Qualified Health Plan Certification Application

Plan Year 2017

Individual Marketplace

COVERED CALIFORNIA, 1601 Exposition Blvd., Sacramento, CA 95815

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1 Attestation

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

Issuer Name: _____

NAIC Company Code: _____

NAIC Group Code: _____

Regulator(s): _____

Federal Employer ID: _____

HIOS/Issuer ID: _____

Corporate Office Address: _____

City: _____

State: _____

Zip Code: _____

Primary Contact Name: _____

Contact Title: _____

Contact Phone Number: _____

Contact Email: _____

On behalf of the Applicant stated above, I hereby attest that I meet the requirements in this Certification Application and certify that the information provided on this Application and in any attachments hereto are true, complete, and accurate. I understand that Covered California may review the validity of my attestations and the information provided in response to this application and if any 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 Certification Application.

Date: _____

Signature: _____

Printed Name: _____

Title: _____

1.2 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 2016, for coverage effective January 1, 2017. All Health Insurance Issuers currently licensed at the time of application response submission are eligible to apply for certification of proposed Qualified Health Plans (QHPs) for the 2017 Plan Year. The Exchange anticipates QHP issuers selected for the 2017 Plan Year will execute multi-year contracts with the Exchange, and application for certification for Plan Years 2018 and 2019 will be limited to those QHP issuers contracted for Plan Year 2017 that continue to meet certification standards and performance requirements, and either: Medi-Cal Managed Care Plans or plans newly licensed and offering in the applicable market after May 2, 2016. The Exchange will exercise its statutory authority to selectively contract for health care coverage offered through the Exchange to review submitted applications and reserves the right to select or reject any Applicant or to cancel the Application at any time.

Issuers who have responded to the Notice of Intent to Apply 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.

1.3 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.; Chapter 655, Statutes of 2010-Perez and Chapter 659, Statutes of 2010-Alquist.) The California state law is referred to as the California Patient Protection and Affordable Care Act (CA-ACA).

The California Health Benefit 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 California Health Benefit Exchange is to improve the health of all Californians by assuring their access to affordable, high quality care coverage. The mission of the California Health Benefit Exchange is to increase the number of insured Californians, improve health care quality, lower costs, and reduce

[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.

health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value.

The California Health Benefit 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.

- **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 California Health Benefit 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 focused on risk selection to achieve profitability 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.

The California Health Benefit 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 California Health Benefit Exchange gave authority to the Exchange to selectively contract with carriers 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 California Health Benefit 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.

1.4 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 2017. 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 includes, 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 2017 plan year.

Encourage Competition Based upon Meaningful QHP Choice and Product Differentiation: Standard 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 that is related to either product, network or both. The exchange is interested in having both HMO 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.

[2] The 2017 Standard Benefit Designs will be finalized when the 2017 federal actuarial value calculator is finalized.

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 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 to the healthcare system as a whole. The technology capabilities of the Issuer is a critical component of being successful on the Exchange so the technology, and associated resources of the Issuer are heavily scrutinized as this relates to long term sustainability for consumers. Additionally, we recognize that there is significant investment that will continue to be needed in areas of quality reform and improvement programs, so the Exchange is offering 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.

1.5 Availability

The Applicant must be available immediately upon contingent certification as a QHP 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, 2017. 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 QHP Issuer contract before public announcement of contingent certification. The successful Applicants must be ready and able to accept enrollment as of October 1, 2016.

1.6 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.

1.7 Intention to Submit a Response

Applicants interested in responding to this application are <u>required</u> to submit a non-binding Letter of Intent to Apply indicating their interest in applying and their proposed products and service areas and to ensure receipt of additional information. Only those Applicants acknowledging interest in this application by submitting a notification of intent to submit a proposal will continue to receive application-related correspondence throughout the application process.

The Applicant's letter of intent must identify the contact person for the application process, along with contact information that includes an email address, a

telephone number, and a fax number. On receipt of the non-binding letter of intent, Covered California will issue instructions and login and password information to gain access to the online portion(s) of the Application.

An Issuer's submission of an Intent to Apply will be considered confidential information and not available to the public; the Exchange reserves the right to release aggregate information about Issuers' responses. Final Applicant information is not expected to be released until selected Issuers and QHP proposals are announced in July 2016. 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 (1) contact person per Applicant. It shall be 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 shall not be 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

1.8 Key Action Dates

Action	Date/Time
Release of Draft Application for Comment	January 2016
Letters of Intent due to Covered California	February 19, 2016
Application Opens	March 1, 2016
Completed Applications Due (include 2017 Proposed Rates & Networks)	May 2, 2016
Negotiations between Applicants and Covered California	June 2016
Final QHP Certification Decisions	June 2016
QHP Contract Execution	June 2016

2. Licensed & Good Standing

2.1 Indicate Applicant entity license status below:

□ Applicant currently holds all of the proper and required licenses from the Department of Managed Health Care to operate as a health issuer as defined herein

□ Applicant currently holds all of the proper and required licenses from the Department of Insurance to operate as a health issuer as defined herein

□ Applying is currently applying for licensure from the Department of Managed Health Care to operate as a health issuer as defined herein

□ Applicant is currently applying for licensure from the Department of Insurance to operate as a health issuer as defined herein

2.2 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 indicate 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.

□ Confirmed
□ Not confirmed

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

□ Confirmed
□ Not confirmed

3. Applicant Health Plan Proposal

Applicant must submit a health plan proposal in accordance with submission requirements outlined in this section. Applicant's proposal will be required to 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 California Health Benefit 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 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 and physician networks are not permitted. Applicants must agree to adhere to the Exchange's standard benefit plan designs without deviation.

Plan or Policy Submission Requirements

QHP 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 be one of the 2017 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.

QHP 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) allows a QHP issuer to limit 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.) Covered California requires contracted QHP issuers to offer the AI/AN zero cost share plan variation at the Bronze level only. This requirement applies to both the standard plan design and the optional Bronze High Deductible Health Plan (HDHP), if the issuer offers the Bronze HDHP. If 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 will not offer the zero cost share variation at the higher metal levels within the 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.

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.

3.1 Applicant must certify 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 from consideration. Complete Attachment A (Plan Type by Rating Region (Individual Market)) to indicate the rating regions and number and type of plans for which you are proposing a QHP in the Individual Exchange.

- ☐ Yes, completed Attachment to indicate the rating regions and number and type of plans proposed
- ☐ No

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

- □ Confirmed
- □ Not confirmed

3.3 QHP Applicant must comply with 2017 Standard Benefit Plans 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/qhp.html.

- □ Confirmed, template submitted
- □ Not confirmed, template not submitted

3.4 Are there operational or administrative barriers to implementing the 2017 Standard Benefit Plan designs?

- □ Yes
- □ No

3.5 Applicant must indicate if seeking approval for deviations from the 2017 Standard Benefit Plan Designs. If yes, Applicant must submit Attachment B Standard

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.

□ Yes, attachment submitted to request deviation(s)

□ No deviation(s) requested, attachment not submitted

3.6 The Exchange is encouraging the offering of plan products which include all ten Essential Health Benefits including the pediatric dental Essential Health Benefit. QHP issuer must indicate if it will adhere to the 2017 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.

Individual Market QHPs proposed for 2017 include all ten Essential Health Benefits.

□ Yes

□ No

3.7 If Applicant's proposed QHPs will include pediatric dental essential health benefit, Applicant must describe how it intends to embed this benefit:

□ Offer benefit directly under full service license

□ Subcontractor relationship

Applicant must describe how it will ensure that 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.

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

□ 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 terms and manner in which Applicant administers out-of-network benefits.

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

3.9 If yes to 3.8 and applicable to response, can Applicant administer a "Usual, Customary, and Reasonable" (UCR) method utilizing the nonprofit FAIR Health (www.fairhealth.org) database to determine reimbursement amounts? What percentile does Applicant target for non-network UCR? Can Applicant administer different percentiles? What percent of Applicant's in-network contract rates does Applicant's standard non-network UCR method reflect?

3.10 Applicant must submit as attachment draft Evidence of Coverage or Policy language and draft Schedules of Benefits describing proposed 2017 QHP benefits. This draft language is to be submitted with the response to this application, prior to or contemporaneous to filing with the applicable regulator.

3.11 QHPs are required to offer products in accordance with Covered California's Standard Benefit Plan Designs, which 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.

□ Template completed and uploaded

□ Template not completed and uploaded

3.12 Describe how Applicant's proposed 2017 formulary will comply with requirements of AB 339.

3.13 Preliminary Premium Proposals

Final negotiated and accepted premium proposals shall be in effect for coverage effective January 1, 2017. Premium proposals are considered preliminary and

may be subject to negotiation as part of QHP certification and selection. The final negotiated premium amounts are expected to align with the product rate filings that will be submitted to the regulatory agencies. Premium proposals will be due May 2, 2016. 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) and the Rates Template located at: https://www.cms.gov/cciio/programs-and-initiatives/health-insurance-marketplaces/qhp.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, upon the Exchange's request, 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.

3.14 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/qhp.html.

- □ Yes, health plan proposal covers entire licensed geographic service area; template uploaded
- □ No, health plan proposal does not cover entire licensed geographic service area; template uploaded

Network sections will be replicated as needed according to number of network products being offered (identified in 4.1.1)

4. Provider Network

4.1 Network Offerings

4.1.1 Please indicate the different network products applicant intends to offer on the exchange individual market for coverage year 2017

	Offered	How many networks?	Network Name(s)
HMO	*Single, Pull-down list.* 1: Yes, 2: No	*Single, Pull-down list.* 1: 1, 2: 2	*10 words.*
PPO	*Single, Pull-down list.* 1: Yes, 2: No	*Single, Pull-down list.* 1: 1, 2: 2	*10 words.*
EPO	*Single, Pull-down list.* 1: Yes, 2: No	*Single, Pull-down list.* 1: 1, 2: 2	*10 words.*
Other	*Single, Pull-down list.* 1: Yes, 2: No	*Single, Pull-down list.* 1: 1, 2: 2	*10 words.*

4.2 HMO

4.2.1 HMO Network 1

4.2.1.1 Network Strategy

4.2.1.1.1 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

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

- Length of the lease agreement
- Start Date
- End Date
- Leasing Organization
- Ability to influence provider contract terms for:
    - Transparency
    - Implementation of new programs and initiatives
    - Acquire timely and up-to-date information on providers

  - Ability to obtain data from providers
- Ability to conduct outreach and education to providers if need arises
- Ability to add new providers

Unlimited.

4.2.1.1.3 Does Applicant contract with providers directly, at the individual practitioner level or at the risk-bearing organization (e.g. medical groups, independent practice associations) level only?

Single, Pull-down list.
1: Direct contract only,
2: Group/Delegated/Capitated contracting,
3: Both: If a combination of both, please answer the next table

4.2.1.1.4 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.*	*Unlimited.*
Region 2	*Percent.*	*Percent.*	*Percent.*	*Unlimited.*
Region 3	*Percent.*	*Percent.*	*Percent.*	*Unlimited.*
Region 4	*Percent.*	*Percent.*	*Percent.*	*Unlimited.*
Region 5	*Percent.*	*Percent.*	*Percent.*	*Unlimited.*
Region 6	*Percent.*	*Percent.*	*Percent.*	*Unlimited.*
Region 7	*Percent.*	*Percent.*	*Percent.*	*Unlimited.*
Region 8	*Percent.*	*Percent.*	*Percent.*	*Unlimited.*
Region 9	*Percent.*	*Percent.*	*Percent.*	*Unlimited.*
Region 10	*Percent.*	*Percent.*	*Percent.*	*Unlimited.*
Region 11	*Percent.*	*Percent.*	*Percent.*	*Unlimited.*
Region 12	*Percent.*	*Percent.*	*Percent.*	*Unlimited.*
Region 13	*Percent.*	*Percent.*	*Percent.*	*Unlimited.*

Region 14	*Percent.*	*Percent.*	*Percent.*	*Unlimited.*
Region 15	*Percent.*	*Percent.*	*Percent.*	*Unlimited.*
Region 16	*Percent.*	*Percent.*	*Percent.*	*Unlimited.*
Region 17	*Percent.*	*Percent.*	*Percent.*	*Unlimited.*
Region 18	*Percent.*	*Percent.*	*Percent.*	*Unlimited.*
Region 19	*Percent.*	*Percent.*	*Percent.*	*Unlimited.*

4.2.1.1.5 Does Applicant currently have contracted providers or networks not offered on the Exchange in regions where Exchange coverage is offered? (Off-Exchange networks in same regions as Exchange networks)

Response	*Single, Pull-down list.* 1: Yes, 2: No
If yes, do the Exchange networks contain fewer providers compared to the comparable off exchange network of same type (HMO PPO EPO, etc.) i.e. narrow networks?	*Unlimited.*
If yes, explain in detail how these more selective networks are developed including details on rationale and criteria used for selection	*Unlimited.*

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

- If and how Applicant assesses geographic access to primary, specialist and hospital care based on enrollee residence.
- If and how Applicant analyses utilization data to assess and address differing demographic and cultural needs.
- If and how Applicant tracks ethnic and racial diversity in the population and ensures access to appropriate culturally competent providers.

Unlimited.

4.2.1.1.7 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 county or region bordering another state?

Single, Radio group.

1: Yes. If yes, does the Applicant allow out of state (non-emergency) providers to

participate in networks to serve Covered California enrollees? [Single, Pull-down list] If yes, explain in detail how this coverage is offered. [Single, Pull-down list] ,
2: No

4.2.1.2 Network Quality

4.2.1.2.1 Networks Built on Quality

As a contractual requirement in future contract years, applicants must base all provider and facility selection decisions on the following factors.
• Quality including clinical quality (answered in QIS)
• Patient safety
• Cost Efficiency
• Patient reported experience

4.2.1.2.1.1 Does contractor currently use Patient safety as a criterion for provider selection for covered California networks? If yes, please explain in detail: this should include the assessment process, the source of the patient safety assessment data, specific measures and metrics, thresholds for inclusion and exclusion.

Single, Radio group.
1: Yes, please explain [Unlimited] ,
2: No

4.2.1.2.1.2 Does contractor currently use cost efficiency as a criterion for provider selection for covered California networks? If yes, please explain in detail: this should include the assessment process, the source of the assessment data, specific measures and metrics, thresholds for inclusion and exclusion.

Single, Radio group.
1: Yes, please explain [Unlimited] ,
2: No

4.2.1.2.1.3 Does contractor currently use Patient reported experience as a criterion for provider selection for covered California networks? If yes, please explain in detail: this should include the assessment process, the source of the Patient reported experience assessment data, specific measures and metrics, thresholds for inclusion and exclusion.

Single, Radio group.
1: Yes, please explain [Unlimited] ,
2: No

4.2.1.2.2 Volume - Outcome Relationship

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.

4.2.1.2.2.1 Is procedure volume per facility for the above mentioned conditions tracked by the issuer?

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

4.2.1.2.2.2 If yes please provide the following details:
• Data Sources
• Methodology for categorizing facilities according to volume-outcome relationship
• Volume thresholds (i.e. at what volume per procedure is a facility considered proficient)

Unlimited.

4.2.1.2.2.3 Does issuer apply this information to enrollee procedure referral (including Covered California enrollees)?

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

4.2.1.2.2.4 If yes please provide the following details:
• Methodology for patient identification and selection.
• Referral procedure and accommodations for patients not residing in close proximity to a recognized higher volume provider

Unlimited.

4.2.1.2.2.5 Please list the preferred facilities for the following procedures

	Response
Stomach cancer surgeries	*Unlimited.*
Esophageal cancer surgeries	*Unlimited.*
Brain cancer surgeries	*Unlimited.*
Lung cancer surgeries	*Unlimited.*
Bladder cancer surgeries	*Unlimited.*
Colon cancer surgeries	*Unlimited.*

Breast cancer surgeries	*Unlimited.*
Pancreatic cancer surgeries	*Unlimited.*
Liver cancer surgeries	*Unlimited.*
Prostatic cancer surgeries	*Unlimited.*
Rectal cancer surgeries	*Unlimited.*
Other cancer surgeries	*Unlimited.*
Coronary Artery Bypass Graft	*Unlimited.*
Angioplasty Procedures (Aka. Percutaneous Coronary Interventions, Balloon Angioplasty, Coronary Artery Balloon Dilation)	*Unlimited.*
Heart Valve Replacement Surgeries	*Unlimited.*
Stent procedures	*Unlimited.*
Minimally Invasive Heart Surgery (Aka. Limited Access Coronary Artery Surgery)	*Unlimited.*
Cardiomyoplasty	*Unlimited.*
Other cardiac procedures	*Unlimited.*
Other conditions	*Unlimited.*

4.2.1.2.3 Centers of Excellence

4.2.1.2.3.1 Heart Transplants

Heart Transplant Center of Excellence	Contracted for Heart Transplants and available to Covered California Enrollees
Rady Childrens Hosp & Health Center	*Unlimited.*
Childrens Hospital Los Angeles	*Unlimited.*
Cedars-Sinai Med Center	*Unlimited.*
Eisenhower Mem Hosp	*Unlimited.*
UCI Medical Center	*Unlimited.*

Loma Linda Univ Med Ctr	*Unlimited.*
Lucile Salter Packard Childrens Hosp	*Unlimited.*
California Pacific Med Ctr	*Unlimited.*
Hoag Mem Hosp Presbyterian	*Unlimited.*
UCSD Medical Center	*Unlimited.*
Univ of CA San Francisco Med Ctr	*Unlimited.*
Sutter Memorial Hospital	*Unlimited.*
Sharp Memorial Hospital	*Unlimited.*
UC Davis Medical Center	*Unlimited.*
Stanford Univ Med Ctr	*Unlimited.*
St. Vincent Medical Center	*Unlimited.*
UCLA Medical Center	*Unlimited.*
Keck Hospital of USC	*Unlimited.*
Other:	*Unlimited.*

Other:	*Unlimited.*

4.2.1.2.3.2 Lung Transplants

Lung Transplant Center of Excellence	Contracted for Lung Transplants and available to Covered California Enrollees
Childrens Hospital Los Angeles	*Unlimited.*
Cedars-Sinai Med Center	*Unlimited.*
Lucile Salter Packard Childrens Hosp	*Unlimited.*
UCSD Medical Center	*Unlimited.*
Univ of CA San Francisco Med Ctr	*Unlimited.*
Sharp Memorial Hospital	*Unlimited.*
UC Davis Medical Center	*Unlimited.*
Stanford Univ Med Ctr	*Unlimited.*
UCLA Medical Center	*Unlimited.*
Keck Hospital of USC	*Unlimited.*
Other (specify)	*Unlimited.*
Other (specify)	*Unlimited.*

4.2.1.2.3.3 Liver Transplants

Liver Transplant Center of Excellence	Contracted for Liver Transplants and available to Covered California Enrollees
Rady Childrens Hosp & Health Center	*Unlimited.*
Childrens Hospital Los Angeles	*Unlimited.*
Cedars-Sinai Med Center	*Unlimited.*
Scripps Green Hospital	*Unlimited.*
UCI Medical Center	*Unlimited.*
Loma Linda Univ Med Ctr	*Unlimited.*
UCSF Medical Center at Mission Bay	*Unlimited.*
Lucile Salter Packard Childrens Hosp	*Unlimited.*
California Pacific Med Ctr	*Unlimited.*
UCSD Medical Center	*Unlimited.*
Univ of CA San Francisco Med Ctr	*Unlimited.*
UC Davis Medical Center	*Unlimited.*

Stanford Univ Med Ctr	*Unlimited.*
St. Vincent Medical Center	*Unlimited.*
UCLA Medical Center	*Unlimited.*
Keck Hospital of USC	*Unlimited.*
Other (specify)	*Unlimited.*
Other (specify)	*Unlimited.*

4.2.1.2.3.4 Kidney Transplants

Kidney Transplants Centers of Excellence	Contracted for Kidney Transplants and available to Covered California Enrollees
St Bernardine Med Center	*Unlimited.*
Alta Bates Med Ctr	*Unlimited.*
Rady Childrens Hosp & Health Center	*Unlimited.*
Childrens Hospital Los Angeles	*Unlimited.*
Cedars-Sinai Med Center	*Unlimited.*
Scripps Green Hospital	*Unlimited.*
UCI Medical Center	*Unlimited.*

Kaiser Permanente-San Fran. Med. Ctr	*Unlimited.*
Harbor UCLA Med Center	*Unlimited.*
St Mary Medical Center	*Unlimited.*
Loma Linda Univ Med Ctr	*Unlimited.*
UCSF Medical Center at Mission Bay	*Unlimited.*
Santa Rosa Memorial Hosp	*Unlimited.*
Lucile Salter Packard Childrens Hosp	*Unlimited.*
California Pacific Med Ctr	*Unlimited.*
Riverside Community Hosp	*Unlimited.*
Arrowhead Reg. Med. Ctr.	*Unlimited.*
Univ of Southern CA Med Ctr	*Unlimited.*
UCSD Medical Center	*Unlimited.*
Univ of CA San Francisco Med Ctr	*Unlimited.*
Sutter Memorial Hospital	*Unlimited.*

Sharp Memorial Hospital	*Unlimited.*
St Joseph Hospital	*Unlimited.*
UC Davis Medical Center	*Unlimited.*
Stanford Univ Med Ctr	*Unlimited.*
St. Vincent Medical Center	*Unlimited.*
UCLA Medical Center	*Unlimited.*
Keck Hospital of USC	*Unlimited.*
Western Medical Center	*Unlimited.*
Other (specify)	*Unlimited.*
Other (specify)	*Unlimited.*

4.2.1.2.3.5 Pancreas Transplants

Pancreas Transplants Centers of Excellence	Contracted for Pancreas Transplants and available to Covered California Enrollees
St Bernardine Med Center	*Unlimited.*
Childrens Hospital Los Angeles	*Unlimited.*
Cedars-Sinai Med Center	*Unlimited.*

Scripps Green Hospital	*Unlimited.*
UCI Medical Center	*Unlimited.*
Loma Linda Univ Med Ctr	*Unlimited.*
Lucile Salter Packard Childrens Hosp	*Unlimited.*
California Pacific Med Ctr	*Unlimited.*
Riverside Community Hosp	*Unlimited.*
UCSD Medical Center	*Unlimited.*
Univ of CA San Francisco Med Ctr	*Unlimited.*
Sutter Memorial Hospital	*Unlimited.*
Sharp Memorial Hospital	*Unlimited.*
UC Davis Medical Center	*Unlimited.*
Stanford Univ Med Ctr	*Unlimited.*
St. Vincent Medical Center	*Unlimited.*
UCLA Medical Center	*Unlimited.*

Keck Hospital of USC	*Unlimited.*
Other (specify)	*Unlimited.*
Other (specify)	*Unlimited.*

4.2.1.2.3.6 Comprehensive Cancer Care Centers

Comprehensive Cancer Care Centers	Contracted for Comprehensive Cancer Care Centers and available to Covered California Enrollees
Chao Family Comprehensive Cancer Center UC Irvine	*Unlimited.*
Stanford Cancer Institute Stanford University	*Unlimited.*
City of Hope Comprehensive Cancer Center	*Unlimited.*
UC Davis Comprehensive Cancer Center	*Unlimited.*
Jonsson Comprehensive Cancer Center UCLA	*Unlimited.*
UC San Diego Moores Cancer Center UCSD	*Unlimited.*
Salk Institute Cancer Center	*Unlimited.*

UCSF Helen Diller Family Comprehensive Cancer Center UCSF	*Unlimited.*
Sanford Burnham Prebys Medical Discovery Institute	*Unlimited.*
USC Norris Comprehensive Cancer Center	*Unlimited.*
Other (specify)	*Unlimited.*
Other (specify)	*Unlimited.*

4.2.1.2.3.7 Burns Centers

Burn Centers	Contracted for Burn Care and available to Covered California Enrollees
LAC+USC Medical Center Burn Center	*Unlimited.*
UCI Regional Burn Center	*Unlimited.*
Shriners Hospital for Children - Northern California Pediatric Burn Center	*Unlimited.*
UC Davis Regional Burn Center Adult Burn Center	*Unlimited.*
University of California San Diego	*Unlimited.*
Saint Francis Memorial Hospital Bothin Burn Center	*Unlimited.*

Santa Clara Valley Medical Center	*Unlimited.*
Torrance Memorial Medical Center Burn Center	*Unlimited.*
Grossman Burn Center at West Hills Hospital Adult Burn Center	*Unlimited.*
Other (specify)	*Unlimited.*
Other (specify)	*Unlimited.*

4.2.1.2.3.8 If applicant listed any facilities under other, please give a justification as to why it should be considered a center of excellence

Unlimited.

4.2.1.2.3.9 In addition to the inclusion and availability of the above-mentioned centers, explain provisions, if any, for enrollees and family members not living in close proximity to a center of excellence and any support given.

Unlimited.

4.2.1.3 Network Stability

4.2.1.3.1 Identify network hospitals terminated between January 1, 2015 and December 31, 2015, 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
Unlimited.	*Unlimited.*	*Unlimited.*	*Unlimited.*
Unlimited.	*Unlimited.*	*Unlimited.*	*Unlimited.*

Unlimited.	*Unlimited.*	*Unlimited.*	*Unlimited.*
Unlimited.	*Unlimited.*	*Unlimited.*	*Unlimited.*
Unlimited.	*Unlimited.*	*Unlimited.*	*Unlimited.*
Unlimited.	*Unlimited.*	*Unlimited.*	*Unlimited.*
Unlimited.	*Unlimited.*	*Unlimited.*	*Unlimited.*
Unlimited.	*Unlimited.*	*Unlimited.*	*Unlimited.*
Unlimited.	*Unlimited.*	*Unlimited.*	*Unlimited.*
Unlimited.	*Unlimited.*	*Unlimited.*	*Unlimited.*

4.2.1.3.2 Total Number of Contracted Hospitals:
Unlimited.

4.2.1.3.3 Identify the number of participating providers who have terminated from the provider network between 1/1/2015-12/31/2015, by rating region.

	Terminated by Issuer	Terminated by Provider
Region 1	*Unlimited.*	*Unlimited.*
Region 2	*Unlimited.*	*Unlimited.*
Region 3	*Unlimited.*	*Unlimited.*
Region 4	*Unlimited.*	*Unlimited.*
Region 5	*Unlimited.*	*Unlimited.*
Region 6	*Unlimited.*	*Unlimited.*
Region 7	*Unlimited.*	*Unlimited.*
Region 8	*Unlimited.*	*Unlimited.*
Region 9	*Unlimited.*	*Unlimited.*

Region 10	*Unlimited.*	*Unlimited.*
Region 11	*Unlimited.*	*Unlimited.*
Region 12	*Unlimited.*	*Unlimited.*
Region 13	*Unlimited.*	*Unlimited.*
Region 14	*Unlimited.*	*Unlimited.*
Region 15	*Unlimited.*	*Unlimited.*
Region 16	*Unlimited.*	*Unlimited.*
Region 17	*Unlimited.*	*Unlimited.*
Region 18	*Unlimited.*	*Unlimited.*
Region 19	*Unlimited.*	*Unlimited.*

4.2.1.3.4 Identify Independent Practice Associations 6 (IPA), Medical Groups, clinics or health centers terminated between January 1, 2015 and December 31, 2015, 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
Unlimited.	*Unlimited.*	*Unlimited.*	*Unlimited.*
Unlimited.	*Unlimited.*	*Unlimited.*	*Unlimited.*
Unlimited.	*Unlimited.*	*Unlimited.*	*Unlimited.*
Unlimited.	*Unlimited.*	*Unlimited.*	*Unlimited.*

Unlimited.	*Unlimited.*	*Unlimited.*	*Unlimited.*
Unlimited.	*Unlimited.*	*Unlimited.*	*Unlimited.*
Unlimited.	*Unlimited.*	*Unlimited.*	*Unlimited.*
Unlimited.	*Unlimited.*	*Unlimited.*	*Unlimited.*
Unlimited.	*Unlimited.*	*Unlimited.*	*Unlimited.*
Unlimited.	*Unlimited.*	*Unlimited.*	*Unlimited.*

4.2.1.3.5 Total Number of Contracted IPA/Medical Groups/Clinics (provide information by region):

	Number of Contracted Entities
Region 1	*Decimal.*
Region 2	*Decimal.*
Region 3	*Decimal.*
Region 4	*Decimal.*
Region 5	*Decimal.*
Region 6	*Decimal.*
Region 7	*Decimal.*
Region 8	*Decimal.*
Region 9	*Decimal.*
Region 10	*Decimal.*
Region 11	*Decimal.*

Region 12	*Decimal.*
Region 13	*Decimal.*
Region 14	*Decimal.*
Region 15	*Decimal.*
Region 16	*Decimal.*
Region 17	*Decimal.*
Region 18	*Decimal.*
Region 19	*Decimal.*

4.2.1.3.6 Describe any plans for network expansion, by product, including the addition of medical groups or hospital systems.

Unlimited.

4.2.1.3.7 Describe any plans for other network changes that will affect Covered California products or enrollees

Unlimited.

4.2.1.3.8 Provide information on any known or anticipated potential network disruption that may affect the Applicant's 2017 provider networks. For example: list any pending terminations of general acute care hospitals or medical groups which can include Independent Practice Associations

Unlimited.

4.2.1.4 Provider Data and Reporting

4.2.1.4.1 Describe the timeline and process for provider information changes (including demographic, address, network or panel status) to be reflected in

Applicants online directory from time change was reported. Applicant should detail process for individuals and groups.

Unlimited.

4.2.1.4.2 Describe in detail Applicant's process for assuring provider data accuracy,

Unlimited.

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

Unlimited.

4.2.1.4.4 Please describe in detail Applicant's process for ensuring providers report changes (including demographic, address, network or panel status) in a timely and consistent manner. Listing incentives, penalties etc.

Unlimited.

4.2.1.4.5 Describe any contractual agreements with Applicant's participating providers that preclude your organization from making contract terms transparent to plan sponsors and members.

Applicant must confirm that, if certified as a QHP, to the extent that any Participating Provider's rates are prohibited from disclosure to the Exchange by contract, Applicant shall identify such Participating Provider. Issuer shall, upon renewal of its Provider contract, but in no event later than July 1, 2016, 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.

• What is your organization doing to change the provisions of your contracts 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

Unlimited.

4.2.1.4.6 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 2017 must be consistent with what will be filed to the appropriate regulator for

approval if selected as a QHP. The Exchange requires the information as requested to allow cross-network comparisons and evaluations.

Unlimited.

4.2.1.4.7 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/qhp.html.

Unlimited.

5. Essential Community Providers

Applicant must demonstrate that its QHP proposals meet requirements for geographic sufficiency of its Essential Community Provider (ECP) network. All of the below criteria must be met.

i. The Exchange will use the provider network data submission to asses applicant's ECP network.

ii. Applicants must demonstrate sufficient geographic distribution of a mix of essential community providers reasonably distributed throughout the geographic service area; **AND**

iii. Applicants must demonstrate contracts with at least 15% of 340B entities (where available) throughout each rating region in the proposed geographic service area; **AND**

iv. 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 available.

Determination that an essential community provider network meets the standard of sufficient geographic distribution with a balance of hospital and non-hospital providers and serves the low-income population within the proposed geographic service area requires the Applicant to apply interactively all four criteria above. The Exchange will evaluate the application of all four criteria to determine whether the 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 sole contracted ECP hospital.

Federal rules 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 rules 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 Clinic or health center licensed as either a "community clinic" or "free clinic", by the State of California under Health and Safety Code section 1204(a), or is a community clinic or free clinic exempt from licensure under Section 1206
5. Physician Providers with approved applications for the HI-TECH Medi-Cal Electronic Health Record Incentive Program
6. Federally Qualified Health Centers (FQHCs)

Low-income is defined as a family at or below 200% of Federal Poverty Level. The ECP data supplied by Applicant will allow 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, the 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.

6. Operational Capacity

6.1 Administration and Account Management Support

6.1.1 Provide the legal name of Applicant entity.

6.1.2 In what year was Applicant's entity founded?

6.1.3 Provide the location of Applicant's corporate headquarters.

6.1.4 Indicate Applicant entity's tax status:
□ Not-for-profit
□ For-profit

6.1.5 Provide name used in consumer-facing materials or communications.

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

□ Attachments completed
□ Attachments not completed

6.1.7 Indicate any experience Applicant has participating in Exchanges or marketplace environments:

□ State-based Marketplace(s), specify state(s) and years of participation:
□ Federally-Facilitated Marketplace, specify state(s) and years of participation:
□ Private Exchange(s), specify exchange(s) and years of participation:

6.1.8 Provide a summary of Applicant's capabilities, including how long Applicant has been in the business as an Issuer.

6.1.9 Does Applicant anticipate making material changes in your 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.

6.1.10 Provide a description of any initiatives, 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

6.1.11 Does Applicant routinely subcontract any significant portion of your 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.

- Billing, invoice, and collection activities
  □ Yes
  □ No

- Database and/or enrollment transactions
  □ Yes
  □ No

- Claims processing and invoicing
  - □ Yes
  - □ No

- Membership/customer service
  - □ Yes
  - □ No

- Welcome package (ID cards, member communications, etc.)
  - □ Yes
  - □ No

- Other (specify)
  - □ Yes
  - □ No

6.1.12 Are any of Applicant's operations, such as member services call centers, conducted outside of the United States? If yes, describe the operations.
- □ Yes
- □ No

6.1.13 Submit a copy of business continuity plans in event of an emergency or disruption of services to Exchange members.

6.1.14 Applicant must include an organizational chart of key personnel who will be assigned to Covered California. The Key Personnel and representatives of the Account Management Team who will be assigned to Covered California must be identified in the following areas:

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

Applicant must identify the individual(s) who will have primary responsibility for servicing the Exchange account. Please indicate where these individuals fit into the organizational chart requested above. Please include the following information and repeat as necessary:

- Name
- Title
- Department
- Functional Area
- Phone
- Fax
- E-mail
- Percent of time dedicated to Covered California account

6.1.15 Applicant must complete and upload through SERFF the Administrative Data template.

□ Template completed and uploaded

□ Template not completed or uploaded

6.2 Implementation Performance

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 supervisor of this manager and support team. If no, please explain why and how Applicant will manage implementation.

□ Yes
□ No
□ No, Applicant is currently operating in the Exchange

6.2.2 Provide a detailed implementation project plan and schedule targeting a January 1, 2017 effective date and including Open Enrollment readiness.

6.2.3 Applicant must indicate current or planned procedures for managing the new enrollee transition period. Check all that apply and describe:

□ Request transfer from prior health or dental plan, if applicable

□ Utilize information received from prior health or dental plan to continue plan or benefit accumulators

□ Load claim history from prior health or dental plan, if any

□ Services that have been pre-authorized but not completed as of the effective date must also be pre-authorized by new plan

□ Will make customer service line available to new or potential Enrollees prior to the effective date

□ Provide member communications regarding change in health or dental plans

6.2.4 If certified by the Exchange, explain how Applicant anticipates accommodating the additional membership effective January 1, 2017. Identify the percentage increase in membership which will require 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			
Claims			
Account Management			
Clinical staff			
Disease Management staff			
Implementation			
Financial			
Administrative			
Actuarial			
Information Technology			
Other (List)			

6.3 Customer Service

6.3.1 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.

6.3.2 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 a.m. to 6 p.m. Saturdays.

Applicant must confirm it will match Exchange Open Enrollment Customer Service operating hours. Describe how Applicant will modify and monitor your customer service center operations to meet Exchange-required operating hours if applicable.

□ Confirmed

□ Not confirmed

6.3.3 Applicant must provide customer service representative ratio to members.

6.3.4 Describe how Customer Service Center Representative training will be modified to include training on Exchange products.

6.3.5 Applicant must list languages spoken by Customer Service Center Representatives.

□ Arabic
□ Armenian
□ Cantonese
□ English
□ Hmong
□ Korean
□ Mandarin
□ Farsi
□ Russian
□ Spanish
□ Tagalog
□ Vietnamese
□ Lao
□ Cambodian
□ Other, specify

6.3.6 Applicant must describe any other modifications that will be required to allow for quality service to Exchange consumers.

6.4 Financial Requirements

6.4.1 Applicant must confirm it has in place systems to invoice members effective October 1, 2016.

□ Yes, confirmed
□ No, not confirmed

6.4.2 Describe systems to invoice members, including issuance of ID cards and record retention. 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.

6.4.3 Applicant must confirm it has in place systems to accept from members effective October 1, 2016 the following premium payment types:

□paper checks
□cashier's checks
□money orders
□Electronic Funds Transfer (EFT)
□Credit cards and debit cards
□web-based payment, which may include accepting online credit card payments, and all general purpose pre-paid debit cards and credit card payment).

6.4.4 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 must accept premium payment from members no later than October 1, 2016. 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.

6.4.5 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 binder and ongoing payments for both on-Exchange and off-Exchange lines of business.

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

6.4.7 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 issuer in California.

6.5 Fraud, Waste and Abuse Detection

The Exchange is committed to working with its QHPs to establish common efforts to minimize fraud, waste and abuse.

Fraud - An intentional deception or misrepresentation made by a person or entity with the knowledge that the deception could result in some unauthorized benefit

to him/herself, itself or some other person or entity. It includes any act that constitutes fraud under applicable federal or state law.

Waste - Waste is the intentional or unintentional, thoughtless or careless 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 also includes incurring unnecessary costs as a result of inefficient or ineffective practices, systems, or controls.

Abuse – Behaviors or practices of providers, physicians, or suppliers of services and equipment that, although normally not considered fraudulent, are inconsistent with accepted sound medical, business, or fiscal practices. The practices may, directly or indirectly, result in unnecessary costs to the program, improper payment, or payment for services that fail to meet professionally recognized standards of care, or which are medically unnecessary. Abuse can also occur with excessive charges, improper billing practices, payment for services that do not meet recognized standards of care and payment for medically unnecessary services. Abuse can occur in financial or non-financial settings.

□ Check here if Applicant has completed the Covered California QHP Certification Application for Plan Year 2017 Covered California for Small Business, and responses apply to this submission.

6.5.1 Describe the processes used in determining when investigations for fraud, waste, and abuse are needed. Include specific event triggers, descriptions of overall monitoring, audits and fraud risk assessment.

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

6.5.3 Describe the processes for fraud, waste and abuse investigation follow-up and corrective measures.

6.5.4 Describe the processes for recovery of fraud funds.

6.5.5 Describe the controls in place to confirm enrollment and disenrollment actions are accurately and promptly executed.

6.5.6 Provide a brief description of your member fraud detection policy.

6.5.7 Provide a brief description of your provider fraud detection policy.

6.5.8 Submit a sample copy of your fraud, waste, and abuse report. Reports can include: investigation reports, fraud summary reports, trends analysis, forecasting, adjudicated investigations, referrals, number of complaints, number of cases.

6.5.9 What was Applicant's recovery success rate and dollars recovered for fraudulent activities?

	Total Loss from Fraud		% of Loss Recovered		Total Dollars Recovered	
	Covered California, if applicable	Book of Business	Covered California, if applicable	Book of Business	Covered California, if applicable	Book of Business
Calendar Year 2013						
Calendar Year 2014						
Calendar Year 2015						

6.5.10 Describe Applicant's revenue recovery process to recoup erroneously paid claims.

6.5.11 Describe Applicant's procedures to educate members to identify and report possible fraud scams.

6.5.12 Describe Applicant's procedures to report fraud scams to law enforcement?

6.5.13 Describe how you safeguard against Social Security and Identity fraud.

6.5.14 What steps are taken after identification of social security and identity fraud? Include services offered to impacted participants.

6.5.15 Indicate how frequently internal audits are performed for each of the following areas.

Claims Administration

- □ Daily
- □ Weekly
- □ Monthly
- □ Quarterly
- □ Other

Customer Service

- □ Daily
- □ Weekly
- □ Monthly
- □ Quarterly
- □ Other

Network Contracting

□ Daily
□ Weekly
□ Monthly
□ Quarterly
□ Other

Eligibility and Enrollment

□ Daily
□ Weekly
□ Monthly
□ Quarterly
□ Other

Utilization Management

□ Daily
□ Weekly
□ Monthly
□ Quarterly
□ Other:

Billing

□ Daily
□ Weekly
□ Monthly
□ Quarterly
□ Other:

6.5.16 Overall, what percent of Claims are subject to internal audit?

6.5.17 Indicate if external audits were conducted for Claims administration for your entire book of business for the last two (2) full calendar years.

- 2015
  - □ Audit Conducted
  - □ Audit Not Conducted

- 2014
  - □ Audit Conducted

□ Audit Not Conducted

6.5.18 Describe Applicant's approach to the following controls to confirm non-contracted providers who file claims for amounts above a defined expected threshold of the reasonable and customary amount for that procedure and area.

6.5.19 Describe Applicant's approach to use of the Healthcare Integrity and Protection Data Bank (HIPDB) as part of the credentialing and re-credentialing process for contracted Providers.

6.5.20 Describe your controls in place to monitor referrals of Plan Members to any health care facility or business entity in which the Provider may have full or partial ownership or own shares.

6.5.21 Indicate the types of Claims and Providers that Applicant typically reviews for possible fraudulent activity. Check all that apply.

- Hospitals
- Physicians
- Skilled nursing
- Chiropractic
- Podiatry
- Behavioral Health
- Substance Use Disorder treatment facilities
- Alternative medical care
- Durable medical equipment Providers
- Other service Providers

6.5.22 Describe the different approaches Applicant takes to monitor these types of Providers.

6.5.23 Describe Applicant's system for flagging unusual patterns of care identified at time of claim submission.

6.5.24 Describe Applicant's system for flagging unusual patterns of care through data mining.

6.5.25 Describe Applicant's system for flagging unusual patterns of care through plan member referrals.

6.5.26 Describe Applicant's system for flagging unusual patterns of care through other methods.

6.5.27 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 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. Issuer also agrees to all audits subject to applicable State and Federal law regarding the confidentiality of and release of confidential Protected Health Information of Enrollees.

- ☐ Yes, confirmed
- ☐ No, not confirmed

6.6 System for Electronic Rate and Form Filing (SERFF)

6.6.1 Applicant must be able to populate and submit SERFF templates in an accurate, appropriate, and timely fashion at the request of Covered California for:

- Administrative Information
- Rates
- Service Area
- Benefit Plan Designs
- Network
- Prescription Drug

6.6.2 Applicant confirms that it will submit and upload corrections to SERFF within three (3) business days of notification by Covered California, adjusted for any SERFF downtime.

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

6.7 Electronic Data Interface

6.7.1 Applicant must provide an overview of its system, data model, vendors, and interface partners. Applicant must submit a copy of its system lifecycle and release schedule.

6.7.2 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 2016. 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 v9 for detailed 834 transaction specifications. Covered California requires QHP Issuers to sign an industry-standard agreement

which establishes electronic information exchange standards in order to participate in the required systems testing.

6.7.3 Applicant must describe its ability and any experience processing and resolving errors identified by a TA1 and 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.

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

6.7.5 Applicant must be prepared and able to conduct testing of data interfaces with the Exchange no later than June 1, 2016 and confirms it will plan and implement testing jointly with Covered California 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.

6.7.6 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.

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

- □ Yes
- □ No

6.8 Healthcare Evidence Initiative

□ Check here if Applicant has completed the Covered California QHP Certification Application for Plan Year 2017 Covered California for Small Business, and responses apply to this submission.

6.8.1 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, Covered California 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 Covered California enrollees. The capabilities

described in this section are requirements of QHP data submission obligations.

6.8.2 Can Applicant adjudicate 100% of fee-for-service (FFS) or price 100% of encounter records for the following claim types? If not, or if yes with deviation, explain.

Claim Type	Yes	No	If No or Yes with deviation, explain.
Professional			
Institutional			
Pharmacy			
Drug (non-Pharmacy)			
Dental			
Mental Health			
Vision			

6.8.3 Covered California is interested in QHP Issuer data that represents the cost of care. Can Applicant provide complete financial detail for all applicable claims and encounters? If not, or if yes with deviation, explain.

Financial Detail to be Provided	Yes	No	If No or Yes with deviation, explain.
Submitted Charges			
Discount Amount			
Allowable Charges			
Copayment			
Coinsurance			
Deductibles			
Coordination of Benefits			
Plan Paid Amount (Net Payment)			
Capitation Financials (per Provider / Facility)[3]			

[3] *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.*

6.8.4 Can Applicant provide member and subscriber IDs assigned by Covered California 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/she moves from one plan to another. If not, or if yes with deviation, explain.

Detail to be Provided	Yes	No	If No or Yes with deviation, explain.
Covered CA Member ID			
Covered CA Subscriber ID			

6.8.5 Can Applicant supply Protected Health Information (PHI) dates in full year / month / day format to the HEI Vendor for data aggregation? If not, or if yes with deviation, explain.

PHI Dates to be Provided in Full Year / Month / Day Format	Yes	No	If No or Yes with deviation, explain.
Member Date of Birth			
Member Date of Death			
Starting Date of Service			
Ending Date of Service			

6.8.5 Can Applicant supply all applicable Provider Tax ID Numbers (TINs), National Provider Identifiers (NPIs), and National Council for Prescription Drug Programs (NCPDP) Numbers (pharmacy only) for individual providers? If not, or if yes with deviation, explain.

Provider IDs to be Supplied	Yes	Yes, unless values represent individual provider Social Security numbers	No	If No or Yes with deviation, explain.
TIN				
NPI				
NCPDP Number				

6.8.6 Can Applicant provide detailed coding for diagnosis, procedures, etc. on all claims for all data sources? If not, or if yes with deviation, explain.

Coding to be Provided	Yes	No	If No or Yes with deviation, explain.
Diagnosis Coding			
Procedure Coding (CPT, HCPCS)			
Revenue Codes (Facility Only)			
Place of Service			
NDC Code (Drug Only)			

6.8.7 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.

6.8.8 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)?

6.8.9 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?

6.9 Privacy and Security Requirements for Personally Identifiable Data

□ Check here if Applicant has completed the Covered California QHP Certification Application for Plan Year 2017 Covered California for Small Business, and responses apply to this submission.

6.9.1 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.]:

6.9.1.1 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].

□ Yes, confirmed
□ No, not confirmed

6.9.1.2 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].

- Yes, confirmed
- No, not confirmed

6.9.1.3 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)].

- Yes, confirmed
- No, not confirmed

6.9.1.4 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].

- Yes, confirmed
- No, not confirmed

6.9.1.5 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)].

- Yes, confirmed
- No, not confirmed

6.9.1.6 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)].

- Yes, confirmed
- No, not confirmed

6.9.1.7 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)].

- Yes, confirmed
- No, not confirmed

6.9.2 Safeguards

6.9.2.1 Applicant must confirm that it has policy, standards, processes, and procedures in place and the 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.

- Yes, confirmed
- No, not confirmed

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

- Yes, confirmed
- No, not confirmed

6.9.2.3 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.

- Yes, confirmed
- No, not confirmed

6.9.2.4 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.

- Yes, confirmed
- No, not confirmed

6.9.2.5 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.

- Yes, confirmed
- No, not confirmed

6.9.3 Breach Notification

6.9.1.3 Applicant must confirm that it currently has policies and procedures in place to determine when a Breach which compromises the security or privacy of consumer PHI has occurred [45 CFR §164.402 et seq] (the "Breach Notification Rule").

- Yes, confirmed
- No, not confirmed

6.9.3.2. Applicant must confirm that it currently has policies and procedures in place to notify consumers whose PHI has been subject to a Breach in accordance with applicable provisions of both the HIPAA Breach Notification Rule [45 CFR §164.404] and the California Information Practices Act [CA Civil Code §1798.29].

- Yes, confirmed
- No, not confirmed
-

6.10 Sales Channels

6.10.1 Does Applicant have experience working with Insurance Agents?
□ Yes. If yes, 6.10.2 through 6.10.7 required.
□ No. If no, 6.10.8 required.

6.10.2 Review Appendix E Covered California Individual Market Agent of Record policy. Applicant must submit a copy of its Agent of Record policy and procedures. The policy and procedures should include the following criteria:

- Appointing Agents
- Agent of Record Changes
- Vested Agents
- Procedures used to manage changes when the Agent of Record files are received on an 834 or other electronic file.

6.10.3 Applicant must provide a primary point of contact for broker or agent services and include the following contact information:

- Name (if applicable)
- Phone Number
- Email Address

6.10.4 If Applicant contracts with general agents, please list the general agents with whom you contract and how long you have maintained those relationships.

6.10.5 Applicant must provide health plan commission schedule for individual and small group business 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 will not vary Agent compensation levels by metal tier; successful Applicants will 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		
Does the compensation level change as the business written by the agent matures? (i.e., Downgraded)		
Specify if the agent is compensated at a higher level as he or she attains certain levels or amounts of enforce business.		
Does the compensation level apply to all plans or does it vary by plan or tier?		
Describe any business for which Applicant will not compensate Agents.		
Describe any business for which Applicant will not make changes to Agent of Record.		
Additional Comments		

Small Business Market - Commission Rate

	On-Exchange Business	Direct Business
Provide Commission Rate or Schedule		
Does the compensation level change as the business written by the agent matures? (i.e., Downgraded)		
Specify if the agent is compensated at a higher level as he or she attains certain levels or amounts of enforce business.		
Does the compensation level apply to all plans or does it vary by plan or tier?		
Describe any business for which Applicant will not compensate Agents.		
Describe any business for which Applicant will not make changes to Agent of Record.		
Additional Comments		

6.10.6 Indicate if Applicant's agent of record policy, appointment process or commission schedule differs outside of California. If so, describe how.

- Agent of Record Policy
  - □ Does not differ outside of California
  - □ Differs outside of California (describe):

- Appointment Process
  - □ Does not differ outside of California
  - □ Differs outside of California (describe):

- Commission Schedule
  - □ Does not differ outside of California
  - □ Differs outside of California (describe):

6.10.7 What initiatives is Applicant undertaking in order to partner more effectively with the agent community?

6.10.8 If Applicant does not currently work with Insurance Agents, describe Applicant approach to develop an agent program. Include plan to develop agent appointment process. Plan should include the following components:

- Appointing Agents
- Agent of Record Changes
- Vested Agents
- Procedures used to manage changes when the Agent of Record files are received on an 834 or other electronic file.
- Applicant must provide a primary point of contact for broker/agent support and include the following contact information:
  - Name
  - Phone Number
  - Email Address

6.10.9 Review Appendix F Covered California's Plan-Based Enrollment (PBE) Program. Are you currently participating in the Plan-Based Enrollment Program?

□ Yes. If yes, questions 6.10.10 through 6.10.18 required.
□ No. If no, question 6.10.19 required.

6.10.10 Do you contract Captive Agents? If yes, are Captive Agents contracted independently or through a vendor?

□ Yes, Captive Agents contracted independently
□ Yes, Captive Agents contracted through vendor
□ No, do not contract Captive Agents

6.10.11 Do you contract with Issuer Application Assisters? If yes, are Issuer Application Assisters contracted independently or through a vendor?

□ Yes, Issuer Application Assisters contracted independently
□ Yes, Issuer Application Assisters contracted through a vendor
□ No, but intend to contract with Issuer Application Assisters independently or through a vendor
□ No, no intention to contract with Issuer Application Assisters

6.10.12 Describe Applicant business cycle, including description of permanent resources, potential seasonal hiring adjustments, and use of temporary resources. If applicable, include anticipated Plan-Based Enroller (Captive Agents and Issuer Application Assisters) volume.

6.10.13 How does Applicant provide agent support? Include use of call centers, number and location(s) of call centers, if applicable.

6.10.14 How do consumers contact the Plan-Based Enrollers? If call center environment, what is Applicant's Service Level Agreement?

6.10.15 Does Applicant offer additional locations where in-person assistance is available to consumers? If yes, provide total number of in-person assistance location, where they are located, and number of Plan-Based Enrollers at each location.

6.10.16 Do the customer service representatives refer consumers to Plan-Based Enrollers for account updates (i.e., reporting changes, termination, etc.)?If so, describe which changes are referred to Plan Based Enrollers.

6.10.17 If Applicant is not currently participating in the PBE program but intends to, what is the expected volume of agents that you anticipate participation in the Plan-Based Enrollment program?

6.10.18 Are you participating in a program that is similar to the Plan-Based Enrollment Program? If yes, please describe the program or provide a model of your program.

6.10.19 Describe any experience Applicant may have working with navigators or similar enrollment entities.

6.11 Marketing and Outreach Activities

6.11.1 The Exchange expects all successful Applicants to promote enrollment in their certified QHPs, including investment of resources and coordination with the Exchange's marketing and outreach efforts. Applicant must provide an organizational chart of its individual sales and marketing department(s), including names and titles. Applicant must identify the individual(s) with primary responsibility for sales and marketing of the Exchange account, indicate where these individuals fit into the organizational chart and include the following contact information for those who will work on Covered California sales and marketing efforts: Name, title, phone number, fax number and email address. Note also which staff oversee Member Retention/Member Communication and Social Media efforts.

6.11.2 Applicant must confirm that, upon contingent certification, it will adhere to Exchange requirements to adhere to the Appendix G Covered

California Brand Style Guide when co-branding materials, including: ID cards, premium invoices, and termination notices issued to Exchange enrollees. Co-branded items must be submitted 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. Please identify the Applicant's marketing team member who will be responsible for submitting these co-branded materials to the Exchange for review.

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

6.11.4 Applicant must complete and submit Attachment D1 Member Communication Calendar, including proposed Exchange member communications.

□ Confirmed, attachment complete

□ Attachment not completed

6.11.5 Applicant must provide a proposed Marketing Plan for the Exchange Individual Marketplace line of business. Applicants serving the Medi-Cal Managed Care population shall include such marketing as "Individual" marketing.

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
- Attachment D2 Media Plan Flowchart

6.11.6 Applicant must use Attachment D3 Estimated Media Spend by Designated Market Area template provided to indicate estimated total expenditures and allocations for Individual Marketplace related marketing and advertising functions. Information supplied in this attachment must match dollars represented in Attachment D2 Media Plan Flowchart.

7. Quality

□ Check here if Applicant has completed the Covered California QHP Certification Application for Plan Year 2017 Covered California for Small Business, and responses apply to this submission.

The Exchange's "Triple Aim" framework seeks to improve the patient care experience including quality and satisfaction, improve the health of the entire California population and reduce the per capita cost of Covered Services. The Quality and Delivery System Reform standards outlined in the QHP Contract describe the ways the Exchange and Contracted QHPs will focus on the promotion of better care and higher value for plan enrollees and other California health care consumers.

7.1 Quality Improvement Strategy

As part of a new federal requirement in 2017, all health plans with two years of state-based Exchange experience will participate in a Quality Improvement Strategy (QIS). (For more information, visit: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/QIS-Technical-Guidance-and-User-Guide.pdf.)

The California Health Benefit Exchange has harmonized federal QIS requirements to align with 2017 quality strategy and direction. As part of a federally mandated Quality Improvement Strategy, Applicant must identify the mechanisms planned to promote improvements in health care quality and access to care, population health outcomes, and making care more affordable for each QIS strategy initiative listed in Section 9. The Exchange will give more weight to those responses from Applicants that engage in programs that foster payment and other practices that encourage primary care, care coordination, quality improvement, promoting health equity and reducing costs.

Note, the QIS question set is presented separately in Section 9 of this application.

7.1.1 Confirm Applicant has completed the QIS in Section 9.

7.1.2 Describe two Quality Improvement Projects (QIPs) conducted by Applicant within the last five (5) years. Include information about results of the QIP, why the QIP was undertaken and why it ended or has continued, if

applicable. Describe the QIP scalability, if it was successful. Also include the following information:

Start/End Dates:
QIP Name/Title:
Problem Addressed:
Rationale (why selected):
Targeted Population:
Study Indicator(s):
Baseline Measurement:
Results:
What Best Practices have been implemented to sustain Improvement (if any):

7.2 Medical Management

7.2.1 Applicant must describe use of Evidence Based Medicine practice guidelines. List all that apply, e.g., Agency for Healthcare Research and Quality, Milliman guidelines.

7.2.2 Indicate the availability of the following demand management activities and health information resources for Exchange members. (Check all that apply)

- ☐ 24/7 Telehealth providers (specifically access to physicians at reduced cost)
- ☐ 24/7 Nurse Advice Line
- ☐ Nurse Advice Line (limited availability)
- ☐ decision support
- ☐ Self-care books
- ☐ Electronic Preventive care reminders
- ☐ Web-based health information
- ☐ Web-based self-care resources
- ☐ Integration with other health care vendors
- ☐ Other (describe)

7.2.3 Indicate 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 2015. 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 2015)	Denominator (all members who were included in applicable line of business in 2015)	Rate (%)	Indicate if PCMH, IHM, or other model (specify)
Exchange Enrollees (if applicable)				
Total book of business				

7.3 Behavioral Health Medical Management

7.3.1 Does Applicant gather and record information related to member mental and behavioral health?

7.3.2 Describe how mental and behavioral health information is incorporated in identifying members for care management programs, interventions, or other needed care.

7.3.3 How are members notified of this need and how are options presented to them?

7.3.4 What steps, if any, are undertaken to monitor member's action after notification, or follow-up if no action is taken?

7.3.5 Does Applicant manage Behavioral Health services in-house or does Applicant subcontract?

7.3.6 Describe how Applicant incorporates Evidence-Based Medicine and monitors outcomes to institute and assess best practices for behavioral health. Include a description of efforts to assess and modify networks and implement best practices that would meet the specific needs of the Exchange population demographics.

7.3.7 Describe any recent efforts to improve integration of behavioral health services and medical services in the past five years.

7.3.8 Describe any recommended models or best practices learned from experience integrating behavioral health and medical services.

7.3.9 Provide the percent of mental and behavioral health services provided in an integrated behavioral health model. Percentage should represent services, identified through claims, in plan year 2015.

Numerator is the total number of services provided in 2015 in an integrated behavioral health medical model, and the denominator is the total number of services provided to enrollees in Applicant's full book of business.

	Numerator (2015 claims provided in integrated behavioral health medical model)	Denominator (all claims in 2015)	Rate (%)	Indicate if PCMH, IHM, or other model (specify)
Exchange Enrollees (if applicable)				
Total book of business				

7.4 Population Health Management

7.4.1 Describe practices in place to address population health management across enrolled members. Include measurement strategy and any specific ability to track impact on Exchange enrollees.

7.4.2 Describe processes, if any, to track and monitor clinical and financial performance measurement related to the Integrated Healthcare Association (IHA). Include measurement strategy and any specific ability to track impact on Exchange enrollees.

7.4.3 Describe ability to track and monitor member satisfaction. Include measurement strategy and any specific ability to track impact on Exchange enrollees.

7.4.4 Describe ability to track and monitor cost and utilization management (e.g., admission rates, complication rates, readmissions). Include measurement strategy and any specific ability to track impact on Exchange enrollees.

7.4.5 Describe ability to track and monitor clinical outcome quality. Include measurement strategy and any specific ability to track impact on Exchange enrollees.

7.4.6 Indicate participation in any disease registries below:

- □ Cancer
- □ Diabetes
- □ Immunization Registry
- □ Other, specify:

7.5 Health and Wellness

7.5.1 For each applicable member population listed below, report the number of unique utilizing members and percent of total membership having one or more of the CPT codes listed below. This list does not include CPT codes that are conditional on additional requirements, for example, mammograms for members over age 40.

CPT Code List Indicating Wellness Benefits

86480	86689	86701	86702	86703	86762	87389	87390
87391	87534	87535	87536	87537	87538	87806	90460
90461	90471	90472	90473	90474	90476	90477	90581
90585	90586	90630	90632	90633	90634	90636	90644
90645	90646	90647	90648	90649	90650	90651	90653
90654	90655	90656	90657	90658	90660	90661	90662
90664	90666	90667	90668	90669	90670	90672	90673
90675	90676	90680	90681	90685	90686	90687	90688
90690	90691	90692	90693	90696	90698	90700	90702
90703	90704	90705	90706	90707	90708	90710	90712
90713	90714	90715	90716	90717	90719	90720	90721
90723	90725	90727	90732	90733	90734	90735	90736
90738	90739	90740	90743	90744	90746	90747	90748
90749	99381	99382	99383	99384	99385	99386	99387
99391	99392	99393	99394	99395	99396	99397	99401
99402	99403	99404	99411	99412	99420	99429	99460
99461	99462	99463	99477	G0008	G0009	G0010	G0101
G0102	G0123	G0124	G0141	G0143	G0144	G0145	G0147
G0148	G0402	G0403	G0404	G0405	G0432	G0433	G0435
G0438	G0439	G0445	G0468	J3530	P3000	P3001	Q0091
Q2034	Q2035	Q2036	Q2037	Q2038	Q2039	S0195	S0302
S0610	S0612	S0613	S3645				

	Numerator (number of unique members who utilized one or more of the	Denominator (all members who were included in applicable line	Rate (%)

	below CPT codes in 2015)	of business in 2015)	
Exchange Enrollees (if applicable)			
Total book of business			

7.5.2 Describe health and wellness communication processes delivered to all Enrollees (across all lines of business) and applicable providers. If the set of messaging is different for Exchange enrollees, if applicable, note this and describe.

7.5.3 Indicate how health and wellness communication processes take into account cultural and linguistic diversity.

7.5.4 Describe processes to incorporate member health and wellness information into Applicant's member-specific data, separate and distinct from member's medical record maintained by provider(s).

7.6 Care Transitions

7.6.1 Describe processes to support care transitions. Transitions refers to movement of an enrollee from one state of care to another, which could include changing type or frequency of services needed, care environment, or type of healthcare professional needed.

7.6.2 Describe processes to coordinate enrollee long term care.

7.6.3 Describe processes to coordinate enrollee catastrophic care.

7.6.4 Describe processes to coordinate end of life care.

7.7 Focus on High Cost Providers

7.7.1 Describe the factors considered when assessing the relative unit prices and total costs of care in current and potential providers.

7.7.2 Does Applicant adjust or analyze the reasons for cost factors based on elements such as area of service, population served, market dominance, services provided by the facility (e.g., trauma or tertiary care) or other factors? If so, describe.

7.7.3 Are factors described in 7.7.2 used in selection of providers or facilities in networks available to the Exchange enrollees?

7.7.4 Please describe how hospital cost variation is identified, and if it is identified by cost deciles or other means of grouping hospitals by cost. Examples of groupings by cost include comparison of costs as percentage of Medicare costs.

7.7.5 Describe strategies to assure contracted providers do not charge unduly high process. Include in response which portions of Applicant's entire enrolled population to which these strategies apply. 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.

7.8 Focus on High Cost Pharmaceuticals

7.8.1 Describe how value is considered in selection of formulary medications. Include how value methodology developed by independent groups or independent drug assessment reports on comparative effectiveness and value is applied to benefit design, price negotiations, consumer pricing, and formulary placement, including within standard benefit designs, if applicable.

7.8.2 Indicate if any of the following sources are used in the methodology described in 7.8.1:

- Drug Effectiveness Review Project (DERP)
- NCCN Resource Stratification Framework (NCCN-RF)
- NCCN Evidence Blocks (NCCN-EB)
- ASCO Value of Cancer Treatment Options (ASCO- VF)
- ACC/AHA Cost/Value Methodology in Clinical Practice Guidelines
- Oregon State Health Evidence Review Commission Prioritization Methodology
- Premera Value-Based Drug Formulary (Premera VBF)
- DrugAbacus (MSKCC) (DAbacus)
- The ICER Value Assessment Framework (ICER-VF)
- Real Endpoints
- Blue Cross/Blue Shield Technology Evaluation Center
- International Assessment Processes (e.g., United Kingdom's National Institute for Health and Care Excellence – "NICE")

- Other (please identify)

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

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

7.8.5 Describe how decision support is provided to prescribers and consumers related to the clinical efficacy and cost impact of treatments and their alternatives.

7.9 Data Exchange with Providers

7.9.1 To be successful under Exchange QIS requirements, contracted plans will need to encourage enhanced exchange of clinical data between providers. Participation in Health Information Exchanges 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.

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 which are important under Article 3 below.
- Racial and ethnic self-reported identity collected at every patient contact.

7.10 Data Aggregation Across Health Plans

7.10.1 Describe participation in initiatives to support the aggregation of claims and clinical data across health plans.

7.10.2 Describe feasibility assessment 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

7.11 Innovations

7.11.1 Applicant must describe its institutional capacity to plan, implement, evaluate, and replicate future healthcare quality and cost innovations for Exchange Members. Of special interest to Exchange are programs with focus on at-risk enrollees (e.g.: communities at risk for health disparities, enrollees with chronic-conditions and those who live in medically underserved areas).

8. 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 an 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) Contract has embodied the Exchange's vision for reform and serves as a roadmap to delivery system improvements. Starting with the 2017 QHP Issuer Contract, contracted health plans 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 will be reflected in the 2017 contract and all successive contracts through 2019, and 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. To be successful, contracted health plans will need to start work in 2016 to develop a work plan and report baseline data.

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 contracted health plans for the 2016 plan year, including those newly certified by Covered California in 2016, as well as new

entrant health plans are required to complete the QIS as part of the Certification Application. Reporting is divided into three parts:

- ❖ Issuer information

- ❖ Multi-year strategy for improvement for each Covered California initiative area:
  - 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)
  - Hospital Quality – Appropriate Use of C-Sections
  - Hospital Quality and Safety
  - Patient Centered Information and Communication

  Specific payment reform elements are specified for promoting Primary Care, Integrated Health Models, Appropriate use of C-Sections, and Hospital Quality.

- ❖ Implementation plans and baseline data/information for Quality Improvement Strategy (QIS) for Covered California Quality and Delivery System Reform – ***Year One***

  The QIS will be evaluated by Covered California as part of the annual application for certification and final approval may require follow-up meetings or documentation as necessary.

  Please submit all questions related to the QIS through Proposal Tech's Q&A forum.

□ Check here if Applicant has completed the Covered California QHP Certification Application for Plan Year 2017 Covered California for Small Business, and responses apply to this submission.

8.1 Issuer Information

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

8.1.1 Type of QIS Submission:

☐ New QIS

8.1.2 QIS Medical Management Contact's Name:

8.1.3 QIS Medical Management Contact's Title:

8.1.4 QIS Medical Management Contact's Phone Number

8.1.5 QIS Medical Management Contact's Email:

8.1.6 QIS Network Management Contact's Name:

8.1.7 QIS Network Management Contact's Title:

8.1.8 QIS Network Management Contact's Phone Number:

8.1.9 QIS Network Management Contact's Email:

8.2 Multi-year strategy for improvement for each Covered California initiative area

Complete one multi-year strategy, not to exceed 300 words, per initiative area. Identify measurable aim(s) for each initiative and change concepts to support each aim. For some initiative areas, measures and/or data sources may not be applicable.

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

8.2.1 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				
Aim(s)	**Measure(s)**	**Change Concept(s)/ Objective(s)**	**Data Sources**	**Target date for achieving goal(s)**
Aim 1.				
Aim 2.				

Aim 3.				
(add other aims as necessary)				

8.2.2 Reducing Health Disparities and Assuring Health Equity

Federal QIS Topic Area: Activities to reduce health and health care disparities				
2017 QHP Issuer Contract, Section 3.01 and 3.02				
Aim(s)	**Measure(s)**	**Change Concept(s)/ Objective(s)**	**Data Sources**	**Target date for achieving goal(s)**
Aim 1.				
Aim 2.				
Aim 3.				
(add other aims as necessary)				

8.2.3 Promoting Development and Use of Care Models – Primary Care

Federal QIS Topic Area: Activities for improving health outcomes				
2017 QHP Issuer Contract, Section 4.01 and 4.02				
Aim(s)	**Measure(s)**	**Change Concept(s)/ Objective(s)**	**Data Sources**	**Target date for achieving goal(s)**

Aim 1.				
Aim 2.				
Aim 3.				
(add other aims as necessary)				

8.2.4 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				
Aim(s)	**Measure(s)**	**Change Concept(s)/ Objective(s)**	**Data Sources**	**Target date for achieving goal(s)**
Aim 1.				
Aim 2.				
Aim 3.				
(add other aims as necessary)				

8.2.5 Appropriate Use of C-Sections

Federal QIS Topic Area: Activities for improving health outcomes
2017 QHP Issuer Contract, Section 5.01

Aim(s)	Measure(s)	Change Concept(s)/ Objective(s)	Data Sources	Target date for achieving goal(s)
Aim 1.				
Aim 2.				
Aim 3.				
(add other aims as necessary)				

8.2.6 Hospital Patient Safety

Federal QIS Topic Area: Activities to improve patient safety and reduce medical errors				
2017 QHP Issuer Contract, Section 5.02 and 5.03				
Aim(s)	**Measure(s)**	**Change Concept(s)/ Objective(s)**	**Data Sources**	**Target date for achieving goal(s)**
Aim 1.				
Aim 2.				
Aim 3.				
(add other aims as necessary)				

8.2.7 Patient-Centered Information and Support

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

Aim(s)	Measure(s)	Change Concept(s)/ Objective(s)	Data Sources	Target date for achieving goal(s)
Aim 1.				
Aim 2.				
Aim 3.				
(add other aims as necessary)				

8.3 Implementation Plans and Baseline Data for Quality Improvement Strategy (QIS) for Covered California Quality and Delivery System Reform – Year One

Refer to Appendix H_2017 QHP Contract: Attachment for all requirements related to each initiative area.

8.3.1 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

8.3.1.1 **BASELINE DATA/INFORMATION:** List all measures and/or criteria used to develop ***provider networks***, and explain in detail the assessment process, source of quality assessment data, specific measures and metrics, and thresholds for inclusion and exclusion.

8.3.1.2 **BASELINE DATA/INFORMATION:** Provide a brief summary of how the criteria listed in 9.3.1.1, 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.

8.3.1.3 **BASELINE DATA/INFORMATION:** List all measures and/or criteria used to develop for ***hospital networks,*** and explain in detail the assessment process, source of quality assessment data, specific measures and metrics, and thresholds for inclusion and exclusion. Specifically address whether any HAC measures are used.

8.3.1.4 **BASELINE DATA/INFORMATION:** Provide a brief summary of how the criteria listed in 8.3.1.3, 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.

8.3.1.5 **BASELINE DATA/INFORMATION:** Report how enrollees with conditions that require highly specialized management (e.g. transplant patients and burn patients) are managed by providers with documented special experience and proficiency based on volume and outcome data such as Centers for Excellence.

8.3.1.6 **BASELINE DATA/INFORMATION:** Report the basis for inclusion of Centers of Excellence in the provider network, the method used to promote consumers' usage of these Centers, and the utilization of these Centers by Covered California Enrollees.

8.3.1.7 When does the Applicant expect to meet the future expectation to develop provider and hospital networks based on quality?

☐ The Applicant currently meets these requirements.

☐ The Applicant will meet requirements by the time of reporting for the 2018 Certification Application (winter/spring 2017)

☐ The Applicant will meet the requirements by the time of reporting for the 2019 Certification Application (winter/spring 2018)

☐ Other (please explain)

8.3.1.8 What activities will be conducted to implement the QIS on provider networks in Year One (2016)? List the activities to be implemented to achieve the identified goals and describe how the activities address market-based incentives, if applicable.

8.3.2 QIS for Reducing Health Disparities and Assuring Health Equity

Federal QIS Topic Area: Activities to reduce health and health care disparities. 2017 QHP Issuer Contract, Section 3.01 and 3.02.

8.3.2.1 **BASELINE DATA/INFORMATION:** Provide a baseline measurement of the percent of members across all lines of business excluding Medicare for whom self-reported data is captured for race/ethnicity in Attachment E QIS Run Charts. Self-identification may take place through the enrollment application, web site registration, health assessment, reported at provider site, etc.

8.3.2.2 **BASELINE DATA/INFORMATION:** Review the two most recently calculated years of HEDIS and IHA measure results for the plan (RY 2015 and 2014) for all lines of business excluding Medicare. Provide baseline measurements for each HEDIS and non-HEDIS measure by race/ethnicity in Attachment E QIS Run Charts. Report data by product (HMO, PPO, EPO).

8.3.2.3 What activities will be conducted to implement the QIS on reducing health disparities and assuring health equity in Year One (2016)? List the activities to be implemented to achieve the identified goals and describe how the activities address market-based incentives, if applicable.

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

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

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

8.3.3.1 **BASELINE DATA/INFORMATION:** Report the percentage of members by product in the Applicant's Exchange business who either selected a Personal Care Physician (PCP) or were auto-assigned in 2015 in Attachment E QIS Run Charts. If the Applicant had no Exchange business in 2015, report full book of business excluding Medicare *only*.

8.3.3.2 **BASELINE DATA/INFORMATION:** Provide a baseline measurement of total dollars paid in 2015 for primary care services by payment type in the **Covered California eValue8 Request for Information** – Question 9.4.12.4.

8.3.3.3 **BASELINE DATA/INFORMATION:** Describe the Applicant's criteria for identifying providers deploying accessible, data-driven, team-based care with accountability for improving triple aim metrics and list any certification/accreditation programs used as standards by the health plan.

8.3.3.4 **BASELINE DATA/INFORMATION:** Does the Applicant deploy payment strategies to incentivize providers to adopt accessible, data-driven, team-based care with accountability for improving triple aim metrics? Describe such payment strategies, the percent of PCPs whose contracts are based on the payment strategy, and specify the product for which the strategy is used (HMO, PPO, EPO).

8.3.3.5 **BASELINE DATA/INFORMATION:** For group contracts, does capitation cascade to the individual providers?

8.3.3.6 **BASELINE DATA/INFORMATION**: How does payment to PCMH practices differ from those payments made to practices that have not met standards?

8.3.3.7 What activities will be conducted to implement the QIS on promoting development and use of care models – primary care in Year One (2016)? List the activities to be implemented to achieve the identified goals and describe how the activities address market-based incentives, if applicable.

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

8.3.4 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

8.3.4.1 **BASELINE DATA/INFORMATION:** 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:

a) Line of business for which system is/will be available (Exchange, Commercial non-Exchange, Medicare, Medicaid, other)

b) Product for which system is/will be available

c) Location (Covered California Rating Region)

d) Indicate whether the IHM is founded on an existing provider organization or if it joins multiple providers/groups together under the IHM.

e) Discuss the accountability model, specifically which measures are used and percent of shared risk.

f) Number and percent of California members in the product who are managed under the IHM

g) Number and percent of Covered California members in the product who are managed under the IHM

8.3.4.2 What activities will be conducted to implement the QIS on promoting development and use of care models – IHMs in Year One (2016)? List the activities to be implemented to achieve the identified goals and describe how the activities address market-based incentives, if applicable.

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

8.3.5 QIS for Appropriate Use of C-Sections
Federal QIS Topic Area: Activities for improving health outcomes
2017 QHP Issuer Contract, Section 5.01

8.3.5.1 **BASELINE DATA/INFORMATION:** 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 here: https://www.cmqcc.org/resource/mdc-participants-list.

8.3.5.2 **BASELINE DATA/INFORMATION:** Report the number of all network hospitals meeting the CalSIM goal of an NTSV C-Section rate at or below 23.9 percent in Attachment E QIS Run Charts.

8.3.5.3 **BASELINE DATA/INFORMATION:** Provide the NTSV C-Section rate and overall C-Section rate for each network hospital providing maternity services in Attachment E QIS Run Charts.

8.3.5.4 **BASELINE DATA/INFORMATION:** 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.

8.3.5.5 What activities will be conducted to implement the QIS on maternity care and appropriate use of C-Sections in Year One (2016)? List the activities to be implemented to achieve the identified goals and describe how the activities address market-based incentives, if applicable.

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

8.3.6 QIS for Hospital Patient Safety

Federal QIS Topic Area: Activities to improve patient safety and reduce medical errors
2017 QHP Issuer Contract, Section 5.02 and 5.03

8.3.6.1 **BASELINE DATA/INFORMATION:** Provide a list of all contracted network hospitals across all lines of business and indicate the baseline rates for each of the following Hospital Acquired Conditions (HACs):

a) Opioid Adverse Events (Patients Treated with Naloxone)
b) CAUTI Rate
c) CAUTI SIR
d) Urinary Catheter Utilization Ratio
e) CLABSI Rate
f) CLABSI SIR
g) Central Line Utilization Ratio
h) C. Diff Rate
i) C. Diff SIR
j) SSI-Colon Rate
k) SSI-Colon SIR

Report all rates in Attachment E QIS Run Charts.

8.3.6.2 **BASELINE DATA/INFORMATION:** Across all lines of business, report the percentage of hospital reimbursement at risk for quality performance in Attachment E QIS Run Charts. “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.

8.3.6.3 **BASELINE DATA/INFORMATION**: Report number of hospitals with reimbursement at risk for quality performance in Attachment E QIS Run Charts.

8.3.6.4 What activities will be conducted to implement the QIS on hospital safety in Year One (2016)? List the activities to be implemented to achieve the identified goals and describe how the activities address market-based incentives, if applicable.

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

8.3.7 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

8.3.7.1 **BASELINE DATA/INFORMATION:** Provide baseline information on existing cost tools Section 9.4.10 of the Covered California eValue8 Request for Information.

8.3.7.2 **BASELINE DATA/INFORMATION:** Provide baseline information on existing tools for transparency on physician and hospital quality in Section 9.4.10 of the Covered California eValue8 Request for Information.

8.3.7.3 What activities will be conducted to implement the QIS on patient-centered information and communication in Year One (2016)? List the activities to be implemented to achieve the identified goals and describe how the activities address market-based incentives, if applicable.

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

9. Covered California eValue8 Request for Information:

Quality and Delivery System Reform Reporting

□ Check here if Applicant has completed the Covered California QHP Certification Application for Plan Year 2017 Covered California for Small Business, and responses apply to this submission.

9.1 General Information and Background

9.1.1 Attestation

9.1.1.1 On behalf of the Health plan, I hereby certify that the information provided on this Quality and Delivery System Reform report and in any attachments hereto are true, complete, and accurate. I understand that Covered California may review the validity of my attestations and the information provided in this report.

Single, Pull-down list. Answer and attachment required

1: Attached
2: Not provided

9.1.2 Health Plan Library

9.1.2.1 Health plans may access the Health Plan Library at:

URL Web link to be determined

The Health Plan Library will allow health plans access to reference documents and information that may be useful for developing the health plan's response. The Health Plan Library will continue to be updated as further documentation related to the application becomes available. Health plans are encouraged to continuously monitor the Health Plan Library, but are not required to access or view documents in the Health Plan Library.

The Exchange makes no warrantees with respect to the contents of the Health Plan Library and requirements specified in this document take precedence over any Health Plan Library contents.

Document.

9.2 2015 Activity for Applicants without prior Covered California business and Applicants with prior Covered California business

9.2.1 Applicants without prior Covered California business

The period for which applicants shall report activity in the Covered California eValue8 Request for Information is January 1-December 31, 2015. Health plans applying for certification with Covered California for the first time will report on activities in 2015 for non-Exchange business. Health plans that are newly certified with the Exchange in 2016 should report on 2015 activity for non-Exchange business.

NOTE: References to "this market" throughout this template should be interpreted as California and/or the local markets in which a regional plan operates. Please pay close attention; some questions below are specific to Covered California membership. If answering with Covered California membership does not apply, please answer these questions with information from California and/or local markets.

9.2.2 Applicants with prior Covered California business

The period for which applicants shall report activity in the Covered California eValue8 Request for Information is January 1-December 31, 2015. The Covered California eValue8 Request for Information fulfills both reporting requirements for Attachment 7 of the 2015 QHP Contract and information requested as part of the 2017 Certification Application.

NOTE: References to "this market" throughout this template should be interpreted as California and/or the local markets in which a regional plan operates. Please pay close attention; some questions below are specific to your Covered California membership. If answering with Covered California membership does not apply, please answer these questions with information from California and/or local markets.

9.3 Product and Enrollment Summary

NOTE: References to "this market" throughout this template should be interpreted as California and/or the local markets in which a regional plan operates.

9.3.1 Plan is responding for the following products

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

9.3.2 Identify the Plan membership in each of the products specified below **for the State of California as of the end of the reporting period.** . Enter 0 if product not offered. Please provide an answer **for all products** the Plan offers.

	Total Commercial HMO/POS	Total Commercial PPO	Total Commercial EPO	All other Commercial products	Total Medicare Members	Total Medicaid Members
Self-funded, Plan administered	*Decimal*	*Decimal*	*Decimal*	*Decimal*	*Decimal*	*Decimal*

Fully-insured, Plan administered	*Decimal*	*Decimal*	*Decimal*	*Decimal*	*Decimal*	*Decimal*
Other (describe in "Other Information")	*Decimal*	*Decimal*	*Decimal*	*Decimal*	*Decimal*	*Decimal*
Total	*For comparison* 0	*For comparison* 0	*For comparison* 0	*For comparison* 0	*For comparison* 0	*For comparison* 0

9.3.3 Identify the Plan membership in each of the products specified below **for Covered California as of the end of the reporting period.** If the Plan did not have Covered California membership in 2015, mark “0” for membership.

	Total Covered California HMO/POS	Total Covered California PPO	All other Covered California products
Fully-insured, Plan administered	*Decimal*	*Decimal*	*Decimal*

9.3.4 Accreditation

9.3.4.1 Please provide the NCQA accreditation status and expiration date of the accreditation achieved for the HMO 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.

	Answer	Expiration date MM/DD/YYYY	Programs (e.g., CD for DM question, COE for PHQ)
NCQA HMO	*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		
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		
NCQA Managed Behavioral Healthcare	*Single, Radio group.* 1: Full Accreditation 2: Accredited – 1 Year 3: Provisional Accreditation 4: Denied Accreditation		
NCQA Disease Management – Accreditation	*Multi, Checkboxes.* 1: Patient and practitioner oriented 2: Patient oriented 3: Plan Oriented 4: NCQA not used		*Unlimited*
NCQA Disease Management – Certification	*Multi, Checkboxes.* 1: Program Design 2: Systems 3: Contact 4: NCQA not used		*Unlimited*
NCQA Case Management Accreditation	*Single, Radio group.* 1: Accredited - 3 years 2: Accredited - 2 years 3: No accreditation		
NCQA PHQ Certification	*Single, Pull-down list.* 1: Certified 2: No PHQ Certification		*Unlimited*

NCQA Multicultural Health Care Distinction	*Single, Pull-down list.* 1: Distinction 2: No MHC Distinction		
URAC Accreditations	*Multi, Checkboxes -optional.* 1: URAC not used		
URAC Accreditations - Health Plan	*Single, Radio group.* 1: URAC Accredited 2: Not URAC Accredited		
URAC Accreditation - Comprehensive Wellness	*Single, Radio group.* 1: URAC Accredited 2: Not URAC Accredited		
URAC Accreditations - Disease Management	*Single, Radio group.* 1: URAC Accredited 2: Not URAC Accredited		
URAC Accreditations - Health Utilization Management	*Single, Radio group.* 1: URAC Accredited 2: Not URAC Accredited		
URAC Accreditations - Case Management	*Single, Radio group.* 1: URAC Accredited 2: Not URAC Accredited		
URAC Accreditations - Pharmacy Benefit Management	*Single, Radio group.* 1: URAC Accredited 2: Not URAC Accredited		

9.3.4.2 If the Health Plan indicated any accreditations above, provide a copy of the accrediting agency's certificate and upload as a file title "Accreditation 1."

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

9.3.4.3 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.

	Answer	Expiration date MM/DD/YYYY	Programs (e.g., CD for DM question, COE for PHQ)
NCQA PPO	*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		
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		
NCQA Managed Behavioral Healthcare	*Single, Radio group.* 1: Full Accreditation 2: Accredited – 1 Year 3: Provisional Accreditation 4: Denied Accreditation		
NCQA Disease Management – Accreditation	*Multi, Checkboxes.* 1: Patient and practitioner oriented 2: Patient oriented 3: Plan Oriented 4: NCQA not used		*Unlimited*
NCQA Disease Management – Certification	*Multi, Checkboxes.* 1: Program Design 2: Systems 3: Contact 4: NCQA not used		*Unlimited*

NCQA Case Management Accreditation	*Single, Radio group.* 1: Accredited - 3 years 2: Accredited - 2 years 3: No accreditation		
NCQA PHQ Certification	*Single, Pull-down list.* 1: Certified 2: No PHQ Certification		*Unlimited*
NCQA Multicultural Health Care Distinction	*Single, Pull-down list.* 1: Distinction 2: No MHC Distinction		
URAC Accreditations	*Multi, Checkboxes - optional.* 1: URAC not used		
URAC Accreditations - Health Plan	*Single, Radio group.* 1: URAC Accredited 2: Not URAC Accredited		
URAC Accreditation - Comprehensive Wellness	*Single, Radio group.* 1: URAC Accredited 2: Not URAC Accredited		
URAC Accreditations - Disease Management	*Single, Radio group.* 1: URAC Accredited 2: Not URAC Accredited		
URAC Accreditations - Health Utilization Management	*Single, Radio group.* 1: URAC Accredited 2: Not URAC Accredited		
URAC Accreditations - Case Management	*Single, Radio group.* 1: URAC Accredited 2: Not URAC Accredited		
URAC Accreditations - Pharmacy Benefit Management	*Single, Radio group.* 1: URAC Accredited 2: Not URAC Accredited		

9.3.4.4 If the Health Plan indicated any accreditations above, provide a copy of the accrediting agency's certificate and upload as a file title "Accreditation 1."

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

9.3.4.5 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.

	Answer	Expiration date MM/DD/YYYY	Programs (e.g., CD for DM question, COE for PHQ)
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		
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		
NCQA Managed Behavioral Healthcare	*Single, Radio group.* 1: Full Accreditation 2: Accredited – 1 Year		

	3: Provisional Accreditation 4: Denied Accreditation		
NCQA Disease Management – Accreditation	*Multi, Checkboxes.* 1: Patient and practitioner oriented 2: Patient oriented 3: Plan Oriented 4: NCQA not used		*Unlimited*
NCQA Disease Management – Certification	*Multi, Checkboxes.* 1: Program Design 2: Systems 3: Contact 4: NCQA not used		*Unlimited*
NCQA Case Management Accreditation	*Single, Radio group.* 1: Accredited - 3 years 2: Accredited - 2 years 3: No accreditation		
NCQA PHQ Certification	*Single, Pull-down list.* 1: Certified 2: No PHQ Certification		*Unlimited*
NCQA Multicultural Health Care Distinction	*Single, Pull-down list.* 1: Distinction 2: No MHC Distinction		
URAC Accreditations	*Multi, Checkboxes - optional.* 1: URAC not used		
URAC Accreditations - Health Plan	*Single, Radio group.* 1: URAC Accredited 2: Not URAC Accredited		
URAC Accreditation - Comprehensive Wellness	*Single, Radio group.* 1: URAC Accredited 2: Not URAC Accredited		

URAC Accreditations - Disease Management	*Single, Radio group.* 1: URAC Accredited 2: Not URAC Accredited		
URAC Accreditations - Health Utilization Management	*Single, Radio group.* 1: URAC Accredited 2: Not URAC Accredited		
URAC Accreditations - Case Management	*Single, Radio group.* 1: URAC Accredited 2: Not URAC Accredited		
URAC Accreditations - Pharmacy Benefit Management	*Single, Radio group.* 1: URAC Accredited 2: Not URAC Accredited		

9.3.4.6 If the Health Plan indicated any accreditations above, provide a copy of the accrediting agency's certificate and upload as a file title "Accreditation 1."

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

9.4 Covered California eValue8 Request for Information:

Quality and Delivery System Reform Reporting

9.4.1 Participation in Collaborative Quality Initiatives

Provide information regarding active participation in quality initiatives.

9.4.1.1 Is the health plan engaged in any of the following organized programs in California? Identify other markets of engagement. "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 selection of "Not Engaged in Any Programs" will lock-out the responses for all rows and columns in this question.

	Engaged in this market/region	Describe nature of engagement	Other markets in which engaged
The Health plan is not engaged in any of the below programs	*Multi, Checkboxes - optional.* 1: Not Engaged in Any Programs		
Leapfrog Hospital Rewards Program	*Single, Radio group.* 1: Engaged 2: Not Engaged	*50 words*	*50 words*
California Hospital Assessment and Reporting Taskforce (CHART)			
California Health Performance Information System (CHPI)			
Integrated Healthcare Association (IHA) Pay for Performance Program			
California Maternal Data Center (sponsored by the California Maternal Quality Care Collaborative (CMQCC)			
Appropriate use of C-sections: multi-stakeholder collaborative sponsored by the California Health and Human Services Agency (CHHS) and other statewide agencies and organizations			
California Joint Replacement Registry developed by the CHCF, California Orthopedic Society and Pacific Business Group on Health (PBGH)			
California Immunization Registry sponsored by the California Department of Public Health			
NCDR® (National Cardiovascular Data Registry that currently includes seven specific registry programs)			
Society of Thoracic Surgeons National Database for the collection of general thoracic surgery clinical data			
National Neurosurgery Quality and Outcomes Database (N2QOD)			
IHA Payment Bundling demonstration			

Centers for Medicare and Medicaid Innovation (CMMI) Bundled Payments for Care Improvement initiative (BPCI)			
CMMI Comprehensive Primary Care initiative (CPC)			
CMMI Transforming Clinical Practice Initiative			
CMMI Shared Savings Program (including Pioneer, Advanced Payment and other models)			
CMMI Partnership for Patients Hospital Safety Initiative			
Health plan-sponsored accountable care programs			
California Perinatal Quality Care Collaborative			
California Quality Collaborative			
Statewide Workgroup on Overuse (opioids, imaging for low back pain, C-sections) sponsored by DHCS, CalPERS, and Covered California			
Other (described in detail box)			

9.4.2 Reducing Health Disparities and Assuring Health Equity

Describe how the health plan collects and uses data on race, ethnicity, gender, disability status, gender identity, and sexual orientation.

9.4.2.1 Identify the sources of information used to gather members' demographic information. **The response "Enrollment Form" pertains only to information reported directly by members (or as passed on by CalHEERS about specific Covered California members).**

In the last two columns, as this is not a region/market specific question, please provide the statewide % for all members excluding Medicare and all Covered California members captured across all products.

	Data proactively collected from all new California enrollees (specify	How data is captured about both new membership and members enrolled before data was proactively collected	California members excluding Medicare for whom data	Covered California members for whom data is captured as

	date started - MM/DD/YYYY)		is captured as a percent of total membership	percent of total Covered California membership (statewide)
Race/ethnicity	*To the day.* N/A OK. From 10/01/13 to 12/31/14.	*Multi, Checkboxes.* 1: Enrollment form 2: Health Assessment 3: Information requested upon Website registration 4: Inquiry upon call to Customer Service 5: Inquiry upon call to Clinical Service line 6: Imputed method - zip code 7: Imputed method - surname analysis 8: Other (specify in detail box below. 200 word limit) 9: Data not collected	*Percent*	*Percent*
Gender	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Primary language	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Disability Status	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Interpreter need	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Education level	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Sexual Orientation	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Gender Identity	*(As above)*	*(As above)*	*(As above)*	*(As above)*

9.4.2.2 Provide an estimate of the percent of network physicians, office staff and health plan personnel in this market for which the health plan has identified race/ethnicity, and a language spoken other than English. Health plan personnel would be those with member interaction (e.g., customer service, health coaches).

Example of numerator and denominator for network physician estimate: Denominator: all physicians in the network. Numerator: all physicians in network where health plan knows what language is spoken by physician. If health plan has 100 physicians in the network and knows that 50 speak only English, 10 speak Spanish and 2 are bilingual in English and Spanish, the numerator would be 62.

If there are efforts to improve the percentage of network physicians, office staff, and health plan personnel for which the health plan has identified race/ethnicity and language spoken, please note them in the details box below.

	Physicians in this market	Physician office staff in this market	Health plan staff in this market
Race/ethnicity	*Percent* From 0 to 100	*Percent* From 0 to 100	*Percent* From 0 to 100
Languages spoken	*(As above)*	*(As above)*	*(As above)*

9.4.2.3 It is estimated that 50% of adult Americans lack *functional health literacy*, which the U.S. Department of Health and Human Services defines as "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions." Health literacy is separate from cultural competency and literacy. *An example may be that members understand they need to go to the radiology department to get an X-ray.*

Please describe below health plan activities to address health literacy in California.

Multi, Checkboxes.

1: No activities currently,
2: Assessed organization activities and/or infrastructure around health literacy,
3: Developed policy and/or procedures to adopt a company-wide approach to clear communication that avoids jargon and medical terms,
4: Adopted a targeted reading level for written communications. Grade level: [Integer]
5: Conducted inventories of jargon and acronyms used by the organization and created lists of “words to avoid” and “words to use” as alternatives,
6: Standardized member communications in clear, plain language, avoiding jargon and medical terms,
7: Trained staff and/ or vendor responsible for written communication to members on principles of clear health communications,
8: Trained customer service staff on principles of clear health communications,
9: Ensured that all documents, including those translated from English into other languages, meet a targeted reading level,
10: Trained staff on teachback methods.

11: Provided on-demand videos with explanatory content or illustrative interactions and information.

12: Tested materials (provide details of testing and results): [200 words]

13: Other: [100 words]

Health plan

9.4.2.4 Indicate how racial, ethnic, language, gender identity or sexual orientation data is used for California members? Check all that apply.

Multi, Checkboxes.

1: Assess adequacy of language assistance to meet members' needs,

2: Calculate HEDIS or other clinical quality performance measures by race, ethnicity, language, gender identity or sexual orientation,

3: Calculate CAHPS or other measures of member experience by race, ethnicity, language, gender identity or sexual orientation,

4: Identify areas for quality improvement/disease management/ health education/promotion,

5: Share with enrollees to enable them to select concordant clinicians,

6: Share with provider network to assist them in providing language assistance and culturally competent care,

7: Set benchmarks (e.g., target goals for reducing measured disparities in preventive or diagnostic care),

8: Determine provider performance bonuses and/or contract renewals (e.g. based on evidence of disparity outlier status),

9: Analyze disenrollment patterns,

10: Develop disease management or other outreach programs that are culturally sensitive (provide details on program in detail box below),

11: Other (describe in detail box below),

12: Racial, ethnic, language data is not used,

13: Gender identity or sexual orientation data is not used

9.4.2.5 How does the health plan support the needs of California members with limited English proficiency? Check all that apply.

Multi, Checkboxes.

1: Test or verify proficiency of bilingual non-clinical Health plan staff,

2: Test or verify proficiency of bilingual clinicians,

3: Certify professional interpreters,

4: Test or verify proficiency of interpreters to understand and communicate medical terminology,

5: Train practitioners to work with interpreters,

6: Distribute translated lists of bilingual clinicians to members,

7: Distribute a list of interpreter services and distribute to provider network,

8: Pay for in-person interpreter services used by provider network,

9: Pay for telephone interpreter services used by provider network,

10: Pay for in-person interpreter services for non-clinical member interactions with plans,

11: Negotiate discounts on interpreter services for provider network,

12: Train ad-hoc interpreters,

13: Provide or pay for foreign language training,

14: Formulate and publicize policy on using minor children, other family, or friends as interpreters,

15: Notify members of their right to free language assistance,

16: Notify provider network of members' right to free language assistance,

17: Develop written policy on providing language services to members with limited English proficiency,

18: Provide patient education materials in different languages. Percent in a language other than English: [Percent] Media: [Multi, Checkboxes]

19: Recruit bilingual health plan staff,

20: Other (describe in detail box below):

21: Health plan does not implement activities to support needs of members with limited English proficiency

9.4.2.6 Indicate which of the following activities the health plan undertook in the applicable calendar year to assure that culturally competent health care is delivered to California members. This shall be evaluated with regard to language, culture or ethnicity, and other factors. Check all that apply.

Multi, Checkboxes.

1: Assess cultural competency needs of members,

2: Conduct an organizational cultural competence assessment of the Plan,

3: Conduct a cultural competence assessment of physician offices,

4: Employ a cultural and linguistic services coordinator or specialists,

5: Seek advice from a Community Advisory Board or otherwise obtain input from community-based organizations,

6: Collaborate with statewide or regional medical association groups focused on cultural competency issues,

7: Tailor health promotion/prevention messaging to particular cultural groups (summarize groups targeted and activity in detail box),

8: Tailor disease management activities to particular cultural groups (summarize activity and groups targeted in detail box),

9: Public reporting of cultural competence programs, staffing and resources,

10: Sponsor cultural competence training for Health plan staff,

11: Sponsor cultural competence training for physician offices,

12: Other (describe in detail box below):

13: No activities in year of this response

9.4.2.7 Has the health plan evaluated or measured the impact of any language assistance activities in California? If yes, describe below the evaluation results of the specific disparities that were reduced and provide a description of the intervention if applicable.

☐ *Yes/No*

9.4.3 Hospital Quality Oversight

For the purposes of this section 8.4.3, please respond to questions based on California business.

9.4.3.1 For the plan's California business, indicate if transparent information comparing **HOSPITAL performance on quality** using any of the following categories of Measure Groups is available to members.

Use of measures in a vendor hospital reporting product qualifies provided that the measurement and ranking methodology is fully transparent

Scores on all-payer data for most hospitals on many of these measures can be viewed at http://www.medicare.gov/hospitalcompare/search.html. Information on the measures is available at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/OutcomeMeasures.html Additional information on the measures is available at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/index.html?redirect=/HospitalQualityInits/08_HospitalRHQDAPU.asp#TopOfPage

Information on impact of early scheduled deliveries and rates by state can be found at: http://www.leapfroggroup.org/news/leapfrog_news/4788210 and http://www.leapfroggroup.org/tooearlydeliveries#State

For preventable ED/ER visits, please see http://info.medinsight.milliman.com/bid/192744/Claims-Based-Analytics-to-Identify-Potentially-Avoidable-ER-Visits and http://wagner.nyu.edu/faculty/billings/nyued-background

Numerator: the number of hospitals for which performance information is able to be calculated and displayed based on threshold of reliability (not just those informed about reporting nor those that say no data available)

Denominator: all hospitals in California network

Efficiency is defined as the cost and quantity of services (i.e., total resources used) for the episode of care. For additional information, see "Measuring Provider Efficiency Version 1.0" available at http://www.leapfroggroup.org/media/file/MeasuringProviderEfficiencyVersion1_12-31-2005.pdf and Hospital Cost Efficiency Measurement: Methodological Approaches at http://www.pbgh.org/storage/documents/reports/PBGHHospEfficiencyMeas_01-2007_22p.pdf

	% total contracted HOSPITALS INCLUDED in PUBLIC REPORTING in market	Description of Other
HQA		
ACUTE MYOCARDIAL INFARCTION (AMI)	*Percent* N/A OK From 0 to 100	
HEART FAILURE (HF)	*(As above)*	
PNEUMONIA (PNE)	*(As above)*	

PATIENT EXPERIENCE/H-CAHPS	*(As above)*	
LEAPFROG Safety Practices http://www.leapfroggroup.org/56440/leapfrog_hospital_survey_copy/leapfrog_safety_practices		
Leapfrog Safety Score	*(As above)*	
Adoption of CPOE	*(As above)*	
Management of Patients in ICU	*(As above)*	
Evidence-Based Hospital referral indicators	*(As above)*	
Adoption of NQF endorsed Safe Practices	*(As above)*	
Maternity – pre 39 week elective induction and/or elective c-section rates	*(As above)*	
HOSPITAL QUALITY INSTITUTE HOSPITAL ENGAGEMENT NETWORK		
CAUTI	*(As above)*	
CLABSI	*(As above)*	
Surgical site infections (SSI)	*(As above)*	
Adverse drug events (ADE)	*(As above)*	
C. difficile colitis	*(As above)*	
Sepsis mortality	*(As above)*	
OTHER MEASURES		
HACs – healthcare acquired conditions also known as hospital acquired conditions (e.g., Surgical site infection following coronary artery bypass graft (CABG)—mediastinitis) http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired_Conditions.html	*(As above)*	
SREs (serious reportable events) that are not HACs (e.g., surgery on the wrong body part or wrong patient) www.qualityforum.org/Topics/SREs/List_of_SREs.aspx (see attachment)	*(As above)*	
Readmissions	*(As above)*	
ED/ER Visits	*(As above)*	
MORTALITY MEASURES (AMI, HF and Pneumonia mortality measures)	*(As above)*	
ICU Mortality	*(As above)*	
HIT adoption/use	*(As above)*	
Efficiency (e.g., relative cost, utilization (ALOS, AD/k) Volume indicators other than Leapfrog EHR)	*(As above)*	
Other standard measures endorsed by National Quality Forum (describe):	*(As above)*	*200 words*

9.4.3.2 Reducing readmissions is an area of great interest to purchasers and payers as it impacts enrollee health and reduces costs in the system. In 2013, NCQA introduced the Plan All Cause Readmissions (PCR) measure which is the percentage of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days, for members 18 years of age and older.

In the table below, please provide the following information based on Health plan submission of **California HMO data** to NCQA.

Age / Sex	Observed Readmissions (Num/Denominator)	Average Adjusted Probability	Observed to Expected Ratio (Observed Readmissions/Average Adjusted Probability)
18-44 Total	*Percent.* From -5 to 100	*Decimal.* From -5 to 1	N/A
45-54 Total	*(As above)*	*(As above)*	N/A
55-64 Total	*(As above)*	*(As above)*	N/A
Total	*(As above)*	*(As above)*	*Decimal* From -10 to 100

9.4.3.3 Reducing readmissions is an area of great interest to purchasers and payers as it impacts enrollee health and reduces costs in the system. In 2013, NCQA introduced the Plan All Cause Readmissions (PCR) measure which is the percentage of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days, for members 18 years of age and older.

In the table below, please report the following information based on Health plan submission of **California PPO data** to NCQA.

Age / Sex	Observed Readmissions (Num/Denominator)	Average Adjusted Probability	Observed to Expected Ratio (Observed Readmissions/Average Adjusted Probability)
18-44 Total	*Percent.* From -5 to 100	*Decimal* From -5 to 1	N/A
45-54 Total	*(As above)*	*(As above)*	N/A
55-64 Total	*(As above)*	*(As above)*	N/A

Total	*(As above)*	*(As above)*	*Decimal* From -10 to 100

9.4.3.4 Reducing readmissions is an area of great interest to purchasers and payers as it impacts enrollee health and reduces costs in the system. In 2013, NCQA introduced the Plan All Cause Readmissions (PCR) measure which is the percentage of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days, for members 18 years of age and older.

In the table below, please report the following information based on Health plan submission of **California EPO data to NCQA.**

Age / Sex	Observed Readmissions (Num/Denominator)	Average Adjusted Probability	Observed to Expected Ratio (Observed Readmissions/Average Adjusted Probability)
18-44 Total	*Percent* From -5 to 100	*Decimal* From -5 to 1	N/A
45-54 Total	*Percent* From -5 to 100	*Decimal* From -5 to 1	N/A
55-64 Total	*Percent* From -5 to 100	*Decimal* From -5 to 1	N/A
Total	*Percent* From -5 to 100	*Decimal* From -5 to 1	*Decimal* From -10 to 100

9.4.4 Determining Enrollee Health Status and Use of Health Assessments

9.4.4.1 Indicate activities and capabilities supporting the plan's Health Assessment (HA) programming. 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: Health plan does not offer an HA.

9.4.4.2 Provide the number of currently enrolled California members who completed a Health Assessment (HA) in the past year.

HMO Response	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 or purchaser level
Geography for data below (automatically determined based on response above)	*For comparison* 4: Awaiting response to rows above
Total commercial enrollment (sum of commercial HMO/POS, PPO and Other Commercial) If Health plan has and tracks use by Medi-Cal members as well, enrollment number here should include Medi-Cal numbers.)	*For comparison* TBD
Number of members completing Plan-based HA in the applicable calendar year. (If Health plan 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)	*For comparison* Unknown
Number of completed HAs resulting in referral to health plan case management staff or assigned provider	*Decimal* *From 0 to 10000000000000000000*
Percent completed HAs resulting in referral to health plan case management staff or assigned provider (Referral number divided by number of completed HAs)	*For comparison* *Unknown*

9.4.4.3 Provide the number of currently enrolled California members who completed a Health Assessment (HA) in the past year.

PPO Response	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 tracked only statewide, 3: Participation only tracked regionally,

	4: Participation not tracked regionally/statewide, 5: Participation can be tracked at Covered California level or purchaser level
Geography for data below (automatically determined based on response above)	*For comparison.* 4: Awaiting response to rows above
Total commercial enrollment (sum of commercial HMO/POS, PPO and Other Commercial) If Health plan has and tracks use by Medi-Cal members as well, enrollment number here should include Medi-Cal numbers.)	TBD
Number of members completing Health plan-based HA for the applicable calendar year. (If Health plan 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)	*For comparison* Unknown
Number of completed HAs resulting in referral to health plan case management staff or assigned provider	*Decimal* *From 0 to 10000000000000000000*
Percent completed HAs resulting in referral to health plan case management staff or assigned provider (Referral number divided by number of completed HAs)	*For comparison* *Unknown*

9.4.4.4 Provide the number of currently enrolled California members who completed a Health Assessment (HA) in the past year.

EPO Response	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 tracked only statewide, 3: Participation only tracked regionally, 4: Participation not tracked regionally/statewide,

	5: Participation can be tracked at Covered California level or purchaser level
Geography for data below (automatically determined based on response above)	*For comparison* 4: Awaiting response to rows above
Total commercial enrollment (sum of commercial HMO/POS, PPO and Other Commercial) If Health plan has and tracks use by Medi-Cal members as well, enrollment number here should include Medi-Cal numbers.)	TBD
Number of members completing Health plan-based HA for the applicable calendar year. (If Health plan 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)	*For comparison.* Unknown
Number of completed HAs resulting in referral to health plan case management staff or assigned provider	*Decimal* *From 0 to 10000000000000000000*
Percent completed HAs resulting in referral to health plan case management staff or assigned provider (Referral number divided by number of completed HAs)	*For comparison* *Unknown*

9.4.4.5 Identify methods for promoting Health Assessment (HA) completion to California members. If incentives are used, provide a general description of how the program works. Indicate all that apply. "Push messaging" is defined as an information system capability that generates regular e-mail or health information to the member about completion of HA.

HMO Response	Answer	Description
HA promoted	*Single, Radio group.* 1: Yes, using at least one of the following methods 2: Yes, but not using any of the	*100 words*

	following methods below (describe) 3: No	
General messaging on Health plan website or member newsletter	*Multi, Checkboxes* 1: 1-2 X per year 2: 3-6 X per year 3: > 6 X per year 4: None of the above	
Targeted messaging (mail or push e-mail) (describe targeting criteria). "Push messaging" is defined as an information system capability that generates regular e-mail or health information to the member regarding identified conditions based on personal Health Assessment (HA) results.	*Single, Radio group* 1: Yes 2: No	*100 words* Nothing required
Financial incentives from Health plan to members (describe): (FOR FULLY INSURED PRODUCTS ONLY)	*Single, Radio group* 1: Yes 2: No 3: Not applicable	*100 words* Nothing required
Promoting use of incentives and working to implement financial incentives for enrollees (describe):	*(As above)*	*(As above)*
Multiple links (3 or more access opportunities) to HA within Health plan website (indicate the number of unique links to the HA). Documentation needed, provide below	*Decimal.* N/A OK From 0 to 100000000000000000	
Promotion through provider (describe):	*Single, Radio group* 1: Yes 2: No	*100 words* Nothing required
Promotion through health coaches or case managers (describe):	*(As above)*	*(As above)*

9.4.4.6 Identify methods for promoting Health Assessment (HA) completion to California members. If incentives are used, provide a general description of how the program works. Indicate all that apply. "Push messaging" is defined as an information system capability that generates regular e-mail or health information to the member about completion of HA.

PPO Response	Answer	Description
HA promoted	*Single, Radio group.* 1: Yes, using at least one of the following methods 2: Yes, but not using any	*100 words*

	of the following methods below (describe) 3: No	
General messaging on Health plan website or member newsletter	*Multi, Checkboxes.* 1: 1-2 X per year 2: 3-6 X per year 3: > 6 X per year 4: None of the above	
Targeted messaging (mail or push e-mail) (describe targeting criteria). "Push messaging" is defined as an information system capability that generates regular e-mail or health information to the member regarding identified conditions based on personal Health Assessment (HA) results.	*Single, Radio group* 1: Yes 2: No	*100 words* Nothing required
Financial incentives from Health plan to members (describe): (FOR FULLY INSURED PRODUCTS ONLY)	*Single, Radio group* 1: Yes 2: No 3: Not applicable	*100 words* Nothing required
Promoting use of incentives and working to implement financial incentives for enrollees (describe):	*(As above)*	*(As above)*
Multiple links (3 or more access opportunities) to HA within Health plan website (indicate the number of unique links to the HA). Documentation needed, provide below	*Decimal* N/A OK From 0 to 100000000000000000	
Promotion through provider (describe):	*Single, Radio group* 1: Yes 2: No	*100 words* Nothing required
Promotion through health coaches or case managers (describe):	*(As above)*	*(As above)*

9.4.4.7 Identify methods for promoting Health Assessment (HA) completion to California members. If incentives are used, provide a general description of how the program works. Indicate all that apply. "Push messaging" is defined as an information system capability that generates regular e-mail or health information to the member about completion of HA.

EPO Response	Answer	Description
HA promoted	*Single, Radio group* 1: Yes, using at least one of the following methods, 2: Yes, but not using any of the	*100 words*

	following methods below (describe), 3: No	
General messaging on Health plan website or member newsletter	*Multi, Checkboxes* 1: 1-2 X per year 2: 3-6 X per year 3: > 6 X per year 4: None of the above	
Targeted messaging (mail or push e-mail) (describe targeting criteria). "Push messaging" is defined as an information system capability that generates regular e-mail or health information to the member regarding identified conditions based on personal Health Assessment (HA) results.	*Single, Radio group* 1: Yes 2: No	*100 words* Nothing required
Financial incentives from Health plan to members (describe): (FOR FULLY INSURED PRODUCTS ONLY)	*Single, Radio group* 1: Yes 2: No 3: Not applicable	*100 words* Nothing required
Promoting use of incentives and working to implement financial incentives for enrollees (describe):	*(As above)*	*(As above)*
Multiple links (3 or more access opportunities) to HA within Health plan website (indicate the number of unique links to the HA). Documentation needed, provide below	*Decimal* N/A OK From 0 to 100000000000000000	
Promotion through provider (describe):	*Single, Radio group* 1: Yes 2: No	*100 words* Nothing required
Promotion through health coaches or case managers (describe):	*(As above)*	*(As above)*

9.4.4.8 If Health plan indicated above that HAs are promoted through multiple links on their website, provide documentation for three web access points and save as a PDF or Word file with the name "***Health Status 1"***. Only documentation of links will be considered by the reviewer. The Web URL link should be clearly identified with the source of the link, e.g. home page, doctor chooser page, etc., delineated.

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

8.4.5 Health and Wellness Services

9.4.5.1 Identify Health plan activities for the applicable calendar year for practitioner education and support related to obesity management. Check all that apply. If any of the following four (4) activities are selected, documentation must be provided as ***Health-Wellness 1*** in the following question:

1: Member-specific reports or reminders to treat (1a)

2: Periodic member program reports (1b)

3: Comparative performance reports (1c)

4: General communication to providers announcing resources/programs available for weight management services (1d)

	Activities supporting practitioners specific to obesity management
Education/Information	*Multi, Checkboxes.* 1: General education of guidelines and Health plan program offerings, 2: Educate providers about screening for obesity in children, 3: Notification of member identification, 4: CME credit for obesity management education, 5: Comparative performance reports (identification, referral, quit rates, etc.), 6: Promotes use of Obesity ICD-9 coding (e.g. 278.0) and ICD-10 (E66.9, E66.01, E66.3 and E66.2), (describe how codes are promoted), 7: Distribution of BMI calculator to physicians, 8: Reminder to HCPs to “turn on” BMI alert in EMR that calculates automatically 9: None of the above
Patient Support	*Multi, Checkboxes.* 1: Supply of materials/education/information therapy for provision to members, 2: Member-specific reports or reminders to screen, 3: Member-specific reports or reminders to treat (obesity status already known), 4: Periodic reports on members enrolled in support programs, 5: None of the above
Incentives	*Multi, Checkboxes.* 1: Incentives to conduct screening (describe), 2: Incentive to refer to program or treat (describe), 3: Health plan reimburses for appropriate use of Obesity ICD-9 coding (e.g. 278.0) and ICD-10 (E66.9, E66.01, E66.3 and E66.2),

	4: Incentives to obtain NCQA Physician Recognition – (e.g. Patient Centered Medical Home or Heart Stroke Recognition), 5: None of the above
Practice Support	*Multi, Checkboxes.* 1: The Health plan provides care managers and/or behavioral health practitioners who can interact with members on behalf of practice (e.g. call members on behalf of practice), 2: Practice support for work flow change to support screening or treatment (describe), 3: Support for office practice redesign (i.e. ability to track patients) (describe), 4: Opportunity to correct information on member-specific reports (information must be used by the Health plan in generating future reports, 5: Care Health plan approval, 6: None of the above
Description (if the following selected above: - Education/Information: 6: Promotes use of ICD codes- Incentives: 1 and/or 2: Incentives to screen and/or refer/treat and - Practice support: 2: Practice support for work flow change to support screening or treatment , and/or 3: Support for office practice redesign)	*200 words.*

9.4.5.2 Provide evidence of the practitioner support that is member or performance specific selected above as a Word or PDF document and save under the file name "***Health-Wellness 1"***.

Multi, Checkboxes.

1: Member-specific reports or reminders to treat (1a)

2: Periodic member program reports (1b),

3: Comparative performance (1c) reports,

4: General communication to providers announcing resources/programs available for weight management services (d),

5: Health-Wellness 1 is not provided

9.4.5.3 Indicate how the Plan identifies commercial members who are obese and the number of obese members identified and participating in weight management activities during the applicable calendar year. Do not report general prevalence.

If health plan is currently contracted with the Exchange, please provide Covered California counts if available. If health plan is not currently contracted with Covered California or if Covered California counts are not available, provide state/regional counts, and indicate in the detail box when Health plan may be able to report Covered California-specific data.

	Answer
Indicate how the plan identifies members who are obese. Respondent 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 with 65 words.* 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. Covered California tracking is preferred. 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. Please select only ONE of response options 1-4 and include response option 5 if applicable	*(As above)*
Geography for data below (automatically determined based on responses above)	*For comparison* 4: Awaiting response to rows above

Total enrollment (sum of commercial HMO/POS, PPO and Other Commercial) If Health plan has and tracks use by Medi-Cal members as well, enrollment number here should include Medi-Cal numbers.) Please verify value and, if necessary, make corrections in the Profile module.	*For comparison* TBD
Total Covered California enrollment	
Number of California members identified as obese for the applicable calendar year as of December 31. (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
Number of Covered California members identified as obese for the applicable calendar year as of December 31.	*(As above)*
% of California members identified as obese	*For comparison* 0.00%
% of Covered California members identified as obese	*(As above)*
Number of California members identified as obese who participated in a weight management program during the applicable calendar year as of December 31. (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
Number of Covered California members identified as obese who participated in weight management program during the applicable calendar year as of December 31.	*(As above)*
% of California members identified as obese who are participating in weight management program (# program participants divided by # of identified obese)	*For comparison* 0.00%
% of Covered California members identified as obese who are participating in weight management program (# program participants divided by # of identified obese)	*For comparison* 0.00%

9.4.5.4 Review the 2015 and 2014 QC HEDIS uploaded results for the HMO Plan. ***Adult BMI Assessment and Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents were eligible for rotation in HEDIS 2015***.

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'

Please refer to the attached document for an explanation of terms

HEDIS/CAHPS 2 Answers / 2 Questions
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	2015 HMO QC results	2014 HMO QC results or Prior Year results for a rotated measure
Weight assessment and counseling for nutrition and physical activity for children and adolescents- BMI percentile. (Total)	[N/A]	[N/A]
Weight assessment and counseling for nutrition and physical activity for children and adolescents- counseling for nutrition (Total)	[N/A]	[N/A]
Weight assessment and counseling for nutrition and physical activity for children and adolescents- counseling for physical activity (Total)	[N/A]	[N/A]
Adult BMI assessment (Total)	[N/A]	[N/A]

9.4.5.5 Review the 2015 and 2014 QC HEDIS uploaded results for the PPO Plan. ***Adult BMI Assessment and Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents were eligible for rotation in HEDIS 2015***.

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'

Please refer to the attached document for an explanation of terms

HEDIS/CAHPS 2 Answers / 2 Questions
PPO Regional 45 Answers / 62 Questions

	2015 PPO QC results	2014 PPO QC results or Prior Year results for a rotated measure
Weight assessment and counseling for nutrition and physical activity for children and adolescents- BMI percentile. (Total)	[N/A]	[N/A]
Weight assessment and counseling for nutrition and physical activity for children and adolescents- counseling for nutrition (Total)	[N/A]	[N/A]
Weight assessment and counseling for nutrition and physical activity for children and adolescents- counseling for physical activity (Total)	[N/A]	[N/A]
Adult BMI assessment (Total)	[N/A]	[N/A]

9.4.5.6 Review the 2015 and 2014 QC HEDIS uploaded results for the EPO Plan. ***Adult BMI Assessment and Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents were eligible for rotation in HEDIS 2015***.

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'

Please refer to the attached document for an explanation of terms

HEDIS/CAHPS 2 Answers / 2 Questions
PPO Regional 45 Answers / 62 Questions

	2015 EPO QC results	2014 EPO QC results or Prior Year results for a rotated measure
Weight assessment and counseling for nutrition and physical activity for children and adolescents- BMI percentile. (Total)	[N/A]	[N/A]

Weight assessment and counseling for nutrition and physical activity for children and adolescents- counseling for nutrition (Total)	[N/A]	[N/A]
Weight assessment and counseling for nutrition and physical activity for children and adolescents- counseling for physical activity (Total)	[N/A]	[N/A]
Adult BMI assessment (Total)	[N/A]	[N/A]

9.4.5.7 Identify Health plan activities in the applicable calendar year for practitioner education and support related to tobacco cessation for networks serving California members. Check all that apply. If any of the following four (4) activities are selected, supporting documentation must be attached in the following question as a Word or PDF file and saved under the file name "***Health-Wellness 2"***. The following selections need documentation:

1: Care managers and/or behavioral health practitioners who can interact with members on behalf of practice (e.g. call members on behalf of practice) (2a)

2: Comparative reporting (2b)

3: Member specific reminders to screen (2c)

4: Member specific reminders to treat (2d)

	Activities supporting practitioners specific to tobacco cessation
Education/ Information	*Multi, Checkboxes.* 1: General education of guidelines and Health plan program offerings 2: Notification of member identification 3: CME credit for smoking cessation education 4: Comparative performance reports (identification, referral, quit rates, etc.) 5: Promotion of the appropriate smoking-related CPT or diagnosis coding (e.g. ICD-9 305.1, ICD-10 F17.200, CPT 99406, 99407 and HCPCS G0436, G0437) (describe) 6: None of the above
Patient Support	*Multi, Checkboxes.* 1: Supply of member materials for provider use and dissemination 2: Member-specific reports or reminders to screen 3: Member-specific reports or reminders to treat (smoking status already known) 4: Routine progress updates on members in outbound telephone management program 5: None of the above
Incentives	*Multi, Checkboxes.* 1: Incentives to conduct screening (describe) 2: Incentive to refer to program or treat (describe) 3: Health plan reimburses for appropriate use of smoking-related CPT or diagnosis coding (e.g. ICD-9 305.1, ICD-10 F17.200, CPT 99406, 99407 and HCPCS G0436, G0437) 4: Incentives to obtain NCQA Physician Recognition – (e.g. Patient Centered Medical Home or Diabetes or Heart Stroke Recognition) 5: None of the above
Practice support	*Multi, Checkboxes.* 1: The Health plan provides care managers and/or behavioral health practitioners who can interact with members on behalf of practice (e.g. call members on behalf of practice) 2: Practice support for work flow change to support screening or treatment (describe) 3: Support for office practice redesign (i.e. ability to track patients) (describe) 4: Opportunity to correct information on member-specific reports (information must be used by the Health plan in generating future reports 5: Care Health plan approval 6: None of the above
Description (if the following selected above: - Education/Information: 5: Promotion of the appropriate smoking-related CPT or diagnosis coding, - Incentives: 1 and/or 2: Incentives to screen and/or refer/treat and - Practice support: 2: Practice support for work flow change to support screening or treatment , and/or 3: Support for office practice redesign)	*200 words.*

9.4.5.8 If Health plan selected response options 1 and 4 in education/information and options 2 and 3 in patient support in question above, provide evidence of practitioner support as a Word or PDF document and save under the title "***Health-Wellness 2"***. Only include the minimum documentation necessary to demonstrate the activity. A maximum of one page per activity will be allowed.

Multi, Checkboxes.

1: General communication to providers announcing resources/programs available for tobacco cessation (2a),

2: Comparative reporting (2b),

3: Member specific reminders to screen (2c),

4: Member specific reminders to treat (2d),

5: Health-Wellness 2 not provided

9.4.5.9 Indicate how the plan identifies commercial members who use tobacco, and the number of tobacco dependent commercial members identified and participating in cessation activities during the applicable calendar year.

If health plan is currently contracted with the Exchange, please provide Covered California counts if available. If health plan is not currently contracted with Covered California or if Covered California counts are not available, provide state/regional counts, and indicate in the detail box when Health plan may be able to report Covered California-specific data.

	Answer
Indicate how the plan identifies members who use tobacco. Respondent 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 to row below on Number of commercial members individually identified as tobacco dependent in 2015 as of December 2015	*Multi, Checkboxes with 65 words.* 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. Covered California tracking is preferred. 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. Covered California tracking is preferred.	*(As above)*

Please select only ONE of response options 1-4 and include response option 5 if applicable	
Geography for data below (automatically determined based on responses above)	*For comparison* 4: Awaiting response to rows above
Total California enrollment for TBD geography (sum of commercial HMO/POS, PPO and Other Commercial) Please verify value and, if necessary, make corrections in the Profile module. (If Health plan has and tracks use by Medi-Cal members as well, enrollment number here should include Medi-Cal numbers.)	*For comparison* TBD geography
Total Covered California enrollment	
Number of California members individually identified as tobacco dependent for the applicable calendar year as of December 31. (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
Number of Covered California members individually identified as tobacco dependent for the applicable calendar year as of December 31.	*(As above)*
% of California members identified as tobacco dependent	*For comparison* 0.00%
% of Covered California members identified as tobacco dependent	*(As above)*
Number of California members identified as tobacco dependent who participated in a smoking cessation program during the applicable calendar year as of December 31. (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
Number of Covered California members identified as tobacco dependent who particated in a smoking cessation program during the applicable calendar year as of December 31.	*(As above)*
% of California members identified as tobacco dependent participating in smoking cessation program (# program participants divided by # identified smokers)	*For comparison* 0.00%
% of Covered California members identified as tobacco dependent participating in smoking cessation program (# program participants divided by # identified smokers)	*For comparison* 0.00%

9.4.5.10 Review the most recent HMO uploaded program results for the tobacco cessation program from QC 2015 and QC 2014.

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'

Please refer to the attached document for an explanation of terms

HEDIS/CAHPS 2 Answers / 2 Questions
HMO Regional 45 Answers / 62 Questions

	2015 HMO and QC 2015 results	2014 HMO and QC 2014 results
HEDIS Medical Assistance with Smoking Cessation - Advising Smokers To Quit (report rolling average)	[N/A]	[N/A]
HEDIS Medical Assistance with Smoking Cessation - Discussing Medications (report rolling average)	[N/A]	[N/A]
HEDIS Medical Assistance with Smoking Cessation - Discussing Strategies (report rolling average)	[N/A]	[N/A]

9.4.5.11 Review the most recent PPO uploaded program results for the tobacco cessation program from QC 2015 and QC 2014.

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'

Please refer to the attached document for an explanation of terms

HEDIS/CAHPS 2 Answers / 2 Questions
PPO Regional 45 Answers / 62 Questions

	2015 PPO and QC 2015 results	2014 PPO and QC 2014 results
HEDIS Medical Assistance with Smoking Cessation - Advising Smokers To Quit (report rolling average)	[N/A]	[N/A]
HEDIS Medical Assistance with Smoking Cessation - Discussing Medications (report rolling average)	[N/A]	[N/A]
HEDIS Medical Assistance with Smoking Cessation - Discussing Strategies (report rolling average)	[N/A]	[N/A]

9.4.5.12 Review the most recent EPO uploaded program results for the tobacco cessation program from QC 2015 and QC 2014.

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'

Please refer to the attached document for an explanation of terms

HEDIS/CAHPS 2 Answers / 2 Questions
PPO Regional 45 Answers / 62 Questions

	2015 EPO and QC 2015 results	2014 EPO and QC 2014 results
HEDIS Medical Assistance with Smoking Cessation - Advising Smokers To Quit (report rolling average)	[N/A]	[N/A]
HEDIS Medical Assistance with Smoking Cessation - Discussing Medications (report rolling average)	[N/A]	[N/A]
HEDIS Medical Assistance with Smoking Cessation - Discussing Strategies (report rolling average)	[N/A]	[N/A]

9.4.5.13 Review the two most recently calculated years of HEDIS results for the HMO Plan (QC 2015 and 2014). *Colorectal Cancer Screening was eligible for rotation in HEDIS 2015.*

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'

Please refer to the Quality Compass Codes document in the Manage Documents for an explanation of terms.

This answer is supplied by National Business Coalition on Health (individually).

	QC 2015	QC 2014, or prior year's HMO QC result
Breast Cancer Screening - Total	*Percent* From -10 to 100	*Percent* From -10 to 100
Cervical Cancer Screening		*NO DATA*
Colorectal Cancer Screening		

9.4.5.14 Review the two most recently calculated years of HEDIS results for the PPO Plan (QC 2015 and 2014). *Colorectal Cancer Screening was eligible for rotation in HEDIS 2015.*

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'

Please refer to the Quality Compass Codes document in the Manage Documents for an explanation of terms.

This answer is supplied by National Business Coalition on Health (individually).

	QC 2015	QC 2014, or prior year's PPO QC result
Breast Cancer Screening - Total	*Percent* From -10 to 100	*Percent* From -10 to 100
Cervical Cancer Screening		*NO DATA*
Colorectal Cancer Screening		

9.4.5.15 Review the two most recently calculated years of HEDIS results for the EPO Plan (QC 2015 and 2014). *Colorectal Cancer Screening was eligible for rotation in HEDIS 2015.*

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'

Please refer to the Quality Compass Codes document in the Manage Documents for an explanation of terms.

This answer is supplied by National Business Coalition on Health (individually).

	QC 2015	QC 2014, or prior year's EPO QC result
Breast Cancer Screening - Total	*Percent.* From -10 to 100	*Percent.* From -10 to 100
Cervical Cancer Screening		*NO DATA*
Colorectal Cancer Screening		

9.4.5.16 Which of the following member interventions applying to at least 75% of your enrolled membership were used by the Plan in calendar year 2015 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			
Colorectal Cancer Screening			

9.4.5.17 Provide copies of all member-specific interventions described in Question 4.5.16 as a Word or PDF document and save under the file name “Healthy 2”. Reviewer will be looking for evidence of member specificity and indication that service is due, if applicable. Note: if the documentation does not specify that a service is needed, then indicate on the attachment how the reminder is based on missed services vs. a general reminder. Do NOT send more examples than is necessary to demonstrate functionality.

Multi, Checkboxes.

1: Healthy 2a is provided - Breast Cancer Screening

2: Healthy 2b is provided - Cervical Cancer Screening

3: Healthy 2c is provided - Colorectal Cancer Screening

4: No attachments provided

9.4.5.18 Review the two most recently uploaded years of HEDIS/CAHPS (QC 2015 and QC 2014) results for the HMO Plan.

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'

Please refer to the Quality Compass Codes document in the Manage Documents for an explanation of terms. ***Childhood Immunization Status and Immunizations for Adolescents were eligible for rotation in HEDIS 2015.***

This answer is supplied by National Business Coalition on Health (individually).

	QC 2015, or most current year’s HMO result	QC 2014, or prior year’s HMO QC result
Childhood Immunization Status - Combo 2	*Percent*	*Percent*
Immunizations for Adolescents - Combination		
CAHPS Flu Shots for Adults (50-64) (report rolling average)		

9.4.5.19 Review the two most recently uploaded years of HEDIS/CAHPS (QC 2015 and QC 2014) results for the PPO Plan.

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'

Please refer to the Quality Compass Codes document in the Manage Documents for an explanation of terms. ***Childhood Immunization Status and Immunizations for Adolescents were eligible for rotation in HEDIS 2015.***

This answer is supplied by National Business Coalition on Health (individually).

	QC 2015, or most current year's PPO result	QC 2014, or prior year's PPO QC result
Childhood Immunization Status - Combo 2	*Percent*	*Percent*
Immunizations for Adolescents - Combination		
CAHPS Flu Shots for Adults (50-64) (report rolling average)		

9.4.5.20 Review the two most recently uploaded years of HEDIS/CAHPS (QC 2015 and QC 2014) results for the EPO Plan.

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'

Please refer to the Quality Compass Codes document in the Manage Documents

for an explanation of terms. ***Childhood Immunization Status and Immunizations for Adolescents were eligible for rotation in HEDIS 2015.***

This answer is supplied by National Business Coalition on Health (individually).

	QC 2015, or most current year's EPO result	QC 2014, or prior year's EPO QC result
Childhood Immunization Status - Combo 2	*Percent*	*Percent*
Immunizations for Adolescents - Combination		
CAHPS Flu Shots for Adults (50-64) (report rolling average)		

9.4.5.21 Identify member interventions used in calendar year 2015 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			

9.4.6 Community Health and Wellness Promotion

9.4.6.1 Provide a narrative report describing initiatives, programs and projects Health plan supports and how such programs specifically address health disparities and/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(ies) below that best describe the specific activity and provide a brief narrative report about the activity. The health plan should select the category(ies) below that best describe their activities and fill out the narrative for that section.

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

Type of activity	Activity details (briefly describe with named collaborators)
Internal facing, member related efforts (e.g.: self-help workshops, prevention, health education programs for members)	*100 words*
Internal facing, member related efforts non-health-related (e.g., education)	*100 words*
External facing, high level community facing activities, health-related (e.g.: health fairs, attendance at community coalitions and collaboratives)	*100 words (name collaborative(s) and Health plan's senior sponsor and number of dedicated FTEs)*
External facing, non-health-related (e.g., education)	*100 words*
Engaged with health systems to conduct community risk assessment to identify high priority needs and health disparities.	*100 words (name health systems)*
Community health effort built on evidence-based program and policy interventions, and planned evaluation included in the initiative.	*100 words (name communities)*
Health plan-funded community health programs based on needs assessments or other activity (not related to disaster relief efforts)	*100 words (name communities and level of funding)*
Participated in geographic disaster relief efforts (e.g., weather, fire, environmental)	*100 words (name communities)*

Plan does not conduct any community health initiatives	

9.4.6.2 If the Health Plan has supporting documentation for any activities listed in 8.4.6.1, upload as a file under the title “Community Health 1.”

Single, Pull-down list.

1: Yes, Community Health 1 attached,

2: Not attached

9.4.7 Health and Wellness Enrollee Support Process

9.4.7.1 For California members, identify the programs or materials that are offered to support health and wellness.

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. Be proactively provided/prescribed to the individual.
3. Support 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. Be tailored to an individual's specific needs and/or characteristics, including their health literacy and numeracy levels.
5. Be accurate, comprehensive, and easy to use.

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. Nurseline support is offered as a benefit to the general membership and is often a one-time interaction with a member seeking advice.

	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	*Multi, Checkboxes.* 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	*(As above)*
On-site bio-metric screenings (blood pressure, lab tests, bone density, body fat analysis, etc)	*(As above)*
Nutrition classes/program	*(As above)*
Fitness classes/program	*(As above)*
Weight loss classes/program	*(As above)*
Weight management program	*(As above)*
Tobacco cessation support program	*(As above)*
24/7 telephonic nurse line	*(As above)*
24/7 Nurse Navigator for Oncology Management	
24/7 Nurse Navigator for complex conditions (specify in detail box)	
Inbound telephonic health coaching	*(As above)*
Outbound telephone health coaching (personal outreach and coaching involving live interaction with a person)	*(As above)*
Member care/service reminders (IVR)	*(As above)*
Member care/service reminders (Paper)	*(As above)*
Targeted personal Health Assessment (HA)	*(As above)*
In-person lectures or classes	*(As above)*
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)	*(As above)*
Access to PCMH and/or ACO Providers	*(As above)*

9.4.7.2 Does the Health plan currently have benefit designs in place that reduce barriers or provide incentives f**or preventive or wellness services** by

any of the means listed in the "Financial incentives" column? In the “Uptake” column, **estimate the percentage of California members participating in Health plan designs with the barrier reduction or incentive features for the row topic (e.g. diabetes)**.

Numerator should be the number of California members actually enrolled in such a Health plan design/Denominator is total Health plan enrollment.

This question does NOT have a regional flag- for uptake percentage, please provide the statewide percentage using numbers in numerator and denominator that reflect the plan's entire membership across all markets. For a regional Health plan operating in only the market of response, their response would be considered statewide in this context.

Please respond accordingly in the last column.

HMO Response - Preventive and Wellness Services	Financial Incentives	Uptake as % of total California statewide membership noted Section 3	Percentage is based on Health plan's California membership in all markets of Health plan operation
Incentives contingent upon member behavior			
Participation in Plan-approved Patient-Centered Medical Home Practices	*Multi, Checkboxes.* 1: Waive/adjust out-of-pocket payments for tests, treatments, Rx contingent upon completion/participation 2: Part of program with reduced Premium Share contingent upon completion/participation 3: Rewards (cash payments, discounts for consumer goods, etc.) administered independently of medical services and contingent upon completion/participation 4: Waived or decreased co-payments/deductibles for reaching prevention goals 5: Incentives to adhere to evidence-based self-management guidelines 6: Incentives to adhere to recommended care coordination encounters 7: Not supported	*Percent.* N/A OK From 0 to 100	*Yes/No*
Participation in other Plan-designated high performance practices	*(As above)*	*(As above)*	*(As above)*

Personal Health Assessment (HA)	*Multi, Checkboxes.* 1: Waive/adjust out-of-pocket payments for tests, treatments, Rx contingent upon completion/participation 2: Part of program with reduced Premium Share contingent upon completion/participation 3: Rewards (cash payments, discounts for consumer goods, etc.) administered independently of medical services and contingent upon completion/participation 4: Not supported	*Percent.* N/A OK. From 0 to 100	*Yes/No.*
Participation in weight-loss program (exercise and/or diet/nutrition)	*(As above)*	*(As above)*	*(As above)*
Success in weight-loss or maintenance	*(As above)*	*(As above)*	*(As above)*
Participation in tobacco cessation	*(As above)*	*(As above)*	*(As above)*
Success with tobacco cessation goals	*(As above)*	*(As above)*	*(As above)*
Participation in wellness health coaching	*(As above)*	*(As above)*	*(As above)*
Success with wellness goals other than weight-loss and tobacco cessation	*(As above)*	*(As above)*	*(As above)*
Incentives not contingent on participation or completion			
Well child & adolescent care	*Multi, Checkboxes.* 1: Waive/adjust out-of-pocket payments for tests, treatments, Rx 2: Part of program with reduced Premium Share 3: Rewards (cash payments, discounts for consumer goods, etc.) administered independently of medical services 4: Not supported	*Percent.* N/A OK. From 0 to 100	*Yes/No*
Preventive care (e.g. cancer screening, immunizations)	*(As above)*	*(As above)*	*(As above)*

9.4.7.3 Does the Health plan currently have benefit designs in place that reduce barriers or provide incentives f**or preventive or wellness services** by any of the means listed in the "Financial incentives" column? In the “Uptake” column, **estimate the percentage of California members participating in Health plan designs with the barrier reduction or incentive features for the row topic (e.g. diabetes)**.

Numerator should be the number of California members actually enrolled in such a Health plan design/Denominator is total Health plan enrollment.

This question does NOT have a regional flag- for uptake percentage, please provide the statewide percentage using numbers in numerator and denominator that reflect the plan's entire membership across all markets. For a regional Health plan operating in only the market of response, their response would be considered statewide in this context.

Please respond accordingly in the last column.

PPO response - Preventive and Wellness Services	Financial Incentives	Uptake as % of total California statewide membership noted in Section 3	Percentage is based on Health plan's California membership in all markets of Health plan operation
Incentives contingent upon member behavior			
Participation in Plan-approved Patient-Centered Medical Home Practices	*Multi, Checkboxes.* 1: Waive/adjust out-of-pocket payments for tests, treatments, Rx contingent upon completion/participation, 2: Part of program with reduced Premium Share contingent upon completion/participation, 3: Rewards (cash payments, discounts for consumer goods, etc.) administered independently of medical services and contingent upon completion/participation,	*Percent* N/A OK From 0 to 100	*Yes/No*

	4: Waived or decreased co-payments/deductibles for reaching prevention goals, 5: Incentives to adhere to evidence-based self-management guidelines, 6: Incentives to adhere to recommended care coordination encounters, 7: Not supported		
Participation in other Plan-designated high performance practices	*(As above)*	*(As above)*	*(As above)*
Personal Health Assessment (HA)	*Multi, Checkboxes.* 1: Waive/adjust out-of-pocket payments for tests, treatments, Rx contingent upon completion/participation, 2: Part of program with reduced Premium Share contingent upon completion/participation, 3: Rewards (cash payments, discounts for consumer goods, etc.) administered independently of medical services and contingent upon completion/participation, 4: Not supported	*Percent* N/A OK From 0 to 100	*Yes/No*
Participation in weight-loss program (exercise and/or diet/nutrition)	*(As above)*	*(As above)*	*(As above)*
Success in weight-loss or maintenance	*(As above)*	*(As above)*	*(As above)*
Participation in tobacco cessation	*(As above)*	*(As above)*	*(As above)*
Success with tobacco cessation goals	*(As above)*	*(As above)*	*(As above)*
Participation in wellness health coaching	*(As above)*	*(As above)*	*(As above)*

Success with wellness goals other than weight-loss and tobacco cessation	*(As above)*	*(As above)*	*(As above)*
Incentives not contingent on participation or completion			
Well child & adolescent care	*Multi, Checkboxes.* 1: Waive/adjust out-of-pocket payments for tests, treatments, Rx 2: Part of program with reduced Premium Share, 3: Rewards (cash payments, discounts for consumer goods, etc.) administered independently of medical services, 4: Not supported	*Percent* N/A OK From 0 to 100	*Yes/No*
Preventive care (e.g. cancer screening, immunizations)	*(As above)*	*(As above)*	*(As above)*

9.4.7.4 Does the Health plan currently have benefit designs in place that reduce barriers or provide incentives f**or preventive or wellness services** by any of the means listed in the "Financial incentives" column? In the “Uptake” column, **estimate the percentage of California members participating in Health plan designs with the barrier reduction or incentive features for the row topic (e.g. diabetes)**.

Numerator should be the number of California members actually enrolled in such a Health plan design/Denominator is total Health plan enrollment.

This question does NOT have a regional flag- for uptake percentage, please provide the statewide percentage using numbers in numerator and denominator that reflect the plan's entire membership across all markets. For a regional Health plan operating in only the market of response, their response would be considered statewide in this context.

Please respond accordingly in the last column.

EPO response - Preventive and Wellness Services	Financial Incentives	Uptake as % of total California statewide membership noted in Section 3	Percentage is based on Health plan's California membership in all markets of Health plan operation
Incentives contingent upon member behavior			
Participation in Plan-approved Patient-Centered Medical Home Practices	*Multi, Checkboxes.* 1: Waive/adjust out-of-pocket payments for tests, treatments, Rx contingent upon completion/participation 2: Part of program with reduced Premium Share contingent upon completion/participation 3: Rewards (cash payments, discounts for consumer goods, etc.) administered independently of medical services and contingent upon completion/participation 4: Waived or decreased co-payments/deductibles for reaching prevention goals 5: Incentives to adhere to evidence-based self-management guidelines 6: Incentives to adhere to recommended care coordination encounters 7: Not supported	*Percent.* N/A OK From 0 to 100	*Yes/No*

Participation in other Plan-designated high performance practices	*(As above)*	*(As above)*	*(As above)*
Personal Health Assessment (HA)	*Multi, Checkboxes.* 1: Waive/adjust out-of-pocket payments for tests, treatments, Rx contingent upon completion/participation 2: Part of program with reduced Premium Share contingent upon completion/participation 3: Rewards (cash payments, discounts for consumer goods, etc.) administered independently of medical services and contingent upon completion/participation 4: Not supported	*Percent* N/A OK From 0 to 100	*Yes/No*
Participation in weight-loss program (exercise and/or diet/nutrition)	*(As above)*	*(As above)*	*(As above)*
Success in weight-loss or maintenance	*(As above)*	*(As above)*	*(As above)*
Participation in tobacco cessation	*(As above)*	*(As above)*	*(As above)*
Success with tobacco cessation goals	*(As above)*	*(As above)*	*(As above)*
Participation in wellness health coaching	*(As above)*	*(As above)*	*(As above)*

Success with wellness goals other than weight-loss and tobacco cessation	*(As above)*	*(As above)*	*(As above)*
Incentives not contingent on participation or completion			
Well child & adolescent care	*Multi, Checkboxes.* 1: Waive/adjust out-of-pocket payments for tests, treatments, Rx 2: Part of program with reduced Premium Share 3: Rewards (cash payments, discounts for consumer goods, etc.) administered independently of medical services 4: Not supported	*Percent* N/A OK From 0 to 100	*Yes/No*
Preventive care (e.g. cancer screening, immunizations)	*(As above)*	*(As above)*	*(As above)*

9.4.7.5 As part of total population management and person-centered care, summarize plan activities/ability to:

(1) Identify members who are non-users (no claims, no PCP),

(2) Engage those members in staying/becoming healthy, and

(3) Support Purchasers in communication and engagement

	Response/Summary	Geography of response
Percent of total commercial membership with no claims in CY 2015	*Percent*	*Single, Radio group* 1: Regional 2: Statewide
Percent of total commercial membership who had no PCP in CY 2015		
Summary (bullet points) of plan activities to engage members who are non-users	*100 words*	
Summary (bullet points) of support provided to Purchasers to engage members who are non-users	*100 words*	

9.4.8 Promoting Development and Use of Care Models

9.4.8.1 Provide a list of any ACO contracts that became effective in this market on or before January 1, 2016 and save as a Word or PDF file under the file name "***Care Model 1***." Indicate the following:

1) Effective date of the contract

2) Whether the ACO is available to Covered California members or would be available to Covered California members

3) Location of the ACO

4) Covered California membership attributed to the ACO if applicable as of December 31 of 2015, and

5) Included in network for HMO, PPO, and/or EPO

Single, Pull-down list.
1: Care Model 1 is provided
2: No

9.4.8.2 Provide as attachments the following related to ACOs:

1. (Provider 1a): Plan methodology for documentation on total quality of care, measures in use and weighting of measures or measurement domains, if used for performance payments in ACO. Describe any applicable performance threshold requirements

2. (Provider 1 b): Example of plan report to the ACO on its quality of care and financial performance, including benchmarking relative to performance improvement goals or market norms.

   Multi, Checkboxes.
   1: Provider 1a
   2: Provider 1b
   3: No attachments

9.4.8.3 Provide a list of any PCMHs available to California members as January 1, 2016 and save as a Word or PDF file under the file name "***Care Model 2***." Indicate the following:

1) Name of the PCMH (physician organization or medical group

2) Whether the PCMH is available to Covered California members or would be available to Covered California members

3) Location of the PCMH

4) Covered California membership attributed to the PCMH if applicable as of December 31 of 2015

   Single, Pull-down list.
   1: Care Model 1 is provided
   2: No

9.4.8.4 Briefly describe the Health plan's efforts to promote the development and use of care models that promote access, care coordination, and early identification of at risk enrollees.

Response	Answer	Availability
Use of a patient-centered, team-based approach to care delivery and member engagement	*100 words*	*Single, Radio group.* 1: All members including Covered California 2: Covered California members but varies by region 3: All Covered California members 4: Offered in California but not currently available to Covered California members 5: Not available

Use of an intensive outpatient care program or "Ambulatory ICU" for enrollees with complex chronic conditions	*(As above)*	*(As above)*

9.4.8.5 Payment Reform Penetration: For those providers that participated in a payment reform contract for the applicable calendar year (or the time period used by respondent for the previous questions) provide an estimate of the percent of commercial, in-network plan members attributed to those providers. If the health plan has Covered California business, report on number of Covered California members attributed to models where indicated.

Attribution refers to a statistical or administrative methodology that aligns a patient population to a provider for the purposes of calculating health care costs/savings or quality of care scores for that population. "Attributed" patients can include those who choose to enroll in, or do not opt-out-of an ACO or PCMH or other delivery models in which patients are attributed to a provider with any payment reform program contract. For the purposes of the Scorecard, Attribution is for Covered California lives only. It does not include Medicare Advantage or Medicaid beneficiaries.

	Regional Response	Autocalc Percent	California Response	Autocalc Percent
Total number of California, in-network members attributed to a provider with a payment reform program contract	*Decimal*	Unknown	*Decimal*	Unknown
Total number of Covered California, in-network members attributed to a provider with a payment reform program contract	*Decimal*	Unknown	*Decimal*	Unknown
Total number of California, in-network members attributed to ACOs	*Decimal*	Unknown	*Decimal*	Unknown
Total number of Covered California, in-network members attributed to ACOs				
Total number of California, in-network members attributed to PCMHs (for PCMH not part of ACO)	*Decimal*	Unknown	*Decimal*	Unknown
Total number of Covered California, in-network members attributed to PCMHs (for PCMH not part of ACO)				
Enrollment of TOTAL California members	0	100%		0
Enrollment of TOTAL Covered California members	0	100%	Unknown	100%

9.4.8.6 Providing patient access to their health information and electronic personal health record (PHR).

	Answer
PHR availability	*Multi, Checkboxes.* 1: PHR not offered, 2: PHR not supported, 3: PHR supported
Plan promotes PHR available in the market through a provider-based effort (describe up to 200 word limit)	*200 words*
Plan promotes PHR available in the market through an independent Web-based effort (list partners and describe up to 200 word limit)	*200 words*

9.4.8.7 Indicate the features and functions the Plan provides to members within an electronic PHR. Features and functions that are not personalized or interactive do not qualify for credit. Check all that apply. If the Plan selects any of the following five PHR capabilities, provide actual, blinded screen prints as Consumer 1 in following question:

1) Targeted push message to member based on member profile,

2) Member can elect to electronically share selected PHR information with their physicians or facilities,

3) Drug checker automatically checks for contraindications for drugs being used and notifies member,

4) Member can electronically chart and trend vital signs and other relevant physiologic values, and

5) Member defines conditions for push-messages or personal reminders from the Plan.

NOTE: For functionality where member can ELECT to share PHR information (all or subset), this functionality must be within the PHR as an option and demonstrated as a screenshot. Information that can be downloaded for email is NOT considered an ELECTION to electronically share PHR information

	Answer
Content	*Multi, Checkboxes.* 1: Demographic and personal information, emergency contacts, PCP name and contact information, etc., 2: Possible health risks based on familial risk assessment. Includes the relationship, condition or symptom, status (e.g. active/inactive), and source of the data, 3: Physiological characteristics such as blood type, height, weight, etc., 4: Member lifestyle, such as smoking, alcohol consumption, substance abuse, etc., 5: Member's allergy and adverse reaction information, 6: Advance directives documented for the patient for intubation, resuscitation, IV fluid, life support, references to power of attorneys or other health care documents, etc., 7: Information regarding any subscribers associated with the individual (spouse, children), 8: OTC Drugs, 9: Information regarding immunizations such as vaccine name, vaccination date, expiration date, manufacturer, etc., 10: None of the above
Functionality	*Multi, Checkboxes.* 1: Plan initiates targeted push-messages to member based on member profile, 2: Member can electronically populate the PHR with biometrics (BP, weight, etc.) through direct feed from a biometric device or wearable sensor, 3: Member can use PHR as a communication platform for physician email or web visits, 4: Member can elect to electronically share all PHR information with their physicians or facilities, 5: Member can elect to electronically share selected PHR information with their physicians or facilities, 6: Alerts resulting from drug conflicts or biometric outlier results are automatically pushed to a clinician, 7: Drug checker automatically checks for contraindications for drugs being used and notifies member, 8: None of the above
Member Specificity	*Multi, Checkboxes.* 1: Member can electronically chart and trend vital signs and other relevant physiologic values, 2: Member can collect and organize personalized member-specific information in actionable ways (e.g. daily routines to manage condition, how to prepare for a doctor's visit), 3: Member defines conditions for push-messages or personal reminders from the Plan, 4: None of the above
Data that is electronically populated by Plan	*Multi, Checkboxes.* 1: Information regarding current insurance benefits such as eligibility status, co-pays, deductibles, etc., 2: Prior medication history such as medication name, prescription date, dosage, pharmacy contact

	information, etc, 3: Plan's prescription fill history including date of each fill, drug name, drug strength and daily dose, 4: Historical health plan information used for plan to plan PHR transfer., 5: Information regarding clinicians who have provided services to the individual, 6: Information regarding facilities where individual has received services, 7: Encounter data in inpatient or outpatient settings for diagnoses, procedures, and prescriptions prescribed in association with the encounter, 8: Any reminder, order, and prescription, etc. recommended by the care management and disease management program for the patient., 9: Lab tests completed with push notification to member, 10: Lab values with push notification to member, 11: X-ray interpretations with push notification to member, 12: None of the above

9.4.8.8 Provide information regarding the Health plan's capabilities to support physician-member consultations using technology (e.g., web consultations, telemedicine). Use the detail box to describe any limitations to availability due to benefit option (PPO, HMO or EPO).

Response	Answer	Technology	Geography of response
Health plan ability to support web/telehealth consultations	*Multi, Checkboxes.* 1: Health plan does not offer/allow web or telehealth consultations 2: Web visit with structured data input of history and symptom 3: Telehealth with interactive face to face dialogue over the Web		*Single, Radio group.* 1: Regional 2: Statewide
Health plan uses a vendor for web/telehealth consultations (indicate vendor)	*50 words*	*Single, Radio group.* 1: Web 2: Telehealth	*Single, Radio group.* 1: Regional 2: Statewide

		3: Combination of Web and Telehealth	
If physicians are designated in provider directory as having Web/Telehealth consultation services available, provide number of physicians in the region	*Decimal with 100 words* N/A OK	*(As above)*	*(As above)*
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 commercial membership in market from 9.3.2 or if statewide response from 9.3.3) If Health plan has and tracks use by Medi-Cal members as well, number here should include Medi-Cal numbers.)	*Percent* N/A OK	*(As above)*	*(As above)*
If members are able to schedule web/telehealth consultations with some physicians, provide percent of members using those physicians (use as denominator total commercial membership in market from 9.3.2 or if statewide response from 9.3.3) If Health plan has and tracks use by Medi-Cal members as well, number here should include Medi-Cal numbers.)	*Percent with 100 words* N/A OK From 0 to 100	*(As above)*	*(As above)*
Number of web/telehealth consultations performed in the applicable calendar year per thousand commercial members (based on total commercial membership in 9.3.2 or if statewide response from 9.3.3) If Health plan has and tracks use by Medi-Cal members as well, number here should include Medi-Cal numbers.)	*Decimal* N/A OK From 0 to 100000000000	*(As above)*	*(As above)*
Number of web/telehealth consultations performed in the applicable calendar year per thousand members	*Decimal* N/A OK	*(As above)*	*(As above)*

If the plan had Covered California business in 2015: Number of web/telehealth consultations performed in the applicable calendar year per thousand Covered California members	*Decimal* N/A OK	*(As above)*	*(As above)*
Number of unique members with a web/telehealth consultation in the applicable calendar year per thousand members	*Decimal* N/A OK From 0 to 100000000000	*(As above)*	*(As above)*
If the plan had Covered California business in 2015: Number of unique Covered California members with a web/telehealth consultation in the applicable calendar year per thousand members	*Decimal* N/A OK From 0 to 100000000000	*(As above)*	*(As above)*
Health plan provides a structured template for web/telehealth consultations (versus free flow email)	*Single, Radio group.* 1: Yes 2: No	*(As above)*	*(As above)*
Health plan reimburses for web/telehealth consultations	*Single, Radio group.* 1: Yes 2: No	*(As above)*	*(As above)*
Plan's web/telehealth consultation services are available to all of members/employers	*Single, Radio group.* 1: Yes - with no additional fee 2: Yes - additional fee may be assessed, depending on contract 3: Yes - always for an additional fee 4: No	*(As above)*	*(As above)*

9.4.9 Identification and Services for At-Risk Enrollees

8.4.9.1 For the California enrollment in this market, please provide (1) the number of members aged 18 and above in first row, (2) the number of members aged 18 and above with **Coronary Artery Disease** (CAD) using the

NCQA “Eligible Population” definition for Cardiovascular Disease in the second row, and (3) the number of members eligible for participation in the Disease Management (DM) program based on Plan’s criteria (NOT Prevalence).

Starting at row 4, based on the Health plan’s stratification of members with CAD, indicate the types of interventions that are received by the population based on the level of risk segmentation. CAD refers to members with a diagnosis of coronary artery disease or those who have had an acute cardiac event. **Hypertension and hypercholesterolemia are considered risk factors for CAD and may be managed as comorbidities but should <u>not</u> be counted as part of the CAD population in the absence of an actual diagnosis**. Enter “Zero” if the intervention is not provided to members with CAD. 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. 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 31who participated in the activity at any time during the applicable calendar year.

	Number of members as specified in rows 1, 2 and 3	Indicate if intervention Offered to CAD Patients in this state/market	Number of California members in this state/market receiving intervention (if Health plan offers intervention but does not track participation, enter zero)	Risk strata that receives this intervention	Autocalcalculated % of HEDIS CAD eligibles who received intervention	Autocalcalculated % of Health plan CAD eligibles who received intervention
Number of members aged 18 and above in this market	*Decimal*					
Using the NCQA “Eligible Population” definition for Cardiovascular disease in the 2015 HEDIS Technical Specifications	*Decimal*					

Vol 3., provide number of members 18 and above with CAD						
Using the plan's own criteria, provide number of members identified with condition and eligible to participate in CAD DM program	*Decimal*					
General member education (e.g., newsletters)		*Multi, Checkboxes* 1: HMO, 2: PPO, 3: Intervention not offered	*Decimal* From 0 to 100000000000000	*Multi, Checkboxes* 1: Low, 2: Medium, 3: High risk, 4: No stratification	Unknown	Unknown
General care education/reminders based on condition alone (e.g., personalized letter)		*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Member-specific reminders for a known gap in clinical/diagnostic maintenance services Answer “member-specific reminders” only if it involves reminders that are independent of the live outbound telephonic program. (Documentation needed)		*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Member-specific reminders for medication events (e.g., level of use, failure to refill)		*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*

Answer “member-specific reminders” only if it involves reminders that are independent of the live outbound telephonic program. (Documentation needed)						
Online interactive self-management support. "Online self-management support" is an intervention that includes two-way electronic communication between the Health 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. (Documentation needed)		*Multi, Checkboxes.* 1: HMO 2: PPO 3: Intervention not offered 4: Regional Number provided 5: National Number provided 6: Offered but not tracked regionally or statewide	*Decimal* From 0 to 100000000000000	*Multi, Checkboxes.* 1: Low, 2: Medium, 3: High risk, 4: No stratification	Unknown	Unknown
Self-initiated text/email messaging		*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Interactive IVR with information capture Answer “Interactive IVR with information capture” only if it involves record		*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*

updates and/or triggering additional intervention.						
IVR with outbound messaging only		*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Live outbound telephonic coaching program (count only members that are successfully engaged)		*Multi, Checkboxes* 1: HMO 2: PPO 3: Intervention not offered	*(As above)*	*(As above)*	*(As above)*	*(As above)*

9.4.9.2 Review the two most recently uploaded years of HEDIS results for the Plan HMO product based on QC 2015 and QC 2014.

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'

Please refer to the attached document for an explanation of terms.

HEDIS/CAHPS 2 Answers / 2 Questions
HMO Regional 45 Answers / 62 Questions

	HMO QC 2015	HMO QC 2014, or Prior Year Results for rotated measure
Controlling High Blood Pressure - Total	[N/A]	[N/A]

Persistence of Beta-Blocker treatment after a heart attack	[N/A]	[N/A]

9.4.9.3 Review the two most recently uploaded years of HEDIS results for the Plan PPO product based on QC 2015 and QC 2014.

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'

Please refer to the attached document for an explanation of terms.

HEDIS/CAHPS 2 Answers / 2 Questions
PPO Regional 45 Answers / 62 Questions

	PPO QC 2015	PPO QC 2014, or Prior Year Results for rotated measure
Controlling High Blood Pressure - Total	[N/A]	[N/A]
Persistence of Beta-Blocker treatment after a heart attack	[N/A]	[N/A]

9.4.9.4 Review the two most recently uploaded years of HEDIS results for the Plan EPO product based on QC 2015 and QC 2014.

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'

Please refer to the attached document for an explanation of terms.

HEDIS/CAHPS 2 Answers / 2 Questions
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	EPO QC 2015	EPO QC 2014, or Prior Year Results for rotated measure
Controlling High Blood Pressure - Total	[N/A]	[N/A]
Persistence of Beta-Blocker treatment after a heart attack	[N/A]	[N/A]

9.4.9.5 For the California enrollment in this market, please provide (1) the number of members aged 18 and above in the first row, (2) the number of members aged 18 and above with **Diabetes** using the NCQA "Eligible Population" definition for Diabetes in the second row, and (3) the Members eligible for participation in the DM program based on Plan's criteria (NOT Prevalence).

Starting at Row 4, based on the Health plan's stratification of members with Diabetes, indicate the types of interventions that are received by the population based on the level of risk segmentation. Enter "Zero" if the intervention is not provided to members with Diabetes. 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. 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 31who participated in the activity at any time during the applicable calendar year.

	Number of members as specified in rows 1, 2 and 3	Indicate if intervention Offered to Diabetes Patients in this state/market	Number of California members 18 years and above in this state/market receiving intervention (if Health plan offers intervention but does not track participation, enter zero)	Risk strata that receives this intervention	Autocalculated % of HEDIS Diabetes eligibles who received intervention	Autocalculated % of Health plan Diabetes eligibles who received intervention
Number of members aged 18 and above in this market	*Decimal*					
Using the NCQA “Eligible Population” definition for Diabetes in the 2015 HEDIS Technical Specifications Vol 3., provide number of members 18 and above with Diabetes	*Decimal*					
Using the plan's own criteria, provide number of members identified with condition and eligible to participate in diabetes DM program	*Decimal*					

General member education (e.g., newsletters)		*Multi, Checkboxes* 1: HMO 2: PPO 3: Intervention not offered	*Decimal* From 0 to 100000000000	*Multi, Checkboxes* 1: Low 2: Medium 3: High risk 4: No stratification	Unknown	Unknown
General care education/reminders based on condition alone (e.g., personalized letter)		*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
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 (Documentation needed)		*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
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 (Documentation needed)		*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Online interactive self-management support. "Online self-management support" is an intervention that includes two-way electronic communication		*Multi, Checkboxes.* 1: HMO 2: PPO	*Decimal* From 0 to 100000000000000	*Multi, Checkboxes.* 1: Low 2: Medium	Unknown	Unknown

between the Health 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. (Documentation needed)		3: Intervention not offered 4: Regional Number provided 5: National Number provided 6: Offered but not tracked regionally or statewide		3: High risk 4: No stratification		
Self-initiated text/email messaging		*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
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.		*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
IVR with outbound messaging only		*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Live outbound telephonic coaching program (count only members that are successfully engaged)		*Multi, Checkboxes* 1: HMO 2: PPO	*(As above)*	*(As above)*	*(As above)*	*(As above)*

		3: Intervention not offered				

9.4.9.6 Review the two most recently uploaded years of HEDIS results for the Plan HMO product based on QC 2015 and QC 2014.

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'

Please refer to the attached document for an explanation of terms.

HEDIS/CAHPS 2 Answers / 2 Questions
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	HMO QC 2015 results	HMO QC 2014 or Prior Year for Rotated measures
Comprehensive Diabetes Care - Eye Exams	[N/A]	[N/A]
Comprehensive Diabetes Care - HbA1c Testing	[N/A]	[N/A]
Comprehensive Diabetes Care - Medical Attention for Nephropathy	[N/A]	[N/A]
Comprehensive Diabetes Care - Poor HbA1c Control > 9%	[N/A]	[N/A]
Comprehensive Diabetes Care - HbA1c Control < 8%	[N/A]	[N/A]

Comprehensive Diabetes Care - HbA1c Control < 7% for a Selected Population	[N/A]	[N/A]
Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	[N/A]	[N/A]

9.4.9.7 Review the two most recently uploaded years of HEDIS results for the Plan PPO product based on QC 2015 and QC 2014.

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'

Please refer to the attached document for an explanation of terms.

HEDIS/CAHPS 2 Answers / 2 Questions
PPO Regional 45 Answers / 62 Questions

	PPO QC 2015 results	PPO QC 2014 or Prior Year for Rotated measures
Comprehensive Diabetes Care - Eye Exams	[N/A]	[N/A]
Comprehensive Diabetes Care - HbA1c Testing	[N/A]	[N/A]
Comprehensive Diabetes Care - Medical Attention for Nephropathy	[N/A]	[N/A]
Comprehensive Diabetes Care - Poor HbA1c Control > 9%	[N/A]	[N/A]
Comprehensive Diabetes Care - HbA1c Control < 8%	[N/A]	[N/A]
Comprehensive Diabetes Care - HbA1c Control < 7% for a Selected Population	[N/A]	[N/A]

Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	[N/A]	[N/A]

9.4.9.8 Review the two most recently uploaded years of HEDIS results for the Plan EPO product based on QC 2015 and QC 2014.

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'

Please refer to the attached document for an explanation of terms.

HEDIS/CAHPS 2 Answers / 2 Questions
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	EPO QC 2015 results	EPO QC 2014 or Prior Year for Rotated measures
Comprehensive Diabetes Care - Eye Exams	[N/A]	[N/A]
Comprehensive Diabetes Care - HbA1c Testing	[N/A]	[N/A]
Comprehensive Diabetes Care - Medical Attention for Nephropathy	[N/A]	[N/A]
Comprehensive Diabetes Care - Poor HbA1c Control > 9%	[N/A]	[N/A]
Comprehensive Diabetes Care - HbA1c Control < 8%	[N/A]	[N/A]

Comprehensive Diabetes Care - HbA1c Control < 7% for a Selected Population	[N/A]	[N/A]
Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	[N/A]	[N/A]

9.4.9.9 For the California enrollment, please provide (1) the number of members aged 5 and above in the first row, (2) the number of members aged 5 and above with **Asthma** using the NCQA "Eligible Population" definition for Asthma in the second row, and (3) the Members eligible for participation in the DM program based on Plan's criteria (NOT Prevalence).

Starting at Row 4, based on the Health plan's stratification of members with Asthma, indicate the types of interventions that are received by the population based on the level of risk segmentation. Enter "Zero" if the intervention is not provided to members with Asthma. 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. 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 31who participated in the activity at any time during the applicable calendar year.

	Number of members as specified in rows 1, 2 and 3	Indicate if intervention Offered to Asthma Patients in this state/market	Number of California members 5 years and above in this state/market receiving intervention (if Health plan offers intervention but does not track	Risk strata that receives this intervention	Autocalculated % of HEDIS Asthma eligibles who received intervention	Autocalculated % of Health plan Asthma eligibles who received intervention

			participation, enter zero)			
Number of members aged 5 and above in this market	*Decimal*					
Using the NCQA "Eligible Population" definition for Asthma in the 2015 HEDIS Technical Specifications Vol 3., provide number of members 5 and above with Asthma	*Decimal*					
Using the plan's own criteria, provide number of members identified with condition and eligible to participate in diabetes DM program	*Decimal*					
General member education (e.g., newsletters)		*Multi, Checkboxes* 1: HMO 2: PPO 3: Intervention not offered	*Decimal* From 0 to 100000000000	*Multi, Checkboxes* 1: Low 2: Medium 3: High risk 4: No stratification	Unknown	Unknown
General care education/reminders based on condition alone (e.g., personalized letter)		*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Member-specific reminders for due or overdue clinical/diagnostic		*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*

maintenance services Answer “member-specific reminders” only if it involves reminders that are independent of the live outbound telephonic program (Documentation needed)						
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 (Documentation needed)		*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Online interactive self-management support. "Online self-management support" is an intervention that includes two-way electronic communication between the Health plan and the member. Examples include devices that monitor weight, lab levels, etc. as well as web-support activities that are customized and tailored		*Multi, Checkboxes.* 1: HMO 2: PPO 3: Intervention not offered 4: Regional Number provided 5: National Number provided 6: Offered but not tracked regionally or statewide	*Decimal* From 0 to 100000000000000	*Multi, Checkboxes.* 1: Low 2: Medium 3: High risk 4: No stratification	Unknown	Unknown

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. (Documentation needed)						
Self-initiated text/email messaging		*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
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.		*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
IVR with outbound messaging only		*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Live outbound telephonic coaching program (count only members that are successfully engaged)		*Multi, Checkboxes* 1: HMO 2: PPO 3: Intervention not offered	*(As above)*	*(As above)*	*(As above)*	*(As above)*

9.4.9.10 Review HEDIS scores for the indicators listed.

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'

Please refer to the attached document for an explanation of terms

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Detail: [N/A]

	HEDIS QC 2015 (HMO)	HEDIS QC 2014 (HMO)
Use of Appropriate Medications for People with Asthma - Total	[N/A]	[N/A]

9.4.9.11 Review HEDIS scores for the indicators listed.

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'

Please refer to the attached document for an explanation of terms

HEDIS/CAHPS 2 Answers / 2 Questions
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Detail: [N/A]

	HEDIS QC 2015 (PPO)	HEDIS QC 2014 (PPO)
Use of Appropriate Medications for People with Asthma - Total	[N/A]	[N/A]

9.4.9.12 Review HEDIS scores for the indicators listed.

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'

Please refer to the attached document for an explanation of terms

HEDIS/CAHPS 2 Answers / 2 Questions
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Detail: [N/A]

	HEDIS QC 2015 (EPO)	HEDIS QC 2014 (EPO)

Use of Appropriate Medications for People with Asthma - Total	[N/A]	[N/A]

9.4.9.13 For the total commercial book of business in this market, 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 the Plan's criteria for high risk medically complex conditions eligible for case management in the second row.

Starting at row 3, indicate the types of interventions that are received by the population based the Plan's criteria for high risk medically complex conditions 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, 2015 who participated in the activity at any time during 2015.

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 Offered to High Risk Medically Complex	Number of members 18 years and above in this state/market	Is intervention a standard or buy-up	Autocalculated % of Plan High Risk Medically Complex

	specified in rows 1, and 2	Patients in this state/market	receiving intervention (if plan offers intervention but does not track participation, enter NA)	option (Cost of Intervention)	eligibles who received intervention
Number of members aged 18 and above in this market	*Decimal*				
Using the Plan's definition, provide number of members 18 and above who are High Risk Medically Complex	*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: Intervention not offered, 4: Regional Number provided, 5: National Number provided, 6: Offered but not tracked	*Decimal* From 0 to 100000000000	*Multi, Checkboxes.* 1: Included as part of Diabetes 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: No Diabetes program but intervention available outside of a specific program as a standard benefit for fully insured lives, 5: No Diabetes program but intervention available	Unknown

				outside of a specific program as a standard benefit for self-insured lives (part of the ASO fee), 6: No Diabetes program but intervention available outside of a specific program as a buy-up option for fully insured lives, 7: No Diabetes program but 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					
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.					
Self-initiated text/email messaging					
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.					Unknown
IVR with outbound messaging only					
Live outbound telephonic coaching program (count only members that are successfully engaged)					
Face-to-Face visits					

9.4.9.14 If the Health plan indicates that it monitors services for gaps in CAD, diabetes and/or asthma in questions above, indicate which services are monitored. If the “other” choice is selected, describe the service that is monitored in the text box. The Health plan can also use this text box to describe their general approach to reminders, such as criteria to distinguish which members are given member-specific reminders.

	Services Monitored	Data Source in general, not per service
CAD	*Multi, Checkboxes.* 1: Blood pressure levels 2: Beta Blocker Use 3: LDL testing 4: LDL control 5: Aspirin therapy 6: Gaps in Rx fills 7: Other 8: Not monitored	*Multi, Checkboxes.* 1: Medical records 2: Claim feed 3: RX Data Feed 4: Vendor feed (lab, x-ray) 5: Patient Self-Report 6: Patient home monitoring
Diabetes	*Multi, Checkboxes.* 1: Retinal Exam 2: LDL Testing 3: LDL Control 4: Foot exams 5: Nephropathy testing 6: HbA1c Control 7: Blood pressure (130/80) 8: Blood pressure (140/90) 9: Gaps in Rx fills 10: Other 11: Not monitored	*Multi, Checkboxes.* 1: Medical records 2: Claim feed 3: RX Data Feed 4: Vendor feed (lab, x-ray) 5: Patient Self-Report 6: Patient home monitoring
Asthma	*Multi, Checkboxes.* 1: Maintenance of asthma controller medication 2: Appropriate medication for persistent asthma 3: Annual monitoring on persistent medications 4: Assessment of asthma control 5: Ambulatory sensitive condition admission for asthma 6: Emergency dept visit frequency 7: Gaps in Rx fills 8: Other 9: Not monitored	*Multi, Checkboxes.* 1: Medical records 2: Claim feed 3: RX Data Feed 4: Vendor feed (lab, x-ray) 5: Patient Self-Report 6: Patient home monitoring

9.4.9.15 If the Health plan indicated member-specific reminders for known gaps in clinical/diagnostic maintenance service and/or medication events in the questions above, provide an actual, blinded copy of the reminders or telephone scripts as a Word or PDF document and save under title "***At Risk 1a, 1b, 1c."*** (if applicable). If the mailing/telephone script(s) does not specifically indicate that the member was identified for the reminder as a result of a gap in a recommended service or Rx refill, please provide further evidence that the reminder targeted members who were due or overdue for the service. Check the boxes below to indicate the disease states illustrated in the reports and whether the reminders addressed more than one service element (e.g., LDL and HbA1c tests for diabetics).

Multi, Checkboxes.
1: At Risk 1a is provided - Coronary Artery Disease
2: At Risk 1b is provided - Diabetes
3: At Risk 1c is provided – Asthma
4: No support is provided

9.4.9.16 If online interactive self-management support is offered, provide screen prints or other documentation illustrating functionality as a Word or PDF document and save under title "***At Risk 2a, 2b, and 2c***." Check the boxes below to indicate the disease states illustrated.

Multi, Checkboxes.
1: At Risk 2a is provided - Coronary Artery Disease
2: At Risk 2b is provided - Diabetes
3: No support is provided

9.4.9.17 Identify action(s) taken when individuals are identified with poor medication adherence through routine monitoring of refill activity. What is the scope of the program **(entity that is primarily responsible for monitoring and action*) and which members are monitored))** and to whom are reminders and alerts directed? Exclude knowledge of medication gaps that are discovered in the course of telephonic outreach, such as might be the case for a chronic condition management program. Include the responsible parties carrying out the reminders/calls/alerts (pharmacy, manufacturer, Health plan DUR staff, etc.) Check all that apply.

***If "other" is a department within the Health plan that monitors and acts - please respond "plan personnel." Note the entity that is responsible for the record of member on medication.** Note that medication adherence refers to ongoing compliance taking medications that have been filled at least once. These lists are not intended to be exhaustive. If your Health plan targets other medications, takes other actions, etc., please describe them in the column provided. Interventions to encourage initiation of appropriate pharmacotherapy do not apply.

	Drugs Monitored for Adherence	Entity responsible for monitoring and acting on medication adherence	Members monitored	Actions taken	Briefly describe role of Health plan in reminder/alert program	Other (describe)
CAD	*Multi, Checkboxes.* 1: Statins 2: Beta Blockers 3: Nitrates 4: Calcium Channel blockers 5: ACEs/ARBs 6: Other (describe) 7: Compliance (medication refills) is not systematically assessed	*Multi, Checkboxes.* 1: Health plan personnel 2: PBM 3: Retail or mail pharmacy 4: Other (describe)	*Single, Radio group.* 1: All members taking the checked drugs are monitored 2: Only DM participants are monitored	*Multi, Checkboxes.* 1: Member must activate reminders 2: Member receives mailed reminders 3: Member receives electronic reminder (e.g. email) 4: Member receives telephone contact 5: Practitioner is mailed an alert 6: Practitioner is contacted electronically 7: Practitioner is contacted by telephone 8: Telephonic coach is notified 9: Gap in fills are communicated electronically to personal health	*100 words*	*100 words*

				record which will trigger a member alert 10: Other (describe)		
Diabetes	*Multi, Checkboxes.* 1: Statins 2: Insulin 3: Alpha-glucosidase 4: Biguanides, 5: DPP-IV inhibitors 6: Meglitinides 7: Thiazolidine diones 8: Sulfonylureas 9: Other (describe) 10: Compliance (medication refills) is not systematically assessed	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Asthma	*Multi, Checkboxes.* 1: Steroidal anti-inflammatories 2: Non-steroidal anti-inflammatories 3: Beta agonists (short and long-acting) 4: Xanthines 5: Anti-cholinergics	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*

	6: Leukotriene receptor agonists 7: Anti-allergics 8: Other (describe) 9: Compliance (medication refills) is not systematically assessed					

9.4.9.18 For members already participating in the telephone management program (beyond the initial contact) indicate the events that will cause the Health plan to call a member outside of the standard schedule for calls. Check all that apply. Please note this refers only to members already participating in the telephone management program.

	Response
Coronary Artery Disease	*Multi, Checkboxes.* 1: Calls are made according to a set schedule only 2: Clinical findings (e.g. lab results) 3: Acute event (e.g. ER, inpatient) 4: Medication events (e.g. failure to refill, excess use, drug/drug or drug/DX interaction) 5: Missed services (e.g. lab tests, office visits) 6: Live outbound telephone management is not offered
Diabetes	*(As above)*
Asthma	*(As above)*

9.4.9.19 Indicate the member support elements used in the Plan's live outbound telephone management program. Only select member support items that are both tracked and reportable. Check all that apply.

	Response

Coronary Artery Disease	*Multi, Checkboxes.* 1: Patient knowledge (e.g. patient activation measure score) 2: Interaction with caregivers such as family members (frequency tracked) 3: Goal attainment status 4: Readiness to change score 5: Care Health plan development, tracking, and follow-up 6: Self-management skills 7: Provider steerage 8: Live outbound telephone management not offered 9: Live outbound telephone management program offered but elements not tracked for reporting to purchaser
Diabetes	*(As above)*
Asthma	*(As above)*

9.4.9.20 Indicate the **types** of data analyses and reporting available to purchasers and/or their designated vendors on health management and chronic conditions, and the **sources** of data used to generate the types of analyses and reports available to Covered California. Health plans are expected to help assess and improve health status of their Enrollees using a variety of sources. Check all that apply and which can be documented in the attachment ***At Risk 3*** below.

	Report Features for HMO	Report Features for PPO	Report Features for EPO	Sources of Data
Chronic Condition Prevalence	*Multi, Checkboxes.* 1: Group-specific results reported 2: Comparison targets/benchmarks of book-of-business 3: Comparison benchmarks of similarly sized groups 4: Trend comparison of two years data – rolling time period	*Multi, Checkboxes.* 1: Group-specific results reported 2: Comparison targets/benchmarks of book-of-business 3: Comparison benchmarks of similarly sized groups 4: Trend comparison of two years data – rolling time period	*Multi, Checkboxes.* 1: Group-specific results reported 2: Comparison targets/benchmarks of book-of-business 3: Comparison benchmarks of similarly sized groups 4: Trend comparison of two years data – rolling time period	*Multi, Checkboxes.* 1: HRAs 2: Medical Claims Data 3: Pharmacy Claims Data 4: Lab Values 5: Other source - please detail below

	5: Trend comparison of two years data – fixed Jan-Dec annual reporting 6: All of the above reports integrated into single report 7: Report available for additional fee 8: Data/reporting not available	5: Trend comparison of two years data – fixed Jan-Dec annual reporting 6: All of the above reports integrated into single report 7: Report available for additional fee 8: Data/reporting not available	5: Trend comparison of two years data – fixed Jan-Dec annual reporting 6: All of the above reports integrated into single report 7: Report available for additional fee 8: Data/reporting not available	
Enrollee Population stratified by Risk and/or Risk Factors	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Chronic Condition/Disease Management (DM) program enrollment	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Change in compliance among DM enrollees (needed tests, drug adherence)	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Health status change among DM enrollees	*(As above)*	*(As above)*	*(As above)*	*(As above)*

9.4.9.21 Attachments are needed to support Health plan responses to the question above. NOTE: Health plan is required to provide only ONE of the two attachments specified below.

Provide as ***At Risk 3***, blinded samples of standard purchaser report(s) for:

A) Chronic condition prevalence OR management,

B) Population risk stratification, and

C) Changes in compliance OR health status

(Attachments needed for 3 of the 5 rows depending on Health plan response).

Provide LABELED samples of reports for (1) group-specific results, (2) Comparison targets/benchmarks of book-of-business OR Comparison benchmarks of similarly sized groups, (3) Trend comparison of two years data - rolling time period, and (4) Trend comparison of two years data - fixed Jan-Dec annual reporting ONLY IF HEALTH PLAN DID NOT SELECT AND PROVIDE SUPPORT FOR "Trend comparison of two years data - rolling time period"

For example if Health plan responds that they can provide group specific results (response option 1) with comparison benchmarks of similarly sized groups are available with trend comparison data of two years rolling and fixed for parameters in first 3 rows (**chronic disease prevalence**, **Enrollee Population stratified by Risk and/or Risk Factors and Chronic Condition/Disease Management (DM) program enrollment)** – the following samples must be attached:

1) Report showing enrollee population stratified by risk or risk factors for the specified group compared to a different similarly sized group over a rolling time frame of 24 months

2) Report showing either prevalence of chronic disease OR DM program enrollment factors for the specified group compared to a different similarly sized group over a rolling time frame of 24 months

IF REPORT FEATURE OPTION 6 "All of the above reports integrated into single report" IS SELECTED, please provide a blinded sample of such an integrated report with the sections CLEARLY LABELED.

Provide as ***At Risk 3***, blinded samples of standard purchaser report(s) for:

A) Chronic condition prevalence OR management,

B) Population risk stratification, and

Provide LABELED samples of reports for (1) group-specific results, (2) Comparison targets/benchmarks of book-of-business OR Comparison benchmarks of similarly sized groups.

IF REPORT FEATURE OPTION 6 "All of the above reports integrated into single report" IS SELECTED, please provide a blinded sample of such an integrated report with the sections CLEARLY LABELED

Single, Radio group.
1: At Risk 3 is provided based on Health plan's statewide enrollment,
2: At Risk 3 is provided based on Health plan's Covered California enrollment,
3: Not provided

9.4.10 Provider Cost and Quality and Enrollee Cost Transparency

9.4.10.1 Describe the web-based cost information that the Health plan makes available for physician and hospital services. Check all that apply.

	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	*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	*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

	7: Information available only to members 8: Information available to public	8: Information available to public	
Episode of care based cost (e.g. vaginal birth, bariatric surgery)	*(As above)*	*(As above)*	*(As above)*

9.4.10.2 Indicate the functionality available in the Plan's cost calculator. Check all that apply. If any of the following four (4) features are selected, documentation for the procedure KNEE REPLACEMENT must be provided in following question as ***Cost-Quality 1***:

1) Demonstrate the search options available for this procedure (e.g., name, condition, symptom and/or procedure)

2) Cost information considers members benefit design relative to copays, cost sharing, coverage exceptions,

3) Cost information considers members benefit design relative to accumulated deductibles, OOP max, service limits,

4) Supports member customization of expected ***professional*** services utilization or medication utilization.

	Answer
	Multi, Checkboxes - optional. 1: The Health plan does not support a cost calculator.
Content	*Multi, Checkboxes.* 1: Medical cost searchable by procedure (indicate number of procedures in detail box below), 2: Medical cost searchable by episode of care (indicate number of care episodes in detail box below), 3: Medication costs searchable by drug,

	4: Medication costs searchable by episode of care, 5: None of the above
Functionality	*Multi, Checkboxes.* 1: Compare costs of alternative treatments, 2: Compare costs of physicians, 3: Compare costs of hospitals, 4: Compare costs of ambulatory surgical or diagnostic centers, 5: Compare drugs, e.g. therapeutic alternatives, 6: Compare costs based on entire bundle of care, allowing user to substitute lower cost or higher quality equivalent elements of bundle, 7: None of the above
Member Specificity	*Multi, Checkboxes.* 1: Cost information considers members benefit design relative to copays, cost sharing, coverage exceptions, 2: Cost information considers members benefit design relative to accumulated deductibles, Out of Pocket max, lifetime, services limits (e.g. number of physical therapy visits covered), 3: Cost information considers members benefit design relative to pharmacy benefit, e.g. brand/generic and retail/mail, 4: Separate service category sets result for user, other adult household members and for children, 5: Explains key coverage rules such as family-level versus individual-level annual accumulation and general rules about portability, accrual, tax allowances, etc, 6: Provides summary Health plan benefits description as linked content with explanatory note about IRS-allowed expenses vs. deductible-applicable covered expenses, 7: Supports member customization of expected services or medications utilization, i.e. member can adjust the default assumptions, 8: None of the above

Account management / functionality	*Multi, Checkboxes.* 1: Supports member entry of tax status/rate to calculate federal/state tax ramifications, 2: Member can view multi-year HSA balances, 3: Calculates a recommended amount for FSA/HSA contribution given anticipated medical expenses, 4: None of the above

9.4.10.3 If any of the following four (4) features are selected in the question above, actual report(s) or illustrative screen prints for the procedure KNEE REPLACEMENT must be attached as ***Cost-Quality 1***:

1) Demonstrate the search options available for this procedure (e.g., name, condition, symptom and/or procedure)

2) Cost information considers members benefit design relative to copays, cost sharing, coverage exceptions,

3) Cost information considers members benefit design relative to accumulated deductibles, OOP max, service limits,

4) Supports member customization of expected ***professional*** services utilization or medication utilization.

The functionality demonstrated in the attachment must be clearly marked. Do NOT include attachments that do not specifically demonstrate one of these features

Multi, Checkboxes.

1: Cost-Quality 1a is provided
2: Cost-Quality 1b is provided
3: Cost-Quality 1c is provided

4: Cost-Quality 1d is provided
5: Not provided

9.4.10.4 Indicate how Health plan tracked the impact of the cost calculator. Report numeric results as indicated for the applicable calendar year and check all that apply. The commercial enrollment reported below should match the statewide number reported in Section 3. If Health plan has and tracks use by Medi-Cal members as well, number should include Medi-Cal numbers.

	Applicable Calendar Year
Health plan does not support a cost calculator, or does not track its impact	*Multi, Checkboxes – optional.* 1: Respondent does not support
Total California enrollment from Health plan's response in Section 3 (sum of commercial HMO/POS, PPO and Other Commercial)	*For comparison* Unknown
Enrollment (list Total commercial number reported in Section 3)	*Decimal*
Number of completed interactive sessions with cost calculator	*Decimal* N/A OK From 0 to 1000000000
Number of unique users across all lines of business to cost calculator portion of site	*(As above)*
Number of unique Covered California users to cost calculator portion of site	*(As above)*
Percentage of completed sessions to total enrollment	*For comparison* 0.00%
Percentage of unique users across all lines of business to total enrollment	*(As above)*

Percentage of unique Covered California users to total Covered California enrollment	*(As above)*
Targeted follow up via email or phone call to assess user satisfaction	*Single, Radio group.* 1: Yes 2: No
Plan can report utilization of cost calculator	*(As above)*

9.4.10.5 If the Health Plan conducted a survey to evaluate the user experience with the cost calculator tool, provide the survey results as an attachment labeled as "Cost Calculator Results." To the extent that experience is tracked by purchaser, report results by full book of business and Covered California only.

Single, Pull-down list.
1: Yes, Cost Calculator Results attached,
2: Not attached

9.4.10.6 How does the Health plan encourage members to use better performing physicians? Check all that apply.

	Answer
Distinction of higher performing individual physicians	*Single, Radio group.* 1: No distinction 2: Distinction is made
General education about individual physician performance standards	*Single, Radio group.* 1: Yes 2: No
Education and information about which individual physicians meet target practice standards	*(As above)*
Messaging included in EOB if member uses provider not designated as high performing relative to peers	*(As above)*

Member steerage at the time of nurseline interaction or telephonic treatment option support	*(As above)*
Members are not actively encouraged at this time to utilize individual physicians that meet targeted practice standards	*(As above)*

9.4.10.7 Indicate the information available through the Plan's on-line physician directory. These data categories are based on the recommendations of the Commonwealth Fund/NCQA consensus panel on electronic physician directories. Use the detail box to describe any updates (e.g., office hours, languages spoken) that a provider is permitted to make directly through an online provider portal or similar tool.

Note that actual screen prints must be provided as Consumer 2 illustrating the following if selected as responses: 1) NCQA recognition programs, availability of: 2) Web visits, 3) email, 4) ePrescribing or 5) EMRs (electronic medical records)

	Response
Physician office hours	*Single, Pull-down list.* 1: Displayed only 2: Indexed and searchable 3: Available from customer service or printed format only 4: Not available
Physician years in practice	

Physician facility privileges	
Physician languages spoken	
NCQA Diabetes Recognition Program [attach documentation] CHECK one of the choices only if the Plan enters and maintains the information element. Self-report from physician practices does not qualify.	
NCQA Heart/Stroke Recognition Program [attach documentation] CHECK one of the choices only if the Plan enters and maintains the information element. Self-report from physician practices does not qualify.	
NCQA Back Pain Recognition Program [attach documentation] CHECK one of the choices only if the Plan enters and maintains the information element. Self-report from physician practices does not qualify.	
NCQA Physician Practice Connection Recognition [attach documentation] CHECK one of the choices only if the Plan enters and maintains the information element. Self-report from physician practices does not qualify.	
NCQA Patient-Centered Medical Home Recognition [attach documentation] **CHECK one of the choices only if the Plan enters and maintains the information element. Self-report from physician practices does not qualify.**	
NCQA Physician Recognition Software Certification - a certification program that supports data collection and reporting for the Diabetes Physician Recognition Program [attach documentation]	
High performance network participation/status	
Uses web visits [attach documentation]	
Uses patient email [attach documentation]	
Uses ePrescribing [attach documentation]	
Uses EMRs [attach documentation]	

9.4.10.8 Indicate the interactive selection features available for members who wish to choose a physician online. Check all that apply, and document the five interactive features selected as available, as Consumer 4a – 4e (as noted in 4.5.7 below).

1) Performance using disease specific individual measures
2) Performance using disease-specific composite measures
3) User can rank/filter physician list by culture/demographics
4) User can rank/filter physician based on HIT adoption
5) User can rank/filter physician based on quality indicators

	Response
Availability	*Single, Radio group.* 1: Online Physician Selection Tool is available 2: Online Physician Selection Tool is not available
Search Features	*Multi, Checkboxes.* 1: User can specify physician proximity to user zip code to limit displayed data 2: User can limit physician choices to preferred network/coverage status 3: User can search by treatment and/or condition 4: None of the above
Content	*Multi, Checkboxes.* 1: User can access information about out-of-network physicians with clear messaging about status and out-of-pocket liability 2: Performance is summarized using disease specific individual measures

	3:) 4: Tool provides user with guidance about physician choice, questions to ask physicians, and questions to ask the Plan 5: Physician photograph present for at least 50% of physicians 6: None of the above
Functionality	*Multi, Checkboxes.* 1: User can weight preferences, e.g. quality vs. cost, to personalize results 2: User can rank physicians based on office hours access (e.g., evening or weekend hours) 3: User can rank or filter physician list by culture/demographics (languages spoken, gender or race/ethnicity) 4: User can rank or filter physician list based on HIT adoption (e.g., e-prescribing, Web visits, EMR use) 5: User can rank or filter physician list based on quality indicator(s) 6: User can compare at least three different physicians/practices side-by-side 7: Plan directs user (during interactive physician selection session) to cost comparison tools (q. 4.8.3) to determine the financial impact of their selection (specifically customized to the member's benefits, such that co-pays, OOP Max, deductible accumulator, and other financial information are presented to the user) 8: User can link to a physician website 9: None of the above
Interface/Integration Of Cost Calculator	*Multi, Checkboxes.* 1: There is a link from tool indicated to cost calculator and user populates relevant information 2: Cost calculator is integrated and contains relevant results from searches of other tools

	3: Other (describe) 4: There is no integration of cost calculator with this tool
Description of "Other"	*50 words*

9.4.10.9 How does the Plan evaluate the use and impact of its physician selection tools? Report 2015 numeric results and check all that apply. The commercial enrollment reported below should match the national number reported in Profile 1.3.3.

	2015	2014
Use/impact not evaluated or tool not available	*Multi, Checkboxes - optional.* 1: not evaluated or tool not available	*Multi, Checkboxes - optional.* 1: not evaluated or tool not available
Total commercial enrollment from plan's response in profile 1.3.3 (sum of commercial HMO/POS, PPO and Other Commercial) [autogenerated from plan response]	*For comparison* 0	
Enrollment (list Total commercial number reported in Profile 1.3.3) [entered by plan]	*Decimal*	*Decimal* N/A OK
Number of completed interactive sessions with physician selection tool	*Decimal*	*Decimal*
Percentage of completed sessions to total enrollment [autocalculated using plan entered enrollment as denominator]	*For comparison* 0.00%	*For comparison* 0.00%
Number of unique users to physician directory portion of site	*Decimal*	*Decimal*
Percentage of unique users to total enrollment [autocalculated using plan entered enrollment as denominator]	*For comparison* 0.00%	*For comparison* 0.00%
Measuring change in use of higher-performing physicians	*Multi, Checkboxes.* 1: PCP Selection 2: Volume of procedures	*Multi, Checkboxes.* 1: PCP Selection 2: Volume of procedures

	3: Paid claims 4: Not measured	3: Paid claims 4: Not measured
Targeted follow up via email or phone call to assess user satisfaction	*Single, Radio group.* 1: Yes 2: No	*Single, Radio group.* 1: Yes 2: No
Plan can report utilization aggregated at the purchaser level		

9.4.10.10 Indicate which of the following functions are available with the hospital chooser tool. Check all that apply, and document as attachment in 4.6.4 as Consumer 6 each of the five (5) interactive features selected below:

1) Distinguishes between condition-specific and hospital-wide performance
2) Discloses scoring methods
3) Reports never events
4) Reports mortality if relevant to treatment
5) User can weight preferences (e.g. quality vs. cost) to personalize results

	Answer
Availability	*Single, Radio group.* 1: Hospital chooser tool is available 2: Hospital chooser tool is not available
Search features	*Multi, Checkboxes.* 1: Supports search for hospital by name 2: Supports search for hospitals within geographic proximity 3: Supports hospital-wide attribute search (e.g., number of beds, major service areas, academic medical center, etc.) 4: Supports condition-specific search 5: Supports procedure-specific search 6: Supports search for hospital-affiliated physicians

	7: Supports search for hospital-affiliated physicians that are plan contracted 8: Supports search for plan-affiliated (in-network) hospitals 9: Supports search for in-network hospital or includes indication of such 10: None of the above
Content	*Multi, Checkboxes.* 1: Provides education about condition/procedure performance vs. overall hospital performance 2: Provides education about the pertinent considerations for a specific procedure or condition 3: Describes treatment/condition for which measures are being reported 4: Distinguishes between condition-specific and hospital-wide performance 5: Discloses reference documentation of evidence base for performance metrics (methodology, population, etc.) 6: Discloses scoring methods, (e.g., case mix adjustment, measurement period) 7: Discloses dates of service from which performance data are derived 8: Reports adherence to Leapfrog patient safety measures 9: Reports performance on AHRQ patient safety indicators 10: Reports volume as proxy for outcomes if relevant to treatment 11: Reports complication indicators if relevant to treatment 12: Reports never events 13: Reports HACs (healthcare acquired conditions also known as hospital-acquired conditions) 14: Reports mortality if relevant to treatment 15: Performance charts or graphics use the same scale for consistent presentation 16: Communicate absolute risks or performance values rather than relative risks 17: Some indication of hospital efficiency rating 18: None of the above
Functionality	*Multi, Checkboxes.* 1: Consumer can weight preferences (e.g. quality vs. cost) to personalize results 2: Consumer can choose a subset of hospitals to compare on distinct features 3: Plan directs user (during interactive hospital selection session) to cost comparison tools (q. 2.7.4) to determine the financial impact of their selection (specifically customized to the member's benefits, such that co-pays, OOP Max, deductible accumulator, and other financial information are presented to the user) 4: None of the above
Interface/Integration Of Cost Calculator	*Multi, Checkboxes.* 1: There is a link from tool to cost calculator and user populates relevant information 2: Cost calculator is integrated and contains relevant results from searches of other tools

	3: Other (describe) 4: There is no integration of cost calculator with this too
Description of "Other"	*200 words*

9.4.10.11 How does the Plan evaluate the use and impact of its hospital choice tools? Report numeric results as indicated and check all that apply. The commercial enrollment reported below should match the national number reported in Profile 1.3.3.

	2015	**2014**
Use/impact not evaluated or tool not available	*Multi, Checkboxes - optional* 1: X	*Multi, Checkboxes - optional* 1: X
Total commercial enrollment from plan's response in profile 1.3.3 (sum of commercial HMO/POS, PPO and Other Commercial)	*For comparison* 0	
Enrollment (list Total commercial number reported in Profile 1.3.3)	*Decimal*	*Decimal*
Number of completed interactive sessions with hospital choice tool		
Percentage of completed sessions to total enrollment	*For comparison* 0.00%	*For comparison* 0.00%
Number of unique users to site		
Percentage of unique users to total enrollment	*For comparison* 0.00%	*For comparison* 0.00%
Targeted follow up via email or phone call to assess user satisfaction	*Single, Radio group.* N/A OK 1: Yes 2: No	*Single, Radio group.* N/A OK 1: Yes 2: No

Measuring use and/or volume of procedures at higher-performing hospitals	*Multi, Checkboxes.* N/A OK 1: Volume of procedures 2: Paid claims	*Multi, Checkboxes.* N/A OK 1: Volume of procedures 2: Paid claims
Measuring use and/or volume of procedures at Centers of Excellence		
Plan can report utilization aggregated at the purchaser level	*Single, Radio group.* N/A OK 1: Yes 2: No	*Single, Radio group.* N/A OK 1: Yes 2: No

9.4.11 Enrollee Shared Decision-Making

9.4.11.1 In order to optimize self-care and member engagement, does the Health plan provide members with any of the following treatment choice support products? Check all that apply.

Multi, Checkboxes.
1: Treatment option support is not available
2: BestTreatments
3: HealthDialog Shared Decision Making Program
4: Healthwise Decision Points
5: NexCura NexProfiler Tools
6: Optum Treatment Decision Support
7: WebMD Condition Centers
8: Cerner
9: Other (name vendor in detail box below)
10: Health plan provides treatment option support using internal sources
11: The service identified above is available subject to a purchaser buy-up for HMO
12: The service identified above is available subject to a purchaser buy-up for PPO

9.4.11.2 Indicate which of the following functions are available with the interactive treatment option decision support tool. Check all that apply. If any of the following six (6) features are selected, documentation for the procedure KNEE REPLACEMENT must be provided in following question as ***SDM 1***:

1) Demonstrate the search options available for this procedure (e.g., name, condition, symptom and/or procedure) (1a)

2) Treatment options include benefits and risks (1b)

3) Provides patient narratives/testimonials so user can consider how patients with similar condition/stage of illness made a decision (1c)

4) Information tailored to the progression of the member's condition (1d)

5) Treatment cost calculator based on the Plan's fee schedule and selection of specific providers (1e), and

6) Linked to the member's benefit coverage to reflect potential out-of-pocket costs (1f)

"Interactive treatment decision support" to help members compare treatment options is defined as interactive tools supported by the Health plan where the member enters his/her own personal health or pharmacy information and receives system-generated customized guidance on specific treatment options available. Interactive implies a response mechanism that results in calibration of subsequent interventions. This does not include audio or video information available from the Health plan that describes general treatment information on health conditions, or personalized HA (health assessment) follow up reports that are routinely sent to all members who complete a HA.

	Answer
Content	*Multi, Checkboxes.* 1: Describes treatment/condition, i.e. symptoms, stages of disease, and expectations/tradeoffs from treatment, 2: Includes information about what the decision factors are with this condition, 3: Treatment options include benefits and risks, 4: Tool includes likely condition/quality of life if no treatment, 5: Includes information about patients' or caregivers' role or responsibilities, 6: Discloses reference documentation of evidence base for treatment option, 7: Provides patient narratives/testimonials so user can consider how patients with similar condition/stage of illness made a decision, 8: Provides member with questions or discussion points to address with provider or enables other follow up option, e.g. health

	coach option, 9: None of the above
Functionality	*Multi, Checkboxes.* 1: Allows user to organize/rank preferences, 2: User can compare treatment options side-by-side if reasonable options exist, 3: None of the above
Telephonic Support	*Multi, Checkboxes.* 1: Member can initiate call to discuss treatment options with clinician, 2: Health plan or vendor may make outbound call to targeted member based on identified triggers (e.g., course of treatment, authorization request, etc.), 3: None of the above
Member Specificity	*Multi, Checkboxes.* 1: Tailored to member's demographic attributes (e.g., age, gender, etc.), 2: Tailored to the progression of the member's condition, 3: Elicits member preferences (e.g., expectations for survival/recurrence rates, tolerance for side effects, patient's role within each course of treatment, etc.), 4: Tailored to member's specific benefits design, such that co-pays, OOP max, deductible, FSA and HSA available funds, and relevant tiered networks or reference pricing are all present in cost information, 5: None of the above
Cost Information/ functionality	*Multi, Checkboxes.* 1: Treatment cost calculator based on the Plan's fee schedule but not tied to selection of specific providers, 2: Treatment cost calculator based on the Plan's fee schedule and selection of specific providers, 3: Treatment cost calculator based on billed charges in the local market, 4: Treatment cost calculator based on paid charges in the local market, 5: Specific to the member's benefit coverage (co-pays, OOP max, deductible, FSA and HSA available funds) to reflect potential out-of-pocket costs, 6: Treatment cost calculator includes medication costs, 7: Treatment cost calculator does not include medication costs – information is not integrated, 8: Treatment cost per an alternative method not listed above (describe in detail box below):, 9: None of the above
Interface/ Integration Of Cost Calculator	*Multi, Checkboxes.* 1: There is a link from tool to cost calculator and user populates relevant information,, 2: Cost calculator is integrated and contains relevant results from searches of other tools,

	3: Other (describe in detail box below), 4: There is no integration of cost calculator with this tool
Description of "Other"	*200 words*

9.4.11.3 If any of the following six (6) features are selected in the question above, actual report(s) or screen prints illustrating each interactive feature selected **for the procedure KNEE REPLACEMENT** as a Word or PDF document saved under the title "***SDM 1"***: 1) Demonstrate the search options available for this procedure (e.g., name, condition, symptom and/or procedure), 2) Treatment options include benefits and risks, 3) Provides patient narratives/testimonials so user can consider how patients with similar condition/stage of illness made a decision, 4) Information tailored to the progression of the member's condition, 5) Treatment cost calculator based on the Plan's fee schedule and selection of specific providers, and 6) Linked to the member's benefit coverage to reflect potential out-of-pocket costs.

The functionality demonstrated in the attachment must be clearly marked. Do NOT include attachments that do not specifically demonstrate one of these features. Health education does not satisfy the documentation requirement. Materials must include discussion of treatment options (e.g., medical management, pharmaceutical intervention, surgical option). Only provide one demonstration per description.

Multi, Checkboxes.

1: SDM 1a (Demonstrate the search options available for this procedure (e.g., name, condition, symptom and/or procedure)) is provided,

2: SDM 1b (Treatment options include benefits and risks) is provided

3: SDM 1c (Provides patient narratives/testimonials) is provided

4: SDM 1d (Information tailored to the progression of the member's condition) is provided

5: SDM 1e (based on the Plan's fee schedule and selection of specific providers) is provided

6: SDM 1f (Linked to the member's benefit coverage to reflect potential out-of-pocket costs) is provided

7: Not provided

9.4.11.4 Does the Health plan 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: 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

9.4.11.5 How does the Health plan evaluate the use and impact of its treatment option support? The commercial enrollment reported below should match the statewide number reported in Section 3. If Health plan has and tracks use by Medi-Cal members as well, number should include Medi-Cal numbers.)

	Applicable Calendar Year
Use/impact not evaluated or tool not available	*Multi, Checkboxes - optional.* 1: Not available

Total commercial enrollment from Health plan's response in Section 3 (sum of commercial HMO/POS, PPO and Other Commercial)	*For comparison* Unknown
Enrollment (list Total commercial number reported in Section 3) If Health plan has and tracks use by Medi-Cal members as well, enrollment number here should include Medi-Cal numbers.)	*Decimal*
Number of completed interactive sessions with treatment option support tool	*Decimal* N/A OK From 0 to 10000000000000
Number of unique users to site. If Health plan has and tracks use by Medi-Cal members as well, number here should include Medi-Cal numbers.)	*(As above)*
Number of unique users making inbound telephone calls. If Health plan has and tracks use by Medi-Cal members as well, number here should include Medi-Cal numbers.)	*Decimal* N/A OK
Number of unique users receiving outbound telephone calls. If Health plan has and tracks use by Medi-Cal members as well, number here should include Medi-Cal numbers.)	*(As above)*
Percentage of unique Website users to total enrollment [autocalc]	*For comparison* 0.00%
Percentage of unique users for telephonic treatment option decision support (inbound and outbound) [autocalc]	*(As above)*
Targeted follow-up via email or phone call to assess user satisfaction	*Single, Radio group* 1: Yes 2: No
Measuring change in utilization patterns for preference-sensitive services (e.g., back surgery, prostate surgery, etc.)	*Multi, Checkboxes.* 1: Volume of procedures 2: Paid claims 3: None of the above

If plan can measure participation and results as indicated above in measuring change in utilization patterns, provide a narrative description of results, including clinical, patient experience, and cost impacts.	*200 words*
Health plan can report utilization aggregated at the purchaser level	*Single, Radio group.* 1: Yes 2: No

9.4.11.6 Does the Health plan provide its network physicians with services that encourage physicians to engage patients in treatment decision support? Check all that apply.

Multi, Checkboxes.

1: Point of service physician decision support (e.g., reminders tagged to patients considering selected therapies like surgery for back pain, hysterectomy, bariatric surgery)

2: Routine reporting to physicians that identifies patient candidates for treatment decision support

3: Patient communication aids (e.g., tear-off treatment tool referral)

4: None of the above services are used to help engage members in treatment decision support

9.4.11.7 Choosing Wisely is part of a multi-year effort of the ABIM Foundation to help physicians be better stewards of finite health care resources. Originally conceived and piloted by the National Physicians Alliance through a Putting the Charter into Practice grant, nine medical specialty organizations, along with Consumer Reports and employer coalitions, have identified five tests or procedures commonly used in their field, whose necessity should be questioned and discussed. http://www.abimfoundation.org/Initiatives/Choosing-Wisely.aspx. A subset of the identified services is listed below. Indicate if the Health plan can track incidence of the procedures listed below and whether treatment decision support or member education are provided. Do not select member

education unless the communication is specific to the Choosing Wisely procedure described (and not general information about the condition).

Choosing Wisely procedure	Health plan activities	Description of other
Imaging for low back pain within the first six weeks, unless red flags are present	*Multi, Checkboxes.* 1: Health plan can report incidence of procedure 2: Health plan provides treatment decision support to member 3: Health plan provides member education about this procedure 4: Other (describe) 5: None of the above	*50 words*
Brain imaging studies (CT or MRI) in the evaluation of simple syncope and a normal neurological examination.	*(As above)*	*(As above)*
Repeat Abdominal CT for functional abdominal pain	*(As above)*	*(As above)*
Use of dual-energy x-ray absorptiometry (DEXA) screening for osteoporosis in women younger than 65 or men younger than 70 with no risk factors	*(As above)*	*(As above)*
Annual electrocardiograms (EKGs) or any other cardiac screening for low-risk patients without symptoms	*(As above)*	*(As above)*
Stress cardiac imaging or advanced non-invasive imaging in the initial evaluation of patients without cardiac symptoms unless high-risk markers are present	*(As above)*	*(As above)*

Annual stress cardiac imaging or advanced non-invasive imaging as part of routine follow-up in asymptomatic patients	*(As above)*	*(As above)*
Stress cardiac imaging or advanced non-invasive imaging as a pre-operative assessment in patients scheduled to undergo low-risk non-cardiac surgery	*(As above)*	*(As above)*
Echocardiography as routine follow-up for mild, asymptomatic native valve disease in adult patients with no change in signs or symptoms	*(As above)*	*(As above)*
Stenting of non-culprit lesions during percutaneous coronary intervention (PCI) for uncomplicated hemodynamically stable ST-segment elevation myocardial infarction (STEMI)	*(As above)*	*(As above)*

9.4.12 Value Based Reimbursement Inventory and Value Pricing Programs

9.4.12.1 Indicate if the following elements are applied when determining eligibility of measures for assessment, public reporting and payment rewards. Purchasers expect health plans to comply with the Consumer-Purchaser Disclosure Project "Patient Charter" for Physician Performance Measurement, Reporting and Tiering Programs (available at http://healthcaredisclosure.org/activities/charter/.)

1: Measures are nationally standardized

2: Defined clinical specifications

3: Methodology for attributing patients to physicians, practice sites or medical group/IPAs

4: Minimum number of observations

5: Statistical significance test or confidence interval when reporting performance differences

6: Case mix or severity adjustment

7: Geographic adjustment to determine peer group average

8: Handling of outlier cases in measurement of cost or resource use

9: Definition of episodes of care for cost or resource use

10: None of the above

9.4.12.2 Identify Plan actions to foster transparency and accountability in the physician performance reporting program.

1: Detailed measurement specifications and rating methodology is fully disclosed to physicians

2: Input to the measures and methodology is solicited from network physicians

3: Network physicians receive notice prior to release of results

4: Plan has a clearly defined process for physicians to request review or correction of results prior to use (e.g., in payment rewards or consumer reports)

5: Input to the measures and methodology is solicited from consumers

6: None of the above

9.4.12.3 The following questions are regarding current payment reform programs for OUTPATIENT services that align financial incentives with reducing waste and/or improving quality or efficiency. How many programs will be described? (After saving, the remaining questions will become "N/A".)

Name: numphysicianincent
Single, Pull-down list.
1: 0,
2: 1,
3: 2,
4: 3,
5: 4,
6: 5

9.4.12.4 For the HMO, indicate if transparent information comparing physician (primary care and/or specialty) performance on quality using any of the following PQRS Measures and Measure Groups or other measures are available to providers or members. Check all that apply. Note that results must be available to compare across at least two entities. Plan level measurement is insufficient to meet the intent of this expectation. Measures may be used individually or in composite (aggregate performance on several diabetes measures) and may be assessed with the actual value or with a relative performance level (report actual rate or interpreted result on a scale such as 1-5 stars).

Please see https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html

Efficiency is defined as the cost and quantity of services (i.e., total resources used) for the episode of care. For additional information, see "Measuring Provider Efficiency Version 1.0" available at http://www.commonwealthfund.org/~/media/files/publications/other/2004/dec/measuring-provider-efficiency--version-1-0--a-collaborative-multi-stakeholder-effort/measurproviderefficiency1-12312004-pdf.pdf and "Advancing Physician Performance Measurement: Using Administrative Data to Assess Physician Quality and Efficiency" available at http://www.pbgh.org/storage/documents/reports/PBGHP3Report_09-01-05final.pdf

For preventable ED/ER visits, please see http://info.medinsight.milliman.com/bid/192744/Claims-Based-Analytics-to-Identify-Potentially-Avoidable-ER-Visits and http://wagner.nyu.edu/faculty/billings/nyued-background

PQRS Measure & Other Measures (same measure set as in 2.8.2)	Level of detail for comparative reporting of physicians who meet the threshold of reliability for reporting. (HMO)	Indicate if reporting covers primary care and/or specialty physicians (HMO)	Description of Other (if plan selected response option 6)	Indicate how measure is used
Optimal Diabetes Care Composite	*Multi, Checkboxes.* 1: Individual Physician 2: Practice Site	*Multi, Checkboxes.* 1: Primary care 2: Specialty	*50 words*	1: Public Reporting 2: Physician Feedback

	3: Medical Group/IPA/Staff model Group 4: PCMH 5: ACO 6: Other (describe) 7: None of the above			3: Physician Feedback with Benchmarking 4: Threshold Element for P4P or Shared Risk 5: P4P Payment (performance determines amount of bonus)
CDC: HbA1c Poor Control (>9.0%)				
CDC: Eye Exam				
CDC: Hemoglobin A1c (HbA1c) testing				
CDC: Foot Exam				
CDC: Medical Attention for Nephropathy				
CDC: Blood Pressure Control (<140/80 mm Hg)				
Statin Therapy for Patients With Diabetes				
Optimal Cardiovascular Care - Composite				
Controlling High Blood Pressure				
Persistent Beta Blocker Treatment After a Heart Attack				

Ischemic Vascular Disease: Use of Aspirin or Another Antithrombotic				
Statin Therapy for Patients With Cardiovascular Disease				
Cervical Cancer Screening				
Breast Cancer Screening				
Colorectal Cancer Screening				
Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps-Avoidance of Inappropriate Use				
Preventive Care Screening: Tobacco Use: Screening and Cessation				
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up				
Screening Unhealthy Alcohol Use				
Tobacco Screening Use and Cessation Intervention				
Other Preventive Care measures				
Use of Imaging Studies for Low Back Pain				
Functional Status Change for Patients with Lumbar Impairments				

CG CAHPS (or Patient Assessment Survey)				
Depression Remission at 12 Months				
Depression Remission at 6 Months				
Antidepressant Medication Management				
Screening for Clinical Depression and Follow-Up Plan				
Medication Management for People with Asthma				
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis				
C-section rate				
Early elective deliveries or early inductions without medical indication				
Prenatal and Postpartum Care				
Appropriate Treatment for Children with Upper Respiratory Infection				
NCQA Recognition program certification (consistent with plan response in directory section) (E)				
Mortality or complication rates where applicable				
Efficiency (resource use not unit cost)				

Pharmacy management (e.g. generic use rate, formulary compliance)				
Medication Safety				
Health IT adoption/use				
Preventable Readmissions				
Preventable ED/ER Visits (NYU)				
Other Measures	500 words or attach list			

9.4.12.5 For the PPO, indicate if transparent information comparing physician (primary care and/or specialty) performance on quality using any of the following PQRS Measures and Measure Groups or other measures are available to providers or members. Check all that apply. Note that results must be available to compare across at least two entities. Plan level measurement is insufficient to meet the intent of this expectation. Measures may be used individually or in composite (aggregate performance on several diabetes measures) and may be assessed with the actual value or with a relative performance level (report actual rate or interpreted result on a scale such as 1-5 stars).

Please see https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html

Efficiency is defined as the cost and quantity of services (i.e., total resources used) for the episode of care. For additional information, see "Measuring Provider Efficiency Version 1.0" available at http://www.commonwealthfund.org/~/media/files/publications/other/2004/dec/measuring-provider-efficiency--version-1-0--a-collaborative-multi-stakeholder-effort/measurproviderefficiency1-12312004-pdf.pdf and "Advancing Physician Performance Measurement: Using Administrative Data to Assess Physician Quality and Efficiency" available at http://www.pbgh.org/storage/documents/reports/PBGHP3Report_09-01-05final.pdf

For preventable ED/ER visits, please see http://info.medinsight.milliman.com/bid/192744/Claims-Based-Analytics-to-Identify-Potentially-Avoidable-ER-Visits and http://wagner.nyu.edu/faculty/billings/nyued-background

PQRS Measure & Other Measures (same measure set as in 2.8.2)	Level of detail for comparative reporting of physicians who meet the threshold of reliability for reporting. (HMO)	Indicate if reporting covers primary care and/or specialty physicians (HMO)	Description of Other (if plan selected response option 6)	Indicate how measure is used
Optimal Diabetes Care Composite	*Multi, Checkboxes.* 1: Individual Physician 2: Practice Site 3: Medical Group/IPA/Staff model Group 4: PCMH 5: ACO 6: Other (describe) 7: None of the above	*Multi, Checkboxes.* 1: Primary care 2: Specialty	*50 words*	1: Public Reporting 2: Physician Feedback 3: Physician Feedback with Benchmarking 4: Threshold Element for P4P or Shared Risk 5: P4P Payment (performance determines amount of bonus)
CDC: HbA1c Poor Control (>9.0%)				
CDC: Eye Exam				
CDC: Hemoglobin A1c (HbA1c) testing				
CDC: Foot Exam				

CDC: Medical Attention for Nephropathy				
CDC: Blood Pressure Control (<140/80 mm Hg)				
Statin Therapy for Patients With Diabetes				
Optimal Cardiovascular Care - Composite				
Controlling High Blood Pressure				
Persistent Beta Blocker Treatment After a Heart Attack				
Ischemic Vascular Disease: Use of Aspirin or Another Antithrombotic				
Statin Therapy for Patients With Cardiovascular Disease				
Cervical Cancer Screening				
Breast Cancer Screening				
Colorectal Cancer Screening				
Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps-Avoidance of Inappropriate Use				

Preventive Care Screening: Tobacco Use: Screening and Cessation				
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up				
Screening Unhealthy Alcohol Use				
Tobacco Screening Use and Cessation Intervention				
Other Preventive Care measures				
Use of Imaging Studies for Low Back Pain				
Functional Status Change for Patients with Lumbar Impairments				
CG CAHPS (or Patient Assessment Survey)				
Depression Remission at 6 Months				
Antidepressant Medication Management				
Screening for Clinical Depression and Follow-Up Plan				
Medication Management for People with Asthma				

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis				
C-section rate				
Early elective deliveries or early inductions without medical indication				
Prenatal and Postpartum Care				
Appropriate Treatment for Children with Upper Respiratory Infection				
NCQA Recognition program certification (consistent with plan response in directory section)				
Mortality or complication rates where applicable				
Efficiency (resource use not unit cost)				
Pharmacy management (e.g. generic use rate, formulary compliance)				
Medication Safety				
Health IT adoption/use				
Preventable Readmissions				

Preventable ED/ER Visits (NYU)				

9.4.12.4 to 9.4.12.8 Purchasers are under significant pressure to address the dual goals of ensuring enrollees access to quality care and controlling health care costs. While it will take some time to develop, implement and evaluate new forms of payment and the corresponding operational systems, performance measurement, etc., there are immediate opportunities to improve value under the current payment systems. These opportunities might include strategies that better manage health care costs by aligning financial incentives to reduce waste and improve the quality and efficiency of care. Keeping in mind that financial incentives can be positive (e.g. bonus payment) or negative (e.g. reduced payment for failure of performance), the current fiscal environment makes it important to think about financial incentives that are not just cost plus, but instead help to bend the cost curve. Examples of these immediate strategies could include: non-payment for failure to perform/deliver outcomes, reduced payment for avoidable readmissions, narrow/tiered performance-based networks and reference pricing, among others.

For your California business, describe below any current payment approaches for physician (primary care and or specialty) outpatient services that align financial incentives with reducing waste and/or improving quality or efficiency.

If there is more than one payment reform program involving outpatient services, please provide descriptions in the following questions.

If Health plan does not have any programs, please provide information on any programs Health plan will implement within the next 6 months for California members.

In addition to being summarized for site visits, answers to this question will be also used to populate Catalyst for Payment Reform's (CPR) National Compendium on Payment Reform, which is an online, searchable, sortable catalogue of all payment reform initiatives across the country. The National Compendium on Payment Reform is a publicly available valuable resource for researchers, policymakers, journalists, plans and employers to highlight innovative Health plan or program entity programs. To view the live Compendium website, please see http://compendium.catalyzepaymentreform.org/

	Program 1	Other markets/details for Program 1	Column #

Name of Payment Reform Program	*65 words*	N/A	1
Contact Name for Payment Reform Program (person who can answer questions about the program being described)	*5 words*	N/A	2
Contact Person's Title	*(As above)*	*(As above)*	3
Contact Person's Email	*(As above)*	*(As above)*	4
Contact Person's Phone	*(As above)*	*(As above)*	5
Contact Name for person who is authorized to update this program entry in ProposalTech after Health plan has submitted response (if same as contact name for the payment reform program, please re-enter his/her name)	*(As above)*	*(As above)*	6
Email for person authorized to update this program entry in ProposalTech after Health plan has submitted response (if same as contact email for the payment reform program, please re-enter his/her email)	*(As above)*	*(As above)*	7
Geographic California region of named payment reform program	*Single, Radio group.* 1: Not in this market (Identify market in column to the right) 2: In this market and other markets (Identify market(s) in column to the right) 3: Only in this market	*Multi, List box.* 1: Alpine, Del Norte, Siskiyou, Modoc, Lassen, Shasta, Trinity, Humboldt, Tehama, Plumas, Nevada, Sierra, Mendocino, Lake, Butte, Glenn, Sutter, Yuba, Colusa, Amador, Calaveras, and Tuolumne 2: Napa, Sonoma, Solano, and Marin	8

		3: Sacramento, Placer, El Dorado, and Yolo 4: San Francisco 5: Contra Costa 6: Alameda 7: Santa Clara 8: San Mateo 9: Santa Cruz, Monterey, and San Benito 10: San Joaquin, Stanislaus, Merced, Mariposa, and Tulare 11: Madera, Fresno, and Kings 12: San Luis Obispo, Santa Barbara, and Ventura 13: Mono, Inyo, and Imperial 14: Kern 15: Los Angeles County ZIP Codes starting with 906 to 912, inclusive, 915, 917, 918, and 935 16: Los Angeles County ZIP Codes in other than those identified above 17: San Bernardino and Riverside 18: Orange 19: San Diego	

In 500 words or less, please provide a general description of the program, including its goals, how it represents an advance, and any high-level results to date (attachments permitted).	*500 words.*	N/A	9
Identify the line(s) of business for which this program is available?	*Multi, Checkboxes.* 1: Self-insured commercial 2: Fully-insured commercial 3: Medicare 4: Medicaid 5: Other – please describe in next column	*50 words*	10
Identify the product(s) for which this program is integrated	*Multi, Checkboxes.* 1: PPO, 2: POS, 3: EPO, 4: HMO, 5: HDHP, 6: Other (please describe in next column)	*50 words*	11
What is current stage of implementation. Provide date of implementation in detail column	*Single, Radio group.* 1: Planning mode 2: Pilot mode (e.g. only available for a subset of members and/or providers) 3: Expansion mode (e.g. passed initial pilot stage and broadening reach) 4: Full implementation (e.g. available to all intended/applicable providers and members)	*To the day*	12
	Single, Radio group. 1: Shared-risk (other than bundled payment) and/or gainsharing with quality	*Multi, List box with 50 words.* 1: Of payment models selected in previous	13

	2: FFS-based Shared-savings with quality 3: Non-FFS-based Shared-savings with quality 4: FFS plus pay for performance 5: Full capitation with quality 6: Partial or condition-specific capitation with quality 7: Bundled payment with quality 8: FFS-based non-visit functions 9: Non-FFS-based non-visit functions 10: Non-payment for specific services that were preventable or services that were unnecessary (detail in row below), 11: Other non-FFS based payment reform models (provide details in box below)	column, note dominant model in detail box in cell	
If you have a payment reform model that includes policies on non-payment for specific services associated with complications that	*Multi, Checkboxes.* 1: N/A 2: Ambulatory care sensitive admissions	*65 words*	14

were preventable or services that were unnecessary, for which outcomes are these policies in place?	3: Healthcare acquired conditions (HACs) also known as hospital-acquired conditions 4: Preventable Admissions 5: Serious Reportable Events (SREs) that are not HACs 6: Never Events 7: Early elective induction or cesarean 8: Other - (provide details in next column)		
Which base payment methodology does your program use?	*Single, Radio group.* 1: Capitation without quality 2: Salary, 3: Bundled or episode-based payment without quality 4: FFS (includes discounted fees, fixed fees, indexed fees) 5: Per diem 6: DRG 7: Percent of charges	*50 words*	15

	8: Other - (provide details in next column)		
What types of providers are participating in your program?	*Multi, Checkboxes.* 1: Primary care physicians 2: Physician Specialists (e.g., Oncology Cardiology, etc.) – describe in next column 3: RNs/NP and other non-physician providers 4: Hospital inpatient 5: Other - (provide details in next column)	*50 words*	16
What is process for providers to participate in program? Are there certain criteria? [edit]	*Multi, Checkboxes with 100 words.* 1: Any provider can opt-in - no criteria, 2: Provider must meet certain criteria (noted in detail box in cell), 3: Providers must be invited to join (provide details in next column) [edit]	*100 words.*	17
Which of the following sets of performance measures does your program use? Note most dominant approach in response option #17	*Multi, Checkboxes.* 1: Achievement (relative to target) of Clinical process goals (e.g., prophylactic antibiotic administration, timeliness of medication administration, testing, screenings) 2. Achievement compared to peers of Clinical process goals (e.g., prophylactic antibiotic administration, timeliness of medication administration, testing, screenings),	*50 words*	18

	3: Achievement relative to target of Clinical outcomes goals(e.g., readmission rate, mortality rate, A1c, cholesterol values under control) 4. Achievement compared to peers of Clinical outcomes goals(e.g., readmission rate, mortality rate, A1c, cholesterol values under control), 5: Improvement over time of NQF-endorsed Outcomes and/or Process measures 6: PATIENT SAFETY (e.g., Leapfrog, AHRQ, medication related safety issues) 7. Improvement based on set percent per year, 8: Appropriate maternity care 9: Longitudinal efficiency relative to target or peers 10: Application of specific medical home practices (e.g., intensive self-management support to patients, action Health plan development, arrangement for social support follow-up with a social worker or other community support personnel) 11: Patient experience 12: Health IT adoption or use 13: Financial results 14: Utilization results		

	15: Pharmacy management 16: Other - (provide details in next column) 17: Most Dominant measure used - [note in detail box in cell]		
Does the program have an attribution model for assigning patients to providers? If yes, please describe in second column [edit]	*Multi, Checkboxes.* 1: No, 2: Yes	*200 words.*	19
Indicate the type(s) of benefit and/or provider network design features that create member incentives or disincentives to support the payment reform program.	*Multi, Checkboxes.* 1: Mandatory use of Centers of Excellence (COE) or higher performing providers 2: Financial incentives (lower premium, waived/lower co-pays) for members to use COE/higher performance providers 3: Financial disincentives for members to use non-COE or lower performing providers (e.g., higher co-pays, etc.) 4: Use of tiered networks 5: Use of narrow networks, 6: Reference pricing, 7: High deductible health plans, 8: Value-based insurance design,	*50 words*	20

	9: Incentives to select lower cost sites of care (e.g. worksite clinic, retail clinic, telehealth, ambulatory surgery centers), 10: Preauthorization (e.g. "gatekeeper"), 11: Precertification (e.g. health plan approval), 12: Continued stay review, 13: Step therapy, 14: Objective information (e.g., performance measure results) provided on COEs to members, providing evidence of higher-quality care rendered by these providers 15: Other (please describe)		
For this payment reform program, do you make information transparent such as performance reports on quality, cost and/or efficiency measures at the provider level?	*Multi, Checkboxes.* 1: We report to the general public 2: We report to our network providers (e.g. hospitals and physicians) 3: We report to patients of our network providers 4: We do not report performance on quality measures 5: We report to state or community data collection processes such as all-payer claims databases (APCDs), or AF4Q sites 6: Other (please describe)	*50 words*	21

Describe evaluation and results for program	*Multi, Checkboxes.* 1: Program not evaluated yet 2: Program evaluation by external third party 3: Program evaluation by insurer 4: Evaluation method used pre/post 5: Evaluation method used matched control group 6: Evaluation method used randomized control trial 7: Other evaluation methodology was used (provide details in column to the right)	*100 words*	22
Does the program produce purchaser-specific cost and utilization reports on a regular basis? If yes, please attach a sample.Indicate if such reports would be specific to Covered California [edit]	*Yes/No.*		23
Do not include this information in the National Compendium on Payment Reform	*Multi, Checkboxes - optional.* 1: X		

9.4.12.4.1 Does the program incur additional administrative costs or require an investment in information systems infrastructure (e.g. EHRR, claims, care management, reporting systems) or personnel (e.g. care coordinators, pharmacists, etc.) on the part of:

	Response	If yes, are these one-time,	What is the PMPM increase in	How long is the estimated	What impact does the program have	What impact does the program

		upfront costs or recurring costs?	spending during the first year of the program? What about for subsequent years?	breakeven period for the health care purchaser to recoup these costs?	on administrative fees?	have on the purchaser's share of premium costs?
The Health Care Purchaser	*Single, Pull-down list.* 1: Yes, 2: No	*500 words.* Nothing required	*500 words.* Nothing required	*500 words.* Nothing required	*500 words.* Nothing required	*500 words.* Nothing required

9.4.12.4.2 Does the program incur additional administrative costs or require an investment in information systems infrastructure (e.g. EHR, claims, care management, reporting systems) or personnel (e.g. care coordinators, pharmacists, etc.) on the part of:

	Response	If yes, are these one-time, upfront costs or recurring costs?	What is the PMPM increase in spending during the first year of the program? What about for subsequent years?	How long is the estimated breakeven period for the health plan to recoup these costs?	Does the health plan pass on these costs to purchasers and/or providers?
The Health Plan	*Single, Pull-down list.* 1: Yes, 2: No	*500 words.* Nothing required	*500 words.* Nothing required	*500 words.* Nothing required	*500 words.* Nothing required

9.4.12.4.3 Does the program incur additional administrative costs or require an investment in information systems infrastructure (e.g. EHR, claims, care management, reporting systems) or personnel (e.g. care coordinators, pharmacists, etc.) on the part of:

	Response	If yes, are these one-time, upfront costs or recurring costs?	What is the PMPM increase in spending during the first year of the program? What about for subsequent years?	How long is the estimated breakeven period for the health care provider to recoup these costs?
The Health Care Provider	*Single, Pull-down list.* 1: Yes, 2: No	*500 words.* Nothing required	*500 words.* Nothing required	*500 words.* Nothing required

9.4.12.4.4 Please describe the tools, education and/or incentive, if any, that the purchaser must provide to consumers to support the program?

500 words.

9.4.12.4.5 What implementation challenges should the health care purchaser expect to encounter? Are these challenges associated with different stages of program implementation? Will some challenges persist even after implementation is complete? Please describe.

500 words.

9.4.12.4.6 Is the program aimed at health care providers who:

Single, Pull-down list.
1: Are already high performers on quality and cost (i.e. lower cost),
2: Need improvement on some or all cost and quality measures

9.4.12.4.7 If the program is aimed at high performers, please explain how it creates incentives for them to participate and maintain, or improve, their high levels of performance.

500 words.

9.4.12.4.8 If the program is aimed at low performers, please explain how it creates incentives for them to participate and improve their performance.

500 words.

9.4.12.4.9 Does the program sponsor or health plan make data on resource use (financial) and utilization available to health care providers? If yes, please provide a de-identified example.

Single, Radio group.
1: Yes, provide example: [500 words] ,
2: No

9.4.12.4.10 Does the sponsor or plan produce and share panel information with providers to ensure they can proactively manage the care of their attributed patients? If yes, please provide a de-identified example.

Single, Radio group.
1: Yes, provide example: [500 words] ,
2: No

9.4.12.4.11 What is the frequency with which the sponsor/plan generates and shares those data?

500 words.

9.4.12.4.12 How does the program ensure that participating providers have sufficient capacity to allow timely access to care for consumers?

500 words.

9.4.12.4.13 If capacity cannot be ensured, does the program have a way to ameliorate this issue?

500 words.

9.4.12.4.14 Can the program be replicated in other markets, settings, populations, etc.?

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

9.4.12.4.15 Please identify and describe any plans to do so.

500 words.

9.4.12.4.16 Can the program broaden the scope of clinical conditions that it addresses, or the number of health care providers or patients it includes? If so, please describe any plans to do so.

Single, Radio group.
1: Yes, please describe: [500 words] ,
2: No

9.4.12.4.17 Has the program been implemented elsewhere? If yes, what was the experience?

Single, Radio group.
1: Yes, please describe: [500 words] ,
2: No

9.4.12.4.18 What challenges occurred, and how will those be addressed in a new implementation?

500 words.

9.4.12.4.19 Which of the following ways does the program intend to reduce costs?

Multi, Checkboxes.
1: Reducing inappropriate utilization (shorter length of stay, fewer readmissions),
2: Reducing the resources required to deliver the same level of care (e.g. lower cost devices, nurses or physician assistants instead of physicians, etc.),
3: Increasing care coordination (e.g. high risk patient management, integration of primary care with pharmacy and behavioral health, etc.),
4: Non-payment or reduced payment to providers for specific procedures or medical events,
5: Increasing the share of costs paid for out-of-pocket by the consumer,
6: Using financial incentives or disincentives to encourage consumers to choose higher-value providers,
7: Changing the site of service for specific types of care (e.g. diagnostic imaging in outpatient setting rather than hospital),
8: Increasing use of primary care providers, as opposed to specialty care providers,
9: Addressing the non-health care needs of patients that impact the utilization of health care services (e.g. housing or transportation needs),
10: Other (please specify): [500 words]

9.4.12.4.20 What percentage of patient members and total health care expenditures does the program address?

500 words.

9.4.12.4.21 What is the total number of members affected by the program?

500 words.

9.4.12.4.22 If applicable, please describe the methodology the program uses to set health care spending targets.

500 words.

9.4.12.4.23 Please indicate how the baseline and the assumed annual rate of increase are calculated and indicate on what data these are based:

Single, Pull-down list.
1: Provider-specific historic claims,
2: Purchaser-specific historic claims,
3: National or regional or book of business benchmark trends,
4: Regulated spending trends

9.4.12.4.24 Are baseline costs, spending targets, and program outcomes calculated using severity adjusted data?

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

9.4.12.4.25 What methodology is used to calculate program savings that accrue to the health care purchaser?

500 words.

9.4.12.4.26 Please list for which clinical conditions or episodes of care the program makes bundled payments to providers and then respond to the questions below for each of the clinical conditions or episodes of care listed.

500 words.

9.4.12.4.27 What health care services related to the condition or episode of care are not covered by the bundled payment?

500 words.

9.4.12.4.28 Is the cost for complications, readmissions, or other such related services included?

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

9.4.12.4.29 Is there an expressed warranty period (e.g. 90 day period within which all complications are addressed)? If yes, please describe.

Single, Radio group.
1: Yes, please describe: [500 words] ,
2: No

9.4.12.4.30 Does the program pay providers prospectively or are they paid retrospectively?

Single, Pull-down list.
1: Prospectively,
2: Retrospectively

9.4.12.4.31 If the program reconciles the bundled payment retrospectively, please describe how the program pays providers during the course of care (e.g. FFS, capitation) and the reconciliation process.

500 words.

9.4.12.4.32 Is the bundled payment amount set below the estimated FFS cost for the same procedures/care?

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

9.4.12.4.33 Is the payment amount risk-adjusted?

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

9.4.12.4.34 Are all health care services offered in the program included in target spending amounts?

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

9.4.12.4.35 What proportion of providers' payment is at risk?

500 words.

9.4.12.4.36 What is the upside or downside potential?

500 words.

9.4.12.4.37 If there are financial losses in the program, are providers required to make a payment, or are losses carried forward to a future period?

500 words.

9.4.12.4.41 What percentage of providers participating in the program has access to accurate price information for the services of other providers to whom they refer patients?

9.4.12.4.42 Please specify which provider types (e.g. hospitals, specialists, primary care physicians, etc.) assume financial risk (if any) in the program.

Percent. *500 words.*

9.4.12.4.43 If applicable, what is the maximum amount an employer or other health care purchaser would have to pay if a provider exceeds the spending target?

500 words.

9.4.12.4.44 Does the program use full capitation, partial capitation (e.g. primary care capitation), or condition-specific capitation?

Single, Radio group.

1: Yes,
2: No

9.4.12.4.45 If partial or condition-specific, please describe what's covered and what's not covered by the payment.

500 words.

9.4.12.4.46 Does the program supplement the capitated payments with the potential for additional payments if quality targets are met? If yes, what is the range in size of these bonuses?

Single, Radio group.
1: Yes, please describe: [500 words] ,
2: No

9.4.12.4.47 Are purchasers asked to cover any of the costs associated with the bonus payments? If yes, for what percentage are they responsible?

Single, Radio group.
1: Yes: [Percent] ,
2: No

9.4.12.4.48 Is there a maximum dollar amount for which purchasers are responsible?

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

9.4.12.4.49 Does this program include incentives to reduce costs, along with incentives to improve the quality of care? If yes, please describe the incentives.

Single, Radio group.
1: Yes, please describe: [500 words] ,
2: No

9.4.12.4.50 Of the total amount paid to providers under pay for performance (base payment plus the bonus payment), what is the approximate percentage of the total payment represented by the bonus (performance) portion (last 12 month period for which data are available)?

500 words.

9.4.12.4.51 Which of the "cross-cutting" quality measures from CPR's Employer-Purchaser Priority Measure Set does the program use? Select all that apply.

Multi, Checkboxes.
1: CAHPS Clinical and Group Surveys (CG-CAHPS) - Adult, Child,
2: HCAHPS,
3: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-,
4: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents,
5: Preventive Care and Screening: Tobacco Use: Screening and Cessation Interventions,
6: Childhood Immunization Status,
7: Hospital-Wide All-Cause Unplanned Readmission Measure,
8: Documentation of Current Medications in the Medical Record,
9: Proportion of Patients with a Chronic Condition Who Have a Potentially Avoidable,

10: Complication During a Calendar Year,
11: Patient Safety for Selected Indicators (Composite)

9.4.12.4.52 If using CAHPS Clinical and Group Surveys, does your administration of the survey include questions regarding the patient's ease of getting an appointment with their provider at the time they sought care?

500 words.

9.4.12.4.53 Does the survey also include questions concerning the length of wait time between trying to get an appointment and actually seeing a provider for services?

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

9.4.12.4.54 Beyond the measures included in the CPR Employer-Purchaser Priority Measure Set, what condition-specific or cross-cutting quality measures does the program use?

500 words.

9.4.12.4.55 Under the program, is quality measurement required to determine provider payment? Or, is the payment approach designed to support quality improvement without being dependent on measurement? For example, a payment reform effort designed to reduce unnecessary cesarean deliveries could either measure the rate of cesarean deliveries and pay bonuses based on reductions, or it could create a single bundled payment for delivery regardless of mode (creating an incentive to reduce cesarean deliveries, which are more expensive, without requiring the results of quality measurement to determine the payment.) If no, please describe.

Single, Radio group.
1: Yes,
2: No, please describe: [500 words]

9.4.12.4.56 Does the program use quality measurement to check for any unidentified negative consequences (underutilization/overutilization) that could result from incentives inherent in the program's payment method?

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

9.4.12.4.57 If so, what quality measures does the program use to assess whether it may unintentionally lead to underuse of evidence-based services?

500 words.

9.4.12.4.58 If so, what quality measures does the program use to assess whether it may unintentionally lead to overuse, or inappropriate use of services?

500 words.

9.4.12.4.59 Is there a minimum quality threshold that providers must meet to participate in the program? If yes, please describe.

Single, Radio group.
1: Yes, please describe: [500 words] ,
2: No

9.4.12.4.60 Is there a minimum quality threshold that providers must meet to receive incentive payments or share in any savings that are generated? If yes, please describe.

Single, Radio group.
1: Yes, please describe: [500 words] ,
2: No

9.4.12.4.61 As part of the program, is information about performance on clinical quality measures made transparent and distributed internally to all providers in the provider group/hospital/health system? If yes, please provide an example.

Single, Radio group.
1: Yes, provide example: [500 words] ,
2: No

9.4.12.4.62 As part of the program, is information about performance on clinical quality measures made transparent and reported to those who use and pay for care (consumers, employers, and other health care purchasers)? If yes, please provide an example.

Single, Radio group.
1: Yes, provide example: [500 words] ,
2: No

9.4.12.4.63 What proportion of provider payments in this program is dependent on cost and/or quality performance (i.e. how big is the incentive portion of the payment in comparison to the total payment)?

500 words.

9.4.12.4.64 Does the program generate savings or incur additional costs?

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

9.4.12.4.65 If so, what is the percent change in spending and the actual dollar savings or additional spending per member per year? To what is the change attributed? By whom are the savings or costs incurred?

500 words.

9.4.12.4.66 What was the impact of the program on total health care spending:

	Response
In the last calendar year, or the most recent 12 month period for which data are available.	*500 words.*
Over the length of the entire program (please specify length).	*500 words.*
In comparison to book of business benchmarks or any other national, regional, or industry benchmarks (please specify).	*500 words.*

9.4.12.4.67 For any measures of efficiency (examples of important measurement areas below) for which there are data available, please specify:

Examples, Measures of Efficiency:

- Utilization of preventive services (e.g. HEDIS measure for well child visit in the first fifteen months of life)
- Utilization of specific services targeted by the program (e.g. visits for these services per 1,000 lives)
- Utilization of primary care services (e.g. outpatient primary care visits per 1,000)
- Utilization of diagnostic tests (e.g. HEDIS measures for various screenings)

- Utilization of emergency department services (e.g. emergency visits per 1,000 lives, percent of emergency visits that are not emergent, etc.)
- Hospital admissions, including ambulatory care-sensitive admissions (e.g. Standardized Hospital Ratio for Admissions; Admissions per 1,000 for defined populations)
- Preventable readmissions within 30 days of discharge (e.g. Risk-Adjusted 30-Day All-Cause Readmission Rate)
- Rate of preventable hospital-acquired conditions (e.g. Potentially Preventable Complications; Falls: Screening, Risk Assessment, and Plan of Care to Prevent Future Falls; Surgical Site Infection; Retained Surgical Item or Unretrieved Device Fragment Count)
- Average length of stay (e.g. Risk-Adjusted Average Length of Inpatient Hospital Stay; Inpatient days per 1,000; Bed occupancy rate; Severity-Standardized Average Length of Stay - Routine Care)
- Rate of hospital-level observation stays
- Pharmacy compliance, generic usage, formulary, etc. (e.g. the percentage of prescriptions for multisource drugs (generic drugs and brand name drugs that have a generic equivalent) that were dispensed as generics)
- Rate of use of inappropriate care (select a measure for reporting)

	Measure	Performance
The baseline performance at the start of the program.	*500 words.*	*500 words.*
Any change in performance in the last calendar year, or the most recent 12 month period for which data are available.	*500 words.*	*500 words.*
Any change in performance over the length of the entire program (please specify length).	*500 words.*	*500 words.*
How the program's performance compares to benchmarks, e.g. regional and national levels of performance, any other comparison group, or projected trend (for programs in place for 12 months or longer).	*500 words.*	*500 words.*

9.4.12.4.68 For programs that have been in place for 24 months or longer, has there been a change in the rate of consumers selecting higher-value providers for services?

500 words.

9.4.12.4.69 If so, what was the percent change in consumers' use of higher-value providers?

9.4.12.4.70 What proportion of program savings was due to this shift?

500 words.

Percent.

9.4.12.4.71 What proportion of program savings was due to reductions in prices agreed to by providers?

500 words.

9.4.12.4.72 For any quality measures the program uses to check for unintended negative consequences resulting from incentives created by the payment method and/or program (using answers to question 5 in Program Design: Quality), please specify:

	Response
The baseline performance at the start of the program.	*500 words.*
Any change in performance over the last calendar year, or the most recent 12 month period for which data are available.	*500 words.*
Any change in performance over the length of the entire program (please specify length).	*500 words.*
How the program's performance compares to regional and national levels of performance (benchmarks) or any other comparison group (for programs in place for 12 months or longer)?	*500 words.*

9.4.12.4.73 For all clinical quality measures the program uses, please specify:

	Response

The baseline performance at the start of the program.	*500 words.*
Any change in performance over the last calendar year, or the most recent 12 month period for which data are available.	*500 words.*
Any change in performance over the length of the entire program (please specify length).	*500 words.*
How the program's performance compares to regional and national levels of performance (benchmarks) or any other comparison group (for programs in place for 12 months or longer)?	*500 words.*
Please list the patient satisfaction/experience measures the program uses, and for each, please specify:	*500 words.*
The baseline performance at the start of the program.	*500 words.*
Any change in performance over the last calendar year, or the most recent 12 month period for which data are available.	*500 words.*
Any change in performance over the length of the entire program (please specify length).	*500 words.*
How the program's performance compares to regional and national levels of performance (benchmarks) or any other comparison group (for programs in place for 12 months or longer)?	*500 words.*

9.4.12.9 This question is used to help define the characteristics of the Payment Reform Environment of the CPR Scorecard (Note: Metrics below apply only to IN-NETWORK dollars paid for ALL commercial members) for all primary care and specialty OUTPATIENT SERVICES (i.e., services for which there is NO ASSOCIATED HOSPITAL CHARGE)

Please count OB-GYNs as specialty care physicians. Please refer to the attached definitions document.

NOTE: This question asks about total $ paid in the applicable **calendar year**. **If, due to timing of payment, sufficient information is not available to answer the questions based on the requested reporting period of the applicable calendar year. Plans may elect to report on the most recent 12 months with sufficient information and note time period in detail box below. If this election is made, ALL answers on CPR payment for the applicable calendar year should reflect the adjusted reporting period.**

- *Unless indicated otherwise, questions apply to Health plans' dollars paid for in-network, commercial California members, not including prescription drug costs.*

- *Commercial includes both self-funded and fully-insured business.*

HELPFUL TIPS: To determine the most appropriate payment category to which dollars from your payment reform program(s) should be allocated, please use the following steps:

1. *Determine if the base payment of the program is fee-for-service (FFS) or not. If it is NOT based on FFS, ensure that the program category you select has "non-FFS based" in the program category.*

2. *Determine if the payment for the program has a quality component or is tied to quality in some way (rather than just tied to efficiency). If the payment reform program does include a quality component, for example, please ensure that the program category you select has "with quality" in the program category.*

3. *Identify the **dominant** payment reform mechanism for a given payment reform program.*

4. *For programs that have hybrid qualities, review the list of definitions to decide which payment model best describes your program (e.g., if your program pays providers based upon thresholds*

for quality or cost, and also provides a PMPM to providers to facilitate care coordination, select the model through which most payment is made (in this case, pay-for-performance).

*NOTE: Health plan should report **ALL** dollars paid through contracts containing this type of payment program, not only the dollars paid out as an incentive.*

ALL OUTPATIENT SERVICES (i.e., services for which there is NO ASSOCIATED HOSPITAL CHARGE)	**ALL Providers for Outpatient Services** (i.e., services for which there is NO ASSOCIATED HOSPITAL CHARGE) **Total $ Paid in the applicable Calendar Year or most current 12 months (Estimate breakout of**	Primary Care physicians paid under listed payment category below *(Estimated Percentage of dollar amount listed in column 1 for each row)*	Specialists (including Ob-GYNs) paid under listed payment category below *(Estimated Percentage of dollar amount listed in column 1 for each row)*	Contracted entities (e.g., ACOs/PCMH/ Medical Groups/ IPAs) paid under listed payment category below *(Estimated Percentage of dollar amount listed in column 1 for each row)*	*This column activated only if there is % listed in column 4 (preceding column)* *Please select which contracted entities are paid*	Autocalculated percent based on responses in column 1. Denominator = total $ in row 1 column 1 Numerator = $ in specific row C1

	amount in this column into percentage by entity paid in next 3 columns)					
Total IN-NETWORK dollars paid for to Providers for ALL commercial members FOR ALL OUTPATIENT SERVICES (i.e., services for which there is NO ASSOCIATED HOSPITAL CHARGE)	*Dollars*	*Percent*	*Percent*	*Percent*	*Multi, Checkboxes* 1: ACO 2: PCMH 3: Medical Groups/IPAs	*For comparison.* Unknown Note: Percentages provided in this row do not total 100%
Provide the total dollars paid to providers through traditional FFS payments in the applicable calendar year or most recent 12 months	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Provide the total dollars paid to providers through bundled payment programs without quality components in the applicable calendar year or most recent 12 months	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Provide the total dollars paid to providers through partial or condition-specific capitation programs without quality components in the applicable calendar year or most recent 12 months	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Provide the total dollars paid to providers through fully capitated programs without quality in the	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*

applicable calendar year or most recent 12 months						
Subtotal: Dollars paid out under the status quo: total dollars paid through traditional payment methods in the applicable calendar year for primary care and specialty outpatient services (i.e., services for which there is NO ASSOCIATED HOSPITAL CHARGE) [Sum of Rows 2, 3 4 and 5]	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Provide the total dollars paid to providers through shared-risk programs with quality components in the applicable calendar year or most recent 12 months	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Provide the total dollars paid to providers through FFS-based shared-savings programs with quality components in the applicable calendar year or most recent 12 months	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Provide the total dollars paid to providers through non-FFS-based shared-savings programs with quality components in the applicable calendar year or most recent 12 months.	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Provide the total dollars paid to providers through FFS base payments plus pay-for-	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*

performance (P4P) programs in the applicable calendar year or most recent 12 months						
Provide the total dollars paid to providers through fully capitated payment with quality components in the applicable calendar year or most recent 12 months.	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Provide the total dollars paid to providers through partial or condition-specific capitation programs with quality components in the applicable calendar year or most recent 12 months	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Provide the total dollars paid to providers through bundled payment programs with quality components in the applicable calendar year or most recent 12 months	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Provide the total dollars paid for FFS-based non-visit functions. (see definitions for examples) in the applicable calendar year or most recent 12 months.	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Provide the total dollars paid for non-FFS-based non-visit functions. (see definitions for examples) in the applicable calendar year or most recent 12 months.	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*

Provide the total dollars paid to providers whose contract contains other types of performance-based incentive program not captured above ***and NOT based on FFS***	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Total dollars paid to payment reform programs based on FFS.	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Total dollars paid to payment reform programs NOT based on FFS.	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*

9.4.12.10 Based on your responses above, on an aggregate basis for the plan's book of business in the market of your response, indicate the relative weighting or allocation of the Plan's financial incentives for outpatient services (no associated hospital charges), and which payment approaches, if any, the Health plan is using currently to tie payment to performance. If the relative weighting varies by contract, describe the most prevalent allocation. The Plan's response should total 100.00% within each column. Enter 0.00% if incentives not used.

	Estimate of allocation of Incentive payments (see question above)	Product where incentive available	Type of Payment Approach	Description of other
Achievement (relative to target or peers) of Clinical process goals (e.g., prophylactic antibiotic administration, timeliness of	*Percent*	*Single, Pull-down list.* 1: HMO 2: PPO 3: Both HMO and PPO 4: Not available	*Multi, Checkboxes.* 1: Shared-risk (other than bundled payment) and/or gainsharing with quality 2: FFS-based Shared-savings with quality	*65 words*

medication administration, testing, screenings)			3: Non-FFS-based Shared-savings with quality 4: FFS plus pay for performance 5: Full capitation with quality 6: Partial or condition-specific capitation with quality 7: Bundled payment with quality 8: FFS-based non-visit functions 9: Non-FFS-based non-visit functions 10: Non-payment for specific services associated with healthcare acquired conditions (HACs) also known as hospital-acquired conditions that were preventable or services that were unnecessary 11: Other non-FFS based payment reform models (provide details in next column)	
Achievement (relative to target or peers) of Clinical outcomes goals(e.g., readmission rate, mortality rate, A1c, cholesterol values under control)	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Improvement over time of NQF-endorsed Outcomes and/or Process measures	*(As above)*	*(As above)*	*(As above)*	*(As above)*
PATIENT SAFETY (e.g., Leapfrog, AHRQ, medication related safety issues)	*(As above)*	*(As above)*	*(As above)*	*(As above)*

Appropriate Maternity Care (adhering to clinical guidelines which if followed, would reduce unnecessary elective interventions)	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Longitudinal efficiency relative to target or peers	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Application of specific medical home practices (e.g., intensive self-management support to patients, action Health plan development, arrangement for social support follow-up with a social worker or other community support personnel)	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Patient experience	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Health IT adoption or use	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Financial results	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Utilization results	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Pharmacy management	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Other	*(As above)*	*(As above)*	*(As above)*	*(As above)*
TOTAL	*(As above)*	*(As above)*	*(As above)*	*(As above)*

9.4.12.11 Please ESTIMATE the break out as percent for primary care SERVICES and specialty SERVICES irrespective of entity that received the payment. If a specialty physician was paid for primary care services, payment $ should be counted as primary care services.

Note that the first column is autopopulated from Health plan response above.

OUTPATIENT SERVICES	ALL Providers for Outpatient Services Total $ Paid in the applicable Calendar Year or most current 12 months (autopopulated)	Estimate of Percent of dollars paid FOR PRIMARY CARE OUTPATIENT SERVICES *Percent of dollar amount listed in column 1 for each row*	Estimate of Percent of dollars paid FOR SPECIALTY OUTPATIENT SERVICES *Percent of dollar amount listed in column 1 for each row*
Total IN-NETWORK dollars paid for to Providers for ALL commercial members FOR ALL OUTPATIENT SERVICES (i.e., services for which there is NO ASSOCIATED HOSPITAL CHARGE	0	*Percent* N/A OK	*Percent* N/A OK
Subtotal: Dollars paid out under the status quo: total dollars paid through traditional payment methods in the applicable calendar year for outpatient services	0	*(As above)*	*(As above)*
Total dollars paid to payment reform programs based on FFS.	0	*(As above)*	*(As above)*
Total dollars paid to payment reform programs NOT based on FFS.	0	*(As above)*	*(As above)*

9.4.12.12 If Health plan is measuring and reporting on physician performance, provide information in table below on network physicians that are being measured and reported on.

One approach to meeting the Consumer -Purchaser Alliance (formerly known as the Consumer-Purchaser Disclosure Project) "Patient Charter" for Physician Performance Measurement, Reporting and Tiering Programs (available at

http://healthcaredisclosure.org/docs/files/PatientCharter.pdf) is meeting the measurement criteria specified in the NCQA Physician and Hospital Quality Standards (available at http://www.ncqa.org).

Response for California business	Response	Auto-calculation
Total number of PCP physicians in network	*Decimal*	
Total number of PCP physicians in network for whom the measurement results meet credibility/reliability thresholds under standards that meet the Patient Charter (e.g., NCQA PHQ threshold of 30 episodes or .7 reliability)	*Decimal* N/A OK From 0 to 1000000000	*For comparison* 0.00%
Total $ value of claims paid to all PCP physicians in network	*Dollars*	
Total $ value of claims paid to those PCP physicians in network who meet the thresholds under standards that meet the Patient Charter (e.g., NCQA PHQ threshold of 30 episodes or .7 reliability)	*Dollars* N/A OK From 0 to 100000000000	*For comparison* 0.00%
Total number of Specialty physicians in network	*Decimal*	
Total number of Specialty physicians in network for whom the measurement results meet credibility/reliability thresholds under standards that meet the Patient Charter (e.g., NCQA PHQ threshold of 30 episodes or .7 reliability)	*Decimal* N/A OK From 0 to 100000000000	*For comparison* 0.00%
Total $ value of claims paid to all Specialty physicians in network	*Dollars*	
Total $ value of claims paid those Specialty physicians in network who meet the thresholds under standards that meet the Patient Charter (e.g., NCQA PHQ threshold of 30 episodes or .7 reliability)	*Dollars* N/A OK From 0 to 100000000000	*For comparison* 0.00%

9.4.12.13 The following questions are regarding current payment reform programs for HOSPITAL services that align financial incentives with reducing waste and/or improving quality or efficiency. How many programs will be described? (After saving, the remaining questions will become "N/A".)

Name: numhospitalincent
Single, Pull-down list.
1: 0,
2: 1,
3: 2,

4: 3,
5: 4,
6: 5

9.4.12.14 to 9.4.12.18 Purchasers are under significant pressure to address the dual goals of ensuring enrollees access to quality care and controlling health care costs. While it will take some time to develop, implement and evaluate new forms of payment and the corresponding operational systems, performance measurement, etc., there are immediate opportunities to improve value under the current payment systems.

These opportunities might include strategies that better manage health care costs by aligning financial incentives to reduce waste and improve the quality and efficiency of care. Keeping in mind that financial incentives can be positive (e.g. bonus payment) or negative (e.g. reduced payment for failure of performance), the current fiscal environment makes it important to think about financial incentives that are not just cost plus, but instead help to bend the cost curve. Examples of these immediate strategies could include: non-payment for failure to perform/deliver outcomes, reduced payment for avoidable readmissions, narrow/tiered performance-based networks and reference pricing, among others.

Describe below any current payment approaches for **HOSPITAL services** that align financial incentives with reducing waste and/or improving quality or efficiency. ***Please refer to the attached definitions document***.

If there is more than one payment reform program involving outpatient services, please provide description(s) in the additional four questions that follow.

If Health plan does not have any programs in market of response, please provide information on a program in the closest market to the market of response, and also provide information on any programs the Health plan will implement in market of response within the next 6 months.

Answers to this question will be also used to populate Catalyst for Payment Reform's (CPR) National Compendium on Payment Reform, which is an online, searchable, sortable catalogue of all payment reform initiatives across the country. The National Compendium on Payment Reform is a publicly available valuable resource for researchers, policymakers, journalists, plans and employers to highlight innovative Health plan or program entity programs. To view the live Compendium website, please see: http://compendium.catalyzepaymentreform.org/

	Program 1	Other markets/details for Program 1	Column #
Name of Payment Reform Program and Name and contact details (email and phone) of contact person who can answer questions about program being described	*65 words*	N/A	1
Contact Name for Payment Reform Program (person who can answer questions about the program being described)	*5 words*	N/A	2
Contact Person's Title	*(As above)*	*(As above)*	3
Contact Person's Email	*(As above)*	*(As above)*	4
Contact Person's Phone	*(As above)*	*(As above)*	5
Contact Name for person who is authorized to update this program entry in ProposalTech after Health plan has submitted response (if same as contact name for the payment reform program, please re-enter his/her name)	*(As above)*	*(As above)*	6
Email for person authorized to update this program entry in ProposalTech after Health plan has submitted response (if same as contact email for the payment	*(As above)*	*(As above)*	7

reform program, please re-enter his/her email)			
Geographic California region of named payment reform program	*Single, Radio group.* 1: Not in this market (Identify market in column to the right) 2: In this market and other markets (Identify market(s) in column to the right) 3: Only in this market	*Multi, List box.* 1: Alpine, Del Norte, Siskiyou, Modoc, Lassen, Shasta, Trinity, Humboldt, Tehama, Plumas, Nevada, Sierra, Mendocino, Lake, Butte, Glenn, Sutter, Yuba, Colusa, Amador, Calaveras, and Tuolumne 2: Napa, Sonoma, Solano, and Marin 3: Sacramento, Placer, El Dorado, and Yolo 4: San Francisco 5: Contra Costa 6: Alameda 7: Santa Clara 8: San Mateo 9: Santa Cruz, Monterey, and San Benito 10: San Joaquin, Stanislaus, Merced, Mariposa, and Tulare 11: Madera, Fresno, and Kings 12: San Luis Obispo, Santa Barbara, and Ventura 13: Mono, Inyo, and Imperial 14: Kern 15: Los Angeles County ZIP Codes starting with 906 to 912, inclusive, 915, 917, 918, and 935	8

		16: Los Angeles County ZIP Codes in other than those identified above 17: San Bernardino and Riverside, 8: Orange 19: San Diego	
In 500 words or less, please provide a general description of the program, including its goals, how it represents an advance, and any high-level results to date (attachments permitted).	*500 words*	N/A	9
Identify the line(s) of business for which this program is available?	*Multi, Checkboxes.* 1: Self-insured commercial, 2: Fully-insured commercial, 3: Medicare, 4: Medicaid, 5: Other – please describe in next column	*50 words*	10
Identify the product(s) for which this program is integrated	*Multi, Checkboxes.* 1: PPO, 2: POS, 3: EPO, 4: HMO, 5: HDHP, 6: Other (please describe in next column)	*50 words*	11
What is current stage of implementation? Provide date of implementation in detail column	*Single, Radio group.* 1: Planning mode 2: Pilot mode (e.g. only available for a subset of members and/or providers) 3: Expansion mode (e.g. passed initial pilot stage and broadening reach)	*To the day*	12

	4: Full implementation (e.g. available to all intended/applicable providers and members)		
Which alternative payment model(s) most accurately describe(s) the payment reform program? Check all that apply. Note most dominant in next column. .	*Single, Radio group.* 1: Shared-risk (other than bundled payment) and/or gainsharing with quality 2: FFS-based Shared-savings with quality 3: Non-FFS-based Shared-savings with quality 4: FFS plus pay for performance 5: Full capitation with quality 6: Partial or condition-specific capitation with quality 7: Bundled payment with quality 8: FFS-based non-visit functions 9: Non-FFS-based non-visit functions 10: Non-payment for specific services that were preventable or services that were unnecessary (detail in row below), 11: Other non-FFS based payment reform models (provide details in box below)	*Multi, List box with 50 words.* 1: Of payment models selected in previous column, note dominant model in detail box in cell	13
If you have a payment reform model that includes policies on non-payment for specific services associated with complications that were preventable or services that were unnecessary, for which outcomes are these policies in place?	*Multi, Checkboxes.* 1: N/A 2: Ambulatory care sensitive admissions 3: Healthcare acquired conditions (HACs) also known as hospital-acquired conditions 4: Preventable Admissions	*65 words*	14

	5: Serious Reportable Events (SREs) that are not HACs 6: Never Events 7: Early elective induction or cesarean 8: Other - (provide details in next column)		
Which base payment methodology does your program use?	*Single, Radio group.* 1: Capitation without quality 2: Salary 3: Bundled or episode-based payment without quality 4: FFS (includes discounted fees, fixed fees, indexed fees) 5: Per diem 6: DRG 7: Percent of charges 8: Other - (provide details in next column)	*50 words*	15
What types of providers are participating in your program?	*Multi, Checkboxes.* 1: Primary care physicians 2: Physician Specialists (e.g., Oncology, Cardiology, etc.) – describe in next column 3: RNs/NP and other non-physician providers 4: Hospital inpatient	*50 words*	

	5: Other - (provide details in next column)		
What is process for providers to participate in program? Are there certain criteria? [edit]	*Multi, Checkboxes with 100 words.* 1: Any provider can opt-in - no criteria, 2: Provider must meet certain criteria (noted in detail box in cell), 3: Providers must be invited to join (provide details in next column) [edit]	*100 words.*	17
Which of the following sets of performance measures does your program use? Note most dominant approach in response option #17	*Multi, Checkboxes.* 1: Achievement (relative to target or peers) of Clinical process goals (e.g., prophylactic antibiotic administration, timeliness of medication administration, testing, screenings) 2. Achievement compared to peers of Clinical process goals (e.g., prophylactic antibiotic administration, timeliness of medication administration, testing, screenings), 3: Achievement (relative to target or peers) of Clinical outcomes goals(e.g., readmission rate, mortality rate, A1c, cholesterol values under control) 4. Achievement compared to peers of Clinical outcomes goals(e.g., readmission rate, mortality rate, A1c, cholesterol values under control), 5: Improvement over time of NQF-endorsed Outcomes and/or Process measures 6: PATIENT SAFETY (e.g., Leapfrog, AHRQ, medication related safety issues)	*50 words*	18

	7. Improvement based on set percent per year, 8: Appropriate maternity care 9: Longitudinal efficiency relative to target or peers 10: Application of specific medical home practices (e.g., intensive self-management support to patients, action plan development, arrangement for social support follow-up with a social worker or other community support personnel) 11: Patient experience 12: Health IT adoption or use 13: Financial results 14: Utilization results 15: Pharmacy management 16: Other - (provide details in next column) 17: Most Dominant measure used - [note in detail box in cell]		
Does the program have an attribution model for assigning patients to providers? If yes, please describe in second column [edit]	*Multi, Checkboxes.* 1: No, 2: Yes	*200 words.*	19
Indicate the type(s) of benefit and/or provider network design features that create member incentives or disincentives to	*Multi, Checkboxes.* 1: Mandatory use of Centers of Excellence (COE) or higher performing providers	*50 words*	20

support the payment reform program.	2: Financial incentives (lower premium, waived/lower co-pays) for members to use COE/higher performance providers 3: Financial disincentives for members to use non-COE or lower performing providers (e.g., higher co-pays, etc.) 4: Use of tiered networks 5: Use of narrow networks 6. Reference pricing, 7: High deductible health plans, 8: Value-based insurance design, 9: Incentives to select lower cost sites of care (e.g. worksite clinic, retail clinic, telehealth, ambulatory surgery centers), 10: Preauthorization (e.g. "gatekeeper"), 11: Precertification (e.g. health plan approval), 12: Continued stay review, 13: Step therapy, 14: Objective information (e.g., performance measure results) provided on COEs to members, providing evidence of higher-quality care rendered by these providers 15: Other (please describe)		
For this payment reform program, do you make information transparent such as performance reports on quality, cost and/or	*Multi, Checkboxes.* 1: We report to the general public	*50 words*	21

efficiency measures at the provider level?	2: We report to our network providers (e.g. hospitals and physicians) 3: We report to patients of our network providers 4: We do not report performance on quality measures 5: We report to state or community data collection processes such as all-payer claims databases (APCDs), or AF4Q sites 6: Other (please describe)		
Describe evaluation and results for program	*Multi, Checkboxes.* 1: Program not evaluated yet 2: Program evaluation by external third party 3: Program evaluation by insurer 4: Evaluation method used pre/post 5: Evaluation method used matched control group 6: Evaluation method used randomized control trial 7: Other evaluation methodology was used (provide details in column to the right)	*100 words*	22
Does the program produce purchaser-specific cost and utilization reports on a regular basis? If yes, please attach a sample. Indicate if such reports	*Yes/No.*		23

would be specific to Covered California [edit]			
Do not include this information in the National Compendium on Payment Reform	*Multi, Checkboxes - optional.* 1: X		

9.4.12.14.1 Does the program incur additional administrative costs or require an investment in information systems infrastructure (e.g. EHRR, claims, care management, reporting systems) or personnel (e.g. care coordinators, pharmacists, etc.) on the part of:

	Response	If yes, are these one-time, upfront costs or recurring costs?	What is the PMPM increase in spending during the first year of the program? What about for subsequent years?	How long is the estimated breakeven period for the health care purchaser to recoup these costs?	What impact does the program have on administrative fees?	What impact does the program have on the purchaser's share of premium costs?
The Health Care Purchaser	*Single, Pull-down list.* 1: Yes, 2: No	*500 words.* Nothing required	*500 words.* Nothing required	*500 words.* Nothing required	*500 words.* Nothing required	*500 words.* Nothing required

9.4.12.14.2 Does the program incur additional administrative costs or require an investment in information systems infrastructure (e.g. EHRR, claims, care management, reporting systems) or personnel (e.g. care coordinators, pharmacists, etc.) on the part of:

	Response	If yes, are these one-time, upfront	What is the PMPM increase in spending during the first year of	How long is the estimated breakeven period	Does the health plan pass on these costs to

		costs or recurring costs?	the program? What about for subsequent years?	for the health plan to recoup these costs?	purchasers and/or providers?
The Health Plan	*Single, Pull-down list.* 1: Yes, 2: No	*500 words.* Nothing required	*500 words.* Nothing required	*500 words.* Nothing required	*500 words.* Nothing required

9.4.12.14.3 Does the program incur additional administrative costs or require an investment in information systems infrastructure (e.g. EHRR, claims, care management, reporting systems) or personnel (e.g. care coordinators, pharmacists, etc.) on the part of:

	Response	If yes, are these one-time, upfront costs or recurring costs?	What is the PMPM increase in spending during the first year of the program? What about for subsequent years?	How long is the estimated breakeven period for the health care provider to recoup these costs?
The Health Care Provider	*Single, Pull-down list.* 1: Yes, 2: No	*500 words.* Nothing required	*500 words.* Nothing required	*500 words.* Nothing required

9.4.12.14.4 Please describe the tools, education and/or incentive, if any, that the purchaser must provide to consumers to support the program?

500 words.

9.4.12.14.5 What implementation challenges should the health care purchaser expect to encounter? Are these challenges associated with different stages of program implementation? Will some challenges persist even after implementation is complete? Please describe.

500 words.

9.4.12.14.6 Is the program aimed at health care providers who:

Single, Pull-down list.
1: Are already high performers on quality and cost (i.e. lower cost),
2: Need improvement on some or all cost and quality measures

9.4.12.14.7 If the program is aimed at high performers, please explain how it creates incentives for them to participate and maintain, or improve, their high levels of performance.

500 words.

9.4.12.14.8 If the program is aimed at low performers, please explain how it creates incentives for them to participate and improve their performance.

500 words.

9.4.12.14.9 Does the program sponsor or health plan make data on resource use (financial) and utilization available to health care providers? If yes, please provide a de-identified example.

Single, Radio group.
1: Yes, provide example: [500 words] ,
2: No

9.4.12.14.10 Does the sponsor or plan produce and share panel information with providers to ensure they can proactively manage the care of their attributed patients? If yes, please provide a de-identified example.

Single, Radio group.
1: Yes, provide example: [500 words] ,
2: No

9.4.12.14.11 What is the frequency with which the sponsor/plan generates and shares those data?

500 words.

9.4.12.14.12 How does the program ensure that participating providers have sufficient capacity to allow timely access to care for consumers?

500 words.

9.4.12.14.13 If capacity cannot be ensured, does the program have a way to ameliorate this issue?

500 words.

9.4.12.14.14 Can the program be replicated in other markets, settings, populations, etc.?

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

9.4.12.14.15 Please identify and describe any plans to do so.

500 words.

9.4.12.14.16 Can the program broaden the scope of clinical conditions that it addresses, or the number of health care providers or patients it includes? If so, please describe any plans to do so.

Single, Radio group.
1: Yes, please describe: [500 words] ,
2: No

9.4.12.14.17 Has the program been implemented elsewhere? If yes, what was the experience?

Single, Radio group.
1: Yes, please describe: [500 words] ,
2: No

9.4.12.14.18 What challenges occurred, and how will those be addressed in a new implementation?

500 words.

9.4.12.14.19 Which of the following ways does the program intend to reduce costs?

Multi, Checkboxes.
1: Reducing inappropriate utilization (shorter length of stay, fewer readmissions),
2: Reducing the resources required to deliver the same level of care (e.g. lower cost devices, nurses or physician assistants instead of physicians, etc.),
3: Increasing care coordination (e.g. high risk patient management, integration of primary care with pharmacy and

behavioral health, etc.),
4: Non-payment or reduced payment to providers for specific procedures or medical events,
5: Increasing the share of costs paid for out-of-pocket by the consumer,
6: Using financial incentives or disincentives to encourage consumers to choose higher-value providers,
7: Changing the site of service for specific types of care (e.g. diagnostic imaging in outpatient setting rather than hospital),
8: Increasing use of primary care providers, as opposed to specialty care providers,
9: Addressing the non-health care needs of patients that impact the utilization of health care services (e.g. housing or transportation needs),
10: Other (please specify): [500 words]

9.4.12.14.20 What percentage of patient members and total health care expenditures does the program address?

500 words.

9.4.12.14.21 What is the total number of members affected by the program?

500 words.

9.4.12.14.22 If applicable, please describe the methodology the program uses to set health care spending targets.

500 words.

9.4.12.14.23 Please indicate how the baseline and the assumed annual rate of increase are calculated and indicate on what data these are based:

Single, Pull-down list.
1: Provider-specific historic claims,
2: Purchaser-specific historic claims,
3: National or regional or book of business benchmark trends,
4: Regulated spending trends

9.4.12.14.24 Are baseline costs, spending targets, and program outcomes calculated using severity adjusted data?

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

9.4.12.14.25 What methodology is used to calculate program savings that accrue to the health care purchaser?

500 words.

9.4.12.14.26 Please list for which clinical conditions or episodes of care the program makes bundled payments to providers and then respond to the questions below for each of the clinical conditions or episodes of care listed.

500 words.

9.4.12.14.27 What health care services related to the condition or episode of care are not covered by the bundled payment?

500 words.

9.4.12.14.28 Is the cost for complications, readmissions, or other such related services included?

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

9.4.12.14.29 Is there an expressed warranty period (e.g. 90 day period within which all complications are addressed)? If yes, please describe.

Single, Radio group.
1: Yes, please describe: [500 words] ,
2: No

9.4.12.14.30 Does the program pay providers prospectively or are they paid retrospectively?

Single, Pull-down list.
1: Prospectively,
2: Retrospectively

9.4.12.14.31 If the program reconciles the bundled payment retrospectively, please describe how the program pays providers during the course of care (e.g. FFS, capitation) and the reconciliation process.

500 words.

9.4.12.14.32 Is the bundled payment amount set below the estimated FFS cost for the same procedures/care?

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

9.4.12.14.33 Is the payment amount risk-adjusted?

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

9.4.12.14.34 Are all health care services offered in the program included in target spending amounts?

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

9.4.12.14.35 What proportion of providers' payment is at risk?

500 words.

9.4.12.14.36 What is the upside or downside potential?

500 words.

9.4.12.14.37 If there are financial losses in the program, are providers required to make a payment, or are losses carried forward to a future period?

500 words.

9.4.12.14.38 Do providers need to reach both cost and quality targets to share in savings?

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

9.4.12.14.39 Is there an initial, start-up period of the program where providers do not share in savings or risk? If yes, please indicate the timeframe.

Single, Radio group.
1: Yes, indicate time frame: [500 words] ,
2: No

9.4.12.14.40 Are claims paid based on the existing FFS fee schedule or are there deeper discounts for the program?

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

9.4.12.14.41 What percentage of providers participating in the program has access to accurate price information for the services of other providers to whom they refer patients?

9.4.12.14.42 Please specify which provider types (e.g. hospitals, specialists, primary care physicians, etc.) assume financial risk (if any) in the program.

Percent. *500 words.*

9.4.12.14.43 If applicable, what is the maximum amount an employer or other health care purchaser would have to pay if a provider exceeds the spending target?

500 words.

9.4.12.14.44 Does the program use full capitation, partial capitation (e.g. primary care capitation), or condition-specific capitation?

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

9.4.12.14.45 If partial or condition-specific, please describe what's covered and what's not covered by the payment.

500 words.

9.4.12.14.46 Does the program supplement the capitated payments with the potential for additional payments if quality targets are met? If yes, what is the range in size of these bonuses?

Single, Radio group.
1: Yes, please describe: [500 words] ,
2: No

9.4.12.14.47 Are purchasers asked to cover any of the costs associated with the bonus payments? If yes, for what percentage are they responsible?

Single, Radio group.
1: Yes: [Percent] ,
2: No

9.4.12.14.48 Is there a maximum dollar amount for which purchasers are responsible?

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

9.4.12.14.49 Does this program include incentives to reduce costs, along with incentives to improve the quality of care? If yes, please describe the incentives.

Single, Radio group.
1: Yes, please describe: [500 words] ,
2: No

9.4.12.14.50 Of the total amount paid to providers under pay for performance (base payment plus the bonus payment), what is the approximate percentage of the total payment represented by the bonus (performance) portion (last 12 month period for which data are available)?

500 words.

9.4.12.14.51 Which of the "cross-cutting" quality measures from CPR's Employer-Purchaser Priority Measure Set does the program use? Select all that apply.

Multi, Checkboxes.
1: CAHPS Clinical and Group Surveys (CG-CAHPS) - Adult, Child,
2: HCAHPS,
3: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-,
4: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents,
5: Preventive Care and Screening: Tobacco Use: Screening and Cessation Interventions,
6: Childhood Immunization Status,
7: Hospital-Wide All-Cause Unplanned Readmission Measure,
8: Documentation of Current Medications in the Medical Record,
9: Proportion of Patients with a Chronic Condition Who Have a Potentially Avoidable,
10: Complication During a Calendar Year,
11: Patient Safety for Selected Indicators (Composite)

9.4.12.14.52 If using CAHPS Clinical and Group Surveys, does your administration of the survey include questions regarding the patient's ease of getting an appointment with their provider at the time they sought care?

500 words.

9.4.12.14.53 Does the survey also include questions concerning the length of wait time between trying to get an appointment and actually seeing a provider for services?

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

9.4.12.14.54 Beyond the measures included in the CPR Employer-Purchaser Priority Measure Set, what condition-specific or cross-cutting quality measures does the program use?

500 words.

9.4.12.14.55 Under the program, is quality measurement required to determine provider payment? Or, is the payment approach designed to support quality improvement without being dependent on measurement? For example, a payment reform effort designed to reduce unnecessary cesarean deliveries could either measure the rate of cesarean deliveries and pay bonuses based on reductions, or it could create a single bundled payment for delivery regardless of mode (creating an incentive to reduce cesarean deliveries, which are more expensive, without requiring the results of quality measurement to determine the payment.) If no, please describe.

Single, Radio group.
1: Yes,
2: No, please describe: [500 words]

9.4.12.14.56 Does the program use quality measurement to check for any unidentified negative consequences (underutilization/overutilization) that could result from incentives inherent in the program's payment method?

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

9.4.12.14.57 If so, what quality measures does the program use to assess whether it may unintentionally lead to underuse of evidence-based services?

500 words.

9.4.12.14.58 If so, what quality measures does the program use to assess whether it may unintentionally lead to overuse, or inappropriate use of services?

500 words.

9.4.12.14.59 Is there a minimum quality threshold that providers must meet to participate in the program? If yes, please describe.

Single, Radio group.
1: Yes, please describe: [500 words] ,
2: No

9.4.12.14.60 Is there a minimum quality threshold that providers must meet to receive incentive payments or share in any savings that are generated? If yes, please describe.

Single, Radio group.
1: Yes, please describe: [500 words] ,
2: No

9.4.12.14.61 As part of the program, is information about performance on clinical quality measures made transparent and distributed internally to all providers in the provider group/hospital/health system? If yes, please provide an example.

Single, Radio group.
1: Yes, provide example: [500 words] ,
2: No

9.4.12.14.62 As part of the program, is information about performance on clinical quality measures made transparent and reported to those who use and pay for care (consumers, employers, and other health care purchasers)? If yes, please provide an example.

Single, Radio group.
1: Yes, provide example: [500 words] ,
2: No

9.4.12.14.63 What proportion of provider payments in this program is dependent on cost and/or quality performance (i.e. how big is the incentive portion of the payment in comparison to the total payment)?

500 words.

9.4.12.14.64 Does the program generate savings or incur additional costs?

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

9.4.12.14.65 If so, what is the percent change in spending and the actual dollar savings or additional spending per member per year? To what is the change attributed? By whom are the savings or costs incurred?

500 words.

9.4.12.14.66 What was the impact of the program on total health care spending:

	Response
In the last calendar year, or the most recent 12 month period for which data are available.	*500 words.*
Over the length of the entire program (please specify length).	*500 words.*
In comparison to book of business benchmarks or any other national, regional, or industry benchmarks (please specify).	*500 words.*

9.4.12.14.67 For any measures of efficiency (examples of important measurement areas below) for which there are data available, please specify:

Examples, Measures of Efficiency:

- Utilization of preventive services (e.g. HEDIS measure for well child visit in the first fifteen months of life)
- Utilization of specific services targeted by the program (e.g. visits for these services per 1,000 lives)
- Utilization of primary care services (e.g. outpatient primary care visits per 1,000)
- Utilization of diagnostic tests (e.g. HEDIS measures for various screenings)
- Utilization of emergency department services (e.g. emergency visits per 1,000 lives, percent of emergency visits that are not emergent, etc.)
- Hospital admissions, including ambulatory care-sensitive admissions (e.g. Standardized Hospital Ratio for Admissions; Admissions per 1,000 for defined populations)
- Preventable readmissions within 30 days of discharge (e.g. Risk-Adjusted 30-Day All-Cause Readmission Rate)
- Rate of preventable hospital-acquired conditions (e.g. Potentially Preventable Complications; Falls: Screening, Risk Assessment, and Plan of Care to Prevent Future Falls; Surgical Site Infection; Retained Surgical Item or Unretrieved Device Fragment Count)

- Average length of stay (e.g. Risk-Adjusted Average Length of Inpatient Hospital Stay; Inpatient days per 1,000; Bed occupancy rate; Severity-Standardized Average Length of Stay - Routine Care)
- Rate of hospital-level observation stays
- Pharmacy compliance, generic usage, formulary, etc. (e.g. the percentage of prescriptions for multisource drugs (generic drugs and brand name drugs that have a generic equivalent) that were dispensed as generics)
- Rate of use of inappropriate care (select a measure for reporting)

	Measure	Performance
The baseline performance at the start of the program.	*500 words.*	*500 words.*
Any change in performance in the last calendar year, or the most recent 12 month period for which data are available.	*500 words.*	*500 words.*
Any change in performance over the length of the entire program (please specify length).	*500 words.*	*500 words.*
How the program's performance compares to benchmarks, e.g. regional and national levels of performance, any other comparison group, or projected trend (for programs in place for 12 months or longer).	*500 words.*	*500 words.*

9.4.12.14.68 For programs that have been in place for 24 months or longer, has there been a change in the rate of consumers selecting higher-value providers for services?

500 words.

9.4.12.14.69 If so, what was the percent change in consumers' use of higher-value providers?

9.4.12.14.70 What proportion of program savings was due to this shift?

500 words.

Percent.

9.4.12.14.71 What proportion of program savings was due to reductions in prices agreed to by providers?

500 words.

9.4.12.14.72 For any quality measures the program uses to check for unintended negative consequences resulting from incentives created by the payment method and/or program (using answers to question 5 in Program Design: Quality), please specify:

	Response
The baseline performance at the start of the program.	*500 words.*
Any change in performance over the last calendar year, or the most recent 12 month period for which data are available.	*500 words.*
Any change in performance over the length of the entire program (please specify length).	*500 words.*
How the program's performance compares to regional and national levels of performance (benchmarks) or any other comparison group (for programs in place for 12 months or longer)?	*500 words.*

9.4.12.14.73 For all clinical quality measures the program uses, please specify:

	Response
The baseline performance at the start of the program.	*500 words.*
Any change in performance over the last calendar year, or the most recent 12 month period for which data are available.	*500 words.*

Any change in performance over the length of the entire program (please specify length).	*500 words.*
How the program's performance compares to regional and national levels of performance (benchmarks) or any other comparison group (for programs in place for 12 months or longer)?	*500 words.*
Please list the patient satisfaction/experience measures the program uses, and for each, please specify:	*500 words.*
The baseline performance at the start of the program.	*500 words.*
Any change in performance over the last calendar year, or the most recent 12 month period for which data are available.	*500 words.*
Any change in performance over the length of the entire program (please specify length).	*500 words.*
How the program's performance compares to regional and national levels of performance (benchmarks) or any other comparison group (for programs in place for 12 months or longer)?	*500 words.*

9.4.12.19 This question is used to help define the characteristics of the Payment Reform Environment of the CPR Scorecard. Note: Metrics below apply only to IN-NETWORK dollars paid for ALL commercial members for HOSPITAL SERVICES*.*

Please refer to the attached definitions document.

NOTE: This question asks about total $ paid in the applicable **calendar year**. **If, due to timing of payment, sufficient information is not available to answer the questions based on the requested reporting period of the applicable calendar year, Health plan may elect to report on the most recent 12 months with sufficient information and note time period in detail box below. If this election is made, ALL answers on CPR payment for the applicable calendar year should reflect the adjusted reporting period.**

- *Unless indicated otherwise, questions apply to Health plans' dollars paid for in-network, commercial California members, not including prescription drug costs.*

- *Commercial includes both self-funded and fully-insured business.*

HELPFUL TIPS: To determine the most appropriate payment category to which dollars from your payment reform program(s) should be allocated, please use the following steps:

1. *Determine if the base payment of the program is fee-for-service (FFS) or not. If it is NOT based on FFS, ensure that the program category you select has "non-FFS based" in the program category.*

2. *Determine if the payment for the program has a quality component or is tied to quality in some way (rather than just tied to efficiency). If the payment reform program does include a quality component, for example, please ensure that the program category you select has "with quality" in the program category.*

3. *Identify the **dominant** payment reform mechanism for a given payment reform program.*

4. *For programs that have hybrid qualities, review the list of definitions to decide which payment model best describes your program (e.g., if your program pays providers based upon thresholds for quality or cost, and also provides a PMPM to providers to facilitate care coordination, select the model through which most payment is made (in this case, pay-for-performance).*

5. *For DRGs, case rates, and per diem payments please consider those as traditional FFS payments.*

NOTE: Health plan should report ALL dollars paid through contracts containing this type of payment program, not only the dollars paid out as an incentive.

HOSPITAL SERVICES	ALL Providers for HOSPITAL Services **Total $ Paid in the applicable Calendar Year or most current 12 months Estimate breakout of amount in this column into percentage by contracted entity paid in next 2 columns**	HOSPITALS paid under listed payment category below *Estimated Percentage of dollar amount listed in column 1 for each row*	Contracted entities (e.g., ACOs/PCMH/Medical Groups/IPAs) paid under listed payment category below *Estimated Percentage of dollar amount listed in column 1 for each row*	*This column activated only if there is % listed in column 3 Please select which contracted entities are paid in column 3*	Autocalculated percent based on responses in column 1. Denominator = total $ in row 1 column 1 Numerator = $ in specific row C1
Total IN-NETWORK dollars paid for to Providers for ALL commercial members for HOSPITAL SERVICES	*Dollars.*	*Percent.*	*Percent.*	*Multi, Checkboxes.* 1: ACO 2: PCMH 3: Medical Groups/IPAs 4: Primary Care 5: Specialists	*For comparison.* Unknown Note: Percentages provided in this row do not total 100%
Provide the total dollars paid to providers through traditional FFS	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*

payments in the applicable calendar year or most recent 12 months					
Provide the total dollars paid to providers through bundled payment programs without quality components in the applicable calendar year or most recent 12 months	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Provide the total dollars paid to providers through partial or condition-specific capitation programs without quality components in the applicable calendar year or most recent 12 months	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Provide the total dollars paid to providers through fully capitated programs without quality in the applicable calendar year or most recent 12 months	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Subtotal: Dollars paid out under the status quo: total dollars paid through traditional payment methods in the applicable calendar year for hospital services [Sum of Rows 2, 3 4 and 5]	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Provide the total dollars paid to providers through shared-risk programs with quality components in the applicable calendar year or most recent 12 months	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Provide the total dollars paid to providers through FFS-based	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*

shared-savings programs with quality components in the applicable calendar year or most recent 12 months					
Provide the total dollars paid to providers through non-FFS-based shared-savings programs with quality components for the applicable calendar year or most recent 12 months.	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Provide the total dollars paid to providers through FFS base payments plus pay-for-performance (P4P) programs for the applicable calendar year or most recent 12 months	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Provide the total dollars paid to providers through fully capitated payment with quality components for the applicable calendar year or most recent 12 months.	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Provide the total dollars paid to providers through partial or condition-specific capitation programs with quality components for the applicable calendar year or most recent 12 months	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Provide the total dollars paid to providers through bundled payment programs with quality components for the applicable calendar year or most recent 12 months	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Provide the total dollars paid for FFS-based non-visit functions. (see	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*

definitions for examples) for the applicable calendar year or most recent 12 months.					
Provide the total dollars paid for non-FFS-based non-visit functions. (see definitions for examples) for the applicable calendar year or most recent 12 months.	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Provide the total dollars paid to providers whose contract contains other types of performance-based incentive program not captured above ***and NOT based on FFS***	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Total dollars paid to payment reform programs based on FFS. AUTOSUM ROWS 8, 10 and 14	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Total dollars paid to payment reform programs NOT based on FFS. AUTOSUM ROWS 7, 9, 11-13, 15 and 16	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*

9.4.12.20 Based on your responses above, on an aggregate basis for the plan's **total California** book of business in the market of your response, indicate the relative weighting or allocation of the Plan's financial incentives for hospital services, and which payment approaches, if any, the Health plan is using currently to tie payment to performance If the relative weighting varies by contract, describe the most prevalent allocation. The Plan's response should total 100.00% within each column. Enter 0.00% if incentives not use.

Hospital Services	Estimate of Allocation of Incentive payments (see question above)	Product where incentive available	Type of Payment Approach	Description of other
Achievement (relative to target or peers) of Clinical process goals (e.g., prophylactic antibiotic administration, timeliness of medication administration, testing, screenings)	*Percent*	*Single, Pull-down list.* 1: HMO 2: PPO 3: Both HMO and PPO 4: Not available	*Multi, Checkboxes.* 1: Shared-risk (other than bundled payment) and/or gainsharing with quality 2: FFS-based Shared-savings with quality 3: Non-FFS-based Shared-savings with quality 4: FFS plus pay for performance 5: Full capitation with quality 6: Partial or condition-specific capitation with quality 7: Bundled payment with quality 8: FFS-based non-visit functions 9: Non-FFS-based non-visit functions	*65 words*

			10: Non-payment policy for specific services associated with hospital-acquired conditions that were preventable or services that were unnecessary 11: Other non-FFS based payment reform models (describe in next column)	
Achievement (relative to target or peers) of Clinical outcomes goals(e.g., readmission rate, mortality rate, A1c, cholesterol values under control)	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Improvement over time of NQF-endorsed Outcomes and/or Process measures	*(As above)*	*(As above)*	*(As above)*	*(As above)*
PATIENT SAFETY (e.g., Leapfrog, AHRQ, medication related safety issues)	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Appropriate Maternity Care (adhering to clinical guidelines which if followed, would reduce unnecessary elective interventions)	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Longitudinal efficiency relative to target or peers	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Application of specific medical home practices (e.g., intensive self-management support to patients, action Health plan development, arrangement for social support follow-up with a social worker or other community support personnel)	*(As above)*	*(As above)*	*(As above)*	*(As above)*

Patient experience	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Health IT adoption or use	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Financial results	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Utilization results	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Pharmacy Management	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Other	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Total	*(As above)*	*(As above)*	*(As above)*	*(As above)*

9.4.12.21 Payment Reform for High Volume/High Spend Conditions - Maternity Care Services (Note: Metrics below apply only to in-network dollars paid for commercial members).

EXAMPLE ASSUMING A HEALTH PLAN CONTRACTS WITH ONLY TWO HOSPITALS (FOR ILLUSTRATION PURPOSES):

Hospital A has a contract that includes a financial incentive or disincentive to adhere to clinical guidelines for maternity care. The maternity care financial incentive or disincentive may be part of a broader quality incentive contract, such as a P4P program for the hospital where a portion of the bonus pay is tied to performance for delivering clinically safe and appropriate maternity care. The total dollars paid to Hospital A for maternity care was $100 (reported in row 1). Because there is a maternity care financial or disincentive incentive in the contract for Hospital A, $100 is also reported in row 2.

Hospital B does **not** have a contract where there is a financial incentive or disincentive to adhere to clinical guidelines for maternity care. The total dollars paid to Hospital B for maternity care is $100 (reported in row 1). However, since Hospital B does NOT have a maternity care financial incentive or disincentive in the contract, $0 is reported on row 2.

Two hundred dollars ($200), the sum of the total dollars paid for maternity care for Hospitals A and B, would be reported in line 1. In row 2, only $100 is reported, as only one of the hospitals has a contract with a financial incentive or disincentive for maternity care services.

If BOTH Hospitals A and B have contracts with financial incentives or disincentives for adhering to clinical guidelines for maternity care, then the total for row 2 is $200. The second row is NOT asking for the specific dollars that are paid for the maternity care financial incentive component of the contract.

Use the process described above for all contracts with hospitals for maternity care to provide a complete numerator and denominator for this question.

Maternity Services Payment Reform	***Response***
Provide the total dollars paid to hospitals for maternity care for the applicable calendar year or most current 12 months with sufficient information	*Dollars.* N/A OK
Provide the total dollars paid for maternity care to hospitals with contracts that include incentives to adhere to clinical guidelines, which, if followed, would reduce unnecessary elective medical intervention during labor and delivery in the past year. Such incentives can either be positive (e.g. pay for performance) or negative (disincentives), such as non-payment for care that is not evidence-based.	*Dollars.* N/A OK From 0 to 1000000000000000000
Autocalc: Row 2/Row 1 **Percent of total maternity care dollars paid that go to hospitals with contracts that provide incentives for adhering to clinical guidelines which, if followed, would reduce unnecessary elective interventions related to unnecessary elective medical intervention during labor and delivery in the past year.**	*For comparison* Unknown

9.4.12.22 For the measures used in determining financial incentives paid to **hospitals and/or physicians involving HOSPITAL SERVICES IN THIS MARKET**, indicate payment approach, system/entities paid and the percentage of the contracted entities receive payment reward. To calculate percentage, please use unduplicated count of hospitals and physicians.

Information on the measures is available at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/OutcomeMeasures.html

The AHRQ Quality Indicators (QIs) are measures of health care quality that make use of readily available hospital inpatient administrative data. The QIs can be used to highlight potential quality concerns, identify areas that need further study and investigation, and track changes over time.

The current AHRQ QI modules represent various aspects of quality:

- Prevention Quality Indicators identify hospital admissions in geographic areas that evidence suggests may have been avoided through access to high-quality outpatient care.
- Inpatient Quality Indicators reflect quality of care inside hospitals, as well as across geographic areas, including inpatient mortality for medical conditions and surgical procedures.
- Patient Safety Indicators reflect quality of care inside hospitals, as well as geographic areas, to focus on potentially avoidable complications and iatrogenic events.

Information on impact of early scheduled deliveries and rates by state can be found at: http://www.leapfroggroup.org/news/leapfrog_news/4788210 and http://www.leapfroggroup.org/tooearlydeliveries#State. Efficiency is defined as the cost and quantity of services (i.e., total resources used) for the episode of care. For additional information, see "Measuring Provider Efficiency Version 1.0" available at http://www.leapfroggroup.org/media/file/MeasuringProviderEfficiencyVersion1_12-31-2005.pdf and Hospital Cost Efficiency Measurement: Methodological Approaches at http://www.pbgh.org/storage/documents/reports/PBGHHospEfficiencyMeas_01-2007_22p.pdf. For preventable ED/ER visits, please see http://info.medinsight.milliman.com/bid/192744/Claims-Based-Analytics-to-Identify-Potentially-Avoidable-ER-Visits and http://wagner.nyu.edu/faculty/billings/nyued-background. In detail box below - please note if needed

any additional information about percentages provided (e.g., if payment is made for a composite set of measures - indicate which)

	Product where incentive available	System/ Entity Paid	Type of Payment Approach	Description of Other	% network hospitals receiving reward	% network physicians receiving reward
HQA						
ACUTE MYOCARDIAL INFARCTION (AMI)	*Single, Radio group.* 1: HMO 2: PPO 3: Both HMO and PPO 4: EPO only 5: All products 6: Not available	*Multi, Checkboxes.* 1: Hospital 2: ACO 3: Physician or physician group 4: Other	*Multi, Checkboxes.* 1: Shared-risk (other than bundled payment) and/or gainsharing with quality 2: FFS-based Shared-savings with quality 3: Non-FFS-based Shared-savings with quality 4: FFS plus pay for performance 5: Full capitation with quality	*65 words.*	*Percent.* N/A OK.	*Percent.* N/A OK.

			6: Partial or condition specific capitation with quality 7: Bundled payment with quality 8: FFS-based non-visit functions 9: Non-FFS-based non-visit functions 10: Non-payment policy for specific services associated with hospital-acquired conditions that were preventable or services that were unnecessary 11: Other non-FFS based payment reform models (describe in next column)			
HEART FAILURE (HF)	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
PNEUMONIA (PNE)	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
SURGICAL INFECTION PREVENTION (SIP)	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Surgical Care Improvement Project (SCIP)	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
PATIENT EXPERIENCE/ H-CAHPS	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
LEAPFROG Safety Practices http://www.leapfroggroup.org/56440/leapfrog_ho	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*

spital_survey_copy/leapfrog_safety_practices						
Leapfrog Hospital Safety Score	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Adoption of CPOE	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Management of Patients in ICU	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Evidence-Based Hospital referral indicators	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Adoption of NQF endorsed Safe Practices	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Maternity – pre 39 week elective induction and/or elective c-section rates	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
HOSPITAL QUALITY INSTITUTE HOSPITAL ENGAGEMENT NETWORK						
CAUTI	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
CLABSI	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Surgical site infections (SSI)	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Adverse drug events (ADE)	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (AHRQ)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*

Inpatient quality indicators	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Patient safety indicators http://www.qualityindicators.ahrq.gov/modules/psi_overview.aspx	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Prevention quality indicators	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
OTHER MEASURES	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
HACs – hospital acquired conditions (e.g., Surgical site infection following coronary artery bypass graft (CABG)—mediastinitis) http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired_Conditions.html	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
SREs (serious reportable events) that are not HACs (e.g., surgery on the wrong body part or wrong	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*

patient) www.qualityforum.org/Topics/SREs/List_of_SREs.aspx . Please refer to attachment						
Readmissions	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
ED/ER Visits	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
MORTALITY MEASURES (AMI, HF and Pneumonia mortality measures)	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
ICU Mortality	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
HIT adoption/use	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Efficiency (e.g., relative cost, utilization (ALOS, AD/k) Volume indicators other than Leapfrog EHR)	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Other standard measures endorsed by National Quality Forum (describe):	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*

9.4.12.23 This question on total prescription drug costs and any related payment innovation contracts complements questions on payment for both outpatient and hospital services. **Please base**

response to this question on how you responded to payment questions for outpatient and hospital services. Please note in row 19 the context of response.

SCENARIO 1: IF the dollars entered in response for outpatient and hospital services INCLUDED prescription costs in the MEDICAL BENEFIT, the response below should only contain prescription dollars from the PHARMACY BENEFIT

SCENARIO 2: IF the dollars entered in response for outpatient and hospital services EXCLUDED ALL prescription costs, the response below should contain prescription cost dollars from BOTH the MEDICAL AND PHARMACY BENEFITS

NOTE: This question asks about total $ paid in **calendar year (CY) 2015**. **If, due to timing of payment, sufficient information is not available to answer the questions based on the requested reporting period of CY 2015, Plans may elect to report on the most recent 12 months with sufficient information and note time period in detail box below. If this election is made, ALL answers on CPR payment (2 for CY 2015 should reflect the adjusted reporting period.**

- Commercial includes both self-funded and fully-insured business.

HELPFUL TIPS: To determine the most appropriate payment category to which dollars from your payment reform program(s) should be allocated, please use the following steps:

1. *Determine if the base payment of the program is fee-for-service (FFS) or not. If it is NOT based on FFS, ensure that the program category you select has "non-FFS based" in the program category.*
2. *Determine if the payment for the program has a quality component or is tied to quality in some way (rather than just tied to efficiency). If the payment reform program does include a quality component, for example, please ensure that the program category you select has "with quality" in the program category.*
3. *Identify the **dominant** payment reform mechanism for a given payment reform program.*
4. *For programs that have hybrid qualities, review the list of definitions to decide which payment model best describes your program, e.g., if your program pays providers based upon thresholds for quality or cost, and also provides a PMPM to providers to facilitate care coordination, select the model through which most payment is made (in this case, pay-for-performance).*

*NOTE: Plan should report **ALL** dollars paid through contracts containing this type of payment program, not only the dollars paid out as an incentive.*

	ALL Providers	Select types of entities	Please note % of $ that went to each	Autocalculated percent based on

PRESCRIPTION DOLLARS **Note in row 19 the context of this response**	**Total $ Paid in Calendar Year (CY) 2015 or most current 12 months)**	**who received payment**	**entity selected in previous column**	**responses in column 1. Denominator = total $ in row 1 column 1 Numerator = $ in specific row C1**
Total IN-NETWORK Rx dollars paid for to ALL Providers for ALL commercial members	*Dollars.*	1.PCP 2. Specialist 3. Hospital 4: ACO, 5: PCMH, 6: Medical Groups/IPAs 7. Other _____	Text [Example: Hospitals:50%; ACO:50%]	*For comparison.*
Provide the total Rx dollars paid to providers through traditional FFS payments in CY 2015 or most recent 12 months				
Provide the total dollars paid to providers through bundled payment programs without quality components in CY 2015 or most recent 12 months				
Provide the total dollars paid to providers through partial or condition-specific capitation programs without quality components in CY 2015 or most recent 12 months				
Provide the total dollars paid to providers through fully capitated programs without quality in CY 2015 or most recent 12 months				
Subtotal: Dollars paid out under the status quo: total dollars paid	**Autosum**			

through traditional payment methods in CY 2015 for primary care and specialty outpatient services (i.e., services for which there is NO ASSOCIATED HOSPITAL CHARGE) **[Sum of Rows 2, 3 4 and 5]**				
Provide the total dollars paid to providers through shared-risk programs with quality components in CY 2015 or most recent 12 months				
Provide the total dollars paid to providers through FFS-based shared-savings programs with quality components in CY 2015 or most recent 12 months				
Provide the total dollars paid to providers through non-FFS-based shared-savings programs with quality components CY 2015 or most recent 12 months.				
Provide the total dollars paid to providers through FFS base payments plus pay-for-performance (P4P) programs CY 2015 or most recent 12 months				
Provide the total dollars paid to providers through fully capitated payment with quality components in CY 2015 or most recent 12 months.				
Provide the total dollars paid to providers through partial or condition-specific capitation programs with quality components in CY 2015 or most recent 12 months				

Provide the total dollars paid to providers through bundled payment programs with quality components CY 2015 or most recent 12 months				
Provide the total dollars paid for FFS-based non-visit functions. (see definitions for examples) in CY 2015 or most recent 12 months.				
Provide the total dollars paid for non-FFS-based non-visit functions. (see definitions for examples) in CY 2015 or most recent 12 months.				
Provide the total dollars paid to providers whose contract contains other types of performance-based incentive program not captured above ***and NOT based on FFS***				
Total dollars paid to payment reform programs based on FFS.	**Autosum**			
Total dollars paid to payment reform programs NOT based on FFS.	**Autosum**			
Note if response above is ALL prescription dollars from both medical AND pharmacy benefit or just the pharmacy benefit	Radio button – single choice allowed **1.** All prescription dollars from both medical and pharmacy benefit			

	2. Pharmacy benefit dollars only **3.** Other____ _____			

9.4.13 Payment Reform and Data Submission (Responses and points incorporated in 9.4.12)

9.4.13.1 Catalyst for Payment Reform (CPR) Scorecard on Payment Reform and National Compendium on Payment Reform

Single, Radio group.

1: Health plan agrees that the Exchange will provide payment reform information to the CPR Scorecard,

2: Information not provided