DEPARTMENT OF Managed Health Care

2023 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 2023, 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 2023	New Applicant; QDP Proposing New Line of Business	Recertification
All Other Exhibits as Necessary	No later than March 1	No later than April 1
Product Designs	No later than March 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.

1. When submitting your filing, please:

   a. **Use the subject title "HBEX QDP Application 2023"**

   b. **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 as separate filings from each other.

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 both the QDP Benefits Filing(s) Exhibit E-1(s) and the Network Filing Exhibit E-1(s), cross-reference both the QDP Benefits Filing Number(s) and the Network Filing Number(s). **Note**: No Network issues will be reviewed in the Plan's Benefit Filing(s). Please file the narrative of the Network(s) used on-exchange, any 10% change updates and relevant Network affirmations in the Plan's separate Network filing.[3] In the QDP benefit filing, please only include the Filing Number of the Network Filing(s).

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[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 2023 Qualified Health Plan Filing Checklist on the Department's website.
[3] Please see the 2023 Networks Filing Checklist and Worksheet for QHP & QDP Plans on the Department's website.

IV. **Helpful Hints based on the Department's Review of Plan Year 2022**

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. Benchmark Plan: The pediatric dental Benchmark Plan is the 2014 Medi-Cal Dental Program.[4]

1. The Benchmark Plan is the same plan used for Plan Years 2017 through 2022.

2. The Benchmark Plan (based on the 2014 Medi-Cal Program) uses *outdated* CDT codes. Covered California's Standard Benefit Design (SBD) for Plan Year 2023 reflects the most recent CDT codes. Please utilize the SBD provided by Covered California for Plan Year 2023.

3. 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:**[5] Please include the following information in the narrative:

A. Explain the types of products the plan intends to offer in 2023. The options for products on the 2023 Exchange are: Individual Family, Individual Child-only, Covered California for Small Business (CCSB) Family, or CSSB Child-Only.

B. Identify if any of the products offered in 2023 are new for the plan.

C. Specify the regions, by regional number or county, where each identified product will be offered for 2023, highlighting any new region for 2023.

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, including:

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

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

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

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

b. If the plan-to-plan agreement will be revised or updated (e.g., to include the Plan Year 2023 benefits), file the plan-to-plan agreement(s) in a separate filing and cross-reference the QDP benefits Filing Number.

2. Explanation of whether any functions (i.e., utilization management, grievances and appeals, etc.) the plan will perform in whole or in part, on behalf of the QHP.

E. **Identify the product(s) to which the filing pertains.**

1. Examples of products are: HMO, PPO, EPO

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

a. For example, if the QHP is offering an EPO product, affirm the QDP is licensed to offer an EPO product.

b. If the plan cannot affirm (e.g., the Plan is not licensed for the type of product 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 a group PPO product, explain how the Plan can offer embedded dental products if the QDP only is licensed for to offer an HMO product.

3. **Note:** File any network revisions in a separate Amendment or Material Modification, as required under the Act based on the change. *See* Section III(E) and the 2023 Networks Filing Checklist and Worksheet for QHP & QDP Plans (available on the Department's website).

F. Confirm the plan has made all necessary changes to its EOC and other documents to ensure compliance with applicable legislative updates.[6] Provide the relevant filing number(s).

G. 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.

[6] Please refer to the All Plan Letter (APL) 21-025.

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

2. ***[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 filing.

H. **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).

1. Please note, changes are anticipated to a plan's previously approved 2022 SOB, because Covered California modeled its 2023 SBD on CDT-2022 by the American Dental Association and the 2022 SOB is based on the CDT-2021. *See* Exhibit S, T, U Section for more information.

2. CDT codes: Covered California will base its SBD on the 2022 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 2023 (usually May/June). SOBs should mirror the CDT codes contained in Covered California's SBD for 2023.

I. **Endnotes:**

1. 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.

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

3. ***[Embedded Filing]*** Provide the page(s) and section(s) where the Covered California SBD endnotes are located within the QDP SOB or QHP SOB.

J. Describe any changes to the plan's organizational charts, administrative capacity, delegation of functions, utilization management, quality assurance system, provider contracts, marketing, broker/solicitor agreements, fiscal solvency and/or grievance and appeals process regarding Covered California filings. 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.

K. **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.

L. **Affirmation Section:**

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

2. 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.[7]

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

   b. 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.

   c. 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.

3. ***[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 alternative EOCs and SOBs.

4. Affirm any anticipated change in the plan's enrollment for its Covered California products is less than 5% of the plan's total enrollment and would not have a material impact on the plan's financial position. Note: If the plan's anticipated enrollment is 5% or greater or the change in enrollment would have a material impact on the plan's financial position, the 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

[7] 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.

enrollment projections. First year of projections should be prepared on a monthly basis and the second year on a quarterly basis.

VI. Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

A. Please refer to the statutory requirements in Health and Safety Code section 1363.04, and any Approved Pending Regulations which may be viewed at https://wpso.dmhc.ca.gov/regulations/#3.

VII. Product Design Exhibits:

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

1. 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.

    a. For example, if the QDP has six HMO products and three PPO products, the QDP 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.

2. 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 filings 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.

    a. 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.

3. If the QDP SBD dental benefits are embedded in a QHP in two or more markets (Individual Family, CSSB Family, or CSSB Child-Only), file an affirmation for each market. *See* Affirmation Section above.

[8] Alaska Native/American Indian

4. 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.).

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

a. **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 2023 Covered California Dental SBD. Note for Plan Year 2023, plans are not required to include CDT codes listed as "not covered" in the SBD for pediatric benefits.

b. **Coinsurance**: Plans are not required to file the list of CDT codes with associated text. However, following the SOB's CDT list and text, and inserting the plan's coinsurance amounts will expedite review. Plans must follow the Covered CA cost share listed in the SBD.

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

d. 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.

e. ***[Embedded Filings]*** File a separate SOB for AI/AN 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.

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

    a. 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.

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

    c. 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.

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

        iii. 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.

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

    a. 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* Affirmation Section above.

VIII. **Other Relevant Exhibits:** 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 I-9: Please file the Renewal Notice using the Covered CA Template.

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

C. Exhibit H and Exhibit I: File in the separate Network Filing, if required by the 2023 Networks Filing Checklist and Worksheet for QHP & QDP Plans.

D. ***[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 contract. If there are changes to the Exhibit N-1 or P-5, please file in a separate filing referencing the benefit filing.

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

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

E. 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 work with their QHP regarding the separate Off-Exchange mirror filing.[9]

F. ***[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.

IX. <u>Actuarial Value Verification</u>

A. ***[Only Standalone Filing]*** Actuarial Value Calculation Exhibit FF-4: Please file the following documents as Exhibit FF-4. The documents are located on CMS QHP certification website under Application Materials -> Plans & Benefits -> Application Resources.

1. PYXX SADP Actuarial Value Supporting Documentation & Justification

2. PYXX SADP – Description of EHB Allocation

[9] For additional information regarding QHP off-exchange mirrored filing requirements, please see the Plan Year 2023 Checklist for Non-Grandfathered Individual and Small Group Market Product(s) Off of the California Health Benefits Exchange.

2023 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*