applicant must confirm all guidelines and due dates will be followed as listed in the Covered California Submission Guidelines Health Individual – Plan Year 2023.

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

Attached Document(s): Appendix D - Covered California Submission Guidelines Health Individual – Plan Year 2023

18.1.3 Applicant must indicate if it is requesting approval for any cost-sharing deviations from the coverage year Patient-Centered Benefit Plan Designs. If yes, Applicant must submit Attachment C - Patient-Centered Benefit Plan Design Deviations.

Note: Alternate benefit design proposals are not permitted in the Individual Marketplace. Covered California's decision whether to approve or deny QHP specific proposed deviations are on a case-by-case basis and are not considered an alternate benefit design.

Attached Document(s): Attachment C - Patient-Centered Benefit Plan Design Deviations

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

18.1.4 Covered California encourages Applicant to offer plan products which include all ten Essential Health Benefits, including the pediatric dental Essential Health Benefit. Applicant must indicate if it will adhere to the coverage year Patient-Centered Benefit Plan Design which includes all ten Essential Health Benefits. Failure to offer a product without pediatric dental will not be grounds for rejection of Applicant's application.

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

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

Single, Radio group.
1: Yes, describe: [100 words]
2: No, proposed QHPs will not include coverage of non-emergent out-of-network services

18.1.6 Applicant must confirm the coverage year Schedule of Benefits and Coverage (SBC), Evidence of Coverage (EOC) or Policy language describing proposed health Benefits will follow the requirements in the Covered California Submission Guidelines Health Individual – Plan Year 2023 and must comply with state and federal laws.

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

18.2 Benefit Administration

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

selected, Applicant must describe how it will ensure that the provision of pediatric dental benefits adheres to contractual requirements, including pediatric dental quality measures. Specifically address the following for the pediatric dental Essential Health Benefit:

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

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

18.2.2 Describe how Applicant administers child eye care benefits as either administered directly by Applicant or subcontracted to a vendor or specialized health care service plan. Use the details section to specifically address the following:

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

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

18.2.3 Covered California supports the innovative use of technology to assist in higher quality, accessible, patient-centered care. Describe Applicant's ability to support web or telehealth consultations, either through a contractor or provided by the medical group/provider.

Multi, Checkboxes.
1: Plan does not offer or allow web or telehealth consultations,
2: Telehealth with interactive face to face dialogue (video and audio),
3: Telehealth with interactive dialogue over the phone,
4: Telehealth asynchronous via email, text, instant messaging or other,
5: Remote patient monitoring,
6: e-Consult: provider-to-provider,
7: Other (specify): [20 words]

18.2.4 Applicant must complete Attachment D – Telehealth with the cost sharing for telehealth services for each metal tier.

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

Attached Document(s): Attachment D - Telehealth

18.2.5 Provide information in the following chart 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 lines of business,

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

	Response	Details
1. Report the percent of members with access to telehealth with interactive face to face dialogue (video and audio) with a network provider (Use as denominator total membership across all lines of business).	*Percent.*	*20 words.*
2. Report the percent of members with access to telehealth with interactive face to face dialogue (video and audio) with a telehealth vendor (Use as denominator total membership across all lines of business).	*Percent.*	*20 words.*
3. Report the percent of members with access to telehealth with interactive dialogue (audio only) by phone with a network provider (Use as denominator total membership across all lines of business).	*Percent.*	*20 words.*
4. Report the percent of members with access to telehealth with interactive dialogue (audio only) by phone with a telehealth vendor (Use as denominator total membership across all lines of business).	*Percent.*	*20 words.*
5. Report the percent of members with access to telehealth asynchronous via email, text, instant messaging, or other with a network provider (Use as denominator total membership across all lines of business).	*Percent.*	*20 words.*
6. Report the percent of members with access to telehealth asynchronous via email, text, instant messaging, or other with a telehealth vendor (Use as denominator total membership across all lines of business).	*Percent.*	*20 words.*
7. Report the percent of members with access to remote patient monitoring with a network provider (Use as denominator total membership across all lines of business).	*Percent.*	*20 words.*
8. Report the percent of members with access to remote patient monitoring with a telehealth vendor (Use as denominator total membership across all lines of business).	*Percent.*	*20 words.* Nothing required
9. Report the percent of providers with access to e-Consult: provider-to-provider (Use as denominator total providers across all lines of business).	*Percent.*	*20 words.*
10. Describe the availability of web or telehealth consultations in languages other than English. Include details on how members are notified about the availability of interpreter services for telehealth. Specify all languages offered in Details box.	*200 words.*	*20 words.*

11. Provide percentage of network physicians and/or physician groups and practices that are designated as having web or telehealth consultation services available (across all lines of business).	*Percent.*	*20 words.*
12. For physicians that are available to deliver web or telehealth consultations, what is the average wait time? If Applicant can provide average wait time, describe how that is monitored in the Details section.	*Compound, Radio group.* *1: On demand,* *2: Within 4 hours,* *3: Within same day,* *4: Scheduled follow-up within 48 hours,* *5: Other (describe): [100 words],* *6: N/A*	*20 words.*
13. Describe how Applicant promotes telehealth (either through vendor or medical group) as an alternative to the Emergency Department for urgent health issues (describe specific engagement efforts and any specific contractual requirements related to this topic for vendors or medical groups).	*200 words.*	
14. Applicant reimburses for web/telehealth consultations.	*Single, Radio group.* *1: Yes,* *2: No*	*20 words.*
15. Discuss how Applicant promotes integration and coordination of care between telehealth providers and primary care providers.	*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.).	*200 words.*	

18.3 Provider Network

18.3.1 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-V1.9.pdf. The provider network submission for the certification year must be consistent with what will be filed to the appropriate regulator for approval if Applicant is selected as a QHP Issuer. Covered California requires the information, as requested, to allow cross-network comparisons and evaluations.

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

3: Not attached, Applicant attesting to no material changes to existing plan year Covered California network for the certification year

18.3.2 Applicant must complete all tabs in Attachment E1 - HMO Provider Network Tables, for their HMO Network.

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

Attached Document(s): Attachment E1 – HMO Provider Network Tables

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

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

18.3.4 For leased networks, Applicant must describe the terms of the lease agreement. If not applicable, put "Not Applicable" in Response box.

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

18.3.5 As part of the lease agreement, 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 Covered California requirements: [500 words]
8: Not applicable

18.3.6 Describe tools and data sources used in assessing geographic access to primary, specialty, behavioral health, and hospital care based on enrollee access.

100 words.

18.3.7 Briefly describe methodology used to assess geographic access to primary, specialist, behavioral health, and hospital care based on enrollee residence, including relevant measurement criteria and benchmarks for ensuring adequate access.

300 words.

18.3.8 Describe tools and data sources used when tracking ethnic and racial diversity in the population and ensuring access to appropriate culturally competent providers.

100 words.

18.3.9 Briefly describe methodology used when tracking ethnic and racial diversity in the population and ensuring access to appropriate culturally competent providers, including relevant measurement criteria and benchmarks for ensuring adequate access.

300 words.

18.3.10 Describe tools and data sources used in assessing enrollee wait times for appointments with primary, specialty, and behavioral health providers.

100 words.

18.3.11 Briefly describe methodology used to assess wait times for appointments with primary, specialty, and behavioral health providers, including relevant measurement criteria and benchmarks for ensuring adequate access.

300 words.

18.3.12 Many California residents live in counties bordering other states where the out-of-state services are closer than in-state services.

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

18.3.13 Has Applicant applied for or received regulatory approval for an alternate network adequacy standard for any counties in proposed service area for the certification year?

Single, Pull-down list.
1: Yes,
2: No,
3: Not Applicable

18.3.14 If Applicant has applied for or received regulatory approval for an alternate network adequacy standard for any counties in proposed service area for the certification year, please list all applicable counties.

300 words.

18.3.15 Total Number of contracted behavioral health individual providers:

Integer.

18.3.16 Total Number of contracted behavioral health facility providers:

Integer.

18.3.17 Total Number of Contracted Hospitals:
Integer.

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

100 words.

18.4 Delivery System and Payment Strategies to Drive Quality

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

The Patient Protection and Affordable Care Act (§1311(g)(1)) requires periodic reporting to Covered California of activities a QHP Issuer has conducted to implement a strategy for quality improvement. This strategy is defined as a multi-year improvement strategy that includes a payment structure that provides increased reimbursement or other incentives for improving health outcomes, reducing hospital readmissions, improving patient safety, and reducing medical errors, implementing wellness and health promotion activities, or reducing 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.

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

- Effective Primary Care
- Accountable Care Organizations (ACOs) and Integrated Delivery Systems (IDSs)
- Appropriate Use of Cesarean Sections
- Hospital Patient Safety

QHP certification and participation in Covered California will be conditional on Applicant developing a multi-year QIS and reporting year-to-year activities and progress on each initiative area.

New entrant Applicants that are not currently operating in Covered California are not required to complete the QIS workplan updates as part of the 2023 Application but must review Attachment 1 with the understanding that engagement in the QIS and Attachment 1 initiatives will be contractually required and measured in the future if Applicant contracts with Covered California.

18.4.1 Provider Networks Based on Value

All questions required for new entrant Applicants that are currently operating in Covered California. Question 18.4.1.1 required for new entrant Applicants that are not currently operating in Covered California.

Applicants shall curate and manage their networks to address variation in quality and cost performance across network hospitals and providers, with a focus on improving the performance of hospitals and providers. Applicants shall measure, analyze, and reduce variation to achieve consistent high performance for all network hospitals and providers. Affordability is core to Covered California's mission to expand the availability of insurance coverage. The wide variation in unit price and total costs of care, with some providers and facilities charging far more for care irrespective of quality, is a key contributor to the high cost of medical services. Applicants shall hold its contracted hospitals and providers accountable for improving quality and managing or reducing cost and provide support to its contracted hospitals and providers to improve performance. The following questions address Applicant's ability to track and address variation in quality and cost performance across network hospitals and providers.

18.4.1.1 In the following table, Applicant must identify key quality and cost measures and criteria that the Applicant uses to evaluate providers and hospitals for network inclusion and continual network management and briefly explain how each measure is used.

	Data Source	*Purpose*	*Provide examples if selected 4 for Purpose*
Hospital Quality	*Multi, checkboxes* *1. Cal Hospital Compare data* *2. California Maternal Quality Collaborative data* *3. Leapfrog Group data* *4. CMS Hospital Quality Reporting* *5. Program or another CMS program* *6. Designated Center of Excellence (COE)* *7. Other, explain*	*Multi, checkboxes* *1. Used for initial contracting assessment* *2. Used for re-contracting assessment* *3. Has been used for incentive payments* *4. Has been used for termination or exclusion (give examples)* *5. Other, explain*	*200 words.*
Hospital Cost	*Multi, checkboxes* *1. Percent of Medicare rates* *2. Diagnosis-Related Group (DRG) costs* *3. Comparison to other hospital costs in geographic area*	*Multi, checkboxes* *1. Used for initial contracting assessment* *2. Used for re-contracting assessment* *3. Has been used for incentive payments*	*200 words.*

	4. Comparison to other hospital costs by decile or other method *5. CMS Hospital Price Transparency data* *6. Other, explain*	*4. Has been used for termination or exclusion (give examples)* *5. Other, explain*	
Provider Quality	*Multi, checkboxes* *1. Integrated Healthcare Association data* *2. Office of Patient Advocate data* *3. Other, explain*	*Multi, checkboxes* *1. Used for initial contracting assessment* *2. Used for re-contracting assessment* *3. Has been used for incentive payments* *4. Has been used for termination or exclusion (give examples)* *5. Other, explain*	*200 words.*
Provider Cost	*Multi, checkboxes* *1. Total Cost of Care data* *2. Comparison to other physician or physician groups in geographic area* *3. Other, explain*	*Multi, checkboxes* *1. Used for initial contracting assessment* *2. Used for re-contracting assessment* *3. Has been used for incentive payments* *4. Has been used for termination or exclusion (give examples)* *5. Other, explain*	*200 words.*

18.4.1.2 Complete Attachment K1 – QHP Networks Based on Value Work Plan to describe updates in Applicant's ability to build networks based on value. Applicant may submit any supporting documentation as an attachment. Address each of the following in the narrative:

- Progress in 2021 toward developing networks based on value including activities conducted, data collected and analyzed, and results
- Further implementation plans for 2022 with milestones and targets for 2022 and 2023 identified
- Describe any potential or current collaboration opportunities, new statewide or regional initiatives, or other activities that would strengthen Applicant's ability to address value and affordability
- Known or anticipated barriers in implementing activities and progress of mitigation activities

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

Attached Document(s): Attachment K1 – QHP Networks Based on Value Work Plan

18.4.2 Effective Primary Care

All questions required for new entrant Applicants that are currently operating in Covered California. Questions 18.4.2.1 and 18.4.2.2 required for new entrant Applicants that are not currently operating in Covered California.

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

This strategy meets the QIS requirements.

18.4.2.1 Report the percentage of members in Applicant's Covered California business who either selected or were matched with a primary care clinician in 2021 in Attachment J - QHP IND Run Charts. If Applicant had no Covered California business in 2021, report full 2021 book of business excluding Medicare. Currently contracted Applicant must enter the number and percentage of providers paid under each model reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, 2021, and 2022 as well. Report data by product (HMO, PPO, EPO, Other).

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

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

18.4.2.2 Report all types of payment methods used for primary care services and number of providers paid under each model in 2021 in Attachment J - QHP IND Run Charts using the alternative payment models (APM) outlined in the Health Care Payment Learning Action & Action Network (HCP LAN) Alternative Payment Model APM Framework. If Applicant had no Covered California business in 2021, report full 2021 book of business excluding Medicare. Currently contracted Applicant must enter the number and percentage of providers paid under each model reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, 2021, and 2022 as well. Report data by product (HMO, PPO, EPO, Other).

References:

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

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

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

18.4.2.3 Complete Attachment K2 – QHP QIS 1 Work Plan - Primary Care to 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 on the PCP matching initiative, including a status report, feedback on the enrollee experience, challenges, and suggestions (if applicable)

- Progress implementing alternative payment models for primary care to align with Category 3 or 4 APMs described in the APM Framework including: activities conducted, data collected and analyzed, and results
- Describe any support or technical assistance (financial, staffing, educational, etc.) that Applicant or multi-insurer collaborative is providing to primary care providers to support their efforts towards accessible, data-driven, team-based care
- How Applicant is encouraging enrollees to use accessible, data-driven, team-based care providers
- Further implementation plans for 2022 with milestones and targets for 2022 and 2023 identified
- Known or anticipated barriers in implementing QIS activities and progress of mitigation activities

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

Attached Document(s): Attachment K2 – QHP QIS 1 Work Plan - Primary Care

18.4.3 Integrated Delivery Systems and Accountable Care Organizations

All questions required for new entrant Applicants that are currently operating in Covered California. Questions 18.4.3.1 - 18.4.3.3 required for new entrant Applicants that are not currently operating in Covered California.

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

The following questions address Applicant's ability to increase enrollment in Integrated Delivery System (IDS) or Accountable Care Organization (ACO) models in its Covered California network.

This strategy meets the QIS requirements.

18.4.3.1 Using the definition for IDS or ACO above, report the number and percentage of Covered California members and total California members who are managed under an IDS or ACO in 2021 in Attachment J - QHP IND Run Charts. Currently contracted Applicants must enter the percentage reported in the Certification Application for 2016, 2017, 2018, 2019, 2020, 2021, and

2022 as well. If Applicant had no Covered California business in 2021, report full 2021 book of business excluding Medicare. Report data by product (HMO, PPO, EPO, Other).

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

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

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

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

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

	Response
(File titled Provider 1a): Applicant's quality and cost measures used to track progress and success of IDS or ACO providers.	*Single, Pull-down list.* *1: Attached,* *2: Not attached*
(File titled Provider 1b): Example of Applicant report to its IDS or ACO providers on its quality of care and financial performance, including benchmarking relative	*Single, Pull-down list.*

to performance improvement goals or market norms.	*1: Attached,* *2: Not attached*
(File titled Provider 1c): Confirm Applicant will submit a copy of Applicant's 2021 IHA Align Measure Perform (AMP) Commercial ACO report when it becomes available, if Applicant participates in the program.	*Single, Pull-down list.* *1: Confirmed,* *2: Not confirmed,* *3: N/A*

18.4.3.4 Complete Attachment K3 – QHP QIS 2 Work Plan - IDS and ACO to describe updates on progress made since the previous QIS submission on each component of the IDS or ACO goals and planned activities. Applicant may submit any supporting documentation as an attachment. Address each of the following in the narrative:

- Progress in 2021 toward the end goal including activities conducted, data collected and analyzed, and results
- Further implementation plans for 2022 with milestones and targets for 2022 and 2023 identified
- How Applicant expects to evolve its model, based on progress or outcomes to date
- How Applicant is providing support for integration and coordination of care through coaching, funding, implementation of information systems, technical assistance, or other means
- Other activities conducted since the previous QIS submission to promote IDSs or ACOs or activities that will be conducted
- Known or anticipated barriers in implementation of QIS and progress of mitigation activities

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

Attached Document(s): Attachment K3 – QHP QIS 2 Work Plan IDs and ACO

18.4.4 Appropriate Use of Cesarean Sections

All questions required for new entrant Applicants that are currently operating in Covered California. Questions 18.4.4.1 - 18.4.4.3, 18.4.4.5 and 18.4.4.6 required for new entrant Applicants that are not currently operating in Covered California.

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) Consider a hospital's NTSV C-section rate, improvement trajectory, and willingness to engage in coaching as part of its maternity hospital contracting decisions and terms. Covered California does not expect Contractor to base poor performance, and potential network removal decisions, on one measure alone. 4) New entrant Applicants are expected to adopt a payment methodology structured to support only medically necessary care with no financial incentive to perform C-sections for all contracted physicians and hospitals serving Enrollees by year end 2023.

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

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

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

This strategy meets the QIS requirements.

18.4.4.1 Describe how Applicant is measuring overuse of Cesarean Sections and how it is implementing Smart Care California guidelines (https://www.iha.org/wp-content/uploads/2020/12/c-section_menu_of_payment_and_contracting_options.pdf) to promote best practices of care in these areas.

100 words.

18.4.4.2 Report number of all network hospitals reporting to the CMQCC's MDC in 2021 in Attachment J - QHP IND Run Charts. A list of all California hospitals participating in the MDC can be found here: https://www.cmqcc.org/about-cmqcc/member-hospitals. Currently contracted applicants must enter the percentage reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, 2021, and 2022 as well. If Applicant had no Covered California business in 2021, report full 2021 book of business excluding Medicare.

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

18.4.4.3 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 2021 in Attachment J - QHP IND Run Charts. Currently contracted Applicants must enter the percentages reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, 2021, and 2022 as well. If Applicant had no Covered California business in 2021, report full 2021 book of business excluding Medicare. References: https://www.iha.org/wp-content/uploads/2020/12/c-section_menu_of_payment_and_contracting_options.pdf.

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

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

18.4.4.4 Complete Attachment K4 – QHP QIS 3 Work Plan - Appropriate Use of C-Sections to describe updates on progress made since the last QIS submission with regards to promoting appropriate use of Cesarean-Sections (C-Sections). Applicant may submit any supporting documentation as an attachment.

Note: Refer to Appendix S for hospital C-section rates.

Address each of the following in the narrative:

- Description of how Applicant engages with its network hospitals to reduce NTSV C-Section rates to 23.9% or less by year end 2023
- Description of its adjustments to payment strategy in alignment with Smart Care California guidelines so that no hospitals or physicians are incentivized to perform an NTSV C-Section by year end 2023
- Description of how NTSV C-section rates are included in network hospital and provider contracting criteria
- Description of how Applicant promotes and encourages all in-network hospitals that provide maternity services to use the resources provided by California Maternity Quality Care Collaborative (CMQCC) and enroll in the CMQCC Maternal Data Center (MDC)
- Updates to hospital participation in CMQCC and hospital engagement in maternity care quality improvement, particularly those with a NTSV rate higher than 23.9%
- List any known or anticipated barriers in implementing QIS activities and progress of mitigation activities

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

Attached Document(s): Appendix M HAI, Sepsis, and NTSV C-Section, Attachment K4 – QHP QIS 3 Work Plan - Appropriate Use of C-Sections

18.4.4.5 Applicant must confirm that all network physicians are paid on a case rate for deliveries and that payment is the same for both vaginal and C-section delivery. If not, Applicant must complete the following table.

	Response			
Confirm that all network physicians are paid on a case rate for deliveries and that payment is the same for both vaginal and C-section delivery.	*Single, Radio group.* *1: Confirmed* *2: Not confirmed, complete table*			
Payment Strategy	**Description**	**Percent of Physicians Paid Under Strategy**	**Numerator**	**Denominator**
Strategy 1: Blended Case Rate	*50 words.*	*Percent.*	*Integer.*	*Integer.*
Strategy 2: Provide quality bonuses for physicians that attain NTSV C-section rate goal or make improvements in reducing NTSV C-sections	*50 words.*	*Percent.*	*Integer.*	*Integer.*
Strategy 3: Population-based payment models	*50 words.*	*Percent.*	*Integer.*	*Integer.*
Strategy 4: Other (explain)	*50 words.*	*Percent.*	*Integer.*	*Integer.*
Strategy 5: Other (explain)	*50 words.*	*Percent.*	*Integer.*	*Integer.*

Strategy 6: Other (explain)	*50 words.*	*Percent.*	*Integer.*	*Integer.*

18.4.5 Hospital Patient Safety

All questions required for new entrant Applicants that are currently operating in Covered California. Questions 18.4.5.1 and 18.4.5.2 required for new entrant Applicants that are not currently operating in Covered California.

Applicant will: 1) Adopt a hospital payment methodology that places all 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 Associated Infection (HAI) measures outlined in Attachment 1 or are working to improve. 3) Promote hospital involvement in improvement programs so that all hospitals comply with Sepsis Management according to CMS guidelines.

The five HAIs and Sepsis Management are:

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

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

This strategy meets the QIS requirements.

18.4.5.1 Report, across all lines of business, the percentage of hospital reimbursement at risk for quality performance and the quality indicators used in 2021 in Attachment J - QHP IND 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 HAIs, readmissions, patient satisfaction, etc. In the same sheet, report quality indicators used to assess quality performance. Currently contracted Applicant must enter the percentages reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, 2021, and 2022 as well. If Applicant had no Covered California business in 2021, report full 2021 book of business excluding Medicare.

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

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

18.4.5.2 Report the number of hospitals contracted under the model described in question 18.4.5.1 with reimbursement at risk for quality performance in 2021 in Attachment J - QHP IND Run Charts. Currently contracted Applicants must enter the numbers reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, 2021, and 2022 as well. If Applicant had no Covered California business in 2021, report full 2021 book of business excluding Medicare.

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

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

18.4.5.3 Complete Attachment K5 – QHP QIS 4 Work Plan - Hospital Patient Safety to describe progress promoting hospital safety since the last submission. Applicant may submit any supporting documentation as an attachment.

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

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

Address each of the following in the narrative:

- How Applicant is engaging with its network hospitals to reduce the five specified HAIs and Sepsis Management measure
- How Applicant is leveraging the poor performing hospitals list provided by Cal Hospital Compare to collaborate with other QHP Issuers who contract with the same poor performing hospitals
- Progress in 2021 toward the end goal and any further implementation plans for 2021 with milestones and targets for 2022 and 2023 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 Infections (HAIs). Refer to Appendix S: CAUTI, CLABSI, CDI, MRSA Rates, and SSI Colon Rates
- Applicant's progress in adopting a progressive payment strategy to tie at least 2% of network hospital payments to value by year end 2023
- 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

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

Attached Document(s): Appendix M HAI, Sepsis, and NTSV C-Section, Attachment K5 – QHP QIS 4 Work Plan - Hospital Patient Safety

19 Preferred Provider Organization (PPO)

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

19.1 Benefit Design

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

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

19.1.2 Applicant must confirm all guidelines and due dates will be followed as listed in the Covered California Submission Guidelines Health Individual – Plan Year 2023.

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

Attached Document(s): Appendix D - Covered California Submission Guidelines Health Individual – Plan Year 2023

19.1.3 Applicant must indicate if it is requesting approval for any cost-sharing deviations from the coverage year Patient-Centered Benefit Plan Designs. If yes, Applicant must submit Attachment C - Patient-Centered Benefit Plan Design Deviations.

> *Note: Alternate benefit design proposals are not permitted in the Individual Marketplace. Covered California's decision whether to approve or deny QHP specific proposed deviations are on a case-by-case basis and are not considered an alternate benefit design.*

Attached Document(s): Attachment C - Patient-Centered Benefit Plan Design Deviations

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

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

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

Single, Radio group.
1: Yes, describe: [100 words]
2: No, proposed QHPs will not include coverage of non-emergent out-of-network services

19.1.6 Applicant must confirm the coverage year Schedule of Benefits and Coverage (SBC), Evidence of Coverage (EOC) or Policy language describing proposed health benefits will follow the requirements in the Covered California Submission Guidelines Health Individual – Plan Year 2023 and must comply with state and federal laws.

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

19.2 Benefit Administration

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

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

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

19.2.2 Describe how Applicant administers child eye care benefits as either administered directly by Applicant or subcontracted to a vendor or specialized health care service plan. Use the details section to specifically address the following:

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

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

19.2.3 Covered California supports the innovative use of technology to assist in higher quality, accessible, patient-centered care. Describe Applicant's ability to support web or telehealth consultations, either through a contractor or provided by the medical group/provider.

Multi, Checkboxes.
1: Plan does not offer or allow web or telehealth consultations,
2: Telehealth with interactive face to face dialogue (video and audio),
3: Telehealth with interactive dialogue over the phone,
4: Telehealth asynchronous via email, text, instant messaging or other,
5: Remote patient monitoring,
6: e-Consult: provider-to-provider,
7: Other (specify): [20 words]

19.2.4 Applicant must complete Attachment D – Telehealth with the cost sharing for telehealth services for each metal tier.

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

Attached Document(s): Attachment D - Telehealth

19.2.5 Provide information in the following chart 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 lines of business, particularly Covered California membership. If Applicant is not currently contracted with Covered California, provide a description of its telehealth capabilities and indicate whether those services will be offered to Covered California members.

	Response	Details
1. Report the percent of members with access to telehealth with interactive face to face dialogue (video and audio) with a network provider (Use as denominator total membership across all lines of business).	*Percent.*	*20 words.*
2. Report the percent of members with access to telehealth with interactive face to face dialogue (video and audio) with a telehealth vendor (Use as denominator total membership across all lines of business).	*Percent.*	*20 words.*
3. Report the percent of members with access to telehealth with interactive dialogue (audio only) by phone with a network provider (Use as denominator total membership across all lines of business).	*Percent.*	*20 words.*
4. Report the percent of members with access to telehealth with interactive dialogue (audio only) by phone with a telehealth vendor (Use as denominator total membership across all lines of business).	*Percent.*	*20 words.*
5. Report the percent of members with access to telehealth asynchronous via email, text, instant messaging, or other with a network provider (Use as denominator total membership across all lines of business).	*Percent.*	*20 words.*
6. Report the percent of members with access to telehealth asynchronous via email, text, instant messaging, or other with a telehealth vendor (Use as denominator total membership across all lines of business).	*Percent.*	*20 words.*
7. Report the percent of members with access to remote patient monitoring with a network provider (Use as denominator total membership across all lines of business).	*Percent.*	*20 words.*
8. Report the percent of members with access to remote patient monitoring with a telehealth vendor (Use as denominator total membership across all lines of business).	*Percent.*	*20 words.*
9. Report the percent of providers with access to e-Consult: provider-to-provider (Use as denominator total providers across all lines of business).	*Percent.*	*20 words.*

10. Describe the availability of web or telehealth consultations in languages other than English. Include details on how members are notified about the availability of interpreter services for telehealth. Specify all languages offered in Details box.	*200 words.*	*20 words.*
11. Provide percentage of network physicians and/or physician groups and practices that are designated as having web or telehealth consultation services available (across all lines of business).	*Percent.*	*20 words.*
12. For physicians that are available to deliver web or telehealth consultations, what is the average wait time? If Applicant can provide average wait time, describe how that is monitored in the Details section.	*Compound, Radio group.* *1: On demand,* *2: Within 4 hours,* *3: Within same day,* *4: Scheduled follow-up within 48 hours,* *5: Other (describe): [100 words],* *6: NA*	*20 words.*
13. Describe how Applicant promotes telehealth (either through vendor or medical group) as an alternative to the Emergency Department for urgent health issues (describe specific engagement efforts and any specific contractual requirements related to this topic for vendors or medical groups).	*200 words.*	
14. Applicant reimburses for web/telehealth consultations.	*Single, Radio group.* N/A OK. *1: Yes,* *2: No*	*20 words.*
15. Discuss how Applicant promotes integration and coordination of care between telehealth providers and primary care providers.	*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.).	*200 words.*	

19.3 Provider Network

19.3.1 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-V1.9.pdf. The provider network submission for the certification year must be consistent with what will be filed to the appropriate regulator for approval if Applicant is selected as a QHP Issuer. Covered California requires the information, as requested, to allow cross-network comparisons and evaluations.

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

19.3.2 Applicant must complete all tabs in Attachment E2 - PPO Provider Network Tables, for their PPO Network.

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

Attached Document(s): Attachment E2 – PPO Provider Network Tables

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

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

19.3.4 For leased networks, Applicant must describe the terms of the lease agreement. If not applicable, put “Not Applicable” in Response box.

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

19.3.5 As part of the lease agreement, 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 Covered California requirements: [500 words]
8: Not applicable

19.3.6 Describe tools and data sources used in assessing geographic access to primary, specialty, behavioral health, and hospital care based on enrollee access.
100 words.

19.3.7 Briefly describe methodology used to assess geographic access to primary, specialist, behavioral health, and hospital care based on enrollee residence, including relevant measurement criteria and benchmarks for ensuring adequate access.
300 words.

19.3.8 Describe tools and data sources used when tracking ethnic and racial diversity in the population and ensuring access to appropriate culturally competent providers.
100 words.

19.3.9 Briefly describe methodology used when tracking ethnic and racial diversity in the population and ensuring access to appropriate culturally competent providers, including relevant measurement criteria and benchmarks for ensuring adequate access.
300 words.

19.3.10 Describe tools and data sources used in assessing enrollee wait times for appointments with primary, specialty, and behavioral health providers.
100 words.

19.3.11 Briefly describe methodology used to assess wait times for appointments with primary, specialty, and behavioral health providers, including relevant measurement criteria and benchmarks for ensuring adequate access.
300 words.

19.3.12 Many California residents live in counties bordering other states where the out-of-state services are closer than in-state services.

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

19.3.13 Has Applicant applied for or received regulatory approval for an alternate network adequacy standard for any counties in proposed service area for the certification year?

Single, Pull-down list.
1: Yes,
2: No,
3: Not Applicable

19.3.14 If Applicant has applied for or received regulatory approval for an alternate network adequacy standard for any counties in proposed service area for the certification year, please list all applicable counties.

300 words.

19.3.15 Total Number of contracted behavioral health individual providers:

Integer.

19.3.16 Total Number of contracted behavioral health facility providers:

Integer.

19.3.17 Total Number of Contracted Hospitals:
Integer.

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

100 words.

19.4 Delivery System and Payment Strategies to Drive Quality

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

The Patient Protection and Affordable Care Act (§1311(g)(1)) requires periodic reporting to Covered California of activities a QHP Issuer has conducted to implement a strategy for quality improvement. This strategy is defined as a multi-year improvement strategy that includes a payment structure that provides increased reimbursement or other incentives for improving health outcomes, reducing hospital readmissions, improving patient safety, and reducing medical errors, implementing wellness and health promotion activities, or reducing 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.

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

- Effective Primary Care
- Accountable Care Organizations (ACOs) and Integrated Delivery Systems (IDSs)

- Appropriate Use of Cesarean Sections
- Hospital Patient Safety

QHP certification and participation in Covered California will be conditional on Applicant developing a multi-year QIS and reporting year-to-year activities and progress on each initiative area.

New entrant Applicants that are not currently operating in Covered California are not required to complete the QIS workplan updates as part of the 2023 Application but must review Attachment 1 with the understanding that engagement in the QIS and Attachment 1 initiatives will be contractually required and measured in the future if Applicant contracts with Covered California.

19.4.1 Provider Networks Based on Value

All questions required for new entrant Applicants that are currently operating in Covered California. Question 19.4.1.1 required for new entrant Applicants that are not currently operating in Covered California. All questions should be answered at the product level, not Issuer level.

Applicants shall curate and manage their networks to address variation in quality and cost performance across network hospitals and providers, with a focus on improving the performance of hospitals and providers. Applicants shall measure, analyze, and reduce variation to achieve consistent high performance for all network hospitals and providers. Affordability is core to Covered California's mission to expand the availability of insurance coverage. The wide variation in unit price and total costs of care, with some providers and facilities charging far more for care irrespective of quality, is a key contributor to the high cost of medical services. Applicants shall hold its contracted hospitals and providers accountable for improving quality and managing or reducing cost and provide support to its contracted hospitals and providers to improve performance. The following questions address Applicant's ability to track and address variation in quality and cost performance across network hospitals and providers.

19.4.1.1 In the following table, Applicant must identify key quality and cost measures and criteria that the Applicant uses to evaluate providers and hospitals for network inclusion and continual network management and briefly explain how each measure is used.

	Data Source	*Purpose*	*Provide examples if selected 4 for Purpose*
Hospital Quality	*Multi, checkboxes* *1. Cal Hospital Compare data* *2. California Maternal Quality Collaborative data* *3. Leapfrog Group data* *4. CMS Hospital Quality Reporting* *5. Program or another CMS program* *6. Designated Center of Excellence (COE)* *7. Other, explain*	*Multi, checkboxes* *1. Used for initial contracting assessment* *2. Used for re-contracting assessment* *3. Has been used for incentive payments* *4. Has been used for termination or exclusion (give examples)* *5. Other, explain*	*200 words.*
Hospital Cost	*Multi, checkboxes*	*Multi, checkboxes*	*200 words.*

	1. Percent of Medicare rates *2. Diagnosis-Related Group (DRG) costs* *3. Comparison to other hospital costs in geographic area* *4. Comparison to other hospital costs by decile or other method* *5. CMS Hospital Price Transparency data* *6. Other, explain*	*1. Used for initial contracting assessment* *2. Used for re-contracting assessment* *3. Has been used for incentive payments* *4. Has been used for termination or exclusion (give examples)* *5. Other, explain*	
Provider Quality	*Multi, checkboxes* *1. Integrated Healthcare Association data* *2. Office of Patient Advocate data* *3. Other, explain*	*Multi, checkboxes* *1. Used for initial contracting assessment* *2. Used for re-contracting assessment* *3. Has been used for incentive payments* *4. Has been used for termination or exclusion (give examples)* *5. Other, explain*	*200 words.*
Provider Cost	*Multi, checkboxes* *1. Total Cost of Care data* *2. Comparison to other physician or physician groups in geographic area* *3. Other, explain*	*Multi, checkboxes* *1. Used for initial contracting assessment* *2. Used for re-contracting assessment* *3. Has been used for incentive payments* *4. Has been used for termination or exclusion (give examples)* *5. Other, explain*	*200 words.*

19.4.1.2 Complete Attachment K1 – QHP Networks Based on Value Work Plan to describe updates in Applicant's ability to build networks based on value. Applicant may submit any supporting documentation as an attachment. Address each of the following in the narrative:

- Progress in 2021 toward developing networks based on value including activities conducted, data collected and analyzed, and results
- Further implementation plans for 2022 with milestones and targets for 2022 and 2023 identified
- Describe any potential or current collaboration opportunities, new statewide or regional initiatives, or other activities that would strengthen Applicant's ability to address value and affordability
- Known or anticipated barriers in implementing activities and progress of mitigation activities

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

Attached Document(s): Attachment K1 – QHP Networks Based on Value Work Plan

19.4.2 Effective Primary Care

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

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

This strategy meets the QIS requirements.

19.4.2.1 Report the percentage of members in Applicant's Covered California business who either selected or were matched with a primary care clinician in 2021 in Attachment J - QHP IND Run Charts. If Applicant had no Covered California business in 2021, report full 2021 book of business excluding Medicare. Currently contracted Applicant must enter the number and percentage of providers paid under each model reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, 2021, and 2022 as well. Report data by product (HMO, PPO, EPO, Other).

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

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

19.4.2.2 Report all types of payment methods used for primary care services and number of providers paid under each model in 2021 in Attachment J - QHP IND Run Charts using the alternative payment models (APM) outlined in the Health Care Payment Learning Action & Action Network (HCP LAN) Alternative Payment Model APM Framework. If Applicant had no Covered California business in 2021, report full 2021 book of business excluding Medicare. Currently contracted Applicant must enter the number and percentage of providers paid under each model reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, 2021, and 2022 as well. Report data by product (HMO, PPO, EPO, Other).

References:

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

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

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

19.4.2.3 Complete Attachment K2 – QHP QIS 1 Work Plan - Primary Care to 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 on the PCP matching initiative, including a status report, feedback on the enrollee experience, challenges, and suggestions (if applicable)
- Progress implementing alternative payment models for primary care to align with Category 3 or 4 APMs described in the APM Framework including: activities conducted, data collected and analyzed, and results
- Describe any support or technical assistance (financial, staffing, educational, etc.) that Applicant or multi-insurer collaborative is providing to primary care providers to support their efforts towards accessible, data-driven, team-based care
- How Applicant is encouraging enrollees to use accessible, data-driven, team-based care providers
- Further implementation plans for 2022 with milestones and targets for 2022 and 2023 identified
- Known or anticipated barriers in implementing QIS activities and progress of mitigation activities

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

Attached Document(s): Attachment K2 – QHP QIS 1 Work Plan - Primary Care

19.4.3 Integrated Delivery Systems and Accountable Care Organizations

All questions required for new entrant Applicants that are currently operating in Covered California. Questions 19.4.3.1 - 19.4.3.3 required for new entrant Applicants that are not currently operating in Covered California. All questions should be answered at the product level, not Issuer level.

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

The following questions address Applicant's ability to increase enrollment in Integrated Delivery System (IDS) or Accountable Care Organization (ACO) models in its Covered California network.

This strategy meets the QIS requirements.

19.4.3.1 Using the definition for IDS or ACO above, report the number and percentage of Covered California members and total California members who are managed under an IDS or ACO in 2021 in Attachment J - QHP IND Run Charts. Currently contracted Applicants must enter the percentage reported in the Certification Application for 2016, 2017, 2018, 2019, 2020, 2021, and 2022 as well. If Applicant had no Covered California business in 2021, report full 2021 book of business excluding Medicare. Report data by product (HMO, PPO, EPO, Other).

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

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

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

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

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

	Response
(File titled Provider 1a): Applicant's quality and cost measures used to track progress and success of IDS or ACO providers.	*Single, Pull-down list.* *1: Attached,* *2: Not attached*
(File titled Provider 1b): Example of Applicant report to its IDS or ACO providers on its quality of care and financial performance, including benchmarking relative to performance improvement goals or market norms.	*Single, Pull-down list.* *1: Attached,* *2: Not attached*
(File titled Provider 1c): Confirm Applicant will submit a copy of Applicant's 2021 IHA Align Measure Perform (AMP) Commercial ACO report when it becomes available, if Applicant participates in the program.	*Single, Pull-down list.* *1: Confirmed,* *2: Not confirmed,* *3: N/A*

19.4.3.4 Complete Attachment K3 – QHP QIS 2 Work Plan - IDS and ACO to describe updates on progress made since the previous QIS submission on each component of the IDS or ACO goals and planned activities. Applicant may submit any supporting documentation as an attachment. Address each of the following in the narrative:

- Progress in 2021 toward the end goal including activities conducted, data collected and analyzed, and results
- Further implementation plans for 2022 with milestones and targets for 2022 and 2023 identified
- How Applicant expects to evolve its model, based on progress or outcomes to date
- How Applicant is providing support for integration and coordination of care through coaching, funding, implementation of information systems, technical assistance, or other means
- Other activities conducted since the previous QIS submission to promote IDSs or ACOs or activities that will be conducted
- Known or anticipated barriers in implementation of QIS and progress of mitigation activities

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

Attached Document(s): Attachment K3 – QHP QIS 2 Work Plan IDs and ACO

19.4.4 Appropriate Use of Cesarean Sections

All questions required for new entrant Applicants that are currently operating in Covered California. Questions 19.4.4.1 - 19.4.4.3, 19.4.4.5 and 19.4.4.6 required for new entrant Applicants that are not currently operating in Covered California. All questions should be answered at the product level, not Issuer level.

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) Consider a hospital's NTSV C-section rate, improvement trajectory, and willingness to engage in coaching as part of its maternity hospital contracting decisions and terms. Covered California does not expect Contractor to base poor performance, and potential network removal decisions, on one measure alone. 4) New entrant Applicants are expected to adopt a payment methodology structured to support only medically necessary care with no financial incentive to perform C-sections for all contracted physicians and hospitals serving Enrollees by year end 2023.

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

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

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

This strategy meets the QIS requirements.

19.4.4.1 Describe how Applicant is measuring overuse of Cesarean Sections and how it is implementing Smart Care California guidelines (https://www.iha.org/wp-content/uploads/2020/12/c-section_menu_of_payment_and_contracting_options.pdf) to promote best practices of care in these areas.

100 words.

19.4.4.2 Report number of all network hospitals reporting to the CMQCC's MDC in 2021 in Attachment J - QHP IND Run Charts. A list of all California hospitals participating in the MDC can be found here: https://www.cmqcc.org/about-cmqcc/member-hospitals. Currently contracted applicants must enter the percentage reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, 2021, and 2022 as well. If Applicant had no Covered California business in 2021, report full 2021 book of business excluding Medicare.

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

19.4.4.3 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 2021 in Attachment J - QHP IND Run Charts. Currently contracted Applicants must enter the percentages reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, 2021, and 2022 as well. If Applicant had no Covered California business in 2021, report full 2021 book of business excluding Medicare.

References: https://www.iha.org/wp-content/uploads/2020/12/c-section_menu_of_payment_and_contracting_options.pdf

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

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

19.4.4.4 Complete Attachment K4 – QHP QIS 3 Work Plan - Appropriate Use of C-Sections to describe updates on progress made since the last QIS submission with regards to promoting appropriate use of Cesarean-Sections (C-Sections). Applicant may submit any supporting documentation as an attachment.

Note: Refer to Appendix S for hospital C-section rates.

Address each of the following in the narrative:

- Description of how Applicant engages with its network hospitals to reduce NTSV C-Section rates to 23.9% or less by year end 2023
- Description of its adjustments to payment strategy in alignment with Smart Care California guidelines so that no hospitals or physicians are incentivized to perform an NTSV C-Section by year end 2023
- Description of how NTSV C-section rates are included in network hospital and provider contracting criteria
- Description of how Applicant promotes and encourages all in-network hospitals that provide maternity services to use the resources provided by California Maternity Quality Care Collaborative (CMQCC) and enroll in the CMQCC Maternal Data Center (MDC)
- Updates to hospital participation in CMQCC and hospital engagement in maternity care quality improvement, particularly those with a NTSV rate higher than 23.9%
- List any known or anticipated barriers in implementing QIS activities and progress of mitigation activities

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

Attached Document(s): Appendix M HAI, Sepsis, and NTSV C-Section , Attachment K4 – QHP QIS 3 Work Plan - Appropriate Use of C-Sections

19.4.4.5 Applicant must confirm that all network physicians are paid on a case rate for deliveries and that payment is the same for both vaginal and C-section delivery. If not, Applicant must complete the following table.

	Response			
Confirm that all network physicians are paid on a case rate for deliveries and that payment is the same for both vaginal and C-section delivery.	*Single, Radio group.* *1: Confirmed* *2: Not confirmed, complete table*			
Payment Strategy	**Description**	**Percent of Physicians Paid**	**Numerator**	**Denominator**

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

19.4.5 Hospital Patient Safety

All questions required for new entrant Applicants that are currently operating in Covered California. Questions 18.4.5.1 and 18.4.5.2 required for new entrant Applicants that are not currently operating in Covered California. All questions should be answered at the product level, not Issuer level.

Applicant will: 1) Adopt a hospital payment methodology that places all 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 Associated Infection (HAI) measures outlined in Attachment 1 or are working to improve. 3) Promote hospital involvement in improvement programs so that all hospitals comply with Sepsis Management according to CMS guidelines.

The five HAIs and Sepsis Management are:

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

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

This strategy meets the QIS requirements.

19.4.5.1 Report, across all lines of business, the percentage of hospital reimbursement at risk for quality performance and the quality indicators used in 2021 in Attachment J - QHP IND 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 HAIs, readmissions, patient satisfaction, etc. In the same sheet, report quality indicators used to assess quality performance. Currently contracted Applicant must enter the percentages reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, 2021, and 2022 as well. If Applicant had no Covered California business in 2021, report full 2021 book of business excluding Medicare.

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

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

19.4.5.2 Report the number of hospitals contracted under the model described in question 19.4.5.1 with reimbursement at risk for quality performance in 2021 in Attachment J - QHP IND Run Charts. Currently contracted Applicants must enter the numbers reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, 2021, and 2022 as well. If Applicant had no Covered California business in 2021, report full 2021 book of business excluding Medicare.

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

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

19.4.5.3 Complete Attachment K5 – QHP QIS 4 Work Plan - Hospital Patient Safety to describe progress promoting hospital safety since the last submission. Applicant may submit any supporting documentation as an attachment.

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

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

Address each of the following in the narrative:

- How Applicant is engaging with its network hospitals to reduce the five specified HAIs and Sepsis Management measure
- How Applicant is leveraging the poor performing hospitals list provided by Cal Hospital Compare to collaborate with other QHP Issuers who contract with the same poor performing hospitals
- Progress in 2021 toward the end goal and any further implementation plans for 2021 with milestones and targets for 2022 and 2023 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 Infections (HAIs). Refer to Appendix S: CAUTI, CLABSI, CDI, MRSA Rates, and SSI Colon Rates
- Applicant's progress in adopting a progressive payment strategy to tie at least 2% of network hospital payments to value by year end 2023
- 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

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

Attached Document(s): Appendix M HAI, Sepsis, and NTSV C-Section , Attachment K5 – QHP QIS 4 Work Plan - Hospital Patient Safety

20 Exclusive Provider Organization (EPO)

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

20.1 Benefit Design

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

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

20.1.2 Applicant must confirm all guidelines and due dates will be followed as listed in the Covered California Submission Guidelines Health Individual – Plan Year 2023.

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

Attached Document(s): Appendix D - Covered California Submission Guidelines Health Individual – Plan Year 2023

20.1.3 Applicant must indicate if it is requesting approval for any cost-sharing deviations from the coverage year Patient-Centered Benefit Plan Designs. If yes, Applicant must submit Attachment C – Patient-Centered Benefit Plan Design Deviations.

Note: Alternate benefit design proposals are not permitted in the Individual Marketplace. Covered California's decision whether to approve or deny QHP specific proposed deviations are on a case-by-case basis and are not considered an alternate benefit design.

Attached Document(s): Attachment C - Patient-Centered Benefit Plan Design Deviations
Single, Pull-down.
1: Yes, deviations requested, attached.
2: No, no deviations requested

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

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

Single, Radio group.
1: Yes, describe: [100 words]
2: No, proposed QHPs will not include coverage of non-emergent out-of-network services

20.1.6 Applicant must confirm the coverage year Schedule of Benefits and Coverage (SBC), Evidence of Coverage (EOC) or Policy language describing proposed health benefits will follow the requirements in the Covered California Submission Guidelines Health Individual – Plan Year 2023 and must comply with state and federal laws.
Single, Radio group.
1: Confirmed
2: Not confirmed: [100 words]

20.2 Benefit Administration

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

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

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

20.2.2 Describe how Applicant administers child eye care benefits as either administered directly by Applicant or subcontracted to a vendor or specialized health care service plan. Use the details section to specifically address the following:

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

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

20.2.3 Covered California supports the innovative use of technology to assist in higher quality, accessible, patient-centered care. Describe Applicant's ability to support web or telehealth consultations, either through a contractor or provided by the medical group/provider.

Multi, Checkboxes.
1: Plan does not offer or allow web or telehealth consultations,
2: Telehealth with interactive face to face dialogue (video and audio),
3: Telehealth with interactive dialogue over the phone,
4: Telehealth asynchronous via email, text, instant messaging or other,
5: Remote patient monitoring,
6: e-Consult: provider-to-provider,
7: Other (specify): [20 words]

20.2.4 Applicant must complete Attachment D – Telehealth with the cost sharing for telehealth services for each metal tier.

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

Attached Document(s): Attachment D – Telehealth

20.2.5 Provide information in the following chart 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 lines of business, particularly Covered California membership. If Applicant is not currently contracted with Covered California, provide a description of its telehealth capabilities, and indicate whether those services will be offered to Covered California members.

	Response	Details
1. Report the percent of members with access to telehealth with interactive face to face dialogue (video and audio) with a network provider (Use as denominator total membership across all lines of business).	*Percent.*	*20 words.*
2. Report the percent of members with access to telehealth with interactive face to face dialogue (video and audio) with a telehealth vendor (Use as denominator total membership across all lines of business).	*Percent.*	*20 words.*
3. Report the percent of members with access to telehealth with interactive dialogue (audio only) by phone with a network provider (Use as denominator total membership across all lines of business).	*Percent.*	*20 words.*
4. Report the percent of members with access to telehealth with interactive dialogue (audio only) by phone with a telehealth vendor (Use as denominator total membership across all lines of business).	*Percent.*	*20 words.*
5. Report the percent of members with access to telehealth asynchronous via email, text, instant messaging, or other with a network provider (Use as denominator total membership across all lines of business).	*Percent.*	*20 words.*
6. Report the percent of members with access to telehealth asynchronous via email, text, instant messaging, or other with a telehealth vendor (Use as denominator total membership across all lines of business).	*Percent.*	*20 words.*

7. Report the percent of members with access to remote patient monitoring with a network provider (Use as denominator total membership across all lines of business).	*Percent*.	*20 words.*
8. Report the percent of members with access to remote patient monitoring with a telehealth vendor (Use as denominator total membership across all lines of business).	*Percent.*	*20 words.*
9. Report the percent of providers with access to e-Consult: provider-to-provider (Use as denominator total providers across all lines of business).	*Percent.*	*20 words.*
10. Describe the availability of web or telehealth consultations in languages other than English. Include details on how members are notified about the availability of interpreter services for telehealth. Specify all languages offered in Details box.	*200 words.*	*20 words.*
11. Provide percentage of network physicians and/or physician groups and practices that are designated as having web or telehealth consultation services available (across all lines of business).	*Percent.*	*20 words.*
12. For physicians that are available to deliver web or telehealth consultations, what is the average wait time? If Applicant can provide average wait time, describe how that is monitored in the Details section.	*Compound, Radio group.* *1: On demand,* *2: Within 4 hours,* *3: Within same day,* *4: Scheduled follow-up within 48 hours,* *5: Other (describe): [100 words],* *6: NA*	*20 words.*
13. Describe how Applicant promotes telehealth (either through vendor or medical group) as an alternative to the Emergency Department for urgent health issues (describe specific engagement efforts and any specific contractual requirements related to this topic for vendors or medical groups).	*200 words.*	
14. Applicant reimburses for web/telehealth consultations.	*Single, Radio group.* *1: Yes,* *2: No*	*20 words.*
15. Discuss how Applicant promotes integration and coordination of care between telehealth providers and primary care providers.	*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.).	*200 words.*	

20.3 Provider Network

20.3.1 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-V1.9.pdf. The provider network submission for the certification year must be consistent with what will be filed to the appropriate regulator for approval if Applicant is selected as a QHP Issuer. Covered California requires the information, as requested, to allow cross-network comparisons and evaluations.

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

20.3.2 Applicant must complete all tabs in Attachment E3 - EPO Provider Network Tables, for their HMO Network.

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

Attached Document(s): Attachment E3 – EPO – Provider Network Tables

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

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

20.3.4 For leased networks, Applicant must describe the terms of the lease agreement. If not applicable, put “Not Applicable” in Response box.

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

20.3.5 As part of the lease agreement 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 Covered California requirements: [500 words]
8: Not applicable

20.3.6 Describe tools and data sources used in assessing geographic access to primary, specialty, behavioral health, and hospital care based on enrollee access.

100 words.

20.3.7 Briefly describe methodology used to assess geographic access to primary, specialist, behavioral health, and hospital care based on enrollee residence, including relevant measurement criteria and benchmarks for ensuring adequate access.

300 words.

20.3.8 Describe tools and data sources used when tracking ethnic and racial diversity in the population and ensuring access to appropriate culturally competent providers.

100 words.

20.3.9 Briefly describe methodology used when tracking ethnic and racial diversity in the population and ensuring access to appropriate culturally competent providers, including relevant measurement criteria and benchmarks for ensuring adequate access.

300 words.

20.3.10 Describe tools and data sources used in assessing enrollee wait times for appointments with primary, specialty, and behavioral health providers.

100 words.

20.3.11 Briefly describe methodology used to assess wait times for appointments with primary, specialty, and behavioral health providers, including relevant measurement criteria and benchmarks for ensuring adequate access.

300 words.

20.3.12 Many California residents live in counties bordering other states where the out-of-state services are closer than in-state services.

Does Applicant offer coverage in a California county or region bordering another state?	*Single, Pull-down list.*

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

20.3.13 Has Applicant applied for or received regulatory approval for an alternate network adequacy standard for any counties in proposed service area for the certification year?

Single, Pull-down list.
1: Yes,
2: No,
3: Not Applicable

20.3.14 If Applicant has applied for or received regulatory approval for an alternate network adequacy standard for any counties in proposed service area for the certification year, please list all applicable counties.

300 words.

20.3.15 Total Number of contracted behavioral health individual providers:

Integer.

20.3.16 Total Number of contracted behavioral health facility providers:

Integer.

20.3.17 Total Number of Contracted Hospitals:
Integer.

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

100 words.

20.4 Delivery System and Payment Strategies to Drive Quality

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

The Patient Protection and Affordable Care Act (§1311(g)(1)) requires periodic reporting to Covered California of activities a QHP Issuer has conducted to implement a strategy for quality improvement. This strategy is defined as a multi-year improvement strategy that includes a payment structure that provides increased reimbursement or other incentives for improving health

outcomes, reducing hospital readmissions, improving patient safety, and reducing medical errors, implementing wellness and health promotion activities, or reducing 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.

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

- Effective Primary Care
- Accountable Care Organizations (ACOs) and Integrated Delivery Systems (IDSs)
- Appropriate Use of Cesarean Sections
- Hospital Patient Safety

QHP certification and participation in Covered California will be conditional on Applicant developing a multi-year QIS and reporting year-to-year activities and progress on each initiative area.

New entrant Applicants that are not currently operating in Covered California are not required to complete the QIS workplan updates as part of the 2023 Application but must review Attachment 1 with the understanding that engagement in the QIS and Attachment 1 initiatives will be contractually required and measured in the future if Applicant contracts with Covered California.

20.4.1 Provider Networks Based on Value

All questions required for new entrant Applicants that are currently operating in Covered California. Question 20.4.1.1 required for new entrant Applicants that are not currently operating in Covered California. All questions should be answered at the product level, not Issuer level.

Applicants shall curate and manage their networks to address variation in quality and cost performance across network hospitals and providers, with a focus on improving the performance of hospitals and providers. Applicants shall measure, analyze, and reduce variation to achieve consistent high performance for all network hospitals and providers. Affordability is core to Covered California's mission to expand the availability of insurance coverage. The wide variation in unit price and total costs of care, with some providers and facilities charging far more for care irrespective of quality, is a key contributor to the high cost of medical services. Applicants shall hold its contracted hospitals and providers accountable for improving quality and managing or reducing cost and provide support to its contracted hospitals and providers to improve performance. The following questions address Applicant's ability to track and address variation in quality and cost performance across network hospitals and providers.

20.4.1.1 In the following table, Applicant must identify key quality and cost measures and criteria that the Applicant uses to evaluate providers and hospitals for network inclusion and continual network management and briefly explain how each measure is used.

	Data Source	*Purpose*	*Provide examples if selected 4 for Purpose*

Hospital Quality	*Multi, checkboxes* *1. Cal Hospital Compare data* *2. California Maternal Quality Collaborative data* *3. Leapfrog Group data* *4. CMS Hospital Quality Reporting* *5. Program or another CMS program* *6. Designated Center of Excellence (COE)* *7. Other, explain*	*Multi, checkboxes* *1. Used for initial contracting assessment* *2. Used for re-contracting assessment* *3. Has been used for incentive payments* *4. Has been used for termination or exclusion (give examples)* *5. Other, explain*	*200 words.*
Hospital Cost	*Multi, checkboxes* *1. Percent of Medicare rates* *2. Diagnosis-Related Group (DRG) costs* *3. Comparison to other hospital costs in geographic area* *4. Comparison to other hospital costs by decile or other method* *5. CMS Hospital Price Transparency data* *6. Other, explain*	*Multi, checkboxes* *1. Used for initial contracting assessment* *2. Used for re-contracting assessment* *3. Has been used for incentive payments* *4. Has been used for termination or exclusion (give examples)* *5. Other, explain*	*200 words.*
Provider Quality	*Multi, checkboxes* *1. Integrated Healthcare Association data* *2. Office of Patient Advocate data* *3. Other, explain*	*Multi, checkboxes* *1. Used for initial contracting assessment* *2. Used for re-contracting assessment* *3. Has been used for incentive payments* *4. Has been used for termination or exclusion (give examples)* *5. Other, explain*	*200 words.*
Provider Cost	*Multi, checkboxes* *1. Total Cost of Care data* *2. Comparison to other physician or physician groups in geographic area* *3. Other, explain*	*Multi, checkboxes* *1. Used for initial contracting assessment* *2. Used for re-contracting assessment* *3. Has been used for incentive payments* *4. Has been used for termination or exclusion (give examples)* *5. Other, explain*	*200 words.*

20.4.1.2 Complete Attachment K1 – QHP Networks Based on Value Work Plan to describe updates in Applicant's ability to build networks based on value. Applicant may submit any supporting documentation as an attachment. Address each of the following in the narrative:

- Progress in 2021 toward developing networks based on value including activities conducted, data collected and analyzed, and results
- Further implementation plans for 2022 with milestones and targets for 2022 and 2023 identified
- Describe any potential or current collaboration opportunities, new statewide or regional initiatives, or other activities that would strengthen Applicant's ability to address value and affordability
- Known or anticipated barriers in implementing activities and progress of mitigation activities

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

Attached Document(s): Attachment K1 – QHP Networks Based on Value Work Plan

20.4.2 Effective Primary Care

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

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

This strategy meets the QIS requirements.

20.4.2.1 Report the percentage of members in Applicant's Covered California business who either selected or were matched with a primary care clinician in 2021 in Attachment J - QHP IND Run Charts. If Applicant had no Covered California business in 2021, report full 2021 book of business excluding Medicare. Currently contracted Applicant must enter the number and percentage of providers paid under each model reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, 2021, and 2022 as well. Report data by product (HMO, PPO, EPO, Other).

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

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

20.4.2.2 Report all types of payment methods used for primary care services and number of providers paid under each model in 2021 in Attachment J - QHP IND Run Charts using the alternative payment models (APM) outlined in the Health Care Payment Learning Action & Action Network (HCP LAN) Alternative Payment Model APM Framework. If Applicant had no Covered

California business in 2021, report full 2021 book of business excluding Medicare. Currently contracted Applicant must enter the number and percentage of providers paid under each model reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, 2021, and 2022 as well. Report data by product (HMO, PPO, EPO, Other).

References:

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

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

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

20.4.2.3 Complete Attachment K2 – QHP QIS 1 Work Plan - Primary Care to 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 on the PCP matching initiative, including a status report, feedback on the enrollee experience, challenges, and suggestions (if applicable)
- Progress implementing alternative payment models for primary care to align with Category 3 or 4 APMs described in the APM Framework including: activities conducted, data collected and analyzed, and results
- Describe any support or technical assistance (financial, staffing, educational, etc.) that Applicant or multi-insurer collaborative is providing to primary care providers to support their efforts towards accessible, data-driven, team-based care
- How Applicant is encouraging enrollees to use accessible, data-driven, team-based care providers
- Further implementation plans for 2022 with milestones and targets for 2022 and 2023 identified
- Known or anticipated barriers in implementing QIS activities and progress of mitigation activities

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

Attached Document(s): Attachment K2 – QHP QIS 1 Work Plan - Primary Care

20.4.3 Integrated Delivery Systems and Accountable Care Organizations

All questions required for new entrant Applicants that are currently operating in Covered California. Questions 20.4.3.1 - 20.4.3.3 required for new entrant Applicants that are not currently operating in Covered California. All questions should be answered at the product level, not Issuer level.

Evidence suggests the adoption and expansion of integrated, coordinated, and accountable systems of care such as IDSs or ACOs can lead to improved quality and reduced costs. An IDS is defined as an organized healthcare delivery system in which payers, hospitals, and providers coordinate to provide patient care, integrate care across settings, and share responsibility for

patient outcomes and resource use. IDS partners are generally managed by the same organization. An ACO is defined as a system of population-based care coordinated across the continuum including multidisciplinary physicians and physician groups, hospitals, and ancillary providers with combined risk sharing arrangements and shared incentives between providers or between payers and providers. Ideally ACO partners are held accountable for nationally recognized clinical, financial, and operational performance. As providers accept more accountability under this provision, Applicant shall ensure that providers have the capacity to manage the risk. There are many variations of ACO implementation with evidence suggesting that there are key characteristics of an ACO model that influence its success.

The following questions address Applicant's ability to increase enrollment in Integrated Delivery System (IDS) or Accountable Care Organization (ACO) models in its Covered California network.

This strategy meets the QIS requirements.

20.4.3.1 Using the definition for IDS or ACO above, report the number and percentage of Covered California members and total California members who are managed under an IDS or ACO in 2021 in Attachment J - QHP IND Run Charts. Currently contracted Applicants must enter the percentage reported in the Certification Application for 2016, 2017, 2018, 2019, 2020, 2021, and 2022 as well. If Applicant had no Covered California business in 2021, report full 2021 book of business excluding Medicare. Report data by product (HMO, PPO, EPO, Other).

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

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

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

Base payment: Global capitation	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*
Base payment: Professional capitation only	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*
Base payment: Separate professional capitation and hospital capitation	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*
Base payment: Fee for service	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*
Base payment: Other	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*
Performance payment: Two-sided shared savings (upside/downside risk)	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*
Performance payment: One-sided shared savings (upside risk)	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*
Performance payment: Pay for performance quality bonus	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*
Performance payment: Other	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*
Leadership: Physician-led	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*
Leadership: Hospital-led	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*
Leadership: Plan-led	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*
Leadership: Other	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*
Leadership: Jointly led by physician and hospitals	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*
Member assignment: Attribution algorithm	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*
Member assignment: Patient selection	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*
Member assignment: Health plan assignment	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*
Member assignment: Other	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*
Timing: Retrospective	*Single, Pull-down list.*	*50 words.*

	1: Yes *2: No*	
Timing: Prospective	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*
Timing: Other	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*

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

	Response
(File titled Provider 1a): Applicant's quality and cost measures used to track progress and success of IDS or ACO providers.	*Single, Pull-down list.* *1: Attached,* *2: Not attached*
(File titled Provider 1b): Example of Applicant report to its IDS or ACO providers on its quality of care and financial performance, including benchmarking relative to performance improvement goals or market norms.	*Single, Pull-down list.* *1: Attached,* *2: Not attached*
(File titled Provider 1c): Confirm Applicant will submit a copy of Applicant's 2021 IHA Align Measure Perform (AMP) Commercial ACO report when it becomes available, if Applicant participates in the program.	*Single, Pull-down list.* *1: Confirmed,* *2: Not confirmed,* *3: N/A*

20.4.3.4 Complete Attachment K3 – QHP QIS 2 Work Plan - IDS and ACO to describe updates on progress made since the previous QIS submission on each component of the IDS or ACO goals and planned activities. Applicant may submit any supporting documentation as an attachment. Address each of the following in the narrative:

- Progress in 2021 toward the end goal including activities conducted, data collected and analyzed, and results
- Further implementation plans for 2022 with milestones and targets for 2022 and 2023 identified
- How Applicant expects to evolve its model, based on progress or outcomes to date
- How Applicant is providing support for integration and coordination of care through coaching, funding, implementation of information systems, technical assistance, or other means
- Other activities conducted since the previous QIS submission to promote IDSs or ACOs or activities that will be conducted
- Known or anticipated barriers in implementation of QIS and progress of mitigation activities

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

Attached Document(s): Attachment K3 – QHP QIS 2 Work Plan IDs and ACO

20.4.4 Appropriate Use of Cesarean Sections

All questions required for new entrant Applicants that are currently operating in Covered California. Questions 20.4.4.1 - 20.4.4.3, 20.4.4.5 and 20.4.4.6 required for new entrant Applicants that are not currently operating in Covered California. All questions should be answered at the product level, not Issuer level.

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) Consider a hospital's NTSV C-section rate, improvement trajectory, and willingness to engage in coaching as part of its maternity hospital contracting decisions and terms. Covered California does not expect Contractor to base poor performance, and potential network removal decisions, on one measure alone. 4) New entrant Applicants are expected to adopt a payment methodology structured to support only medically necessary care with no financial incentive to perform C-sections for all contracted physicians and hospitals serving Enrollees by year end 2023.

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

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

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

This strategy meets the QIS requirements.

20.4.4.1 Describe how Applicant is measuring overuse of Cesarean Sections and how it is implementing Smart Care California guidelines (https://www.iha.org/wp-content/uploads/2020/12/c-section_menu_of_payment_and_contracting_options.pdf) to promote best practices of care in these areas.

100 words.

20.4.4.2 Report number of all network hospitals reporting to the CMQCC's MDC in 2021 in Attachment J - QHP IND Run Charts. A list of all California hospitals participating in the MDC can be found here: https://www.cmqcc.org/about-cmqcc/member-hospitals. Currently contracted applicants must enter the percentage reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, 2021, and 2022 as well. If Applicant had no Covered California business in 2021, report full 2021 book of business excluding Medicare.

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

20.4.4.3 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 2021 in Attachment J - QHP IND Run Charts. Currently contracted Applicants must enter the percentages reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, 2021, and 2022 as well. If Applicant had no Covered California business in 2021, report full 2021 book of business excluding Medicare. References: https://www.iha.org/wp-content/uploads/2020/12/c-section_menu_of_payment_and_contracting_options.pdf.

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

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

20.4.4.4 Complete Attachment K4 – QHP QIS 3 Work Plan - Appropriate Use of C-Sections to describe updates on progress made since the last QIS submission with regards to promoting appropriate use of Cesarean-Sections (C-Sections). Applicant may submit any supporting documentation as an attachment.

Note: Refer to Appendix S for hospital C-section rates.

Address each of the following in the narrative:

- Description of how Applicant engages with its network hospitals to reduce NTSV C-Section rates to 23.9% or less by year end 2023
- Description of its adjustments to payment strategy in alignment with Smart Care California guidelines so that no hospitals or physicians are incentivized to perform an NTSV C-Section by year end 2023
- Description of how NTSV C-section rates are included in network hospital and provider contracting criteria
- Description of how Applicant promotes and encourages all in-network hospitals that provide maternity services to use the resources provided by California Maternity Quality Care Collaborative (CMQCC) and enroll in the CMQCC Maternal Data Center (MDC)
- Updates to hospital participation in CMQCC and hospital engagement in maternity care quality improvement, particularly those with a NTSV rate higher than 23.9%
- List any known or anticipated barriers in implementing QIS activities and progress of mitigation activities

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

Attached Document(s): Appendix M HAI, Sepsis, and NTSV C-Section, Attachment K4 – QHP QIS 3 Work Plan - Appropriate Use of C-Sections

20.4.4.5 Applicant must confirm that all network physicians are paid on a case rate for deliveries and that payment is the same for both vaginal and C-section delivery. If not, Applicant must complete the following table.

	Response			

Confirm that all network physicians are paid on a case rate for deliveries and that payment is the same for both vaginal and C-section delivery.	*Single, Radio group.* *1: Confirmed* *2: Not confirmed, complete table*			
Payment Strategy	**Description**	**Percent of Physicians Paid Under Strategy**	**Numerator**	**Denominator**
Strategy 1: Blended Case Rate	*50 words.*	*Percent.*	*Integer.*	*Integer.*
Strategy 2: Provide quality bonuses for physicians that attain NTSV C-section rate goal or make improvements in reducing NTSV C-sections	*50 words.*	*Percent.*	*Integer.*	*Integer.*
Strategy 3: Population-based payment models	*50 words.*	*Percent.*	*Integer.*	*Integer.*
Strategy 4: Other (explain)	*50 words.*	*Percent.*	*Integer.*	*Integer.*
Strategy 5: Other (explain)	*50 words.*	*Percent.*	*Integer.*	*Integer.*
Strategy 6: Other (explain)	*50 words.*	*Percent.*	*Integer.*	*Integer.*

20.4.5 Hospital Patient Safety

All questions required for new entrant Applicants that are currently operating in Covered California. Questions 21.4.5.1 and 21.4.5.2 required for new entrant Applicants that are not currently operating in Covered California. All questions should be answered at the product level, not Issuer level.

Applicant will: 1) Adopt a hospital payment methodology that places all 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 Associated Infection (HAI) measures outlined in Attachment 1 or are working to improve. 3) Promote hospital involvement in improvement programs so that all hospitals comply with Sepsis Management according to CMS guidelines.

The five HAIs and Sepsis Management are:

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

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

This strategy meets the QIS requirements.

20.4.5.1 Report, across all lines of business, the percentage of hospital reimbursement at risk for quality performance and the quality indicators used in 2021 in Attachment J - QHP IND 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 HAIs, readmissions, patient satisfaction, etc. In the same sheet, report quality indicators used to assess quality performance. Currently contracted Applicant must enter the percentages reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, 2021, and 2022 as well. If Applicant had no Covered California business in 2021, report full 2021 book of business excluding Medicare.

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

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

20.4.5.2 Report the number of hospitals contracted under the model described in question 20.4.5.1 with reimbursement at risk for quality performance in 2021 in Attachment J - QHP IND Run Charts. Currently contracted Applicants must enter the numbers reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, 2021, and 2022 as well. If Applicant had no Covered California business in 2021, report full 2021 book of business excluding Medicare.

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

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

20.4.5.3 Complete Attachment K5 – QHP QIS 4 Work Plan - Hospital Patient Safety to describe progress promoting hospital safety since the last submission. Applicant may submit any supporting documentation as an attachment.

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

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

Address each of the following in the narrative:

- How Applicant is engaging with its network hospitals to reduce the five specified HAIs and Sepsis Management measure
- How Applicant is leveraging the poor performing hospitals list provided by Cal Hospital Compare to collaborate with other QHP Issuers who contract with the same poor performing hospitals
- Progress in 2021 toward the end goal and any further implementation plans for 2021 with milestones and targets for 2022 and 2023 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 Infections (HAIs). Refer to Appendix S: CAUTI, CLABSI, CDI, MRSA Rates, and SSI Colon Rates
- Applicant's progress in adopting a progressive payment strategy to tie at least 2% of network hospital payments to value by year end 2023
- 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

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

Attached Document(s): Appendix M HAI, Sepsis, and NTSV C-Section , Attachment K5 – QHP QIS 4 Work Plan - Hospital Patient Safety

21 Other Network Type

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

21.1 Benefit Design

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

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

21.1.2 Applicant must confirm all guidelines and due dates will be followed as listed in the Covered California Submission Guidelines Health Individual– Plan Year 2023.

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

Attached Document(s): Appendix D - Covered California Submission Guidelines Health Individual – Plan Year 2023

21.1.3 Applicant must indicate if it is requesting approval for any cost-sharing deviations from the coverage year Patient-Centered Benefit Plan Designs. If yes, Applicant must submit Attachment C - Patient-Centered Benefit Plan Design Deviations.

Note: Alternate benefit design proposals are not permitted in the Individual Marketplace. Covered California's decision whether to approve or deny QHP specific proposed deviations are on a case-by-case basis and are not considered an alternate benefit design.

Attached Document(s): Attachment C - Patient-Centered Benefit Plan Design Deviations

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

21.1.4 Covered California encourages Applicant to offer plan products which include all ten Essential Health Benefits, including the pediatric dental Essential Health Benefit. Applicant must

indicate if it will adhere to the coverage year Patient-Centered Benefit Plan Design which includes all ten Essential Health Benefits. Failure to offer a product without pediatric dental will not be grounds for rejection of Applicant's application.

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

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

Single, Radio group.
1: Yes, describe: [100 words]
2: No, proposed QHPs will not include coverage of non-emergent out-of-network services

21.1.6 Applicant must confirm the coverage year Schedule of Benefits and Coverage (SBC), Evidence of Coverage (EOC) or Policy language describing proposed health benefits will follow the requirements in the Covered California Submission Guidelines Health Individual – Plan Year 2023 and must comply with state and federal laws.

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

21.2 Benefit Administration

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

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

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

21.2.2 Describe how Applicant administers child eye care benefits as either administered directly by Applicant or subcontracted to a vendor or specialized health care service plan. Use the details section to specifically address the following:

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

- If the benefit is subcontracted, state the name of the contractor, and describe any performance incentives included in the child eye care benefits subcontractor contract including metrics used for performance assessment.

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

21.2.3 Covered California supports the innovative use of technology to assist in higher quality, accessible, patient-centered care. Describe Applicant's ability to support web or telehealth consultations, either through a contractor or provided by the medical group/provider.

Multi, Checkboxes.
1: Plan does not offer or allow web or telehealth consultations,
2: Telehealth with interactive face to face dialogue (video and audio),
3: Telehealth with interactive dialogue over the phone,
4: Telehealth asynchronous via email, text, instant messaging or other,
5: Remote patient monitoring,
6: e-Consult: provider-to-provider,
7: Other (specify): [20 words]

21.2.4 Applicant must complete Attachment D – Telehealth with the cost sharing for telehealth services for each metal tier.

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

Attached Document(s): Attachment D - Telehealth

21.2.5 Provide information in the following chart 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 lines of business, particularly Covered California membership. If Applicant is not currently contracted with Covered California, provide a description of its telehealth capabilities, and indicate whether those services will be offered to Covered California members.

	Response	Details
1. Report the percent of members with access to telehealth with interactive face to face dialogue (video and audio) with a network provider (Use as denominator total membership across all lines of business).	*Percent.*	*20 words.*
2. Report the percent of members with access to telehealth with interactive face to face dialogue (video and audio) with a telehealth vendor (Use as denominator total membership across all lines of business).	*Percent.*	*20 words.*
3. Report the percent of members with access to telehealth with interactive dialogue (audio only) by phone with a network provider (Use as denominator total membership across all lines of business).	*Percent.*	*20 words.*
4. Report the percent of members with access to telehealth with interactive dialogue (audio only) by phone with a telehealth vendor (Use as denominator total membership across all lines of business).	*Percent.*	*20 words.*

5. Report the percent of members with access to telehealth asynchronous via email, text, instant messaging, or other with a network provider (Use as denominator total membership across all lines of business).	*Percent.*	*20 words.*
6. Report the percent of members with access to telehealth asynchronous via email, text, instant messaging, or other with a telehealth vendor (Use as denominator total membership across all lines of business).	*Percent.*	*20 words.*
7. Report the percent of members with access to remote patient monitoring with a network provider (Use as denominator total membership across all lines of business).	*Percent.*	*20 words.*
8. Report the percent of members with access to remote patient monitoring with a telehealth vendor (Use as denominator total membership across all lines of business).	*Percent.*	*20 words.*
9. Report the percent of providers with access to e-Consult: provider-to-provider (Use as denominator total providers across all lines of business).	*Percent.*	*20 words.*
10. Describe the availability of web or telehealth consultations in languages other than English. Include details on how members are notified about the availability of interpreter services for telehealth. Specify all languages offered in Details box.	*200 words.*	*20 words.*
11. Provide percentage of network physicians and/or physician groups and practices that are designated as having web or telehealth consultation services available (across all lines of business).	*Percent.*	*20 words.*
12. For physicians that are available to deliver web or telehealth consultations, what is the average wait time? If Applicant can provide average wait time, describe how that is monitored in the Details section.	*Compound, Radio group.* *1: On demand,* *2: Within 4 hours,* *3: Within same day,* *4: Scheduled follow-up within 48 hours,* *5: Other (describe): [100 words],* *6: NA*	*20 words.*
13. Describe how Applicant promotes telehealth (either through vendor or medical group) as an alternative to the Emergency Department for urgent health issues (describe specific engagement efforts and any specific contractual requirements related to this topic for vendors or medical groups).	*200 words.*	

14. Applicant reimburses for web/telehealth consultations.	*Single, Radio group.* *1: Yes,* *2: No*	*20 words.*
15. Discuss how Applicant promotes integration and coordination of care between telehealth providers and primary care providers.	*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.).	*200 words.*	

21.3 Provider Network

21.3.1 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-V1.9.pdf. The provider network submission for certification year must be consistent with what will be filed to the appropriate regulator for approval if Applicant is selected as a QHP Issuer. Covered California requires the information, as requested, to allow cross-network comparisons and evaluations.

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

21.3.2 Applicant must complete all tabs in Attachment E4 - Other Provider Network Tables, for their HMO Network.

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

Attached Document(s): Attachment E4 – Other Provider Network Tables

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

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

21.3.4 For leased networks, Applicant must describe the terms of the lease agreement. If not applicable, put “Not Applicable” in Response box.

	Response

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

21.3.5 As part of the lease agreement, 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 Covered California requirements: [500 words]
8: Not applicable

21.3.6 Describe tools and data sources used in assessing geographic access to primary, specialty, behavioral health, and hospital care based on enrollee access.
100 words.

21.3.7 Briefly describe methodology used to assess geographic access to primary, specialist, behavioral health, and hospital care based on enrollee residence, including relevant measurement criteria and benchmarks for ensuring adequate access.
300 words.

21.3.8 Describe tools and data sources used when tracking ethnic and racial diversity in the population and ensuring access to appropriate culturally competent providers.
100 words.

21.3.9 Briefly describe methodology used when tracking ethnic and racial diversity in the population and ensuring access to appropriate culturally competent providers, including relevant measurement criteria and benchmarks for ensuring adequate access.
300 words.

21.3.10 Describe tools and data sources used in assessing enrollee wait times for appointments with primary, specialty, and behavioral health providers.
100 words.

21.3.11 Briefly describe methodology used to assess wait times for appointments with primary, specialty, and behavioral health providers, including relevant measurement criteria and benchmarks for ensuring adequate access.

300 words.

21.3.12 Many California residents live in counties bordering other states where the out-of-state services are closer than in-state services.

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

21.3.13 Has Applicant applied for or received regulatory approval for an alternate network adequacy standard for any counties in proposed service area for the certification year?

Single, Pull-down list.
1: Yes,
2: No,
3: Not Applicable

21.3.14 If Applicant has applied for or received regulatory approval for an alternate network adequacy standard for any counties in proposed service area for the certification year, please list all applicable counties.

300 words.

21.3.15 Total Number of contracted behavioral health individual providers:

Integer.

21.3.16 Total Number of contracted behavioral health facility providers:

Integer.

21.3.17 Total Number of Contracted Hospitals:
Integer.

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

100 words.

21.4 Delivery System and Payment Strategies to Drive Quality

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

The Patient Protection and Affordable Care Act (§1311(g)(1)) requires periodic reporting to Covered California of activities a QHP Issuer has conducted to implement a strategy for quality improvement. This strategy is defined as a multi-year improvement strategy that includes a payment structure that provides increased reimbursement or other incentives for improving health outcomes, reducing hospital readmissions, improving patient safety, and reducing medical errors, implementing wellness and health promotion activities, or reducing 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.

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

- Effective Primary Care
- Accountable Care Organizations (ACOs) and Integrated Delivery Systems (IDSs)
- Appropriate Use of Cesarean Sections
- Hospital Patient Safety

QHP certification and participation in Covered California will be conditional on Applicant developing a multi-year QIS and reporting year-to-year activities and progress on each initiative area.

New entrant Applicants that are not currently operating in Covered California are not required to complete the QIS workplan updates as part of the 2023 Application but must review Attachment 1 with the understanding that engagement in the QIS and Attachment 1 initiatives will be contractually required and measured in the future if Applicant contracts with Covered California.

21.4.1 Provider Networks Based on Value

All questions required for new entrant Applicants that are currently operating in Covered California. Question 21.4.1.1 required for new entrant Applicants that are not currently operating in Covered California. All questions should be answered at the product level, not Issuer level.

Applicants shall curate and manage their networks to address variation in quality and cost performance across network hospitals and providers, with a focus on improving the performance of hospitals and providers. Applicants shall measure, analyze, and reduce variation to achieve consistent high performance for all network hospitals and providers. Affordability is core to Covered California's mission to expand the availability of insurance coverage. The wide variation in unit price and total costs of care, with some providers and facilities charging far more for care irrespective of quality, is a key contributor to the high cost of medical services. Applicants shall hold its contracted hospitals and providers accountable for improving quality and managing or reducing cost and provide support to its contracted hospitals and providers to improve

performance. The following questions address Applicant's ability to track and address variation in quality and cost performance across network hospitals and providers.

21.4.1.1 In the following table, Applicant must identify key quality and cost measures and criteria that the Applicant uses to evaluate providers and hospitals for network inclusion and continual network management and briefly explain how each measure is used.

	Data Source	*Purpose*	*Provide examples if selected 4 for Purpose*
Hospital Quality	*Multi, checkboxes* *1. Cal Hospital Compare data* *2. California Maternal Quality Collaborative data* *3. Leapfrog Group data* *4. CMS Hospital Quality Reporting* *5. Program or another CMS program* *6. Designated Center of Excellence (COE)* *7. Other, explain*	*Multi, checkboxes* *1. Used for initial contracting assessment* *2. Used for re-contracting assessment* *3. Has been used for incentive payments* *4. Has been used for termination or exclusion (give examples)* *5. Other, explain*	*200 words.*
Hospital Cost	*Multi, checkboxes* *1. Percent of Medicare rates* *2. Diagnosis-Related Group (DRG) costs* *3. Comparison to other hospital costs in geographic area* *4. Comparison to other hospital costs by decile or other method* *5. CMS Hospital Price Transparency data* *6. Other, explain*	*Multi, checkboxes* *1. Used for initial contracting assessment* *2. Used for re-contracting assessment* *3. Has been used for incentive payments* *4. Has been used for termination or exclusion (give examples)* *5. Other, explain*	*200 words.*
Provider Quality	*Multi, checkboxes* *1. Integrated Healthcare Association data* *2. Office of Patient Advocate data* *3. Other, explain*	*Multi, checkboxes* *1. Used for initial contracting assessment* *2. Used for re-contracting assessment* *3. Has been used for incentive payments* *4. Has been used for termination or exclusion (give examples)* *5. Other, explain*	*200 words.*
Provider Cost	*Multi, checkboxes* *1. Total Cost of Care data* *2. Comparison to other physician or physician groups in geographic area* *3. Other, explain*	*Multi, checkboxes* *1. Used for initial contracting assessment* *2. Used for re-contracting assessment* *3. Has been used for incentive payments*	*200 words.*

		4. Has been used for termination or exclusion (give examples) *5. Other, explain*	

21.4.1.2 Complete Attachment K1 – QHP Networks Based on Value Work Plan to describe updates in Applicant's ability to build networks based on value. Applicant may submit any supporting documentation as an attachment. Address each of the following in the narrative:

- Progress in 2021 toward developing networks based on value including activities conducted, data collected and analyzed, and results
- Further implementation plans for 2022 with milestones and targets for 2022 and 2023 identified
- Describe any potential or current collaboration opportunities, new statewide or regional initiatives, or other activities that would strengthen Applicant's ability to address value and affordability
- Known or anticipated barriers in implementing activities and progress of mitigation activities

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

Attached Document(s): Attachment K1 – QHP Networks Based on Value Work Plan

21.4.2 Effective Primary Care

All questions required for new entrant Applicants that are currently operating in Covered California. Questions 21.4.2.1 and 21.4.2.2 required for new entrant Applicants that are not currently operating in Covered California. All questions should be answered at the product level, not Issuer level.

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

This strategy meets the QIS requirements.

21.4.2.1 Report the percentage of members in Applicant's Covered California business who either selected or were matched with a primary care clinician in 2021 in Attachment J - QHP IND Run Charts. If Applicant had no Covered California business in 2021, report full 2021 book of business excluding Medicare. Currently contracted Applicant must enter the number and percentage of providers paid under each model reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, 2021, and 2022 as well. Report data by product (HMO, PPO, EPO, Other).

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

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

21.4.2.2 Report all types of payment methods used for primary care services and number of providers paid under each model in 2021 in Attachment J - QHP IND Run Charts using the alternative payment models (APM) outlined in the Health Care Payment Learning Action & Action Network (HCP LAN) Alternative Payment Model APM Framework. If Applicant had no Covered California business in 2021, report full 2021 book of business excluding Medicare. Currently contracted Applicant must enter the number and percentage of providers paid under each model reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, 2021, and 2022 as well. Report data by product (HMO, PPO, EPO, Other).

References:

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

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

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

21.4.2.3 Complete Attachment K2 – QHP QIS 1 Work Plan - Primary Care to 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 on the PCP matching initiative, including a status report, feedback on the enrollee experience, challenges, and suggestions (if applicable)
- Progress implementing alternative payment models for primary care to align with Category 3 or 4 APMs described in the APM Framework including: activities conducted, data collected and analyzed, and results
- Describe any support or technical assistance (financial, staffing, educational, etc.) that Applicant or multi-insurer collaborative is providing to primary care providers to support their efforts towards accessible, data-driven, team-based care
- How Applicant is encouraging enrollees to use accessible, data-driven, team-based care providers
- Further implementation plans for 2022 with milestones and targets for 2022 and 2023 identified
- Known or anticipated barriers in implementing QIS activities and progress of mitigation activities

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

Attached Document(s): Attachment K2 – QHP QIS 1 Work Plan - Primary Care

21.4.3 Integrated Delivery Systems and Accountable Care Organizations

All questions required for new entrant Applicants that are currently operating in Covered California. Questions 21.4.3.1 - 21.4.3.3 required for new entrant Applicants that are not currently operating in Covered California. All questions should be answered at the product level, not Issuer level.

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

The following questions address Applicant's ability to increase enrollment in Integrated Delivery System (IDS) or Accountable Care Organization (ACO) models in its Covered California network.

This strategy meets the QIS requirements.

21.4.3.1 Using the definition for IDS or ACO above, report the number and percentage of Covered California members and total California members who are managed under an IDS or ACO in 2021 in Attachment J - QHP IND Run Charts. Currently contracted Applicants must enter the percentage reported in the Certification Application for 2016, 2017, 2018, 2019, 2020, 2021, and 2022 as well. If Applicant had no Covered California business in 2021, report full 2021 book of business excluding Medicare. Report data by product (HMO, PPO, EPO, Other).

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

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

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

	1: Yes *2: No*	
Participation: 3-way (health plan/provider organization/hospital)	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*
Participation: 4-way (health plan/provider organization/purchaser)	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*
Participation: Includes advanced primary care providers or patient-centered medical homes	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*
Participation: Other	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*
Base payment: Global capitation	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*
Base payment: Professional capitation only	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*
Base payment: Separate professional capitation and hospital capitation	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*
Base payment: Fee for service	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*
Base payment: Other	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*
Performance payment: Two-sided shared savings (upside/downside risk)	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*
Performance payment: One-sided shared savings (upside risk)	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*
Performance payment: Pay for performance quality bonus	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*
Performance payment: Other	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*
Leadership: Physician-led	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*
Leadership: Hospital-led	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*
Leadership: Plan-led	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*
Leadership: Other	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*
Leadership: Jointly led by physician and hospitals	*Single, Pull-down list.* *1: Yes* *2: No*	*50 words.*

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

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

	Response
(File titled Provider 1a): Applicant's quality and cost measures used to track progress and success of IDS or ACO providers.	*Single, Pull-down list.* *1: Attached,* *2: Not attached*
(File titled Provider 1b): Example of Applicant report to its IDS or ACO providers on its quality of care and financial performance, including benchmarking relative to performance improvement goals or market norms.	*Single, Pull-down list.* *1: Attached,* *2: Not attached*
(File titled Provider 1c): Confirm Applicant will submit a copy of Applicant's 2021 IHA Align Measure Perform (AMP) Commercial ACO report when it becomes available, if Applicant participates in the program.	*Single, Pull-down list.* *1: Confirmed,* *2: Not confirmed,* *3: N/A*

21.4.3.4 Complete Attachment K3 – QHP QIS 2 Work Plan - IDS and ACO to describe updates on progress made since the previous QIS submission on each component of the IDS or ACO goals and planned activities. Applicant may submit any supporting documentation as an attachment. Address each of the following in the narrative:

- Progress in 2021 toward the end goal including activities conducted, data collected and analyzed, and results
- Further implementation plans for 2022 with milestones and targets for 2022 and 2023 identified

- How Applicant expects to evolve its model, based on progress or outcomes to date
- How Applicant is providing support for integration and coordination of care through coaching, funding, implementation of information systems, technical assistance, or other means
- Other activities conducted since the previous QIS submission to promote IDSs or ACOs or activities that will be conducted
- Known or anticipated barriers in implementation of QIS and progress of mitigation activities

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

Attached Document(s): Attachment K3 – QHP QIS 2 Work Plan IDs and ACO

21.4.4 Appropriate Use of Cesarean Sections

All questions required for new entrant Applicants that are currently operating in Covered California. Questions 21.4.4.1 - 21.4.4.3, 21.4.4.5 and 21.4.4.6 required for new entrant Applicants that are not currently operating in Covered California. All questions should be answered at the product level, not Issuer level.

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) Consider a hospital's NTSV C-section rate, improvement trajectory, and willingness to engage in coaching as part of its maternity hospital contracting decisions and terms. Covered California does not expect Contractor to base poor performance, and potential network removal decisions, on one measure alone. 4) New entrant Applicants are expected to adopt a payment methodology structured to support only medically necessary care with no financial incentive to perform C-sections for all contracted physicians and hospitals serving Enrollees by year end 2023.

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

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

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

This strategy meets the QIS requirements.

21.4.4.1 Describe how Applicant is measuring overuse of Cesarean Sections and how it is implementing Smart Care California guidelines (https://www.iha.org/wp-content/uploads/2020/12/c-section_menu_of_payment_and_contracting_options.pdf) to promote best practices of care in these areas.

100 words.

21.4.4.2 Report number of all network hospitals reporting to the CMQCC's MDC in 2021 in Attachment J - QHP IND Run Charts. A list of all California hospitals participating in the MDC can be found here: https://www.cmqcc.org/about-cmqcc/member-hospitals. Currently contracted applicants must enter the percentage reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, 2021, and 2022 as well. If Applicant had no Covered California business in 2021, report full 2021 book of business excluding Medicare.

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

21.4.4.3 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 2021 in Attachment J - QHP IND Run Charts. Currently contracted Applicants must enter the percentages reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, 2021, and 2022 as well. If Applicant had no Covered California business in 2021, report full 2021 book of business excluding Medicare. References: https://www.iha.org/wp-content/uploads/2020/12/c-section_menu_of_payment_and_contracting_options.pdf.

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

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

21.4.4.4 Complete Attachment K4 – QHP QIS 3 Work Plan - Appropriate Use of C-Sections to describe updates on progress made since the last QIS submission with regards to promoting appropriate use of Cesarean-Sections (C-Sections). Applicant may submit any supporting documentation as an attachment.

Note: Refer to Appendix S for hospital C-section rates.

Address each of the following in the narrative:

- Description of how Applicant engages with its network hospitals to reduce NTSV C-Section rates to 23.9% or less by year end 2023
- Description of its adjustments to payment strategy in alignment with Smart Care California guidelines so that no hospitals or physicians are incentivized to perform an NTSV C-Section by year end 2023
- Description of how NTSV C-section rates are included in network hospital and provider contracting criteria
- Description of how Applicant promotes and encourages all in-network hospitals that provide maternity services to use the resources provided by California Maternity Quality Care Collaborative (CMQCC) and enroll in the CMQCC Maternal Data Center (MDC)
- Updates to hospital participation in CMQCC and hospital engagement in maternity care quality improvement, particularly those with a NTSV rate higher than 23.9%

- List any known or anticipated barriers in implementing QIS activities and progress of mitigation activities

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

Attached Document(s): Appendix M HAI, Sepsis, and NTSV C-Section , Attachment K4 – QHP QIS 3 Work Plan - Appropriate Use of C-Sections

21.4.4.5 Applicant must confirm that all network physicians are paid on a case rate for deliveries and that payment is the same for both vaginal and C-section delivery. If not, Applicant must complete the following table.

	Response			
Confirm that all network physicians are paid on a case rate for deliveries and that payment is the same for both vaginal and C-section delivery.	*Single, Radio group.* *1: Confirmed* *2: Not confirmed, complete table*			
Payment Strategy	**Description**	**Percent of Physicians Paid Under Strategy**	**Numerator**	**Denominator**
Strategy 1: Blended Case Rate	*50 words.*	*Percent.*	*Integer.*	*Integer.*
Strategy 2: Provide quality bonuses for physicians that attain NTSV C-section rate goal or make improvements in reducing NTSV C-sections	*50 words.*	*Percent.*	*Integer.*	*Integer.*
Strategy 3: Population-based payment models	*50 words.*	*Percent.*	*Integer.*	*Integer.*
Strategy 4: Other (explain)	*50 words.*	*Percent.*	*Integer.*	*Integer.*
Strategy 5: Other (explain)	*50 words.*	*Percent.*	*Integer.*	*Integer.*
Strategy 6: Other (explain)	*50 words.*	*Percent.*	*Integer.*	*Integer.*

21.4.5 Hospital Patient Safety

All questions required for new entrant Applicants that are currently operating in Covered California. Questions 21.4.5.1 and 21.4.5.2 required for new entrant Applicants that are not currently operating in Covered California. All questions should be answered at the product level, not Issuer level.

Applicant will: 1) Adopt a hospital payment methodology that places all 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 Associated Infection (HAI) measures outlined in Attachment 1 or are working to improve. 3) Promote hospital

involvement in improvement programs so that all hospitals comply with Sepsis Management according to CMS guidelines.

The five HAIs and Sepsis Management are:

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

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

This strategy meets the QIS requirements.

21.4.5.1 Report, across all lines of business, the percentage of hospital reimbursement at risk for quality performance and the quality indicators used in 2021 in Attachment J - QHP IND 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 HAIs, readmissions, patient satisfaction, etc. In the same sheet, report quality indicators used to assess quality performance. Currently contracted Applicant must enter the percentages reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, 2021, and 2022 as well. If Applicant had no Covered California business in 2021, report full 2021 book of business excluding Medicare.

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

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

21.4.5.2 Report the number of hospitals contracted under the model described in question 21.4.5.1 with reimbursement at risk for quality performance in 2021 in Attachment J - QHP IND Run Charts. Currently contracted Applicants must enter the numbers reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, 2021, and 2022 as well. If Applicant had no Covered California business in 2021, report full 2021 book of business excluding Medicare.

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

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

21.4.5.3 Complete Attachment K5 – QHP QIS 4 Work Plan - Hospital Patient Safety to describe progress promoting hospital safety since the last submission. Applicant may submit any supporting documentation as an attachment.

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

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

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

Address each of the following in the narrative:

- How Applicant is engaging with its network hospitals to reduce the five specified HAIs and Sepsis Management measure
- How Applicant is leveraging the poor performing hospitals list provided by Cal Hospital Compare to collaborate with other QHP Issuers who contract with the same poor performing hospitals
- Progress in 2021 toward the end goal and any further implementation plans for 2021 with milestones and targets for 2022 and 2023 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 Infections (HAIs). Refer to Appendix S: CAUTI, CLABSI, CDI, MRSA Rates, and SSI Colon Rates
- Applicant's progress in adopting a progressive payment strategy to tie at least 2% of network hospital payments to value by year end 2023
- 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

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

Attached Document(s): Appendix M HAI, Sepsis, and NTSV C-Section, Attachment K5 – QHP QIS 4 Work Plan - Hospital Patient Safety

22 Glossary

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

Certification Year – The year for which Applicant is applying for proposed product(s) to be certified.

Coverage Year – The year the benefits will cover an enrollee.

Covered California Enrollee – Refers to every individual enrolled in Covered California for the purpose of receiving health benefits. Also referred to as "On-Exchange".

Current Year – The calendar year Applicant is completing application for certification of proposed product(s).

Definition of Good Standing – Department of Insurance - Verification that issuer holds a state health care service plan license or insurance certificate of authority: Approved for lines of business sought in the Exchange (e.g., commercial, small group, individual; Approved to operate in what geographic service areas and most recent market conduct exam reviewed.

Affirmation of no material[2] statutory or regulatory violations, including penalties levied, in the past two years in relation to any of the following, where applicable: Financial solvency and reserves reviewed; Benefit Design; State mandates (to cover and to offer) - Essential health benefits (State required), Basic health care services, Copayments, deductibles, out-of-pocket maximums, Actuarial value confirmation (using the certification year Federal Actuarial Value Calculator); Network adequacy and accessibility standards are met – provider contracts; Language access; uniform disclosure (summary of benefits and coverage); Claims payment and policies and practices; Enrollee/Member grievances/complaints and appeals policies and practices; Independent medical review; Marketing and advertising; Guaranteed issue individual and small group; Rating Factors; Medical Loss Ratio; Premium rate review – Geographic rating regions and rate development justification is consistent with ACA requirements.

Definition of Good Standing – Department of Managed Health Care - Verification that issuer holds a state health care service plan license or insurance certificate of authority: Approved for lines of business sought in the Exchange (e.g., commercial, small group, individual; Approved to operate in what geographic service areas and most recent financial exam and medical survey report reviewed.
Affirmation of no material[2] statutory or regulatory violations, including penalties levied, in the past two years in relation to any of the following, where applicable: Financial solvency and reserves reviewed; Administration and organizational capacity acceptable; Benefit Design; State mandates (to cover and to offer) - Essential health benefits (State required), Basic health care services, Copayments, deductibles, out-of-pocket maximums, Actuarial value confirmation (using the certification year Federal Actuarial Value Calculator); Network adequacy and accessibility standards are met – provider contracts; Language access; uniform disclosure (summary of benefits and coverage); Claims payment and policies and practices; Enrollee/Member grievances/complaints and appeals policies and practices; Independent medical review; Marketing and advertising; Guaranteed issue individual and small group; Rating Factors; Medical Loss Ratio; Premium rate review – Geographic rating regions and rate development justification is consistent with ACA requirements.

Enrollee – Refers to every individual enrolled for the purpose of receiving health benefits, including Covered California Enrollees and Off-Exchange membership.

External Audit – A formal audit process that includes an independent and objective examination of an organization's programs, operations, and records performed by a third party (e.g., independent audit or consulting firm, state and federal oversight agencies, etc.) to evaluate and improve the effectiveness of its policies and procedures. The results, conclusions, and findings of an audit in California or any other state(s) where Applicant provides services are formally communicated through an audit report delivered to management of the audited entity.

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.

Health Issuer - 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

[2] Covered California, in its sole discretion and in consultation with the appropriate health insurance regulator,determines what constitutes a material violation for this purpose.

policy or plan to be sold to a consumer that has been certified by Covered California. The term “product” means a discrete package of health insurance coverage benefits that are offered using a product network type (such as health maintenance organization, preferred provider organization, or exclusive provider organization) within a service area (45 CFR § 144.103). The term “plan” shall have the same meaning as that term is defined in 45 CFR § 144.103. The term "Applicant" refers to a Health Insurance Issuer who is applying to have its plans certified as Qualified Health Plans. Also referred to as “Issuer”.

Internal Audit Function - An internal audit function is accountable to an organization’s senior management and those charged with governance of the audited entity. An internal auditing activity is an independent, objective assurance and consulting activity designed to add value and improve an organization’s operations. Internal Auditing helps an organization accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control, and governance processes.

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.