2021 CHECKLIST and ATTACHMENT
FOR QUALIFIED DENTAL PLANS IN THE
CALIFORNIA HEALTH BENEFIT EXCHANGE

In anticipation of Qualified Dental Plans (QDP) filings in relation to the Qualified Dental Plan Certification Application for Plan Year 2021, for Individual and Covered California for Small Business (CCSB) issued by the California Health Benefit Exchange (Exchange or Covered California), the Department of Managed Health Care (Department) offers the following checklist with some helpful hints to expedite approval based on previous experience working with Covered California and QDP filings. The checklist takes into account the Knox-Keene Act (Act or Sections) and implementing regulations at California Health & Safety Code Sections 1351 and 1352, and California Code of Regulations (Rules) Section 1300.51 and 1300.52.

This checklist is not intended to be all-inclusive. Additional information, as needed, may be requested by the Department within the course of review. The information gathered here is based on lessons learned from previous filing years. This checklist applies to both dental plans that contract directly with Covered California to offer standalone dental products and dental plans that contract with Full Service Qualified Health Plans (QHP) to offer pediatric dental essential health benefits (embedded). ***Information specific to only standalone or embedded filings is noted in brackets throughout the checklist.***

I. *This checklist is provided to the plan's e-Filing designated contact and is available on the Department's website.*

II. Filing Timeframes

Prior to Covered California certification, plans must have regulatory approval from the Department of necessary filings including, but not limited to, networks and products. **To ensure adequate time for the Department's review, the filing due date is earlier than Covered California application deadline.**

Plan Year 2021	**New Applicant; QDP Proposing New: Rating Region, Network Service Area Expansion and/or Line of Business**	**Recertification**
All Other Exhibits as Necessary	No later than April 1	No later than April 1
Provider Network	No later than March 2	No later than April 1
Product Designs	No later than April 1	No later than April 1

III. General Filing Information

a. For dental plans licensed pursuant to the Act, the Department has primary responsibility for regulatory review and issuing preliminary recommendations with respect to certain selection criteria identified by Covered California. The Department will evaluate whether an applicant is in "good standing," in addition to applying the minimum licensure requirements.

b. Filing Process: Prepare and submit an **Amendment or Material Modification**[1], addressing compliance with the Act, Rules, California Patient Protection and Affordable Care Act (CA-ACA) and Federal Patient Protection and Affordable Care Act of 2010 (ACA) laws and regulations relative to QDP certification.

   i. When submitting your filing, please:
      1. **Use the subject title "HBEX QDP Application 2021" and**

      2. **Select "QDP" under "Product & Issues - Issues" in the e-Filing system.** This selection will allow the Department to effectively track QDP-related filings.

c. File standalone dental benefits and embedded pediatric dental benefits with QHP(s) as separate filings.

d. ***[Embedded Filings]*** File contractual relationships (plan-to-plan agreements) with QHP(s) for embedded Essential Health Benefits (EHB) pediatric dental benefits **separately** from the plan's benefits filing(s).[2]

e. Network Filings for embedded EHBs and Standalone products are to be filed **separately** from the plan's QDP benefits filing(s). In each Exhibit E-1, cross-reference the QDP benefits and network Filing Numbers.

IV. Helpful Hints based on the Department's Review of Plan Year 2020

a. **Naming Convention:** Please refer back to Covered California and adhere to Covered California's naming convention for on-exchange plans and off-exchange mirror products pursuant to Government Code section 100503(f).

[1] If the QDP is revising its products such that the revisions result in a new "product," please submit the product revision as a Material Modification, pursuant to Sections 1351 and 1352.
[2] For additional information regarding QHP filing requirements, please see the 2021 Qualified Health Plan Filing Checklist on the Department's website.

b. **Benchmark Plan:** The pediatric dental Benchmark Plan is the 2014 Medi-Cal Dental Program.[3]

   i. The Benchmark Plan is the same plan used for Plan Years 2017 through 2020.

   ii. The Benchmark Plan (based on the 2014 Medi-Cal Program) uses *outdated* CDT codes. Covered California's Standard Benefit Design (SBD) for Plan Year 2021 reflects the most recent CDT codes. Please utilize the SBD provided by Covered California for Plan Year 2021. *See* Section V(j)(ii).

   iii. If you need a copy of the Benchmark Plan, please reach out to your OPL assigned reviewer as soon as possible.

V. **Exhibit E-1**[4]**:** Please include the following information in the narrative:

a. Explain the **types of products** the plan intends to offer in 2021. The options for products on the 2021 Exchange are: Individual Family, Individual Child-only, CCSB Family, or CSSB Child-Only.

b. Identify if any of the products offered in 2021 are new for the plan.

c. Specify the regions, by regional number or county, where each identified product will be offered for 2021, highlighting any new region for 2021.

d. ***[Embedded Filing]*** Identify the full service plan(s) to which this filing pertains and provide a brief explanation of the nature of the contractual relationship, include:

   i. Explanation of the type of contractual relationship (i.e., renting/leasing (no risk) of the network through a provider contract or an ASA or through a plan-to-plan (risk arrangement) contract.

      1. Explain whether this is a new or previously approved contractual relationship. If previously approved, provide the filing number.

      2. If the plan-to-plan agreement will be revised or updated (e.g., to include the Plan Year 2021 benefits) file the plan-to-plan agreement(s) in a **separate filing** and cross-reference the QDP benefits Filing Number.

[3]Section 1367.005(a)(5) was modified in 2015 by Senate Bill 43 (Hernandez).

[4] Pursuant to Sections 1351 and 1352, the Exhibits and information listed below may need to be included in the Plan's QDP Filing. If applicable, please file.

ii. Explain any functions (i.e., utilization management, grievances and appeals, etc.) the plan will perform on behalf of the QHP.

e. Identify the type of network(s) to which the filing pertains.

i. Examples of types of networks are: HMO, PPO, EPO

ii. ***[Embedded Filing]*** In the Exhibit E-1, provide an affirmation the plan is licensed for the type of network utilized for the QHP filing. *See* Affirmation Section below.

1. For example, if the QHP is offering an EPO, affirm the QDP is licensed to operate as an EPO.

2. If the plan cannot affirm (e.g., the Plan is not licensed for the type of network utilized in the QHP filing), describe the contractual relationship that allows the Plan to offer embedded dental products for the full service plan. For example, if the QHP is offering an EPO, explain how the Plan can offer embedded dental products if only licensed for a PPO.

f. Provide a description of the provider network(s) used to provide health care services to enrollees in the health plan's proposed QDP, including:

i. The name of network for each network

ii. The e-File number associated with the most recent time each network was filed and reviewed (even if the network was reviewed under a different name or connected to a different product), and

iii. A brief overview of any changes to the plan's networks previously approved for use on the Exchange.

Note: File any network revisions in a separate Amendment or Material Modification, as appropriate based on the change.

g. Confirm the plan has made all necessary changes to its EOC and other documents to ensure compliance with Rule 1300.65 (cancellation regulation) and all other applicable legislative updates.[5] Provide the relevant filing number(s).

h. **Evidence of Coverage (EOC):** Provide the filing number for the EOC previously approved for use on the Exchange and explain whether the plan is making any changes.

[5] Please refer to the All Plan Letter – APL 20-001

i. Identify any changes to the EOC by page and section number(s). *See* Exhibit S, T, U Section for more information.

ii. ***[Embedded Filing]*** If the information on dental benefits is contained within the full service EOC (rather than through an attachment or addendum) file the portions of the EOC containing the pediatric dental information in the separate embedded filing.

i. **Schedule of Benefits (SOB):** Provide the filing number of the previously approved SOB. Identify any redlined changes made to the SOB previously approved for use on the Exchange by page and section number(s).

i. Please note, changes are anticipated to a plan's previously approved 2020 SOB, because Covered California modeled its 2021 SBD on CDT-2020 by the American Dental Association and the 2020 SOB is based on the CDT-2019. *See* Exhibit S, T, U Section for more information.

ii. **CDT codes**: Covered California will base its SBD on the 2020 CDT codes in effect at the time of its Board approval (typically March) and will not require updates to the CDT codes when the American Dental Association releases its new and revised codes for 2021 (usually May/June). 2021 SOBs should mirror the CDT codes contained in Covered California's SBD for 2021.

j. **Endnotes:**

i. Endnotes are not required to be duplicated word for word. However, the information contained in the SBD endnotes needs to be substantially similar and easily understandable for the plan's enrollees.

ii. Provide the exhibit, page(s) and section number(s) in the SOB where the Covered California SBD endnotes are located within the QDP filing.

iii. ***[Embedded Filing]*** Provide the page(s) and section(s) where the Covered California SBD endnotes are located within the QDP SOB or QHP SOB. *See* Exhibit S, T, U Section for more information.

k. Describe any changes to the plan's organizational chart, administrative capacity, delegation of functions, utilization management, quality assurances, provider contracts, marketing, broker/solicitor agreements, fiscal solvency and/or grievance and appeals. Note the page and section number where the changes were made and file the applicable exhibit(s). Provide the filing number(s) of previously approved exhibits.

l. **Confidentiality:** Note whether the plan will be applying for confidential treatment of any exhibits. If applicable, file a Request for Confidentiality and comply with Rule 1007.

m. **Affirmation Section:**

i. Please file the affirmation section within the plan's Exhibit E-1.

ii. For any differences from the Benchmark Plan for a SBD product in **a) CDT codes, b) limitations and exclusions and/or c) endnotes**, please include an affirmation that the differences lead the plan to offer a benefit that is identical or better than the benefits provided in the Benchmark Plan.[6]

1. The Department will accept a general affirmation from the plan (versus an affirmation per CDT code or per limitation or per endnote).

2. If the Department identifies additional revisions needed to the plan's a) CDT codes, b) limitations and exclusions and/or c) endnotes, during the course of the Department's review, the plan may need to provide a specific affirmation per a) CDT code, b) limitation and exclusion, and/or c) endnote.

3. During the course of the Department's review, the Department may need to ask follow up comments regarding the plan's a) CDT codes, b) limitations and exclusions and/or c) endnotes in addition to the Plan's affirmation.

iii. ***[Embedded Filings]*** Only one EOC and one SOB for each filing type (i.e., HMO, PPO, and/or EPO) that is an SBD are required to be filed for embedded filings. If the product is a SBD, affirm the filed EOC and SOB will apply to all metal levels. If the product filed is for a non-SBD, e.g. an alternative, file all alternatives.

iv. For each previously approved provider network the plan proposes to use for the QDP, please include an affirmation of whether the ***provider network has experienced a 10 percent or greater change*** in the names included in the network since it was most recently filed and reviewed. **Note:** If any of the networks have experienced a 10 percent or greater change in provider names, the plan must file a separate network change amendment as described below.

[6] The affirmation should make it clear the plan's description of benefits and cost share have an identical or better effect for the enrollee than the Benchmark Plan.

v. Affirm any anticipated change in the plan's enrollment for its Covered California products is nominal (i.e., less than 5% change in enrollment or less than 5% impact (negative or positive) to the plan's financial projections). **Note**: If the plan's anticipated enrollment is 5% or greater or the change in enrollment will have a 5% or greater impact (negative or positive) to the plan's financial projections, plan must submit as Exhibit HH two (2) years of financial projections and as Exhibit CC (Individual Contracts) and/or Exhibit DD (Group Contracts) two (2) years of enrollment projections. First year of projections should be prepared on a monthly basis and the second year on a quarterly basis.

VI. **Product Design Exhibits: Exhibits S, T, U[7]:**

a. ***[Embedded Filings]*** General Instructions:

i. If plan's SBD dental benefits (EOC, CDT Codes, limitations and exclusions, SOB, and endnotes) are filed in a separate addendum from the contracted QHP, file only one addendum for each filing type (i.e. HMO, PPO, EPO, Catastrophic and AIAN)[8] and include the affirmation that the filed SBD dental benefits will apply to all metal levels. *See Affirmative Section,* above.

1. For example, if the plan has six HMO products and three PPO products, the plan will only need to file four EOCs: a) one for the HMO products, b) one for the PPO products, (c) one for the AIAN benefits, and (d) one for catastrophic benefits.

ii. If plan's SBD dental benefits (EOC, CDT Codes, limitations and exclusions, SOB, and endnotes) are listed within a QHP's EOC (not a separate addendum), follow all information for embedded filing and additionally file an affirmation in the plan's QDP Exhibit E-1, stating that the dental benefits (EOC, limitations and exclusions, SOB, and endnotes) are identical across all metal levels for each filing type (HMO, PPO, EPO). *See* Affirmation Section above.

1. If the plan's SBD dental benefits (EOC, CDT Codes, limitations and exclusions, SOB, and endnotes) are not identical across all metal levels per product, please contact your assigned OPL reviewer.

iii. If the QDP SBD dental benefits are embedded in a QHP in two or more markets (Individual Family, CSSB Family, or CSSB Child-

[7] Id.
[8] Alaska Native/American Indian

Only), file an affirmation for each market. *See* Affirmation Section above.

iv. If the dental benefits (EOC, CDT codes, limitations and exclusions, SOB, and endnotes) are not SBD, but rather an alternative benefit design, please contact your assigned OPL reviewer.

b. Exhibit S, Exhibit T: (individual and group health care service plan contracts) may be required to be filed or revised. The plan is not required to file these Exhibits unless changes have been made to the previously approved documents utilized by the plan for its Covered California filings. Provide the filing number of previously approved contracts.

c. Exhibit U: (EOC) All QDPs must comply with Covered California's SBDs and Covered California's naming convention pursuant to Government Code Section 100503(f) (if applicable). New and revised product designs must be filed (e.g., cost-sharing, EOCs, etc.).

i. **Schedule of Benefits (SOB)**

1. ***Copayment:*** For efficiency and review of the Copay SOB, the Department recommends the plan follow the same order and text of CDT codes as listed in the 2021 Covered California Dental SBD.

2. ***Coinsurance:*** Plans are not required to file the list of CDT codes with associated text. However, following the CDT list and text, and inserting the plan's coinsurance amounts will expedite review.

3. **CDT codes**: Plans must ***affirm*** the CDT codes have the identical or better effect than the Benchmark Plan. *See* Affirmation Section above.

4. Include the top portion of the Covered California SBD matrix (i.e., waiting periods, out of pocket max, etc.) at the top of the plan's SOB.

5. ***[Embedded Filings]*** File a separate SOB for AIAN benefit and catastrophic benefit. Rather than file separate SOBs for each metal level of AI/AN benefits, please affirm in the Exhibit E-1 that the AI/AN benefits and cost-share are identical across all metal levels. The eligibility section and explanation of the cost share for these two benefit designs should be contained in the full service health plan disclosure documents. Please work with your contracting full service plan to ensure this eligibility and cost sharing information is disclosed to the enrollees.

ii. **Limitations and Exclusions:** Please ensure the QDP's limitations and exclusions mirror the Benchmark Plan.

1. If plan's limitations and exclusions deviate from the Benchmark Plan, to ensure compliance with the Act, the plan must ***affirm*** the limitations and exclusions have an identical or better effect upon the enrollee's coverage than the Benchmark Plan. *See* Affirmation Section above.

2. The format in the Benchmark Plan lists the limitation and exclusions by CDT codes.

    a. For each limitation and exclusion, include the corresponding CDT code.

        i. If the plan wishes to not include the CDT codes in its published documents, include the corresponding CDT code in parentheses or brackets for Departmental review.

    b. Many plans have chosen to add the limitations and exclusions to the copay schedule by developing a chart. *See* Attachment.

    c. If the plan chooses not to utilize a limitation and exclusion chart, but instead lists the limitations and exclusions per service in another format, the plan will still need to include the corresponding CDT codes for Departmental review.

iii. **Endnotes:** Incorporate the endnotes provided by Covered California into the plan's SOB.

1. Endnotes do not need to be word for word, but in order to be in compliance with the Act, the plan must ***affirm*** the plan's endnotes have an identical or a better effect for enrollee's coverage as Covered California's endnotes. *See* above.

VII. **Other Relevant Exhibits[9]:** These exhibits may be required to be filed or revised. The plan is not required to file these exhibits unless changes have been made to the ***previously approved documents utilized by the plan for its Covered California filings***.

a. ***[Standalone Filing]*** Exhibit FF-4: *See* Actuarial Value Verification Section.

[9] Id.

b. Exhibit H and Exhibit I: *See* Network Section.

c. ***[Embedded Filing]*** Exhibit N-1 or P-5: Administrative service agreements (ASA) for administrative services **or plan-to-plan agreements related to Covered California products**. If no change to the previously approved contracts, please indicate that in Exhibit E-1. Provide the filing numbers for the previously approved ASA or plan-to-plan. If there are changes to the Exhibit N-1 or P-5, please file in a separate filing referencing the benefit filing.

   i. ***[Embedded Filing]*** File as a P-5 a plan-to-plan contract where the dental plan is at financial risk.

   ii. ***[Embedded Filing]*** File an Exhibit N-1 when the dental plan is not at financial risk, i.e. renting the network.

d. Exhibit P and Exhibit Q: individual or group dental plan contracts. ***[Embedded Filing]*** **Dental plans that contract with QHPs to offer EHB dental benefits should file the Off-Exchange mirror filing separate from the plan's QDP filing(s)**.

e. ***[Embedded Filing]*** Summary of Benefits and Coverage (SBC): The Individual Silver SBC will be filed in the QHP Filing. Do not file a SBC in the dental filing.

f. Provider Networks: Exhibits H and I

   i. Health plans are not required to file network exhibits for the sole purpose of QHP recertification. Health plans must submit a complete network when required under the Act, as follows:

      1. New License Application: The plan is applying for a new license to operate as a health care service plan under the Knox Keene Act. (*See* Section 1351, Rule 1300.51.) Network information must be filed with the Department as part of the application for licensure. (Rule 1200.51).

      2. Service Area Change or New Network: The plan is expanding its existing, approved network into a new service area, proposing a materially different provider network for use in an existing service area, or withdrawing from a service area. (*See* Section 1351; Rule 1300.52.4(d).) Network information must be filed with the Department as a Notice of Material Modification. (Rule 1300.52.4(d).)

      3. 10 Percent Change to Already-Approved Network: the plan has experienced a 10 percent or greater change in the names included in its previously approved network. (*See*

Section 1367.27(r); Rule 1300.52(f).) Network information may be filed with the Department as an Amendment to the plan license. (Rule 1300.52(f).)

ii. Material Modification Filing or New License Application: Any service area expansions, withdrawals, new networks, or new license applications for the 2021 benefit year must be filed as soon as practicable, but **no later than March 2, 2020.** A network filing proposing a service area expansion, new network, or withdrawal must be submitted as a **separate Notice of Material Modification** to the plan's license in the e-File system. Plans are strongly encouraged to contact the Department and schedule a pre-filing conference before submission in the e-File system. Please refer to the checklist for New Networks and Service Area Expansions, and/or the checklist for Service Area Withdrawals available in the "Downloads" section of the e-File webportal, and be sure to include the following Exhibits with your filing:

1. Provider Network Roster (Exhibit I-3, utilizing the Department's template available for download on e-File)
2. Provider-to-Enrollee Ratios (Exhibit I-4)
3. Description of Service Area, by ZIP Code (Exhibit H-1, utilizing the Department's template available for download on e-File)
4. Standards of Accessibility (Exhibit I-5)
5. Enrollment Projections (Exhibit I-4, utilizing the Department's template available for download on e-File)

iii. Amendment Filing: If the health plan has determined that its QDP network has experienced a 10 percent or greater change, please submit an amendment to the plan's license in the e-File system **no later than April 1, 2020**. Please visit the "Downloads" section of the eFiling webportal to locate and utilize the Checklist for Network Amendment Filings and the DMHC templates for filing provider roster information.

iv. Significant Enrollment Changes: If the health plan experienced greater enrollment in 2020 than was projected in the prior year's QDP filing, or if the plan projects a significant increase in enrollment in 2021 beyond what was previously projected for 2021, please submit the following:

1. Enrollment Projections (projected over two years) (Exhibit I-4, utilizing the DMHC template available for download on e-File)

2. Provider-to-Enrollee Ratios (Exhibit I-4)

v. ***[Embedded Filings]*** <u>New or Revised Plan-to-Plan Arrangement</u>: If the embedded dental plan intends to enter into a new plan-to-plan arrangement with a QHP to provide some or all of its network providers, the Department will require information from both the QHP and the embedded dental plan as follows:

1. The QHP must file:

   a. A statement within the Exhibit E-1 identifying the portion of the service area in which the QHP plan intends to utilize the embedded dental plan's network and affirming that the embedded dental plan has been approved to operate a network in that portion of the service area.

   b. In some cases, Exhibit I-3 and Exhibit H-1. These need only be filed if the change in embedded dental plan arrangement will result in a 10 percent or greater change to the QHP's network, as described in Rule 1300.52, subd. (f) and Section 1367.27, subd. (r).

2. The embedded dental plan must file:

   a. Provider-to-enrollee Ratios (Exhibit I-4) demonstrating that the embedded dental plan has the capacity to take on the enrollment from the QHP plan.

   b. A statement within the Exhibit E-1 indicating the filing number of the most recent network review conducted by the Department and the filing in which the embedded dental plan was approved to operate in the service area covered by the QHP.

   c. A statement within the Exhibit E-1 indicating whether the network being used has experienced a change of 10 percent or greater in provider names since the most recent time the network was filed and reviewed.

   d. An Exhibit H-1 demonstrating that the embedded dental plan is approved for the service area in which the QHP plan intends to utilize the embedded dental plan's network.

vi. Required Network Information for All Re-Certification Filings: As described in the "Exhibit E-1" section above, for each recertification filing, regardless of whether a network filing is required under the Act, include the following network information in the Exhibit E-1:

1. the name of network for each network,

2. the e-File number associated with the most recent time each network was filed and reviewed (even if the network was reviewed under a different name or connected to a different product), and

3. a brief overview of any changes to the plan's networks previously approved for use on the Exchange.

j. ***[Only Standalone Filing]*** Actuarial Value Calculation Exhibit FF-4: Please file the following documents as Exhibit FF-4. The documents are located on CMS's QHP certification website in the Justifications/Supporting Documents section under the Application Resources.

i. Chapter 15a: Stand-Alone Dental Plan Actuarial Value Supporting Documentation and Justification

ii. Chapter 15b: Stand-Alone Dental Plan—Description of EHB Allocation

2021 ATTACHMENT FOR QUALIFIED DENTAL PLANS IN THE CALIFORNIA HEALTH BENEFIT EXCHANGE

CDT Code	**Description**	**Pediatric Copay**	**Adult Copay**	**Limitation/Exclusion for Pediatric enrollee**
*D0120**	*Periodic Oral Evaluation – established patient*	*No cost*	*No Cost*	*1 in 6 months per dentist*
	Repeat as necessary			

**example*