

Qualified Health Plan Certification Application Plan Year 2022 Individual Marketplace

1 Application Overview

1.1 Purpose

The California Health Benefit Exchange (Covered California) is accepting applications from eligible Health Insurance Issuers^[1] (Applicants or Health Issuer) to submit proposals to offer, market, and sell qualified health plans (QHPs) through Covered California beginning in 2021, for coverage effective January 1, 2022. All Health Insurance Issuers currently licensed at the time of application response submission are eligible to apply for certification of proposed Qualified Health Plans (QHPs) for the 2022 Plan Year. QHP Issuers contracted for Plan Year 2021 will complete a simplified certification application since those 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 2022. Covered California reserves the right to select or reject any Applicant or to cancel this Application at any time.

^[1] The term “Health Issuer” used in this document refers to both health plans regulated by the California Department of Managed Health Care and insurers regulated by the California Department of Insurance. It also refers to the company issuing health coverage, while the term “Qualified Health Plan” refers to a specific policy or plan to be sold to a consumer that has been certified by Covered California. The term “product” means a discrete package of health insurance coverage benefits that are offered using a product network type (such as health maintenance organization, preferred provider organization, or exclusive provider organization) within a service area (45 CFR § 144.103). The term “plan” shall have the same meaning as that term is defined in 45 CFR § 144.103. The term “Applicant” refers to a Health Insurance Issuer who is seeking to have its plans certified as Qualified Health 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:

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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 that will be offered in Covered California.

The state legislation to establish Covered California gave authority to Covered California to selectively contract with Issuers to provide health care coverage options that offer the optimal combination of choice, value, quality, and service, and to establish and use a competitive process to select the participating health Issuers. These concepts, and the inherent trade-offs among Covered California values, must be balanced in the evaluation and selection of the Qualified Health Plans (QHPs) that will be offered on the Individual Exchange.

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

1.3 Application Evaluation and Selection

The evaluation of QHP Certification Applications will not be based on a single, strict formula; instead, the evaluation will consider the mix of health plans for each region of California that best meet the needs of consumers in that region and Covered California's goals. Covered California wants to provide an appropriate range of high-quality health plans to participants at the best available price that is balanced with the need for consumer stability and long-term affordability. In consideration of the mission and values of Covered California, the Board of Covered California articulated guidelines for the selection and oversight of Qualified Health Plans which are used when reviewing the Applications for 2022. These guidelines are:

Promote affordability for the consumer– both in terms of premium 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 QHP proposals will focus on quality and service components, including history of performance, administrative capacity, reported quality and satisfaction metrics, quality improvement plans and commitment to serve Covered California population. This commitment to serve Covered California population is evidenced through general cooperation with Covered California's operations and contractual requirements which include provider network adequacy, cultural and linguistic competency, programs addressing health equity and disparities in care, innovations in delivery system improvements and payment reform. The application responses, in conjunction with the approved filings, will be evaluated by Covered California and used as part of the selection criteria to offer Issuers' products on Covered California for the 2022 plan year.

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

Covered California is committed to fostering competition by offering QHPs with features that present clear choice, product and provider network differentiation. QHP Applicants are required to adhere to Covered California's standard benefit plan designs in each region for which they submit a proposal. In addition, QHP Applicants may offer Covered California's standard Health Savings Account-eligible (HSA) High Deductible Health Plan (HDHP) designs. Applicants may choose to offer either or both Gold and Platinum standard benefit plan designs if there is differentiation between two plans in the same metal tier that is related to either product, network or both or an additional benefit explained. Covered California is interested in having HMO, EPO 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

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

Encourage Competition throughout the State

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

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

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

Encourage Delivery System Improvement, Effective Prevention Programs and Payment Reform

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

Demonstrate Administrative Capability and Financial Solvency

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 starting with 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

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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 calculator is finalized.

1.4 Availability

Applicant must be available immediately upon contingent certification of its plans as QHPs to start working with Covered California to establish all operational procedures necessary to integrate and interface with Covered California information systems and to provide additional information necessary for Covered California to market, enroll members, and provide health plan services effective January 1, 2022. Successful Applicants will also be required to adhere to certain provisions through their contracts with Covered California, including meeting data interface requirements with the California Healthcare Enrollment, Eligibility, and Retention System (CalHEERS). Successful Applicants must execute the QHP Issuer Contract before public announcement of contingent certification. Failure to execute the QHP Issuer Contract may preclude Applicant from offering QHPs through Covered California. The successful Applicants must be ready and able to accept enrollment as of October 1, 2021.

1.5 Application Process

The application process shall consist of the following steps:

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

1.6 Intention to Submit a Response

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

Applicant's Letter of Intent must identify the contact person for the application process, that includes an email address and telephone number. On receipt of the Letter of Intent, Covered California will issue instructions 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 QHPs are announced. Applicant information will not be released to the public but may be shared with appropriate regulators as part of the cooperative arrangement between Covered California and the regulators.

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

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received by Applicant if Applicant fails to notify Covered California, in writing, of any changes pertaining to the designated contact person.

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

1.7 Key Action Dates

Action	Date/Time
Release of Draft Application for Comment	December 2020
Letters of Intent due to Covered California	February 12, 2021
Application Opens	March 1, 2021
Completed Applications Due (include 2022 Proposed Rates & Networks)	April 30, 2021
Negotiations between Applicants and Covered California	June 2021
Final QHP Contingent Certification Decisions	July 2021
QHP Contract Execution	September 2021
Final QHP Certification	October 2021

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.

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Federal Employer ID	10 words.
HIOS/Issuer ID	10 words.
Applicant tax status	Single, Pull-down list. 1: Not-for-profit, 2: For-profit
Year Applicant was founded	10 words.
Corporate Office Address	10 words.
City	10 words.
State	10 words.
Zip Code	10 words.
Primary Contact Name	10 words.
Contact Title	10 words.
Contact Phone Number	10 words.
Contact Email	10 words.
Applicant Eligibility	Single, Pull-down list. 1: Contracted in 2021, 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 Health Plans, may decertify those Qualified Health Plans should any material information provided be found to be inaccurate. I confirm that I have the capacity to bind the issuer stated above to the terms of this Application.	
Date	To the day.
Signature	10 words.
Printed Name	10 words.
Title	10 words.

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

- Chief Executive Officer
- Chief Finance Officer
- Chief Operations Officer
- Contracts

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- 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.

Answer and attachment required

1: Attached,

2: Not attached

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

- Mergers
- Acquisitions
- New venture capital
- Management team
- Location of corporate headquarters or tax domicile
- Stock issue
- Other

If yes, Applicant must describe the material changes.

Single, Radio group.

1: Yes, describe: [200 words]

2: No

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

Commercial General Liability	Limit of not less than \$1,000,000 per occurrence/ \$2,000,000 general aggregate
Comprehensive Business Automobile Liability	Limit of not less than 1,000,000 per accident
Employers Liability Insurance	Limits of not less than \$1,000,000 per accident for bodily injury by accident and \$1,000,000 per employee for bodily injury by disease and \$1,000,000 disease policy limit.
Umbrella Policy	An amount not less than \$10,000,000 per occurrence and in the aggregate
Crime Coverage	At such levels reasonably determined by Contractor to cover occurrences

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Professional Liability or Errors and Omissions	Coverage of not less than \$1,000,000 per claim/ \$2,000,000 general aggregate.
Statutory CA's Workers' Compensation Coverage	Provide Proof of Coverage

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

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 health issuer as defined herein in the commercial individual market,

2: Applicant currently holds all of the proper and required licenses from the California Department of Insurance to operate as a health issuer as defined herein in the commercial individual market,

3: Applicant is currently applying for licensure from the California Department of Managed Health Care to operate as a health issuer as defined herein in the commercial individual market. If Yes, enter date application was filed: [To the day],

4: Applicant is currently applying for licensure from the California Department of Insurance to operate as a health issuer as defined herein in the commercial individual market. If yes, enter date application was filed: [To the day]

3.2 In addition to holding or pursuing all the proper and required licenses to operate as a Health Issuer, Applicant must confirm that it has had no material fines, no material penalties levied or material ongoing disputes with applicable licensing authorities in the last two years (See Appendix A Definition of Good Standing). If Applicant has any material disputes with the applicable health insurance regulator in the last two years, Applicant must provide notification of disputes. Covered California, in its sole discretion and in consultation with the appropriate health insurance regulator, determines what constitutes a material violation for determining Good Standing.

Single, Pull-down list.

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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 health plan proposal in accordance with all requirements outlined in this section.

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

Applicant must submit a standard set of QHPs including all four metal tiers and a catastrophic plan in its proposed rating regions. The QHPs in the standard set must adhere to the 2022 Patient-Centered Benefit Plan Designs. The same provider network type must be used for each QHP in the standard set of QHPs. Applicant's proposal must include coverage of its entire licensed geographic service area. Applicant may not submit a proposal that includes a tiered hospital, physician, or pharmacy network. Applicants must adhere to Covered California's standard benefit plan designs and the requirements in this section without deviation unless approved by Covered California.

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

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

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

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

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

Single, Radio group.

- 1: Yes, proposal meets requirements,
- 2: No: [500 words]

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

Single, Pull-down list.

- 1: Confirmed,
- 2: Not confirmed

4.3 Preliminary Premium Proposals.

Final negotiated and accepted premium rates shall be in effect for coverage effective January 1, 2022.

Premium proposals are considered preliminary and may be subject to negotiation as part of QHP certification and selection process. The final negotiated premium rates must align with the product rate filings that will be submitted to the applicable regulatory agency. Premium proposals must be submitted with the Application. To submit premium proposals for Individual products Applicant must complete and upload through System for Electronic Rate and Form Filing (SERFF) the Unified Rate Review Template (URRT), the Supplemental Rate Review Template (SRRT), Actuarial Memorandum and the Rates Data Template available at:

<https://www.qhpcertification.cms.gov/s/QHP>. Premium may vary only by geography (rating region), by age band (within 3:1 range requirement), by coverage tier, and by actuarial value metal level.

Applicant shall provide, in connection with any negotiation process as reasonably requested by Covered California, detailed documentation on Covered California-specific rate development methodology. Applicant shall provide justification, documentation, and support used to determine rate changes, including adequately supported cost projections. Cost projections include factors impacting rate changes, assumptions, transactions and other information that affects Covered California-specific rate development process. Covered California may also request information pertaining to the key indicators driving the medical factors on trends in medical, pharmacy or other healthcare provider costs. This information may be necessary to support the assumptions made in forecasting and may be supported by information from Applicant's actuarial systems pertaining to Covered California-specific account.

Single, Pull-down list.

- 1: Template completed and uploaded,
- 2: Template not completed and uploaded

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

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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.ghpcertification.cms.gov/s/QHP>.

Single, Pull-down list.

1: Yes, health plan proposal covers entire licensed geographic service area; template uploaded

2: No, health plan proposal does not cover entire licensed geographic service area; template uploaded

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.ghpcertification.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 2022. 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)
HMO	<i>Single, Pull-down list.</i> 1: Yes, 2: No	<i>Single, Pull-down list.</i> 1: New Network, 2: New to Covered California, 3: Existing Covered California	<i>10 words.</i>
PPO	<i>Single, Pull-down list.</i> 1: Yes, 2: No	<i>Single, Pull-down list.</i> 1: New Network, 2: New to Covered California, 3: Existing Covered California	<i>10 words.</i>
EPO	<i>Single, Pull-down list.</i> 1: Yes, 2: No	<i>Single, Pull-down list.</i> 1: New Network, 2: New to Covered California, 3: Existing Covered California	<i>10 words.</i>
Other	<i>Single, Pull-down list.</i> 1: Yes, 2: No	<i>Single, Pull-down list.</i> 1: New Network, 2: New to Covered California, 3: Existing Covered California	<i>10 words.</i>

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5 Benefit Design

Questions 5.1 – 5.3 and 5.8 – 5.11 are required for currently contracted Applicants. All questions are required for new entrant Applicants.

5.1 Applicant must comply with 2022 Patient-Centered Benefit Plan Designs. Applicant must complete and upload through System for Electronic Rate and Form Filing (SERFF) the Plans and Benefits template located at <https://www.ghpcertification.cms.gov/s/QHP>.

Single, Pull-down list.

1: Confirmed, template submitted,

2: Not confirmed, template not submitted

5.2 Applicant must indicate if it is requesting approval for any cost-sharing deviations from the 2022 Patient-Centered Benefit Plan Designs. If yes, Applicant must submit QHP Attachment B Patient-Centered Benefit Design Health Deviations to describe the proposed deviations and the rationale for the deviation. Proposed deviations may include, but are not limited to:

- Operational or administrative barriers to implementing the 2022 Patient-Centered Benefit Plan Designs? Operational or administrative barriers are defined as infrastructure limitations that preclude administration of a type of member cost-sharing specified in the standard plan design. Required cost share changes for MHPAEA compliance
- Deviations that are condition- or place specific, such as 1) waived or reduced cost shares to treat a certain disease or condition, or 2) waived or reduced cost shares for medical or pharmacy benefits that are administered in a place other than the typical site of administration, such as in the home, telehealth, etc.

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

Attached Document(s): [QHP Attachment B Patient-Centered Benefit Plan Design Deviations.xlsx](#)

Single, Pull-down.

1: Attached.

5.3 Covered California is encouraging the offering of plan products which include all ten Essential Health Benefits, including the pediatric dental Essential Health Benefit. Applicant must indicate if it will adhere to the 2022 Patient-Centered Benefit Plan Design which includes all ten Essential Health Benefits. Failure to offer a product with all ten Essential Health Benefits will not be grounds for rejection of Applicant's application.

Single, Pull-down list.

1: Yes. Individual market QHPs proposed for 2022 include all ten Essential Health Benefits.,

2: No. Individual market QHPs proposed for 2022 do not include all ten Essential Health Benefits.

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

- Activities conducted for consumer education and communication
- Oversight conducted for dental quality and network management

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- If the benefit is subcontracted, state the name of the contractor and whether the contract with the dental benefits subcontractor includes performance incentives

Single, Radio group.

1: Offer benefit directly under full-service license: [100 words],

2: Subcontractor relationship: [100 words],

3: Not Applicable

5.5 Describe how Applicant administers mental health and substance use disorder (MHSUD) benefits as either administered directly by Applicant or subcontracted to a contractor. Use the details section to specifically address the following:

- Activities conducted for consumer education and communication
- Oversight conducted for quality and network management
- If the benefit is subcontracted, state the name of the contractor and whether the contract with the MHSUD benefits subcontractor includes performance incentives

Single, Radio group.

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

2: Subcontractor relationship: [200 words],

3: Other: [200 words]

5.6 Describe how Applicant administers child eye care benefits as either administered directly by Applicant or subcontracted to a contractor. Use the details section to specifically address the following:

- Activities conducted for consumer education and communication related to child eye care benefits
- Oversight conducted for quality and network management
- If the benefit is subcontracted, state the name of the contractor, and whether the contract with the child eye care benefits subcontractor includes performance incentives.

Single, Radio group.

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

2: Subcontractor relationship: [200 words],

3: Other: [200 words]

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

Single, Radio group.

1: Yes, describe: [100 words],

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

5.8 Applicant must complete QHP Attachment L – Telehealth with the cost sharing for telehealth services for each metal tier. If cost sharing does not differ per metal tier, complete the Platinum tab and indicate that cost sharing does not differ by metal tier in the Comments column. Indicate “Not Offered” in the Telehealth Modality column if telehealth is not offered.

Attachment required

1: Attached,

2: Not attached

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

Single, Radio group.

1: Confirmed, attachment(s) submitted,

2: Not confirmed, attachment(s) not submitted: [100 words]

5.10 Applicant must submit final Evidence of Coverage (EOC) or Policy language, final Schedules of Benefits, and final Summary of Benefits and Coverages (SBC) for 2022 by the due date listed in Appendix T Covered California PY 2022 Individual Health Submission Guidelines.

Single, Radio group.

1: Confirmed, will submit final PY 2022 EOC, Schedule of Benefits, and SBC by due date,

2: Not confirmed

Attached Document(s): [QHP Appendix T - Covered California PY 2022 Individual Health Submission Guidelines.pdf](#)

5.11 Covered California's Patient-Centered Benefit Plan Designs require four tiers of drug coverage:

(1) Tier 1

(2) Tier 2

(3) Tier 3

(4) Tier 4

Applicant must complete and upload through SERFF the Prescription Drug Template available at:

<https://www.qhpcertification.cms.gov/s/QHP>.

Single, Pull-down list.

1: Template completed and uploaded,

2: Template not completed and uploaded

5.12 Applicant must select all options that apply from the following list to indicate how Applicant's proposed 2022 formulary will comply with California Health and Safety Code § 1342.71 and Insurance Code § 10123.193 requirements prohibiting discrimination in prescription drug benefits. Use the details section for any additional comments.

Multi, Checkboxes.

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

2: Covers single-tablet regimens for HIV/AIDS,

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

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

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

6: Updates formularies with any changes on a monthly basis,

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

8: Available on the internet to the general public,

9: Other: [200 words]

6 Operational Capacity

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6.1 Issuer Operations and Account Management Support

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

6.1.1 Applicant must complete QHP Attachment C1 C2- 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 QHP Attachment C1 C2 – Current and Projected Enrollment will require a resubmission of the templates.

Single, Pull-down list.

Answer and attachment required

1: Attachments completed,

2: Attachments not completed

Attached Document(s): [QHP Attachment C1 C2 Enrollment - Current and Projected Enrollment.xlsx](#)

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

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Other (specify)	<i>Single, Pull-down list.</i> 1: Yes, 2: No	50 words.	<i>Single, Pull-down list.</i> 1: Yes, 2: No
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6.1.4 Applicant must provide a summary of its operational capabilities, including how long it has been a licensed health issuer. For example, enrollment system, claims, provider services, sales, etc.

100 words.

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

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

6.2 Implementation Performance

Questions required only for new entrant Applicants.

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

Attached Document(s): [QHP Attachment F - Implementation Organizational Chart.xlsx](#)

Single, Radio group.

1: Yes, attached. Describe: [100 words],

2: No, not attached,

3: No, Applicant is currently operating in 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 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	<i>Percent.</i>	<i>50 words.</i>	<i>50 words.</i>
Claims	<i>Percent.</i>	<i>50 words.</i>	<i>50 words.</i>
Account Management	<i>Percent.</i>	<i>50 words.</i>	<i>50 words.</i>
Clinical staff	<i>Percent.</i>	<i>50 words.</i>	<i>50 words.</i>
Disease Management staff	<i>Percent.</i>	<i>50 words.</i>	<i>50 words.</i>
Implementation	<i>Percent.</i>	<i>50 words.</i>	<i>50 words.</i>
Financial	<i>Percent.</i>	<i>50 words.</i>	<i>50 words.</i>
Administrative	<i>Percent.</i>	<i>50 words.</i>	<i>50 words.</i>
Actuarial	<i>Percent.</i>	<i>50 words.</i>	<i>50 words.</i>
Information Technology	<i>Percent.</i>	<i>50 words.</i>	<i>50 words.</i>

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Other (List)	Percent.	50 words.	50 words.
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6.2.5 Applicant must describe in detail its 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. 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]

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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 certified 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.

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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, 2021 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]

8.3 If systems to accept payment are not currently in place, describe plans to implement such systems, including the use of vendors for any functions related to premium payment, if applicable, and an implementation work plan. QHP issuer must be able to accept premium payment from members no later than October 1, 2021. Note: QHP issuer must accept electronic payments, such as debit and credit cards for binder payments. Electronic payment is encouraged, but not required, for payment of ongoing invoices.

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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 charges will be imposed on any member who requests paper premium invoices for any individual products sold by Applicant in California.

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

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.

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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.

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

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 fraud in the introduction to this section, what was Applicant's recovery success rate and dollars recovered for fraudulent activities for each year below?

	Total Loss from Fraud Covered California book of business, if applicable	Total Loss from Fraud Total Book of Business	% of Loss Recovered Covered California book of business, if applicable	% of Loss Recovered Total Book of Business	Total Dollars Recovered Covered California book of business, if applicable	Total Dollars Recovered Total Book of Business
Calendar Year 2017	<i>Dollars.</i>	<i>Dollars.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>Dollars.</i>	<i>Dollars.</i>
Calendar Year 2018	<i>Dollars.</i>	<i>Dollars.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>Dollars.</i>	<i>Dollars.</i>
Calendar Year 2019	<i>Dollars.</i>	<i>Dollars.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>Dollars.</i>	<i>Dollars.</i>

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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 physician 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 internal audit function in the introduction to this section, does Applicant maintain an internal audit function? If yes, provide a brief description of Applicant's internal audit function's responsibilities and its reporting structure, including what oversight authority is there over the internal audit function? For example: does the internal audit function report to a board, audit committee, or executive office?

Single, Radio group.

1: Yes, describe: [200 words],

2: No

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 applicable to financial, performance, and compliance audits.

Single, Pull-down list.

1: Attached,

2: Not attached

9.2.3 If Applicant answered yes to 9.2.2, 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.)	<i>Single, Pull-down list.</i> 1: Quarterly,	<i>10 words.</i>

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	2: Semi-annually, 3: Annually, 4: Biennially, 5: Other:	
Performance Audits (e.g., operations, system, risk management, internal control, governance processes, etc.)	<i>Single, Pull-down list.</i> 1: Quarterly, 2: Semi-annually, 3: Annually, 4: Biennially, 5: Other:	10 words.
Compliance Audits (e.g., regulatory, security controls, etc.)	<i>Single, Pull-down list.</i> 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 external audit in the introduction to this section, indicate what external audits, particular to business done in California, were conducted over the last three years by third parties? For each audit, specify the year of the audit and the name of the agency that conducted the audit.

200 words.

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

1. Evaluation of the correctness of premium rate setting;
2. Payments to Agents;
3. Questions pertaining to 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 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.

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

- Rates,
- Service Area,
- Benefit Plan Designs,
- Network,
- Prescription Drug,
- 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 three (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 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

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

- See Appendix L 834 Companion Guide 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 L 834 Companion Guide.pdf](#)

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

Single, Radio group.

1: Yes, confirmed, describe: [200 words],

2: No, not confirmed, describe: [200 words]

11.5 Applicant must communicate any testing or production changes to system configuration (URL, certification, bank information) to 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 D Reconciliation Process Guide. Applicant must provide a description of its ability to make system updates to reconcilable enrollment fields on a timely basis and provide verification of completion.

200 words.

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

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

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Single, Radio group.

1: Yes, describe: [100 words],

2: No, describe [100 words]

12 Healthcare Evidence Initiative (HEI)

All questions are required only for new entrant Applicants.

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

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

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

Attached Document(s): [Appendix H HEI File Specifications.pdf](#)

Claim / Encounter Type	Response	If No or Yes with deviation, explain.
Professional	<i>Single, Pull-down list.</i> 1: Yes, 2: No	50 words. Nothing required
Institutional	<i>Single, Pull-down list.</i> 1: Yes, 2: No	50 words. Nothing required
Pharmacy	<i>Single, Pull-down list.</i> 1: Yes, 2: No	50 words. Nothing required
Drug (non-Pharmacy)	<i>Single, Pull-down list.</i> 1: Yes, 2: No	50 words. Nothing required
Dental	<i>Single, Pull-down list.</i> 1: Yes, 2: No	50 words. Nothing required

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Mental Health	<i>Single, Pull-down list.</i> 1: Yes, 2: No	<i>50 words.</i> Nothing required
Vision	<i>Single, Pull-down list.</i> 1: Yes, 2: No	<i>50 words.</i> Nothing required

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

Attached Document(s): [Appendix H HEI File Specifications.pdf](#)

Financial Detail to be Provided	Response	If No or Yes with deviation, explain.
Submitted Charges	<i>Single, Pull-down list.</i> 1: Yes, 2: No	<i>50 words.</i> Nothing required
Allowable Charges	<i>Single, Pull-down list.</i> 1: Yes, 2: No	<i>50 words.</i> Nothing required
Copayment	<i>Single, Pull-down list.</i> 1: Yes, 2: No	<i>50 words.</i> Nothing required
Coinsurance	<i>Single, Pull-down list.</i> 1: Yes, 2: No	<i>50 words.</i> Nothing required
Deductibles	<i>Single, Pull-down list.</i> 1: Yes, 2: No	<i>50 words.</i> Nothing required
Plan Paid Amount (Net Payment)	<i>Single, Pull-down list.</i> 1: Yes, 2: No	<i>50 words.</i> Nothing required
Capitation Financials (per Provider / Facility) [1] <i>If a portion of Applicant provider payments are capitated. If capitation does not apply, check "No" and state "Not applicable, no provider payments are capitated" in the rightmost column.</i>	<i>Single, Pull-down list.</i> 1: Yes, 2: No	<i>50 words.</i> Nothing required

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

Detail to be Provided	Response	If No or Yes with deviation, explain.
Covered CA Member ID	<i>Single, Pull-down list.</i> 1: Yes, 2: No	<i>50 words.</i> Nothing required
Covered CA Subscriber ID	<i>Single, Pull-down list.</i> 1: Yes, 2: No	<i>50 words.</i> Nothing required
Member and Subscriber SSN	<i>Single, Pull-down list.</i> 1: Yes, 2: No	<i>200 words.</i> 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 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 H HEI File Specifications.pdf](#)

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

12.5 Applicant must supply all applicable Provider Tax ID Numbers (TINs), National Provider Identifiers (NPIs), and National Council for Prescription Drug Programs (NCPDP) Provider IDs (pharmacy only) for individual providers. If yes with deviation, explain. If unable to provide all requested detail as outlined in Appendix H HEI

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File Specifications, provide a plan and timeline to correct problematic Provider IDs and estimate the number and percentage of affected providers, claims, and encounters.

Attached Document(s): [Appendix H HEI File Specifications.pdf](#)

Provider IDs to be Supplied	Response	If No or Yes with deviation, explain.
TIN	<i>Single, Pull-down list.</i> 1: Yes, 2: No	<i>50 words.</i> Nothing required
NPI	<i>Single, Pull-down list.</i> 1: Yes, 2: No	<i>50 words.</i> Nothing required
NCPDP	<i>Single, Pull-down list.</i> 1: Yes, 2: No	<i>50 words.</i> Nothing required

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

Attached Document(s): [Appendix H HEI File Specifications.pdf](#)

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

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, such as a Pharmacy Benefit Manager (PBM)?

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?

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Single, Radio group.

1: Yes, describe: [50 words],

2: No,

3: Not Applicable

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

Single, Radio group.

1: Yes, describe: [50 words],

2: No

13 Privacy and Security Requirements for Personally Identifiable Data

Question 13.2.6 is required for currently contracted Applicants. All 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 it permits enrollees to request an alternative means or location for receiving their PHI than what Applicant would typically employ [45 CFR

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§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.

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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 (SSN) and identity theft within its organization.

200 words.

14 Sales Channels

Question 14.4 and 14.7 is 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 broker)?

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

14.3 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 submit its AOR policy document as an attachment.

Individual Market – AOR Policy	Off-Exchange Business
What are the requirements Agents must meet to become appointed? Include general agency participation requirement, if any.	50 words.
Describe AOR appointment process. Include mandatory requirements for agents to be with a general agency contracted with Applicant.	50 words.
Provide the timeline for AOR appointment to be complete.	50 words.
Provide AOR Appointment 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.

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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 changes 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.

14.5 Applicant must describe below and 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.

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.
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.

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Does the compensation level apply to all plans or does it vary by tier? Include if this differs between AOR Appointment Commission and AOR Change Commission Rates.	Not Applicable.	50 words.
Does the compensation level vary by product? Include if this differs between AOR Appointment Commission and AOR Change Commission Rates.	50 words.	50 words.
Does the compensation level vary by subsidized plan and non-subsidized plan? Include if this differs between AOR Appointment Commission and AOR Change Commission Rates.	50 words.	50 words.
Describe any reasons for which Applicant will not compensate Agents for an enrollment.	50 words.	50 words.
Describe any reasons for which Applicant will not make changes to AOR for an enrollment.	Not applicable.	50 words.
Describe process for assigning commission payments to an agent's Federal Employer Identification Number (FEIN) and how changes to FEIN are 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.

14.6 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.

14.7 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.

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Describe how applicable commissions are determined for the new servicing agent in an AOR change.	50 words.
Provide the timeline for processing an AOR change. Include how the effective date is determined for the new servicing agent and any factors that would result in a retroactive AOR change.	50 words.
Describe procedures used to manage AOR changes when the AOR files are received electronically from an outside source. Include explanation of how changes to assignment of the Federal Employer Identification Number (FEIN) are handled.	50 words.
Describe AOR reconciliation and error resolution processes, include information on how Applicant resolves commission and AOR discrepancies for Agents.	50 words.
Describe requirements for Vested Agents. Include definition of vesting, to whom vesting applies, duration of vesting, how vesting is affected by AOR changes, and vesting rules when an enrollee leaves and then returns for coverage.	50 words.
Describe any reasons for which Applicant will not compensate Agents for an enrollment.	50 words.
Describe any reasons for which Applicant will not make changes to AOR for an enrollment.	50 words.
Provide AOR Appointment Commission Rate or Schedule for a new enrollment, returning new enrollment, and a renewing enrollment. Include general agency commission, if any.	50 words.
Provide AOR Change Commission Rate or Schedule for a new enrollment, returning new enrollment, and a renewing enrollment. Include general agency commission, if any.	50 words.
Does the compensation level change as the business written by the agent matures? (i.e., Downgraded)	50 words.
Specify if the agent is compensated at a different level as he or she attains certain levels or amounts of in-force business.	50 words.
Does the compensation level vary by product? Include if this differs between AOR Appointment Commission and AOR Change Commission Rates.	50 words.
Does the compensation level vary by agent type? (i.e., general agent, sub agent) Include if this differs between AOR Appointment Commission and AOR Change Commission Rates.	50 words.
Does the compensation level vary by subsidized plan and non-subsidized plan? Include if this differs between AOR Appointment Commission and AOR Change Commission Rates.	50 words.
Describe any reasons for which Applicant will not compensate Agents for an enrollment.	50 words.
Describe any reasons for which Applicant will not make changes to AOR.	50 words.
Describe any agent commission bonus program(s) in the individual market on or off exchange that is currently available in the 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
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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 QHPs. Applicant must provide an organizational chart of its marketing department(s), including names and titles of the main marketing contacts that will be responsible for marketing their Individual and Family Plans (both, on and off exchange).

Single, Pull-down list.

Attachment required

1: Attached,

2: Not attached

15.2 Applicant must confirm that, upon contingent certification of its QHPs, it will cooperate with Covered California Marketing Department, and adhere to the Covered California Brand Style Guide

https://hbex.coveredca.com/toolkit/PDFs/Brand_Style_Guide_022819_for-external-partners.pdf, (and Marketing Guidelines, if applicable) when co-branded materials are issued to Covered California enrollees. If

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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 QHP 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:	<i>Dollars.</i>
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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:	<i>Percent.</i>
Retention efforts:	<i>Percent.</i>

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:	<i>Percent.</i>
Special Enrollment Period:	<i>Percent.</i>

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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 QHP. Submit provider data according to the data file layout in the Covered California Provider Data Submission Guide, <https://hbex.coveredca.com/stakeholders/plan-management/library/Covered-California-Provider-Data-Submission-Guide-V1.10.pdf>. The provider network submission for 2022 must be consistent with what will be filed to the appropriate regulator for approval if Applicant is selected as a QHP Issuer. Covered California requires the information, as requested, to allow cross-network comparisons and evaluations.

Single, Pull-down list.

1: Attached (confirming provider data is for plan year 2022),

2: Not attached,

3: Not attached, currently contracted Applicant attesting to no material changes to existing 2021 Covered California network for plan year 2022

16.1.2 Applicant must complete and upload through SERFF, the Network ID Template located at:

<https://www.ghpcertification.cms.gov/s/QHP>.

Single, Pull-down list.

1: Template Uploaded,

2: Template not Uploaded

16.2 HMO

16.2.1 Network Strategy

Question 16.2.1.1 is required for currently contracted Applicants. All questions are required for Applicants that are new entrants or proposing new networks.

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16.2.1.1 Applicant must complete all tabs in QHP Attachment J1 - HMO Provider Network Tables, for their HMO Network.

Single, Pull-down list.

- 1: Attached,
- 2: Not attached

Attached Document(s): [QHP Attachment J1 - HMO Provider Network Tables.xlsx](#)

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

Single, Pull-down list.

- 1: Applicant contracts and manages network,
- 2: Applicant leases network

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

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

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

Multi, Checkboxes.

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

16.2.1.5 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.

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Briefly describe methodology used when tracking ethnic and racial diversity in the population and ensuring access to appropriate culturally competent providers:	200 words.
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16.2.1.6 Many California residents live in counties bordering other states where the out-of-state services are closer than in-state services. Does Applicant offer coverage in a California county or region bordering another state?

Single, Radio group.

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

2: No

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

200 words.

16.2.2 Volume - Outcome Relationship

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

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

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

Single, Radio group.

1: Yes,

2: No

16.2.2.2 If yes to question 16.2.2.1, describe how Applicant tracks procedure volume per facility by responding to each category below:

Briefly describe the methodology used for categorizing facilities according to volume-outcome relationship:	200 words.
List data sources used:	100 words.
Provide volume thresholds (i.e. at what volume per procedure is a facility considered proficient):	200 words.

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

Single, Radio group.

1: Yes,

2: No

16.2.2.4 If yes to 16.2.2.3, describe how this information is applied to enrollee referral procedure by responding to each category below:

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Describe methodology for patient identification and selection, such as consideration of patient residence, language proficiency:	200 words.
Describe the referral procedure for identified patients:	200 words.
Describe accommodations provided for patients not residing in close proximity to a recognized higher volume provider:	200 words.

16.2.3 Network Stability

All questions are required for existing Covered California networks and newly proposed networks.

16.2.3.1 Total Number of Contracted Hospitals:

Integer.

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

100 words.

16.3 PPO

16.3.1 Network Strategy

Question 16.3.1.1 is 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 QHP Attachment J2 - PPO Provider Network Tables, for their PPO Network.

Single, Pull-down list.

1: Attached,

2: Not attached

Attached Document(s): [QHP Attachment J2 - PPO Provider Network Tables.xlsx](#)

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

Single, Pull-down list.

1: Applicant contracts and manages network,

2: Applicant leases network

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

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

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

Multi, Checkboxes.

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

16.3.1.5 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.

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

Single, Radio group.

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

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

200 words.

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16.3.2 Volume - Outcome Relationship

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

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

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

Single, Radio group.

1: Yes,

2: No

16.3.2.2 If yes to question 16.3.2.1, describe how Applicant tracks procedure volume per facility by responding to each category below:

Briefly describe the methodology used for categorizing facilities according to volume-outcome relationship:	200 words.
List data sources used:	100 words.
Provide volume thresholds (i.e. at what volume per procedure is a facility considered proficient):	200 words.

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

Single, Radio group.

1: Yes,

2: No

16.3.2.4 If yes to 16.3.2.3, describe how this information is applied to enrollee referral procedure by responding to each category below:

Describe methodology for patient identification and selection, such as consideration of patient residence, language proficiency:	200 words.
Describe the referral procedure for identified patients:	200 words.
Describe accommodations provided for patients not residing in close proximity to a recognized higher volume provider:	200 words.

16.3.3 Network Stability

All questions are required for existing Covered California networks and newly proposed networks.

16.3.3.1 Total Number of Contracted Hospitals:

Integer.

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

100 words.

16.4 EPO

16.4.1 Network Strategy

Question 16.4.1.1 is 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 QHP Attachment J3 - EPO Provider Network Tables, for their EPO Network.

Single, Pull-down list.

1: Attached,

2: Not attached

Attached Document(s): [QHP Attachment J3 - EPO Provider Network Tables.xlsx](#)

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

Single, Pull-down list.

1: Applicant contracts and manages network,

2: Applicant leases network

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

	Response
Length of the lease agreement	<i>100 words.</i>
Start Date	<i>To the day.</i>
End Date	<i>To the day.</i>
Leasing Organization	<i>100 words.</i>

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

Multi, Checkboxes.

1: Transparency,

2: Implementation of new programs and initiatives,

3: Acquire timely and up-to-date information on providers,

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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]

16.4.1.5 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.

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

Single, Radio group.

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

2: No

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

200 words.

16.4.2 Volume - Outcome Relationship

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

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

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

Single, Radio group.

1: Yes,

2: No

16.4.2.2 If yes to question 16.4.2.1, describe how Applicant tracks procedure volume per facility by responding to each category below:

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Briefly describe the methodology used for categorizing facilities according to volume-outcome relationship:	200 words.
List data sources used:	100 words.
Provide volume thresholds (i.e. at what volume per procedure is a facility considered proficient):	200 words.

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

Single, Radio group.

1: Yes,

2: No

16.4.2.4 If yes to 16.4.2.3, describe how this information is applied to enrollee referral procedure by responding to each category below:

Describe methodology for patient identification and selection, such as consideration of patient residence, language proficiency:	200 words.
Describe the referral procedure for identified patients:	200 words.
Describe accommodations provided for patients not residing in close proximity to a recognized higher volume provider:	200 words.

16.4.3 Network Stability

All questions required for existing Covered California networks and newly proposed networks.

16.4.3.1 Total Number of Contracted Hospitals:

Integer.

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

100 words.

16.5 Other

16.5.1 Network Strategy

Question 16.5.1.1 is required for currently contracted Applicants. All questions are required for Applicants that are new entrants or proposing new networks.

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

Single, Pull-down list.

- 1: Attached,
- 2: Not attached

Attached Document(s): [QHP Attachment J4 - Other Provider Network Tables.xlsx](#)

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

Single, Pull-down list.

- 1: Applicant contracts and manages network,
- 2: Applicant leases network

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

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

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

Multi, Checkboxes.

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

16.5.1.5 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.

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Briefly describe methodology used when tracking ethnic and racial diversity in the population and ensuring access to appropriate culturally competent providers:	200 words.
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16.5.1.6 Many California residents live in counties bordering other states where the out-of-state services are closer than in-state services. Does Applicant offer coverage in a California county or region bordering another state?

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? [Yes/No],

2: No

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

200 words.

16.5.2 Volume - Outcome Relationship

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

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

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

Single, Radio group.

1: Yes,

2: No

16.5.2.2 If yes to question 16.5.2.1, describe how Applicant tracks procedure volume per facility by responding to each category below:

Briefly describe the methodology used for categorizing facilities according to volume-outcome relationship:	200 words.
List data sources used:	100 words.
Provide volume thresholds (i.e. at what volume per procedure is a facility considered proficient):	200 words.

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

Single, Radio group.

1: Yes,

2: No

16.5.2.4 If yes to 16.5.2.3, describe how this information is applied to enrollee referral procedure by responding to each category below:

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Describe methodology for patient identification and selection, such as consideration of patient residence, language proficiency:	200 words.
Describe the referral procedure for identified patients:	200 words.
Describe accommodations provided for patients not residing in close proximity to a recognized higher volume provider:	200 words.

16.5.3 Network Stability

All questions are required for existing Covered California networks and newly proposed networks.

16.5.3.1 Total Number of Contracted Hospitals:

Integer.

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

100 words.

17 Essential Community Providers

Question required only for new entrant Applicants.

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

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

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

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Essential Community Providers include those providers posted in the Covered California Consolidated Essential Community Provider List available as a resource under “Provider Data Submission Support Documents” at: <http://hbex.coveredca.com/stakeholders/plan-management/ecp-list/>

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

Categories of Essential Community Providers:

Essential Community Providers include the following:

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

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

Alternate standard:

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

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

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

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

Single, Pull-down list.

1: Requesting consideration of alternate standard, explanation attached,

2: Not requesting consideration under the alternate standard

18 Quality

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

18.1 Accreditation

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

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

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

Details limited to 50 words.

	Answer	Expiration date MM/DD/YYYY	Programs Reviewed
NCQA Accreditation- Health Plan	<i>Multi, Checkboxes</i> 1: Population Health Program Accreditation 2: Case Management 3: Utilization Management 4: Credentialing	<i>To the day.</i>	

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	5: Credentials Verification Organization (CVO) 6: Long-Term Services and Supports (LTSS) 7: Provider Network 8: Managed Behavioral Healthcare Organization (MCHO) 9: Wellness and Health Promotion 10: Multicultural Health Care 11: Disease Management 12: Health Information Products 13: Physician and Hospital Quality		
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18.1.2 Applicant must provide a copy of the accrediting agency's certificate, and upload as a file titled "[NCQA, URAC, or AAAHC] "Accreditation".

Single, Pull-down list.

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

18.1.3 If Applicant reported any provisional, interim, denied, in process, scheduled, or expired status for any accreditation, Applicant must submit a workplan to achieve Health Plan accreditation within 12 months of accrediting entity's notification. The workplan should be uploaded as a file with the file name "Accreditation Workplan."

Single, Pull-down list.

- 1: Yes, Accreditation Workplan attached,
2: Not attached3: Not applicable

18.2 Focus on High Cost Providers

Question required for currently contracted Applicants and new entrant Applicants.

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

18.2.1 Describe Applicant's efforts to understand price variation and strategies to ensure the Applicant is managing provider and hospital costs. In describing Applicant's strategy to monitor, manage, and prevent unduly high costs, Applicant must specifically address each of the following in the response:

- The factors Applicant considers in assessing the relative unit prices and total costs of care

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- The extent to which Applicant analyzes the reasons for variation in costs of care, including capitation rates
- The extent to which Applicant adjusts or analyzes the reasons for cost factors based on elements such as area of service, population served, market dominance, services provided by the facility (e.g. trauma or tertiary care), or other factors
- How variation in unit prices or total cost of care is used in the selection of providers and facilities in networks available to enrollees, e.g. identifying specific hospitals with cost deciles by region and calculating percentage of costs expended in each cost decile
- How variation in unit prices or total cost of care impact enrollee out-of-pocket costs
- The frequency with which these analyses are conducted
- Comment on potential collaboration opportunities, new statewide or regional initiatives, or other activities that would strengthen this delivery system reform aim to improve affordability

500 words.

18.3 Demonstrating Action on High Cost Pharmaceuticals

Question required for currently contracted Applicants and new entrant Applicants.

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

18.3.1 Describe Applicant's approach to achieving value in the delivery of pharmacy services and controlling drug costs as a percent of the total cost of care. Currently contracted Applicants must describe any changes to its previous response to plan Year 2021 QHP Certification Application. New entrant Applicants must specifically address each of the following in the response:

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

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

1000 words.

18.4 Participation in Collaborative Quality Initiatives

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

Covered California believes that improving health care quality and reducing costs can only be done over the long-term through collaborative efforts that effectively engage and support clinicians, hospitals, health systems and other providers of care. There are several established statewide and national collaborative initiatives for quality improvement that are aligned with priorities established by Covered California. The following questions address Applicant's current involvement in quality collaborative efforts. Applicants will be assessed based on the breadth and depth of their involvement.

18.4.1 Describe how Applicant is measuring overuse of Cesarean Sections and opioids, and how it is implementing Smart Care California guidelines (<https://www.iha.org/our-work/insights/smart-care-california>) to promote best practices of care in these areas.

100 words.

18.4.2 Identify key quality improvement collaboratives and organizations in which Applicant is engaged and briefly explain how Applicant participates. "Engagement" is defined as active participation through regular meeting attendance, health plan representatives serving as advisory members, providing funding, submitting data to the collaborative, or providing feedback on initiatives and projects. If Applicant provides financial support for a collaborative, Applicant must explain the amount and nature of that financial support.

Multi, Checkboxes.

1: Smart Care California, explain: [100 words] ,

2: California Improvement Network (includes CQC, CCI, SNI, others) <https://www.chcf.org/program/california-improvement-network/partners/>

3: The CalHIVE Network, explain: [100 words],

4: California Maternity Quality Care Collaborative, explain: [100 words],

5: Collaborative Healthcare Patient Safety Organization (CHPSO) Right Care Initiative, explain: [100 words],

6: California Quality Collaborative (CQC), explain: [100 words]

7: Other, explain: [100 words]

18.5 Data Exchange with Providers

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

To be successful under Covered California Quality Improvement Strategy (QIS) requirements, and to improve the quality of care and successfully manage costs, successful Applicants will need to encourage enhanced exchange of clinical data between providers. Participation in Health Information Exchanges (HIE) will enable notification of physicians when their patients are admitted to the hospital and allow contracted plans to track, trend and improve performance on conditions such as hypertension or diabetes control. In this section,

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Applicants will be assessed on the extent to which clinical data exchange is occurring, plans to improve data exchange, and current participation in regional and statewide initiatives to improve data exchange.

18.5.1 Describe Applicant's efforts to improve routine exchange of timely information and clinical data with providers to support their delivery of high-quality care. Applicant must specifically address each of the following:

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

500 words.

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

	<i>Answer</i>	<i>Contract Requirement</i>	<i>Define Engagement</i>	<i>Data Contributed</i>	<i>Details</i>
HIE Participation	<i>Multi, Checkboxes.</i> 1: Manifest MedEx (formerly CallIndex), 2: Los Angeles Network for Enhanced Services (LANES), 3: Orange County Partnership Regional Health Information Organization (OCPRHIO), 4: San Diego Health Connect, 5: Santa Cruz Health Information Exchange, 6: Other, explain in Details section	<i>Single, Radio group.</i> 1: Yes, 2: No	<i>Multi, Checkboxes.</i> 1: Submitting Data, 2: Receiving Data, 3: Providing Funding, 4: Other, explain in Details section	<i>Multi, Checkboxes.</i> 1: Eligibility Files, 2: Medical Claims, 3: Pharmacy Claims, 4: Other, explain in Details section	<i>100 words.</i>

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

	<i>Response/Summary</i>
Number of professional providers that participate in HIEs	<i>Decimal.</i>
Percent of professional providers that participate in HIEs (Calculated as number of professional providers that participate in HIEs divided by total number of professional providers contracted with Applicant)	<i>Percent.</i>
Number of hospitals that participate in HIEs	<i>Decimal.</i>

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Percent of hospitals that participate in HIEs (Calculated as number of hospitals that participate in HIEs divided by total number of hospitals contracted with Applicant)	<i>Percent.</i>
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18.5.4 Provide details on the status of electronic information exchange to notify primary care providers of Admission, Discharge, Transfer (ADT) events for Covered California Enrollees.

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

18.6 Data Aggregation Across Health Plans

Question required for currently contracted Applicants and new entrant Applicants.

Covered California recognizes the importance of aggregating data across purchasers and payers to more accurately understand the performance of providers that have contracts with multiple health plans. Such aggregated data reflecting a larger portion of a provider, group or facility's practice can potentially be used to support performance improvement, contracting and public reporting. Covered California encourages Applicants to participate in the Integrated Healthcare Association's (IHA) programs to aggregate data. In this section, Applicant will be assessed on the extent to which it is engaging with other payers and stakeholders to support aggregation.

18.6.1 Identify the data aggregation initiatives in which Applicant is engaged to support aggregation of claims or other information across payers.

Multi, Checkboxes.

- 1: Integrated Health Association (IHA)Align Measure Perform (AMP) Commercial HMO and Commercial ACO program,
- 2: IHA Encounter Data Initiative,
- 3: IHA Cost and Quality Atlas,
- 4: IHA Provider Directory Utility (Symphony),
- 5: CalHospitalCompare,
- 6: CMQCC,
- 7: Other: [100 words]

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18.7 Behavioral Health Management

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

Covered California recognizes the critical importance of behavioral health services (mental health and substance use disorder services collectively) as part of the broader set of medical services provided to enrollees. Answers will be evaluated based on the degree of integration and accessibility relative to industry trends and market innovations, as well as the thoroughness of the response.

18.7.1 Describe Applicant's mechanisms to ensure enrollees have timely access to and receive appropriate, evidence-based behavioral health services. Applicant must specifically address the following:

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

Applicant may include behavioral health provider network reports from its accrediting organization (NCQA, URAC, AAAHC) as a supplemental attachment

200 words. Attachment permitted

18.7.2 Describe the methods Applicant uses to monitor behavioral health services' quality, effectiveness, and cultural competency.

200 words.

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

Single, Pull-down list.

1: No measures are tracked,

2: 1,

3: 2,

4: 3,

5: 4,

6: 5,

7: 6,

8: 7,

9: 8,

10: 9,

11: 10,

12: 11,

13: 12,

14: 13,

15: 14,

16: 15,

17: 16,

18: 17,

19: 18,

20: 19,

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21: 20,
22: 21,
23: 22,
24: 23,
25: 24,
26: 25

18.7.4 Applicant must specify which measures are tracked (e.g., clinical measures, patient-reported experience, or others) to ensure enrollees receive appropriate, evidence-based treatment and provide the outcomes for these measures for 2017, 2018, 2019, and 2020.

	Measure	Outcome - 2017	Outcome - 2018	Outcome - 2019	Outcome - 2020
1	50 words.	50 words.	50 words.	50 words.	50 words.
2	50 words.	50 words.	50 words.	50 words.	50 words.
3	50 words.	50 words.	50 words.	50 words.	50 words.
4	50 words.	50 words.	50 words.	50 words.	50 words.
5	50 words.	50 words.	50 words.	50 words.	50 words.
6	50 words.	50 words.	50 words.	50 words.	50 words.
7	50 words.	50 words.	50 words.	50 words.	50 words.
8	50 words.	50 words.	50 words.	50 words.	50 words.
9	50 words.	50 words.	50 words.	50 words.	50 words.
10	50 words.	50 words.	50 words.	50 words.	50 words.
11	50 words.	50 words.	50 words.	50 words.	50 words.
12	50 words.	50 words.	50 words.	50 words.	50 words.
13	50 words.	50 words.	50 words.	50 words.	50 words.
14	50 words.	50 words.	50 words.	50 words.	50 words.
15	50 words.	50 words.	50 words.	50 words.	50 words.
16	50 words.	50 words.	50 words.	50 words.	50 words.
17	50 words.	50 words.	50 words.	50 words.	50 words.
18	50 words.	50 words.	50 words.	50 words.	50 words.
19	50 words.	50 words.	50 words.	50 words.	50 words.
20	50 words.	50 words.	50 words.	50 words.	50 words.
21	50 words.	50 words.	50 words.	50 words.	50 words.
22	50 words.	50 words.	50 words.	50 words.	50 words.
23	50 words.	50 words.	50 words.	50 words.	50 words.
24	50 words.	50 words.	50 words.	50 words.	50 words.
25	50 words.	50 words.	50 words.	50 words.	50 words.

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

- Describe Applicant's integrated behavioral health-medical model and specify whether Applicant uses standardized models such as the Collaborative Care Model, co-located care, or Primary Care Behavioral Health. Indicate whether these efforts are implemented in association with Patient Centered Medical Homes (PCMHs) or Integrated Delivery Systems (IDSs) or Accountable Care Organizations (ACOs)
- Number and Percent of consumers cared for under an integrated behavioral health-medical model, as defined and recognized by Applicant, in both its Covered California business (if Applicant had Covered California business in 2019) and total book of business
- How Applicant improves the integration of behavioral health services and medical services with its contracted network providers, including whether it reimburses for the Collaborative Care Model claims codes
- If Applicant does not reimburse for the Collaborative Care Model claims codes, describe the barriers to reimbursing for these codes and efforts to address those barriers
- Comment on any innovative models in California or nationwide and potential collaborative opportunities to adopt these models on a larger scale

References:

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

500 words.

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

References:

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

See pages 69-76.

200 words.

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

Single, Pull-down list.

1: Yes, Applicant offers telehealth for behavioral health services.

2: No, Applicant does not offer telehealth for behavioral health services.

Details: [200 words]

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18.8 Health Technology (Telehealth and Remote Monitoring)

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

Covered California supports the innovative use of technology to assist in higher quality, accessible, patient-centered care. The following questions address Applicant's adoption and use of health technology, and answers will be evaluated based on Applicant's capacity for telehealth and remote monitoring relative to industry trends.

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

Multi, Checkboxes.

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

18.8.2 Provide information in the following chart regarding Applicant's capabilities to support provider-member consultations using technology (e.g., web consultations, telemedicine). Applicant will be evaluated based on the availability of telehealth services for all books of business, particularly Covered California membership. If Applicant is not currently contracted with Covered California, provide a description of its telehealth capabilities and indicate whether those services will be offered to Covered California members

Details 400 words.

Response	Response	Details
1. Report the percent of members with access to Telehealth with interactive face to face dialogue (video and audio) provided by: (Use as denominator total membership across all lines of business).	<i>Percent. From 0 to 100. N/A</i>	<i>20 words. Nothing required</i>
2. Report the percent of members with access to Telehealth with interactive dialogue (audio only) by phone (Use as denominator total membership across all lines of business).	<i>Percent. From 0 to 100.</i>	<i>20 words. Nothing required</i>
3. Report the percent of members with access to Telehealth asynchronous via email, text, instant messaging, or other (Use as denominator total membership across all lines of business.)	<i>Percent. From 0 to 100. N/A OK</i>	<i>20 words. Nothing required</i>
4. Report the percent of members with access to Remote patient monitoring (Use as denominator total membership across all lines of business.)	<i>Percent. From 0 to 100. N/A OK</i>	<i>20 words. Nothing required</i>
5. Report the percent of providers with access to e-Consult: provider-to-provider (Use as denominator total membership across all lines of business.)	<i>Percent From 0 to 100. N/A OK</i>	<i>20 words. Nothing required</i>

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6. Indicate availability of web/telehealth consultations in languages other than English. Specify all languages offered in Response box.	100 words.	20 words. Nothing required
7. If physicians and/or physician groups/practices are designated in provider directory as having web/telehealth consultation services available, provide percentage of physicians in the network (across all lines of business)	Percent. 0 to 100. N/A OK	20 words. Nothing required
8. For physicians that are available to deliver web/telehealth consultations, what is the average wait time? If Applicant can provide average wait time- describe how that is monitored in detail box at end of question.	Single, Radio group. N/A OK. 1: On demand, 2: Within 4 hours, 3: Within same day, 4: Scheduled follow-up within 48 hours, 5: Other (describe)	20 words. Nothing required
9. Applicant promotes telehealth (either through vendor or medical group) as an alternative to the ED for urgent health issues (describe specific engagement efforts and any specific contractual requirements related to this topic for vendors or medical groups)	50 words. N/A OK.	
10. Applicant reimburses for web/telehealth consultations	Single, Radio group. N/A OK. 1: Yes, 2: No	20 words. Nothing required
11. Discuss how Applicant promotes integration and coordination of care between Telehealth providers and primary care providers		200 words.
12. Discuss any innovations or pilot programs adopted by Applicant that are not reflected in this table (such as plans for new programs, expansion of existing programs, new telehealth features, etc.)		100 words.

18.8.3 Indicate whether Applicant has implemented a secure, standards-based Patient Access Application Programming Interface. If yes, include the number and percent of patients accessing this interface.

	Response/Summary
Applicant has implemented a secure, standards-based Patient Access API	Single, Radio group. 1: Yes, 2: No
Number of patients accessing interface	Decimal. N/A OK.

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Percent of patients accessing interface (Calculated as number of Exchange members accessing interface divided by total Exchange membership)	Percent. N/A OK.
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18.9 Health Promotion and Prevention Wellness

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

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

18.9.1 Identify member interventions used in calendar year 2020 to improve immunization rates. Check all that apply and provide a description of selected activities in Details fields.

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

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	email/text, automated phone or live outbound telephone calls triggered by the ABSENCE of a service) 3: None of the above 4: Other [explain]:	
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18.9.2 Indicate whether Applicant currently participates in the California Immunization Registry (both submitting and receiving data). If yes, include a description of how Applicant uses the data obtained in the registry, e.g. supporting outreach to those with gaps in care and/or evaluating effectiveness of provider interventions.

Single, Radio group.

1: Yes (explain) [50 words],

2: No

18.9.3 Indicate the number and percent of tobacco-dependent commercial members identified and participating in cessation activities during 2020. Do not report general prevalence.

If Applicant is currently contracted with Covered California, provide Covered California counts if available. If Covered California counts are not available, provide state or regional counts.

	Answer
Indicate how Applicant identifies members who use tobacco.	<i>Multi, Checkboxes.</i> 1: Plan Health Assessment 2: Employer/Vendor Health Assessment 3: Member PHR 4: Claims/Encounter Data5: Disease or Care Management 6: Wellness Vendor 7: Other [explain]:
Indicate the tobacco cessation interventions Applicant provides to enrollees.	<i>Multi, Checkboxes.</i> 1: Nicotine Replacement Therapy 2: Smoking cessation class or program 3: Smoking cessation counseling via health coach 4: Medication assisted cessation 5: None 6: Other [explain]:
Number of California members individually identified as tobacco dependent in 2020. (If Applicant has and tracks use by Medi-Cal members as well, number here should include Medi-Cal numbers.)	<i>Decimal.</i>
Percent of California members identified as tobacco dependent (Calculated as number of California members individually identified as tobacco dependent divided by total California membership)	<i>Percent.</i>

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Number of Covered California members individually identified as tobacco dependent in 2020.	<i>Decimal.</i>
Percent of Covered California members identified as tobacco dependent (Calculated as number of Covered California members individually identified as tobacco dependent divided by total Covered California membership)	<i>Percent.</i>
Number of California members identified as tobacco dependent who participated in a smoking cessation program during 2020. (If Applicant has and tracks use by Medi-Cal members as well, number here should include Medi-Cal numbers.)	<i>Decimal.</i>
Percent of California members who completed a smoking cessation program (Number of participants who completed program divided by number of participants who enrolled in the program)?	<i>Percent.</i>
Number of Covered California members identified as tobacco dependent who participated in a smoking cessation program during 2020.	<i>Decimal.</i>
Percent of Covered California members who completed a smoking cessation program during 2020 (Number of Covered California participants who completed program divided by number of Covered California participants who enrolled in the program)?	<i>Percent.</i>

18.9.4 Describe the strategies Applicant is implementing to decrease the rate of Enrollees with tobacco and smoking dependency.
500 words.

18.9.5 Indicate the number of members with unhealthy body weight identified and participating in weight management programs during 2020. Do not report general prevalence.

If Applicant is currently contracted with Covered California, provide Covered California counts if available. If Covered California counts are not available, provide state/regional counts.

	Answer
Indicate how Applicant identifies members with unhealthy body weight.	<i>Multi, Checkboxes.</i> 1: Plan Health Assessment, 2: Employer/Vendor Health Assessment, 3: Member PHR, 4: Claims/Encounter Data, 5: Disease or Care Management, 6: Wellness Vendor, 7: Other (describe in box in cell)
Indicate the type of weight management interventions that Applicant provides to Enrollees	<i>Multi, Checkboxes.</i> 1: Applicant offers gym

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	membership 2: Weight management class or program 3: Weight management via health coach 4: Medication assisted weight loss 5: None 6: Other [explain]:
Number of California members identified as having unhealthy body weight in 2020. (If Applicant has and tracks use by Medi-Cal members as well, number here should include Medi-Cal numbers.)	<i>Decimal.</i>
Percent of California members identified as having unhealthy body weight in 2020. (Calculated as number of California members individually identified as having unhealthy body weight divided by total California membership)	<i>Percent.</i>
Number of Covered California members identified as having unhealthy body weight in 2020.	<i>Decimal.</i>
Percent of Covered California members identified as having unhealthy body weight (Calculated as number of Covered California members individually identified as having unhealthy body weight divided by total Covered California membership)	<i>Percent.</i>
Number of eligible California members who enrolled in a weight management program during 2020. (If Applicant has and tracks use by Medi-Cal members as well, number here should include Medi-Cal numbers.)	<i>Decimal.</i>
Percent of California members who completed a weight management program (Number of participants who completed program divided by number of participants who enrolled in the program)?	<i>Percent.</i>
Number of eligible Covered California members who enrolled in a weight management program during 2020.	<i>Decimal.</i>
Percent of Covered California members who completed a weight management program during 2020 (Number of Covered California participants who completed program divided by number of Covered California participants who enrolled in the program)?	<i>Percent.</i>

18.9.6 Describe the strategies Applicant is implementing to decrease the rate of Enrollees with unhealthy body weight.

500 words.

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

https://nccd.cdc.gov/DDT_DPRP/Programs.aspxhttps://nccd.cdc.gov/DDT_DPRP/Programs.aspx.

In the following table, currently contracted Applicants should provide details for measurement year 2020. New applicants should provide details on their current interventions or planned activities.

	Response
Indicate how Applicant identifies eligible enrollees for the Diabetes Prevention Program.	<i>Multi, Checkboxes.</i> 1: Plan Health Assessment, 2: Employer/Vendor Health Assessment, 3: Member PHR, 4: Claims/Encounter Data, 5: Disease or Care Management, 6: Wellness Vendor, 7: Other (describe in box in cell)
Describe how Applicant informs its enrollees about the Diabetes Prevention Program.	<i>100 words.</i>
Number of total commercial enrollees eligible for Diabetes Prevention Program.	<i>Decimal.</i>
Percent of total commercial enrollees eligible for Diabetes Prevention Program.	<i>Percent.</i>
Number of total eligible Covered California enrollees who complete the Diabetes Prevention Program.	<i>Decimal.</i> <i>N/A ok</i>
Percent of total eligible Covered California enrollees who complete the Diabetes Prevention Program.	<i>Percent.</i> <i>N/A ok</i>
Describe how Applicant monitors and evaluates the effectiveness of the Diabetes Prevention Program.	<i>100 words.</i>

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

	Response/Summary	Geography of response

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Percent of total commercial membership with no claims in CY 2020	<i>Percent.</i> N/A OK.	<i>Single, Radio group.</i> 1: Regional, 2: State
Summary (bullet points) of plan activities to engage members who are non-users	<i>100 words.</i> N/A OK.	

18.10 Advancing Health Equity and Community Health

Question required for currently contracted Applicants and new entrant Applicants.

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

18.10.1 Provide a description of the external-facing initiatives, programs and projects Applicant supports to promote better community health, and how such programs specifically address health disparities or efforts to improve community health apart from the health delivery system. Examples include the California Reducing Disparities Project (CRDP), Health in All Policies (HIAP), The California Endowment Healthy Communities, and Beach Cities Health District, among others. Provide a description of any statewide, regional or cross organizational initiatives or collaborative efforts Applicant is leading or participating in to promote advance health equity. Please note the definition of external-facing provided in the previous paragraph and include any evaluation results of the activity or program, if available.

500 words.

18.11 Population Health Management

Questions 18.11.1 thru 18.11.9 are required for currently contracted Applicants. All questions are required for new entrant Applicants.

Covered California recognizes that effective population health management, including identifying and proactively managing at-risk enrollees (defined as individuals with existing and newly diagnosed chronic conditions, such as diabetes, heart disease, asthma, hypertension or a medically complex condition) results in improved outcomes and lowers costs. The following questions assess Applicant's ability to identify, stratify, track and manage enrollees. Responses will be evaluated on Applicant's use of data and interventions to proactively manage enrollees as well as the thoroughness of the response.

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18.11.1 Indicate capabilities supporting Applicant's Health Assessment (HA) programming (formerly known as Health Risk Assessment-HRA or Personal Health Assessment-PHA). Check all that apply.

Multi, Checkboxes.

- 1: HA Accessibility: Both online and in print,
- 2: HA Accessibility: IVR (interactive voice recognition system),
- 3: HA Accessibility: Telephone interview with live person,
- 4: HA Accessibility: Multiple language offerings,
- 5: HA Accessibility: HA offered at initial enrollment,
- 6: HA Accessibility: HA offered on a regular basis to members,
- 7: Applicant does not offer an HA

18.11.2 Indicate activities supporting Applicant's Health Assessment (HA) programming (formerly known as Health Risk Assessment-HRA or Personal Health Assessment-PHA). Check all that apply.

Multi, Checkboxes.

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

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

	Answer
Indicate how Applicant tracks HA participation Select only ONE of response options 1-4 and include response option 5 if applicable (If option 4 selected, responses to the following questions in the table are not required.)	<i>Multi, Checkboxes.</i> 1: Participation tracked statewide & regionally, 2: Participation only tracked statewide, 3: Participation only tracked regionally, 4: Participation not tracked regionally/statewide,

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	5: Participation can be tracked at Covered California level
Number of members completing Plan-based HA in 2020 (If Applicant has and tracks use by Medi-Cal members as well, number here should include Medi-Cal numbers.)	<i>Decimal.</i>
Percent HA completion (Health plan HA completion number divided by total enrollment)	<i>Percent.</i>
Number of completed HAs resulting in referral to health plan case management staff or assigned provider	<i>Decimal.</i>
Percent completed HAs resulting in referral to health plan case management staff or assigned provider (Referral number divided by number of completed HAs)	<i>Percent.</i>
Explain how HA results lead to referrals for Applicant's case management or assigned provider	<i>50 words.</i>

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

200 words.

18.11.5 How does Applicant identify at-risk enrollees who would benefit from early, proactive interventions? Describe applicable diseases for at-risk identification, sources of data, and any predictive analytic capabilities. Note: NCQA-accredited Applicants may submit reports demonstrating compliance with Population Health Management Standards 1 and 2 in lieu of response.

100 words. Attachment permitted.

18.11.6 For Covered California business, Applicant must provide (1) the number of members aged 18 and above in first row, (2) the number of members aged 18 and above identified under Applicant's criteria for at-risk enrollees eligible for case management in the second row. If Applicant does not currently have Covered California business, report on all lines of business excluding Medicare. Note: NCQA-accredited Applicants may submit reports demonstrating compliance with Population Health Management Standards 1 and 2 in lieu of response.

Attachment permitted.

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

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18.11.7 Building on the National Committee for Quality Assurance (NCQA) Population Health Management plans submission requirement. Applicant must describe outreach and interventions used to ensure at-risk enrollees get needed care. If more than one of the strategies below are used, provide a description of the multimodal approach or use of modalities in succession. In addition, report the number of outreach attempts per Enrollee.

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

500 words.

18.11.8 Provide information regarding extent of Applicant's outreach efforts.

	Response/Summary
Number of At-Risk Enrollees successfully contacted	<i>Decimal.</i>
Percent of At-Risk Enrollees successfully contacted (Calculated as number of At-Risk Enrollees engaged in an assessment or self-declined divided by total number of At-Risk Enrollees)	<i>Percent.</i>
Number of At-Risk Enrollees engaged in appropriate care management	<i>Decimal.</i>
Percent of At-Risk Enrollees engaged in appropriate care management (Calculated as number of At-Risk Enrollees enrolled in a care management program or receiving care from specialty provider divided by total number of At-Risk Enrollees)	<i>Percent.</i>

18.11.9 Does Applicant share registries (disease-specific or gaps in care) of enrollees, as permitted by state and federal law, with appropriate accountable providers, especially the enrollee's PCP? If yes, describe. Note: NCQA-accredited Applicants may submit reports demonstrating compliance with Population Health Management Standards 1 and 2 in lieu of response.

Single, Radio group. Attachment permitted.

1: Yes, describe: [65 words],

2: No

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

100 words.

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18.12 Complex Care

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

18.12.1 Describe the mechanisms used to ensure enrollees can access providers with documented special experience and proficiency, based on volume and outcome data, that treat conditions requiring highly specialized management.

18.12.2 Provide details describing use of Centers of Excellence, if used.

Question is required for currently contracted Applicants and new entrant Applicants.

	Response/Summary
Applicant uses Centers of Excellence	<i>Single, Radio group.</i> 1: Yes, 2: No
If Centers of Excellence are utilized, provide a list of affiliated facilities with conditions treated at each institution	<i>200 words.</i> N/A OK.
For Centers of Excellence related to total joint replacement, spine conditions, and bariatric treatments, provide the criteria for provider inclusion in COE and the methods of consumer promotion	<i>100 words.</i> N/A OK.
For each condition with an associated Center of Excellence provide the number and percent of Enrollees in the plan population with the condition (Calculated as number of Enrollees with each condition divided by total number of Enrollees)	<i>100 words.</i> N/A OK.
For each condition with an associated Center of Excellence provide the number and percent of Enrollees treated at a Center of Excellence (Calculated as number of Enrollees with each condition treated at a Center of Excellence divided by total number of Enrollees with each condition)	<i>100 words.</i> N/A OK.

19 Covered California Quality Improvement Strategy

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

Attachment 7 of the Covered California Qualified Health Plan (QHP) Issuer Contract embodies Covered California's vision for reform and serves as a roadmap to delivery system improvements. Beginning with the 2017 QHP Issuer Contract, QHP Issuers have been engaged in supporting existing quality improvement initiatives and programs that are sponsored by other major purchasers including the Department of Health Care Services (DHCS), the California Public Employees' Retirement System (CalPERS), the Pacific Business

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Group on Health (PBGH), and CMS. These requirements are reflected in the 2017 contract and will be in all successive contracts through 2022. QHP certification and participation in Covered California will be conditional on Applicant developing a multi-year strategy and reporting year-to-year activities and progress on each initiative area.

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

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

New Entrant Applicants: New entrant Applicants are not required to complete the QIS as part of the 2022 Application but must review Attachment 7 with the understanding that engagement in the QIS and Attachment 7 initiatives will be contractually required and measured in the future if Applicant joins Covered California.

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

19.1 Applicant Information

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

19.1.1 Confirm Applicant has reviewed Attachment 7 and will comply with contractually required quality improvement initiatives if selected by Covered California.

Single, Pull-down list.

- 1: Confirmed,
- 2: Not confirmed

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

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1000 words.

19.1.3 Complete this section and designate one contact for medical management and one contact for network management.

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

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

Multi, Checkboxes.

- 1: HMO,
- 2: PPO,
- 3: EPO,
- 4: Other

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

19.2.1 QIS for Provider Networks Based on Value

QIS Goal: Applicant should 1) evaluate providers and hospitals based on network quality and cost criteria for inclusion in network, 2) have a process for continual management of their network based on quality and cost, and 3) have a process for exclusion of poor performers based on inability to meet quality and cost criteria or lack of effort toward improvement.

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

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

19.2.1.2 Complete QHP Attachment M1 - QIS 1 Work Plan - Networks Based on Value to describe updates in Applicant's ability to build networks based on value since the previous QIS submission. Applicant may submit any supporting documentation as an attachment. Address each of the following in the narrative:

- Progress in 2020 toward the end goal including activities conducted, data collected and analyzed, and results
- Further implementation plans for 2021 with milestones and targets for 2021 and 2022 identified
- Known or anticipated barriers in implementing QIS activities and progress of mitigation activities

Attached Document(s): [QHP Attachment M1 - QIS 1 Work Plan - Networks Based on Value.pdf](#)

Single, Radio group.

1: Attached,
2: Not attached

19.2.2 QIS for Reducing Health Disparities and Ensuring Health Equity

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

19.2.2.1 Provide the percent of Covered California members for whom self-reported data is captured for R/E in Attachment E QIS Run Charts. Self-identification may take place through the enrollment application, web site registration, health assessment, reported at provider site, etc. The percentage should exclude members whose race or ethnicity is unknown, missing, or who have "declined to state" either actively or passively. Enter the percentage reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, and 2021 as well.

Single, Pull-down list.

1: Attached,
2: Not attached

Attached Document(s): [QHP Attachment E - QIS Run Charts.pdf](#)

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

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- Updates in efforts to increase self-reported R/E information including whether there are barriers to self-report
- To what extent is Applicant capturing missing race or ethnicity self-identification from increased telehealth utilization and related member interaction
- Any plans to implement or test new programs to increase self-identification If applicable, include any experience or lessons learned regarding race and ethnicity self-identification capture resulting from increased telehealth utilization and related member interaction

500 words.

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

Single, Radio group.

- 1: Applicant uses the RAND proxy methodology, describe: [100 words],
2: Applicant uses another methodology to estimate R/E, describe: [100 words],
3: Applicant does not use a methodology to estimate R/E, describe: [100 words]

19.2.2.4 Confirm Applicant submitted progress report on its Disparity Intervention to address health care disparities. Include a brief description or any progress or challenges experienced during implementation in the details box.

Single, Radio group.

- 1: Progress report submitted, describe: [200 words],
2: Progress report not submitted, describe: [100 words]

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

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

19.2.3.1 Report the percentage of members in Applicant's Covered California business who either selected a Primary Care Physician (PCP) or were matched with a Primary Care Physician in 2020 in Attachment E QIS Run Charts. If Applicant had no Covered California business in 2019, report full book of business excluding Medicare. Enter the percentage reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, and 2021 as well. Report data by product (HMO, PPO, EPO, Other).

Single, Pull-down list.

- 1: Attached,
2: Not attached

Attached Document(s): [QHP Attachment E - QIS Run Charts.pdf](#)

19.2.3.2 Report the number and percentage of Covered California members who obtain their primary care in 2019 with a provider or clinic that has received PCMH recognition from NCQA, The Joint Commission, or the Accreditation Association for Ambulatory Health Care (AAAHC) in Attachment E QIS Run Charts. For currently contracted Applicants, enter the percentage reported in the Certification Application for 2016, 2017, 2018, 2019, 2020, and 2021 as well. If Applicant did not have Covered California business during the prior calendar year, report on the full book of business. Report data by product (HMO, PPO, EPO, Other).

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Single, Pull-down list.

1: Attached,

2: Not attached

Attached Document(s): [QHP Attachment E - QIS Run Charts.pdf](#)

19.2.3.3 Report all types of payment methods, used for primary care services and number of providers paid under each model in 2020 in Attachment E QIS Run Charts using the alternative payment model (APM) outlined in the Health Care Payment Learning Action & Action Network (HCP LAN) Draft White Paper on Primary Care Payment Models (Levels 1, 2, 3, and 4) . Enter the number and percentage of providers paid under each model reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, and 2021 as well. Report data by product (HMO, PPO, EPO, Other).

References:

HCP LAN Primary Care Payment Models Draft White Paper: <http://hcp-lan.org/workproducts/pcpm-whitepaper-draft.pdf>

As the paper states, “it is essential for provider organizations to use the payment and incentive structures outlined in this paper when compensating individual primary care practices. In order to enable frontline practitioners to implement delivery reforms, and properly hold them accountable for managing costs and population health, these practitioners must receive payments that support the infrastructure needed for coordination and patient engagement” and “primary care population-based payment models should be “in excess of historical primary care payments to support additional expectations”.

Single, Pull-down list.

1: Attached,

2: Not attached

Attached Document(s): [QHP Attachment E - QIS Run Charts.pdf](#)

19.2.3.4 Complete QHP Attachment M3 - QIS 3 Work Plan - Primary Care to describe updates on progress made since the previous QIS submission in each part of the primary care goals, and planned activities. Applicant may submit any supporting documentation as an attachment. Address each of the following in the narrative:

- Updates on the PCP matching initiative, including a status report, feedback on the enrollee experience, complaints, positive feedback, unanticipated challenges, and suggestions (if applicable)
- Progress in updating primary care payment models, including those for contracted groups, to align with Level 3 or 4 APMs described in the LAN Draft White Paper (above) including: activities conducted, data collected and analyzed, and results
- Describe any support or technical assistance (financial, staffing, educational, etc.) that Applicant or multi-insurer collaborative is providing to primary care providers to support their efforts towards accessible, data-driven, team-based care
- How Applicant is encouraging enrollees to use accessible, data-driven, team-based care providers
- Further implementation plans for 2021 with milestones and targets for 2021 and 2022 identified
- Known or anticipated barriers in implementing QIS activities and progress of mitigation activities

1000 words.

Attached Document(s): [QHP Attachment M3 - QIS 3 Work Plan - Primary Care.pdf](#)

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Single, Radio group.

1: Attached,

2: Not attached.

19.2.4 QIS for Promoting Development and Use of Care Models - Integrated Delivery Systems or Accountable Care Organizations

QIS Goal: Applicant will increase Integrated Delivery System (IDS) or Accountable Care Organization (ACO) presence in its Covered California network by providing various types of support to providers to elevate their processes and practice toward this goal. If expanding its network, Applicant will also increase the proportion of Covered California enrollees receiving care in an IDS or ACO.

An IDS or ACO is defined as a system of population-based care coordinated across the continuum, including multidisciplinary physicians and physician groups, hospitals, and ancillary providers that has combined risk sharing arrangements and incentives between Applicant and providers, holding the IDS or ACO accountable for nationally recognized evidence-based clinical, financial, and operational performance.

19.2.4.1 Using the definition for IDS or ACO above, report the number and percentage of Covered California members and total California members who are managed under an IDS or ACO in 2020 in Attachment E QIS Run Charts. For currently contracted Applicants, enter the percentage reported in the Certification Application for 2016, 2017, 2018, 2019, 2020, and 2021 as well. If Applicant did not have Covered California business during the prior calendar year, report on the full book of business. Report data by product (HMO, PPO, EPO, Other).

Single, Pull-down list.

1: Attached,

2: Not attached

19.2.4.2 Provide as attachments the following documents related to IDSs or ACOs or confirm Applicant will submit the documents as they become available:

(File titled Provider 1a): Applicant's IDS or ACO business model including measures used to track progress and success of IDS or ACO providers and the payment model for the IDS or ACO.	<i>Single, Pull-down list.</i> 1: Attached, 2: Not attached
(File titled Provider 1b): Example of Applicant report to its IDS or ACO providers on its quality of care and financial performance, including benchmarking relative to performance improvement goals or market norms.	<i>Single, Pull-down list.</i> 1: Attached, 2: Not attached
(File titled Provider 1c): Confirm Applicant will submit a copy of Applicant's 2020 IHA Align Measure Perform (AMP) Commercial ACO report when it becomes available, if Applicant participates in the program.	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not confirmed, 3: N/A

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19.2.4.3 Complete QHP Attachment M4 – QIS 4 Work Plan – IDS and ACO to describe updates on progress made since the previous QIS submission on each component of the IDS or ACO goals, and planned activities. Applicant may submit any supporting documentation as an attachment. Address each of the following in the narrative:

- Progress in 2020 toward the end goal including activities conducted, data collected and analyzed, and results
- Further implementation plans for 2021 with milestones and targets for 2021 and 2022 identified
- How Applicant expects to evolve its model, based on progress or outcomes to date
- How Applicant is providing support for integration and coordination of care through coaching, funding, implementation of information systems, technical assistance, or other means where no provider organization is accepting accountability
- Other activities conducted since the previous QIS submission to promote IDSs or ACOs, or activities that will be conducted
- Known or anticipated barriers in implementation of QIS and progress of mitigation activities

Attached document(s): [QHP Attachment M4 – QIS 4 Work Plan – IDS and ACO.pdf](#)

Single, Radio group.

1: Attached,

2: Not attached

19.2.5 QIS for Appropriate Use of Cesarean Sections

QIS Goal: Applicant will: 1) Progressively adopt physician and hospital payment strategies so that revenue for labor and delivery only supports medically necessary care and no financial incentive exists to perform a low-risk Nulliparous Term Singleton Vertex (NTSV) Cesarean Section (C-Section). 2) Promote improvement work through the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center (MDC), so that all maternity hospitals achieve an NTSV C-Section rate of 23.9% or lower or are at least working toward that goal. 3) Include NTSV C-Section rate into contracting criteria so that all hospitals either meet the 23.9% goal, or if not, the plan has rationale for continued inclusion. 4) Adopt a payment methodology structured to support only medically necessary care with no financial incentive to perform C-sections for all contracted physicians and hospitals serving Enrollees by year end 2022. Smart Care California has outlined three payment strategies to align payment with medically necessary use of C-sections:

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

19.2.5.1 Report number of all network hospitals reporting to the CMQCC's MDC in Attachment E QIS Run Charts. A list of all California hospitals participating in the MDC can be found here:

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<https://www.cmqcc.org/about-cmqcc/member-hospitals>. Enter the percentage reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, and 2021 as well.

Single, Pull-down list.

- 1: Attached,
- 2: Not attached

Attached Document(s): [QHP Attachment E - QIS Run Charts.pdf](#)

19.2.5.2 Provide a description of all current payment models for maternity services across all lines of business, and specifically address whether payment differs based on vaginal or C-Section delivery. Report models and number of network hospitals paid using each payment strategy in 2020 in Attachment E QIS Run Charts. Enter the percentages reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, and 2021 as well. References: http://www.ihc.org/sites/default/files/files/page/c-section_menu_of_payment_and_contracting_options.pdf.

Single, Pull-down list.

- 1: Attached,
- 2: Not attached

Attached Document(s): [QHP Attachment E - QIS Run Charts.pdf](#)

19.2.5.3 Complete QHP Attachment M5 - QIS 5 Work Plan - Appropriate Use of C-Sections to describe updates on progress made since the last QIS submission with regards to promoting appropriate use of Cesarean-Sections (C-Sections). Applicant may submit any supporting documentation as an attachment. Address each of the following in the narrative:

- Description of how Applicant engages with its network hospitals to reduce NTSV C-Section rates to 23.9% or less by year end 2022
- Description of its adjustments to payment strategy in alignment with Smart Care California guidelines so that no hospitals or physicians are incentivized to perform an NTSV C-Section by year end 2022
- Description of how NTSV C-section rates are included in network hospital and provider contracting criteria
- Description of how Applicant promotes and encourages all in-network hospitals that provide maternity services to use the resources provided by California Maternity Quality Care Collaborative (CMQCC) and enroll in the CMQCC Maternal Data Center (MDC)
- Updates to hospital participation in CMQCC and hospital engagement in maternity care quality improvement, particularly those with a NTSV rate higher than 23.9%
- List any known or anticipated barriers in implementing QIS activities and progress of mitigation activities

Attached document(s): [QHP Attachment M5 - QIS 5 Work Plan - Appropriate Use of C-Sections.pdf](#)

Single, Radio group.

- 1: Attached,
- 2: Not attached

19.2.5.4 Confirm that all network physicians are paid on a case rate for deliveries and that payment is the same for both vaginal and C-section delivery.

Single, Pull-down list.

- 1: Confirmed,
- 2: Not Confirmed

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19.2.5.5 If Applicant answered no to 19.2.5.4, complete the table below.

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

19.2.6 QIS for Hospital Patient Safety

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

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

19.2.6.1 Report, across all lines of business, the percentage of hospital reimbursement at risk for quality performance and the quality indicators used in 2020 in Attachment E QIS Run Charts. In the details section of the spreadsheet, describe the model used to put payment at risk, and note if more than one model is used. "Quality performance" includes any number or combination of indicators, including HAIs, readmissions, patient satisfaction, etc. In the same sheet, report quality indicators used to assess quality performance. Enter the percentages reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, and 2021 as well.

Single, Pull-down list.

1: Attached,

2: Not attached

Attached Document(s): [QHP Attachment E - QIS Run Charts.pdf](#)

19.2.6.2 Report the number of hospitals contracted under the model described in question 19.2.6.1 with reimbursement at risk for quality performance in 2020 in Attachment E QIS Run Charts. Enter the numbers reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, and 2021 as well.

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Single, Pull-down list.

1: Attached,

2: Not attached

Attached Document(s): [QHP Attachment E - QIS Run Charts.pdf](#)

19.2.6.3 Complete QHP Attachment M6 - QIS 6 Work Plan - Hospital Patient Safety to describe progress promoting hospital safety since the last submission. Applicant may submit any supporting documentation as an attachment.

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

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

Address each of the following in the narrative:

- How Applicant is engaging with its network hospitals to reduce the five specified HAIs and Sepsis Management measure
- How Applicant is leveraging the poor performing hospitals list provided by Cal Hospital Compare to collaborate with other QHP Issuers who contract with the same poor performing hospitals
- Progress in 2020 toward the end goal and any further implementation plans for 2020 with milestones and targets for 2021 and 2022 identified
- Updates to strategy for promoting HIIN participation among the non-participating network hospitals, especially those with a standardized infection ratio (SIR) above 1.0 for the five designated Hospital Acquired Infections (HAIs). Refer to Appendix S1 CAUTI Rates, Appendix S2 CLABSI Rates, Appendix S3 CDI Rates, Appendix S4 MRSA Rates, and Appendix S5 SSI Colon Rates
- Applicant's progress in adopting a progressive payment strategy to tie at least 2% of network hospital payments to value by year end 2022
- Collaborations with other QHP Issuers on approaching hospitals to suggest improvement program involvement or alignment on a payment strategy to tie hospital payment to quality

Attachment document(s): [QHP Attachment M6 - QIS 6 Work Plan - Hospital Patient Safety.pdf](#)

Single, Radio group.

1: Attached,

2: Not attached

19.2.7 QIS for Patient-Centered Information and Support

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

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

If Applicant has or anticipates having Covered California enrollment more than 100,000 members, describe plans to ensure, members will have online access to:

- 1) Provider specific cost shares for common inpatient, outpatient and ambulatory services, (either as a procedure or as an episode of care). (Waived for Applicants with only HMO products.)
- 2) Access to costs for prescription drugs and member specific real-time understanding of accumulations toward deductibles, maximum out of pockets.

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

- 1) Provider specific cost shares for common inpatient, outpatient and ambulatory services, (either as a procedure or as an episode of care). Information does not need to be provided online. (Waived for Applicants with only HMO products.)
- 2) Access to costs for prescription drugs and member specific real-time understanding of accumulations toward deductibles, maximum out of pockets.

Single, Radio group.

1: Confirm.,

2: Not Confirmed, details: [100 words]

19.2.7.2 Describe any quality information currently included with cost information that enables enrollees to compare providers based on quality performance in selecting a primary care clinician or common elective specialty and hospital providers. If quality information is not included, describe feasibility for inclusion by 2022.
200 words.

19.2.7.3 If Applicant has cost tools available to members, report number and percent of unique enrollees for Covered California line of business who used the tool in 2020. Applicant must also describe how it tracks utilization and effectiveness of the cost tools.
200 words.

19.2.7.4 If Applicant has shared decision-making tools available to members, report number and percent of unique enrollees for Covered California line of business who used the tool in 2020. Applicant must also describe how it tracks utilization and effectiveness of the shared decision-making tools.
200 words

19.2.7.5 Based on the utilization reported in 19.2.7.3 and 19.2.7.4, what strategies does Applicant currently utilize or intend to implement to increase engagement with the tools?
200 words.

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

19.3.1 QIS for Provider Networks Based on Value

QIS Goal: Applicant should 1) evaluate providers and hospitals based on network quality and cost criteria for inclusion in network, 2) have a process for continual management of their network based on quality and cost, and 3) have a process for exclusion of poor performers based on inability to meet quality and cost criteria or lack of effort toward improvement.

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

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

19.3.1.2 Complete QHP Attachment M1 - QIS 1 Work Plan - Networks Based on Value to describe updates in Applicant's ability to build networks based on value since the previous QIS submission. Applicant may submit any supporting documentation as an attachment. Address each of the following in the narrative:

- Progress in 2020 toward the end goal including activities conducted, data collected and analyzed, and results
- Further implementation plans for 2021 with milestones and targets for 2021 and 2022 identified
- Known or anticipated barriers in implementing QIS activities and progress of mitigation activities

Attached Document(s): [QHP Attachment M1 - QIS 1 Work Plan - Networks Based on Value.pdf](#)

Single, Radio group.

1: Attached,
2: Not attached

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19.3.2 QIS for Reducing Health Disparities and Ensuring Health Equity

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

19.3.2.1 Provide the percent of Covered California members for whom self-reported data is captured for R/E in Attachment E QIS Run Charts. Self-identification may take place through the enrollment application, web site registration, health assessment, reported at provider site, etc. The percentage should exclude members whose race or ethnicity is unknown, missing, or who have “declined to state” either actively or passively. Enter the percentage reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, and 2021 as well.

Single, Pull-down list.

1: Attached,

2: Not attached

Attached Document(s): [QHP Attachment E - QIS Run Charts.pdf](#)

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

- Updates in efforts to increase self-reported R/E information including whether there are barriers to self-report
- To what extent is Applicant capturing missing race or ethnicity self-identification from increased telehealth utilization and related member interaction
- Any plans to implement or test new programs to increase self-identification If applicable, include any experience or lessons learned regarding race and ethnicity self-identification capture resulting from increased telehealth utilization and related member interaction

500 words.

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

Single, Radio group.

1: Applicant uses the RAND proxy methodology, describe: [100 words],

2: Applicant uses another methodology to estimate R/E, describe: [100 words],

3: Applicant does not use a methodology to estimate R/E, describe: [100 words]

19.3.2.4 Confirm Applicant submitted progress report on its Disparity Intervention to address health care disparities. Include a brief description or any progress or challenges experienced during implementation in the details box.

Single, Radio group.

1: Progress report submitted, describe: [200 words],

2: Progress report not submitted, describe: [100 words]

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

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

19.3.3.1 Report the percentage of members in Applicant's Covered California business who either selected a Primary Care Physician (PCP) or were matched with a Primary Care Physician in 2020 in Attachment E QIS Run Charts. If Applicant had no Covered California business in 2019, report full book of business excluding Medicare. Enter the percentage reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, and 2021 as well. Report data by product (HMO, PPO, EPO, Other).

Single, Pull-down list.

- 1: Attached,
- 2: Not attached

Attached Document(s): [QHP Attachment E - QIS Run Charts.pdf](#)

19.3.3.2 Report the number and percentage of Covered California members who obtain their primary care in 2019 with a provider or clinic that has received PCMH recognition from NCQA, The Joint Commission, or the Accreditation Association for Ambulatory Health Care (AAAHC) in Attachment E QIS Run Charts. For currently contracted Applicants, enter the percentage reported in the Certification Application for 2016, 2017, 2018, 2019, 2020, and 2021 as well. If Applicant did not have Covered California business during the prior calendar year, report on the full book of business. Report data by product (HMO, PPO, EPO, Other).

Single, Pull-down list.

- 1: Attached,
- 2: Not attached

Attached Document(s): [QHP Attachment E - QIS Run Charts.pdf](#)

19.3.3.3 Report all types of payment methods, used for primary care services and number of providers paid under each model in 2020 in Attachment E QIS Run Charts using the alternative payment model (APM) outlined in the Health Care Payment Learning Action & Action Network (HCP LAN) Draft White Paper on Primary Care Payment Models (Levels 1, 2, 3, and 4) . Enter the number and percentage of providers paid under each model reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, and 2021 as well. Report data by product (HMO, PPO, EPO, Other).

References:

HCP LAN Primary Care Payment Models Draft White Paper: <http://hcp-lan.org/workproducts/pcpm-whitepaper-draft.pdf>

As the paper states, “it is essential for provider organizations to use the payment and incentive structures outlined in this paper when compensating individual primary care practices. In order to enable frontline practitioners to implement delivery reforms, and properly hold them accountable for managing costs and population health, these practitioners must receive payments that support the infrastructure needed for coordination and patient engagement” and “primary care population-based payment models should be “in excess of historical primary care payments to support additional expectations”.

Single, Pull-down list.

- 1: Attached,
- 2: Not attached

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Attached Document(s): [QHP Attachment E - QIS Run Charts.pdf](#)

19.3.3.4 Complete QHP Attachment M3 - QIS 3 Work Plan - Primary Care to describe updates on progress made since the previous QIS submission in each part of the primary care goals, and planned activities.

Applicant may submit any supporting documentation as an attachment. Address each of the following in the narrative:

- Updates on the PCP matching initiative, including a status report, feedback on the enrollee experience, complaints, positive feedback, unanticipated challenges, and suggestions (if applicable)
- Progress in updating primary care payment models, including those for contracted groups, to align with Level 3 or 4 APMs described in the LAN Draft White Paper (above) including: activities conducted, data collected and analyzed, and results
- Describe any support or technical assistance (financial, staffing, educational, etc.) that Applicant or multi-insurer collaborative is providing to primary care providers to support their efforts towards accessible, data-driven, team-based care
- How Applicant is encouraging enrollees to use accessible, data-driven, team-based care providers
- Further implementation plans for 2021 with milestones and targets for 2021 and 2022 identified
- Known or anticipated barriers in implementing QIS activities and progress of mitigation activities

1000 words.

Attached Document(s): [QHP Attachment M3 - QIS 3 Work Plan - Primary Care.pdf](#)

Single, Radio group.

1: Attached,

2: Not attached.

19.3.4 QIS for Promoting Development and Use of Care Models - Integrated Delivery Systems or Accountable Care Organizations

QIS Goal: Applicant will increase Integrated Delivery System (IDS) or Accountable Care Organization (ACO) presence in its Covered California network by providing various types of support to providers to elevate their processes and practice toward this goal. If expanding its network, Applicant will also increase the proportion of Covered California enrollees receiving care in an IDS or ACO.

An IDS or ACO is defined as a system of population-based care coordinated across the continuum, including multidisciplinary physicians and physician groups, hospitals, and ancillary providers that has combined risk sharing arrangements and incentives between Applicant and providers, holding the IDS or ACO accountable for nationally recognized evidence-based clinical, financial, and operational performance.

19.3.4.1 Using the definition for IDS or ACO above, report the number and percentage of Covered California members and total California members who are managed under an IDS or ACO in 2020 in Attachment E QIS Run Charts. For currently contracted Applicants, enter the percentage reported in the Certification Application for 2016, 2017, 2018, 2019, 2020, and 2021 as well. If Applicant did not have Covered California business during the prior calendar year, report on the full book of business. Report data by product (HMO, PPO, EPO, Other).

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Single, Pull-down list.

- 1: Attached,
2: Not attached

19.3.4.2 Provide as attachments the following documents related to IDSs or ACOs or confirm Applicant will submit the documents as they become available:

(File titled Provider 1a): Applicant's IDS or ACO business model including measures used to track progress and success of IDS or ACO providers and the payment model for the IDS or ACO.	<i>Single, Pull-down list.</i> 1: Attached, 2: Not attached
(File titled Provider 1b): Example of Applicant report to its IDS or ACO providers on its quality of care and financial performance, including benchmarking relative to performance improvement goals or market norms.	<i>Single, Pull-down list.</i> 1: Attached, 2: Not attached
(File titled Provider 1c): Confirm Applicant will submit a copy of Applicant's 2020 IHA Align Measure Perform (AMP) Commercial ACO report when it becomes available, if Applicant participates in the program.	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not confirmed, 3: N/A

19.3.4.3 Complete QHP Attachment M4 – QIS 4 Work Plan – IDS and ACO to describe updates on progress made since the previous QIS submission on each component of the IDS or ACO goals, and planned activities. Applicant may submit any supporting documentation as an attachment. Address each of the following in the narrative:

- Progress in 2020 toward the end goal including activities conducted, data collected and analyzed, and results
- Further implementation plans for 2021 with milestones and targets for 2021 and 2022 identified
- How Applicant expects to evolve its model, based on progress or outcomes to date
- How Applicant is providing support for integration and coordination of care through coaching, funding, implementation of information systems, technical assistance, or other means where no provider organization is accepting accountability
- Other activities conducted since the previous QIS submission to promote IDSs or ACOs, or activities that will be conducted
- Known or anticipated barriers in implementation of QIS and progress of mitigation activities

Attached document(s): [QHP Attachment M4 – QIS 4 Work Plan – IDS and ACO.pdf](#)

Single, Radio group.

- 1: Attached,
2: Not attached

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19.3.5 QIS for Appropriate Use of Cesarean Sections

QIS Goal: Applicant will: 1) Progressively adopt physician and hospital payment strategies so that revenue for labor and delivery only supports medically necessary care and no financial incentive exists to perform a low-risk Nulliparous Term Singleton Vertex (NTSV) Cesarean Section (C-Section). 2) Promote improvement work through the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center (MDC), so that all maternity hospitals achieve an NTSV C-Section rate of 23.9% or lower or are at least working toward that goal. 3) Include NTSV C-Section rate into contracting criteria so that all hospitals either meet the 23.9% goal, or if not, the plan has rationale for continued inclusion. 4) Adopt a payment methodology structured to support only medically necessary care with no financial incentive to perform C-sections for all contracted physicians and hospitals serving Enrollees by year end 2022. Smart Care California has outlined three payment strategies to align payment with medically necessary use of C-sections:

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

19.3.5.1 Report number of all network hospitals reporting to the CMQCC's MDC in Attachment E QIS Run

Charts. A list of all California hospitals participating in the MDC can be found here:

<https://www.cmqcc.org/about-cmqcc/member-hospitals>. Enter the percentage reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, and 2021 as well.

Single, Pull-down list.

- 1: Attached,
- 2: Not attached

Attached Document(s): [QHP Attachment E - QIS Run Charts.pdf](#)

19.3.5.2 Provide a description of all current payment models for maternity services across all lines of business, and specifically address whether payment differs based on vaginal or C-Section delivery. Report models and number of network hospitals paid using each payment strategy in 2020 in Attachment E QIS Run Charts. Enter the percentages reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, and 2021 as well.

References: [http://www.ihc.org/sites/default/files/files/page/c-section menu of payment and contracting options.pdf](http://www.ihc.org/sites/default/files/files/page/c-section%20menu%20of%20payment%20and%20contracting%20options.pdf).

Single, Pull-down list.

- 1: Attached,
- 2: Not attached

Attached Document(s): [QHP Attachment E - QIS Run Charts.pdf](#)

19.3.5.3 Complete QHP Attachment M5 - QIS 5 Work Plan - Appropriate Use of C-Sections to describe updates on progress made since the last QIS submission with regards to promoting appropriate use of Cesarean-Sections (C-Sections). Applicant may submit any supporting documentation as an attachment. Address each of the following in the narrative:

- Description of how Applicant engages with its network hospitals to reduce NTSV C-Section rates to 23.9% or less by year end 2022

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- Description of its adjustments to payment strategy in alignment with Smart Care California guidelines so that no hospitals or physicians are incentivized to perform an NTSV C-Section by year end 2022
- Description of how NTSV C-section rates are included in network hospital and provider contracting criteria
- Description of how Applicant promotes and encourages all in-network hospitals that provide maternity services to use the resources provided by California Maternity Quality Care Collaborative (CMQCC) and enroll in the CMQCC Maternal Data Center (MDC)
- Updates to hospital participation in CMQCC and hospital engagement in maternity care quality improvement, particularly those with a NTSV rate higher than 23.9%
- List any known or anticipated barriers in implementing QIS activities and progress of mitigation activities

Attached document(s): [QHP Attachment M5 - QIS 5 Work Plan - Appropriate Use of C-Sections.pdf](#)

Single, Radio group.

1: Attached,

2: Not attached

19.3.5.4 Confirm that all network physicians are paid on a case rate for deliveries and that payment is the same for both vaginal and C-section delivery.

Single, Pull-down list.

1: Confirmed,

2: Not Confirmed

19.3.5.5 If Applicant answered no to 19.3.5.4, complete the table below.

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

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19.3.6 QIS for Hospital Patient Safety

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

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

19.3.6.1 Report, across all lines of business, the percentage of hospital reimbursement at risk for quality performance and the quality indicators used in 2020 in Attachment E QIS Run Charts. In the details section of the spreadsheet, describe the model used to put payment at risk, and note if more than one model is used. "Quality performance" includes any number or combination of indicators, including HAIs, readmissions, patient satisfaction, etc. In the same sheet, report quality indicators used to assess quality performance. Enter the percentages reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, and 2021 as well.

Single, Pull-down list.

- 1: Attached,
2: Not attached

Attached Document(s): [QHP Attachment E - QIS Run Charts.pdf](#)

19.3.6.2 Report the number of hospitals contracted under the model described in question 19.3.6.1 with reimbursement at risk for quality performance in 2020 in Attachment E QIS Run Charts. Enter the numbers reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, and 2021 as well.

Single, Pull-down list.

- 1: Attached,
2: Not attached

Attached Document(s): [QHP Attachment E - QIS Run Charts.pdf](#)

19.3.6.3 Complete QHP Attachment M6 - QIS 6 Work Plan - Hospital Patient Safety to describe progress promoting hospital safety since the last submission. Applicant may submit any supporting documentation as an attachment.

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

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

Address each of the following in the narrative:

- How Applicant is engaging with its network hospitals to reduce the five specified HAIs and Sepsis Management measure

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- How Applicant is leveraging the poor performing hospitals list provided by Cal Hospital Compare to collaborate with other QHP Issuers who contract with the same poor performing hospitals
- Progress in 2020 toward the end goal and any further implementation plans for 2020 with milestones and targets for 2021 and 2022 identified
- Updates to strategy for promoting HIIN participation among the non-participating network hospitals, especially those with a standardized infection ratio (SIR) above 1.0 for the five designated Hospital Acquired Infections (HAIs). Refer to Appendix S1 CAUTI Rates, Appendix S2 CLABSI Rates, Appendix S3 CDI Rates, Appendix S4 MRSA Rates, and Appendix S5 SSI Colon Rates
- Applicant's progress in adopting a progressive payment strategy to tie at least 2% of network hospital payments to value by year end 2022
- Collaborations with other QHP Issuers on approaching hospitals to suggest improvement program involvement or alignment on a payment strategy to tie hospital payment to quality

Attachment document(s): [QHP Attachment M6 - QIS 6 Work Plan - Hospital Patient Safety.pdf](#)

Single, Radio group.

1: Attached,

2: Not attached

19.3.7 QIS for Patient-Centered Information and Support

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

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

If Applicant has or anticipates having Covered California enrollment more than 100,000 members, describe plans to ensure, members will have online access to:

- 1) Provider specific cost shares for common inpatient, outpatient and ambulatory services, (either as a procedure or as an episode of care). (Waived for Applicants with only HMO products.)
- 2) Access to costs for prescription drugs and member specific real-time understanding of accumulations toward deductibles, maximum out of pockets.

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

- 1) Provider specific cost shares for common inpatient, outpatient and ambulatory services, (either as a procedure or as an episode of care). Information does not need to be provided online. (Waived for Applicants with only HMO products.)
- 2) Access to costs for prescription drugs and member specific real-time understanding of accumulations toward deductibles, maximum out of pockets.

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Single, Radio group.

1: Confirm.,

2: Not Confirmed, details: [100 words]

19.3.7.2 Describe any quality information currently included with cost information that enables enrollees to compare providers based on quality performance in selecting a primary care clinician or common elective specialty and hospital providers. If quality information is not included, describe feasibility for inclusion by 2022.
200 words.

19.3.7.3 If Applicant has cost tools available to members, report number and percent of unique enrollees for Covered California line of business who used the tool in 2020. Applicant must also describe how it tracks utilization and effectiveness of the cost tools.
200 words.

19.3.7.4 If Applicant has shared decision-making tools available to members, report number and percent of unique enrollees for Covered California line of business who used the tool in 2020. Applicant must also describe how it tracks utilization and effectiveness of the shared decision-making tools.
200 words

19.3.7.5 Based on the utilization reported in 19.3.7.3 and 19.3.7.4, what strategies does Applicant currently utilize or intend to implement to increase engagement with the tools?
200 words.

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

19.4.1 QIS for Provider Networks Based on Value

QIS Goal: Applicant should 1) evaluate providers and hospitals based on network quality and cost criteria for inclusion in network, 2) have a process for continual management of their network based on quality and cost, and 3) have a process for exclusion of poor performers based on inability to meet quality and cost criteria or lack of effort toward improvement.

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

(File titled Provider Network): All quality measures and criteria used to develop provider networks. Include patient safety and patient-reported experience (noting any measures that are new). An	<i>Single, Pull-down</i>

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

19.4.1.2 Complete QHP Attachment M1 - QIS 1 Work Plan - Networks Based on Value to describe updates in Applicant's ability to build networks based on value since the previous QIS submission. Applicant may submit any supporting documentation as an attachment. Address each of the following in the narrative:

- Progress in 2020 toward the end goal including activities conducted, data collected and analyzed, and results
- Further implementation plans for 2021 with milestones and targets for 2021 and 2022 identified
- Known or anticipated barriers in implementing QIS activities and progress of mitigation activities

Attached Document(s): [QHP Attachment M1 - QIS 1 Work Plan - Networks Based on Value.pdf](#)

Single, Radio group.

1: Attached,
2: Not attached

19.4.2 QIS for Reducing Health Disparities and Ensuring Health Equity

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

19.4.2.1 Provide the percent of Covered California members for whom self-reported data is captured for R/E in Attachment E QIS Run Charts. Self-identification may take place through the enrollment application, web site registration, health assessment, reported at provider site, etc. The percentage should exclude members whose race or ethnicity is unknown, missing, or who have "declined to state" either actively or passively. Enter the percentage reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, and 2021 as well.

Single, Pull-down list.

1: Attached,
2: Not attached

Attached Document(s): [QHP Attachment E - QIS Run Charts.pdf](#)

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

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- Updates in efforts to increase self-reported R/E information including whether there are barriers to self-report
- To what extent is Applicant capturing missing race or ethnicity self-identification from increased telehealth utilization and related member interaction
- Any plans to implement or test new programs to increase self-identification If applicable, include any experience or lessons learned regarding race and ethnicity self-identification capture resulting from increased telehealth utilization and related member interaction

500 words.

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

Single, Radio group.

- 1: Applicant uses the RAND proxy methodology, describe: [100 words],
2: Applicant uses another methodology to estimate R/E, describe: [100 words],
3: Applicant does not use a methodology to estimate R/E, describe: [100 words]

19.4.2.4 Confirm Applicant submitted progress report on its Disparity Intervention to address health care disparities. Include a brief description or any progress or challenges experienced during implementation in the details box.

Single, Radio group.

- 1: Progress report submitted, describe: [200 words],
2: Progress report not submitted, describe: [100 words]

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

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

19.4.3.1 Report the percentage of members in Applicant's Covered California business who either selected a Primary Care Physician (PCP) or were matched with a Primary Care Physician in 2020 in Attachment E QIS Run Charts. If Applicant had no Covered California business in 2019, report full book of business excluding Medicare. Enter the percentage reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, and 2021 as well. Report data by product (HMO, PPO, EPO, Other).

Single, Pull-down list.

- 1: Attached,
2: Not attached

Attached Document(s): [QHP Attachment E - QIS Run Charts.pdf](#)

19.4.3.2 Report the number and percentage of Covered California members who obtain their primary care in 2019 with a provider or clinic that has received PCMH recognition from NCQA, The Joint Commission, or the Accreditation Association for Ambulatory Health Care (AAAHC) in Attachment E QIS Run Charts. For currently contracted Applicants, enter the percentage reported in the Certification Application for 2016, 2017, 2018, 2019, 2020, and 2021 as well. If Applicant did not have Covered California business during the prior calendar year, report on the full book of business. Report data by product (HMO, PPO, EPO, Other).

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Single, Pull-down list.

1: Attached,

2: Not attached

Attached Document(s): [QHP Attachment E - QIS Run Charts.pdf](#)

19.4.3.3 Report all types of payment methods, used for primary care services and number of providers paid under each model in 2020 in Attachment E QIS Run Charts using the alternative payment model (APM) outlined in the Health Care Payment Learning Action & Action Network (HCP LAN) Draft White Paper on Primary Care Payment Models (Levels 1, 2, 3, and 4) . Enter the number and percentage of providers paid under each model reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, and 2021 as well. Report data by product (HMO, PPO, EPO, Other).

References:

HCP LAN Primary Care Payment Models Draft White Paper: <http://hcp-lan.org/workproducts/pcpm-whitepaper-draft.pdf>

As the paper states, “it is essential for provider organizations to use the payment and incentive structures outlined in this paper when compensating individual primary care practices. In order to enable frontline practitioners to implement delivery reforms, and properly hold them accountable for managing costs and population health, these practitioners must receive payments that support the infrastructure needed for coordination and patient engagement” and “primary care population-based payment models should be “in excess of historical primary care payments to support additional expectations”.

Single, Pull-down list.

1: Attached,

2: Not attached

Attached Document(s): [QHP Attachment E - QIS Run Charts.pdf](#)

19.4.3.4 Complete QHP Attachment M3 - QIS 3 Work Plan - Primary Care to describe updates on progress made since the previous QIS submission in each part of the primary care goals, and planned activities. Applicant may submit any supporting documentation as an attachment. Address each of the following in the narrative:

- Updates on the PCP matching initiative, including a status report, feedback on the enrollee experience, complaints, positive feedback, unanticipated challenges, and suggestions (if applicable)
- Progress in updating primary care payment models, including those for contracted groups, to align with Level 3 or 4 APMs described in the LAN Draft White Paper (above) including: activities conducted, data collected and analyzed, and results
- Describe any support or technical assistance (financial, staffing, educational, etc.) that Applicant or multi-insurer collaborative is providing to primary care providers to support their efforts towards accessible, data-driven, team-based care
- How Applicant is encouraging enrollees to use accessible, data-driven, team-based care providers
- Further implementation plans for 2021 with milestones and targets for 2021 and 2022 identified
- Known or anticipated barriers in implementing QIS activities and progress of mitigation activities

1000 words.

Attached Document(s): [QHP Attachment M3 - QIS 3 Work Plan - Primary Care.pdf](#)

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Single, Radio group.

- 1: Attached,
- 2: Not attached.

19.4.4 QIS for Promoting Development and Use of Care Models - Integrated Delivery Systems or Accountable Care Organizations

QIS Goal: Applicant will increase Integrated Delivery System (IDS) or Accountable Care Organization (ACO) presence in its Covered California network by providing various types of support to providers to elevate their processes and practice toward this goal. If expanding its network, Applicant will also increase the proportion of Covered California enrollees receiving care in an IDS or ACO.

An IDS or ACO is defined as a system of population-based care coordinated across the continuum, including multidisciplinary physicians and physician groups, hospitals, and ancillary providers that has combined risk sharing arrangements and incentives between Applicant and providers, holding the IDS or ACO accountable for nationally recognized evidence-based clinical, financial, and operational performance.

19.4.4.1 Using the definition for IDS or ACO above, report the number and percentage of Covered California members and total California members who are managed under an IDS or ACO in 2020 in Attachment E QIS Run Charts. For currently contracted Applicants, enter the percentage reported in the Certification Application for 2016, 2017, 2018, 2019, 2020, and 2021 as well. If Applicant did not have Covered California business during the prior calendar year, report on the full book of business. Report data by product (HMO, PPO, EPO, Other).

Single, Pull-down list.

- 1: Attached,
- 2: Not attached

19.4.4.2 Provide as attachments the following documents related to IDSs or ACOs or confirm Applicant will submit the documents as they become available:

(File titled Provider 1a): Applicant's IDS or ACO business model including measures used to track progress and success of IDS or ACO providers and the payment model for the IDS or ACO.	<i>Single, Pull-down list.</i> 1: Attached, 2: Not attached
(File titled Provider 1b): Example of Applicant report to its IDS or ACO providers on its quality of care and financial performance, including benchmarking relative to performance improvement goals or market norms.	<i>Single, Pull-down list.</i> 1: Attached, 2: Not attached
(File titled Provider 1c): Confirm Applicant will submit a copy of Applicant's 2020 IHA Align Measure Perform (AMP) Commercial ACO report when it becomes available, if Applicant participates in the program.	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not

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	confirmed, 3: N/A
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19.4.4.3 Complete QHP Attachment M4 – QIS 4 Work Plan – IDS and ACO to describe updates on progress made since the previous QIS submission on each component of the IDS or ACO goals, and planned activities. Applicant may submit any supporting documentation as an attachment. Address each of the following in the narrative:

- Progress in 2020 toward the end goal including activities conducted, data collected and analyzed, and results
- Further implementation plans for 2021 with milestones and targets for 2021 and 2022 identified
- How Applicant expects to evolve its model, based on progress or outcomes to date
- How Applicant is providing support for integration and coordination of care through coaching, funding, implementation of information systems, technical assistance, or other means where no provider organization is accepting accountability
- Other activities conducted since the previous QIS submission to promote IDSs or ACOs, or activities that will be conducted
- Known or anticipated barriers in implementation of QIS and progress of mitigation activities

Attached document(s): [QHP Attachment M4 – QIS 4 Work Plan – IDS and ACO.pdf](#)

Single, Radio group.

1: Attached,

2: Not attached

19.4.5 QIS for Appropriate Use of Cesarean Sections

QIS Goal: Applicant will: 1) Progressively adopt physician and hospital payment strategies so that revenue for labor and delivery only supports medically necessary care and no financial incentive exists to perform a low-risk Nulliparous Term Singleton Vertex (NTSV) Cesarean Section (C-Section). 2) Promote improvement work through the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center (MDC), so that all maternity hospitals achieve an NTSV C-Section rate of 23.9% or lower or are at least working toward that goal. 3) Include NTSV C-Section rate into contracting criteria so that all hospitals either meet the 23.9% goal, or if not, the plan has rationale for continued inclusion. 4) Adopt a payment methodology structured to support only medically necessary care with no financial incentive to perform C-sections for all contracted physicians and hospitals serving Enrollees by year end 2022. Smart Care California has outlined three payment strategies to align payment with medically necessary use of C-sections:

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

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19.4.5.1 Report number of all network hospitals reporting to the CMQCC's MDC in Attachment E QIS Run Charts. A list of all California hospitals participating in the MDC can be found here: <https://www.cmqcc.org/about-cmqcc/member-hospitals>. Enter the percentage reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, and 2021 as well.

Single, Pull-down list.

- 1: Attached,
- 2: Not attached

Attached Document(s): [QHP Attachment E - QIS Run Charts.pdf](#)

19.4.5.2 Provide a description of all current payment models for maternity services across all lines of business, and specifically address whether payment differs based on vaginal or C-Section delivery. Report models and number of network hospitals paid using each payment strategy in 2020 in Attachment E QIS Run Charts. Enter the percentages reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, and 2021 as well. References: [http://www.iha.org/sites/default/files/files/page/c-section menu of payment and contracting options.pdf](http://www.iha.org/sites/default/files/files/page/c-section%20menu%20of%20payment%20and%20contracting%20options.pdf).

Single, Pull-down list.

- 1: Attached,
- 2: Not attached

Attached Document(s): [QHP Attachment E - QIS Run Charts.pdf](#)

19.4.5.3 Complete QHP Attachment M5 - QIS 5 Work Plan - Appropriate Use of C-Sections to describe updates on progress made since the last QIS submission with regards to promoting appropriate use of Cesarean-Sections (C-Sections). Applicant may submit any supporting documentation as an attachment. Address each of the following in the narrative:

- Description of how Applicant engages with its network hospitals to reduce NTSV C-Section rates to 23.9% or less by year end 2022
- Description of its adjustments to payment strategy in alignment with Smart Care California guidelines so that no hospitals or physicians are incentivized to perform an NTSV C-Section by year end 2022
- Description of how NTSV C-section rates are included in network hospital and provider contracting criteria
- Description of how Applicant promotes and encourages all in-network hospitals that provide maternity services to use the resources provided by California Maternity Quality Care Collaborative (CMQCC) and enroll in the CMQCC Maternal Data Center (MDC)
- Updates to hospital participation in CMQCC and hospital engagement in maternity care quality improvement, particularly those with a NTSV rate higher than 23.9%
- List any known or anticipated barriers in implementing QIS activities and progress of mitigation activities

Attached document(s): [QHP Attachment M5 - QIS 5 Work Plan - Appropriate Use of C-Sections.pdf](#)

Single, Radio group.

- 1: Attached,
- 2: Not attached

19.4.5.4 Confirm that all network physicians are paid on a case rate for deliveries and that payment is the same for both vaginal and C-section delivery.

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Single, Pull-down list.

1: Confirmed,

2: Not Confirmed

19.4.5.5 If Applicant answered no to 19.4.5.4, complete the table below.

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

19.4.6 QIS for Hospital Patient Safety

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

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

19.4.6.1 Report, across all lines of business, the percentage of hospital reimbursement at risk for quality performance and the quality indicators used in 2020 in Attachment E QIS Run Charts. In the details section of the spreadsheet, describe the model used to put payment at risk, and note if more than one model is used. "Quality performance" includes any number or combination of indicators, including HAIs, readmissions, patient satisfaction, etc. In the same sheet, report quality indicators used to assess quality performance. Enter the percentages reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, and 2021 as well.

Single, Pull-down list.

1: Attached,

2: Not attached

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Attached Document(s): [QHP Attachment E - QIS Run Charts.pdf](#)

19.4.6.2 Report the number of hospitals contracted under the model described in question 19.4.6.1 with reimbursement at risk for quality performance in 2020 in Attachment E QIS Run Charts. Enter the numbers reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, and 2021 as well.

Single, Pull-down list.

- 1: Attached,
- 2: Not attached

Attached Document(s): [QHP Attachment E - QIS Run Charts.pdf](#)

19.4.6.3 Complete QHP Attachment M6 - QIS 6 Work Plan - Hospital Patient Safety to describe progress promoting hospital safety since the last submission. Applicant may submit any supporting documentation as an attachment.

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

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

Address each of the following in the narrative:

- How Applicant is engaging with its network hospitals to reduce the five specified HAIs and Sepsis Management measure
- How Applicant is leveraging the poor performing hospitals list provided by Cal Hospital Compare to collaborate with other QHP Issuers who contract with the same poor performing hospitals
- Progress in 2020 toward the end goal and any further implementation plans for 2020 with milestones and targets for 2021 and 2022 identified
- Updates to strategy for promoting HIIN participation among the non-participating network hospitals, especially those with a standardized infection ratio (SIR) above 1.0 for the five designated Hospital Acquired Infections (HAIs). Refer to Appendix S1 CAUTI Rates, Appendix S2 CLABSI Rates, Appendix S3 CDI Rates, Appendix S4 MRSA Rates, and Appendix S5 SSI Colon Rates
- Applicant's progress in adopting a progressive payment strategy to tie at least 2% of network hospital payments to value by year end 2022
- Collaborations with other QHP Issuers on approaching hospitals to suggest improvement program involvement or alignment on a payment strategy to tie hospital payment to quality

Attachment document(s): [QHP Attachment M6 - QIS 6 Work Plan - Hospital Patient Safety.pdf](#)

Single, Radio group.

- 1: Attached,
- 2: Not attached

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19.4.7 QIS for Patient-Centered Information and Support

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

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

If Applicant has or anticipates having Covered California enrollment more than 100,000 members, describe plans to ensure, members will have online access to:

- 1) Provider specific cost shares for common inpatient, outpatient and ambulatory services, (either as a procedure or as an episode of care). (Waived for Applicants with only HMO products.)
- 2) Access to costs for prescription drugs and member specific real-time understanding of accumulations toward deductibles, maximum out of pockets.

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

- 1) Provider specific cost shares for common inpatient, outpatient and ambulatory services, (either as a procedure or as an episode of care). Information does not need to be provided online. (Waived for Applicants with only HMO products.)
- 2) Access to costs for prescription drugs and member specific real-time understanding of accumulations toward deductibles, maximum out of pockets.

Single, Radio group.

1: Confirm.,

2: Not Confirmed, details: [100 words]

19.4.7.2 Describe any quality information currently included with cost information that enables enrollees to compare providers based on quality performance in selecting a primary care clinician or common elective specialty and hospital providers. If quality information is not included, describe feasibility for inclusion by 2022.
200 words.

19.4.7.3 If Applicant has cost tools available to members, report number and percent of unique enrollees for Covered California line of business who used the tool in 2020. Applicant must also describe how it tracks utilization and effectiveness of the cost tools.

200 words.

19.4.7.4 If Applicant has shared decision-making tools available to members, report number and percent of unique enrollees for Covered California line of business who used the tool in 2020. Applicant must also describe how it tracks utilization and effectiveness of the shared decision-making tools.

200 words

19.4.7.5 Based on the utilization reported in 19.4.7.3 and 19.4.7.4, what strategies does Applicant currently utilize or intend to implement to increase engagement with the tools?

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200 words.

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

19.5.1 QIS for Provider Networks Based on Value

QIS Goal: Applicant should 1) evaluate providers and hospitals based on network quality and cost criteria for inclusion in network, 2) have a process for continual management of their network based on quality and cost, and 3) have a process for exclusion of poor performers based on inability to meet quality and cost criteria or lack of effort toward improvement.

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

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

19.5.1.2 Complete QHP Attachment M1 - QIS 1 Work Plan - Networks Based on Value to describe updates in Applicant's ability to build networks based on value since the previous QIS submission. Applicant may submit any supporting documentation as an attachment. Address each of the following in the narrative:

- Progress in 2020 toward the end goal including activities conducted, data collected and analyzed, and results
- Further implementation plans for 2021 with milestones and targets for 2021 and 2022 identified
- Known or anticipated barriers in implementing QIS activities and progress of mitigation activities

Attached Document(s): [QHP Attachment M1 - QIS 1 Work Plan - Networks Based on Value.pdf](#)

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Single, Radio group.

1: Attached,

2: Not attached

19.5.2 QIS for Reducing Health Disparities and Ensuring Health Equity

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

19.5.2.1 Provide the percent of Covered California members for whom self-reported data is captured for R/E in Attachment E QIS Run Charts. Self-identification may take place through the enrollment application, web site registration, health assessment, reported at provider site, etc. The percentage should exclude members whose race or ethnicity is unknown, missing, or who have “declined to state” either actively or passively. Enter the percentage reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, and 2021 as well.

Single, Pull-down list.

1: Attached,

2: Not attached

Attached Document(s): [QHP Attachment E - QIS Run Charts.pdf](#)

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

- Updates in efforts to increase self-reported R/E information including whether there are barriers to self-report
- To what extent is Applicant capturing missing race or ethnicity self-identification from increased telehealth utilization and related member interaction
- Any plans to implement or test new programs to increase self-identification If applicable, include any experience or lessons learned regarding race and ethnicity self-identification capture resulting from increased telehealth utilization and related member interaction

500 words.

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

Single, Radio group.

1: Applicant uses the RAND proxy methodology, describe: [100 words],

2: Applicant uses another methodology to estimate R/E, describe: [100 words],

3: Applicant does not use a methodology to estimate R/E, describe: [100 words]

19.5.2.4 Confirm Applicant submitted progress report on its Disparity Intervention to address health care disparities. Include a brief description or any progress or challenges experienced during implementation in the details box.

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Single, Radio group.

1: Progress report submitted, describe: [200 words],

2: Progress report not submitted, describe: [100 words]

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

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

19.5.3.1 Report the percentage of members in Applicant's Covered California business who either selected a Primary Care Physician (PCP) or were matched with a Primary Care Physician in 2020 in Attachment E QIS Run Charts. If Applicant had no Covered California business in 2019, report full book of business excluding Medicare. Enter the percentage reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, and 2021 as well. Report data by product (HMO, PPO, EPO, Other).

Single, Pull-down list.

1: Attached,

2: Not attached

Attached Document(s): [QHP Attachment E - QIS Run Charts.pdf](#)

19.5.3.2 Report the number and percentage of Covered California members who obtain their primary care in 2019 with a provider or clinic that has received PCMH recognition from NCQA, The Joint Commission, or the Accreditation Association for Ambulatory Health Care (AAAHC) in Attachment E QIS Run Charts. For currently contracted Applicants, enter the percentage reported in the Certification Application for 2016, 2017, 2018, 2019, 2020, and 2021 as well. If Applicant did not have Covered California business during the prior calendar year, report on the full book of business. Report data by product (HMO, PPO, EPO, Other).

Single, Pull-down list.

1: Attached,

2: Not attached

Attached Document(s): [QHP Attachment E - QIS Run Charts.pdf](#)

19.5.3.3 Report all types of payment methods, used for primary care services and number of providers paid under each model in 2020 in Attachment E QIS Run Charts using the alternative payment model (APM) outlined in the Health Care Payment Learning Action & Action Network (HCP LAN) Draft White Paper on Primary Care Payment Models (Levels 1, 2, 3, and 4) . Enter the number and percentage of providers paid under each model reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, and 2021 as well. Report data by product (HMO, PPO, EPO, Other).

References:

HCP LAN Primary Care Payment Models Draft White Paper: <http://hcp-lan.org/workproducts/pcpm-whitepaper-draft.pdf>

As the paper states, “it is essential for provider organizations to use the payment and incentive structures outlined in this paper when compensating individual primary care practices. In order to enable frontline practitioners to implement delivery reforms, and properly hold them accountable for managing costs and population health, these practitioners must receive payments that support the infrastructure needed for coordination and patient engagement” and “primary care population-based

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payment models should be “in excess of historical primary care payments to support additional expectations”.

Single, Pull-down list.

1: Attached,

2: Not attached

Attached Document(s): [QHP Attachment E - QIS Run Charts.pdf](#)

19.5.3.4 Complete QHP Attachment M3 - QIS 3 Work Plan - Primary Care to describe updates on progress made since the previous QIS submission in each part of the primary care goals, and planned activities.

Applicant may submit any supporting documentation as an attachment. Address each of the following in the narrative:

- Updates on the PCP matching initiative, including a status report, feedback on the enrollee experience, complaints, positive feedback, unanticipated challenges, and suggestions (if applicable)
- Progress in updating primary care payment models, including those for contracted groups, to align with Level 3 or 4 APMs described in the LAN Draft White Paper (above) including: activities conducted, data collected and analyzed, and results
- Describe any support or technical assistance (financial, staffing, educational, etc.) that Applicant or multi-insurer collaborative is providing to primary care providers to support their efforts towards accessible, data-driven, team-based care
- How Applicant is encouraging enrollees to use accessible, data-driven, team-based care providers
- Further implementation plans for 2021 with milestones and targets for 2021 and 2022 identified
- Known or anticipated barriers in implementing QIS activities and progress of mitigation activities

1000 words.

Attached Document(s): [QHP Attachment M3 - QIS 3 Work Plan - Primary Care.pdf](#)

Single, Radio group.

1: Attached,

2: Not attached.

19.5.4 QIS for Promoting Development and Use of Care Models - Integrated Delivery Systems or Accountable Care Organizations

QIS Goal: Applicant will increase Integrated Delivery System (IDS) or Accountable Care Organization (ACO) presence in its Covered California network by providing various types of support to providers to elevate their processes and practice toward this goal. If expanding its network, Applicant will also increase the proportion of Covered California enrollees receiving care in an IDS or ACO.

An IDS or ACO is defined as a system of population-based care coordinated across the continuum, including multidisciplinary physicians and physician groups, hospitals, and ancillary providers that has combined risk sharing arrangements and incentives between Applicant and providers, holding the IDS or ACO accountable for nationally recognized evidence-based clinical, financial, and operational performance.

19.5.4.1 Using the definition for IDS or ACO above, report the number and percentage of Covered California members and total California members who are managed under an IDS or ACO in 2020 in Attachment E QIS Run Charts. For currently contracted Applicants, enter the percentage reported in the Certification Application

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for 2016, 2017, 2018, 2019, 2020, and 2021 as well. If Applicant did not have Covered California business during the prior calendar year, report on the full book of business. Report data by product (HMO, PPO, EPO, Other).

Single, Pull-down list.

- 1: Attached,
2: Not attached

19.5.4.2 Provide as attachments the following documents related to IDSs or ACOs or confirm Applicant will submit the documents as they become available:

(File titled Provider 1a): Applicant's IDS or ACO business model including measures used to track progress and success of IDS or ACO providers and the payment model for the IDS or ACO.	<i>Single, Pull-down list.</i> 1: Attached, 2: Not attached
(File titled Provider 1b): Example of Applicant report to its IDS or ACO providers on its quality of care and financial performance, including benchmarking relative to performance improvement goals or market norms.	<i>Single, Pull-down list.</i> 1: Attached, 2: Not attached
(File titled Provider 1c): Confirm Applicant will submit a copy of Applicant's 2020 IHA Align Measure Perform (AMP) Commercial ACO report when it becomes available, if Applicant participates in the program.	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not confirmed, 3: N/A

19.5.4.3 Complete QHP Attachment M4 – QIS 4 Work Plan – IDS and ACO to describe updates on progress made since the previous QIS submission on each component of the IDS or ACO goals, and planned activities. Applicant may submit any supporting documentation as an attachment. Address each of the following in the narrative:

- Progress in 2020 toward the end goal including activities conducted, data collected and analyzed, and results
- Further implementation plans for 2021 with milestones and targets for 2021 and 2022 identified
- How Applicant expects to evolve its model, based on progress or outcomes to date
- How Applicant is providing support for integration and coordination of care through coaching, funding, implementation of information systems, technical assistance, or other means where no provider organization is accepting accountability
- Other activities conducted since the previous QIS submission to promote IDSs or ACOs, or activities that will be conducted
- Known or anticipated barriers in implementation of QIS and progress of mitigation activities

Attached document(s): [QHP Attachment M4 – QIS 4 Work Plan – IDS and ACO.pdf](#)

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Single, Radio group.

1: Attached,

2: Not attached

19.5.5 QIS for Appropriate Use of Cesarean Sections

QIS Goal: Applicant will: 1) Progressively adopt physician and hospital payment strategies so that revenue for labor and delivery only supports medically necessary care and no financial incentive exists to perform a low-risk Nulliparous Term Singleton Vertex (NTSV) Cesarean Section (C-Section). 2) Promote improvement work through the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center (MDC), so that all maternity hospitals achieve an NTSV C-Section rate of 23.9% or lower or are at least working toward that goal. 3) Include NTSV C-Section rate into contracting criteria so that all hospitals either meet the 23.9% goal, or if not, the plan has rationale for continued inclusion. 4) Adopt a payment methodology structured to support only medically necessary care with no financial incentive to perform C-sections for all contracted physicians and hospitals serving Enrollees by year end 2022. Smart Care California has outlined three payment strategies to align payment with medically necessary use of C-sections:

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

19.5.5.1 Report number of all network hospitals reporting to the CMQCC's MDC in Attachment E QIS Run Charts. A list of all California hospitals participating in the MDC can be found here:

<https://www.cmqcc.org/about-cmqcc/member-hospitals>. Enter the percentage reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, and 2021 as well.

Single, Pull-down list.

1: Attached,

2: Not attached

Attached Document(s): [QHP Attachment E - QIS Run Charts.pdf](#)

19.5.5.2 Provide a description of all current payment models for maternity services across all lines of business, and specifically address whether payment differs based on vaginal or C-Section delivery. Report models and number of network hospitals paid using each payment strategy in 2020 in Attachment E QIS Run Charts. Enter the percentages reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, and 2021 as well.

References: [http://www.ihc.org/sites/default/files/files/page/c-section menu of payment and contracting options.pdf](http://www.ihc.org/sites/default/files/files/page/c-section%20menu%20of%20payment%20and%20contracting%20options.pdf).

Single, Pull-down list.

1: Attached,

2: Not attached

Attached Document(s): [QHP Attachment E - QIS Run Charts.pdf](#)

19.5.5.3 Complete QHP Attachment M5 - QIS 5 Work Plan - Appropriate Use of C-Sections to describe updates on progress made since the last QIS submission with regards to promoting appropriate use of Cesarean-

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Sections (C-Sections). Applicant may submit any supporting documentation as an attachment. Address each of the following in the narrative:

- Description of how Applicant engages with its network hospitals to reduce NTSV C-Section rates to 23.9% or less by year end 2022
- Description of its adjustments to payment strategy in alignment with Smart Care California guidelines so that no hospitals or physicians are incentivized to perform an NTSV C-Section by year end 2022
- Description of how NTSV C-section rates are included in network hospital and provider contracting criteria
- Description of how Applicant promotes and encourages all in-network hospitals that provide maternity services to use the resources provided by California Maternity Quality Care Collaborative (CMQCC) and enroll in the CMQCC Maternal Data Center (MDC)
- Updates to hospital participation in CMQCC and hospital engagement in maternity care quality improvement, particularly those with a NTSV rate higher than 23.9%
- List any known or anticipated barriers in implementing QIS activities and progress of mitigation activities

Attached document(s): [QHP Attachment M5 - QIS 5 Work Plan - Appropriate Use of C-Sections.pdf](#)

Single, Radio group.

- 1: Attached,
2: Not attached

19.5.5.4 Confirm that all network physicians are paid on a case rate for deliveries and that payment is the same for both vaginal and C-section delivery.

Single, Pull-down list.

- 1: Confirmed,
2: Not Confirmed

19.5.5.5 If Applicant answered no to 19.5.5.4, complete the table below.

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

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19.5.6 QIS for Hospital Patient Safety

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

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

19.5.6.1 Report, across all lines of business, the percentage of hospital reimbursement at risk for quality performance and the quality indicators used in 2020 in Attachment E QIS Run Charts. In the details section of the spreadsheet, describe the model used to put payment at risk, and note if more than one model is used. "Quality performance" includes any number or combination of indicators, including HAIs, readmissions, patient satisfaction, etc. In the same sheet, report quality indicators used to assess quality performance. Enter the percentages reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, and 2021 as well.

Single, Pull-down list.

- 1: Attached,
2: Not attached

Attached Document(s): [QHP Attachment E - QIS Run Charts.pdf](#)

19.5.6.2 Report the number of hospitals contracted under the model described in question 19.5.6.1 with reimbursement at risk for quality performance in 2020 in Attachment E QIS Run Charts. Enter the numbers reported in the Certification Applications for 2016, 2017, 2018, 2019, 2020, and 2021 as well.

Single, Pull-down list.

- 1: Attached,
2: Not attached

Attached Document(s): [QHP Attachment E - QIS Run Charts.pdf](#)

19.5.6.3 Complete QHP Attachment M6 - QIS 6 Work Plan - Hospital Patient Safety to describe progress promoting hospital safety since the last submission. Applicant may submit any supporting documentation as an attachment.

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

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

Address each of the following in the narrative:

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- How Applicant is engaging with its network hospitals to reduce the five specified HAIs and Sepsis Management measure
- How Applicant is leveraging the poor performing hospitals list provided by Cal Hospital Compare to collaborate with other QHP Issuers who contract with the same poor performing hospitals
- Progress in 2020 toward the end goal and any further implementation plans for 2020 with milestones and targets for 2021 and 2022 identified
- Updates to strategy for promoting HIIN participation among the non-participating network hospitals, especially those with a standardized infection ratio (SIR) above 1.0 for the five designated Hospital Acquired Infections (HAIs). Refer to Appendix S1 CAUTI Rates, Appendix S2 CLABSI Rates, Appendix S3 CDI Rates, Appendix S4 MRSA Rates, and Appendix S5 SSI Colon Rates
- Applicant's progress in adopting a progressive payment strategy to tie at least 2% of network hospital payments to value by year end 2022
- Collaborations with other QHP Issuers on approaching hospitals to suggest improvement program involvement or alignment on a payment strategy to tie hospital payment to quality

Attachment document(s): [QHP Attachment M6 - QIS 6 Work Plan - Hospital Patient Safety.pdf](#)

Single, Radio group.

1: Attached,

2: Not attached

19.5.7 QIS for Patient-Centered Information and Support

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

19.5.7.1 Fulfilling the QIS Requirement: Respond as applicable based on anticipated Covered California enrollment:

If Applicant has or anticipates having Covered California enrollment more than 100,000 members, describe plans to ensure, members will have online access to:

- 1) Provider specific cost shares for common inpatient, outpatient and ambulatory services, (either as a procedure or as an episode of care). (Waived for Applicants with only HMO products.)
- 2) Access to costs for prescription drugs and member specific real-time understanding of accumulations toward deductibles, maximum out of pockets.

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

- 1) Provider specific cost shares for common inpatient, outpatient and ambulatory services, (either as a procedure or as an episode of care). Information does not need to be provided online. (Waived for Applicants with only HMO products.)
- 2) Access to costs for prescription drugs and member specific real-time understanding of accumulations toward deductibles, maximum out of pockets.

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Single, Radio group.

1: Confirm.,

2: Not Confirmed, details: [100 words]

19.5.7.2 Describe any quality information currently included with cost information that enables enrollees to compare providers based on quality performance in selecting a primary care clinician or common elective specialty and hospital providers. If quality information is not included, describe feasibility for inclusion by 2022.
200 words.

19.5.7.3 If Applicant has cost tools available to members, report number and percent of unique enrollees for Covered California line of business who used the tool in 2020. Applicant must also describe how it tracks utilization and effectiveness of the cost tools.
200 words.

19.5.7.4 If Applicant has shared decision-making tools available to members, report number and percent of unique enrollees for Covered California line of business who used the tool in 2020. Applicant must also describe how it tracks utilization and effectiveness of the shared decision-making tools.
200 words

19.5.7.5 Based on the utilization reported in 19.5.7.3 and 19.5.7.4, what strategies does Applicant currently utilize or intend to implement to increase engagement with the tools?
200 words.