CERTIFICATION APPLICATION
QUALIFIED DENTAL PLAN
INDIVIDUAL MARKETPLACE
PLAN YEAR ~~2022~~2023
DRAFT

Certification Application Qualified Dental Plan Individual Marketplace Plan Year 2023

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Certification Application Qualified Dental Plan Individual Marketplace Plan Year 2023

1 Application Overview

1.1 **Purpose**

The California Health Benefit Exchange (Covered California) is accepting applications from eligible Dental ~~Issuer~~Issuers[1] (Applicants) to submit proposals to offer, market, and sell qualified dental plans (QDPs) through Covered California beginning in 2022~~1~~, for coverage effective January 1, 2023~~2~~. All Dental ~~Issuer~~Issuers currently licensed at the time of application response submission are eligible to apply for certification of proposed Qualified Health Plans (QHPs) for the 2023~~2~~ Plan Year. QDP I~~issuer~~Issuers contracted for Plan Year 2022~~1~~ will complete a simplified certification application since those ~~issuer~~Issuers already have a contract with Covered California that imposes ongoing requirements that are similar to or satisfy the requirements in the certification application and consideration of this contract performance is included in the evaluation process. Covered California will exercise its statutory authority to selectively contract for health care coverage offered through Covered California for Plan Year 2023~~2~~. Covered California reserves the right to select or reject any Applicant or to cancel this Application at any time.

~~[1] The term "Dental Issuer" used in this document refers to both dental 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 dental coverage, while the term "Qualified Dental Plan" refers to a specific 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 Dental Issuer who is seeking to have its plans certified as Qualified Dental Plans.~~

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 Affordable Care Act 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 (QHPs) that will be offered in Covered California.

The state legislation to establish Covered California gave authority to Covered California to selectively contract with ~~issuer~~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 ~~issuer~~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 QDP Certification Applications will not be based on a single, strict formula; instead, the evaluation will consider the mix of health and dental plans for each region of California that best meet the needs of consumers in that region and Covered California's goals. Covered California wants to provide an appropriate range of high-quality health and dental plans to participants at the best available price that is balanced with the need for consumer stability and long-term affordability. In consideration of the mission and values of Covered California, the Board of Covered California articulated guidelines for the selection and oversight of Qualified Health Plans which are used when reviewing the Applications for 20233. These guidelines are:

Promote affordability for the consumer– Both in terms of 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 premium 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 QDP proposals will focus on quality and service components, including history of performance, administrative capacity, reported quality and satisfaction metrics, quality improvement plans and commitment to serve Covered California population. 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 issuerIssuers' products on Covered California for the Plan Year 20233 plan year.

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

Covered California is committed to fostering competition by offering QDPs with features that present clear choice, product, and provider network differentiation. QDP Applicants are required to adhere to Covered California's standard benefit plan designs in each region for which they submit a proposal. Covered California is interested in having HMO, and PPO products offered statewide. Within a given product design, Covered California will look for differences in network providers and the use of innovative delivery models. Under such criteria, Covered California may choose not to contract with two plans with broad overlapping networks within a rating region unless they offer different innovative delivery system or payment reform features.

Encourage Competition throughout the State

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

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

Encourage 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 QDP offerings that incorporate innovations in delivery system improvement, prevention, and wellness, and/or payment reform that will help foster these broad goals. This will include models of primary care dentists~~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 on Covered California, so Applicant's technology and associated resources are heavily scrutinized as this relates to long term sustainability for consumers. Additionally, in recognition of the significant investment that will continue to be needed in areas of quality reform and improvement programs, Covered California offered a multi–year contract agreement through the 2017 application. 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] The 2022 Patient-Centered Benefit Designs will be finalized when the 2022 federal actuarial value calculator is finalized.~~

1.4 **Availability**

Applicant must be available immediately upon contingent certification of its plans as QDPs to start working with Covered California to establish all operational procedures necessary to integrate and interface with Covered California information systems, and to provide additional information necessary for Covered California to market, enroll members, and provide dental plan services effective January 1, 2023~~2~~. Successful Applicants will also be required to adhere to certain provisions through their contracts with Covered California, including meeting data interface requirements with the California Healthcare Enrollment, Eligibility, and Retention System (CalHEERS). Successful Applicants must execute the QDP I~~issuer~~Issuer C~~o~~ontract before public announcement of contingent certification. Failure to execute the QDP I~~issuer~~Issuer C~~o~~ontract may preclude Applicant from offering QDPs through Covered California. The successful Applicants must be ready and able to accept enrollment as of October 1, 2022~~1~~.

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 QDP I~~issuer~~Issuers.

1.6 **Intention to Submit a Response**

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

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

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

Certification Application Qualified Dental Plan Individual Marketplace Plan Year 2023

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

1.7 **Key Action Dates**

Action	Date/Time
Release of Draft Application for Comment	December 20210
Letters of Intent to Apply Due to Covered California	February 112, 20221
Application Opens	March 1, 20221
Completed Applications Due (include certification plan year Proposed Rates & Networks)	April 2930, 20221
Proposed Rates and Networks Due	June 1, 20221
Negotiations between Applicants and Covered California	July 20221
Final QDP Contingent Certification Decisions	August 20221
QDP Contract Execution	September 20221
Final QDP Certification	October 20221

1.8 **Preparation of Application Response**

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

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

2 Administration and Attestation

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

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 Dental 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.*
Applicant Eligibility	*Single, Pull-down list.* 1: Contracted in 20221, 2: New Entrant Applicant
On behalf of Applicant stated above, I hereby attest that I meet the requirements in this Application and certify that the information provided on this Application and in any attachments hereto are true, complete, and accurate. I understand that Covered California may review the validity of my attestations and the information provided in response to this Application and if an Applicant is selected to offer Qualified Dental Plans, may decertify those Qualified Dental Plans should any material information provided be found to be inaccurate. I confirm that I have the capacity to bind the ~~issuer stated~~Issuer stated above to the terms of this Application.	
Date	*10 words.*
Signature	*10 words.*
Printed Name	*10 words.*
Title	*10 words.*

2.2 Applicant must 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 and Quality
- Enrollment and Eligibility
- Legal
- Marketing and Communications

- Information Technology
- Information Security
- Policy
- Dedicated Liaison

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.*

- ~~Mergers~~
- ~~Acquisitions~~
- ~~New venture capital~~
- ~~Management team~~

- ~~Location of corporate headquarters or tax domicile~~
- ~~Stock issue~~
- ~~Other~~

~~If yes, Applicant must describe the material changes.~~

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

2.4 Applicant must a~~A~~ttach a copy of Applicant's 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

Question 3.2 is required for currently contracted Applicants. All questions are required for new entrant Applicants.

3.1 Indicate Applicant license status below:

Single, Radio group.
1: Applicant currently holds all of the proper and required licenses from the California Department of Managed Health Care to operate as a ~~d~~Dental ~~i~~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 D~~d~~ental ~~Iissuer~~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 D~~d~~ental ~~Iissuer~~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 D~~d~~ental ~~Iissuer~~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 Dental ~~Issuer~~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 19 – Glossary ~~- Appendix A~~ 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 dental insurance regulator, determines what constitutes a material violation for determining Good Standing.

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

~~Attached Document(s): Appendix A Definition of Good Standing.pdf~~

4 Applicant Health Plan Proposal

Questions 4.3 – 4.7 are required for currently contracted Applicants. All questions are required for new entrant Applicants.
Applicant must submit a dental plan proposal in accordance with all requirements outlined in this section.

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

Applicant may submit proposals to offer both a Children's Dental Plan and a Family Dental Plan. Applicant may submit DPPO and DHMO product proposals in its proposed rating regions. Applicant's proposal must include coverage of its entire licensed geographic service area for which it has an adequate network. Applicant may not submit a proposal that includes a tiered network. Applicants

must adhere to Covered California's standard benefit plan designs and the requirements in this section without deviation unless approved by Covered California.

4.1 Applicant must certify that its proposal includes a dental product including the pediatric dental Essential Health Benefit meeting an actuarial value of 85% for each individual plan it proposes to offer in a rating region. If not, Applicant's response will be disqualified from consideration.
Single, Pull-down list.
1: Yes, proposal meets requirements,
2: No

4.2 Applicant must confirm that it will adhere to Covered California naming conventions for on-Exchange plans and off-Exchange mirror products where applicable, pursuant to Government Code 100503(f).
Single, Pull-down list.
1: Confirmed,
2: Not confirmed

4.3 Preliminary Premium Proposals: Final negotiated and accepted premium rates shall be in effect for coverage effective January 1, 20233~~2~~. Premium proposals are considered preliminary and may be subject to negotiation as part of QDP certification and selection. Premium proposals must be submitted with the Application. To submit premium proposals for Individual products, Applicant must complete and upload through System for Electronic Rate and Form Filing (SERFF) the Rates Template available at https://www.qhpcertification.cms.gov/s/QHP. Premium may vary only by geography (rating region), by age, and by actuarial value.

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

Applicant shall provide, in connection with any negotiation process as reasonably requested by Covered California, detailed documentation on Covered California-specific rate development methodology. Applicant shall provide justification, documentation, and support used to determine rate changes, including adequately supported cost projections. Cost projections include factors impacting rate changes, assumptions, transactions, and other information that affects Covered California-specific rate development process. This information may be necessary to support the assumptions made in forecasting and may be supported by information from Applicant's actuarial systems pertaining to Covered California-specific account.
Single, Pull-down list.
1: Template completed and uploaded,
2: Template not completed and uploaded

4.4 Applicant must certify that for each rating region in which it submits a dental plan proposal, it is submitting a proposal that covers the entire geographic service area for which it is licensed within that rating region. To indicate which zip codes are within the licensed geographic service area by proposed Covered California product, complete and upload through SERFF the Service Area Template located at https://www.qhpcertification.cms.gov/s/QHP.

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

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

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

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

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

4.7 Applicant must indicate the different network products it intends to offer on Covered California in the individual market for coverage year 20233~~2~~. 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	New or Existing Network?	Network Name(s)
DHMO	*Single, Pull-down list.* 1: Yes, 2: No	*Single, Pull-down list.* 1: New Network, 2: New to Covered California, 3: Existing Covered California	*10 words.*
DPPO	*Single, Pull-down list.* 1: Yes, 2: No	*Single, Pull-down list.* 1: New Network, 2: New to Covered California, 3: Existing Covered California	*10 words.*
Other	*Single, Pull-down list.* 1: Yes, 2: No	*Single, Pull-down list.* 1: New Network, 2: New to Covered California, 3: Existing Covered California	*10 words.*

5 Benefit Design

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

5.1 If applicable, Applicant must certify its proposed dental products include coverage of Diagnostic, Preventive, Restorative, Periodontics, Endodontics, Prosthodontics and Oral Surgery services for

adults age 19 years and older comparable to those benefits found in Applicant's commercially available dental plan products for each individual plan it proposes to offer in a rating region. If not, Applicant's response will be disqualified from consideration.

Single, Pull-down list.
1: Yes,
2: No,
3: Not Applicable, only offering Children's Dental Plan

5.2 Applicant must comply with the certification year~~2022~~ Patient-Centered Benefit Plans Designs. Applicant must complete and upload through System for Electronic Rate and Form Filing (SERFF) the Plans and Benefits template located at https://www.qhpcertification.cms.gov/s/QHP.

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

5.3 Applicant must confirm the coverage year Schedule of Benefits of Coverage (SBC), Evidence of Coverage (EOC), or Policy language ~~and draft Schedule of Benefits~~ describing proposed health benefits will follow the requirements in ~~the~~Appendix G - Covered California Submission Guidelines Dental Individual and Small Business – Plan Year 2023 and must comply with state and federal laws.

~~Applicant must submit, as an attachment, the draft Evidence of Coverage (EOC) or Policy language and draft Schedules of Benefits describing proposed 2022 QDP benefits.~~

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

Attached Document(s): Appendix G - Covered California Submission Guidelines Dental Individual and Small Business – Plan Year 2023

5.4 Applicant must submit final SBCs, EOCs, ~~Evidence of Coverage (EOC)~~ or Policy language and ~~final Schedules of Benefits~~ for Plan Year 2023~~2~~ by the due date issued in Appendix G~~V~~ Covered C~~A~~alifornia ~~QDP Ind and Small Business~~ Submission Guidelines Dental Individual and Small Business – Plan Year 2023.

Single, Pull-down list.
1: Confirmed, will submit final PY 2023~~2~~ SBC, EOC~~, and Schedule of Benefits~~SBC, and Dental Matrix by due date,
2: Not confirmed

~~5.5 Applicant must indicate how it provides plan enrollees with current information about utilization of services and deductible and annual out-of-pocket costs to date. Select all that apply.~~

~~*Multi, Checkboxes.*~~
~~1: Status of oral health services received to date provided through member login to the dental plan website,~~
~~2: Status of oral health services received to date provided by mailed document upon request,~~
~~3: Status of oral health services received to date available upon member request to customer service,~~
~~4: Status of deductible and benefit limit provided through member login to the dental plan website,~~
~~5: Status of deductible and benefit limit provided by mailed document upon request,~~
~~6: Status of deductible and benefit limit available upon member request to customer service,~~
~~7: Status of deductible not applicable to DHMO product,~~
~~8: Status of out-of-pocket costs provided through member login to the dental plan website,~~
~~9: Status of out-of-pocket costs provided by mailed document upon request,~~
~~10: Status of out-of-pocket costs available upon member request to customer service,~~
~~11: Other, describe: [20 words] ,~~
~~12: Status of oral health services received to date not provided,~~
~~13: Status of deductible and benefit limit not provided,~~
~~14: Status of out-of-pocket costs not provided~~

5.56 Applicant must indicate how it provides plan enrollees with current information about utilization of services and deductible and annual out-of-pocket costs to date for the DHMO product. Select all that apply.

Multi, Checkboxes.
1: Status of oral health services received to date provided through member login to the dental plan website,
2: Status of oral health services received to date provided by mailed document upon request,
3: Status of oral health services received to date available upon member request to customer service,
4: Status of deductible and benefit limit provided through member login to the dental plan website,
5: Status of deductible and benefit limit provided by mailed document upon request,
6: Status of deductible and benefit limit available upon member request to customer service,
7: Status of out-of-pocket costs provided through member login to the dental plan website,
8: Status of out-of-pocket costs provided by mailed document upon request,
9: Status of out-of-pocket costs available upon member request to customer service,
10: Other, describe: [20 words] ,
11: Status of oral health services received to date not provided,
12: Status of deductible and benefit limit not provided,
13: Status of out-of-pocket costs not provided

5.67 Applicant must indicate how it provides plan enrollees with current information about utilization of services and deductible and annual out-of-pocket costs to date for the DPPO product. Select all that apply.

Multi, Checkboxes.
1: Status of oral health services received to date provided through member login to the dental plan website,
2: Status of oral health services received to date provided by mailed document upon request,
3: Status of oral health services received to date available upon member request to customer service,
4: Status of deductible and benefit limit provided through member login to the dental plan website,
5: Status of deductible and benefit limit provided by mailed document upon request,
6: Status of deductible and benefit limit available upon member request to customer service,
7: Status of out-of-pocket costs provided through member login to the dental plan website,
8: Status of out-of-pocket costs provided by mailed document upon request,
9: Status of out-of-pocket costs available upon member request to customer service,
10: Other, describe: [20 words] ,
11: Status of oral health services received to date not provided,
12: Status of deductible and benefit limit not provided,
13: Status of out-of-pocket costs not provided

5.78 Applicant must indicate how it provides plan enrollees with current information about utilization of services and deductible and annual out-of-pocket costs to date for the Other Network Type product. Select all that apply.

Multi, Checkboxes.
1: Status of oral health services received to date provided through member login to the dental plan website,
2: Status of oral health services received to date provided by mailed document upon request,
3: Status of oral health services received to date available upon member request to customer service,
4: Status of deductible and benefit limit provided through member login to the dental plan website,
5: Status of deductible and benefit limit provided by mailed document upon request,
6: Status of deductible and benefit limit available upon member request to customer service,
7: Status of out-of-pocket costs provided through member login to the dental plan website,
8: Status of out-of-pocket costs provided by mailed document upon request,
9: Status of out-of-pocket costs available upon member request to customer service,
10: Other, describe: [20 words] ,
11: Status of oral health services received to date not provided,
12: Status of deductible and benefit limit not provided,
13: Status of out-of-pocket costs not provided

5.~~8~~9 Applicant must indicate if proposed QDPs will include coverage of non-emergent out-of-network services.

Single, Radio group.
1: Yes, proposed DPPO QDPs will include coverage of non-emergent out-of-network services. If yes, with respect to non-network, non-emergency claims, describe how Applicant informs consumers about out-of-network benefits and the pricing methodology used for service payment and consumer cost sharing: [50 words],

2: Yes, proposed DPPO QDPs will include coverage of non-emergent out-of-network services. If yes, with respect to non-network, non-emergency claims, describe how Applicant informs consumers about out-of-network benefits and the pricing methodology used for service payment and consumer cost sharing. Proposed DHMO QDPs do not cover non-emergent out-of-network services.: [50 words]
3: No, proposed DPPO QDPs will not include coverage of non-emergent out-of-network services,
4: No, offering a DHMO QDPs

6 Operational Capacity

6.1 ~~Issuer~~Issuer Operations and Account Management Support

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

6.1.1 Applicant must complete Attachment ~~C1 C2~~A1 A2 – QDP 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 ~~C1 C2~~A1 A2 – QDP 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 – QDP Current and Projected Enrollment

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

200 words.

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

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

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

6.1.4 Applicant must provide a summary of its operational capabilities~~, including how long it has been a licensed dental issuer~~Issuer. For example, enrollment system, claims, provider services, sales, etc. *100 words.*

6.1.5 ~~Based on the definition of review in the introduction to this section, i~~Indicate how frequently reviews are performed for each of the following areas:

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

Utilization Management Reviews	*Single, Pull-down list.* 1: Daily, 2: Weekly, 3: Monthly, 4: Quarterly, 5: Other:	*10 words.*
Billing Reviews	*Single, Pull-down list.* 1: Daily, 2: Weekly, 3: Monthly, 4: Quarterly, 5: Other:	*10 words.*

6.2 Implementation Performance

Questions required only for new entrant Applicants.

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

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

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

6.2.2 Applicant must submit a Renewal and Open Enrollment Readiness Plan. Applicant must include in their plan a timeline (dates) for Communications (Regulated and Marketed), system and website updates and readiness, and trainings for staff and agents.

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

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

200 words.

6.2.4 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.*

6.2.5 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.

7 Customer Service

Questions required only for new entrant Applicants.

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

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

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

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

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

100 words.

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

10 words.

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

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

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

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

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

50 words.

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

50 words.

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

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

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

Which language line vendor is contracted for support?

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

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

100 words.

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

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

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

50 words.

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

20 words.

8 Financial Requirements

Questions 8.4 and 8.6 are required for currently contracted Applicants. All questions are required for new entrant Applicants.

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

200 words.

8.2 Applicant must confirm which systems it has in place to accept payment from members effective October 1, 2022~~1~~ for the following premium payment types:

Multi, Checkboxes.
1: Paper checks,
2: Cashier's checks,
3: Money orders,
4: Electronic Funds Transfer (EFT),

5: Credit cards,
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]
Note - electronic payments, such as debit and credit cards for binder payments are required

8.3 If systems to accept payment are not currently in place, describe plans to implement such systems, including the use of vendors for any functions related to premium payment, if applicable, and an implementation workplan. QDP ~~i~~Issuer must be able to accept premium payment from members no later than October 1, 2022~~1~~. Note: QDP ~~i~~Issuer must accept electronic payments, such as debit and credit cards for binder payments. Electronic payment is encouraged, but not required, for payment of ongoing invoices.
200 words.

8.4 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.

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

~~8.6 Applicant must confirm no administrative fees or charges will be imposed on any member for terminating coverage.~~
~~*Single, Pull-down list.*~~
~~1: Yes, confirmed,~~
~~2: No, not confirmed~~

9 Fraud, Waste and Abuse Detection

Questions 9.2.1-9.2.3. 9.2.5-9.2.6 are required for currently contracted Applicants. All questions are required for new entrant Applicants.

Covered California is committed to working with its QDP ~~i~~Issuers to minimize F~~f~~raud, W~~w~~aste, and A~~a~~buse, as defined in Section 19 - Glossary. ~~-~~The framework for managing fraud risks is detailed in Appendix A ~~-O~~ U.S. Government Accountability Office circular GAO-15-593SP (located on the Manage Documents page). ~~-~~Covered California expects QDP ~~i~~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.

Definitions:

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

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

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

External Audit – A formal 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.

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.

9.1 Prevention / Detection / Response

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

200 words.

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

200 words.

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

200 words.

9.1.4 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.

9.1.5 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.

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

Multi, Checkboxes.

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

9.1.7 Describe the different approaches Applicant takes to monitor the types of providers indicated above in question 9.1.6 for possible fraudulent activity.

100 words.

9.1.8 If applicable, Applicant must provide an explanation why any provider types not indicated in 9.1.7 are not typically reviewed for possible fraudulent activity.

100 words.

9.1.9 Based on the definition of Ffraud in Section 19 - Glossary in the introduction to this section, what was Applicant's recovery success rate and dollars recovered for fraudulent activities for each year below?

	Total Loss from Fraud Covered California book of business, if applicable	**Total Loss from Fraud** Total Book of Business (Includes non-Covered California	**% of Loss Recovered** Covered California book of business, if applicable	**% of Loss Recovered** Total Book of Business (Includes non-Covered California	**Total Dollars Recovered** Covered California book of business, if applicable	**Total Dollars Recovered** Total Book of Business (Includes non-Covered California Business)

		Business)		Business)		
Calendar Year 20187	*Dollars.*	*Dollars.*	*Percent.*	*Percent.*	*Dollars.*	*Dollars.*
Calendar Year 20198	*Dollars.*	*Dollars.*	*Percent.*	*Percent.*	*Dollars.*	*Dollars.*
Calendar Year 202019	*Dollars.*	*Dollars.*	*Percent.*	*Percent.*	*Dollars.*	*Dollars.*

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

200 words.

9.1.11 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.

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

200 words.

9.1.13 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.

9.2 Audits

9.2.1 Based on the definition of Iinternal Aaudit Ffunction in Section 19 - Glossary in the introduction to this section, does Applicant maintain an Iinternal Aaudit Ffunction? If yes, provide a brief description of Applicant's Iinternal Aaudit function's responsibilities and its reporting structure, including what oversight authority is there over the Iinternal Aaudit Ffunction. For example: does the Iinternal Aaudit Ffunction report to a board, audit committee, or executive office? Applicant mustPlease provide the Internal Audit Charter.

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

9.2.2 If Applicant answered yes to 9.2.1, provide a copy of the organization's list of internal audits conducted over the last three years and the current year audit plan. applicable to financial, performance, and compliance audits.

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

9.2.3 If Applicant answered yes to 9.2.1, ~~based on the definition of internal audit function in the introduction to this section,~~ 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:	*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:	*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:	*10 words.*

9.2.4 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.

9.2.5 Based on the definition of Eexternal Aaudit in Section 19 - Glossary ~~in the introduction to this section~~, indicate what external audits applicable to business done in California were conducted over the last three years by third parties? For each audit, specify the year of the audit and the name of the agency that conducted the audit.

200 words.

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

1. Evaluation of the correctness of premium rate setting;
2. Payments to Agents;
3. Questions pertaining to Covered California enrollee premium payments and advance premium tax credit payments or state premium assistance payments;

4. Participation fee payments made to Covered California;
5. Applicant's compliance with the provisions set forth in a contract with Covered California; and
6. Applicant's internal controls to perform specified duties.

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

10 System for Electronic Rate and Form Filing (SERFF)

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

10.1 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 GJ - Covered California Submission Guidelines Dental Individual and Small Business- Plan Year 2023.

- ~~Is Applicant able to populate and submit SERFF templates in an accurate, appropriate, and timely fashion at Covered California request for:~~

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

- Attached Document(s): Appendix GJ - Covered California Submission Guidelines Dental Individual and Small Business- Plan Year 2023 ~~Rates,~~
- ~~Service Area,~~
- ~~Benefit Plan Designs,~~
- ~~Network~~
- ~~Plan ID Crosswalk~~

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

10.2 Applicant confirms that it will submit and upload corrections to SERFF within five~~three~~ (5~~3~~) 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

10.3 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

10.4 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

10.3 Applicant may 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

11 Electronic Data Interface

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

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

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

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

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

11.3 Applicant must be prepared and able to engage with Covered California to develop data interfaces between Applicant's system(s) and Covered California's systems, including the eligibility and enrollment system used by Covered California, as early as May 2021. Applicant must confirm it will implement system(s) to accept and generate 834, 999, TA1, and other standard format electronic files for enrollment and premium remittance in an accurate, consistent and timely fashion and utilize the information received and transmitted for its intended purpose.

- See Appendix B - EDI 834 Companion Guide CA v20.9.05 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

Attached Document(s): Appendix B - EDI 834 Companion Guide CA v20.9.05

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

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

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

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

11.6 Applicant must be prepared and able to conduct testing of data interfaces with Covered California no later than June 1, 2021 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

11.7 Applicant must describe its ability to produce financial, eligibility, and enrollment data monthly for reconciliation. Standard file requirements and timelines are documented in Appendix C - D Reconciliation Process Guide Carrier Process Guide for Recon & Disputes v9. Applicant must provide a description of its ability to make system updates to reconcilable enrollment fields on a timely basis and provide verification of completion.

200 words.

Attached Document(s): Appendix C - D Reconciliation Process Guide Carrier Process Guide for Recon & Disputes v9

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

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

12 Healthcare Evidence Initiative (HEI)

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

To fulfill its mission to ensure that consumers have available the plans that offer the optimal combination of choice, value, quality, and service, Covered California relies on evidence about the enrollee experience with health care. The timely and accurate submission of QDP data is an essential component of assessing the quality and value of the coverage and health care received by Covered California enrollees. QDP ~~Issuer~~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~~Appendix F -~~E~~ QDP HEI File Specifications.

The data elements required to be submitted pursuant to this application, and the resulting QDP ~~Issuer~~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.

12.1 Applicant must provide Covered California, through its HEI Vendor, with monthly extracts of all requested detail from applicable ~~fee-for-service (FFS)~~ claims or encounter records for the following types (both on-Exchange and non-grandfathered off-Exchange). Responses must address whether and the extent to which Applicant is able to provide data for ALL utilization, including patient encounters with capitated providers who may not need to submit such data to the Applicant for reimbursement. If yes with deviation, explain. If unable to provide all requested detail as outlined in ~~Appendix H~~Appendix ~~E~~F - QDP 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.

Attached Document(s): Appendix F - QDP HEI File Specifications

Claim ~~Type~~/ 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, if applicable	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Drug (non-Pharmacy), if applicable	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*

12.2 State law requires QDP Iissuers 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~~Appendix F~~E~~ - QDP HEI File Specifications, provide a plan and timeline to correct problematic data elements and estimate the number and percentage of affected claims and encounters.

Attached Document(s): Appendix F - QDP HEI File Specifications

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.*
Encounter Financials – Covered California requires QDP Issuers to report entire cost of care, including Issuers offering dental HMO or other non-fee-for-service products. -This may necessitate QDP Issuers assigning costs or cost equivalents to encounter records submitted to Covered California.	*Single, Pull-down list.* *1: Yes,* *2: No*	*50 words.*
Capitation Financials (per Provider / Facility) ***Note:[1]*** *If a portion of Applicant provider payments are capitated. If*	*Single, Pull-down list.*	*50 words.*

capitation does not apply, check "No" and state "Not applicable, no provider payments are capitated" in the rightmost column.	1: Yes, 2: No	

12.3 Applicant must provide Covered California member IDs and Covered California subscriber IDs, and Social Security Numbers (SSNs) on all applicable records submitted (on-Exchange and non-grandfathered off-Exchange). In the absence of other Personally Identifiable Information (PII), these elements are critical for the 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	*50 words.* ~~Nothing required~~

12.4 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~~Appendix F~~E~~ - QDP HEI File Specifications, provide a plan and timeline to correct problematic dates and estimate the number and percentage of affected enrollments, claims, and encounters.

Attached Document(s): Appendix F - QDP HEI File Specifications

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

12.5 Applicant must supply all applicable Provider Tax ID Numbers (TINs), ~~and~~ National Provider Identifiers (NPIs)~~,~~ and descriptive codes for individual providers. If yes with deviation, explain. If

unable to provide all requested detail as outlined in ~~Appendix H~~Appendix F~~E~~ - QDP HEI File Specifications, provide a plan and timeline to correct problematic Provider IDs and ~~and~~ descriptive codes and estimate the number and percentage of affected providers, claims, and encounters.

Attached Document(s): Appendix F - QDP HEI File Specifications

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.*
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.*

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

Attached Document(s): Appendix F - QDP HEI File Specifications

Coding to be Provided	Response	If No or Yes with deviation, explain.
Procedure Coding (CDT, 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.*

12.7 Can Applicant submit all data directly to Covered California or is a third party required to submit the data on Applicant's behalf?

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

12.8 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

13 Privacy and Security Requirements for Personally Identifiable Data

Questions required only for new entrant Applicants.

13.1 HIPAA Privacy Rule

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

13.1.1 Individual access: Unless otherwise exempted by the HIPAA Privacy Rule, Applicant must confirm that it provides enrollees with the opportunity to access, inspect and obtain a copy of any 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

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

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

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

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

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

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

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

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

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

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

13.1.7 Openness and Transparency: Unless otherwise exempted by the HIPAA Privacy Rule, Applicant must confirm that it currently maintains a HIPAA-compliant Notice of Privacy Practices to ensure that enrollees are aware of their privacy-related rights and Applicant's privacy-related obligations related to the enrollee's PHI [45 CFR §§164.520(a)&(b)].

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

13.2 Safeguards

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

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

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

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

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

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

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

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

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

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

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

200 words

14 Sales Channels

All questions are required for currently contracted Applicants and new entrant Applicants.
~~Questions 14.4 – 14.5 and 14.7 are required for currently contracted Applicants. Question 14.1 is required for new entrant Applicants.~~

14.1 Does Applicant have experience working with Insurance Agents (also referred to as Insurance B~~b~~rokers or Producers)?

Single, Radio group.
1: Yes. ~~If yes, 14.2 required,~~
2: No. ~~If no, 14.5 -14.7 required~~

~~14.2 Does Applicant have Agent of Record policy?~~

~~*Single, Pull-down list.*~~
~~1: Yes. If yes, 14.3 -14.5 and 4.7 required,~~
~~2: No. If no, 14.5 -14.7 required~~

14.2~~3~~ ~~Review the Covered California Delegation Policy, https://hbex.coveredca.com/toolkit/PDFs/Delegation_Change_Policy_FINAL.pdf.~~ Applicant must describe Agent of Record (AOR) policy and procedures for the individual market and ~~must~~ ~~is required to~~ submit its AOR policy document as an attachment. Review the Covered California Delegation Policy, https://hbex.coveredca.com/toolkit/PDFs/Delegation_Change_Policy_FINAL.pdf.

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

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

Sub-Topic	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 ~~the~~ 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.*

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

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

~~14.4 Does Applicant have any changed to their AOR policy and procedures for the individual market for the upcoming benefit year? If yes, attach new AOR policy document.~~

~~*Single, Radio group.*~~
~~1: Yes. If yes, Attachment required,~~
~~2: No.~~

14.4~~3~~5 Applicant must describe below and~~-~~ is required to provide as an attachment, its current Agent of Record (AOR) Commission Schedule for the individual market in California. ~~provide as an attachment, its Agent of Record (AOR) Commission Schedule for the individual market in California.~~
Note: successful Applicants will be required to use a standardized Agent commission program with levels and terms that result in the same aggregate compensation amounts to Agents, whether products are sold within or outside of 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]

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

Sub-Topic	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 polices.	*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, A~~the a~~pplicant 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 ~~the~~ 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 ~~the~~ Applicant pays an	*100 words.*	*100 words.*

Sub-Topic	Individual Market - Commission Rate	On-Exchange Business	Off-Exchange Business
	AOR commission based on the agent's Social Security Number (SSN) and how changes to SSN are captured 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.*
~~**Individual Market - Commission Rate**~~		~~**On-Exchange Business**~~	~~**Off-Exchange Business**~~
~~Provide AOR Commission Rate or Schedule for a new enrollment, returning new enrollment, and a renewing enrollment. Include general agency commission, if any.~~		~~*50 words.*~~	~~*50 words.*~~
~~Provide AOR Change Commission Rate or Schedule for a new enrollment, returning new enrollment, and a renewing enrollment. Include general agency commission, if any.~~		~~*50 words.*~~	~~*50 words.*~~
~~Does the compensation level change as the business written by the agent matures? (i.e., Downgraded)~~		~~*50 words.*~~	~~*50 words.*~~

Sub-Topic	Individual Market - Commission Rate	On-Exchange Business	Off-Exchange Business
~~Specify if the agent is compensated at a different level as he or she attains certain levels or amounts of in force business.~~		~~*50 words.*~~	~~*50 words.*~~
~~Does the compensation level apply to all plans or does it vary by plan? Include if this differs between AOR Appointment Commission and AOR Change Commission Rates.~~		~~Not applicable~~	~~*50 words.*~~
~~Does the compensation level vary by product? Include if this differs between AOR Appointment Commission and AOR Change Commission Rates.~~		~~*50 words.*~~	~~*50 words.*~~
~~Describe any reasons for which Applicant will not compensate Agents for an enrollment.~~		~~*50 words.*~~	~~*50 words.*~~
~~Describe any reasons for which Applicant will not make changes to AOR for an enrollment.~~		~~Not applicable~~	~~*50 words.*~~
~~Describe process for assigning commission payments to an agent's Federal Employer Identification Number (FEIN) and how changes to FEIN are captured and updated.~~		~~*50 words.*~~	~~*50 words.*~~
~~Describe any agent commission bonus program(s) in the individual market on or off exchange that is currently available in the 2021 calendar year or will be made available to agents for the 2022 calendar year.~~		~~*50 words.*~~	~~*50 words.*~~
~~Provide an estimated average percentage of premium that will be paid in total commissions inclusive of base commissions and bonuses.~~		~~*50 words.*~~	~~*50 words.*~~
~~Additional Comments~~		~~*50 words.*~~	~~*50 words.*~~

144.66 Applicant is required to provide a copy of ~~the~~ Applicant's Individual Family Plan 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.)

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

~~Name~~

~~Phone Number~~

~~Email Address~~

~~*50 words.*~~

14.75 Agents have become an integral channel of ~~the~~ Applicant's enrollment; Covered California requires Applicants to have an agent~~/broker~~ services support team to provide communication and sales strategy that assists in facilitating the ease of business. Therefore, part of the strategy requires

the Applicant to provide support services to the agents/brokers who enroll consumers in the applicant's plan product in the Individual and Family Plan market in California.

Applicant must provide a description for Agent/Broker Services. "Not Applicable" is not considered a response.Applicant must answer all questions. "Not Applicable" is not considered a response.

Sup-Topic	Agent/Broker Services	On-Exchange Business	Off-Exchange Business
Support Services	Describe your agent/broker support services to your appointed agents/brokers. Include different ways on how an appointed agent/broker can reach out to the 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/broker 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.*

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

AOR Program Plan	On-Exchange Business
What are the requirements Agents must meet to become appointed? Include general agency participation requirement, if any.	*50 words.*
Describe AOR appointment process. Include mandatory requirements for agents to be with a general agency contracted with Applicant.	*50 words.*
Provide the timeline for AOR appointment to be complete.	*50 words.*
Provide AOR Appointment and AOR Change Commission payment timelines. Include any factors that would result in differing timelines.	*50 words.*
Describe AOR Appointment and AOR Change Commission payment dispute processes.	*50 words.*
Describe criteria and requirements that constitute AOR change.	*50 words.*
Describe how applicable commissions are determined for the new servicing agent in an AOR change.	*50 words.*
Provide the timeline for processing an AOR change. Include how the effective date is determined for the new servicing agent and any factors that would result in a retroactive AOR change.	*50 words.*
Describe procedures used to manage AOR changes when the AOR files are received electronically from an outside source. Include explanation of how changes to assignment of the Federal Employer Identification Number (FEIN) are handled.	*50 words.*
Describe AOR reconciliation and error resolution processes, include information on how Applicant resolves commission and AOR discrepancies for Agents.	*50 words.*
Describe requirements for Vested Agents. Include definition of vesting, to whom vesting applies, duration of vesting, how vesting is affected by AOR changes, and vesting rules when an enrollee leaves and then returns for coverage.	*50 words.*
Describe any reasons for which Applicant will not compensate Agents for an enrollment.	*50 words.*
Describe any reasons for which Applicant will not make changes to AOR for an enrollment.	*50 words.*
Provide AOR Appointment Commission Rate or Schedule for a new enrollment, returning new enrollment, and a renewing enrollment. Include general agency commission, if any.	*50 words.*
Provide AOR Change Commission Rate or Schedule for a new enrollment, returning new enrollment, and a renewing enrollment. Include general agency commission, if any.	*50 words.*
Does the compensation level change as the business written by the agent matures? (i.e., Downgraded)	*50 words.*
Specify if the agent is compensated at a different level as he or she attains certain levels or amounts of in-force business.	*50 words.*
Does the compensation level apply to all plans or does it vary by plan? Include if this differs between AOR Appointment Commission and AOR Change Commission Rates.	Not applicable
Does the compensation level vary by product? Include if this differs between AOR Appointment Commission and AOR Change Commission Rates.	*50 words.*

Does the compensation level vary by agent type? (i.e., general agent, sub agent) Include if this differs between AOR Appointment Commission and AOR Change Commission Rates.	*50 words.*
Does the compensation level vary by subsidized plan and non-subsidized plan? Include if this differs between AOR Appointment Commission and AOR Change Commission Rates.	*50 words.*
Describe any reasons for which Applicant will not compensate Agents for an enrollment.	*50 words.*
Describe any reasons for which Applicant will not make changes to AOR.	*50 words.*
Describe any agent commission bonus program(s) in the individual market on or off exchange that is currently available in the 2021 calendar year or will be made available to agents for the 2022 calendar year.	*50 words.*
Additional Comments	*50 words.*

14.8 Since Agents have become an integral channel of the Applicant's enrollment, Covered California recommends having a communication and sales strategy that assists in facilitating the ease of business. Applicant must provide its agent/broker services for the individual market in California.

Agent Communication and Sales Strategy	On-Exchange Business
What is your overall communication strategy and what methods do you use to get messages and program updates out to Agents?	*50 words.*
How often are Agents updated on network changes?	
Describe sales tools you have available for Agents. Please differentiate between sales collateral and online sales tool resources. Include how you disburse these.	*50 words.*
Explain how you utilize Plan Based Enrollers?	*50 words.*
Do you evaluate off-exchange consumers to determine if they qualify for Advanced Premium Tax Credit?	*50 words.*
If an off-exchange consumer is eligible for Advanced Premium Tax Credit what is your commitment with direct outreach to make them aware of their potential cost-savings?	*50 words.*
What support services are available to Agents to assist them with consumer enrollment issues?	*50 words.*
Does your sales strategy include niche populations? Explain how you outreach to them?	*50 words.*
Are you working with Agents that can directly assist consumers in the niche populations? Explain.	*50 words.*
What tools do you provide Agents to help in reconciling their Book of Business?	*50 words.*

15 Marketing and Outreach Activities

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

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

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

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

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

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

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

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

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

Single, Radio group.
1: Alternate proposed marketing investment: [500 words],
2: ~~Not Applicable.~~ Confirmed to meet marketing spend expectations.

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

Proposed Marketing Investment:	*Dollars.*

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

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

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

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

15.8 Indicate the percentage of the total proposed marketing spend Applicant projects allocating to Brand Advertising and Direct Response Advertising Tactics 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.*

16 Provider Network

16.1 Network Offerings

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

16.1.1 Provider network data must be included in this submission for all geographic locations to which Applicant is applying for certification as a QDP. Submit provider data according to the data file layout in the Covered California Provider Data Submission Guide, https://hbex.coveredca.com/stakeholders/plan-management/library/Covered-California-Provider-Data-Submission-Guide-V1.10.pdf. The provider network submission for 20232 must be consistent with what will be filed to the appropriate regulator for approval if Applicant is selected as a QDP lissuer. 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 plan year 20232),
2: Not attached
3: Not attached, Applicant attesting to no material changes to existing plan year Covered California network for the certification year.

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

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

16.2 DHMO

16.2.1 Network Strategy

Questions 16.2.1.1 – 16.2.1.4 are required for currently contracted Applicants. All questions are required for Applicants that are new entrants or proposing new networks.

16.2.1.1 Applicant must complete all tabs in Attachment H~~K~~1 - DHMO Provider Network Tables, for their DHMO Network.

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

Attached Document(s): Attachment H1 - DHMO Provider Network Tables

16.2.1.2 Does Applicant conduct provider negotiations?

Single, Pull-down list.
1: Yes,
2: No

16.2.1.3 Describe the steps or process Applicant uses to monitor networks adequacy. Include detail, such as monitoring panel sizes, individual provider terminations or provider group terminations.

200 words.

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

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

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

Multi, Checkboxes.
1: Transparency,
2: Implementation of new programs and initiatives,
3: Acquire timely and up-to-date information on providers,
4: Ability to obtain data from providers,
5: Ability to conduct outreach and education to providers if need arises,
6: Ability to add new providers,

7: If no, describe plans to ensure Applicant's ability to control network and meet Covered California requirements: [500 words] ,
8: N/A

16.2.1.6 Describe in detail how Applicant ensures access to care for all enrollees by responding to each category below:

Describe tools used in assessing geographic access to primary, emergency, and specialist care based on enrollee residence:	*100 words.*
Briefly describe methodology used to assess geographic access to primary, emergency, and specialist care based on enrollee residence:	*200 words.*
Describe tools used when tracking ethnic and racial diversity in the population and ensuring access to appropriate culturally competent providers:	*100 words.*
Briefly describe methodology used when tracking ethnic and racial diversity in the population and ensuring access to appropriate culturally competent providers:	*200 words.*

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

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

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

200 words.

16.2.2 Network Quality

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

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

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

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

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

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

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

16.2.2.4~~3~~ To what extent does Applicant encourage use of high-quality network dental providers?

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

~~16.2.2.4 If Applicant encourages use of high-performing dental providers, what criteria does Applicant use to identify high-performing providers?~~

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

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

200 words.

16.2.3 Network Stability

All questions are required for currently contracted Applicants and new entrant Applicants.
16.2.3.1 Describe any plans for network additions, by product, including any new dental provider groups or clinic systems that Applicant would like to highlight for Covered California attention.

100 words.

16.2.3.2 Provide information on any known or anticipated potential network disruption that may affect Applicant's 2023~~2~~ provider networks. For example: list any pending terminations of dental groups which can include Independent Practice Associations.

100 words.

16.3 DPPO

16.3.1 Network Strategy

Questions 16.3.1.1 – 16.3.1.4 are required for currently contracted Applicants. All questions are required for Applicants that are new entrants or proposing new networks.

16.3.1.1 Applicant must complete all tabs in Attachment H~~K~~2 - DPPO Provider Network Tables, for their DPPO Network.

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

Attached Document(s): Attachment H2 - DPPO Provider Network Tables

16.3.1.2 Does Applicant conduct provider negotiations?

Single, Pull-down list.
1: Yes,
2: No

16.3.1.3 Describe the steps or process Applicant uses to monitor networks adequacy. Include detail, such as monitoring individual provider terminations or provider group terminations.

200 words.

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

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

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

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

16.3.1.6 Describe in detail how Applicant ensures access to care for all enrollees by responding to each category below:

Describe tools used in assessing geographic access to primary, specialist, and hospital care based on enrollee residence:	*100 words.*

Briefly describe methodology used to assess geographic access to primary, specialist, and hospital care based on enrollee residence:	*200 words.*
Describe tools used when tracking ethnic and racial diversity in the population and ensuring access to appropriate culturally competent providers:	*100 words.*
Briefly describe methodology used when tracking ethnic and racial diversity in the population and ensuring access to appropriate culturally competent providers:	*200 words.*

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

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

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

16.3.2 Network Quality

All questions are required for currently contracted Applicants and new entrant Applicants
16.3.2.1 Describe in detail, how Applicant use patient safety as a criterion for provider selection for Covered California networks including the assessment process, the source of the patient safety assessment data, specific measures and metrics, thresholds for inclusion and exclusion.

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

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

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

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

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

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

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

~~16.3.2.4 If Applicant encourages use of high-performing dental providers, what criteria does Applicant use to identify high-performing providers?~~

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

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

200 words.

16.3.3 Network Stability

All questions are required for currently contracted Applicants and new entrant Applicants.
16.3.3.1 Describe any plans for network additions, by product, including any new dental provider groups or clinic systems that Applicant would like to highlight for Covered California attention.

100 words.

16.3.3.2 Provide information on any known or anticipated potential network disruption that may affect Applicant's 20233 provider networks. For example: list any pending terminations of dental groups which can include Independent Practice Associations.

100 words.

16.4 Other Network Type

16.4.1 Network Strategy

Questions 16.4.1.1 – 16.4.14. are required for currently contracted Applicants. All questions are required for Applicants that are new entrants or proposing new networks.
16.4.1.1 Applicant must complete all tabs in Attachment HK3 - Other Provider Network Tables, for their Other Network.

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

Attached Document(s): Attachment H3 - Other Provider Network Tables

16.4.1.2 Does Applicant conduct provider negotiations?

Single, Pull-down list.
1: Yes,
2: No

16.4.1.3 Describe the steps or process Applicant uses to monitor networks. Include detail, such as monitoring terminations.

200 words.

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

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

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

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

16.4.1.6 Describe in detail how Applicant ensures access to care for all enrollees by responding to each category below:

Describe tools used in assessing geographic access to primary, specialist, and hospital care based on enrollee residence:	*100 words.*
Briefly describe methodology used to assess geographic access to primary, specialist, and hospital care based on enrollee residence:	*200 words.*
Describe tools used when tracking ethnic and racial diversity in the population and ensuring access to appropriate culturally competent providers:	*100 words.*
Briefly describe methodology used when tracking ethnic and racial diversity in the population and ensuring access to appropriate culturally competent providers:	*200 words.*

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

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

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

500 words.

16.4.2 Network Quality

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

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

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

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

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

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

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

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

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

~~16.4.2.4 If Applicant encourages use of high-performing dental providers, what criteria does Applicant use to identify high-performing providers?~~

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

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

200 words.

16.4.3 Network Stability

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

16.4.3.1 Describe any plans for network additions, by product, including any new dental provider groups or clinic systems that Applicant would like to highlight for Covered California attention.
100 words.

16.4.3.2 Provide information on any known or anticipated potential network disruption that may affect Applicant's 20233 ~~2~~ provider networks. For example: list any pending terminations of dental groups which can include Independent Practice Associations.
100 words.

17 Essential Community Providers

Question required only for new entrant Applicants.

17.1 Applicant must demonstrate that its QDP proposals meet requirements for geographic sufficiency of its Essential Community Provider (ECP) network. All ~~of~~ the criteria below must be met.

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

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

Federal regulations currently require health issuers to adhere to rules regarding payment to non-contracted FQHCs for services when those services are covered by the QDP's benefit plan. Dental ~~i~~issuers will be required in their contract with Covered California to operate in compliance with all federal regulations issued pursuant to the Affordable Care Act, including those applicable to essential community providers.

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

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

18 Quality

18.1 Quality Improvement Strategy

Questions 18.1.1 and 18.1.2 are required for currently contracted Applicants. All questions are required for new entrant Applicants.

18.1.1 Consistent with Covered California's mission to promote better care, better health and lower cost as part of a Quality Improvement Strategy, Applicants must confirm it will implement a quality assurance program in accordance with Title 2, CCR, Section 1300.70, for evaluating the appropriateness and quality of the covered services provided to member.

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

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

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

18.1.3 QIP #1: Describe a Quality Improvement Project (QIP) conducted by Applicant within the last five (5) years. Quality Improvement is defined as systematic actions taken to measurably improve oral health care, structure, processes, or outcomes. Include information about results of the QIP, why the QIP was undertaken and why it ended or has continued, if applicable. Describe the QIP scalability, if it was successful. Also include the following information:

- Start/End Dates:
- QIP Name/Title:
- Problem Addressed:
- Rationale (why selected):
- Targeted Population:
- Study Indicator(s):
- Baseline Measurement:
- Results:
- What best practices have been implemented to sustain Improvement (if any):

500 words.

18.1.4 QIP #2: Describe a second Quality Improvement Project (QIP) conducted by Applicant within the last five (5) years. Quality Improvement is defined as systematic actions taken to measurably improve oral health care, structure, processes, or outcomes. Include information about results of the QIP, why the QIP was undertaken and why it ended or has continued, if applicable. Describe the QIP scalability, if it was successful. Also include the following information:

- Start/End Dates:
- QIP Name/Title:
- Problem Addressed:
- Rationale (why selected):
- Targeted Population:

- Study Indicator(s):
- Baseline Measurement:
- Results:
- What best practices have been implemented to sustain Improvement (if any):

500 words.

18.2 Care Management

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

18.2.1 Applicant must confirm it will make available to Covered California enrollees the following programs and services.

Care Reminders	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed
Risk Assessments	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed
Disease Management Programs	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed

18.2.2 Which of the following activities are used or will be by Applicant to encourage use of diagnostic and preventive services?

Multi, Checkboxes.
1: Mailed printed materials about preventive services with $0 cost-share to members (oral exam, cleaning, X-rays),
2: Emails sent to membership about preventive services with $0 cost-share to members (oral exam, cleaning, X-rays),
3: Automated outbound telephone reminders about preventive services with $0 cost-share to members (oral exam, cleaning, X-rays),
4: Other (explain): [100 words],
5: No current activities used to encourage use of preventive services; discuss any planned activities to encourage use of diagnostic and preventive services: [100 words]

18.2.3 If Applicant indicated that any of the activities in 18.2.2 are used to encourage use of diagnostic and preventive services, upload as an attachment screenshots or other materials demonstrating these activities.

200 words.

18.2.4 Which of the following activities are currently used by Applicant to communicate oral health and wellness (i.e. self-care for maintaining good oral health)?

Multi, Checkboxes.
1: Mailed printed materials about oral health self-care,
2: Emails sent to membership about oral health self-care,
3: Other (please explain): [100 words],
4: No current activities used to encourage oral health self-care; discuss any planned activities to communicate oral health and wellness information to Enrollees: [100 words]

18.2.5 If Applicant indicated that any of the activities in 18.2.4 are used to communicate oral health and wellness, please upload as an attachment screenshots or other materials demonstrating these activities.

200 words.

18.2.6 Indicate the availability of the following demand management activities and health information resources for Covered California members. (Check all that apply)

Multi, Checkboxes.
1: Teledentistry,
2: Decision support,
3: Self-care books,
4: Electronic Preventive care reminders,
5: Web-based health information,
6: Web-based self-care resources,
7: Integration with other health care vendors,
8: Other (describe): [200 words]

18.3 Health Status and Risk Assessment

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

18.3.1 Indicate if oral health risk assessment is used to determine enrollee oral health status, and if so, select all oral health risk assessment features that apply.

Multi, Checkboxes.
1: Oral health risk assessment offered online or in print,
2: Oral health risk assessment offered through telephone interview with a live person,
3: Oral health risk assessment offered in multiple languages,
4: Upon completion of oral health risk assessment, risk-factor education is provided to member based on member-specific risk, e.g. if member reports tobacco use, education is provided on gum disease risk,
5: Personalized oral health risk assessment report is generated with risk modification actions,
6: Member is directed to interactive intervention module for behavior change upon risk assessment completion,
7: Email on self-care generated based on enrollee responses,
8: Email or phone call reminders to schedule preventive or diagnostic visits generated based on enrollee responses,
9: Oral health risk assessment not offered

18.3.2 If applicable, indicate any new or additional oral health risk assessment features that will be used to determine enrollee oral health status. Select all that apply.

Multi, Checkboxes.
1: Oral health risk assessment offered online or in print,
2: Oral health risk assessment offered through telephone interview with a live person,
3: Oral health risk assessment offered in multiple languages,
4: Upon completion of oral health risk assessment, risk-factor education is provided to member based on member-specific risk, e.g. if member reports tobacco use, education is provided on gum disease risk,
5: Personalized oral health risk assessment report is generated with risk modification actions,
6: Member is directed to interactive intervention module for behavior change upon risk assessment completion,
7: Email on self-care generated based on enrollee responses,
8: Email or phone call reminders to schedule preventive or diagnostic visits generated based on enrollee responses,
9: Oral health risk assessment not offered

18.3.3 Does Applicant collect information on enrollee oral health status using any of the following sources of data? Select all that apply.

Multi, Checkboxes.
1: Oral health risk assessment,
2: Claims data,

3: Other (please explain): [100 words],
4: Data on oral health status not collected

18.3.4 Describe any efforts undertaken in the last year to improve collection of ~~capacity or systems to determine~~ enrollee oral health status, including member outreach or communication strategies to encourage the use of oral health risk self-assessment offered by Applicant. If applicable, include description of planned activities to expand or improve capacity to determine enrollee oral health status.

100 words.

18.3.5. Does Applicant use any of the following sources of data to track changes in oral health status among individual ~~P~~plan ~~E~~enrollees? Select all that apply.

Multi, Checkboxes.
1: Oral health risk assessment,
2: Claims data,
3: Other (please explain): [200 words],
4: Describe any planned activities to build capacity or systems to track changes in individual enrollee oral health status (please explain): [200 words],
5: Data on oral health status not used

~~18.3.6 Discuss any planned activities to build capacity or systems to track changes in enrollee oral health status~~.

~~*200 words.*~~

18.3.~~6~~7 How does Applicant currently identify at-risk enrollees, which may include members with existing or newly diagnosed needs for dental treatment or members with co-morbid conditions?

Multi, Checkboxes.
1: Claims data,
2: Website registration prompts self-report of existing/newly diagnosed need for dental treatment and/or co-morbid conditions,
3: Oral health risk assessment,
4: Other (please explain): [200 words],
5: Describe any planned activities to identify at-risk enrollees (please explain): [200 words],
6: Plan does not currently identify at-risk enrollees

~~18.3.8 Discuss any planned activities to identify at-risk enrollees.~~

~~*100 words.*~~

18.3.~~7~~9 Report the number of enrollees who have been identified as “at-risk.”

	Covered California Enrollees, if applicable	Book of Business
Number of enrollees who have been identified as “at-risk”	*Integer.*	*Integer.*
Number of enrollees	*Integer.*	*Integer.*

18.4 Enrollee Population Management

All questions are required for currently contracted Applicants and new entrant Applicants.
18.4.1 Describe practices in place to address population health management across enrolled members. Include measurement strategy and any specific ability to track impact on Covered California enrollees.

100 words.

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

100 words.

18.4.3 Describe ability to track and monitor cost and utilization management. Include measurement strategy, any specific ability to track impact on Covered California enrollees and how Applicant uses this information as part of its population health management strategy.

100 words.

18.4.4 Describe ability to track and monitor clinical outcome quality. Include measurement strategy, any specific ability to track impact on Covered California enrollees how Applicant uses this information as part of its population health management strategy.

100 words.

18.5 Innovations

Question required only for new entrant Applicants.
18.5.1 Describe institutional capacity to plan, implement, evaluate, and replicate future healthcare quality and cost innovations for Covered California Members. Of special interest to Covered California are programs with focus on at-risk enrollees (e.g.: communities at risk for health disparities, enrollees with chronic-conditions and those who live in medically underserved areas).

200 words.

18.6 Reducing Health Disparities and Ensuring Health Equity

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

18.6.1 Identify the sources of data used to gather members' race and ethnicity. The response “enrollment form” pertains only to information reported directly by members or passed on by CalHEERS. Report on Covered California membership if applicable.

Data Element	Data Collection Method (Select all that apply)	Other, explain	Percent of membership for whom data is captured
Race and ethnicity	*Multi, Checkboxes.* 1: Enrollment form, 2: Oral health risk assessment, 3: Information requested upon website registration, 4: Inquiry upon call to customer service,	*50 words.*	*Percent.* N/A OK.

	5: Indirect method such as surname or zip code analysis, 6: Other (please explain), 7: Data not collected		

18.6.2 Identify the sources of data used to gather members' primary language. The response "enrollment form" pertains only to information reported directly by members or passed on by CalHEERS. Report on Covered California membership if applicable.

Primary language	*Multi, Checkboxes.* 1: Enrollment form, 2: Oral health risk assessment, 3: Information requested upon website registration, 4: Inquiry upon call to customer service, 5: Indirect method such as surname or zip code analysis, 6: Other (Please explain), 7: Data not collected	*50 words.*	*Percent.* N/A OK.

18.6.3 Identify the sources of data used to gather members' disability status. The response "enrollment form" pertains only to information reported directly by members or passed on by CalHEERS. Report on Covered California membership if applicable.

Disability Status	*Multi, Checkboxes.* 1: Enrollment form, 2: Oral health risk assessment, 3: Information requested upon website registration, 4: Inquiry upon call to customer service, 5: Indirect method such as surname or zip code analysis, 6: Other (Please explain), 7: Data not collected	*50 words.*	*Percent.* N/A OK.

18.6.4 If Applicant answered "data not collected" to 18.6.1, discuss how Applicant intends to collect race and ethnicity data elements to support improving health equity.

200 words.

18.6.5 If Applicant answered "data not collected" to 18.6.2, discuss how Applicant intends to collect primary language data elements to support improving health equity.

18.6.6 If Applicant answered "data not collected" to 18.6.3, discuss how Applicant intends to collect disability data elements to support improving health equity.

18.6.7 Indicate how race and ethnicity data are used to address quality improvement and health equity. Select all that apply.

Multi, Checkboxes.

1: Calculate dental quality performance measures by race/ethnicity, status,
2: Calculate member experience measures by race/ethnicity, status,
3: Identify areas for quality improvement,
4: Identify areas for health education/promotion,
5: Share provider race/ethnicity/language data with member to enable selection of concordant dentists,
6: Share with dental 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: Develop outreach programs that are culturally sensitive (please explain): [100 words],

10: Other (please explain): [100 words],
11: Race/ethnicity data not used for quality improvement or health equity

18.6.8 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 dental quality performance measures by language status,
3: Calculate member experience measures by language status,
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 dental 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: Develop outreach programs that are culturally sensitive (please explain): [100 words],
11: Other (please explain): [100 words],
12: Language data not used for quality improvement or health equity

18.6.9 Indicate how disability status data are used to address quality improvement and health equity. Select all that apply.

Multi, Checkboxes.
1: Calculate dental 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 dental 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: Other (please explain): [100 words],
10: Disability data not used for quality improvement or health equity

18.6.10 List the specific measures and the demographic factors by which each measure is stratified if indicated in questions 18.6.7, 18.6.8, 18.6.9. Include access, utilization, quality of care, patient experience, or other equity metrics as applicable.

200 words.

18.7 Promotion, Development, and Use of Care Models

All questions are required for currently contracted Applicants and new entrant Applicants.
18.7.1 If applicable to Applicant's delivery system, report the number of enrollees who have been encouraged to select or assigned a primary care dentist.

	Covered California DHMO Enrollees, if applicable	Covered California DPPO Enrollees, if applicable	Book of Business
Number of enrollees who have been encouraged to select or assigned a primary care dentist	*Integer.*	*Integer.*	*Integer.*

Number of enrollees	*Integer.*	*Integer.*	*Integer.*

18.7.2 If selection of or assignment to a primary care dentist is not required due to the Applicant's product type, describe how Applicant encourages member's use of dental home.

100 words.

18.7.3 If selection of or assignment to a primary care dentist is not required due to the Applicant's product type, describe how Applicant encourages contracted providers to retain patients for continued care.

100 words.

18.8 Provider Cost Information

All questions are required for currently contracted Applicants and new entrant Applicants proposing to offer DPPO products.

18.8.1 Indicate how Applicant provides DPPO members with cost information for network providers. Select all that apply.

Multi, Checkboxes.

1: Web site includes a cost calculator tool for dental services (e.g. crowns, casts, endodontics, periodontics, etc.),
2: Web site provides information on average regional charges for dental services (e.g. crowns, casts, endodontics, periodontics, etc.),
3: Cost information on provider-specific contracted rates available upon request through Web site or customer service line,
4: Members directed to network providers to request cost information,
5: Other (please explain): [100 words],
6: Cost information not provided to membership

18.8.2 If Applicant does not currently provide DPPO members with cost information, report how Applicant intends to make provider-specific cost information available to members.

100 words.

18.9 Community Health and Wellness Promotion

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

18.9.1 Applicant must indicate the type of initiatives, programs, and projects Applicant supports and describe how such activities specifically promote community health and/or address health disparities. Select all that apply and provide a narrative description in the “details” describing the activity.

Type of Activity	Response	Details
Internal facing, member-related efforts to promote oral health (e.g. oral health education programs)	*Single, Pull-down list.* 1: Yes, 2: No	*100 words.*
External, high-level community facing activities (e.g. health fairs, attendance at community coalitions, participation in health collaboratives)	*Single, Pull-down list.*	*100 words.*

	1: Yes, 2: No	
Engaged with non-profit health systems or local health agencies to conduct community risk assessments to identify high priority needs and health disparities related to oral health	*Single, Pull-down list.* 1: Yes, 2: No	*100 words.*
Community oral health effort built on evidence-based program and policy interventions, and planned evaluation included in the initiative	*Single, Pull-down list.* 1: Yes, 2: No	*100 words.*
Funded community health programs based on needs assessment or other activity	*Single, Pull-down list.* 1: Yes, 2: No	*100 words.*
Plan is currently planning a community oral health promotion activity	*Single, Pull-down list.* 1: Yes, 2: No	*100 words.*
Plan does not conduct any community oral health initiatives	*Single, Pull-down list.* 1: Yes, 2: No	*100 words.*

18.10 Utilization

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

18.10.1 Applicant must provide dental utilization for the most recent benefit year for the following utilization measures. Provide current Covered California membership if applicable, and California book of business. Pediatric membership is defined as younger than 19 years of age.

Pediatric Utilization	Covered California enrollees, if applicable	California Book of Business
Percentage of membership that received any covered dental service	*Percent.*	*Percent.*
Percentage of membership that received a preventive/diagnostic dental service	*Percent.*	*Percent.*
Percentage of members receiving dental treatment services (excluding preventive and diagnostic services)	*Percent.*	*Percent.*
Percentage of members who received a treatment for caries or a caries-preventive procedure	*Percent.*	*Percent.*

Percentage of members with one (1) or more fillings in the past year who received a topical fluoride or sealant application	*Percent.*	*Percent.*
Percentage of pediatric membership identified as moderate or high caries risk	*Percent.*	*Percent.*
Percentage of pediatric membership who reached their annual out-of-pocket maximum.	*Percent.*	*Percent.*

18.10.2 Applicant must provide dental utilization for the most recent benefit year for the following utilization measures. Provide current Covered California membership if applicable, and California book of business. Adult membership is defined as 19 years of age and older.

Adult Utilization	*For comparison.* Covered California enrollees, if applicable	*For comparison.* California Book of Business
Percentage of membership that received any covered dental service	*Percent.*	*Percent.*
Percentage of membership that received a preventive/diagnostic dental service	*Percent.*	*Percent.*
Percentage of members receiving dental treatment services (excluding preventive and diagnostic services)	*Percent.*	*Percent.*
Percentage of members who received a treatment for caries or a caries-preventive procedure	*Percent.*	*Percent.*
Percentage of members with one (1) or more fillings in the past year who received a topical fluoride or sealant application	*Percent.*	*Percent.*
Percentage of membership identified as high risk	*Percent.*	*Percent.*
Percentage of members whom reached the plan's maximum annual benefit, if applicable	*Percent.*	*Percent.*

18.10.3 Applicant must submit copies of the most recent Dental Medical Loss Ratio Reports filed with the applicable regulator.

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

19 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.

Covered California Enrollee – Refers to every individual enrolled in Covered California for the purpose of receiving health benefits. Also referred to "On-Exchange".

Definition of Good Standing – California Department Insurance – –Verification that ~~issuer~~Issuer holds a state health care service plan license or insurance certificate of authority: Approved for lines of business sought in the Exchange (e.g., commercial, small group, individual; Approved to operate in what geographic service areas and most recent market conduct exam reviewed.
Affirmation of no material[2] statutory or regulatory violations, including penalties levied, in the past two years in relation to any of the following, where applicable: Financial solvency and reserves reviewed; Benefit Design; State mandates (to cover and to offer) - Essential health benefits (State required), Basic health care services, Copayments, deductibles, out-of-pocket maximums, Actuarial value confirmation (using certification year Federal Actuarial Value Calculator); Network adequacy and accessibility standards are met – provider contracts; Language access; uniform disclosure (summary of benefits and coverage); Claims payment and policies and practices; Enrollee/Member grievances/complaints and appeals policies and practices; Independent medical review; Marketing and advertising; Guaranteed issue individual and small group; Rating Factors; Medical Loss Ratio; Premium rate review – Geographic rating regions and rate development justification is consistent with ACA requirements.

Definition of Good Standing – Department of Managed Health Care – –Verification that ~~issuer~~Issuer holds a state health care service plan license or insurance certificate of authority: Approved for lines of business sought in the Exchange (e.g., commercial, small group, individual; Approved to operate in what geographic service areas and most recent financial exam and medical survey report reviewed.
Affirmation of no material[2] statutory or regulatory violations, including penalties levied, in the past two years in relation to any of the following, where applicable: Financial solvency and reserves reviewed; Administration and organizational capacity acceptable; Benefit Design; State mandates (to cover and to offer) - Essential health benefits (State required), Basic health care services, Copayments, deductibles, out-of-pocket maximums, Actuarial value confirmation (using certification year Federal Actuarial Value Calculator); Network adequacy and accessibility standards are met – provider contracts; Language access; uniform disclosure (summary of benefits and coverage); Claims payment and policies and practices; Enrollee/Member grievances/complaints and appeals policies and practices; Independent medical review; Marketing and advertising; Guaranteed issue individual and small group; Rating Factors; Medical Loss Ratio; Premium rate review – Geographic rating regions and rate development justification is consistent with ACA requirements.

[1] ~~The term "~~**Dental ~~Issuer~~Issuer**~~"~~ – ~~used in this document~~ R~~r~~efers to both dental 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 dental coverage, while the term "Qualified Dental Plan" refers to a specific 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 Dental ~~Issuer~~Issuer who is seeking to have its plans certified as Qualified Dental Plans.

Enrollee – Refers to every individual enrolled for the purpose of receiving health benefits, including Covered California Enrollees and Off-Exchange membership.

External Audit – A formal audit process that includes an independent and objective examination of an organization's programs, operations, and records performed by a third party (e.g., independent audit or consulting firm, state and federal oversight agencies, etc.) to evaluate and improve the effectiveness of its policies and procedures. The results, conclusions, and findings of an audit in California or any other state(s) where Applicant provides services are formally communicated through an audit report delivered to management of the audited entity.

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

Internal Audit Function - An internal audit function is accountable to an organization's senior management and those charged with governance of the audited entity. An internal auditing activity is an independent, objective assurance and consulting activity designed to add value and improve an organization's operations. Internal Auditing helps an organization accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control, and governance processes.

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

[2] Covered California, in its sole discretion and in consultation with the appropriate health insurance regulator, determines what constitutes a material violation for this purpose.