COVERED CALIFORNIA
QUALIFIED HEALTH PLAN CONTRACT THROUGH 2015
between

Covered California, the California Health Benefit Exchange (the "Exchange")

and

("Contractor")

List of Attachments to Qualified Health Plan Model Contract

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2015 Standard Benefit Plan Designs

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Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.	Platinum Coinsurance Plan	Platinum Copay Plan
Actuarial Value - AV Calculator	88.10%	88.00%
Individual Overall deductible	$0	$0
Other individual deductibles for specific services		
Medical	$0	$0
Brand Drugs	$0	$0
Dental	$0	$0
Individual Out–of–pocket maximum	$4,000	$4,000

Common Medical Event	Service Type	Platinum Coinsurance Plan: Member Cost Share	Platinum Coinsurance Plan: Deductible Applies	Platinum Copay Plan: Member Cost Share	Platinum Copay Plan: Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness	$20		$20	
	Specialist visit	$40		$40	
	Preventive care/ screening/ immunization	No cost share		No cost share	
Tests	Laboratory Tests	$20		$20	
	X-rays and Diagnostic Imaging	$40		$40	
	Imaging (CT/PET scans, MRIs)	10%		$150	
Drugs to treat illness or condition	Generic drugs	$5		$5	
	Preferred brand drugs	$15		$15	
	Non-preferred brand drugs	$25		$25	
	Specialty drugs	10%		10%	
Outpatient surgery	Facility fee (e.g., ASC)	10%		$250	
	Physician/surgeon fees	10%			
Need immediate attention	Emergency room services (waived if admitted)	$150		$150	
	Emergency medical transportation	$150		$150	
	Urgent care	$40		$40	
Hospital stay	Facility fee (e.g. hospital room)	10%		$250 per day up to 5 days	
	Physician/surgeon fee	10%			
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20		$20	
	Mental/Behavioral health inpatient services	10%		$250 per day up to 5 days	
	Substance use disorder outpatient services	$20		$20	
	Substance use disorder inpatient services	10%		$250 per day up to 5 days	
Pregnancy	Prenatal care and preconception visits	No cost share		No cost share	
	Delivery and all inpatient services – Hospital	10%		$250 per day up to 5 days	
	Delivery and all inpatient services – Professional	10%			
Help recovering or other special health needs	Home health care	10%		$20	
	Outpatient Rehabilitation services	$20		$20	
	Outpatient Habilitation services	$20		$20	
	Skilled nursing care	10%		$150 per day up to 5 days	
	Durable medical equipment	10%		10%	
	Hospice service	No cost share		No cost share	
Child eye care	Eye exam	No cost share		No cost share	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No cost share		No cost share	
Child Dental Diagnostic and Preventive	Oral Exam	No cost share		No cost share	
	Preventive - Cleaning				
	Preventive - X-ray				
	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic Services	Amalgam Fill - 1 Surface	20%		$25	
Child Dental Major Services	Root Canal- Molar	50%		$300	
	Gingivectomy per Quad			$150	
	Extraction- Single Tooth Exposed Root or			$65	
	Extraction- Complete Bony			$160	
	Porcelain with Metal Crown			$300	
Child Orthodontics	Medically necessary orthodontics	50%		$1,000	

See endnotes.

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Member Cost Share amounts describe the Enrollee's out of pocket costs.	Gold Coinsurance Plan	Gold Copay Plan
Actuarial Value - AV Calculator	78.80%	78.60%
Individual Overall deductible	$0	$0
Other individual deductibles for specific services		
Medical	$0	$0
Brand Drugs	$0	$0
Dental	$0	$0
Individual Out–of–pocket maximum	$6,250	$6,250

Common Medical Event	Service Type	Gold Coinsurance Plan: Member Cost Share	Gold Coinsurance Plan: Deductible Applies	Gold Copay Plan: Member Cost Share	Gold Copay Plan: Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness	$30		$30	
	Specialist visit	$50		$50	
	Preventive care/ screening/ immunization	No cost share		No cost share	
Tests	Laboratory Tests	$30		$30	
	X-rays and Diagnostic Imaging	$50		$50	
	Imaging (CT/PET scans, MRIs)	20%		$250	
Drugs to treat illness or condition	Generic drugs	$15		$15	
	Preferred brand drugs	$50		$50	
	Non-preferred brand drugs	$70		$70	
	Specialty drugs	20%		20%	
Outpatient surgery	Facility fee (e.g., ASC)	20%		$600	
	Physician/surgeon fees	20%			
Need immediate attention	Emergency room services (waived if admitted)	$250		$250	
	Emergency medical transportation	$250		$250	
	Urgent care	$60		$60	
Hospital stay	Facility fee (e.g. hospital room)	20%		$600 per day up to 5 days	
	Physician/surgeon fee	20%			
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30		$30	
	Mental/Behavioral health inpatient services	20%		$600 per day up to 5 days	
	Substance use disorder outpatient services	$30		$30	
	Substance use disorder inpatient services	20%		$600 per day up to 5 days	
Pregnancy	Prenatal care and preconception visits	No cost share		No cost share	
	Delivery and all inpatient services: Hospital	20%		$600 per day up to 5 days	
	Delivery and all inpatient services: Professional	20%			
Help recovering or other special health needs	Home health care	20%		$30	
	Outpatient Rehabilitation services	$30		$30	
	Outpatient Habilitation services	$30		$30	
	Skilled nursing care	20%		$300 per day up to 5 days	
	Durable medical equipment	20%		20%	
	Hospice service	No cost share		No cost share	
Child eye care	Eye exam	No cost share		No cost share	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No cost share		No cost share	
Child Dental Diagnostic and Preventive	Oral Exam	No cost share		No cost share	
	Preventive - Cleaning				
	Preventive - X-ray				
	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic Services	Amalgam Fill - 1 Surface	20%		$25	
Child Dental Major Services	Root Canal- Molar	50%		$300	
	Gingivectomy per Quad			$150	
	Extraction- Single Tooth Exposed Root or			$65	
	Extraction- Complete Bony			$160	
	Porcelain with Metal Crown			$300	
Child Orthodontics	Medically necessary orthodontics	50%		$1,000	

See endnotes.

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Summary of Benefits and Coverage		Individual	Individual
Member Cost Share amounts describe the Enrollee's out of pocket costs.		**Silver Coinsurance Plan**	**Silver Copay Plan**
Actuarial Value - AV Calculator		70.30%	69.90%
Individual Overall deductible		N/A	N/A
Other individual deductibles for specific services			
	Medical	$2,000	$2,000
	Brand Drugs	$250	$250
	Dental	$0	$0
Individual Out–of–pocket maximum		$6,250	$6,250

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness	$45		$45	
	Specialist visit	$65		$65	
	Preventive care/ screening/ immunization	No cost share		No cost share	
Tests	Laboratory Tests	$45		$45	
	X-rays and Diagnostic Imaging	$65		$65	
	Imaging (CT/PET scans, MRIs)	20%	X	$250	
Drugs to treat illness or condition	Generic drugs	$15		$15	
	Preferred brand drugs	$50	X	$50	X
	Non-preferred brand drugs	$70	X	$70	X
	Specialty drugs	20%	X	20%	X
Outpatient surgery	Facility fee (e.g., ASC)	20%		20%	
	Physician/surgeon fees	20%		20%	
Need immediate attention	Emergency room services (waived if admitted)	$250	X	$250	X
	Emergency medical transportation	$250	X	$250	X
	Urgent care	$90		$90	
Hospital stay	Facility fee (e.g. hospital room)	20%	X	20%	X
	Physician/surgeon fee	20%			
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$45		$45	
	Mental/Behavioral health inpatient services	20%	X	20%	X
	Substance use disorder outpatient services	$45		$45	
	Substance use disorder inpatient services	20%	X	20%	X
Pregnancy	Prenatal care and preconception visits	No cost share		No cost share	
	Delivery and all inpatient services — Hospital	20%	X	20%	X
	Delivery and all inpatient services — Professional	20%			
Help recovering or other special health needs	Home health care	20%		$45	
	Outpatient Rehabilitation services	$45		$45	
	Outpatient Habilitation services	$45		$45	
	Skilled nursing care	20%	X	20%	X
	Durable medical equipment	20%		20%	
	Hospice service	No cost share		No cost share	
Child eye care	Eye exam	No cost share		No cost share	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No cost share		No cost share	
Child Dental Diagnostic and Preventive	Oral Exam	No cost share		No cost share	
	Preventive - Cleaning				
	Preventive - X-ray				
	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic Services	Amalgam Fill - 1 Surface	20%		$25	
Child Dental Major Services	Root Canal- Molar	50%		$300	
	Gingivectomy per Quad			$150	
	Extraction- Single Tooth Exposed Root or			$65	
	Extraction- Complete Bony			$160	
	Porcelain with Metal Crown			$300	
Child Orthodontics	Medically necessary orthodontics	50%		$1,000	

See endnotes.

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Summary of Benefits and Coverage		SHOP		SHOP	
Member Cost Share amounts describe the Enrollee's out of pocket costs.		Silver Coinsurance Plan		Silver Copay Plan	
Actuarial Value - AV Calculator		71.50%		71.00%	
Individual Overall deductible		N/A		N/A	
Other individual deductibles for specific services					
Medical		$1,500		$1,500	
Brand Drugs		$500		$500	
Dental		$0		$0	
Individual Out–of–pocket maximum		$6,250		$6,250	
Common Medical Event	**Service Type**	**Member Cost Share**	**Deductible Applies**	**Member Cost Share**	**Deductible Applies**
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness	$45		$45	
	Specialist visit	$65		$65	
	Preventive care/ screening/ immunization	No cost share		No cost share	
Tests	Laboratory Tests	$45		$45	
	X-rays and Diagnostic Imaging	$65		$65	
	Imaging (CT/PET scans, MRIs)	20%	X	$250	
Drugs to treat illness or condition	Generic drugs	$15		$15	
	Preferred brand drugs	$50	X	$50	X
	Non-preferred brand drugs	$70	X	$70	X
	Specialty drugs	20%	X	20%	X
Outpatient surgery	Facility fee (e.g., ASC)	20%		20%	
	Physician/surgeon fees	20%		20%	
Need immediate attention	Emergency room services (waived if admitted)	$250	X	$250	X
	Emergency medical transportation	$250	X	$250	X
	Urgent care	$90		$90	
Hospital stay	Facility fee (e.g. hospital room)	20%	X	20%	X
	Physician/surgeon fee	20%			
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$45		$45	
	Mental/Behavioral health inpatient services	20%	X	20%	X
	Substance use disorder outpatient services	$45		$45	
	Substance use disorder inpatient services	20%	X	20%	X
Pregnancy	Prenatal care and preconception visits	No cost share		No cost share	
	Delivery and all inpatient services — Hospital	20%	X	20%	X
	Delivery and all inpatient services — Professional	20%			
Help recovering or other special health needs	Home health care	20%		$45	
	Outpatient Rehabilitation services	$45		$45	
	Outpatient Habilitation services	$45		$45	
	Skilled nursing care	20%	X	20%	X
	Durable medical equipment	20%		20%	
	Hospice service	No cost share		No cost share	
Child eye care	Eye exam	No cost share		No cost share	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No cost share		No cost share	
Child Dental Diagnostic and Preventive	Oral Exam	No cost share		No cost share	
	Preventive - Cleaning				
	Preventive - X-ray				
	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic Services	Amalgam Fill - 1 Surface	20%		$25	
Child Dental Major Services	Root Canal- Molar	50%		$300	
	Gingivectomy per Quad			$150	
	Extraction- Single Tooth Exposed Root or			$65	
	Extraction- Complete Bony			$160	
	Porcelain with Metal Crown			$300	
Child Orthodontics	Medically necessary orthodontics	50%		$1,000	

See endnotes.

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Summary of Benefits and Coverage	**SHOP**
Member Cost Share amounts describe the Enrollee's out of pocket costs.	**Silver HSA Plan**
Actuarial Value - AV Calculator	71.60%
Individual Overall deductible	$1,500 integrated Med/Rx Ded
Other individual deductibles for specific services	
Medical	N/A
Brand Drugs	N/A
Dental	N/A
Individual Out–of–pocket maximum	$6,250

Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness		20%	X
	Specialist visit		20%	X
	Preventive care/ screening/ immunization		No cost share	
Tests	Laboratory Tests		20%	X
	X-rays and Diagnostic Imaging		20%	X
	Imaging (CT/PET scans, MRIs)		20%	X
Drugs to treat illness or condition	Generic drugs		20%	X
	Preferred brand drugs		20%	X
	Non-preferred brand drugs		20%	X
	Specialty drugs		20%	X
Outpatient surgery	Facility fee (e.g., ASC)		20%	X
	Physician/surgeon fees		20%	X
Need immediate attention	Emergency room services (waived if admitted)		20%	X
	Emergency medical transportation		20%	X
	Urgent care		20%	X
Hospital stay	Facility fee (e.g. hospital room)		20%	X
	Physician/surgeon fee		20%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		20%	X
	Mental/Behavioral health inpatient services		20%	X
	Substance use disorder outpatient services		20%	X
	Substance use disorder inpatient services		20%	X
Pregnancy	Prenatal care and preconception visits		No cost share	
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	X
Help recovering or other special health needs	Home health care		20%	X
	Outpatient Rehabilitation services		20%	X
	Outpatient Habilitation services		20%	X
	Skilled nursing care		20%	X
	Durable medical equipment		20%	X
	Hospice service		No cost share	X
Child eye care	Eye exam		No cost share	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No cost share	
Child Dental Diagnostic and Preventive	Oral Exam		No cost share	
	Preventive - Cleaning			
	Preventive - X-ray			
	Sealants per Tooth			
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic Services	Amalgam Fill - 1 Surface		20%	
Child Dental Major Services	Root Canal- Molar		50%	
	Gingivectomy per Quad			
	Extraction- Single Tooth Exposed Root or			
	Extraction- Complete Bony			
	Porcelain with Metal Crown			
Child Orthodontics	Medically necessary orthodontics		50%	

See endnotes.

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Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.	Silver Coinsurance Plan 100%-150% FPL	Silver Coinsurance Plan 150%-200% FPL
Actuarial Value - AV Calculator	94.80%	88.00%
Individual Overall deductible	$0	N/A
Other individual deductibles for specific services		
Medical	$0	$500
Brand Drugs	$0	$50
Dental	$0	$0
Individual Out–of–pocket maximum	$2,250	$2,250

Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness		$3		$15	
	Specialist visit		$5		$20	
	Preventive care/ screening/ immunization		No cost share		No cost share	
Tests	Laboratory Tests		$3		$15	
	X-rays and Diagnostic Imaging		$5		$20	
	Imaging (CT/PET scans, MRIs)		10%		15%	X
Drugs to treat illness or condition	Generic drugs		$3		$5	
	Preferred brand drugs		$5		$15	X
	Non-preferred brand drugs		$10		$25	X
	Specialty drugs		10%		15%	X
Outpatient surgery	Facility fee (e.g., ASC)		10%		15%	
	Physician/surgeon fees		10%		15%	
Need immediate attention	Emergency room services (waived if admitted)		$25		$75	X
	Emergency medical transportation		$25		$75	X
	Urgent care		$6		$30	
Hospital stay	Facility fee (e.g. hospital room)		10%		15%	X
	Physician/surgeon fee		10%		15%	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		$3		$15	
	Mental/Behavioral health inpatient services		10%		15%	X
	Substance use disorder outpatient services		$3		$15	
	Substance use disorder inpatient services		10%		15%	X
Pregnancy	Prenatal care and preconception visits		No cost share		No cost share	
	Delivery and all inpatient services	Hospital	10%		15%	X
		Professional	10%		15%	
Help recovering or other special health needs	Home health care		10%		15%	
	Outpatient Rehabilitation services		$3		$15	
	Outpatient Habilitation services		$3		$15	
	Skilled nursing care		10%		15%	X
	Durable medical equipment		10%		15%	
	Hospice service		No cost share		No cost share	
Child eye care	Eye exam		No cost share		No cost share	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No cost share		No cost share	
Child Dental Diagnostic and Preventive	Oral Exam		No cost share		No cost share	
	Preventive - Cleaning					
	Preventive - X-ray					
	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic Services	Amalgam Fill - 1 Surface		20%		20%	
Child Dental Major Services	Root Canal- Molar		50%		50%	
	Gingivectomy per Quad					
	Extraction- Single Tooth Exposed Root or					
	Extraction- Complete Bony					
	Porcelain with Metal Crown					
Child Orthodontics	Medically necessary orthodontics		50%		50%	

See endnotes.

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Member Cost Share amounts describe the Enrollee's out of pocket costs.	Silver Coinsurance Plan 200%-250% FPL
Actuarial Value - AV Calculator	rounded up to 74.0%
Individual Overall deductible	N/A
Other individual deductibles for specific services	
Medical	$1,600
Brand Drugs	$250
Dental	$0
Individual Out–of–pocket maximum	$5,200

Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness		$40	
	Specialist visit		$50	
	Preventive care/ screening/ immunization		No cost share	
Tests	Laboratory Tests		$40	
	X-rays and Diagnostic Imaging		$50	
	Imaging (CT/PET scans, MRIs)		20%	X
Drugs to treat illness or condition	Generic drugs		$15	
	Preferred brand drugs		$35	X
	Non-preferred brand drugs		$60	X
	Specialty drugs		20%	X
Outpatient surgery	Facility fee (e.g., ASC)		20%	
	Physician/surgeon fees		20%	
Need immediate attention	Emergency room services (waived if admitted)		$250	X
	Emergency medical transportation		$250	X
	Urgent care		$80	
Hospital stay	Facility fee (e.g. hospital room)		20%	X
	Physician/surgeon fee		20%	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		$40	
	Mental/Behavioral health inpatient services		20%	X
	Substance use disorder outpatient services		$40	
	Substance use disorder inpatient services		20%	X
Pregnancy	Prenatal care and preconception visits		No cost share	
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	
Help recovering or other special health needs	Home health care		20%	
	Outpatient Rehabilitation services		$40	
	Outpatient Habilitation services		$40	
	Skilled nursing care		20%	X
	Durable medical equipment		20%	
	Hospice service		No cost share	
Child eye care	Eye exam		No cost share	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No cost share	
Child Dental Diagnostic and Preventive	Oral Exam		No cost share	
	Preventive - Cleaning			
	Preventive - X-ray			
	Sealants per Tooth			
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic Services	Amalgam Fill - 1 Surface		20%	
Child Dental Major Services	Root Canal- Molar		50%	
	Gingivectomy per Quad			
	Extraction- Single Tooth Exposed Root or			
	Extraction- Complete Bony			
	Porcelain with Metal Crown			
Child Orthodontics	Medically necessary orthodontics		50%	

See endnotes.

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Member Cost Share amounts describe the Enrollee's out of pocket costs.	Silver Copay Plan 100%-150% FPL	Silver Copay Plan 150%-200% FPL
Actuarial Value - AV Calculator	94.90%	88.00%
Individual Overall deductible	$0	N/A
Other individual deductibles for specific services		
Medical	$0	$500
Brand Drugs	$0	$50
Dental	$0	$0
Individual Out–of–pocket maximum	$2,250	$2,250

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness	$3		$15	
	Specialist visit	$5		$20	
	Preventive care/ screening/ immunization	No cost share		No cost share	
Tests	Laboratory Tests	$3		$15	
	X-rays and Diagnostic Imaging	$5		$20	
	Imaging (CT/PET scans, MRIs)	$50		$100	
Drugs to treat illness or condition	Generic drugs	$3		$5	
	Preferred brand drugs	$5		$15	X
	Non-preferred brand drugs	$10		$25	X
	Specialty drugs	10%		15%	X
Outpatient surgery	Facility fee (e.g., ASC)	10%		15%	
	Physician/surgeon fees	10%		15%	
Need immediate attention	Emergency room services (waived if admitted)	$25		$75	X
	Emergency medical transportation	$25		$75	X
	Urgent care	$6		$30	
Hospital stay	Facility fee (e.g. hospital room) Physician/surgeon fee	10%		15%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$3		$15	
	Mental/Behavioral health inpatient services	10%		15%	X
	Substance use disorder outpatient services	$3		$15	
	Substance use disorder inpatient services	10%		15%	X
Pregnancy	Prenatal care and preconception visits	No cost share		No cost share	
	Delivery and all inpatient services — Hospital / Professional	10%		15%	X
Help recovering or other special health needs	Home health care	$3		$15	
	Outpatient Rehabilitation services	$3		$15	
	Outpatient Habilitation services	$3		$15	
	Skilled nursing care	10%		15%	X
	Durable medical equipment	10%		15%	
	Hospice service	No cost share		No cost share	
Child eye care	Eye exam	No cost share		No cost share	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No cost share		No cost share	
Child Dental Diagnostic and Preventive	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	No cost share		No cost share	
Child Dental Basic Services	Amalgam Fill - 1 Surface	$25		$25	
Child Dental Major Services	Root Canal- Molar	$300		$300	
	Gingivectomy per Quad	$150		$150	
	Extraction- Single Tooth Exposed Root or	$65		$65	
	Extraction- Complete Bony	$160		$160	
	Porcelain with Metal Crown	$300		$300	
Child Orthodontics	Medically necessary orthodontics	$1,000		$1,000	

See endnotes.

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Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.	Silver Copay Plan 200%-250% FPL
Actuarial Value - AV Calculator	73.50%
Individual Overall deductible	N/A
Other individual deductibles for specific services	
Medical	$1,600
Brand Drugs	$250
Dental	$0
Individual Out–of–pocket maximum	$5,200

Common Medical Event	Service Type	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness	$40	
	Specialist visit	$50	
	Preventive care/ screening/ immunization	No cost share	
Tests	Laboratory Tests	$40	
	X-rays and Diagnostic Imaging	$50	
	Imaging (CT/PET scans, MRIs)	$250	
Drugs to treat illness or condition	Generic drugs	$15	
	Preferred brand drugs	$35	X
	Non-preferred brand drugs	$60	X
	Specialty drugs	20%	X
Outpatient surgery	Facility fee (e.g., ASC)	20%	
	Physician/surgeon fees	20%	
Need immediate attention	Emergency room services (waived if admitted)	$250	X
	Emergency medical transportation	$250	X
	Urgent care	$80	
Hospital stay	Facility fee (e.g. hospital room) Physician/surgeon fee	20%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$40	
	Mental/Behavioral health inpatient services	20%	X
	Substance use disorder outpatient services	$40	
	Substance use disorder inpatient services	20%	X
Pregnancy	Prenatal care and preconception visits	No cost share	
	Delivery and all inpatient services — Hospital Professional	20%	X
Help recovering or other special health needs	Home health care	$40	
	Outpatient Rehabilitation services	$40	
	Outpatient Habilitation services	$40	
	Skilled nursing care	20%	X
	Durable medical equipment	20%	
	Hospice service	No cost share	
Child eye care	Eye exam	No cost share	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No cost share	
Child Dental Diagnostic and Preventive	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	No cost share	
Child Dental Basic Services	Amalgam Fill - 1 Surface	$25	
Child Dental Major Services	Root Canal- Molar	$300	
	Gingivectomy per Quad	$150	
	Extraction- Single Tooth Exposed Root or	$65	
	Extraction- Complete Bony	$160	
	Porcelain with Metal Crown	$300	
Child Orthodontics	Medically necessary orthodontics	$1,000	

See endnotes.

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Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.		Bronze Plan		Bronze HSA Plan	
Actuarial Value - AV Calculator		60.60%		59.40%	
Individual Overall deductible		$5,000 integrated Med/Rx Ded		$4,500 integrated Med/Rx	
Other individual deductibles for specific services					
	Medical	N/A		N/A	
	Brand Drugs	N/A		N/A	
	Dental	$0		N/A	
Individual Out–of–pocket maximum		$6,250		$6,250	
Common Medical Event	**Service Type**	**Member Cost Share**	**Deductible Applies**	**Member Cost Share**	**Deductible Applies**
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness	$60	After 1st three non-preventive visits	40%	X
	Specialist visit	$70	X	40%	X
	Preventive care/ screening/ immunization	No cost share		No cost share	
Tests	Laboratory Tests	30%	X	40%	X
	X-rays and Diagnostic Imaging	30%	X	40%	X
	Imaging (CT/PET scans, MRIs)	30%	X	40%	X
Drugs to treat illness or condition	Generic drugs	$15	X	40%	X
	Preferred brand drugs	$50	X	40%	X
	Non-preferred brand drugs	$75	X	40%	X
	Specialty drugs	30%	X	40%	X
Outpatient surgery	Facility fee (e.g., ASC)	30%	X	40%	X
	Physician/surgeon fees	30%	X	40%	X
Need immediate attention	Emergency room services (waived if admitted)	$300	X	40%	X
	Emergency medical transportation	$300	X	40%	X
	Urgent care	$120	After 1st three non-preventive visits	40%	X
Hospital stay	Facility fee (e.g. hospital room)	30%	X	40%	X
	Physician/surgeon fee	30%	X	40%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$60	After 1st three non-preventive visits	40%	X
	Mental/Behavioral health inpatient services	30%	X	40%	X
	Substance use disorder outpatient services	$60	After 1st three non-preventive visits	40%	X
	Substance use disorder inpatient services	30%	X	40%	X
Pregnancy	Prenatal care and preconception visits	No cost share		No cost share	
	Delivery and all inpatient services — Hospital	30%	X	40%	X
	Delivery and all inpatient services — Professional	30%	X	40%	X
Help recovering or other special health needs	Home health care	30%	X	40%	X
	Outpatient Rehabilitation services	$60	X	40%	X
	Outpatient Habilitation services	$60	X	40%	X
	Skilled nursing care	30%	X	40%	X
	Durable medical equipment	30%	X	40%	X
	Hospice service	No cost share	X	No cost share	X
Child eye care	Eye exam	No cost share		No cost share	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No cost share		No cost share	
Child Dental Diagnostic and Preventive	Oral Exam	No cost share		No cost share	
	Preventive - Cleaning				
	Preventive - X-ray				
	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic Services	Amalgam Fill - 1 Surface	20%		20%	
Child Dental Major Services	Root Canal- Molar	50%		50%	
	Gingivectomy per Quad				
	Extraction- Single Tooth Exposed Root or				
	Extraction- Complete Bony				
	Porcelain with Metal Crown				
Child Orthodontics	Medically necessary orthodontics	50%		50%	

See endnotes.

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Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.	Catastrophic Plan
Actuarial Value - AV Calculator	
Individual Overall deductible	$6,600 integrated Med/Rx
Other individual deductibles for specific services	
Medical	N/A
Brand Drugs	N/A
Dental	N/A
Individual Out–of–pocket maximum	$6,600

Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness		0%	After 1st three non-preventive visits
	Specialist visit		0%	X
	Preventive care/ screening/ immunization		No cost share	
Tests	Laboratory Tests		0%	X
	X-rays and Diagnostic Imaging		0%	X
	Imaging (CT/PET scans, MRIs)		0%	X
Drugs to treat illness or condition	Generic drugs		0%	X
	Preferred brand drugs		0%	X
	Non-preferred brand drugs		0%	X
	Specialty drugs		0%	X
Outpatient surgery	Facility fee (e.g., ASC)		0%	X
	Physician/surgeon fees		0%	X
Need immediate attention	Emergency room services (waived if admitted)		0%	X
	Emergency medical transportation		0%	X
	Urgent care		0%	After 1st three non-preventive visits
Hospital stay	Facility fee (e.g. hospital room)		0%	X
	Physician/surgeon fee		0%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		0%	After 1st three non-preventive visits
	Mental/Behavioral health inpatient services		0%	X
	Substance use disorder outpatient services		0%	After 1st three non-preventive visits
	Substance use disorder inpatient services		0%	X
Pregnancy	Prenatal care and preconception visits		No cost share	
	Delivery and all inpatient services	Hospital	0%	X
		Professional	0%	X
Help recovering or other special health needs	Home health care		0%	X
	Outpatient Rehabilitation services		0%	X
	Outpatient Habilitation services		0%	X
	Skilled nursing care		0%	X
	Durable medical equipment		0%	X
	Hospice service		No cost share	X
Child eye care	Eye exam		No cost share	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No cost share	x
Child Dental Diagnostic and Preventive	Oral Exam		No cost share	
	Preventive - Cleaning			
	Preventive - X-ray			
	Sealants per Tooth			
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic Services	Amalgam Fill - 1 Surface		20%	X
Child Dental Major Services	Root Canal- Molar		50%	X
	Gingivectomy per Quad			X
	Extraction- Single Tooth Exposed Root or			X
	Extraction- Complete Bony			X
	Porcelain with Metal Crown			X
Child Orthodontics	Medically necessary orthodontics		50%	X

See endnotes.

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Notes:

1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values. Except for the deductibles in High Deductible Health Plans (HDHPs) linked to Health Savings Accounts (HSAs), in a family plan, an individual is responsible only for the individual deductible and the individual out-of-pocket maximum amount. Cost sharing payments (deductibles, copayments and coinsurance, but not premiums) for essential health benefits made by each individual apply to the deductible and out-of-pocket maximum. However, cost sharing payments made for non-emergent out-of-network services that are not plan-authorized exceptions do not apply to the in-network family deductible and out of pocket maximum. The family deductible may be satisfied by any combination of individual deductible payments, after which member copays or coinsurance apply until the family out of pocket maximum is reached. Once the family out-of-pocket maximum is reached, the carrier pays all costs for covered services for all family members.
2) For HDHPs linked to HSAs, in a family plan, each individual in the family must meet a deductible of $2,600 until the family as a whole meets the family deductible. For HDHPs linked to HSAs, in a family plan, each individual in the family must meet the individual out of pocket maximum amount that is the same as that for self-only coverage until the family as a whole meets the family out of pocket maximum amount.
3) Cost sharing payments for all in-network services accumulate toward the deductible, if deductible applies to that service, and the out-of-pocket maximum.
4) Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount (the maximum amount on which payment is based for covered health care services).
5) For the Bronze and Catastrophic plans, deductible is waived for the first three non-preventive office or urgent care visits, including outpatient Mental Health/Substance Abuse visits.
6) Member cost-share for oral anti-cancer drugs shall not exceed $200 per month.
7) In the Platinum and Gold Copay Plans, hospital, in-patient and skilled nursing facility stays have no additional cost share after 5 days.
8) For drugs to treat an illness or condition the copay or coinsurance applies to the prescription supply. Nothing in this note precludes a carrier from offering mail order prescriptions at a reduced cost.
9) For the child dental portion of the benefit design, a carrier may choose the copay or coinsurance child dental benefit design, regardless of whether the carrier selects the copay or the coinsurance design for the non-child dental portion of the benefit design. In the Catastrophic plan, the deductible must apply to copays for non-preventive child dental benefits.

Attachment 3 – Good Standing

Attachment 3. Good Standing

Definition of Good Standing	Agency
Verification that issuer holds a state health care service plan license or insurance certificate of authority.	
Approved for applicable lines of business (e.g. commercial, small group, individual)	DMHC
Approved to operate in what geographic service areas	DMHC
Most recent financial exam and medical survey report reviewed	DMHC
Most recent market conduct exam reviewed	CDI
Affirmation of no material[1] statutory or regulatory violations, including penalties levied, in the past two years in relation to any of the following, where applicable:	
Financial solvency and reserves reviewed	DMHC and CDI
Administrative and organizational capacity acceptable	DMHC
Benefit design	
• State mandates (to cover and to offer)	DMHC and CDI
• Essential Health Benefits (State required)	DMHC and CDI
• Basic health care services	CDI
• Copayments, deductibles, out-of-pocket maximums	DMHC and CDI
• Actuarial value confirmation (using 2015 Federal Actuarial Value Calculator)	DMHC and CDI
Network adequacy and accessibility standards are met	DMHC and CDI
• Provider contracts	DMHC and CDI
Language access	DMHC and CDI
Uniform disclosure (summary of benefits and coverage)	DMHC and CDI
Claims payment policies and practices	DMHC and CDI
• Provider complaints	DMHC and CDI
Utilization review policies and practices	DMHC and CDI
Quality assurance/management policies and practices	DMHC
Enrollee/member grievances/complaints and appeals policies and practices	DMHC and CDI
Independent medical review	DMHC and CDI
Marketing and advertising	DMHC and CDI
Guaranteed issue individual and small group	DMHC and CDI
Rating factors	DMHC and CDI
Medical loss ratio	DMHC and CDI
Premium rate review	DMHC and CDI
• Geographic rating regions	DMHC and CDI
• Rate development and justification is consistent with the Affordable Care Act requirements	

[1] "Material" violations are defined in Article 3, Section 3.02 of the Contract.

Attachment 4 – Service Area Listing

Attachment 5 – Provider Agreement Standard Terms

Attachment 5. Provider Agreement - Standard Terms

Contractor shall use commercially reasonable efforts to require the following provisions to be included in each: (i) Provider Agreement entered into by and between Contractor and a Participating Provider, and (ii) any subcontracting arrangement entered into by a Participating Provider. To the extent that such terms are not included in the Contractor's current agreements, Contractor shall take commercially reasonable efforts to assure that such provisions are included in the contract by July 1, 2014. Except as expressly set forth herein, capitalized terms set forth herein shall have the same meaning as set forth in the Agreement between Contractor and the Exchange; provided that Contractor may use different terminology as necessary to be consistent with the terms used in the Provider Agreement or subcontracting arrangements entered into by Participating Providers so long as such different terminology does not change the meaning set forth herein and the Agreement.

1. Provision of Covered Services. Contractor shall undertake commercially reasonable efforts to require each Participating Provider to assure that each Participating Provider Agreement and each subcontracting arrangement entered into by each Participating Provider complies with the applicable terms and conditions set forth in the Agreement, as mutually agreed upon by the Exchange and Contractor, and which may include the following: Coordination with the Exchange and other programs and stakeholders (Section 1.06);

   - Relationship of the parties as independent contractors (Section 1.08(a)) and Contractor's exclusive responsibility for obligations under the Agreement (Section 1.08(b));
   - Participating Provider directory requirements (Section 3. 07(b));
   - Implementation of processes to enhance stability and minimize disruption to provider network (Section 3. (c) and (d));
   - Notice, network requirements and other obligations relating to costs of out-of-network and other benefits (Section 3.17);
   - Credentialing, including, maintenance of licensure and insurance (Section 3.18);
   - Customer service standards (Section 3.20);
   - Utilization review and appeal processes (Section 3.19);
   - Maintenance of a corporate compliance program (Section 3.21);
   - Enrollment and eligibility determinations and collection practices (Sections 3.22 to 3.28);
   - Appeals and grievances (Section 3.29);
   - Enrollee and marketing materials (Section 3.30);
   - Disclosure of information required by the Exchange, including, financial and clinical (Section 3.34; Quality, Network Management and Delivery System Standards (Article 4) and other data, books and records (Article 10));

- Nondiscrimination (Section 3.35);
- Conflict of interest and integrity (Section 3.36);
- Other laws (Section 3.37);
- Quality, Network Management and Delivery System Standards to the extent applicable to Participating Providers (Article 4), including, disclosure of contracting arrangements with Participating Providers as required under Attachment 7, Section 7.01 of the Quality, Network Management and Delivery System Standards;
- Performance Measures, to the extent applicable to Participating Providers (Article 6);
- Continuity of care, coordination and cooperation upon termination of Agreement and transition of Enrollees (Article 7);
- Security and privacy requirements, including compliance with HIPAA (Article 9); and
- Maintenance of books and records (Article 10).

2. In addition to the foregoing, Contractor shall include in each Provider Agreement a requirement that Participating Providers comply with other applicable laws, rules and regulations.

3. The descriptions set forth in this Attachment shall not be deemed to limit the obligations set forth in the Agreement, as amended from time to time.

Attachment 6 – Customer Service Standards

Attachment 6. Customer Service Standards

Customer Service Standards

1. Customer Service Call Center.

(a) During Open Enrollment Period, call center hours shall be Monday through Friday eight o'clock (8:00) a.m. to eight o'clock (8:00) p.m. and Saturday eight o'clock (8:00) a.m.) to six o'clock (6:00) p.m. (Pacific Standard Time), except on holidays observed by the Exchange. During non-Open Enrollment Periods, the Contractor shall maintain call center hours Monday through Friday eight o'clock (8:00) a.m. to six o'clock (6:00) p.m. and Saturday eight o'clock (8:00) a.m. to five o'clock (5:00) p.m. (Pacific Standard Time), however, Contractor may adjust Saturday hours as required by customer demand. Contractor shall inform the Exchange of its standard call center hours during non-Open-Enrollment Periods.

(b) The center will be staffed at such levels as reasonably necessary to handle call volume and achieve compliance with Performance Measurement Standards set forth in Article 6. Contractor shall staff the Call Center with highly trained individuals to provide detailed benefit information, answer Enrollee questions about the QHP, and resolve claim and benefit issues.

(c) Contractor shall use a telephone system that includes welcome messages in English, Spanish and other languages as required by State and Federal laws, rules and regulations.

(d) Oral interpreter services shall be available at no cost for non-English speaking or hearing impaired Enrollees during regular business hours as required by Federal and State law. Contractor shall monitor the quality and accessibility of call center services on an ongoing basis. Contractor shall report to the Exchange, in a format and frequency to be determined by the Exchange, but no more frequently than monthly, on the volume of calls received by the call center and Contractor's ability to meet the Performance Measurement Standards.

(e) As required under Section 3.18, for 2014, and 3.20 for 2015, the Contractor shall meet all State requirements for language assistance services for all of its commercial lines of business. The Exchange and Contractor agree to assess the adequacy of the language services during 2014, both phone and written material, and consider the adoption of additional standards in 2015.

2. Customer Service Transfers.

(a) During Contractor's regularly scheduled customer service hours, Contractor shall have the capability to accept and handle calls transferred from the Exchange to respond to callers requesting additional information from Contractor. Contractor shall maintain such staffing resources necessary to comply with Performance Measurement Standards and to assure that the Exchange can transfer the call to a live representative of Contractor prior to handing off the call. Contractor shall also maintain live call transfer resources to

facilitate a live transfer (from the Exchange to Contractor) of customers who call the Exchange with issues or complaints that need to be addressed by Contractor.

(b) During Contractor's regularly scheduled customer service hours, Exchange shall have the capability to accept and handle calls transferred from the Contractor to respond to callers requesting additional information from the Exchange. The Exchange shall maintain such staffing resources necessary to assure that Contractor can transfer the call to a live representative of the Exchange prior to handing off the call. The Exchange shall also maintain a live all transfer resource to facilitate a live transfer (from Contactor to the Exchange) of customers who call Contractor with issues or complaints that need to be addressed by the Exchange.

(c) Examples of issues or complaints include but are not limited to premium billing or claims issues; benefit coverage questions (before and after enrollment); complaints; network or provider details; and Issuer-specific questions or issues.

(d) Contractor shall refer Enrollees and applicants with questions regarding premium tax credit and the Exchange eligibility determinations to the Exchange's website or Service Center, as appropriate.

(e) Contractor shall work with the Exchange to develop a mechanism to track handling and resolution of calls referred from the Exchange to Contractor (such as through the use of call reference numbers).

3. Customer Care.

(a) Contractor shall comply with the applicable requirements of the Americans with Disabilities Act and provide culturally competent customer service to all the Exchange enrollees in accordance with the applicable provisions of 45 C.F.R. §155.205 and §155.210, which refer to consumer assistance tolls and the provision of culturally and linguistically appropriate information and related products.

(b) Contractor shall comply with HIPAA rules and other laws, rules and regulations respecting privacy and security, as well as establish protocols for handling the Exchange customers who have documented domestic violence or other security concerns. Contractor shall monitor compliance and file these protocols with the Exchange yearly.

4. Notices.

(a) For all forms of notices required under Federal and State law to be sent to Enrollees regarding rates, benefit design, network changes, or security/HIPAA references, Contractor shall submit an electronic copy to the Exchange at least five (5) business days in advance of the message transaction. If Contractor is unable to notify the Exchange in advance due to Federal or State notice requirements, Contractor shall send the Exchange notification simultaneously.

(b) Contractor shall provide a link to the Exchange website on its website.

(c) When Contractor provides direct contacts for getting membership assistance, Contractor shall also include the Exchange website for Exchange-related issues.

(d) All legally required notices sent by Contractor to Enrollees shall be translated into and available in languages other than English as required under applicable Federal and State laws, rules and regulations, including, Health and Safety Code 1367.04.

(e) Contractor shall release notices in accordance with Federal and State law. All such notices shall meet the accessibility and readability standards in the Exchange regulations (45 C.F.R. Parts 155 and 156) located in 10 CCR Sections 6400 et. seq.

5. Issuer-Specific Information.

(a) Upon request, Contractor shall provide training materials and participate in the Exchange customer service staff training.

(b) Contractor shall provide summary information about its administrative structure and the QHPs offered on the Exchange. This summary information will be used by the Exchange customer service staff when referencing Contractor or Qualified Health Plan information. The Exchange will develop a form to collect uniform information from Contractor.

6. Enrollee Materials.

(a) Contractor shall provide or make available to Enrollees Plan materials required under the terms of the Agreement and applicable laws, rules and regulations. Such materials shall be available in languages as required by Federal and State law and receive any necessary regulatory approvals from Health Care Regulators, be provided to the Exchange as directed by the Exchange, and shall include information brochures, a summary of the Plan that accurately reflects the coverage available under the Plan (a Summary of Benefits and Coverage) and related communication materials. Contractor shall, upon request by the Exchange, provide copies of Enrollee communications and give the Exchange the opportunity to comment and suggest changes in such material.

(b) Enrollee materials shall be available in English, Spanish and other languages as required by applicable laws, rules and regulations. Contractor shall comply with Federal and State laws, rules and regulations regarding language access. To the extent possible, Enrollee materials shall be written in plain language, as that term is defined in applicable laws, rules and regulations. Plan materials that require Exchange notification before usage are those that communicate specific eligibility and enrollment and other key information to Enrollees. Such materials may include, but are not limited to:

i. Welcome letters

ii. Enrollee ID card

iii. Billing notices and statements

iv. Notices of actions to be taken by Plan that may impact coverage or benefit letters

v. Termination Grievance process materials

vi. Drug formulary information

vii. Uniform summary of benefits and coverage

viii. Other materials required by the Exchange.

(c) New Enrollee Enrollment Packets.

i. Contractor shall mail or provide online enrollment packets to all new Individual Exchange Enrollees in individual Exchange QHPs within ten (10) business days of receiving complete and accurate enrollment information from the Exchange and the binder payment; and within ten (10) business days of receipt of complete and accurate enrollment information for SHOP QHP Enrollees. Contractor may deliver Enrollee materials pursuant to other methods that are consistent with; (1) Contractor's submission of materials to enrollees of its other plans; (2) the needs of Enrollees; (3) the consent of the Enrollee; and (4) with applicable laws, rules and regulations. Contractor shall report to the Exchange monthly, in a format mutually agreed upon by the Exchange and Contractor, on the number and accuracy rate of identification cards that were sent to new Enrollees and Contractor's compliance with the Performance Measurement Standards set forth in this Agreement. The enrollment packet shall include, at the minimum, the following:

a. Welcome letter;

b. Enrollee ID card, in a form approved by the Exchange

1. If Enrollee ID card is not included in the enrollment packet, Contractor must send a notice to the Enrollee that states the ID card will be sent separately, and when the Enrollee should expect to receive it,

c. Summary of Benefits and Coverage;

d. Pharmacy benefit information;

e. Nurse advice line information; and

f. Other materials required by the Exchange.

ii. Contractor shall maintain access to enrollment packet materials; Summary of Benefits and Coverage ("SBC"); claim forms and other Plan-related documents in both English and Spanish and any other languages required by State and Federal laws, rules and regulations to the extent required to timely meet all requirements of this Agreement for timely mailing and delivery of Plan materials to Enrollees. Contractor shall be responsible for printing, storing and stocking, as applicable, all materials.

(d) Summary of Benefits and Coverage. Contractor shall develop and maintain an SBC as required by Federal and State laws, rules and regulations. The SBC will be available online and the hard copy sent to Enrollees on request shall be available to Enrollees in

English, Spanish, and other languages as required by Federal and State laws, rules and regulations. Contractor shall update the SBC annually and Contractor shall make the SBC available to Enrollees pursuant to Federal and State laws, rules and regulations.

(e) Electronic Listing of Participating Providers. Contractor shall create and maintain a continually updated electronic listing of all Participating Providers and make it available online for Enrollees, potential Enrollees, and Participating Providers, 24 hours a day, 7 days a week. The listing shall comply with the requirements required under applicable laws, rules and regulations, including those set forth at 45 C.F.R. Section 156.230 relating to identification of Providers who are not accepting new Enrollees.

(f) Access to Medical Services Pending ID Card Receipt. Contractor shall promptly coordinate and ensure access to medical services for Enrollees who have not received ID cards but are eligible for services.

(g) Explanation of Benefits. Contractor shall send each Enrollee, by mail, an Explanation of Benefits (EOB) to Enrollees in Plans that issue EOBs or similar documents as required by Federal and State laws, rules and regulations. The EOB and other documents shall be in a form that is consistent with industry standards.

(h) Secure Plan Website for Enrollees and Providers. Contractor shall maintain a secure website, 24 hours, 7 days a week. All content on the secure Enrollee website shall be available in English upon implementation of Plan and in Spanish within ninety (90) days after the Effective Date and any other languages required under applicable laws, rules or regulations. The secure website shall contain information about the Plan, including, but not limited to, the following:

i. Upon implementation by Contractor, benefit descriptions, information relating to covered services, cost sharing and other information available;

ii. Ability for Enrollees to view their claims status such as denied, paid, unpaid;

iii. Ability to respond via e-mail to customer service issues posed by Enrollees and Participating Providers;

iv. Ability to provide online eligibility and coverage information for Participating Providers;

v. Support for Enrollees to receive Plan information by e-mail; and

vi. Enrollee education tools and literature to help Enrollees understand health costs and research condition information.

7. Standard Reports. Contractor shall submit standard reports as described below, pursuant to timelines, periodicity, rules, procedures, demographics and other policies mutually established by

the Exchange and Contractor, which may be amended by mutual agreement from time to time. Standard reports shall include, but are not limited to:

(a) Enrollee customer service reports including phone demand and responsiveness, initial call resolution, response to written correspondence, and number/accuracy/timeliness of ID card distribution n;

(b) Contractor shall provide utilization data regarding its nurse advice line based on its current standard reporting. Contractor and the Exchange shall work together in good faith to identify mutually agreeable information for Contractor to provide to the Exchange that will be useful in identifying patterns of utilization, including regarding health conditions or symptoms that are frequent topics of calls from Contractor's members.

(c) Use of Plan website;

(d) Quality assurance activities;

(e) Enrollment reports; and

(f) Premiums collected.

8. **Performance Measurement Standards for Subcontractors.** Contractor shall, as applicable, ensure that all Subcontractors comply with all Agreement requirements and Performance Measurement Standards, including, but not limited to, those related to customer service. Subcontractor's failure to comply with Agreement requirements and all applicable Performance Measurement Standards shall result in specific remedies referenced in Attachment 14 applying to Subcontractor.

9. **Contractor Staff Training about the Exchange**

(a) Contractor shall arrange for and conduct their staff training regarding the relevant laws, mission, administrative functions and operations of the Exchange including the Exchange program information and products in accordance with Federal and State laws, rules and regulations and using training materials developed by the Exchange as applicable.

(b) Upon request by the Exchange, Contractor shall provide the Exchange with a list of upcoming staff trainings and make available training slots for the Exchange staff to attend upon request.

10. **Customer Service Training Process.** Contractor shall demonstrate to the Exchange that it has in place initial and ongoing customer service protocols, training, and processes to appropriately interface with and participate in the Exchange. As part of this demonstration, Contractor shall permit the Exchange to inspect and review its training materials. The Exchange will share its customer service training modules with Contractor.

Attachment 7 – Quality, Network Management and Delivery System Standards

Quality, Network Management and Delivery System Standards

Preamble

PROMOTING HIGHER QUALITY AND BETTER VALUE

The mission of Covered California (the "Exchange") is to increase the number of insured Californians, improve health care quality and access to care, promote better health, lower costs, and reduce health disparities through an innovative and competitive marketplace that empowers consumers to choose the health plan and providers that offer the best value. The Exchange's "Triple Aim" framework seeks to improve the patient care experience including quality and satisfaction, improve the health of the population, and reduce the per capita cost of Covered Services. The Exchange and Contractor recognize that promoting better quality and value will be contingent upon smooth implementation and large enrollment in the Exchange.

Qualified Health Plans ("QHP" or "Contractor") are central partners for the Exchange in achieving its mission. By entering into an agreement with the Exchange ("Agreement"), QHPs agree to work in partnership with the Exchange to develop and implement policies and practices that will promote the Triple Aim, impacting not just the Enrollees of the Exchange but the Contractor's California membership. QHPs have the opportunity to take a leading role in helping the Exchange support new models of care which promote the vision of the Affordable Care Act and meet consumer needs and expectations. At the same time, the Contractor and the Exchange can promote improvements in the entire care delivery system. The Exchange will seek to promote care that reduces excessive costs, minimizes unpredictable quality and reduces inefficiencies of the current system. For there to be a meaningful impact on overall healthcare cost and quality, solutions and successes need to be sustainable, scalable and expand beyond local markets or specific groups of individuals. The Exchange expects its QHP partners to engage in a culture of continuous quality and value improvement, which will benefit all Enrollees.

These Quality, Network Management and Delivery System Standards outline the ways that the Exchange and the Contractor will focus on the promotion of better care and higher value for the Plan Enrollees and for other California health care consumers. This focus will require both the Exchange and the Contractor to coordinate with and promote alignment with other organizations and groups that seek to deliver better care and higher value. By entering into the Agreement with the Exchange, Contractor affirms its commitment to be an active and engaged partner with the Exchange and to work collaboratively to define and implement additional initiatives and programs to continuously improve quality and value.

Article 1. Improving Care, Promoting Better Health and Lowering Costs

1.01 Coordination and Cooperation. Contractor and the Exchange agree that the Quality, Network Management and Delivery System Standards serve as a starting point for what must be ongoing, refined and expanded efforts to promote improvements in care for Enrollees and across Contractor's California members. Improving and building on these efforts to improve care and reduce administrative burdens will require active partnership between both the Exchange and the Contractor, but also with Providers, consumers and other important stakeholders.

(a) The Exchange shall facilitate ongoing discussions with the Contractor and other stakeholders through the Exchange's Plan Management and Delivery System Reform Advisory Group and through other forums as may be appropriate to work with Contractors to assess the elements of this Section and their impact, and ways to improve upon them on:

i. Enrollees and other consumers;

ii. Providers in terms of burden, changes in payment and rewarding the triple aim of improving care, promoting better health and lowering costs; and

iii. Contractors in terms of the burden of reporting, participating in quality or delivery system efforts.

(b) The Contractor agrees to participate in Exchange advisory and planning processes, including but not limited to participating in the Plan Management and Delivery System Reform Advisory Group.

1.02 Participation in Collaborative Quality Initiatives. Contractor shall participate in one or more established statewide and national collaborative initiatives for quality improvement. Specific collaborative initiatives may include, but are not limited to:

(a) Leapfrog

(b) California Maternal Data Center (sponsored by the California Maternal Quality Care Collaborative (CMQCC)

(c) California Joint Replacement Registry developed by the California Healthcare Foundation (CHCF), California Orthopaedic Association (COA) and Pacific Business Group on Health (PBGH)

(d) NCDR® (National Cardiovascular Data Registry that currently includes seven specific registry programs)

(e) Society of Thoracic Surgeons National Database for the collection of general thoracic surgery clinical data

(f) National Neurosurgery Quality and Outcomes Database (N2QOD)

(g) Integrated Healthcare Association's (IHA) Pay for Performance Program

(h) IHA Payment Bundling demonstration

(i) Centers for Medicare and Medicaid Innovation (CMMI) Bundled Payments for Care Improvement initiative (BPCI)

(j) CMMI Comprehensive Primary Care initiative (CPC)

(k) CMMI Shared Savings Program (including Pioneer, Advanced Payment and other models)

(l) Contractor-sponsored accountable care programs

(m) California Perinatal Quality Care Collaborative

(n) California Quality Collaborative

Contractor will provide the Exchange information regarding their active participation. Such information shall be in a form that shall be mutually agreed to by the Contractor and the Exchange and may include copies of reports used by the Contractor for other purposes. Contractor understands that the Exchange will seek increasingly detailed reports over time that will facilitate the assessment of the impacts of these programs which should include: (1) the percentage of total Participating Providers, as well as the percentage of the Exchange specific providers participating in the programs; (2) the number and percentage of potentially eligible Plan Enrollees who participate through the Contractor in the Quality Initiative; (3) the results of Contractors' participation in each program, including clinical, patient experience and cost impacts; and (4) such other information as the Exchange and the Contractor identify as important to identify programs worth expanding.

The Exchange and Contractor will collaboratively identify and evaluate the most effective programs for improving care for enrollees and the Exchange and Contractor may consider participation by Contractor as a requirement for future certification.

1.03 Reducing Health Disparities and Assuring Health Equity. Covered California and the Contractor recognize that promoting better health requires a focus on addressing health disparities and health equity. Because of this, Contractor agrees to work with the Exchange to identify strategies that will address health disparities in meaningful and measurable ways. This shall include:

(a) Contractor to complete select components of the eValue8 Submission specific to Racial, Cultural and Language Competency (previously Section 2.5.1.7 in the 2013 QHP Solicitation), which describes its programs to address health equity and health disparities;

(b) Participating in Exchange workgroups and forums to share strategies and tactics that are particularly effective;

(c) Describing to the Exchange how, if at all, it collects and uses the data elements described in 1.03(d) that follows regarding Exchange's Enrollees to: (1) understand how health care is being differently delivered to different populations and (2) to support targeted clinical or preventive services; and

(d) Working with the Exchange to determine how data can best be collected and used to support improving health equity including the extent to which data might be better collected by the Exchange or the Contractor and how to assure that the collection and sharing of data is sensitive to Enrollees' preferences. In working with the Exchange, Contractor agrees to report how it plans to collect and use data on demographic characteristics, including but not limited to:

iv. Race

v. Ethnicity

vi. Gender

vii. Primary language

viii. Disability status

ix. Sexual orientation

x. Gender identity

Article 2. Accreditation: NCQA, URAC or AAAHC

2.01 Contractor shall be currently accredited and shall maintain its NCQA, URAC or AAAHC health plan accreditation throughout the term of the Agreement. Contractor shall notify the Exchange of the date of any accreditation review scheduled during the term of this Agreement and the results of such review.

2.02 Upon completion of any health plan accreditation review conducted during the term of this Agreement, Contractor shall provide the Exchange with a copy of the Assessment Report within forty-five (45) days of report receipt.

2.03 If Contractor receives a rating of less than "accredited" in any category, Contractor shall notify the Exchange within ten (10) business days of such rating(s) change and shall be required to provide the Exchange with all corrective action(s) that will be taken to raise the category rating to a level of at least "accredited". Contractor will submit a written corrective action plan (CAP) to the Exchange within forty-five 45 days of receiving its initial notification of the change in category ratings.

2.04 Following the initial submission of the corrective action plans ("CAPs"), Contractor shall provide a written report to the Exchange on at least a quarterly basis regarding the status and progress of the submitted corrective action plan(s). Contractor shall request a follow-up review by accreditation entity at the end of twelve (12) months and a copy of the follow-up Assessment Report will be submitted to the Exchange within thirty (30) days of receipt.

2.05 In the event Contractor's overall accreditation is suspended, revoked, or otherwise terminated, or in the event Contractor has undergone review prior to the expiration of its current accreditation and reaccreditation is suspended, revoked, or not granted at the time of expiration, the Exchange reserves the right to terminate any agreement by and between Contractor and the Exchange.

2.06 Upon request by the Exchange, Contractor will identify all health plan certification or accreditation programs undertaken, including any failed accreditation or certifications, and will also provide the full written report of such certification or accreditation undertakings to the Exchange.

Article 3. Provision and Use of Data and Information for Quality of Care

3.01 HEDIS and CAHPS Reporting. For Measurement Year 2014 and thereafter Contractor shall collect and report to the Exchange, for each QHP Product Type, its HEDIS, CAHPS and other performance data (numerators, denominators, and rates) subject to the federal Quality Rating System requirements.

For Measurement Year 2014 and thereafter, if requested, Contractor shall submit to the Exchange HEDIS and CAHPS scores to include the measure numerator, denominator and rate for the required measures set that is reported to NCQA Quality Compass and/or DHCS, per each Product Type for which it collects data in California. The timeline for Contractor's HEDIS and CAHPS quality data submission shall be consistent with the timeline for submitting data to the NCQA Quality Compass and/or DHCS. The Exchange reserves the right to use the Contractor-reported measures scores to construct Contractor summary quality ratings that the Exchange may use for such purposes as supporting consumer choice and the Exchange's plan oversight management.

3.02 Hospital Quality Oversight. Contractor agrees to develop and implement oversight programs (if not already in place by January 1, 2015) targeting the following areas related to hospital-based services, as outlined by the Center for Medicare and Medicaid Services (CMS) Hospital Compare Program, including:

(a) Deaths and readmissions;

(b) Serious complications related to specific conditions;

(c) Hospital acquired conditions; and

(d) Healthcare associated infections.

These oversight programs should be consistent with Medicare performance areas whenever possible and should reflect the overall performance of the hospital. Contractor agrees to provide/submit regular reporting of program(s) results from Contractor. Standard reporting requirements, including format, frequency and other technical specifications will be mutually agreed upon between the Exchange and Contractor.

3.03 Data Submission Requirements to the Exchange. Contractor shall provide to the Exchange information regarding Contractor's membership through the Exchange in a consistent manner to that which Contractor currently provides to its major purchasers. Contractor and the Exchange shall work together in good faith to further define mutually agreeable information and formats for Contractor to provide to the Exchange, in all cases to remain generally consistent with the information shared by Contractor with its major purchasers.

Covered California's Enterprise Analytics Solution (EAS) Vendor shall provide Issuer with a written list of data elements ["EAS Dataset"] and a data submission template that defines the data elements and format for transmitting the data. A preliminary list of data elements, to be finalized when Vendor prepares the proposed EAS Dataset, is attached as Appendix 1 to Attachment 7. These data elements are subject to change based on mutual agreement.

Health Plan may propose, in writing, revisions to the EAS Dataset or the data submission template. Unless there is inadequate data documentation, Vendor will recommend to Covered California the

adoption of the Issuer proposed revisions. Upon the mutual agreement of Issuer, Vendor and Covered California, the EAS Dataset shall be finalized. The Issuer and Vendor shall execute a Data Use Agreement whose terms shall govern the EAS Dataset.

Issuer shall disclose Personally Identifiable Health Information only in accordance with the terms and conditions contained in the Issuer-Covered California Agreement and this Amendment hereof, and in compliance with all applicable federal and state laws, rules and regulations, including the Privacy Rules. In complying with the EAS Dataset terms, Issuer shall submit Personally Identifiable Health Information to the Vendor. The Issuer and Vendor shall execute a Business Associate Agreement. Vendor shall protect the EAS Dataset information as required under applicable laws, rules and regulations. Personally Identifiable Health Information that Issuer discloses to the Vendor shall be de-identified in any data or analyses provided to the Covered California.

3.04 eValue8 Submission. During each Contract Year, starting in 2015, Contractor shall submit to the Exchange certain information that is a required disclosure under the Covered California eValue8 Health Plan Request for Information, as modified by the Exchange and may be updated from time to time by the Exchange. The Covered California eValue8 Request for Information questions are listed in Appendix 3 to Attachment 7. Contractor is absolved of the responsibility to complete the original eValue8 as outlined in Attachment 14, Group 3, Item 3.5 of the 2014 Qualified Health Plan Contract. For calendar year 2014, the Covered California eValue8 may be optionally submitted to satisfy Quality/Network Management reporting requirements 4.1 through 4.15 as listed in Appendix 2 to Attachment 7.

Such information will be used by the Exchange to evaluate Contractor's performance under the terms of the Quality, Network Management and Delivery System Standards and/or in connection with the evaluation regarding any extension of the Agreement and/or the recertification process. The timing, nature and extent of such disclosures will be established by the Exchange based on its evaluation of various quality-related factors. Contractor's response shall include information relating to all of Contractor's then-current California-based business and Contractor shall disclose any information that reflects California-based information that is provided by Contractor due to Contractor's inability to report on all Exchange-specific business. Contractor shall also report data separately for HMO/POS, PPO and EPO product lines.

3.05 Determining Enrollee Health Status and Use of Health Assessments. Contractor shall demonstrate the capacity and systems to collect, maintain and use individual information about Exchange Plan Enrollees' health status and behaviors in order to promote better health and to better manage Enrollees' health conditions.

To the extent the Contractor uses or relies upon Health Assessments to determine health status, Contractor shall offer, upon initial enrollment and on a regular basis thereafter, a Health Assessment to all Plan Enrollees over the age of 18, including those Plan Enrollees that have previously completed such an assessment. If a Health Assessment tool is used, Contractor should select a tool that adequately evaluates Plan Enrollees current health status and provides a mechanism to conduct ongoing monitoring for future intervention(s).

3.06 Reporting to and Collaborating with the Exchange Regarding Health Status. Contractor shall provide to the Exchange, in a format that shall be mutually agreed upon, information on how it collects and reports, at both individual and aggregate levels, changes in Exchange Plan Enrollees' health status.

Reporting may include a comparative analysis of health status improvements across geographic regions and demographics.

Contractor shall report to the Exchange its process to monitor and track Plan Enrollees' health status, which may include its process for identifying individuals who show a decline in health status, and referral of such Plan Enrollees to Contractor care management and chronic condition program(s) as defined in Section 5.04, for the necessary intervention. Contractor shall annually report to the Exchange the number of Plan Enrollees who are identified through their selected mechanism and the results of their referral to receive additional services.

Contractor agrees to work with the Exchange to standardize: (1) indicators of Plan Enrollee risk factors; (2) health status measurement; and (3) health assessment questions across all Contractors, with the goal of having standard measures used across the Exchange's Contractors in a period of time mutually agreed upon by Contractor and the Exchange.

Article 4. Preventive Health and Wellness

4.01 Health and Wellness Services. Contractor is required to encourage and monitor the extent to which Exchange Plan Enrollees obtain preventive health and wellness services within the Enrollee's first year of enrollment. Contractor shall submit information annually to the Exchange related to Plan Enrollees' access to preventive health and wellness services. Such information should be coordinated with existing national measures, whenever possible, including HEDIS. Specifically, Contractor shall assess and discuss the participation by Plan Enrollees in:

(a) necessary preventive services appropriate for each enrollee;

(b) tobacco cessation intervention, inclusive of evidenced based counseling and appropriate pharmacotherapy, if applicable; and

(c) obesity management, if applicable.

4.02 Community Health and Wellness Promotion. The Exchange and Contractor recognize that promoting better health for Plan Enrollees also requires engagement and promotion of community-wide initiatives that foster better health, healthier environments and the promotion of healthy behaviors across the community. Contractor shall report annually in a mutually agreed upon form the initiatives, programs and/or projects that it supports that promote wellness and better community health that specifically reach beyond the Contractors' Enrollees. Such programs may include, but are not limited to, partnerships with local or state public health departments (e.g. Let's Get Healthy California) and voluntary health organizations which operate preventive and other health programs.

Contractor shall develop and provide a report regarding its participation in community health and wellness promotion. Report information should be coordinated with existing national measures (e.g. Healthy People 2020), whenever possible.

4.03 Health and Wellness Enrollee Support Process. Contractor shall annually submit to the Exchange the following:

(a) Documentation of health and wellness communication process to Exchange Enrollees and appropriate Participating Providers;

(b) Documentation of process to ensure network adequacy required by State or Federal laws, rules and regulations - given the focus on prevention and wellness and the impact it may have on network capacity; and

(c) Documentation of a process to incorporate Enrollees health and wellness information into Contractor's data and information specific to each individual Enrollee. This Enrollee's data is Contractor's most complete information on each Enrollee and is distinct from the Enrollee's medical record maintained by the providers.

Article 5. Access, Coordination, and At-Risk Enrollee Support

The Exchange and Contractor recognize that access to care, coordination of care and early identification of high risk enrollees are central to the improvement of Enrollee health. Traditionally, Primary Care Providers have provided an entry point to the system (access), coordination of care and early identification of at risk patients, and the Exchange strongly encourages the full use of PCPs by Contractors. Contractor and the Exchange shall identify further ways to increase access and coordination of care and agree to work collaboratively to achieve these objectives.

5.01 Encouraging Consumers' Access to Appropriate Care. Contractor is encouraged to assist Exchange Enrollees in selecting a Primary Care Provider (PCP), Federally Qualified Health Center (FQHC) or a Patient-Centered Medical Home (PCMH) within sixty (60) days of enrollment. In the event the Enrollee does not select a PCP, FQHC or a PCMH, Contractor may auto-assign the enrollee to a PCP, FQHC or a PCMH and the assignment shall be communicated to the Plan Enrollee. Nothing in this section shall be construed to prohibit Contractor from assigning an Enrollee to a PCP, FQHC or a PCMH prior to the expiration of the sixty (60) day self-selection period. In the event of an auto-assignment, Contractor shall use commercially reasonable efforts to make assignment to a participating provider consistent with an Enrollee's stated gender, language, ethnic and cultural preferences, and will consider geographic accessibility and existing family member assignment or prior provider assignment.

5.02 Promoting Development and Use of Care Models. In addition to fostering appropriate linkage of enrollees with primary care providers, Contractor is encouraged to actively promote the development and use of care models that promote access, care coordination and early identification of at risk enrollees. Such models may include, but are not limited to:

(a) Accountable Care Organizations (ACO);

(b) Patient Centered Medical Homes (PCMH);

(c) The use of a patient-centered, team-based approach to care delivery and member engagement;

(d) A focus on additional primary care recruitment, use of Advanced Practice Clinicians (e.g. Nurse Practitioner, Certified Nurse Midwife and Physician Assistant) and development of new primary care and specialty clinics;

(e) A focus on expanding primary care access through payment systems and strategies;

(f) The use of an intensive outpatient care programs ("Ambulatory ICU") for enrollees with complex chronic conditions;

(g) The use of qualified health professionals to deliver coordinated patient education and health maintenance support, with a proven approach for improving care for high-risk and vulnerable populations;

(h) Support of physician and patient engagement in shared decision-making;

(i) Providing patient access to their health information;

(j) Promoting team care;

(k) The use of telemedicine; and

(l) Promoting the use of remote patient monitoring.

Contractor shall report annually, in a format to be mutually agreed upon between Contractor and Exchange, on: (1) the number and percentage of Exchange Plan Enrollees who have selected or been assigned to a Primary Care Provider, as described in Section 5.01; (2) the involvement of Exchange Plan Enrollees in the models described in Section 5.02 or such other models as the Contractor identifies as promoting better access, coordination and care for at risk enrollees; and (3) the results of such involvement , including clinical, patient experience and costs impacts. In the event that the reporting requirements identified herein include Protected Health Information, Contractor shall provide the Exchange only with de-identified Protected Health Information as defined in 45 C.F.R. Section 164.514. All information provided to the Exchange in this section shall be treated by the Exchange as confidential information.

Contractor shall not be required to provide the Exchange any data, information or reports that would violate peer review protections under applicable laws, rules and regulation.

5.03 Supporting At-Risk Enrollees Requiring Transition. Contractor shall have an evaluation and transition plan in place for the Enrollees of the Exchange with existing health coverage including, but not limited to, those members transferring from Major Risk Medical Insurance Program, Pre-Existing Condition Insurance Plan, AIDS Drug Assistance Program, or other individuals under active care for complex conditions and who require therapeutic provider and formulary transitions. It is the intention of the Exchange to work with Contractors and State partners to facilitate early identification of at-risk patients where possible.

In a manner that is consistent with California law the evaluation and transition plan will include the following:

(a) Identification of in-network providers with appropriate clinical expertise or any alternative therapies including specific drugs when transitioning care;

(b) Clear process(es) to communicate Enrollee's continued treatment using a specific therapy, specific drug or a specific provider when no equivalent is available in-network;

(c) Where possible, advance notification and understanding of out-of-network provider status for treating and prescribing physicians; and

(d) A process to allow incoming Enrollees access to Contractor's formulary information prior to enrollment.

It is not the intention of the Exchange to require that Contractor's transition plans for At-Risk Enrollees impose any obligations on contractor which are not otherwise required under applicable State Law or by other provisions of this Agreement

5.04 Identification and Services for At-Risk Enrollees. Contractor agrees to identify and proactively manage the Plan Enrollees with existing and newly diagnosed chronic conditions and who are most likely to benefit from well-coordinated care ("At-Risk Enrollees"). Contractor will target at-risk enrollees, typically with one or more conditions, including, but not limited to, diabetes, asthma, heart disease or hypertension. As described in Section 3.06, Contactor shall determine the health status of its

new enrollees including identification of those with chronic conditions or other significant health needs. For Enrollees transitioning from state and federal programs such as the Major Risk Medical Insurance Program or Pre Existing Condition Insurance Plan, Contractor shall provide the Exchange with a documented process, care management plan and strategy for targeting these specific Enrollees. Such documentation may include the following:

(e) Methods to identify and target At-Risk Enrollees;

(f) Description of Contractor's predictive analytic capabilities to assist in identifying At Risk Plan Enrollees who would benefit from early, proactive intervention;

(g) Communication plan for known At-Risk Enrollees to receive information prior to provider visit;

(h) Process to update At-Risk Enrollee medical history in the Contractor maintained Plan Enrollee health profile;

(i) Mechanisms to evaluate access within provider network, on an ongoing basis, to ensure that an adequate network is in place to support a proactive intervention and care management program for At-Risk Enrollees;

(j) Care and network strategies that focus on supporting a proactive approach to at-risk Plan Enrollee intervention and care management. Contractor agrees to provide the Exchange with a documented plan and include "tools" and strategies to supplement and/or expand care management and provider network capabilities, including an expansion and/or reconfiguration of specialties or health care professionals to meet clinical needs of At Risk Enrollees;

(k) Strategies or "tools" not otherwise described in Section 5.02 may include but are not limited to the following:

i. Enrollment of At-Risk Enrollees in care, case and disease management program(s); and

ii. At Risk Plan Enrollee's access to Accountable Care Organizations (ACOs), Patient Centered Medical Homes (PCMH), Ambulatory ICUs or other delivery models designed to focus on individual chronic condition management and focused intervention.

Article 6. Patient-Centered Information and Communication

6.01 Provider Cost and Quality. Contractor shall provide the Exchange with its plan, measures and process to provide Plan Enrollees with current cost and quality information for network providers, including at the individual physician and hospital level, using the most current nationally recognized or endorsed measures, including National Quality Forum (NQF), in accordance with the principles of the Patient Charter for Physician Performance Measurement. At a minimum, Contractor shall document its plans to make available to Plan Enrollees information provided for public use, as it becomes available, that reflects the CMS Hospital Compare Program and CMS Physician Quality Reporting System, or Health Resources and Services Administration (HRSA) Uniform Data System as appropriate. Contractor shall report how it is or intends to make provider specific cost and quality information available by region, and the processes by which it updates the information. Information delivered through Contractor's Provider performance programs should be meaningful to Plan Enrollees and reflect a diverse array of Provider clinical attributes and activities, including, but not be limited to: provider background; quality performance; patient experience; volume; efficiency; price of services; and should be integrated and accessible through one forum providing Plan enrollees with a comprehensive view.

6.02 Enrollee Cost Transparency. The Exchange and Contractor acknowledge and agree that information relating to the cost of procedures and services is important to enrollees, the Exchange, the Contractor and providers. The Exchange also understands that Contractor negotiates Agreements with providers, including physicians, hospitals, physician groups and other clinical providers, which may or may not result in varied provider reimbursement levels for identical services and or procedures. In the event that Contractor's provider contracts do result in different provider reimbursement levels that have an impact on Plan Enrollee out of pocket costs within a specific region, as defined by paid claims for like CPT, ICD9/10 and DRG based services: (1) Contractor agrees to provide the Exchange with its plan, measures and process to assist Plan Enrollees identify total cost and out-of-pocket cost information for the highest frequency and highest cost service(s) and or procedure(s); (2) when available, this pricing information shall be prominently displayed and made available to both Plan Enrollees and contracted Contractor providers if provided; and (3) this information shall be updated on at least an annual basis; provided however, if there is a contractual change that would change enrollee out-of-pocket costs by more than 10%, information must be updated within 30 days of the effective date of the new contract.

6.03 Enrollee Benefit Information. Contractor shall provide Plan Enrollees with current information regarding annual out-of-pocket costs, status of deductible and total Covered Services received to date.

6.04 Enrollee Shared Decision-Making. Contractor shall demonstrate effective engagement of enrollees with information, decision support, and strategies to optimize self-care and make the best choices about their treatment, with materials from sources such as Consumer Reports, developed as part of the American Board of Internal Medicine ("ABIM") Foundation campaign, "Choosing Wisely" or structured shared decision-making programs.

Contractor shall also provide specific information to the Exchange regarding the number of Plan Enrollees who have accessed consumer information and/or have participated in a shared decision-making process prior to reaching an agreement on a treatment plan. For example, Contractor may adopt shared-decision-making practices for preference-sensitive conditions, including but not limited to breast cancer, prostate cancer, and knee and hip replacements, that feature patient-decision-making aids in addition to physician opinions and present trade-offs regarding quality or length of life. Contractor shall report the percentage of Enrollees with identified health conditions above who received information that allowed the Enrollee to share in the decision-making process prior to agreeing to a treatment plan. Contractor shall report annually to the Exchange documenting participation in these programs and their results, including

clinical, patient experience and costs impacts and to the extent collected provide the results to the Exchange.

Article 7. Promoting Higher Value Care

7.01 Reward-based Consumer Incentive Programs. Contractor may, to the extent permitted by law, maintain or develop a Reward-based Consumer Incentive Program to promote evidence-based, optimal care for Plan Enrollees with identified chronic conditions. To the extent Contractor implements such a program for Plan Enrollees and to the extent such information is known, Contractor shall report participation rates and outcomes results, including clinical, patient experience and cost impacts, to the Exchange.

7.02 Value Based Reimbursement Inventory and Performance. Contractor will provide an inventory of all current value based provider reimbursement methodologies within the geographic regions served by the Exchange. Value based reimbursement methodologies will include those payments to hospitals and physicians that are linked to quality metrics, performance, costs and/or value measures. Integrated care models that receive such value based reimbursements may be included, but are not limited to, those referenced in Section 5.02.

This inventory must include:

(d) The percentage of total valued based reimbursement to providers, by provider and provider type.

(e) The total number of Contractor Plan Enrollees accessing participating providers reimbursed under value based payment methodologies.

(f) The percentage of total Contractor Network Providers participating in value based provider payment programs.

(g) An evaluation of the overall performance of Contractor network providers, by geographic region, participating in value based provider payment programs.

Contractor and the Exchange shall reach an annual agreement on the targeted percentage of providers to be reimbursed under value based provider reimbursement methodologies.

7.03 Value Based Reimbursement and Adherence to Clinical Guidelines. If not already in place, by January 1, 2016, Contractor agrees to develop and/or implement alternative reimbursement methodologies to promote adherence to clinical guidelines. Methodologies will target the highest frequency conditions and procedures as mutually agreed upon by the Exchange and Contractor.

When considering the implementation of value based reimbursement programs, Contractor shall demonstrate and design approaches to payment that reduce waste and inappropriate care, while not diminishing quality.

7.04 Value-Pricing Programs. Contractor agrees to provide the Exchange with the details of any value-pricing programs for procedures or in service areas that have the potential to improve care and generate savings for the Exchange enrollees. Contractor agrees to share the results with the Exchange of programs that may focus on high cost regions or those with the greatest cost variation(s). These programs may include but are not limited to payment bundling pilots for specific procedures where wide cost variations exist.

7.05 Payment Reform and Data Submission.

(h) Contractor will provide information to the Exchange noted in all areas of this Article 7 understanding that the Exchange will provide such information to the Catalyst for Payment Reform's (CPR) National Scorecard on Payment Reform and National Compendium on Payment Reform.

(i) The CPR National Scorecard will provide a view of progress on payment reform at the national level and then at the market level as the methodology and data collection mechanisms allow.

(j) The CPR National Compendium will be an up-to-date resource regarding payment reforms being tested in the marketplace and their available results. The Compendium will be publicly available for use by all health care stakeholders working to increase value in the system.

Article 8. Drug Formulary Changes

Except in cases where patient safety is an issue, Contractor shall give the affected Exchange Plan Enrollee(s), and their prescribing physician(s), sixty (60) calendar days, unless it is determined that a drug must be removed for safety purposes more quickly, written notice prior to the removal of a drug from formulary status. Notice shall apply only to single source brand drug and will include information related to the appropriate substitute. It will also include a statement of the requirements of the Health and Safety Code and Insurance Code prohibiting Contractor from limiting or excluding coverage for a drug to a Plan Enrollee if the drug had been previously approved for coverage by Contractor for a medical condition of the Plan Enrollee, except under specified conditions. An exception to the notice requirement will be allowed when Contractor continues to cover a drug prescribed for a Plan Enrollee without interruption and under the same conditions, including copayment and limits that existed prior to the removal of the drug from formulary status.

Quality, Network Management and Delivery System Standards

Glossary of Key Terms

Accountable Care Organization (ACO) - A healthcare organization characterized by a payment and care delivery model that seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients. An ACO is intended to provide incentives for participating providers (i.e. clinics, hospitals and physicians) to collectively share financial risk, working towards common goals to 1) reduce medical costs, 2) reduce waste and redundancy, 3) adhere to best care practices (i.e. evidence-based care guidelines, and 4) improve care quality. Care Management and Population Health Management are critical program components that are intended to enable ACOs to achieve favorable financial outcomes as the result of improved care outcomes.

Active Purchaser - Health care purchasers, typically employers or employer coalitions, that proactively define and manage performance expectations through their health plan contracts or direct contracting arrangements with providers. These expectations include a range of service models including (but not limited to) benefit design and incentives, health and wellness, service delivery for enrollees, transaction processing, delivery system performance and reform, health information technology adoption and use, quality of care for enrollees, and other innovation models. Further, these expectations may also include active development, financial support, and contractual expectations for collaborative participation in accordance with applicable laws, rules and regulations, among multiple payers and/or providers that collectively serve a specific geographic area and/or multiple purchasers.

Bundled Payments (also known as Global Payment Bundles, episode-of-care payment, or global case rates) - An alternative payment method to reimburse healthcare providers for services that provides a single payment for all physician, hospital and ancillary services that a patient uses in the course of an overall treatment for a specific, defined condition, or care episode. These services may span multiple providers in multiple settings over a period of time, and are reimbursed individually under typical fee-for-service models. The Payment Bundle may cover all inpatient/outpatient costs related to the care episode, including physician services, hospital services, ancillary services, procedures, lab tests, and medical devices/implants. Using Payment Bundles, providers assume financial risk for the cost of services for a particular treatment or condition, as well as costs associated with preventable complications, but not the insurance risk (that is, the risk that a patient will acquire that condition, as is the case under capitation).

Care Management - Healthcare services, programs and technologies designed to help individuals with certain long-term conditions better manage their overall care and treatment. Care management typically encompasses Utilization Management (UM), Disease Management (DM) and Case Management (CM). Care Management’s primary goal is to prevent the sick from getting sicker, and avoiding acute care events. Care Management is usually considered a subset of Population Health Management.

Complex Conditions - Clinical conditions that are of a complex nature that typically involve ongoing case management support from appropriately trained clinical staff. Frequently, individuals have multiple chronic clinical conditions that complicate management (“polychronic”) or may have a complex, infrequent specialty condition that requires specialized expertise for optimal management.

Delivery System Transformation - A set of initiatives taken by purchasers, employers, health plans or providers, together or individually, to drive the creation and preferred use of care delivery models that are designed to deliver higher value aligned with the “triple aim” goals of patient care experience including quality and satisfaction, improve the health of the populations, and reduce the per capita cost of Covered Services. Generally these models require improved care coordination, provider and payer information sharing and programs that identify and manage populations of individuals through care delivery and payment models.

Patient Centered Medical Home - A health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner. The medical home is best described as a model or philosophy of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety.

Population Health Management - A management process that strives to address health needs at all points along the continuum of health and wellbeing, through participation of, engagement with and targeted interventions for the population. The goal of a Population Health Management program is to maintain and/or improve the physical and psychosocial wellbeing of individuals through cost-effective and tailored health solutions.

Preventive Health and Wellness Services - The provision of specified preventive and wellness services and chronic disease management services, including preventive care, screening and immunizations, set forth under Section 1302 of the Affordable Care Act (42 U.S.C. Section 18022) under the Section 2713 of the Affordable Care Act (42 U.S.C. Section 300gg-13), to the extent that such services are required under the California Affordable Care Act.

Reference Pricing - A payor contracting, network management and enrollee information process that identifies and differentially promotes delivery system options for care based on transparent display of comparative costs for identical services or procedures, typically after each provider has passed a quality assessment screen. In some cases, value pricing will identify the individual enrollees out of pocket costs accounting for plan design and deductible status. While quality is incorporated in the process, typically there is no differentiation based on comparative quality once a threshold performance level is achieved.

Remote Patient Monitoring - A technology or set of technologies to enable monitoring of patients outside of conventional clinical settings (e.g. in the home), which may increase access to care and decrease healthcare delivery costs.

Reward Based Consumer Incentive Program - (aka: Value-Based Insurance Design) individualizes the benefits and claims adjudication to the specific clinical conditions of each high risk member and to reward participation in appropriate disease management & wellness programs. Positive Consumer Incentive programs help align employee incentives with the use of high-value services and medications, offering an opportunity for quality improvement, cost savings and reduction in unnecessary and ineffective care.

Shared Decision Making - The process of making decisions regarding health care diagnosis and treatment that are shared by doctors and patients, informed by the best evidence available and weighted according to the specific characteristics and values of the patient. Shared decision making combines the measurement of patient preferences with evidence-based practice.

Team Care - A plan for patient care that is based on philosophy in which groups of professional and non-professional personnel work together to identify, plan, implement and evaluate comprehensive client-centered care. The key concept is a group that works together toward a common goal, providing qualitative comprehensive care. The team care concept has its roots in team nursing concepts developed in the 1950's.

Telemedicine - Professional services given to a patient through an interactive telecommunications system by a practitioner at a distant site. Telemedicine seeks to improve a patient's health by permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site. This electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment.

Value Pricing - A payor contracting, network management and enrollee information process that identifies and differentially promotes delivery system options for care that provide better value through the identification and transparent display of comparative total cost, out of pocket cost for enrollees and standardized quality performance to allow for informed consumer choice and provider referrals for individual services and bundles of services.

Value Based Reimbursement - Payment models that rewards physicians and providers for taking a broader, more active role in the management of patient health, and provides for a reimbursement rate that reflects results and quality instead of solely for specific visits or procedures.

Appendix 1 to Attachment 7. Enterprise Analytics Solution Dataset

As specified in Section 3.03 of Attachment 7, Contractor shall submit data regarding Contractor's membership through the Exchange. The required data is identified in the Covered California QHP Data Format Template. Covered California intends to contract with a data warehouse and analytic vendor to support its oversight and management of the health exchange. The Covered California QHP Data Format Template is a survey of claims and clinical data elements captured in Issuers' current systems. Contractor shall submit the data elements outlined in the QHP Data Format Template to the Exchange by February 27, 2016 provided that a vendor has been selected by the Exchange and that vendor has executed a Business Associate Agreement with Contractor.

Contractor is not required to provide the Exchange with Individually Identifiable Health Information as to any Enrollee unless authorized by federal and state law. When conformance with data submission requirements necessitates disclosure of Individually Identifiable Health Information not authorized by law, such information shall be submitted by Contractor to a third-party vendor that will aggregate and de-identify the data for the Contractor. Any such third party vendor must enter into a Business Associate Agreement and other agreements as may be required by Contractor that shall protect the information provided as required under applicable federal and state laws, rules and regulations. The Business Associate Agreement and other agreements may include further restrictions on the third party vendor's use and disclosure of the data provided under this Agreement. Any Individually Identifiable Health Information disclosed to the third party vendor shall be de-identified in any subsequent analysis provided to the Exchange.

Plan Header Record Data Elements		
Field #	**Field Name**	**Description**
1	Issuer_Name	Issuer Name (Standard Full Name)
2	HIOS_Issuer_ID	HIOS Issuer Identifier assigned by CMS (standard component)

Member Header Data Elements		
Field #	**Field Name**	**Description**
1	Exch_Member_ID	Unique code assigned by CC to the member
2	Exch_Subscriber_ID	Unique code assigned by CC to subscriber
3	Issuer_MemberID	Unique code assigned by Issuer to identify a member
4	Dep_Suffix	Unique code assigned by Issuer to identify dependents (spouse, children, etc.)
5	SSN	Member's SSN
6	HIOS_Plan_ID	HIOS ID identifies Issuer and product (Standard Component and Variant Component)
7	Field name to be supplied	Cost-sharing suffix 01 – Standard, 02 - AI/AN 03 - AiAN > 300%, 4 - 201-250 05 - 151-200, 06 - 100-150
8	M_Lname	Member's last name
9	M_Fname	Member's first name
10	M_MI	Member's middle initial
11	M_DOB	Member's date of birth
12	M_Gender	Member's Gender: M=male F=female U=unknown
13	M_Language	Member Primary Language (ICE abbreviations)
14	M_Race1	Member Race 1
15	M_Ethnicity1	Member Ethnicity 1
16	M_Addr1	Member's Street Address
17	M_Addr2	Member's Street Address2
18	M_City	Member's City
19	M_State	Member's State
20	M_Zip	Member zip code (5 digit zip; include 4-digit locator if available)
21	M_Phone	Member phone
22	Eff_Date	Effective date of coverage (current effective date of coverage with benefit design)
23	Term_Date	Termination date - Last day of continuous coverage
24	Premium_Amount	Subscriber monthly total premium charged by Issuer including APTC
25	PCP_NPI	NPI of primary care physician selected/assigned

Member Header Data Elements		
Field #	**Field Name**	**Description**
26	Plan_PID	Plan assigned ID for primary care physician if NPI not available

Member Detail Data Elements		
Field #	**Field Name**	**Description**
1	Exch_Member_ID	Unique code assigned by CC to the member
2	Exch_Subscriber_ID	Unique code assigned by CC to policyholder
3	Plan_MemberID	Unique code assigned by health plan to identify a member
4	Dep_Suffix	Unique code assigned by the health plan to identify dependents (spouse, children, etc.)
5	Eff_Date_Init	Original effective date of coverage (Same as Eff_Date unless there is a break in coverage)
6	Eff_Date	Effective date of coverage (current effective date of coverage with benefit design)
7	Term_Date	Termination date - Last day of continuous coverage
8	Enroll_Period_Activity	Type of activity associated with enrollment period (e.g., new, modified, add member, renewal)
9	HIOS_Plan_ID	HIOS ID identifies Issuer and product (standard component and variant component)
10	Field name to be supplied	Cost-sharing suffix 01 – Standard, 02 - AI/AN 03 - AiAN > 300%, 4 - 201-250 05 - 151-200, 06 - 100-150
11	PCP_NPI	NPI of primary care physician selected/assigned
12	Plan_PID	Plan assigned ID for primary care physician if NPI not available

Professional Claims Data Elements		
Field #	**Field Name**	**Description**
1	P_Claim_ID	Plan internal claim number.
2	Plan_MemberID	Unique code assigned by Issuer to identify a particular member
3	Dep_Suffix	Unique code assigned by Issuer to identify dependents (spouse, children, etc.)
4	Line_No	The detail line number for the service on the claim.
5	DatePaid	Date the claim was paid.
6	Place	Code indicating the place of service (e.g., Acute Care Hospital, Office, Patient's Home, etc.). CMS standard values preferred.
7	Service_Type_Qualifier	Indicator if dental or HCPCS/CPT service
8	Void_Replace	Indicator if previously accepted claim is to be voided or replaced (V/R)
9	Init_Date	Date of the first service reported on the claim.
10	Last_Date	Date of the last service reported on the claim.
11	Dx_Qualifier	Indicates if ICD-9 or ICD-10 code
12	Dx1	Primary diagnosis code ICD-9 from claim line
13	Dx2	Secondary diagnosis code ICD-9 from claim line
14	Dx3	Third diagnosis code ICD-9 from claim line
15	Dx4	Fourth diagnosis code ICD-9 from claim line
16	Dx5	Fifth diagnosis code ICD-9 from claim line
17	Dx6	Sixth diagnosis code ICD-9 from claim line
18	ICD-10Dx1	Primary diagnosis code from the claim line

Professional Claims Data Elements		
Field #	**Field Name**	**Description**
19	ICD-10Dx2	Secondary diagnosis code from the claim line
20	ICD-10Dx3	Third diagnosis code from the claim line
21	ICD-10Dx4	Fourth diagnosis code from the claim line
22	ICD-10Dx5	Fifth diagnosis code from the claim line
23	ICD-10Dx6	Sixth diagnosis code from the claim line
24	Proc1	Procedure Code for line on a CMS-1500 claim form.
25	Mod1	The 2-character code of the first procedure code modifier on the professional claim. Procedure modifiers only apply to CPT procedure codes.
26	Mod2	The 2-character code of the second procedure code modifier on the professional claim. Procedure modifiers only apply to CPT procedure codes.
27	Mod3	The 2-character code of the third procedure code modifier on the professional claim. Procedure modifiers only apply to CPT procedure codes.
28	Mod4	The 2-character code of the fourth procedure code modifier on the professional claim. Procedure modifiers only apply to CPT procedure codes.
29	RenderingProvider_NPI	NPI for the rendering provider
30	RenderingProvider_PlanID	The plan assigned ID for the rendering provider
31	Billing_NPI	NPI Type 2 for the billing provider
33	BillingProviderTaxID	The Tax ID for the billing provider
34	P_ClaimNtwk	Claim paid as in-network (Y/N/U=Unknown)
35	P_Cap	Service is/is not capitated (Y/N)
36	P_BilledAmt	Amount billed for procedure

Professional Claims Data Elements		
Field #	**Field Name**	**Description**
37	P_Allowed	Amount allowed for procedure
38	P_AmountPaid	Amount paid by payer
39	P_Deductible	Applied to deductible (Y/N)
40	P_MemberDed	Deductible Amount (patient responsibility)
41	P_Coins	Co-insurance amount (patient responsibility)
42	P_Copay	Copay amount (patient responsibility)
43	P_TotalPaid	Total paid equals deductible, co-insurance and copay amounts (patient responsibility)

Facility Claim Header Data Elements		
Field #	**Field Name**	**Description**
1	H_Claim_ID	Plan internal claim number.
2	H_TaxID	Facility Tax ID Number
3	H_ID	Facility ID Number Assigned by Issuer
4	Plan_MemberID	Unique code assigned by Issuer to identify a member
5	Dep_Suffix	Unique code assigned by Issuer to identify dependents (spouse, children, etc.)
6	DatePaid	Date the claim was paid.
7	Bill_Type	The UB-04 standard code for the billing type, indicating type of facility, bill classification, and frequency of bill.
8	Place	Code indicating the place of service (e.g., Acute Care Hospital, Office, Patient's Home, etc.). CMS standard values preferred.
9	Void_Replace	Indicator if previously accepted claims is to be voided or replaced (V/R)

Facility Claim Header Data Elements		
Field #	**Field Name**	**Description**
10	Init_Date	Date of the first service reported on the claim.
11	Last_Date	Date of the last service reported on the claim.
12	Adm_Date	Date the patient was admitted to the facility
13	Dc_Date	Date the patient was discharged from the facility
14	Dc_Disp	The UB-04 standard patient status code, indicating patient disposition at the time of billing.
15	Dx_Qualifier	Indicates if ICD-9 or ICD-10 code
16	Dx1	Primary diagnosis code ICD-9 from claim line
17	Dx2	Secondary diagnosis code ICD-9 from claim line
18	Dx3	Third diagnosis code ICD-9 from claim line
19	Dx4	Fourth diagnosis code ICD-9 from claim line
20	Dx5	Fifth diagnosis code ICD-9 from claim line
21	Dx6	Sixth diagnosis code ICD-9 from claim line
22	ICD-10Dx1	Primary diagnosis code from the claim line
23	ICD-10Dx2	Secondary diagnosis code from the claim line
24	ICD-10Dx3	Third diagnosis code from the claim line
25	ICD-10Dx4	Fourth diagnosis code from the claim line
26	ICD-10Dx5	Fifth diagnosis code from the claim line
27	ICD-10Dx6	Sixth diagnosis code from the claim line
28	H_Proc1	The primary ICD-9 procedure code on the facility claim.
29	H_Proc2	The secondary ICD-9 procedure code on the facility claim.
30	H_Proc3	The third ICD-9 procedure code on the facility claim.
31	H_Proc4	The fourth ICD-9 procedure code on the facility claim.
32	H_Proc5	The fifth ICD-9 procedure code on the facility claim.

Facility Claim Header Data Elements		
Field #	**Field Name**	**Description**
33	H_Proc6	The sixth ICD-9 procedure code on the facility claim.
34	AdmittingProvider_NPI	NPI for the admitting provider
35	AttendingProvider_NPI	NPI for the rendering provider
36	POA1	CMS Code indicating whether primary Dx was present on admission
37	POA2	CMS Code indicating whether secondary Dx was present on admission
38	POA3	CMS Code indicating whether tertiary Dx was present on admission
39	POA4	CMS Code indicating whether quaternary Dx was present on admission
40	H_ClaimNtwk	Claim paid as in-network (Y/N/U=Unknown)
41	H_Cap	Service is/is not capitated (Y/N)
42	H_BilledAmt	Amount billed
43	H_Allowed	Amount allowed
44	H_AmountPaid	Amount paid by payer
45	H_Deductible	Applied to deductible (Y/N)
46	H_MemberDed	Deductible Amount (patient responsibility)
47	H_Coins	Co-insurance amount (patient responsibility)
48	H_Copay	Copay amount (patient responsibility)
49	P_TotalPaid	Total paid equals deductible, co-insurance and copay amounts (patient responsibility)

Facility Claim Detail		
Field #	**Field Name**	**Description**
1	H_Claim ID	The Issuer internal claim number.
2	Plan_MemberID	Unique code assigned by Issuer to identify a particular member
3	Dependent_Suffix	Unique code assigned by Issuer to identify dependents (spouse, children, etc.)
4	Line Number	The detail line number for the service on the claim.
6	Service_Date	The date of service for this detail record.
7	H_Proc1	The primary ICD-9 procedure code on the facility claim.
8	H_Proc2	The secondary ICD-9 procedure code on the facility claim.
9	H_Proc3	The third ICD-9 procedure code on the facility claim.
10	H_Proc4	The fourth ICD-9 procedure code on the facility claim.
11	H_Proc5	The fifth ICD-9 procedure code on the facility claim.
12	H_Proc6	The sixth ICD-9 procedure code on the facility claim.
13	Rev_Code	The CMS standard revenue code from the facility claim.
14	D_ClaimNtwk	Claim paid as in-network (Y/N/U=Unknown)
15	D_Cap	Service is/is not capitated (Y/N)
16	D_BilledAmt	Amount billed

Facility Claim Detail		
Field #	**Field Name**	**Description**
17	D_Allowed	Amount allowed
18	D_AmountPaid	Amount paid by payer
20	D_Deductible	Applied to deductible (Y/N)
21	D_MemberDed	Deductible Amount (patient responsibility)
22	D_Coins	Co-insurance amount (patient responsibility)
23	D_Copay	Copay amount (patient responsibility)
24	P_TotalPaid	Total paid equals deductible, co-insurance and copay amounts (patient responsibility)

Drug Claims Data Elements		
Field #	**Field Name**	**Description**
1	Claim ID	The Issuer internal claim number (ICN).
2	Plan_MemberID	Unique code assigned by Issuer to identify a particular member
3	Dependent_Suffix	Unique code assigned by Issuer to identify dependents (spouse, children, etc.)
4	Void_Replace	Indicator if previously accepted claim is to be voided or replaced (V/R)
5	Generic_RX	Generic drug dispensed flag
6	Brand_RX	Preferred brand drug or non-preferred brand drug dispensed flag
7	Specialty_RX	Specialty drug dispensed flag
8	NDC Number Code	The FDA (Food and Drug Administration) registered number for the drug, as reported on the prescription drug claims.

Drug Claims Data Elements		
Field #	**Field Name**	**Description**
9	Days Supply	The number of days of drug therapy covered by this prescription.
10	Metric Quantity Dispensed	The number of units dispensed for the prescription drug claim, as defined by the NCPDP (National Council for Prescription Drug Programs) standard format.
11	Date of Service	The date of service/drug dispensed
12	Date Paid	The date the claim was paid
13	Prescriber_NPI	Prescribing provider's National Provider Identifier Type 1
14	Prescriber_ID	Prescribing provider's ID assigned by plan
15	Service Provider_ID	Pharmacy ID (NPI Type 2, NCPDP or TIN) NPI Type 2 preferred
16	R_ClaimNtwk	Claim paid as in-network (Y/N/U=Unknown)
17	R_Cap	Service is/is not capitated (Y/N)
18	R_BilledAmt	Amount billed
19	R_Allowed	Amount allowed
20	R_AmountPaid	Amount paid by payer
21	R_Deductible	Applied to deductible (Y/N)
22	R_MemberDed	Deductible Amount (patient responsibility)
23	R_Coins	Co-insurance amount (patient responsibility)
24 25	R_Copay P_TotalPaid	Copay amount (patient responsibility) Total paid equals deductible, co-insurance and copay amounts (patient responsibility)

Capitation Data Elements		
Field #	**Field Name**	**Description**
1	Plan_MemberID	Unique code assigned by Issuer to identify a particular member
2	Dependent_Suffix	Unique code assigned by Issuer to identify dependents (spouse, children, etc.)
3	Cap_Type	Capitation Type P-Professional; H-Hospital; M-Professional+Hospital; R-Drug S-Professional+Drug; F-Full Capitation (Prof, Hosp and Drug); O-Other
4	Cap_Payment_Date	Date Capitation Payment was made
5	Cap_Service_Date_Start	Start date for period that capitation applies
6	Cap_Service_Date_End	End date for period that capitation applies
7	P_NPI	NPI of the provider to whom the capitation payment is made
8	P_TaxID	Tax Identification Number of the provider to whom the capitation payment is made
9	Withhold Amount	Withheld Capitation Payment
10	Capitation Payment	Capitation Payment Amount

Physician Medical Group File		
Field #	**Field Name**	**Description**
1	PMGID	Plan ID for Physician Medical Group
2	PMG	Provider Group Name
3	PMG_TaxID	Tax ID for Physician Medical Group

Physician Medical Group File		
Field #	**Field Name**	**Description**
4	DMHC ID	DMHC ID for Physician Medical Group
5	CC_Regions	Covered California Regions serviced by Physician Medical Group
6	PMG_HMO	PMG HMO Contract Flag (Y/N)
7	PMG_PPO	PMG PPO/EPO Contract Flag (Y/N)
8	PMG_HPN	PMG Narrow Network Flag (Y/N)
9	PMG_ACO	PMG ACO Contract Flag (Y/N)
10	PMG_MCal	PMG Medi-Cal Managed Care Contracting Flag (Y/N)
11	PMG_Cap	Contract with PMG for HMO services is primarily fully Capitated (C), Partially capitated (P), Fee-for-Service (F), Other (O)
12	PMG_HCap	Contract with PMG's referred hospital services is primarily fully Capitated (C), Shared Risk (S), Fee-for-Service (F), Other (O)

Provider File (including all providers, including non-par, for whom claims have been paid)		
Field #	**Field Name**	**Description**
1	P_Fname	Physician First Name
2	P_MI	Physician Middle Name or Initial
3	P_Lname	Physician Last Name
4	P_Suffix	Physician Type Suffix (e.g., MD, DO, etc.)
5	P_DOB	Physician Date of Birth (MM/DD/YYYY)
6	P_TaxID	Physician Tax ID Number
7	P_SSN	Physician SSN
8	P_NPI	Physician type-1 National Provider Identifier (NPI)
9	P-NPI2	Physician NPI Number (type-2 organizational)

Provider File (including all providers, including non-par, for whom claims have been paid)		
Field #	**Field Name**	**Description**
10	DEA	Physician DEA Number
11	Plan_PID	Physician ID Number Assigned by Plan
12	LicenseNo	Physician State Medical License Number (DO or NP license if acting as PCPs)
13	P_Addr1	Physician Address Line 1
14	P_Addr2	Physician Address Line 2
15	P_City	Physician City
16	P_State	Physician State
17	P_Zip	Physician Zip Code
18	P_Phone	Physician Phone Number
19	Spec1	Physician Specialty 1 (primary)
20	Spec2	Physician Specialty 2 (secondary)
21	Spec3	Physician Specialty 3 (tiertiary)
22	PMGID	Provider Group (Primary affiliation)
23	PMGID2	Provider Group2 (Secondary affiliation)
24	PMGID3	Provider Group3 (Tertiary affiliation)
25	P_HMO	Physician HMO Contract Flag (Y/N)
26	P_PPO	Physician PPO Contract Flag (Y/N)
27	P_HPN	Physician Narrow Network Flag (Y/N)
28	P_ACO	Physician ACO Contract Flag (Y/N)
28	P_MCal	Physician Medi-Cal Managed Care Contract Flag (Y/N)

Hospital File		
Field #	**Field Name**	**Description**

Hospital File		
Field #	**Field Name**	**Description**
1	H_TaxID	Facility Tax ID Number
2	H_ID	Facility ID Number Assigned by Health Plan
3	H_StateID	Facility ID Number Assigned by State Licensing Agency
4	H_Addr1	Facility Address Line 1
5	H_Addr2	Facility Address Line 2
6	H_City	Facility City
7	H_State	Facility State
8	H_Zip	Facility Zip Code
9	H_Phone	Facility Phone Number
10	H_HMO	Facility HMO Contract Flag (Y/N)
11	H_PPO	Facility PPO Contract Flag (Y/N)
12	H_HPN	Facility Narrow Network Flag (Y/N)
13	H_ACO	Facility ACO Contract Flag (Y/N)
14	H_MCal	Facility Medi-Cal Managed Care Contract Flag (Y/N)
15	H_Cap	Service is/is not capitated (Y/N)

Appendix 2 to Attachment 7: Required Reports

Contractor shall provide such reports, data, documentation and other information reasonably requested by the Exchange and as reasonably necessary to document and evaluate Contractor's provision of Services in accordance with the terms and conditions set forth in the Agreement and under applicable laws, rules and regulations. Notwithstanding any other reporting requirements in the Original Agreement, for calendar year 2015, Contractor is only required to provide the Exchange with the items identified below. This limited reporting requirement for 2015 does not exclude Contractor from the operational requirements in the Original Agreement, such as 834 transactions and payment of Participation Fees.

Report Name	Data Reported	Submission Method
1 Operations Reporting		
1.1 Inbound Call Volume	Total number of calls received by the ACD.	Send to EEPlans@covered.ca.gov on the tenth (10th) of each month following the month covering the reported data using the Carrier Metrics Template provided by the Exchange
1.2 Abandoned Call Volume	Number of calls offered to the service center by the ACD, but terminated by the person originating the call outside the Service Level (i.e. 30 seconds).	Same as above.
1.3 Abandonment Rate	Percentage of calls abandoned, calculated by dividing the Abandon Call Volume by the Inbound Call Volume	Same as above.
1.4 Call Answer Timeliness	The percentage of calls answered within a defined period of time (i.e., 80% of all calls answered within 30 seconds)	Same as above.
1.5 Average Handling Time	Average Handle Time is the average number of minutes of talk time, hold time and wrap time necessary to complete the interaction.	Same as above.
1.6 Number of Binder Payment Notices Generated	For the Individual Exchange, number of binder payment notices generated and mailed to the consumer.	Same as above.
1.7 Binder Payment Processing Timeframe	For the Individual Exchange, the time elapsed from the date the binder payment invoice was mailed through the date the carrier received the binder payment from the consumer.	Same as above.

Report Name	Data Reported	Submission Method
1.8 Number of Binder Payments Processed	For the Individual Exchange, number of binder payments paid-in-full and processed.	Same as above.
1.9 ID Card Processing Time	For the Individual Exchange: The time elapsed from receipt of complete and accurate enrollment information and binder payment for a specific consumer through the date carrier mails the ID card to that consumer. For SHOP: Time elapsed from the receipt of complete and accurate enrollment information for a specific consumer through the date a carrier mails the ID card to that consumer.	Same as above.
1.10 Number of ID Cards Issued	Number of initial ID cards processed and issued to the consumer.	Same as above.
1.11 Initial Call Resolution	Number of calls where the enrollee's issue is resolved within one business day of receipt of the issue. Expectation of 85% resolved within 1 business day of receipt of the issue.	Same as above.
1.12 Grievance Resolution	Percentage of enrollee grievances resolved within 30 calendar days of initial receipt. Expectation of 95% within 30 business days of initial receipt.	Same as above.
1.13 Member Email or Written Inquiries	Total number of member email or written inquiries received.	Same as above.
1.14 Member Email or Written Inquiries Answered.	Percentage of email or written inquiries answered within 15 business days of inquiry. Does not include appeals or grievances. Expectation is 90% within 15 business days of the inquiry.	Same as above.
2 Financial Management Division		
2.1 Payment Reconciliation – Schedule of Notifications	Contractors participating in the individual market shall report delinquent full or partial payments of premiums to the Exchange. The schedule shall include a record of all notifications, including phone calls and letters, to participants of delinquent accounts.	Effective April 1, 2015, send to AccountingSCRtickets@covered.ca.gov on the first of each month following the month covering the reported data using the FMD Issuer Schedule of Notifications Template

Report Name	Data Reported	Submission Method
2.2 Billing Detail - Discrepancy Report	Contractors participating in the individual market shall use the billing discrepancy template to communicate disputed or contested PM/PM (per member, per month) billed amounts to the Exchange. Contractors shall use the PM/PM billing detail, as provided by the Exchange, to reconcile and identify discrepancies with their roster of covered lives. Discrepancies are defined as member duplication, individual cancelled, individual terminated, calculation error, individual missing or other.	Send to AccountingSCRtickets@covered.ca.gov on the first of each month following the month covering the reported data using the FMD Issuer Billing Discrepancy Report Template
3 Marketing Reports		
3.1 Marketing Materials	Contractor to submit to the Exchange all information and material required pursuant to the QHP Marketing Guidelines incorporated herein by reference.	Send in a PDF format to QHPMarketingMaterials@covered.ca.gov
4 Quality/Network Management		
4.1 Attach 7, 1.02 Participation in Collaborative Quality Initiatives	For calendar year 2014, select one of the following options: (A) provide information regarding active participation in quality initiatives- pick list in Attachment 7, Section 1.02 OR (B) provide responses to the Covered California eValue8 items listed in Appendix 3 to Attachment 7. If Contractor elects Option B, Contractor must use Option B to respond to reports 4.1 through 4.15. For calendar year 2015 and thereafter, provide responses to the Covered California eValue8 items listed in Appendix 3 to Attachment 7.	For calendar year 2014, if Contractor elects Option A, send report to qhp@covered.ca.gov by April 30, 2015. If Contractor elects Option B, submit responses via Proposal Tech by April 30, 2015. For calendar year 2015 and thereafter, submit responses via Proposal Tech by April 30 of the following calendar year.

Report Name	Data Reported	Submission Method
4.2 Attach 7, 1.03(d) Reducing Health Disparities and Assuring Health Equity	For calendar year 2014, select one of the following options: (A) provide narrative report describing how, if at all, Contractor collects and uses the data elements described in Attachment 7, 1.03(d) OR (B) provide responses to eValue8 items listed in Appendix 3 to Attachment 7. If Contractor elects Option B, Contractor must use Option B to respond to reports 4.1 through 4.15 For calendar year 2015, provide responses to eValue8 items listed in Appendix 3 to Attachment 7.	Same as above

Report Name	Data Reported	Submission Method
4.3 Attach 7, 3.02 Hospital Quality Oversight	For calendar year 2014, select one of the following options: (A) Hospital Quality Oversight - metrics for network hospitals as reported on CalQualityCompare.org for (a) Deaths and readmissions (b) Serious complications related to specific conditions (c) Hospital acquired conditions and (d) Healthcare associated infections OR (B) provide responses to eValue8 items listed in Appendix 3 to Attachment 7. If Contractor elects Option B, Contractor must use Option B to respond to reports 4.1 through 4.15 For calendar year 2015, provide responses to eValue8 items listed in Appendix 3 to Attachment 7.	Same as above

Report Name	Data Reported	Submission Method
4.4 Attach 7, 3.06 Reporting to and Collaborating with the Exchange Regarding Health Status	For calendar year 2014, select one of the following options: (A) (1) Narrative: Information on how Contractor collects and reports, at both individual and aggregate levels, changes in Plan Enrollees health status. Engagement may include, for example: Welcome calls/on-boarding interactions where a member was reached (spoken to, responded to a voice prompt, etc.) Returned/Completed Health Assessment Forms Member Contract QHP to assist with PCP selection, assistance with service access, etc. (2) Number of Plan Enrollees who are identified for care management and chronic conditions programs and results of referral Report Covered California Enrollees who have been "engage" by the QHP. Suggested formula: # of Members Engaged (numerator) / # of Members Enrolled (denominator) OR (B) provide responses to eValue8 items listed in Appendix 3 to Attachment 7. If Contractor elects Option B, Contractor must use Option B to respond to reports 4.1 through 4.15 For calendar year 2015, provide responses to eValue8 items listed in Appendix 3 to Attachment 7.	Same as above

Report Name	Data Reported	Submission Method
4.5 Attach 7, 4.01 Health and Wellness Services	For calendar year 2014, select one of the following options: (A) (1) Report Covered California Enrollees who had a health care service. A service may include, for example: Prescriptions filled, Visits completed, (ER, PCP, specialist), hospitalization etc. Services could be confirmed by claims, encounters, utilization review data, EMR detail, pre-authorizations processed, etc. Data may need to be requested from provider groups. (2) Narrative report: discuss participation from Plan enrollees in (a) preventive services (b) tobacco cessation intervention, if applicable (c) obesity management, if applicable. OR (B) provide responses to eValue8 items listed in Appendix 3 to Attachment 7. If Contractor elects Option B, Contractor must use Option B to respond to reports 4.1 through 4.15 For calendar year 2015, provide responses to eValue8 items listed in Appendix 3 to Attachment 7.	Same as above
4.6 Attach 7, 4.02 Community Health and Wellness Promotion	For calendar year 2014, select one of the following options: (A) Narrative report describing initiatives, programs and projects Contractor supports and how such programs specifically address health disparities and/or efforts to improve community health apart from the health delivery system OR (B) provide responses to eValue8 items listed in Appendix 3 to Attachment 7. If Contractor elects Option B, Contractor must use Option B to respond to reports 4.1 through 4.15 For calendar year 2015, provide responses to eValue8 items listed in Appendix 3 to Attachment 7.	Same as above

Report Name	Data Reported	Submission Method
4.7 Attach 7, 4.03 Health and Wellness Enrollee Support Process	For calendar year 2014, select one of the following options: (A) Contractor to submit information on health and wellness communication process to Enrollee and Participating Provider; process to ensure network adequacy given the focus on health and wellness; documentation of process to incorporate Enrollee's health and wellness information into Contractor's data specific to individual Enrollees, as distinct from medical record. OR (B) provide responses to eValue8 items listed in Appendix 3 to Attachment 7. If Contractor elects Option B, Contractor must use Option B to respond to reports 4.1 through 4.15 For calendar year 2015, provide responses to eValue8 items listed in Appendix 3 to Attachment 7.	Same as above
4.8 Attach 7, 5.02 Promoting Development and Use of Care Models	For calendar year 2014, select one of the following options: (A) (1) Report Covered CA Enrollees who had a PCP visit. Suggested formula: # of Members who had a PCP visit (numerator)/ # of Members Enrolled (denominator). (2) Narrative report describing (a) QHP methods to promote and use care models to promote access, care coordination and early identification of "at risk" enrollees; (b) implementation of models such as team-based care, use of Advance Practice Clinicians, expanded primary care access through payment reforms, Ambulatory ICU, etc; (c) use of health status information to match enrollees to integrated providers that are specifically available to Exchange Enrollees OR (B) provide responses to eValue8 items listed in Appendix 3 to Attachment 7. If Contractor elects Option B, Contractor must use Option B to respond to reports 4.1 through 4.15 For calendar year 2015, provide responses to eValue8 items listed in Appendix 3 to Attachment 7.	Same as above

Report Name	Data Reported	Submission Method
4.9 Attach 7, 5.04 Identification and Services for At-Risk Enrollees	For calendar year 2014, select one of the following options: (A) (1) Report Covered California Enrollees who have been identified as "At Risk". May have been identified, for example: Had ER Visit, Had prescription for Diabetes, Cardiac, Asthma, Hypertension Medications, etc. Was hospitalized, Called QHP and requested assistance, Completed Health Assessment and indicated have health condition. Suggested formula: # of Members Identified (numerator) / # of Members Enrolled (denominator) (2) Report Covered California Enrollees who have been identified as "At Risk". May have been identified, for example: Had ER Visit, Had prescription for Diabetes, Cardiac, Asthma, Hypertension Medications, etc. Was hospitalized, Called QHP and requested assistance, Completed Health Assessment and indicated have health condition. Report by number of enrollees identified who participate in such programs. OR (B) provide responses to eValue8 items listed in Appendix 3 to Attachment 7. If Contractor elects Option B, Contractor must use Option B to respond to reports 4.1 through 4.15 For calendar year 2015, provide responses to eValue8 items listed in Appendix 3 to Attachment 7.	Same as above
4.10 Attach 7, 6.01 Provider Cost and Quality	For calendar year 2014, select one of the following options: (A) Narrative report describing Contractor's measures and process for providing current provider-specific cost and quality information, including at the individual physician and hospital level, available to Enrollees. OR (B) provide responses to eValue8 items listed in Appendix 3 to Attachment 7. If Contractor elects Option B, Contractor must use Option B to respond to reports 4.1 through 4.15 For calendar year 2015, provide responses to eValue8 items listed in Appendix 3 to Attachment 7.	Same as above

Report Name	Data Reported	Submission Method
4.11 Attach 7, 6.02 Enrollee Cost Transparency	For calendar year 2014, select one of the following options: (A) Narrative report describing (a) any current benefit design features, including in-network vs. out-of-network provisions that may expose enrollees to higher OOP costs, including costs that may not be covered under the OOP max (b) process for assisting enrollees and identifying highest frequency and highest cost services OR (B) provide responses to eValue8 items listed in Appendix 3 to Attachment 7. If Contractor elects Option B, Contractor must use Option B to respond to reports 4.1 through 4.15 For calendar year 2015, provide responses to eValue8 items listed in Appendix 3 to Attachment 7.	Same as above
4.12 Attach 7, 6.04 Enrollee Shared Decision-Making	For calendar year 2014, select one of the following options: (A) (1) Narrative report describing (a) plans for assisting Exchange enrollees to access consumer information and participate in shared decision-making process (b) results including clinical, patient experience and cost impacts (to the extent collected). (2) Number of enrollees who have accessed strategies to optimize consumer self-care; specific focus on using Choosing Wisely information OR (B) provide responses to eValue8 items listed in Appendix 3 to Attachment 7. If Contractor elects Option B, Contractor must use Option B to respond to reports 4.1 through 4.15 For calendar year 2015, provide responses to eValue8 items listed in Appendix 3 to Attachment 7.	Same as above

Report Name	Data Reported	Submission Method
4.13 Attach 7, 7.01 Rewards-based Consumer Incentive Programs	For calendar year 2014, select one of the following options: (A) Description of Rewards-based Consumer Incentive Program to promote evidence-based optimal care for enrollees with identified chronic conditions. Enrollee participation rates and outcome results including clinical, patient experience and cost impacts OR (B) provide responses to eValue8 items listed in Appendix 3 to Attachment 7. If Contractor elects Option B, Contractor must use Option B to respond to reports 4.1 through 4.15 For calendar year 2015, provide responses to eValue8 items listed in Appendix 3 to Attachment 7.	Same as above
4.14 Attach 7, 7.02 Value-Based Reimbursement Inventory and Performance	For calendar year 2014, select one of the following options: (A) Inventory of all current value based provider reimbursement methodologies for Exchange enrollees. Inventory to include data listed in Att.7, Article 7, Sec. 7.02 (a) through (d) OR (B) provide responses to eValue8 items listed in Appendix 3 to Attachment 7. If Contractor elects Option B, Contractor must use Option B to respond to reports 4.1 through 4.15 For calendar year 2015, provide responses to eValue8 items listed in Appendix 3 to Attachment 7.	Same as above
4.15 Attach 7, 7.04 Value-Pricing Programs	For calendar year 2014, select one of the following options: (A) Narrative report detailing value pricing programs available to Exchange enrollees, including results of programs that may focus on high cost geographic regions or those with greatest cost variations, or payment bundling pilots for procedures with wide cost variations OR (B) provide responses to eValue8 items listed in Appendix 3 to Attachment 7. If Contractor elects Option B, Contractor must use Option B to respond to reports 4.1 through 4.15 For calendar year 2015, provide responses to eValue8 items listed in Appendix 3 to Attachment 7.	Same as above

Report Name	Data Reported	Submission Method
4.16 Attach 7, 7.05 Payment Reform and Data Submission	Information from Contractor under Att.7, Article 7 will be provided **by Exchange** to the Catalyst for Payment Reform's National Scorecard on Payment Reform and National Compendium on Payment Reform	**Exchange to provide to CPR Q1 2016**

The information set forth in this Attachment shall not limit the Exchange’s right to obtain information in accordance with the terms set forth in the Agreement and/or applicable laws, rules and regulations.

Appendix 3 to Attachment 7: Covered California eValue8 Request for Information

1 General Information and Background

1.1 Attestation

1.1 On behalf of the Contractor, I hereby certify that the information provided on this Contract Compliance 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

1.2 Contractor Library

1.2 Contractors may access the Contractor Library at:

URL Web link to be determined

The Contractor Library will allow Contractors access to reference documents and information that may be useful for developing the Contractor's response. The Contractor Library will continue to be updated as further documentation related to the application becomes available. Contractors are encouraged to continuously monitor the Contractor Library, but are not required to access or view documents in the Contractor Library.
The Exchange makes no warrantees with respect to the contents of the Contractor Library and requirements specified in this document take precedence over any Contractor Library contents.
Document.

2 Covered California Qualified Health Plan (QHP) Contract Compliance (Required Reports)

All contract reporting requirements and submissions for Appendix 2 to Attachment 7: Required Reports other than those required for Quality/ Network Management are delineated separately from this document.

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. For future years, all reports may be modified to more specifically request data on Covered California membership.

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.
3.1 Plan is responding for the following products
Multi, Checkboxes.
1: HMO/POS,
2: PPO,
3: EPO

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 for this contract compliance report.** . 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 Commercial HMO/POS	Total Commercial PPO	Total Commercial EPO	All other Commercial products	Total Medicare Members	Total Medicaid Members
Total	*For comparison.* 0	*For comparison.* 0	*For comparison.* 0	*For comparison.* 0	*For comparison.* 0	*For comparison.* 0

3.3 Identify the Plan membership in each of the products specified below **for Covered California as of the end of the reporting period for this contract compliance report.**

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

4 Contract Compliance - Attachment 7 Reporting for Quality and Network Management

4.1 Attachment 7, 1.02 Participation in Collaborative Quality Initiatives (10 points)

Provide information regarding active participation in quality initiatives.

4.1.1 Is the Contractor engaged in any of the following organized programs in California? Identify other markets of engagement.

Note that selection of "Not Engaged in Any Programs" will lock-out the responses for all rows and columns in this question.

	Engaged in any market/region	Engaged in this market	Other markets in which engaged
The Contractor 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	*Single, Radio group.* 1: Engaged, 2: Not Engaged	*50 words.*
Aligning Forces for Quality	*(As above)*	*(As above)*	*(As above)*
Multi-payer Medical Home (name additional payers in detail box)			
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)			
California Joint Replacement Registry developed by the CHCF, California Orthopedic Society and Pacific Business Group on Health (PBGH)			
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)Society of Thoracic			

Surgeons National Database for the collection of general thoracic surgery clinical data			
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 Shared Savings Program (including Pioneer, Advanced Payment and other models)			
Contractor-sponsored accountable care programs			
California Perinatal Quality Care Collaborative			
California Quality Collaborative			
Other (described in detail box)			

4.1.2 The California Maternal Data Center (CMDC), sponsored by the California Maternal Quality Care Collaborative (CMQCC), is an online tool (https://www.cmqcc.org/california_maternal_data_center_cmdc) that generates rapid-cycle performance metrics on maternity care services. The tool is designed to support hospital quality improvement activities and service-line management in a way that is **low burden, low cost and high value** for participants.

Updated lists of participating facilities may be accessed at: **https://www.cmqcc.org/resources/2919**.

HMO Response - Maternity Services	Number	Uptake as % of total commercial statewide membership reported in Section 3
CMDC-participating facilities in Contractor's network	*Decimal.*	
CMDC-participating facilities in Contractor's Covered California network	*Decimal.*	
Volume of births at CMDC-participating facilities in Contractor's network	*Decimal.*	*Percent.* N/A OK. From 0 to 100.
Volume of births at CMDC-participating facilities in Contractor's Covered California network	*Decimal.*	*Percent.* N/A OK. From 0 to 100.

4.1.3 The California Maternal Data Center (CMDC), sponsored by the California Maternal Quality Care Collaborative (CMQCC), is an online tool (https://www.cmqcc.org/california_maternal_data_center_cmdc) that generates rapid-cycle performance metrics on maternity care services. The tool is designed to support hospital quality improvement activities and service-line management in a way that is **low burden, low cost and high value** for participants.

Updated lists of participating facilities may be accessed at: **https://www.cmqcc.org/resources/2919**

PPO Response - Maternity Services	Number	Uptake as % of total commercial statewide membership reported in Section 3
CMDC-participating facilities in Contractor's network	*Decimal.*	
CMDC-participating facilities in Contractor's Covered California network	*Decimal.*	
Volume of births at CMDC-participating facilities in Contractor's network	*Decimal.*	*Percent.* N/A OK. From 0 to 100.
Volume of births at CMDC-participating facilities in Contractor's Covered California network	*Decimal.*	*Percent.* N/A OK. From 0 to 100.

4.1.4 The California Maternal Data Center (CMDC), sponsored by the California Maternal Quality Care Collaborative (CMQCC), is an online tool (https://www.cmqcc.org/california_maternal_data_center_cmdc) that generates rapid-cycle performance metrics on maternity care services. The tool is designed to support hospital quality improvement activities and service-line management in a way that is **low burden, low cost and high value** for participants.

Updated lists of participating facilities may be accessed at: **https://www.cmqcc.org/resources/2919**.

EPO Response - Maternity Services	Number	Uptake as % of total commercial statewide membership reported in Section 3
CMDC-participating facilities in Contractor's network	*Decimal.*	
CMDC-participating facilities in Contractor's Covered California network	*Decimal.*	
Volume of births at CMDC-participating facilities in Contractor's network	*Decimal.*	*Percent.* N/A OK. From 0 to 100.
Volume of births at CMDC-participating facilities in Contractor's Covered California network	*Decimal.*	*Percent.* N/A OK. From 0 to 100.

4.2 Attachment 7, 1.03(d) Reducing Health Disparities and Assuring Health Equity (40 points)

Describe how Contractor collects and uses the data elements described in Attachment 7, 1.03
4.2.1 Identify the sources of information used to gather members' race/ethnicity, primary language and interpreter need. **The response "Enrollment Form" pertains only to information reported directly by members (or as passed on by CalHEERS about specific members).**

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

	Data proactively collected from all new California enrollees (specify date started - MM/DD/YYYY)	How data is captured from previously enrolled California members (i.e., those who were not new enrollees when respondent started collecting information) - specify method	Covered California members for whom data is captured as percent of total Covered California population (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 such as zip code or surname analysis, 7: Other (specify in detail box below. 200 word limit), 8: Data not collected	*Percent.*
Gender	*(As above)*	*(As above)*	*(As above)*
Primary language	*(As above)*	*(As above)*	*(As above)*
Disability Status	*(As above)*	*(As above)*	*(As above)*
Interpreter need	*(As above)*	*(As above)*	*(As above)*
Education level	*(As above)*	*(As above)*	*(As above)*
Sexual Orientation	*(As above)*	*(As above)*	*(As above)*
Gender Identity	*(As above)*	*(As above)*	*(As above)*

4.2.2 Provide an estimate of the percent of network physicians, office staff and Contractor personnel in this market for which the Contractor has identified race/ethnicity, and a language spoken other than English? Contractor 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 Contractor knows what language is spoken by physician. If Contractor 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.

	Physicians in this market	Physician office staff in this market	Contractor staff in this market
Race/ethnicity	*Percent.*	*Percent.*	*Percent.*

	From 0 to 100.	From 0 to 100.	From 0 to 100.
Languages spoken	*(As above)*	*(As above)*	*(As above)*

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 Contractor activities to address health literacy in California.
Single, Radio group.
1: No activities currently,
2: Contractor addresses health literacy of members – Describe how health literacy is addressed, including testing of materials: [200 words]

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

4.2.5 How does the Contractor 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 Contractor 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: Other (describe in detail box below):,
20: Contractor does not implement activities to support needs of members with limited English proficiency

4.2.6 Indicate which of the following activities the 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 Contractor staff,
11: Sponsor cultural competence training for physician offices,
12: Other (describe in detail box below):,
13: No activities in year of this response

4.2.7 Has the Contractor 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.

4.3 Attachment 7, 3.02 Hospital Quality Oversight (20 points)

For the purposes of this section 4.3, please respond to questions based on California business.
4.3.1 For the plan's California business, indicate if ***PUBLIC REPORTS and PROVIDER REPORTING/BENCHMARKING*** that compares **HOSPITAL quality** performance are available for any of the following categories of Measure Groups.

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

	% total contracted HOSPITALS INCLUDED in PUBLIC REPORTING in market	% total contracted HOSPITALS INCLUDED in PROVIDER FEEDBACK AND BENCHMARKING in market	Description of Other
HQA			
ACUTE MYOCARDIAL INFARCTION (AMI)	*Percent.* N/A OK. From 0 to 100.	*Percent.* N/A OK. From 0 to 100.	
HEART FAILURE (HF)	*(As above)*	*(As above)*	
PNEUMONIA (PNE)	*(As above)*	*(As above)*	
SURGICAL INFECTION PREVENTION (SIP)	*(As above)*	*(As above)*	
Surgical Care Improvement Project (SCIP)	*(As above)*	*(As above)*	
PATIENT EXPERIENCE/H-CAHPS	*(As above)*	*(As above)*	
LEAPFROG Safety Practices http://www.leapfroggroup.org/56440/leapfrog_hospital_survey_copy/leapfrog_safety_practices			
Leapfrog Safety Score	*(As above)*	*(As above)*	
Adoption of CPOE	*(As above)*	*(As above)*	
Management of Patients in ICU	*(As above)*	*(As above)*	
Evidence-Based Hospital referral indicators	*(As above)*	*(As above)*	
Adoption of NQF endorsed Safe Practices	*(As above)*	*(As above)*	
Maternity – pre 39 week elective induction and/or elective c-section rates	*(As above)*	*(As above)*	
AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (AHRQ)*	*(As above)*	*(As above)*	
Inpatient quality indicators http://www.qualityindicators.ahrq.gov/Modules/iqi_overview.aspx	*(As above)*	*(As above)*	
Patient safety indicators http://www.qualityindicators.ahrq.gov/modules/psi_overview.aspx	*(As above)*	*(As above)*	
Prevention quality indicators http://www.qualityindicators.ahrq.gov/Modules/pqi_overview.aspx	*(As above)*	*(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)*	*(As above)*	
SREs (serious reportable events) that are not HACs (e.g., surgery on	*(As above)*	*(As above)*	

the wrong body part or wrong patient) www.qualityforum.org/Topics/SREs/List_of_SREs.aspx (see attachment)			
Readmissions	*(As above)*	*(As above)*	
ED/ER Visits	*(As above)*	*(As above)*	
MORTALITY MEASURES (AMI, HF and Pneumonia mortality measures)	*(As above)*	*(As above)*	
ICU Mortality	*(As above)*	*(As above)*	
HIT adoption/use	*(As above)*	*(As above)*	
Efficiency (e.g., relative cost, utilization (ALOS, AD/k) Volume indicators other than Leapfrog EHR)	*(As above)*	*(As above)*	
Other standard measures endorsed by National Quality Forum (describe):	*(As above)*	*(As above)*	*200 words.*

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. http://www.qualityindicators.ahrq.gov/Modules/pqi_overview.aspx
- Inpatient Quality Indicators reflect quality of care inside hospitals, as well as across geographic areas, including inpatient mortality for medical conditions and surgical procedures. http://www.qualityindicators.ahrq.gov/Modules/iqi_overview.aspx
- Patient Safety Indicators reflect quality of care inside hospitals, as well as geographic areas, to focus on potentially avoidable complications and iatrogenic events. http://www.qualityindicators.ahrq.gov/Modules/psi_overview.aspx

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 Covered 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

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 Contractor 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.

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 Contractor 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.

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 **Covered California HMO data**. **If Contractor is unable to report Covered California data, please indicate in the detail box the date by which such data will be available.**

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.

4.3.5 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 **Covered California PPO data**. **If Contractor is unable to report Covered California data, please indicate in the detail box the date by which such data will be available.**

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.

4.3.6 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 **Covered California EPO data**. **If Contractor is**

unable to report Covered California data, please indicate in the detail box the date by which such data will be available.

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.

4.4 Attachment 7, 3.06 Reporting to and Collaborating with the Exchange Regarding Health Status (25 points)

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: 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.,
6: Addressing At-risk Behaviors: Personalized HA report is generated after HA completion that provides member-specific risk modification actions based on responses,
7: Addressing At-risk Behaviors: Members are directed to targeted interactive intervention module for behavior change upon HA completion.,
8: 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).,
9: Addressing At-risk Behaviors: Member is automatically enrolled into a disease management or at-risk program based on responses,
10: Addressing At-risk Behaviors: Case manager or health coach outreach call triggered based on HA results,
11: Addressing At-risk Behaviors: Member can elect to have HA results sent electronically to personal physician,
12: Addressing At-risk Behaviors: Member can update responses and track against previous responses,
13: Partnering with Employers: Employer receives trending report comparing current aggregate results to previous aggregate results,
14: Partnering with Employers: Contractor can import data from employer-contracted HA vendor.,
15: Contractor does not offer a HA

4.4.2 Provide the number of currently enrolled commercial and Covered 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
Geography for data below (automatically determined based on response above)	*For comparison.* 4: Awaiting response to rows above
Total commercial enrollment for TBD geography (sum of commercial HMO/POS, PPO and Other Commercial) If Contractor 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 Contractor has and tracks use by Medi-Cal members as well, number here should include Medi-Cal numbers.)	*Decimal.* From 0 to 10000000000000000000.
Number of Covered California members completing a Contractor-based vendor HA in the applicable calendar year.	*Decimal.* N/A OK. From 0 to 100000000000.
Percent HA completion (Contractor HA completion number + Covered California HA completion number divided by total enrollment)	*For comparison.* Unknown

4.4.3 Provide the number of currently enrolled commercial and Covered 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
Geography for data below (automatically determined based on response above)	*For comparison.* 4: Awaiting response to rows above
Total commercial enrollment for TBD geography (sum of commercial HMO/POS, PPO and Other Commercial) If Contractor has and tracks use by Medi-Cal members as well, enrollment number here should include Medi-Cal numbers.)	TBD
Number of members completing Contractor-based HA for the applicable calendar year. (If Contractor has and tracks use by Medi-Cal members as well, number here should include Medi-Cal numbers.)	*Decimal.* From 0 to 10000000000000000000.
Number of Covered California members completing an Contractor-based HA for the applicable calendar year	*Decimal.* N/A OK. From 0 to 100000000000.
Percent HA completion (Contractor HA completion number + Covered California HA completion number divided by total enrollment)	*For comparison.* Unknown

4.4.4 Provide the number of currently enrolled commercial and Covered 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
Geography for data below (automatically determined based on response above)	*For comparison.* 4: Awaiting response to rows above
Total commercial enrollment for TBD geography (sum of commercial HMO/POS, PPO and Other Commercial) If Contractor has and tracks use by Medi-Cal members as well, enrollment number here should include Medi-Cal numbers.)	TBD
Number of members completing Contractor-based HA for the applicable calendar year. (If Contractor has and tracks use by Medi-Cal members as well, number here should include Medi-Cal numbers.)	*Decimal.* From 0 to 10000000000000000000.
Number of Covered California members completing an Contractor-based HA for the applicable calendar year	*Decimal.* N/A OK. From 0 to 100000000000.
Percent HA completion (Contractor HA completion number + Covered California HA completion number divided by total enrollment)	*For comparison.* Unknown

4.4.5 Identify methods for promoting Health Assessment (HA) completion to Covered 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 following methods below (describe), 3: No	*100 words.*
General messaging on Contractor 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 Contractor 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 Contractor 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)*

4.4.6 Identify methods for promoting Health Assessment (HA) completion to Covered 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 of the following methods below (describe), 3: No	*100 words.*
General messaging on Contractor 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 Contractor 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 Contractor 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)*

4.4.7 Identify methods for promoting Health Assessment (HA) completion to Covered 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 following methods below (describe), 3: No	*100 words.*
General messaging on Contractor 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 Contractor 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 Contractor 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)*

4.4.8 If Contractor indicated above that HAs are promoted through multiple links on their website, provide documentation for three web access points as ***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

4.5 Attachment 7, 4.01 Health and Wellness Services (20 points)

4.5.1 Identify Contractor activities for the applicable calendar year for practitioner education and support related to obesity management for networks serving Covered California members. 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
Education/Information	*Multi, Checkboxes.* 1: General education of guidelines and Contractor 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) (describe), 7: Distribution of BMI calculator to physicians, 8: 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: Contractor reimburses for appropriate use of Obesity ICD-9 coding (e.g. 278.0), 4: Incentives to obtain NCQA Physician Recognition – (e.g. Physician Practice Connections or Patient Centered Medical Home), 5: None of the above
Practice Support	*Multi, Checkboxes.* 1: The Contractor 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 Contractor in generating future reports, 5: Care Contractor approval, 6: None of the above
Description	*200 words.*

4.5.2 Provide evidence of the practitioner support that is member or performance specific selected above as ***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

4.5.3 Indicate the number of obese members identified and participating in weight management activities during the applicable calendar year. Do not report general prevalence.

Please provide Covered California counts if available. If Covered California counts are not available, provide state/regional counts, and indicate in the detail box when Contractor may be able to report Covered California-specific data.

	Answer
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. 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 for TBD geography (sum of commercial HMO/POS, PPO and Other Commercial) If Contractor 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
Number of California members identified as obese for the applicable calendar year as of December 31. (If Contractor 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 participating in weight management	*Decimal.*

program during the applicable calendar year as of December 31. (If Contractor has and tracks use by Medi-Cal members as well, number here should include Medi-Cal numbers.)	From 0 to 1000000000.
Number of Covered California members participating 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%

4.5.4 Identify Contractor activities in the applicable calendar year for practitioner education and support related to tobacco cessation for networks serving Covered California members. Check all that apply. If any of the following four (4) activities are selected, documentation to support must be attached in the following question as ***Health-Wellness 2***. The following selections need documentation:

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)

	Activities
Education/ Information	*Multi, Checkboxes.* 1: General education of guidelines and Contractor 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 305.1, CPT 99401, 9402, and HCPCS G0375, G0376) (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: Contractor reimburses for appropriate use of smoking-related CPT or diagnosis coding (e.g. ICD 305.1, CPT 99401, 99402, and HCPCS G0375, G0376), 4: Incentives to obtain NCQA Physician Recognition – (e.g. Physician Practice Connections or Patient Centered Medical Home), 5: None of the above
Practice support	*Multi, Checkboxes.* 1: The Contractor 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 Contractor in generating future reports, 5: Care Contractor approval, 6: None of the above
Description	*200 words.*

4.5.5 If Contractor 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 ***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

4.5.6 Indicate the number and percent of tobacco dependent commercial members identified and participating in cessation activities during the applicable calendar year.

Please provide <u>Covered California</u> counts if available. If Covered California counts are not available, provide state/regional counts, and indicate in the detail box when Contractor may be able to report Covered California-specific data.

	Answer
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. 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 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 Contractor has and tracks use by Medi-Cal members as well, enrollment number here should include Medi-Cal numbers.)	*For comparison.* TBD geography
Number of California members individually identified as tobacco dependent for the applicable calendar year as of December 31. (If Contractor 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 participating in smoking cessation program during the applicable calendar year as of December 31. (If Contractor 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 participating in 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%

4.5.7 If the Contractor provides in-person or telephonic smoking cessation counseling, please indicate all of the following that describe the most intensive program below. For more information on the recommended standard for cessation treatment, see http://www.businessgrouphealth.org/preventive/topics/tobacco_treatment.cfm.

Multi, Checkboxes.
1: Each course of treatment (member's term of participation in a smoking cessation program) routinely includes up to 300 minutes of counseling,
2: At least two courses of treatment (original + 1 extra) are routinely available per year for members who don't succeed at the first attempt,
3: There are at least 12 sessions available per year to smokers,
4: Counseling not included

4.5.8 For the tobacco cessation program described above, please indicate the following:

	Describe measure methodology/definition	Not tracked
Program defined 6-month quit rate	*Unlimited.*	*Multi, Checkboxes - optional.* 1: Not tracked
Program defined 12-month quit rate	*(As above)*	*(As above)*
Other (describe in "describe measure...")	*(As above)*	*(As above)*

4.6 Attachment 7, 4.02 Community Health and Wellness Promotion (10 points)

4.6.1 Provide a narrative report describing initiatives, programs and projects Contractor 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.

200 words.

4.7 Attach 7, 4.03 Health and Wellness Enrollee Support Process (10 points)

4.7.1 For Covered 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)*
Smoking cessation support program	*(As above)*
24/7 telephonic nurse line	*(As above)*
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) formerly known as health risk assessment (HRA)	*(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)*

4.7.2 Does the Contractor 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 Covered California members participating in Contractor 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 Contractor design/Denominator is total Contractor 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 Contractor 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 Contractor's Covered California membership in all markets of Contractor 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	*Percent.* N/A OK. From 0 to 100.	*Yes/No.*

	independently of medical services, 4: Not supported		
Preventive care (e.g. cancer screening, immunizations)	*(As above)*	*(As above)*	*(As above)*

4.7.3 Does the Contractor 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 Covered California members participating in Contractor 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 Contractor design/Denominator is total Contractor 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 Contractor 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 Contractor's Covered California membership in all markets of Contractor 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)*

4.7.4 Does the Contractor 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 Covered California members participating in Contractor 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 Contractor design/Denominator is total Contractor 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 Contractor 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 Contractor's Covered California membership in all markets of Contractor 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,	*Percent.* N/A OK. From 0 to 100.	*Yes/No.*

	3: Rewards (cash payments, discounts for consumer goods, etc.) administered independently of medical services and contingent upon completion/participation, 4: Not supported		
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)*

4.8 Attachment 7, 5.02 Promoting Development and Use of Care Models (20 points)

This report requirement is partially met by the completion of sections 4.7 above. Shared decision-making is addressed in section 4.12.

4.8.1 Provide a list of any ACO contracts that became effective in this market on or before January 1, 2016 as ***Care Model 1***. Indicate the following: 1) effective date of the contract, 2) whether the ACO is available to Covered California members, 3) rating region that is served by the ACO, and 4) Covered California membership attributed to the ACO as of December 31 of the applicable calendar year.

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

4.8.2 Briefly describe the Contractor'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
Primary care recruitment and expanding use of mid-level practitioners (also known as Advanced Practice Clinicians: Nurse Practitioners,	*(As above)*	*(As above)*

Physician Assistants, Nurse Midwives)		
Use of an intensive outpatient care program or "Ambulatory ICU" for enrollees with complex chronic conditions	*(As above)*	*(As above)*
Use of remote patient monitoring	*(As above)*	*(As above)*

4.8.3 Payment Reform Penetration - Covered California Members: 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.

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 Covered 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 ACOs	*Decimal.*	Unknown	*Decimal.*	Unknown
Total number of Covered California, in-network members attributed to PCMHs (for PCMH not part of ACO)	*Decimal.*	Unknown	*Decimal.*	Unknown
Enrollment of TOTAL Covered California members	0	100%	Unknown	100%

4.8.4 If the Contractor differentiates its contracted physicians via tiered networks or other plan design that provide financial incentives to "steer" consumers to a subset of higher performing providers, please complete the following table for total commercial book of business in market of response.

If plan has 40 specialties and only 21 of those 40 are eligible for tiered networks, **plan should provide the number of physicians in the 21 specialties eligible to be tiered rather than number of physicians in the 40 specialties.**

	Primary care	Specialty care
Tiered networks, PCMH or ACOs not used	*Multi, Checkboxes - optional.* 1: Not used	*Multi, Checkboxes - optional.* 1: Not used
Number of physicians in full product network	*Decimal.* N/A OK. From 0 to 10000000000.	*Decimal.* N/A OK. From 0 to 10000000000000.
Number of physicians in preferred tier/narrow network(exclude those in PCMHs and ACOs)	*(As above)*	*(As above)*
Percent of network physicians in preferred tier/narrow network	*For comparison.* N/A%	*For comparison.* N/A%
Number of physicians in PCMH only (exclude those in ACOs)	*Decimal.* N/A OK. From 0 to 10000000000.	*Decimal.* N/A OK. From 0 to 10000000000.
Percent of network physicians in PCMH	*For comparison.* N/A%	*For comparison.* N/A%
Number of physicians in ACOs	*Decimal.* N/A OK. From 0 to 10000000000.	*Decimal.* N/A OK. From 0 to 10000000000.
Percent of network physicians in ACOs	*For comparison.* N/A%	*For comparison.* N/A%

Percent of total physician payments made to physicians in the preferred tier (not in PCMH nor ACOs) (most recent 12 months)	*Percent.* N/A OK. From 0 to 100.	*Percent.* N/A OK. From 0 to 100.
Percent of total physician payments made to physicians in the preferred tier (not in PCMH nor ACOs) (prior 12 months)	*(As above)*	*(As above)*
Percent of total physician payments made to PCMHs (not to those in ACOs) (most recent 12 months)	*(As above)*	*(As above)*
Percent of total physician payments made to physicians in the ACO (most recent 12 months)	*(As above)*	*(As above)*
Design incentives - HMO	*Multi, Checkboxes.* 1: Differential copay, 2: Differential coinsurance, 3: Differential deductible, 4: Lower premium (narrow network), 5: Not applicable	*Multi, Checkboxes.* 1: Differential copay, 2: Differential coinsurance, 3: Differential deductible, 4: Lower premium (narrow network), 5: Not applicable
Design incentives - PPO	*(As above)*	*(As above)*
Design incentives - EPO	*(As above)*	*(As above)*
Briefly describe (100 words or less) the impact and any quantitative results of plan efforts to promote member selection of higher performing physicians for the applicable calendar year.. This could include (1) reduction in costs, (2) change in amount paid to higher performing physicians or (3) change in percent of membership using higher performing physicians	*100 words.*	*100 words.*

4.8.5 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.*

4.8.6 Indicate the features and functions the Contractor 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.

	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

4.8.7 Is the PHR portable, enabling electronic member data transfer upon disenrollment from the Contractor? Check all that apply.
Multi, Checkboxes.
1: No, but information may be printed or exported as a pdf file by member,
2: Yes, Contractor provides electronic files that can be uploaded to other PHR programs. (specify other programs in detail box below),
3: Yes, Contractor provides software that can be used at home,
4: Yes, the vendor/Contractor allows continued use on an individual basis at no charge,
5: Yes, the vendor/Contractor makes this available for continued use for a charge,
6: PHR is not portable

4.8.8 Provide information regarding the Contractor'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
Contractor ability to support web/telehealth consultations	*Multi, Checkboxes.* 1: Contractor 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
Contractor uses a vendor for web/telehealth consultations (indicate vendor)	*50 words.*	*Single, Radio group.* 1: Web, 2: Telehealth, 3: Combination of Web and Telehealth	*Single, Radio group.* 1: Regional, 2: Statewide
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 1.3.2 or if statewide response from 1.3.3 or if national response from 1.3.4) If Contractor 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 1.3.2 or if statewide response from 1.3.3 or if national response from 1.3.4) If Contractor 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 1.3.2 or if statewide response from 1.3.3 or if national response from 1.3.4) If Contractor 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)*
Contractor provides a structured template for web/telehealth consultations (versus free flow email)	*Single, Radio group.* 1: Yes, 2: No	*(As above)*	*(As above)*
Contractor 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)*

4.9 Attachment 7, 5.04 Identification and Services for At-Risk Enrollees (45 points)

4.9.1 For the California and Covered 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 Contractor'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 not 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 Contractor offers intervention but does not track participation, enter zero)	Number of Covered California members in this state/market receiving intervention (if Contractor 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 Contractor CAD eligibles who received intervention	Autocalcalculated % of Covered California 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 on pages 138-139 of the 2014 HEDIS Technical Specifications Vol 2., provide number of members 18 and above with CAD	*Decimal.*							
Using the plan's own criteria, provide number of members identified with condition and eligible	*Decimal.*							

to participate in CAD DM program								
General member education (e.g., newsletters)		*Multi, Checkboxes* 1: HMO, 2: PPO, 3: Intervention not offered	*Decimal.* From 0 to 100000000000000.	*Decimal.* From 0 to 100000000000000.	*Multi, Checkboxes* 1: Low, 2: Medium, 3: High risk, 4: No stratification	Unknown	Unknown	Unknown
General care education/reminders based on condition alone (e.g., personalized letter)		*(As above)*	*(As above)*	*(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)*	*(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)*	*(As above)*	*(As above)*
Online interactive self-management support. "Online self-management support" is an intervention that includes two-way electronic communication between the Contractor 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.	*Decimal.* From 0 to 100000000000000.	*Multi, Checkboxes.* 1: Low, 2: Medium, 3: High risk, 4: No stratification	Unknown	Unknown	Unknown
Self-initiated text/email messaging		*(As above)*	*(As above)*	*(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 updates and/or triggering additional intervention.		*(As above)*	*(As above)*	*(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)*	*(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)*	*(As above)*	*(As above)*

4.9.2 For the California and Covered 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 Contractor'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 Contractor offers intervention but does not track participation, enter zero)	Number of Covered California members 18 years and above in this state/market receiving intervention (if Contractor 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 Contractor Diabetes eligibles who received intervention	Autocalculated % of Covered California Diabetes eligibles who received intervention
Number of members aged 18 and above in this market	*Decimal.*							
Using the NCQA “Eligible Population” definition for Diabetes on pages 153-155 of the 2014 HEDIS Technical Specifications Vol 2., 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.	*Decimal.* From 0 to 100000000000.	*Multi, Checkboxes* 1: Low, 2: Medium, 3: High risk, 4: No stratification	Unknown	Unknown	Unknown
General care education/reminders based on condition alone (e.g., personalized letter)		*(As above)*	*(As above)*	*(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)*	*(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)*	*(As above)*	*(As above)*
Online interactive self-management support. "Online self-management support" is an intervention that includes two-way electronic communication between the Contractor 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.	*Decimal.* From 0 to 100000000000000.	*Multi, Checkboxes.* 1: Low, 2: Medium, 3: High risk, 4: No stratification	Unknown	Unknown	Unknown

Self-initiated text/email messaging		*(As above)*	*(As above)*	*(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)*	*(As above)*	*(As above)*
IVR with outbound messaging only		*(As above)*	*(As above)*	*(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)*	*(As above)*	*(As above)*

4.9.3 For the California and Covered 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 Contractor'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 18 years and above in this state/market receiving intervention (if Contractor offers intervention but does not track participation, enter zero)	Number of Covered California members 18 years and above in this state/market receiving intervention (if Contractor offers intervention but does not track participation, enter zero)	Risk strata that receives this intervention	Autocalculated % of HEDIS Asthma eligibles who received intervention	Autocalculated % of Contractor Asthma eligibles who received intervention	Autocalculated % of Covered California Asthma eligibles who received intervention
Number of members aged 18 and above in this market	*Decimal.*							
Using the NCQA "Eligible Population" definition for Diabetes on pages 153-155 of the 2014 HEDIS Technical Specifications Vol 2., 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.	*Decimal.* From 0 to 100000000000.	*Multi, Checkboxes* 1: Low, 2: Medium, 3: High risk, 4: No stratification	Unknown	Unknown	Unknown
General care education/reminders based on condition alone (e.g., personalized letter)		*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Member-specific reminders for due or overdue clinical/diagnostic maintenance services		*(As above)*	*(As above)*	*(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)								
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)*	*(As above)*	*(As above)*
Online interactive self-management support. "Online self-management support" is an intervention that includes two-way electronic communication between the Contractor 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.	*Decimal.* From 0 to 100000000000000.	*Multi, Checkboxes* . 1: Low, 2: Medium, 3: High risk, 4: No stratification	Unknown	Unknown	Unknown
Self-initiated text/email messaging		*(As above)*	*(As above)*	*(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)*	*(As above)*	*(As above)*
IVR with outbound messaging only		*(As above)*	*(As above)*	*(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)*	*(As above)*	*(As above)*

4.9.4 If the Contractor 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 Contractor 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

4.9.5 If the Contractor 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 ***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

4.9.6 If online interactive self-management support is offered, provide screen prints or other documentation illustrating functionality as ***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

4.9.7 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, Contractor DUR staff, etc.) Check all that apply.

***If "other" is a department within the Contractor 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 Contractor 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 Contractor 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: Contractor 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 record which will trigger a member alert, 10: Other (describe)	*100 words.*	*100 words.*
Diabetes	*Multi, Checkboxes.* 1: Statins, 2: Insulin,	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*

	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					
Asthma	*Multi, Checkboxes.* 1: Steroidal anti-inflammatories, 2: Non-steroidal anti-inflammatories, 3: Beta agonists (short and long-acting), 4: Xanthines, 5: Anti-cholinergics, 6: Leukotriene receptor agonists, 7: Anti-allergics, 8: Other (describe), 9: Compliance (medication refills) is not systematically assessed	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*

4.9.8 For members already participating in the telephone management program (beyond the initial contact) indicate the events that will cause the Contractor 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)*

4.9.9 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 Contractor 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)*

4.9.10 Indicate the **types** of data analyses and reporting available to employers 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. Contractors 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-	*Multi, Checkboxes.* 1: Group-specific results reported, 2: Comparison targets/benchmarks of book-of-	*Multi, Checkboxes.* 1: Group-specific results reported, 2: Comparison targets/benchmarks of book-of-	*Multi, Checkboxes.* 1: HRAs, 2: Medical Claims Data,

	business, 3: Comparison benchmarks of similarly sized groups, 4: Trend comparison of two years data – rolling time period, 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	business, 3: Comparison benchmarks of similarly sized groups, 4: Trend comparison of two years data – rolling time period, 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	business, 3: Comparison benchmarks of similarly sized groups, 4: Trend comparison of two years data – rolling time period, 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	3: Pharmacy Claims Data, 4: Lab Values, 5: Other source - please detail below
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)*

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

<u>If reporting on Contractor's statewide business ONLY</u>, 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 Contractor 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 CONTRACTOR DID NOT SELECT AND PROVIDE SUPPORT FOR "Trend comparison of two years data - rolling time period"
For example if Contractor 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.
<u>If reporting on Contractor's Covered California enrollment</u>, 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 Contractor's statewide enrollment,
2: At Risk 3 is provided based on Contractor's Covered California enrollment,
3: Not provided

4.10 Attachment 7, 6.01 Provider Cost and Quality (20 points)

4.10.1 Describe the web-based cost information that the Contractor 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, 7: Information available only to members, 8: Information available to public	*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	*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
Episode of care based cost (e.g. vaginal birth, bariatric surgery)	*(As above)*	*(As above)*	*(As above)*

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 Contractor 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 Contractor 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

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

4.10.4 How does the Contractor 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)*

4.11 Attachment 7, 6.02 Enrollee Cost Transparency (Responses and points are incorporated into 4.10 above)

4.11.1 Describe activities to identify for members/consumers those providers (hospitals and/or physicians) that are more efficient and/or lower cost.
Single, Radio group.
1: Description,
2: Contractor does not identify those providers (hospitals and/or physicians) that are more efficient and/or lower cost

4.11.2 Indicate how Contractor 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 Contractor has and tracks use by Medi-Cal members as well, number should include Medi-Cal numbers. It is expected that reporting in future years will reflected Covered California enrollment.

	Applicable Calendar Year
Contractor does not support a cost calculator, or does not track its impact	*Multi, Checkboxes - optional.* 1: Respondent does not support
Total California enrollment from Contractor'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 to cost calculator portion of site	*(As above)*
Percentage of completed sessions to total enrollment	*For comparison.* 0.00%
Percentage of unique users to total 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)*

4.12 Attachment 7, 6.04 Enrollee Shared Decision-Making (20 points)

4.12.1 In order to optimize self-care and member engagement, does the Contractor 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: Other (name vendor in detail box below):,,
9: Contractor provides treatment option support using internal sources,,
10: The service identified above is available subject to an employer buy-up for HMO,
11: The service identified above is available subject to an employer buy-up for PPO

4.12.2 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 Contractor 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 Contractor 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/trade offs 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: Contractor 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/	*Multi, Checkboxes.*

functionality	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.*

4.12.3 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 ***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

4.12.4 Does the Contractor 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

4.12.5 How does the Contractor 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 Contractor has and tracks use by Medi-Cal members as well, number should include Medi-Cal numbers.) It is expected that reporting in future years will reflected Covered California enrollment.

	Applicable Calendar Year
Use/impact not evaluated or tool not available	*Multi, Checkboxes - optional.* 1: Not available
Total commercial enrollment from Contractor'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 Contractor 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 Contractor 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 Contractor has and tracks	*Decimal.*

use by Medi-Cal members as well, number here should include Medi-Cal numbers.)	N/A OK.
Number of unique users receiving outbound telephone calls. If Contractor 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
Contractor can report utilization aggregated at the purchaser level	*Single, Radio group.* 1: Yes, 2: No

4.12.6 How does the Contractor PROMOTE the availability and encourage use of specialist physician performance data to primary care physicians? Check all that apply.

Multi, Checkboxes.
1: Physician newsletter,
2: Targeted communication (mailing, email, fax alert),
3: Prominent placement on physician web portal,
4: Incorporated in online physician referral request,
5: Availability of specialist performance information is not promoted to PCPs in any of the above ways,
6: Individual or practice site results for specialists exist but are not shared with PCPs,
7: None of the above

4.12.7 How does the Contractor PROMOTE the availability and encourage use of hospital performance data by physicians?

Note that responses to this question need to be supported by attachments (e.g., if Contractor selects response option #2 – Contractor needs to attach a sample of the targeted communication to the physician). ***If Contractor supports a portal that is accessed by members, physicians and brokers and has no physician only portal, acceptable to select response option # 3***.

Multi, Checkboxes.
1: Physician newsletter,
2: Targeted communication (mailing, email, fax alert),
3: Prominent placement on physician web portal,
4: Incorporated in inpatient prior authorization or notification system,
5: Hospital performance information is not promoted to PCPs in any of the above ways,
6: Hospital performance information is not shared with PCPs

4.12.8 Does the Contractor 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

4.12.9 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 Contractor 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	Contractor activities	Description of other
Imaging for low back pain within the first six weeks, unless	*Multi, Checkboxes.*	*50 words.*

red flags are present	1: Contractor can report incidence of procedure, 2: Contractor provides treatment decision support to member, 3: Contractor provides member education about this procedure, 4: Other (describe), 5: None of the above	
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)*

4.13 Attachment 7, 7.01 Rewards-based Consumer Incentive Programs (Responses and points are incorporated into 4.4 and 4.7 above)

4.14 Attachment 7, 7.02 Value-Based Reimbursement Inventory and Performance (20 points. Additional responses and points are incorporated into 4.15 below)

4.14.1 Purchasers expect that Contractors implementing physician transparency and performance-based payment initiatives are in compliance with the Consumer -Purchaser Alliance (formerly known as the Consumer-Purchaser Disclosure Project) "Patient Charter" for Physician Performance Measurement, Reporting and Tiering Programs (see http://healthcaredisclosure.org/docs/files/PatientCharter.pdf). One approach to complying with the Disclosure Project's "Patient Charter" is to meet the measurement criteria specified in the NCQA Physician and Hospital Quality Standards (available at http://www.ncqa.org). Respondents are asked to confirm if they are in compliance with the Patient Charter.

Multi, Checkboxes.
1: Contractor is not in compliance with the Patient Charter,
2: Contractor is in compliance with some/all of the following elements of the Patient Charter: [Multi, Checkboxes] ,
3: Contractor uses own criteria [200 words] ,
4: Contractor meets the measurement criteria specified in the NCQA PHQ standards,
5: Contractor does not meet the NCQA PHQ standards

4.15 Attachment 7, 7.04 Value-Pricing Programs (Physician and Hospital) (40 points)

4.15.1 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 additional columns
If Contractor does not have any programs, please provide information on any programs Contractor will implement within the next 6 months for Covered 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 Contractor or program entity programs. To view the live Compendium website, please see http://compendium.catalyzepaymentreform.org/

	Program 1	Other markets/details for Program 1	Columns Repeat for Programs 2-5
Name of Payment Reform Program	*65 words.*	N/A	
Contact Name for Payment Reform Program (person who can answer questions about the program being described)	*5 words.*	N/A	
Contact Person's Title	*(As above)*	*(As above)*	
Contact Person's Email	*(As above)*	*(As above)*	
Contact Person's Phone	*(As above)*	*(As above)*	
Contact Name for person who is authorized to update this program entry in ProposalTech after Contractor has submitted response (if same as contact name for the payment reform program, please re-enter his/her name)	*(As above)*	*(As above)*	
Email for person authorized to update this program entry in ProposalTech after Contractor has submitted response (if same as contact email for the payment reform program, please re-enter his/her email)	*(As above)*	*(As above)*	
Geographic Covered 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, 16: Los Angeles County ZIP Codes in other than those identified above, 17: San Bernardino and Riverside, 18: Orange, 19: San Diego	
Summary/Brief description of Program (500 words or less)	*500 words.*	N/A	
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.*	
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.*	
To which payment reform model does your program most closely align? For programs that have hybrid qualities, review the list of definitions to decide which payment model best describes your program, or is the most dominant payment reform model of those that are used in the program.	*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 associated with HACs (healthcare acquired conditions 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)	*65 words.*	
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.*	
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.*	
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, 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)	*65 words.*	

Which of the following sets of performance measures does your program use?	*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 (relative to target or peers) of Clinical outcomes goals(e.g., readmission rate, mortality rate, A1c, cholesterol values under control), 3: Improvement over time of NQF-endorsed Outcomes and/or Process measures, 4: PATIENT SAFETY (e.g., Leapfrog, AHRQ, medication related safety issues), 5: Appropriate maternity care, 6: Longitudinal efficiency relative to target or peers, 7: Application of specific medical home practices (e.g., intensive self management support to patients, action Contractor development, arrangement for social support follow-up with a social worker or other community support personnel), 8: Patient experience, 9: Health IT adoption or use, 10: Financial results, 11: Utilization results, 12: Pharmacy management, 13: Other - (provide details in next column)	*50 words.*	
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/high performance or narrow networks, 5: Objective information (e.g., performance measure results) provided on COEs to members, providing evidence of higher-quality care rendered by these providers, 6: No active steerage, 7: No COE or high performing providers program, 8: Other (please describe)	*50 words.*	
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.*	
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.*	
Do not include this information in the National Compendium on Payment Reform	*Multi, Checkboxes - optional.* 1: X		

4.15.2 For HMO, indicate if payment rewards for physician (primary care and/or specialty) quality performance is assessed and used for any of the following categories of PQRS Measure Groups and other measures. Check all that apply. Note that results must be available to compare across at least two entities. Contractor 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 http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html

Denominator (preferred): all PCPs in Covered California network and relevant specialists in network that would treat the condition
Denominator (alternate if cannot tease out relevant specialist): all PCPs and specialists in Covered California network – please insert this number in appropriate column - newly created last column
Only one of the last two columns needs a %response – system will not allow Contractor to save responses if both of the last 2 columns have responses
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 "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

Category of PQRS Measure & Other Measures	Level/system at which reward is assessed/ paid (HMO)	Indicate if rewards available to primary care and/or specialty physicians (HMO)	Description of Other (HMO)	(Preferred) % total contracted physicians in market receiving reward (Denominator = all PCPs and relevant specialists) (HMO)	(Alternate) % total contracted physicians in market receiving reward (Denominator = all PCPs and all specialists in network) (HMO)
Diabetes Mellitus	*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.*	*Percent.* N/A OK.	*Percent.* N/A OK.
Preventive Care (Osteoporosis screening, urinary incontinence, flu shot, pneumonia vaccination, screening mammography, colorectal cancer screening, BMI screening and follow-up, screening unhealthy alcohol use, tobacco screening use and cessation intervention)	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Coronary Artery Bypass Graft	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Perioperative Care	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Back pain	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Coronary Artery Disease	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Heart Failure	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Community-Acquired Pneumonia	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Asthma	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
NCQA Recognition program	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*

certification					
Patient experience survey data (e.g., A-CAHPS)	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Mortality or complication rates where applicable	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Efficiency (resource use not unit cost)	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Pharmacy management (e.g. generic use rate, formulary compliance)	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Medication Safety	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Health IT adoption/use	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Preventable Readmissions	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Preventable ED/ER visits (NYU)	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*

4.15.3 For PPO, indicate if payment rewards for physician (primary care and/or specialty) quality performance is assessed and used for any of the following categories of PQRS Measure Groups and other measures. Check all that apply. Note that results must be available to compare across at least two entities. Contractor 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 http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html

Denominator (preferred): all PCPs in Covered California network and relevant specialists in network that would treat the condition
Denominator (alternate if cannot tease out relevant specialist): all PCPs and specialists in Covered California network – please insert this number in appropriate column - newly created last column
Only one of the last two columns needs a %response – system will not allow Contractor to save responses if both of the last 2 columns have responses
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 "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

Category of PQRS Measure & Other Measures	Level/system at which reward is assessed/ paid (PPO)	Indicate if rewards available to primary care and/or specialty physicians (PPO)	Description of Other (PPO)	(preferred) % total contracted physicians in market receiving reward (Denominator = all PCPs and relevant specialists) (PPO)	(Alternate)% total contracted physicians in market receiving reward (Denominator = all PCPs and all specialists in network) (PPO)
Diabetes Mellitus	*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.*	*Percent.* N/A OK.	*Percent.* N/A OK.
Preventive Care (Osteoporosis screening, urinary incontinence, flu shot, pneumonia vaccination,	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*

screening mammography, colorectal cancer screening, BMI screening and follow-up, screening unhealthy alcohol use, tobacco screening use and cessation intervention)					
Coronary Artery Bypass Graft	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Perioperative Care	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Back pain	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Coronary Artery Disease	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Heart Failure	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Community-Acquired Pneumonia	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Asthma	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
NCQA Recognition program certification	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Patient experience survey data (e.g., A-CAHPS)	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Mortality or complication rates where applicable	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Efficiency (resource use not unit cost)	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Pharmacy management (e.g. generic use rate, formulary compliance)	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Medication Safety	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Health IT adoption/use	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Preventable Readmissions	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Preventable ED/ER visits (NYU)	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*

4.15.4 For EPO, indicate if payment rewards for physician (primary care and/or specialty) quality performance is assessed and used for any of the following categories of PQRS Measure Groups and other measures. Check all that apply. Note that results must be available to compare across at least two entities. Contractor 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 http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html

Denominator (preferred): all PCPs in Covered California network and relevant specialists in network that would treat the condition
Denominator (alternate if cannot tease out relevant specialist): all PCPs and specialists in Covered California network – please insert this number in appropriate column - newly created last column
Only one of the last two columns needs a %response – system will not allow Contractor to save responses if both of the last 2 columns have responses
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 "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

Category of PQRS Measure & Other Measures	Level/system at which reward is assessed/ paid (EPO)	Indicate if rewards available to primary care and/or specialty physicians	Description of Other (EPO)	(preferred) % total contracted physicians in market receiving reward (Denominator = all PCPs and	(Alternate)% total contracted physicians in market receiving reward (Denominator = all PCPs and all

		(EPO)		relevant specialists) (EPO)	specialists in network) (EPO)
Diabetes Mellitus	*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.*	*Percent.* N/A OK.	*Percent.* N/A OK.
Preventive Care (Osteoporosis screening, urinary incontinence, flu shot, pneumonia vaccination, screening mammography, colorectal cancer screening, BMI screening and follow-up, screening unhealthy alcohol use, tobacco screening use and cessation intervention)	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Coronary Artery Bypass Graft	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Perioperative Care	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Back pain	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Coronary Artery Disease	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Heart Failure	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Community-Acquired Pneumonia	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Asthma	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
NCQA Recognition program certification	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Patient experience survey data (e.g., A-CAHPS)	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Mortality or complication rates where applicable	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Efficiency (resource use not unit cost)	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Pharmacy management (e.g. generic use rate, formulary compliance)	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Medication Safety	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Health IT adoption/use	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Preventable Readmissions	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
Preventable ED/ER visits (NYU)	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*

4.15.5 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 Contractors' 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: Contractor 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 amount in this column into percentage by entity paid in next 3 columns)**	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
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 applicable calendar year or most recent 12 months	*(As above)*	*(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 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-performance (P4P) programs 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 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)*

4.15.6 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 Contractor 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 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, 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)	*65 words.*
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 Contractor 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)*

4.15.7 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 Contractor 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)*

4.15.8 If Contractor 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	Autocalculation
Total number of PCP physicians in network	*Decimal.*	
Total number of PCP physicians in network for whom the measurement	*Decimal.*	*For*

results meet credibility/reliability thresholds under standards that meet the Patient Charter (e.g., NCQA PHQ threshold of 30 episodes or .7 reliability)	N/A OK. From 0 to 1000000000.	*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%

4.15.9 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 columns.
If Contractor does not have any programs in market of response, please provide information on a program in the closest market to market of response, and also provide information on any programs you Contractor to 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 Contractor or program entity programs. To view the live Compendium website, please see: http://compendium.catalyzepaymentreform.org/

	Program 1	Other markets/details for Program 1	Columns repeat for Programs 2-5
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	
Contact Name for Payment Reform Program (person who can answer questions about the program being described)	*5 words.*	N/A	
Contact Person's Title	*(As above)*	*(As above)*	
Contact Person's Email	*(As above)*	*(As above)*	
Contact Person's Phone	*(As above)*	*(As above)*	
Contact Name for person who	*(As above)*	*(As above)*	

is authorized to update this program entry in ProposalTech after Contractor has submitted response (if same as contact name for the payment reform program, please re-enter his/her name)			
Email for person authorized to update this program entry in ProposalTech after Contractor has submitted response (if same as contact email for the payment reform program, please re-enter his/her email)	*(As above)*	*(As above)*	
Geographic Covered 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, 16: Los Angeles County ZIP Codes in other than those identified above, 17: San Bernardino and Riverside, 18: Orange, 19: San Diego	
Summary/Brief description of Program (500 words or less)	*500 words.*	N/A	
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.*	
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.*	
To which payment reform model does your program most closely align? For programs that have hybrid qualities, review the list of definitions to decide which payment model best describes your program, or is the most	*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,	*65 words.*	

dominant payment reform model of those that are used in the program.	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 HACs (healthcare acquired conditions 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)		
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.*	
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.*	
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, 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)	*65 words.*	
Which of the following sets of performance measures does your program use?	*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 (relative to target or peers) of Clinical outcomes goals(e.g., readmission rate, mortality rate, A1c, cholesterol values under control), 3: Improvement over time of NQF-endorsed Outcomes and/or Process measures, 4: PATIENT SAFETY (e.g., Leapfrog, AHRQ, medication related safety issues), 5: Appropriate maternity care, 6: Longitudinal efficiency relative to target or peers, 7: 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), 8: Patient experience, 9: Health IT adoption or use, 10: Financial results, 11: Utilization results, 12: Pharmacy management, 13: Other - (provide details in next column)	*50 words.*	
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.),	*50 words.*	

	4: Use of tiered/high performance or narrow networks, 5: Objective information (e.g., performance measure results) provided on COEs to members, providing evidence of higher-quality care rendered by these providers, 6: No active steerage, 7: No COE or high performing providers program, 8: 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.*	
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.*	
Do not include this information in the National Compendium on Payment Reform	*Multi, Checkboxes - optional.* 1: X		

4.15.10 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, Contractor 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 Contractors' 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: Contractor 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**	HOSPITALS paid under listed payment category	Contracted entities (e.g., ACOs/PCMH/Medical Groups/IPAs) paid	*This column activated only if there is % listed in column 3 Please select which*	Autocalculated percent based on responses in column 1.

	Year or most current 12 months Estimate breakout of amount in this column into percentage by contracted entity paid in next 2 columns	below *Estimated Percentage of dollar amount listed in column 1 for each row*	under listed payment category below *Estimated Percentage of dollar amount listed in column 1 for each row*	*contracted entities are paid in column 3*	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 payments 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 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 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)*
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 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 for non-FFS-based	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*

non-visit functions. (see definitions for examples) for the applicable calendar year 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***	*(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)*

4.15.11 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 Contractor 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, 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)	*65 words.*
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 Contractor 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)

4.15.12 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 CONTRACTOR 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

4.15.13 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, 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)	*65 words.*	*Percent.* N/A OK.	*Percent.* N/A OK.
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_hospital_survey_copy/leapfrog_safety_practices	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
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)*
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 patient) www.qualityforum.org/Topics/SREs/List_of_SREs.aspx . Please refer to attachment	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*	*(As above)*
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)*

4.16 Attach 7, 7.05 Payment Reform and Data Submission (Responses and points incorporated in 4.15)

4.16.1 Catalyst for Payment Reform (CPR) Scorecard on Payment Reform and National Compendium on Payment Reform

Single, Radio group.

1: Contractor agrees that the Exchange will provide payment reform information to the CPR Scorecard,
2: Information not provided

Attachment 8 – 2015 Rates – Individual Market

Attachment 9 - Reserved

Attachment 10 – 2015 Rates - SHOP

Attachment 11 - Reserved

Attachment 12 – Overview of the Model QHP Addendum for Indian Health Care Providers

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

Overview of the Model QHP Addendum for Indian Health Care Providers

I. Purpose

CMS has developed the attached Model QHP Addendum for Indian health care providers to facilitate the inclusion of Indian Health Service (IHS), tribes and tribal organizations, and urban Indian organization (I/T/U) providers in qualified health plan (QHP) provider networks and help health insurance issuers comply with the QHP certification standards set forth in 45 C.F.R. Part 156. Similar to the standardized contract addendum used in the Medicare Part D program, this Model QHP Addendum has been developed for QHP issuers to use when contracting with I/T/U providers. This Model QHP Addendum is not required, but the U.S. Department of Health and Human Services (HHS) received several comments supporting the development and issuance of a model addendum for this purpose to assist QHP issuers in including I/T/U providers in their networks.

The federal government has a historic and unique government-to-government relationship with Indian tribes. In adhering to QHP certification standards, QHP issuers should reach out to I/T/U providers. A significant portion of American Indians and Alaska Natives (AI/ANs) access care through longstanding relationships with providers in the Indian health system. An important consideration in evaluating network adequacy and essential community provider accessibility will be the extent to which a QHP includes I/T/U providers and whether it can assure that services to AI/ANs will be accessible without unreasonable delay.

It is anticipated that the Model QHP Addendum will assist issuers to meet the QHP certification standards and facilitate acceptance of network contracts by I/T/U providers. We anticipate that offering contracts that include the Model QHP Addendum will provide QHP issuers with an efficient way to establish contract relationships with I/T/U providers, and also ensure that AI/ANs can continue to be served by their Indian provider of choice.

Indian tribes are entitled to special protections and provisions under federal law, which are described further in Section II. The Addendum identifies several specific provisions that have been established in federal law that apply when contracting with I/T/U providers. The use of this Model QHP Addendum benefits both QHP issuers and the I/T/U providers by lowering the perceived barriers to contracting, assuring QHP issuers comply with key federal laws that apply when contracting with I/T/U providers, and minimizing potential disputes. AI/ANs enrolled in QHPs will be better served when I/T/U providers can coordinate their care through the QHP issuer provider network.

II. Background on Indian Health Care

Indian tribes are afforded specific protections and provisions under federal laws, including the Indian Health Care Improvement Act (IHCIA), the Indian Self-Determination and Education Assistance Act (ISDEAA), and the Patient Protection and Affordable Care Act (ACA). In order

to carry out its obligation to provide health care to American Indians and Alaska Natives (AI/ANs), the federal government has established a unique health care delivery system through the Indian Health Service (IHS). As part of the Indian health care system, health care services to AI/ANs are provided either directly by the IHS, by tribes or tribal organizations, or by urban Indian programs.

Today the Indian health care system includes 44 Indian hospitals (16 of which are tribally-operated and all of which are accredited) and nearly 570 Indian health centers, clinics, and health stations (of which 83 percent are tribally-operated). When specialized services are not available at these sites, health services are purchased from public and private providers through the IHS-funded Contract Health Services (CHS) program. Additionally, 33 urban programs offer services ranging from community health to comprehensive primary care.

III. Key Provisions in the Addendum

The following is a synopsis of key provisions outlined in the Addendum.

<u>Persons Eligible for Items and Services from an Indian Health Care Provider:</u> This section acknowledges that Indian health programs are generally not available to the public; they are established to serve AI/ANs, as provided in the IHCIA. The applicable eligibility rules are generally set out in the IHS regulations at 42 C.F.R. Part 136. The IHCIA § 813 (25 U.S.C. §1680c) sets out the circumstances under which certain non-AI/ANs connected with an AI/AN (such as minor children or a spouse) can receive services as beneficiaries. Also, the IHCIA § 813 authorizes services to certain other non-AI/ANs if defined requirements are satisfied. Pursuant to 45 C.F.R. 80.3(d), an individual shall not be deemed as subjected to discrimination by reason of his/her exclusion from benefits limited by federal law to individuals eligible for services from an Indian health program.

Providers should note that 45 C.F.R. 80.3(d) is not an exemption from civil rights obligations generally. It simply clarifies that certain types of exclusions are not considered discrimination under Title VI of the Civil Rights Act of 1964. Providers may be subject to applicable federal nondiscrimination statutes.

<u>Applicability of Other Federal Law</u>: This section describes several federal laws that apply variously when contracting with I/T/U providers.

- *Indian Self-Determination and Education Assistance Act (ISDEAA), 25 U.S.C. § 450 et seq.* This law directs HHS at the request of an Indian tribe, to enter into a contract or compact with a tribe, a tribal organization, or an inter-tribal consortium to operate federal health programs for AI/ANs with the funds the IHS would have otherwise used to carry out the program directly. Through this law, many Indian tribes and tribal organizations have taken over direct operation of health programs from the IHS.

- *Federal Tort Claims Act (FTCA), 28 U.S.C. §§ 2671-2680.* Congress generally extended the FTCA to cover Indian tribes and tribal organizations operating federal programs pursuant to contracts or compacts under the ISDEAA, 25 U.S.C. § 450f. Urban Indian organization health providers who acquire Federally Qualified Health Center status under Section 224 of the Public Health Service Act can acquire FTCA coverage. Since a claim under the FTCA is

the exclusive remedy for actions against Indian health care providers that are covered by the FTCA, those entities are not required to obtain separate professional liability insurance.

- *Federal Medical Care Recovery Act (FMCRA), 42 U.S.C. §§ 2651-2653.* This law authorizes federal agencies, including the IHS, to recover from a tortfeasor (or an insurer of a tortfeasor) the reasonable value of health services furnished to a tortfeasor's victim. The right of recovery under the FMCRA extends to Indian tribes and tribal organizations operating ISDEAA contracts and compacts. 25 U.S.C. § 1621.

- *Federal Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b.* This law and its regulations apply to the IHS, and may apply Indian tribes, tribal organizations, and urban Indian organizations that operate federally-funded health care programs. The Privacy Act governs the use and disclosure of personally identifiable information about individuals that is maintained in a federal system of records. While the Privacy Act generally applies to federal records maintained by a government contractor, patient records of a Tribal health program are not considered federal records for the purposes of chapter 5 of title 5 of the United States Code (including the Privacy Act and the Freedom of Information Act - see 25 U.S.C. § 450l).

- *Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2.* These regulations restrict disclosure and use of drug abuse patient records that are maintained in connection with the performance of any federally assisted alcohol or drug abuse program. The restrictions would apply to any such records maintained by the IHS, an Indian tribe, tribal organization, or urban Indian organization.

- *Health Insurance Portability and Accountability Act (HIPAA), (45 C.F.R. Parts 160 and 164).* These regulations restrict access to and disclosure of protected health information maintained by covered entities, including covered health care providers operated by the IHS, Indian tribes, tribal organizations, and urban Indian organizations.

- *Indian Health Care Improvement Act (IHCIA), 25 U.S.C. § 1601 et seq.* This law provides the comprehensive statutory framework for delivery of health care services to AI/ANs. It applies to all Indian health providers operating ISDEAA contracts and compacts from the Secretary of the HHS; and urban Indian organizations that receive grants from IHS under Title V of the IHCIA. Specific provisions of the IHCIA that would impact contracts between Indian health care providers and QHPs issuers are cited in various provisions of the Addendum.

Insurance and Indemnification: IHS, tribes and tribal organization providers are generally covered by the FTCA. Some urban Indian organizations are also covered under FTCA. Since a claim under the FTCA is the exclusive remedy for actions against FTCA covered I/T/U providers, those entities are not required to obtain professional liability insurance.

Licensure of Health Care Professionals: Section 221 of the IHCIA, 25 U.S.C. § 1621t, permits an Indian tribe or tribal organization to employ a health care professional who is subject to licensure if that individual is licensed in any state. Employees of the IHS obtain their "licensed in any state" status through other federal law.

Medical Quality Assurance Requirements: Section 805 of the IHCIA, 25 U.S.C. § 1675, facilitates internal medical program quality reviews; shields participants in those reviews; and restricts disclosure of medical quality assurance records, subject to the exceptions in 25 U.S.C. 1675(d), which provides that medical quality assurance records created by or for I/T/U providers may not be disclosed to any person or entity. These disclosure limitations are also applicable to anyone to whom the I/T/U provider discloses such medical quality assurance records under the authority of 25 U.S.C. 1675(d). Although restrictive, we expect these limitations will have limited applicability to QHPs because there will be few, if any circumstances, where such records may be disclosed to a QHP under the law.

Claims Format: Section 206(h) of the IHCIA, 25 U.S.C. § 1621e(h) is applicable to issuers when processing claims from an I/T/U provider. Section 206(h) of IHCIA states than a health insurance issuer may not deny a claim submitted by the IHS, an Indian tribe or tribal organization based on the format on which the claim is submitted if the format complies with the Medicare claims format requirements.

Payment of Claims: Federal laws, including Section 206(a) and (i) of the IHCIA, 25 U.S.C. § 1621e(a) and (i) and Title 45 Code of Federal Regulation, Part 156, Subpart E[1], are applicable to health insurance issuers when paying claims from I/T/U providers. Section 206(a) and (i) of IHCIA provide that the IHS, an Indian tribe, tribal organization, and urban Indian organization have a right to recover the reasonable charges billed, or, if higher, the highest amount an insurance carrier would pay to other providers. However, this paragraph also notes if the issuer and I/T/U Provider mutually agree to rates or amounts specified in the QHP agreement as payment in full, the QHP issuer is deemed to be compliant with Section 206 of IHCIA.

Contract Health Service Referral Requirements: In some instances, I/T/U providers may be subject to referral requirements under the contract health services program. For example, IHS may have existing contractual arrangements that require IHS to refer to specific providers and suppliers; or IHS may be prohibited from referring to a provider that has been excluded from Federal Health Care Programs, as defined in § 1128 of the Social Security Act. We believe these circumstances will be rare, but to the extent that they occur, the I/T/U provider may not be able to adhere to QHP issuer referral requirements to use in-network providers. This section acknowledges the potential for conflicting requirements, and that I/T/U providers may be prevented from following QHP issuer referral requirements in such instances. This section affirms that the I/T/U provider will otherwise comply with in network coordination of care and referral requirements.

IV. Database of Indian Providers

To assist issuers in identifying I/T/U providers in their service areas, please use the attached link to obtain a database of I/T/U provider locations, developed with the assistance of the Indian Health Service: http://cciio.cms.gov/programs/exchanges/qhp.html.

[1] Title 45 Code of Federal Regulation, Part 156, Subpart E describes rules for the elimination of cost sharing for EHB, for Indians at or below 300% of the Federal Poverty Level, and for no cost sharing for Indians receiving an item or service that is an EHB furnished by the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization, or through referral under contract health services. 78 Fed. Reg. 15410, 15535-39 (Mar. 11, 2013).

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Model QHP Addendum for Indian Health Care Providers

1. Purpose of Addendum; Supersession.

The purpose of this Addendum for Indian health care providers is to apply special terms and conditions necessitated by federal law and regulations to the network provider agreement by and between _______________________ (herein "Qualified Health Plan issuer" and/or "QHP issuer") and ____________________________ (herein " Provider"). To the extent that any provision of the Qualified Health Plan issuer's network provider agreement or any other addendum thereto is inconsistent with any provision of this Addendum, the provisions of this Addendum shall supersede all such other provisions.

2. Definitions.

For purposes of the Qualified Health Plan issuer's agreement, any other addendum thereto, and this Addendum, the following terms and definitions shall apply:

(a) "Contract health services" has the meaning given in the Indian Health Care Improvement Act (IHCIA) Section 4(5), 25 U.S.C. § 1603(5).
(b) "Indian" has the meaning given in 45 C.F.R. 155.300.
(c) "Provider" means a health program administered by the Indian Health Service, a tribal health program, an Indian tribe or a tribal organization to which funding is provided pursuant to 25 U.S.C. § 47(commonly known as the "Buy Indian Act"), or an urban Indian organization that receives funding from the IHS pursuant to Title V of the IHCIA (Pub. L. 94-437), as amended, and is identified by name in Section 1 of this Addendum.
(d) "Indian Health Service or IHS" means the agency of that name within the U.S. Department of Health and Human Services established by the IHCIA Section 601, 25 U.S.C. § 1661.
(e) "Indian tribe" has the meaning given in the IHCIA Section 4(14), 25 U.S.C. § 1603(14).
(f) "Qualified Health Plan" (QHP) has the meaning given in Section 1301 of the Affordable Care Act, 42 U.S.C. § 18021.
(g) "Tribal health program" has the meaning given in the IHCIA Section 4(25), 25 U.S.C. § 1603(25).
(h) "Tribal organization" has the meaning given in the IHCIA Section 4(26), 25 U.S.C. § 1603(26).
(i) "Urban Indian organization" has the meaning given in the IHCIA Section 4(29), 25 U.S.C. § 1603(29).

3. Description of Provider.

The Provider identified in Section 1 of this Addendum is (check the appropriate box):

/_/ The IHS.

/_/ An Indian tribe that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. § 450 et seq.

/_/ A tribal organization that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. § 450 et seq.

/_/ A tribe or tribal organization that operates a health program with funding provided in whole or part pursuant to 25 U.S.C. § 47 (commonly known as the Buy Indian Act).

/_/ An urban Indian organization that operates a health program with funds in whole or part provided by IHS under a grant or contract awarded pursuant to Title V of the IHCIA.

4. Persons Eligible for Items and Services from Provider.

(a) The parties acknowledge that eligibility for services at the Provider's facilities is determined by federal law, including the IHCIA, 25 U.S.C. § 1601, et seq. and/or 42 C.F.R. Part 136. Nothing in this agreement shall be construed to in any way change, reduce, expand, or alter the eligibility requirements for services through the Provider's programs.

(b) No term or condition of the QHP issuer's agreement or any addendum thereto shall be construed to require the Provider to serve individuals who are ineligible under federal law for services from the Provider. The QHP issuer acknowledges that pursuant to 45 C.F.R. 80.3(d), an individual shall not be deemed subjected to discrimination by reason of his/her exclusion from benefits limited by federal law to individuals eligible for services from the Provider. Provider acknowledges that the nondiscrimination provisions of federal law may apply.

5. Applicability of Other Federal Laws.

Federal laws and regulations affecting the Provider, include but are not limited to the following:

(a) The IHS as a Provider:

(1) Anti-Deficiency Act, 31 U.S.C. § 1341;
(2) ISDEAA, 25 U.S.C. § 450 et seq.*;*
(3) Federal Tort Claims Act ("FTCA"), 28 U.S.C. §§ 2671-2680;
(4) Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
(5) Federal Privacy Act of 1974 ("Privacy Act"), 5 U.S.C. § 552a, 45 C.F.R. Part 5b;
(6) Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2;
(7) Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164; and
(8) IHCIA, 25 U.S.C. § 1601 et seq.

(b) An Indian tribe or a Tribal organization that is a Provider:

(1) ISDEAA, 25 U.S.C. § 450 et seq.*;*
(2) IHCIA, 25 U.S.C. § 1601 et seq.*;*
(3) FTCA, 28 U.S.C. §§ 2671-2680;
(4) Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
(5) Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b; and
(6) HIPAA, 45 C.F.R. Parts 160 and 164.

(c) An urban Indian organization that is a Provider:

(1) IHCIA, 25 U.S.C. § 1601 et seq. (including without limitation pursuant to the IHCIA Section 206(e)(3), 25 U.S.C. § 1621e(e)(3), regarding recovery from tortfeasors)*;*
(2) Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b; and
(3) HIPAA, 45 C.F.R. Parts 160 and 164.

6. Non-Taxable Entity.

To the extent the Provider is a non-taxable entity, the Provider shall not be required by a QHP issuer to collect or remit any federal, state, or local tax.

7. Insurance and Indemnification.

(a) *Indian Health Service*. The IHS is covered by the FTCA which obviates the requirement that IHS carry private malpractice insurance as the United States consents to be sued in place of federal employees for any damages to property or for personal injury or death caused by the negligence or wrongful act or omission of federal employees acting within the scope of their employment. 28 U.S.C. §§ 2671-2680. Nothing in the QHP network provider agreement shall be interpreted to authorize or obligate any IHS employee to perform any act outside the scope of his/her employment. The IHS shall not be required to acquire insurance, provide indemnification, or guarantee that the QHP will be held harmless from liability.

(b) *Indian Tribes and Tribal Organizations*. A Provider which is an Indian tribe, a tribal organization, or employee of a tribe or tribal organization shall not be required to obtain or maintain professional liability insurance to the extent such Provider is covered by the FTCA pursuant to federal law (Public Law 101-512, Title III, § 314, as amended by Public Law 103-138, Title III, § 308 (codified at 25 U.S.C. § 450f note); and 25 C.F.R. Part 900, Subpart M; 25 U.S.C. §458aaa-15(a); and 42 C.F.R. § 137.220). Nothing in the QHP issuer network provider agreement or any addendum thereto shall be interpreted to authorize or obligate such Provider or any employee of such provider to operate outside of the scope of employment of such employee. Such Provider shall not be required to acquire insurance, provide indemnification, or guarantee that the QHP issuer will be held harmless from liability.

(c) *Urban Indian Organizations*. To the extent a Provider that is an urban Indian organization is covered by the FTCA pursuant to Section 224(g)-(n) of the Public Health Service Act, as amended by the Federally Supported Health Centers Assistance Act, Public Law 104-73, (codified at 42 U.S.C. § 233(g)-(n)), 42 C.F.R. Part 6, such Provider shall not be required to obtain or maintain professional liability insurance. Nothing in the QHP issuer network provider agreement or any addendum thereto shall be interpreted to authorize or obligate such Provider or any employee of such Provider to operate outside of the scope of employment of such employee. Such Provider shall not be required to acquire insurance, provide indemnification, or guarantee that the QHP issuer will be held harmless from liability.

8. Licensure of Health Care Professionals.

(a) *Indian Health Service.* States may not regulate the activities of IHS-operated health care programs nor require that IHS health care professionals be licensed in the state where they are providing services, whether the IHS employee is working at an IHS-operated facility or has been assigned to a health care program of a tribe, tribal organization, or urban Indian organization. The parties agree that during the term of the QHP issuer's agreement, IHS health care professionals shall hold state licenses in accordance with applicable federal law, and that IHS facilities shall be accredited in accordance with federal statutes and regulations.

(b) *Indian tribes and tribal organizations.* Section 221 of the IHCIA, 25 U.S.C. § 1621t, exempts a health care professional employed by an Indian tribe or tribal organization from the licensing requirements of the state in which such tribe or organization performs services, provided the health care professional is licensed in any state. The parties agree that these federal laws apply to the QHP issuer's agreement and any addenda thereto.

(c) *Urban Indian organizations.* To the extent that any health care professional of an urban Indian provider is exempt from state regulation, such professional shall be deemed qualified to perform services under the QHP Sponsor's agreement and all addenda thereto, provided such employee is licensed to practice in any state. The parties agree that this federal law applies to the QHP issuer's agreement and any addenda thereto.

9. Licensure of Provider; Eligibility for Payments.

To the extent that the Provider is exempt from state licensing requirements, such Provider shall not be required to hold a state license to receive any payments under the QHP issuer's network provider agreement and any addendum thereto.

10. Dispute Resolution.

In the event of any dispute arising under the QHP issuer's network provider agreement or any addendum thereto, the parties agree to meet and confer in good faith to resolve any such disputes prior to resolution of any disputes through any process identified in the network provider agreement. If the Provider is an IHS provider, the laws of the United States shall apply to any problem or dispute hereunder that cannot be resolved by and between the parties in good faith. Notwithstanding any provision in the provider network agreement, IHS shall not be required to submit any disputes between the parties to binding arbitration.

11. Governing Law.

The QHP issuer's network provider agreement and all addenda thereto shall be governed and construed in accordance with federal law of the United States. In the event of a conflict between such agreement and all addenda thereto and federal law, federal law shall prevail. Nothing in the QHP issuer's network provider agreement or any addendum thereto shall subject an Indian tribe, tribal organization, or urban Indian organization to state law to any greater extent than state law is already applicable.

12. Medical Quality Assurance Requirements.

To the extent the QHP issuer imposes any medical quality assurance requirements on its network providers, any such requirements applicable to the Provider shall be subject to Section 805 of the IHCIA, 25 U.S.C. § 1675.

13. Claims Format.

The QHP issuer shall process claims from the Provider in accordance with Section 206(h) of the IHCIA, 25 U.S.C. § 1621e(h), which does not permit an issuer to deny a claim submitted by a Provider based on the format in which submitted if the format used complies with that required for submission of claims under Title XVIII of the Social Security Act or recognized under Section 1175 of such Act.

14. Payment of Claims.

The QHP issuer shall pay claims from the Provider in accordance with federal law, including Section 206 of the IHCIA (25 U.S.C. §1621e), and 45 C.F.R., Part 156, Subpart E. The QHP issuer shall be deemed compliant with Section 206 to the extent the QHP issuer and Provider mutually agree to the rates or amounts specified in the QHP issuer agreement as payment in full.

15. Hours and Days of Service.

The hours and days of service of the Provider shall be established by the Provider. Though not required prior to the establishment of such service hours, the QHP issuer and the Provider may negotiate and agree on specific hours and days of service. At the request of the QHP issuer, such Provider shall provide written notification of its hours and days of service.

16. Contract Health Service Referral Requirements

The Provider shall comply with coordination of care and referral obligations of the QHP issuer except only in specific circumstances in which such referrals would conflict with federal law or that referral requirements applicable to Contract Health Services would not be met. The Provider will notify the QHP issuer when such circumstances occur.

17. Sovereign Immunity.

Nothing in the QHP issuer's network provider agreement or in any addendum thereto shall constitute a waiver of federal or tribal sovereign immunity.

18. Endorsement.

An endorsement of a non-federal entity, event, product, service, or enterprise may be neither stated nor implied by the IHS Provider or IHS employees in their official capacities and titles. Such agency names and positions may not be used to suggest official endorsement or preferential treatment of any non-federal entity under this agreement.

APPROVALS

For the Qualified Health Plan Issuer:	**For the Provider:**
______________________________	______________________________
Date ________________________	Date ________________________

Attachment 13 - Reserved

Attachment 14 – Performance Measurement Standards

Attachment 14. Performance Measurement Standards

In the event that the reporting requirements identified herein include Personal Health Information, Contractor shall provide the Exchange only with de-identified Personal Health Information as defined in 45 C.F.R. Section 164.514. Contractor shall not be required to provide the Exchange any data, information or reports that would violate peer review protections under applicable laws and regulations.

During the term of this Agreement, Contractor shall meet or exceed the Performance Measurement Standards identified in this Attachment. Contractor shall be liable for payment of penalties that may be assessed by the Exchange with respect to Contractor's failure to meet or exceed the Performance Measurement Standards in accordance with the terms set forth at Section 6.01 of the Agreement and this Attachment.

The assessment of the penalties by the Exchange shall be determined in accordance with the computation methodology set forth in this Attachment and shall be based on the following conditions: (i) the total amount at risk with respect to Contractor's failure to comply with the Performance Measurement Standards shall not exceed ten percent (10%) of the total Participation Fee that is payable to the Exchange in accordance with the terms set forth in Section 5.03 of the Agreement for the Individual Market and four percent (4%) for SHOP, and (ii) the amount of performance penalty to be assessed with respect to Contractor's failure to meet a Performance Measurement Standard shall be offset (i.e., reduced) by a Service Level Credit that is provided in the event that Contractor exceeds a Performance Measurement Standard in a separate category.

The Exchange will also comply with the Performance Measurement Standards as described herein. In the event that the Exchange fails to meet a Performance Measurement Standard with respect to its operations for any applicable period, Contractor shall receive a credit against the penalty amounts that are due based on Contractor's performance. The failure of the Exchange to meet the Performance Measurement Standards shall represent at the maximum a 25% credit towards the total amount at risk with respect to Contractor's failure to comply with its Performance Measurement Standards.

In no event shall the total credits to Contractor exceed the total amount of the performance penalty that may be assessed during any applicable period.

An example of how penalties and credits will be assessed is attached hereto as Appendix 2.

Any amounts collected as performance penalties under this Attachment shall be used for Exchange operations to reduce future Participation Fees that support the operations of the Exchange.

1. Call Center Operations

(a) 800 Numbers: Contractor shall make information available regarding the Exchange pursuant to Contractor's toll-free hotline (i.e., 1-800 number) that shall be available to enrollees of Contractor both inside and outside the Exchange. The hotline and information services shall be staffed and operated in accordance with the Customer Service Standards set forth at Section 3.20 to provide support to Exchange Enrollees and in a manner designed to assure compliance with these Performance Measurement Standards.

(b) Reporting; Contractor shall provide the following minimum reports to the Exchange at the specified time and frequency at no additional charge to the Exchange:

- Performance Measurement Standards reporting: Customer Service, Operational and Quality, Network Management and Delivery System Reform: monthly, quarterly and annually.
- Monthly accumulative monitoring scoring:

2. Performance Measurement Standards Reporting- Group 1 - Customer Service and Group 2 – Operational, Performance Standards 1.1 – 1.8 and 2.1 – 2.5

(a) **Monthly Performance Report:** Beginning January 1, 2015, Contractor shall monitor and track its performance each month against the Performance Measurement Standards set forth below. Contractor shall provide detailed supporting information (as mutually agreed by the parties) for each Monthly Performance Report to the Exchange in electronic format. Contractor shall report on Exchange business only and shall report Contractor's Exchange Enrollees in the Individual Exchange separate from Contractor's Exchange Enrollees in SHOP.

(b) **Measurement Rules:** Except as otherwise specified below in the Performance Measurement Standards Table, the reporting period for each Performance Guarantee shall be one calendar month; all references to time of day shall be to Pacific Standard Time; all references to hours will be actual hours during a calendar day; and all references to days, months, and quarters shall be to calendar days, calendar months, and calendar quarters, respectively.

(c) **Penalty Assessment: Except as otherwise specified in the Performance Measurement Standards table, the penalty and credit assessment will be based on the total annual performance for each Performance Measurement Standard.**

(d) **Performance Measurement Standards:**

i. General - The Performance Measurement Standards Table sets forth the categories of Performance Measurement Standards and their associated measurements. In performing its services under this Agreement, Contractor shall use commercially reasonable efforts to meet or exceed the Performance Measurement Standards.

ii. Root Cause Analysis/Corrective Action - If Contractor fails to meet any Performance Measurement Standard in any calendar month (whether or not the failure is excused), Contractor shall promptly (a) investigate and report on the root cause of the problem; (b) develop a corrective action plan (where applicable); (c) to the extent within Contractor's control, remedy the cause of the performance failure and resume meeting the affected Performance Measurement Standards; (d) implement and notify the Exchange of measures taken by Contractor to prevent recurrences if the performance failure is otherwise likely to recur; and (e) make written recommendations to the Exchange for improvements in procedures.

iii. Performance Guarantee Exceptions; Contractor shall not be responsible for any failure to meet a Performance Guarantee if and to the extent that the failure is

excused pursuant to Section 12.07 of the Agreement (Force Majeure) or the parties agree that the lack of compliance is due to the Exchange's failure to properly or timely perform (or cause to be properly or timely performed) any responsibility, duty, or other obligation under this Agreement, provided that Contractor timely notifies the Exchange of the problem and uses commercially reasonable efforts to perform and meet the Performance Measurement Standards notwithstanding the Exchange's failure to perform or delay in performing.

If Contractor wishes to avail itself of one of these exceptions, Contractor shall indicate in the applicable performance report delivered in the second month following the failure to meet such Performance Measurement Standard: (a) the identity of the Performance Measurement Standard that is subject to the exception, and (b) the circumstances that gave rise to the exception in sufficient detail to permit the Exchange to evaluate whether Contractor's claim of exception is valid. Notwithstanding anything to the contrary herein, in no event shall any failure to meet a Customer Satisfaction Performance Guarantee fall within an exception.

The Exchange will also comply with the Performance Measurement Standards set forth herein to the extent that such measurements are applicable to Exchange's operations. In the event that Exchange fails to meet a Performance Measurement Standard with respect to its operations for any applicable period, the additional fees that may be assessed by the Exchange under this Attachment will not be imposed on Contractor with respect to Contractor's failure to meet the same Performance Measurement Standard.

iv. Agreed Adjustments/Service Level Relief - In addition, the Parties may agree on Performance Measurement Standard relief or adjustments to Performance Measurement Standards from time to time, including, the inclusion of new and/or temporary Performance Measurement Standards.

v. Performance Measurement Defaults - If the Exchange elects to assess sanctions for failure to meet Performance Measurement Standards, it will so notify Contractor in writing following the Exchange's receipt of the Monthly Performance Report setting forth the performance level attained by Contractor for the calendar quarter to which the sanctions relate. If Contractor does not believe it is appropriate for the Exchange to assess sanctions for a particular calendar quarter or calendar year (as applicable), it shall so notify the Exchange in writing within thirty (30) days after receipt of the Exchange's notice of assessment and, in such event, the Exchange will meet with Contractor to consider, in good faith, Contractor's explanation of why it does not believe the assessment of sanctions to be appropriate; provided, however, that it is understood and agreed that the Exchange, acting in good faith, will make the final determination of whether or not to assess the sanctions.

vi. Service Level Credits - For certain measures of the performance standards set forth in the Performance Measurement Table, Contractor will have the opportunity to earn service level credit ("Service Level Credits") for performance that exceeds the Performance Measurement Standards. The Service Level Credits shall be used to offset (i.e., reduce) any sanctions that are imposed during any Contract Year.

vii. Performance Measurement Tables - The Performance Measurement Standards are set forth in the below table, Covered California Performance Standards for Contractor.

3. Performance Measurement Standards Reporting-Group 3- Quality, Network Management and Delivery System Reform, Performance Standards 3.1-3.3

For 2015, Group 3 Performance Standards 3.1-3.3 are derived from CMS's QRS Requirements for QHP Issuers[1]. Based on Section 1311(c) of the Affordable Care Act, CMS developed the Quality Rating System (QRS) to: (i) inform consumer selection of Qualified Health Plans (QHPs) offered through a Health Insurance Market-place (Marketplace), (ii) facilitate regulatory oversight of QHPs, and (iii) provide actionable information to QHPs for performance improvement. CMS also developed the Qualified Health Plan Enrollee Experience Survey (QHP Enrollee Survey), which will yield member experience data. CMS issued regulations in May 2014 that established standards and requirements related to QHP issuer data collection and public reporting of quality rating information by every Marketplace as early as open enrollment 2016.

QHP issuers are required by CMS in 2016 to collect and submit third-party validated QRS measure data, for measurement year 2015 that will be used by CMS to calculate QHP scores and ratings as a beta test. Covered California will use a subset of these measures to create a Covered California specific QRS in 2016. This QRS will be used for public reporting and for performance assessment as outlined in this attachment. The methods used by Covered California for assessing QRS performance of each plan, including measures, benchmarks and scoring, is developed and updated annually by Covered California and is available for review by each QHP prior to public release of performance information. As federal QRS requirements change, Covered California will annually review and modify the measures and methods used to determine each QHP's QRS performance.

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[1] http://cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html

Covered California Performance Standards for Contractor

Group 1: Customer Service Performance Standards 25% of Total Performance Penalty or Credit				
Performance Standard		**Individual**	**SHOP**	**Performance Requirements**
1.1	**Inbound Call Volume**	X	X	Reporting Required Only. No penalty or credit. Volume will be used in calculation of performance standards 1.3 and 1.4 Total number of calls received by the ACD.
1.2	**Abandoned Call Volume**	X	X	Reporting Required Only. No penalty or credit. Volume will be used in calculation of performance standards 1.3 and 1.4 Number of calls offered to the service center by the ACD, but terminated by the person originating the call outside of the service level.
1.3	**Call Answer Timeliness**	X	X	Expectation: 80% of calls answered 30 seconds or less. 5% of total performance penalty at risk. Performance Level: <80%: 5% performance penalty. 80%-90%: no penalty. >90%: 5% performance credit.
1.4	**Telephone Abandonment Rate**	X	X	Expectation: No more than 3% of incoming calls in a calendar month. 5% of total performance penalty at risk. Performance Level: >3% abandoned: 5% performance penalty. 2-3% abandoned: no penalty. <2% abandoned: 5% performance credit.

Covered California Performance Standards for Contractor

Group 1: Customer Service Performance Standards 25% of Total Performance Penalty or Credit				
Performance Standard		**Individual**	**SHOP**	**Performance Requirements**
1.5	**Initial Call Resolution**	X	X	Expectation: 85% of enrollee issues will be resolved within one (1) business day of receipt of the issue. 5% of total performance penalty at risk. Performance Level: <85%: 5% performance penalty. 85-95%: no penalty. >95%: 5% performance credit.
1.6	**Grievance Resolution**	X	X	Expectation: 95% of enrollee grievances resolved within 30 calendar days of initial receipt. 5% of total performance penalty at risk. Performance Level: <95% resolved within 30 calendar days of initial receipt: 5% performance penalty. 95% or greater resolved within 30 calendar days of initial receipt: no penalty. 95% or greater resolved within 15 calendar days of initial receipt: 5% performance credit.
1.7	**Member Email or Written Inquiries**	X	X	Reporting Required Only. No penalty or credit. Volume will be used in calculation of performance standard 1.8 Total number of member email or written inquiries received.
1.8	**Member Email or Written Inquiries Answered**	X	X	Expectation: 90% of member email or written inquiries answered within 15 business days of the inquiry. Does not include appeals or grievances. 5% of total performance penalty at risk. Performance Level: <90%: 5% performance penalty. 90-95%: no penalty. >95% in 15 days: 5% performance credit.

Group 2: Operational Performance Standards **30% of Total Performance Penalty or 5% Credit**				
Performance Standard		**Individual**	**SHOP**	**Performance Requirements**
2.1	**ID Card Processing Time**	X	X	For the Individual Exchange: Expectation: 99% of ID cards issued within 10 business days of receiving complete and accurate enrollment information and binder payment for a specific consumer(s) For SHOP: Expectation: 99% of ID cards issued within 10 business days of receipt of complete and accurate enrollment information for a specific consumer(s). Performance Level: <99%: 5% performance penalty.
2.2	**Enrollment and payment transactions** **3 month pilot period: 1/1/15-3/31/15** **Measurement period: 4/1/15-12/31/15**	X		Expectation: The Exchange will receive the 999 file within two to three business days of receipt of the 834 file 85% of the time. Performance Level: <85%: 5% performance penalty.
2.3	**Reconciliation of Pended Status Enrollee(s)** **3 month pilot period: 1/1/15-3/31/15** **Measurement period: 4/1/15-12/31/15**	X		Expectation: The Exchange will receive the effectuation 834 file within 60 days from effective date of member 90% of the time. Performance Level: <90%: 5% performance penalty
2.4	**Reconciliation Process** **3 month pilot period: 1/1/15-3/31/15**	X		Expectation: For non-payment, the Exchange will receive an 834 cancellation file within 60 days of the members intended effective date 90% of the time. Performance Level: <90%: 5%

Group 2: Operational Performance Standards 30% of Total Performance Penalty or 5% Credit				
Performance Standard		**Individual**	**SHOP**	**Performance Requirements**
	Measurement period: 4/1/15-12/31/15			performance penalty
2.5	**Data Submission specific to contract Section 3.07(b) Network Requirements and Attachment 7, Section 3.03 Data Submission**	X	X	Expectation: Full and regular submission of data according to the standards outlined. 10% of total performance penalty at risk. Performance Level: Incomplete, irregular, late or non-useable data submission: 10% penalty of total performance requirement. Full and regular submission according to the formats specified and useable by Covered California within 30 days of each quarter end: no penalty.

<table>
<tr><td colspan="3">Group 3: Covered California Performance Standards

Quality, Network Management and Delivery System Standards

45% of total Performance Penalty or Credit for Measurement Year 2015 and thereafter

Covered California and Contractor shall work together to periodically review and adjust the specific measures consistent with any applicable Federal regulations.</td></tr>
<tr><td colspan="2">Performance Standard</td><td>Performance Requirements</td></tr>
<tr><td>3.1</td><td>Quality Rating System (QRS)- Access to Care; related to Attachment 7, Section 3.01. Specific measures noted in Appendix 1 to this Attachment 14.</td><td><u>Expectation</u>: Access to Care Domain Rating - QHP Enrollee Survey (product type reporting):

<u>Performance Level</u>: <50th PCT: 5% performance penalty. 50-75th PCT: no penalty. >75th PCT: 5% performance credit. The credit/penalty will be based on a regional-national blended marketplace benchmark. Covered California will use a single benchmark for all product types.</td></tr>
</table>

Group 3: Covered California Performance Standards Quality, Network Management and Delivery System Standards 45% of total Performance Penalty or Credit Covered California and Contractor shall work together to periodically review and adjust the specific measures consistent with any applicable Federal regulations.		
Performance Standard		**Performance Requirements**
3.2	**Quality Rating System (QRS) - Doctors & Care; related to Attachment 7, Section 3.01. Specific measures noted in Appendix 1 to this Attachment 14.**	Expectation: -Doctors and Care Domain Rating - QHP Enrollee Survey -(product type reporting) Performance Level: <50th PCT: 5% performance penalty. 50-75th PCT: no penalty. >75th PCT: 5% performance credit. The credit/penalty will be based on a regional-national blended marketplace benchmark. Covered California will use a single benchmark for all product types.
3.3	**Quality Rating System (QRS) - Plan Service; related to Attachment 7, Section 3.01. Specific measures noted in Appendix 1 to this Attachment 14.**	Expectation: Plan Service Domain Rating - QHP Enrollee Survey (product type reporting) Performance Level: <50th PCT: 5% performance penalty. 50-75th PCT: no penalty. >75th PCT: 5% performance credit. The credit/penalty will be based on a regional-national blended marketplace benchmark. Covered California will use a single benchmark for all product types.

Group 3: Covered California Performance Standards Quality, Network Management and Delivery System Standards 45% of total Performance Penalty or Credit Covered California and Contractor shall work together to periodically review and adjust the specific measures consistent with any applicable Federal regulations.		
Performance Standard		**Performance Requirements**
3.4	**QHP Contract Compliance: Completion of Covered California eValue8 Request For Information (RFI) annual submission – specific to Attachment 7, Section 3.04, Appendix 2 to Attachment 7, Reports 4.1 – 4.15**	Expectation: Total Covered California eValue8 performance, 300 points total available. 20% of total performance penalty at risk. Performance Level: 1. < 40% of total points (<120 points earned): 20% performance penalty. 2. 40-74% of total points (120 – 222 points earned): no penalty. 3. 75% or greater of total points (223 – 300 points earned): 20% performance credit.
3.5	**Essential Community Providers – Article 3, Section 3.08**	Expectation: 10% of total performance penalty at risk. Contractor shall maintain a network that includes a sufficient geographic distribution of essential community providers to provide reasonable and timely access to Covered Services for low income populations in regions served by Contractor. Contractor to demonstrate provider agreements with at least 15% of 340B non-hospital providers in each applicable rating region. Contractor to demonstrate provider agreements that reflect a mix of essential community providers (hospital and non-hospital) reasonably distributed to serve the low-income populations. Performance Level: 1. Sufficient ECP participation: 10% performance credit. 2. Developing ECP participation: no penalty or credit. 3. Insufficient ECP participation: 10% performance penalty. Alternate Standard Contractor Expectation: Contractor to produce access map to demonstrate low income, medically underserved enrollee access to health care services. Low income, medically underserved individuals shall be defined as those Covered California enrollees who fall below 200 percent of the Federal Poverty Level (FPL). Maps shall demonstrate the extent to which provider sites are accessible to and have services that meet the needs of specific underserved populations, including:

		• Individuals with HIV/AIDS • American Indians and Alaska Natives • Low income and underserved individuals seeking women's health and reproductive health services • Other specific populations served by Essential Community Providers in the service area such as STD Clinics, Tuberculosis Clinics, Hemophilia Treatment Centers, Black Lung Clinics and other entities that serve predominantly low income, medically underserved individuals. Performance level: Alternate Standard Contractors shall not be eligible for performance credits, nor shall they be subject to performance penalties. Submission of the above required mapping is a contract compliance requirement.

Group 4: Covered California Performance Standards for Covered California

Potential 25% Credit

Customer Service Measures		Covered California Performance Requirements
4.1	**Call Answer Timeliness for Covered California**	Expectation: 80% of calls answered in 30 seconds or less. 6.25% of total performance penalty at risk available as a potential credit towards Contractor's performance penalties. Performance Level: <80%: 6.25% performance credit. 80%-90%: no credit. >90%: 6.25% reduction in performance credit.
4.2	**Telephone Abandonment Rate for Covered California**	Expectation: No more than 3% of incoming calls in a calendar month. 6.25% of total performance penalty at risk available as a potential credit towards Contractor's performance penalties. Performance Level: >3% abandoned: 6.25% performance credit. 2-3% abandoned: no credit. <2% abandoned: 6.25% reduction in performance credit.
4.3	**Initial Call Resolution for Covered California**	Expectation: 85% of enrollee issues will be resolved within one (1) business day of receipt of the issue. 6.25% of total performance penalty at risk available as a potential credit towards Contractor's performance penalties. Performance Level: <85%: 6.25% performance credit. 85-95%: no credit. >95%: 6.25% reduction in performance credit.
4.4	**Grievance Resolution for Covered California**	Expectation: 95% of enrollee grievances resolved within 30 calendar days. 6.25% of total performance penalty at risk available as a potential credit towards Contractor's performance penalties. Performance Level: <95% resolved within 30 calendar days: 6.25% performance credit. 95% or greater resolved within 30 calendar days: no credit. 95% or greater resolved within 15 calendar days: 6.25% reduction in performance credit

Appendix 1 to Attachment 14. Quality, Network Management and Delivery Systems Standards

Covered California Performance Requirements, Group 3, 3.1-3.3

3.1 Quality Rating System – (QRS) - Access to Care Member Experience

Access to Care Domain Rating
Getting Care Quickly Composite • In the last 12 months, when you needed care right away, how often did you get care as soon as you thought you needed? • In the last 12 months, not counting the times you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?
Getting Needed Care Composite • In the last 12 months, how often was it easy to get appointments with specialists? • In the last 12 months, how often was it easy to get the care, tests, or treatment you thought you needed through your health plan?

3.2 Quality Rating System – (QRS) – Doctors and Care Member Experience

Doctor and Care Domain Rating
Global Rating of Health Care
Global Rating of Personal Doctor
Global Rating of Specialist

3.3 Quality Rating System (QRS) - Plan Service Member Experience

Plan Service Domain Rating
Customer Service Composite • In the last 12 months, how often did your health plan's customer service give you the information or help you needed? • In the last 12 months, how often did your health plan's customer service staff treat you with courtesy and respect?
Global Rating of Plan

Individual Group 1: Customer Service Performance Standards - 25% of Total Performance Penalty or Credit								
		Total Participation Fee Penalty or Credit in Percentages		*Total Participation Fee Penalty or Credit in Dollars*		**Expectation**		
#	**Performance Measure**	**Maximum Penalty**	**Maximum Credit**	**Maximum Penalty**	**Maximum Credit**	**Maximum Penalty**	**No Penalty**	**Credit**
1.1	Inbound Call Volume	Reporting Measures Only						
1.2	Abandoned Call Volume							
1.3	Call Answer Timeliness	-0.5%	0.5%	($0.07)	$0.07	<80%	80%-90%	>90%
1.4	Telephone Abandonment Rate	-0.5%	0.5%	($0.07)	$0.07	>3%	2%-3%	<2%
1.5	Initial Call Resolution	-0.5%	0.5%	($0.07)	$0.07	<85%	85%-95%	>95%
1.6	Grievance Resolution	-0.5%	0.5%	($0.07)	$0.07	<95%	>95%	>95%[1]
1.7	Member Email or Written Inquiries	Reporting Measure Only						
1.8	Member E-Mail or Written Inquiries Answered	-0.5%	0.5%	($0.07)	$0.07	<90%	90%-95%	>95%
Total Group 1 Customer Service Performance		**-2.5%**	**2.5%**	**($0.35)**	**$0.35**			

Note 1. Credit is based on 95% or greater resolved with 15 calendar days of receipt

Individual Group 2: Operational Performance Standards - 30% of Total Performance Penalty								
		Total Participation Fee Penalty in Percentages		*Total Participation Fee Penalty in Dollars*		**Expectation**		
#	**Performance Measure**	**Maximum Penalty**	**Maximum Credit**	**Maximum Penalty**	**Maximum Credit**	**Maximum Penalty**	**No Penalty**	**Credit**
2.1	ID Card Processing Time	-0.5%	N/A	($0.07)	N/A	<99%	99% or greater	N/A
2.2	Enrollment and Payment Transactions	-0.5%	N/A	($0.07)	N/A	<85%	85% or greater	N/A
2.3	Reconciliation of Pended Status Enrollee(s)	-0.5%	N/A	($0.07)	N/A	<90%	90% or greater	N/A
2.4	Reconciliation Process	-0.5%	N/A	($0.07)	N/A	<90%	90% or greater	N/A
2.5	Data Submission specific to contract Section 3.07(b) and Attach 7, Section 3.03	-1.0%	N/A	($0.14)	N/A	>30 days	30 days or less	N/A
Total Group 2 Operational Performance Standards		**-3.0%**	**N/A**	**($0.42)**	**N/A**			**N/A**

Individual Group 3: Quality, Network Management and Delivery Standards 45% of Total Performance Penalty or Credit								
		Total Participation Fee Penalty or Credit in Percentages		*Total Participation Fee Penalty or Credit in Dollars*		Expectation		
#	**Area of Performance**	**Maximum Penalty**	**Maximum Credit**	**Maximum Penalty**	**Maximum Credit**	**Maximum Penalty**	**No Penalty**	**Credit**
3.1	Quality Rating System (QRS)-Access to Care; related to Attachment 7, Section 3.01. Specific measures noted in Appendix 1 to this Attachment 14	-0.5%	0.5%	($0.07)	$0.07	<50th PCT	50-75th PCT	>75th PCT
3.2	Quality Rating System (QRS) - Doctors & Care; related to Attachment 7, Section 3.01. Specific measures noted in Appendix 1 to this Attachment 14	-0.5%	0.5%	($0.07)	$0.07	<50th PCT	50-75th PCT	>75th PCT
3.3	Quality Rating System (QRS) - Plan Service; related to Attachment 7, Section 3.01. Specific measures noted in Appendix 1 to this Attachment 14	-0.5%	0.5%	($0.07)	$0.07	<50th PCT	50-75th PCT	>75th PCT
3.4	QHP Contract Compliance: Completion of Covered California eValue8 Request For Information (RFI) annual submission - specific to Attachment 7, Section 3.04, Appendix 2 to Attachment 7, Reports 4.1 - 4.15	-2.0%	2.0%	($0.28)	$0.28	<40%	40-74%	75% or greater
3.5	Essential Community Providers - Article 3, Section 3.08	-1.0%	1.0%	($0.14)	$0.14	<15%	developing	15% or greater
Total Group 3 Operational Performance Standards		**-4.5%**	**4.5%**	**($0.63)**	**$0.63**			
Total Groups 1-3 Performance Standards [2]		**-10.0%**	**7.0%**	**($1.40)**	**$0.98**			

Note 2. Performance Measurement Standards at risk is 10% of Participation Fee which is $13.95 PMPM in 2015

Group 4: Covered California Peformance Standards - Individual								
		Total Participation Fee Credit or Credit Reduction in Percentages		*Total Participation Fee Credit or Credit Reduction in Dollars*		Expectation		
#	**Performance Measure**	**Maximum Credit**	**Maximum Credit Reduction**	**Maximum Credit**	**Maximum Credit Reduction**	**Maximum Credit**	**No Credit**	**Reduction in Performance Credit**
4.1	Call Answer Timeliness	-0.625%	0.625%	($0.09)	$0.09	<80%	80%-90%	>90%
4.2	Telephone Abandonment Rate	-0.625%	0.625%	($0.09)	$0.09	>3%	2%-3%	<2%
4.3	Initial Call Resolution	-0.625%	0.625%	($0.09)	$0.09	<85%	85%-95%	>95%
4.4	Grievance Resolution	-0.625%	0.625%	($0.09)	$0.09	<95%	>95%	>95%[1]
Total Group 4 Customer Service Performance		**-2.5%**	**2.5%**	**($0.36)**	**$0.36**			

Note 1. Reduction in Performance Credit is based on 95% or greater resolved in 15 calendar days of receipt

SHOP Group 1: Customer Service Performance Standards - 62% of Total Performance Penalty or Credit								
		Total Participation Fee Penalty or Credit in Percentages		*Total Participation Fee Penalty or Credit in Dollars*		**Expectation**		
#	**Performance Measure**	**Maximum Penalty**	**Maximum Credit**	**Maximum Penalty**	**Maximum Credit**	**Maximum Penalty**	**No Penalty**	**Credit**
1.1	Inbound Call Volume	Reporting Measures Only						
1.2	Abandoned Call Volume							
1.3	Call Answer Timeliness	-0.5%	0.5%	($0.09)	$0.09	<80%	80%-90%	>90%
1.4	Telephone Abandonment Rate	-0.5%	0.5%	($0.09)	$0.09	>3%	2%-3%	<2%
1.5	Initial Call Resolution	-0.5%	0.5%	($0.09)	$0.09	<85%	85%-95%	>95%
1.6	Grievance Resolution	-0.5%	0.5%	($0.09)	$0.09	<95%	>95%	>95%[1]
1.7	Member Email or Written Inquiries	Reporting Measure Only						
1.8	Member E-Mail or Written Inquiries Answered	-0.5%	0.5%	($0.09)	$0.09	<90%	90% - 95%	>95%
Total Group 1 Customer Service Performance		**-2.5%**	**2.5%**	**($0.45)**	**$0.45**			

Note 1. Credit is based on 95% or greater resolved within 15 calendar days of receipt

SHOP Group 2: Operational Performance Standards - 38% of Total Performance Penalty or Credit								
		Total Participation Fee Penalty or Credit in Percentages		*Total Participation Fee Penalty or Credit in Dollars*		**Expectation**		
#	**Performance Measure**	**Maximum Penalty**	**Maximum Credit**	**Maximum Penalty**	**Maximum Credit**	**Maximum Penalty**	**No Penalty**	**Credit**
2.1	ID Card Processing Time	-0.5%	N/A	($0.09)	N/A	<99%	99% or greater	N/A
2.5	Data Submission specific to contract Section 3.07(b) and Attach 7, Section 3.03	-1.0%	N/A	($0.19)	N/A	>30 days	30 days or less	N/A
Total Group 2 Operational Performance Standards		**1.5%**	**0.0%**	**($0.28)**	**$0.00**			
Total Groups 1-2 Performance Standards [2]		**4.0%**	**2.5%**	**($0.73)**	**$0.45**			

Note 2. Performance Measurement Standards at risk is 4.0% of Participation Fee which is $18.60 PMPM in 2015

Group 4: Covered California Peformance Standards - SHOP									
		Total Participation Fee Credit or Credit Reduction in Percentages		*Total Participation Fee Credit or Credit Reduction in Dollars*		**Expectation**		
#	**Performance Measure**	**Maximum Credit**	**Maximum Credit Reduction**	**Maximum Credit**	**Maximum Credit Reduction**	**Maximum Credit**	**No Credit**	**Reduction in Performance Credit**
4.1	Call Answer Timeliness	-0.625%	0.625%	($0.12)	$0.12	<80%	80%-90%	>90%
4.2	Telephone Abandonment Rate	-0.625%	0.625%	($0.12)	$0.12	>3%	2%-3%	<2%
4.3	Initial Call Resolution	-0.625%	0.625%	($0.12)	$0.12	<85%	85%-95%	>95%
4.4	Grievance Resolution	-0.625%	0.625%	($0.12)	$0.12	<95%	>95%	>95%[1]
Total Group 4 Customer Service Performance		**-2.5%**	**2.5%**	**($0.48)**	**$0.48**			

Note 1. Reduction in Performance Credit is based on 95% or greater resolved in 15 calendar days of receipt