Qualified Health Plan Application

Plan Year 2018

Individual Marketplace

March 7, 2017

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1 Application Overview

1.1 Purpose

The California Health Benefit Exchange (Exchange) is accepting applications from eligible Health Insurance Issuers[1] (Applicants) to submit proposals to offer, market, and sell qualified health plans (QHPs) through the Exchange beginning in 2017, for coverage effective January 1, 2018. Based on the Covered California Qualified Health Plan Certification Application for Plan Year 2017, QHP issuers selected for the 2017 Plan Year executed multi-year contracts with the Exchange. As provided in the 2017 Application, application for certification for Plan Years 2018 and 2019 is limited to (1) those QHP issuers contracted for Plan Year 2017 that continue to meet certification standards and performance requirements, (2) Medi-Cal Managed Care Plans and (3) plans newly licensed and offered for sale in the individual market after May 2, 2016. QHP Issuers contracted for Plan Year 2017 will complete a simplified certification application since those issuers have a three year contract with the Exchange that imposes ongoing requirements that are similar to the requirements in the certification application and consideration of this contract performance is included in the evaluation process. The Exchange will exercise its statutory authority to selectively contract for health care coverage offered through the Exchange for plan year 2018. The Exchange reserves the right to select or reject any Applicant or to cancel this Application at any time.

1.2 Background

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

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

The Exchange is guided by the following values:

Consumer-Focused: At the center of the Exchange's efforts are the people it serves. The Exchange will offer a consumer-friendly experience that is accessible to all Californians, recognizing the diverse cultural, language, economic, educational and health status needs of those it serves.
Affordability: The Exchange will provide affordable health insurance while assuring quality and access.
Catalyst: The Exchange will be a catalyst for change in California's health care system, using its market role to stimulate new strategies for providing high-quality, affordable health care, promoting prevention and wellness, and reducing health disparities.
Integrity: The Exchange will earn the public's trust through its commitment to accountability, responsiveness, transparency, speed, agility, reliability, and cooperation.

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

Transparency: The Exchange will be fully transparent in its efforts and will make opportunities available to work with consumers, providers, health plans, employers, purchasers, government partners, and other stakeholders to solicit and incorporate feedback into decisions regarding product portfolio and contract requirements.
Results: The impact of the Exchange will be measured by its contributions to decrease the number of uninsured, have meaningful plan and product choice in all regions for consumers, improve access to quality healthcare, promote better health and health equity, and achieve stability in healthcare premiums for all Californians.

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

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

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

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

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

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

1.3 Application Evaluation and Selection

The evaluation of QHP Certification Applications will not be based on a single, strict formula; instead, the evaluation will consider the mix of health plans for each region of California that best meet the needs of consumers in that region and the Exchange's goals. The Exchange wants to provide an appropriate range of high quality health plans to participants at the best available price that is balanced with the need for consumer stability and long term affordability. In consideration of the mission and values of the Exchange, the Board of the Exchange articulated guidelines for the selection and oversight of Qualified Health Plans which are used when reviewing the QHP application proposals for 2018. These guidelines are:

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

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

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

While premium will be a key consideration, contracts will be awarded based on the determination of "best value" to the Exchange and its participants. The evaluation of Issuer QHP proposals will focus on quality and service components, including past history of performance, administrative capacity, reported quality and satisfaction metrics, quality improvement plans and commitment to serve the Exchange population. This commitment to serve the Exchange population is evidenced through general cooperation with the Exchange's operations and contractual requirements which include provider network adequacy, cultural and linguistic competency, programs addressing health equity and disparities in care, innovations in delivery system improvements and payment reform. The application responses, in conjunction with the approved filings, will be evaluated by Covered California and used as part of the selection criteria to offer issuers' products on the Exchange for the 2018 plan year.

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

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

Encourage Competition throughout the State

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

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

Performing effective outreach, enrollment and retention of the low income population that will be eligible for premium tax credits and cost sharing subsidies through the Exchange is central to the Exchange's mission. Responses that demonstrate an ongoing commitment to the low income population or demonstrate a capacity to serve the cultural, linguistic and health care needs of the low income and uninsured populations beyond the minimum requirements adopted by the Exchange will

[2] The 2018 Patient-Centered Benefit Designs will be finalized when the 2018 federal actuarial calculator is finalized.

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 in order to improve service delivery and integration.

Encourage Delivery System Improvement, Effective Prevention Programs and Payment Reform

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

Demonstrate Administrative Capability and Financial Solvency

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

Encourage Robust Customer Service

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

1.4 Availability

The Applicant must be available immediately upon contingent certification of its plans as QHPs to start working with the Exchange to establish all operational procedures necessary to integrate and interface with the Exchange information systems and to provide additional information necessary for the Exchange to market, enroll members, and provide health plan services effective January 1, 2018. Successful Applicants will also be required to adhere to certain provisions through their contracts with the Exchange, including meeting data interface requirements with the California Healthcare Enrollment, Eligibility, and Retention System (CalHEERS). Successful Applicants must execute the QHP Issuer contract before public announcement of contingent certification. The successful Applicants must be ready and able to accept enrollment as of October 1, 2017.

1.5 Application Process

The application process shall consist of the following steps:

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

1.6 Intention to Submit a Response

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

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

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

Application Contact: Taylor Priestley
Taylor.Priestley@covered.ca.gov
(916) 228-8397

1.7 Key Action Dates

Action	Date/Time
Release of Draft Application for Comment	December 2016
Letters of Intent due to the Exchange	February 15, 2017
Application Opens	March 3, 2017
Completed Applications Due (include 2018 Proposed Rates & Networks)	May 1, 2017
Negotiations between Applicants and Covered California	June 2017 July 10, 2017

Action	Date/Time
Quality and Quality Improvement Strategy Submissions due for Currently Contracted Applicants	
Final QHP Contingent Certification Decisions	July 2017
QHP Contract Execution	July 2017
Final QHP Certification	October 2017

1.8 Preparation of Application Response

Application responses are completed in an electronic proposal software program. Eligible applicants who complete the non-binding Letter of Intent will be provided login and password information to access this portal. Applicants will have access to a Question and Answer function within the portal and may submit questions related to the application through this mechanism.

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

2 Administration and Attestation

2.1 – 2.4 required for all Applicants, all questions required for new entrant Applicants

2.1 The Exchange intends to make this application available electronically. Applicant must complete the following:

	Response
Issuer Legal Name	*10 words.*
NAIC Company Code	*10 words.*
NAIC Group Code	*10 words.*
Regulator(s)	*10 words.*
Federal Employer ID	*10 words.*
HIOS/Issuer ID	*10 words.*
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 2017, 2: Newly licensed since May 2, 3: Medi-Cal Managed Care Plan
On behalf of the Applicant stated above, I hereby attest that I meet the requirements in this Application and certify that the information provided on this Application and in any attachments hereto are true, complete, and accurate. I understand that the Exchange may review the validity of my attestations and the information provided in response to this application and if an Applicant is selected to offer Qualified Health Plans, may decertify those Qualified Health Plans should any material information provided be found to be inaccurate. I confirm that I have the capacity to bind the issuer stated above to the terms of this Application.	
Date	*To the day.*
Signature	*10 words.*
Printed Name	*10 words.*

Title	*10 words.*

2.2 Provide entity name used in consumer-facing materials or communications.

10 words.

2.3 Applicant must include an organizational chart of key personnel who will be assigned to the Exchange, identifying the individual(s) who will have primary responsibility for servicing the Exchange account. The Key Personnel and representatives of the Account Management Team who will be assigned to the Exchange must be identified in the following areas:

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

Single, Pull-down list.

Answer and attachment required

1: Attached,

2: Not attached

2.4 Does Applicant anticipate making material changes in corporate structure in the next 24 months, including:

- 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

2.5 Indicate Applicant entity's tax status:

Single, Pull-down list.

1: Not-for-profit,

2: For-profit

2.6 In what year was Applicant's entity founded?

10 words.

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

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

3 Licensed and Good Standing

All questions required for all Applicants.

3.1 Indicate Applicant entity 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 of the proper and required licenses to operate as a health issuer as defined herein, the 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). Covered California, in its sole discretion and in consultation with the appropriate health insurance regulator, determines what constitutes a material violation for the purpose of determining Good Standing. Applicant must check the appropriate box. If Applicant does not confirm, the application will be disqualified from consideration.

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

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

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

4 Applicant Health Plan Proposal

All questions required for all Applicants

Applicant must submit a health plan proposal in accordance with submission requirements outlined in this section. Applicant's proposal must include at least one of the standard plan designs, and use the same provider network for each type of standard plan design in a set of standard plans or insurance policies for specified metal level actuarial values.

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

Tiered hospital, physician, and pharmacy networks are not permitted. Applicants must agree to adhere to the Exchange's standard benefit plan designs without deviation unless approved by the Exchange.

Plan or Policy Submission Requirements

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 2018 Standard Benefit Plan Designs and cannot vary by metal tier other than by cost sharing and premium. The same provider network must be available for each QHP in the standard set of QHPs. Applicant's proposal must include coverage of its entire licensed geographic service area.

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. Additionally, Applicant may submit proposals to offer additional QHPs for consideration. The additional QHP offerings proposed must be differentiated by product or network and must include all four metal tiers and a catastrophic plan in order to be considered by the Exchange.

The 2014 Payment Parameters rule preamble (78 Fed Reg at 15494) clarifies that an Exchange will be adequately enforcing the requirements of 45 CFR 156.420(b) if a QHP issuer limits the American Indian/Alaska Native (AI/AN) zero cost share plan variation to the lowest level QHP in a set of standard QHPs. (A set of standard QHPs refers to a collection of standard QHPs identical except for differences in cost sharing or premium.) Accordingly, the Exchange requires QHP issuers 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 the QHP issuer'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. The QHP issuer may not offer the zero cost share AI/AN variation at the higher metal levels within the set of QHPs. However, Issuers offering the additional QHPs, that do not include a Bronze plan, must offer the AI/AN zero cost share plan variation at the lowest cost in that additional set of QHPs. This requirement does not apply to the limited cost share AI/AN plan variation because the member cost sharing differs depending on the provider sought by the member. Limited cost share AI/AN plan variations must be offered for each QHP.

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

4.1 Applicant must certify that its proposal includes a health product offered at all four metal tiers (bronze, silver, gold and platinum) and catastrophic for each individual plan it proposes to offer in a rating region. If not, the Applicant's response will be disqualified.

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

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

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

4.3 Preliminary Premium Proposals.

Final negotiated and accepted premium proposals shall be in effect for coverage effective January 1, 2018. Premium proposals are considered preliminary and may be subject to negotiation as part of QHP certification and selection. The final negotiated premium amounts must align with the product rate filings that will be submitted to the applicable regulatory agency. Premium proposals are due with submission of Applicant's application response. To submit premium proposals for Individual products, QHP applicants 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.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Plan-Year-2018-Qualified-Health-Plan-Application-Materials.html. Premium may vary only by geography (rating region), by age band (within 3:1 range requirement), by coverage tier, and by actuarial value metal level.

Applicant shall provide, in connection with any negotiation process as reasonably requested by the Exchange, detailed documentation on the Exchange-specific rate development methodology. Applicant shall provide justification, documentation, and support used to determine rate changes, including adequately supported cost projections. Cost projections include factors impacting rate changes, assumptions, transactions and other information that affects the Exchange-specific rate development process. The Exchange may also request information pertaining to the key indicators driving the medical factors on trends in medical, pharmacy or other healthcare provider costs. This information may be necessary to support the assumptions made in forecasting and may be supported by information from the Applicant's actuarial systems pertaining to the Exchange-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 indicate which zip codes are within the licensed geographic service area by proposed Exchange product, complete and upload through SERFF the Service Area Template located at

https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Plan-Year-2018-Qualified-Health-Plan-Application-Materials.html.

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 Applicants must indicate if requesting changes to licensed geographic service area with applicable 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

5 Benefit Design

All questions required for all Applicants

5.1 QHP Applicant must comply with 2018 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.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Plan-Year-2018-Qualified-Health-Plan-Application-Materials.html.

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

5.2 Are there operational or administrative barriers to implementing the 2018 Patient-Centered Benefit Plan designs?

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

5.3 Applicant must indicate if seeking approval for deviations from the 2018 Patient-Centered Benefit Plan Designs. If yes, Applicant must submit Attachment B Patient-Centered Benefit Design Deviations to describe the proposed deviations and the rationale for the deviation. Alternate benefit design proposals are not permitted in the Individual Marketplace.

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

5.4 The Exchange is encouraging the offering of plan products which include all ten Essential Health Benefits, including the pediatric dental Essential Health Benefit. Applicant must indicate if it will adhere to the 2018 standard 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 2018 include all ten Essential Health Benefits.,
2: No. Individual Market QHPs proposed for 2018 do not include all ten Essential Health Benefits.

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

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

5.6 Applicant must indicate if proposed QHPs will include coverage of non-emergent out-of-network services.

Single, Radio group.
1: Yes, 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 the administration of out-of-network benefits including consumer communication, pricing methodology, and claims adjudication: [100 words],
2: No, proposed QHPs will not include coverage of non-emergent out-of-network services

5.7 Complete the following table to report availability of telehealth services to the Exchange enrollees and applicable cost-sharing. Indicate "Not Offered" if telehealth is not offered.

Telehealth Visit or Service Type	Modality	Specify Applicable Cost-Share(s)/Comments
Primary Care Visit	*Multi, Checkboxes.* 1: Phone, 2: Video, 3: Instant Message/Live Chat, 4: Email, 5: Other, describe in comments, 6: Not Offered	*50 words.*
Specialist Visit	*Multi, Checkboxes.* 1: Phone, 2: Video, 3: Instant Message/Live Chat, 4: Email, 5: Other, describe in comments, 6: Not Offered	*50 words.*
Mental/Behavioral Health Visit	*Multi, Checkboxes.* 1: Phone, 2: Video, 3: Instant Message/Live Chat, 4: Email, 5: Other, describe in comments, 6: Not Offered	*50 words.*
Substance Abuse Treatment Visit	*Multi, Checkboxes.* 1: Phone, 2: Video, 3: Instant Message/Live Chat, 4: Email, 5: Other, describe in comments, 6: Not Offered	*50 words.*
Other, describe: [20 words]	*Multi, Checkboxes.* 1: Phone, 2: Video, 3: Instant Message/Live Chat, 4: Email, 5: Other, describe in comments, 6: Not Offered	*50 words.*

5.8 Applicant must submit, as an attachment, draft Evidence of Coverage or Policy language and draft Schedules of Benefits describing proposed 2018 QHP benefits. This draft language must be submitted with the response to this application, prior to or contemporaneous to filing with the applicable regulator.

Single, Pull-down list.
1: Confirmed, attachment(s) submitted,
2: Not confirmed, attachment(s) not submitted

5.9 The Exchange's Patient-Centered Benefit Plan Designs stipulate 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.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Plan-Year-2018-Qualified-Health-Plan-Application-Materials.html.

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

5.10 Describe how Applicant's proposed 2018 formulary will comply with California Health and Safety Code § 1342.71 and Insurance Code § 10123.193 requirements prohibiting discrimination in prescription drug benefits.

200 words.

6 Operational Capacity

6.1 Issuer Operations and Account Management Support

6.1.1-6.1.3 required for all Applicants, all questions required for new entrant Applicants

6.1.1 Complete Attachments C1 Current and Projected Enrollment and C2 California Off-Exchange Enrollment to provide current enrollment and enrollment projections.

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

6.1.2 Provide a description of any initiatives, including a timeline, either current or planned, over the next 24 months which may impact the delivery of services to Exchange members during the contract period. Examples include:

- System changes or migrations
- Call center opening, closing or relocation
- Network re-contracting
- Other

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

6.1.4 Are any of Applicant's operations, such as member services call centers, conducted outside of the United States? If yes, describe: the operations.

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

6.1.5 Provide a summary of Applicant’s capabilities, including how long Applicant has been in the business as an issuer.

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

6.2 Implementation Performance

6.2.3 and 6.2.4 required for currently contracted Applicants, 6.2.1-6.2.2 and 6.2.4-6.2.5 required for new entrant Applicants

6.2.1 Will an implementation manager and support team (not part of the regular Account Management Team) be assigned to lead and coordinate the implementation activities with the Exchange? If yes, specify the name and title of the individual(s) including the implementation manager and support team. If no, please explain why and how Applicant will manage implementation.

Single, Radio group.
1: Yes, describe: [50 words],
2: No,
3: No, Applicant is currently operating in the Exchange

6.2.2 Applicant must submit a detailed implementation project plan and schedule targeting a January 1, 2018 effective date, including adequate description of how Applicant will ensure Open Enrollment readiness.

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

6.2.3 Applicant must submit a Renewal and Open Enrollment Readiness Plan.

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

6.2.4 Applicant must describe current or planned procedures for managing new enrollees. Please address continuity of care, availability of customer service line prior to coverage effective date, and describe what member communications regarding change in plans are provided to new enrollees.

100 words.

6.2.5 Explain how Applicant anticipates accommodating additional membership effective January 1, 2018. Completion of this question is required and is unrelated to enrollment projections submitted with this application. Identify the percentage increase in membership which will trigger increases to current resources and describe resource adjustment(s) to accommodate additional membership:

Resource	Membership Increase (as % of Current Membership)	Resource Adjustment (specify)	Approach to Monitoring
Members Services	*Percent.*	*50 words.*	*50 words.*
Claims	*Percent.*	*50 words.*	*50 words.*
Account Management	*Percent.*	*50 words.*	*50 words.*

Clinical staff	*Percent.*	*50 words.*	*50 words.*
Disease Management staff	*Percent.*	*50 words.*	*50 words.*
Implementation	*Percent.*	*50 words.*	*50 words.*
Financial	*Percent.*	*50 words.*	*50 words.*
Administrative	*Percent.*	*50 words.*	*50 words.*
Actuarial	*Percent.*	*50 words.*	*50 words.*
Information Technology	*Percent.*	*50 words.*	*50 words.*
Other (List)	*Percent.*	*50 words.*	*50 words.*

7 Customer Service

7.1 – 7.14 required for new entrant Applicants. 7.15 required for currently contracted 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 contractual member services performance standards. During Open Enrollment, Exchange operating hours are 8 am to 8 pm Monday through Friday (except holidays) and 8 am to 6 pm Saturdays. Applicant must confirm it will match Exchange Open Enrollment Customer Service operating hours. Describe how Applicant will modify customer service center operations to meet Exchange-required operating hours if applicable. Describe how Applicant will modify current Interactive Voice Response (IVR) system to meet exchange required operating hours.

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

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

100 words.

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

10 words.

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

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

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

Multi, Checkboxes.
1: Case-Study,
2: Roleplaying,
3: Shadowing,
4: Observation,
5: Pre-tests,
6: Post-tests,

7: Training Evaluations,
8: Other, describe: [50 words]

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

50 words.

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

50 words.

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

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

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

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

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

100 words.

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

Multi, Checkboxes.
1: Customer Satisfaction Surveys,
2: Monitoring Social Media,
3: Monitoring Call Drivers,

4: Common Problems Tracking,
5: Observation of Representative Calls,
6: Other, describe: [50 words]

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

7.14 How many calls per Representative, per week are scored?
20 words.

7.15 Applicant must confirm if previous Customer Service responses require updates.
Single, radio group.
Attachment allowed.
1: Confirmed, no update required.
2: Confirmed, updated responses attached.

8 Financial Requirements

8.1 – 8.7 required for new entrant Applicants. 8.8 required for currently contracted Applicants.

8.1 Applicant must confirm it has in place systems to invoice members effective October 1, 2017.

Single, Pull-down list.
1: Yes, confirmed system is currently in place, no changes anticipated,
2: Yes, confirmed system will be in place by required date,
3: No, not confirmed

8.2 Describe systems 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 workplan.

200 words.

8.3 Applicant must confirm it has in place systems to accept payment from members effective October 1, 2017 the following premium payment types:

Multi, Checkboxes.
1: Paper checks,
2: Cashier's checks,
3: Money orders,
4: Electronic Funds Transfer (EFT),
5: Credit cards and debit cards,
6: Web-based payment, which may include accepting online credit card payments, and all general purpose pre-paid debit cards and credit card payment

8.4 If such systems are not currently in place, describe plans to implement such systems, including the use of vendors for any functions related to premium payment, if applicable, and an implementation workplan. QHP issuer must be able to accept premium payment from members no later than October 1, 2017. Note: QHP issuer must accept credit cards for binder payments and is encouraged, but not required, to accept credit cards for payment of ongoing invoices.

200 words.

8.5 Describe how Applicant will comply 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.

200 words.

8.6 Applicant must confirm it can provide detailed documentation, as defined by the Exchange, including member level detail to substantiate each participation fee payment. This documentation is specified in Appendix B Issuer Participation Fee Billing Discrepancy Resolution and Appendix C PMPM_Member_Level_Detail_Response SAMPLE.

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

8.7 Applicant agrees not to impose any fees or charges on any members who request paper invoices for premiums due for any individual products sold by Applicant in California.

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

8.8 Applicant must confirm if previous Financial Requirements responses require updates.

Single, radio group.
Attachment allowed.
1: Confirmed, no update required.
2: Confirmed, updated responses attached.

9 Fraud, Waste and Abuse Detection

9.2.4, 9.2.5, 9.2.8, 9.3.5, 9.3.6, 9.4.4, 9.4.5, 9.4.6 and 9.4.14 required for currently contracted Applicants. All questions required for new entrant Applicants.

The Exchange is committed to working with contracted QHP issuers to establish efforts 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. The Exchange expects QHP issuers to adopt leading practices outlined in the framework to the extent applicable. Fraud prevention is centered on integrity and expected behaviors from employees and others. All issuer measures to detect, deter, and prevent fraud before it occurs are vital to all issuer and Exchange operations.

Definitions:

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

Waste - Intentional or unintentional, extravagant careless or needless expenditures, consumption, mismanagement, use, or squandering of resources, to the detriment or potential detriment of entities, but without an intent to deceive or misrepresent. Waste includes incurring unnecessary costs as a result 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 so as 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.

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

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

9.1 Prevention

9.1.1 Describe the roles and responsibilities of those tasked with carrying out dedicated antifraud and fraud risk management activities.

200 words.

9.1.2 Describe specific anti-fraud strategies and the data analytical tools, methods, and sources used to gather information about fraud risks.

200 words.

9.1.3 Describe how Applicant safeguards against Social Security number and identity theft within its organization and the policy for verifying identity prior to receiving services at the provider level.

200 words.

9.1.4 What steps are taken after identification of social security and potential identity theft? Include services offered to impacted members.

200 words.

9.2 Detection

Describe the following specific control activities to prevent and detect fraud.
9.2.1 Data-analytics activities: Describe and distinguish between member and provider activities (For example: data matching, data mining). Specifically address unusual patterns of care.

200 words.

9.2.2 Fraud-awareness programs: Describe and distinguish between member and provider programs to identify and report possible fraud scams.

200 words.

9.2.3 Internal and External Reporting mechanisms for the reporting of potential fraudulent activities: Describe and distinguish between member and provider reports.

200 words.

9.2.4 Employee-integrity activities (For example: fraud awareness training, code of conduct, conflict of interest policy).

200 words.

9.2.5 Special Enrollment Period (SEP) membership. Describe specific activities to prevent and detect fraud related to SEP.

200 words.

9.2.6 Describe the plan to respond to identified instances of fraud and ensure the response is prompt and consistently applied. Describe and distinguish between member and provider activities.

200 words.

9.2.7 Describe the controls in place to evaluate that enrollment and disenrollment actions (i.e., membership files) are accurately and promptly executed. Specifically address any queries to identify membership red flags.

200 words.

9.2.8 Describe Utilization Management (UM) activities or program efforts in place that validate appropriate medical services and treatments to ensure health care service provided for member care is efficient and cost effective.

200 words.

9.3 Response

9.3.1 Describe the evaluation method for determining whether fraud, waste and abuse has occurred.

200 words.

9.3.2 Describe the processes for fraud, waste and abuse investigation follow-up and corrective measures. Address how and when the results of monitoring, evaluation and adverse actions will be or are communicated to Covered California.

200 words.

9.3.3 Describe how the results of investigations and adverse actions are used to enhance fraud prevention and detection.

200 words.

9.3.4 Describe Applicant's revenue recovery process to recoup erroneously paid claims from members and providers.

200 words.

9.3.5 Refer to definition of fraud in the introduction to this section. What was Applicant's recovery success rate and dollars recovered for fraudulent activities?

	Total Loss from Fraud Covered California, if applicable	**Total Loss from Fraud** Total Book of Business	**% of Loss Recovered** Covered California, if applicable	**% of Loss Recovered** Total Book of Business	**Total Dollars Recovered** Covered California, if applicable	**Total Dollars Recovered** Total Book of Business
Calendar Year 2014	*Dollars.*	*Dollars.*	*Percent.*	*Percent.*	*Dollars.*	*Dollars.*

Calendar Year 2015	*Dollars.*	*Dollars.*	*Percent.*	*Percent.*	*Dollars.*	*Dollars.*
Calendar Year 2016	*Dollars.*	*Dollars.*	*Percent.*	*Percent.*	*Dollars.*	*Dollars.*

9.3.6 If applicable, please explain any trends attributing to the total loss from fraud for Exchange business.
200 words.

9.3.7 Describe Applicant's procedures to report potential fraud to law enforcement and the Exchange.
200 words.

9.4 Audits and Reviews

9.4.1 Refer to 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	*Single, Pull-down list.* 1: Daily, 2: Weekly, 3: Monthly, 4: Quarterly, 5: Other:	*10 words.*
Customer Service Reviews	*Single, Pull-down list.* 1: Daily, 2: Weekly, 3: Monthly, 4: Quarterly, 5: Other:	*10 words.*
Eligibility and Enrollment Reviews	*Single, Pull-down list.* 1: Daily, 2: Weekly, 3: Monthly, 4: Quarterly, 5: Other:	*10 words.*
Utilization Management Reviews	*Single, Pull-down list.* 1: Daily, 2: Weekly, 3: Monthly, 4: Quarterly, 5: Other:	*10 words.*
Billing Reviews	*Single, Pull-down list.* 1: Daily, 2: Weekly, 3: Monthly,	*10 words.*

	4: Quarterly, 5: Other:	

9.4.2 Refer to definition of audit in the introduction to this section. Indicate how frequently internal auditing is performed for the following areas:

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

9.4.3 For the prior fiscal year, what percent of claims were audited?

Percent.

9.4.4 Does Applicant maintain an independent, internal audit function? If yes, provide a brief description of Applicant's internal audit function and its reporting structure.

Multi, Checkboxes.
1: Yes, describe: [200 words],
2: No.

9.4.5 If Applicant answered yes to 9.4.4, provide a copy of the organization's internal audit function's annual audit plan applicable to claims administration, eligibility and enrollment, billing, and network providers.

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

9.4.6 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)?

100 words.

9.4.7 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.

9.4.8 Indicate if external audits were conducted for claims administration for Applicant's entire book of business for the last two (2) full calendar years.

	Response
2016	*Single, Pull-down list.* 1: Audit Conducted, 2: Audit Not Conducted
2015	*Single, Pull-down list.* 1: Audit Conducted, 2: Audit Not Conducted

9.4.9 Describe Applicant's approach to defining the expected threshold reasonable and customary amount for a procedure and geographic area for use when reviewing claims submitted by non-contracted providers, and steps taken when claims received exceed this threshold.

200 words.

9.4.10 Describe Applicant's approach to use of the National Practitioner Data Bank as part of the credentialing and re-credentialing process for contracted providers.

200 words.

9.4.11 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.

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

Multi, Checkboxes.
1: Hospitals,
2: Physicians,
3: Skilled nursing,
4: Chiropractic,

5: Podiatry,
6: Behavioral Health,
7: Substance Use Disorder treatment facilities,
8: Alternative medical care,
9: Durable medical equipment Providers,
10: Other service Providers

9.4.13 Describe the different approaches Applicant takes to monitor these types of providers. Provide an explanation why any provider types not indicated by Applicant in 9.4.12 are not typically reviewed for possible fraudulent activity.

200 words.

9.4.14 Describe in detail Applicant's process to validate provider information during initial contracting and when a change is reported (including demographic, address, network or panel status).

200 words.

9.4.15 Applicant must confirm that, if certified, it will agree to subject itself to the Exchange for audits and reviews, either by the Exchange or its designee, or the California Department of General Services, the California State Auditor or its designee, as they deem necessary to determine the correctness of premium rate setting, the Exchange's payments to agents based on the Issuer's report, questions pertaining to enrollee premium payments and Advance Premium Tax Credit (APTC) payments and participation fee payments Issuer made to the Exchange. Applicant also agrees to all audits subject to applicable State and Federal law 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 required for all Applicants

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

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

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

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

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

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

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

11 Electronic Data Interface

11.2-11.6 required for all Applicants, all questions required for new entrant Applicants

11.1 Applicant must provide an overview of its system, data model, vendors, and interface partners.

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

11.2 Applicant must submit a copy of its system lifecycle and release schedule.

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

11.3 Applicant must be prepared and able to engage with the Exchange to develop data interfaces between the Issuer's systems and the Exchange's systems, including the eligibility and enrollment system used by the Exchange, as early as May 2017. Applicant must confirm it will implement system(s) in order 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 v16.9.40 for detailed 834 transaction specifications.
- Note: The Exchange requires QHP issuers to sign an industry-standard agreement which establishes electronic information exchange standards in order to participate in the required systems testing.

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

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.

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

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

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

11.6 Applicant must be prepared and able to conduct testing of data interfaces with the Exchange no later than June 1, 2017 and confirms it will plan and implement testing jointly with the Exchange in order to meet system release schedules. Applicant must confirm testing with the Exchange will be under industry security standard: 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 on a monthly basis for the purpose of reconciliation. Standard file requirements and timelines are documented in Appendix D Reconciliation Process Guide. Applicant must provide description of its ability to make system updates to reconcilable enrollment fields on a timely basis and provide verification of completion.

200 words.

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

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

12 Healthcare Evidence Initiative

In order to fulfill its mission to ensure that consumers have available the plans that offer the optimal combination of choice, value, quality, and service, the Exchange relies on evidence about the enrollee experience with health care. QHP data submission requirements are an essential component of assessing the quality and value of the coverage and health care received by Exchange enrollees. The capabilities described in this section are requirements of QHP data submission obligations.

12.1 required for all Applicants, 12.2 – 12.10 required for new entrant Applicants

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

Applicant must confirm that, if contracted as a QHP issuer, to the extent that any Participating Provider's rates are prohibited from disclosure to the Exchange by contract, Applicant shall identify such Participating Provider. Applicant shall, upon renewal of its Provider contract, but in no event later than July 1, 2018, make commercially reasonable efforts to obtain agreement by that Participating Provider to amend such provisions, to allow disclosure. In entering into a new contract with a Participating Provider, Applicant agrees to make commercially reasonable efforts to exclude any contract provisions that would prohibit disclosure of such information to the Exchange. (For example: enrollment, medical and prescription claims, and capitation data required by the Exchange's HEI Vendor: allowed amounts, charge and charge submitted amounts, coinsurance, copayment, and deductible amounts, paid and net payment amounts, patient total out-of-pocket amounts, capitation amounts, etc.).

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

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

12.2 Will Applicant provide the Exchange's HEI Vendor with monthly extracts of all requested detail from applicable fee-for-service (FFS) claims or encounter records for the following claim types? If not, or if yes with deviation, explain. If unable or unwilling to provide all requested detail, elaborate on problematic claim types, estimating the number and percentage of affected claims and encounters.

Claim Type	Response	If No or Yes with deviation, explain.
Professional	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.* Nothing required
Institutional	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.* Nothing required

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

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

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

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

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

Detail to be Provided	Response	If No or Yes with deviation, explain.
Covered CA Member ID	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.* Nothing required
Covered CA Subscriber ID	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.* Nothing required

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

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

	1: Yes, 2: No	
Starting Date of Service	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.* Nothing required
Ending Date of Service	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.* Nothing required

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

Provider IDs to be Supplied	Response	If No or Yes with deviation, explain.
TIN	*Single, Pull-down list.* 1: Yes, 2: Yes, unless values represent individual provider Social Security Numbers, 3: No	*50 words.* Nothing required
NPI	*Single, Pull-down list.* 1: Yes, 2: Yes, unless values represent individual provider Social Security Numbers, 3: No	*50 words.* Nothing required
NCPDP	*Single, Pull-down list.* 1: Yes, 2: Yes, unless values represent individual provider Social Security Numbers, 3: No	*50 words.* Nothing required

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

Coding to be Provided	Response	If No or Yes with deviation, explain.
Diagnosis Coding	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.* Nothing required
Procedure Coding (CPT, HCPCS)	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.* Nothing required

Revenue Codes (Facility Only)	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.* Nothing required
Place of Service	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.* Nothing required
NDC Code (Drug Only)	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.* Nothing required

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

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

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

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

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

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

13 Privacy and Security Requirements for Personally Identifiable Data

All questions required 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 consumers with the opportunity to access, inspect and obtain a copy of any 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 consumers 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 consumers 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 consumers with an accounting of any disclosures made by Applicant of the consumer's PHI upon the consumer's request [45 CFR §164.528].

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

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

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

13.1.6 Minimum Necessary Disclosure & Use: Unless otherwise exempted by the HIPAA Privacy Rule, Applicant must confirm that Applicant 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 Applicant currently maintains a HIPAA-compliant Notice of Privacy Practices to ensure that consumers are aware of their privacy-related rights and Applicant's privacy-related obligations related to the consumer's PHI [45 CFR §§164.520(a)&(b)].

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

13.2 Safeguards

All questions required for all Applicants

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

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

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

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

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

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

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

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

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

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

14 Sales Channels

All questions required for all Applicants, as applicable

14.1 Does Applicant have experience working with Insurance Agents?

Single, Radio group.
1: Yes. If yes, 14.2 through 14.4 required,
2: No. If no, 14.4 and 14.5 required

14.2 Review Appendix E Covered California Individual Market Agent of Record (AOR) policy. Describe Applicant's AOR policy and procedures. The policy and procedures must include the following components:

- Appointing Agents, including requirements a broker must meet to be appointed, appointment process, and timeline for appointment to be complete.
- Agent of Record (AOR) Changes, including incoming broker commission schedule. Include requirements for an AOR change to be processed, how applicable commissions are determined for the Agent taking over the case, rules regarding when the AOR change is effective, policy - if any - on retroactive AOR changes, and AOR processing timelines. Additionally, describe procedures used to manage changes when the Agent of Record files are received on an 834 or other electronic file.
- Vested Agents, if applicable, including definition of vesting, to whom vesting applies, duration of vesting, how vesting is affected by AOR changes, vesting rules when a case leaves and then returns for coverage.

500 words.

14.3 Applicant must provide its commission schedule for individual in California. Note: successful Applicants will be required to use a standardized Agent compensation program with levels and terms that result in the same aggregate compensation amounts to Agents, whether products are sold within or outside of the Exchange. Successful Applicants may not vary Agent compensation levels by metal tier, and must pay the same commission during Open and Special Enrollment for each plan year.

Individual Market - Commission Rate	**On-Exchange Business**	**Direct Business**
Provide Commission Rate or Schedule	*10 words.*	*10 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 enforce business.	*50 words.*	*50 words.*
Does the compensation level apply to all plans or does it vary by tier?	*Not Applicable*	*50 words.*
Does the compensation level vary by product?	*50 words.*	*50 words.*

Describe any business for which Applicant will not compensate Agents.	*50 words.*	*50 words.*
Describe any business for which Applicant will not make changes to Agent of Record.	*Not applicable*	*50 words.*
Additional Comments	*50 words.*	*50 words.*

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

- Name
- Phone Number
- Email Address

50 words.

14.5 The Exchange recommends that Applicants develop relationships with the agent community. It has been shown that Applicants with relationships to the agent community achieve greater success in the Exchange. If Applicant does not currently work with Insurance Agents, describe Applicant's approach to develop an agent program. Include plan to develop agent appointment process. Plan should include the following components:

- Appointing Agents, including requirements a broker must meet to be appointed, appointment process, and timeline for appointment to be complete.
- Agent of Record (AOR) Changes, including requirements for an AOR change to be processed, how applicable commissions are determined for the Agent taking over the case, rules regarding when the AOR change is effective, policy - if any - on retroactive AOR changes, and AOR processing timelines. Additionally, please describe procedures used to manage changes when the Agent of Record files are received on an 834 or other electronic file.
- Vested Agents, including definition of vesting, who vesting applies to, duration of vesting, how vesting is affected by AOR changes, vesting rules when a case leaves and then returns for coverage.
- Applicant must provide a primary point of contact for development of broker or agent program and include the following contact information:
    - Name
    - Phone Number
    - Email Address

500 words.

15 Marketing and Outreach Activities

15.1 The Exchange expects all successful Applicants to promote enrollment in their QHPs, including investment of resources and coordination of staff with the Exchange's Marketing Department, which includes social media and member communications efforts. Applicant must provide an organizational chart of its marketing department(s), including names and titles of the main contacts with the following primary responsibility related to the Exchange account:

- Marketing (designate who will submit cobranded documents to the Exchange)
- Social Media Efforts
- Member Retention/Member Communication Efforts

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

15.2 Applicant must confirm that, upon contingent certification of its QHPs, it will cooperate with the Exchange Marketing Department, and adhere to the Appendix G Covered California Brand Style Guide (and Marketing Guidelines, if applicable) when co-branded materials are issued to Exchange enrollees. If Applicant is certified, co-branded items must be submitted using the Member Communications Calendar prior to use and in a timely manner; ID cards are to be submitted to the Exchange at least 30 days prior to Open Enrollment. The Exchange retains the right to communicate directly with Exchange consumers and members.

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

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

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

15.4 Applicant must complete and submit Attachment D1 Member Communication Calendar, including proposed Exchange member communications. Documents and materials may be draft placeholders. Upon contingent certification, when co-branding materials are issued to Exchange enrollees, or Star Ratings are used, the Member Communication Calendar and accompanying documents must be submitted to the Exchange prior to use and in a timely manner.

Single, Pull-down list.
1: Confirmed, attachment complete,
2: Attachment not completed

15.5 Applicant must submit the following documents for the Individual Market line of business:

(1) Proposed Marketing Plan

Proposed marketing plan must include the following components:

- Regions to be supported with marketing efforts,
- Proposed marketing investment,
- Enrollment goals,
- Strategy and tactics,
- Target audience parameters (age range, household income, ethnicity, gender, marital status),
- Timing,
- Proportion of marketing expenditure for on-Exchange QHPs in relation to off-Exchange plan marketing expenditure.

(2)Attachment D2 Media Plan Flowchart

(3)Attachment D3 Estimated Media Spend by Designated Market Area (DMA) *Single, Pull-down list.*

1: Attached,

2: Not attached

16 Provider Network

16.1 Network Offerings

All questions required for all Applicants.

16.1.1 Please indicate the different network products Applicant intends to offer on the Exchange in the individual market for coverage year 2018. 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	*Single, Pull-down list.* 1: Yes, 2: No	*Single, Pull-down list.* 1: New Network, 2: New to Exchange, 3: Existing Exchange	*10 words.*
PPO	*Single, Pull-down list.* 1: Yes, 2: No	*Single, Pull-down list.* 1: New Network, 2: New to Exchange, 3: Existing Exchange	*10 words.*
EPO	*Single, Pull-down list.* 1: Yes, 2: No	*Single, Pull-down list.* 1: New Network, 2: New to Exchange, 3: Existing Exchange	*10 words.*
Other	*Single, Pull-down list.* 1: Yes, 2: No	*Single, Pull-down list.* 1: New Network, 2: New to Exchange, 3: Existing Exchange	*10 words.*

16.1.2 Provider network data must be included in this submission for all geographic locations to which Applicant is applying for certification as a QHP. Submit provider data according to the data file layout in Appendix I Covered California Provider Data Submission Guide. The provider network submission for 2018 must be consistent with what will be filed to the appropriate regulator for approval if Applicant is selected as a QHP Issuer. The Exchange requires the information, as requested, to allow cross-network comparisons and evaluations.

Single, Pull-down list.
Attachment required
1: Attached (confirming provider data is for plan year 2018),
2: Not attached

16.1.3 Applicant must also complete and upload through SERFF the Network ID Template located at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Plan-Year-2018-Qualified-Health-Plan-Application-Materials.html.

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

16.2 HMO

16.2.1.6 required for existing networks, all questions required for newly proposed networks

16.2.1 Network Strategy

16.2.1.1 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

16.2.1.2 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.*

16.2.1.3 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, please describe plans to ensure Applicant's ability to control network and meet Exchange requirements: [500 words]

16.2.1.4 By rating region covered, please provide the percentages of providers in capitated vs non-capitated arrangements:

	Direct Contract	Capitated	Other (explain in comments)	Comments
Region 1	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 2	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 3	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 4	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 5	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 6	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 7	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 8	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 9	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 10	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 11	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 12	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 13	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 14	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 15	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 16	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 17	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 18	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 19	*Percent.*	*Percent.*	*Percent.*	*100 words.*

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

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

200 words.

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

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

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

500 words.

16.2.2 Volume - Outcome Relationship

All questions required for all 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 please provide specific details for each category:

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

500 words.

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

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

16.2.2.4 If yes to 16.2.2.3, please provide the following details:

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

200 words.

16.2.3 Network Stability

All questions required for all networks

16.2.3.1 Total Number of Contracted Hospitals:

Integer.

16.2.3.2 Identify network hospitals terminated between January 1, 2016 and December 31, 2016, including any hospitals that had a break in maintaining a continuous contract during this period. Indicate reason for hospital termination: non-agreement on rates, non-compliance with contract provisions, re-design of network, other (explain). Applicants with no prior California presence should use out of state experience.

Name of Terminated Hospital	Terminated by:	Reason	Reinstated
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words.*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words.*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words.*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words.*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words.*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words.*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words.*

10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words.*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words.*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words.*

16.2.3.3 Identify the number of participating providers who have terminated from the provider network between January 1, 2016 and December 31, 2016, by rating region. Indicate reason for termination: non-agreement on rates, non-compliance with contract provisions, re-design of network or, other (explain).

	Terminated by Issuer	Terminated by Provider	Reason
Region 1	*Integer.*	*Integer.*	*20 words.*
Region 2	*Integer.*	*Integer.*	*20 words.*
Region 3	*Integer.*	*Integer.*	*20 words.*
Region 4	*Integer.*	*Integer.*	*20 words.*
Region 5	*Integer.*	*Integer.*	*20 words.*
Region 6	*Integer.*	*Integer.*	*20 words.*
Region 7	*Integer.*	*Integer.*	*20 words.*
Region 8	*Integer.*	*Integer.*	*20 words.*
Region 9	*Integer.*	*Integer.*	*20 words.*
Region 10	*Integer.*	*Integer.*	*20 words.*
Region 11	*Integer.*	*Integer.*	*20 words.*
Region 12	*Integer.*	*Integer.*	*20 words.*
Region 13	*Integer.*	*Integer.*	*20 words.*

Region 14	*Integer.*	*Integer.*	*20 words.*
Region 15	*Integer.*	*Integer.*	*20 words.*
Region 16	*Integer.*	*Integer.*	*20 words.*
Region 17	*Integer.*	*Integer.*	*20 words.*
Region 18	*Integer.*	*Integer.*	*20 words.*
Region 19	*Integer.*	*Integer.*	*20 words.*

16.2.3.4 List total Number of Contracted IPA/Medical Groups/Clinics by region:

	Number of Contracted Entities
Region 1	*Integer.*
Region 2	*Integer.*
Region 3	*Integer.*
Region 4	*Integer.*
Region 5	*Integer.*
Region 6	*Integer.*
Region 7	*Integer.*
Region 8	*Integer.*
Region 9	*Integer.*
Region 10	*Integer.*
Region 11	*Integer.*
Region 12	*Integer.*
Region 13	*Integer.*
Region 14	*Integer.*

Region 15	*Integer.*
Region 16	*Integer.*
Region 17	*Integer.*
Region 18	*Integer.*
Region 19	*Integer.*

16.2.3.5 Identify Independent Practice Associations 6 (IPA), Medical Groups, clinics or health centers terminated between January 1, 2016 and December 31, 2016, including any IPAs or Medical Groups, Federally Qualified Health Centers, or community clinics that had a break in maintaining a continuous contract during this period. Indicate reason for termination: non-agreement on rates, non-compliance with contract provisions, re-design of network or other (explain). Applicants with no prior California presence should use out-of-state experience.

Name of Terminated IPA/Medical Groups/Clinics	Terminated by:	Reason	Reinstated
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words*

10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words*

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

100 words.

16.2.3.7 Provide information on any known or anticipated potential network disruption that may affect the Applicant's 2018 provider networks. For example: list any pending terminations of general acute care hospitals or medical groups which can include Independent Practice Associations.

100 words.

16.3 PPO

16.3.1.6 required for existing networks, all questions required for newly proposed networks

16.3.1 Network Strategy

16.3.1.1 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

16.3.1.2 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.*

16.3.1.3 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, please describe plans to ensure Applicant's ability to control network and meet Exchange requirements: [500 words]

16.3.1.4 By rating region covered, please provide the percentages of providers in capitated vs non-capitated arrangements:

	Direct Contract	Capitated	Other (explain in comments)	Comments
Region 1	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 2	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 3	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 4	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 5	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 6	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 7	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 8	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 9	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 10	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 11	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 12	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 13	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 14	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 15	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 16	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 17	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 18	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 19	*Percent.*	*Percent.*	*Percent.*	*100 words.*

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

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

200 words.

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

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

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

500 words.

16.3.2 Volume - Outcome Relationship

All questions required for all 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 the Applicant track procedure volume per facility for the above mentioned conditions?

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

16.3.2.2 If yes, please provide specific details for each category:

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

500 words.

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

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

16.3.2.4 If yes, please provide the following details:

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

200 words.

16.3.3 Network Stability

All questions required for all networks

16.3.3.1 Total Number of Contracted Hospitals:

Integer.

16.3.3.2 Identify network hospitals terminated between January 1, 2016 and December 31, 2016, including any hospitals that had a break in maintaining a continuous contract during this period. Indicate reason for hospital termination: non-agreement on rates, non-compliance with contract provisions, re-design of network or other (explain). Applicants with no prior California presence should use out-of-state experience.

Name of Terminated Hospital	Terminated by:	Reason	Reinstated
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words.*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words.*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words.*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words.*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words.*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words.*
10 words.	*Single, Pull-down list.* *1: Applicant*	*20 words.*	*10 words.*

	2: Hospital		
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words.*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words.*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words.*

16.3.3.3 Identify the number of participating providers who have terminated from the provider network between January 1, 2016 and December 31, 2016, by rating region. Indicate reason for termination: non-agreement on rates, non-compliance with contract provisions, re-design of network or other (explain).

	Terminated by Issuer	Terminated by Provider	Reason
Region 1	*Integer.*	*Integer.*	*20 words.*
Region 2	*Integer.*	*Integer.*	*20 words.*
Region 3	*Integer.*	*Integer.*	*20 words.*
Region 4	*Integer.*	*Integer.*	*20 words.*
Region 5	*Integer.*	*Integer.*	*20 words.*
Region 6	*Integer.*	*Integer.*	*20 words.*
Region 7	*Integer.*	*Integer.*	*20 words.*
Region 8	*Integer.*	*Integer.*	*20 words.*
Region 9	*Integer.*	*Integer.*	*20 words.*
Region 10	*Integer.*	*Integer.*	*20 words.*
Region 11	*Integer.*	*Integer.*	*20 words.*
Region 12	*Integer.*	*Integer.*	*20 words.*
Region 13	*Integer.*	*Integer.*	*20 words.*

Region 14	*Integer.*	*Integer.*	*20 words.*
Region 15	*Integer.*	*Integer.*	*20 words.*
Region 16	*Integer.*	*Integer.*	*20 words.*
Region 17	*Integer.*	*Integer.*	*20 words.*
Region 18	*Integer.*	*Integer.*	*20 words.*
Region 19	*Integer.*	*Integer.*	*20 words.*

16.3.3.4 List total Number of Contracted IPA/Medical Groups/Clinics by region:

	Number of Contracted Entities
Region 1	*Integer.*
Region 2	*Integer.*
Region 3	*Integer.*
Region 4	*Integer.*
Region 5	*Integer.*
Region 6	*Integer.*
Region 7	*Integer.*
Region 8	*Integer.*
Region 9	*Integer.*
Region 10	*Integer.*
Region 11	*Integer.*
Region 12	*Integer.*
Region 13	*Integer.*
Region 14	*Integer.*

Region 15	*Integer.*
Region 16	*Integer.*
Region 17	*Integer.*
Region 18	*Integer.*
Region 19	*Integer.*

16.3.3.5 Identify Independent Practice Associations 6 (IPA), Medical Groups, clinics or health centers terminated between January 1, 2016 and December 31, 2016, including any IPAs or Medical Groups, Federally Qualified Health Centers, or community clinics that had a break in maintaining a continuous contract during this period. Indicate reason for termination: non-agreement on rates, non-compliance with contract provisions, re-design of network or other (explain). Applicants with no prior California presence should use out-of-state experience.

Name of Terminated IPA/Medical Groups/Clinics	Terminated by:	Reason	Reinstated
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words*

10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words*

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

100 words.

16.3.3.7 Provide information on any known or anticipated potential network disruption that may affect the Applicant's 2018 provider networks. For example: list any pending terminations of general acute care hospitals or medical groups which can include Independent Practice Associations.

100 words.

16.4 EPO

16.4.1.6 required for existing networks, all questions required for newly proposed networks

16.4.1 Network Strategy

16.4.1.1 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

16.4.1.2 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.*

16.4.1.3 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, please describe plans to ensure Applicant's ability to control network and meet Exchange requirements: [500 words]

16.4.1.4 By rating region covered, please provide the percentages of providers in capitated vs non-capitated arrangements:

	Direct Contract	Capitated	Other (explain in comments)	Comments
Region 1	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 2	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 3	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 4	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 5	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 6	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 7	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 8	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 9	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 10	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 11	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 12	*Percent.*	*Percent.*	*Percent.*	*100 words.*

Region 13	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 14	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 15	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 16	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 17	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 18	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 19	*Percent.*	*Percent.*	*Percent.*	*100 words.*

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

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

200 words.

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

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

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

500 words.

16.4.2 Volume - Outcome Relationship

All questions required for all 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 the Applicant track procedure volume per facility for the above mentioned conditions?

Single, Radio group.

1: Yes,
2: No

16.4.2.2 If yes, please provide specific details for each category:

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

500 words.

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

Single, Radio group.

1: Yes,
2: No

16.4.2.4 If yes, please provide the following details:

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

200 words.

16.4.3 Network Stability

All questions required for all networks

16.4.3.1 Total Number of Contracted Hospitals:

Integer.

16.4.3.2 Identify network hospitals terminated between January 1, 2016 and December 31, 2016, including any hospitals that had a break in maintaining a continuous contract during this period. Indicate reason for hospital termination: non-agreement on rates, non-compliance with contract provisions, re-design of network or other (explain). Applicants with no prior California presence should use out-of-state experience.

Name of Terminated Hospital	Terminated by:	Reason	Reinstated
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words.*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words.*

10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words.*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words.*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words.*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words.*
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16.4.3.3 Identify the number of participating providers who have terminated from the provider network between January 1, 2016 and December 31, 2016, by rating region. Indicate reason for termination: non-agreement on rates, non-compliance with contract provisions, re-design of network or other (explain).

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Region 17	*Integer.*	*Integer.*	*20 words.*
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Region 19	*Integer.*	*Integer.*	*20 words.*

16.4.3.4 List total Number of Contracted IPA/Medical Groups/Clinics by region:

	Number of Contracted Entities
Region 1	*Integer.*
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	2: Hospital		
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16.4.3.6 Describe any plans for network additions, by product, including any new medical groups or hospital systems that Applicant would like to highlight for Exchange attention.

100 words.

16.4.3.7 Provide information on any known or anticipated potential network disruption that may affect the Applicant's 2018 provider networks. For example: list any pending terminations of general acute care hospitals or medical groups which can include Independent Practice Associations.

100 words.

16.5 Other

16.5.1.6 required for existing networks, all questions required for newly proposed networks

16.5.1 Network Strategy

16.5.1.1 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

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

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

16.5.1.3 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, please describe plans to ensure Applicant's ability to control network and meet Exchange requirements: [500 words]

16.5.1.4 By rating region covered, please provide the percentages of providers in capitated vs non-capitated arrangements:

	Direct Contract	Capitated	Other (explain in comments)	Comments
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Region 6	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 7	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 8	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 9	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 10	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 11	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 12	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 13	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 14	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 15	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 16	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 17	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 18	*Percent.*	*Percent.*	*Percent.*	*100 words.*
Region 19	*Percent.*	*Percent.*	*Percent.*	*100 words.*

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

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

200 words.

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

Single, Radio group.

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

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

500 words.

16.5.2 Volume - Outcome Relationship

All questions required for all 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 procedure volume per facility for the above mentioned conditions?

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1: Yes,
2: No

16.5.2.2 If yes, please provide specific details for each category:

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

500 words.

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

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

16.5.2.4 If yes, please provide the following details:

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

200 words.

16.5.3 Network Stability

All questions required for all networks

16.5.3.1 Total Number of Contracted Hospitals:
Integer.

16.5.3.2 Identify network hospitals terminated between January 1, 2016 and December 31, 2016, including any hospitals that had a break in maintaining a continuous contract during this period. Indicate reason for hospital

termination: non-agreement on rates, non-compliance with contract provisions, re-design of network or other (explain). Applicants with no prior California presence should use out-of-state experience.

Name of Terminated Hospital	Terminated by:	Reason	Reinstated
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words.*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words.*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words.*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words.*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words.*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words.*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words.*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words.*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words.*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words.*

16.5.3.3 Identify the number of participating providers who have terminated from the provider network between January 1, 2016 and December 31, 2016, by rating region. Indicate reason.

	Terminated by Issuer	Terminated by Provider	Reason
Region 1	*Integer.*	*Integer.*	*20 words.*
Region 2	*Integer.*	*Integer.*	*20 words.*
Region 3	*Integer.*	*Integer.*	*20 words.*
Region 4	*Integer.*	*Integer.*	*20 words.*
Region 5	*Integer.*	*Integer.*	*20 words.*
Region 6	*Integer.*	*Integer.*	*20 words.*
Region 7	*Integer.*	*Integer.*	*20 words.*
Region 8	*Integer.*	*Integer.*	*20 words.*
Region 9	*Integer.*	*Integer.*	*20 words.*
Region 10	*Integer.*	*Integer.*	*20 words.*
Region 11	*Integer.*	*Integer.*	*20 words.*
Region 12	*Integer.*	*Integer.*	*20 words.*
Region 13	*Integer.*	*Integer.*	*20 words.*
Region 14	*Integer.*	*Integer.*	*20 words.*
Region 15	*Integer.*	*Integer.*	*20 words.*
Region 16	*Integer.*	*Integer.*	*20 words.*
Region 17	*Integer.*	*Integer.*	*20 words.*
Region 18	*Integer.*	*Integer.*	*20 words.*
Region 19	*Integer.*	*Integer.*	*20 words.*

16.5.3.4 List total Number of Contracted IPA/Medical Groups/Clinics by region:

	Number of Contracted Entities
Region 1	*Integer.*
Region 2	*Integer.*
Region 3	*Integer.*
Region 4	*Integer.*
Region 5	*Integer.*
Region 6	*Integer.*
Region 7	*Integer.*
Region 8	*Integer.*
Region 9	*Integer.*
Region 10	*Integer.*
Region 11	*Integer.*
Region 12	*Integer.*
Region 13	*Integer.*
Region 14	*Integer.*
Region 15	*Integer.*
Region 16	*Integer.*
Region 17	*Integer.*
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Region 19	*Integer.*

16.5.3.5 Identify Independent Practice Associations 6 (IPA), Medical Groups, clinics or health centers terminated between January 1, 2016 and December 31, 2016, including any IPAs or Medical Groups, Federally

Qualified Health Centers, or community clinics that had a break in maintaining a continuous contract during this period. Indicate reason for termination: non-agreement on rates, non-compliance with contract provisions, re-design of network or other (explain). Applicants with no prior California presence should use out-of-state experience.

Name of Terminated IPA/Medical Groups/Clinics	Terminated by:	Reason	Reinstated
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words*
10 words.	*Single, Pull-down list.* *1: Applicant* *2: Hospital*	*20 words.*	*10 words*

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

100 words.

16.5.3.7 Provide information on any known or anticipated potential network disruption that may affect the Applicant's 2018 provider networks. For example: list any pending terminations of general acute care hospitals or medical groups which can include Independent Practice Associations.

100 words.

17 Essential Community Providers

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

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

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

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

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

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

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

Categories of Essential Community Providers:

Essential Community Providers include the following:

1. The Center for Medicare & Medicaid Services (CMS) non-exhaustive list of available 340B providers in the PHS Act and section 1927(c)(1)(D)(i)(IV) of the Social Security Act.
2. Facilities listed on the California Disproportionate Share Hospital Program, Final DSH Eligibility List FY 2013-2014
3. Federally designated 638 Tribal Health Programs and Title V Urban Indian Health Programs
4. Community Clinics or health centers licensed as either "community clinic" or "free clinic", by the State of California under Health and Safety Code section 1204(a), or operating as a community clinic or free clinic exempt from licensure under Section 1206
5. Physician Providers with approved applications for the HI-TECH Medi-Cal Electronic Health Record Incentive Program
6. Federally Qualified Health Centers (FQHCs)

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

Alternate standard:

QHP issuers 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 a QHP issuer to have a sufficient number and geographic distribution of employed providers and hospital facilities, or providers of its contracted integrated medical group and hospital facilities to ensure reasonable and timely access for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards.

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

1. Percent of services received by Applicant's members which are rendered by Issuer'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 Issuer's network is designed to ensure reasonable and timely access for low-income, medically underserved individuals; **AND**
4. Efforts Issuer will undertake to measure how/if low-income, medically underserved individuals are accessing needed health care services (e.g. maps of low-income members relative to 30-minute drive time to providers; survey of low-income members experience such as CAHPS "getting needed care" survey).

If existing provider capacity does not meet the above criteria, Applicant may be required to provide additional contracted or out-of-network care. Applicants are encouraged to consider contracting with identified ECPs in order 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

The Exchange's "Triple Aim" framework seeks to (1) improve the patient care experience including quality and satisfaction, (2) improve the health of the entire California population, and (3) reduce the per capita cost of covered services. The Quality and Delivery System Reform standards outlined in the QHP Issuer Contract describe the ways the Exchange and contracted health plans will focus on the promotion of better care and higher value for plan enrollees and other California health care consumers. This section of the application assesses the Applicant's current and future capacity to work with the Exchange to achieve these aims. Currently contracted Applicants will submit responses reflecting contractually required progress in these areas by July 10, 2017.

18.1 Accreditation

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

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

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

18.1.2 Please provide the NCQA or URAC accreditation status and expiration date of the accreditation achieved for the HMO product identified in this response. Indicate all that apply.

	Answer	Expiration date MM/DD/YYYY	Programs Reviewed
NCQA HMO	*Single, Pull-down list.* 1: Excellent, 2: Commendable, 3: Accredited, 4: Provisional, 5: Interim, 6: In Process, 7: Denied, 8: Scheduled, 9: Expired, 10: NCQA not used or product not eligible	*To the day.* From December 30, 1973 to December 31, 2023.	
NCQA Exchange	*Single, Pull-down list.* 1: Completed Health Plan Add-On Application, 2: Interim, 3: First, 4: Renewal, 5: NCQA Exchange not used	*To the day.* From December 30, 1973 to December 31, 2023.	

NCQA Wellness & Health Promotion Accreditation	*Single, Radio group.* 1: Accredited and Reporting Measures to NCQA, 2: Accredited and NOT reporting measures, 3: Did not participate	*To the day.* From December 30, 1973 to December 31, 2023.	
NCQA Managed Behavioral Health Organization Accreditation	*Single, Radio group.* 1: Full Accreditation, 2: Accredited – 1 Year, 3: Provisional Accreditation, 4: Denied Accreditation, 5: NCQA not used	*To the day.* From December 30, 1973 to December 31, 2023.	
NCQA Disease Management – Accreditation	*Multi, Checkboxes.* 1: Patient and practitioner oriented, 2: Patient oriented, 3: Plan Oriented, 4: NCQA not used	*To the day.* From December 30, 1973 to December 31, 2023.	*50 words*
NCQA Disease Management – Certification	*Multi, Checkboxes.* 1: Program Design, 2: Systems, 3: Contact, 4: NCQA not used	*To the day.* From December 30, 1973 to December 31, 2023.	*50 words*
NCQA Case Management Accreditation	*Single, Radio group.* 1: Accredited - 3 years, 2: Accredited - 2 years, 3: No accreditation	*To the day.* From December 30, 1973 to December 31, 2023.	*50 words*
NCQA PHQ Certification	*Single, Pull-down list.* 1: Certified, 2: No PHQ Certification	*To the day.* From December 30, 1973 to December 31, 2023.	*50 words*
NCQA Multicultural Health Care Distinction	*Single, Radio group.* 1: Distinction, 2: No MHC Distinction	*To the day.* From December 30, 1973 to December 31, 2023.	
URAC Accreditations	*Single, Radio group.* 1: URAC used 2: URAC not used		
URAC Accreditations - Health Plan	*Single, Radio group.* 1: URAC Accredited, 2: Not URAC Accredited	*To the day.* From December 30, 1973 to December 31, 2023.	
URAC Accreditation - Comprehensive Wellness	*Single, Radio group.* 1: URAC Accredited, 2: Not URAC Accredited	*To the day.* From December 30, 1973 to December 31, 2023.	
URAC Accreditations - Disease Management	*Single, Radio group.* 1: URAC Accredited, 2: Not URAC Accredited	*To the day.* From December 30, 1973 to December 31, 2023.	

URAC Accreditations - Health Utilization Management	*Single, Radio group.* 1: URAC Accredited, 2: Not URAC Accredited	*To the day.* From December 30, 1973 to December 31, 2023.	
URAC Accreditations - Case Management	*Single, Radio group.* 1: URAC Accredited, 2: Not URAC Accredited	*To the day.* From December 30, 1973 to December 31, 2023.	
URAC Accreditations - Pharmacy Benefit Management	*Single, Radio group.* 1: URAC Accredited, 2: Not URAC Accredited	*To the day.* From December 30, 1973 to December 31, 2023.	

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

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

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

Details limited to 50 words.

	Answer	Expiration date MM/DD/YYYY	Programs Reviewed
NCQA PPO	*Single, Pull-down list.* 1: Excellent, 2: Commendable, 3: Accredited, 4: Provisional, 5: Denied, 6: In Process, 7: Denied, 8: Scheduled, 9: Expired, 10: NCQA not used or product not eligible	*To the day.* From December 30, 1973 to December 31, 2023.	
NCQA Exchange	*Single, Pull-down list.* 1: Completed Health Plan Add-On Application, 2: Interim, 3: First, 4: Renewal, 5: NCQA Exchange not used	*To the day.* From December 30, 1973 to December 31, 2023.	

NCQA Wellness & Health Promotion Accreditation	*Single, Radio group.* 1: Accredited and Reporting Measures to NCQA, 2: Accredited and NOT reporting measures, 3: Did not participate	*To the day.* From December 30, 1973 to December 31, 2023.	*50 words*
NCQA Managed Behavioral Healthcare Accreditation	*Single, Radio group.* 1: Full Accreditation, 2: Accredited – 1 Year, 3: Provisional Accreditation, 4: Denied Accreditation, 5: NCQA not used	*To the day.* From December 30, 1973 to December 31, 2023.	*50 words.*
NCQA Disease Management – Accreditation	*Multi, Checkboxes.* 1: Patient and practitioner oriented, 2: Patient oriented, 3: Plan Oriented, 4: NCQA not used	*To the day.* From December 30, 1973 to December 31, 2023.	*50 words*
NCQA Disease Management – Certification	*Multi, Checkboxes.* 1: Program Design, 2: Systems, 3: Contact, 4: NCQA not used	*To the day.* From December 30, 1973 to December 31, 2023.	*50 words*
NCQA Case Management Accreditation	*Multi, Checkboxes.* 1: Accredited - 3 years, 2: Accredited - 2 years, 3: No accreditation	*To the day.* From December 30, 1973 to December 31, 2023.	*50 words*
NCQA PHQ Certification	*Single, Pull-down list.* 1: Certified, 2: No PHQ Certification	*To the day.* From December 30, 1973 to December 31, 2023.	
NCQA Multicultural Health Care Distinction	*Single, Pull-down list.* 1: Distinction, 2: No MHC Distinction	*To the day.* From December 30, 1973 to December 31, 2023.	
URAC Accreditations	*Single, Radio group.* 1: URAC used 2: URAC not used		
URAC Accreditations - Health Plan	*Single, Radio group.* 1: URAC Accredited, 2: Not URAC Accredited	*To the day.* From December 30, 1973 to December 31, 2023.	
URAC Accreditation - Comprehensive Wellness	*Single, Radio group.* 1: URAC Accredited, 2: Not URAC Accredited	*To the day.* From December 30, 1973 to December 31, 2023.	
URAC Accreditations - Disease Management	*Single, Radio group.* 1: URAC Accredited, 2: Not URAC Accredited	*To the day.* From December 30, 1973 to December 31, 2023.	

URAC Accreditations - Health Utilization Management	*Single, Radio group.* 1: URAC Accredited, 2: Not URAC Accredited	*To the day.* From December 30, 1973 to December 31, 2023.	
URAC Accreditations - Case Management	*Single, Radio group.* 1: URAC Accredited, 2: Not URAC Accredited	*To the day.* From December 30, 1973 to December 31, 2023.	
URAC Accreditations - Pharmacy Benefit Management	*Single, Radio group.* 1: URAC Accredited, 2: Not URAC Accredited	*To the day.* From December 30, 1973 to December 31, 2023.	

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

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

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

Details limited to 50 words.

	Answer	Expiration date MM/DD/YYYY	Programs Reviewed
NCQA EPO	*Single, Pull-down list.* 1: Excellent, 2: Commendable, 3: Accredited, 4: Provisional, 5: Interim, 6: Denied, 7: In Process, 8: Denied, 9: Scheduled, 10: Expired, 11: NCQA not used or product not eligible	*To the day.* From December 30, 1973 to December 31, 2023.	
NCQA Exchange	*Single, Pull-down list.* 1: Completed Health Plan Add-On Application, 2: Interim, 3: First, 4: Renewal, 5: NCQA Exchange not used	*To the day.* From December 30, 1973 to December 31, 2023.	

NCQA Wellness & Health Promotion Accreditation	*Single, Radio group.* 1: Accredited and Reporting Measures to NCQA, 2: Accredited and NOT reporting measures, 3: Did not participate	*To the day.* From December 30, 1973 to December 31, 2023.	*50 words*
NCQA Managed Behavioral Healthcare	*Single, Radio group.* 1: Full Accreditation, 2: Accredited – 1 Year, 3: Provisional Accreditation, 4: Denied Accreditation, 5: NCQA not used	*To the day.* From December 30, 1973 to December 31, 2023.	*50 words*
NCQA Disease Management – Accreditation	*Multi, Checkboxes.* 1: Patient and practitioner oriented, 2: Patient oriented, 3: Plan Oriented, 4: NCQA not used	*To the day.* From December 30, 1973 to December 31, 2023.	*50 words*
NCQA Disease Management – Certification	*Multi, Checkboxes.* 1: Program Design, 2: Systems, 3: Contact, 4: NCQA not used	*To the day.* From December 30, 1973 to December 31, 2023.	*50 words*
NCQA Case Management Accreditation	*Multi, Checkboxes.* 1: Accredited - 3 years, 2: Accredited - 2 years, 3: No accreditation	*To the day.* From December 30, 1973 to December 31, 2023.	*50 words*
NCQA PHQ Certification	*Single, Pull-down list.* 1: Certified, 2: No PHQ Certification	*To the day.* From December 30, 1973 to December 31, 2023.	
NCQA Multicultural Health Care Distinction	*Single, Pull-down list.* 1: Distinction, 2: No MHC Distinction	*To the day.* From December 30, 1973 to December 31, 2023.	
URAC Accreditations	*Single, Radio group.* 1: URAC used 2: URAC not used		
URAC Accreditations - Health Plan	*Single, Radio group.* 1: URAC Accredited, 2: Not URAC Accredited	*To the day.* From December 30, 1973 to December 31, 2023.	
URAC Accreditation - Comprehensive Wellness	*Single, Radio group.* 1: URAC Accredited, 2: Not URAC Accredited	*To the day.* From December 30, 1973 to December 31, 2023.	
URAC Accreditations - Disease Management	*Single, Radio group.* 1: URAC Accredited, 2: Not URAC Accredited	*To the day.* From December 30, 1973 to December 31, 2023.	

URAC Accreditations - Health Utilization Management	*Single, Radio group.* 1: URAC Accredited, 2: Not URAC Accredited	*To the day.* From December 30, 1973 to December 31, 2023.	
URAC Accreditations - Case Management	*Single, Radio group.* 1: URAC Accredited, 2: Not URAC Accredited	*To the day.* From December 30, 1973 to December 31, 2023.	
URAC Accreditations - Pharmacy Benefit Management	*Single, Radio group.* 1: URAC Accredited, 2: Not URAC Accredited	*To the day.* From December 30, 1973 to December 31, 2023.	

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

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

18.2 Focus on High Cost Providers

Affordability is core to the Exchange’s mission to expand the availability of insurance coverage and promote the Triple Aim. The wide variation in unit price and total costs of care charged by providers, with some providers charging far more for care irrespective of quality, is one of the biggest contributors to high costs of medical services. The following questions address the Applicant’s efforts to understand price variation and strategies to ensure providers and hospitals do not charge unduly high costs. Applicants will be assessed on the thoroughness of the response, activities in place to assess variation, and strategies to prevent unduly high prices.

18.2.1 Does Applicant conduct analysis on variation in unit price and total cost of care among contracted providers and/or potential contracted providers?

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

18.2.2 If yes to 18.2.1, select the factors considered when assessing the relative unit prices and total costs of care in current and potential contracted providers.

Multi, Checkboxes.
1: Comparison to similar providers in the market,
2: Utilization,
3: Contribution with affiliated providers to total cost of care,
4: Area of service,
5: Population served (e.g. health status, socioeconomic status, etc.),
6: Market dominance,
7: Services provided by the facility (e.g. trauma or tertiary care),
8: Alignment with applicant’s fee schedule,
9: Alignment with Medicare fee schedule,
10: None of the above,

11: Other (describe): [50 words],
12: Not applicable

18.2.3 Describe how factors described in 18.2.2 are used in selection of providers or facilities in networks available to the Exchange enrollees, and identify any factor(s) that are prioritized over others in selection.

100 words.

18.2.4 Describe how hospital cost variation is identified, if it is identified by cost deciles or other means of grouping hospitals by cost, and if this information is used to make network decisions. Specifically address how utilization is considered in the analysis of cost variation. Include the percentage of costs that are expended in each cost decile. Examples of groupings by cost include comparison of costs as percentage of Medicare costs.

100 words.

18.2.5 Describe strategies to ensure contracted providers do not charge unduly high prices. Include in response which portions of Applicant's entire enrolled population are subject to these strategies. Examples of strategies include telemedicine, use of Centers of Excellence, reference pricing, and efforts to make variation in provider or facility cost transparent to consumers.

200 words.

18.3 Demonstrating Action on High Cost Pharmaceuticals

Appropriate treatment with pharmaceuticals is often the best clinical strategy to treating conditions, as well as managing chronic and life threatening conditions. At the same time, the Exchange is concerned with the trend in rising prescription drug costs, including those in specialty pharmacy, and compounding increases in costs of generic drugs, which are a growing driver of total cost of care. The following questions address the Applicant's approach to achieving value in delivery of pharmacy services, and answers will be assessed on the thoroughness of the response, the extent to which the Applicant conducts value assessments of drugs, and how these assessments are used to achieve value.

18.3.1 Describe how Applicant considers value in its selection of medications for use in its formulary and formulary placement.

50 words.

18.3.2 Does Applicant apply value assessment methodology developed by independent groups or use independent drug assessment reports on comparative effectiveness and value for the following activities as part of its Pharmacy and Therapeutics (P&T) process? If yes, describe: how this information is used.

	Response	If Yes, describe:
Designing benefits	*Yes/No.*	*50 words.*
Negotiating prices	*Yes/No.*	*50 words.*

Developing pricing for consumers	*Yes/No.*	*50 words.*
Determining formulary placement (drug tiers)	*Yes/No.*	*50 words.*
Tiering within Exchange patient-centered benefit designs	*Yes/No.*	*50 words.*

18.3.3 Indicate if any of the following sources are used in the methodology described in 18.3.2:

Multi, Checkboxes.

1: Drug Effectiveness Review Project (DERP),
2: NCCN Resource Stratification Framework (NCCN-RF),
3: NCCN Evidence Blocks (NCCN-EB),
4: ASCO Value of Cancer Treatment Options (ASCO- VF),
5: ACC/AHA Cost/Value Methodology in Clinical Practice Guidelines,
6: Oregon State Health Evidence Review Commission Prioritization Methodology,
7: Premera Value-Based Drug Formulary (Premera VBF),
8: DrugAbacus (MSKCC) (DAbacus),
9: The ICER Value Assessment Framework (ICER-VF),
10: Real Endpoints,
11: Blue Cross/Blue Shield Technology Evaluation Center,
12: International Assessment Processes (e.g., United Kingdom's National Institute for Health and Care Excellence – "NICE"),
13: Other (please identify): [Unlimited]

18.3.4 Describe how construction of formularies is based on total cost of care rather than on drug cost alone.

100 words.

18.3.5 Describe how off-label use of pharmaceuticals is monitored and what efforts are undertaken to ensure any off-label prescriptions are evidence-based.

100 words.

18.3.6 Describe how decision support is provided to prescribers and consumers related to the clinical efficacy and cost impact of drug treatments and their alternatives. Examples of decision support include web-based comparative drug pricing and effectiveness resources for providers, shared decision making tools for consumers, etc.

100 words.

18.4 Participation in Collaborative Quality Initiatives

The Exchange believes that improving health care quality and reducing costs can only be done over the long-term through collaborative efforts that effectively engage and support clinicians and other providers of care. There are many established statewide and national collaborative initiatives for quality improvement that are aligned with priorities established by the Exchange. The following questions address the Applicant's current

involvement in collaborative efforts. Applicants will be assessed based on the breadth and depth of their involvement as well as on the thoroughness of the response.

18.4.1 Is Applicant a participant of Smart Care California, a public-private partnership to support efforts to drive appropriate use of C-sections, prescription of opioids, and low-back imaging? Participants are defined as having attended at least one meeting and listed on the collaborative's web site: http://www.iha.org/sites/default/files/swgro-participant-list.pdf.

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

18.4.2 Has Applicant undertaken efforts to address overuse? Please select all efforts undertaken and describe outcomes as applicable.

Multi, Checkboxes with 50 words.
1: Assessed current levels of overuse of select interventions; describe: [20 words],
2: Enhanced data exchange to assess overuse; describe: [20 words],
3: Studied regional variation; describe: [20 words],
4: Studied variation by provider; describe: [20 words],
5: Developed interventions to address overuse that are directed at providers; describe: [20 words],
6: Developed interventions to address overuse that are directed at members; describe: [20 words],
7: Other (please specify): [20 words],
8: No activities conducted to address overuse

18.4.3 Describe how Applicant is measuring overuse of C-sections, opioids, and low back pain imaging, and if it is aligning with Smart Care California recommendations.

100 words.

18.4.4 Is Applicant engaged in any of the following organized programs in California? "Engagement" is defined as active participation through regular meeting attendance, health plan representatives serving as advisory members, submitting data to the collaborative, and/or providing feedback on initiatives and projects.

Note that Applicants selecting "Not Engaged in Any Programs" will not complete the responses for all rows and columns in this question.

	Engaged in California	Describe the nature of engagement
Applicant is not engaged in any of the below programs	*Single, Radio group.* 1: Yes, 2: No	*N/A.*
Leapfrog Hospital Rewards Program	*Single, Radio group.* 1: Engaged, 2: Not Engaged	*50 words.*
Cal Hospital Compare	*Single, Radio group.*	*50 words.*

	1: Engaged, 2: Not Engaged	
California Health Performance Information System (CHPI)	*Single, Radio group.* 1: Engaged, 2: Not Engaged	*50 words.*
California Joint Replacement Registry developed by the CHCF, California Orthopedic Society and Pacific Business Group on Health (PBGH)	*Single, Radio group.* 1: Engaged, 2: Not Engaged	*50 words.*
California Immunization Registry sponsored by the California Department of Public Health	*Single, Radio group.* 1: Engaged, 2: Not Engaged	*50 words.*
1115 Medicaid Waiver Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program	*Single, Radio group.* 1: Engaged, 2: Not Engaged	*50 words.*
Integrated Healthcare Association (IHA) Pay for Performance Program	*Single, Radio group.* 1: Engaged, 2: Not Engaged	*50 words.*
IHA Payment Bundling demonstration	*Single, Radio group.* 1: Engaged, 2: Not Engaged	*50 words.*
The IHA Encounter Standardization Project	*Single, Radio group.* 1: Engaged, 2: Not Engaged	*50 words.*
Centers for Medicare and Medicaid Innovation (CMMI) Bundled Payments for Care Improvement initiative (BPCI)	*Single, Radio group.* 1: Engaged, 2: Not Engaged	*50 words.*
CMMI Comprehensive Primary Care initiative (CPC)	*Single, Radio group.* 1: Engaged, 2: Not Engaged	*50 words.*
CMMI Transforming Clinical Practice Initiative	*Single, Radio group.* 1: Engaged, 2: Not Engaged	*50 words.*
CMMI Shared Savings Program (including Pioneer, Advanced Payment and other models)	*Single, Radio group.* 1: Engaged, 2: Not Engaged	*50 words.*

CMMI Partnership for Patients Hospital Safety Initiative	*Single, Radio group.* 1: Engaged, 2: Not Engaged	*50 words.*
California Perinatal Quality Care Collaborative	*Single, Radio group.* 1: Engaged, 2: Not Engaged	*50 words.*
California Quality Collaborative	*Single, Radio group.* 1: Engaged, 2: Not Engaged	*50 words.*
Other (described in detail box)	*Single, Radio group.* 1: Engaged, 2: Not Engaged	*50 words.*

18.5 Data Exchange with Providers

To be successful under Exchange QIS requirements, and in order 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. The following questions address the Applicant's efforts to improve routine exchange of data. 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 the extent to which data, other than claims information, is exchanged between providers and the Applicant. Include the proportion of providers in the network that currently submit non-claims data (clinical, demographic, etc.) to Applicant or other providers.

100 words.

18.5.2 Describe initiatives in place to improve routine exchange of timely information with providers to support their delivery of high quality care. Examples may include:

- Notifying Personal Care Physicians (PCPs) when one of their empaneled patients is admitted to a hospital, a critical event that often occurs without knowledge of either the primary care or specialty provider who have been managing the patient on an ambulatory basis.
- Developing systems to collect clinical data as a supplemental to the annual HEDIS process such as HbA1c lab results and blood pressure readings
- Racial and ethnic self-reported identity collected at every patient contact.

100 words.

18.5.3 Describe participation in statewide or regional initiatives that seek to make data exchange routine. Participation is defined as regular meeting attendance, health plan representatives serving as

advisory members, submitting data to the collaborative, or providing feedback on initiatives and projects. Examples of HIEs include:

- Inland Empire Health Information Exchange (IEHIE)
- Los Angeles Network for Enhanced Services (LANES)
- Orange County Partnership Regional Health Information Organization (OCPRHIO)
- San Diego Health Connect
- Santa Cruz Health Information Exchange
- CalIndex

100 words.

18.5.4 Indicate participation in any disease registries below and specify the names of specific registries.

Multi, Checkboxes.
1: Cancer, [20 words],
2: Diabetes, [20 words],
3: Immunization Registry, [20 words],
4: Other, specify: [50 words]

18.6 Data Aggregation Across Health Plans

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

18.6.1 Describe Applicant's participation in initiatives to support the aggregation of claims and clinical data across payers.

100 words.

18.6.2 Describe the feasibility of additional opportunities to improve measurement and reduce the burden of data collection on providers through such proposals as a statewide All Payer Claims Database.

Examples to date have included:

- The Integrated Health Association (IHA) for Medical Groups
- The California Healthcare Performance Information System (CHPI)
- The CMS Physician Quality Reporting System
- CMS Hospital Compare or CalHospital Compare

100 words.

18.7 Mental and Behavioral Health Management

The Exchange recognizes the critical importance of Mental and Behavioral Health Services as part of the broader set of medical services provided to enrollees. The following questions address the Applicant's strategies to improve accessibility of mental and behavioral health services and further integrate mental and

behavioral health with medical services. 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 any recent efforts to improve the accessibility and availability of mental and behavioral health services, such as changes in benefit management, networks, contracting with accountable care organizations, etc.

65 words.

18.7.2 Describe the Applicant's strategy or strategies to improve the integration of mental and behavioral health services and medical services in the past five years. Include a description of any recommended models or best practices integrating behavioral health and medical services.

100 words.

18.7.3 If some or all of Applicant's network providers deliver care in an integrated behavioral health-medical model, provide the percent of mental and behavioral health services, identified through claims, provided in an integrated behavioral health-medical model in such settings in plan year 2016. The numerator is the total number of services provided in 2016 in an integrated behavioral health-medical model, and the denominator is the total number of mental and behavioral health services provided to members.

	Numerator (2016 mental and behavioral health claims provided in integrated behavioral health-medical model)	Denominator (all mental and behavioral health claims in 2016)	Rate (%)	Indicate if the providers in the numerator are Patient-Centered Medical Home (PCMH), Integrated Healthcare Models (IHM), or other model (specify)
Exchange members (if Applicant had Exchange business in 2016)	*Integer.*	*Integer.*	*Percent.*	*50 words.*
Total book of business	*Integer.*	*Integer.*	*Percent.*	*50 words.*

18.8 Health Technology (Telehealth and Remote Monitoring)

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

18.8.1 Provide information regarding Applicant's capabilities to support physician-member consultations using technology (e.g., web consultations, telemedicine). In the third and fourth columns, select the books of

business and product to which the answer applies to provide meaningful reference points to compare with current or future Exchange business. Applicant will be evaluated based on the availability of telehealth services for all books of business, particularly Exchange membership (if Applicant is not currently contracted with the Exchange, select "1" if the service would be offered to Exchange members, and include a description in the details section).
Note that Applicants selecting "Plan does not offer or allow web or telehealth consultations" will not complete the responses for all rows and columns in this question.

Details limited to 100 words.

Response	Answer	Technology	Availability by book of business	Availability by product	Details
Applicant ability to support web/telehealth consultations, either through a contractor or provided by the medical group/provider	*Multi, Checkboxes.* 1: Plan does not offer/allow web or telehealth consultations, 2: Web visit using instant messaging, 3: Telehealth with interactive face to face dialogue (video) over the Web, 4: Telehealth with interactive dialogue over the phone, 5: Telehealth via email, 6: Other (specify)		*Multi, Checkboxes.* N/A OK. 1: Exchange, 2: All large group, 3: Large group, buy-up option only, 4: Medicaid, 5: Medicare, 6: Other	*Multi, Checkboxes.* 1: HMO, 2: PPO, 3: EPO, 4: Other	*20 words.*
Applicant uses a vendor for web/telehealth consultations (indicate vendor)	*50 words.* N/A OK.	*Multi, Checkboxes.* N/A OK. 1: Telehealth via web (video), 2: Telehealth via phone, 3: Combination of web (video) and phone, 4: Instant messaging, 5: Email, 6: Other (specify)	*Multi, Checkboxes.* N/A OK. 1: Exchange, 2: All large group, 3: Large group, buy-up option only, 4: Medicaid, 5: Medicare, 6: Other	*Multi, Checkboxes.* 1: HMO, 2: PPO, 3: EPO, 4: Other	*20 words.*
Applicant contracts with medical groups/providers that offer web/telehealth consultations (yes/no with details)	*50 words.* N/A OK.	*Multi, Checkboxes.* N/A OK. 1: Telehealth via web (video), 2: Telehealth	*Multi, Checkboxes.* N/A OK. 1: Exchange, 2: All large group,	*Multi, Checkboxes.* 1: HMO, 2: PPO, 3: EPO, 4: Other	*20 words.*

		via phone, 3: Combination of web (video) and phone, 4: Instant messaging, 5: Email, 6: Other (specify)	3: Large group, buy-up option only, 4: Medicaid, 5: Medicare, 6: Other		
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.* From 0 to 100.	*Multi, Checkboxes.* N/A OK. 1: Telehealth via web (video), 2: Telehealth via phone, 3: Combination of web (video) and phone, 4: Instant messaging, 5: Email, 6: Other (specify)	*Multi, Checkboxes.* N/A OK. 1: Exchange, 2: All large group, 3: Large group, buy-up option only, 4: Medicaid, 5: Medicare, 6: Other	*Multi, Checkboxes.* 1: HMO, 2: PPO, 3: EPO, 4: Other	*20 words.*
For physicians that are available to deliver web/telehealth consultations, what is the average wait time? If Applicant can provide average wait time - please describe how that is monitored in detail box at end of question	*Single, Radio group.* N/A OK. 1: On demand, 2: Within 4 hours, 3: Within same day, 4: Scheduled follow-up within 48 hours, 5: Other (describe)	*Multi, Checkboxes.* N/A OK. 1: Telehealth via web (video), 2: Telehealth via phone, 3: Combination of web (video) and phone, 4: Instant messaging, 5: Email, 6: Other (specify)	*Multi, Checkboxes.* N/A OK. 1: Exchange, 2: All large group, 3: Large group, buy-up option only, 4: Medicaid, 5: Medicare, 6: Other	*Multi, Checkboxes.* 1: HMO, 2: PPO, 3: EPO, 4: Other	*20 words.*
Member reach of physicians providing web/telehealth consultations (i.e. what % of members are attributed to those physicians offering web/telehealth consultations) (use as denominator total membership across all lines of business). If Applicant has and tracks use by Medi-Cal members as well, number here should include Medi-Cal numbers.)	*Percent.* From 0 to 100.	*Multi, Checkboxes.* N/A OK. 1: Telehealth via web (video), 2: Telehealth via phone, 3: Combination of web (video) and phone, 4: Instant messaging, 5: Email, 6: Other (specify)	*Multi, Checkboxes.* N/A OK. 1: Exchange, 2: All large group, 3: Large group, buy-up option only, 4: Medicaid, 5: Medicare, 6: Other	*Multi, Checkboxes.* 1: HMO, 2: PPO, 3: EPO, 4: Other	*20 words.*

What percentage of the current total membership has access to web/telehealth consultations as a covered core benefit (no buy-up required)? (use as denominator total membership across all lines of business).	*Percent.* N/A OK. From 0 to 100.	*Multi, Checkboxes.* N/A OK. 1: Telehealth via web (video), 2: Telehealth via phone, 3: Combination of web (video) and phone, 4: Instant messaging, 5: Email, 6: Other (specify)	*Multi, Checkboxes.* N/A OK. 1: Exchange, 2: All large group, 3: Medicaid, 4: Medicare, 5: Other	*Multi, Checkboxes.* 1: HMO, 2: PPO, 3: EPO, 4: Other	*20 words.*
What is the average utilization of web/telehealth consultations per 1,000 members based on 2016 utilization? (Denominator should be all members that have access to web/telehealth consultations)	*Decimal.* N/A OK. From 0 to 100000000000.	*Multi, Checkboxes.* N/A OK. 1: Telehealth via web (video), 2: Telehealth via phone, 3: Combination of web (video) and phone, 4: Instant messaging, 5: Email, 6: Other (specify)	*Multi, Checkboxes.* N/A OK. 1: Exchange, 2: All large group, 3: Large group, buy-up option only, 4: Medicaid, 5: Medicare, 6: Other	*Multi, Checkboxes.* 1: HMO, 2: PPO, 3: EPO, 4: Other	*20 words.*
If Applicant had Exchange business in 2016: Number of web/telehealth consultations performed in the applicable calendar year per thousand Exchange members	*Decimal.* N/A OK. From 0 to 100000000000.	*Multi, Checkboxes.* N/A OK. 1: Telehealth via web (video), 2: Telehealth via phone, 3: Combination of web (video) and phone, 4: Instant messaging, 5: Email, 6: Other (specify)			*20 words.*
Percentage of unique members with a web/telehealth consultation in 2016	*Percent.* N/A OK. From 0 to 100.	*Multi, Checkboxes.* N/A OK. 1: Telehealth via web (video), 2: Telehealth via phone,	*Multi, Checkboxes.* N/A OK. 1: Exchange, 2: All large group, 3: Large group,	*Multi, Checkboxes.* 1: HMO, 2: PPO, 3: EPO, 4: Other	*20 words.*

		3: Combination of web (video) and phone, 4: Instant messaging, 5: Email, 6: Other (specify)	buy-up option only, 4: Medicaid, 5: Medicare, 6: Other		
If Applicant had Exchange business in 2016: Percentage of unique Exchange members with a web/telehealth consultation in 2016	*Percent.* N/A OK. From 0 to 100.	*Multi, Checkboxes.* N/A OK. 1: Telehealth via web (video), 2: Telehealth via phone, 3: Combination of web (video) and phone, 4: Instant messaging, 5: Email, 6: Other (specify)			*20 words.*
Applicant reimburses for web/telehealth consultations	*Single, Radio group.* 1: Yes, 2: No	*Multi, Checkboxes.* N/A OK. 1: Telehealth via web (video), 2: Telehealth via phone, 3: Combination of web (video) and phone, 4: Instant messaging, 5: Email, 6: Other (specify)	*Multi, Checkboxes.* N/A OK. 1: Exchange, 2: All large group, 3: Large group, buy-up option only, 4: Medicaid, 5: Medicare, 6: Other	*Multi, Checkboxes.* 1: HMO, 2: PPO, 3: EPO, 4: Other	*20 words.*
Among members in plans with available web/telehealth consultation, what is the member cost share?	*Multi, Checkboxes.* 1: No cost share, 2: Same cost as a primary care visit, 3: Same cost as a specialist visit, 4: Telehealth visit cost share (please explain):, 5: Other (explain):	*Multi, Checkboxes.* N/A OK. 1: Telehealth via web (video), 2: Telehealth via phone, 3: Combination of web (video) and phone, 4: Instant messaging, 5: Email, 6: Other (specify)	*Multi, Checkboxes.* N/A OK. 1: Exchange, 2: All large group, 3: Large group, buy-up option only, 4: Medicaid, 5: Medicare, 6: Other	*Multi, Checkboxes.* 1: HMO, 2: PPO, 3: EPO, 4: Other	*20 words.*

18.8.2 Provide utilization of remote monitoring for Exchange enrollees, if applicable, and for total covered lives, defined as the number of unique patients and number of separate services provided to patients involved in a remote monitoring program in plan year 2016. Remote monitoring is monitoring of patients outside of conventional clinical settings, which may increase access to care if utilized appropriately and for the right conditions.

	Numerator (number of unique members who received remote monitoring in 2016)	Denominator (all members who were included in applicable line of business in 2016)	Rate (%)	Indicate if PCMH, IHM, or other model (specify)
Exchange Enrollees (if Applicant had Exchange business in 2016)	*Integer.*	*Integer.*	*Percent.*	*50 words.*
Total book of business	*Integer.*	*Integer.*	*Percent.*	*50 words.*

18.9 Health and Wellness

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

18.9.1 Report selected measures below for the two most recently calculated years of HEDIS results for the HMO Applicant (QC 2016 and 2015). ***Colorectal Cancer Screening was eligible for rotation in HEDIS 2015.***

If Applicant did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised: -1 means 'NR', -2 means 'NA', -3 means 'ND', -4 means 'EXC', and -5 means 'NB'.

	HMO QC 2016	QC 2015, or prior year's HMO QC result
Breast Cancer Screening - Total	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Cervical Cancer Screening	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.

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

18.9.2 Report selected measures below for the two most recently calculated years of HEDIS results for the PPO Applicant (QC 2016 and 2015). ***Colorectal Cancer Screening was eligible for rotation in HEDIS 2015.***

If Applicant did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised: -1 means 'NR', -2 means 'NA', -3 means 'ND', -4 means 'EXC', and -5 means 'NB'.

	PPO QC 2016	PPO QC 2015, or prior year's PPO QC result
Breast Cancer Screening - Total	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Cervical Cancer Screening	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Colorectal Cancer Screening	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.

18.9.3 Report selected measures below for the two most recently calculated years of HEDIS results for the EPO Applicant (QC 2016 and 2015). ***Colorectal Cancer Screening was eligible for rotation in HEDIS 2015.***

If Applicant did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised: -1 means 'NR', -2 means 'NA', -3 means 'ND', -4 means 'EXC', and -5 means 'NB'.

	EPO QC 2016	EPO QC 2015, or prior year's EPO QC result
Breast Cancer Screening - Total	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Cervical Cancer Screening	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Colorectal Cancer Screening	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.

18.9.4 Which of the following member interventions were used by Applicant in calendar year 2016 to improve cancer screening rates? Indicate all that apply.

	Educational messages identifying screening options discussing risks and benefits	Member-specific reminders (electronic or written, etc.) sent to members for needed care based on general eligibility (age/gender)	Member-specific reminders for gaps in services based on administrative or clinical information (mail, e-mail/text, automated phone or live outbound telephone calls triggered by the ABSENCE of a service)
Breast Cancer Screening	*Single, Radio group.* 1: Yes, 2: No	*Single, Radio group.* 1: Available to > 75% of members, 2: Available to < 75% of members, 3: Not Available	*Single, Radio group.* 1: Available to > 75% of members, 2: Available to < 75% of members, 3: Not Available
Cervical Cancer Screening	*Single, Radio group.* 1: Yes, 2: No	*Single, Radio group.* 1: Available to > 75% of members, 2: Available to < 75% of members, 3: Not Available	*Single, Radio group.* 1: Available to > 75% of members, 2: Available to < 75% of members, 3: Not Available
Colorectal Cancer Screening	*Single, Radio group.* 1: Yes, 2: No	*Single, Radio group.* 1: Available to > 75% of members, 2: Available to < 75% of members, 3: Not Available	*Single, Radio group.* 1: Available to > 75% of members, 2: Available to < 75% of members, 3: Not Available

18.9.5 Report selected measures below for the two most recently uploaded years of HEDIS/CAHPS (QC 2016 and QC 2015) results for HMO Applicant.

If Applicant did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised: -1 means 'NR', -2 means 'NA', -3 means 'ND', -4 means 'EXC', and -5 means 'NB'.

Childhood Immunization Status and Immunizations for Adolescents were eligible for rotation in HEDIS 2015.

	QC 2016, or most current year's HMO result	QC 2015, or prior year's HMO QC result
Childhood Immunization Status - Combo 2	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Immunizations for Adolescents - Combination	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
CAHPS Flu Shots for Adults (50-64) (report rolling average)	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.

18.9.6 Report selected measures below for the two most recently uploaded years of HEDIS/CAHPS (QC 2016 and QC 2015) results for PPO Applicant.

If Applicant did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised: -1 means 'NR', -2 means 'NA', -3 means 'ND', -4 means 'EXC', and -5 means 'NB'.

Childhood Immunization Status and Immunizations for Adolescents were eligible for rotation in HEDIS 2015.

	QC 2016, or most current year's PPO result	QC 2015, or prior year's PPO QC result
Childhood Immunization Status - Combo 2	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Immunizations for Adolescents - Combination	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
CAHPS Flu Shots for Adults (50-64) (report rolling average)	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.

18.9.7 Report selected measures below for the two most recently uploaded years of HEDIS/CAHPS (QC 2015 and QC 2014) results for EPO Applicant.

If a plan did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised: -1 means 'NR', -2 means 'NA', -3 means 'ND', -4 means 'EXC', and -5 means 'NB'

Childhood Immunization Status and Immunizations for Adolescents were eligible for rotation in HEDIS 2015.

	QC 2016, or most current year's EPO result	QC 2015, or prior year's EPO QC result
Childhood Immunization Status - Combo 2	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.

Immunizations for Adolescents - Combination	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
CAHPS Flu Shots for Adults (50-64) (report rolling average)	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.

18.9.8 Identify member interventions used in calendar year 2016 to improve immunization rates. Check all that apply.

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

18.9.9 Indicate the number and percent of tobacco-dependent commercial members identified and participating in cessation activities during 2016.

If Applicant is currently contracted with the Exchange, please provide <u>Exchange</u> counts if available. If Exchange counts are not available, provide state or regional counts.

	Answer
Indicate how Applicant identifies members who use tobacco. Applicant may add up the tobacco users identified in each of the ways identified in this row with the recognition that this may result in some duplication or over counting in response	*Multi, Checkboxes.* 1: Plan Health Assessment, 2: Employer/Vendor Health Assessment,

to row below on number of commercial members individually identified as tobacco dependent in 2016.	3: Member PHR, 4: Claims/Encounter Data, 5: Disease or Care Management, 6: Wellness Vendor, 7: Other (describe in box in cell)
Indicate ability to track identification of tobacco-dependent members. Please select only ONE of response options 1-4 and include response option 5 if applicable	*Multi, Checkboxes.* 1: Identification tracked statewide & regionally, 2: Identification only tracked statewide, 3: Identification only tracked regionally, 4: Identification not tracked regionally/statewide, 5: Identification can be tracked at Covered California level
Indicate ability to track participation of tobacco-dependent members in cessation activities. Please select only ONE of response options 1-4 and include response option 5 if applicable	*Multi, Checkboxes.* 1: Participation tracked statewide & regionally, 2: Participation only tracked statewide, 3: Participation only tracked regionally, 4: Participation not tracked regionally/statewide, 5: Participation can be tracked at Covered California level
Number of California members individually identified as tobacco dependent in 2016. (If Applicant has and tracks use by Medi-Cal members as well, number here should include Medi-Cal numbers.)	*Decimal.* From 0 to 1000000000.
% of California members identified as tobacco dependent	*Percent.*
Number of Exchange members individually identified as tobacco dependent in 2016.	*Decimal.* From 0 to 1000000000.
% of Exchange members identified as tobacco dependent	*Percent.*
Number of California members identified as tobacco dependent who participated in a smoking cessation program during 2016. (If Health plan has and tracks use by Medi-Cal members as well, number here should include Medi-Cal numbers.)	*Decimal.* From 0 to 1000000000.

% of California members identified as tobacco dependent participating in smoking cessation program (# program participants divided by # identified smokers)	*Percent.*
Number of Exchange members identified as tobacco dependent who participated in a smoking cessation program during 2016.	*Decimal.* From 0 to 1000000000.
% of Exchange members identified as tobacco dependent participating in smoking cessation program (# program participants divided by # identified smokers)	*Percent.*

18.9.10 Indicate the number of obese members identified and participating in weight management programs during 2016. Do not report general prevalence.

If Applicant is currently contracted with the Exchange, please provide <u>Exchange</u> counts if available. If Exchange counts are not available, provide state/regional counts.

	Answer
Indicate how the Applicant identifies members who are obese. Applicant may add up the obese members identified in each of the ways identified in this row with the recognition that this may result in some duplication or over counting in response to row below on Number of commercial members individually identified as obese in 2015 as of December 2015	*Multi, Checkboxes.* 1: Plan Health Assessment, 2: Employer/Vendor Health Assessment, 3: Member PHR, 4: Claims/Encounter Data, 5: Disease or Care Management, 6: Wellness Vendor, 7: Other (describe in box in cell)
Indicate ability to track identification of obese members. Please select only ONE of response options 1-4 and include response option 5 if applicable	*Multi, Checkboxes.* 1: Identification tracked statewide & regionally, 2: Identification only tracked statewide, 3: Identification only tracked regionally, 4: Identification not tracked regionally/statewide, 5: Identification can be tracked at Covered California level
Indicate ability to track participation of obese members in weight management programs. Please select only ONE of response options 1-4 and include response option 5 if applicable	*Multi, Checkboxes.* 1: Participation tracked statewide & regionally, 2: Participation tracked only statewide, 3: Participation only tracked

	regionally, 4: Participation not tracked regionally/statewide, 5: Participation can be tracked at Covered California level
Number of California members identified as obese in 2016. (If Applicant has and tracks use by Medi-Cal members as well, number here should include Medi-Cal numbers.)	*Decimal.* From 0 to 1000000000.
% of California members identified as obese	*Percent.*
Number of Exchange members identified as obese in 2016.	*Decimal.* From 0 to 1000000000.
% of Exchange members identified as obese	*Percent.*
Number of California members identified as obese who participated in a weight management program during 2016. (If the Applicant has and tracks use by Medi-Cal members as well, number here should include Medi-Cal numbers.)	*Decimal.* From 0 to 1000000000.
% of California members identified as obese who are participating in weight management program (# program participants divided by # of identified obese)	*Percent.*
Number of Exchange members identified as obese who participated in weight management program during 2016.	*Decimal.* From 0 to 1000000000.
% of Exchange members identified as obese who are participating in weight management program (# program participants divided by # of identified obese)	*Percent.*

18.9.11 Identify the programs or materials that are offered to support health and wellness for currently enrolled commercial and Exchange members.

Requirements that include the term "targeted" when referencing information or education should be consistent with threshold criteria for Information Therapy ("Ix"). Requirements for being classified as Ix include:

1. Being targeted to one or more of the individual's current moments in care.
2. Being proactively provided/prescribed to the individual.

3. Supporting one of more of the following: informed decision making, and/or skill building and motivation for effective self-care and healthy behaviors to the moment in care, and/or patient comfort/acceptance.
4. Being tailored to an individual's specific needs and/or characteristics, including their health literacy and numeracy levels.
5. Being accurate, comprehensive, and easy to use.

	Program offered
Template newsletter articles/printed materials about those preventive services (e.g., cancer screenings, immunizations) that are available to beneficiaries with $0 cost share under the ACA	*Single, Pull-down list.* 1: Offered, 2: Service/program not available
Customized printed materials about those preventive services (e.g., cancer screenings, immunizations) that are available to beneficiaries with $0 cost share under the ACA	*Single, Pull-down list.* 1: Offered, 2: Service/program not available
On-site bio-metric screenings (blood pressure, lab tests, bone density, body fat analysis, etc.)	*Single, Pull-down list.* 1: Offered, 2: Service/program not available
Nutrition classes/program	*Single, Pull-down list.* 1: Offered, 2: Service/program not available
Fitness classes/program	*Single, Pull-down list.* 1: Offered, 2: Service/program not available
Weight loss classes/program	*Single, Pull-down list.* 1: Offered, 2: Service/program not available
Weight management program	*Single, Pull-down list.* 1: Offered, 2: Service/program not available

Tobacco cessation support program	*Single, Pull-down list.* 1: Offered, 2: Service/program not available
24/7 telephonic nurse line: Nurseline support is offered as a benefit to the general membership and is often a one-time interaction with a member seeking advice.	*Single, Pull-down list.* 1: Offered, 2: Service/program not available
24/7 Nurse Navigator for Oncology Management	*Single, Pull-down list.* 1: Offered, 2: Service/program not available
24/7 Nurse Navigator for complex conditions (specify in detail box)	*Single, Pull-down list.* 1: Offered, 2: Service/program not available
Inbound telephonic health coaching: Inbound Telephone Coaching means a member enrolled in a Chronic Condition Management (CCM) Program has the ability to call and speak with a health coach at any time and support is on-going as long as the member remains in the DM/CCM program.	*Single, Pull-down list.* 1: Offered, 2: Service/program not available
Outbound telephone health coaching (personal outreach and coaching involving live interaction with a person)	*Single, Pull-down list.* 1: Offered, 2: Service/program not available
Member care/service reminders (IVR)	*Single, Pull-down list.* 1: Offered, 2: Service/program not available
Member care/service reminders (Paper)	*Single, Pull-down list.* 1: Offered, 2: Service/program not available
Targeted personal Health Assessment (HA) formerly known as health risk assessment (HRA)	*Single, Pull-down list.* 1: Offered, 2: Service/program not available
In-person lectures or classes	*Single, Pull-down list.* 1: Offered,

	2: Service/program not available
Social Networks for group-based health management activities, defined as online communities of people who voluntarily share health information or exchange commentary based on a common health issue or interests (e.g., managing diabetes, weight loss, or smoking cessation)	*Single, Pull-down list.* 1: Offered, 2: Service/program not available
Access to PCMH and/or ACO Providers	*Single, Pull-down list.* 1: Offered, 2: Service/program not available

18.9.12 As part of total population management and person-centered care, summarize Applicant activities and ability to:

- identify members who are non-users (no claims),
- engage those members in staying/becoming healthy, and
- support Purchasers in communication and engagement

	Response/Summary	Geography of response
Percent of total commercial membership with no claims in CY 2016	*Percent.* N/A OK.	*Single, Radio group.* 1: Regional, 2: State
Summary (bullet points) of plan activities to engage members who are non-users	*100 words.* N/A OK.	
Summary (bullet points) of support provided to Purchasers to engage members who are non-users	*100 words.* N/A OK.	

18.9.13 Indicate activities and capabilities supporting the 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: 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,

8: Addressing At-risk Behaviors: Personalized HA report is generated after HA completion that provides member-specific risk modification actions based on responses,
9: Addressing At-risk Behaviors: Members are directed to targeted interactive intervention module for behavior change upon HA completion,
10: 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),
11: Addressing At-risk Behaviors: Member is automatically enrolled into a disease management or at-risk program based on responses,
12: Addressing At-risk Behaviors: Case manager or health coach outreach call triggered based on HA results,
13: Addressing At-risk Behaviors: Member can elect to have HA results sent electronically to personal physician,
14: Addressing At-risk Behaviors: Member can update responses and track against previous responses,
15: Tracking health status: HA responses incorporated into member health record,
16: Tracking health status: HA responses tracked over time to observe changes in health status,
17: Tracking health status: HA responses used for comparative analysis of health status across geographic regions,
18: Tracking health status: HA responses used for comparative analysis of health status across demographics,
19: Partnering with Employers: Employer receives trending report comparing current aggregate results to previous aggregate results,
20: Partnering with Employers: Health plan can import data from employer-contracted HA vendor,
21: Applicant does not offer an HA

18.9.14 Provide the number of currently enrolled commercial and Exchange members who completed a Health Assessment (HA) in the past year.

	Answer
Geography reported below for HA completion Please select only ONE of response options 1-4 and include response option 5 if applicable	*Multi, Checkboxes.* 1: Participation tracked statewide & regionally, 2: Participation only tracked statewide, 3: Participation only tracked regionally, 4: Participation not tracked regionally/statewide, 5: Participation can be tracked at Covered California level
Number of members completing Plan-based HA in 2016. (If Applicant has and tracks use by Medi-Cal members as well, number here should include Medi-Cal numbers.)	*Decimal.* From 0 to 10000000000000000000.
Percent HA completion (Health plan HA completion number divided by total enrollment)	Percent.
Number of completed HAs resulting in referral to health plan case management staff or assigned provider	*Decimal.*
Percent completed HAs resulting in referral to health plan case management staff or assigned provider (Referral number divided by number of completed HAs)	Percent.

18.9.15 Does Applicant collect information, at both individual and aggregate levels, on changes in Enrollees' health status? Please describe Applicant's process to monitor and track changes in Enrollees' health status, which may include its process for identifying individuals who show a decline in health status, and referral of such Enrollees to care management and chronic condition program(s). Include in the answer how many Exchange enrollees, across all lines of business, have been identified through the process and referred to care management, chronic condition program(s), or other services as a result of a change in health status. If Applicant does not currently have Exchange business, report on all lines of business.

100 words.

18.10 Community Health and Wellness Promotion

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

18.10.1 Provide a description of the initiatives, programs and projects Applicant supports, and how such programs specifically address health disparities or efforts to improve community health apart from the health delivery system. Examples include California State Innovation Model (CalSIM), Health in All Policies (HIAP), The California Endowment Healthy Communities, and Beach Cities Health District. Please select the category or categories below that best describe the specific activity and provide a brief narrative report about the activity. Please include any evaluation results of the activity or program, if available.

Definitions:

- Internal: initiative, program, or project is only available to enrolled plan members.
- External: initiative, program, or project is available to anyone in a community, regardless of membership in the health plan.
- Evidence-based program: initiatives that have undergone or are being piloted through systematic review to determine effectiveness in promoting health and preventing disease, injury, or disability and have been recommended by the Community Preventive Services Task Force.

Multi, Checkboxes.

1: Internal facing, member related efforts (e.g.: self-help workshops, prevention, health education programs for members): [100 words],
2: Internal facing, member related efforts non-health-related (e.g., education, goal-setting, environment, literacy, etc.): [100 words],
3: External facing, high level community facing activities, health-related (e.g.: health fairs, attendance at community coalitions and collaboratives): [100 words],
4: External facing, non-health-related (e.g., education): [100 words],
5: Engaged with health systems to conduct community risk assessment to identify high priority needs and health disparities: [100 words],
6: Community health effort (e.g. screening programs, exercise programs, etc.) built on evidence-based program and policy interventions, and planned evaluation included in the initiative: [100 words],
7: Health plan-funded community health programs based on needs assessments or other activity (not related to disaster relief efforts): [100 words],
8: Participated in geographic disaster relief efforts (e.g., weather, fire, environmental): [100 words],
9: Plan does not conduct any community health initiatives

18.10.2 If Applicant has supporting documentation for any activities listed in 18.10.1, upload as a file under the title “Community Health 1” and include question number 18.10.2.

Single, Pull-down list.
1: Yes, Community Health 1 attached,
2: Not attached

18.11 At-Risk Enrollees

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

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

100 words.

18.11.2 For the Exchange business, please provide (1) the number of members aged 18 and above in first row, (2) the number of members aged 18 and above identified under Applicant’s criteria for at-risk enrollees eligible for case management in the second row. If Applicant does not currently have Exchange business, report on all lines of business excluding Medicare.

Starting at row 3, indicate the types of interventions that are received by the population based on Applicant’s criteria for at-risk enrollees eligible for case management.

- Select “Interactive IVR with information capture” only if it involves record updates and/or triggering additional intervention.
- Select “member-specific reminders” only if it involves reminders that are independent of the live outbound telephonic program.
- Select online interactive self-management only if the application involves customized information based on branch logic. Examples include devices that monitor weight, lab levels, etc., as well as web-support activities that are customized and tailored based on the member's health status/risk factors. Interactive implies a response mechanism that results in calibration of subsequent interventions. This category does not include static web information. A member is “actively engaged” in the outbound telephonic program if they participate beyond the initial coaching call.

For member counts use the number of members as of December 31st, 2016 who participated in the activity at any time during 2016.

Note column 3 # members should be unique and not double counted - if ONE member receives 10 member specific reminders, that member should only be counted ONCE.

Respondent must select either response option 4 OR 5 for response to be considered "complete".

	Number of members as	Indicate if intervention is offered to at-risk	Number of members 18 years and above in this	Is intervention a standard or buy-up option	Auto-calculated % of at-risk enrollee

	specified in rows 1, and 2	enrollees in this state/region	state/market receiving intervention (if plan offers intervention but does not track participation, enter NA)	(Cost of Intervention)	eligibles who received intervention
Number of members aged 18 and above in this state or market	*Decimal.*				
Using Applicant's definition, provide number of members 18 and above who are at-risk enrollees	*Decimal.*				
Member-specific reminders for due or overdue clinical/diagnostic maintenance services Answer "member-specific reminders" only if it involves reminders that are independent of the live outbound telephonic program		*Multi, Checkboxes.* 1: HMO, 2: PPO, 3: EPO, 4: Intervention not offered, 5: Regional number provided, 6: State number provided, 7: Offered but not tracked	*Decimal.* From 0 to 100000000000.	*Multi, Checkboxes.* 1: Included as part of high-risk program with no additional fee, 2: Inclusion of this intervention requires an additional fee, 3: Inclusion of this intervention sometimes requires additional fee, depending on contract, 4: Intervention available outside of a specific program as a standard benefit for fully insured lives, 5: Intervention available outside of a specific program as a standard benefit for self-insured lives (part of the	Percent.

				ASO fee), 6: Intervention available outside of a specific program as a buy-up option for fully insured lives, 7: Intervention available outside of a specific program as buy-up option for self-insured lives, 8: Not available	
Member-specific reminders for medication events (e.g., level of use, failure to refill) Answer "member-specific reminders" only if it involves reminders that are independent of the live outbound telephonic program		*Multi, Checkboxes.* 1: HMO, 2: PPO, 3: EPO, 4: Intervention not offered, 5: Regional number provided, 6: State number provided, 7: Offered but not tracked	*Decimal.* From 0 to 100000000000.	*Multi, Checkboxes.* 1: Included as part of high-risk program with no additional fee, 2: Inclusion of this intervention requires an additional fee, 3: Inclusion of this intervention sometimes requires additional fee, depending on contract, 4: Intervention available outside of a specific program as a standard benefit for fully insured lives, 5: Intervention available outside of a specific program as a standard benefit for self-insured lives (part of the ASO fee), 6: Intervention available outside of a specific program as a buy-up option for fully insured lives, 7: Intervention available outside of a specific program as buy-up option for self-	Percent.

				insured lives, 8: Not available	
Online interactive self-management support. "Online self-management support" is an intervention that includes two-way electronic communication between the Plan and the member. Examples include devices that monitor weight, lab levels, etc. as well as web-support activities that are customized and tailored based on the member's health status/risk factors. Interactive implies a response mechanism that results in calibration of subsequent interventions. This category does not include searchable static web information.		*Multi, Checkboxes.* 1: HMO, 2: PPO, 3: EPO, 4: Intervention not offered, 5: Regional number provided, 6: State number provided, 7: Offered but not tracked	*Decimal.* From 0 to 100000000000.	*Multi, Checkboxes.* 1: Included as part of high-risk program with no additional fee, 2: Inclusion of this intervention requires an additional fee, 3: Inclusion of this intervention sometimes requires additional fee, depending on contract, 4: Intervention available outside of a specific program as a standard benefit for fully insured lives, 5: Intervention available outside of a specific program as a standard benefit for self-insured lives (part of the ASO fee), 6: Intervention available outside of a specific program as a buy-up option for fully insured lives, 7: Intervention available outside of a specific program as buy-up option for self-insured lives, 8: Not available	Percent.
Self-initiated text/email messaging		*Multi, Checkboxes.* 1: HMO, 2: PPO, 3: EPO, 4: Intervention not offered, 5: Regional number	*Decimal.* From 0 to 100000000000.	*Multi, Checkboxes.* 1: Included as part of high-risk program with no additional fee, 2: Inclusion of this intervention requires an	Percent.

		provided, 6: State number provided, 7: Offered but not tracked		additional fee, 3: Inclusion of this intervention sometimes requires additional fee, depending on contract, 4: Intervention available outside of a specific program as a standard benefit for fully insured lives, 5: Intervention available outside of a specific program as a standard benefit for self-insured lives (part of the ASO fee), 6: Intervention available outside of a specific program as a buy-up option for fully insured lives, 7: Intervention available outside of a specific program as buy-up option for self-insured lives, 8: Not available	
Interactive IVR with information capture Answer "Interactive IVR with information capture" only if it involves information capture of member response information for record updates and/or triggering additional intervention.		*Multi, Checkboxes.* 1: HMO, 2: PPO, 3: EPO, 4: Intervention not offered, 5: Regional number provided, 6: State number provided, 7: Offered but not tracked	*Decimal.* From 0 to 100000000000.	*Multi, Checkboxes.* 1: Included as part of high-risk program with no additional fee, 2: Inclusion of this intervention requires an additional fee, 3: Inclusion of this intervention sometimes requires additional fee, depending on contract, 4: Intervention available outside of a specific program as a	Percent.

				standard benefit for fully insured lives, 5: Intervention available outside of a specific program as a standard benefit for self-insured lives (part of the ASO fee), 6: Intervention available outside of a specific program as a buy-up option for fully insured lives, 7: Intervention available outside of a specific program as buy-up option for self-insured lives, 8: Not available	
IVR with outbound messaging only		*Multi, Checkboxes.* 1: HMO, 2: PPO, 3: EPO, 4: Intervention not offered, 5: Regional number provided, 6: State number provided, 7: Offered but not tracked	*Decimal.* From 0 to 100000000000.	*Multi, Checkboxes.* 1: Included as part of high-risk program with no additional fee, 2: Inclusion of this intervention requires an additional fee, 3: Inclusion of this intervention sometimes requires additional fee, depending on contract, 4: Intervention available outside of a specific program as a standard benefit for fully insured lives, 5: Intervention available outside of a specific program as a standard benefit for self-insured lives (part of the ASO fee), 6: Intervention	Percent.

				available outside of a specific program as a buy-up option for fully insured lives, 7: Intervention available outside of a specific program as buy-up option for self-insured lives, 8: Not available	
Live outbound telephonic coaching program (count only members that are successfully engaged)		*Multi, Checkboxes.* 1: HMO, 2: PPO, 3: EPO, 4: Intervention not offered, 5: Regional number provided, 6: State number provided, 7: Offered but not tracked	*Decimal.* From 0 to 100000000000.	*Multi, Checkboxes.* 1: Included as part of high-risk program with no additional fee, 2: Inclusion of this intervention requires an additional fee, 3: Inclusion of this intervention sometimes requires additional fee, depending on contract, 4: Intervention available outside of a specific program as a standard benefit for fully insured lives, 5: Intervention available outside of a specific program as a standard benefit for self-insured lives (part of the ASO fee), 6: Intervention available outside of a specific program as a buy-up option for fully insured lives, 7: Intervention available outside of a specific program as buy-up option for self-insured lives, 8: Not available	Percent.

Face-to-Face visits		*Multi, Checkboxes.* 1: HMO, 2: PPO, 3: EPO, 4: Intervention not offered, 5: Regional number provided, 6: State number provided, 7: Offered but not tracked	*Decimal.* From 0 to 100000000000.	*Multi, Checkboxes.* 1: Included as part of high-risk program with no additional fee, 2: Inclusion of this intervention requires an additional fee, 3: Inclusion of this intervention sometimes requires additional fee, depending on contract, 4: Intervention available outside of a specific program as a standard benefit for fully insured lives, 5: Intervention available outside of a specific program as a standard benefit for self-insured lives (part of the ASO fee), 6: Intervention available outside of a specific program as a buy-up option for fully insured lives, 7: Intervention available outside of a specific program as buy-up option for self-insured lives, 8: Not available	Percent.

18.11.3 Describe Applicant's process for keeping and updating a medical history of at-risk enrollees in the Applicant's maintained enrollee health profile.

65 words.

18.11.4 Does Applicant share registries of enrollees with their identified risk, as permitted by state and federal law, with appropriate accountable providers, especially the enrollee's PCP. If yes, please describe.

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

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

100 words.

18.12 Payment Incentives to Promote Higher Value Care

The Exchange recognizes the critical role of both consumer and provider incentives to achieve value in the health system and bend the cost curve. The Exchange supports the work of Catalyst for Payment Reform's (CPR) in redesigning professional payment to align with the Triple Aim. The Exchange will work with QHP issuers and other purchasers to support the completion of the National Scorecard on Payment Reform and the CPR Payment Reform Evaluation Framework.

18.12.1 The Exchange will coordinate with QHP issuers and purchasers to define reporting requirements to support overall CPR efforts. Applicant confirms it will comply with potential future reporting requirements and support for CPR efforts.

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

19 Covered California Quality Improvement Strategy (QIS)

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

Attachment 7 of the Covered California Qualified Health Plan (QHP) Issuer Contract embodies the Exchange's vision for reform and serves as a roadmap to delivery system improvements. Beginning with the 2017 QHP Issuer Contract, QHP issuers will be engaged in and supporting existing quality improvement initiatives and programs that are sponsored by other major purchasers including the Department of Health Care Services (DHCS), the California Public Employees' Retirement System (CalPERS), the Pacific Business Group on Health (PBGH), and CMS. These requirements are reflected in the 2017 contract and will be in all successive contracts through 2019. Certification and participation in the Exchange will be conditional on the 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 also serves as the foundational improvement plan and progress report for certification and contractual requirements. All Applicants, both those previously contracted with the Exchange as well as new entrants, are required to complete the QIS as part of this Application. Reporting is divided into two parts:

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

The QIS will be evaluated by the Exchange as part of the annual application for certification and final approval by the Exchange may require follow-up meetings or documentation as necessary. Currently contracted Applicants will submit responses reflecting contractually required progress in these areas by July 10, 2017. QHP Issuers applying for the 2018 Plan Year may submit an update to the QIS submitted in the Plan Year 2017 Certification Application, but please note new questions for reporting progress on the initiative area. New entrant Applicants applying for 2018 should refer to Appendix H 2017 QHP Issuer Contract Attachment 7 for information on each initiative area. Throughout this section, Year One refers to the first year of an Applicant's QIS, and Year Two refers to the second year of an Applicant's QIS.

19.1 Issuer Information

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

19.1.1

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

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

Refer to Appendix H 2017 QHP Contract Attachment 7 for all requirements related to each initiative area.

19.2.1 QIS for Provider Networks Based on Quality

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

19.2.1.1 List all quality measures and criteria used to develop provider networks, including patient safety and patient-reported experience, and explain the assessment process, source of quality assessment data, specific measures and metrics, and thresholds for inclusion and exclusion in the network.

100 words.

19.2.1.2 Provide a brief summary of how the criteria listed in 19.2.1.1, and any additional considerations, are used to develop provider networks. If applicable, describe which criteria are prioritized above other criteria to determine the provider network.

100 words.

19.2.1.3 List all measures and criteria used to develop for hospital networks, including patient safety, and explain the assessment process, source of quality assessment data, specific measures and metrics, and thresholds for inclusion and exclusion in the network. Specifically address whether any hospital-acquired condition (HAC) measures are used.

100 words.

19.2.1.4 Provide a brief summary of how the criteria listed in 19.2.1.3, and any additional considerations, are used to develop hospital networks. If applicable, describe which criteria are prioritized above other criteria to determine the hospital network.

100 words.

19.2.1.5 Report the basis for inclusion of Centers of Excellence in the provider network, the method used to promote members' usage of these centers, and the utilization of these centers by Exchange enrollees.

100 words.

19.2.1.6 If new entrant Applicant, what activities will be conducted to implement the QIS on provider networks in Year One (2018)? List the activities to be implemented to achieve the identified goals and describe how the activities address market-based incentives, if applicable.

200 words.

19.2.1.7 If Applicant is currently contracted for the 2017 Plan Year, report on progress made in Year One of the QIS, and any planned activities for Year Two to achieve the Applicant's aims. If applicable, report on the development of market-based incentives to improve network quality.

200 words.

19.2.1.8 List any known or anticipated barriers in implementing QIS activities and describe mitigation activities that will be incorporated into the QIS if needed.

200 words.

19.2.2 QIS for Reducing Health Disparities and Ensuring Health Equity

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

2017 QHP Issuer Contract, Section 3.01 and 3.02.

19.2.2.1 Provide the percent of Exchange members, for whom self-reported data is captured for race/ethnicity in Attachment E QIS Run Charts. If Applicant does not currently have Exchange business, report on all lines of business excluding Medicare. Self-identification may take place through the enrollment application, web site registration, health assessment, reported at provider site, etc. For currently contracted Applicants, enter the percentage reported in the plan year 2017 Certification Application as well.

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

19.2.2.2 The Exchange requires annual reporting of health disparities measures. For more information on the measures, refer to Appendix R Attachment 7_Measurement Specifications.
Applicant must confirm it will comply with measure reporting requirements and timeline.

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

19.2.2.3 If new entrant Applicant for the 2018 Plan Year, what activities will be conducted to implement the QIS on reducing health disparities and ensuring health equity in Year One (2018)? List the activities to be implemented to achieve the identified goals and describe how the activities address market-based incentives, if applicable.

200 words.

19.2.2.4 If Applicant is currently contracted for the 2017 Plan Year, report on progress made in Year One of the QIS and planned activities for Year Two to achieve the Applicant's aims. If applicable, report on the development of market-based incentives to reduce disparities and assure health equity.

200 words.

19.2.2.5 List any known or anticipated barriers in implementing QIS activities and describe mitigation activities that will be incorporated into the QIS if needed.

200 words.

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

*Federal QIS Topic Area: Activities for improving health outcome*s
2017 QHP Issuer Contract, Sections 4.01 and 4.02.

19.2.3.1 Report, by product, the percentage of members by product in Applicant's Exchange business who either selected a Personal Care Physician (PCP) or were matched with a Personal Care Physician in 2016 in Attachment E QIS Run Charts. If the Applicant had no Exchange business in 2016, report full book of business

excluding Medicare. For currently contracted Applicants, enter the percentage reported for the 2015 Plan Year as well. Report data by product (HMO, PPO, EPO).

Single, Pull-down list.
1: Attached,
2: Not attached,
3: N/A

19.2.3.2 If Applicant engaged in the PCP matching initiative for plan year 2017 to assign members in PPO and EPO plans to a PCP, provide a status report on implementation, including feedback on the consumer experience, complaints, and positive feedback, as well as suggestions for open enrollment for the 2018 Plan Year. If the Applicant already assigned members to PCPs prior to plan year 2017 or did not engage in this initiative, enter "N/A."

200 words.

19.2.3.3 Report the number and percentage of Exchange members who obtain their primary care with a provider or clinic that has received either NCQA PCMH Recognition or The Joint Commission PCMH Certification in Attachment E QIS Run Charts. If Applicant did not have Exchange business during the prior calendar year, please report on the full book of business.

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

19.2.3.4 Report the types of payment strategies used for primary care services and number of providers paid under each strategy in Attachment E QIS Run Charts. If the Applicant has adopted a model consistent with a Level 3 or 4 alternative payment model (APM) as outlined in the LAN Draft White Paper on Primary Care Payment Models or aligned with CMMI's Comprehensive Primary Care Plus program, please include the strategy and description in the attachment (even if newly adopted but not yet implemented among providers).

References:

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

CMMI Comprehensive Primary Care Plus: https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus

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

19.2.3.5 In designing payment for their primary care physicians, have contracted physician organizations adopted Level 3 or 4 APMs described in the LAN Draft White Paper? Describe the predominant payment structure used among contracted groups and their progress towards implementing APMs.

200 words.

19.2.3.6 Describe any specific educational support that the Applicant or multi-insurer collaborative is providing to PCMH practices to help support their efforts at transformation. Check all that apply and provide any additional details in the details box.

Multi, Checkboxes.
1: Coaching by practice coaches trained in the PCMH, details: [20 words],
2: Participation in a multiple session learning collaborative focusing on PCMH, details: [20 words],
3: Other, specify: [20 words],
4: No support is provided,
5: No PCMH in this market

19.2.3.7 What other support (e.g., technical, financial, personnel, etc.) is being provided to PCMHs to help in transformation?

Type Support	Description of support	Regions or specific practices where support is available
Financial	*200 words.*	*200 words.*
Technical	*200 words.*	*200 words.*
Personnel	*200 words.*	*200 words.*
Other:	*200 words.*	*200 words.*

19.2.3.8 How will Applicant encourage enrollees to use providers with PCMH recognition?
100 words.

19.2.3.9 If new entrant Applicant, what activities will be conducted to implement the QIS on promoting development and use of care models - primary care in Year One (2018)? List the activities to be implemented to achieve the identified goals and describe how the activities address market-based incentives, if applicable.
200 words.

19.2.3.10 If Applicant is currently contracted for the 2017 Plan Year, report on progress made in Year One of the QIS and any planned activities for Year Two to achieve the Applicant's aims. If applicable, report on the development of market-based incentives to promote primary care models.
200 words.

19.2.3.11 List any known or anticipated barriers in implementing QIS activities and describe mitigation activities that will be incorporated into the QIS if needed.
200 words.

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

Federal QIS Topic Area: Activities for improving health outcomes
2017 QHP Issuer Contract, Section 4.03

19.2.4.1 Using the definition for IHMs in Appendix H 2017 QHP Contract Attachment 7, provide details on existing or planned integrated systems of care. State the following:

	Response
Line of business for which the IHM is or will be available (Exchange, Commercial non-Exchange, Medicare, Medicaid, other)	*Multi, Checkboxes.* 1: Exchange, 2: Commercial non-Exchange, 3: Medicare, 4: Medicaid, 5: other, 6: N/A
Product for which the IHM is or will be available	*Multi, Checkboxes.* 1: HMO, 2: EPO, 3: POS, 4: Other, 5: PPO
Location (California Rating Region)	*Multi, Checkboxes.* 1: Region 1, 2: Region 2, 3: Region 3, 4: Region 4, 5: Region 5, 6: Region 6, 7: Region 7, 8: Region 8, 9: Region 9, 10: Region 10, 11: Region 11, 12: Region 12, 13: Region 13, 14: Region 14, 15: Region 15, 16: Region 16, 17: Region 17, 18: Region 18, 19: Region 19, 20: No planned or existing systems in any region
Indicate whether the IHM is founded on an existing provider organization or if it joins multiple providers/groups together under the IHM.	*100 words.*
Number of California members in the product who are managed under the IHM	*Integer.*

Percent of California members in the product who are managed under the IHM	*Percent.*
Number or percent of California members in the product who are managed under the IHM unknown	*Yes/No.*
Number of Exchange members in the product who are managed under the IHM	*Integer.*
Percent of Exchange members in the product who are managed under the IHM	*Percent.*
Number or percent of Exchange members in the product who are managed under the IHM unknown	*Yes/No.*

19.2.4.2 Provide as attachments the following documents related to IHMs:

1. (File titled Provider 1a): Plan methodology for documentation on the Triple Aim (quality, enrollee experience, total cost of care), measures in use and weighting of measures or measurement domains, if used for performance payments in IHM. Describe any applicable performance threshold requirements. Indicate the measures that are used for measurement and reporting, and those measures that are used for determination of gainsharing or performance rewards.
2. (File titled Provider 1b): Example of plan report to the IHM on its quality of care and financial performance, including benchmarking relative to performance improvement goals or market norms.

Single, Pull-down list.
1: Attached,
2: Not attached,
3: N/A

19.2.4.3 Describe any specific educational support that the Applicant or multi-insurer collaborative is providing to IHMs to help support their efforts at transformation. Check all that apply.

Multi, Checkboxes.
1: Coaching by practice coaches trained in IHMs,
2: Participation in a multiple session learning collaborative focusing on IHMs,
3: Other, specify: [20 words],
4: No support is provided,
5: No ACO in this market

19.2.4.4 What other support (e.g., technical, financial, personnel, etc.) is being provided to IHMs to help in transformation?

Type Support	Description of support	Regions or specific practices where support is available
Financial	*200 words.*	*200 words.*
Technical	*200 words.*	*200 words.*
Personnel	*200 words.*	*200 words.*
Other:	*200 words.*	*200 words.*

19.2.4.5 If new entrant, what activities will be conducted to implement the QIS on promoting development and use of care models - IHMs in Year One (2018)? List the activities to be implemented to achieve the identified goals and describe how the activities address market-based incentives, if applicable.

500 words.

19.2.4.6 If Applicant is currently contracted for the 2017 Plan Year, report on progress made in Year One of the QIS and any planned activities for Year Two to achieve the Applicant's aims. If applicable, report on the development of market-based incentives to promote development of IHMs.

200 words.

19.2.4.7 List any known or anticipated barriers in implementing QIS activities and describe mitigation activities that will be incorporated into the QIS if needed.

200 words.

19.2.5 QIS for Appropriate Use of C-Sections

Federal QIS Topic Area: Activities for improving health outcomes
2017 QHP Issuer Contract, Section 5.03

19.2.5.1 Report number of all network hospitals reporting to the California Maternity Quality Care Collaborative's (CMQCC) Maternal Data Center (MDC) in Attachment E QIS Run Charts. A list of all California hospitals participating in the MDC can be found in the link in the question "Who's already participating?" on the MDC's FAQ page: https://www.cmqcc.org/maternal-data-center/california-mdc/faq-why-participate." For currently contracted Applicants, enter the percentage reported for the Plan Year 2017 Certification Application as well.

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

19.2.5.2 Has Applicant included the following factors for consideration when developing the network of maternity hospitals?

1) Participation in CMQCC
2) Maternity care quality improvement for hospitals, particularly those with an NTSV rate higher than 23.9
3) Achievement of a NTSV C-section rate of 23.9% or less by year-end 2019

Use the applicable details box to describe how these factors are considered in the network development process, or if they are not used, what criteria Applicant considers to develop the maternity hospital network.

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

19.2.5.3 Provide a description of current payment strategies for maternity services across all lines of business, and specifically address whether payment differs based on vaginal or C-Section delivery. Report strategies and number of network hospitals paid using this payment strategy in Attachment E QIS Run Charts. For currently contracted Applicants, enter the percentages reported for the Plan Year 2017 Certification Application as well.

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

19.2.5.4 If new entrant Applicant, what activities will be conducted to implement the QIS on maternity care and appropriate use of C-Sections in Year One (2018)? List the activities to be implemented to achieve the identified goals and describe how the activities address market-based incentives, if applicable.

200 words.

19.2.5.5 If Applicant is currently contracted for the 2017 Plan Year, report on progress made in Year One of the QIS and any planned activities for Year Two to achieve the Applicant's aims. If applicable, report on the development of market-based incentives to promote appropriate use of C-Sections.

200 words.

19.2.5.6 List any known or anticipated barriers in implementing QIS activities and describe mitigation activities that will be incorporated into the QIS if needed.

200 words.

19.2.6 QIS for Hospital Patient Safety

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

19.2.6.1 Describe Applicant's strategy for promoting Hospital Improvement Innovation Networks (HIIN) participation among the non-participating network hospitals.

References:

Information on Partnership for Patients: https://partnershipforpatients.cms.gov/

Hospital participation in HIINs: https://partnershipforpatients.cms.gov/about-the-partnership/hospital-engagement-networks/thehospitalengagementnetworks.html

200 words.

19.2.6.2 Describe Applicant's strategy to track hospitals in network with Hospital Acquired Conditions (HACs) that have a standardized infection ratio (SIR) above 1.0 and progress towards improvement. Please refer to Appendix S1 CAUTI Rates, Appendix S2 CLABSI Rates, Appendix S3 C Diff Rates, Appendix S4 MRSA Rates, and Appendix S5 SSI Colon Rates.

200 words.

19.2.6.3 Report, across all lines of business, the percentage of hospital reimbursement at risk for quality performance and the quality indicators used in Attachment E QIS Run Charts. In the details section of the spreadsheet, describe the model used to put payment at risk, and note if more than one model is used. "Quality performance" includes any number or combination of indicators, including HACs, readmissions, patient satisfaction, etc. In the same sheet, report quality indicators used to assess quality performance. For currently contracted Applicants, enter the percentages reported for the Plan Year 2017 Certification Application as well.

Single, Pull-down list.

1: Attached,
2: Not attached

19.2.6.4 Report the number of hospitals contracted under the model described in question 19.3.6.3 with reimbursement at risk for quality performance in Attachment E QIS Run Charts. For currently contracted Applicants, enter the numbers reported for the Plan Year 2017 Certification Application as well.

Single, Pull-down list.

1: Attached,
2: Not attached

19.2.6.5 If new entrant Applicant, what activities will be conducted to implement the QIS on hospital safety in Year One (2018)? List the activities to be implemented to achieve the identified goals and describe how these activities address market-based incentives, if applicable. Please refer to Appendix S1 CAUTI Rates, Appendix S2 CLABSI Rates, Appendix S3 C Diff Rates, Appendix S4 MRSA Rates, and Appendix S5 SSI Colon Rates.

200 words.

19.2.6.6 If Applicant is currently contracted for the 2017 Plan Year, report on progress made in Year One of the QIS and any planned activities for Year Two to achieve the Applicant's aims. If applicable, report on the development of market-based incentives to promote hospital patient safety. Please refer to Appendix S1 CAUTI Rates, Appendix S2 CLABSI Rates, Appendix S3 C Diff Rates, Appendix S4 MRSA Rates, and Appendix S5 SSI Colon Rates.

200 words.

19.2.6.7 List any known or anticipated barriers in implementing QIS activities and describe mitigation activities that will be incorporated into the QIS if needed.

200 words.

19.2.7 QIS for Patient-Centered Information and Support

Federal QIS Topic Area: Activities for improving health outcomes
2017 QHP Issuer Contract, Sections 7.01 and 7.02

19.2.7.1 Describe the web-based cost information that Applicant makes available for each provider category below. Web based cost information should include common elective procedures where members have time to shop and there may be variation in contract price and out of pocket costs to the member. Check all that apply to Applicant's non-HMO products. (Note, applicants offering only HMO products may answer "not applicable".)

	Physicians	Hospitals	Ambulatory surgery or diagnostic centers
Procedure-based cost	*Multi, Checkboxes.* 1: National average billed charges, 2: National average paid charges, 3: Regional or provider average billed charges, 4: Regional or provider average paid charges, 5: Provider specific contracted rates, 6: Cost information not available, 7: Information available only to members, 8: Information available to public, 9: Not applicable (HMO only)	*Multi, Checkboxes.* 1: National average billed charges, 2: National average paid charges, 3: Regional or provider average billed charges, 4: Regional or provider average paid charges, 5: Provider specific contracted rates, 6: Cost information not available, 7: Information available only to members, 8: Information available to public, 9: Not applicable (HMO only)	*Multi, Checkboxes.* 1: National average billed charges, 2: National average paid charges, 3: Regional or provider average billed charges, 4: Regional or provider average paid charges, 5: Provider specific contracted rates, 6: Cost information not available, 7: Information available only to members, 8: Information available to public, 9: Not applicable (HMO only)
Episode of care based cost (e.g. vaginal birth, bariatric surgery)	*Multi, Checkboxes.* 1: National average billed charges, 2: National average paid charges, 3: Regional or provider average billed charges, 4: Regional or provider average paid charges, 5: Provider specific contracted rates, 6: Cost information not available,	*Multi, Checkboxes.* 1: National average billed charges, 2: National average paid charges, 3: Regional or provider average billed charges, 4: Regional or provider average paid charges, 5: Provider specific contracted rates, 6: Cost information not available,	*Multi, Checkboxes.* 1: National average billed charges, 2: National average paid charges, 3: Regional or provider average billed charges, 4: Regional or provider average paid charges, 5: Provider specific contracted rates, 6: Cost information not available,

	7: Information available only to members, 8: Information available to public, 9: Not applicable (HMO only)	7: Information available only to members, 8: Information available to public, 9: Not applicable (HMO only)	7: Information available only to members, 8: Information available to public, 9: Not applicable (HMO only)

19.2.7.2 For the provider categories in 19.2.7.1, where cost information is available to members, please indicate how it is available: online and searchable, online but not searchable, or through other means (for example, a call center). *(Note, Applicants offering only HMO products may answer "not applicable".)*

Multi, Checkboxes.
1: Online and searchable,
2: Online but not searchable,
3: Other, specify: [20 words],
4: Not Applicable (HMO only)

19.2.7.3 For each type of information below, indicate if it is available to members, and if it is available online or through other means.

	Available to members?	Available online or other means? (If other, please describe.)
Do members have a way to obtain their real time accumulation toward deductible(s), specific to their benefit plan?	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Do members have a way to obtain their real time accumulations toward out of pocket maximums specific to their benefit plan?	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
Do members have a way to obtain cost share information for prescription drugs specific to their benefit plan?	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*
If the applicant offers or plans to offer a Health Savings Account (HSA), do members have a way to obtain account deposit and withdrawal/payment amounts?	*Single, Pull-down list.* 1: Yes, 2: No	*50 words.*

19.2.7.4 Fulfilling the QIS Requirement: Please respond to (a) or (b) below as applicable based on anticipated Exchange enrollment.

a) If Applicant has or anticipates having Exchange enrollment of over 100,000 members, describe plans to ensure, by 2019, 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 all information described in Table 19.2.7.3 (a through d).

(Note in response if these requirements have already been fulfilled.)

b) If Applicant has or anticipates having Exchange enrollment of fewer than 100,000 members in Plan Year 2018, describe how Applicant will ensure, by 2019, 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 all information described in Table 19.2.7.3 (a through d). Information does not need to be provided online.

(Note in response if these requirements have already been fulfilled.)

200 words.

19.2.7.5 If Applicant offers online consumer support tools that require login, provide sample login information in lieu of screenshots.

50 words.

19.2.7.6 Please describe any quality related information currently included with cost information. If quality information is not included, please describe feasibility for inclusion by 2019.

200 words.

19.2.7.7 List any known or anticipated barriers in implementing QIS activities and describe mitigation activities that will be incorporated into the QIS if needed.

200 words.

19.2.7.8 8 If Applicant already has cost tools available to members, please report number and percent of unique enrollees for the Exchange line of business who used the tool in 2016.

100 words.

19.2.7.9 If Applicant has conducted a survey to evaluate the user experience with existing member cost tools, provide the survey results as an attachment labeled “Cost Calculator Results.” To the extent that experience is tracked by purchaser, report results by Applicant’s full book of business and Exchange line of business.

Single, Pull-down list.

1: Yes, Cost Calculator Results attached,
2: Not attached,
3: Not applicable, no survey conducted

19.2.7.10 Does Applicant use any of the following activities to identify members who would benefit from treatment decision support? Check all that apply.

Multi, Checkboxes.

1: Claims or clinical record profiling,
2: Specialty care referral process,
3: Personal Health Assessment,
4: Nurse advice line referral,
5: Care/case management support,
6: None of the above activities are used to identify specific treatment option decision support outreach