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Subject:	APL 17-005(OPL) 2018 DMHC Checklist and Attachment for Qualified Dental Plans in the California Health Benefits Exchange
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Attachments:	Qualified Dental Plans.pdf Attachment to Dental Checklist.pdf

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Dear Health Plans,

Attached is the 2018 DMHC Checklist and Worksheets for Health Care Service Plan Filings Relating to Qualified Dental Plans ("QDP") in the California Health Benefits Exchange. Please note, that this checklist and worksheet are not intended to be all-inclusive and represent only those issues, at a minimum, that are required to be addressed by a health plan for purposes of compliance with the Knox-Keene Act and Rules in relation to proposing a QDP and that additional information may be requested by the Department within the course of reviewing a plan filing. Please contact your assigned licensing counsel for questions.

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2018 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 2018, for Individual, Covered California for Small Business ("CCSB") and Employer Sponsored Group Products 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 the last couple of years of 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 and embedded dental plans that contract with Full Service Qualified Health Plans ("QHP") which contract with Covered California. ***Information specific to only standalone or embedded filings is noted in brackets throughout the checklist.***

This checklist is provided to the plan's e-Filing designated contact. If the plan would like its Covered California contact to be someone else, please contact the the plan's assigned attorney in the Office of Plan Licensing ("OPL") as soon as possible.

I. Filing Timeframes

Prior to certification, plans must have regulatory approval of necessary filings including, but not limited to, networks and products.

II.	**New Applicant; QDP Proposing New: Rating Region, and/or Line of Business**	**Recertification**
All Other Exhibits as Necessary	No later than May 1	No later than May 1
Provider Network	No later than May 1	No later than May 1
Product Designs	No later than May 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 the Exchange in evaluating whether an applicant is in "good standing," in addition to applying the minimum licensure requirements.

b. ***[Only Embedded Filings]*** Contractual relationships with QHP(s) for embedded Essential Health Benefits ("EHB") pediatric dental benefits are to be **filed separately** from the plan's QDP filing(s).[1]

c. Network Filings for embedded EHBs and Standalone products are to be filed separately in a separate filing from the plan's QDP filing(s).

IV. Filing Process

a. Filing Process: Prepare and submit an **Amendment or Material Modification**[2] pursuant to Sections 1351 and 1352, to a health plan's license in regard to a QDP Application(s) to address 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 2018" 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.

V. Helpful Hints based on the Department's Review of Plan Year 2017

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).

b. **Types of Filings:** To ensure that one filing does not hold up another filing, please file the following separate from the QDP Filing: 1) ***[Only Embedded Filings]*** embedded contractual relationship (i.e. plan-to-plan Arrangements, Leased Network Administrative Service Agreements) and 2) any network changes. *See* Network Section.

[1] For additional information regarding QHP filing requirements, please request the 2018 Qualified Health Plan Filing Checklist from the Plan's assigned attorney in OPL.

[2] In the event that the QDP is revising its products such that the revisions result in a new "product," please submit such product revision as a Material Modification.

c. **Benchmark Plan**

i. Note that 2015 Senate Bill 43 (Hernandez) modified Section 1367.005(a)(5). The Benchmark Plan has changed from 2011-2012 Healthy Families Program to 2014 Medi-Cal Dental Program.

ii. Please note, the *new* Benchmark Plan (based on the 2014 Medi-Cal Program) uses *outdated* CDT codes. However, Covered California's Standard Benefit Design (SBD) reflects the most recent CDT codes. Thus, please utilize the SBD provided by Covered California for plan year 2018.

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

VI. **Exhibit E-1**[3]**:** Please include the following information in the narrative:

a. Explain the **types of products** the plan is anticipating offering in 2018. The options for products on the Exchange are: Individual Family, Individual Child-only, CCSB Family or CSSB Child-Only, Employer Sponsored, or cost sharing variation for eligible members American Indian and Alaskan Native (AI/AN) benefits.

b. Identify if any of the products being offered in 2018 are a new offering for the plan.

c. Specify the regions, by regional number or county, where each identified product will be offered for 2018, highlighting any new region for 2018.

d. ***[Only Embedded Filing]*** Identify the full service plan(s) to which this filing pertains.

e. ***[Only Embedded Filing]*** Identify the type of network(s) to which the filing pertains.

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

ii. In the Exhibit E-1, provide an affirmation that plan is licensed for the type of network utilized for the QHP filing. *See* Affirmation Section in Section E-1.

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

[3] 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.

f. Provide a brief overview of any changes to the plan's network previously approved for use on the Exchange. **Note:** File any network revisions in a separate Amendment or Material Modification.

g. ***[Only Embedded Filing]*** 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.

    ii. Explanation of whether the plan will be performing functions, such as utilization management, grievances, and appeals, etc., on behalf of the QHP.

h. **Evidence of Coverage (EOC):** Provide the filing number for the EOC previously approved for use on the Exchange. If no changes to the previously approved EOC, please indicate in the Exhibit E-1.

    i. Advise of any changes made to the EOC previously approved for use on the Exchange by identifying the page(s) and section number(s) within the EOC where changes are located. *See* Exhibit S, T, U Section for more information.

i. **Schedule of Benefits (SOB):** Note whether there are any redlined changes made to the SOB previously approved for use on the Exchange. Please provide the filing number of the previously approved SOB.

    i. Please note, it is anticipated that there will be changes to the plan's SOB as Covered California modeled its 2018 SBD from changes made to CDT-17 by the American Dental Association. *See* Exhibit S, T, U Section for more information.

j. **Endnotes:**

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

    ii. ***[Only 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. Note any changes to the plan's organizational chart, administrative capacity, delegation of functions, utilization management, quality assurances, 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. **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.

      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.

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

   iv. ***[Only 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 SBD, include an affirmation that the filed EOC and SOB will apply to all metal levels. If filed as an alternative, file all alternatives.

m. **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.

VII. **Product Design Exhibits: Exhibits S, T, U[4]:**

a. General Instructions for ***Embedded Filings***:

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, and/or EPO). Include an affirmation that the filed EOC will apply to all metal levels. *See* Affirmation Section in Section Exhibit E-1.

1. For example, if the plan has six HMO products and three PPO products, the plan will only need to file two EOCs. The two filed will be: a) one for the HMO products and b) one for the PPO products.

ii. If plan's SBD dental benefits (EOC, CDT Codes, limitations and exclusions, SOB, and endnotes) are filed within a QHP's EOC (not a separate addendum), 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 in Section Exhibit E-1.

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 attorney.

iii. If the QDP SBD dental benefits are embedded in a QHP in two markets (Individual Family, CSSB Family or CSSB Child-Only, Employer Sponsored, cost-sharing variation for eligible members AI/AN), file an affirmation for both markets. *See* Affirmation Section in Section Exhibit E-1.

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 attorney.

b. Exhibit S, Exhibit T: (individual and group health care service plan contracts)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. Please provide the filing number of previously approved contracts.

[4] Id.

c. Exhibit U: (EOC) All QDPs must comply with Covered California's SBDs, alternative benefit designs 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 2018 Covered California Dental SBD.

2. ***Coinsurance:*** Plans are not required to follow 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**: The Benchmark Plan does not reflect the most current CDT codes used in practice. If the plan is utilizing current CDT codes, note any deviations from the Benchmark Plan. Identify the deviation by each specific CDT code.

    a. If the CDT codes deviate, in order to be in compliance with the Act, the plan must ***affirm*** the CDT codes have the identical or better effect than the Benchmark Plan. *See* Affirmation Section in Section Exhibit E-1.

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.

ii. **Limitations and Exclusions:** Please ensure that 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 in Section Exhibit E-1.

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

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

b. Many plans have chosen to add the limitation 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 in another format, the plan will still need to include the corresponding CDT codes for Departmental review.

d. 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.

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

1. In order to be in compliance with the Act, the plan must ***affirm*** that the plan's endnotes are identical or a better effect for enrollee's coverage as Covered California's endnotes. *See* Affirmation Section in Section Exhibit E-1.

iv. ***[Only Embedded Filings]*** File a separate SOB with $0 cost share for AI/AN benefits for eligible enrollees whose income is less than 300% of the Federal Poverty Level.

VIII. **Other Relevant Exhibits[5]:** 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. ***[Only Standalone Filing]*** Exhibit FF-4: *See* Actuarial Value Verification Section.

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

c. Exhibit K: (Provider contracts) If there are no changes to the provider contracts, please indicate in Exhibit E-1.

d. Exhibit L: Organizational chart(s).

e. ***[Only Embedded Filing]*** Exhibit N: Administrative service agreements (ASA) for administrative services **related to Covered California products**. If no change to the previously approved administrative service contract,

[5] Id.

please indicate in Exhibit E-1. Provide the filing numbers for the previously approved ASA.

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

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

f. Exhibit P and Exhibit Q: individual or group dental plan contracts. ***[Only 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)**. If there are no changes to the plan-to-plan agreements or ASA with full service plans, please indicate in Exhibit E-1. Specialized health plans are required to submit a mirror filing for new or amended plan-to-plan agreements and administrative service agreements with full service plans.

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

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

g. Exhibit W: Please file for review new or revised enrollee/subscriber grievance procedures.

h. Exhibit V, Exhibit Y, Exhibit Z, Exhibit AA, Exhibit BB: Please file for review all new or amended advertising and marketing materials related to QDP products.

i. Exhibit Y, Exhibit Z: The plan should describe its marketing plan for individual and small group products being sold on the Exchange. Redline any changes to the plan's previously approved filing.

j. Exhibit BB: Include all new or revised solicitation contracts that the plan intends on entering into with brokers and/or marketers. If the using a previously approved solicitor/broker contract, please indicate the filing number.

k. Exhibit CC, Exhibit DD, Exhibit EE: By region, please file enrollment projections for all individual and small group contracts, and summary enrollment projections for the QDP.

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

m. Networks: Provider Services Geographic Access/Availability:Exhibits H and I

i. Please report information related to each provider network that is connected to a QDP product, as described below. All plans must provide the e-Filing number identifying the last time the network was reviewed by the Department, even if the network was reviewed under a different name or connected to a different product. A plan need only submit a complete provider network filing for any of its QDP provider networks if the plan is required to submit network information pursuant to the Act. When submitting a network for review, please be sure to identify the name of the network and which products utilize that network in an Exhibit E-1.

ii. As a reminder, the Act requires plans to submit a complete network filing for review under the following circumstances:

1. 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.) Plans are strongly encouraged to contact the Department and schedule a pre-filing conference before filing a new license application. Any new license applicants for the 2018 benefit year must file a network with the Department as soon as practicable, but **no later than May 1, 2017**. Please be sure to include the following Exhibits with the network portion of your filing:

    a. Provider Network Rosters (Exhibits I-1, I-2 and I-3, utilizing the Department's templates available for download on e-File)
    b. Provider-to-Enrollee Ratios (Exhibit I-4)
    c. Description of Service Area, by zip code (Exhibit H-1)
    d. Standards of Accessibility (Exhibit I-5)
    e. Enrollment Projections (Exhibit EE)

2. The plan is expanding its existing, approved network into a new service area or withdrawing from a service area. (*See* Section 1351; Rule 1300.52.4(d).) A network filing proposing a service area expansion or withdrawal must be submitted as a 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 filing a service area expansion or withdrawal. Any service area expansions or withdrawals for the 2018 benefit year must be filed as soon as practicable, but **no later than May 1, 2017.** Please be sure to include the following Exhibits with your filing:

a. Provider Network Rosters (Exhibits I-1, I-2 and I-3, utilizing the Department's templates available for download on e-File)
b. Provider-to-Enrollee Ratios (Exhibit I-4)
c. Description of Service Area, by zip code (Exhibit H-1)
d. Standards of Accessibility (Exhibit I-5)
e. Enrollment Projections (Exhibit EE)

iii. Under certain circumstances, a plan may be required to file an amendment to its license identifying a major network change. (See Rule 1300.52(f), Section 1367.27, (r).) If the health plan has determined that its QDP network meets those circumstances, please submit an amendment to the plan's license in the e-File system **no later than June 1, 2017**. On or about April 2017, the Department will make available a new template for the purpose of filing provider network information pursuant to Rule 1300.52, subd. (f) and Section 1367.27, subd. (r). Please visit the "Downloads" section of the efiling webportal to locate and utilize the new template.

iv. If the health plan experienced greater enrollment in 2017 than was projected in the prior year's QDP filing, or if the plan projects a significant increase in enrollment in 2018 beyond what was previously projected for 2018, please submit the following:

1. Enrollment Projections (projected over two years) (Exhibit EE)
2. Provider-to-Enrollee Ratios (Exhibit I-4)

v. ***[Only Embedded Filings]*** 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, Exhibits I-1, I-2, and/or I-3, as applicable, and Exhibit H-1. These need only be filed if the change in embedded dental plan arrangement will result in a significant 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. 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.

n. ***[Only Standalone Filing]*** Actuarial Value Calculation: Please file the following documentation. The documents can be found at the following hyperlinks:

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

        1. https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/Chapter15aSADPActuarialValue_Version1_022916.pdf

        2. File as an Exhibit FF-4.

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

        1. https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/Chapter15bSADPDiscriptionofEHBAllocation_Version1_022916.pdf

        2. File as an Exhibit FF-4.

2018 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*

**example*